DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HEALTH POLICY

PHONE: (202) 690-6870 FAX: (202) 401-7321

Date:

From: Ken T.

To: CHRIS JENNINGS ~~Jane Horvath~~

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Number of Pages (Including Cover): 5

Comments:

Mike D-H

ANALYSIS OF REG
CONSTRAINED
Split Families Follo

SINGLE

Alliance Firmsize	AFDC Only Per Capita	AFDC Only Change from CBO Base	AFDC Only Total Premiums	SSI Only Per Capita	SSI Only % Change	SSI Only Total Premiums	Non-Cash Only Per Capita	Non-Cash Only % Change	Non-Cash Only Total Premiums
	$2,200			$2,200			$2,200		
All	$2,200	100.0%	$101,577	$2,288	104.0%	$107,283	$2,237	101.7%	$105,850
5000	$2,291	104.1%	$88,743	$2,393	108.8%	$94,448	$2,332	106.0%	$93,015
1000	$2,359	107.2%	$81,289	$2,473	112.4%	$86,994	$2,403	109.2%	$85,561
500	$2,391	108.7%	$78,079	$2,510	114.1%	$83,784	$2,436	110.7%	$82,351
100	$2,506	113.9%	$69,352	$2,643	120.1%	$75,058	$2,554	116.1%	$73,625

COUPLE

Alliance Firmsize	AFDC Only Per Capita	AFDC Only Change from CBO Base	AFDC Only Total Premiums	SSI Only Per Capita	SSI Only % Change	SSI Only Total Premiums	Non-Cash Only Per Capita	Non-Cash Only % Change	Non-Cash Only Total Premiums
	$2,200			$2,200			$2,200		
All	$2,200	100.0%	$86,195	$2,223	101.0%	$87,541	$2,213	100.6%	$87,571
5000	$2,247	102.1%	$66,937	$2,277	103.5%	$68,283	$2,263	102.9%	$68,313
1000	$2,267	103.0%	$56,393	$2,303	104.7%	$57,739	$2,286	103.9%	$57,769
500	$2,249	102.2%	$51,244	$2,288	104.0%	$52,589	$2,269	103.2%	$52,619
100	$2,311	105.0%	$40,347	$2,361	107.3%	$41,693	$2,336	106.2%	$41,723

ANALYSIS OF RE
CONSTRAINED
Split Families Foll

1 ADULT & KIDS

Alliance Firmsize	AFDC Only Per Capita	AFDC Only % Change	AFDC Only Total Premiums	SSI Only Per Capita	SSI Only % Change	SSI Only Total Premiums	Non-Cash Only Per Capita	Non-Cash Only % Change	Non-Cash Only Total Premiums
	$1,412			$1,412			$1,412		
All	$1,435	101.6%	$42,446	$1,497	106.0%	$32,743	$1,476	104.5%	$36,548
5000	$1,479	104.7%	$37,586	$1,574	111.5%	$27,864	$1,538	108.9%	$31,669
1000	$1,510	106.9%	$34,791	$1,636	115.8%	$25,089	$1,585	112.2%	$28,893
500	$1,525	108.0%	$33,695	$1,667	118.0%	$23,983	$1,608	113.9%	$27,787
100	$1,568	111.0%	$30,721	$1,768	125.2%	$21,019	$1,679	118.9%	$24,824

2 ADULTS & KIDS

Alliance Firmsize	AFDC Only Per Capita	AFDC Only % Change	AFDC Only Total Premiums	SSI Only Per Capita	SSI Only % Change	SSI Only Total Premiums	Non-Cash Only Per Capita	Non-Cash Only % Change	Non-Cash Only Total Premiums
	$1,288			$1,288			$1,288		
All	$1,292	100.5%	$144,791	$1,301	101.1%	$142,885	$1,322	102.6%	$151,168
5000	$1,328	103.2%	$113,941	$1,340	104.2%	$112,016	$1,366	106.2%	$120,318
1000	$1,353	105.2%	$96,669	$1,369	106.4%	$94,743	$1,399	108.7%	$103,046
500	$1,368	106.3%	$89,053	$1,386	107.7%	$87,127	$1,416	110.1%	$95,430
100	$1,420	110.3%	$70,340	$1,446	112.4%	$68,415	$1,490	115.1%	$76,718

SOURCE: HCFA,

ANALYSIS OF REG
CONSTRAINED
Split Families Follo

SINGLE

Alliance Firmsize	AFDC & SSI Per Capita	AFDC & SSI % Change	AFDC & SSI Total Premiums	All Per Capita	All % Change	All Total Premiums
	$2,200			$2,200		
All	$2,288	104.0%	$108,087	$2,321	105.5%	$113,163
5000	$2,392	108.7%	$95,253	$2,427	104.6%	$100,329
1000	$2,470	112.3%	$87,799	$2,507	108.0%	$92,875
500	$2,507	114.0%	$84,589	$2,544	109.6%	$89,665
100	$2,638	119.9%	$75,862	$2,673	115.2%	$80,938

COUPLE

Alliance Firmsize	AFDC & SSI Per Capita	AFDC & SSI % Change	AFDC & SSI Total Premiums	All Per Capita	All % Change	All Total Premiums
	$2,200			$2,200		
All	$2,223	101.1%	$87,630	$2,235	101.6%	$89,096
5000	$2,277	103.5%	$68,372	$2,292	104.2%	$69,837
1000	$2,302	104.7%	$57,828	$2,320	105.5%	$59,294
500	$2,287	104.0%	$52,679	$2,307	104.9%	$54,144
100	$2,360	107.3%	$41,783	$2,394	108.4%	$43,248

ANALYSIS OF RE
CONSTRAINED
Split Families Foll

1 ADULT & KIDS

Alliance Firmsize	AFDC & SSI Per Capita	AFDC & SSI % Change	AFDC & SSI Total Premiums	All Per Capita	All % Change	All Total Premiums
	$1,412			$1,412		
All	$1,497	106.0%	$44,878	$1,536	108.8%	$51,114
5000	$1,550	109.8%	$39,998	$1,589	112.5%	$46,235
1000	$1,588	112.4%	$37,223	$1,625	115.1%	$43,459
500	$1,605	113.7%	$36,117	$1,642	116.3%	$42,353
100	$1,658	117.4%	$33,154	$1,691	119.8%	$39,390

2 ADULTS & KIDS

Alliance Firmsize	AFDC & SSI Per Capita	AFDC & SSI % Change	AFDC & SSI Total Premiums	All Per Capita	All % Change	All Total Premiums
	$1,286			$1,286		
All	$1,306	101.6%	$146,826	$1,341	104.2%	$157,165
5000	$1,346	104.7%	$115,977	$1,388	107.9%	$126,315
1000	$1,375	106.9%	$98,704	$1,423	110.6%	$109,043
500	$1,382	108.2%	$91,088	$1,443	112.2%	$101,427
100	$1,451	112.8%	$72,376	$1,511	117.5%	$82,714

SOURCE: HCFA,

Employer Premium Payments

		2000
TOTAL		
All Firms	Baseline	324,023
	Reform	304,072
Currently Offering	Baseline	324,023
	Reform	270,156
Less than 10		
All Firms	Baseline	19,830
	Reform	22,856
Currently Offering	Baseline	19,830
	Reform	14,050
10 - 15		
All Firms	Baseline	18,799
	Reform	24,254
Currently Offering	Baseline	18,799
	Reform	14,825
25 - 99		
All Firms	Baseline	34,798
	Reform	36,908
Currently Offering	Baseline	34,798
	Reform	31,534
100 - 499		
All Firms	Baseline	52,843
	Reform	47,069
Currently Offering	Baseline	52,843
	Reform	44,336
500 - 999		
All Firms	Baseline	23,962
	Reform	19,865
Currently Offering	Baseline	23,962
	Reform	18,983
1,000 - 4,999		
All Firms	Baseline	91,513
	Reform	77,601
Currently Offering	Baseline	91,513
	Reform	74,766
5,000 + In Regional Alliance		
All Firms	Baseline	28,935
	Reform	25,687
Currently Offering	Baseline	28,935
	Reform	24,339
5,000 + In Corporate Alliance		
All Firms	Baseline	53,342
	Reform	49,833
Currently Offering	Baseline	53,342
	Reform	47,328

CBO Premiums, Big Firms Out
Model 139
6-June-1994

OPTIONAL FORM 99 (7-90)
FAX TRANSMITTAL
# of pages ▶
To CHRIS JENNINGS
From Thorpe
Dept./Agency
Phone #
Fax # OK TO STEVE
NSN 7540-01-317-7368 5099-101 GENERAL SERVICES ADMINISTRATION

NOTE FOR DAVID NEXON

1. Total Premium Payments, 1996-2000 under the Kennedy Mark =$1.72 Trillion

2. Of this, federal government pays 22% ($376 Billion), households pay 16% ($275 Billion) and employers pay 62% ($1.07 Trillion).

3. State MOE payments 1996-2000 total $64 Billion

4. State and federal capitation payments between 96-00 total $225 Billion.

ESTIMATES ARE PRELIMINARY AND NOT OFFICIAL

OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL # of pages ► 1

To Chris J	From Ken T
Dept./Agency	Phone #
Fax #	Fax #

NSN 7540-01-317-7368 5099-101 GENERAL SERVICES ADMINISTRATION

MEMORANDUM FOR JEAN HEARN & SCOTT HARRISON

FROM: JOCELYN GUYER & JANE HORVATH

DATE: JUNE 7, 1994

SUBJ: REVISIONS TO OPTION 11

After learning from Jocelyn's conversation with Jean yesterday afternoon that CBO will assume that States will increase their spending to some extent as a result of an enhanced long term match, we are concerned that option 11 will be far too expensive. Accordingly, please disregard the option 11 that we sent you yesterday and use as a substitute the following:

Option 11

- Calculate a "base" FMAP using total taxable resources and poverty rather than per capita income. Change the multiplier to obtain budget neutrality.
- Add ten percentage points to this base FMAP
- Impose a floor on the FMAP of 60% and a ceiling of 83%.
- In the event that a State somehow ends up with a lower FMAP as a result of these changes, it should be given the option of using its regular FMAP or the enhanced home and community based FMAP.

Options 1 and 11 are still the two top priorities.

NOTE TO DAVID NEXON

1. Year 2000 :

total premiums = $510 Billion
households = $100
employers = $290
federal = $120

2. Corporate Assessment+

$43.6 Billion between 1996-2000; of this $41 Billion comes from firms over 1000.

3. OTHER 2 requests to follow shortly.

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OFFICE OF HEALTH POLICY

PHONE: (202) 690-6870 FAX: (202) 401-7321

Date: Chris Jennings

From: Ken T. To: Len Nichols

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Number of Pages (Including Cover): 6

Comments: FOR SENATE FINANCE

PRELIMINARY, NOT OFFICIAL ESTIMATES

Options for Cost Sharing with Lower Premiums.

1. Subsidize low-income people without access to low-cost sharing plan to HSA low-cost sharing level. ***Example:*** the poor pay $10 physician visit copay; no hospital deductible

   This assumes that low-income individuals (less than 150% poverty) will pay the copayments that are specified in the Health Security Act (e.g., $10 copay for physician visit). Since the average cost sharing for the high-cost plan is increased with the decrease in the premium cost, there is more cost-sharing covered by the federal government through the subsidy.

2. Subsidize low-income people without access to low-cost sharing plan to new low-cost sharing plan levels. ***Example:*** at premiums 15% lower than HSA, the poor pay $20 physician visit copay; $400 hospital deductible

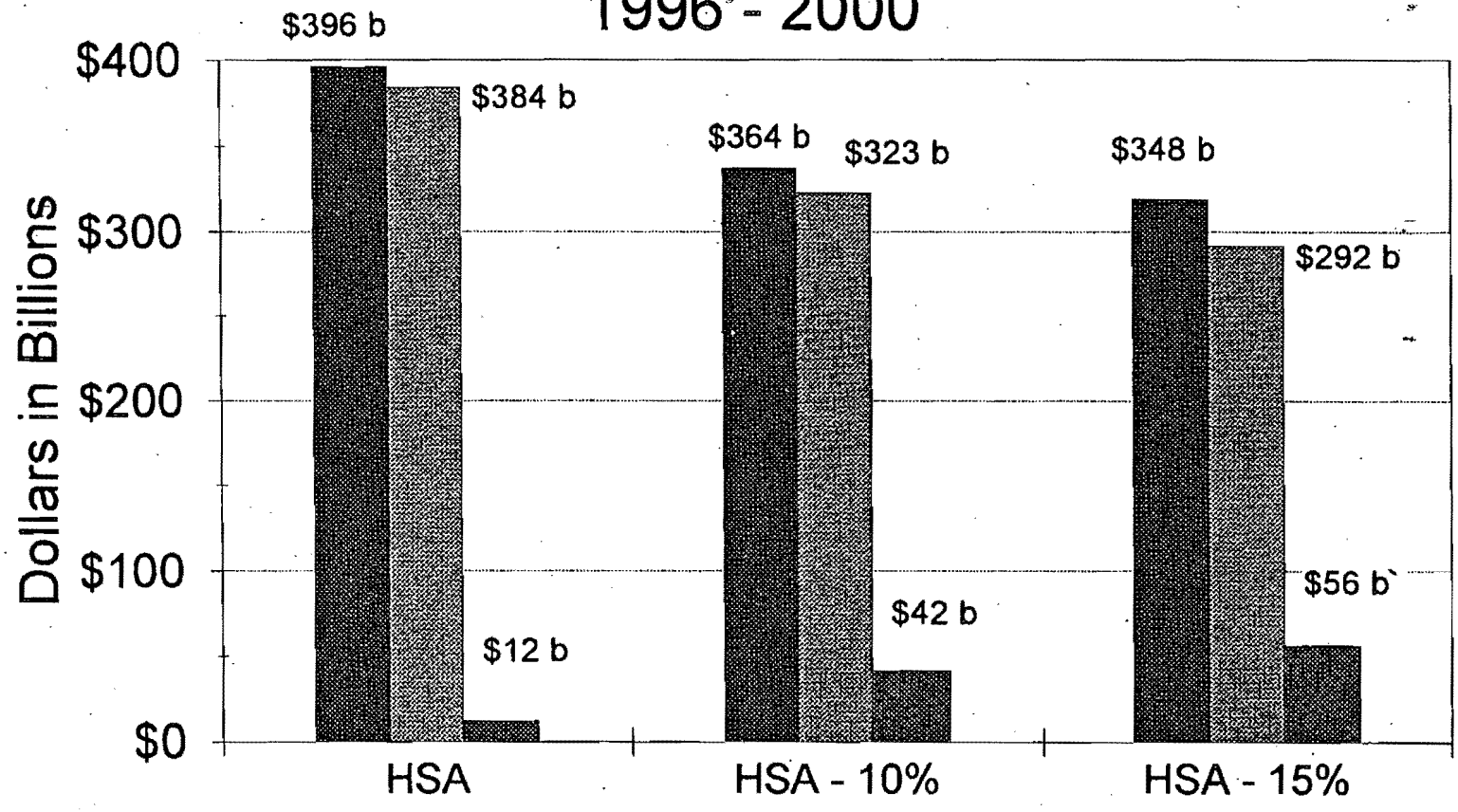
   This assumes that low-income individuals will pay the copayments for the low-cost sharing plan with the lower premium. Since both the low-and high-cost sharing plans are 10% to 15% lower, there is no change in the difference between the average cost sharing in the high- and low-cost plans. Thus, the federal subsidy dollars do not change.

3. Additional subsidies for low-income people. ***Example:*** at premiums 15% lower than HSA, the poor less than 100% of poverty pay $8 physician visit copay; $160 hospital deductible

   Subsidize low-income people for their low-cost plan cost sharing. The individual or family with income less than 100% of poverty would pay 40% of the cost-sharing; the individual or family with income between 100% and 160% of poverty would pay 80% of the cost-sharing; and those between 160% and 200% of poverty would receive a subsidy that is phased down so the individual or family pays from 80% to 100% of cost sharing. These estimates are in addition to the cost of buying low-income people without access to low-cost sharing plan to the low-cost sharing plan levels.

Federal Subsidies with Lower Premiums

Assuming HSA Cost Sharing Subsidies
1996 - 2000



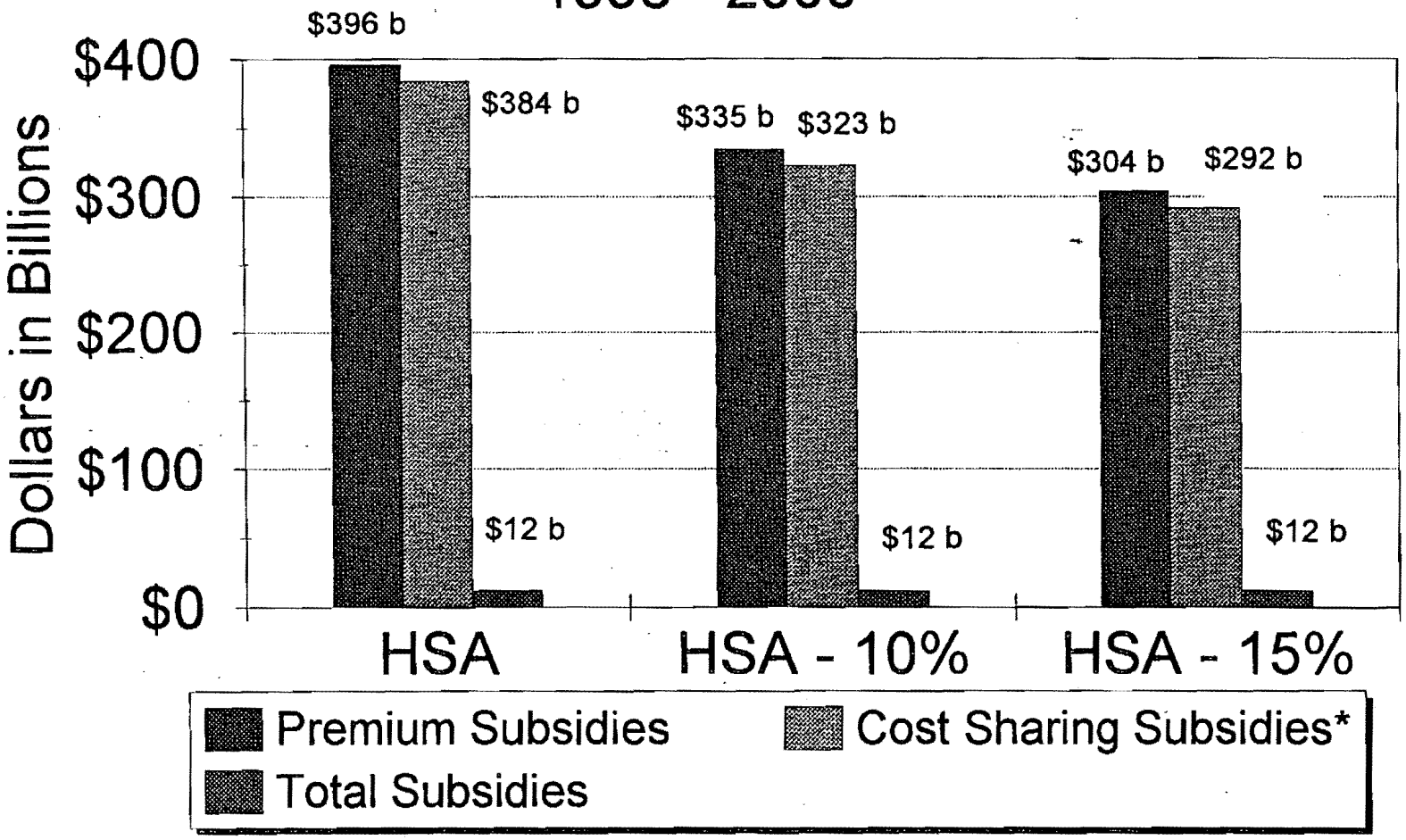
* HSA Cost Sharing: No deductible or coinsurance; $10 co-pay on most services.

CHART 1

Federal Subsidies with Lower Premiums

Cost Sharing at Low-Cost Plan Level

1996 - 2000

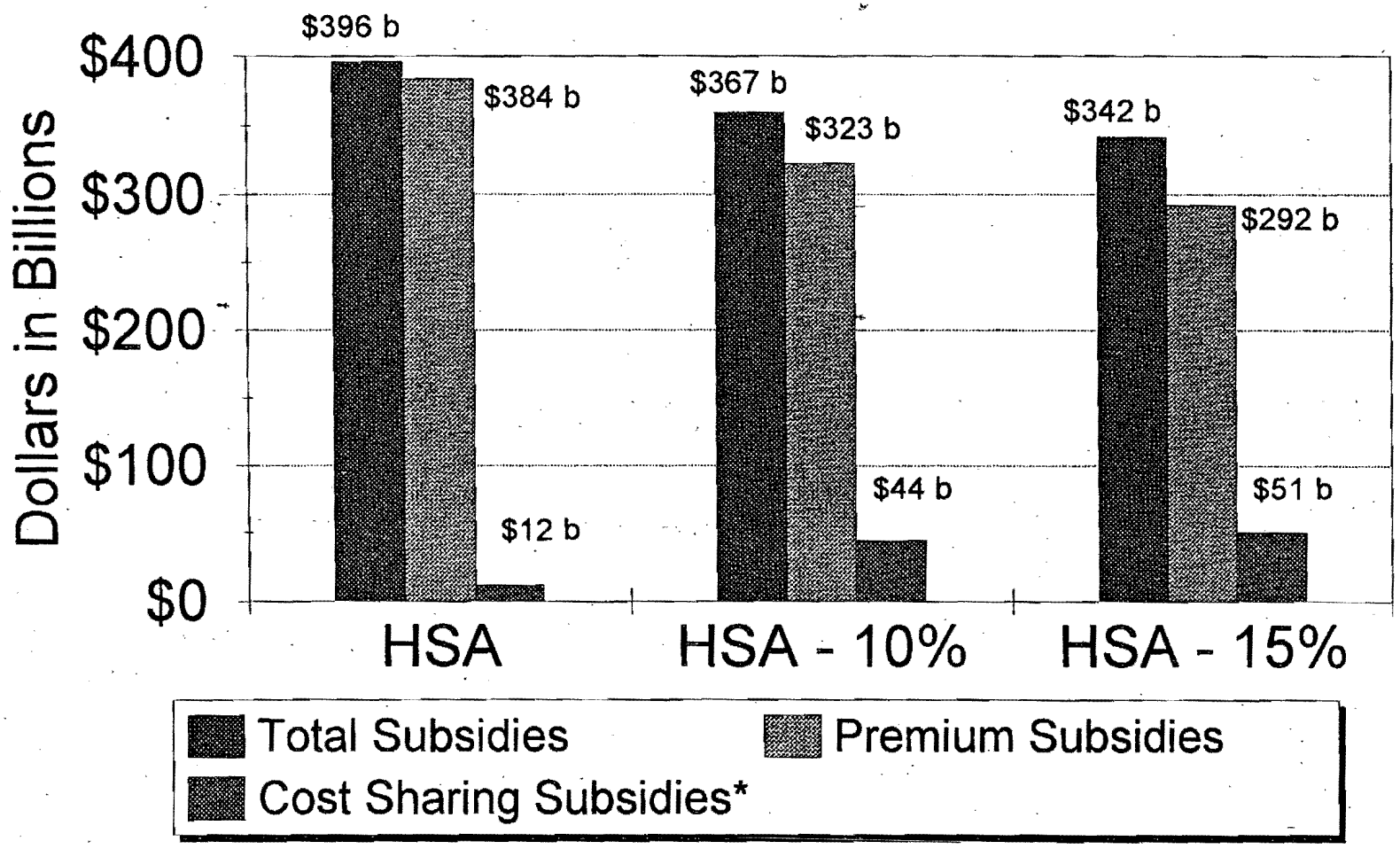


* Cost Sharing: For Less than 150%, Subsidize from High-to-Low-Cost Sharing Plan

CHART 2

Federal Subsidies with Lower Premiums

40%/80% with Phase-Down to 200% PL



* Cost Sharing: 40% of low-cost sharing plan for people <100% PL; 80% of low-cost sharing plan for people 100-160% PL; phase-down to 200%. NOTE: This includes the $12 b cost of buying down low-income people without access to a low-cost plan to the low-cost plan cost sharing levels.

CHART 3

3. Cost Sharing Subsidies: Additional cost of subsidizing the low-cost plan's cost sharing for low-income people.

Estimates of the effects of additional cost sharing subsidies were initially calculated for the Senate Labor and Human Resources mark, and were subsequently modified for different specifications. The Kennedy estimates were calculated by multiplying the total premiums by three factors.

The first factor is the percent of the total premiums that represents the cost of moving to a Kennedy cost-sharing waiver subsidy for persons under 200% of poverty. For those in HMOs, this factor is 1.5%, split into .78% for those less than 100% of poverty, and 0.72% for those between 100 and 200% of poverty. This was based on the tabulations of the CPS by income band, with cost-sharing waivers estimates based on average expense levels. Because a change in the specifications called for the 40% of cost sharing subsidy to apply to the FFS cost sharing rather than the HMO cost sharing for those above 150% of poverty without access to a low-cost plan, two changes were made to the original estimates. First, the 0.72% increase in costs associated with the HMO subsidy was reduced since the subsidy now applied to only those with access to an HMO. Second, a factor accounting for the cost of moving to the new Kennedy subsidy for those in FFS plans was calculated to be 1% for the population less than 200% of poverty in FFS plans. Since it is estimated that 15% of low-income people do not have access to a low-cost plan, it is assumed that portion of those without access who have incomes between 150% and 200% of poverty is 4% (.15 * 0.25) of those under 200% of poverty.

The second factor is the ratio of the new HMO cost sharing to the old HMO cost sharing with a change in premiums. For the Kennedy mark, this factor was 1.78.

These Kennedy estimates were used as the base for calculating additional specifications under different plans. For Senate Finance, the goal was to estimate the cost of the subsidies for premiums 10% to 15% below HSA, with the low-income paying 40% of cost sharing if they are below 100% of poverty, 80% for those between 100% and 160% of poverty, and phased into 100% for those at 200% of poverty.

The Kennedy estimates were modified in three ways to conform to these specifications. First, the ratio of the new HMO cost sharing to the old HMO cost sharing was changed. For premiums 10% lower than HSA, the factor is 2.54 and for premiums 15% lower than HSA, the factor is 3.35. Second, the different levels of subsidies were accounted for by multiplying the ratio of the new level to the Kennedy level (e.g., for those less than 100% of poverty: 60% / 80% federal payments). Third, different income brackets and the phase-down for those between 160% and 200% of poverty were factored in, using assumptions about equal distribution of the population across income brackets and a linear phase-down in the subsidies.

ISSUES REGARDING HIGH COST PLAN PAYMENT ADJUSTMENT

1. Size of adjustment required (assuming no second order revenue effects)

2. Effect of policy changes on the size of the adjustment required (that is, how rules of thumb change with changes in subsidies and benefits -- Question: What model are the current rules of thumb based on?)

3. Discussion of second order revenue effects

4. Size of the remaining hole from revenue effects of no cost containment

5. Handling of self-insured/experience rated plans

6. Issues in a voluntary market (with no experience rating below a certain size of employer)

7. Workability of allowing target premium to grow at a higher rate

8. Enforcement

GNP Total spending if [illegible]. It is in GNP but not in income. There will be less income revenue coming in.

(Medicaid and Medicare) and we need to propose it, fight for it and, perhaps, suffer for it or it will never happen.

Time is of the essence. As I see it, we must:

May - Develop a bi-partisan consensus; 70 votes, minimum.

June - Mark-ups in Senate and House committees

July - Floor action and conference
(GOP requires advance agreement in principle)

August - President signs the bill

One final point on politics. Democrats need leadership. Moderate Republicans have put their cards on the table in both the Chafee bill and the Managed Competition Act. There are many members of good will on both sides of the aisle that will support a bill that grows from the center. I believe it will be a program that we can all be proud of.

We need a strongly bipartisan bill. The support of one party is not enough to get a credible package to the American people. But, even more importantly, we need health reform that will stick. If the support is too thin, it will be easy for those who will resist changing their behavior in response to reform (i.e., insurers, some physicians, etc.) to press for repeal. We can't afford nor do we want another Catastrophic catastrophe!

Comparison of Clinton and Alternative Proposal
(dollars in billions)

	FY 95 - 99	FY 2000 - 4	10 - Year
Clinton 1/1/96 eff, 58% ded. $250/288	52.5	101.1	153.5
Alternative 1/1/98 eff, 50% ded. $415	20.2	74.4	94.6
Alternative 1/1/98 eff, 45% ded. $500	18.4	67.5	85.8

with a 20/30 copayment schedule

(after 2/30
558-0297

Comparison of Clinton and Alternative Proposal
(dollars in billions)

Fiscal Year	1995	1996	1997	1998	1999	5-year	6-year
Clinton	0.0	7.0	14.2	15.1	16.2	52.5	69.9
1/1/98 effect date		-7.0	-14.2	-3.8	0.0	-25.0	-25.0
$500 (45%) r/t $288 (58%) in 98				-2.5	-3.6	-6.1	-9.9
5 DF in 98 r/t $5.35				-0.1	-0.1	-0.2	-0.4
30% Coinsurance				-1.2	-1.7	-2.9	-4.7
Total Revised	0.0	0.0	0.0	7.6	10.8	18.4	30.0

Fiscal Year	2000	2001	2002	2003	2004	5-year	10-year
Clinton	17.4	18.4	19.9	21.8	23.6	101.1	153.5
1/1/98 effect date	0.0	0.0	0.0	0.0	0.0	0.0	-25.0
$500 (45%) r/t $288 (58%) in 98	-3.8	-4.0	-4.4	-4.8	-5.2	-22.2	-28.3
5 DF in 98 r/t $5.35	-0.1	-0.2	-0.2	-0.2	-0.2	-0.9	-1.1
30% Coinsurance	-1.8	-1.9	-2.1	-2.3	-2.5	-10.5	-13.4
Total Revised	11.6	12.3	13.3	14.6	15.8	67.5	85.8

Comparison of Clinton and Alternative Proposal
(dollars in billions)

Fiscal Year	1995	1996	1997	1998	1999	5-year	6-year
Clinton	0.0	7.0	14.2	15.1	16.2	52.5	69.9
1/1/98 effect date		-7.0	-14.2	-3.8	0.0	-25.0	-25.0
$415 (50%) r/t $288 (58%) in 98				-1.6	-2.3	-3.9	-6.3
5 DF in 98 r/t $5.35				-0.1	-0.2	-0.3	-0.4
30% Coinsurance				-1.3	-1.9	-3.2	-5.1
Total Revised	0.0	0.0	0.0	8.3	11.9	20.2	33.0

Fiscal Year	2000	2001	2002	2003	2004	5-year	10-year
Clinton	17.4	18.4	19.9	21.8	23.6	101.1	153.5
1/1/98 effect date	0.0	0.0	0.0	0.0	0.0	0.0	-25.0
$415 (50%) r/t $288 (58%) in 98	-2.4	-2.6	-2.8	-3.1	-3.3	-14.1	-18.0
5 DF in 98 r/t $5.35	-0.2	-0.2	-0.2	-0.2	-0.2	-1.0	-1.2
30% Coinsurance	-2.0	-2.1	-2.3	-2.5	-2.7	-11.6	-14.7
Total Revised	12.8	13.5	14.6	16.1	17.4	74.4	94.6

COUNCIL OF ECONOMIC ADVISERS

Memorandum

TO: Chris Jennings
FROM: Pam Short
SUBJECT: Individual Mandate as the Basis for Universal Coverage
DATE: July 15, 1994

If desperate times warrant desperate measures, is there any point in coming back to an individual mandate? There is more hope of making it palatable to both sides than anything else that's on the table. I believe that we could design the incentives to produce an individual mandate with more (voluntary) employer participation than we have now.

As I understand it, the bi-partisan Centrist group in Senate Finance had moved to an individual mandate before things kind of fell apart...

cc. Laura Tyson
Joe Stiglitz
Ira Magaziner
Gene Sperling

ADVANTAGES AND DISADVANTAGES OF THE STATE FLEXIBILITY APPROACH

ADVANTAGES

- ♦ Offers states the option to unite administrative and fiscal responsibility rather than giving fiscal responsibility to the federal government and administrative responsibility to the states.

- ♦ Allows maximum flexibility to tailor state systems -- including financing -- to state circumstances.

- ♦ Provides incentives for states to implement cost containment, and flexibility to states in devising methods to do so.

DISADVANTAGES

- ♦ The degree of financial protection for low income persons may vary across states.[1]

- ♦ Encourages state vs. state and state vs. federal disputes over the level of initial premium targets and maintenance of effort payments, since these affect the amount of money each state can receive for subsidies.

- ♦ Large employers will be strongly opposed to allowing states to pre-empt ERISA and impose state specific requirements on multi-state employers.

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[1] Some states may adopt relatively regressive financing systmes. This could be minimized by a requirement that the federal government apporve state financing arrangements. However, in practice, unless the federal government engaged in comprehensive reviews of entire state tax systems, the actual protection afforded to low income persons would still vary across states.

06-27-94 09:10 AM FROM OLP

OFFICE OF LEGISLATIVE & INTER-GOVERNMENTAL AFFAIRS FAX COVER SHEET

of Pages: Cover + 2 DATE: _____

TO:
Chris Jennings

Fax: _____

Phone: _____

FROM:
Peter Hudson

Fax: (202) 690 - 8168

Phone: _____

REMARKS:

HEALTH CARE FINANCING ADMINISTRATION

Washington, D.C.

Savings from HSA for Reduced Dispensing Fees

	FY 96	FY 97	FY 98	FY 99	FY 2000	5-Year	Savings from HSA
Dispensing Fees							
HSA - $5.00 in 96	2,453	3,428	3,638	3,863	4,100	17,480	
$4.75	2,329	3,257	3,454	3,669	3,894	16,603	877
$4.50	2,206	3,086	3,272	3,476	3,689	15,729	1,751
$4.25	2,084	2,914	3,091	3,283	3,484	14,856	2,624
$4.00	1,961	2,743	2,909	3,089	3,279	13,981	3,499

	96	97	98	99	2000
Dispensing Fee	$5.00	$5.17	$5.35	$5.53	$5.72
CPI		0.034	0.034	0.034	0.034

SAVINGS FROM HSA DRUG BENEFIT USING VARIOUS HIGHER DEDUCTIBLE LEVELS

PERCENT OF BENEFICIARIES MEETING DEDUCTIBLE	DEDUC-TIBLE	OUTLAYS FY 96	OUTLAYS FY 97	OUTLAYS FY 98	OUTLAYS FY 99	OUTLAYS FY 20	OUTLAYS 5 YR TOTAL	PERCENT OF SAVINGS FROM HSA
HSA 36.8%	$250	$6,969	$14,223	$15,112	$16,174	$17,395	$69,873	
50%	$363	($972)	($1,966)	($2,107)	($2,272)	($2,445)	($9,763)	14.0%
45%	$441	($1,546)	($3,129)	($3,349)	($3,602)	($3,882)	($15,507)	22.2%
40%	$528	($2,103)	($4,274)	($4,573)	($4,899)	($5,282)	($21,131)	30.2%
35%	$629	($2,643)	($5,365)	($5,743)	($6,160)	($6,634)	($26,545)	38.0%
30%	$746	($3,135)	($6,364)	($6,810)	($7,305)	($7,867)	($31,480)	45.1%

Prepared by: OLIGA/D.Oxenreider/G:medpartb\drugs.wk1/3-25-94

Q: What does the Administration think of Senator Chafee's plan?

A: There is a great deal of activity in the Senate Finance Committee right now, and that's very encouraging. I'd like to think we're seeing good-faith efforts to craft a plan that can answer the concerns of some members, but at the same time meet the President's bottomline goal of universal coverage. Senator Chafee has repeatedly said he's for health care reform, and he's for universal coverage. His knowledge and experience has placed him at the center of activity in the Finance Committee. He has been a critical to the negotiations. But if in the end his plan does not contain universal coverage, it won't be a plan we can support.

Q: But does his plan achieve universal coverage? If not, isn't it close enough?

A: The President has said time and time again that his bottom line is guaranteed private insurance for every American. The Finance Committee is still working on this -- the proposal that came out last week moves us in the right direction, but there's work yet to be done. Our bottom line hasn't changed.

Why? Because without universal coverage it's the middle class that gets hardest hit. We think health reform has to be about helping middle class working people, not leaving them out in the cold.

Q: What will the Adminstration accept as universal coverage? 91% 95%

A: We don't think it's useful to get into a numbers game. Universal means universal -- it means guaranteed private insurance for every American.

Q: What should we be doing to make sure Senator Chafee gets the message on universal coverage?

A: Well, the White House isn't allowed to suggest that outside groups lobby the Congress. The best I can say is that what makes democracy is work is when individual citizens rise up and tell their elected leaders what they need, what policies will help make their lives better. That's why I'm so heartened you're here in Washington today.

7:30

AN ANALYSIS OF THE MANAGED COMPETITION ACT

EMBARGOED UNTIL
MAY 4, 1994, 10:00 A.M.

The Congress of the United States
Congressional Budget Office

EMBARGOED UNTIL
MAY 4, 1994, 10:00 A.M.

EMBARGOED UNTIL
MAY 4, 1994, 10:00 A.M.

NOTES

Numbers in the text and tables of this report may not add to totals because of rounding.

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EMBARGOED UNTIL

Preface

The Congressional Budget Office (CBO) has prepared this analysis of the Managed Competition Act of 1993 in response to several Congressional requests. The report summarizes the main provisions of the proposal, examines how they relate to the key features necessary to achieve the full potential of the managed competition approach, and estimates the proposal's effects on national health expenditures and the federal budget. The report also examines the proposal's impact on the economy and other considerations affecting its design and implementation.

Many staff members in several of CBO's divisions contributed to the analysis contained in this report. Paul Van de Water coordinated the analysis and the preparation of the report. Linda Bilheimer was responsible for the Summary and Chapter 5, Paul Van de Water for Chapters 1 and 3, Leonard Burman and Sandra Christensen for Chapter 2, and Douglas Hamilton for Chapter 4.

In the Budget Analysis Division, under the supervision of C.G. Nuckols, Paul Van de Water, and Charles Seagrave, contributors were Paul Cullinan, Alan Fairbank, Scott Harrison, Jean Hearne, Lori Housman, Lisa Layman, Jeffrey Lemieux, Patrick Purcell, and Connie Takata. In the Health and Human Resources Division, under the supervision of Nancy Gordon and Linda Bilheimer, contributors were B.K. Atrostic, Carol Frost, Carla Pedone, Constance Rhind, Murray Ross, and Cori Uccello. In the Macroeconomic Analysis Division, under the supervision of Robert Dennis and Douglas Hamilton, Douglas Elmendorf made important contributions. In the Tax Analysis Division, under the supervision of Rosemary Marcuss, contributors were David Weiner and Roberton Williams. Gail Del Balzo, CBO's General Counsel, also contributed.

CBO would like to acknowledge the significant contribution of the staff of the Joint Committee on Taxation, particularly Bernard Schmitt, Ron Jeremias, Thomas Koerner, Pamela Moomau, Michael Udell, Laura Wheeler, and Judy Xanthopoulos. Michael O'Grady of the Congressional Research Service also provided invaluable assistance.

Paul L. Houts supervised the editing and production of the report. Major portions were edited by Paul L. Houts, Sherry Snyder, and Leah Mazade. Jeanne Burke, Sharon Corbin-Jallow, Dorothy Kornegay, and Linda Lewis assisted in the typing. Christian Spoor provided editorial assistance during production. With the assistance of Martina Wojak-Piotrow, Kathryn Quattrone prepared the study for final publication.

Robert D. Reischauer
Director

April 1994

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EMBARGOED UNTIL
MAY 4, 1994, 10:00 A.M.

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Summary

The Managed Competition Act of 1993 endeavors to slow the growth of health care costs and expand access to health insurance by strengthening competitive forces in health care markets and providing people with better access to affordable coverage. It would restructure health insurance markets, provide people with strong incentives to purchase health insurance prudently, and subsidize health insurance for low-income people.

The proposal would make health insurance available to all but would not establish universal coverage. Individuals would not have to obtain coverage if they did not choose to do so, and employers would only have to offer--not pay for--coverage for their workers. Even without individual or employer mandates, the number of uninsured people would drop significantly under the proposal.

The major vehicle for reorganizing the health insurance marketplace would be regional health plan purchasing cooperatives (HPPCs). Through them, employees of small firms (generally those with 100 or fewer employees) and individuals with no attachment to the labor force would purchase coverage. (Medicare's coverage would, however, be essentially unchanged.) The HPPC would offer those people a choice of accountable health plans (AHPs), which would provide a standard benefit package. The AHPs would have to meet strict requirements regarding open enrollment, limits on exclusions for preexisting conditions, and modified community rating--allowing each AHP's premiums to vary only by age and the type of enrollment (individual, individual and spouse, individual and one child, and individual and family).

Firms with more than 100 employees would also have to offer their employees the opportunity to purchase coverage from an AHP. They could accomplish this either by self-insuring--that is, setting up their own AHPs--or by purchasing coverage from an AHP offered in the non-HPPC marketplace. They could not participate in a HPPC, however, unless they were located in states that took advantage of the option to raise the maximum size of firms that must participate in a HPPC.

The proposal would make changes in the tax code, some of which would promote more widespread insurance coverage while others would discourage the purchase of generous policies. Premiums paid to AHPs would be tax deductible up to the "reference premium"--that is, the premium for the lowest-cost plan offered through the HPPC that covered at least a specified proportion of eligible enrollees. The deduction would encourage people to purchase health insurance: under current law, the self-employed and people purchasing individual policies generally do not qualify for tax subsidies. Because premiums in excess of the reference premium would not be deductible, employers would be encouraged to limit their contributions for health insurance premiums, and consumers motivated to select lower-cost health plans.

Under the proposal, the Medicaid program would end, and a broad system of federal subsidies would enable low-income people to purchase acute care coverage from AHPs. States would assume responsibility for the long-term care component of Medicaid, with most of them benefiting from the new division of responsibilities with the federal government.

Subsidies for premiums and cost sharing would be available for everyone with income below 200 percent of the poverty level. (The only exceptions would be Medicare beneficiaries for whom subsidies would mirror current Medicaid benefits for dually eligible enrollees and "qualified Medicare beneficiaries.") Those at or below 100 percent of the poverty level would be fully subsidized for the reference premium. The premium subsidies would be phased out between 100 percent and 200 percent of the poverty level. By contrast, the subsidies for cost sharing would be the same throughout the entire income range up to 200 percent of the poverty level; no one in this group would have to pay more than nominal cost-sharing amounts. Individuals with income below 100 percent of the poverty level would also be eligible to receive a package of wraparound benefits--additional benefits that would not be part of the standard benefit package.

Spending on the subsidies would be limited to the amounts generated by proposed reductions in current health care programs, revenue changes, and prefunding of retiree health benefits for the Postal Service. Low-income participants would not be required to pay more if insufficient funds were available to fund the subsidies fully; rather, AHPs would have to absorb the shortfalls.

A new federal agency, the Health Care Standards Commission, would oversee the health care system and design the uniform benefit package. It would establish broad principles and standards for the system and would also undertake such day-to-day activities as determining eligibility for subsidies and registering AHPs. The commission's responsibilities would be far-reaching and would generally transcend those of state and local governments in the health care arena.

Managed Competition

The managed competition approach, which provides the basis for this proposal, remains largely untried. Advocates of the approach believe it has the potential to slow the rate of growth of health spending, but estimates of the magnitude of such effects are highly speculative. When the Congressional Budget Office (CBO) examined this issue in a 1993 study, it concluded that the capacity of any particular managed competition proposal to control costs would depend on the degree to which it included the following eight features:

- Regional purchasing cooperatives that would oversee a restructured health insurance market;
- Universal access to health insurance with community rating of premiums and limited restrictions on coverage;
- Universal health insurance coverage;
- A standard package of benefits for all health plans;
- Comparative information on the price and the quality of all health plans;
- Health plans with almost no overlap in their networks of providers;
- Effective mechanisms to adjust the premiums paid to health plans for the health risks of their enrollees; and
- Limits on the amount of health insurance premiums that people could shelter from taxes set at the cost of the least expensive plan.

The Managed Competition Act includes all or part of seven of these features. It would not, however, require universal coverage, even though the number of uninsured people would certainly fall. Whether an effective risk-adjustment mechanism could be developed is uncertain, but that problem besets many health care proposals--not this one alone. The proposal would also be in closer accord with the eight conditions if all of the population had to purchase health insurance through HPPCs and if HPPCs were given more power to negotiate with health plans.

CBO believes that the proposal incorporates the key attributes of managed competition sufficiently well that--over time--significant savings would result from both the more competitive market environment and the enrollment of more people in effec-

tively managed plans. The magnitude of these savings, however, remains largely a matter of speculation. Presumably, the effect on the growth rate of national health expenditures (NHE) would depend on the benefits included in the standard package. The more comprehensive the package, the larger the proportion of NHE that would be under the managed competition system and, hence, subject to its cost-reducing incentives. For the purpose of its cost estimates, CBO assumed that increasing enrollment in effectively managed plans would slow the growth in costs of AHPs by 0.6 percentage point per year for the first five years. In addition, competitive forces would dampen the rate of growth of costs of AHPs by increasing amounts over the projection period, thereby reducing the annual rate of growth by 1 percentage point after 2004.

Financial Impact of the Proposal

As with other proposals to restructure the health care system fundamentally, estimates of the effects of this proposal on national health expenditures and on the federal budget are highly uncertain. In addition to the lack of evidence about the effects of managed competition per se, the proposal leaves many important details--such as the standard benefit package--unspecified.

In preparing its cost estimates, therefore, CBO had to make a number of assumptions about the effectiveness of managed competition and the unspecified dimensions of the proposal. The estimates are extremely sensitive to these assumptions, the most important of which relate to the standard benefit package. In general, a more comprehensive benefit package would result in a higher premium, which would--in turn--translate into higher budgetary costs and national health expenditures. Although a more limited benefit package would have a lower premium, it would probably have little effect on the number of people with insurance. More limited standard benefits would, however, raise the after-tax costs of insurance for people who currently have more comprehensive policies, many of whom would probably purchase supplementary coverage out of after-tax income. As a result, they would probably become more prudent purchasers of health insurance.

Because of the uncertainty regarding the benefit package, CBO estimated the financial effects of the proposal under two illustrative alternatives. The first is the comprehensive benefit package proposed in the Administration's Health Security Act. The second is a benefit package costing 20 percent less than the first; it would have limited hospital coverage and would not cover prescription drugs, dental care, mental health, and preventive services. CBO concluded that, for differing reasons, neither alternative would be feasible without further adjustments to the proposal.

Under the more comprehensive alternative, the number of uninsured people would drop by almost 40 percent in 1996 (from 39 million to 24 million), with less than 10 percent of the population remaining uninsured thereafter. National health expenditures would rise above CBO's baseline initially--reflecting the increase in the number of people with insurance--but would fall below the baseline once the effects of managed competition, more enrollment in managed care, and cuts in the Medicare program began to be felt. By 2004, NHE would be $30 billion (or about 1½ percent) below the baseline.

Under this alternative, spending on subsidies would far exceed the funds designated for them; between 1996 and 2000, the average annual shortfall would be over 30 percent of the subsidies for premiums for non-Medicare enrollees. Although the proposal would require health plans to absorb shortfalls in subsidies, shortfalls of that magnitude could cause turmoil in HPPC markets. To avoid that possibility, the subsidies would have to be close to or fully funded. Consequently, some other features of the proposal would have to change if one wished to maintain a comprehensive benefit package. Possible options include reducing the generosity of the subsidies or augmenting the pool of resources available to fund the subsidies by cutting other programs, raising taxes, or allowing the budget deficit to increase.

Under the less comprehensive benefit package, the number of uninsured people would be about the

same as under the first alternative. As before, national health expenditures would rise in the early years--but by less than under the comprehensive alternative--and then fall below CBO's baseline.

Even though the premium would be 20 percent lower under the second alternative, the resources available under the proposal would be insufficient to fund the premium subsidies fully. Rather than cut back the already Spartan benefit package further, CBO chose to modify the proposal's subsidy scheme to permit full funding of the subsidies without exceeding the funds available in the subsidy pool. For the purposes of this illustration, CBO assumed that the cost-sharing subsidies for people with income between 100 percent and 200 percent of the poverty level would be dropped. With that additional assumption, the subsidies would be funded in full or nearly so after 1997.

Effects of the Proposal on the Economy

By ensuring that people could purchase health insurance at community rates regardless of their health status, the proposed restructuring of the health insurance market would improve certain aspects of labor markets. For example, it would assure workers who have health insurance through their jobs that they could continue to obtain coverage if they changed jobs or left the labor force. Insofar as some workers hesitate to change jobs because of the possibility of losing their health insurance, the problem of "job lock" would be reduced. Moreover, some workers might choose to retire early if they knew they could still obtain health insurance.

The subsidies for premiums and cost sharing would greatly reduce the number of people without coverage and would be very beneficial for low-income workers. But such workers would receive the full benefit of the proposed subsidy system only if their employers did not pay for insurance and, consequently, low-income workers would have incentives to work for employers that did not pay for insurance. If the employer of a low-wage worker contributed some amount toward insurance coverage, the subsidy would be reduced dollar for dollar under the proposal. In addition, the worker's wage would be lower than it would be if the employer did not contribute because employers shift the costs of such contributions back onto workers through reduced cash wages.

These effects would be particularly pronounced for workers with employment-based insurance and income close to the poverty level; they could earn considerably more if their employers no longer paid for coverage and subsidies would pay for most of their health insurance. By contrast, higher-income workers, who would not be eligible for subsidies, would probably prefer that their employers pay for insurance rather than pay them higher cash wages in order to avoid the payroll taxes they would pay on higher wages.

A less desirable consequence of the proposed system of subsidies is that it could discourage some people with incomes between 100 percent and 200 percent of the poverty level from working more. People with income in the range in which the subsidies were phased out would have to pay more for health insurance as their income rose. Some workers in this income range already face high effective marginal tax rates because of the phaseout of the earned income tax credit and the payment of income and payroll taxes. The phaseout of the subsidies for premiums would impose an additional marginal levy on workers of 15 percentage points to 30 percentage points, depending on their family type and the comprehensiveness of the benefit package.

Low-income families would also lose valuable benefits abruptly if their income rose to the point at which they lost eligibility for cost-sharing subsidies. (That income level would be 200 percent of poverty under the proposal as written, or 100 percent of poverty under CBO's second alternative with limited benefits.) Since there would be no graduated phaseout of those subsidies, a large "cliff" effect would result: below the income cutoff, people would have full cost-sharing benefits--worth an average of approximately $1,400 for a family of four in 1995--and above that income level they would not have any. A similar "cliff" would occur when people's income reached 100 percent of the poverty level and they lost their eligibility for wrap-around benefits. The amount they would lose

would depend on the benefits covered by the standard benefit package--the more generous the coverage the less would be included in the wraparound benefits. Thus, under the comprehensive benefit package, the wraparound benefits would be worth an average of $600 for a family of four in 1995; under the less generous alternative, they would be worth $2,900.

The problem of high effective marginal tax rates for people affected by the phaseout of subsidies is not unique to this proposal. Unfortunately, alternative solutions--such as reducing subsidies or phasing them out over a wider income range--would generate other problems. Smaller subsidies would require low-income people to pay a higher percentage of their health care costs; a slower phaseout would increase federal subsidy payments and cause workers at higher income levels to face disincentives for additional work.

How Shortfalls in Payments Would Affect AHPs and Insurance Markets

Certain features of the proposal might produce unintended consequences, lengthen the time needed for implementation, or limit the effectiveness of the proposal. Some of those features could be modified quite easily. Modifying others might prove more difficult.

One particularly problematic feature of the proposal is the large shortfalls that could face AHPs. If the funding designated for subsidies was insufficient to pay them in full, the federal government would reduce the proportion of the premium subsidies it paid and the AHPs would have to absorb the difference. They could not require low-income enrollees to pay more.

Shortfalls in premiums paid to health plans could also occur with full funding of the federal subsidies because the maximum federal subsidy could not exceed the reference premium for the HPPC. Low-income enrollees who chose AHPs with premiums higher than that amount would have to pay only a portion of the difference; the plans would have to absorb the shortfall. Some plans might also experience shortfalls in subsidies for cost sharing because those payments would not be related to the actual use of services by a plan's low-income enrollees.

To ensure that shortfalls in payments would not disproportionately affect AHPs enrolling large numbers of low-income people, the proposal would establish an interplan reconciliation process for low-income assistance. The scheme would require all AHPs, including self-insured plans, to participate in a nationwide system to distribute shortfalls in premiums and cost sharing equitably among health plans. This process would be extremely complicated; its feasibility is doubtful. Yet, without an effective mechanism, premiums in the HPPC could be highly unstable.

Instability of premiums would be a consequence of both the uncertainty plans would face in setting premiums and their probable responses to shortfalls. Although health plans could adapt to some uncertainties, as they do today, the proposed approach for shifting shortfalls in payments to plans would require them to deal concurrently with many unknown, interdependent variables in determining their premiums. As a result, the process would be exceptionally difficult. Moreover, there would be no guarantee that the uncertainties would lessen over time.

AHPs could respond to shortfalls in payments in various ways. But the responses and their impacts would generally be greater within HPPCs than outside them because low-income people would constitute a much higher proportion of the HPPC population. In the short term, AHPs might lower payments to providers or reduce the quantity or quality of the services they provided. In the longer term--when AHPs had the opportunity to do so--they would almost certainly raise their premiums. Plans facing strong competitive pressures might withdraw from the market altogether.

Because enrollment in AHPs would be voluntary, some people whose premiums were not heavily subsidized might drop their insurance coverage if premiums rose significantly. Healthy people who

felt the least need for coverage would be the most likely to withdraw in those circumstances. The loss of healthier people would cause the average risk level of enrollees in the HPPC to rise, placing further upward pressure on premiums. An upward spiral of premiums in the HPPC might result.

In the absence of an effective distribution process, extremely high shortfalls in payments could rapidly undermine insurance markets. For example, under the comprehensive benefit package assumed in CBO's first alternative, the shortfalls in premium subsidies would be so large that the HPPC system might collapse if AHPs had to absorb them.

Conclusion

The Managed Competition Act would significantly reduce the number of people lacking health insurance, but--because key elements of the proposal are unspecified--its effects on the budget, the economy, and health insurance markets are uncertain. Although several features of the proposal as written might impair its effectiveness or prove difficult to implement, the majority of them could probably be addressed quite easily through minor modifications.

More controversial are those elements of the proposal that both reflect its underlying philosophy and might also limit its feasibility. For example, allowing enrollment in AHPs to be voluntary and restricting the size of firms that could participate in the HPPC would have the potential to produce unstable premiums--especially if the federal subsidies were not fully funded. Moreover, without additional revenues or spending cuts, deficit neutrality would be difficult to reconcile with a comprehensive benefit package and full funding of the subsidies.

Such problems present difficult choices and trade-offs. The most immediate question, however, concerns the issues that should be resolved now as part of the proposal versus those that should be left to the Health Care Standards Commission, other government agencies, or the Congress to decide in the future.

Chapter One

Overview of the Managed Competition Act

The Managed Competition Act of 1993 seeks to slow the growth of health costs and expand health insurance coverage by adopting the managed competition approach to health care financing.[1] This approach, which was developed by a group of experts in health policy known as the Jackson Hole Group, emphasizes motivating consumers, insurers, and providers to be more cost-conscious, and it tries to imbue the health care system with the efficiency, flexibility, and innovation of competitive markets, without the undesirable outcomes of the present system. It leaves much decisionmaking decentralized. Managed competition also pursues expanded access to health insurance coverage, partly because that is an objective in its own right and partly because shrinking the pool of uninsured people would enhance the effectiveness of other changes designed to contain costs.[2]

The Managed Competition Act would regulate the health insurance market to make insurance more available and affordable, but it would not require either employers or individuals to purchase insurance. Various incentives would encourage health care providers, insurers, and consumers to focus more on the cost and quality of care; the government, though, would not limit insurance premiums, reimbursement rates, or total spending for health.

The proposal would create a system of managed competition consisting of a federal Health Care Standards Commission, regional health plan purchasing cooperatives (HPPCs), and a large number of accountable health plans (AHPs). It would repeal Medicaid and establish a new federal program that would help low-income people purchase health insurance coverage from an accountable health plan. Other provisions are designed to improve access to health care in rural and other underserved areas, expand preventive health programs, establish uniform standards for malpractice claims, and simplify the administration of health insurance. For the most part, the system of managed competition created by the proposal would not affect the Medicare program or private medigap health insurance policies.

Managed Competition

Managed competition is intended to encourage health insurers and health care providers to compete by offering high-quality, low-cost care and not by risk selecting--that is, by attempting to cover only the healthiest individuals. Under the proposal, a Health Care Standards Commission would oversee the health insurance market and establish a standard benefit package and other criteria for accountable health plans. Changes in the tax code would strongly encourage the use of accountable health plans. Regional health plan purchasing cooperatives would allow individuals and small groups to pur-

1. H.R. 3222 was introduced by Congressman Jim Cooper and has 57 current cosponsors. A similar Senate bill, S. 1579, was introduced by Senator John Breaux and has three cosponsors. For an analysis of an earlier version of the bill, see "Estimates of Health Care Proposals from the 102nd Congress," CBO Paper (July 1993), Chapter 5.

2. See Congressional Budget Office, *Managed Competition and Its Potential to Reduce Health Spending* (May 1993).

chase health insurance on much the same terms as large groups. Firms would be required to offer health insurance to their employees but would not be required to pay for it. People eligible for Medicare would continue to receive health benefits through that program and would not participate in accountable health plans.

Health Care Standards Commission

A new federal Health Care Standards Commission would be created to oversee the system of managed competition. The commission would specify a uniform set of health insurance benefits, and the commission's recommendations would go into effect unless overturned by a joint resolution of the Congress. These recommendations would supersede state laws requiring insurers to cover specific health care services. The commission would establish uniform cost-sharing requirements for all health plans, but no cost sharing would be allowed for clinical preventive health services. The commission would set these cost-sharing requirements to ensure that the use of health care services by the currently insured would not increase. It would also establish standards for reporting prices, health outcomes, and measures of consumer satisfaction. Plans that met the commission's standards would be registered as accountable health plans.

The commission would also play a substantial role in the ongoing operation of the health care system. It would determine the eligibility of low-income families for subsidies, distribute subsidies to health plans on behalf of eligible families, ensure that any shortfalls in subsidies for premiums were shared equitably among AHPs, set up a methodology for allocating risks among health plans within each HPPC, coordinate the payment of premiums to health plans when employees resided outside their employer's HPPC area, provide for the auditing of health plans, monitor the reinsurance market for health plans, ensure that enrollees were protected against the potential insolvency of their health plan, establish standards for a national health data system, and conduct various analyses of health care expenditures and use. By 1997, the commission would also submit to the Congress recommendations for achieving universal health insurance coverage, including one regarding an individual mandate purchase health insurance.

Accountable Health Plans

Accountable health plans would provide hea coverage in a variety of ways. Some, such health maintenance organizations, might offer hea insurance and health care as a single product. O ers might provide indemnity insurance benefi AHPs would be of two types--closed and op Closed plans generally would be limited to empl ees of firms employing more than 100 people, p ticipants in plans established under a collecti bargaining agreement prior to September 1993, a students enrolled in a university or college. Clos plans would be required to offer health insurance all members of the relevant group and would not offered through a health plan purchasing coope tive. Open plans would be required to accept eligible applicants and would be available o through a HPPC.

AHPs would be prohibited from basing pre ums on a person's health status or previous cla but could differentiate among demographic grou The Health Care Standards Commission wo establish premium classes based on type of enr ment and age. The proposal provides for four ty of enrollment--individual, individual and spo individual and one child, and individual and fam the age groups would be established by the comm sion. In general, each open AHP would establis standard premium for its plan in each HPPC which it was offered. The premium charged each class would equal the standard premium m plied by a premium class factor, which the comm sion would determine. Closed AHPs would establish a standard premium, but they could premiums only on type of enrollment and c disregard the adjustment for age. Closed A would also be allowed, but not required, to estab common premiums for two or more HPPC area

An accountable health plan could offer benefits than the standard package, but these i would have to be offered and priced separately the uniform benefit package. No AHP or insurer could offer benefits that duplicated tho

the standard package or reduce cost sharing below the uniform amounts established by the commission.

Accountable health plans would face extensive requirements for reporting information, which would have to be collected and transmitted to the Health Care Standards Commission or the local HPPC in standardized formats. Plans would have to provide information on their preventive health activities, outcomes of treatments, and consumer satisfaction. Moreover, plans would be taxed for failing to comply with these requirements and would be prohibited from paying providers who failed to report the required information. AHPs would also have to pay several taxes and assessments, including taxes on premiums to finance graduate medical education and assessments to equalize the burden of any shortfalls in subsidies for premiums for low-income families.

All open AHPs that are health maintenance organizations (HMOs) would have to become Medicare risk contractors--that is, if Medicare beneficiaries chose to enroll, the plans would have to provide services for a predetermined periodic payment from Medicare and would not be reimbursed separately for each service provided. All other AHPs (including closed plans) would be required to make compensating payments if the Health Care Standards Commission found that Medicare risk contracting put open HMO plans at a disadvantage.

Changes in the tax code would strongly encourage the use of accountable health plans. The proposal would limit the tax deductibility of health insurance spending to the "reference premium rate," which is the lowest premium for the individual's premium class charged by an open AHP enrolling a significant percentage of eligible individuals in the local HPPC. A 35 percent excise tax would be imposed on employers' payments for health insurance or a self-insured plan above the reference premium, as well as on all payments to plans that were not AHPs.[3] Individuals (both employed and self-employed) could take an income tax deduction for premiums paid to an accountable health plan, but the individual and the employer could together deduct no more than the reference premium. Unlike the present deduction for medical expenses, the proposed deduction for premiums would be available to all individual taxpayers, even if they did not itemize their deductions or their medical expenses did not exceed 7.5 percent of adjusted gross income.

Health Plan Purchasing Cooperatives

Each state would set up health plan purchasing cooperatives through which individuals and small businesses would have access to health insurance coverage. Except for those individuals working for businesses with more than 100 employees, everyone would generally be required to purchase their accountable health plan through the HPPC to receive a tax deduction. States would have the flexibility to make larger firms participate in the HPPC, as long as no more than half of the employees in the state would be eligible to purchase insurance through HPPCs. Each HPPC would cover an exclusive geographic area--an entire state, a portion of a state, or an interstate region. Once a year, a HPPC would offer each eligible individual the option of enrolling in any one of the open AHPs available in its area. This open enrollment period would have to last at least 30 days. During this period, the HPPC would provide standardized information on each open plan, including data on price, quality of care, and consumer satisfaction. The HPPC could also collect and disseminate information on the quality of care provided by closed AHPs in its area; if the HPPC did not do so, the Health Care Standards Commission would perform this task.

The HPPC would collect all premiums from individual purchasers and small businesses and distribute them to the open AHPs. Small businesses would have to enter into an agreement with the local HPPC, furnish the appropriate HPPC with the name and address of each employee, and provide for the payroll deduction of an individual's premium; employers would not be required to enroll their employees in a plan or contribute to the cost of coverage. Using a procedure to be established by the Health Care Standards Commission, the HPPC would pay relatively more to open AHPs that en-

3. H.R. 3222 and S. 1579 would set the excise tax rate at 34 percent, the top tax rate on corporate income in effect when the bills were drafted. The sponsors have told CBO that they intend the excise tax rate to equal the current top corporate tax rate, which was raised to 35 percent in the Omnibus Budget Reconciliation Act of 1993.

rolled high-risk individuals and less to AHPs with low-risk enrollees. The proposal provides for no adjustment of risks among HPPCs or between open and closed AHPs. The expenses of the HPPC would be financed by a surcharge on premiums for insurance bought through the HPPC. HPPCs would be prohibited from any actions that affected premiums, the reimbursement of providers, or the performance of AHPs.

Like small firms, large firms (in general, those with more than 100 employees) would be required to provide an accountable health plan in which their employees could enroll and to provide for the payroll deduction of premiums. Unlike small businesses, large firms could not offer a plan through the local HPPC, but rather would have to contract directly with a plan offered outside the HPPC or establish a self-insured plan. Insurers offering AHPs in the non-HPPC marketplace would not be required to charge large firms the same rate charged enrollees in the HPPC or the same rate charged employees of other large firms. Thus, the cost of the least expensive AHP available to a large firm might exceed the reference premium. In such situations, employers would be required to contribute to their employees' coverage. They would have to pay the difference between the lowest available premium and the reference premium to ensure that their employees could obtain coverage at no more than the reference rate.

So there is an employer mandate?

Because people would always have access to health insurance coverage, either through the local HPPC or their employer, the proposal would repeal the so-called COBRA requirement for continuation coverage. Currently, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that employers providing health insurance and with 20 or more employees must allow participants and other beneficiaries to purchase continuing coverage for at least 18 months after coverage would otherwise cease--for example, because of job loss, death, or divorce.

Assistance to Low-Income People

The Managed Competition Act would repeal Medicaid and establish a new program to assist many more low-income people with the costs of health care. The federal government would provide subsidies for health insurance premiums, cost-sharing requirements, and certain benefits commonly covered under Medicaid that were not part of the standard benefit package. Medicare beneficiaries would be eligible for similar subsidies. The Health Care Standards Commission would be responsible for taking applications for low-income assistance, verifying the information provided, computing the amount of assistance, and distributing subsidies to health plans on behalf of eligible families. The subsidies and other budgetary costs would be financed by repealing Medicaid, limiting the deductibility of health insurance expenses for employers, reducing certain payments under Medicare, and making other changes in taxes and spending.

Subsidies for Premiums and Cost Sharing

For people not eligible for Medicare, the subsidy on their premium would be based on the reference premium--the premium for the least expensive AHP enrolling a significant number of people in the HPPC. In general, those with adjusted gross income up to 100 percent of the poverty level (adjusted for the state's cost of living) would be eligible for a federal subsidy equal to the reference premium. The subsidy would be phased out for people with incomes between 100 percent and 200 percent of the state-adjusted poverty level. Recipients of Aid to Families with Dependent Children or Supplemental Security Income would be deemed to be poor for the purpose of computing subsidies. An employer's payments for health insurance on behalf of an individual would reduce the amount of the federal subsidy dollar for dollar. Medicare beneficiaries with income below 120 percent of the poverty level would receive a full subsidy of their premium for Medicare's Supplementary Medical Insurance--currently $493 a year.

Low-income people who chose to enroll in AHPs charging more than the reference premium would receive a reduction in their premium, but the reduction would be absorbed by other participants in the plan and not financed by the government. People with incomes up to 110 percent of poverty would pay only 10 percent of the difference between their plan's premium and the reference

...m. This reduction in premiums would be ...ed out for people with incomes between 110 ...cent and 200 percent of poverty.

All non-Medicare enrollees with income below ...0 percent of the poverty level would be required ...pay only nominal cost-sharing amounts, as cur...ly defined for the Medicaid program. Health ...ns would be reimbursed by the federal govern...nt for these cost-sharing subsidies based on the ...mber and type of low-income people in the plan, ...t on the amount of services they used. Medicare ...eficiaries with income below 100 percent of ...verty would be exempt from all cost-sharing ...uirements. In this case, Medicare would pay ...viders the full amount allowed, and the Hospital ...rance Trust Fund would receive an appropria... to pay for the subsidies.

For individuals with family income below 100 ...rcent of poverty, a wraparound benefit would ...cover certain items commonly covered under Med...id, including prescription drugs, eyeglasses, and ...ring aids. Specifically excluded would be long-...m care services and services included in the ...ndard benefit package. Because prescription ...gs would most likely be covered in the standard ...efit package, the prescription drug coverage in ...package of wraparound benefits would primarily ...ist poor Medicare beneficiaries.

States would no longer be responsible for cover...g acute care for the former Medicaid population. ...ey would, however, assume full responsibility for ...g-term care. This trade would provide substan...l fiscal relief to most states. Moreover, states in ...ich state and federal spending on long-term care ...ceeds the state's share of Medicaid would receive ...porary federal financial assistance, which would ...phased out over four years.

...inancing

...everal changes in taxes and spending would fi...nce the assistance to low-income people, the ...panded deductibility of health insurance premiums ...r employees and the self-employed, and other ...maller costs associated with program expansions. The proposal would cap the deductibility of health insurance expenses for employers, reduce payments to providers under Medicare, phase out Medicare's disproportionate share payments to hospitals, increase Medicare premiums for upper-income beneficiaries, require the Postal Service to prefund its retiree health benefits, and repeal Medicaid.

The proposal is intended to produce no increase in the federal budget deficit. If the savings fell short of covering the new federal costs, the proposal would scale back the amount of premium assistance provided to low-income people not eligible for Medicare. Under those circumstances, AHPs could not increase the premiums charged low-income people but would have to absorb the shortfall in federal payments by increasing premiums, reducing payments to providers, or other means. Alternatively, the Health Care Standards Commission could tailor the standard benefit package to fit the available funding, additional spending cuts could be made, or additional revenues provided.

To ensure that AHPs enrolling large numbers of low-income people were not disproportionately burdened by any shortfall in federal subsidies of premiums, the Health Care Standards Commission would establish a system to ensure the equitable distribution of the shortfall among health plans. This same reconciliation process would also be used to equalize reductions in premiums and cost sharing.

Other Provisions

The proposal also contains provisions relating to health care services in underserved areas, graduate medical education, preventive health services, medical malpractice, and administrative simplification.

The proposal would improve access to health care in rural and other underserved areas by allowing HPPCs to require AHPs in the HPPC to serve such areas, promoting the development of AHPs in rural areas, authorizing additional funds for migrant and community health centers, and establishing a new system of Medicare payments for rural emergency access care hospitals.

Title III of the bill would alter the system of federal funding for medical education. It would establish a National Medical Education Fund, to be financed by a levy of 1 percent on the premiums of all AHPs and by payments from Medicare. The Health Care Standards Commission would approve programs for training medical residents and would pay each approved program out of the fund. The current medical education payments under Medicare would be repealed. The proposal would also increase funding for training midlevel practitioners, the National Health Service Corps, and area health education centers.

Title IV would expand preventive health services. It would increase authorizations for several public health programs, including immunization against vaccine-preventable diseases, prevention of lead poisoning, prevention of breast and cervical cancer, health information and health promotion, and the Preventive Health Services Block Grant. It would also expand Medicare to cover screening for colon and breast cancer, vaccination against influenza and tetanus-diphtheria, and well-child care fo disabled children eligible for Medicare. The addi tional preventive services provided under Medicar would be financed by an increase in the premiun paid by Medicare beneficiaries for Supplementar Medical Insurance.

Title V would establish uniform federal star dards for malpractice claims, including limitin claims for noneconomic damages and reducing lon statutes of limitations. It would also authoriz grants to states to develop systems of resolvin malpractice disputes other than through court pr ceedings and to develop medical practice guideline

Title VI would attempt to reduce the administr tive costs of health insurance. Initially, the Heal Care Standards Commission would establish goa for standardizing claims forms and electronic tran mission of data. If the goals were not met, tl commission would set standards and requiremer for health plans.

Chapter Two

The Proposal's Adherence to the Key Features of the Managed Competition Approach

The managed competition approach seeks to improve access to health insurance and to restrain the growth of health care costs by making consumers, insurers, and providers more conscious of cost. Such an approach would create purchasing cooperatives to improve access to affordable insurance for individuals and small groups. It would also increase insurers' incentives to compete on the basis of price and quality instead of by avoiding high-risk enrollees. The extent to which any managed competition proposal could achieve the full potential of this approach depends, in large measure, on the degree to which the proposal incorporates the following eight key features.[1]

- Regional health plan purchasing cooperatives (HPPCs) would oversee a restructured insurance market, with the objective of fostering competition among insurers on the basis of price and quality instead of by seeking to exclude high-risk enrollees.
- Access to insurance would be universal and on an essentially equal basis, accomplished by open-enrollment periods, community-rated premiums, and limited restrictions on coverage, to avoid current insurance practices that have made insurance unavailable to many individuals and small groups. (Under community rating, premiums vary only by type of enrollment and sometimes by the age or sex of the enrollee.)
- Insurance coverage would be universal, to avoid the shifting of costs for the uninsured to insured groups.
- All plans would offer a standard benefit package, to minimize nonprice differences so that consumers could more easily compare plans based on price.
- The HPPCs would provide comparable information on both price and the quality of care under each health plan, to facilitate competition based on those two factors.
- Health plans would have substantially nonoverlapping networks of affiliated providers, to facilitate each plan's ability to induce providers to adopt more cost-effective practice patterns.
- Payments from HPPCs to health plans would be adjusted for risk (while maintaining community-rated premiums for enrollees), to reduce plans' incentives to seek lower-cost enrollees rather than lower-cost means of providing high-quality care.
- The amount of tax-sheltered health insurance premiums would be limited to the level of the least expensive plan offered through the HPPC in each region, to make consumers more conscious of costs.

This chapter discusses the extent to which the Managed Competition Act incorporates each of these key features. In brief, the proposal lacks one (the assurance of universal coverage), but it has part or all of the other seven. The chapter concludes

1. These features were identified and discussed in greater detail in Congressional Budget Office, *Managed Competition and Its Potential to Reduce Health Spending* (May 1993).

with a description of the Congressional Budget Office's (CBO's) assumptions regarding the degree to which the growth of health care costs would be restrained by the managed competition features of the proposal.

For the most part, the discussion in this chapter assumes that the standard benefit package would be comprehensive, covering most health care needs. If, instead, the standard package was so limited that many people purchased supplementary insurance, then a substantial portion of health care spending would take place outside the system of managed competition. Consequently, the effects of managed competition would also be limited, and many of the problems evident in the insurance market now would be present in the market for supplementary insurance.

Regional Health Plan Purchasing Cooperatives

Conceptually, regional health plan purchasing cooperatives are a key element to the success of managed competition. HPPCs are intended to integrate the market for health insurance sold to individuals and small employers, which is currently segmented by risk. By organizing the demand side of the market and enforcing open access to health insurance, the HPPC would create countervailing power for purchasers in their relationships with insurers. In addition, the HPPC would restructure competition within insurance markets by providing clearer information about the differences among insurers' networks of providers, reducing incentives for insurers to engage in nonprice competition based on enrolling low-risk members, and increasing incentives for insurers to reduce premiums by delivering high-quality care to their enrollees in more cost-effective ways.

The proposal would establish a single HPPC in each region to coordinate all offerings by accountable health plans (AHPs) to individuals and small employers. The HPPC would provide information on each plan's price and quality of care; it would also collect premiums from enrollees and make risk-adjusted payments to the plans.

Under this proposal, however, the role of t HPPC would be more limited than might be nece sary to achieve fully the objectives of manage competition. A significant proportion of the insur population in each state would be outside t authority of the HPPC because large employe could not obtain insurance through it. The propos defines a large employer as one with more than 1(employees, but it would allow states to raise th threshold as long as no more than half of all en ployees in the state would then be eligible to obta insurance through a HPPC. Because the HPPC pool of insured people would exclude those in pla offered by large employers, it would be smaller ar higher in risk than a pool that included all AHPs the region.

Even for HPPC-sponsored health plans, t HPPC would not be permitted to bargain or othe wise influence plans' premiums or the rates paid providers. In addition, the HPPC would have r authority to approve or disapprove health pla seeking to offer insurance in the region--this autho ity would reside, instead, in the new federal Heal Care Standards Commission.

Universal Access to Insurance

The proposal would ensure universal access health insurance, and it would provide subsidies low-income people to help them pay the costs that insurance. All HPPC-sponsored AHPs wou have to hold open-enrollment periods and char community-rated premiums. Plans could not der coverage on the basis of health status, and the could restrict coverage for preexisting conditio only for the first six months of a new policy.

The proposal would not, however, guarant universal coverage. In the absence of a requireme for such coverage, people who anticipated relative high costs for health care would be more likely purchase insurance than people who expected rel tively low costs. With a portion of the populati remaining uninsured, per capita insurance costs f the insured population would be higher, compar with universal coverage, for two reasons. First, t

average level of risk among those who purchased coverage would be higher than the level among those who did not. Second, when uninsured people required care, providers would probably shift any uncompensated costs for that care to the insured population through higher charges that would be reflected in higher insurance premiums.

Standard Benefit Packages and Comparative Information

In addition to the tax cap discussed in a later section, two other features of the proposal would encourage price consciousness in health insurance and health care markets. First, all AHPs (both the open plans offered through the HPPC and the closed plans offered by large employers) would have to offer a standard benefit package, which would facilitate meaningful price comparisons among plans because the product would be uniform. Second, the HPPC would be required to compile comparable information--not only about price but also about quality of care--for all its AHPs to help purchasers balance quality against costs when choosing a plan.

Both open and closed AHPs would have to meet similar requirements with regard to the standard benefit package, which would include a standard cost-sharing requirement. The proposal's provision for a standard benefit package would override current laws in some states that require insurers to cover specific services.

Plans could offer benefits beyond the standard package subject to two conditions: the extra benefits could not reduce cost-sharing requirements on the standard benefits, and the extra benefits would have to be offered and priced separately from the standard package. Anyone eligible to purchase insurance through the HPPC could purchase an open AHP's supplemental policy, whether or not they purchased that plan's standard policy. The latter condition would help to ensure that insurers' supplemental benefits would not become a means for their achieving favorable risk selection in their standard health plans.

Nonoverlapping Networks of Providers

To realize fully the potential savings from managed competition, insurers would have to compete vigorously with respect to price and quality of care. Effective competition would probably require that insurers have nonoverlapping networks of providers. If, instead, most providers were affiliated with several insurance networks, price differences among the plans would mostly reflect differences in discounts that the plans had negotiated. Providers' incentives to adopt the cost-effective patterns of treatment encouraged by any one of the networks they served would be weakened in direct proportion to the percentage of their patients whose insurers were associated with other networks.

The proposal would override laws that in some states require managed care plans to enroll all providers in the service area who wish to serve the plan's membership. Thus, the proposal would permit insurers to form nonoverlapping networks of affiliated providers, but to what extent insurers would actually do so is unclear. Competitive pressures might be sufficient to induce insurers to develop such networks, but the incentives would be even stronger if insurers were held accountable for the quality of care provided under their plans.

Effective accountability for the quality of care provided under their health plans would substantially change the incentives insurers now face. It would encourage much closer scrutiny of the providers they enrolled and closer involvement in the day-to-day practice of those providers. A degree of accountability would be achieved through the discipline of a market in which consumers were well informed about differences in the quality of care provided through each network; under the proposal the HPPC would provide such information to individual consumers and small employers. Another, more certain way to achieve accountability would be to hold insurers liable, along with their affiliated providers, under current standards for malpractice, but the proposal has no such provision.

Risk-Adjusted Payments to Health Plans

In any system that required open enrollment with community-rated premiums but that had no mechanism to neutralize the financial effects of risk selection, the main factor determining profitability for insurers would be how successfully they could attract relatively healthy enrollees. Under the managed competition approach, even if the benefit package was uniform and enrollment in plans was controlled by the HPPCs, plans might nevertheless find ways to achieve favorable risk selection. For example, plans might target their marketing to more active (and presumably healthier) people, or they might limit the number of affiliated physicians in strategic specialties. Plans with limited access to cardiologists, for instance, would be unlikely to attract many people with heart disease.[2] Without compensating payments, plans that enrolled a relatively large proportion of high-cost members might be unable to compete because of the characteristics of their membership, even if they provided care very efficiently.

In principle, the proposal would establish a system of payments to compensate plans for differences in risk, but no accurate mechanism currently exists to calculate such payments. Also unclear is how quickly risk-adjustment mechanisms could be developed or how accurate they would have to be to eliminate incentives for plans to compete based on risk selection rather than price and quality. What is certain is that without a mechanism that was "good enough," efficient plans would not necessarily be rewarded appropriately.

Limits on the Amount of Tax-Sheltered Insurance Premiums

One of the key elements of managed competition is limiting the amount of tax-sheltered health insurance premiums to the cost of the least expensive pl available to each enrollee. Because the addition cost of purchasing a more expensive plan would n be subsidized through the tax system, consume would be more conscious of the cost of heal insurance. This awareness, in turn, would make i surers more conscious of the costs they incurred provide benefits.

Under the proposal, only premiums for pla that met the requirements established by the Heal Care Standards Commission--accountable heal plans--would be deductible, and for these plans t tax preference would be limited. The propos would cap the currently unlimited tax subsidy f employment-based health insurance by imposing excise tax on employers' contributions that we above the premium for the lowest-cost plan in t HPPC--the reference premium. (If an employ contributed less than the amount of the referen premium, the difference between the reference pr mium--or the actual premium, if less--and t employer's contribution could be deducted fro taxable income by the worker.) The proposal wou also allow self-employed people and individu enrollees to deduct premium payments, up to t amount of the reference premium, from their i come. That provision would expand the tax subsi for these people because most premiums paid l individuals do not qualify for tax subsidies und current law.[3]

The Effect of the Current Unlimited Tax Subsidy on Spending for Health Care

Health care costs are high in part because heal insurance premiums are subsidized through the t code. Employers' contributions toward the cost employees' health insurance are not taxable co pensation. Unlike cash wages, they are not subj to income or Social Security payroll taxes. As result, saving a dollar's worth of employment-bas

2. See J.P. Newhouse, "Patients at Risk: Health Reform and Risk Adjustment," *Health Affairs*, vol. 13, no. 1 (Spring (I) 1994).

3. For self-employed people and other individual purchasers, ins ance premiums up to the cap would be a deductible expense income tax purposes but not for calculating liability under Social Security payroll tax.

health insurance gains the typical employee in 1994 only 74 cents in take-home pay.[4]

The tax subsidy for employment-based health insurance has encouraged employers to sponsor health insurance coverage for their employees. About 75 percent of workers and their families are covered by such insurance. But the subsidy has also discouraged workers and employers from seeking less expensive forms of health insurance because the tax subsidy is unlimited. Because the subsidy is more valuable for comprehensive health insurance with few controls on costs than for more economical health insurance coverage, employers exert less pressure on insurers to control costs than they otherwise would.

The subsidy adds to health spending in two ways. First, people tend to buy more of anything, including insurance, when its price is reduced. Second, the additional spending on insurance indirectly translates into additional spending on health care. People with health insurance pay little or none of the cost of care when they get sick; instead, insurance pays the cost for them. As a result, they and their doctors have little incentive to pay attention to the costs of diagnostic and treatment options.

The Effect of the Tax Cap in the Proposal

Limiting the tax subsidy by imposing a tax cap of some form would encourage employees and employers to choose more cost-effective health insurance. One type of cap would require employees to include in their taxable income the portion of their employer's payments for health insurance premiums that exceeds the cost of the lowest-cost plan available to them--the cap amount. Another option would prohibit employers from claiming as a business income tax deduction any health insurance payments in excess of the cap amount. A third option, which is the approach taken in the proposal, would apply an excise tax to employers' contributions in excess of the cap. (Like other excise taxes, the 35 percent excise tax in this proposal would be a deductible business expense.)

Effect on Employers' Contributions for Health Insurance. Under the proposed tax cap, an employer that contributed more than the amount of the reference premium would have to pay a 35 percent excise tax on the excess contribution. That tax would be passed on to employees in the form of lower cash wages. Thus, employees would ultimately pay the tax even if the employer chose to contribute more than the cap amount. If, instead, the employer limited its contribution to the amount of the cap, employees could select a more expensive plan, but they would pay the additional cost out of after-tax, rather than pretax, income. In other words, if the excise tax caused employers to limit their contributions to the reference premium, the tax would have the same effect as a limit on the amount of health insurance premiums that could be excluded from employees' taxable income.

The excise tax would create a strong incentive for employers to limit their contributions to the reference premium, but the cap in the proposal would constrain the choices of some employers and their employees more than others. For small employers, who would have to obtain coverage through the HPPC, the cap would--by definition--equal the cost of the lowest-cost AHP available to their employees. Thus, any additional expenditures for health insurance would either be subject to an excise tax, if the employer paid the additional premium, or income and payroll taxes, if the employee paid it.

Because a large employer--generally, one with more than 100 employees--that wanted to pay for insurance for its employees would be required to purchase insurance outside the HPPC, the premium for its lowest-cost plan would not necessarily equal the reference premium. Plans sponsored by employers whose workers were less healthy than the average participant in the HPPC areas in which the firm operated would typically cost more than the reference premium. Those employers would be least likely to pay more than the premium for the least expensive plan available to them. Moreover, if they limited their contributions to the cap amount, employees who wanted health insurance would have

4. See Congressional Budget Office, *The Tax Treatment of Employment-Based Health Insurance* (March 1994).

to pay the amount in excess of the reference premium out of after-tax wages.

But some other large firms would be less constrained by the cap in the proposal. Their premium for a plan that covered the standard benefits would be less than the reference premium because their workers would be healthier than average.[5] These firms would still have a strong incentive to limit their contribution to the cap, but that contribution might pay for basic insurance that cost more than the reference premium or for supplemental health insurance policies offered through an AHP. Thus, the cap would constrain the behavior of those large firms less than the behavior of small firms under the proposal.[6]

The adjustment of employers' contributions to the cap levels might take several years. Over the short run, employers might continue to make contributions that exceeded the reference premium--because of multiyear labor contracts, for example.[7] But over time, most would have a strong incentive to limit their contributions to the amount of the cap and increase employees' wages. An employer who contributed more than the cap would have to pay excise taxes on its excess contributions for all employees--even for those employees who would have been satisfied with a plan that could be purchased for the reference premium. Thus, the employer would be paying a tax (plus the additional premiums) to provide a benefit that was valuable only to some employees. By limiting contributions to the amount of the cap, the employer could make employees who chose the low-cost plan bett employees who preferred the high-cost plan still pay the extra premiums out of after-tax in

Over the long run, firms would be likely t more than the cap amount for their empl health insurance only if almost all employees a that they wanted a health insurance plan with mium that exceeded the cap. Those empl would pay less for their insurance if their em paid the 35 percent excise tax and passed on t in the form of lower wages than if they had t the extra premiums out of after-tax wages.[8] less comprehensive the standard benefit packa more likely it would be that employees would on additional health benefits. Thus, more would elect to offer health insurance that exc the reference premium (and would thus incu excise tax) under a limited standard benefit pa than under a more comprehensive one.

Effect of a Tax Cap on the Choice of Heal surance Plans. An example illustrates how cap, such as the one in the proposal, would p a stronger incentive than exists at present to low-cost health insurance. Suppose that the cost health insurance plan in an area costs $ for family coverage and that the high-cost plan costs $5,000. Under current law, if th ployer is willing to contribute the entire pre (in exchange for paying lower cash wages), dollar of health insurance costs the employee lar of cash wages minus the income and p taxes that would be paid on those wages. A ployee subject to a marginal tax rate of 30 p who was covered by the low-cost health inst plan for $4,000 would save $1,200 in taxes pared with receiving the $4,000 in cash wage Table 2-1).[9] If the employee was covered l

5. The proposal would also allow large employers that maintained a closed AHP to elect to use simplified rules for computing the reference premium. For example, an employer with younger-than-average employees would have a higher tax cap if it elected to use a "community rate" reference premium rather than one based on the age composition of its work force. That election might allow the employer to avoid the excise tax or to offer additional health benefits without exceeding the tax cap.

6. Some self-insured firms might also be able to circumvent the caps by recharacterizing insurance costs as company overhead or by artificially reallocating costs from enterprises with low insurance costs to those with high costs. For a discussion of this issue, see Chapter 6 of Congressional Budget Office, *The Tax Treatment of Employment-Based Health Insurance*.

7. The proposal provides a temporary exception from the excise tax for health insurance contributions made by employers as part of a collective bargaining agreement ratified before the date of enactment of the proposal, or January 1, 1998, whichever is earlier.

8. Because the reduction in wages as a result of the excise t reduce employees' income and payroll tax liability, the tax rate on the excess premiums paid by the employe range from 20 percent to 25 percent for employees with income. Those rates are lower than the combined inc payroll tax rates for most employees, so employees who a more expensive health insurance plan would rather h employer pay for it--and pay the excise tax--than receive tional compensation as taxable wages.

9. The 30 percent tax rate corresponds roughly to the c income and payroll tax rates (both the employer and e

Table 2-1.
Employees' Incentive to Purchase More Expensive Health Insurance Under Present Law, a Tax Cap, and No Tax Exclusion (In dollars)

	Low-Cost Insurance Plan				High-Cost Insurance Plan				Additional Cost of High-Cost Plan After Taxes
	Before-Tax Cost	Amount Excluded from Taxes	Tax Savings	After-Tax Cost[a]	Before-Tax Cost	Amount Excluded from Taxes	Tax Savings[a]	After-Tax Cost	
Present Law (Full exclusion)	4,000	4,000	1,200	2,800	5,000	5,000	1,500	3,500	700
Tax Cap of $4,000	4,000	4,000	1,200	2,800	5,000	4,000	1,200	3,800	1,000
No Tax Exclusion	4,000	0	0	4,000	5,000	0	0	5,000	1,000

SOURCE: Congressional Budget Office.

a. Based on a marginal tax rate of 30 percent.

high-cost plan for $5,000, the tax savings from the exclusion would increase to $1,500. Thus, the additional cost of the more expensive plan after taxes is only $700. When the additional services or reduced cost sharing in the more expensive plan are worth more than $700, under current law an employee would choose the more expensive plan, even though the additional premiums cost $1,000 before considering the tax savings.

Suppose that under the proposal the employer chose to contribute only $4,000. The cost to the employee of the low-cost health insurance plan would not change because the employer's contribution would continue to be fully excluded from taxation. If the employee paid the additional $1,000 in premiums for the high-cost health insurance, the tax savings would not change because of the cap. As a result, the after-tax cost of insurance would increase from $2,800 to $3,800. The additional cost would be the same as if no tax exclusion had existed at all (see Table 2-1). Thus, if the cap was in place, the employee would choose the more expensive plan only if it was worth its full additional cost. For example, if the additional services covered under the high-cost plan were worth only $850 to the employee, the cheaper plan would be chosen under the tax cap. But under present law, the employee would choose the more expensive plan.

Assumed Effects of the Proposal on the Growth of Health Care Costs

If the standard benefit package was a comprehensive one, the Managed Competition Act would put in place, to some degree, all of the features important to the success of managed competition except universal coverage, but it would be unlikely to realize the full potential of that approach to containing health care costs. Its potential would be enhanced if the HPPCs had more power to negotiate with AHPs and if everyone purchased health insurance through these cooperatives (which would mean that an effective tax cap would apply to them all). Achieving the full potential of managed competition would also depend on developing an adequate mechanism for adjusting payments to plans to compensate for

shares) for a taxpayer in the 15 percent income tax bracket. Note that eventually the immediate savings in payroll taxes are offset in part by lower Social Security benefits than would be paid if all compensation had been in the form of wages.

risk selection; this problem, however, is one that would affect all managed competition proposals.

CBO assumes that the proposal would restrain the growth of health care costs through two main avenues. First, the incentives created by the managed competition environment would accelerate the shift in insurance enrollment that is already under way toward effectively managed plans. CBO assumes that this effect would slow the growth in costs of AHPs by 0.6 percentage point per year for the first five years, compared with the rate of growth that would result under current law. Because of this effect, national health expenditures by the year 2000 would be about 1 percent lower than they would be otherwise.

Second, CBO assumes that the competitive pressures fostered by the proposal would cause all insurers to intensify their efforts to control costs. How successful they would be, and the resulting effect on the growth of overall health care spending, are uncertain. There are no credible estimates of the potential savings under managed competition, largely because this approach is untried. Although some features of managed competition exist in California, Minnesota, Wisconsin, and perhaps a few other states in which large purchasing cooperatives have been formed in recent years, the broa context in which these cooperatives operate diff from the environment that would exist under curr managed competition proposals. For the cost e mates provided in the next chapter, CBO assun that the competitive pressures created by the p posal would dampen the rate of growth of costs AHPs by increasing amounts over a 10-year peri until the restraint amounted to a 1 percentage-po reduction in the rate of growth of these costs each year after 2004.

These assumptions are used for both of alternatives examined in the next chapter--one ba on a comprehensive standard benefit package a one based on a more limited package. Growth national health expenditures would be more c strained under the comprehensive package th under the limited one, though, because a lar portion of that spending would flow through managed competition system if the package w comprehensive. Thus, in 2004 the estimated rate growth in national health expenditures would be percent under the alternative with a comprehens standard benefit package, 7.8 percent under alternative with a more limited package, and percent under current law. However, a great deal uncertainty surrounds these estimates.

Chapter Three

Financial Impact of the Proposal

The Managed Competition Act aims to slow the growth of national health expenditures and increase the number of people with health insurance. In the Congressional Budget Office's (CBO's) estimation, the proposal would lead to a slight increase in national health expenditures in the near term but would reduce health spending in the long run. Under the proposal, more than 15 million additional people would be covered by health insurance, and the number of uninsured would fall to less than 10 percent of the population.

The Managed Competition Act would achieve these outcomes by fundamentally transforming the nation's health insurance markets and its health care delivery system. The effects of these changes, however, are difficult to predict. Like the estimates of other proposals for comprehensive reform, such as the Administration's proposal or the single-payer plans, CBO's estimates of the effects of the Managed Competition Act are unavoidably uncertain.[1] Despite their lack of precision, however, estimates of the effect of different approaches to health reform provide useful comparative information on their relative costs or savings.

CBO's estimates of the effects of the Managed Competition Act on national health expenditures and the federal budget use CBO's baseline projections as their starting point. *The Economic and Budget Outlook: Fiscal Years 1995-1999* (January 1994) describes CBO's current economic assumptions and baseline budget projections. A CBO Memorandum, "Projections of National Health Expenditures: 1993 Update" (October 1993), sets out CBO's baseline projections of national health expenditures.

Determining the Standard Benefit Package

The Managed Competition Act poses a major problem for estimation because it does not specify one of the most crucial elements of the new system--the standard benefit package that would be offered by accountable health plans (AHPs). Over the 10 years covered by CBO's estimate, a more comprehensive package would add to budgetary costs and national health expenditures. With a comprehensive standard benefit package, people would have little need to purchase supplementary health insurance coverage, but the demand for such supplementary coverage could be considerable if the standard package was very limited.

Under the proposal, the Health Care Standards Commission would specify the standard benefit package. This package would go into effect unless disapproved by a joint resolution of the Congress, which would have to be signed by the President. The commission could change the benefit package annually under the same procedure.

One can only speculate about the comprehensiveness of the benefit package that the commission might choose. As a politically appointed body, the

1. CBO has released estimates of the costs of the Administration's proposal (H.R. 3600) and two single-payer plans (H.R. 1200 and S. 491) and will soon be providing estimates for other pending proposals. See Congressional Budget Office, *An Analysis of the Administration's Health Proposal* (February 1994).

commission would be subject to many pressures, including the need to obtain Congressional and Presidential approval for its recommendations. It might find it difficult to limit the services that would be covered under the standard package. If so, the benefits could be fairly comprehensive--for example, somewhat more generous than the average of existing private health insurance policies--and the package would be relatively costly. Alternatively, the commission could try to design a benefit package whose cost did not exceed the savings generated by the proposal. Such a limited package, however, would be far less comprehensive than the benefits now enjoyed by the vast majority of people with health insurance.

Because of the uncertainty regarding the benefit package, CBO has estimated the financial impacts of the proposal using two illustrative alternatives--a comprehensive benefit package, which is identical to that proposed by the Administration, and a limited benefit package, which is 20 percent less costly. For differing reasons, however, neither of these two alternatives is likely to be workable without further adjustments to the proposal.

Alternative 1: A Comprehensive Benefit Package

The first benefit package--a relatively comprehensive one--would cover the same services in the first year as the package specified in the Administration's health proposal. This package is roughly 5 percent more generous than the average private health insurance plan, but a bit less generous than the average plan provided by large firms.

The explicit limits on the growth of health insurance premiums included in the Administration's proposal but absent in the Managed Competition Act complicate the comparison of the benefit packages in the two proposals after the first year. Ultimately, the Administration's proposal would limit the growth of premiums to roughly the rate of growth of the economy. The rate of growth of premiums under the Managed Competition Act, which would rely primarily on market forces to constrain costs, would be higher. Whether the Administration's proposal could actually provide the same level of health benefits and services as th Managed Competition Act with a much lower lev of spending is not clear. To some extent, th Administration's proposal might constrain costs b reducing inefficiencies or limiting payments providers of health care. But it is also possible th the Administration's proposal would result in lower amount or quality of health care services tha the Managed Competition Act, even if the benef packages in the two proposals were nominally th same.

Under the comprehensive alternative, the subs dies and other costs to the federal governme would far exceed the savings generated by the pr posal. Because the proposal would largely precluc increases in the deficit, other steps would have to b taken to make up the shortfall. If the Congress di not adopt additional spending cuts or tax increase the commission would be required to reduce th premium subsidies provided to accountable heal plans for low-income participants. In that cas AHPs would have to accept the reduced subsidies full payment and would have to find ways to de with the shortfall. As Chapter 5 describes in detai however, CBO believes that the uncertainty ar instability inherent in this process could seriousl compromise the orderly functioning of the mark for accountable health plans.

Alternative 2: A Limited Benefit Package

The second illustrative option is a much mo limited standard benefit package. This package 20 percent less expensive than the comprehensi one and would roughly balance the savings ar costs of the proposal over its first five years operation. Equating the costs and savings each ye would require annual changes in the benefit pac age, both up and down, and would create serio administrative problems for consumers, health plan and health plan purchasing cooperatives (HPPC The benefit package that could be obtained for th lower premium would be less generous than that e joyed by 90 percent of people with private heal insurance coverage. Such a benefit package wou not cover mental health services, prescription drug preventive health services, or dental care and wou

severely limit coverage of hospitalization. In addition, CBO has assumed that this alternative would not provide cost-sharing subsidies to people with incomes above 100 percent of the poverty level.

The second alternative is as problematic as the first, although for different reasons. First, the limited benefit package assumed by CBO may not be consistent with the proposal's requirement that the benefit package cover all medically appropriate treatments and a full range of preventive and diagnostic services. Second, in order to make the proposal fit within the available funds, CBO has eliminated the cost-sharing subsidies that the proposal specified for persons with incomes between the poverty level and twice the poverty level.

Under the limited alternative, those with income below 100 percent of poverty would continue to have rather generous coverage: the wraparound benefit would cover the excluded services, and they would be required to pay only nominal cost sharing. Those with incomes not far above the poverty level, however, would have less comprehensive benefits and would have to pay significant amounts of cost sharing from after-tax income. Under the proposal, they could not obtain supplementary policies that covered this cost sharing. Among upper-income people, supplementary insurance covering the excluded services and bought with after-tax dollars could become widespread. Thus, under this alternative, health insurance coverage would probably be more limited for middle-income people than for the rich or poor.

Estimating Health Insurance Premiums

A second critical element in assessing the impact of the Managed Competition Act is estimating the premiums that would be charged for accountable health plans inside and outside the HPPCs. This section describes how CBO estimated the initial level of premiums for the comprehensive benefit package and their subsequent rate of growth. The premiums for the limited benefit package were assumed to be 20 percent lower across the board.

Initial Level of Premiums

The premiums to be paid to health insurance plans and the extent of health insurance coverage under the proposal must be estimated jointly. For a given set of benefits, the level of the premium, net of any government subsidy or employer contribution, affects the number of people who buy insurance, and the number of people who buy insurance affects the premium.

The estimate proceeds in three steps: calculate the amount of health spending under the proposal for people who would be eligible to participate in the HPPC and for those who would have to purchase their AHP through their employer, estimate the proportion of people in various demographic categories who would decide to purchase health insurance, and compute the average premiums inside and outside the HPPC based on the amount of health spending for those who would choose to participate in the program.

The estimate of premiums relies on demographic and income data from the March 1993 Current Population Survey (CPS) and data on the use of health care services from the 1987 National Medical Expenditure Survey. The population was subdivided into categories based on the proposed premium classes (individual, individual and spouse, individual and one child, and individual and family), current insurance coverage (employer-sponsored insurance, individually purchased insurance, Medicaid, or no insurance), level of income, size of the primary worker's firm, and whether or not the employer now contributes to the cost of insurance. The data on use of health care services were used to allocate national health expenditures among each category of people. The expenditure figures were boosted to reflect the higher use of services expected for those becoming newly insured, the generosity of the comprehensive benefit package, and an increase in rates of payment for services previously paid by Medicaid.

All people who currently receive cash welfare benefits, purchase individual health insurance, or work for large employers that provide health insurance were assumed to purchase health insurance coverage under the new system. As discussed in

Chapter 4, however, enacting the proposal is likely to cause some employers to reduce their contributions to their employees' health insurance and allow the government to assume the cost of covering their low-income workers. The estimate assumes that 10 percent of workers with employer-sponsored insurance in small firms would lose their employer's contribution and that half of these workers would still decide to purchase insurance. In addition, for workers with incomes below the poverty level, the average payment by contributing employers was assumed to fall from about 85 percent of the cost initially to about 75 percent over 10 years, since some employers would cease making contributions for low-income workers. For the rest of the population--primarily the uninsured and Medicaid recipients who do not receive cash welfare benefits--the decision to purchase or not purchase health insurance was assumed to hinge on its net price.[2] The participation rates for low-income people, who would see large reductions in the net price of insurance, was assumed to depend on the ratio of price to household income.[3]

The estimated average premiums in 1994 for the comprehensive benefit package for the four types of policies specified in the proposal are as follows:

	Inside HPPC	Outside HPPC
Individual	$2,500	$2,345
Individual and Spouse	$5,000	$4,690
Individual and One Child	$3,976	$3,560
Individual and Family	$6,796	$6,153

Based on data on the distribution of insurance premiums, the estimate assumes that the reference premium--the premium for the least expensive plan in the HPPC with substantial enrollment--would be 90 percent of the premium of the average plan.

2. Congressional Budget Office, "Behavioral Assumptions for Estimating the Effects of Health Care Proposals," CBO Memorandum (November 1993), pp. 4-5.

3. Lewin-ICF, Inc., "Insurance Coverage and Health Expenditures Under the Bush and Clinton Health Reform Plans" (October 1992), p. 12.

The premiums inside the HPPCs would ex those outside the HPPCs by about 10 percent cause of differences in the use of health care vices by the insured population. In particular, HPPCs would cover most current recipients of M icaid as well as many early retirees, both of w are relatively heavy users of health care. Cong man Jim Cooper has informed CBO that he int to modify his proposal by placing disabled Med beneficiaries in a separate risk pool. This ch could reduce the difference in premiums bet plans in HPPCs and those outside by as muc one-half.

Although the comprehensive benefit packa the Managed Competition Act is assumed to b same as the standard package in the Admin tion's proposal, the cost of the package would fer. For example, the 1994 premium for a s person would be an estimated $2,100 unde Administration's proposal and almost $2,400 f AHPs (both inside and outside HPPCs) unde Managed Competition Act. About $50 of thi ference stems from treatment of Medicaid bene ries, whose costs would be largely excluded the premium calculation for the Administrat plan. The generous cost-sharing subsidies--w would increase the use of health care servic low-income enrollees--and the assumed increa Medicaid's payment rates add another $100 t premium for the Managed Competition Act. remaining difference is largely attributable t verse selection; the Administration's proposal w require universal participation, but low-risk in uals could opt to go without insurance unde Managed Competition Act.

Rate of Growth of Premiums

The estimate assumes that the proposal would the rate of growth of health expenditures and insurance premiums for two reasons. Firs proposal would encourage more people to en health maintenance organizations (HMOs). Se the competitive pressures created by managed petition would cause all insurers to intensify efforts to control costs.

Because group- or staff-model HMOs can provide health care more efficiently than other organizational forms, they would probably be the lowest bidders in most HPPC areas. Thus, the proposal would increase the difference in effective prices between fee-for-service plans and HMOs because people would have to pay the higher cost of fee-for-service plans out of after-tax rather than before-tax income. Based on the experience of California, Minnesota, and Wisconsin--states whose health insurance programs for public employees embody aspects of managed competition--CBO assumes that three-quarters of the nonpoor, urban population would ultimately choose HMOs instead of more expensive fee-for-service plans. Based on its review of the available evidence, CBO finds that the most effective HMOs reduce the use of health care services by about 9 percent compared with the fee-for-service sector and that the average reduction is about 4 percent.[4] All in all, the estimate assumes that the shift to managed care would slow the growth in costs for private health plans by 0.6 percentage point per year for the first five years of the proposal. This assumption presumes that HMOs would find some way to cope with the difficulties created for them by the cost-sharing requirements and the limited benefit package (see Chapter 5).

As detailed in Chapter 2, the proposal incorporates, to some degree, all of the features important to the success of managed competition in controlling health care costs, except universal health insurance coverage. Because managed competition is an untried concept, however, no data exist that would allow one to estimate its effect on the growth of health expenditures. In the absence of any data, this estimate assumes that the system of managed competition established by the proposal would dampen the rate of growth of private health insurance costs by an amount reaching 1 percentage point a year after 2004. The same assumption about the effect of managed competition is used for both alternatives--the comprehensive and the limited benefit packages--although managed competition would affect a smaller share of health spending if the standard package was limited in its scope.

4. Congressional Budget Office, "Effects of Managed Care: An Update," CBO Memorandum (March 1994).

How the Proposal Would Affect Health Insurance Coverage and National Health Expenditures

The Managed Competition Act would encourage more people to obtain health insurance coverage by subsidizing its purchase. People with very low incomes would receive direct government subsidies, and people with higher incomes would be allowed to deduct the cost of health insurance from their taxable income. At first, the expansion of health insurance coverage would increase the demand for health care services and would add to national health expenditures. In the longer run, however, the system of managed competition would slow the growth of health spending and bring national health expenditures below the baseline level.

The estimates of health insurance coverage and national health expenditures assume that the premium assistance specified in the proposal is fully funded, either through additional spending cuts, tax increases, or borrowing. Failure to fund the subsidies could result in an upward spiral of health insurance premiums, declines in health insurance coverage, and, potentially, the collapse of the HPPC system (see Chapter 5).

Health Insurance Coverage

The low-income assistance and tax subsidies contained in the proposal would induce 18 million of the uninsured in 1996 to purchase health insurance. More than 2 million people who would be eligible for Medicaid under current law, however, would have their health insurance only partly subsidized and would choose not to obtain coverage. Another 1 million people now covered by small employers would drop coverage after their employer ceased to contribute to the cost of their plan. The net increase in health insurance coverage would be 15 million people (see Table 3-1). Most of the increase in coverage--11 million people--would occur for people in poor families, whose purchase of insurance would be fully subsidized.

The proposal would leave 24 million people uninsured. About 4 million poor people are assumed not to participate in the program despite the availability of a full subsidy--a rate similar to that for other public benefit programs. In addition, the cost of insurance would continue to deter some 16 million people with family incomes between 100 percent and 300 percent of the poverty level from participating. For nonelderly people with incomes over 300 percent of poverty, the rate of coverage would exceed 96 percent. In all, the proportion of the population without coverage would drop f an estimated 15 percent in 1995 to 9 percen 1996 and remain roughly the same thereafter.

Insurance coverage would be similar with the comprehensive and the limited benefit packa Although the premiums for the limited pac would be 20 percent lower than for the compre sive package, the benefits would be 20 percent and the effective price of insurance would be changed.

Table 3-1.
Health Insurance Coverage Under the Managed Competition Act (By calendar year, in millions of pe

	1996	1997	1998	1999	2000	2001	2002	2003	2
Baseline									
Insured	222	224	226	228	229	230	232	233	
Uninsured	39	40	40	40	41	42	43	43	
Total	261	264	266	268	270	272	274	276	
Uninsured as Percentage of Total	15	15	15	15	15	15	16	16	
Alternative 1: Comprehensive Benefit Package									
Insured	237	239	242	243	245	247	249	251	
Uninsured	24	24	24	25	25	25	25	26	
Total	261	264	266	268	270	272	274	276	
Increase in Insured	15	15	16	16	16	17	17	18	
Uninsured as Percentage of Total	9	9	9	9	9	9	9	9	
Alternative 2: Limited Benefit Package									
Insured	237	240	242	244	246	247	249	251	
Uninsured	24	24	24	24	25	25	25	25	
Total	261	264	266	268	270	272	274	276	
Increase in Insured	15	16	16	16	16	17	18	18	
Uninsured as Percentage of Total	9	9	9	9	9	9	9	9	

SOURCE: Congressional Budget Office.

NOTE: The estimates assume full funding of the subsidies.

Table 3-2.
Projections of National Health Expenditures Under the Managed Competition Act
(By calendar year, in billions of dollars)

	1996	1997	1998	1999	2000	2001	2002	2003	2004
Baseline									
Total	1,163	1,263	1,372	1,488	1,613	1,748	1,894	2,052	2,220
Alternative 1: Comprehensive Benefit Package									
Total	1,196	1,288	1,392	1,495	1,610	1,750	1,888	2,035	2,190
Change from Baseline	33	25	20	7	-3	2	-6	-17	-30
Alternative 2: Limited Benefit Package									
Total	1,178	1,271	1,375	1,480	1,597	1,726	1,865	2,013	2,171
Change from Baseline	15	8	4	-8	-16	-23	-30	-39	-50

SOURCE: Congressional Budget Office.

NOTE: The estimates assume full funding of the subsidies.

National Health Expenditures

The proposal would make health insurance available to a much larger group than is currently covered, which would initially increase national health expenditures. The estimate assumes that the newly insured would increase their use of covered health services by 57 percent.[5] It also assumes that the comprehensive benefit package would initially be about 5 percent more expensive than the average benefit of privately insured people in the baseline. In 1996, the increase in national health expenditures would amount to some $30 billion for the comprehensive benefit package and half that amount for the limited benefit package (see Table 3-2).

The institution of managed competition, the shift to HMOs, and the cuts in Medicare would slow the growth of health spending and would eventually bring national health expenditures below the baseline. With the comprehensive benefit package, CBO projects that total spending on health in 2004 would be $30 billion below what it would be if current policies and trends continued. With the limited benefit package, health spending in 2004 would be $50 billion--or 2 percent--below the baseline.

5. CBO, "Behavioral Assumptions," p. 21.

How the Proposal Would Affect the Budget

The Managed Competition Act would create a program of federal subsidies to help low-income people purchase health insurance and meet its cost-sharing requirements. It would also allow taxpayers to deduct in full spending for health insurance premiums (up to the reference premium rate) from income for tax purposes. These new federal costs would be financed primarily by repealing Medicaid and achieving savings in Medicare. In addition, by reducing

Table 3-3.
Estimated Budgetary Effects of the Managed Competition Act (By fiscal year, in billions of dollars)

	1996	1997	1998	1999	2000	2001	2002	2003	20
Alternative 1: Comprehensive Benefit Package									
Outlays									
Premium Assistance									
Non-Medicare	68	97	105	113	122	134	145	157	1
Medicare	3	4	5	5	5	6	6	6	
Subtotal	71	101	109	118	127	139	151	163	1
Cost-Sharing Assistance[a]									
Non-Medicare	29	41	45	48	52	57	62	67	
Medicare	9	15	17	18	20	23	25	28	
Subtotal	38	56	61	67	72	80	87	94	1
Repeal of Medicaid	-81	-121	-135	-151	-168	-186	-206	-227	-2
Medicare Savings	-1	-6	-9	-13	-17	-18	-19	-21	
Assistance for Long-Term Care	1	1	1	b	0	0	0	0	
Medical Education	a	3	3	3	3	3	3	3	
Postal Service Retirement	-2	-2	-3	-3	-3	-3	-3	-3	
Federal Administrative Costs	8	10	10	11	11	11	12	12	
Other Spending	b	1	b	b	b	b	b	b	
Total, Outlays	35	42	38	32	26	26	24	21	
Revenues									
Deduction of Health Insurance Premiums	-6	-15	-16	-17	-18	-20	-23	-24	
Increase in Medicare Premium for High-Income Individuals	1	1	2	2	2	3	4	5	
Income and Payroll Taxes on Additional Income	3	5	5	6	6	6	6	6	
Assessment for Medical Education	4	5	5	6	6	7	7	8	
Excise Tax and Other	b	-1	b	-1	-1	-1	-1	-1	
Total, Revenues	1	-4	-4	-4	-4	-6	-7	-6	
Deficit									
Deficit with Full Amount of Subsidies	35	46	42	36	30	32	31	27	
Shortfall in Subsidies	-30	-42	-38	-33	-28	-39	-50	-59	
Net Deficit Effect	5	4	4	3	3	-8	-19	-32	

SOURCES: Congressional Budget Office; Joint Committee on Taxation.

NOTES: The figures in the table include changes in authorizations of appropriations and in Social Security that would not be counted f as-you-go scoring under the Budget Enforcement Act of 1990. The table excludes the effects of sections 1421 and 1422 relate to rural emergency access care hospitals.

Table 3-3.
Continued

	1996	1997	1998	1999	2000	2001	2002	2003	2004
Alternative 2: Limited Benefit Package									
Outlays									
Premium Assistance									
Non-Medicare	54	77	83	90	97	105	113	122	131
Medicare	3	4	5	5	5	6	6	6	6
Subtotal	57	81	88	95	102	111	119	128	138
Cost-Sharing Assistance[a]									
Non-Medicare	30	42	45	49	53	57	61	66	71
Medicare	9	15	17	18	20	23	25	28	31
Subtotal	39	57	62	67	73	80	87	94	102
Repeal of Medicaid	-81	-121	-135	-151	-168	-186	-206	-227	-250
Medicare Savings	-1	-6	-9	-13	-17	-18	-19	-21	-23
Assistance for Long-Term Care	1	1	1	b	0	0	0	0	0
Medical Education	a	3	3	3	3	3	3	3	3
Postal Service Retirement	-2	-2	-3	-3	-3	-3	-3	-3	-3
Federal Administrative Costs	8	10	10	11	11	11	12	12	12
Other Spending	b	1	b	b	b	b	b	b	b
Total, Outlays	22	23	17	10	2	-3	-8	-14	-21
Revenues									
Deduction of Health Insurance Premiums	-3	-7	-8	-9	-9	-11	-13	-13	-14
Increase in Medicare Premium for High-Income Individuals	1	1	2	2	2	3	4	5	7
Income and Payroll Taxes on Additional Income	5	7	7	8	8	8	8	8	9
Assessment for Medical Education	3	4	4	5	5	5	6	6	7
Excise Tax and Other	3	5	6	7	7	7	8	8	9
Total, Revenues	8	10	11	12	14	13	13	15	17
Deficit									
Deficit with Full Amount of Subsidies	14	14	6	-3	-11	-16	-21	-29	-39
Shortfall in Subsidies	-8	-8	-1	0	0	0	0	-1	-6
Net Deficit Effect	6	5	5	-3	-11	-16	-21	-31	-45

a. Includes wraparound benefit.

b. Less than $500 million.

the growth of health spending, the proposal would reduce spending by employers for health insurance, raise earnings or other taxable income by a similar amount, and increase collection of income and payroll taxes. With the limited benefit package, the savings in the proposal would nearly equal its costs in the early years, and the savings would exceed the costs in 1999 and beyond. With the comprehensive benefit package, however, the savings would fall far short of covering the costs, and the proposal would require scaling back premium subsidies for the non-Medicare population by amounts ranging up to 45 percent.

Budgetary Treatment

The Managed Competition Act raises no knotty issues of budgetary treatment or classification. Unlike the Administration's health proposal, the Managed Competition Act would create no universal federal entitlement to health insurance. Participation would be voluntary. Also, unlike the health alliances in the Administration's plan, the HPPCs would have no authority to assess mandatory premiums. Therefore, although the HPPCs would be established under the terms of a federal statute, they would not exercise sovereign power, and their transactions should not be included in the accounts of the federal government. The budget would include, however, the taxes and spending items that would flow through the Treasury--for example, premium and cost-sharing assistance, federal administrative costs, and the changes to existing programs. Depending on how the system was structured, the redistribution of shortfalls in subsidies might also be considered a federal activity.

Subsidies

By far the largest cost of the proposal would be the premium and cost-sharing assistance for low-income people. Under the proposal, nonelderly persons with incomes up to 200 percent of the poverty level would be eligible for both types of subsidy. For Medicare beneficiaries, the premium assistance would extend to 120 percent of poverty, and cost-sharing subsidies would be provided to those with incomes below 100 percent of the poverty level.

CBO based its estimate of subsidies for no elderly people on the March 1993 Current Popul tion Survey. Using data from the CPS and the rul specified in the proposal, CBO assigned people insurance units and categorized these units accor ing to their premium class, demographic characteri tics, and income bracket. The estimated amount premium assistance for each category of unit d pends on the reference premium for the class, t number of units, their average income, and t estimated rate of purchase of health insuranc Cost-sharing subsidies were assumed to equal 2 percent of the premium for the standard benef package--a figure derived from the 1987 Nation Medical Expenditure Survey. The wraparoun benefit was assumed to cost 9 percent of the sta dard premium. The estimated premium and cos sharing assistance for Medicare beneficiaries a based on data for 1990 from the Health Care F nancing Administration's Continuous Medica History Sample.

With the comprehensive benefit package, pr mium assistance would total $101 billion in fisc year 1997--the first full year of the proposal--an $175 billion in 2004 (see Table 3-3). Cost-sharin assistance (including both cost-sharing subsidies an the wraparound benefit) would grow from $56 bi lion to $102 billion over the same period. Over 6 percent of families insured through HPPCs an about 20 percent of families insured through oth AHPs would receive some subsidy.

Premium assistance would be about 20 perce smaller with the limited benefit package than wit the comprehensive one, but cost-sharing assistanc would be about the same. To make the proposa roughly deficit neutral, the estimate eliminates cos sharing subsidies for people with incomes above th poverty level. The additional cost of the wrap around benefit for people in poverty, howeve would use up the savings generated by this chang so the total amount of cost-sharing assistance woul be roughly the same for the two alternatives.

Other Outlays

The federal government would incur significan administrative costs to determine eligibility fo

premium and cost-sharing assistance and to oversee the AHPs and HPPCs. In its first year of full operation, the Health Care Standards Commission would obligate almost $10 billion and have outlays of more than $8 billion. Processing applications for subsidies would require $8.6 billion, assuming 43 million applications for assistance at a cost of $200 per application. By comparison, it currently costs about $160 to process an elderly person's claim for Supplemental Security Income and $620 to process an application for Aid to Families with Dependent Children. The commission's other activities, primarily oversight of the health plans and HPPCs, would cost another $1 billion.

Repeal of Medicaid would provide most of the funding for the proposal, totaling $121 billion in 1997 and $250 billion in 2004. In addition, the proposal would cut Medicare spending, primarily by slowing the growth of payments to hospitals and physicians, phasing out payments to disproportionate share hospitals, and changing the method of paying for medical education. CBO's estimates of the savings from these changes are consistent with the baseline projections of spending for the affected items.

The proposal would also make several smaller changes in federal spending. It would establish a temporary program of assistance for states that spend a very large share of their Medicaid funds on long-term care, create a new system for financing medical education, require the Postal Service to prefund health benefits for retirees, and expand several public health programs.

Revenues

The Joint Committee on Taxation (JCT) has estimated the impact of the provisions of the proposal that would affect income and payroll taxes. The major revenue-losing item is allowing full deductibility of health insurance premiums (up to the reference premium rate) from income for tax purposes. The revenue loss would reach $25 billion in 2004 with the comprehensive benefit package, but only $14 billion with the limited benefit package because the maximum allowable deduction would be less.

For the comprehensive benefit package, CBO and JCT assume that firms would largely avoid paying the 35 percent excise tax on excess health insurance premiums by limiting their contributions to the reference premium amount and returning the excess to workers primarily in the form of higher wages. Federal revenues would then rise because more compensation would be subject to both personal income and payroll taxation. If the commission adopted the limited benefit package, the tax cap would be lower, but many employees would want to obtain supplementary health insurance coverage. In this case, as explained in Chapter 2, workers could find it advantageous to have their employer pay for their supplementary policy--and pay the excise tax--rather than to receive that portion of their compensation as taxable earnings. Not all employers would take this tack, however, and the increase in income and payroll taxes would be slightly higher as a result of the lower tax cap.

Two other provisions of the proposal would also increase federal revenues. High-income individuals would be subject to an increase in their premiums for Medicare's Supplementary Medical Insurance. Also, each accountable health plan would be subject to an assessment of 1 percent of gross premium receipts to finance medical residency training.

Shortfall in Subsidies

The proposal would create a process to scale back premium assistance for low-income people not receiving Medicare if the proposed savings failed to cover the additional costs. With the comprehensive benefit package, the shortfall in subsidies would amount to about $35 billion a year over the first five years. The required reduction in premium assistance for the non-Medicare population would range from almost 45 percent in 1996 to 23 percent in 2000. With the limited benefit package, the shortfall would amount to 15 percent in 1996, 10 percent in 1997, and little or nothing thereafter.

Despite the provision for limiting the amount of premium assistance, the proposal would add slightly to the deficit in the first few years, largely because the formula for computing the shortfall excludes federal administrative costs. With the limited bene-

fit package, the proposal would reduce the deficit in later years. The proposal could also reduce the deficit with the comprehensive benefit, but only because after 1999 it would not permit all the spending reductions to be counted against the cost of the subsidies. It would limit the growth of the countable savings in spending to the rate of growth of gross domestic product, even though the actua savings would increase at a more rapid rate. If al the savings were made available to fund the subsi dies, there would be no net deficit reduction, an the shortfall in funding the subsidies would b smaller.

Chapter Four

The Economic Effects of the Managed Competition Act

Like the current system, the Managed Competition Act of 1993 would not require that employers purchase insurance for their employees, nor would it mandate that individuals purchase insurance on their own. Nevertheless, the proposal would affect the economy because of the changes it would make to the cost-effectiveness and affordability of the nation's health insurance system. Since most people currently receive insurance through their employer, changes in the financing of that insurance would inevitably affect the nation's job market.

The Effect of Insurance Reforms on the Labor Market

The proposal would significantly alter the nation's insurance markets in several ways that would affect the functioning of labor markets. Health insurance considerations would be less likely to lock workers into their current jobs. As a result, workers would be more likely to choose the jobs in which they would be the most productive and from which they would derive the most satisfaction.

People Would No Longer Have to Work Just for the Insurance

Given the high cost of care in the current system, timely and complete access to modern medicine depends in large part on having insurance. People without insurance typically receive roughly one-third less health care than fully insured people who are otherwise similar.[1] Moreover, many families can afford insurance only by having someone in the family work at a company that offers it. Over the past decade, soaring premiums have made individual policies for nonworkers prohibitively expensive, especially for those with significant health problems or risk factors.[2] As a result, some people have had to work just because they need insurance.

The proposal would change this situation by guaranteeing universal access to insurance coverage. Because fear of becoming uninsured would no longer be a significant factor in decisions about work, some people would stop working. Some older workers, for instance, might seek an early retirement; others might choose to devote more of their energies to raising their families.

Fewer People Would Be Locked into Their Jobs

The proposal would also reduce a related problem with the current system: job lock. Currently, some people may be reluctant to leave the safety of a large corporation to work in a small company, start a small business, or even change jobs because they

1. Congressional Budget Office, "Behavioral Assumptions for Estimating the Effects of Health Care Proposals," CBO Memorandum (November 1993).

2. The majority of the uninsured work full time at firms that do not offer insurance; see Congressional Budget Office, *Economic Implications of Rising Health Care Costs* (October 1992).

fear losing their health insurance or being denied coverage for a preexisting health condition.

The proposal would reduce these concerns. Insurance would always be available at a reasonable price because all workers would be able to purchase coverage at no more than the reference premium—that is, the cost of the least expensive plan in their area with more than a minimum number of enrollees. Moreover, the proposal would prohibit insurers from denying insurance to people with preexisting conditions, although health plans would be permitted to exclude coverage (except for services to newborns and pregnant women) of most preexisting conditions for six months after enrollment. Those features of the proposal would reduce distortions created by the current health system in the decisions of workers about where to work.

The quantitative importance of job lock, however, in reducing economic efficiency in the current system is unclear. Public opinion surveys suggest that 10 percent to 30 percent of people feel locked into their current jobs because they fear losing health insurance.[3] But statistical studies of the extent to which this fear actually reduces job mobility have reached mixed conclusions.[4] Overall, the evidence suggests that job lock probably hinders the operation of the labor market to some degree, but the magnitude of that effect is uncertain.

Benefits of Subsidies to Low-Income People

The proposal would significantly improve the well-being of the poor and near-poor by subsidizing their purchase of health insurance. It would significantly reduce the number of poor people who were uninsured and could slightly reduce the tendency of the current system to lock people into welfare.

Table 4-1.
Projected Poverty Guidelines, U.S. Average, by Family Type, 1995 (In dollars)

Number of Family Members[a]	100 Percent of Poverty	200 Percent of Poverty
1	7,520	15,040
2	10,080	20,160
3	12,640	25,280
4	15,200	30,400
5	17,760	35,520
6	20,320	40,640
7	22,880	45,760
8[b]	25,440	50,880

SOURCE: Congressional Budget Office.

NOTE: The U.S. average excludes Hawaii and Alaska.

a. Includes adults.

b. For families with more than eight members, the poverty level increases by $2,560 for each additional member.

Factors That Would Reduce the Average Cost of Insurance for Low-Income People

The proposal would provide free insurance to everyone whose family income was below the poverty level and who chose a health plan that cost no more than the reference plan.[5] Subsidies would also be available to people under 65 with family incomes between 100 percent and 200 percent of poverty, although they would be phased out over this income range (see Table 4-1 for poverty levels). In addition, families with incomes less than 200 percent of the poverty level would receive assistance in paying the cost-sharing requirements of their health plan.

3. Erik Eckholm, "Health Benefits Found to Deter Switches in Jobs," *The New York Times*, September 26, 1991, p. 1; Christopher Conte, "Labor Letter," *The Wall Street Journal*, June 15, 1993, p. A1.

4. Douglas Holtz-Eakin, "Job-Lock: An Impediment to Labor Mobility?" *Jerome Levy Economics Institute of Bard College Public Policy Brief*, vol. 10 (1993); Brigitte Madrian, "Employment-Based Health Insurance and Job Mobility: Is There Evidence of Job Lock?" Working Paper 4476 (National Bureau of Economic Research, Cambridge, Mass., September 1993).

5. In addition, those with incomes below 200 percent of poverty would be able to purchase plans that were more expensive than the reference plan for only a fraction of the additional cost.

Those with incomes below poverty would also receive help in purchasing certain services and items that were not covered by the standard benefit package--the so-called wraparound benefits.

A considerable fraction of the population would be eligible for some subsidy. For example, in 1993 roughly 46 million people under 65 had family incomes below poverty, and 84 million people--almost 40 percent of the nonaged population--had incomes below 200 percent of poverty.

The proposal could make insurance somewhat more affordable in other ways--and not just for people with low incomes. The health plan purchasing cooperatives (HPPCs) would reduce administrative costs of insurance available to small employers and individuals by creating large insurance pools, and several features of the plan would strengthen competition in the health care sector and reduce the growth of premiums. For the poorest families, however, the subsidies would be the most important factor in reducing the cost of their insurance.

Effect on Insurance Coverage

Combined with other cost-saving features of the proposal, the subsidies for low-income families would significantly reduce the number of uninsured poor people (see Table 4-2). The Congressional Budget Office (CBO) estimates that, if the proposal were enacted, the total number of uninsured at all income levels would decline by 15 million--or almost 40 percent--by 1996. Most of the reduction would be among uninsured people with incomes below the poverty line: their number would drop by 11 million.

Table 4-2.
The Effect of the Managed Competition Act on the Number of Uninsured, by Income Category, 1996 (In millions of people)

Income Category (As a percentage of the poverty level)	Under Current Policy	Under MCA	Decrease in the Number of Uninsured
Under 100 Percent	15	4	11
100 Percent to 150 Percent	7	6	2
150 Percent to 200 Percent	5	4	a
200 Percent to 300 Percent	6	6	1
300 Percent to 400 Percent	3	2	a
400 Percent to 500 Percent	1	1	a
500 Percent and Above	2	1	1
Total	39	24	15

SOURCE: Congressional Budget Office.

NOTE: MCA = Managed Competition Act of 1993.

a. Less than 500,000.

By contrast, the number of uninsured between 100 percent and 200 percent of poverty would decline much less because the cost of insurance for many of these people, even after subsidies, would still amount to a significant expenditure. (For example, the premium costs, net of subsidies and tax benefits, for the comprehensive benefit package would be about $2,100, or about 9 percent of income, for a four-person family with income equal to 150 percent of the poverty threshold.) In total, the proposal would leave some 24 million without insurance in 1996. Reducing the generosity of the benefit package, as discussed in Chapter 3, would have little effect on the number--and distribution--of uninsured people.

Effect on Welfare Beneficiaries

The subsidies in the proposal would also reduce an incentive in the current system for beneficiaries of Aid to Families with Dependent Children (AFDC) to remain on welfare. Under current rules, when a welfare beneficiary goes to work and earns income above certain thresholds, the beneficiary loses eligibility both for cash assistance and for Medicaid.[6] (Children of working mothers, however, remain eligible for Medicaid coverage in families with higher incomes, even if the mother loses eligibility for her own coverage.) Unless such workers find employment at a firm that offers insurance, they lose some access to affordable health benefits. Moreover, even if their firm offers insurance, employers pass the cost of that insurance to workers in the form of lower wages. In both cases, welfare beneficiaries lose the value of free insurance if they take a job.

Under the proposal, by contrast, welfare beneficiaries would not risk losing insurance coverage if they worked. They would be able to earn up to 100 percent of the poverty level--considerably higher than the income thresholds for AFDC beneficiaries--and still have free insurance with nominal cost sharing.

6. Different thresholds apply for AFDC eligibility and Medicaid eligibility. Medicaid coverage may be maintained for a transition period of up to 12 months after starting work. Pregnant women can retain Medicaid coverage at higher income levels.

Empirical evidence suggests that, under cur rules, AFDC and Medicaid have discouraged par pation in the labor force, but the evidence is directly applicable to the proposal. Neverthel the responses found in the literature suggest that Managed Competition Act could slightly incr the participation of AFDC beneficiaries in the l force.

Incentives Inherent in the Subsidy System

The subsidy scheme in the Managed Competi Act is designed to encourage low-income peopl obtain health insurance. However, it would cr certain other incentives and disincentives that co affect employers' willingness to pay for t employees' insurance and the work effort of cer low-income people.

The Subsidy System and Employers Health Insurance Contributions

Under the proposal, employer-paid health insura for low-income workers would be costly to fin but would have little or no value to poor work This situation would occur because the subsidies premiums for low-income workers would be duced dollar for dollar by the amount that t employers contributed to the workers' health ins ance.

Thus, excluding other considerations, neither employer nor its low-income employees would any advantage in having the employer pay for health insurance of its low-income workers. If employer paid none of the premium, the insura would be free for workers whose incomes were or below the poverty level. By contrast, if employer paid some or all of the premium, the co would be shifted back onto the workers in the fo of reduced wages. The loss of the subsidy co cost each poor worker thousands of dollars. E cause of this, AFDC beneficiaries and other lo income workers eligible for subsidies would hav strong incentive to work for employers that did

contribute to insurance and instead paid higher wages.

This incentive could create a number of responses among low-income workers and firms. First, firms could "outsource" or contract out their low-income jobs. By outsourcing these jobs to companies that did not pay for insurance, firms could reduce their labor costs and the affected workers would become eligible to receive full subsidies. Second, companies that currently pay for insurance could stop paying for it, thereby allowing low-income workers to claim federal subsidies. The net cost of insurance for higher-income workers in these firms would increase, however, because their insurance premiums would no longer be excluded from the payroll tax. Thus, some high-income workers might seek employment elsewhere.

Both of these responses would be costly and disruptive to employers and employees. Some workers would have to find new employers, and some firms would have to reorganize their production. This reshuffling would reduce the efficiency of the economy because labor would be allocated partly with regard to the availability of subsidies, and not solely with regard to efficiency and productivity.

A third response is that companies could expand their use of certain types of "cafeteria" plans. In cafeteria plans, each employee chooses the desired mix of cash wages and certain fringe benefits (such as health insurance, life insurance, and dependent care assistance programs), subject to some restrictions. If a low-income worker did not want the employer to pay for insurance, the worker could receive higher wages or a more generous package of other benefits instead. High-income workers would still have the option of having the employer pay for their insurance.

Under the proposal, every firm--even those that did not pay any of the premium--would have to offer insurance to its workers and would be required to set up a payroll deduction scheme for them. Given this requirement, the additional administrative cost of establishing a cafeteria plan could be small relative to those in the current system.

However, three factors would limit the interest of some employers in establishing a cafeteria plan. First and foremost, companies with more than 100 employees could face adverse selection if some of their healthiest employees decided not to take the insurance. As some healthy workers dropped out of the insurance pool, the company's insurance premiums would rise, causing more people to withdraw from the pool.[7] Second, some companies might face resistance to establishing a cafeteria plan if it caused a redistribution of wage income among single and family workers. (Such a redistribution could occur, for instance, if firms currently reduce each worker's wages by the average cost of insurance for both single workers and those with families, instead of reducing each worker's wages by the actual cost of insurance.) Third, some firms might be concerned that their cafeteria plans would not meet certain legal provisions that prohibit discrimination in favor of highly compensated and certain "key" employees, such as officers of the company. For example, cafeteria plans cannot provide more than 25 percent of their qualified benefits to key employees. Although these provisions might not influence decisions in a large number of firms, they could affect some firms' decisions about setting up cafeteria plans.

All of those behavioral responses would increase the cost of the subsidy program to the federal government because they would expand the pool of people who would receive subsidies. But the use of cafeteria plans would probably be the least costly to economic efficiency. Cafeteria plans would allow workers and firms to adjust to the proposal without inducing an inefficient reshuffling of workers among firms in an effort to find employers that provided a better mix of benefits.

Work Disincentives of the Subsidy Scheme

Although the subsidies would reduce the average cost of insurance for low-income people and im-

7. Adverse selection would not affect decisions to establish a cafeteria plan for firms with 100 or fewer employees. These companies would purchase insurance through the HPPC at community-rated premiums, which would be unaffected by their employees' decisions to take insurance as a fringe benefit.

prove their circumstances as a result, the subsidy system would also discourage certain low-income people from working more hours or, in some cases, from working at all. This work disincentive would arise from phasing out the subsidies as family income rose between 100 percent and 200 percent of the poverty guidelines. Workers who earned more money within this income range would have to pay more for health insurance, thereby cutting into the increase in their take-home wage. In essence, phasing out the subsidies would implicitly tax their income from work.

Once a family's income (net of premium) reached 200 percent or more of poverty, the proposal would not affect decisions about work. And lower-income families--with incomes below the poverty level--would not be affected by the phaseout either. But for families with incomes between 100 percent and 200 percent of poverty, the impact could be rather large.

Families in this income range already pay--and will continue to pay under current law--relatively high marginal tax rates on their earnings. For example, in 1995, some workers in this range will have to give up more than 45 cents in federal taxes for each additional dollar of compensation. This large bite reflects the 15 percent federal income tax rate, the 15.3 percent federal payroll tax, and the phaseout of the earned income tax credit (EITC).[8] For a husband and wife with two children, the phaseout of the EITC will impose about a 20 percent tax on 1995 earned incomes between $11,290 and $26,691. In addition, many of these workers pay state and local income taxes and some receive food stamp benefits that are phased out as income rises. Both of these factors increase their marginal tax rates even more.

The proposal would further increase the implicit marginal tax on the incomes of those families earning between 100 percent and 200 percent of poverty. Although estimating the precise effects requires detailed information that is not available, a simple example can illustrate the economic effect of the proposal in broad brush. Consider a hypothetical two-parent family with two children, with one member of the family working 35 hours per week for total annual compensation of $24,000 (see Table 4-3). For such a family, the least expensive health plan would cost about $6,650 in 1995, assuming the comprehensive benefit package described in Chapter 3.

If the worker worked an additional five hours per week, his or her total annual compensation would increase by $3,429. But federal payroll taxes would take an additional $487, and federal income taxes (before the EITC) would claim another $332. The family would lose $644 of benefits from the earned income tax credit and $968 in low-income subsidies for health insurance. (The example assumes that the employer does not pay for insurance).

The net increase in the family's income from five hours more work per week would be only $996 per year assuming the premiums associated with the comprehensive benefit package; federal taxes and increased insurance premiums would claim about 70 percent of the worker's added compensation. In other words, the marginal return from working the additional hours would be only about 30 percent of the increase in gross compensation--an estimate that does not even include the additional costs of state and local income taxes.

The marginal tax on work would be smaller if the premiums used in the example were those associated with the limited benefit package described in Chapter 3 (see Table 4-4). In that case, the value of the full subsidy would be lower and the phaseout rate would be smaller. Nevertheless, the marginal tax on work would still be high--about 67 percent.

Phaseout rates would vary among workers in different types of families because the maximum subsidy and poverty level would depend on family size (see Figures 4-1 and 4-2). Nevertheless, the phaseout of these subsidies would impose hefty marginal levies on workers from all types of families over certain income ranges. The Managed Competition Act would increase the implicit mar-

8. Although the employer legally pays half of the federal payroll tax, economic analysis indicates that employers shift these costs to workers in the form of lower wages. For this reason, the employer's share is counted as a tax on the employee. See Congressional Budget Office, *Economic Implications of Rising Health Care Costs*.

ginal tax as much as 20 percentage points on the incomes of single workers, 25 percentage points on heads of households, and 30 percentage points on married workers if the premiums were those associated with the comprehensive benefit package. Under the premiums of the limited benefit package, the marginal levies would increase from about 15 percentage points to 25 percentage points.

Besides the phaseout of subsidies for premiums, the loss of assistance for cost sharing would occur abruptly when a family's income hit 200 percent of poverty and it became ineligible for this assistance. For example, in 1995 a married couple with two children would lose cost-sharing subsidies worth about $1,400 under the comprehensive benefit package when its income rose from $30,399 to $30,400, which would be 200 percent of the poverty guideline for a family of four.

Another "cliff" would occur at 100 percent of poverty, where workers would lose subsidies for the wraparound benefits. Assuming the comprehensive benefit package, the loss of wraparound benefits would cost such a family $600 in 1995 at this cliff. Under the limited benefit package, CBO assumes that workers would not only lose the wraparound benefits at poverty, but also assistance for cost sharing. Under this less generous package, the combined loss of both benefits would be huge--amounting to $2,900 for such a family in 1995. (As discussed in Chapter 3, the wraparound benefits would be worth much more under the limited benefit package than under the comprehensive one.) These estimates reflect the average amount of assistance for cost sharing and wraparound benefits. But high health costs are extremely concentrated among certain families. As a result, the majority of eligible families would receive levels of assistance that were less than average. Still, even for the median family, the loss of assistance for cost sharing and wraparound benefits would probably result in a significant cliff at certain income levels.

Faced with these incentives, some low-income workers could decide that earning additional income by working longer hours was not worth the trouble. These incentives could also discourage them from moonlighting at a second job or working harder at their existing job in order to secure a raise or a promotion.

Workers could respond in ways that would reduce these high marginal levies on work: they could become uninsured, for instance. (The proposal would not mandate insurance.) Certainly, becoming uninsured would increase take-home pay and might reduce the disincentive to work, but it would not eliminate it. As long as workers value health insurance, they would lose a valued benefit (insurance) if they earned more than the poverty level and took this option. Thus, the subsidies would improve the well-being of the poor by expanding insurance coverage, but the phaseout of the subsidies would reduce the marginal return from working and thereby discourage additional work effort.

The incentives created by the subsidy system would also lead some workers to drop out of the labor force or not enter in the first place. Although most workers' decisions about participating in the labor force are generally not sensitive to changes in net returns, one group is relatively responsive: second workers in households in which one person is already employed. These so-called secondary workers are more responsive to changes in net returns from work because they can rely on their spouse's income. They will participate in the labor market when the net returns from work exceed their costs of working, including the value of the time that would otherwise be available for leisure or other activities.

The proposal would reduce the willingness of secondary workers in some low-income households to take a job. If the family's income was between 100 percent and 200 percent of the poverty level and the second worker's income did not raise the family's income beyond the 200 percent level, the reward from the second worker's efforts would be only about 30 percent of the gross compensation if the premiums were those for the comprehensive benefit package, and only slightly higher if the lower premiums for the limited benefit package were charged. (Again, this assumes that the

Table 4-3.
Take-Home Pay for Additional Hours of Work:
A Comprehensive Standard Benefit Package Under the Managed Competition Act

	35-Hour Work Week	40-Hour Work Week	Chang
	In Dollars		
Compensation	24,000	27,429	3,429
minus			
Employer's Share of Payroll Tax	1,706	1,949	244
equals			
Base Wage	22,294	25,479	3,185
minus			
Net Insurance Cost (After subsidy)[a]	2,157	3,126	968
equals			
Adjusted Gross Income	20,137	22,354	2,217
minus			
Personal Exemptions and Standard Deduction	16,550	16,550	0
equals			
Taxable Income	3,587	5,804	2,217
Federal Tax Before Credit	538	871	332
minus			
Earned Income Tax Credit	889	245	-644
equals			
Net Federal Income Tax	-351	626	976
plus			
Employee's Share of Payroll Tax	1,706	1,949	244
equals			
Total Federal Tax Paid Directly by Employee	1,355	2,575	1,220
Net Income After Tax and Insurance	18,783	19,779	996
	As a Percentage of Additional Wages		
Net Income from Working Five Additional Hours	n.a.	n.a.	29
Marginal Levy on Wages from Working Five Additional Hours	n.a.	n.a.	71

SOURCE: Congressional Budget Office.

NOTE: Table assumes a hypothetical two-parent, two-child family in 1995; n.a. = not applicable.

a. Assumes that employers pay nothing for insurance and that the family chooses the least expensive health plan, which would cost $6,641 before subsidies.

Table 4-4.
Take-Home Pay for Additional Hours of Work: A Limited Standard Benefit Package Under the Managed Competition Act

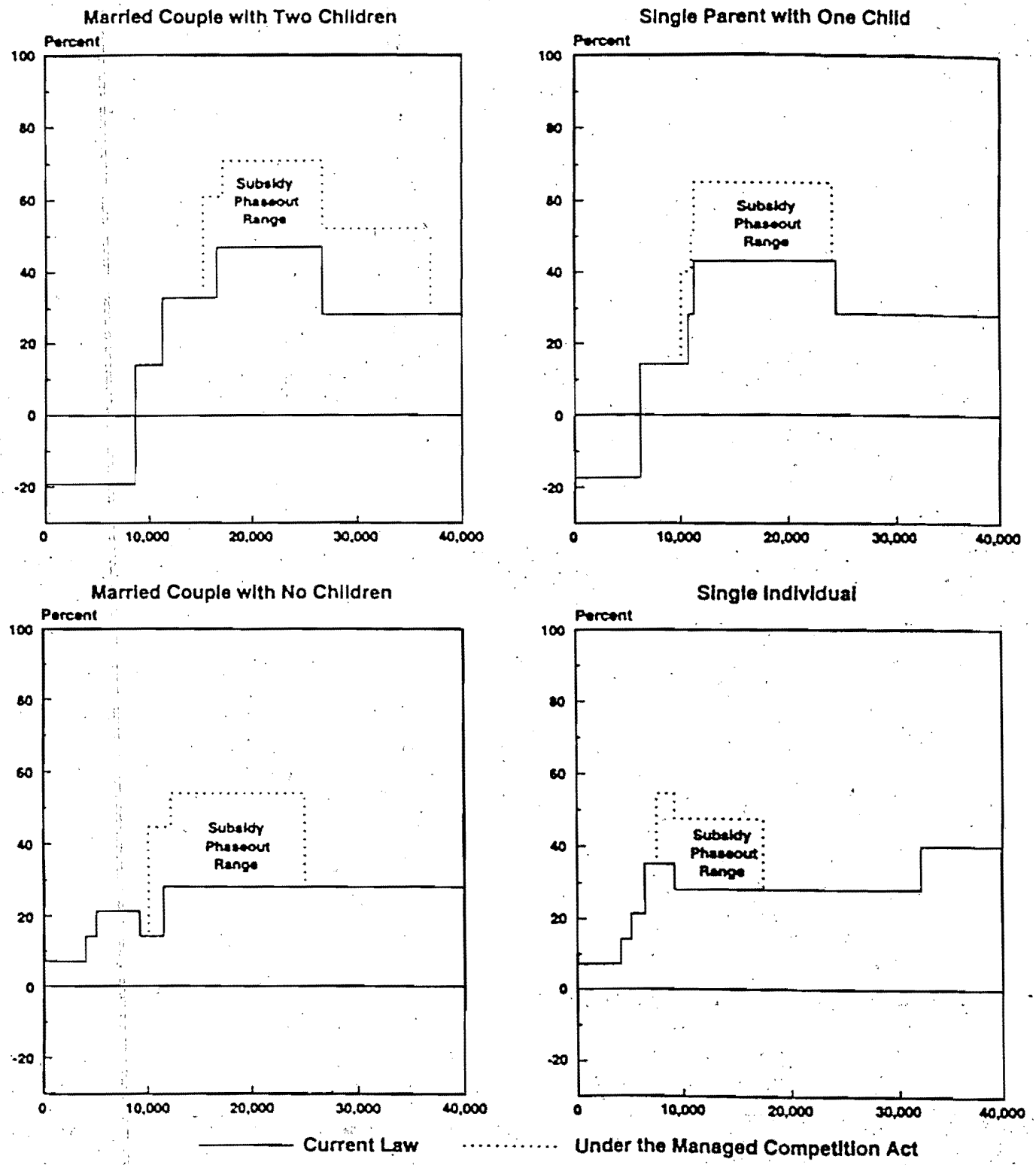
	35-Hour Work Week	40-Hour Work Week	Change
	In Dollars		
Compensation	24,000	27,429	3,429
minus			
Employer's Share of Payroll Tax	1,706	1,949	244
equals			
Base Wage	22,294	25,479	3,185
minus			
Net Insurance Cost (After subsidy)[a]	1,838	2,662	825
equals			
Adjusted Gross Income	20,457	22,817	2,360
minus			
Personal Exemptions and Standard Deduction	16,550	16,550	0
equals			
Taxable Income	3,907	6,267	2,360
Federal Tax Before Credit	586	940	354
minus			
Earned Income Tax Credit	889	245	-644
equals			
Net Federal Income Tax	-303	695	998
plus			
Employee's Share of Payroll Tax	1,706	1,949	244
equals			
Total Federal Tax Paid Directly by Employee	1,403	2,644	1,242
Net Income After Tax and Insurance	19,054	20,173	1,118
	As a Percentage of Additional Wages		
Net Income from Working Five Additional Hours	n.a.	n.a.	33
Marginal Levy on Wages from Working Five Additional Hours	n.a.	n.a.	67

SOURCE: Congressional Budget Office.

NOTE: Table assumes a hypothetical two-parent, two-child family in 1995; n.a. = not applicable.

a. Assumes that employers pay nothing for insurance and that the family chooses the least expensive health plan, which would cost $5,313 before subsidies.

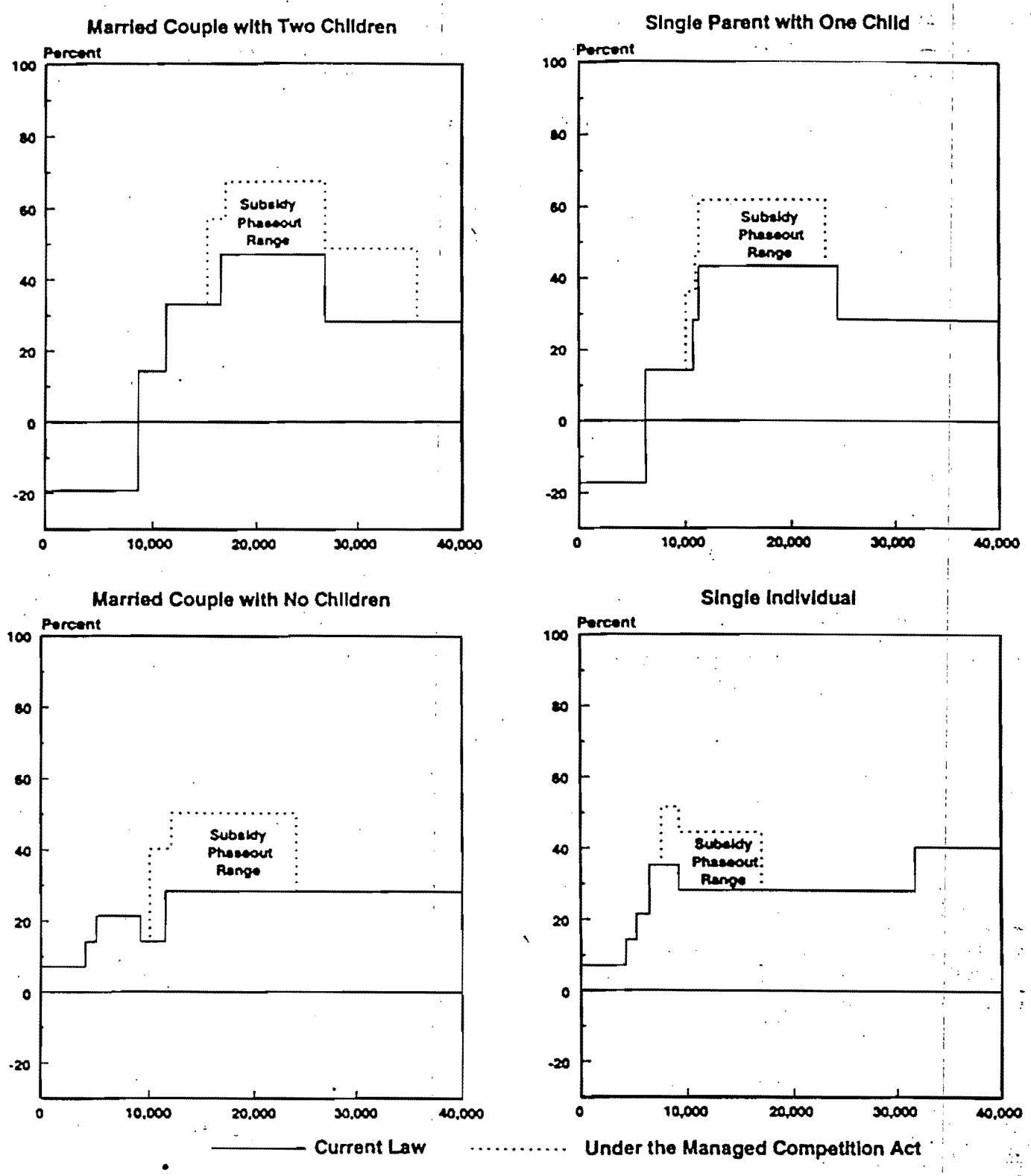
Figure 4-1.
Effective Marginal Tax Rates on Compensation in 1995: A Comprehensive Standard Benefit Package Under the Managed Competition Act



SOURCE: Congressional Budget Office.

NOTE: The effective marginal tax rate includes the individual income tax, the earned income credit, both the employee's and the employer's share of the payroll tax, and the phaseout of the premium subsidy in H.R. 3222. It does not include the loss of cost-sharing subsidies or wraparound benefits.

Figure 4-2.
Effective Marginal Tax Rates on Compensation in 1995: A Limited Standard Benefit Package Under the Managed Competition Act



SOURCE: Congressional Budget Office.

NOTE: The effective marginal tax rate includes the individual income tax, the earned income credit, both the employee's and the employer's share of the payroll tax, and the phaseout of the premium subsidy in H.R. 3222. It does not include the loss of cost-sharing subsidies or wraparound benefits.

worker's employer does not pay for insurance.) In either case, the returns from work would be low, and the second earner's net income might not be enough even to cover the costs of transportation and child care. Moreover, by going to work, the second earner would lose time that could be spent on homemaking, childrearing, or other pursuits.

Of course, the work disincentive would be smaller if the second worker's income increased the family's income well above 200 percent of poverty. Moreover, if the primary worker earned 200 percent or more of the poverty level, the phaseout of the subsidies would have no effect on the second earner's decision to take a job.

Inherent Trade-Offs in Designing Subsidies

The work disincentives under the Managed Competition Act are an inherent element in all health plans that target subsidies toward low-income people because those benefits must be phased out as income rises. Although changing the design of the subsidy system could reduce the marginal levy on the income of low-income people, doing so would introduce other problems.

One way to reduce the subsidy phaseout rate would be to provide a smaller subsidy to people earning income at (or below) the poverty level. With a smaller subsidy to start--something less tha 100 percent of the premium--less of it would hav to be taken away as income rose. But this chang would make it more difficult for low-income peopl to afford insurance and would undercut one of th major goals of the proposal. In addition, such change would do less to reduce Medicaid "lock. As long as Medicaid offered free care--but peopl who worked had to pay for a significant fraction o their care--welfare beneficiaries would face som incentive to stay out of the job market.

A second way to reduce the marginal lev would be to phase out the subsidies over a broade income range--in other words, to raise the incom threshold at which subsidies were terminated to say, two and one-half or three times the poverty level. This approach, however, would dramatically raise the overall cost of the subsidies, since it woul greatly increase the number of eligible families.

Moreover, these additional subsidies would have to be financed--and that financing could also distor decisions about work. Inevitably, such a policy would spread the work disincentives to a large fraction of the population than would be true under the proposal. Thus, although a slower phaseou would significantly improve the work incentives fo people earning between 100 and 200 percent of poverty, it would increase the work disincentives fo others. The net effect of these changes on economic efficiency is uncertain.

Chapter Five

Other Considerations

The Managed Competition Act of 1993 proposes to restructure the health care system using market reforms, competitive forces, and subsidies for low-income families to expand health care coverage and slow the rate of growth of health spending. Changes in the tax system would make people with employment-based coverage more sensitive to its price, as well as provide incentives for uninsured people to purchase coverage. The proposal would not require people to obtain health insurance, but under it the number of uninsured people would drop significantly.

To strengthen the demand side of the insurance marketplace, employees of small firms and people without ties to the labor force would purchase health care coverage through regional health plan purchasing cooperatives (HPPCs), which would offer a choice of accountable health plans (AHPs). All AHPs would provide coverage for a standard package of benefits that would be specified by a federal Health Care Standards Commission. Consequently, purchasers would base their choices on price, quality, and convenience. Within the HPPC, a modified form of community rating would prevail that would ensure that a plan's premiums would vary only by type of enrollment (individual, individual and spouse, individual and one child, and individual and family) and the age of the principal enrollee. All people, regardless of their actuarial risk status, would be assured that they could obtain coverage.

All employers would have to offer their employees health insurance coverage through an AHP, but they would be under no obligation to contribute to the cost of that coverage. Small employers could meet this requirement only by contracting with a HPPC. Large employers would have more flexibility; they could self-insure by establishing an AHP for their employees or purchase coverage in the marketplace from an insurance carrier offering AHPs, but they would be prohibited from purchasing coverage through the HPPC. Large employers would, however, have to ensure that their employees were at no financial disadvantage from being outside the HPPC; generally, one of the plans that they offered would have to provide coverage at a cost to their employees that was no higher than the reference premium for their area (that is, the premium for the lowest-cost plan in the HPPC that enrolled a specified proportion of the eligible population).

The proposal would terminate the Medicaid program and provide federal subsidies to low-income families to enable them to purchase health care coverage from plans of their choice, either through the HPPC or, in the case of low-income families with a worker employed by a large firm, from their employer. The subsidy program would not be open ended; federal expenditures for subsidies would be limited to the savings and increased receipts generated by the proposal. Although the federal liability for subsidies would be effectively capped, the Congressional Budget Office (CBO) believes that if the shortfall in subsidies was substantial, the mechanism for limiting the federal subsidies would seriously disrupt the insurance marketplace and could render it unworkable.

Even with subsidies for low-income people, this voluntary system of health care coverage would still leave a significant number of people uninsured. Although premiums would be community rated,

they might still represent a considerable bite out of the budgets of those low- and moderate-income families who were eligible for, at most, a partial subsidy. Nevertheless, proponents of the managed competition approach believe that the market system should be given an opportunity to work before mandates on individuals are considered.

As with other proposals that would fundamentally restructure the health care system, estimates of the cost and other consequences of the Managed Competition Act are highly uncertain. One reason for this is that managed competition remains a largely untried system, and there is little analytical evidence to indicate how effective it might be. Although a few large purchasers of health insurance have implemented components of the managed competition approach, and voluntary purchasing cooperatives exist in some markets, these experiments offer little insight because they operate in a larger environment that is unmanaged. The ramifications of the proposal are also uncertain because important features--including the standard benefit package and many operational details--are not specified and would be left for the Health Care Standards Commission, the Congress, or later regulations to resolve.

In preparing its cost estimates, therefore, CBO had to make a number of assumptions about both the effectiveness of managed competition and the unspecified dimensions of the proposal. Several of the underlying assumptions were difficult to develop and, together with other uncertainties about the proposal, gave rise to fundamental questions about how the system would actually work. This chapter discusses several of these issues.

Determining Eligibility for Subsidies

As described in Chapter 1, the Managed Competition Act would establish a complex system of subsidies that would be a challenge for the Health Care Standards Commission to administer and for beneficiaries to cope with. Subsidies for premiums and cost sharing would be available for non-Medicare enrollees with family income below 200 percent of the poverty level. Medicare beneficiaries with income below 120 percent of the poverty level would be eligible for premium subsidies; those with income below 100 percent of poverty would also be eligible for cost-sharing subsidies. People with income below the poverty level would also be entitled to federally financed wraparound benefits--services that are now covered by Medicaid but would not be included in the standard benefit package promulgated by the commission. All those receiving Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) would be eligible for full premium and cost-sharing subsidies as well as the wraparound benefits, regardless of whether their family income was below the poverty line. Although, in principle, the eligibility criteria are straightforward, several questions arise about the feasibility and possible consequences of the system for establishing eligibility.

State-Adjusted Measures of Poverty

The proposal does not adopt the usual approach to means-tested programs, which is to employ a national poverty standard. Rather, it would use state-specific measures in an attempt to adjust the eligibility criteria for the wide variations in the cost of living across the country. The goal of this approach is to target subsidies more effectively toward the neediest people. Although this goal has obvious appeal, it is not clear whether it could be accomplished. Cost-of-living indices for states do not exist, and the Departments of Labor and Commerce would have to undertake a major statistical effort to generate reliable indices. Consequently, CBO was unable to take such adjustments into account in its cost estimates.

Even if reliable indices could be developed, using state-specific measures of poverty could create considerable confusion in the many multistate urban markets in which eligibility for a subsidy would vary according to the jurisdiction in which one lived (assuming that eligibility was based on one's state of residence rather than place of employment). The variation in eligibility criteria could cause low-income families to cluster in certain border jurisdictions. In addition, the commission's job would be made more difficult if it had to calculate subsidies

based on more than 50 separate poverty levels. In the end, switching to state-specific measures might result in only modest improvements in the targeting of subsidies, because variation in the cost of living within states could be as great as that between states.

The Eligibility Process and Access to Care

With the exception of AFDC and SSI beneficiaries, who would automatically be eligible for subsidies, low-income people might find the process of obtaining subsidies rather daunting. They would have to apply to a federal agency--the Health Care Standards Commission--submitting proper information about their family circumstances, income, employer, and the AHP in which they were enrolled or wished to enroll. Those receiving subsidies would have to reapply for them each year in October to be eligible for subsidies for the following year; if their income fell during the year, they could apply for larger subsidies at quarterly intervals. If they failed to file an annual income reconciliation statement in April, they would lose their eligibility for future subsidies.

How accessible would this system of subsidies be to low-income people, particularly those with limited education, complex family circumstances, unstable income, and a high degree of residential mobility? The proposal provides some assistance for local organizations to help people apply for subsidies, but the appropriation for these activities would be small. State and local governments would have no explicit role in this process, although they probably would facilitate enrollment in order to avoid costs they would otherwise incur for uncompensated care. If adequate outreach and assistance were not provided, many low-income families might remain uninsured and not seek to enroll in health plans until they needed medical care. Yet many of these uninsured people might find that they could not enroll in AHPs at the particular time they needed care because, unlike enrollment in the Medicaid program, which is year-round, enrollment in AHPs would be restricted to an annual 30-day open-enrollment period. (Special enrollment periods would be available for people who experienced changes in family or employment status.)

Thus, although the proposal would allow many low-income families to purchase health insurance in a systematic or planned way, it would also remove the ready--or "as needed"--access to coverage that Medicaid affords to eligible populations. This change could leave the providers of last resort that serve the low-income population--hospital emergency rooms, outpatient departments, and public clinics--in difficult circumstances. Some could experience an increase in uncompensated care.

The Potential for Overpaying Subsidies

The methods that the proposal specifies for determining eligibility for subsidies and distributing subsidies to AHPs also raise the possibility that subsidies might be misdirected or overpaid. The Health Care Standards Commission would establish the eligibility of individuals and then send premium and cost-sharing subsidies directly to their chosen plan. Thus, AHPs enrolling low-income people would receive subsidy payments from the federal government with relatively little ongoing federal monitoring of the process. Verification would be performed for only a sample of those receiving subsidies.

The proposal specifies an annual process for reconciling the premium subsidies by comparing actual with expected income using data from the tax system, although many of those eligible for subsidies would not be required to file tax returns and would therefore have to file a separate income statement with the commission. There would be no reconciliation for the cost-sharing subsidies or the wraparound benefits for low-income people. Apparently, AHPs would have no liability for repaying any excess subsidy payments that they might receive.

Because of the constant movement of people in and out of HPPC areas, their changing eligibility for subsidies, and the fact that some people would probably be dropped from health plans if they did not pay their share of the premium, it would be difficult for the commission to avoid misdirecting some subsidy payments. To minimize the extent of that problem, it would need to track the enrollment and disenrollment records of low-income individu-

als and their eligibility for subsidies very closely--probably on a quarterly basis. The commission would also have to make the subsidy payments that frequently; the probability of overpayment would increase considerably if subsidies were paid annually or even semiannually.

The Consequences of Shortfalls in Payments for Low-Income Enrollees

The complex subsidy mechanism that would be created by the Managed Competition Act and the controls that would be established to ensure that the subsidies did not add to the federal deficit could present AHPs with shortfalls in payments for low-income enrollees and considerable amounts of uncertainty that could undermine the effective functioning of the HPPC marketplace.

Shortfalls in premiums for low-income enrollees could arise from the limits that the proposal would place on federal subsidies. The annual amount available for subsidies would be limited to the sum of any additional revenues generated by the tax changes in the proposal and the savings from eliminating the Medicaid program, reducing spending for Medicare, and prefunding retiree health benefits in the Postal Service. This pool of resources would finance premium and cost-sharing subsidies, wrap-around benefits for low-income people, transition assistance for the states (between 1995 and 1998) as they took over the long-term care portion of the Medicaid program, and other grants and expenditures included in the proposal.

The premium subsidies for non-Medicare enrollees, however, would be paid only after all of the other required payments had been made; hence, these subsidies would bear the brunt of any shortfall. If the available funding was insufficient, AHPs would have to accept reduced premiums for their low-income enrollees. Moreover, even with full funding of the subsidies, some AHPs could experience shortfalls in premiums and cost-sharing payments for low-income enrollees.

If shortfalls in payments for low-income enrollees occurred--for whatever reason--AHPs would probably have to raise their premiums for all enrollees. Although the proposal includes provisions to distribute the burden of premium and cost-sharing shortfalls across all health plans (including closed AHPs) and across HPPCs, it would be extremely difficult to develop and implement an accurate and effective distribution mechanism. Consequently, this approach to subsidizing the health care coverage of low-income people--which is an explicit form of cost shifting--could introduce considerable uncertainty and instability into HPPC markets. Moreover, if shortfalls were substantial, the amount of cost shifting that would be necessary to cover them might be untenable.

Shortfalls in Premiums

In general, AHPs enrolling low-income people would experience shortfalls in premiums if federal subsidies were not fully funded. In that case AHPs would be required to cut their premiums for low-income people and absorb the difference themselves (see the appendix). Because any subsidy would be inversely related to a family's income--reaching zero for those at 200 percent of the poverty level--the corresponding premium shortfall would decline as income rose above poverty. Even if the unspecified mechanism for distributing the shortfalls among health plans worked perfectly, AHPs would have to raise premiums for all enrollees to cover the average systemwide shortfall. If the distribution mechanism was not perfect, AHPs would have to raise their premiums by differential amounts to cover their particular shortfalls. That response could change AHP premium rankings within a HPPC, possibly changing which AHP was the reference plan (the lowest-cost plan enrolling a specified proportion of the eligible enrollees).

The only situation in which an AHP might not experience a shortfall with partial funding of federal subsidies would be if a low-income person received an employer's contribution for the entire premium. Although the proposal is silent on what would happen if an employer contributed more than the maximum premium that an AHP could charge a low-income person, it would be illogical to ask a plan to accept a lower payment in those circumstances. In general, however, the primary beneficiary of employers' contributions would be the federal government, which would reduce its premium subsid

accordingly. Given that employees "pay" for their employers' contributions to health insurance through lower wages, every dollar from an employer that substituted for a federal subsidy dollar would make low-income workers worse off.

Even with full funding of the subsidies, AHPs with premiums higher than the reference premium would have to lower them for low-income enrollees. The amount of the reduction would be a function of the family's income and the degree to which a plan's premium exceeded the reference premium. For example, a poor family participating in a higher-cost plan would be required to pay only 10 percent of the difference between the reference premium and the plan's actual premium. There would be no federal subsidy to cover this shortfall because the maximum subsidy could not exceed the reference premium. If, in addition, the federal subsidies were only partially funded, the plan would face a higher premium reduction--reflecting both effects.

It is not at all clear how many low-income families would choose to enroll in plans that charged more than the reference premium. Much would depend on the distribution of premiums among AHPs in the HPPC area, the availability and accessibility of plans that cost no more than the reference premium, the perceived quality of care in such plans, total out-of-pocket premium costs, and the additional out-of-pocket premium costs associated with the higher-cost plans. Families with income around the poverty level, particularly those with health problems, might find the higher-cost plans an attractive option because at that level of income they would be required to pay little out of pocket to enroll. By contrast, families with income in the declining-subsidy range might be discouraged from purchasing any insurance (either at the level of the reference premium or higher) because of the substantial individual obligation they would face.

Shortfalls in Cost-Sharing Subsidies

All AHPs would be required to lower cost-sharing amounts to "nominal" levels for non-Medicare beneficiaries with income less than 200 percent of the poverty level. Under the proposal, plans would receive cost-sharing subsidies that would not be tied to the actual health care expenditures of their low-income enrollees. Rather, the cost-sharing subsidies would be lump-sum payments that would vary only by the type of enrollment and the age of the principal enrollee.

These payments would be uniform nationwide and consequently could vary widely as a percentage of total costs in different markets. Some plans could gain and others lose under such an arrangement, depending on the utilization patterns of their enrollees. Moreover, there is no guarantee that reductions in cost sharing would be fully subsidized in the aggregate, since the Health Care Standards Commission would allocate the annual funds for cost sharing in advance based on estimates that could be far off the mark, especially in the initial years of implementation.

The Interplan Reconciliation Process

To ensure that AHPs enrolling large numbers of low-income people would not be disproportionately affected by shortfalls in subsidies or premiums, all AHPs--including self-insured firms--would be required to participate in a nationwide system that would distribute reductions in premiums and cost sharing equitably among plans. Developing a national transfer system involving the thousands of AHPs in the country would be an extremely difficult task, and whether it could be implemented effectively is doubtful.

The proposal does not spell out the principles on which the transfers would be based. Would, for example, plans with higher premiums be entitled to receive larger interplan transfer amounts for subsidized enrollees than plans with lower premiums in markets with the same reference premium? Certainly, the shortfalls in premiums would be greater for the higher-cost plans, but requiring other plans to contribute more in consequence raises the possibility that unsubsidized enrollees in low-cost health plans would have to pay higher premiums to help subsidize low-income enrollees in higher-cost plans.

A further complexity for the transfer system is that reference premiums could vary greatly among

HPPCs, reflecting differences in input costs, practice patterns, quality of care, competitiveness of the marketplace, and the efficiency with which health care was delivered. Because federal subsidies in any HPPC area would be tied to the reference premium, plans in markets with high reference premiums would receive larger subsidies than plans in markets with low reference premiums. Questions would inevitably arise about whether such discrepancies could be justified or whether they were unfair to health plans in highly competitive markets.

Conceptual questions such as these are difficult to address and would be politically charged. They also evoke concerns about equity among individuals, plans, and geographic areas and may not be appropriate issues for an appointed commission to resolve.

The Effects of Shortfalls on Insurance Markets

The proposal's complex subsidy mechanisms would introduce a good deal of uncertainty and instability into HPPC and non-HPPC insurance markets. AHPs would have to estimate their potential shortfalls under a number of circumstances in order to set their premiums. These calculations would be extremely complex because each plan's expected shortfall would be related to a number of factors that would be difficult to predict, including:

- The federal premium subsidy percentage for the year;
- The relationship of the plan's premium to the reference premium and to the premiums of other plans in the market;
- The number of low-income families who might enroll in the plan by type of enrollment, age of principal enrollee, and family income as a percentage of the poverty level;
- The amount to be received for cost-sharing subsidies relative to the use of services by eligible enrollees;
- The effectiveness of the mechanism for adjusting premiums for risk within the HPPC; and
- The amount that the plan might receive through the interplan reconciliation process.

The estimating process would have to be a dynamic one because a plan's anticipated shortfall would be related to the level of its premium. A higher premium would probably change the relationship of the plan's premium to the reference premium, which would itself depend on the final decisions made by all the plans. A higher premium would also cause some enrollees to drop their coverage or switch plans. Those that dropped coverage might be healthier than average, causing the average level of risk of the plan's enrollees to rise and placing further pressure on premiums. Thus, when setting premiums, plans would find themselves dealing with many unknown and interdependent variables.

Determining premiums would not become less complex or more certain over time. The federal subsidy percentage could vary from year to year; the reference premium in the HPPC would probably change annually, as might the plan or plans offering that rate; and considerable numbers of people--particularly low-income people--could switch plans each year to minimize their out-of-pocket premium payments. In short, the premiums of health plans in HPPCs with a high percentage of low-income enrollees could be unstable and unpredictable.

In the absence of an effective distribution process, AHPs might respond in a variety of ways to shortfalls in payments. The responses and their impacts would generally be greater within the HPPC than outside it because low-income people would constitute a much higher proportion of the HPPC population. Once a plan had set its premiums for the year, it presumably could not change them until the following year. Consequently, if the projection of the shortfall in payments for low-income enrollees on which the premium was based turned out to be too low, a plan could not adjust its premiums to compensate in the short run. Small shortfalls would probably pose little problem. Large shortfalls, however, might produce various interim responses, such

as lowering payments to providers and reducing the quality or quantity of care provided.

In the longer term, plans faced with significant reductions in payments would almost certainly raise their premiums; some might even withdraw from the market. If people chose to drop their coverage when premiums rose, the consequences would not be confined to the plans immediately affected. Because enrollment in AHPs would be voluntary, some healthier people might drop out of the HPPC market altogether rather than just switch plans. This response would cause the average risk level of all enrollees in the HPPC to rise, potentially resulting in an upward spiral of premiums in the HPPC. Very large shortfalls in premiums could cause the HPPC system to collapse entirely because the amount that AHPs would have to pass on in higher premiums would be unacceptable. CBO believes that to avoid such consequences, the subsidies would have to be close to or fully funded.

The Tension Between Covered Benefits and the Proposed System of Subsidies

CBO's analysis suggests that it would not be possible to implement the proposed system of subsidies in conjunction with a relatively generous benefit package, full funding of the federal subsidies, and no increase in the federal budget deficit. The available funding for the proposed subsidy pool would be insufficient.

If the commission established a standard package of benefits that was similar to that required by the Administration's proposal--which is about 5 percent more generous than the average employer-sponsored plan--the annual shortfalls for premium subsidies for the non-Medicare population would average over 30 percent between 1996 and 2000. If such shortfalls were reflected in reduced premium subsidies, they could well jeopardize the orderly functioning of insurance markets. If so, policymakers would have only three ways to respond. First, they could fund the subsidies by allowing the deficit to increase. Second, they could approve additional spending cuts and tax increases to augment the pool of resources available to fund the subsidies. Finally, they could scale back the program either by changing the standard benefit package to reduce premiums or by trimming the generosity of the subsidies.

This third approach, which may appear to be the obvious response, could be problematic; it provides a good illustration of the problems and difficulties that one encounters when modifications are made in comprehensive health proposals. Often, ad hoc adjustments designed to reduce costs in one area interact with other components to raise costs elsewhere in the proposal. For example, if the commission increased the cost-sharing requirements for the standard benefit package in an effort to reduce premiums and, hence, premium subsidies, it would find that net federal costs would be reduced little because there would be a concomitant increase in the spending for the cost-sharing subsidies that are paid for people with income below 200 percent of poverty. Alternatively, if the commission tried to reduce premiums by narrowing the range of services covered in the standard benefit package, it would soon discover that much of the savings achieved from lower premium and cost-sharing subsidies was offset by increased federal costs for the wraparound benefits available to people below the poverty level. Thus, under the proposal, lowering federal subsidy costs by reducing premiums is, at best, a "two steps forward, one step back" process.

In formulating an alternative that permitted full funding of subsidies from the pool of resources generated by the proposal, CBO found that it had to alter the proposal's subsidy structure in addition to scaling back premiums by limiting the benefit package. This route was taken because CBO concluded, after discussions with health insurance actuaries, that the level of premiums consistent with fully funding the subsidies using the pool of resources specified in the proposal would be insufficient to purchase what most would regard as a minimally adequate package of benefits. Accordingly, the premium constraint was achieved with a fairly Spartan benefit package and the elimination of the cost-sharing subsidies called for in the proposal for people with income between 100 percent and 200 percent of the poverty level.

There would be many ramifications for the health care system and the people it serves if covered benefits and subsidies were reduced to this degree. More people--mostly in income ranges between 100 percent and 200 percent of the poverty level--might purchase health insurance in response to lower premiums. But some others might be discouraged from purchasing because the benefit package would be lean and they would have no cost-sharing assistance. (People with income below poverty would not be affected at all because they would make up in wraparound benefits what they lost in standard coverage.) Others who could afford to do so would probably purchase supplementary insurance for benefits not covered by the standard package; they would generally have to pay for additional coverage out of after-tax income, which would enhance their cost-consciousness. The resulting health care system might provide quite comprehensive coverage for both poor and relatively well-to-do families, and rather meager benefits for those with moderate income.

Effects of the Proposal on Employers and Employees in Certain Firms

Although employers would only be required to offer--not to pay for--health insurance coverage for their employees, many could find their circumstances altered considerably under this proposal and not always for the better. Ultimately, however, those faced with higher costs for health care would pass them on to their employees through lower wages.

Depending on the standard benefit package specified by the Health Care Standards Commission, some small firms that currently offer health insurance to their employees might face considerably higher premiums under the proposed system. If the benefit package resembled CBO's more comprehensive option, voluntary participation and community rating in the HPPC could cause premiums to be significantly higher for those firms that currently have healthy employees and low, experience-rated premiums. They would also tend to be higher for firms whose current benefits were less generou than those in the standard benefit package. B contrast, with a less comprehensive benefit packag experience-rated firms with healthy employee might face similar or higher premiums for les generous coverage than they currently have. More over, if AHPs in the HPPC experienced significar shortfalls in premiums and subsidies for low-incom people, all small firms might face increases in pre miums the next year. To the extent that healthie workers chose to drop their coverage in the face o rising premiums, adverse risk selection in the HPP pool would become more severe.

Some large employers--who would have t obtain their plans outside the HPPC--might als consider themselves to be "losers" under the pro posed system in the short run. In particular, thos that did not intend to pay for their employees health care coverage might, nonetheless, find them selves involuntarily contributing to such coverage This situation could occur because some large firm might not be able to obtain insurance coverage i the non-HPPC market for a price equal to or belov the reference premium although they would b required to offer their employees a plan that was n more expensive than that amount.[1]

The firms most likely to be confronting thi problem would be those just slightly larger than th size cutoff for mandatory participation in the HPP (generally 100 employees) that did not contribute t the cost of their employees' coverage. With many workers in these firms choosing coverage through a spouse who worked for a firm that contributed t employees' insurance costs, the firm's actual insur ance pool could be well under 100. Such firms might face relatively high premiums if they had even a few participants in their plan with health problems. Thus, although in theory firms would only be required to offer, not to pay for, coverage, some firms might have to make some contribution to satisfy the requirement that the premium be no higher than the reference premium in the HPPC. In

1. This provision, which would generally apply for each type of enrollment and age group of the principal enrollee, would be modified for closed AHPs that elected to use community rating across types of enrollment or HPPC areas.

the end, those payments would be passed on to workers in the form of lower wages.

Under the circumstances just described, an inequitable anomaly would occur. Although the firm would be contracting to obtain the cheapest possible AHP for its workers, the workers would have to pay taxes on a portion of their contributions for health insurance. This situation, which would never face an individual who chose the cheapest available plan in a HPPC, would arise because the tax-exempt amount of premiums paid by both the employer and enrollee could not exceed the HPPC's reference premium.

Effect of Cost-Sharing Provisions and Alternative Benefit Packages on AHPs of Different Types

Advocates of the managed competition approach assume that one of the consequences of a more competitive marketplace would be that more people would enroll in health maintenance organizations (HMOs). Some of the provisions of the proposal would have major consequences for HMOs and might affect in unforeseen ways their ability to compete.

Cost-Sharing Provisions

The basic tenet of the managed competition approach is that all health plans should offer a standard benefit package. Opinions differ, however, on whether that package should encompass standardized cost-sharing amounts. Advocates for standardizing cost sharing, which is the approach adopted in the proposal, maintain that such standardization is necessary if consumers are to be able to compare premiums among plans and make informed choices.[2]

Other observers, however, contend that even under managed competition, two cost-sharing options--one lower and one higher--should be permitted. Their reasoning is that cost sharing plays very different roles in plans of different types. Effective health maintenance organizations, for example, typically have low cost sharing and limit their patients' use of services through careful management. Fee-for-service plans, in contrast, rely on higher cost sharing to control utilization, imposing much less restrictive management on patients. Consumers understand the alternatives they face when selecting a particular type of plan: lower out-of-pocket spending and more restrictions on choice in HMOs versus higher out-of-pocket spending and fewer restrictions on choice in fee-for-service plans.

Given the different functions of cost sharing in different kinds of plans, proposals that would standardize cost sharing across all plans could have very disruptive effects on the health care system, at least for the first few years. If, for example, the standard benefit package required cost-sharing amounts for all plans that were similar to those charged by HMOs today, fee-for-service plans might experience large increases in use of services. The only way for them to compensate for that increased use would be to increase their premiums significantly, which could eventually drive them out of the market.

Conversely, if the standardized cost-sharing amounts reflected current fee-for-service patterns, HMOs could find themselves at a competitive disadvantage, since low cost sharing is the major attraction of HMOs for many of their enrollees. Although HMOs could probably lower their premiums in those circumstances, their ability to do so might be limited by the additional administrative costs imposed by the new cost-sharing provisions. Moreover, it is unclear how consumers would respond to HMOs with lower premiums and higher cost sharing. As a result, the overall effects of the proposal's cost-sharing provisions on the market shares of HMOs and fee-for-service plans are uncertain.

In both of the situations just described, competitive forces would drive those plans that could not survive out of the market, but the transition to a new market structure could be difficult for health plans, providers, and patients alike. To avoid some

2. The proposal actually requires uniform cost sharing for all types of plans, with one exception. Network plans would be required to implement higher levels of cost sharing than the standard amounts for out-of-network use.

of the potentially disruptive consequences of standardized cost sharing, the proposal includes a requirement that cost sharing be set so that utilization rates would not change from their current average level.

Although the appeal of that idea is understandable, how the cost-sharing requirements would be determined in practice and what their effects would be are unclear. Because the majority of the insured population is still in fee-for-service plans, however, the resulting cost-sharing provisions would probably be closer to those of current fee-for-service plans than to those of HMOs. Thus, although all types of plans would have to adjust to the new cost-sharing structure, the consequences might be more far-reaching for HMOs. The extent to which they could regain their competitive position through lower premiums would depend on the form that the additional cost sharing took, the effects on administrative costs, and the response of consumers to the new payment requirements. There appears to be no guarantee that the proposal's provision of a constant rate of utilization would ensure a smooth transition to a new market structure.

Alternative Benefit Packages

Another important characteristic of HMOs is their relatively comprehensive benefits, which generally emphasize preventive health care. A meager standard benefit package could, therefore, limit the effective functioning of HMOs. The impact would depend on the particular benefits that were or were not covered and the extent to which people purchased supplementary policies for uncovered benefits.

From an HMO's perspective, the most serious deficit in coverage would probably result from limits on preventive health services. Although the less comprehensive package used in CBO's cost estimate does not include coverage of those services, the commission would face tremendous pressure to include them. To cover preventive health care and not allow the subsidies to rise, however, would require even stiffer reductions elsewhere that could erode the typical HMO benefit package in other ways.

Role of the Health Care Standards Commission

The proposal would create a new federal agency, the Health Care Standards Commission, which would have major responsibilities for almost every component of the health care system, eclipsing the role of the states and in some cases that of other federal agencies. As described in Chapter 1, those responsibilities would be exceptionally broad, ranging from setting national program standards to implementing nationwide subsidy programs. Could a single centralized federal agency perform all of the diverse functions of the commission effectively, and could an appointed body withstand the many political pressures the commission would face?

The tasks that might be fitting responsibilities for a single centralized agency are those that relate to the design and establishment of the proposed new health care system. Examples include specifying the benefit package (including the cost-sharing requirements), developing the factors for adjusting premiums for risk, setting standards for AHPs and HPPCs, establishing information standards, and determining annual federal expenditures for premium and cost-sharing subsidies.[3]

Yet the decisions made in some of those areas would affect the future viability of the health care system and could be highly controversial and politically sensitive. Designing the benefit package is an important case in point. Under the proposal, the commission would basically be faced with a Hobson's choice. It would be told the maximum amount that would be available for subsidies and could design a benefit package that was consistent with that amount. But to ensure full funding of the subsidies, the benefit package would have to be so lean that it would probably be unacceptable to many people. Because the commission would have to ob-

3. Two additional federal boards responsible to the commission would assist in some of those activities. The Benefits, Evaluations, and Data Standards Board would provide advice on benefits, information standards, and the evaluation of health care services. The Health Plan Standards Board would advise the commission on standards for AHPs and HPPCs.

tain Congressional and Presidential approval for its recommendations, limiting the benefit package might be extremely difficult. If it adopted a generous benefit package, however, the subsidy shortfall could cause major disruptions to the health care system.

The commission would also have major responsibilities for the day-to-day operations of the health care system--activities that it might be less capable of undertaking. The commission's functions would include monitoring the HPPCs and the reinsurance market for health plans, determining the eligibility of low-income families for premium and cost-sharing subsidies, distributing those subsidies to health plans, and developing and implementing the system of transfer payments among HPPCs to ensure that premium and cost-sharing adjustments for low-income families were distributed equitably. The commission would also be required to register and oversee all AHPs in the country, including the plans of self-insured firms. (State certification would not be a requirement for registration, which raises the possibility that plans would not have to be licensed in the states in which they operated.)

In addition, the commission would have to ensure that states had established satisfactory protections regarding solvency for enrollees in insured health plans and would itself have to establish solvency protections for enrollees in other plans. To be appropriately responsive to needs and problems at the local level, a federal agency performing these functions would probably need to have regional, state, and local offices across the country. The proposal, however, makes no explicit provisions for such a structure.

Conclusion

Several features of the Managed Competition Act that might otherwise produce unintended consequences, lengthen the time needed for implementation, or limit the effectiveness of the approach could be modified quite simply. One could, for example, allow two alternative cost-sharing structures for AHPs, use a single poverty standard nationwide to set the eligibility criteria for subsidies, and allow low-income people to establish their eligibility for subsidies at local offices (possibly using local offices of the Social Security Administration, or state and local welfare agencies).

Changing other aspects of the proposal that might affect its feasibility could prove more controversial because some of them are inherent elements of the underlying philosophy of the approach. As described in this chapter, for example, allowing voluntary enrollment in AHPs and permitting only those firms with no more than 100 employees to participate in the HPPC would have the potential to produce unstable premiums, especially if federal subsidies were not fully funded. Moreover, without additional revenues or spending cuts, deficit neutrality would be difficult to reconcile with a comprehensive benefit package and full funding of the subsidies.

These problems present difficult choices and trade-offs. The most immediate question, however, concerns the issues that should be resolved now as part of the proposal versus those that should be left to the commission, other government agencies, or the Congress to decide in the future.

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Appendix

Illustrative Effects of Shortfalls in Federal Subsidies and Premiums Under the Managed Competition Act

The examples in this appendix illustrate several important characteristics of the Managed Competition Act's premium subsidy system. First, if the federal subsidies were not fully funded, premium shortfalls could be substantial for accountable health plans (AHPs) charging the reference premium as well as for higher-cost plans. Second, AHPs charging more than the reference premium could experience significant shortfalls if they attracted large numbers of low-income enrollees--regardless of whether the subsidies were fully funded. Third, poor families would face rather small out-of-pocket costs if they chose to enroll in higher-cost plans. Finally, the cost of insurance could be substantial for those with income between 100 percent and 200 percent of the poverty level--the income range in which the subsidies would be phased out.

The effects of a shortfall in federal subsidies are illustrated in Table A-1 for an AHP charging the reference premium (assumed to be $2,300 for an individual). Case 1, the simplest situation, assumes that the subsidies are fully funded and that individuals receive no contributions from employers. Because the plan charges the reference premium, it is allowed to charge low-income people the full amount. Individuals with income up to 100 percent of the poverty level receive full subsidies. For individuals with income above the poverty level, the subsidy falls 1 percentage point for every percentage point that their income exceeds the poverty level, reaching zero at 200 percent of the poverty level.

In Case 2, which assumes a federal subsidy percentage of only 70 percent, the amount that plans can charge all low-income people drops, with the reduction being proportional to the amount of the original federal subsidy. In other words, the reduction in the total premium paid to the plan is 30 percent of the full subsidy at each level of income. The enrollee's payment remains the same, and the plan absorbs the shortfall.

Cases 3 and 4 show the effects of contributions from employers, which are assumed to be 80 percent of the reference premium. In both cases, the federal subsidy drops dramatically. In Case 3, which assumes that the subsidies are fully funded, the subsidy becomes zero for individuals with income at 120 percent of the poverty level. With partial funding of the subsidies, the subsidy becomes zero at a lower level of income. In the particular example shown in Case 4, which assumes a federal subsidy percentage of 70 percent and an employer's contribution of 80 percent of the reference premium, there is no subsidy at any income level. (Case 4 also assumes that plans can accept all of an employer's contribution, so that the shortfall in premiums is reduced for low-income enrollees up to the income level at which that contribution equals the premium the plan can charge--which is at 133 percent of the poverty threshold in this example.)

Under the proposal, plans charging more than the reference premium would have to lower their premiums for low-income people, regardless of

Table A-1.
Shortfalls in Federal Subsidies for an AHP Charging the Reference Premium (In dollars)

	Payment (By income, as a percentage of the poverty level)			
	100	120	150	175
Case 1: Federal Subsidy Percentage = 100 Employer's Contribution = 0				
Actual Premium	2,300	2,300	2,300	2,300
Premium AHP Could Charge	2,300	2,300	2,300	2,300
Employer's Payment	0	0	0	0
Federal Subsidy Payment	2,300	1,840	1,150	575
Enrollee's Payment	0	460	1,150	1,725
Premium Shortfall	0	0	0	0
Case 2: Federal Subsidy Percentage = 70 Employer's Contribution = 0				
Actual Premium	2,300	2,300	2,300	2,300
Premium AHP Could Charge	1,610	1,748	1,955	2,128
Employer's Payment	0	0	0	0
Federal Subsidy Payment	1,610	1,288	805	403
Enrollee's Payment	0	460	1,150	1,725
Premium Shortfall	690	552	345	173
Case 3: Federal Subsidy Percentage = 100 Employer's Contribution = 0.8 x 2,300 = 1,840				
Actual Premium	2,300	2,300	2,300	2,300
Premium AHP Could Charge	2,300	2,300	2,300	2,300
Employer's Payment	1,840	1,840	1,840	1,840
Federal Subsidy Payment	460	0	0	0
Enrollee's Payment	0	460	460	460
Premium Shortfall	0	0	0	0
Case 4: Federal Subsidy Percentage = 70 Employer's Contribution = 0.8 x 2,300 = 1,840				
Actual Premium	2,300	2,300	2,300	2,300
Premium AHP Could Charge	1,610	1,748	1,955	2,128
Employer's Payment	1,840 [a]	1,840 [a]	1,840	1,840
Federal Subsidy Payment	0	0	0	0
Enrollee's Payment	0	0	115	288
Premium Shortfall	460 [a]	460 [a]	345	173

SOURCE: Congressional Budget Office.

NOTES: The reference premium is assumed to be $2,300 for a single individual.

AHP = accountable health plan.

a. The proposal does not address the situation in which an employer's contribution is greater than the amount that the AHP is allowed to charge. In this example, CBO assumes that the employer pays, and the plan can keep, the employer's full contribution.

whether the subsidies were fully funded. The effects of this provision are shown in Table A-2 for a plan charging $2,500 for an individual policy with a reference premium of $2,300. In Case 1, which assumes full funding of the subsidies, the shortfall in premiums reflects only the consequences of the plan's premium being above the reference premium. In Case 2, the premium shortfalls are the result of the combined effects of a 70 percent federal subsidy and the plan's premium being above the reference premium. Consequently, in this example, which assumes no contributions from employers, the shortfalls in Case 2 are more than four times as large as the shortfalls in Case 1.

Table A-2.
Shortfalls in Premiums and Federal Subsidies for an AHP Charging More Than the Reference Premium

	Payment (By income, as a percentage of the poverty level)			
	100	120	150	175
Case 1: Federal Subsidy Percentage = 100 Employer's Contribution = 0				
Actual Premium	2,500	2,500	2,500	2,500
Premium AHP Could Charge	2,320	2,340	2,400	2,450
Employer's Payment	0	0	0	0
Federal Subsidy Payment	2,300	1,840	1,150	575
Enrollee's Payment	20	500	1,250	1,875
Premium Shortfall	180	160	100	50
Case 2: Federal Subsidy Percentage = 70 Employer's Contribution = 0				
Actual Premium	2,500	2,500	2,500	2,500
Premium AHP Could Charge	1,630	1,788	2,055	2,278
Employer's Payment	0	0	0	0
Federal Subsidy Payment	1,610	1,288	805	403
Enrollee's Payment	20	500	1,250	1,875
Premium Shortfall	870	712	445	223

SOURCE: Congressional Budget Office.

NOTES: The reference premium is assumed to be $2,300 for a single individual; the actual premium is assumed to be $2,500.

AHP = accountable health plan.