PRELIMINARY DRAFT
May 16, 1994 (10:51am)

GENERAL DESCRIPTION	**Benefit Package:** · To reduce the costs of the mandate to employers in the first few years, two benefit packages, a basic package and a standard package, would be defined. The basic package would be [20%] less than the standard package. Employer payment requirements would be based on the basic package. · Over a 5-year period, if federal saving are achieved, the value of the basic package would be phased-up to the value of the standard package. ‣ Savings would be assessed annually before benefits are expanded. **Firms with more than 20 employees:** · Employers would be required to pay 80% of the average premium for the basic benefit package. · Employers payments would be capped at a specified percentage of each worker's wage. Smaller firms would receive more generous subsidies. · All firms would be eligible for subsidies. **Firms with 20 or fewer employees ("exempt employers"):** · Exempt employers would not be required to provide coverage. · Exempt employers with fewer than 10 workers pay 1% of payroll. · Exempt employers with 11 to 20 workers pay 2% of payroll. · Employers with 20 or fewer employees that choose to cover their workers pay 80% of the average premium for the basic package and are eligible for subsidies. · The exemption would be eliminated if 90% of currently uninsured workers are not insured by 1998 and 95% insured by 2000. **Tax treatment:** – Tax treatment of employer contributions is the same as in the HSA. **Maintenance of Effort:** OPTION, require employers that currently contribute more than the cost of the basic package to maintain effort (modelling should assume MOE).

Gary: reflects most issues.

+ allows more discrimination in form out
+ adverse selection to standard, c mkt
+ supplemental at all to either?

Jerry

GENERAL DESCRIPTION (Continued).	**Families:** · Families working for nonexempt employers pay the difference between the 80% of the average premium for the basic package and the premium of the plan they choose. · Families working for exempt employers pay the entire premium. · Families choosing the standard package are responsible for the full difference between the two packages. · Low-income families are capped at a percentage of income for the family share for the basic package. · Families working for exempt employers are capped at percentage of income for the entire premium for the basic package. · Special subsidies toward cost-sharing are provided for low-income families during the phase-in period. **Cost Containment:** · Reverse trigger approach. **Subsidies:** · Federal subsidy costs are capped as in HSA **Community Rating:** · The threshold for community rating is reduced to firms with 1000 or fewer employees. · Firms above the threshold would pay a payroll surcharge of 1%.

DETAILED SPECIFICATIONS	
. Structure	· Each health plan would offer two benefit packages, a basic package and a standard package. · Employers would be required to pay 80% of the average premium for the basic benefit package. Employers could pay more (toward the standard package or for supplemental benefits). · Families would be required to have at least the basic package. · All families, including families working for exempt employers, could choose either package. Families would pay the difference between the basic and standard package (without subsidies, although employers may contribute).
. Benefit package; phase-in	Two benefit packages, a standard package and a basic package. Basic package phases-up to standard package over five years. Standard package: · HSA benefit package (with 5% reduction). ▸ FFS and HMO packages as in HSA, with 5% reduction as in Energy and Commerce Staff Draft. Basic package (still under development): · [20%][1] lower value than standard package. ▸ FFS package with higher (e.g., $1500 - $2000) hospital deducible and higher (e.g., 25%) coinsurance; reduce value of other benefits through higher cost sharing or limits. Preserve preventive care (either with minor copayments or put in the wrap package for children). ▸ HMO package would closely resemble FFS package, with copayments rather than coinsurance. · Federal deficit reduction targets would be incorporated into law. Annual reviews would be conducted to determine if targets met. Benefit expansion would occur only if deficit reduction target is met. ▸ Deficit reduction target would be $50-100 B over ten years (assume lower targets in early years).
	Issues: · With two different levels of benefits, adverse selection against the standard benefit package is a danger. Risk adjustment across the packages could increase the cost of the basic package (Jim is working on this).

[1] Three scenarios should be tested, with the value of the basic package 10%, 15% and 20% less than the standard package.

. Employer Payments	Firms with more than 20 employees: · Employers generally would be required to pay 80% of the average per worker premium for the basic benefit package. ▸ Employer payment for each worker would be capped at the lower of 80% of the average per worker premium or a specified percentage of the worker's wages (Scenario A schedule). ▸ Large firms (over 1000 threshold) would be eligible for subsidies based on the average per worker premium for community- rated employers in the area. Exempt firms: · Exempt employers would not be required to provide coverage. ▸ Exempt employers with fewer than 10 workers pay 1% of payroll. ▸ Exempt employers with 11 to 20 workers pay 2% of payroll. · Employers with 20 or fewer employees that choose to cover their workers are treated as above. · The exemption would be eliminated if specified percentages of the population are not covered by specified dates: ▸ 90% of currently uninsured working families must be insured by 1998; ▸ 95% of currently uninsured working families must be insured by 2000. Self-employed people: · OPTION 1. Self-employed people with employees are treated as employees of themselves and are eligible for exemption. Self-employed people without employees pay as under the HSA (e.g., self-employed with working spouses make payments that are applied to reduce federal subsidies). · OPTION 2. All self-employed people are eligible for exemption.

by employers

Chris Williams · is mandate how to pay includes mandate right

. Employer Payments (Continued)	Per worker premiums: The per worker premium calculation would be based on the employer contributions for the basic package; employer contributions above the amount required (including any payment toward the difference between the basic package and the standard package) would be considered to offset family payment responsibility. Firms with fewer than 20 employee that choose to provide coverage are counted in per worker premium calculation.
. Family Payments	Families working for nonexempt firms (including exempt firms that choose to provide coverage): · Families pay 20% of the average premium for the basic package. · Low-income families are capped at a percentage of income for the family share for the basic package. (Scenario A subsidies). Families working for exempt employers: · Families working for exempt employers pay the entire premium (a per worker employer share and a family share) for the basic package. · Families working for exempt employers are capped at a percentage of income for the entire premium. ‣ The cap ranges from 4–6% (Kennedy schedule for exempt workers). Nonworking families: · Nonworkers pay toward the employer share as under Scenario A. Families choosing standard package: · Families choosing the standard package are responsible for the full difference between the basic and standard packages. · No subsidies apply to the difference. Special rules for dual earners: · Families with a worker in an exempt firm and a worker in a nonexempt firm are treated as a family working for a nonexempt firm.

. Subsidies	Federal costs for subsidies are capped as under the HSA. Employers: · Employer payments for an employee for the basic plan are capped at 2.8% to 12% of the employee's wages. (The Scenario A subsidy schedule applies.) · Caps apply to all employers. For experience rated employer, payments are subsidized only up to the level of required employer contributions for the basic plan in the appropriate community rating area. Families: · Family payments for the family share of the basic plan are capped at 3.9% of income. (The Scenario A subsidy schedule applies.) · Families working for exempt employers are capped at 4-6% of income for the entire premium obligation (Kennedy schedule for exempt workers). · Payments for nonworking families for the employer share are based on nonwage income and are capped as under the Scenario A approach. · Special subsidies for cost-sharing are provided for low-income families during the benefit phase-in period. ‣ Low income families enroll in HMOs (if available). For those under poverty, the difference between the standard HMO cost-sharing and the basic HMO cost-sharing is fully subsidized. For those with incomes below 150% [200%?] of poverrty a portion of the difference would be subsidized (on a sliding scale basis). ‣ If no HMO is available, low-income families would be subsidized to the same extent in a non-HMO plan. Self-employed: · OPTION 1. Self-employed people without employees pay as under Scenario A (e.g., self-employed without employees capped at small employer schedule). · OPTION 2. All self-employed people are treated as exempt workers unless they employ more than 20 workers in their firm.

. **Community rating threshold**	Firms with 1000 or fewer employees are part of community rated pools. · Large firms cannot elect to be community rated. · Taft-Hartley trusts and rural electric and telephone cooperatives can elect to be experience rated. · State and local governments are community-rated employers. · All experience rated employers (including state and local governments) pay a 1% of payroll surcharge.
. **Cost containment**	· Constrain initial premiums (as under HSA) and growth rates as follows: ▸ OPTION 1. HSA growth rates. ▸ OPTION 2. ~~Managed competition growth rates~~ through 1998, HSA growth rates thereafter. HSA -> MC

TECHNICAL ASSISTANCE REQUEST SHEET

NAME: CJ

DATE: _____

PRIORITY: (1)

SAME OR NEXT DAY: _____ WITHIN 2 WEEKS: _____
2 TO 3 DAYS: _____ OTHER: _____
WITHIN 1 WEEK: _____

REQUEST FROM: John Hilley

COMMITTEE: _____

PHONE: _____ FAX: _____

REQUEST: (1) Breen trigger modification model (1 page CJ has)
- need to do a run
- 100 above; 3 1st yrs → 95-26 after 5 years. 25-1
w/ Indiv. mandate need as back-up. → 5 years
if no trigger pulled; full coverage of non-working.
After 5 years → leftovers must purchase.

ASSIGNMENT:

TO: _____

DATE: _____

DUE DATE: _____

STATUS:

ASSIGNED _____ OMB REVIEW _____ COMPLETED _____

NOTE: _____

TECHNICAL ASSISTANCE REQUEST SHEET

NAME: CJ

DATE: _____

PRIORITY: (2)

SAME OR NEXT DAY: _____ WITHIN 2 WEEKS: _____
2 TO 3 DAYS: _____ OTHER: _____
WITHIN 1 WEEK: _____

REQUEST FROM: Mitchell → John Hilley

COMMITTEE: _____

PHONE: _____ FAX: _____

REQUEST: (1) Trigger carve out model - 20/10 - 2/1 financing out compassment model w/ Cat benefit pkg phased-in to comp be- Pkg over 5 years.

(2) release prem. cap mech.

ASSIGNMENT:

TO: (3) Ken | (4) JK | - (2) Len / (1) Nancy Ann (5) Gary C.

DATE: _____

DUE DATE: by (6/30) Tues - (6/2) Thurs

STATUS:

ASSIGNED ✓ OMB REVIEW _____ COMPLETED _____

NOTE: _____

TECHNICAL ASSISTANCE REQUEST SHEET

NAME: _____

DATE: _____

PRIORITY: (3)

SAME OR NEXT DAY: _____ WITHIN 2 WEEKS: _____
2 TO 3 DAYS: _____ OTHER: _____
WITHIN 1 WEEK: _____

REQUEST FROM: Mitchell.

COMMITTEE: _____

PHONE: _____ FAX: _____

REQUEST: Breaux model overlayed on priority (2) (1+2 combined).

ASSIGNMENT:

TO: _____

DATE: _____

DUE DATE: _____

STATUS:

ASSIGNED _____ OMB REVIEW _____ COMPLETED _____

NOTE: _____

TECHNICAL ASSISTANCE REQUEST SHEET

NAME: _____

DATE: _____

PRIORITY:

SAME OR NEXT DAY: _____ WITHIN 2 WEEKS: _____
2 TO 3 DAYS: _____ OTHER: _____
WITHIN 1 WEEK: _____

REQUEST FROM: Nancy Ann Min / CJ / Paulette / IM

COMMITTEE: _____

PHONE: _____ FAX: _____

REQUEST: (1) Labor Committee mark → Budget implications of the entire mark.

ASSIGNMENT:

TO: Len / Nancy Ann.

DATE: _____

DUE DATE: by Wed.

STATUS:

ASSIGNED ✓ OMB REVIEW _____ COMPLETED _____

NOTE: _____

Actuarial Research Corporation
6928 Little River Turnpike, Suite E
Annandale, Virginia 22003

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(703) 941-7400
FAX (703) 941-3951

Date: 26 May 94

---------*Please Deliver Immediately*---------

To: Jennifer Klein

From: Jim Mays

Re:

Memo: HSA minus 5 minus 10, 15, 20%

Gordon is working on HMO's - 20% more may not be practical in a reasonable manner

We are transmitting 2 pages (including this transmittal sheet).

MEMORANDUM

To : Jennifer Klein

From : Jim Mays

Subject : More Cost-sharing Variations - (Fee-for-service only)

Copy : Ken Thorpe

Following up on your request for options to cut 10%, 15%, and 20% off the "HSA-5%" level, here are cost-sharing changes which should generate approximately these additional savings.

Additional 10% cut:

deductible = $500/$1,000
coinsurance = 25%
cost-sharing maximum = $2,500/$3,000

Additional 15% cut:

deductible = $700/$1,400
coinsurance = 25%
cost-sharing maximum = $3,000/$3,000

Additional 20% cut:

deductible = $1000/$2,000
coinsurance = 25%
cost-sharing maximum = $3,000/$3,000

ccsol
/a /s

MEMORANDUM

TO: SENATOR MITCHELL

DT: MAY 25, 1994

FR: YOUR HEALTH STAFF

RE: BREAUX PROPOSAL

It is impossible to provide any thorough assessment of the Breaux plan without knowing the answers to a slew of questions about just what he is proposing. We called his staff over to meet with us to provide such answers but the only thing he could tell us is that the proposal does not include a mandate on individuals.

As you will recall, that creates its own set of problems because without universal coverage it becomes much more problematic to do a premium cap, and we have to cutback on the scope of insurance market reforms, including community rating and pre-existing exclusion limitations. The more reform we do, the greater the potential instability we could create in the small business insurance market.

Moving beyond those questions, the basic question is what Breaux proposes to do to voluntarily expand employer coverage of health insurance. What kind of community rating would apply? What kind of pre-existing exclusions. More importantly, what kind of subsidies would be provided to encourage voluntary coverage?

And, if subsidies are provided, how are they financed? What is the definition of coverage of an employee, 80% of the premium, 50%? What is required of dependent coverage? How are part time and seasonal employees treated?

Another important question is what kind of subsidy would be assumed for nonworkers and how would those subsidies be financed? Does this assume elimination of the prescription drug and long term health care benefits for the elderly? Does that mean that the employer subsidies would be financed in large part by cutting Medicare costs?

If you add up his trigger levels, a mandate could be avoided while leaving 4.2 million employees without coverage. Just guessing, we would assume that would total about 10 million people after taking into account their dependents. Then we don't know how many more million would be left uncovered from the nonworking and part-time worker population.

We could fill in our own answers to these questions but we really don't know where to begin. Questions about subsidy levels, insurance market reform, financing, benefits, etc. go to the very heart of the proposal. And we can't start with the Cooper proposal because that is a system of household not employer subsidies.

Car @ 11:15 am

#67

Chris

Chris –
do you want a car for 10:50 to Heflin's office?

(Jon Kline should be attending Mtg. as well)

* Please note revised schedule for today

1. REVERSE TRIGGER:

Set-up for Middle Ground Solution: Neither the Clinton Plan nor the Republican plan adequately hit the middle ground necessary for a bipartisan compromise. The Clinton Plan is good for providing protection for families, businesses and the federal government deficit, yet it is not pro-competition enough because it calls for premium caps indefinitely -- not just during a temporary transitional period while competition starts to work. On the other hand, while some Republican plans rely purely on competition, they provide no protection against initial abuses by insurance companies. The insurance industry has never been subject to anti-trust enforcement, and while new competition and anti-trust enforcement should be fully effective in a only a few years, the federal government, families and businesses need to have protection against insurance companies jacking up prices or failing to return the windfall back to consumers.

What we need is a bipartisan middle ground protection that both has protection for families, businesses and the government against temporary abuse in the transition, yet relies ultimately on competition to bring prices down.

Presumption for Competition: First: We start with the proposition that once we fix the health care market, and ensure that it is up and running, competition -- not government controls -- will bring down costs.

Fiscal Responsibility: Competition should be given every chance to work, but we should let it do so within a framework that assumes that the deficit is not increased.

windfall recapture

Temporary Provisions to Ensure Health Cost Security or Temporary Consumer Protection: We also start with the proposition that in the first two years, both families, businesses and the federal deficit need protection against insurance companies hoarding windfalls that should be returned to consumers or in any way undercutting the competitive markets. The solution to this lies not in permanent premium caps, but a temporary windfall profits tax (consumer protection recapture) that *ensures that savings from uncompensated care are returned to consumers and to protecting the deficit* -- and are not hoarded by any party other than consumers.

Such a pro-consumer and pro-competition middle ground would work as follows:

1. Plans Relieved of Having to Charge More to Pay for Uninsured: Plans would be guaranteed that with universal coverage they would no longer have to pick up the costs for those without coverage.

2. Plans Must Return Savings to Families and Businesses: Yet, because they no longer have to pick up the costs of those without coverage, insurance companies have to do their part and no longer continue to charge extra on their premiums.

3. Plans Must Engage in Competitive Bidding: In each area, plans must engage in a competitive bidding process designed to ensure the lowest cost and highest quality for consumers.

4. Presumption of Competition Means Zero Price Regulation Where Competitive Markets Function Immediately: In competitive markets excessive prices and windfall profits should not happen. Because our starting principle is competition, there should be a presumption that competition works and, therefore, in the cases where prices in an area (alliance) show that overall -- on average, companies are not price-fixing or hoarding windfall -- there will be no government regulation of any kind.

5. Temporary Consumer Protection (Windfall Profits) Recapture: Yet, for the first two years, where overall prices in an area show that the windfall is not being passed back to consumers, the government will capture the extra costs from the high cost plans and use it to protect the government from increased costs to the deficit and consumers from being overcharged.

6. Competition that Protects the Deficit: After the two year period is over, competition should be allowed to exist -- as long as high cost plans do not have a negative effect in driving up the deficit. In that case, all plans that are not driving up the deficit should be held harmless, and those that drive up the deficit should be allowed to charge as high prices as they wish -- subject to the provision that these high cost plans, and only these high costs plans, would hold the federal government harmless.

2. STATE OPTION

Set Up for Middle Ground Solution: Right now we are engaged in a debate of arrogance from Washington. Ideolouges on both sides seek to dictate from Washington not only that every state must provide universal coverage, but one preferred option for how every state must control costs. Why? President Clinton's bottom line was universal coverage -- not a specific mechanism for ensuring cost control. Some Clintonites claim that health care can only work with premium caps. Others on the right say that states must make markets work right from the start -- with no authority to do anything to protect themselves from escalating prices, temporary price fixing or windfall profit hoarding. The fact is that neither side knows for sure what is best, and we should let states be in the driver seats.

Three principles:

1. Universal Coverage: Each state would be required to provide a core universal package to their citizens.

2. Deficit Reduction Through a Subsidy Entitlement Cap: States would essentially receive a "subsidy block grant" to ensure that they have adequate funds for universal coverage. Yet, states would have to live within their subsidy block grant to ensure that there is not a run on the federal deficit.

3. State Flexibility on Cost Control: Rather than having the federal government dictate one way and only one way to do cost controls, states would have options to whatever way they thought best -- as long as they did not require more funds from the federal budget. States have the option of a federal premium cap option to ensure that their subsidy block grants are sufficient to pay for subsidies necessary for universal coverage. States that provide full coverage and use less than their block grant, are allowed keep their remaining portion. States that rely on cost-control provisions that fail to maintain costs, must find the additional revenues to ensure universal coverage.

or:

3. Competition With State Option for Premium Caps: Our starting proposition should be that competition will work. Therefore, we should allow states to rely on competition to get costs down. Yet, so that states can provide protection to their families, businesses and treasuries, the federal government should provide states the default position of premium caps, an a back-up protection -- particularly in the first few years of the plan.

Hiller desires:

- Reverse Trigger w/ without caps
- Pay as you go - Basic to Standard w/ trigger
- Board -> Fast-track rules
  - reduce benefits
  - add premium caps
  - raise taxes
- Initial premium Cost windfall

Vice P. 662-6384

4 years - 1999

- How cost [illegible]

- Wednesday - Hawaii or Florida
- Cancer presentation 30/40
- [illegible] - Individual makes [illegible]

Dombeck
- Cost containment w/ should be savings.
- Don't use cost containment as device to pay for universal.

MAY3A.TXT Tuesday, May 3, 1994 3:37 pm Pag

Benefit Change Options for Premium Reductions (HSA Base)

1. 5% reduction

   a. Raise coinsurance from .2 to .25
   b. Raise cost-sharing maximum from $1,500 per person to $2,500
   c. Raise deductible from $200 per person to $325.

2. 10% reduction

   a. Raise coinsurance maximum to $2,000, raise deductible to $325, and cut mental health benefit to Blue Cross Standard Option level.
   b. Raise coinsurance maximum to $2,000, raise deductible to $325, and eliminate special preventive services package.
   c. Eliminate prescription drug coverage.
   d. Eliminate mental health coverage.

3. 20% reduction

   a. Raise coinsurance maximum to $2,000, raise deductible to $300, eliminate mental health coverage, and eliminate special preventive services package.

   b. Raise coinsurance maximum to $2,000, raise deductible to $325, eliminate prescription drug coverage, and eliminate special preventive services package.

4. 30% reduction

   a. Raise coinsurance maximum to $2,000, raise coinsurance rate to .25, eliminate mental health coverage, eliminate prescription drug coverage, and eliminate special preventive services package.

   b. Raise coinsurance maximum to $2,000, raise coinsurance rate to .25, raise deductible to $325, eliminate mental health coverage, and eliminate prescription drug coverage.

OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL # of pages ►

To Chris Jennings | From Ken Thorpe

Dept./Agency | Phone #

Fax # | Fax #

5/25/94

TABLE 2
OPTION PACKAGE FOR 10% and 15% HMO REDUCTIONS (HSA BASE)

In order to get a 10% or 15% reduction all of the following would be needed:

Change	HSA	-10%	-15%
Hosptial or specialized facilities admission deductible	0	$250	$400
Emergency Room Use (includes physician charges	$10	$100	$150
Inpatient Surgery (in addition to hospital deductible)	$10	$100	$150
Delivery (in addition to hospital deductible)	$10	$100	$150
Outpatient Surgery (includes facility charge):			
Outpatient hospital	$10	$50	$75
Freestanding facility	$10	$25	$35
Office Surgery	$10	$15	$20
Physician, dental visits, Other practioners (other than prevention, ADM, and vision)	$10	$15	$20
ADM residential or outpatient	$25	$35	$45
Routine vision exams	$10	$25	$35
Home Health Care	$10	$15	$20
Ambulance	0	$50	$75
DME	0	20%	30%
Prescription Drugs	$5	$10	$15

OPTIONAL FORM 99 (7-90)
FAX TRANSMITTAL # of pages ► 1
To LEN OR CHRIS J. From KEN T.
Dept./Agency Phone #
Fax # Fax #

	Model 1
Total Employer Payments 1 Year (1994) ($m)	226,847
Average Employer Payments per Family	2,192
Total Family Payments 1 Year (1994) ($m)	60,398
Average Family Direct Premium Payments	584
Government Subsidies: 1 Year (1994) ($m)	82,096
employer	34,489
household	47,607
Government Subsidies: 5 Years ($m)	359,906
employer	145,199
household	214,708
Government Subsidies: 10 Years ($m)	962,004
employer	412,144
household	549,861
Select Revenue Estimates: *	
Corporate Assessment	40,600
Other Revenue	24,600
Total (5 Years)	65,200
Select Revenue Estimates: *	
Corporate Assessment	81,200
Other Revenue	49,200
Total (10 Years)	130,400
Net Effect on Deficit * (5 Years)	(394)
Net Effect on Deficit * (10 Years)	(70,596)

Model 1: An 80% employer mandate on firms of all sizes.

Firms pay the lesser of the full employer premium share or 5.5% to 12% of that worker's wages, whichever is less. Cap is determined by firm size and average wage in the firm. Firms of all sizes are eligible for these caps.

Firms of 1000 workers or more pay a 1% payroll assessment.

Firms of 1000 workers or more are outside of the community rating pool.

Premiums are equal to the CBO scoring of the HSA.

	Model 2
Total Employer Payments 1 Year (1994) ($m)	218,242
Average Employer Payments per Family	2,108
Total Family Payments 1 Year (1994) ($m)	57,430
Average Family Direct Premium Payments	555
Government Subsidies: 1 Year (1994) ($m)	75,567
employer	30,800
household	44,767
Government Subsidies: 5 Years ($m)	381,567
employer	129,668
household	201,899
Government Subsidies: 10 Years ($m)	885,119
employer	368,060
household	517,059
Select Revenue Estimates: *	
Corporate Assessment	41,000
Other Revenue	27,000
Total (5 Years)	68,000
Select Revenue Estimates: *	
Corporate Assessment	82,000
Other Revenue	54,000
Total (10 Years)	136,000
Net Effect on Deficit * (5 Years)	(31,533)
Net Effect on Deficit * (10 Years)	(153,081)

Model 2: An 80% employer mandate on firms of all sizes.

Firms pay the lesser of the full employer premium share or 5.5% to 12% of that worker's wages, whichever is less. Cap is determined by firm size and average wage in the firm. Firms of all sizes are eligible for these caps.

Firms of 1000 workers or more pay a 1% payroll assessment.

Firms of 1000 workers or more are outside of the community rating pool.

Premiums are 5% below the CBO scoring of the HSA.

	Model 3
Total Employer Payments 1 Year (1994) ($m)	207,655
Average Employer Payments per Family	2,006
Total Family Payments 1 Year (1994) ($m)	63,320
Average Family Direct Premium Payments	612
Government Subsidies: 1 Year (1994) ($m)	83,218
employer	25,130
household	58,088
Government Subsidies: 5 Years ($m)	373,982
employer	130,912
household	243,069
Government Subsidies: 10 Years ($m)	1,009,331
employer	419,118
household	590,213
Select Revenue Estimates: *	
Corporate Assessment	45,200
Other Revenue	36,080
Total (5 Years)	81,280
Select Revenue Estimates: *	
Corporate Assessment	86,200
Other Revenue	64,080
Total (10 Years)	150,280
Net Effect on Deficit * (5 Years)	(2,398)
Net Effect on Deficit * (10 Years)	(43,149)

Model 3: An 80% employer mandate on firms of more than 20 workers. If after 3 years, 90% of workers in firms of 20 or less do not receive employment based coverage, a full employer mandate is implemented.

Firms covering their workers pay the lesser of the employer premium share or 2.8% to 12% of that worker's wages, whichever is less. Cap is determined by firm size and average wage in the firm.

Firms not covering their workers pay a payroll assessment of 1% if firm has 1-10 workers and 2% if 11-20 workers.

Firms of 1000 workers or more are outside of the community rating pool and pay a 1% payroll assessment.

Families not receiving coverage through their employer have their contributions capped at 4-6% of income; appropriate cap is determined by family income.

Premiums are 5% below the CBO scoring of the HSA.

	Model 1
Total Employer Payments 1 Year (1994) ($m)	226,847
Average Employer Payments per Family	2,192
Total Family Payments 1 Year (1994) ($m)	60,398
Average Family Direct Premium Payments	584
Government Subsidies: 1 Year (1994) ($m)	82,096
employer	34,489
household	47,607
Government Subsidies: 5 Years ($m)	359,906
employer	145,199
household	214,708
Government Subsidies: 10 Years ($m)	962,004
employer	412,144
household	549,861
Select Revenue Estimates: *	
Corporate Assessment	40,600
Other Revenue	24,600
Total (5 Years)	65,200
Select Revenue Estimates: *	
Corporate Assessment	81,200
Other Revenue	49,200
Total (10 Years)	130,400
Net Effect on Deficit * (5 Years)	(394)
Net Effect on Deficit * (10 Years)	(70,596)

Model 1: An 80% employer mandate on firms of all sizes.

Firms pay the lesser of the full employer premium share or 5.5% to 12% of that worker's wages, whichever is less. Cap is determined by firm size and average wage in the firm. Firms of all sizes are eligible for these caps.

Firms of 1000 workers or more pay a 1% payroll assessment.

Firms of 1000 workers or more are outside of the community rating pool.

Premiums are equal to the CBO scoring of the HSA.

	Model 2
Total Employer Payments 1 Year (1994) ($m)	218,242
Average Employer Payments per Family	2,108
Total Family Payments 1 Year (1994) ($m)	57,430
Average Family Direct Premium Payments	555
Government Subsidies: 1 Year (1994) ($m)	75,567
employer	30,800
household	44,767
Government Subsidies: 5 Years ($m)	331,567
employer	129,668
household	201,899
Government Subsidies: 10 Years ($m)	885,119
employer	368,060
household	517,059
Select Revenue Estimates: *	
Corporate Assessment	41,000
Other Revenue	27,000
Total (5 Years)	68,000
Select Revenue Estimates: *	
Corporate Assessment	82,000
Other Revenue	54,000
Total (10 Years)	136,000
Net Effect on Deficit * (5 Years)	(31,533)
Net Effect on Deficit * (10 Years)	(153,081)

Model 2: An 80% employer mandate on firms of all sizes.

Firms pay the lesser of the full employer premium share or 5.5% to 12% of that worker's wages, whichever is less. Cap is determined by firm size and average wage in the firm. Firms of all sizes are eligible for these caps.

Firms of 1000 workers or more pay a 1% payroll assessment.

Firms of 1000 workers or more are outside of the community rating pool.

Premiums are 5% below the CBO scoring of the HSA.

	Model 3
Total Employer Payments 1 Year (1994) ($m)	207,655
Average Employer Payments per Family	2,006
Total Family Payments 1 Year (1994) ($m)	63,320
Average Family Direct Premium Payments	612
Government Subsidies: 1 Year (1994) ($m)	83,218
employer	25,130
household	58,088
Government Subsidies: 5 Years ($m)	373,982
employer	130,912
household	243,069
Government Subsidies: 10 Years ($m)	1,009,331
employer	419,118
household	590,213
Select Revenue Estimates: *	
Corporate Assessment	45,200
Other Revenue	36,080
Total (5 Years)	81,280
Select Revenue Estimates: *	
Corporate Assessment	86,200
Other Revenue	64,080
Total (10 Years)	150,280
Net Effect on Deficit * (5 Years)	(2,398)
Net Effect on Deficit * (10 Years)	(43,149)

Model 3: An 80% employer mandate on firms of more than 20 workers. If after 3 years, 90% of workers in firms of 20 or less do not receive employment based coverage, a full employer mandate is implemented.

Firms covering their workers pay the lesser of the employer premium share or 2.8% to 12% of that worker's wages, whichever is less. Cap is determined by firm size and average wage in the firm.

Firms not covering their workers pay a payroll assessment of 1% if firm has 1-10 workers and 2% if 11-20 workers.

Firms of 1000 workers or more are outside of the community rating pool and pay a 1% payroll assessment.

Families not receiving coverage through their employer have their contributions capped at 4-6% of income; appropriate cap is determined by family income.

Premiums are 5% below the CBO scoring of the HSA.

DATE:
TIME:

FAX

Income Maintenance Branch
Office of Management and Budget
Executive Office of the President
Washington, DC 20503

To: Chris Jennings

From: Len Nichols

Fax Destination:

Place:
Fax Number:
Voice Number:

Additional Pages: 1

Notes:

Feinstein;

Len - Ind mandate

Carla:
224-0172

	Bingaman Plan Savings vs. HSA ($ billions)
Description	individual wage caps from 4%-12%, based on firm size and average wage; Kennedy benefit package (HSA-2%), firms with ≤ 10 exempt if average wage ≤ $24,000; ≤ 5 non-offering and 1000+ pay 1% of payroll, 6-10 non-offering pay 2% of payroll; exempt workers pay no more than 4-6% of AGI;
1996-2000 subsidy savings	15
1996-2004 subsidy savings	71
1996-2000 Revenue gains (assessments plus other revenue)	49
1996-2004 Revenue gains (assessments plus other revenue)	97

	Model 3
Total Employer Payments 1 Year (1994) ($m)	207,655
Average Employer Payments per Family	2,006
Total Family Payments 1 Year (1994) ($m)	63,320
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Firms of 1000 workers or more are outside of the community rating pool and pay a 1% payroll assessment.

Families not receiving coverage through their employer have their contributions capped at 4-6% of income; appropriate cap is determined by family income.

Premiums are 5% below the CBO scoring of the HSA.

Estimated Differences in Premium Inside and Outside the Community Rate

♦ We have provided 'back of the envelope' estimates that the 'premium' for a community rated pool including non-workers, public employees, and employees in firms below 100 will be 7% to 16% higher than the 'premium' for a community rated pool that includes all employees. However, there are two reasons that this does not mean that the premium inside the community rated pool will be 7% to 16% higher than the premium outside.

- First, these estimates refer to the difference in 'benefits paid', and do not include amdinistrative loads. The administrative load for plans in the community rate is likely to be 6% to 8% higher than for plans outside the community rate. This larger load reflects factors such as the greater costs of collecting premiums from individuals and small employers and the 1.5% add-on for academic health centers.

- Second, the smaller community rated pool includes slightly under one-half of the community rated pool that includes all employees (this assumes that families with more than one full-time worker follow the higher earner). If per capita benefits are 16% higher for a pool at 100 than in a pool including all workers, per capita benefits in the pool at 100 will be 34% higher than average per capita benefits for employees outside the pool. The 7% to 16% estimates for per capita benefits in the pool (compared to per capita benefits in a pool containing all workers) correspond to estimates that per capita benefits are betweeen 16% and 34% higher in a community rated pool of employers at 100 and below than per capita benefits for employers outside of the community rated pool. The most likely part of this range is that per capita benefits will be 20% to 25% higher in the community rated pool than outside.

♦ **Combining estimates of differences in administrative load and differences in per capita benefits, if employers above 100 are excluded from the community rate, unsubsidized employers participating in the community rate will be paying premiums between 27% and 35% higher than employers not participating in the community rate. This is likely to be perceived by small employers as patently unfair.**[1]

♦ The premium difference between employers in and out of the community rate cannot be lessened by changing the treatment of cash Medicaid recipients; rather it results from loading the higher costs of non-workers who are not receiving Medicaid onto the community rate paid by small employers. Since many people move in and out of employment throughout the year, it is not clear that there is any feasible method of segregating the costs of non-workers, even if we had extra funds to pay government subsidies for them. In order to bring equity to a system that cuts off community rating at employers of 100 and below, it would be desirable to raise money from employers who are outside of the community rate and use this money to lower the average premium paid by employers who are participating in the community rate.

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[1] This assumes that per capita benefits are 20% to 25% higher in the community rate and that the administrative load is 6% to 8% higher. When combining these factors, they multiply rather than add.

	Model 1
Government Subsidies:	
1 Year (1994) ($m)	82,096
employer	34,489
household	47,607
Government Subsidies:	
5 Years ($m)	359,906
employer	145,199
household	214,708
Government Subsidies:	
10 Years ($m)	962,004
employer	412,144
household	549,861
Select Revenue Estimates: *	
Corporate Assessment	40,600
Other Revenue	24,600
Total (5 Years)	65,200
Select Revenue Estimates: *	
Corporate Assessment	81,200
Other Revenue	49,200
Total (10 Years)	130,400
Net Effect on Deficit * (5 Years)	(394)
Net Effect on Deficit * (10 Years)	(70,596)
Net Effect on Deficit *** adjusted by 50% (5 Years)	(197)
Net Effect on Deficit *** adjusted by 50% (10 Years)	(35,298)

Model 1: An 80% employer mandate on firms of all sizes.

Firms pay the lesser of the full employer premium share or 5.5% to 12% of that worker's wages, whichever is less. Cap is determined by firm size and average wage in the firm. Firms of all sizes are eligible for these caps.

Firms of 1000 workers or more pay a 1% payroll assessment.

Firms of 1000 workers or more are outside of the community rating pool.

Premiums are equal to the CBO scoring of the HSA.

Notes on the estimates:

* Revenue estimates are for those components that differ from the HSA. Deficit effects are relative to the current system. Revenue estimates are preliminary; they are not official estimates.

** Sorting of firms is assumed to be 25% of HSA sorting. This is a preliminary estimate and may understate outsourcing effects.

*** Due to the unofficial nature of these estimates, it is advisable to use a measure of conservatism in considering these models. We suggest a deficit reduction estimate that is half of that coming out of the model as a reasonable adjustment.

Model 1

Private Sector Payments
In 1 Fully Phased-In Year, 1994

	Family Payments	Employer Payments
Total (in millions)	$60,398	$226,847
Average per Family	$584	$2,192

Marginal rates used for calculating household payments:

Household ("20%") share:

Marginal rates applied to income between $1000 and 100% of poverty range from 3.2 to 3.5%, depending upon family type.
Marginal rate applied to income between 100% of poverty and 150% of poverty is 5.7% for all family types.
In addition, no family is required to pay more than 3.9% of their income for the household share.

Non-worker ("80%") share:

Marginal rates applied to non-wage income between $1000 and 100% of poverty range from 5.9 to 6.4%, depending upon family type.
Marginal rates applied to non-wage income between 100% of poverty and 250% of poverty range from 10% to 12.8%, depending upon family type.

	Model 2
Government Subsidies:	
1 Year (1994) ($m)	75,567
employer	30,800
household	44,767
Government Subsidies:	
5 Years ($m)	331,567
employer	129,668
household	201,899
Government Subsidies:	
10 Years ($m)	885,119
employer	368,060
household	517,059
Select Revenue Estimates: *	
Corporate Assessment	41,000
Other Revenue	27,000
Total (5 Years)	68,000
Select Revenue Estimates: *	
Corporate Assessment	82,000
Other Revenue	54,000
Total (10 Years)	136,000
Net Effect on Deficit *	
(5 Years)	(31,533)
Net Effect on Deficit *	
(10 Years)	(153,081)
Net Effect on Deficit	
adjusted by 50% (5 Years)***	(15,767)
Net Effect on Deficit *	
adjusted by 50% (10 Years)***	(76,541)

Model 2: An 80% employer mandate on firms of all sizes.

Firms pay the lesser of the full employer premium share or 5.5% to 12% of that worker's wages, whichever is less. Cap is determined by firm size and average wage in the firm. Firms of all sizes are eligible for these caps.

Firms of 1000 workers or more pay a 1% payroll assessment.

Firms of 1000 workers or more are outside of the community rating pool.

Premiums are 5% below the CBO scoring of the HSA.

Notes on the estimates:

* Revenue estimates are for those components that differ from the HSA.
Deficit effects are relative to the current system.
Revenue estimates are preliminary; they are not official estimates.

** Sorting of firms is assumed to be 25% of HSA sorting.
This is a preliminary estimate and may understate outsourcing effects.

*** Due to the unofficial nature of these estimates, it is advisable to use a measure of conservatism in considering these models. We suggest a deficit reduction estimate that is half of that coming out of the model as a reasonable adjustment.

Model 2

Private Sector Payments
In 1 Fully Phased-In Year, 1994

	Family Payments	Employer Payments
Total (in millions)	$57,430	$218,242
Average per Family	$555	$2,108

Marginal rates used for calculating household payments:

Household ("20%") share:

Marginal rates applied to income between $1000 and 100% of poverty range from 3.2 to 3.5%, depending upon family type.
Marginal rate applied to income between 100% of poverty and 150% of poverty is 5.7% for all family types.
In addition, no family is required to pay more than 3.9% of their income for the household share.

Non-worker ("80%") share:

Marginal rates applied to non-wage income between $1000 and 100% of poverty range from 5.9 to 6.4%, depending upon family type.
Marginal rates applied to non-wage income between 100% of poverty and 250% of poverty range from 9.3% to 12.0%, depending upon family type.

Possible Mitchell-Breaux-Boren-Like Compromise

- An 80% employer requirement on firms of more than 20 workers. If after 3 years, 90% of workers and families in firms of 20 or less do not receive employment based coverage, a full employer mandate is triggered.

- Firms covering their workers pay the lesser of the employer premium share or 2.8% to 12% of that worker's wages, whichever is less. Employer premium share is determined by firm size and average wage in the firm.

- Firms not covering their workers pay a payroll assessment of 1% if firms has 1-10 workers and 2% if 11-20 workers.

- Firms of 1000 workers or more are outside of the community rating pool and pay a 1% payroll assessment

- Workers and families not receiving coverage through their employer must pay the full share of the premium, but their contributions are capped at 4 to 6% of their income (cap level determined by family income level); just as in HSA, non-workers receive the same out-of-pocket protections and must pay the full share of their premium.

- Premiums/benefits package are 5% below the CBO scoring of the HSA.

	Mitchell-Breaux-Boren-Like Compromise
Government Subsidies:	
1 Year (1994) ($m)	83,218
employer	25,130
household	58,088
Government Subsidies:	
5 Years ($m)	359,142
employer	131,013
household	228,129
Government Subsidies:	
10 Years ($m)	949,907
employer	401,261
household	548,646
Select Revenue Estimates: *	
Corporate Assessment	45,200
Other Revenue	36,080
Total (5 Years)	81,200
Select Revenue Estimates: *	
Corporate Assessment	86,200
Other Revenue	64,080
Total (10 Years)	150,280
Net Effect on Deficit * (5 Years)	(17,238)
Net Effect on Deficit * (10 Years)	(102,573)
Net Effect on Deficit, Adjusted by 50% (5 Years) ***	(8,619)
Net Effect on Deficit, Adjusted by 50% (10 Years) ***	(51,287)

Model 3: An 80% employer mandate on firms of more than 20 workers. If after 3 years, 90% of workers in firms of 20 or less do not receive employment based coverage, a full employer mandate is implemented.

Firms covering their workers pay the lesser of the employer premium share or 2.8% to 12% of that worker's wages, whichever is less. Cap is determined by firm size and average wage in the firm.

Firms not covering their workers pay a payroll assessment of 1% if firm has 1-10 workers and 2% if 11-20 workers.

Firms of 1000 workers or more are outside of the community rating pool and pay a 1% payroll assessment.

Families not receiving coverage through their employer have their contributions capped at 4-6% of income; appropriate cap is determined by family income.

Premiums are 5% below the CBO scoring of the HSA.

Notes on the estimates:

* Revenue estimates are for those components that differ from the HSA. Deficit effects are relative to the current system. Revenue estimates are preliminary; they are not official estimates.

** Sorting of firms is assumed to be 25% of HSA sorting. This is a preliminary estimate and may underestimate outsourcing effects.

*** Due to the unofficial nature of these estimates, it is advisable to use a measure of conservatism in considering these models. We suggest a deficit reduction estimate that is half of that coming out of the model as a reasonable adjustment.

**** 1 Year subsidy estimates assume a fully phased-in carve-out year.

Mitchell-Breaux-Boren-Like Compromise

Private Sector Payments
In 1 Fully Phased-In Year, 1994 *

	Family Payments	Employer Payments
Total (in millions)	$63,320	$207,655
Average per Family	$612	$2,006

* Assumes small firm exemption in place.

Marginal rates used for calculating household payments:

Household ("20%") share:

Marginal rates applied to income between $1000 and 100% of poverty range from 3.2 to 3.5%, depending upon family type.
Marginal rate applied to income between 100% of poverty and 150% of poverty is 5.7% for all family types.
In addition, no family is required to pay more than 3.9% of their income for the household share.

Non-worker ("80%") share:

Marginal rates applied to non-wage income between $1000 and 100% of poverty range from 5.9 to 6.4%, depending upon family type.
Marginal rates applied to non-wage income between 100% of poverty and 250% of poverty range from 10.5% to 13.4%, depending upon family type.

	HSA
Government Subsidies:	
1 Year (1994) ($m)	88,170
employer	40,082
household	48,088
Government Subsidies:	
5 Years ($m)	396,000
employer	179,000
household	217,000
Government Subsidies:	
10 Years ($m)	1,082,000
employer	521,000
household	561,000
Select Revenue Estimates: *	
Corporate Assessment	7,600
Other Revenue	19,300
Total (5 Years)	26,900
Select Revenue Estimates: *	
Corporate Assessment	15,200
Other Revenue	38,600
Total (10 Years)	53,800
Net Effect on Deficit * (5 Years)	74,000
Net Effect on Deficit * (10 Years)	126,000
Net Effect on Deficit, Adjusted by 50% (5 Years) **	37,000
Net Effect on Deficit, Adjusted by 50% (10 Years) ***	63,000

HSA: An 80% employer mandate on firms of all sizes.

Regional alliance firms pay the lesser of the employer premium share for each worker in the firm, of 3.5 to 7.9% of total payroll in the firm, whichever is less. Caps is determined by firm size and average wage of the firm.
Firms of 5000 workers or more choosing to form their own corporate alliances are not eligible for subsidies.

Corporate alliance firms are outside of the community rating pool and pay a 1% payroll assessment.

Notes on the estimates:

* Revenue estimates are for those components that differ from the other models presented. Deficit effects are relative to the current system.
** Revenue estimates and multi-year subsidy estimates are consistent with CBO scoring. Revenue estimates include 1995 savings of $10 billion.

ALTERNATIVE COMPROMISE PROPOSAL

This proposal builds on the Mitchell/Breaux/Boren-type model, with the following changes:

- It allows for a voluntary insurance market to achieve universal coverage.

- Employers and families who choose to purchase coverage receive subsidies to make coverage affordable (as in the Mitchell/Breaux/Boren-type model).

- For the working population, coverage objectives are established by size of employer, and are evaluated over a five year period.

  - **For firms with 100 or more employees:** After three years, unless 85% of the currently uninsured families with employees working for these firms are covered by their employers, a mandate goes into effect for these firms.

  - **For firms with 25 to 99 employees:** After four years, unless 80% of the currently uninsured families with employees working for these firms are covered by their firms, a mandate goes into effect for firms with 25 or more employees.

  - **For firms with fewer than 25 employees:** After five years, unless 75% of the currently uninsured families with employees working for these firms are covered by their firms, a mandate goes into effect for all firms.

- After five years, to ensure universal coverage, any family not covered through their employer must purchase coverage.

- Insurance market reforms apply upon enactment (e.g., guaranteed issue of coverage and community rating), but special provisions are made so long as the purchase of insurance is voluntary.

  - Insurers are permitted to apply a waiting period for pre-existing conditions when previously uninsured people purchase coverage.

  - Insurers are permitted to adjust community rates by age, but not by health status or other factors.

- To enhance competition and ensure fair application of fall-back premium caps, uncompensated care pools are formed so that the financial burden of serving the remaining uninsured is spread fairly across all health care providers.

This approach achieves universal coverage while providing a similar amount of deficit reduction as the Mitchell/Breaux/Boren-type model. However, without premium caps, the deficit would be substantially increased, and employers and families would pay much more.

PARTICULAR COMPLEXITIES ASSOCIATED WITH A TRIGGER WITHOUT UNIVERSAL COVERAGE AT THE START

Some proposals for triggered mandates require universal coverage from the start (e.g. an employer requirement above a certain size, with an individual requirement below that size), where the trigger applies only to whether certain employers are required to contribute for employees and their families.

Universal coverage makes it easier to establish a competitive and fair insurance market, because uncompensated care is eliminated and risk selection can be more easily controlled.

A trigger without universal coverage from the start (i.e. with no individual mandate to begin with) makes implementation more complicated in a number of ways, including:

- **UNCOMPENSATED CARE.** Without universal coverage, uncompensated care will continue to distort competition among providers and health plans. Uncompensated are pools are needed to spread the financial burden of serving the remaining uninsured fairly across all health care providers. Accurately measuring uncompensated care can be difficult, and uncompensated care pools require a new (and temporary) administrative structure.

- **PRE-EXISTING CONDITION EXCLUSIONS.** To guard against people delaying the purchase of insurance until they need health services, pre-existing condition exclusions for the previously uninsured are necessary.

- **AGE RATING.** Similarly, until universal coverage is achieved, age adjustments to premiums are necessary to prevent younger/healthier individuals from dropping existing coverage. Age rating is unfair, increases subsidy costs, and is more complicated for employers and families.

- **MEASUREMENT.** Evaluating whether coverage objectives have been met (particularly if the objectives vary by employer size) is more difficult and costly without universal coverage because there would not likely be an enrollment system that includes information about all families.

May 24, 1994

NOTE TO: Ken Thorpe

FROM: Bridgett Taylor

Maureen Testoni, Senator Baucus' office, called and said that she and Senator Durenberger's office had been working on "trigger" options for the premium caps. - They were wondering if they could get some idea from us how much savings would be lost, assuming the HSA baseline, if the premium caps kicked in when States didn't meet their targets at two, three or four years out. Or put another way how much savings would be achieved if you applied a premium target to current baseline, but had it kick in two, three or four years out. (Durenberger's office has been floating this by Kennedy's people, but they said they can't get CBO numbers so wanted to know if we could give them a ballpark idea).

Maureen would also like to know what would happen if the targets only applied to States whose health care spending costs placed them in the upper quartile of all States.

Maureen would like to have a meeting by the end of this week to discuss this if possible.

Thanks.

cc: Jerry Klepner
Karen Pollitz
Chris Jennings

2 YEARS
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TODAY
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640-7417

STATEMENT OF THE PROBLEM

♦ In a system based on voluntary purchase of insurance along with guaranteed issue, it is possible that the risk pool of insured will deteriorate: that the healthy will be more likely than they are today to be uninsured, and that premiums for those who are insured will increase. This would be undesirable and we would want to protect against this scenario.

IS IT LIKELY THAT THE MANY OF THE HEALTHY WILL DROP INSURANCE?
(answer: It depends on what assumptions one makes about employer maintenance of effort.)

♦ **If the subsidy schedule and tax treatment is such that it is reasonable to assume that most current employer effort will be maintained, then significant deterioration of the risk pool over a three to five year time period is probably not a serious concern.** The current non-group market is relatively small (approximately 7% of the under-65 population). Some of those who purchase non-group coverage might drop it as a result of movement towards community rating and guaranteed issue. However, if the community rating pool is broad -- e.g., community rating up to 1,000 (or even 100) -- the effects on the overall composition of the risk pool should be relatively small.[1]

♦ However, if the subsidies are generous enough that significant numbers of employers would be expected to drop coverage, provide a wage increase, and allow their employees to choose whether or not to purchase insurance, then the numbers of people potentially purchasing in the non-group market would increase. In this scenario, we might expect the pool of insured persons to deteriorate over time as the healthy chose to exit.

HOW COULD WE MEASURE WHETHER THE RISK POOL OF INSURED IS DETERIORATING?

♦ If the average age of insured persons is increasing, then we could assume deterioration in the risk pool. Assuming we had some data system which indicated whether or not each individual (or a sample of people) are insured, we could measure whether the average age of insured persons increases during the pre-trigger time

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[1] From the vantage point of individuals, 'relatively small' might mean a premium increase of 2%-5% (e.g.). That is, premium increases of this order of magnitude would be hard for the individual to distinguish from background noise. However, in later discussions on how premium caps could be implemented in a system with voluntary enrollment, fluctuations of this order of magnitude would be relevant and would require adjustments in the premium cap formula.

period. A similar data system will be required in order to determine whether or not to 'pull the trigger'.

- Average age is an extremely weak proxy for measuring the deterioration of the risk pool. With the appropriate age rating, there might be no change in average age among the insured, but it could still be the case that the relatively healthy (at any given age) are exiting the pool of the insured.

- However, there are probably no other good choices for obtaining reliable and timely measurement of whether the risk pool is deteriorating.[2]

IF THE RISK POOL IS DETERIORATING, WHAT POLICY RESPONSES ARE POSSIBLE?

♦ If we find that the pool of insured persons is aging, then we would want to protect the insured against the increased premiums that would result.

♦ We could provide this protection, in theory, by providing an outside funding source which would allow health plans to reduce the premiums they charge to the insured. For exmaple, to the extent we determined that deterioration of the risk pool was raising premiums for the insured, we might assess employers not providing health insurance.

♦ This money could be used to 'buy down' premiums for the insured. The simples method would be to make a per capita payment to all health plans for each person insured; this would reduce premiums to the insured to compensate for a deteriorating risk pool. Alternatively, the outside funding source could be used to provide reinsurance for very high cost cases -- e.g., for the 1.6% of households with

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[2] Assuming we could get the data, we could examine the percent of insured persons with expense above some level -- e.g., $10,000 or $30,000. Then if the percentage of the insured with high expenditures increases from year to year, we could assume that the risk pool deteriorated. However, there would be a number of complications with such an approach. From NMES data, 8.1% of the under-65 health insurance units have expenditures over $10,000 per year. If the healthiest 5% of the currently insured chooses not purchase insurance, the 8.1% would increase to 8.5%. Differentiating an increase of this magnitude from the background effects of general medical care inflation, measurement error, white noise, and changed incentives for reporting would be extremely difficult (and even worse if we were trying to do this at a state-by-state level). Alternatively, we could add some questions to the CPS on self-reported health status to attempt to track deterioration in the risk pool of the insured. While this might give us some indication of the direction of change, it would not be sufficient to allow measurement of the effect of any such changes on average premium.

expenditures above $30,000 per year that account for 20.3% of expenditures.

♦ This outside funding source could be raised, for example, by an assessment on those employers who do not provide health insurance. As the number of people insured increased, both the need for the assessment and the revenue from it would decline in tandem.

♦ **It is not likely, however, that we will be able to do a good job of measuring the extent to which the risk pool is deteriorating or the effect of such changes on the average premium paid by the insured.**

MANDATORY REINSURANCE FOR HIGH COST CASES

♦ The HSA specifies that prospective and retrospective 'risk adjustment' should be used to assure that plans with a disproportionate number of high cost cases should not be disadvantaged as a result.

♦ A risk adjustment system, including, potentially, retrospective reinsurance for high cost cases, would be required in a system without universal coverage as well. In fact, the stress placed on the risk adjustment system will be greater when people are choosing whether or not to be insured than in a system of mandatory insurance.

♦ However, a reinsurance system for high cost cases is neither necessary nor sufficient to deal with the potential problem of deterioration of the risk pool. If the healthy exit the insurance system, the premiums for the remaining insured will increase. Providing reinsurance for high cost cases (funded by an outside source) will protect against part of the effect on premium, but most of the effect will not be accounted for by such a mechanism.[3]

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[3] If the healthy exit the insurance market, the insured will have a higher proportion of 'high cost cases' than previously. A reinsurance mechanism could protect against the effect of this on premiums. However, there will also be a higher proportion of 'fairly high cost cases', and of 'somewhat high cost cases'; we have no good way of protecting against these effects. Unless we are thinking of reinsuring more than 20% of expenditures, at least 80% of the effect of a deteriorating risk pool would not be compensated for by a reinsurance mechanism.

SUMMARY

♦ If the structure of subsidies and the tax treatment of employer provided and individually purchased insurance is such that it is reasonable to assume that most employers will maintain effort, then we do not need to worry much about deterioration of the risk pool and its effects on premiums paid by the insured.

♦ If significant numbers of employers are likely to drop effort, then deterioration of the risk pool may be a problem. However, in this case we are unlikely to be able to do a good job of either measuring the magnitude of the effect, or of adjusting for it.

♦ Setting up a national reinsurance mechanism for high cost cases will not resolve the major problems that would be created if the risk pool does deteriorate.

♦ When considering how to implement premium caps in a system with voluntary enrollment, careful attention must be paid to the effects of changes in the composition of the risk pool on the level of premium increase that should be allowed.

I. Proposed Policy

This policy is aimed at expanding employer-based coverage over a five-year period, at which time an individual mandate would be implemented. Within three years of enactment, the employer segment comprised of firms with over 100 employees would be required to cover 85% of their previously uninsured employees. Within a four-year period, firms with 25-99 employees would be required to cover 80% of their previously uninsured workers, and within five years, firms with less than 25 employees would be required to cover 75% of their uninsured workers. If any employer segment does not meet its coverage "trigger" within the specified timeframe, they would be subject to an employer mandate.

II. The Problem

It would be extremely difficult to implement this policy, due to:

- <u>System Dynamics</u> the volatility and complexity of both the labor force and the health insurance system

- <u>Data Availability</u> lack of sufficient baseline data and problems in ongoing data requirements

III. Issues

A. System Dynamics

- <u>Volatility</u> Within a given year, millions move into and out of the workforce, into and out of the ranks of the uninsured, and into and out of firms of different sizes. In light of this how do we:

  - quantify the baseline of uninsured by firm size?
  - measure compliance?
  - monitor ongoing compliance?

- **Complexity** The complexity of both the workforce and the insurance system raises numerous Definitional and measurement issues. For example:

  - **Dual-Worker Families** A significant segment of the labor force is comprised of two-worker families. How would we allocate these workers and their children to firms of different sizes?

  - **Definition and Measurement of "Employees"** How is "employment" defined? For a given employer segment, is the target percentage applied to full-time employees, all employees, or all employees and families? Definitional changes affect both the baseline number of uninsured and the level of responsibility placed

on employers.

- **Definition and Measurement of "Covered"** How is "covered" defined? Does an employer segment get credit for coverage if the employee gets coverage through a non-employer source? A smaller employer segment source?
  - Does an employer segment get credit only if an employer contributes to the premium?
  - Does an employer get penalized if an employee opts not to buy coverage?
  - Does being insured all through the year or part of the year constitute "covered"
- **Definition and Measurement of "Coverage"** How is "coverage" defined? Is there a minimum level of benefits that constitutes "coverage"? If so, how would we assess whether a firm is in compliance with this level of benefits, given the heterogeneity of current insurance products?
- **Definition and Measurement of "Uninsured"** Is the number of uninsured measured at a point in time or over a period of time? The baseline number of uninsured and the magnitude of the coverage goals will vary greatly depending upon whether point-in-time or longitudinal estimates are used to determine the number of uninsured workers.
- **Definition and Measurement of Compliance** What would it mean to be in compliance? Would an employer segment be in compliance if it reduced the number of previously uninsured workers by the specified percentage, or would compliance depend on achieving a specified percentage of insured workers given the current size and makeup of the workforce?

B. Data Availability

- Data needed at the national level:
  - Number (and type) of employees by firm size
  - Number of dual worker families
  - Number of dependents by firm size
  - Insurance coverage by firm size: source, type and duration of coverage
  - Number of People subject to probationary and waiting periods
- Current Data Sources:

- National Medical Expenditure Survey (NMES)
- National Employer Health Insurance Survey (NEHIS)
- Current Population Survey (CPS)
- National Health Insurance Survey (NHIS)

- Limitations of current data sources

  - Available statistics do not capture dynamics of system (employment fluctuations, changes in insurance coverage)
  - Lack of information on number of dual worker families, number of dependents by firm size, and insurance coverage (source, type and duration of coverage)
  - Long delay between collection and availability of data
  - Current data is cross-sectional. Point-in-time estimates of the uninsured are not representative of (underestimate) the number of people without coverage over a period of time.
  - Current data sources are survey-based. May be unable to disaggregate data to the firm size level.