

**[JOINT COMMITTEE PRINT]**

**DESCRIPTION AND ANALYSIS OF THE  
EMPLOYER MANDATE AND RELATED  
PROVISIONS OF H.R. 3600  
("HEALTH SECURITY ACT")**

SCHEDULED FOR A HEARING  
BEFORE THE  
HOUSE COMMITTEE ON WAYS AND MEANS  
ON FEBRUARY 3, 1994

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PREPARED BY THE STAFF  
OF THE  
JOINT COMMITTEE ON TAXATION



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## INTRODUCTION

This pamphlet,<sup>1</sup> prepared by the staff of the Joint Committee on Taxation, provides a description and analysis of the employer mandate and related provisions of H.R. 3600 ("Health Security Act"). The Committee on Ways and Means has scheduled a public hearing on the employer mandate and related provisions in the Health Security Act, H.R. 3600, on February 3, 1994.

The Committee on Ways and Means began its consideration of the employer and individual premium mandate provisions in the Health Security Act during its November 1993 hearings on the financing provisions of the Act. These hearings were held prior to the formal introduction of the Act as H.R. 3600 on November 20, 1993.

Part I of the pamphlet is an overview of the Health Security Act; Part II is a description of the employer mandate and related provisions of the Health Security Act; Part III sets forth examples of premium calculations; and Part IV is an analysis of the economic effects of the employer mandate and related provisions of the Health Security Act.

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<sup>1</sup> This pamphlet may be cited as follows: Joint Committee on Taxation, *Description and Analysis of the Employer Mandate and Related Provisions of H.R. 3600 ("Health Security Act")* (JCS-1-94), February 2, 1994.

## I. OVERVIEW OF THE HEALTH SECURITY ACT

### *Universal coverage and comprehensive benefit package*

Under the Health Security Act, all American citizens and residents would be guaranteed a comprehensive health benefit package. Individuals would generally be required to enroll in an applicable health plan providing the guaranteed benefit package through an appropriate health alliance. The comprehensive benefit package would be set forth in the statute initially, and would be subject to the cost sharing requirements of the bill, the exclusions in the bill, and the duties and authority of the National Health Board to be established by the bill. Individuals would be able to purchase supplemental health insurance to cover health services not included within the comprehensive benefit package.

Each health plan would be required to offer one, and only one, of three prescribed cost sharing schedules: lower cost sharing; higher cost sharing; or combination cost sharing (secs. 1131-1139). These cost sharing schedules would be defined generally as follows.

Under a lower cost sharing plan, deductibles would be prohibited. The annual limit on individual out-of-pocket cost sharing would be \$1,500, and the annual limit on family out-of-pocket cost sharing would be \$3,000. Copayments<sup>2</sup> would be permitted as specified in the bill (e.g., \$10 for outpatient services, \$25 for hospital services, and \$20 for certain dental services). No coinsurance<sup>3</sup> (except for an out-of-network item or service<sup>4</sup>) would be permitted under a lower cost sharing plan.

A higher cost sharing plan would have deductibles (for most items and services in the comprehensive benefit package) of \$200 for individuals and \$400 for families. Coinsurance would be required under a higher cost sharing plan. The annual limits on out-of-pocket cost sharing would be the same as under a lower cost sharing plan.

A combination plan could have cost sharing that differs depending on whether the enrollee uses preferred providers or out-of-network providers.

The dollar limits on deductibles and copayments would be indexed for inflation after 1994.

<sup>2</sup> Copayments are amounts, expressed as a dollar amount, that an individual may be required to pay with respect to an item or service, such as \$10 per office visit.

<sup>3</sup> Coinsurance is an amount, expressed as a percentage of an amount otherwise payable, that an individual may be required to pay with respect to an item or service, such as 20 percent of the total fee for a service.

<sup>4</sup> Under the bill, a "provider network" would mean providers who have entered into an agreement with a health plan under which the providers are obligated to provide items and services in the comprehensive benefit package to individuals enrolled in the plan. An "out-of-network" good or service would mean items or services provided to an individual enrolled under a health plan by a provider who is not a member of a provider network of the plan (sec. 1402(f)).

## ***National Health Board***

The operation of the new health care system would be overseen by a National Health Board (the "Board"). The Board would consist of seven members appointed by the President by and with the advice and consent of the Senate. The chair of the Board would serve a term concurrent with that of the President, and could serve a maximum of three terms. The other members of the Board would serve staggered, 4-year terms. A member other than the chair could serve a maximum of two terms.

Among other things, the Board would have the authority to establish requirements for State plans and monitor compliance with the bill's requirements, interpret and update the comprehensive benefit package, and recommend changes in the package to the President and the Congress. It would also establish a baseline budget for alliances and certify compliance with the budget.

## ***Health alliances***

### *In general*

Individuals would generally obtain health insurance through regional health alliances established and overseen by States or through corporate health alliances established by large employers or certain other entities. In general, if a family has only one worker and that worker is eligible to enroll in a corporate alliance plan, then the entire family would obtain insurance through the corporate alliance. Otherwise, the family would obtain insurance through the regional health alliance for the alliance area in which the family resides.

*Comment:* It is unclear what would happen in the case of a family whose members reside in more than one regional alliance area. The bill provides that the Board is to develop rules to deal with such cases and similar situations, including treatment of children of divorced or separated parents and changes in family composition occurring during a year (sec. 1011(f)). It is also not clear how residence is to be determined. For example, suppose an individual maintains a household in California, but is currently living in New York where she is working on an indefinite basis. It is not clear where the individual would be considered to reside.

Special rules would apply in determining the appropriate alliance if more than one family member is employed. If an individual and his or her spouse are employed and eligible to participate in different corporate alliances or if one spouse is eligible to participate in a regional alliance and the other in a corporate alliance, they must choose the alliance in which the entire family will participate. Similarly, a single individual who is employed by a regional alliance employer (or employers) and a corporate alliance employer (or employers) may elect to enroll in a health plan offered by the regional alliance for the alliance area in which the individual resides or a corporate alliance health plan (if applicable).

In lieu of establishing a system of regional alliances, States would be permitted to establish single-payer systems.

### *Regional alliances*

The bill would require States to establish regional alliances by January 1, 1997. Regional alliances could be organized as non-profit organizations, independent State agencies, or agencies of the State. Only one regional alliance could serve any geographic area, and no regional alliance could serve a geographic area crossing State boundaries. States would be required to certify health plans that can offer coverage through an alliance.

*Comment:* Employers may be required to make premium payments to more than one regional alliance. This will be particularly true of large employers, but may also occur in the case of small employers in areas in which a metropolitan area crosses more than one State. For example, a small employer located in the District of Columbia may have employees who reside in the District of Columbia, Maryland, Virginia, and possibly even West Virginia and Pennsylvania. Because each State will establish its own regional alliances and the premium payments will be based on the demographics of the individuals residing within the regional alliance area, it is likely that even a small employer will be making different premium payments on behalf of its employees to the extent that they reside in different regional alliance areas.

Regional alliances would be governed by a Board of Directors with equal representation of employers whose employees purchase health coverage through the alliance (including self-employed individuals), and individual consumers. Each regional alliance would also be required to have a provider advisory board consisting of representatives of health care providers and professionals who provide covered services through health plans offered by the alliance.

Regional alliances would negotiate with State-certified health plans and enter into contracts with health plans to provide health services to eligible individuals. Regional alliances would be required to offer at least one "fee-for-service" plan among the health plans offered to eligible individuals.<sup>5</sup>

Regional alliances would receive funds from the following sources: employer and individual premiums (directly and through transfer payments from other alliances); State and Federal payments for recipients of Aid to Families with Dependent Children (AFDC) and supplemental security income (SSI); State maintenance of effort payments; payments from corporate alliances for dual earner families; and Federal payments for premium subsidies. Regional alliances would disburse funds for the following reasons: payments to health plans; administrative costs; payments to other alliances for dual earner families and for certain other situations; and payments to the Federal Government for academic health centers.

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<sup>5</sup> In general, a "fee-for-service" plan would be defined as a health plan that provides coverage for all items and services included in the comprehensive benefit package, subject to reasonable restrictions, and makes payments for such benefits to providers without regard to whether there is a contractual arrangement between the plan and the provider.

### *Corporate alliances*

In general, under the bill, most employers with more than 5,000 full-time employees (large employers), certain multiemployer plans,<sup>6</sup> rural electric cooperatives, rural telephone cooperatives,<sup>7</sup> and the U.S. Postal Service could elect to provide health care coverage through corporate alliances rather than purchasing coverage through regional alliances. The following employers would not be entitled to maintain a corporate alliance: an employer whose primary business is employee leasing; the Federal Government (other than the U.S. Postal Service); and a State government, a unit of local government, and an agency or instrumentality of government, including any special purpose unit of government.

Full-time employees of a large employer that elected to form a corporate alliance would be eligible to enroll in a health plan offered by the alliance. Part-time employees of a corporate alliance employer would not be eligible to enroll in a corporate alliance by reason of such employment, but would be eligible to enroll in a regional alliance. The following individuals also would not be eligible to enroll in a corporate alliance: recipients of Aid to Families with Dependent Children (AFDC); recipients of supplemental security income (SSI) benefits; certain military personnel and their families, veterans, and Indians who have coverage under another health plan; and seasonal or temporary workers (as defined by the National Health Board), other than workers who are treated as eligible to enroll in a corporate alliance health plan pursuant to a collective bargaining agreement. In general, a full-time employee would be an employee who is employed for at least 120 hours in a month. An employee who is not so employed nevertheless would be a full-time employee if the employee is employed on a continuing basis that, taking into account the structure or nature of the employment in the industry, represents full-time employment pursuant to rules established by the National Health Board.

In general, if an individual is the only worker in a family and is eligible to participate in a corporate alliance, then the individual and his or her family would be required to participate in a health plan of the corporate alliance, and could not obtain coverage through a regional alliance. Special rules would apply if both the individual and his or her spouse were employed by different employers. Thus, if an employee eligible to participate in a corporate alliance is married to a working individual eligible to receive coverage under another corporate alliance or a regional alliance, then they may choose where the entire family is to be covered.

An employer would have only one opportunity to elect to form a corporate alliance. If the employer did not elect to form a corporate alliance when first eligible to do so, it could never do so. Elections

<sup>6</sup> A multiemployer plan could form a corporate alliance if (1) the plan offered health benefits as of September 1, 1993, and (2) as of both September 1, 1993, and January 1, 1996, the plan (a) has more than 5,000 active participants in the United States or (b) the plan is maintained by one or more affiliates of the same labor organization (or one or more affiliates of labor organizations representing employees in the same industry) covering more than 5,000 employees.

<sup>7</sup> Rural electric and telephone cooperatives may maintain a corporate alliance with respect to a group health plan maintained by such cooperative if (1) the plan offered health benefits as of September 1, 1993, and (2) as of both September 1, 1993, and January 1, 1996, the cooperative has more than 5,000 full-time employees in the United States entitled to benefits under the plan.

to form a corporate alliance would have to be filed with the Department of Labor.

The bill contains specific provisions regarding the time by which elections to form a corporate alliance would have to be made. In the case of an eligible sponsor that is a large employer on January 1, 1997, the election would have to be made by January 1, 1996, or, if the State elects to participate under the Health Security Act before January 1, 1998, no later than the April 1 after the State forms regional alliances. In the case of an employer that is not an eligible large employer on January 1, 1997, and later becomes one, the election to form a corporate alliance would have to be made no later than March 1 of the year following the year in which the employer first becomes such a sponsor. In the case of multiemployer plans and rural cooperative plans, the election would have to be made no later than March 1, 1996. All elections to form a corporate alliance would be effective for coverage provided under health plans on and after January 1 of the year following the year in which the election is made.

*Comment:* The rules regarding timing of elections for large employers present a number of issues. For example, how will a large employer know on January 1, 1996, that it will still be a large employer on the following January 1? Also, the election to form a corporate alliance may be required to be made before the State is participating and before regional alliances are formed.

The election to maintain a corporate alliance could be terminated voluntarily by the employer. In addition, the election would be terminated if the number of full-time employees falls below 4,800. The Department of Labor could terminate an election if it finds that corporate the alliance has failed to fulfill its requirements or that it has violated the prohibition against excess increases in premium expenditure. If an election terminates for any reason, the employer could not again elect to form a corporate alliance. A termination of a corporate alliance would be effective as of the effective date of enrollments in regional alliance health plans made during the next open season.

### ***Employer mandate***

All employers would be required to pay a portion of the cost of the comprehensive benefit package for their employees.

### ***Premiums***

#### ***Regional alliances***

*In general.*—Each regional alliance would contract with the various health plans interested in providing health benefits to individuals residing in the alliance area. An individual who resides in the alliance area (and who is not eligible to participate in a corporate alliance) could choose coverage by any of the available plans.

Participating plans would submit a per capita bid for providing the comprehensive benefits package to all eligible individuals residing within the alliance area. Using set formulas, this per capita bid would be converted into premiums for each type of family class: individual; couple-only (i.e., a married couple without children); sin-

gle parent; or dual parent (i.e., a married couple with children). For this purpose, marital status would be determined in accordance with state law.

*Employer share of premiums.*—An employer would be required to pay, for each employee, 80 percent of the weighted-average premium for all plans in the alliance for the employee's class of enrollment. This weighted-average premium would be computed for each family class on an alliance-wide basis according to a formula specified in the bill. Thus, employers would pay a fixed amount for each employee in a given family class, regardless of which plan actually is selected by the employee. The calculated averages would be based upon the number of wage earners in a given class (rather than the number of families covered in the class), to reflect that some families may have more than one wage earner. Under the bill, a single weighted-average premium would be calculated and would apply both to the single parent and dual parent classes of enrollment.

In addition to the required employer premiums, employers could pay some or all of the family share of premiums on behalf of their employees, as long as all employees in the same class of enrollment received the same dollar amount. For part-time employees (those whose monthly employment is at least 40 hours, but less than 120 hours), the required employer premium would be calculated on a pro rata basis, using 120 hours per month as a measure of full-time employment.

Employer premiums would be capped at 7.9 percent of an employer's total payroll. Small employers (those employing 75 or fewer employees) who pay average annual wages of \$24,000 or less would be entitled to caps of 3.5 percent to 7.9 percent of total payroll, depending upon the average number of employees and their average annual wage. These caps would not apply to governmental employers before January 1, 2002.

*Special rule for large employers.*—A large employer who is eligible to form a corporate alliance, but who chooses not to do so, or who forms a corporate alliance that is later terminated, would not be eligible for the percent of payroll caps for the first four years of regional alliance coverage. The benefit of the caps would be phased in ratably for such employers over the fifth through seventh years of regional alliance coverage, and would be fully available after seven years of regional alliance coverage. In addition, such employers would be required to make "excess risk" payments if the demographic risk of its employee pool exceeds the average demographic risk of all individuals eligible to participate in the regional alliance. (Demographic risk would be measured based on demographic characteristics such as age, gender, and socio-economic status.) The excess risk adjustment would be phased out ratably over the fifth through seventh years of regional alliance coverage.

*Bad debt.*—Employers would be required to make additional premium payments to compensate for 80 percent of the anticipated bad debt losses of the regional alliance. The regional alliance would estimate the total premiums unlikely to be collected, and divide it by the number of people covered by the alliance to obtain a per capita shortfall amount. The per capita shortfall amount would be converted into a premium amount for each family class using the same

methodology as used to calculate base premiums. All employers would be required to make this payment regardless of any percent of payroll caps that would otherwise apply.

*Self-employed individuals.*—A self-employed individual (i.e., an individual whose earnings are subject to self-employment taxes) would be treated as employing himself or herself for purposes of calculating the employer premium due. The individual's net self-employment earnings would be deemed wages paid. The amount of employer premium due for a self-employed individual would be reduced by the amount of any employer premiums paid by other employers of the individual. The bill also would provide an anti-abuse rule applicable to any individual who is both an employee and a substantial owner of a closely-held business.

*Family share of premiums.*—The premium owed by a family living in an alliance area would depend upon the specific plan selected by the family. Each family having a family member employed on a full-time basis would be entitled to a "credit" of 80 percent of the weighted average premium for all plans in the alliance for its family class. The credit would be reduced proportionately if family members were employed only on a part-time basis, or were unemployed.<sup>8</sup> The family premium due would be the difference between the total premium for the plan actually selected and this computed credit. The family premium could be less than 20 percent of the average premium if a low-cost plan is selected or more if a higher-priced plan is selected.

Families also would be required to make additional premium payments to compensate for 20 percent of the anticipated bad debt losses of the regional alliance, under a calculation similar to that described above for employers.

Certain low-income families would be entitled to a reduction in the family share of premiums owed. Such families include Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) recipients, those having family adjusted income below 150 percent of the poverty level, or those earning less than \$40,000 and for whom the family obligation amount would otherwise exceed 3.9 percent of the family's adjusted income. Depending upon income, the reduction would be an amount up to 20 percent of the weighted-average premium for all plans in the alliance for its family class.

#### *Corporate alliances*

Each corporate alliance would determine its own weighted average premium for health plans offered by the alliance. Premiums charged by a corporate alliance for health care coverage under a plan could vary only by class of family enrollment and by premium area. Corporate alliances would be required to designate premium areas which reasonably reflect labor market areas or health care delivery areas and are consistent with rules to be established by the Department of Labor. The employer premium for corporate alliance employers would be 80 percent of the weighted average premium. In addition, corporate alliance employers would be required

<sup>8</sup>The statutory language calls this reduction a "repayment" of the alliance credit. As a practical matter, no repayment would be involved; the amount of the credit simply would be reduced and the family would be required to pay a greater premium.

to subsidize the premiums of full-time workers who have wages of less than \$15,000 on an annualized basis. The \$15,000 threshold would be indexed annually for inflation after 1994. Individuals would be required to pay the difference between the employer share and the cost of the plan they select (subject to the low-wage subsidy). The 7.9-percent payroll cap on employer premiums would not apply to corporate alliance employers.

*Employer payments with respect to retiree health benefits*

The bill would impose two additional obligations on certain employers (whether regional or corporate alliance employers) with respect to the health benefits of early retirees and their dependents. In general, the bill would provide that the employer share of the cost of providing the comprehensive benefit package to early retirees (other than high-income early retirees) is to be paid by the Federal Government. In some cases, employers may have had plans which obligated them to pay these retiree medical costs.

To prevent a windfall to such employers, the bill would impose a temporary assessment on employers whose retiree health costs would be reduced by reason of the Federal subsidy. In addition, under the bill, employers who were paying for a portion of an early retiree's health costs on October 1, 1993, would be required to pay 20 percent of the average weighted premium for such early retiree's class of enrollment. The payment obligation would apply for each month beginning with January 1, 1998, but would be limited to individuals who were early retirees on October 1, 1993.

*Cap on health care expenditures*

The Administration expects that the Act would result in increased competition in the health care market, and that such competition would reduce the growth in health care expenses. In addition, the Act would impose limits on the payments made by alliances to health plans and providers.

*Regional alliances*

The amount that regional alliances would be allowed to pay health plans and providers would be subject to a budget. The Federal Government would be responsible for enforcing this budget, generally as described below.

No later than January 1, 1995, the National Health Board would be required to establish a national per capita baseline premium target for the comprehensive benefit package based on 1993 per capita health expenditures, trended forward. This amount would be increased annually for inflation based on the "general health care inflation factor." For 1996, the inflation factor would be the percentage increase in the consumer price index (CPI), plus 1.5 percentage points; for 1997, the inflation factor would be the percentage increase in the CPI plus 1.0 percentage points; for 1998, the inflation factor would be the percentage increase in the CPI plus 0.5 percentage points; for 1999 and 2000, the inflation factor would be the percentage increase in the CPI. For later years, the Board would be required to submit to Congress recommendations of what the general health care inflation factor should be.

The Board would then set an initial per capita premium target for each regional alliance based on the national per capita target and the general health care inflation factor. In setting alliance targets, the inflation factor and the overall target would be adjusted for factors specific to each regional alliance, such as variations in health care expenditures and the rate of uninsurance and underinsurance. The Board would adjust the regional per capita targets annually by a regional inflation factor.

Regional alliances would be required to conduct a bidding and negotiation process with health plans. If the alliance's weighted average accepted premium exceeds the target set by the Board, the alliance could renegotiate premiums. If the final bids submitted by health plans exceed the alliance's premium target, premium caps would be triggered. As a result, payments to noncomplying plans and providers and enrollee premium payments would be reduced.

#### *Corporate alliances*

The National Health Board would be required to develop a methodology for calculating an annual per capita equivalent for amounts paid for coverage for the comprehensive benefit package within a corporate alliance. If a corporate alliance exceeds the allowable increase in health care costs as determined by the Board for two years in a 3-year period, then the Secretary of Labor would terminate the corporate alliance.

#### *Modifications to the Internal Revenue Code*

The bill would make a number of changes to the Internal Revenue Code (the "Code"). Some of these changes are intended to be financing provisions. These provisions are contained in Title VII of the bill.<sup>9</sup>

#### *Financing provisions*

*Increase in tobacco excise taxes (secs. 7111-7113).*—The bill would increase the tax rate on all tobacco products by approximately \$12.50 per pound of tobacco content, and would extend the tax to tobacco to be used in "roll-your-own" cigarettes. The provisions would be effective for tobacco products removed from a bonded production premises after September 30, 1994. A floor stocks tax would be imposed on tobacco products held on the effective date.

*Assessment on corporate alliance employers (sec. 7121).*—The bill would impose an annual assessment equal to 1 percent of payroll on large employers that elect to form corporate alliances. The assessment would be effective on January 1, 1996.

*Temporary assessment on employers with retiree health costs (sec. 7121).*—In general, the bill would provide that the cost of providing the comprehensive benefit package to retirees between the ages of 55 and 65 is to be paid by the Federal Government. In some cases, employers may have had plans which obligated them to pay these retiree medical costs. To prevent a windfall to such employers, the bill would impose a temporary assessment on all employers with retiree health costs for the period 1991 to 1993 (the "base period").

<sup>9</sup>For a detailed description and analysis of these provisions, see Joint Committee on Taxation, *Description and Analysis of Title VII of H.R. 3600, S. 1757, and S. 1775 ("Health Security Act")* (JCS-20-93), December 20, 1993.

The assessment for a year would be equal to 50 percent of the greater of (1) the "adjusted base period retiree health costs" of the employer for the year, or (2) the amount by which the employer's applicable retiree health costs for the year were reduced by reason of the enactment of the Health Security Act. The temporary assessment would apply to 1998, 1999, and 2000.

*Recapture of certain health care subsidies received by high-income individuals (sec. 7131).*—Under the bill, taxpayers with modified adjusted gross income (AGI) above a threshold amount would be required to pay additional premiums for coverage under part B of Medicare. In addition, eligible retirees and qualified spouses and children with modified AGI above the threshold amount would be required to pay the employer share of their premium for health care under the comprehensive benefit package. The threshold amount would be \$90,000 for unmarried taxpayers and \$115,000 for married taxpayers filing joint returns. The amount of these payments would be phased in for taxpayers with modified AGI which exceeds the threshold amount by less than \$15,000 (\$30,000 in the case of married taxpayers filing a joint return). The provision relating to part B Medicare premiums would be effective for taxable years beginning after December 31, 1995. The provision relating to payment of premiums under the comprehensive benefits package would be effective January 1, 1998.

*Modification of self-employment tax treatment of certain S corporation shareholders and partners (sec. 7141).*—The bill would (1) amend the definition of net earnings from self-employment subject to self-employment taxes to include the pro rata share of certain S corporation income of certain shareholders and (2) modify the definition of net earnings from self-employment as applied to limited partners in a partnership for self-employment tax and health insurance premiums purposes. These provisions would apply to taxable years of individuals beginning after December 31, 1995, and to taxable years of S corporations and partnerships ending with or within such taxable years of individuals.

*Extending Medicare coverage to all State and local government employees (sec. 7142).*—Under present law, State and local government employees hired before April 1, 1986, are not covered under Medicare unless a voluntary agreement providing for such coverage is in effect. The bill would extend Medicare coverage on a mandatory basis to all employees of State and local governments not otherwise covered under present law, without regard to their dates of hire. These employees and their employers would become liable for the hospital insurance tax, and the employee would earn credit toward Medicare eligibility. This provision would apply to services performed by State and local government employees after September 30, 1995.

#### *Tax treatment of employer-provided health care*

*Exclusion for employer-provided accident or health care (sec. 7201).*—Under present law, all employer contributions for accident or health coverage are excludable from an employee's income. Under the bill, employer contributions to an accident or health plan would be excludable from gross income and wages for income and employment tax purposes only to the extent the contributions are

for (1) the comprehensive benefit package provided for under the bill, (2) cost sharing amounts under the comprehensive benefit package (including cost sharing policies) or (3) permitted coverage. Permitted coverage would mean (1) coverage providing wages or payments in lieu of wages for any period during which the employee is absent from work on account of sickness or injury, (2) coverage providing payment for permanent injuries of an employee, or his or her spouse or dependent, that are computed with reference to the nature of the injury without regard to the period the employee is absent from work, (3) retiree health coverage provided to former employees after age 65, (4) coverage under a qualified long-term care policy, (5) coverage provided under Federal law to veterans or any member of the Armed Forces of the United States and their spouses and dependents, and (6) any other employer-provided coverage which the Secretary of the Treasury determines should be excludable.

The limit on the exclusion for employer-provided accident or health coverage would be effective on and after January 1, 2004, except that it would apply to flexible spending accounts on and after January 1, 1997. For this purposes, a flexible spending account would be defined as a benefit program that provides employees with coverage under which specified, incurred expenses may be reimbursed and under which the maximum amount of reimbursement that is reasonably available to a participant for such coverage is less than 200 percent of the value of such coverage.

*Cafeteria plans (sec. 7202).*—Under the bill, accident or health coverage could not be provided through a cafeteria plan unless the coverage constitutes wages or payments in lieu of wages for any period during which the employee is absent from work on account of sickness or injury. This provision would be effective on and after January 1, 1997.

*Health insurance expenses of self-employed individuals (sec. 7203).*—Under prior law, self-employed individuals could deduct 25 percent of the health insurance costs for themselves and their spouses or dependents. This deduction expired December 31, 1993. The bill would make the deduction for health insurance expenses permanent. In addition, effective on the earlier of January 1, 1997, or the first day on which the taxpayer could purchase comprehensive health coverage under the bill, up to 100 percent of the cost of the comprehensive health coverage could be deductible. The 25-percent deduction would continue until the 100-percent deduction is available.

*Limitation on prepayment of medical insurance premiums (sec. 7204).*—Under present law, taxpayers who itemize deductions may deduct amounts paid during the taxable year (if not reimbursed by insurance or otherwise) for medical care of the taxpayer and the taxpayer's spouse or dependents to the extent that the total of such expenses exceeds 7.5 percent of the taxpayer's adjusted gross income. The Internal Revenue Service recently issued a revenue rul-

ing<sup>10</sup> stating that previous rulings<sup>11</sup> permitting a current deduction for fees for medical services to be provided in the future (if at all) should not be interpreted to allow a current deduction of payments for medical care (including medical insurance) extending substantially beyond the close of the taxable year in situations where the future care is not purchased in connection with obtaining lifetime care of the type described in the earlier rulings. Under the bill, for purposes of this itemized deduction, amounts paid during a taxable year that are allocable to insurance coverage or medical care to be provided during periods more than 12 months after the month in which the payment is made would be treated as paid ratably over the period during which the coverage or care is to be provided. This limitation would not apply to any premium paid under a qualified long-term care policy. The provision would apply to amounts paid after December 31, 1996.

*Employment status provisions*

*Definition of employee (secs. 7301 and 7303).*—The bill would repeal section 530 of the Revenue Act of 1978, which provides safe harbor rules under which service recipients can treat individuals as not being employees for employment tax purposes. The bill would codify a modified version of section 530 which would protect taxpayers against retroactive reclassification of workers as employees. The bill would also give the Secretary of the Treasury the authority to define the term “employee” by prospective regulations. The modified rules would generally apply for income tax purposes, employment tax purposes, and the bill’s health care provisions. The provision relating to section 530 would generally be effective for periods beginning after December 31, 1995. The provision authorizing regulations would be effective on the date of enactment.

*Increase in penalties for failure to file current information returns with respect to non-employees (sec. 7302).*—The Internal Revenue Code contains a number of information reporting requirements. The bill would modify the penalties for failure to comply with these requirements in the case of two types of information returns: (1) information returns under Code section 6041(a) which relate to payments to any person for services performed by such person (other than as an employee); and (2) returns regarding remuneration for services under Code section 6041A(a). Both of these sections of the Code relate to information returns with respect to payments made to non-employees, such as independent contractors. In general, the bill would increase the penalty for failure to file correct information returns on or before August 1 from \$50 for each return to the greater of \$50 or 5 percent of the amount required to be reported correctly but not so reported. The provision would apply to information returns the due date for which (without regard to extensions) is more than 30 days after the date of enactment.

<sup>10</sup> Rev. Rul. 93-72, 1993-34 IRB 7 (Nov. 1, 1993). The ruling applies to amounts paid on or after October 14, 1993, except amounts paid pursuant to the terms of a binding contract entered into before that date.

<sup>11</sup> Rev. Rul. 75-302, 1975-2 C.B. 86; Rev. Rul. 75-303, 1975-2 C.B. 87; Rev. Rul. 76-481, 1976-2 C.B. 82.

*Tax treatment of funding of retiree health benefits (secs. 7401 and 7402)*

Under present law, an employer may deduct contributions, within limits, made to a welfare benefit fund to prefund post-retirement medical and life insurance benefits. These rules generally permit the cost of the benefits to be funded over the working life of the employee. In addition, retiree medical benefits may be prefunded (within limits) through a separate account maintained under a tax-qualified pension plan (Code sec. 401(h)).

Effective with respect to contributions paid or accrued after December 31, 1994, the bill would provide that the minimum period during which the cost of post-retirement medical and life insurance coverage could be funded under a welfare benefit fund would be at least 10 years. In addition, contributions would not be permitted to be made to retiree medical accounts under pension plans after December 31, 1994.

*Coordination with health care continuation rules (sec. 7501)*

The health care continuation rules require that qualified beneficiaries that received coverage under a group health plan be provided the opportunity to purchase health insurance for a specified period under the group health plan after the occurrence of a qualifying event (e.g., termination of employment) that otherwise would have terminated such health insurance coverage. These rules are designed to prevent gaps in health care coverage. The bill would repeal the health care continuation rules, effective on the earlier of January 1, 1998, or the first day of the calendar year following the calendar year in which each State has in effect health plans under which individuals are eligible to receive comprehensive health coverage under the bill.

*Tax treatment of organizations providing health care services and related organizations (secs. 7601-7603)*

The bill would establish certain new requirements applicable to nonprofit health care providers (hospitals and health maintenance organizations (HMOs)) seeking to qualify as tax-exempt charitable organizations under Code section 501(c)(3). In particular, the bill would amend the Code specifically to require that, in order for the provision of health care services to constitute a charitable activity for purposes of section 501(c)(3), the organization providing such services must periodically assesses the health care needs of its community and develop a plan to meet those needs. In addition, the bill would provide that an HMO seeking tax-exempt status under section 501(c)(3) must furnish health care services to its members at its own facilities through health care professionals who do not provide substantial health care services other than on behalf of such organization. These provisions would be effective January 1, 1995.

The bill further would provide that organizations which serve as parent holding companies for hospitals or medical research organizations constitute public charities rather than private foundations. Finally, the bill would add the to-be-established regional alliances to the list of tax-exempt organizations set forth in section 501(c). These provisions would be effective on the date of enactment.

The bill would also subject HMOs that are exempt under either 501(c)(3) or 501(c)(4) to new rules defining "commercial-type" insurance for purposes of section 501(m). In general, health insurance provided by an HMO would be treated as commercial-type insurance if it relates to care which is not provided pursuant to a pre-existing arrangement between the HMO and a health care provider (other than emergency care provided to a member of such organization at a location outside such member's area of residence). The bill would identify four types of health insurance provided by an HMO that would not be treated as commercial-type insurance and thus, would not jeopardize the organization's tax-exempt status. Such non-commercial-type health insurance coverages generally would address emergency situations and situations in which a health care provider has a pre-existing relationship with an HMO whereby the HMO exerts control over either the fee charged by the service provider or the member's use of such provider's services. These provisions would be effective on the date of enactment.

The bill also would redefine the scope of organizations treated as taxable property and casualty insurance companies. Effective for taxable years beginning after December 31, 1996, any organization that is not tax-exempt, and whose primary and predominant business activity during the taxable year falls in one of three categories, would be treated as a property and casualty insurance company. The three categories of activities would be: (1) issuing accident and health insurance contracts or reinsuring accident and health risks; (2) operating as an HMO; or (3) entering into arrangements to provide or arrange for the provision of health care services in exchange for fixed payments or premiums that do not vary depending on the amount of health care services provided.

Finally, the bill would repeal two of the special rules provided under Code section 833 to Blue Cross and Blue Shield organizations and other eligible organizations, and would provide transition rules for organizations that become subject to section 833 after the effective date. These provisions generally would be effective for taxable years beginning after December 31, 1996.

#### *Tax treatment of long-term care services and insurance*

*Long-term care services and insurance (secs. 7701 and 7702).—*The bill would provide that expenditures for qualified long-term care services provided to an incapacitated individual are treated as medical care for purposes of the itemized deduction for medical expenses. The bill would provide that, for purposes of the Internal Revenue Code: (1) a qualified long-term care insurance policy is treated as an accident or health insurance contract; (2) any plan of an employer that provides coverage under a qualified long-term care insurance policy is treated as an accident or health insurance contract (so that employer contributions for such a policy are excludable from income); (3) amounts (other than policy holder dividends or premium refunds) received under such a contract or plan with respect to qualified long-term care services are treated as amounts received for personal injuries or sickness and as reimbursements for expenses actually incurred for purposes of the medical expense deduction (and thus, are excludable from gross income); (4) amounts paid for a qualified long-term care insurance

policy are treated as amounts paid for insurance for purposes of the medical expense deduction, and (5) a qualified long-term care insurance policy is treated as a guaranteed renewable contract subject to the rules of Code section 816(e).

The provision relating to the deductibility of expenses for qualified long-term care services would apply to taxable years beginning after December 31, 1995. The other provisions of the bill relating to long-term care would apply to policies issued after December 31, 1995.

*Accelerated death benefits under life insurance contracts (secs. 7703 and 7704).*—Effective for taxable years beginning after December 31, 1993, the bill would provide an exclusion from gross income for certain distributions (accelerated death benefits) received by an individual under a life insurance contract if the insured under the contract is terminally ill. For insurance company tax purposes, the bill would provide that a qualified accelerated death benefit rider to a life insurance contract is treated as life insurance and that such a rider is treated as a qualified additional benefit. The provision relating to the tax treatment of insurance companies would apply to contracts issued after December 31, 1993.

#### *Tax incentives for health services providers*

*Nonrefundable credit for certain primary health services providers (sec. 7801).*—Under the bill, a physician who provides primary health services in certain medically underserved areas would be eligible for a nonrefundable credit against Federal income taxes of \$1,000 per month for up to 60 months. The provision would be effective for taxable years beginning after December 31, 1994.

*Expensing of medical equipment (sec. 7802).*—Under present law, in lieu of taking depreciation, a taxpayer with a sufficiently small amount of annual investment may elect to deduct up to \$17,500 of the cost of qualifying property placed in service for the taxable year under Code section 179. The bill would increase the amount allowed to be deducted under section 179 in a taxable year by the lesser of (1) the cost of section 179 property which is health care property placed in service during the year, or (2) \$10,000. The provision would apply to property placed in service after December 31, 1994.

#### *Miscellaneous provisions*

*Tax credit for personal assistance services (sec. 7901).*—Effective for taxable years beginning after December 31, 1995, the bill would provide a nonrefundable tax credit for up to 50 percent of an employed individual's personal assistance expenses up to \$15,000.

*Denial of tax-exempt status for borrowings of health-related entities (sec. 7902).*—Under present law, interest on bonds issued to finance activities of State and local governments generally is tax exempt. However, interest on private activity bonds is taxable unless the bonds are issued for a purpose specifically identified in the Internal Revenue Code. The bill would provide that regional and corporate health alliances created pursuant to the bill would be treated as private businesses that are generally not eligible for tax-exempt financing. Similarly, State guaranty funds established pursuant to section 1204 of the bill would be treated as private business

users and generally could not be funded with the proceeds of tax-exempt bonds. This provision would be effective for obligations issued after the date of enactment.

*Disclosure of return information (sec. 7903).*—The Internal Revenue Code prohibits disclosure of tax returns and return information, except to the extent specifically authorized by the Code. The bill would permit disclosure of certain tax return information to any Federal or State agency providing assistance under the Health Security Act for use in verifying eligibility for such assistance. The provision would be effective on the date of enactment.

### ***Effective dates***

The general effective date of the bill would be January 1, 1998 (sec. 1006). The right to coverage under the guaranteed benefit package would be effective with respect to regional alliance coverage when the State in which the individual resides becomes a participating State. In the case of persons eligible to receive coverage through a corporate alliance, the effective date of coverage under the Act would be January 1, 1998. In the case of a State that participates before the general effective date, transition rules would apply with respect to employees who are covered by a plan of an employer that intends to form a corporate alliance.

The effective date of many of the provisions of the bill depend on when a State becomes a participating State. In general, in order to be a participating State, the State must gain approval of its health care system by the Board and comply with the State obligations set forth in the bill (e.g., establish regional alliances). The earliest a State could become a participating State would be January 1, 1996. States would be required to become participating States no later than January 1, 1998. In order to become a participating State for a year, a State would have to establish regional alliances no later than March 1 of the previous year. Thus, for example, if a State wanted to be a participating State on January 1, 1997, it would have to establish regional alliances by March 1, 1996. (See secs. 1200–1202 and 1511.)

Some of the provisions of the bill have separate effective dates, such as the provisions of Title VII, described above.

## **II. DESCRIPTION OF THE EMPLOYER MANDATE AND RELATED PROVISIONS OF THE HEALTH SECURITY ACT**

### **A. Premium Caps**

#### **1. Regional alliance health expenditures**

In general, the bill would limit the initial premiums, as well as subsequent yearly increases, charged by health plans that participate in regional alliances. The National Health Board (the "Board") would determine the limit through a process that begins with setting a national baseline premium target. Based on that national target, the Board would establish a separate target for each regional alliance that takes into account regional variations and demographics. If plans in a regional alliance, on a weighted average basis, charge premiums that exceed the alliance's per capita target, they would be subject to a premium reduction. The premium reduction would affect the amount of payments from employers and consumers to the alliance, from an alliance to a noncomplying plan, and from the noncomplying plan to its providers.

##### **a. Computation of targets and accepted bids (secs. 6001-6007)**

##### ***Board determination of national per capita baseline premium target***

By January 1, 1995, the Board would be required to determine a national per capita baseline premium target.<sup>12</sup> In general, this target would equal the current (i.e., 1993) cost of items included in the comprehensive benefit package divided by the number of people who would be eligible to participate in regional alliances (excluding SSI or AFDC recipients).

For purposes of this calculation, payments made for items and services included in the comprehensive benefit package in 1993 would not include the proportion of such payments attributable to Medicare beneficiaries, AFDC or SSI recipients, expenditures paid through workers' compensation or automobile or other liability insurance, and other expenditures that the Board determines would not be payable by regional alliance health plans. In addition, the cost of the comprehensive benefit package would be decreased by amounts which would be subject to cost sharing (i.e., out-of-pocket costs paid by consumers) and any decrease in utilization of services estimated to occur as a result of higher cost sharing.<sup>13</sup> Thus, for

<sup>12</sup> Under Section 5232 of the bill, there could be no administrative or judicial review of any determination made by the Board with respect to Subtitle A of Title VI (regarding premium caps).

<sup>13</sup> Under the bill, a health plan could offer consumers one of three alternative cost sharing arrangements—lower cost sharing, higher cost sharing, and combination cost sharing. Under lower cost sharing, a plan enrollee would pay a nominal copayment (i.e., \$10 for outpatient services, \$25 for hospital services and \$20 for certain dental services, adjusted for inflation). Under

example, the amount would not include the cost of supplemental insurance policies, costs of long-term care (which would not be included in the comprehensive benefit package), and out-of-pocket costs paid by consumers to cover deductibles and co-insurance for the comprehensive benefit package.

The cost of the comprehensive benefit package would be increased to take into account increased utilization of or expenditures for items and services under the package likely to be incurred by individuals who, as of 1993, were uninsured or underinsured with respect to such benefits. In making this calculation, expenditures would be based on the estimated average cost for such services in 1993, rather than on private payment rates; uncompensated care would be disregarded. In addition, the cost of the comprehensive benefit package would be increased by a percentage (not to exceed 15 percent) that reflects the proportion of premiums required for health plan and regional alliance costs of administration and for State premium taxes (to the extent attributable in 1993 to health benefits included in the comprehensive benefits package).

The Board would update the amount for 1994 and 1995 to take into account private sector health care spending for items and services included in the comprehensive benefit package (as of 1996). The cumulative update could not exceed 15 percent.

#### ***Determination of alliance per capita premium targets***

***Initial target.***—By January 1, 1995, the Board also would be required to determine a per capita premium target for each regional alliance for 1996. The target would equal the national per capita baseline premium (determined as set forth above), adjusted by the adjustment factor for the regional alliance, and updated by the regional alliance inflation factor.

***Adjustment factor.***—After consultation with States and regional alliances, the Board would establish an adjustment factor for each regional alliance. This factor would take into account variations between the national average of factors used in computing the national per capita baseline premium target and such factors for a particular regional alliance, including variations in health care expenditures, rates of uninsurance and underinsurance, and variations in the proportion of expenditures for services provided by academic health centers. The Board would make this determination based on information regarding variations in premiums across States and across alliance areas within a State, variations in per capita health spending by States, variations across States in per capita spending under the Medicare program and in such spending among alliance areas within a State, and area rating factors commonly used by actuaries.

These adjustment factors would be applied by the Board for 1996 in a neutral manner so as to ensure that the weighted average of all regional alliance per capita premium targets for 1996 equals the national per capita baseline premium target.

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a higher cost sharing arrangement, an enrollee would pay an annual deductible (\$200 per individual and \$400 per family, subject to adjustment for inflation) and a coinsurance rate of 20 percent (a higher coinsurance rate would apply to certain services) up to the maximum out-of-pocket limit of \$1,500 (individual) and \$3,000 (family). A combination cost sharing arrangement would apply the lower cost sharing scheme to enrollees using preferred providers; the higher cost sharing scheme would apply when enrollees use out-of-network providers.

*Inflation factor.*—The Board would also compute and publish not later than March 1 of each year (beginning in 1995) an inflation factor for each regional alliance which would be based on a general health care inflation factor. For years 1996 through 2000, the general health care inflation factor would mean the percentage increase in the CPI plus (1) 1.5 percentage points for 1996, (2) 1.0 percentage points for 1997, (3) .5 percentage points for 1998 and (4) 0 percentage points for 1999 and 2000. The Board would recommend to Congress an appropriate general health care inflation factor for years after 2000. If Congress fails to specify the general health care inflation factor for any year after 2000, the Board would be authorized to compute a default factor—which would generally approximate nominal growth in per capita gross domestic product (GDP)—in accordance with a predetermined formula set forth in the bill.

The bill would allow a special adjustment to a regional alliance's inflation factor in the event of material changes in the demographic characteristics of the population served by the alliance that arise out of two specified occurrences. First, an adjustment would be allowed for changes occasioned by corporate alliances opting into a regional alliance. Second, an adjustment would be allowed in the event of disparity between changes in regional demographic characteristics (including age, gender, and socio-economic status) and the average change in such characteristics nationwide.

In addition, a regional alliance's inflation factor would be reduced by a percentage (calculated as set forth in the bill) for two succeeding years if the actual weighted average accepted bid for the alliance exceeded the alliance's per capita premium target for any given year.<sup>14</sup> As discussed below, an alliance's weighted average accepted bid is based on projected enrollment; if more individuals than anticipated enroll in high premium plans, then the actual weighted average accepted bid could exceed the regional alliance's per capita target. This would trigger the 2-year reduction in the regional alliance's inflation factor.<sup>15</sup>

Further, the bill would provide for a special adjustment to all regional alliance inflation factors in the year 2001. At that time, regional alliance inflation factors would be increased by a factor determined by the Board to reflect the ratio of (1) the actuarial value of the increase in benefits provided in that year under the comprehensive benefit package to (2) the actual value of the benefits that would have been in such package in the year without regard to the increase. A special rule would apply for purposes of calculating the actuarial value of the increase with respect to mental illness and substance abuse services.

In establishing the regional alliance inflation factors for each year, the Board would be required to consult with representatives of States and regional alliances.

<sup>14</sup>Section 6001(a)(2)(C) of the bill incorrectly cross references section 6001(d) with respect to adjustments for previous excess expenditures; the correct cross reference should be to section 6003(e).

<sup>15</sup>The 2-year reduction would appear not to apply if the premium caps were triggered. In other words, if a regional alliance's weighted average accepted bid exceeds its per capita target, the premium caps will be triggered. The Board would compute a reduced weighted average accepted bid and certain plans would be subject to plan payment reductions. If, based on actual enrollment, the reduced weighted average accepted bid exceeds the per capita premium target, the 2-year reduction would appear not to apply.

*Special rules.*—For purposes of establishing the regional alliance per capita premium targets, if a State is not participating in the bill's health care program or has not established regional alliances, the entire State would be treated as composing a single regional alliance.

In addition, if a State changes the boundaries of its regional alliances (or adds new regional alliances after 1996), the Board would provide a method for computing the per capita premium target of each regional alliance affected by the change. The method would be required to reflect the factors taken into account in establishing the initial adjustment factors (applied in 1996), and the weighted average of the newly computed per capita premium targets for regional alliances affected by the change would equal the weighted average of the premium targets for the regional alliances as previously established.

#### ***Targets revised annually***

Not later than March 1 of each year after 1995, the Board would determine a revised per capita premium target for each regional alliance for the succeeding year by updating the prior year's per capita target by the regional alliance inflation factor for the year.

#### ***Alliance initial bidding and negotiation process***

Under the bill, by July 1 of the first year of a State's participation in the bill's health care program and by August 1 of each year thereafter, regional alliances would be required to obtain premium bids from each plan seeking to participate as a regional alliance health plan in the following year. In obtaining such bids, a regional alliance could, but would not be required to, disclose its per capita premium target for the year involved.

Each bid would have to be legally binding with respect to the plan involved and would be conditioned upon the plan's agreement to accept any payment reduction imposed under section 6011 of bill to enforce the premium targets (described below).

Following submission of bids, a State could negotiate with health plans with respect to the premiums to be charged by such plans. The Board would be required to provide regional alliances with information and technical assistance to assist alliances in the bidding process. As a result of such negotiations, a plan may resubmit a bid, but any subsequent bids could not be higher than the prior bid.

By September 1 of each year, each regional alliance would be required to submit to the Board a report containing information regarding the final accepted bids submitted by the different plans and any limitations on the capacity of the plans. In addition, for the first year of participation, the report must contain any information requested by the Board concerning an estimation of the likely enrollment in each plan. For succeeding years, the report must set forth the actual distribution of enrollment of alliance eligible individuals in regional alliance health plans.<sup>16</sup>

Following receipt of the reports, the Board would determine an average accepted bid for each regional alliance (weighted by enroll-

<sup>16</sup>The Board would be required to establish special rules regarding the treatment of enrollment in newly-offered or discontinued plans.

ment), taking into account the information on accepted bids and enrollment distribution. By October 1 of each year, the Board would notify a regional alliance if the premium caps were triggered because its weighted average accepted bid exceeded its per capita premium target. In this event, the Board would notify the alliance of the reduced weighted average accepted bid, and would notify the alliance and each noncomplying plan of any plan payment reduction (computed under section 6011 and described further below).

### ***State financial incentives***

Under the bill, participating States may elect to assume responsibility for containment of health care expenditures. This responsibility would include submitting annual reports to the Board on cost containment activities undertaken. In exercising this responsibility, a participating State could regulate rates charged by providers of health care items and services to private payers. However, such regulation must not result in differential treatment of corporate alliance health plans and other health plans.

The bill would provide a financial incentive for States to elect to assume such cost containment responsibility. With respect to an electing State, if the statewide weighted average of the reduced weighted average accepted bids is less than the statewide weighted average of the regional alliance per capita premium targets for such alliances for such year, then a percentage of such savings would be made available to the State by reducing the State's Medicaid maintenance of effort payment for the following year.

### ***Recommendations to eliminate regional variations in alliance targets due to variation in practice patterns; Congressional consideration***

In an effort to reduce regional variations in premium targets over time, the bill would require the chair of the Board to establish an advisory commission on regional variations in health expenditures. The advisory commission would be composed of consumers, employers, providers, representatives of health plans, States, regional alliances, individuals with expertise in the financing of health care, individuals with expertise in the economics of health care, and representatives of diverse geographic areas.

In general, the advisory commission would provide the Board, States, and regional alliances with information regarding regional differences in health care costs and practice patterns. In addition, the bill would identify two specific issues for the advisory commission to study. First, the advisory commission would examine methods of eliminating, by 2002, variations in regional alliance per capita premium targets due to variation in practice patterns (but not due to other factors, such as health care input prices or demographics). In addition, the advisory commission would examine methods of reducing, by 2002, variation among States in the level of payments for AFDC and SSI recipients and for Medicaid maintenance of effort payments. The advisory commission would be required to submit to the Board a report specifying one or more methods for eliminating and reducing these variations.

Not later than July 1, 1995, the Board would be required to submit to Congress detailed recommendations regarding the specific

method to be used to eliminate the variations in regional alliance per capita premium targets due to variation in practice patterns and to reduce the variation in State payments for cash assistance recipients and for maintenance of effort, in a manner that is budget neutral with respect both to total government payments and payments by the Federal Government. In making reduction recommendations, the Board would take into account the fiscal capacity of the States.

The detailed recommendations submitted by the Board would apply unless Congress enacts a joint resolution disapproving such recommendations within 60 days after such recommendations are submitted. The bill would contain specific requirements regarding the timing, form, and method of consideration applicable to such joint resolutions.

**b. Plan and provider payment reductions to maintain expenditures within targets (secs. 6011-6012)**

***Plan payment reduction***

If a regional alliance's weighted average accepted bid exceeds its per capita premium target for the year, the alliance would be considered a "noncomplying alliance" and the premium caps would be triggered, resulting in premium reductions for certain plans in the alliance. If, on the other hand, a regional alliance's weighted average accepted bid does not exceed the applicable per capita premium target, no premium caps would be triggered. Thus, in a complying alliance, no plans would be subject to premium reductions, even those plans that charge premiums in excess of the per capita target.<sup>17</sup>

Health plans offered through noncomplying alliances would be subject to premium reductions if the final accepted bid for the year exceeds the maximum complying bid for the year. For the first year of participation, the maximum complying bid for each plan offered by a regional alliance would be the regional alliance per capita premium target for the year. Accordingly, the premiums for all plans in a regional alliance that is a noncomplying alliance in its first year would be capped at the alliance's per capita premium target. Plans could charge lower premiums, but none could charge premiums in excess of the target.

The premium caps would operate somewhat differently in subsequent years. After the first year, the maximum complying bid for any plan in a noncomplying alliance would be the sum of (1) the accepted bid for the previous year, minus the amount of any plan payment reduction for the plan for that year (discussed below) and (2) the amount by which the regional alliance's per capita premium target for the year exceeds either the previous year's target or, if less, the previous year's weighted average accepted bid.

For new plans, the maximum complying bid would be the regional alliance per capita premium target for the year, subject to the ability of the Board to establish special rules to prevent abusive

<sup>17</sup>This could occur because the per capita premium target would be compared to a *weighted average* of premiums charged by all plans in a regional alliance. Thus, certain plans could charge premiums in excess of the per capita target, so long as, on a weighted basis, the average premium for all plans did not exceed the target.

premium practices and encourage the availability of a wide range of plans.

To ensure that payments to regional alliance health plans by a regional alliance conform to the regional alliance's per capita target, each noncomplying plan for a year would be subject to a plan payment reduction. In general, a noncomplying plan's bid would be reduced by its proportionate share of the amount by which the weighted average bid for the regional alliance exceeds the regional alliance's per capita target. The bill would set forth a formula for determining the exact amount of the plan payment reduction applicable to each noncomplying plan.

Thus, in establishing premiums for any year (including the first year), plans would have to consider the potential impact of the application of premium caps in the following year; such caps could act to exacerbate a pricing differential.

*Example:* For example, assume that Plan A bids \$1,000 in year 1, Plan B bids \$1,500, and Plan C bids \$2,000, and that anticipated enrollment is evenly distributed among the three plans. The weighted average accepted bid would be \$1,500. Assume further that the regional alliance's per capita premium target is \$1,500. In year one, the regional alliance would be a complying alliance and no premium caps would be triggered.

In year two, assume that the regional alliance's premium target has increased by five percent, to \$1,575. Plan A bids \$1,500, Plan B bids \$1,750, and Plan C bids \$2,075; enrollment remains evenly distributed among the three plans. The weighted average accepted bid would be \$1,775; because this exceeds the premium target, the premium caps would be triggered. Each plan's maximum allowed bid would be its prior year's bid plus the increase in the alliance's target. Thus, Plan A's maximum allowed bid would be \$1,075, Plan B's would be \$1,575, and Plan C's would be \$2,075. Plan A would have an excess bid (plan bid minus maximum allowed bid) of \$425 and Plan B of \$175; Plan C would not have an excess bid. The average of the excess bids would be \$200 ( $\$425 + \$175 + 0 / 3$ ). The reduction percentage would be 100 percent (weighted average accepted bid minus alliance premium target divided by average of excess bids ( $\$1,775 - \$1,575 / \$200$ )). Thus, Plan A's payment reduction (excess bid multiplied by the reduction percentage) would be \$425; Plan B's would be \$175; and Plan C's would be 0. Accordingly, the final payments to the plans after the application of the premium caps would be as follows: Plan A, \$1,075; Plan B, \$1,575; and Plan C, \$2,075. The weighted average of the final plan payments, \$1,575, equals the alliance's per capita premium target. Thus, although Plan A's initial bid of \$1,500 was below the premium target of \$1,575, Plan A would be subject to a premium reduction because its bid increased more than did the alliance's per capita target. Although Plan C's bid exceeded the per capita premium target for the second year, it would not be subject to reduction because it did not increase by more than did the alliance's per capita target.

A noncomplying plan would have an opportunity voluntarily to reduce its accepted bid to avoid a mandatory plan payment reduction. This reduction could take place after the Board notifies the regional alliance (by October 1 of each year) that it is a noncomplying alliance and specifies the amount of the requisite plan payment reduction. If a noncomplying plan voluntarily reduces its bid, the reduced bid would be reflected on the list of plan premiums presented to potential enrollees. If the premium caps were triggered in the subsequent year, the plan's premium increase would be based on its reduced bid.

If a noncomplying plan does not voluntarily reduce its bid, it would receive a reduced payment from the regional alliance, as set forth above. In addition, the premium amount presented to potential enrollees is the higher, unreduced, amount; thus, the plan may suffer a competitive disadvantage vis a vis other plans. Enrollees would pay unreduced premiums, and the excess amount would be returned to all families in the alliance in the form of an "excess premium credit." As in the case of voluntary reduction, if premium caps were triggered in the subsequent year, the plan's premium increase would be based on the reduced premium. Finally, as described below, payments to providers would be reduced by a specified percentage.

#### ***Provider payment reduction***

Each regional alliance health plan would be required, as part of its contract with any participating provider, to include a provision specifying that, if the plan is a noncomplying plan for a year, payments to the provider would be reduced by a specified percentage (the "applicable network reduction percentage"). Similarly, no contract could include a provision which the State determines varies the payments to a provider because of, or in relation to, a plan payment reduction or is otherwise intended to subvert the provider payment reduction requirement.

The "applicable network reduction percentage" would be the plan payment reduction amount for the plan for the year divided by the final accepted bid for the plan for the year. The reduction percentage would be increased to take into account any estimated increase in volume reasonably anticipated as a consequence of applying a payment reduction. Similar rules would apply with respect to alliance health plan contracts with providers other than participating providers.

Finally, amounts paid by individual consumers (i.e., balance billing and cost sharing) would be based on the reduced provider payments by noncomplying plans, as determined under this section.

## **2. Corporate alliance health expenditures (secs. 6021 and 6022)**

### ***Calculation of premium equivalents (sec. 6021)***

The bill would impose caps on corporate alliance expenditures similar to the caps applicable to regional alliances. For purposes of measuring the allowable increase in the health care costs of a corporate alliance, the bill would require the National Health Board to develop by January 1, 1998, a methodology for calculating an an-

nual per capita expenditure equivalent for amounts paid for coverage for the comprehensive benefit package within a corporate alliance. Corporate alliances would be permitted to petition the Secretary of Labor for an adjustment of the inflation adjustment that would otherwise apply to compensate for material changes in the demographic characteristics of the individuals receiving coverage through the alliance. Beginning in 2001, each corporate alliance would be required to report to the Secretary of Labor the average of the annual per capita expenditure equivalent for the previous 3-year period. Such report would be made in the form and manner specified by the Secretary of Labor.

***Termination of corporate alliance for excess increase in expenditures (sec. 6022)***

Under the bill, if a corporate alliance has two excess years in a 3-year period, then, beginning with the second year following the second excess year in such period, the Secretary of Labor would terminate the corporate alliance and large employers that were corporate alliance employers with respect to such corporate alliance would become regional alliance employers.<sup>18</sup> In the case of a corporate alliance sponsored by a multiemployer plan or a rural electric or rural telephone cooperative association, the employers of a terminated corporate alliance could become corporate alliance employers with respect to another such corporate alliance. No employer that was a corporate alliance employer with respect to a terminated corporate alliance could ever be eligible to sponsor a corporate alliance. This provision would first apply to the 3-year period beginning with 1998.

The term "excess year" would mean a year after 2000 for which the rate of increase for the corporate alliance for the year exceeds the national corporate inflation factor for the year. The rate of increase for a corporate alliance for a year would be the percentage by which the average of the annual per capita expenditure equivalent for the corporate alliance for the 3-year period ending with such year exceeds the average of the annual per capita expenditure equivalent for the corporate alliance for the 3-year period ending with the previous year. The national corporate inflation factor for a year would be the average of the general health care inflation factors (as defined in sec. 6001(a)(3) of the bill) for each of the three years ending with such year.

*Comment:* There appears to be an inconsistency in the bill regarding the definition of the term "excess year". Section 6022(a)(2) provides that the provisions regarding termination of a corporate alliance for excess years first applies to the 3-year period beginning with 1998. This would appear to mean that the first year an alliance could be terminated under the provision would be 2001. This would occur if 1998 and 1999 were excess years because 2001 would be the second year following the second excess year.

<sup>18</sup> As described below in Part II.B., the payroll cap on premiums would be phased in for such employers and the premiums of such employers would also be subject to the excess risk adjustment.

However, section 6022(b)(1) defines an excess year to mean a year after 2000. Under this section, the first year a corporate alliance could be terminated would be 2004. This would occur if 2001 and 2002 were excess years.

It is unclear what is intended. If 1998, 1999, and 2000 are intended to count as excess years, then the definition of excess year may require modification.

### **3. Treatment of single-payer States (sec. 6031)**

#### ***In general***

Under the bill and subject to the approval of the National Health Board, each State would be permitted to establish a single-payer system in lieu of establishing a system of regional alliances. States would be permitted to establish single-payer systems on a State-wide basis or alliance-specific basis.<sup>19</sup> Under the bill, States which establish single-payer systems on a State-wide basis would be referred to as single-payer States.

#### ***Requirements for State-wide single-payer systems***

Under the bill, the National Health Board would be required to approve the application of a State to operate a State-wide single-payer system if it finds that the system would meet the general requirements for single-payer systems set forth in section 1222 of the bill and the State meets special rules for State-wide single-payer systems set forth in section 1223 of the bill.

#### ***General requirements***

Under the bill, all single-payer systems would be established under State law and would be operated by the State or a designated agency of the State. State law would provide for mechanisms to enforce the requirements of the system. All single-payer systems could require the mandatory enrollment of all individuals residing in the State (or in the case of an alliance-specific single-payer system, in the alliance area) and provide for the optional enrollment of Medicare-eligible individuals (subject to the approval of the Secretary of Health and Human Services) and corporate alliance-eligible individuals but could not require the enrollment of veterans, active duty personnel or Indians. All single-payer systems would require States to make all payments to providers who furnish items and services included in the comprehensive benefit package and assume all financial risk with respect to such payments unless the State and providers agree otherwise. All single-payer systems would provide the items and services included in the comprehensive benefit package and impose cost-sharing requirements no greater than those imposed by regional alliance health plans. All single-payer systems would establish cost-containment procedures (satisfactory to the National Health Board) which would (1) compute and effectively monitor the amount of per capita ex-

<sup>19</sup>Under the bill, States with more than one alliance area could operate a single-payer system in one alliance area but not the other alliance areas. Single-payer systems offered in a single alliance in a State would be required to meet the general requirements for single-payer systems set forth in section 1222 of the bill and the requirements for alliance-specific single-payer systems set forth in section 1224 of the bill.

penditures incurred for the provision of items and services included in the comprehensive benefit package each year, (2) ensure that such per capita expenditures would not exceed the per capita premium targets that would have applied if the State had established an alliance system, and (3) impose automatic, mandatory, non-discretionary reductions in payments to health providers as necessary to contain such per capita expenditures within the single-payer system's per capita premium target. Finally, all single-payer systems would meet the requirements applicable to health plans under the bill (secs. 1401-1414), except that systems would not be subject to restrictions on the marketing of plan materials (sec. 1404(a)) or the health plan solvency requirements (sec. 1408), nor could systems limit the enrollment of eligible individuals on the basis of plan capacity limits (sec. 1402(a)(2)).

#### *Special rules for single-payer States*

Under the bill, a single-payer State would operate the system throughout the State through a single alliance. A single-payer State would meet the requirements applicable to all States under the bill (secs. 1201-1205), except that the State would not be subject to the requirements relating to (1) the establishment of regional alliances (sec. 1202); (2) health plans (sec. 1203), other than the requirement relating to the coordination of health coverage with workers' compensation and automobile liability insurance (sec. 1203(f)); and (3) the financial solvency of health plans in the State (sec. 1204). Single-payer States could choose any method to finance a State-wide single-payer system, except that the State would be required to finance the system, at least partially through a payroll-based system under which employers would pay at least the amount they would pay under an alliance-based system. In addition, the following requirements would apply to single-payer States in the same manner such requirements would apply to regional alliances under the bill: (1) enrollment rules and procedures (sec. 1323); (2) the rules and administrative procedures relating to the reduction in cost-sharing payments for low-income families (sec. 1371); (3) the quality management and improvement, health information systems, privacy of information and administrative simplification provisions in the bill (Subtitles A and B of Title V); and (4) non-discrimination rules and the requirement that alliances coordinate their enrollment and disenrollment activities with each other (sec. 1328).

#### *Per capita premium targets for single-payer States*

The provision would direct the National Health Board to compute a State-wide per capita premium target for each year for State-wide single-payer systems in the same manner that it would compute the per capita premium targets for regional alliances. The National Health Board would be required to determine a per capita premium target for 1996 for each State-wide single-payer system no later than January 1, 1995. The manner in which the bill would require the National Health Board to determine per capita premium targets for regional alliances is described in Part II.A.1 of this pamphlet.

#### **4. Transition provisions—monitoring prices and expenditures (sec. 6041)**

The bill would require the Secretary of Health and Human Services (the Secretary) to establish a program to monitor health care prices and expenditures in the United States. Under the program, the Secretary would report to the President and issue reports to the public on a periodic basis regarding (1) the rate of increase in expenditures in each sector of the health care system and (2) how such rates compare with the rate of increase in health care spending overall and the rate of increase in the consumer price index.

In addition, the provision would direct the Secretary to obtain information on prices and expenditures for health care services through surveys or other means and would give the Secretary the authority to compel health care providers and third party payers to disclose such information as is necessary to carry out the monitoring program. Finally, the provision would provide that non-public information obtained by the Secretary with respect to individual patients would be confidential.

#### **B. Premium-Related Financings**

##### **1. Employer premium payments for regional alliance employers (secs. 6121–6126)**

###### **a. In general**

Employers would be required to make monthly premium payments for each employee who is employed by the employer for at least 40 hours in a given month. The premium amount would be based on two factors: (1) the regional alliance area in which the employee resides; and, (2) the class of enrollment of the employee (i.e., individual, couple-only, single parent, or dual parent). The amount of employer premium would be uniform for all persons residing in a given alliance area and in a particular class of enrollment. (For purposes of calculating the employer premium, the health plan actually selected by an employee would not be considered.) If an employee were employed for at least 40 hours (but less than 120 hours) in a given month, the amount of employer premium would be reduced proportionately.

###### **b. Base employment premiums (sec. 6122)**

###### ***In general***

Each year, each regional alliance would compute the base employment premiums applicable to all residents of the alliance area for the year. Three base employment premium amounts would be calculated by each regional alliance: one applicable to individuals, one applicable to couples with no children, and a third applicable to all families with children (whether single parent or dual parent families).

The first step in calculating base employment premiums would be to calculate the "credit-adjusted weighted average premium" for each class of enrollment. The credit-adjusted weighted average premium would be determined by calculating the weighted average premium for the class, then reducing it to reflect any "excess risk" payments made by large employers to the regional alliance. (These

“excess risk” payments are discussed in more detail in Part II. B.1.e., below.)

The weighted average premium for a class of enrollment would be the average annual premium for the class of enrollment for all health plans offered by the regional alliance, weighted to reflect the anticipated relative enrollment of each plan.

*Example:* Assume that a regional alliance were to offer two different health plans, and that the premiums for the individual class were \$1,500 for Plan A, and \$2,000 for Plan B. If the regional alliance anticipated that two-thirds of the individuals in the alliance would choose Plan A, and one-third would choose Plan B, the weighted average premium for the individual class would be  $(66.6\% \times 1,000) + (33.3\% \times \$2,000) = \$1,666$ .

The weighted average premium would then be reduced to reflect any “excess risk” payments made to the regional alliance by large employers who provide coverage through the regional alliance (rather than through a corporate alliance). The resulting amount would be the “credit-adjusted weighted average premium”.

### ***Part-time employment***

Under the bill, part-time employees would be viewed in terms of their “full-time equivalence”. An employee employed by an employer for at least 120 hours in a month would be considered a full-time employee. An employee employed by an employer for less than 40 hours in a month would be disregarded. An employee who is employed by an employer for at least 40 hours, but less than 120 hours, in a given month would be considered a part-time employee. For part-time employees, the bill sets forth a formula for calculating the “full-time equivalent” of the employee’s employment, by comparing the number of hours the employee worked in a month to 120 hours. For example, an employee who worked 60 hours in a month would be a half-time employee, and any amounts in the bill which are described in terms of full-time employment would be reduced by one-half.

*Comment:* The bill does not specify a method for computing hours of employment, but instead delegates this responsibility to the Board. In determining the method to be used, the Board would be required to take into account rules used under the Fair Labor Standards Act. (See sec. 1901(b)(3) of the bill.) Thus, for example, it is not clear what rules would apply in the case of workers not compensated on an hourly basis.

### ***Individual class of enrollment***

For individuals, the base employment monthly premium would be equal to 1/12 of 80 percent of the credit-adjusted weighted average premium for the individual class of enrollment.

*Example:* Assume that the credit-adjusted weighted average premium for all plans in a regional alliance for the individual class were \$2,000. The annual base employment premium for a full-time employee in the individual class

would be 80 percent of \$2,000, or \$1,600. In other words, each employer of a full-time employee in the individual class would pay an annual premium of \$1,600.

### *Couple-only class of enrollment*

For a "couple-only" family (i.e., a married couple with no children), the base employment premium would be calculated as follows. First, the credit-adjusted weighted average premium for the couple-only class of employment would be computed (as described above). This amount then would be multiplied by the number of couple-only families receiving coverage through health plans offered by the regional alliance, in order to determine the total premiums for all couple-only families in the regional alliance.<sup>20</sup> This total amount of couple-only premiums then would be divided by the number of employer premium payments being made for workers in the alliance with couple-only enrollment, in order to determine the amount of employment premium per wage earner. Every employer of a full-time employee in the couple-only class would pay a monthly premium equal to 1/12 of 80 percent of this calculated premium per wage earner.

*Example:* Assume that the credit-adjusted weighted average premium for all plans in a regional alliance for the couple-only class is \$3,000. Assume further that there are 1,000 couple-only families covered by health plans in the regional alliance, 500 of whom have one spouse employed on a full-time basis and one spouse who does not work at all, and 500 of whom have both spouses employed on a full-time basis. (In other words, there are 1,500 full-time equivalent workers in the couple-only class.) The calculation would be as follows:  $\$3,000 \times 1,000/1,500 = \$2,000$  premium per wage earner. Every employer of a full-time worker in the couple-only class would pay 80 percent of this premium amount, or \$1,600 per year. Thus, the employers of a couple-only family in which both spouses have full-time jobs would together pay \$3,200 in premiums for that family. (Each spouse's employer would pay \$1,600.) For a couple-only family in which one spouse is employed on a full-time basis, and the other spouse is not employed, employer payments for that family would be only \$1,600.<sup>21</sup>

*Comment:* As the above example shows, under the structure of the bill, two-worker families would be partially subsidizing the premiums for single-worker families. (For a more detailed discussion on the economics of these cross-subsidies, see Part IV.C.3.c., below.)

<sup>20</sup> In making this computation, certain families would not be considered: families who are recipients of Supplemental Security Income (SSI) or Aid to Families with Dependent Children (AFDC), families in which one spouse is a Medicare-eligible individual, or families enrolled in health plans other than regional alliance health plans.

<sup>21</sup> As explained more fully in Part II.B.4. (describing the family share of premiums), the family share of premium due for any family having at least one full-time equivalent worker will be the same whether the family contains one full-time worker, two full-time workers, or something in between.

### ***Single parent and dual parent classes of enrollment***

For single parent and dual parent families, one base employment premium would be calculated by the regional alliance to apply to both classes, using methodology similar to that described above for couple-only families. First, the credit-adjusted weighted average premium for the single parent class of employment would be computed (as described above). This amount then would be multiplied by the number of single parent families receiving coverage through health plans offered by the regional alliance, in order to determine the total premiums for all single parent families in the regional alliance. The same procedure would be used to calculate the premiums for all dual parent families in the regional alliance.<sup>22</sup> The total amount of premiums for single parent families and the total amount of premiums for dual parent families would then be added together to get the total premiums for both classes. This sum then would be divided by the number of full-time equivalent workers with either single parent or dual parent enrollment, in order to determine the amount of employment premium per wage earner. Every employer of a full-time employee in the single parent or dual parent class of enrollment would pay a monthly premium equal to 1/12 of 80 percent of this calculated premium per wage earner.

*Example:* Assume that the credit-adjusted weighted average premium for all plans in a regional alliance for the single parent class is \$3,500, and for the dual parent class is \$4,000. Assume further that there are 1,000 single parent families and 1,000 dual parent families covered by health plans in the regional alliance. Of the 1,000 dual parent families, assume that 500 have one spouse employed on a full-time basis and one spouse who does not work at all, and that the other 500 have both spouses employed on a full-time basis. Further assume that all of the single parents are employed on a full-time basis. In other words, there are 2,500 full-time workers in the single parent and dual parent classes. The calculation would be as follows:  $((\$3,500 \times 1,000) + (\$4,000 \times 1,000))/2,500 = \$3,000$  premium per wage earner. Every employer of a full-time worker in the single parent class or the dual parent class would pay 80 percent of this premium amount, or \$2,400 per year. Thus, the employers of a dual parent family in which both spouses have full-time jobs would together pay \$4,800 in premiums for that family. (Each spouse's employer would pay \$2,400.) For a single parent family, or for a dual parent family in which one spouse is employed on a full-time basis, and the other spouse is not employed, employer payments for that family would be only \$2,400.<sup>23</sup>

<sup>22</sup> Again, in making these computations, families who are recipients of SSI or AFDC, families in which one spouse is a Medicare-eligible individual, or families enrolled in health plans other than regional alliance health plans, would not be considered.

<sup>23</sup> Each family in a given class of enrollment enrolled in a given health plan, as long as the family contains at least one full-time equivalent worker, would pay the same family share of premium regardless of whether the family contains one full-time worker, two full-time workers, or something in between.

*Comment:* Again, this example shows that two-worker families would be partially subsidizing the premiums for single-worker families.

### ***Correction of estimation errors***

The base employment monthly premiums to be used in a given calendar year would be calculated by each regional alliance no later than December 1 of the preceding year (or such other date as the Board may specify). If the total of base employment premiums actually received by an alliance during a year is not the same as the amount estimated by the alliance for the year, and the difference is due to an incorrect estimate of the average number of premium payments per family, the alliance would be required to make an adjustment in the second succeeding year. In the second succeeding year, the alliance would adjust its estimate of the average number of premium payments per family so as to result in a corresponding increase or decrease to the total receipts of the alliance in that second succeeding year. However, if the incorrect estimate results in a surplus of funds to the alliance, a "reasonable amount" (to be specified by the Secretary of Health and Human Services) may be held in a contingency fund established by the alliance and used to fund any future shortfalls resulting from such estimation discrepancies in the future (sec. 1361(b)(3)).

### **c. Premium payment required of each employer (sec. 6121)**

Each employer would be required to make premium payments to the regional alliances in which its employees reside on the first of each month, based on employment in the previous month. The amount due would be determined by taking the number of "full-time equivalent" employees employed by the employer in a given class of enrollment who resided in a given regional alliance area in the previous month, and multiplying it by the applicable base employment premium for that class of enrollment for that alliance for the previous month. Similar calculations would be made for each class of enrollment and for each regional alliance in which the employer's employees reside. The employer would pay to each regional alliance the sum of the payment amounts computed for each class of enrollment with respect to the employees residing in that alliance area.

*Comment:* Note that these regional alliance payments would be paid by an employer for all employees residing in an alliance area, regardless of whether or not the employee is actually covered by a regional alliance health plan. For example, suppose a family contains two working adults—the wife is eligible for regional alliance coverage through her employer, whereas the husband is eligible for corporate alliance coverage through his employer. If the family chooses to enroll in a corporate alliance health plan, the wife's employer still would be required to make payments to the regional alliance in which she resides with respect to her employment. The regional alliance, in turn, would forward those payments to the husband's corporate alliance (sec. 1346(f)).

*Comment:* In computing the employer premiums due with respect to any particular employee, it would be irrelevant if the employee is also employed by other employers. Every employer employing a qualifying employee for at least 40 hours per month would be required to make employer premium payments based on the number of hours worked for that employer. Thus, it would be possible for the total employer payments made with respect to one individual to exceed the base employment premium due for one full-time worker. For example, if an individual works 120 hours in a month for one employer, and 60 hours in the month for another employer, the two employers together would pay one and one-half times the base employment premium for that employee.

The bill provides default rules for calculating the employer premiums due for employees who are not enrolled in any alliance health plan. Such employees would be deemed to be enrolled in the dual parent class of enrollment for the alliance area in which the individual resides. If the employee's residence is not known, the employee would be deemed to reside in the alliance area where the employee principally is employed by the employer.

The bill also provides that "divided families" would not be divided for purposes of calculating the amount of employer payment due. (See discussion of divided families in Part II.B.4.d.) For example, assume that a couple has no children, and that the husband is an Indian (qualifying for coverage under the Indian Health Service program), but his wife is not of Indian descent. For purposes of applying the provisions of the Health Security Act, the family would generally be split into two separate families (an individual enrolled in a regional alliance, and an individual enrolled in an Indian program). However, for purposes of calculating the employer payments due to a regional alliance with respect to the wife's employment, the family would be combined, and the calculations would be based on couple-only enrollment. The regional alliance would then make proportional payments to the health plans in which the family members were actually enrolled (in this example, to the wife's regional alliance health plan and to the Indian Health Service program).

#### **d. Caps on employer premiums (sec. 6123)**

For regional alliance employers, the required employer premium payments for a given year would be capped at a set percentage of the employer's wages paid for that year. The percentage applicable to a given employer would be based on the average number of employees employed by that employer and their average annual wage. Federal, state, and local governmental employers would not be eligible for the caps until 2002. Also, as described in the following section, certain large employers that are eligible to form corporate alliances, but instead participate in regional alliances, may only be eligible for these caps on a phased-in basis.

An employer who employs an average of more than 75 full-time equivalent employees would be subject to a 7.9 percent cap. In other words, the required amount of employer premiums under the Act would be limited to 7.9 percent of the employer's total payroll.

Small employers (those who employ an average of 75 or fewer full-time equivalent employees) who paid an average annual wage of \$24,000 or less (per full-time equivalent employee) would be subject to a cap of between 3.5 and 7.9 percent of their total payroll.

*Comment:* The bill does not specify the cap applicable to small employers whose employees earn an average annual wage of more than \$24,000. Presumably, these employers would also be subject to a cap of 7.9 percent.

The number of full-time equivalent employees and their average annual wage would be calculated on an annual basis, based on the average number of full-time equivalent employees employed in each month during the year.

*Comment:* The bill is unclear as to whether the employer calculations of the number of employees and their annual wages would be based on employment in the current year or the prior year. In other words, it is not clear whether the employer would determine its eligibility at the beginning of each year, based on the prior year's employment, or, wait until the end of the year to determine whether it had employed an average of 75 or fewer employees having average annual wages of \$24,000 or less, and thus was entitled to a refund of some portion of the premiums paid. In the latter case, it is not clear whether the employer could make estimated payments during the year, based on projected employment, then reconcile at the end of the year if its projections were inaccurate. It is also unclear whether an employer who qualifies for the caps would reduce its payments pro rata throughout the year, or would pay up to the limiting amount, then make no further payments during the year.

For purposes of calculating the number of employees and their average annual wage, the bill provides that certain self-employment earnings<sup>24</sup> would be deemed to be wages paid, and the individuals earning such amounts would be deemed to be employees of the relevant entity. This rule would apply to any individual who is a partner in a partnership, a two-percent shareholder of an S corporation, or an individual who carries on a trade or business as a sole proprietorship.

An employer who claims that the caps apply would be required to so notify the appropriate regional alliance(s) at the time of making its payments. Such employers would also be required to make information available to the alliances to allow them to audit the average number of employees, their average annual wage, and the total wages paid by the employer to qualifying employees.

If an employer that qualifies for the caps makes payments to more than one regional alliance, the payments to each regional alliance would be reduced proportionately.

<sup>24</sup> Self-employment earnings for this purpose would be the same as those subject to self-employment taxes under section 1402 of the Internal Revenue Code, as modified by the bill.

### **e. Adjustments for large employers who participate in regional alliances (sec. 6124)**

#### ***In general***

If a large employer eligible to form a corporate alliance<sup>25</sup> instead participates in a regional alliance, two adjustments would be made for the first seven years of regional alliance coverage.<sup>26</sup> First, the employer would only be eligible for the percent of payroll caps (described above) on a phased-in basis. Second, the employer would be required to make additional premium payments to the regional alliance if the demographic risk of its employees were greater than the demographic risk of the regional alliance participants as a whole.

If an employer was not initially eligible to form a corporate alliance (for example, an employer who employed only 4,990 full-time employees when the Act is first effective), but later becomes eligible for corporate alliance coverage (in this example, by hiring more than ten additional employees), the employer would not be subject to these adjustments solely as a result of having grown in size. If, however, such an employer were to form a corporate alliance which was later terminated, these adjustments would apply as for any other employer that terminates a corporate alliance once one has been formed.

For employers that form a corporate alliance which is later terminated, these adjustments would be made beginning in the first year following termination. For employers who choose not to form a corporate alliance initially, these adjustments would be made beginning January 1, 1996, or the first year of the state program, whichever is later.

#### ***Percentage of payroll cap***

Large employers that participate in regional alliances (rather than corporate alliances) would only be eligible for the percent-of-payroll cap (limiting the amount of required employer premiums to 7.9 percent of payroll) on a phased-in basis. For the first four years of regional alliance coverage, no cap would apply to such employers. In the fifth year of regional alliance coverage, such employers could reduce their premium payments by 25 percent of the amount by which the required premiums exceed 7.9 percent of payroll. In the sixth year, the premium payments would be reduced by 50 percent of the excess, and in the seventh year, the required payments would be reduced by 75 percent of the excess. In the eighth year of regional alliance participation (and in all succeeding years), these employers would receive the full benefit of the 7.9 percent cap.

*Example:* Assume that a firm has constant employment of 10,000 full-time equivalent employees at an average annual wage of \$20,000. The firm's total payroll would thus be \$200 million per year. If this employer is eligible to form a corporate alliance, but instead participates in a re-

<sup>25</sup> The bill generally provides that employers employing more than 5,000 full-time employees in the United States are eligible to form corporate alliances.

<sup>26</sup> There are two reasons why a large employer could be participating in a regional alliance: (1) the employer could elect to do so; or (2) the corporate alliance formed by the employer could be involuntarily terminated.

gional alliance, the following would result. Assume that the employer calculates its base employment premiums for regional alliance coverage to be \$20 million per year. In this case, 7.9 percent of the firm's payroll would be \$15.8 million, thus the firm's base employment premiums would exceed 7.9 percent of payroll by \$4.2 million.

For the first four years of regional alliance coverage, the employer would be required to pay the full \$20 million each year to the regional alliances in which its employees reside. In the fifth year, however, the employer would be entitled to a "discount" of 25 percent of the excess \$4.2 million (i.e., \$1.05 million). The employer would thus only be required to pay premiums of \$18.95 million in year 5. In year 6, the required employer premium payments would be \$17.9 million; in year 7, they would be \$16.85 million; and in all subsequent years, they would be \$15.8 million. For the years in which the discounts apply, the employer's payments to all regional alliances in which its employees reside would be reduced proportionally.

#### ***Excess risk payments***

Large employers that participate in regional alliances may be required to make excess risk payments to the regional alliances for the first seven years of regional alliance coverage. Such payments would be required if the demographic risk of the employer's employees residing in a particular regional alliance area exceeds the average risk of all individuals eligible to participate in the regional alliance. The bill specifies that demographic risk would be measured based on demographic characteristics including, but not limited to, age, gender and socio-economic status.<sup>27</sup>

The excess risk percentage for an employer for a particular regional alliance would be the percentage by which the demographic risk of the employer's employees living in the alliance area exceeds the demographic risk of all individuals living in the alliance area, in the year before the employer is first subject to making such payments. This percentage would be multiplied by the reduced weighted average accepted bid for the alliance for the year (which is a per capita amount) and the number of full-time employees employed by the employer who lived in the alliance area in the year before the employer was first subject to making these payments. The resulting amount, for each of the first four years of regional alliance coverage, would equal the amount of excess risk payment due to the regional alliance from the employer. In the fifth year of regional alliance coverage, the employer would be required to pay 75 percent of this calculated amount; in the sixth year, 50 percent; and in the seventh year, 25 percent. No excess risk payments would be owed in subsequent years. Note that excess risk is separately computed for each regional alliance in which the employer's employees reside. Thus, it would be possible for an employer to be required to make

<sup>27</sup> The bill provides that demographic risk would be measured in a manner specified by the Board. Each employer would be required to submit to the regional alliances any information required by the Board in order to determine demographic risk.

excess risk payments to certain regional alliances where its employees reside, but not others.

**f. Additional employer payments for bad debt losses (sec. 6125)**

All employers would be required to make annual payments to the regional alliances in which their employees reside to compensate for the anticipated bad debt losses of the regional alliance. The percent-of-payroll caps (discussed above) would not apply to such payments.

For each year, each regional alliance would be required to estimate the total amount of payments due the alliance which are not likely to be collected. Payments due from Federal, State, or local governments which are anticipated to be uncollectible would not be included in this estimate. The estimate for any particular year would be adjusted to reflect any incorrect estimates in prior years (calculated by comparing prior years' estimates of uncollectible amounts to actual collections, and taking into account any interest paid or received that is attributable to the prior over- or under-estimate). The total estimated amount of uncollectible payments owed the alliance would be divided by the average number of eligible individuals residing in the alliance during the year in order to determine a per capita shortfall amount.<sup>28</sup>

The per capita shortfall amount would be converted into separate amounts for each class of enrollment using the same formulas as used to convert the average per capita bid amounts into base employment premiums (i.e., the per capita amount would be multiplied by the uniform per capita conversion factor and the premium class factor, adjusted to reflect the number of premium payments per family, then multiplied by 80 percent to get the employer share). The effect of this calculation would be that employers would be responsible for payment of 80 percent of the anticipated bad debt losses of the regional alliance.<sup>29</sup> The shortfall amount paid by an employer with respect to any particular employee therefore would vary depending upon the employee's class of enrollment, in the same relative proportion as the base employer premiums vary for each class of enrollment. (e.g., an employer would be required to make a greater shortfall payment for an employee in the dual parent class than in the couple-only class).

*Comment:* It should be noted that the amount of shortfall payments received by a regional alliance based on this formula may be less than the alliance's total estimate of uncollectible amounts. The reason for this is that the shortfall payments are allocated to all individuals and employers who are responsible for making premium payments to the regional alliance, and are not "grossed up" to reflect that some of these individuals and employers would fail to pay the basic premiums (and shortfall amounts) for which they are responsible. In other words, because some portion of the shortfall payments would allocated back to the indi-

<sup>28</sup> For this purpose, individuals who have no family premium obligations under the Act would be disregarded (e.g., families including AFDC or SSI recipients).

<sup>29</sup> The other 20 percent of the shortfall amount would be paid by families in the regional alliance (see Part II.B.4.j. for further discussion of the family share).

viduals (or employers) who fail to pay even the basic premiums owed, a portion of the shortfall payments would be uncollectible as well.

**g. "Employer" payments for self-employed individuals (sec. 6126)**

Under the bill, a self-employed individual would be any person who has earnings subject to self-employment taxes under section 1402(a) of the Internal Revenue Code (as modified by the bill). Self-employed individuals would be required to make "employer" premium payments based upon their self-employment earnings. In calculating the "employer" premium due, a self-employed individual would be considered to be his or her own employer, and the total amount of self-employment earnings would be treated as wages paid. The required amount of employer premiums would be capped as a percentage of "wages" paid, just as for any other small employer (see section 6123 of the bill, described above).<sup>30</sup> If a self-employed individual has had any employer payments made with respect to his or her employment (or self-employment earnings), the amount of "employer" premiums due from the self-employed individual would be reduced by the total amount of such payments. The bill would also provide an anti-abuse rule applicable to any individual who is both an employee and a substantial owner of a closely-held business, to prevent individuals from avoiding payment of the full amount owed through fraudulent or secondary employment arrangements.

**2. Corporate alliance employer payments**

**a. Employer premium payment required (sec. 6131)**

Each corporate alliance would determine its own weighted average premium. Premiums charged by a corporate alliance for health care coverage under a plan could vary only by class of family enrollment and by premium area. Corporate alliances would be required to designate premium areas, which would be required to reasonably reflect labor market areas or health care delivery areas and be consistent with rules to be established by the Department of Labor.

Each corporate alliance employer that, during any month, employs a qualifying employee who is enrolled in a corporate alliance health plan offered by the alliance would be required to pay the corporate employer premium for that month. In the case of a qualifying employee that is not enrolled in a corporate alliance health plan offered by the alliance, the employer generally would make premium payments in the same manner as if the employer were a regional alliance employer. This provision would apply, for example, in the case of part-time employees (who always receive coverage under a regional alliance rather than a corporate alliance) or a married employee who receives coverage through the alliance of his or her spouse.

<sup>30</sup> As described in that section, in certain circumstances (e.g., if an individual is a partner in a partnership), an individual's self-employment earnings would also be used to calculate the caps applicable to the related entity. The calculation described here is a separate calculation from that made for the entity.

The amount of the corporate employer premium for a month for a class of family enrollment for a family residing in a premium area would be 80 percent of the weighted average monthly premium of the corporate alliance health plans offered by the corporate alliance for that class of enrollment for families residing in that area.

In the case of self-insured plans, the premium for the plan would be the actuarial equivalent of such premium determined based on the methodology used by the National Health Board to determine the annual per capita expenditure equivalent (under sec. 6021 of the bill) applicable to corporate alliance health plans or a consistent methodology. In addition, the premium for different classes of enrollment and different premium areas would be computed in a manner based on such factors that bear a reasonable relationship to costs for the provision of the comprehensive benefit package to the different classes in such areas. The Secretary of Labor would be directed to establish rules to carry out the provisions relating to self-insured plans.

Corporate alliance employers would be required to pay an additional amount for certain low-wage employees and their families enrolled in a corporate alliance health plan by virtue of the employment of a low-wage employee. The additional amount the corporate alliance employer would be required to pay would be the amount by which (1) 95 percent of the premium for the least expensive corporate alliance health plan that is offered to the employee and that is a lower or combination cost sharing plan exceeds (2) the amount of the required corporate employer premium. In other words, a corporate alliance employer would be required to contribute at least 95 percent of the premium for the least expensive lower or combination cost sharing plan offered by the corporate alliance health plan, if that amount exceeds the otherwise applicable required employer premium payment.

*Comment:* The additional requirement for low-wage workers should create an incentive for a corporate alliance employer to offer a corporate alliance health plan for which 95 percent of the premium is less than or equal to the otherwise applicable required employer premium. By so doing, the employer would minimize its contribution requirements under the bill. Thus, this provision may help ensure that low-wage employees have a relatively affordable health plan available to them.

A low-wage employee would mean an employee who is employed on a full-time basis and who is receiving wages from the employer at an annual rate of less than \$15,000 (adjusted annually for inflation after 1994). The determination of whether an employee is a low-wage employee would be made at the time of initial enrollment and at the time of each subsequent open enrollment period on the basis of the wages payable by the employer at that time. Wages would be defined the same as for social security tax purposes (sec. 3121 of the Code).

**b. Assessment on corporate alliance employers (sec. 7121 of the bill and new sec. 3461 of the Code)**

The bill would impose an assessment on corporate alliance employers in addition to their premium obligations. The assessment is intended to ensure that corporate alliance employers bear some of the cost of certain items that are expected to be reflected in the premiums for regional alliance health plans, such as graduate medical education, academic health centers, and the costs of providing universal health care coverage.

***Corporate alliances*<sup>31</sup>**

In general under the bill, employers with more than 5,000 full-time employees (large employers), certain multiemployer plans, rural electric cooperatives, rural telephone cooperatives, and the U.S. Postal Service could elect to provide health care coverage to their employees through corporate alliances rather than through regional alliances. The corporate alliance could provide insurance through self-insurance or through commercial insurance. The corporate alliance would be responsible for providing the comprehensive benefit package.

***Assessment on corporate alliance employers***

Under the bill, every corporate alliance employer would be required to pay an assessment of 1 percent of the employer's payroll for each calendar year. Payroll would mean the sum of: (1) wages (as defined for social security tax purposes, but without regard to the wage cap); (2) in the case of a sole proprietorship, the net earnings from self employment of the proprietor attributable to the trade or business; (3) in the case of a partnership, the aggregate of the net earnings from self employment of each partner which is attributable to such partnership; and (4) in the case of an S corporation, the aggregate of the net earnings from self employment (as defined under the bill) of each shareholder which is attributable to such corporation for the taxable year of such corporation. The assessment would be imposed on total payroll, and thus would be imposed with respect to all employees of the corporate alliance employer even if they do not obtain health coverage through the corporate alliance. The assessment is in essence a 1 percent payroll tax.

A corporate alliance employer would include any employer if any individual is provided with health coverage through any corporate alliance because the individual is employed by the employer. An employer would include any person for whom an individual performs services, of whatever nature, as an employee (as defined in Code sec. 3401(c)). For purposes of the bill, any individual who owns the entire interest in an unincorporated trade or business would be treated as the individual's own employer. In addition, a partnership would be treated as the employer of each partner and an S corporation would be treated as the employer of each shareholder of the corporation. All persons treated as a single employer under section 1901 of the Health Security Act would be treated as a single employer for purposes of the 1-percent assessment.

The 1-percent assessment would not apply to an employer that is a corporate alliance employer solely by reason of employees who

<sup>31</sup>Corporate alliances are discussed in detail in Part II.A.2., above.

are provided with health coverage through a corporate alliance sponsored by a multiemployer plan. In the case of an employer that is a corporate alliance employer in part (but not solely) by reason of such employees, the assessment on the employer would be determined without taking into account the payroll of such employees.

The 1-percent assessment would be deductible by the employer. The assessment would be paid at the same time and in the same manner as employment taxes. For purposes of the provisions relating to the filing of tax returns and information reports and other rules relating to procedure and administration under subtitle F of the Internal Revenue Code, the 1-percent assessment would be treated as an employment tax.

### ***Effective date***

The provision would be generally effective on January 1, 1996. Every employer eligible to elect to be an eligible sponsor of a corporate alliance (other than an employer that is a corporate alliance employer solely by reason of employees who are provided with health coverage through a corporate alliance sponsored by a multiemployer plan) would be treated as a corporate alliance employer as of January 1, 1996, unless the employer irrevocably elects to waive its rights ever to be treated as such a sponsor.

*Comment:* The effective date of the provision could be clarified if it were modified to provide that every employer eligible to elect to be an eligible sponsor *as of some specified date* would be treated as a corporate alliance employer as of January 1, 1996, unless it elects never to sponsor a corporate alliance. As written, it is unclear what happens if an employer is not eligible to form a corporate alliance on January 1, 1996 (e.g., does not have enough employees to be a large employer) but does become eligible at a later time.

### **3. Employer payments with respect to retiree health benefits**

The bill imposes two additional obligations on certain employers (whether regional or corporate alliance employers) with respect to retiree health benefits.

#### **a. Employer retiree obligation (sec. 1608)**

In general, under the bill, employers who, as of October 1, 1993, were paying for a portion of the retiree health costs of qualifying retired beneficiaries would be required to make payments to or on behalf of such beneficiaries. This provision would impose a maintenance—of—effort requirement; that is, if the employer were paying for a portion of an individual's retiree health benefits on October 1, 1993, then it must continue to do so.

In particular, the payment obligation applies for each month beginning with January 1998, with respect to any qualifying beneficiary for whom the employer, as of October 1, 1993, was paying at least 20 percent of the premium (or premium equivalent) for coverage of any item or service that is part of the comprehensive benefit package provided under the bill. The employer obligation would

cease to apply when the individual is no longer a qualifying retired beneficiary. The amount of the required payment would be equal to 20 percent of the weighted average premium for the individual's class of enrollment in the regional alliance for the area in which the individual resides.

Under the provision, a qualifying retired beneficiary would include an eligible retiree or a qualified spouse or child of an eligible retiree as those terms are defined in the bill. Under the bill, the determination of whether an individual is an eligible retiree or a qualified spouse or child would be made on a monthly basis. An individual would be required to establish to the satisfaction of the regional alliance (for the alliance area in which the individual resides) his or her status as an eligible retiree or qualified spouse or child. An individual would be considered an eligible retiree for a month if, as of the first day of the month, such individual (1) is between the ages of 55 and 65, (2) is not employed on a full-time basis,<sup>32</sup> (3) is not currently eligible for Medicare coverage, and (4) would have satisfied the employment requirements for Medicare Part A eligibility at age 65.

An individual would be considered a qualified spouse for a month if the spouse is under age 65 and has been married to the eligible retiree for at least one year. An individual would be considered a qualified child for a month if the individual is a child of the eligible retiree.

Under the bill, the surviving spouse of an eligible retiree would also be considered a qualified spouse for a month if he or she (1) has not remarried, (2) was married to the eligible retiree at the time of his or her death, (3) is under age 65, (4) is not employed on a full-time basis,<sup>33</sup> and (5) the deceased spouse would still have been considered an eligible retiree for the month at issue if such spouse had not died. If a surviving spouse would be considered a qualified spouse for a month, his or her children also would be considered qualified children for the month.

*Comment:* The scope of liability for an employer to make payments with respect to qualifying retirees, or qualified spouses or children of qualifying retirees, would be fairly limited. The provision would apply, beginning on January 1, 1998, only to those individuals who were at least age 55 as of October 1, 1993 (and who met the other requirements of a qualifying retiree as of that date). Thus, qualifying retirees would be at least age 59 on January 1, 1998, and the continuing liability would not extend past September 1, 2003.

*Comment:* There may be a definitional problem with the provision as drafted. By definition, an individual could not have been a qualifying retired beneficiary under the bill on October 1, 1993, because in order to be a qualifying beneficiary, an individual would be required to establish to the satisfaction of the regional alliance (for the alliance area in

<sup>32</sup> Eligible retirees who work at least 120 hours in a month would be considered full-time employees (secs. 6114(b)(2) and 1901(b)(2)(A)).

<sup>33</sup> Surviving spouses who work at least 120 hours in a month would be considered full-time employees (secs. 6114(c)(2)(C) and 1901(b)(2)(A)).

which the individual resides) his or her status as a qualifying retired beneficiary. Obviously, there were no regional alliances in existence on October 1, 1993. This could be solved by clarifying that the determination of whether someone is a qualifying retired beneficiary is made without regard to the requirement that the individual establish to the satisfaction of the regional alliance his or her status as a qualifying retired beneficiary.

Any liability to continue payments would be in addition to any other requirement imposed on an employer by the bill or otherwise. Thus, for example, the bill would not alter any contractual obligations that an employer may have to make payments for health benefits on behalf of retired employees.

In addition, the provision would not affect any rights under collective bargaining agreements.

**b. Temporary assessment on employers with retiree health benefit costs (sec. 7121)**

In general, the bill would provide that the employer share of the cost of providing the comprehensive benefit package to retirees between the ages of 55 and 65 is to be paid by the Federal Government. In some cases, employers may have had plans which obligated them to pay these retiree medical costs. To prevent a windfall to such employers, the bill would impose a temporary assessment on employers with base period retiree health costs. The assessment for a year would be equal to 50 percent of the greater of (1) the adjusted base period retiree health costs of the employer for the year, or (2) the amounts (determined in the manner to be prescribed by the Secretary) by which the employer's applicable retiree health costs for such calendar year were reduced by reason of the enactment of the Health Security Act.

"Base period retiree health costs" would mean the average of the applicable retiree health costs of the employer for calendar years 1991, 1992, and 1993. "Adjusted period retiree health costs" would mean the base period retiree health costs adjusted in the manner prescribed by the Secretary of the Treasury to reflect increases in the medical care component of the Consumer Price Index during the period after 1992 and before such calendar year. Rules similar to the rules of section 41(f)(3) (relating to adjustments to the research and development credit in the case of business transactions) would apply in determining adjusted base period retiree health costs in the case of acquisitions and dispositions after December 31, 1993. In general, these rules would increase the adjusted base period retiree health costs by costs attributable to acquisitions of the employer, and would decrease by dispositions of the portion of a business by the employer.

"Applicable retiree health costs" would mean, for any year, the aggregate cost (including administrative costs) of the health benefits or coverage provided during the year (whether directly by the employer or through a sec. 401(h) plan or a welfare benefit fund) to individuals who are entitled to receive such benefits or coverage by reason of being retired employees between ages 55 and 65 (or by reason of being a spouse or other beneficiary of such an employee).

The assessment applies to governmental and tax-exempt employers as well as otherwise taxable employers.

The assessment for each year would be paid on or before March 15 of the following year, but the Secretary of the Treasury would require quarterly estimated payments. Reporting requirements and interest and penalties for failure to make timely payment would apply in the same manner as in the case of Federal employment taxes.

The assessment would apply to calendar years 1998, 1999, and 2000.

#### **4. Regional alliance family share of premiums (secs. 6106-6107 and 6111-6115)**

##### **a. In general**

Under the bill, each family enrolled in a regional alliance health plan in a class of family enrollment (i.e., individual, couple only, single parent, or dual parent) would be required to pay the family share of premium payable with respect to such enrollment. This required premium could also be paid by an employer<sup>34</sup> or by any other person on behalf of the family.

In general, for a family containing at least one full-time worker, the family share of premiums would equal the premium for the health plan selected by the family, less a credit of 80 percent of the weighted average premium for the family's class of enrollment. Certain other credits would also be provided to low-income families, or those receiving AFDC or SSI payment. Families would also be required to pay a "shortfall" amount to compensate for 20 percent of the anticipated bad debt losses of the alliance. For employed individuals, the family share would generally be collected through payroll deduction. Each regional alliance would be responsible for calculating the family share of premium due for each family and so notifying each family.

##### **b. Notification requirements**

Each regional alliance would be required to determine the family share of premium and the amount of any alliance credit required to be repaid for each year for families enrolled in regional alliance health plans (sec. 1343 of the bill). The information required for an alliance to determine the family share of premium would be based on information obtained or maintained by the alliance in the conduct of its business, including information required for income-related determinations, information on SSI and AFDC recipients, information submitted monthly or annually by employers, information submitted by self-employed individuals, applications for premium reductions, information concerning medicare-eligible individuals, and whether or not the family is an SSI or AFDC family.

At least 45 days before the deadline for payment of premiums for a year as specified by the Secretary of Health and Human Services

<sup>34</sup> If paid by the employer, the amount of the premium would be excludable from income under the bill (sec. 7201). The bill would also require that, if the employer pays for any portion of the family premium for any employee, the employer must make the same dollar payment for all employees. The difference between this dollar amount and the family premium for the plan selected by the employee would be paid in cash to the employee and would be includible in the employee's gross income (sec. 1607(b)(2)).

("the Secretary"), the regional alliance would be required to provide notices to each family enrolled in a health plan of amounts due to the regional alliance (sec. 1344). The notice would include detailed information relating to the amount owed, the basis for the computation, and the date the amount would be due and the manner in which the amount due would be payable. The notice would also include information relating to the discounts and reductions in premium liability available and a worksheet that could be used to calculate reductions in liability based on income. In the case of a family that would have been provided a premium discount (under sec. 6104) for the previous year based on income, the notice would include an income reconciliation statement to be completed and returned to the regional alliance by the deadline for payment. Any family not provided with a premium discount, but that would have been eligible for such a discount, could submit an income reconciliation statement and, if eligible, would receive a rebate of the amount of excess family share of premium paid for the previous year.

In the case of a family that, during the year, changes the regional alliance through which the family obtains coverage under a regional alliance health plan, the regional alliance providing coverage as of the end of the year would be responsible for collecting the premiums owed for the year (to any regional alliance). Further, the regional alliance would be required to transfer to each of the other regional alliances providing coverage during the year the portion of premiums attributable to such other coverage.<sup>35</sup>

*Comment:* It is unclear under the bill how payment transfers occur in the case of people switching between regional and corporate alliance plans during the year. It is also unclear what will happen to the transfers if there is a shortfall with respect to the amount of premium required to be transferred.

Under the bill, no individual or family would be denied coverage under a health plan due to failure to pay amounts owed to a regional alliance.

### **c. Regional alliance family share**

In the case of a family enrolled in a regional alliance health plan, the family share of premium would equal the base amount minus any credits and discounts.

The base amount would be the sum of the following amounts:

(1) The regional alliance premium for the class of enrollment and the health plan in which the family is enrolled (i.e., individual, single parent, couple, dual parent). This amount would be the total premium due with respect to a family enrolled in a particular class of enrollment without regard to the amount that is required to be paid by an employer.

(2) 20 percent of the family collection shortfall add-on. The family collection shortfall add-on is designed to collect bad debts of the regional alliance, that is, to collect amounts owed to the regional alliance, but not otherwise received.

<sup>35</sup>The methods for determining the manner in which the required premiums would be collected and transferred among regional alliances would be established by the Secretary.

Credits and discounts would equal the sum of the following amounts:

(1) The alliance credit. This credit would equal 80 percent of the weighted average premium in the alliance for the class of enrollment and is designed to reduce the family share of premium by an amount assumed to be paid by an employer of a member of the family.<sup>36</sup> Certain families, as described below, are liable to the regional alliance for repayment of the alliance credit. In other words, for such families, the amount of the alliance credit is reduced, but not below zero.

(2) Any income-related discount to which the family would be entitled.

(3) Any excess premium credit. This credit is designed to pass on to families the benefit of any plan payment reductions due to enforcement of the premium caps.

(4) The amount of any corporate alliance opt-in credit. This credit is designed to compensate families for higher premiums in regional alliance health plans that may result from corporate alliance employers with employees with higher than average health risks opting into the regional alliance.

(5) An additional credit for SSI and AFDC recipients and certain other families.

In no event could the family share of premiums be less than zero.

The additional credit for SSI and AFDC recipients and certain other families is intended to ensure that these families can enroll in a low-cost health plan and owe no family premiums. The credit would be determined as follows. In the case of an AFDC or SSI family<sup>37</sup> or in the case of a family for whom the income-related discount would equal 20 percent of the weighted average premium for regional alliance health plans offered by the regional alliance for that class of enrollment (increased as specified in bill sec. 6104(b)(2)), the additional credit for SSI and AFDC recipients would equal 20 percent of the family collection shortfall add-on. Thus, such a family would not be liable for any portion of the family collection shortfall add-on.

*Comment:* However, it appears that a family that is not entitled to the full premium discount (i.e., a family that is not an AFDC or SSI family and that has adjusted income in excess of \$1,000) (see the discussion in Part II.B.4.e., below, of the calculation of the premium discount based on income) would be required to pay the full amount of the family collection shortfall add-on. Thus, the bill does not appear to phase in the liability for the family collection shortfall add-on as it does the liability for the family share of premiums.

<sup>36</sup>Note, however, that this credit would not necessarily be the same amount as that paid by the employer. (See the discussion of the alliance credit below.)

<sup>37</sup>An AFDC family would mean a family composed entirely of one or more AFDC recipients (sec. 1902(2)). Similarly, an SSI family would mean a family composed entirely of one or more SSI recipients (sec. 1902(32)). See the discussion relating to divided families below, which describes how a family containing an AFDC or SSI recipient and other individuals would be treated under the bill.

#### **d. Amount of premium**

##### ***In general***

In the case of a regional alliance health plan, the amount of the premium charged by a regional alliance for all families in a class of family enrollment under that health plan would equal the final accepted bid for the plan (which is a per capita amount) times the uniform per capita conversion factor for the alliance and the national premium class factor. The uniform per capita conversion factor, which is separately calculated by each regional alliance, would convert the final accepted bid to a premium for an individual only enrollment. The premium class factor, which is determined by the Board and is applied uniformly to all regional alliances, would convert the premium calculated for the individual only enrollment to the premiums for other classes of enrollment in the plan (such as dual parent).

##### ***Divided families***

The bill would divide certain families for purposes of applying the provisions of the bill, if one or more members of the family qualifies for special treatment under the bill. The divided family rules generally apply if a member of the family qualifies for a health plan that is not part of a regional alliance or a corporate alliance. In general, the divided families rule would split up a legal family for purposes of applying the bill's provisions and would instead treat the family as two (or more) separate families--one family consisting of the individual eligible for special treatment, and a separate family consisting of the remaining members of the legal family.

However, under certain circumstances, these divided families would be combined back into one family for purposes of computing the family share of premiums due. In the case of an individual who is a qualifying employee (i.e., who is employed by an employer for at least 40 hours in a month), if the individual has a spouse or child who is not treated as part of the individual's family, then the combined premium for both families would be computed. If such combined premium is less than the total of the premiums otherwise applicable, then the combined premium would be calculated as though the spouse or child is treated as part of the qualifying employee's family. The regional alliance would then divide the combined premium between the families proportionally (under rules established by the National Health Board) and credits and other amounts to which the families would be entitled would be pro-rated in a manner consistent with rules established by the Board.

For purposes of the bill, a divided family means a family that includes one or more individuals who are part of a group under which all individuals in each such group within the family are treated collectively as a separate family, and all individuals not described in any such group are treated collectively as a separate family. The groups to which the separate family status would apply are (1) AFDC recipients, (2) disabled SSI recipients, (3) SSI recipients who are not disabled SSI recipients, (4) veterans who elect to enroll with a health plan of the Department of Veterans Affairs, unless the veteran elects family enrollment under the plan (instead of individual enrollment), (5) active duty military personnel (i.e., an individual on active duty in the Uniformed Services of the United

States), but not with respect to any family coverage elected, (6) Indians who elect a health program of the Indian Health Service instead of a health plan, but only if an election is made with respect to all eligible individuals who are family members of the family, or (7) prisoners (i.e., an eligible individual during a period of imprisonment under Federal, State, or local authority after conviction as an adult).

#### **e. Premium discount based on income**

##### ***In general***

A premium discount would be provided with respect to each family enrolled in a regional alliance health plan that is (1) an AFDC or SSI family, (2) has family adjusted income below 150 percent of the applicable poverty level and is determined to be eligible for reductions in cost sharing (secs. 1371-1375 of the bill), or (3) is a family for which the family obligation amount for the year would otherwise exceed a specified percentage of family adjusted income. In the case of an AFDC or SSI family, the premium discount would be applied to the premium only for those months in which the family is an AFDC or SSI family.

The amount of the premium discount for a family enrolled in a regional alliance health plan under a class of family enrollment would be 20 percent of the weighted average premium for regional alliance health plans offered by the regional alliance for that class of enrollment reduced (but not below zero) by the sum of the family obligation amount (described below) and the amount of any employer payment toward the family share of premiums for covered members of the family (i.e., an employer payment in excess of required payments). Thus, the premium discount to which certain families are entitled is reduced by any employer payments in excess of its minimum required payment.

*Comment:* The bill appears to create a disincentive for any employer to pay more than the required minimum for its low-wage employees because then the premium discount is not available. Most economists believe that employees ultimately bear the full cost of amounts, such as payroll taxes, that employers pay on their behalf. If this is true, then there is a clear incentive for an employer not to pay more than the minimum required contribution because it appears under the bill to reduce the availability of the income-related premium discount.

If a regional alliance determines that a family eligible for the premium discount is unable to enroll in an at-or-below-average-cost plan that serves the area in which the family resides, the premium discount would be increased by 20 percent of the amount by which the premium for the lowest-cost plan for which the family is eligible exceeds the weighted average premium for that class of enrollment. An at-or-below-average-cost plan means a regional alliance health plan the premium for which would not exceed, for the class of family enrollment involved, the weighted average premium for the regional alliance.

### ***Family obligation amount***

If the family adjusted income of a family (described below) is less than \$1,000<sup>38</sup> (the income threshold amount), or if the family is an AFDC or SSI family, the family obligation amount would be zero. Thus, such a family would be entitled to the full premium discount under the bill because the premium discount would not be reduced by any family obligation amount. The amount of the discount would still be reduced by any employer payments in excess of the minimum required employer payment. Families with adjusted income of \$1,000 or more would have some family obligation amount, determined as described below.

In the case of a family with adjusted income above the income threshold amount, the family obligation amount would be the sum of two amounts. The first amount would be the product of (1) the initial marginal rate and (2) the amount by which the portion of the family adjusted income not in excess of the poverty level exceeds the income threshold amount. The second amount would be the product of (1) the final marginal rate and (2) the amount by which the family adjusted income exceeds 100 percent (but is less than 150 percent) of the applicable poverty level.

In the case of an individual class of enrollment, the initial marginal rate for a year would be the ratio of (1) 3 percent of the applicable poverty level for the individual class of enrollment to (2) the amount by which the poverty level exceeds the income threshold amount. The final marginal rate would be the ratio of (1) the amount by which the general family share for an individual class of enrollment exceeds 3 percent of the applicable poverty level (for an individual class of enrollment for the year) to (2) 50 percent of the poverty level. The general family share would mean, for a class of enrollment, the weighted average premium for the class minus the alliance credit (determined without regard to the calculation of the family obligation amount).

*Example:* Assume that a single individual has adjusted income of \$14,000 for 1994, the applicable poverty level is \$10,000, the income threshold is \$1,000, and the general family share is \$400. The initial marginal rate is the ratio of \$300 (3 percent of \$10,000) to \$9,000 (the amount by which the poverty exceeds the income threshold), or .0333. The final marginal rate is the ratio of \$100 (the amount by which the general family share exceeds 3 percent of the poverty level, or \$400 minus \$300) to \$5,000 (50 percent of the poverty level (\$10,000)), or .020.

The family obligation amount is calculated as follows:

- (1) .0333 (the initial marginal rate) times \$9,000 (the amount by which the portion of family income not in excess of the poverty level exceeds the income threshold amount), plus
- (2) .020 (the final marginal rate) times \$4,000 (the amount by which the family adjusted income exceeds 100 percent (but is less than 150 percent) of the poverty level).

<sup>38</sup>This amount would be indexed for changes in the CPI in years after 1994 and would be rounded to the nearest multiple of \$10.

Thus, the family obligation amount for the individual is \$380 (\$300 plus \$80).

For a year for a nonindividual class (i.e., couple-only, single parent, or dual parent) of enrollment, the initial marginal rate would be the ratio of (1) 3 percent of the applicable poverty level for a dual parent class of enrollment for the year to (2) the amount by which the applicable poverty level exceeds the income threshold amount. The final marginal rate would be the ratio of (1) the amount by which the general family share for a dual parent class of enrollment exceeds 3 percent of the applicable poverty level (for such a class for the year) to (2) 50 percent of the applicable poverty level.

In the case of a family with family adjusted income of less than 150 percent of the applicable poverty level, in no case could the family obligation amount exceed 3.9 percent of the amount of such adjusted income. The 3.9 percent would be adjusted for any year after 1994 so that the percentage for the year bears the same ratio to the percentage so specified as the ratio of 1 plus the general health care inflation factor for the years bears to 1 plus the percentage specified in section 1136(b) (relating to indexing of dollar amounts related to cost sharing for the year). Any adjustment to the 3.9 percent shall be rounded to the nearest multiple of 1/10 of 1 percentage point.

In the case of a family with family adjusted income of at least 150 percent of the applicable poverty level but less than \$40,000 (adjusted after 1994 for changes in the CPI and rounded to the nearest multiple of \$100), the family obligation amount for the year would equal 3.9 percent (adjusted as described above) of the adjusted income. For families with family adjusted income of at least \$40,000, there would be no cap on the family obligation amount.

Under the bill, family adjusted income would mean the sum of the adjusted incomes for all members of the family (determined without regard to the divided families rules) (sec. 1372(d)). Adjusted income would mean adjusted gross income (as defined in section 62(a) of the Internal Revenue Code of 1986 (the Code)) determined without regard to (1) the exclusion from gross income with respect to the redemption during the year of qualified U.S. savings bonds used to pay qualified higher education expenses (sec. 135 of the Code), (2) the deduction for health insurance costs of self-employed individuals (sec. 162(1) of the Code), (3) the exclusion from income for certain income of U.S. citizens or residents living abroad (sec. 911 of the Code), (4) the exclusion from income from sources within Guam, American Samoa, or the Northern Mariana Islands (sec. 931 of the Code), and (5) the exclusion from income for income from sources within Puerto Rico (sec. 933 of the Code). This amount would be increased by the amount of tax-exempt interest received or accrued by the individual. At an individual's option, family adjusted income could include the income of individuals who are claimed as dependents of the family for income tax purposes (but who are not considered members of the family for purposes of applying the Health Security Act generally). In such circumstances, these dependents would not be considered part of the family for purposes of determining the family's class of enrollment.

### ***Ineligible individuals***

Certain individuals would not be entitled to a premium discount because the applicable health plan would not impose any premium obligation on such individuals. These individuals would include (1) electing veterans enrolled under a health plan of the Department of Veterans Affairs who, under the laws and rules in effect as of December 31, 1994, have a service-connected disability or are unable to defray the expenses of necessary care as determined under title 38 of the USC, (2) active duty military personnel, and (3) Indians who elect a health program of the Indian Health Service instead of a regional alliance health plan, but only if an election is made with respect to all eligible individuals who are family members of the family.

#### **f. Alliance credit**

An alliance credit would reduce the amount of the family share of premium that would otherwise be owed. The alliance credit is intended to reflect the employer's share of premiums presumed to be paid on behalf of an individual.

In the case of a regional alliance, the alliance credit for a class of family enrollment would be 80 percent of the weighted average premium for health plans offered by the alliance for the class. Thus, if an individual elects coverage under a regional alliance health plan that has a premium equal to the weighted average premium for plans offered by the alliance for the same class of enrollment, the individual would not be obligated to pay, in any event, more than 20 percent of the weighted average premium.

*Examples:* The alliance credit to which any family is entitled does not necessarily equal the amount of employer premium payments made on behalf of the family. A number of examples will illustrate this point.

Assume that the weighted average premium for the couple-only class is \$3,000 and that the average couple-only family has 1.5 full-time workers. The employer premium (or base employment monthly premium) to be paid for a full-time worker would be 80 percent of \$3,000 divided by 1.5, or \$1,600. However, the credit for each family would be 80 percent of \$3,000, or \$2,400. The effect on different couples would vary depending upon the number of full-time workers they represent. In each of the following examples, assume that the couple elects a health plan with a \$3,000 premium (i.e., an average health plan) and that there are no other credits or discounts available.

*Example 1:* Both spouses are full-time employees. Their employers will each pay \$1,600 of premiums for a total of \$3,200. Assuming no other credits or discounts and no family collection shortfall add on, the couple will be required to pay \$600 for their health plan (the \$3,000 premium minus the \$2,400 alliance credit). Thus, the couple and their employers pay a total of \$3,800 (\$3,200 plus \$600) for coverage in a \$3,000 health plan.

*Example 2:* Assume one spouse is a full-time employee and one spouse is unemployed. The working spouse's employer pays a \$1,600 premium and the couple pays \$600 (after the alliance credit). The couple and employer pay a total of \$2,200 (\$1,600 plus \$600) for coverage in a \$3,000 health plan.

*Example 3:* Assume both spouses are half-time (i.e., 60 hours a month) workers. Each employer would be required to pay an \$800 premium (one-half of the full-time worker premium) and the couple is required to pay \$600. Thus, the result is the same as example 2; a total premium of \$2,200 (\$800 plus \$800 plus \$600) is collected for coverage in a \$3,000 health plan.

*Example 4:* Assume the couple has one half-time worker and one nonworker. The employer pays \$800 (one half the premium for a full-time worker). The family is entitled to an alliance credit of \$2,400. However, the family's repayment liability (described in detail below) is 50 percent of the base monthly employment premium, or \$800. Thus, the family's premium payment would be \$1,400 (\$3,000 minus \$2,400 plus \$800) and the total premium paid with respect to the family would be \$2,200 (\$1,400 plus \$800). Note that the alliance collects the same total premium in this example as in example 2 or 3, in which the couples have at least (in total) one full-time worker.

*Example 5:* Assume that neither spouse of the couple is employed. The family is entitled to the alliance credit of \$2,400 (80 percent of \$3,000). However, the family's repayment liability equals the base monthly employment premium, or \$1,600. Thus, the family's premium payment would be \$2,200 (\$3,000 minus \$2,400 plus \$1,600).

*Comment:* In the aggregate, as long as the alliance can predict accurately the number of full-time workers per family, the total employer payments and the total family credits should be the same. As the above examples illustrate, if it is assumed that employees ultimately bear the full burden of the required premium payments through reduced wages, then families with more than one full-time worker will effectively be paying more for their health care than will families with less than one full-time worker. This result could create a disincentive to work in certain cases.

#### **g. Repayment of alliance credit by certain families**

##### ***In general***

Under the bill, certain families that are provided an alliance credit (i.e., a credit that reduces the family share of premium by an amount assumed to be paid by an employer of a member of the family) for a class of enrollment would be liable to the regional alliance for repayment of an amount equal to the base employment monthly premium (applicable to such class) for the month (sec. 6122). The base employment monthly premium would be the amount payable each month by an employer with respect to each

full-time employee enrolled in a class of family enrollment under a regional alliance health plan.

*Comment:* The amount of the alliance credit would be based upon the weighted average premium for all health plans offered by a regional alliance for a class of coverage, whereas the calculation of any repayment liability would be based upon the base employment monthly premium paid by an employer with respect to a full-time employee. For individuals, these amounts will be the same. However, for families, these amounts will generally not be the same.

The repayment of the alliance credit would have the effect of requiring payment of an additional premium with respect to a family enrolled in a regional alliance health plan in situations in which an employer did not make premium payments with respect to the family. Thus, for example, the liability of a family for a year would be reduced (but not below zero) by the amount of any employer payments made in the year based on the net earnings from self employment of a family member (sec. 6126).

***No liability for families employed full time; reduction in liability for part-time employment***

If any family member works at least 40 hours during the month (and his or her employer would be required to make payments with respect to such employment), the family's repayment obligation would be reduced or eliminated. Thus, the amount of any liability for repayment of the alliance credit would be reduced, in accordance with rules established by the Board, based on employer premiums payable with respect to the employment of a family member who is a qualifying employee or with respect to a family member. In no case could the reduction result in any payment due to a family (i.e., the reduction could not reduce the liability for repayment of the alliance credit below zero).

If a family member is a qualifying employee for a month, is not an eligible retiree or a qualifying spouse or child of an eligible retiree, and the employer is liable for payment with respect to the qualifying employee based on such employment, then the liability for repayment of the alliance credit would be reduced depending upon whether the employment is full time or part time. If the employment is on a full-time basis, the liability would be reduced by the full-time monthly credit. The full-time monthly credit, with respect to employment in a month, is 1/12 of the repayment liability based on the class of enrollment for the year. If the employment is on a part-time basis, (i.e., for at least 40 hours, but less than 120 hours, in a month) the liability would be reduced by the employment ratios (the ratio of the number of hours of employment for a month to 120) of the full-time monthly credit. In other words, in the case of part-time employment, the liability would be reduced proportionately by the percentage the hours of employment are to 120 hours. In the case of a family that is not enrolled in a regional alliance health plan for all the months in a year, the full-time monthly credit would be deemed to be the repayment liability divided by the number of months in a year in which the family was enrolled in such a plan.

In the case of an individual who is a qualifying employee of more than one employer in a month, the full-time monthly credit for the month would be the sum of the credits earned with respect to employment by each employer. In the case of a couple each spouse of which is a qualifying employee in a month, the credit for the month would be the sum of the credits earned with respect to employment by each spouse. In either case, the sums of the credits may exceed the full-time monthly credit amount.

In the case of a family for which the class of family enrollment changes during a year (e.g., from single parent to dual parent), the Board would be required to establish rules for appropriate conversion and allocation of the credit amounts in a manner that reflects the relative values of the base employment monthly premiums among the different classes of family enrollment.

***Limitation on repayment obligation based on income***

In the case of a family that has wage-adjusted income below 250 percent of the applicable poverty level, the repayment amount required (after taking into account any reduction in liability on account of full or part-time employment) with respect to a year would be limited. Wage-adjusted income would mean, for a family, the adjusted income of the family, reduced by the sum of (1) the amount of any wages included in such family's income that is received for employment with respect to which employment premiums would be required to be paid, (2) the amount of net earnings from self employment of the family, and (3) the amount of unemployment compensation included in gross income (sec. 85 of the Internal Revenue Code). For purposes of the reduction described in (1), above, the reduction would not exceed \$5,000 for a year (indexed for inflation) multiplied by the number of months (including portions of months) of employment with respect to which employer premiums would be payable.

If the wage-adjusted income of a family is less than \$1,000<sup>39</sup> (the income threshold) or if the family is an AFDC or SSI family, the amount of liability would be zero. If the wage-adjusted income at least equals the income threshold, the amount of liability would be the sum of (1) the initial marginal rate multiplied by the amount by which the wage-adjusted income (not including any portion that exceeds the applicable poverty level for the class of family involved), exceeds the income threshold amount, plus (2) the final marginal rate multiplied by the amount by which the wage-adjusted income exceeds 100 percent of the applicable poverty level. The initial marginal rate for a year for a class of enrollment would be the ratio of 5.5 percent of the applicable poverty level for the class of enrollment for the year, to the amount by which such poverty level exceeds the income threshold amount. The final marginal rate for a year for a class of enrollment would be the ratio of the amount by which the repayment amount exceeds 5.5 percent of the applicable poverty level to 150 percent of the applicable poverty level.

<sup>39</sup>This amount would be indexed for changes in the CPI after 1994 and rounded to the nearest multiple of \$10.

*Example:* Assume that a family in the dual parent class of enrollment has family adjusted income of \$14,000 for 1994, and the applicable poverty level is \$10,000. Of the family's \$14,000 income, assume that \$11,000 was earned by one spouse from her part-time employment. (She works 60 hours every month throughout the year.) The other \$3,000 was earned by her husband in employment that never totalled 40 or more hours per month (thus, his employer was not required to pay any employment premiums with respect to his employment). The weighted average premium for the dual parent class is \$3,000. The base employment premium is \$1,600.

The family's total qualifying employment would be equal to .5 full-time equivalent worker (60 hours divided by 120 hours). The repayment obligation (before considering any low-income limitation) would therefore be .5 times \$1,600, or \$800.

The initial marginal rate is the ratio of \$550 (5.5 percent of \$10,000) to \$9,000 (the amount by which the poverty level exceeds the income threshold, but not in excess of the poverty level), or .0611. The final marginal rate is the ratio of \$1,050 (the base employment premium minus 5.5 percent of the poverty level, or \$1,600 minus \$550) to \$15,000 (150 percent of the poverty level), or .07.

The family's repayment obligation would be calculated as follows. The family's "wage-adjusted income" would be equal to the family's adjusted income less any wages with respect to which an employer was required to pay employment premiums: \$14,000 less \$11,000, or \$3,000. The repayment obligation would be limited to .0611 (the initial marginal rate) times \$3,000, or \$183. Note that the final marginal rate is not needed in this example because wage-adjusted income does not exceed 100 percent of the poverty level.

In the case of an AFDC or SSI family, the liability amount would be reduced to zero only for those months in which the family is an AFDC or SSI family. However, the family's income could be so low as to reduce the liability to zero in those months in which the family is not otherwise an AFDC or SSI family.

A family's wage-adjusted income and the amount of liability would be determined by the applicable regional alliance upon application by a family. Under the bill, there would be no repayment liability for electing Indians and certain veterans and military personnel because there would be no required premium payments for such individuals.

### ***Special treatment of certain retirees and qualified spouses and children***

An individual who is an eligible retiree or a qualified spouse or child of an eligible retiree for a month in a year (beginning in 1998) would be considered, for purposes of determining any repayment liability, to be a full-time employee for such month. Thus, there would be no repayment liability with respect to such individuals. An eligible retiree means, for a month, an individual who estab-

lishes to the satisfaction of the regional alliance for the alliance area in which the individual resides, that the individual, as of the first day of the month, is at least 55, but less than 65, years old, is not employed on a full-time basis (sec. 1901(b)(2)(A)), would be eligible for medicare benefits if the individual were 65 years of age based only on the employment of the individual, and is not a medicare-eligible individual.

A qualified spouse or child of an eligible retiree would mean an individual who establishes to the satisfaction of the regional alliance for the alliance area in which the individual resides that the individual (1) is under age 65 years of age and has been married for at least one year to an eligible retiree or is a child of an eligible retiree, (2) was married to an eligible retiree for at least one year at the time of the eligible retiree's death, is under age 65, is not employed on a full-time basis, and is not remarried, provided the deceased spouse (the eligible retiree) would still be an eligible retiree in the month if the spouse had not died, or (3) is a child of an eligible retiree who died.

An individual could not be determined to be an eligible retiree or qualified spouse or child of an eligible retiree unless an application has been filed with the regional alliance. The application would contain such information as may be required to establish status as an eligible retiree or qualified spouse or child and to verify information in the application. Any material misrepresentation in the application would be subject to a penalty.

### ***Special treatment of certain Medicare beneficiaries***

In the case of an individual who would be a medicare-eligible individual in a month but for the employment in the month or in a previous month of the individual or the individual's spouse or parent, the individual (or spouse or parent, as the case may be) so employed is considered to be a full-time employee described in such month. Thus, there would be no repayment liability with respect to such individuals.

#### **h. Excess premium credit**

If plan payment reductions were imposed on one or more regional alliance health plans in a year under section 6011, the excess premium credit would reduce premiums for each family enrolled in a regional alliance health plan in the year.<sup>40</sup>

As discussed in more detail in Part II.A.1.b., a health plan that participates in a noncomplying alliance would be a noncomplying plan if its final accepted bid for the year exceeds the maximum complying bid for the year. In this case, the health plan could voluntarily reduce its bid, and enrollees would pay the reduced premium. If a plan does not reduce its bid, it would be subject to a mandatory plan payment reduction. In the case of a mandatory plan payment reduction, plan enrollees pay the higher, unreduced, premium (such plans are referred to as "excess premium plans"). However, the excess is returned to each family enrolled in any plan offered by the regional alliance in the form of an excess premium

<sup>40</sup>Although the statute refers to section 6021, the correct statutory reference appears to be section 6011 (relating to plan payment reduction).

credit. The credit would be available to families enrolled in any health plan offered by the regional alliance, and would not be limited to the families in excess premium plans.

In general, the amount of the credit for a class of family enrollment for a year would be the weighted average premium for the alliance, class, and year, if the per capita excess premium amount for the alliance for the year were substituted for the reduced weighted average accepted bid for the regional alliance for the year. The per capita excess premium amount for a regional alliance for a year would be the amount by which the alliance's weighted average accepted bid for the year exceeds the alliance's per capita premium target for the year.

The bill would provide for an adjustment to the amount of excess premium credits if more (or fewer) families than anticipated enrolled in excess premium plans. If the total payments made by a regional alliance to all regional alliance health plans in a year<sup>41</sup> would exceed (or would be less than) the total of such payments estimated by the alliance because of the distribution of enrolled families, the amount of the excess premium credit in the second succeeding year would be reduced (or increased, respectively) by the amount of such excess (or deficit).

#### **i. Corporate alliance opt-in credit**

A corporate alliance opt-in credit would be available if a regional alliance is owed an excess risk adjustment because a large employer participates in a regional alliance (sec. 6124 of the bill). For each class of enrollment for a regional alliance for a year, the amount of the credit would equal 20 percent of the weighted average premium for such alliance, class, and year, if the per capita corporate alliance opt-in amount for the alliance for the year were substituted for the reduced weighted average accepted bid for the regional alliance for the year.

The per capita corporate alliance opt-in amount, for a regional alliance for a year, would be the total amount of the payment adjustments owed for the year by all employers (determined under bill sec. 6124), divided by the estimated average number of regional alliance eligible individuals in the regional alliance during the year.<sup>42</sup>

#### **j. Family collection shortfall add-on**

The family collection shortfall add-on, for a regional alliance for a class of enrollment for a year would be the weighted average premium for such alliance, class, and year, if the per capita collection shortfall amount for the alliance for the year were substituted for the reduced weighted average accepted bid for the regional alliance for the year.

The per capita collection shortfall amount, for a regional alliance for a year, would equal the aggregate collection shortfall divided by the estimated average number of regional alliance eligible individ-

<sup>41</sup>This would be calculated by taking into account the relative actuarial risk associated with the coverage under section 1351(b) of the bill.

<sup>42</sup>For this purpose, individuals whose family share of premiums is zero, determined without regard to the corporate alliance opt-in credit and the family collection shortfall add-on, would be disregarded.

uals in the regional alliance during the year<sup>43</sup>. The aggregate collection shortfall would be estimated by a regional alliance for each year (beginning with the first year) and would be the total amount of payments that the alliance could reasonably identify as owed to the alliance (taking into account any premium reduction or discount and including amounts owed as a result of the repayment of the alliance credit by certain families (sec. 6111 of the bill) and not taking into account any penalties) for the year and not likely to be collected (after making collection efforts) during a period specified by the Secretary beginning on the first day of the year. Payments owed to a regional alliance by the Federal Government or any State or local governments would not be taken into account in calculating the aggregate collection shortfall.

The amount estimated for a year would be adjusted to reflect over (or under) estimations in the amounts computed for previous years (based on actual collections) taking into account interest payable based upon borrowings (or savings) attributable to such over- or under-estimations.

## **5. Corporate alliance family share of premiums (secs. 6101-6107)**

### **a. In general**

Under the bill, each family enrolled in a corporate alliance health plan in a class of family enrollment (i.e., individual, couple only, single parent, or dual parent) would be required to pay the family share of premium payable with respect to such enrollment. This required premium could also be paid by an employer<sup>44</sup> or by any other person on behalf of the family.

In the case of a family enrolled in a corporate alliance health plan, the family share of premium would be the premium for the health plan selected by the family for the class of enrollment in which the family is enrolled, reduced (but not below zero) by the alliance credit and any income-related discount to which the family would be entitled.

In the case of a family enrolled in a corporate alliance health plan, the alliance credit would equal the minimum required employer premium. The minimum required employer premium payment for a class of family enrollment for a family residing in a premium area would be 80 percent of the weighted average premium of the corporate alliance health plans offered by the corporate alliance for that class of enrollment for families residing in the premium area.

### **b. Amount of premium**

In the case of a corporate alliance, the amount of the premium charged by the alliance would be determined in accordance with

<sup>43</sup>The average number of regional alliance eligible individuals would be reduced by the average number of such individuals whose family share of premiums is zero, determined without regard to the family collection shortfall add on and the corporate alliance opt-in credit.

<sup>44</sup>If paid by the employer, the amount of the premium would be excludable from income under the bill (sec. 7201). The bill would also require that, if the employer pays for any portion of the family premium for any employee, the employer must make the same dollar payment for all employees. The difference between this dollar amount and the family premium for the plan selected by the employee would be paid in cash to the employee and would be includable in the employee's gross income (sec. 1607 (b)(2)).

the following rules (sec. 1384 of the bill). The premiums charged to families by a corporate alliance for enrollment in a corporate alliance health plan (not taking into account the minimum employer premium payment required under sec. 6131) could vary only by class of family enrollment and by premium area. Thus, the bill generally would require that corporate alliances provide community rating of premiums within any premium area.

Each corporate alliance would be required to designate premium areas to be used for the imposition of premiums and calculation of employer premium payments. The boundaries of a premium area would reasonably reflect labor market areas and health care delivery areas and would be consistent with rules established by the Secretary of Labor so that there would not be substantial differences in average per capita health care expenditures within such areas. The corporate alliance could not establish boundaries for premium areas that discriminate on the basis of or otherwise take into account race, age, language, religion, national origin, socio-economic status, disability, or perceived health status. Further, a corporate alliance would be required to include the entire portion of a metropolitan statistical area located in a State in the same premium area.

The Secretary of Labor could exempt multiemployer plans that establish a corporate alliance from such requirements as may be appropriate to reflect the unique historical relationship between employers and employees under such alliances.

### **c. Premium discount based on income**

Each family enrolled with a corporate alliance health plan on account of the full-time employment of a low-wage employee would be entitled to a premium discount. The permitted premium discount would equal the amount (if any) by which 95 percent of the premium for the least expensive corporate alliance health plan that is offered to the employee (and that is a lower or combination cost sharing plan) exceeds the alliance credit for the class of family enrollment.<sup>45</sup>

A low-wage employee would be an employee who is employed on a full-time basis and who is receiving wages for employment with the employer at an annual rate of less than \$15,000.<sup>46</sup> The determination of whether an employee is a low-wage employee would be made at the time of initial enrollment in the plan and at the time of each subsequent open enrollment period, on the basis of the wages payable by the employer at that time. The determination that an individual is a low-wage employee would apply as of the effective date of the initial enrollment in a plan or, in the case of an open enrollment period, as of the effective date of changes in enrollment during that period.

*Example:* As an example of the calculation of the premium discount, assume that an individual earning \$14,900 a year has single coverage under a corporate alliance health

<sup>45</sup> See the description of a lower or combination cost sharing plan in Part I, above.

<sup>46</sup> The \$15,000 would be indexed for any year after 1994 by the percentage increase (or decrease) by which the average consumer price index (CPI) for the 12-month period ending with August 31 of the preceding year exceeds the average for the 12-month period ending with August 31, 1993.

plan of the individual's employer. The individual is a low-wage employee because his or her annual rate of pay does not exceed \$15,000. The premium for the plan in which the employee enrolls is \$2,300. The premium for the least expensive health plan that is a lower or combination cost sharing plan is \$1,800. The alliance credit (i.e., the minimum employer premium payment required with respect to individual coverage) is \$1,600.

The premium discount for the individual is \$110 (.95 (\$1,800) - \$1,600).

If this individual earns \$15,000 per year, the individual would not be entitled to a premium discount because there is no phase out of the premium discount under the bill.

*Comment:* The premium discount to which any family is entitled would be determined solely by the relationship between the minimum employer premium payment and the least expensive combination or lower cost sharing plan offered to the employee and is not affected by the particular plan in which the family is enrolled.

#### **d. Alliance credit**

An alliance credit would reduce the amount of the family share of premium. The alliance credit is intended to reflect the employer's share of premiums presumed to be paid on behalf of an individual.

In the case of a corporate alliance, the alliance credit for a family enrolled in a corporate alliance health plan for a class of family enrollment would be the minimum employer premium payment required with respect to the family. The minimum employer premium payment for a class of family enrollment for a family residing in a premium area would be 80 percent of the weighted average premium of the corporate alliance health plans offered by the corporate alliance for that class of enrollment for families residing in the premium area. Families would have no repayment obligations in the case of a corporate alliance.

### **6. Recapture of certain health care subsidies received by high-income individuals (sec. 7131)**

#### ***In general***

Under the bill, taxpayers with modified adjusted gross income above a threshold amount would be required to pay additional premiums for coverage under Part B of Medicare. In addition, under the bill, eligible retirees and qualified spouses and children would be eligible to receive a Federal subsidy equal to the employer share of the health care premium for full-time employees under the comprehensive benefit package. Eligible retirees and qualified spouses and children with modified adjusted gross income above the threshold amount would be required to pay the employer share of their premium for health care under the nationally guaranteed comprehensive benefits package.

For the purpose of both of these additional payments, modified adjusted gross income would be adjusted gross income plus tax-exempt interest, certain foreign source income, and income from higher education U.S. savings bonds. The modified adjusted gross in-

come of married taxpayers filing joint returns would be the combined modified adjusted gross income of both spouses.

For the purpose of both of these payments, the threshold amount would be \$90,000 for unmarried taxpayers, \$115,000 for married taxpayers filing joint returns, and \$0 for married taxpayers filing separate returns. If a taxpayer's modified adjusted gross income for any taxable year exceeds the threshold amount by less than \$15,000 (\$30,000 for married taxpayers filing joint returns if each spouse were required to pay additional premiums), the amount of any additional payments imposed under this provision would be computed by multiplying the total amount due for the taxable year by a ratio, the numerator of which would be the amount of the taxpayer's modified adjusted gross income above the threshold amount and the denominator of which would be \$15,000 (\$30,000 for married taxpayers filing joint returns if each spouse is required to pay additional premiums).

Any additional premiums imposed under this provision would be treated as income taxes for purposes of subtitle F of the Code (relating to income tax procedure and administration) but would not be treated as income taxes for alternative minimum tax purposes (Code sec. 55) or for the purpose of determining the amount of other tax credits under the Code. Finally, additional premiums imposed under this provision would be considered deductible to the same extent as other health insurance premiums and would be excludable from the recipient's gross income if paid by a former employer.

Under the provision, penalties for failure to pay estimated income tax would not be imposed on a taxpayer for any period prior to April 16, 1997, to the extent that the underpayment resulted from the failure to pay additional Medicare Part B premiums. In addition, penalties for failure to pay estimated income tax would not be imposed on a taxpayer for any period prior to April 16, 1999, to the extent that the underpayment resulted from the failure to pay additional premiums for health care coverage under this provision.<sup>47</sup>

### ***Additional Medicare Part B premiums***

Under the bill, taxpayers with modified adjusted gross income above the threshold amount would be required to pay additional Medicare Part B premiums for each month of enrollment in Part B of Medicare. The additional monthly amount would be equal to the excess of 150 percent of the monthly actuarial rate for Medicare Part B enrollees age 65 or older over the monthly Medicare Part B premium.

Proceeds from the collection of additional Medicare Part B premiums would be credited at least quarterly to the Supplemental Medical Insurance Trust Fund.

<sup>47</sup> For a complete discussion of the issues relating to section 7131 of the bill, see Joint Committee on Taxation, *Description and Analysis of Title VII of H.R. 3600, S. 1757, and S. 1775 ("Health Security Act")* (JCS-20-93), December 20, 1993, p. 34.

## ***Additional health care premiums***

### *In general*

Under the bill, eligible retirees and qualified spouses and children would be eligible to receive a Federal subsidy equal to the employer share of the health care premium for full-time employees under the comprehensive benefit package. For this purpose, the employer share of an individual's health care premium generally would be 80 percent of the average premium charged by health plans in the individual's health alliance for the individual's class of enrollment.<sup>48</sup> Eligible retirees and qualified spouses and children with modified adjusted gross income above the threshold amount would be required to pay the employer share of their premium for health care under the comprehensive benefits package. The determination of whether an individual is an eligible retiree or a qualified spouse or child would be made on a monthly basis. An individual would be required to establish his or her status as an eligible retiree or qualified spouse or child by filing an application with the regional alliance in the area in which the individual resides.<sup>49</sup>

### *Definition of eligible retiree*

An individual would be considered an eligible retiree for a month if, as of the first day of the month, such individual (1) is between the ages of 55 and 65, (2) is not employed on a full-time basis,<sup>50</sup> (3) is not currently eligible for Medicare coverage, and (4) would have satisfied the employment requirements for Medicare Part A eligibility at age 65.

### *Definition of qualified spouse or child*

An individual would be considered a qualified spouse for a month if the spouse is under age 65 and has been married to the eligible retiree for at least one year. An individual would be considered a qualified child for a month if the individual is a child of the eligible retiree.

Under the bill, the surviving spouse of an eligible retiree would also be considered a qualified spouse for a month if he or she (1) has not remarried, (2) was married to the eligible retiree at the time of his or her death, (3) is under age 65, (4) is not employed on a full-time basis,<sup>51</sup> and (5) the deceased spouse would still have been considered an eligible retiree for the month at issue if such spouse had not died. If a surviving spouse would be considered a qualified spouse for a month, his or her children also would be considered qualified children for the month.

<sup>48</sup> Sections 6121 and 6122.

<sup>49</sup> Under the bill, if an individual makes any material misrepresentations relating to his or her status as an eligible retiree or qualified spouse or child to a regional alliance, he or she would be required to pay a penalty to the State in which the regional alliance is located equal to the greater of \$2,000 or three times the excess payments made based on the misrepresentation (secs. 6114(d) and 1374(i)(2)).

<sup>50</sup> Eligible retirees who work at least 120 hours in a month would be considered full-time employees (secs. 6114(b)(2) and 1901(b)(2)(A)).

<sup>51</sup> Surviving spouses who work at least 120 hours in a month would be considered full-time employees (secs. 6114(c)(2)(C) and 1901(b)(2)(A)).

***Effective date***

The provisions relating to additional Medicare Part B premiums would be effective for taxable years beginning after December 31, 1995. The provisions relating to additional health care premiums would not become effective until January 1, 1998.

**C. Payments to Regional Alliance Health Plans (secs. 6201 and 6202)*****In general***

Under the bill, each regional alliance would contract with various health plans interested in providing benefits to individuals residing in the alliance area. Participating plans would submit a per capita premium bid for providing the comprehensive benefit package to individuals residing within the alliance area.

In addition, under the bill, recipients of Aid to Families with Dependent Children (AFDC)<sup>52</sup> and supplemental security income (SSI)<sup>53</sup> benefits would remain eligible for medical coverage through their State's Medicaid program<sup>54</sup> but would also be required to enroll in a regional alliance health plan to receive the health care items and services included in the comprehensive benefit package.<sup>55</sup> Payments to a health plan for the coverage of AFDC and SSI recipients would be unrelated to the plan's per capita premium bids. The Secretary of Health and Human Services (the Secretary) would separately determine AFDC and SSI per capita premiums for each regional alliance in a State. The same AFDC and SSI per capita premium would apply to each health plan in a regional alliance. The AFDC and SSI per capita premiums would generally equal a State's per capita Medicaid spending for AFDC and SSI recipients residing in the alliance area with respect to items and services included in the comprehensive benefit package.<sup>56</sup>

Because each health plan's per capita premium could differ from the AFDC and SSI per capita premiums, and because the enrollment of AFDC and SSI recipients among plans would vary, the bill would require regional alliances to calculate "blended plan per capita payment amounts" or "blended premiums" for participating plans each year. To determine a participating plan's blended premium, the regional alliance would use a formula that would combine the plan's per capita premium and the AFDC and SSI per capita premiums but would treat each participating plan as if it enrolled the same percentage of non-AFDC/SSI and AFDC/SSI recipients as the alliance enrolled as a whole. The blended premium would apply to all individuals enrolled in the plan.

<sup>52</sup> Under the bill, the term "AFDC recipient" would include an individual who is receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A or part E of title IV of the Social Security Act for the month (sec. 1902(3)).

<sup>53</sup> Under the bill, the term "SSI recipient" would include (1) an individual with respect to whom supplemental security income benefits are being paid under Title XVI of the Social Security Act for the month, (2) an individual who is receiving a supplementary payment under section 1616 of such Act or under section 212 of Public Law 93-66 for the month, or (3) who is receiving monthly benefits under section 1619(a) of the Social Security Act (whether or not pursuant to section 1616(c)(3) of such Act) for the month (sec. 1902(33)).

<sup>54</sup> Under present law, in general, AFDC and SSI recipients receive medical coverage through Medicaid. Each State administers its own Medicaid program and receives partial funding from the Federal government.

<sup>55</sup> Section 4201(a).

<sup>56</sup> Section 9012.

*Comment:* By calculating a blended premium for health plans in this manner, the advantages or disadvantages of providing coverage to AFDC and SSI recipients would be spread evenly among all health plans in a regional alliance.

The regional alliance would use the blended premiums to calculate the actual payments made to participating plans. The bill would require the regional alliance to reduce a plan's blended premium by an administrative allowance percentage which could not exceed 2.5 percent. The bill would also require the regional alliance to reduce a plan's blended premium by an additional 1.5 percent. Amounts attributable to the 1.5 percent would be sent to the Federal government for the support of academic health centers and graduate medical education. A plan's blended premium would also be reduced, if necessary, to maintain health care expenditures within the regional alliance's per capita premium target set by the National Health Board.<sup>57</sup>

Finally, regional alliances would adjust each plan's reduced blended premium to take into account the relative actuarial risk associated with the individuals covered under the plan in accordance with a risk-adjustment methodology developed by the National Health Board.<sup>58</sup>

*Comment:* Section 1341(a)(2)(E) of the bill would require regional alliances to provide health plans interested in submitting bids with information relating to the risk-adjustment factors and reinsurance methodology and payment amounts (published under section 1341(c)) to be used by the regional alliance in computing blended plan premiums in accordance with section 6201 of the bill. Section 1341(c) would require each regional alliance to compute and publish the risk-adjustment factors and reinsurance payment amounts to be used by the regional alliance in computing blended premiums under section 6201 of the bill. However, the calculation in section 6201 for determining blended premiums does not include risk-adjustment factors and reinsurance payment amounts. Under section 1351(c), risk-adjustment factors would apply to blended premiums after such amounts are calculated. Thus, it is not clear why sections 1341(a)(2)(E) and 1341(c) refer to section 6201 rather than section 1351(c).

Payments to veterans health plans of the Department of Veterans Affairs, Uniformed Services Health Plans of the Department of Defense, and health programs of the Indian Health Service would be calculated in accordance with special rules set forth in the bill.<sup>59</sup>

### ***Calculation of blended premium***

#### *In general*

Each participating plan's blended premium for a year would equal the sum of (1) the plan bid component for the plan, (2) the

<sup>57</sup> Section 1351(b)(2).

<sup>58</sup> Sections 1351(c), 1541, and 1542.

<sup>59</sup> Section 1351(e).

AFDC component for the alliance, and (3) the SSI component for the alliance, multiplied by any adjustment factor which would be applied for the year under section 6202(d) of the bill.

*The plan bid component*

The plan bid component for a participating plan would be the product of the final accepted bid for the plan and the plan bid proportion.

*The final accepted bid.*—The final accepted bid for a plan would be the per capita premium bid for providing the comprehensive benefit package to individuals residing within the alliance area as agreed to by the regional alliance and the plan. The final accepted bid also would reflect voluntary reductions made by the plan to its per capita premium bid to avoid a mandatory plan payment reduction.

*The plan bid proportion.*—The plan bid proportion for a year would be a percentage equal to one minus the sum of the AFDC proportion and the SSI proportion. The AFDC proportion for a year would be the ratio of the average of the number of AFDC recipients enrolled in the regional alliance's health plans for the year to the average of the total number of individuals enrolled in the regional alliance's health plans for the year. The SSI proportion for the year would be calculated in the same way. For example, assume that there are 1000 alliance-eligible individuals and that 100 of those individuals would be receiving AFDC payments and 100 of those individuals would be receiving SSI benefits. Under this example, the AFDC and SSI proportions would each equal 10 percent and the plan bid proportion would equal 80 percent.

*Comment:* Section 6202(a)(1) of the bill states that the plan bid proportion should be determined "for a class of enrollment." Sections 6202(a)(2) and (3) of the bill state that the AFDC and SSI proportions should be determined "for a class of family enrollment." The bill does not specifically define either phrase but generally the term class of enrollment in the bill means one of the four premium classes under the bill (i.e., individual, couple only, single parent, or dual parent). It is unclear why the bill refers to classes of enrollment to calculate the plan bid, AFDC and SSI proportions because the premiums to which the proportions are applied are per capita premiums and have not been converted into premiums for each type of family class. In addition, the blended premium is a per capita amount and payments to health plans are based on adjusted blended premiums.

States would determine the AFDC and SSI proportions based on the best available data at least one month before the date health plans would be required to submit bids to regional alliances for the next calendar year. For the purpose of determining the number of AFDC and SSI recipients enrolled in a regional alliance, Medicare-eligible AFDC and SSI recipients would be excluded.

*The AFDC component*

The AFDC component for each regional alliance would be the product of the AFDC per capita premium for the regional alliance for the year (as determined under section 9012 of the bill) and the AFDC proportion described above. The Secretary would determine the AFDC per capita premium for each regional alliance in a State. The AFDC per capita premium for a regional alliance would equal the product of (1) the per capita State Medicaid expenditures for the comprehensive benefit package for AFDC recipients for the State for the year and (2) the regional alliance adjustment factor for the year for the regional alliance.

*Per capita State Medicaid expenditures.*—The per capita State Medicaid expenditures for the comprehensive benefit package for AFDC recipients for a year would be equal to the gross amount of payments under the State Medicaid plan with respect to health care items and services included in the comprehensive benefit package for AFDC recipients in fiscal year 1993<sup>60</sup> divided by the number of AFDC recipients enrolled in the State Medicaid plan in fiscal year 1993. The Secretary would rely on actual reports from the State to determine the number of AFDC recipients in the State in fiscal year 1993.<sup>61</sup> The amount of the per capita State Medicaid expenditures for fiscal year 1993 would be adjusted to take into account increases in Medicaid spending between the end of fiscal year 1993 and the year before the first year a State implemented health care reform. The amount of a State's fiscal year 1993 Medicaid expenditures for AFDC recipients would be increased by the lesser of (1) 32.2 percent if 1996 is the State's first year of health care reform (the first year), 46.6 percent if 1997 is the State's first year, or 62.1 percent if 1998 is the State's first year, or (2) the actual estimated rate of increase in per capita State Medicaid expenditures between fiscal year 1993 and the year before the State's first year as determined by the Secretary. The Secretary would be required to adjust its estimate so as to eliminate any change in Medicaid expenditures that are attributable to a reduction in the scope of services, an arbitrary reduction in payment rates, or a reduction in access to high quality services under the State Medicaid plan. For a State's first year and each year thereafter, the National Health Board would increase the State's per capita State Medicaid expenditures by a factor equal to 1 plus the general health care inflation factor for the year (as defined under section 6001(a)(3) of the bill).

*Regional alliance adjustment factors.*—The bill would require the Secretary to calculate per capita Medicaid expenditures for AFDC recipients on a State-wide basis. If the State established more than one regional alliance, the bill would require the State to calculate a regional alliance adjustment factor for each regional alliance. The Secretary would multiply the State's per capita Medicaid expenditures by the regional alliance adjustment factor to determine the alliance's AFDC per capita premium.

<sup>60</sup> For the purpose of determining a State's Medicaid expenses in 1993, expenses for which no Federal financial participation was provided would be excluded. In addition, disproportionate share payments under section 1923 of the Social Security Act would also be excluded.

<sup>61</sup> Section 9014(a).

The regional alliance adjustment factor would reflect variations in each regional alliance's per capita premium targets as well as variations in Medicaid spending across regional alliances where the weighted average of such factors would be one. For the purpose of computing adjustment factors, the weighted average would be determined based on the number of AFDC recipients enrolled in each regional alliance in a State. In determining the number of AFDC recipients enrolled in a State, States would be required to use the same data that would be used to determine the AFDC and SSI proportions (described above).

#### *The SSI component*

The SSI component for each regional alliance would be the product of the SSI per capita premium amount for the regional alliance for the year (as determined under section 9013 of the bill) and the SSI proportion described above. The Secretary would determine the SSI per capita premium for each regional alliance in a State for the year in the same manner as it would determine the AFDC per capita premium for the regional alliance, except that the percentages applied to account for increases in State-Medicaid spending for SSI recipients between fiscal year 1993 and a State's first year would be different. The percentages would be 29.4 percent if a State's first year is 1996, 43.7 percent if a State's first year is 1997, and 58.8 percent if a State's first year is 1998.

#### *Blended premium adjustment factor*

Under the bill, blended premiums would be calculated based on each State's projected estimate of the proportion of AFDC and SSI recipients that would enroll in the regional alliance in the following calendar year (referred to as the reference year). If a State's projected AFDC or SSI proportions for the reference year prove to be incorrect based on actual enrollment data, the bill would require the regional alliance to increase or decrease each participating plan's blended premium in the following year (referred to as the applicable year) to eliminate any underpayment or overpayment to participating plans in the reference year. The provision would also permit the Secretary to adjust incorrect blended premiums during the reference year with final adjustments in the applicable year as provided in regulations.

The regional alliance would determine the amount of any adjustment as follows. The regional alliance would first determine the amount of any underpayment or overpayment to participating plans in the reference year by calculating the difference between (1) the total amount paid to participating plans in the reference year using projected AFDC and SSI proportions to compute blended premiums and (2) the total amount that would have been paid to participating plans in the reference year using actual AFDC and SSI proportions to compute blended premiums. Next, the regional alliance would determine an adjustment percentage based on the ratio of the underpayment or overpayment to participating plans in the reference year to the amount of the total blended premiums which the regional alliance estimates it would pay to all participating plans in the applicable year. If participating plans were underpaid in the reference year due to incorrect projections, the blended

premiums for the applicable year would be increased by the adjustment percentage. On the other hand, if participating plans were overpaid in the reference year due to incorrect projections, the blended premiums would be reduced by the adjustment percentage.

*Example of a blended premium calculation:* Assume that the final accepted bid for Plan A is \$2,000 and the plan bid proportion for Plan A is 60 percent for 1997. Thus, the plan bid component for Plan A would equal \$2,000 times 60 percent, or \$1,200.

Further assume that the AFDC per capita premium for the regional alliance in which Plan A participates is \$1,800, the SSI per capita premium is \$1,700, the AFDC proportion is 30 percent, and the SSI proportion is 10 percent for 1997. Thus, the AFDC component would equal \$1,800 times 30 percent or \$540 and the SSI component would equal \$1,700 times 10 percent or \$170. Plan A's blended premium for 1997 would equal \$1,200 plus \$540 plus \$170 or \$1,910 in 1997.

Assume, however, that the State incorrectly projected the AFDC and SSI proportions used by the regional alliance to calculate Plan A's blended premium for 1997 and that the correct AFDC and SSI proportions were 35 percent and 15 percent, respectively. Thus, the plan bid proportion should have been 50 percent. Plan A's blended premium based on corrected proportions would equal \$1,000 (\$2,000 times 50 percent), plus \$255 (\$1,800 times 35 percent), plus \$255 (\$1,700 times 15 percent) or \$1,855.

The regional alliance would reduce Plan A's 1998 blended premium to correct the overpayment to Plan A for 1997 as follows. The regional alliance would first determine the difference between the amounts paid to all plans in 1997 and the amount that should have been paid in 1997 based on actual enrollment. Assuming that Plan A is the only plan in the alliance, the difference would be \$25 (\$1,910 minus \$1,855). The regional alliance would then determine an adjustment percentage to be applied to Plan A's blended premium in 1998. The adjustment percentage would be the ratio of \$25 to the total estimated blended premiums for 1998. Plan A's blended premium for 1998 would be decreased by the adjustment percentage.

### III. EXAMPLES OF PREMIUM CALCULATIONS

#### A. Example 1: Regional Alliances

##### 1. Assumptions

For a given year, a regional alliance receives bids from two health plans. Plan A submits a per capita bid of \$1,500. Plan B submits a bid of \$1,600.

The National Health Board has set the per capita premium target for the alliance for the year at \$1,550. The Board has set the national premium class factor (applicable to all regional alliances) for the single parent class of enrollment at 2.05, and for the dual parent class of enrollment at 2.25. (The premium class factors for the individual class and the couple-only class are statutorily specified to be 1.0 and 2.0, respectively.)

The regional alliance has calculated its uniform per capita conversion factor to be 1.25. The alliance estimates that 10,500 regional alliance eligible individuals reside in the alliance, and that these individuals are members of 4,000 separate families. The alliance estimates that 1,000 families will be in the individual class of enrollment, 1,000 will be in the couple-only class of enrollment, 1,000 will be in the single parent class of enrollment, and 1,000 will be in the dual parent class of enrollment. The alliance further estimates that each couple-only family, on average, will include 1.5 full-time equivalent wage earners, and that each dual parent family will include, on average, 1.3 full-time equivalent wage earners. (In other words, there would be a total of 1,500 full-time equivalent wage earners in the couple-only class of enrollment, and a total of 1,300 full-time equivalent wage earners in the dual parent class of enrollment.)

The regional alliance also estimates that \$500,000 of the total payments it expects to be owed for the year are not likely to be collected. Lastly, the alliance estimates that 75 percent of the participants in each class of enrollment will choose Plan A, and 25 percent will choose Plan B.

##### 2. Premium calculation for each plan

Based on the per capita bids submitted to the regional alliance by each health plan, and using the premium class factors and uniform per capita conversion factors, the alliance would calculate a premium amount for each health plan in the alliance:

	(A) Plan A	(B) Plan B	Weighted average (.75A+.25B)
(a) Per capita bid .....	1,500	1,600	1,525
(b) Uniform per capita conversion factor .....	1.25	1.25	.....
(c) Plan premium for an individual ((a) × (b)) .....	1,875	2,000	1,906
(d) Plan premium for couples ((c) × 2.0) .....	3,750	4,000	3,813
(e) Plan premium for single parent enrollment ((c) × 2.05) .....	3,844	4,100	3,908
(f) Plan premium for dual parent enrollment ((c) × 2.25) .....	4,219	4,500	4,289

Note that the weighted average bid for the alliance (\$1,525) is less than the per capita premium target for the alliance (\$1,550). As a result, the premium caps will not be triggered, and Plan B will not be subject to any reductions, even though the per capita bid for Plan B exceeds the regional alliance target.

### **3. Employer share/family share of premiums for each class of enrollment (generally)**

For each class of enrollment, the regional alliance would calculate the base employment premium (i.e., the amount that would be due from each employer for each full-time employee (or reduced proportionally for part-time employees)), and the family share of premiums for each family. The following family share amounts would apply to any family including a total of at least one full-time equivalent employee that qualifies for no other credits or discounts.

#### *Individuals:*

Base employment premium:  $80\% \times \$1,906 = \$1,525$

#### Family share

Plan A:  $\$1,875 - 80\%(\$1,906) = \$350$

Plan B:  $\$2,000 - 80\%(\$1,906) = \$475$

#### *Couple-only:*

#### Base employment premium

(equal to 80% of the total premiums for couple-only families divided by the number of full-time equivalent employees in the couple-only class)

$$80\% \times (\$3,813 \times 1,000) / 1,500 = \$2,033$$

#### Family share

Plan A:  $\$3,750 - 80\%(\$3,813) = \$700$

Plan B:  $\$4,000 - 80\%(\$3,813) = \$950$

#### *Single parent:*

Base employment premium (also applies to dual parent class):

(equal to 80% of: the total premiums for single parent families plus the total premiums for dual parent families, divided by the number of full-time equivalent employees in both classes)

$$80\% \times [((\$3,908 \times 1,000) + (\$4,289 \times 1,000)) / (1,000 + 1,300)] = \$2,851$$

**Family share**

Plan A:  $\$3,844 - 80\%(\$3,908) = \$718$

Plan B:  $\$4,100 - 80\%(\$3,908) = \$974$

**Dual parent:**

Base employment premium (as calculated above) = \$2,851

**Family share**

Plan A:  $\$4,219 - 80\%(\$4,289) = \$788$

Plan B:  $\$4,500 - 80\%(\$4,289) = \$1,069$

**Shortfall add-ons**

**Assumptions:**

Of the 10,500 regional alliance eligible individuals residing in the alliance area, 500 are members of families whose family share of premiums is zero (e.g., because they are AFDC or SSI recipients, or their adjusted income is less than \$1,000).

**Per capita shortfall amount:**

The per capita collection shortfall amount would be:

$$\$500,000 / (10,500 - 500) = \$50 \text{ per person}$$

To determine the amount of shortfall payment to be paid by each employer and each family in the alliance, the same formulas are used as were used to calculate the premium amount for each plan, but the per capita shortfall amount is substituted for the per capita bid amount:

**Family share:**

	(A) Total	Family share 20% × (A)
(a) Per capita shortfall amount .....	50	.....
(b) Uniform per capita conversion factor .....	1.25	.....
(c) Individual class ((a) × (b)) .....	63	13
(d) Couple-only class ((c) × 2.0) .....	125	25
(e) Single parent class ((c) × 2.05) .....	128	26
(f) Dual parent class ((c) × 2.25) .....	141	28

Note: Due to rounding, some of the calculations may appear inconsistent.

**Employer share:**

Individuals:  $80\% \times \$63 = \$50$

Couple-only:  $80\% \times (\$125 \times 1,000) / 1,500 = \$67$

Single parent/Dual parent:  $80\% \times [((\$128 \times 1,000) + (\$141 \times 1,000)) / (1,000 + 1,300)] = \$94$

### ***Specific employer calculation***

#### ***Assumptions:***

ABC Co. employs 20 full-time workers and 50 half-time (i.e., 60 hours per month) workers, all of whom are qualifying employees residing in the regional alliance described above. All of the full-time workers are in the couple-only class of enrollment, and all of the half-time workers are in the individual class of enrollment. This year, ABC Co. pays all of its workers a total of \$900,000 in wages. The amount it would pay to the regional alliance is calculated as follows.

#### ***Base employment premiums:***

The base employment premiums of \$1,525 per employee in the individual class and \$2,033 per employee in the couple-only class (as calculated above) would be utilized to calculate the total base employment premiums for ABC Co.

- (a) Individual class (25 full-time equivalent employees)  
 $25 \times \$1,525 = \$38,125$
- (b) Couple-only class (20 full-time equivalent employees)  
 $20 \times \$2,033 = \$40,660$
- (c) Total base employment premiums ((a) + (b))  
 $\$38,125 + \$40,660 = \$78,785$

#### ***Percent of payroll caps:***

ABC Co. would first calculate its average annual wage per full-time equivalent employee (i.e., total wages paid to qualifying employees divided by the number of full-time equivalent employees):

$$\$900,000/45 = \$20,000$$

The bill provides that an employer with between 25 and 50 full-time equivalent employees earning an average annual wage of between \$18,001 and \$21,000 would be subject to a payroll cap of 7.1 percent. Applying the payroll cap to ABC's total payroll of \$900,000, we get  $7.1 \text{ percent} \times \$900,000 = \$63,900$ .

Because the cap is less than the total base employment premiums calculated above, ABC will only be required to pay to the regional alliance \$63,900 in base employment premiums this year.

#### ***Shortfall add-on:***

- Individual employees:  $25 \times \$50 = \$1,250$
- Couple-only employees:  $20 \times \$67 = \$1,340$
- Total shortfall add-on:  $\$1,250 + \$1,340 = \$2,590$

Because the percent of payroll caps do not apply to the shortfall add-on, ABC Co. will have to pay an additional \$2,590 to the regional alliance (to compensate for a portion of the alliance's bad debts). Thus, ABC Co. will make payments to the regional alliance totalling \$66,490 this year.

***Specific family calculation (for a low-income family)******Assumptions:***

The Green family consists of two adults and one child (i.e., they are in the "dual parent" class of enrollment). They have selected Plan A for their health care coverage (although they were eligible to enroll in either Plan A or Plan B). Mr. Green had regular employment of 60 hours every month during the year, and Mrs. Green had regular employment of 40 hours every month during the year. Their family adjusted income for the year was \$12,000. Of this adjusted income, \$9,000 was from Mr. and Mrs. Green's regular employment, and the other \$3,000 was from odd jobs which never amounted to more than 40 hours of employment per month (i.e., employment with respect to which no employer premium payments were required). The applicable poverty level for this year is \$10,000, and the income threshold amount is \$1,000. Neither of the Greens' employers have made any voluntary premium payments in excess of the required employment premium amounts. The family share of premiums would be calculated as follows.

***Base amount of family premiums:***

The base amount of premiums for the Greens would be equal to the premium for the plan they select, plus the family share of the shortfall add-on:

$$\$4,219 + \$28 = \$4,247$$

***Credits and discounts:******Alliance credit***

Every family is entitled to an alliance credit of 80 percent of the weighted average premium for their class of enrollment:

$$80\% \times \$4,289 = \$3,431$$

***Income-related discount***

The Greens would also qualify for an income-related discount. First, the "family obligation amount" would be calculated, based upon the Green's \$12,000 of adjusted income, the assumed income threshold amount of \$1,000, the assumed poverty level of \$10,000, the calculated weighted average premium for the dual parent class of \$4,289, the calculated alliance credit of \$3,431, and the 3-percent formula specified in the bill:

$$[(3\% \times \$10,000)/(\$10,000 - \$1,000)] \times (\$10,000 - \$1,000) = \$300$$

plus,

$$[(\$4,289 - \$3,431) - (3\% \times \$10,000)] / (50\% \times \$10,000) \times (\$12,000 - \$10,000) = \$223$$

for a total of  $\$300 + \$223 = \$523$ . However, the bill provides that the family obligation amount is limited to 3.9 percent of adjusted income. In this case, 3.9 percent of \$12,000 is \$468. Thus, the family obligation amount for the Green family is only \$468.

The amount of the income-related premium discount is equal to 20 percent of the weighted average premium, less the family obligation amount:

$$(20\% \times \$4,289) - \$468 = \$390$$

*Excess premium credit*

Because the example assumes that no plan payment reductions were necessary (because the weighted average bid was less than the premium target for the alliance), there will be no excess premium credit.

*Corporate alliance opt-in credit*

For simplicity, assume that there are no large employers with employees residing in the regional alliance area who are eligible to form a corporate alliance, but instead participate in the regional alliance. Thus, there will be no corporate alliance opt-in credit.

*Total credits and discounts*

The Greens would be entitled to total credits and discounts of  $\$3,431 + \$390 = \$3,821$ .

*Repayment obligation:*

Because Mr. and Mrs. Green's total employment is less than one full-time equivalent worker, they must repay a portion of the alliance credit.

First, the general repayment obligation amount would be calculated. It is equal to the base employment premium for the class of enrollment, here \$2,851.

Because both of the Greens were employed on a part-time basis, their repayment obligation is partially reduced. Mr. Green's employment is the equivalent of .5 full-time employee (calculated as 60 hours/120 hours). Mrs. Green's employment is the equivalent of .33 full-time employee (calculated as 40 hours/120 hours). Together, their employment is the equivalent of .83 full-time employee. Their repayment obligation would therefore be reduced by  $.83 \times \$2,851$ , or \$2,366. The reduced repayment obligation thus would be equal to \$2,851 less \$2,366, or \$485.

The Greens' repayment obligation, however, would also be limited based on their income. First, the Greens' "wage-adjusted income" would be determined. This amount equals the family's adjusted income less any wages with respect to which an employer was required to pay employment premiums: \$12,000 less \$9,000, or \$3,000.

Then, the amount of liability would be calculated, based upon the Greens' wage-adjusted income of \$3,000, the assumed poverty level of \$10,000, the assumed income threshold amount of \$1,000, and the 5.5-percent formula specified in the bill:

$$[(5.5\% \times \$10,000) / (\$10,000 - \$1,000)] \times (\$3,000 - \$1,000) = \$122$$

Thus, the Green's repayment obligation would be limited to \$122.

*Total family share:*

After considering all available credits and discounts, the Green family's share of premiums would be the base amount, less the credits and discounts, plus the repayment obligation:

$$\$4,247 - \$3,821 + \$122 = \$548$$

*Self-employed individuals**Individual class of enrollment:**Assumptions*

Self-employed individual John Doe, who is single and has no dependents, has net earnings from self-employment for a year of \$60,000, and enrolls in Plan A. John has no employees. Under the bill, he is treated as his own employer for purposes of calculating the premium owed.

*Premium payment required*

John Doe's total premium payment would be calculated as follows:

$$\begin{aligned} \text{Employer share: } & 80\% \times \$1,906 = \$1,525 \\ \text{Employer share of shortfall add-on (see above): } & \$50 \\ \text{Family share: } & \$1,875 - 80\% (\$1,906) = \$350 \\ \text{Family share of shortfall add-on (see above): } & \$13 \\ \text{Total required premium payment: } & \$1,525 + \$50 + \$350 + \$13 = \\ & \$1,938 \end{aligned}$$

*Couple-only class of enrollment:**Assumptions*

Self-employed individual Jane Jones is married and has no children (that is, she is in the couple-only class of enrollment). Jane's husband (Mr. Jones), works full-time for a regional alliance employer. Jane has net earnings from self-employment for a year of \$60,000 and enrolls in Plan A. She has no employees.

*Premium payment required*

Jane Jones's total premium would be calculated as follows (see above for derivation of the numbers):

$$\begin{aligned} \text{Employer share: } & 80\% \times (\$3,813 \times 1,000) / 1,500 = \$2,033 \\ \text{Employer share of shortfall add-on (see above): } & \$67 \\ \text{Family share: } & \$3,750 - 80\% (\$3,813) = \$700 \\ \text{Family share of shortfall add-on: } & \$25 \\ \text{Total required premium payment from Jane Jones: } & \$2,033 + \$67 \\ & + \$700 + \$25 = \$2,825 \end{aligned}$$

Note: Mr. Jones' employer would also be required to pay to the regional alliance the base employment premium for the couple-only class and the employer share of shortfall add-on, \$2,033 + \$67 = \$2,100. The total payments made to the regional alliance with respect to the Jones family would thus total \$4,925.

## B. Example 2: Corporate Alliance

### *Assumptions*

A corporate alliance offers two health plans in a given premium area, Plan A and Plan B. The alliance estimates that 75 percent of participants in each class of enrollment will choose Plan A and that 25 percent will choose Plan B.

Under the bill, the corporate alliance determines the premiums for each plan for each premium area for each class of enrollment. The corporate alliance determines that the premiums for a given premium area for each plan for each class of enrollment are as shown in the following table. The weighted average premium is also shown.

Class of enrollment	(A) Plan A	(B) Plan B	Weighted average (.75A + .25B)
Individual .....	\$1,875	\$2,000	\$1,906
Couple .....	3,750	4,000	3,813
Single parent .....	3,844	4,100	3,908
Dual parent .....	4,219	4,500	4,289

[Note: In order to make this example comparable to the preceding example for regional alliances, the premium numbers used in the examples are the same. However, the processes by which regional alliance premiums and corporate alliance premiums are arrived at are very different.]

### *Employer share and family share of premiums for each class of enrollment*

For each class of enrollment, the corporate alliance employer is required to pay 80 percent of the weighted average premium for each class of enrollment for each full-time employee enrolled in the corporate alliance plan. [Note, for employees not enrolled in the corporate alliance plan, the employer pays premiums under the rules applicable to regional alliance plans. This could happen in a number of cases. For example, part-time employees receive coverage under the regional alliance plan, not under a corporate alliance plan. If full-time employee who has a spouse the couple could elect to be covered under the spouse's plan (whether through a corporate or regional alliance.)] For a family that is not entitled to any credit or discount other than the alliance credit, the family would pay the difference between the required corporate employer premium and the premium for the plan the family is enrolled in.

### *Individuals:*

Corporate employer premium:  $80\% \times \$1,906 = \$1,525$

**Family share:**

Plan A: \$1,875 - \$1,525=\$350

Plan B: \$2,000 - \$1,525=\$475

**Couple only:**Corporate employer premium:  $80\% \times \$3,813 = \$3,050$ **Family share:**

Plan A: \$3,750 - \$3,050 = \$700

Plan B: \$4,000 - \$3,050 = \$950

**Single parent:**Corporate employer premium:  $80\% \times \$3,908 = \$3,126$ **Family share:**

Plan A: \$3,844 - \$3,126 = \$718

Plan B: \$4,100 - \$3,126 = \$974

**Dual parent:**Corporate employer premium:  $80\% \times \$4,289 = \$3,431$ **Family share:**

Plan A: \$4,219 - \$3,431 = \$788

Plan B: \$4,500 - \$3,431 = \$1,069

Note: The corporate alliance employer premium is higher for the couple, single parent, and dual parent classes of enrollment than the comparable premiums for regional alliance employers. This is because in the case of regional alliance employers, the employer premium is reduced to take into account the fact that there may be more than one worker per family and the regional alliance uses a blended rate for single- and dual-parent families. No such adjustments are made in the case of corporate alliance employers.

***Total employer premium***

The total employer premium (not taking into account any additional premiums for low-wage employees, described below) would be equal to the number of employees in each class of enrollment multiplied by the employer premium for that class of enrollment. In addition, as described below, the employer would have to pay the corporate assessment and would have to pay an additional amount for low-wage employees.

***Additional employer premium for low-wage employees***

Employees who have annualized wages of less than \$15,000 are not required to pay the entire amount of the family share, but are entitled to a premium subsidy. The corporate alliance employer is required to pay the amount the employee would have paid but for the subsidy. In other words, corporate alliance employers are required to pay an additional amount for their low-wage employees.

The amount of the low-wage subsidy is equal to the excess (if any) of (1) 95 percent of the premium for the least expensive plan that is a lower or combination cost sharing plan (as determined for the class of enrollment and premium area) over (2) the amount of the required employer premium (for the class of enrollment and premium area).

In this example, Plan A is a lower cost sharing plan. The additional amount the employer would have to pay for low-wage employees for each class of enrollment is as follows:

Class of enrollment	(A) 95% × Plan A	(B) Required employer premium	Low-wage subsidy (A-B)
Individual .....	\$1,781	\$1,525	\$256
Couple only .....	3,563	3,050	513
Single parent .....	3,652	3,126	526
Dual parent .....	4,008	3,431	577

#### ***Corporate assessment***

In addition to required premiums, corporate alliance employers would have to pay a corporate assessment equal to 1 percent of payroll.

## **IV. ANALYSIS OF THE ECONOMIC EFFECTS OF HEALTH INSURANCE MANDATES**

### **A. Overview**

The bill would require that all individuals purchase health insurance and that employers pay for a portion of the cost of insurance for their employees. The bill raises a number of issues relating to why and how the purchase of health insurance is mandated. These issues can be considered both generally (e.g., the general impact of mandates on an individual's behavior and well being) and under the bill specifically (e.g., the effects that the particular provisions of the bill may have on (1) the decision to hire an employee and (2) the manner in which firms are organized).

### **B. Rationales for Mandated Health Insurance**

#### ***The goals of universal coverage and uniform pricing***

##### *In general*

Universal coverage is an explicit, central goal of the bill. The bill also assumes that some level of uniform pricing is a desirable element. These two goals combine to necessitate a mandate on individuals to be insured.

People differ in their health risks—some have healthy lifestyles and have no history of family illness, while others are more susceptible to either accident or disease, or both. Other things being equal, an insurance company would normally charge people with higher risks higher premiums, because they are expected to use more medical services, at higher cost, than average. Similarly, in a competitive insurance market, the insurer would charge lower premiums to lower risk individuals, because they are expected to have fewer, less costly, claims in a given year.

Economists generally support pricing policies that charge individuals the full cost of the services they purchase. This is because an individual who pays less than the cost of the service will be induced to consume too much of the service from a social point of view. On the other hand, if the individual pays more than the cost of the service he or she will choose to consume too little of it.

Differential pricing of health insurance across individuals of different risk may be either undesirable or impossible (see the discussion below). If insurance must be priced uniformly—either because such an approach is desired by society or because it is necessary—then without a mandate on individuals to be insured (be it through their employer or otherwise), universal coverage will not occur because persons who pay more than the cost of the service they receive will choose not to buy it. If people are not required to purchase insurance at the uniform price, then adverse selection may

occur, with the possible result that only bad risks are left in the insurance pool (see discussion below).

#### *Adverse selection*

Suppose health insurance is priced uniformly for a pool of individuals who have different health risks. At first, high-risk individuals in the pool would benefit from such an arrangement, because their premium would be less than their expected costs (which are higher than average). Low-risk individuals would be disadvantaged because their premium would be higher than their expected costs (which are lower than average). In effect, the good risks would be subsidizing the bad risks in this situation and, if individuals are allowed to choose whether to be insured or not, the good risks might decide that it is better to forgo insurance at such a high price (relative to the value they put on it). When the good risks leave the pool, however, the average cost of those left increases. Prices must increase for the insurer to break even, and the lower-risk individuals will face a premium greater than the value of the insurance. These individuals will then leave the pool. This process of attrition, known as adverse selection, could continue until only the very bad risks are left in the insurance pool.<sup>62</sup> Of course, not all good risks will necessarily leave the pool. Those with high incomes or less willingness to bear risk may be willing to pay a higher price for greater coverage.

If an explicit policy goal of health care reform is universal coverage, then the effects of adverse selection require some government intervention. One response would be for the government to mandate that all individuals buy insurance, so that good risks cannot drop out of the market. In practice this would require that all individuals purchase some minimum level of insurance, covering what is considered a suitable range of services and incorporating suitable cost sharing (e.g., deductibles, coinsurance, and copayments).<sup>63</sup> Such a system could permit individuals who desire more protection to purchase additional insurance, presumably at a cost that reflects actual value.

While the goal of universal coverage is central to many health care reform proposals, adverse selection will mean that, under a mandate with uniform pricing, individuals who face less risk will subsidize those who are more likely to need medical care.

#### *Desirability of uniform pricing*

The main argument against uniform pricing of mandated purchases of goods and services is that individuals with expensive needs or tastes should not receive subsidies from those with more modest needs or tastes. In the context of health services, this argument would take the form that individuals with low health needs should not be required to subsidize those with greater needs. This

<sup>62</sup> Not requiring that all individuals buy insurance would be like trying to redistribute income through the tax system while allowing individuals to decide whether they wished to pay tax or not. The rich would prefer not to be in the system, because they would subsidize the poor. Only a limited amount of redistribution would occur, through charitable organizations.

<sup>63</sup> The determinants of "suitable" in this context are a separate issue. If the government wishes to control health care costs, then the mandated package may be quite limited, and the cost sharing requirements relatively high. On the other hand, a sufficiently wide range of services should be included to satisfy basic medical needs, and the out-of-pocket expenses must be low enough to protect individuals in times of serious illness.

argument is frequently made most strongly where the health risks are the result of life-style choices, such as smoking, drinking, or eating habits. However, the argument may not be particularly compelling. Although redistribution of resources in our society is usually thought of in terms of money income—those who earn more are required to transfer resources to those who earn less—the same moral/ethical principles underlying the redistributive aspects of the Federal (and State) tax and spending programs could apply with equal force to health needs. To the extent that healthy individuals are considered to be better off than individuals with high health care needs, redistribution from the first group to the second is consistent with the general approach of other Federal (and State) programs.

Furthermore, the amount of such redistribution is significantly reduced if the analysis is performed on a longer range basis. Health risk characteristics change over the course of an individual's life. Single men in their twenties have much lower health care needs than women of child-bearing age, who in turn have fewer needs than the elderly.<sup>64</sup> In any given year the health care needs of two different people may vary significantly, but over individuals' lifetimes, such needs are less variable. In this case, redistribution from low- to high-risk individuals in any given year may not represent a large redistribution between individuals over their lifetimes. This argument supports uniform pricing without regard to age as a means of effecting lifetime (as opposed to annual) health insurance.<sup>65</sup>

However, there could be a number of problems with community rating across individuals of different ages. First, younger (generally healthier) people, who in any given year would subsidize older people, may face liquidity constraints, in which case an unreasonable burden might be placed on them. Second, the transitional effects of moving to a system with full community rating might be considered undesirable because the adoption of such a policy would have an equivalent effect to an increase in the national debt.<sup>66</sup> Further, annual community rating could result in a redistribution from people who live short lives to longer lived individuals.<sup>67</sup>

Apart from these possible problems, if society believes that the Federal Government has a role in redistributing not only from rich to poor in the normal sense, but also from healthy to sick, and if effective lifetime insurance is desired, then some degree of uniform

<sup>64</sup> Of course, other factors besides age influence an individual's risk characteristics.

<sup>65</sup> A common concern in current insurance markets is that if an individual has a large medical expense in one year, premiums will increase in all subsequent years. Thus, insurance may cover expenses in a particular year, but may not protect fully against future costs.

<sup>66</sup> To see this, note that in the first few years after a policy change to uniform pricing, members of the current older generation would be subsidized by the current young, without being responsible for subsidizing anyone else themselves. This pattern of transfers is exactly identical to that which would occur in setting up a new pay-as-you-go social security system (where taxes on the current young pay for benefits to the current elderly). In both cases, the current elderly receive a transfer which is paid for by future generations. Similarly, when the national debt is increased, current generations can increase their consumption at the expense of future generations. For more discussion of these issues, see Laurence J. Kotlikoff, *Generational Accounting: Knowing Who Pays, and When, for What We Spend*, (1992) (New York: The Free Press).

<sup>67</sup> For example, suppose one individual lives 80 years, and another lives 40 years. If individuals' medical expenses increase with their age, then the first individual will receive a net transfer from the second.

pricing is desirable. As discussed above, if such a policy is chosen, a mandate is necessary.<sup>68</sup>

#### *Factors that make uniform pricing necessary*

Even without government intervention in pricing decisions, it might be difficult for an insurance company to distinguish among individuals of different risk. Two individuals who are identical in all respects other than their risk of incurring medical expenses would then have to be charged the same premium, equal to the average cost of all policyholders of the particular company. Low-risk individuals would again subsidize high-risk ones, and tend to leave the market. In extreme cases, the market could fail completely, and insurance would not be available to many who were willing to pay more than its actuarial cost. This is inefficient, and a mandate would help reduce the inefficiency.<sup>69</sup>

Currently there is more concern that insurance companies *can* distinguish between individuals of different risk than that they *cannot* do so. That is, policymakers may be more concerned with excessive "cream-skimming" behavior of insurance companies than with their inability to price differentially.<sup>70</sup> This suggests that the desirability of uniform pricing is a stronger argument for a mandate than is the necessity of uniform pricing due to information constraints on firms.

#### *Other rationales for mandates on individuals*

##### *In general*

There are a number of other arguments, independent of the goals of universal coverage and uniform pricing, for requiring individuals to purchase insurance. These stem from the idea that the markets for health care and health insurance are somewhat different from what are commonly thought of as "typical" markets (like those for bread or automobiles). First, individuals may not know what is in their best interests or if they do, this might not conform to what society sees as being in their best interests. Second, the government may not be able to commit to denying health care services to those needing them, in which case individuals will have an incentive to "free ride", that is, to obtain services that others pay for.

##### *Consumer information*

Generally, economists argue that in the absence of public policy goals to the contrary, governments should not interfere in decisions made by individuals about how to spend their money. For example, an individual who chooses to consume more bread and less potatoes

<sup>68</sup> A mandate may not be necessary if the uniform price is set low enough, and large enough government subsidies are provided to everyone. As an extreme example, if the price of the comprehensive package were set at \$1, then it is very likely that everyone would buy it, even without an explicit mandate to do so.

<sup>69</sup> The welfare properties of compulsory insurance *vis à vis* unregulated insurance are difficult to predict in general. However, if universal coverage is an explicit policy goal, then information problems suggest the need for a mandate. See Charles Wilson (1977) "A Model of Insurance Markets With Incomplete Information," *Journal of Economic Theory*, and Michael Rothschild and Joseph Stiglitz (1976) "Equilibrium in Competitive Insurance Markets," *Quarterly Journal of Economics*.

<sup>70</sup> Cream-skimming is also referred to as "cherry-picking", whereby insurance companies try to select the least risky individuals.

probably has a preference for bread, which economists believe should be respected.

It is frequently argued that government intervention is appropriate when individuals are not well informed about the benefits or costs (to themselves or others) of some of their choices. For example, if some parents underestimate the benefits of schooling for their children, they may not send them to school for the appropriate length of time. It may thus be socially beneficial for the government to mandate school attendance. Similarly, if individuals consistently underestimate the chance or potential cost of a car accident, the government might wish to require them to purchase auto insurance. Under this reasoning, if individuals do not understand or appreciate the health risks they face, the government might want to require them to purchase some level of health insurance. Since individuals differ considerably with respect to health needs, the government would have difficulty knowing exactly what level of insurance is appropriate for each person. As a result, the government would be likely to impose relatively uniform insurance requirements on all individuals, regardless of their actual needs or how well informed they actually are.

Some view this argument for government intervention as overly paternalistic (i.e., that the government knows better than at least some individuals what is best for them). If a uniform mandate is imposed, it is likely to impose an unnecessarily high level of insurance on some individuals. To the extent that only some individuals are uninformed about the appropriate level of insurance for themselves, the rest of the population may be forced to conform with an externally imposed level of insurance that they do not desire.

#### *Government commitment*

By buying health insurance, an individual protects himself or herself against the expense of current or future health care needs at the price of giving up some other extra consumption today. Other things being equal, the consumer will buy more insurance if he or she wants further to reduce this risk.

Many societies provide health services to those who need them, even to those who do not pay for the services. Suppose, for example, that an individual has an accident and needs more health care services than her insurance (if any) covers. If the government were to act as it does in the example of bread and potatoes, it would have no reason to intervene; the individual was willing to accept the higher risk in return for a lower premium. But the government will usually not promise to allow accident victims without insurance to die, or to withhold necessary care from other uninsured individuals. By providing at least catastrophic insurance (free of charge), the government could induce some (possibly many) individuals not to purchase insurance themselves. The quantitative significance of the implicit insurance, in terms of the number of individuals that choose not to purchase their own coverage, clearly depends on the quality of the publicly provided care.<sup>71</sup> In such a sys-

<sup>71</sup>For example, long waiting lines in emergency rooms could be necessary to discourage too many people from relying on emergency care. This argument is sometimes used to rationalize high transactions costs in the consumption of other public services, such as unemployment benefits, food stamps, etc. For a more general discussion of these issues see "Stigma and Quality

tem some people will buy insurance, while others "free-ride", i.e., obtain the services without paying for them. Other members of society will pay for the health care of the free-riders, through increased taxes, higher insurance premiums, or other means.<sup>72</sup> To prevent the perceived unfairness of free-riding, the government may mandate that all individuals purchase at least a minimum level of insurance.<sup>73</sup>

The government may attempt to counteract the free-rider problem by committing ahead of time to withholding medical services from the uninsured. If all individuals believed this promise, they would likely buy private insurance, without the need for an explicit mandate. However, not only would such a commitment be considered by some to be morally unpalatable, it would be virtually impossible to make such a commitment credibly. This inability to commit means that an explicit mandate is required.

### ***Rationales for employer mandates***

The bill requires employers to pay a certain amount of the insurance costs of their employees. The arguments for such a financing mechanism are less well established in economic theory than are those for an individual mandate. Some of the more compelling arguments are premised on the assumption that health care reform must proceed leaving the existing health care delivery system in place, and recognize that large changes in organization may be costly. Five possible arguments in favor of an employer mandate are presented below.

First, it may be easier for the government to enforce an employer mandate. This is really an argument about the desirability of withholding of premium payments at source, just as Federal income taxes are withheld.<sup>74</sup> The issues of employer mandates and withholding, however, are distinct. In particular, an employer mandate (a requirement that employers pay some or all of the cost, of insurance for their employees, with the balance being withheld at source) should induce identical compliance rates to an individual mandate with withholding (i.e., a requirement that an individual be insured and pay the full cost through wage withholding, with no employer share). However, these different policies may have different economic consequences, depending on the way wages are set.<sup>75</sup>

as Self-Selection Mechanisms" by Norman J. Ireland (paper presented at "World Bank conference on Public Expenditures and the Poor: Incidence and Targeting").

<sup>72</sup> Charities and private physicians often also provide "free" catastrophic care.

<sup>73</sup> The mandate could have the additional positive effect of helping to control health care costs. It is possible that individuals who rely on emergency treatment are more costly to care for than others that seek more regular and timely treatment, because generally, hospital emergency treatment is more costly than other means of providing comparable treatment. Also, women with access to pre-natal care have lower total costs per healthy child on average than women who see a doctor only at their child's birth. Clearly, the net effect on health spending will depend on the generosity of the comprehensive package. If many high cost services are covered, and utilization rates increase, total health care costs may rise.

<sup>74</sup> As reported in Table 990 of the 1988 *Individual Taxpayer Compliance Measurement Program* (Internal Revenue Service), income tax returns for wage and salary earners were 99.8 percent accurate, in dollar terms, while those for sole proprietors were only 75.2 percent accurate.

<sup>75</sup> See the discussion of hourly employees in the next section.

Second, many individuals currently obtain insurance through their employers.<sup>76</sup> Some commentators view retaining the employer's role in insurance provision as a means of minimizing the disruption that health care reform might impose on the majority of individuals. While it is true that discontinuing employer coverage might be disruptive, such a discontinuation would only occur if employer schemes were expressly prohibited. As long as employers were permitted to continue their current practices of paying some or all of their employees' health premiums, purchasing choices would not be disrupted. In fact, to the extent that individuals who currently choose not to purchase insurance through their employers would be required to do so under the bill, the employer mandate could actually cause disruption instead of avoiding it. Therefore, some argue that there is little merit to the argument that *all* employers should be forced to provide insurance for their workers.

Third, purchasing insurance through a group is both more effective and usually cheaper than purchasing an individual policy. It is more effective because the larger the pool of insured individuals, the more effectively risk is spread. It is often cheaper because of administrative, advertising, and underwriting costs.<sup>77</sup> Some argue that firms offer natural groupings of individuals for this purpose, so employer coverage should be encouraged. However, small businesses are usually not large enough to achieve the efficiencies of group purchase and, if they were, they would be more likely to provide insurance currently. Moreover, under the Health Security Act, the employer mandate is not necessary to obtain the benefit of group rates. The regional and corporate health alliances are intended to serve this purpose.<sup>78</sup>

Fourth, some analysts argue that employers have a responsibility to ensure that employees have sufficient health insurance. This argument is deficient in two respects. First, it is not clear why employers should be responsible for their employees' health insurance any more than they should be responsible for their employees' pur-

<sup>76</sup> In March 1992, 54.5 percent of workers aged 18 to 64 received insurance directly from their employers, while 71 percent received it either directly or indirectly (e.g., through their spouse). These figures are reported in *Sources of Health Insurance and Characteristics of the Uninsured*, Employment Benefits Research Institute, Special Report and Issue Brief, number 133, January 1993.

<sup>77</sup> Large group insurance purchase may be less costly than small group purchase if advertising and underwriting costs per enrollee vary. For example, the advertising activities of a large employer group may consist primarily of internal staff memos, while for small employers, more intensive targeted advertising by insurance companies would be necessary. Also, if insurance companies are permitted (as under present law) to vary premiums on the basis of risk characteristics, then it is worth examining the medical history and lifestyles of small groups to make this adjustment. These examinations, known as underwriting, are costly. On the other hand, as long as all individuals in a particular large group face the same choice of policies, the implied risk pooling makes it less profitable for the insurance company to make detailed examinations of the insured.

The bargaining power of insurance companies may also differ when they are selling to small versus large employee groups. For example, by threatening to take its business elsewhere, a firm with 10,000 employees has more chance of obtaining insurance at a low markup. For small firms, on the other hand, the markup is likely to be higher. Higher markups give insurance companies less incentives to cut costs and provide insurance efficiently. See Peter A. Diamond, "National Health Reform - Comment", presented at the annual meetings of the Allied Social Science Association, Boston, January 1994, for more discussion of these issues.

<sup>78</sup> A related reason that employer provision may be desirable is that purchase through a regional alliance could be closer to individual purchase than group purchase. As Diamond, *ibid.*, has discussed, one of the efficiencies of employer purchase is that the choice of plans is narrowed down by the employer, who then presents a small number of plans to employees to choose from. This advantage however could be attained by mandating that employers (or health alliances) determine the choice of plans, or information about plans, and not that employers actually make payments for insurance on behalf of employees.

chases of other consumption goods such as bread, automobiles, and ski equipment. Second, even if some justification could be articulated for increasing employees' total compensation indirectly through the provision of insurance, it would probably not be achieved through a mandate that employers simply pay for the insurance. As argued more fully in the following section, it is very likely that the employee would bear the cost of employer-provided insurance, so that their total compensation would not increase.

A fifth argument for the employer mandate may be based on the government's desire to provide a subsidy for the purchase of health insurance. If the subsidy can only be provided by allowing employer-paid premiums to be excluded from an individual's taxable income, then the government would want to encourage purchase through the employer. However, it is unclear why an employer mandate is necessary in this case. An individual mandate accompanied by preferential tax treatment for employer provision would appear to give individuals sufficient incentive to purchase insurance through their employers. Moreover, subsidies for the purchase of health insurance can be provided in many ways other than through excluding the cost of employer-provided health care from taxable income.

### **C. Economic Effects of a Health Insurance Mandate**

#### **1. In general**

Conceptually, the health insurance mandate contained in the Health Security Act consists of three components: an individual mandate, an employer financing mandate, and subsidies.

\* **Individual mandate:** The individual mandate under the Health Security Act would require that all individuals be insured. An individual mandate has different effects on individuals depending on whether they are currently insured and on how much they value the mandated coverage and how much it costs. This aspect of the mandate may have small effects on employment.

\* **Employer financing:** The employer mandate in the Health Security Act would require that employers pay a portion of the cost of the comprehensive benefit package. Such financing requirements can have additional effects on individuals' (particularly hourly employees') incentives to work and on employment levels.

\* **Subsidies:** The Health Security Act would subsidize a portion of the otherwise required health care premium of both individuals and employers. The way in which firms and individuals receive subsidies has implications for firm structure and employment decisions.

For simplicity, the following analysis concentrates on single individuals, although distinct issues raised by family coverage are discussed where appropriate.

#### **2. Individual mandates**

##### **a. In general**

The simplest mandate requires each individual to purchase insurance. This kind of mandate is contained in the bill. While the mandate is often referred to as an employer mandate, that term has more to do with the financing of the premium costs rather than

with the responsibility of individuals to be insured. The bill requires unemployed and self-employed individuals to be insured, and employed individuals are required to pay any portion of the premium not required to be paid by their employer and not subsidized by the Federal Government.

Prior to the imposition of the mandate, some individuals would have no insurance, others would have minimal levels, while yet others would have coverage that is at least as generous as the comprehensive benefit package defined in the bill. In general, any particular individual pays a certain premium for insurance which has a particular value to the individual. For an individual currently buying insurance, it can usually be assumed that the value is larger than the premium (otherwise, the individual would not buy it).<sup>79</sup> Those not buying insurance can be thought of as paying a premium of zero and receiving no insurance (so the value of insurance received is zero).

With the introduction of the mandate, all individuals would be required to purchase a certain amount of insurance. This would tend to change the value of the insurance which any given individual has. For example, those who were previously uninsured would probably obtain some value out of the mandated coverage. On the other hand, those who were well insured previously are likely to want to keep the same or similar level of coverage, and thus may not see any change in the value of the coverage they have.

In addition to the basic mandate, the bill includes a number of changes relating to the way health insurance is purchased and priced. For example, insurance would have to be purchased through either a regional or corporate alliance, and premiums would generally be community rated. These changes could affect the premiums that individuals must pay. In particular, the Administration expects that group purchase through the alliance system will lower costs, and that community rating will tend to average costs across individuals of different risk.<sup>80</sup> The bill would also impose ceilings on the increase in health care premiums.

Thus, under the bill, not only could an individual see the value of his or her insurance change, but the individual could also face a different premium. The net change in a given individual's well being can be thought of as being made up of two parts—the change in the premium paid, plus the change in the value of insurance that the individual has.<sup>81</sup> Two special cases can be examined.

First, if an individual is not currently insured, then the value and cost of insurance that the individual has are both zero. The net impact of the bill on the individual's well being would be the difference between the value of the mandated coverage to the individual and the premium that must be paid. If, for example, the premium is larger than the value the individual places on the insur-

<sup>79</sup>This might not be a valid assumption if a group of individuals buys insurance collectively. If they all make the same contributions to the cost of the coverage, then those who would prefer lower coverage might be paying more than the value of the insurance to them. However, this may be preferred to leaving the group and purchasing insurance on an individual basis.

<sup>80</sup>The mandate could affect premiums in other ways. First, if it requires higher levels of insurance, then induced utilization increases may cause premiums to rise. Also, since part of the premium payment is earmarked for medical research, it may be higher than otherwise.

<sup>81</sup>If the net change is negative, then the individual is made worse off.

ance, then the effect is a decrease in well-being equal to the difference between the two.<sup>82</sup>

Next, suppose an individual currently purchases insurance that is at least as generous as the coverage that would be provided under the comprehensive benefit package. In this case, (unless the bill induces the individual to change his or her coverage for some reason), the value the individual places on the insurance should not change. The net impact of the change will be just the change, if any, in the premium the individual must pay.

The bill could also result in other changes in coverage that are not reflected in premiums, but that could affect the value of the coverage and an individual's well-being. For example, waiting times could increase, more services could be provided by health care providers who are not doctors, and choice of providers could be more limited. The quantitative significance of such negative effects is difficult to ascertain. Of course, these effects should be weighed against any positive effects on premiums and insurance coverage.

### **b. Employment effects of an individual mandate**

The changes described above induced by the individual mandate effectively increase or decrease a person's income. Such income changes may, in turn, trigger changes in an individual's employment behavior. Consider first those who suffer a loss: in the face of an unexpected reduction in real income, they may respond by working a bit more, for example, by increasing the overtime they put in (if this is possible), getting a second part-time job (or having their spouse do so), or changing to less palatable but higher-paid work. On the other hand, those who enjoy a net benefit from the reform may respond by working less hard. This type of response by individuals to changes in real income is described by economists as resulting from the "income effect".<sup>83</sup>

The net impact of this change on employment is unlikely to be large. If it is expected that some individuals will gain and some will lose (in terms of the net benefits described above), then the aggregate effect on labor supply may be small. However, for particular individuals, the effect could be significant if the net benefit (or loss) is large enough.

A potentially more important effect may stem from a reduction in the current problem known as "job-lock". Briefly, many analysts note that insurance is currently intimately linked with employment. When an individual leaves a job, he or she often relinquishes the right to current insurance when Federally, or State-required continuation insurance coverage ends and may face experience-rated (and hence potentially higher) premiums when purchasing a new policy or when applying for a new job. In addition, pre-existing conditions may not be covered by the new insurance. These prob-

<sup>82</sup> This result has been used by some commentators to suggest that a mandate is like a payroll tax equal to the difference between the cost and value of the insurance. See, e.g., Lawrence H. Summers (1989) "Some Simple Economics of Mandated Benefits," *American Economic Review*, 79(2), pp 177-183. However, the employer part of the mandate disrupts this simple interpretation somewhat, as discussed in the next section.

<sup>83</sup> The assumption that an increase in income will, other things being equal, cause an individual to work less is the same as assuming that it will cause an individual's use of leisure-time to increase. This assumption, that leisure is what economists refer to as a "normal good", seems reasonable.

lems impose a high cost both in terms of being temporarily unemployed (when the cost of non-group insurance may be high) and in terms of reduced earnings in future jobs (which may provide insurance on an experience-rated basis upon entering the firm).<sup>84</sup> This constraint on leaving a job for a better one can be termed the "lock-in" effect. Community rating, disregarding of pre-existing conditions, and general insurance reform may reduce this labor market inefficiency, with positive effects on the allocation of labor in the economy.

Similarly, in the absence of a mandate, an individual who does not want insurance may choose not to work for a particular firm that includes insurance in the benefits packages of all employees. Such an individual may decide either to work for a firm that pays less in total compensation but more in non-insurance compensation, or not to work at all. This can be thought of as a "lock-out" effect. By forcing the individual to be insured independent of the job he or she chooses, the individual mandate removes the consideration of health insurance from the employment choice.<sup>85</sup>

### 3. Employer mandates

#### a. In general

Under the bill, employers would be required to contribute to the insurance costs of employees. This requirement can be thought of as an additional financing rule. All individuals would be required to be insured, while the premiums of those who are employed would be partially paid by their employer.

Economists usually argue that independent of whether a particular payment on behalf of an employee is made by the employer or employee, the true economic impact of the requirement is the same. For example, although the employer and employee each are required to pay 7.65 percent of the employee's wage in social security taxes, it is usually assumed that the employee bears the full burden of both portions.<sup>86</sup> However, this conclusion is not necessarily valid in the case of the employer mandates contained in the bill. In particular, while the impact of the employer mandate on salaried workers is likely to be similar to that of the pure individual mandate, its effect on hourly wage earners will likely be different. This is because the cost of insurance is not necessarily proportional to an individual's income, but wage reductions for hourly workers are usually effected by proportional decreases in the hourly rate of pay.

<sup>84</sup>These problems are somewhat addressed by the health care continuation rules (Code sec. 4980B). In general, these rules require that qualified beneficiaries that are covered under an employer's group health plan be offered the opportunity to purchase coverage under the plan for a specified period following the occurrence of certain events that would otherwise result in loss of coverage (e.g., a termination of employment). For a further description of the health care continuation rules, see Joint Committee on Taxation, *Description and Analysis of Title VII of H.R. 3600, S. 1757, and S. 1775 ("Health Security Act")* (JCS-20-93), December 20, 1993, p.79.

<sup>85</sup>Empirical evidence on the extent of job-lock is varied. See, for example, Bridgette Madrian (1992), "Employment-based Health Insurance and Job Mobility: Is there Evidence of Job-Lock?", mimeo, Massachusetts Institute of Technology, and Douglas Holtz-Eakin (1993), "Health Insurance Provision and Labor Market Efficiency in the United States and Germany", working paper No. 4388, National Bureau of Economic Research.

<sup>86</sup>The employee pays the employee share of the tax directly, and wages are reduced by the amount of the employer's share. Thus, her net after-tax wage falls by the full portion of the tax. See Joint Committee on Taxation, *Methodology and Issues in Measuring Changes in the Distribution of Tax Burdens* (JCS-7-93), June 14, 1993.

Economists usually assume that, in the long run, wages and salaries adjust so that the full cost is somehow passed on to the employee (who also receives the benefit of insurance). It is possible, however, that the cost will not be fully passed on to workers, but will be borne to some extent by the owners of the firm, or other input suppliers. The issue is not *whether* employers can pass the costs of insurance on to their employees, but *how* they can achieve such a pass through. The extent to which the cost is passed through is not of central importance in this part of the analysis of employment effects, except for minimum wage workers (see below), and the discussion assumes that the worker bears the full burden.<sup>87</sup>

To examine these issues, a mandate where employers are required to pay the full costs of their employees' insurance will be considered first. A partial employer mandate of the type found in the bill will be discussed subsequently. Salaried and hourly employees will be discussed separately.

### **b. Full employer mandate**

#### ***Salaried employees***

Salaried employees can be thought of as earning a certain annual income that is essentially independent of the hours they work or the effort they exert. While it may be true that bonuses and rewards such as promotions can be earned through greater effort, there is usually a fixed base salary amount. For salaried employees, it may be relatively easy for the employer to adjust the base salary to offset the cost to the employer of complying with a full employer mandate without affecting the employees' incentives to work more.<sup>88</sup> For example, if this cost is expected to be passed on to salaried employees, their base salary would be reduced by the full premium.<sup>89</sup> A salaried employee receives insurance which has some value to the employee, so his or her economic income, as in the case of an individual mandate, is increased or decreased by the difference between the premium and the value of the insurance.<sup>90</sup>

Thus, assuming that salaried employees can have their annual income reduced by a fixed amount, the effects of a full employer mandate on salaried employees are likely to be similar to the effects of an individual mandate. In particular, one might expect a small increase in labor supply from those who suffer a net loss in well-being as a result of the reforms and, correspondingly, a small decrease for those with a net benefit.

Also, a full employer mandate may create some incentive for salaried employees to switch between firms that can form corporate alliances and those that cannot. If the quality of the insurance is

<sup>87</sup>This assumption is often made for employment and other taxes. See Joint Committee on Taxation, *Methodology and Issues in Measuring Changes in the Distribution of Tax Burdens* (JCS-7-93), June 14, 1993, for a more complete discussion.

<sup>88</sup>That is, if only the base wage is reduced, and bonuses, promotions, and other rewards for extra effort are not changed, the employees will have the same incentive as before to attain these rewards.

<sup>89</sup>This reduction in base salary may be effected through smaller raises than would otherwise have occurred over time.

<sup>90</sup>In fact, this outcome does not depend on the assumption that the full cost is passed on to the individual. If only half of it was passed on under the employer mandate, then with an individual mandate we would expect to see half of the cost imposed on the individual being shifted to the employer. The net effect is the same.

the same under corporate and regional alliances but the premiums differ, individuals will have an incentive to switch if they will receive the benefit of the cost saving.<sup>91</sup> Since it is unlikely that employers will establish corporate alliances unless their insurance costs would be less than those of the regional alliance, this incentive will exist with respect to all corporate alliances to some degree.<sup>92</sup>

### *Hourly employees*

Any reductions in the wages of hourly employees are usually implemented through a reduction in the hourly rate. In this case, the effect of the full employer mandate on hourly employees is as follows: each employee receives insurance of a certain annual value, which may vary across individuals. Assuming that the employer passes the cost of the premium on to the employee, the hourly wage would be reduced by some fraction that is sufficient to cover the cost of the insurance to the employer.<sup>93</sup>

As an example, suppose an individual earns \$10 per hour before the introduction of a full employer mandate and does not have insurance.<sup>94</sup> The mandated insurance is worth \$1,000 to her and costs the employer \$2,000. Suppose that to pass the full cost on to the employee, the employee's hourly wage must be reduced to \$9 per hour. Then the effect is the same as if the employee were given a lump-sum payment of \$1,000 and a 10-percent tax were levied on her earned income.

The "income effect" for such an hourly employee is the same as discussed in the case of the salaried employee. If the value of insurance is less than the cost to the employee, then the implied decrease in economic income will result in a small increase in labor supply. However, there is an extra effect now on the hourly employee's decision to work: her hourly wage is 10 percent less than it was, so any extra work is rewarded less. This so-called "substitution effect" results in the hourly employee working less, because the return on extra effort has decreased.<sup>95</sup> To the extent that she has control over the number of hours worked, one would expect her to reduce the time that she is willing to work. This reduction in hours may come in the form of less overtime work or a switch to a job with more flexible hours. Thus, the substitution effect, by re-

<sup>91</sup> This incentive also will be available to hourly employees.

<sup>92</sup> See Joint Committee on Taxation, *Description and Analysis of Title VII of H.R. 3600, S. 1757, and S. 1775 ("Health Security Act")* (JCS-20-93), December 20, 1993, for more discussion of the role and nature of corporate alliances.

<sup>93</sup> Because of this structure, a full employer mandate has similar effects on hourly employees to what economists refer to as a "negative income tax". Under a negative income tax, an individual receives a fixed lump-sum grant, and then pays tax proportional to his earned income. Thus, all individuals receive at least the lump-sum grant. In the context of the employer mandate, the annual benefit that each individual receives (in the form of the change in the value of insurance) is similar to the lump-sum grant of the negative income tax (although normally, the lump-sum grant of the negative income tax does not vary among individuals). The proportionate reduction in hourly wages to cover the cost of the premium corresponds to the proportional tax component of the negative income tax.

<sup>94</sup> If the individual works 50 40-hour weeks in a year, she will work 2,000 hours and make \$20,000.

<sup>95</sup> It is called the substitution effect for the following reason. The hourly wage can be thought of as the price of an hour's leisure because an extra hour of leisure could be "purchased" by giving up an hour of work. The extra hour of leisure thus requires the individual to forgo an hour's worth of wages. A reduction in the wage then is like a reduction in the price of leisure. When the price of a good falls relative to that of other goods, we usually see individuals substituting consumption of the first good for that of the others. In this case, the individual would consume more leisure or, equivalently, supply less labor.

ducing the incentive to work, acts in the opposite direction to the income effect.

It should be noted that the disincentive effects of a full employer mandate operating through this "substitution effect" are directly related to the *full* premium, that is, the full cost of providing the insurance, and not to the difference between this cost and the value placed on the insurance. Thus, in the numerical example above, the percentage reduction in the hourly wage had to be large enough (10 percent) to pay for the full cost of the insurance (\$2,000). This is not an insignificant adjustment to take-home wages. Furthermore, the disincentive exists even when the net effect of the purchase is to increase the employee's well-being (i.e., even when the income effect of the mandate is positive).

### ***Distinguishing effects on employment levels and hours worked***

As set forth above, the effects of a full employer mandate on incentives to work would differ for salaried and hourly employees. Both types of employee would face a change in annual economic income equal to the change in the premium they pay less the change in the value of their insurance coverage. The induced changes in labor supply from the income effect could be either in terms of changes in labor force participation rates or changes in hours worked and effort. For example, an individual who experiences a large net increase in well-being due to the reforms may decide not to work, or to work less, while an individual who experiences a reduction in well-being might enter the labor force or work more in his or her current job. Because it is expected that the income effects will be small in the aggregate, they should not induce large changes in employment levels or output.

On the other hand, for hourly employees the principal effect of the reduction in hourly wages should be on hours worked. One would expect to see these employees reduce the number of hours they work, rather than decide not to work.<sup>96</sup> The strength of this substitution effect is related to the *full* cost of the insurance, while the income effect is related to the change in the individual's net economic income. As well as being larger for a given individual, the effect is negative for *all* affected individuals because there are no individuals for whom the proportional wage reduction induces extra labor supply. While not conclusive, this suggests that the substitution effect will be quantitatively more important than will the income effect, and that while employment levels would not change, hours worked by hourly employees, and hence output, would fall.<sup>97</sup>

<sup>96</sup>Of course, if hours are reduced to zero, then participation in the labor force falls.

<sup>97</sup>There is no firm empirical evidence on these issues. It is possible that, if the substitution effect is small (so that individuals are not responsive to changes in their hourly wage rates) but the income effect is large (so that they care significantly about total annual compensation), then the income effect could outweigh the substitution effect. If this were the case, and if it were still expected that the income effects for different individuals will roughly cancel out, then the aggregate employment effects of the mandate, both in terms of numbers of individuals employed and hours worked, could be small.

### c. Partial employer mandates

#### *Effects on individuals*

The bill would not impose a full employer mandate, but rather would require employers to pay only a portion of health care premiums. In the case of salaried employees, because it is assumed that the employer's cost will generally be passed through to the employee, the split between employer and employee payments is generally not important (except from the perspective of their relative tax treatments, discussed below). Thus, for salaried individuals, the effect of the partial employer mandate is just the same as that under a full employer mandate, as discussed above.

In the case of hourly workers, if employer costs are passed on to employees, the wages of such workers must fall by a percentage sufficient to cover the employer's share of the premium. In the numerical example above, if the insurance cost \$2,000, and the employer's share is \$1,600, then the percentage reduction would have to be at least 8 percent<sup>98</sup> rather than at least 10 percent in the previous example, when the employer was required to pay the full amount.<sup>99</sup> Thus, if the share of the premium that the employer pays is lower, the reduction in hourly wages will be smaller and the disincentive to work caused by the substitution effect will also be smaller.

For individuals then, the partial employer mandate determines the manner in which the cost of a particular insurance policy is split between the employer and employee, but does not affect the total amount paid for insurance. For hourly employees, this split determines the amount that is paid as a lump-sum compared to the amount paid through a proportional reduction in wages, with consequent effects on labor supply decisions.

#### *Effects on families*

For families, however, the partial employer mandate in the bill may also affect the total amount paid for a given policy, depending on family employment structure. This can create strong incentives for families to change their employment decisions, because some families may not be treated as having received the total amount that their employer would be required to pay on their behalf.<sup>100</sup> In particular, the amount paid by an employer is related to the employee's employment status (i.e., full-time versus part-time), but the credit received by such an employee may not change with employment status if the employee is a member of a family.

For example, assume that the weighted average premium for an individual class of enrollment is \$2,000 and that an individual elects to participate in a plan with a \$2,000 premium. The em-

<sup>98</sup>This is calculated as follows. First assume that the number of hours worked by the individual stays fixed at 2,000 per year. The reduction in hourly wage,  $\Delta w$ , in money terms, must satisfy the equation  $(\Delta w \times 2,000) = 1,600$  or  $\Delta w = 1,600/2,000 = 80$  cents. This is an 8-percent reduction in the \$10 hourly rate. If this causes the individual to work less, then the \$1,600 cost must be spread over fewer than 2,000 hours, and the proportionate wage reduction must be larger.

<sup>99</sup>Because the employee must pay \$400 annually himself, if he did not previously have insurance, the mandate is like a negative income tax with a lump-sum payment equal to the value of the insurance less \$400, with a marginal tax rate of (at least) 8 percent.

<sup>100</sup>In addition, the design of the employer obligation could create significant disincentives for individuals to marry, depending on the relative size of family and single premiums.

ployer is required to pay 80 percent of the weighted average premium (i.e., \$1,600). The individual receives an alliance credit of \$1,600 and is required to pay the balance of \$400.

However, for families, the employer share and the credit can differ. Suppose that the premium for the average cost plan for the couple-only class of enrollment is \$3,000. If the average number of full-time workers per couple in this class is 1.5, then the premium for a full-time employee for this class is  $\$3,000/1.5 = \$2,000$ . An employer is required to pay 80 percent of this value (\$1,600) towards the cost of insurance for a full-time employee and half of that (\$800) for a half-time employee.

Under the bill, however, the couple receives a credit of (i.e., is deemed to have paid) 80 percent of the full cost of the average plan, equal to \$2,400. For a couple in which one partner works full-time and the other works half-time,<sup>101</sup> the total employer share of the premium is  $\$1,600 + \$800 = \$2,400$ , which equals the credit received by the couple. The couple pays the balance of the premium for their selected plan, so that the employer plus employee contributions equal the actual cost of the plan.

The total employer and employee contributions for couples with non-representative employment patterns may be greater or less than the full cost of their chosen health plan. For example, the employers of a couple with two full-time workers will jointly pay \$3,200 (\$1,600 each), while the couple will receive a credit for only \$2,400, and will still be required to pay \$600 if they have chosen a plan with a \$3,000 premium. Thus, the total contributions of employers and employees will be \$800 more than the cost of the plan. On the other hand, a couple with just one full-time worker would receive a credit (\$2,400) in excess of the employer contribution (\$1,600), and pay in total \$800 less than the cost of the plan (i.e., a total of  $\$2,200 = \$1,600 + \$600$ ). This differential between one- and two-worker couples imposes an implicit tax of \$1,600 on the decision of the second worker to enter the labor force. Presumably, this could amount to a substantial annual burden on a low wage, full-time worker (married to another full-time worker).

These employment incentives and disincentives for families stem from the fact that the employer share of the premium is related to an individual's employment status (i.e., full-time versus part-time), while the credit received by the family may not be affected by the employment status of different members of the family (e.g., a couple with a single full-time worker receives the same credit as one with two full-time workers, and one with one full-time and one half-time worker).

The design of the credit is probably meant to ensure that a family does not receive too large a credit. For example, if the credit were \$2,400 per full-time worker, a couple with two full-time workers would receive total credits (\$4,800) far in excess of the cost of the plan. On the other hand, the employer share may be designed to be fair to employers (since the share is proportional to the employee's employment status). That is, an employer should not have to pay 80 percent of the full premium cost (for the average cost plan) for an employee who only works part-time. Such a fairness

<sup>101</sup>That is, this couple has the exact characteristics of the average couple for this class.

objective is probably not well placed, however, once it is understood that the economic incidence of the mandate (i.e., who bears the costs of the mandated coverage) is independent of the statutory incidence (i.e., who is responsible for writing the checks to the alliances).<sup>102</sup> Thus, if it is assumed that the employer contributions are passed on to the worker in the form of lower wages, then there is no need to "be fair" to employers, since they are not affected by the mandate.

These labor market distortions could be removed by making the employer contribution equal to the credit received. However, the problem with such an approach is that the employer of one member of a family would need to know the employment status of the other members, and the contributions being made by their employers (which in turn depend on the contribution made by the first employer), in order to calculate its contribution. This would be administratively difficult and costly. It is difficult to tell if the real economic costs resulting from distorted labor supply decisions would be less than the administrative costs (which are equally real) associated with matching family credits and employer contributions. Of course, this problem would not arise if the mandate were not based on employment.

#### **d. Other issues regarding employer mandates**

##### ***Determining the value of insurance to workers***

There are a number of reasons to expect the value of insurance to vary across individuals. First, individuals may have different medical needs. For example, suppose a comprehensive health insurance plan includes long-term care, which is predominantly used by the elderly. A young healthy individual would place a very low value on the probability that he or she will need such care in the current year, so such an individual would not value that part of the insurance. If only young and healthy people were included in the insurance pool, the cost of including long-term care in the package would be small, because there would be very low utilization rates. However, if the insurance package is available to other individuals who are more likely to need long-term care, then this aspect of the package will tend to make it more costly than it is worth to the young person. Similarly, if the package includes accident insurance and is offered to workers in dangerous occupations (working with heavy machinery, for example) as well as to those in less dangerous jobs (such as a clerical job), then the individuals in the less dangerous jobs are likely to value the accident insurance coverage at less than its cost, other things being equal. This reasoning suggests that whenever insurance is priced uniformly across individuals, some will value it above cost, while others will value it below cost.<sup>103</sup>

Another reason individuals may place different values on insurance is that they have different incomes. Low-income individuals are likely to value insurance less than those with high incomes for

<sup>102</sup> This argument is true in the long run, that is, after wages and prices have had time to adjust. In the short run, when labor contracts, etc., are fixed, the economic incidence may be closely related to the statutory incidence. To the extent that the bill would only gradually phase in, there could be sufficient time for wages and prices to adjust in anticipation of the changes.

<sup>103</sup> See the discussion on adverse selection in Part IV.B., above.

at least two reasons. First, one of the benefits of employer-provided health insurance is that it is a tax-free form of compensation. The benefit of shifting compensation from taxable wages to non-taxable health insurance is proportional to an individual's marginal tax rate. Thus, if a \$1,500 policy is purchased, an individual with a marginal tax rate of 20 percent saves \$300 (i.e., 20 percent of \$1,500), while an individual with a marginal tax rate of 30 percent saves \$450 (30 percent of \$1,500). Therefore, low-income individuals may value employer-provided insurance less than high-income individuals due to its tax treatment.<sup>104</sup>

The second reason that low-income individuals may place a lower value on health insurance than do high-income individuals is that, even if there is a tax benefit associated with the insurance, a \$2,000 policy will necessarily make up a larger fraction of a low-income individual's expenditures on goods and services than it will of the expenditures of a high-income individual. For example, a very poor person with income of only \$4,000 would be unlikely to want to spend half of her income on health insurance because other goods, like food, clothing, and shelter, could constitute a higher priority. Such a person would probably value the insurance at much less than \$2,000. An individual making \$100,000 a year would be more likely to spend at least 2 percent of his or her income on insurance since other basic needs would be easily satisfied.

A further reason that individuals may value insurance differently is that, under the bill, families with children pay the same premium, independent of the number of children they have. Other things being equal, a large family would therefore tend to value a given insurance package more than a small family.

### ***Minimum wage employees***

The previous discussion has assumed that employers can adjust cash wages. If cash wages cannot adjust downward in response to the mandated employer premium payments, the total cost to the employer of employing an individual will rise. If employers cannot absorb these additional costs, they will be forced to lay off employees whose cash wages cannot fall.

An important class of such employees is minimum-wage employees. In effect, an employer mandate acts as an increase in the total minimum wage paid by the employer equal to the cost of insurance. The possibility that such an increase will lead to unemployment has long been recognized. However, debate over the empirical significance of the effect has been more contentious.<sup>105</sup> Estimates of induced unemployment vary widely—in fact, one recent study of

<sup>104</sup>This aspect of the tax treatment of health insurance is not changed under the bill with respect to the mandated benefits. Many employers that provide insurance do not pay the full cost (so that some portion of the premium is paid with after-tax dollars). This practice does not maximize the benefit of the favorable tax treatment. One explanation for the employer paying less than the full cost is the following: the employer and employee know that the favorable tax treatment of employer-paid premiums subsidizes insurance and tends to induce the employee to purchase more extensive coverage than if the employee were paying the full cost. This over consumption creates what economists refer to as a "deadweight loss" which results because the value to the employee is less than the full cost of the insurance. This real economic cost is borne by the employer/employee pair. To reduce this cost, the subsidy is explicitly limited by obtaining it on less than the full premium.

<sup>105</sup>For a review of the issues, see "The Effect of the Minimum Wage on Employment and Unemployment," by Charles Brown, Curtis Gilroy, and Andrew Kohen, *Journal of Economic Literature*, June, 1982, pp. 487-528.

the effects of minimum wages in New Jersey and Pennsylvania found the perverse effect of a small increase in employment.<sup>106</sup>

The reduction in employment discussed here, due to inflexible cash wages, is different from the disincentives to work discussed above with respect to the income and substitution effects, which result from increased economic incomes (including the value of insurance) or reduced wage rates. In these latter cases, individuals voluntarily would choose to work less at the available wage. On the other hand, the unemployment that may arise because of the minimum wage constraint is qualitatively different, because more people are willing to work at the prevailing minimum wage than can get jobs.

#### **4. Mandates with subsidies**

##### **a. In general**

One problem with mandates is that some people simply cannot afford to comply with the law. For example, if the annual family premium were \$4,000, a family of four at the poverty line (\$13,950 in 1992) would have to spend approximately 29 percent of its disposable income on health insurance. Other basic necessities of life would have to be forgone in such circumstances.

Policymakers also have expressed concern that it may be more expensive for small firms to comply with the mandate than it is for large firms. This concern stems mainly from the observations that the current insurance costs of small firms are higher than the average and that many of the employed who are uninsured work in the small business sector.<sup>107</sup> Because economists would generally argue that the burden of the cost of complying with the mandate is borne by the employee, the concern for small businesses is best interpreted as a concern for the employees of such businesses. To the extent that the establishment of regional alliances reduces the costs of insurance to small business, this concern will decrease but not disappear.

As a result of these concerns, the bill would provide subsidies (1) to low-income individuals and families, and (2) to firms based on firms' average wages and size. Both of these subsidies, but especially the second, could have distortionary effects on employment decisions.

##### **b. Subsidies to low-income individuals and families**

Under the bill, the subsidy to low-income individuals depends on their income relative to the poverty level and the direct cost they incur to purchase coverage under the comprehensive benefit package. If an unemployed individual with income only from unemployment compensation enrolls in a plan costing \$2,000, then he or she

<sup>106</sup> See David Card and Alan Krueger, "Minimum Wages and Employment: A Case Study of the Fast Food Industry in New Jersey and Pennsylvania", National Bureau of Economic Research, working paper No. 4509, October 1993.

<sup>107</sup> Employee Benefits Research Institute, *op. cit.*, reports that of all uninsured employed individuals, 22.3 percent work in firms with less than 10 employees, 12.7 percent work in firms with between 10 and 24 employees, and 12.7 percent are self-employed.

generally receives a subsidy related to the cost. Assume for simplicity that the subsidy is 10 percent of the direct cost of the insurance, or \$200.<sup>108</sup> Now suppose that this individual becomes employed and earns a monthly wage that is equal to the amount of monthly unemployment benefits. If the employer pays 80 percent of the cost of the insurance, then the individual will only receive a subsidy of 10 percent of \$400 (the balance of the premium that she must pay directly), or \$40. Note that the subsidy has been reduced by \$160, or 80 percent, equal to the employer share percentage of the premium.

Even if the individual is treated as bearing the burden of the employer mandate such that her annual cash wage would have been \$1,600 higher without the insurance, she loses the subsidy on the employer portion of the premium by returning to the workplace. If the subsidy is based on the cost borne directly by the employee, given the same income, the subsidy she receives is reduced. In particular, if the subsidy is proportional to the direct cost, the subsidy is reduced by a percentage which is the same as the employer's percentage share of the premium. This could act as a substantial disincentive for individuals to re-enter the labor force after a period of unemployment.

### c. Firm level subsidies

Under the bill, firm level subsidies are effected through a series of caps on the total costs different firms must incur in complying with the mandate. For example, no firm that purchases insurance through a regional alliance will be required to pay more than 7.9 percent of its payroll in the form of health insurance premiums (excluding the short-fall add-on). This is equivalent to capping the premium per employee at 7.9 percent of the average wage of all employees in the firm. For firms with fewer employees<sup>109</sup> or lower average annual wages, the cap percentage is lower. The applicable percentage limits on the cost of insurance are shown in Table I. For example, in the case of a firm with 24 employees and an average wage of \$10,000 per employee, the average cost of the mandated insurance policy per employee would be no greater than \$350 (3.5 percent of \$10,000).

**Table I.—Limiting Percentages Under the Firm-Based Subsidies of the Health Security Act**

Average number of full-time equivalent employees	Employer's average annual wages per full-time equivalent employee are:				
	\$0-\$12,000	\$12,001-\$15,000	\$15,001-\$18,000	\$18,001-\$21,000	\$21,001-\$24,000
Fewer than 25	3.5	4.4	5.3	6.2	7.1
25 but fewer than 50 .....	4.4	5.3	6.2	7.1	7.9

<sup>108</sup>This is only an illustrative example.

<sup>109</sup>The bill defines the size of the firm based on the number of "full-time equivalent employees".

**Table I.—Limiting Percentages Under the Firm-Based Subsidies of the Health Security Act—Continued**

Average number of full-time equivalent employees	Employer's average annual wages per full-time equivalent employee are:				
	\$0- \$12,000	\$12,001- \$15,000	\$15,001- \$18,000	\$18,001- \$21,000	\$21,001- \$24,000
50 but not over 75 .....	5.3	6.2	7.1	7.9	7.9

SOURCE: Section 6123 of the bill.

Because the subsidy is based on the characteristics of firms (size and average payroll) and not on those of individuals, economic effects in addition to those described above are likely. In the case of a mandate without any subsidies, the economic impact stems from the increase in the cost of employing any given individual (assuming the firm in question did not previously offer insurance), in relation to the value the individual places on the mandated coverage. When a subsidy based on the wages and size of a firm is introduced, the impact of the mandate depends not only on the cost and valuation of coverage but also on characteristics that are not directly related to the individual: the number of other workers in the firm and their wages. The effective tax rate imposed on any particular worker by the mandate depends on all these variables. For convenience, the effects of the subsidies are examined by looking first at the impact of a subsidy related to firm size and then at a subsidy linked to average wages.

### *Subsidies based on firm size*

To concentrate on the effects of firm size, assume that all employees of a particular firm earn the same wage.<sup>110</sup> For all firms with a particular average wage, the cost per employee of complying with the mandate is limited to a certain percentage of the average payroll. For example, for firms with average wages of \$17,000, those with fewer than 25 workers need pay no more than \$901 (5.3 percent of \$17,000) per employee for insurance. Thus, if the actual cost of insurance is \$1,500, there is a subsidy of \$599 per employee.<sup>111</sup> For firms with between 25 and 50 workers, the limit is \$1,054 (6.2 percent of \$17,000), with an implied subsidy of \$446 per worker per year.

### *Effects on employment decisions*

Firms will face very different subsidy rates per employee (and hence insurance costs) depending on their size. More importantly, the subsidy can change considerably when employment levels change by a small amount. For example, if a firm with average wages of \$17,000 increases its number of employees from 24 to 25,

<sup>110</sup>That is, each employee earns the average wage of the firm in which she is employed. This simplification is made for the purposes of illustration, and does not affect the general results.

<sup>111</sup>This subsidy does not mean that the effective tax rate imposed by the mandate is negative. If an employee values the insurance less than \$901, she faces a positive net effective tax rate. The subsidy does, however, reduce the size of the net effective tax rate imposed by the mandate by \$599 per year.

it must not only pay an extra \$1,054 in insurance costs for the new employee, it must also pay an extra \$153 for the insurance costs of *all* existing employees - that is, an extra \$3,672 (24 x \$153). Thus, the cost of employing the 25th worker is \$21,726 (\$17,000 + 1,054 + 3,672); unless the worker is worth at least this much to the firm, the worker will not be hired. The 25th employee may be willing to work for less than the value he or she adds to the firm. However, due to the form of the subsidy, the financial cost to the employer of hiring the worker could be much higher than the value the worker adds, so that the worker would not be employed.

This may appear to be a problem only causing those firms that would like to have exactly 25 employees, to choose 24 instead. However, consider a firm that wishes to expand its employment from 24 to 34. This increase in employment will cost the firm \$18,054 (\$17,000 + \$1,054) per new employee directly, plus \$3,672 in additional insurance costs for the existing employees. The total cost of employing the extra ten employees is then \$184,212, or \$18,421.20 each.<sup>112</sup> Unless each of them adds on average at least this much value to the firm, they will not be employed. Even if each of the ten employees increased the value to the firm by \$18,000, and were willing to work for \$17,000, they would not be employed. Thus, economically desirable growth of small firms could be impeded by the subsidy.

In fact, these examples do not concern only firms that are contemplating increases in employment. A firm currently employing 34 workers would face exactly the same incentives, but in the opposite direction. That is, by eliminating 10 jobs, it could reduce its total payroll by \$184,212. By choosing to fire the least productive of its workers, this could be very profitable for the firm, but not socially desirable, because the value of their output is greater than the true cost of their labor.

In addition to these general economic inefficiencies relating to employment decisions, the subsidy would have the unfortunate effect of working against itself in terms of health insurance costs. The subsidy is based on firm size because there is evidence that small firms face higher costs of providing insurance than do large firms. As firms grow, one would then expect that their costs of insurance per employee would fall. However, one impact of the subsidy is to discourage this growth in firm size, thus keeping per employee insurance costs high.<sup>113</sup> The proponents hope that group purchase of health insurance through regional alliances will temper the tendency of insurance costs to fall with increasing firm size, so this may not be important. On the other hand, if the regional alliances do succeed in reducing costs for small businesses, the necessity of the subsidy based on firm size would be called into question.

#### *Effects on firm organization and employment status*

The different subsidies available to firms of different sizes may affect firms' organizational decisions. For example, one way for the

<sup>112</sup>That is, the total cost is made up of \$17,000 in cash wages, plus \$1,054 in direct insurance costs, plus an additional \$367.20 in additional insurance charges, per employee.

<sup>113</sup>These arguments are not meant to suggest that large firms are necessarily better (or worse) than small firms. However, if it were desired to encourage the formation of small firms, there would be no obvious reason to do so in the context of health care reform.

owners of a firm to increase production through an increase in labor, while not losing the benefits of the high subsidy for small firms, would be to create two firms. That is, instead of increasing employment from 24 to 25 in the example above, the owners could form two firms of 12 and 13 individuals each. The per-employee subsidy would then remain at \$599. This ability to reorganize firms offsets the effect of the subsidy to constrain employment growth. However, it will still entail economic inefficiencies to the extent that business organization decisions would be distorted.<sup>114</sup> As above, if per-employee insurance costs are higher for the two small firms combined than for the original firm, then by encouraging the formation of small firms this outcome works directly against the perceived problem the subsidy is designed to address.

Instead of creating two firms in the example above, the original firm could re-employ some existing employees as independent contractors.<sup>115</sup> The individuals involved would perform exactly the same tasks but not be included in the firm's employment total. Similarly, janitorial needs and legal and accounting services could be "out-sourced" to companies that specialize in these activities, thus reducing the size of the original firm's employment and possibly increasing the per-employee subsidy. Again, such labor arrangements, if not observed without the subsidy, are likely to be inefficient. They may represent a sub-optimal mix of different kinds of employees (high- and low-skilled) within a firm, and they could increase aggregate health insurance costs.

#### *Subsidies based on average wages*

The bill would limit the amount that all firms, regardless of size, must spend per employee on health insurance. This limit is proportional to the average payroll of the firm. The subsidy (the cap on costs based on payroll) is intended to defray the costs of complying with the mandate for low-income individuals. If it is assumed that the costs of health insurance paid by an employer are passed through to employees, then the subsidy can be viewed as another means by which the bill provides relief to low-income individuals.

#### *Targeting of subsidy to low-income individuals*

Assume for simplicity that the bill requires an employer pay 100 percent of the costs of health insurance for its employees (i.e., a full employer mandate). Under the bill, the limit on the employer's costs is equal to 7.9 percent of average wages (disregarding the short-fall add-on). This limit provides a subsidy that decreases as average wages increase. For example, if the cost of insurance is \$1,500 per employee, a firm with average wages of \$10,000 will pay an average of \$790 per employee due to the mandate. On the other hand, a firm with average wages of \$100,000 will pay an average of \$1,500 per employee because the cap is not binding.

While the subsidy is directed to firms with low average wages, it is not specifically targeted to low-wage individuals. Some low-in-

<sup>114</sup>It is not necessary here to discuss whether and when there are economies of scale in business size. It suffices to note that if firms would be larger in the absence of the subsidy, the subsidy induces inefficient choices based on size, absent any other relevant market failure in firm organization decisions.

<sup>115</sup>The bill contains provisions intended to prevent abuses in the reclassification of employees as independent contractors. See sections 7301-7303 of the bill.

come employees do not receive a subsidy, and some high-income employees will be subject to a very large implicit tax. Consider a firm of 100 employees with average wages of \$10,000 that is required to purchase health insurance at a cost of \$1,500 per employee. The firm must pay 7.9 percent of payroll in health insurance costs, or \$79,000. It would prefer to pay \$79,000 than to pay the full cost of insurance for all its workers, which is \$150,000. However, the cost of employing a particular worker increases by 7.9 percent of the worker's wage. The cost of employing an individual at a wage of \$10,000 will increase by \$790, while that of employing a \$100,000-wage employee rises by \$7,900. If it is assumed that all workers value insurance at cost, then the low-wage employee receives a net subsidy of \$710 ( $\$1,500 - \$790$ ), while the high-wage employee pays an implicit tax of \$6,400 ( $\$7,900 - \$1,500$ ). In general, low-wage workers at low average-wage firms receive a subsidy while high-wage workers at such firms bear a tax.

In contrast, no employees of high-average-wage firms receive a subsidy. For example, a firm with a \$100,000 average wage will pay \$1,500 extra per employee for insurance, and the mandate will impose this extra cost on low- and high-wage employees alike. If both types of employees value the insurance at cost, the net subsidy to each is zero.

This analysis shows that low-wage employees in low average-wage firms receive a subsidy, while low-wage employees in high-average-wage firms do not and that high-wage employees in low average-wage firms suffer an implicit tax increase, while high-wage employees in high average-wage firms do not.

While this discussion has centered on firms that currently do not provide insurance, firms that currently do provide insurance will face similar effects. For example, a firm with average wages of \$10,000 that currently provides insurance at \$1,500 will see its total labor costs fall by an average of \$710 per employee. However, the firm's cost of employing a \$100,000 employee will have increased by \$6,400. Therefore, the subsidy still has differential effects on different employees of such a firm.

This means that any behavioral response of firms and workers to the implicit subsidies is not confined to those who do not currently offer insurance. On the contrary, all firms will have incentives to alter employment patterns due to the change in the relative prices of employing low- versus high-wage workers. These incentive effects are addressed in the following section.

#### *Incentive effects on hiring and employment*

The mandate imposes a high implicit tax on high-wage employees at firms with low average wages, but no such tax on similar workers in firms with high average wages. Similarly, low-wage employees of firms with low average wages receive a subsidy, but low-wage employees at firms with high average wages do not. As long as there is some flexibility in the labor market, these conditions should not be expected to persist.

For example, suppose that firms can easily reorganize. Then an existing low average-wage firm will have a large incentive to split into two firms: one employing its original employees who earned

low wages, and the other employing those who earned high wages. It would then still receive the subsidy for the low-wage employees but would not incur the tax on the high-wage employees. Similarly, high average-wage firms that employ some low-wage employees will have an incentive to split. By forming a new firm that employs only the low-wage employees, it will receive a subsidy for them, but will not increase its costs with respect to its high-wage employees.

This would result in better targeting of the subsidy, in that all low-wage workers would work in low average-wage firms, and hence get the subsidy, while no high-wage employees would receive a subsidy. However, the additional subsidy to low-wage workers in previously high average-wage firms would need to be financed by the government from general tax revenue (or other sources, such as increased health insurance premiums). In addition, the subsidy that low-wage workers in low average-wage firms previously received was financed in part by the implicit tax on their high-wage colleagues. Without this implicit tax, the cost of providing the subsidies increases.

In practice, firms incur costs to reorganize into separate entities in this fashion. Since the subsidies accrue to employees of similar skill and productivity in different firms differently, there will be incentives for some employees to seek employment in other firms where they can receive larger subsidies (or face lower implicit taxes). Coincidentally, employers will be induced to hire individuals who impose lower labor costs on the employer and shift away from the higher-cost employees.

For example, because high-wage employees in low average-wage firms face a high implicit tax, they will be induced to seek employment in high average-wage firms. This shift in labor supply will have the effect of bidding down the pre-tax wages of highly skilled employees in the high average-wage firms, and bidding them up in low-average-wage firms. If labor is mobile enough between the different firms, then in the long term, the net after-tax wages of highly skilled individuals will be equated in their different occupations. There will be fewer high-skilled employees in firms with low average wages, and more in firms with high average wages.

Similarly, because the subsidy bestows a larger benefit on low-wage employees in low average-wage firms than it does on similar employees in high average-wage firms, it will induce a shift in the supply of lower-skilled workers to the low average-wage firms. In the long term, the wages of lower-skilled individuals, net of the subsidy, should be equated in the different firms.

These reallocations of labor between sectors of the economy could be quite costly, in the sense that firms are induced to use skilled and unskilled labor in less economical proportions than usual. These effects can be incorporated in models of the efficiency and equity costs of mandates with firm level subsidies.<sup>116</sup> Compared

with individual-based subsidies, the poor generally do much less well than might otherwise be expected, and the program of firm subsidies under the bill is likely to be more expensive for the government (even taking into account the possibly higher administrative costs of individual subsidies).

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