Health Care Reform: Managed Competition and Beyond

• Since the election, the health care reform debate has focused on three broad features: implementation of managed competition, changes in the tax treatment of health insurance, and the imposition of budget caps or targets.

• The basic element of managed competition is the creation of sponsors who act as collective purchasing agents for large groups of individuals.

• One of the potentially most politically difficult issues in implementing any health care reform proposal is likely to be defining the minimum standard benefit package. It will determine the costs society bears, the income of providers, the health of many individuals, and the attributes of a workable health care reform package.

• Managed competition is intended to foster competition among health plans on the basis of cost and quality. The measures of quality actually employed in the health care system will determine in large part the incentives faced by insurers, providers, and consumers.

• The problem of adverse selection is potentially the most important issue in reforming the health insurance market. If individuals can opt not to purchase health benefits, poorer risks will be more likely to purchase health insurance than good risks, and at minimum the price of these benefits will be higher than would otherwise be the case.

• Managed competition requires that individuals share at least some of the financial consequences of their choices among health plans. As a result, most managed competition proposals change the tax code by limiting the exclusion of employer contributions to health insurance from worker’s taxable income.

• Changing the health insurance market, mandating employer health benefits, and changing the tax code may have significant effects on the health care delivery system, but they are unlikely to reduce health care cost inflation in the near term. One of the proposals for restraining the growth in health care costs is the imposition of a budget on the amount spent on health care services.

• The combination of the constraints placed on federal governmental action by the budget and the significant political problems involved in reaching a consensus on the important elements of health care reform may limit the ability of the federal government to implement national health care reform in the near term. As a result, individual states may be encouraged by the federal government to continue to experiment with their own health reform programs.
The debate on health care reform has become more focused as a result of the 1992 political campaigns. During the presidential campaign the proposals put forth by the two major parties differed considerably in philosophy but did not differ greatly in their basic approaches to health care reform. Both parties’ proposals built on the present employment-based financing system, reformed the health insurance market, and suggested changing the tax treatment of health insurance purchases.

Proposals to reform the health care system have focused on costs and access to care. It is estimated that the United States will spend more than $900 billion on health care in 1993, while more than 36 million Americans do not have either private or public health insurance (Foley, 1993). Reform proposals intended to reduce health care cost inflation have attempted either to correct flaws in the organization of health care financing and delivery or place an overall cap on costs or prices. Malpractice reform, small group insurance market reform, removal of regulatory barriers to managed care, and efforts to change the tax code are all intended to address specific problems. At the other extreme are proposals for a national health care system that would create a single payer, which would essentially budget national health expenditures. Between these extremes are proposals for a national health care system that would create a single payer, which would essentially budget national health expenditures. Between these extremes are a number of measures that would overlay some features of set budgets on the present system by controlling prices or reform the system but retain a public-private mix in the financing and delivery of health care services.

Proponents of health care reform have enunciated a number of objectives for the health care delivery system. They usually include providing universal access to health care services, controlling health care costs, and maintaining and increasing the quality of health care services. While the proponents of the various proposals generally assert that these goals are compatible, they are much too vague to be adequately used as criteria to evaluate alternative proposals.

It is often said that the United States is the only industrialized country that does not provide some degree of health care access to all its citizens, but the United States does provide a minimal level of health care, which, for some, means emergency care for preventable illnesses. However, many believe that the minimum level is unacceptably low and that the costs of the care provided are not borne equitably. What is not clear is what constitutes an acceptable minimum level of care. Defining all the dimensions of that minimum level is one of the more difficult political challenges in health care reform. These dimensions include the specific services that need to be provided to all Americans, how much individuals are expected to pay for these benefits and whether they are required to purchase health insurance, whether individuals who can afford to purchase more services than others will be able to do so, and what limits are imposed on individuals’ choices of providers or treatment sites.

Choices along these dimensions will affect the methods used to restrain the growth in health care costs and the effectiveness of these methods. If the minimum benefit level is relatively comprehensive, the health care delivery system will have to absorb additional demand unless the individuals bear a substantial portion of the costs. However, if individuals are required to bear a share of the costs, many will opt not to purchase coverage unless they are required to by law. Reform proposals that envision a national health system such as Canada’s impose no cost sharing on individuals but distribute the costs through the tax system and impose a fee schedule on physicians and budgets on hospitals to control costs. Reform proposals that rely on markets to manage health care costs often have as a central feature that individuals spend their own money for health benefits.
Finally, measuring the quality of health care has proven to be problematic, in large part because quality has many different components. Increasing access to coverage would increase the quality of care available to the uninsured. How the reform proposals affect the quality of care for those who are currently insured is an important subject of debate among the proponents of the competing proposals.

Since the election, the health care reform debate has focused on three broad features: implementation of managed competition, changes in the tax treatment of health insurance, and the imposition of budget caps or targets. Managed competition is a term that describes a wide variety of models for reforming the health insurance market. These models have in common the creation of a sponsor who manages the competition among health insurers for enrollees.

Changing the tax treatment of health insurance is an important element of health care reform both in extending coverage and managing the increase in health care costs. Although it is argued that these reforms will ultimately control the rate of health care cost inflation, neither managed competition nor changes in the tax treatment of health insurance is likely to significantly control costs in the short run. As a result, some have argued that budget caps should be placed on the health care delivery system at least in the short run, to limit health care cost increases immediately.

President Clinton has made health care reform a top priority for his administration. The White House Interagency Health Care Task Force is developing a health care reform proposal to be released in early May. Clinton’s plan is expected to be based on a managed competition model combined with global budgets.

The federal government may find it difficult to reach consensus around a specific health care reform proposal and even more difficult to implement a reform proposal in the near term. While public policy attention has been focused on national reform, individual states have moved forward in seeking their own solutions. Many states have proposed implementing the various reform proposals in their own jurisdictions. However, they face a number of barriers, including federal law, in implementing these proposals. Many policy analysts have urged the federal government to develop mechanisms to allow states to experiment with the various reform proposals before implementing them throughout the nation.

This Issue Brief analyzes a number of issues raised by the broad outlines of the proposals on health care reform. It examines the basic elements of managed competition, contrasting this approach with the current employment-based health care financing system and other health care reform proposals. The Issue Brief discusses the likely impact of moving toward a managed competition system, changing the tax treatment of health insurance purchases, and imposing budgets on the health care system. In addition, it discusses recent state reform activity.

Stanford Professor Alain Enthoven, building on earlier efforts by a number of analysts, developed a concept known as managed competition in the late 1970s as an alternative to the present markets for health insurance and health care services. A number of groups have integrated Enthoven’s concept into their health care reform proposals, with adaptations.

The basic element of managed competition is the creation of sponsors who act as collective purchasers.
Managed competition is intended to shift the market for health insurance from competition based on risk to price competition. As a result, competition in the health care services markets will also theoretically move toward price competition.

Enthoven's original proposal was called the Consumer Choice Health Plan. In that proposal and in his later writings Enthoven described a sponsor as "an agency that assures each eligible beneficiary financial coverage of health care expenses at a reasonable price." The sponsor's role is to act as a broker between the beneficiaries and the health plans, negotiating with health plans on the basis of price and quality and offering that range of choices to individual consumers.

Many recent descriptions of managed competition use the term health insurance purchasing cooperative (HIPC) interchangeably with the term sponsor. This is not strictly correct in that many managed competition proposals allow large employers to act as sponsors for their employees. HIPCs can be sponsors only for small employers and individuals, or conversely, in some models of managed competition there is only one HIPC per region and all individuals purchase health insurance through that HIPC.

Aside from large employers, the organization of the sponsors differs from proposal to proposal. These sponsors, or HIPCs, could be federal, state, or local government agencies; private, not-for-profit organizations; or regulated for-profit entities such as public utilities. The organization of the sponsors is an important issue that needs to be addressed in implementing a managed competition model. These issues are discussed below.

The terms managed care and managed competition have often been confused in the media and elsewhere. Enthoven's description of how managed competition would work contributed to this confusion because his vision of the result of managed competition built on the ideas of Dr. Paul Ellwood, Walter McLure and others who helped create the movement toward health maintenance organizations (HMOs). Enthoven believed managed competition would lead to a health care delivery system composed of competing health plans resembling HMOs or other managed care networks with limited choices of providers. Managed competition is intended to change the health insurance market fundamentally because individuals would choose among plans on the basis of costs and quality. To the extent that this is true, it is assumed that cost-effective plans such as HMOs and other managed care plans would attract more enrollees than the more traditional insurance arrangements that offer more choice of providers and treatment sites. That result need not occur, nor is it fundamental to managed competition.

Under managed competition, the health insurance market would be altered by the substitution of the sponsor as a knowledgeable negotiator with health insurance plans in the place of individual consumers or employee benefit managers. The sponsor would represent a group of consumers, whether they be the employees or dependents of employees of large employers or all individuals in a geographic area. Insurers would be required to accept any individuals who purchase health coverage through the sponsor. In theory, the health

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insurance market would be fundamentally changed under managed competition in that insurers could no longer attempt to avoid poorer risks and would need to find ways to control the costs of providing care.

Individuals under managed competition would be offered a menu of choices of health plans and given price and quality of care information for each plan. Theoretically, they could then choose the plan whose price and quality combination most suited their preferences. Such a choice requires that insurance policies be standardized to facilitate consumer choice, consumers be given a financial stake in their choice, and quality measures be developed that consumers can use to make choices.

A number of proposals for health care reform incorporate managed competition. These proposals differ in a number of aspects, including whether employers are mandated to offer health insurance coverage to their employees, the changes the proposals make in the tax treatment of health insurance premiums, the organization of the sponsors, and the description of the standard benefits offered. For illustrative purposes, two of these proposals are described below.

Jackson Hole Group

A group of analysts called the Jackson Hole Group, led by Dr. Paul Ellwood and Alain Enthoven, have advanced a proposal that would create HIPCs to act as purchasing agents for small employers and individuals not covered by an employer-sponsored plan; accountable health partnerships (AHPs) that would function as both insurer and provider of health care services; and an independent federal agency, the National Health Board (NHB), that would develop a set of uniform health benefits and licensing standards for AHPs. Employers would be required to offer health insurance to their employees. The tax treatment of health benefits would change in two ways. First, that portion of an employer’s contribution to an employee’s health insurance premium attributable to benefits that exceed the NHB’s minimum benefit package would be included in taxable income. Second, where employers offer a choice of health plans, only premiums for the least costly plan would be excluded from an employee’s taxable income. Finally, low-income individuals’ purchase of health insurance would be subsidized through a payroll tax and the revenue from the new limit on the deductibility of health benefits.

Conservative Democratic Forum

The Conservative Democratic Forum’s (CDF) proposal, introduced by Rep. Jim Cooper (D-TN) in the 102nd Congress as H.R. 5936, incorporates many of the elements of managed competition. It differs from the Jackson Hole Group’s proposal in that there is no mandate for coverage and in the tax treatment of health care as an employee benefit. It would create health plan purchasing cooperatives (HPPCs) through which all individuals not covered by Medicare or by large employer (more than 1,000 employees) health plans would purchase health insurance. The HPPC would negotiate with accountable health plans (AHPs) that would provide health insurance and health care services. A federal board would determine a core benefit package that all certified AHPs must provide at a minimum and the quality indicators that the HPPC would present along with the premium to individuals. Individuals would then use this information in making choices among health plans.

The Medicaid program would no longer be in existence. Individuals in families with incomes below 200 percent of the federal poverty line would have their coverage subsidized in two ways. First, the maximum premium that could be charged these individuals by the AHP would be reduced from the standard premium for the basic benefit package. This reduction would be determined initially by the percentage of the state’s Medicaid expenditures received from the federal govern-
ment and by the individuals’ income level. Adjustments would be made by the federal board and the HPPC to give AHPs with a disproportionate share of low-income individuals a subsidy from its competitor AHPs. In that way, AHPs would not have an incentive to avoid covering low-income individuals.

The second subsidy would be provided by the federal government on a sliding scale, depending on income. For individuals in families below the federal poverty level the federal government would pay all of the reduced premium. For those who live in families with incomes between 100 percent and 200 percent of the poverty level the subsidy would be reduced as income increases.

This subsidy would be financed by funds currently allocated to the Medicaid program and by an excise tax on public and private employers. An excise tax would be levied on employers for the amount they contribute to their employees’ health benefits above the cost of the basic benefit package. The exclusion from the employees’ taxable income of the employers’ contribution to health benefits would be maintained, while self-employed individuals and those without employer-sponsored health benefits would be given a 100 percent deduction for health insurance premiums paid to an AHP.

There are also other managed competition proposals. They all differ in ways that could have potentially important impacts on the health care financing and delivery system, but they retain the market constructed around sponsors purchasing health care services. Managed competition proposals represent a significant departure from the current system of financing health care services. They are intended to correct many of the problems currently observed in the employment-based financing system. Policymakers have embraced managed competition as a compromise between market-based and regulatory-based approaches to health care reform. Understanding the current employment-based system is important to understanding the rationale behind these proposals, and the barriers to implementing them as well as their implications for employees, employers, providers, taxpayers, and patients. Following this section on the current employment-based system, the issues in implementing managed competition will be examined.

Health insurance costs in the private sector are not currently distributed equally among all payers. The cost of employer-sponsored health insurance depends on the characteristics of an employer’s work force, risk factors attributed to the industry, and the local health care service market. There are significant differences in average costs among industries and between large and small employers. Health insurance for small firms may cost more because of higher administrative costs and insurers’ reduced ability to pool risks.

Health expenditures represent an increasingly large component of employee compensation, public budgets, and individuals’ disposable income. The employer share of national health expenditures has remained virtually constant since 1980, but national expenditures for health have grown faster than income. As a result, health benefits as a percentage of compensation (averaged over all workers whether they receive health benefits or not) have grown from 4.4 percent in 1980 to 6.4 percent in 1990 (U.S. Department of Commerce, 1992). Although more employers today require employee contributions to group health plan premiums than they did 10 years ago, and deductibles are higher and copayments more common, individual health spending as a share of adjusted personal income
Table 1
Nonelderly and Elderly Americans with Selected Sources of Health Insurance Coverage

<table>
<thead>
<tr>
<th>Source of Coverage</th>
<th>Total Population</th>
<th>Nonelderly</th>
<th>Elderly</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number (millions)</td>
<td>Percentage</td>
<td>Number (millions)</td>
</tr>
<tr>
<td>Total Population</td>
<td>248.7</td>
<td>100.0%</td>
<td>218.1</td>
</tr>
<tr>
<td>Total with Private Health Insurance</td>
<td>178.4</td>
<td>71.7%</td>
<td>157.7</td>
</tr>
<tr>
<td>Employer coverage</td>
<td>150.0</td>
<td>60.3%</td>
<td>139.8</td>
</tr>
<tr>
<td>Other private coverage</td>
<td>28.6</td>
<td>11.5%</td>
<td>18.0</td>
</tr>
<tr>
<td>Total with Public Health Insurance</td>
<td>61.2</td>
<td>24.6%</td>
<td>31.7</td>
</tr>
<tr>
<td>Medicare</td>
<td>32.9</td>
<td>13.2%</td>
<td>3.5</td>
</tr>
<tr>
<td>Medicaid</td>
<td>26.8</td>
<td>10.8%</td>
<td>23.9</td>
</tr>
<tr>
<td>CHAMPUS/CHAMPVAa</td>
<td>7.1</td>
<td>2.9%</td>
<td>5.9</td>
</tr>
<tr>
<td>No Health Insurance</td>
<td>36.6</td>
<td>14.7%</td>
<td>36.3</td>
</tr>
</tbody>
</table>

Note: Details may not add to totals because individuals may receive coverage from more than one source.
aIncludes the Civilian Health and Medical Program of the Uniformed Services and the Civilian Health and Medical Program for the Department of Veterans Affairs.

has increased by only 0.9 percentage points since 1965. Of course, the increase in health care as a component of total compensation means that employees bear at least some of the costs attributed to employers in the form of lower wages or lower levels of other benefits.

Employer contributions to employee health plans are not counted as taxable income to employees and are deducted from the calculation of income as a normal business expense for those employers who pay taxes. The tax preference gives employees an incentive to receive part of their income as health benefits rather than cash. It also gives them an incentive to purchase more comprehensive coverage with lower deductibles and other out-of-pocket expenditures, which has the effect of increasing the demand for health care services. Lower administrative costs and the ability to avoid or reduce adverse selection3 give large employer health plans a considerable cost advantage over individually purchased plans or small group plans.

These considerations have led many to argue that tying the financing of health care to the labor market results in an inequitable distribution of both benefits and costs. Currently, 64 percent of Americans under age 65 receive health insurance through an employer- or union-sponsored plan (table 1). Separation from the labor market—through job loss, divorce, or death—may result in the loss of health insurance coverage. Individuals without health insurance are predominantly nonworkers, self-employed, workers in small establishments, or persons in families headed by a member of one of these groups. Moreover, if employees with health insurance coverage are reluctant to change jobs because of concern about health insurance, they may forgo opportunities that would increase their productivity.

Most of the health care reform proposals focus on the difficulty individuals and small groups have in obtaining health insurance at the same cost as larger groups. Small groups often face higher costs per participant because of their higher per capita administrative costs and insurance companies' limited ability to pool risks. Insurers currently price their policies on the basis of the expected risk of the individual group. If an insurer pools all the groups it insures together and charges a premium based on that total pool, some of the groups in the pool will pay higher premiums than they would if the premiums were set on their risk alone, while others will pay lower premiums. In the current health insurance market, insurers who attempt to pool risk across groups in that manner will find the lower risk groups will choose another insurer whose premiums reflect only their own risks and are therefore lower. By removing barriers that prevent insurers from pooling small groups, employment-based coverage may expand to include many of the employed uninsured in small firms and their dependents (who constitute 37 percent of the nonelderly uninsured).

Insurance Reform

A number of proposals have been offered to reform the health insurance market. Although there are

3 Adverse selection refers to differences in risk. A health insurance plan that attracts enrollees who are more likely than average to utilize health care services is said to suffer from adverse selection. Adverse selection may also be used to describe the phenomenon that the individuals most likely to need health care services are also more likely to purchase health insurance.
significant differences among these proposals, there is agreement on some basic principles: small groups should be guaranteed access to insurance, restrictions on preexisting conditions should be limited, new restrictions should not be imposed when individuals change jobs or when groups change insurers, coverage should not be canceled because of high utilization of services, insurers should be required to offer coverage to all small groups (if they offer insurance to any), premium rates should be stabilized, and policies should be renewable (except for reasonable cause such as nonpayment of premiums). Proponents of insurance market reform disagree on the means to achieve guaranteed access to insurance and on some of the measures needed to make such a guarantee work, including limits on premium rates and rate increases (George Washington University Health Policy Forum, 1991).

Most proposals include some means for guaranteeing that all small groups have access to insurance and are not denied coverage based on individual characteristics. However, proponents of insurance market reform recognize that guaranteed availability alone accomplishes little unless premium rates for small groups are stabilized. Without some limits, insurers could use rating practices to raise the cost of coverage for riskier groups until the price becomes so high that these groups choose not to purchase insurance. Some proponents suggest moving toward community rating so that insurance would be offered to all small groups at fixed rates. Others would allow insurers to adjust community rates for factors such as age, sex, geographic location, and industry type (class rating). Generally, proposals would limit medical underwriting and restrictions on preexisting conditions.

Premium limits are common to a wide variety of health reform proposals. These proposals would allow insurers to use medical underwriting and factors such as claims experience, health status, age, and sex to set rates but only within permitted rate bands. Some analysts argue that mandating community rating or eliminating demographic adjustments would raise rates for many groups and create adverse selection.

Adverse selection occurs when individuals with greater health risks are disproportionately enrolled in a particular plan. Community rating limits insurers’ ability to charge different premiums to groups on the basis of risk. As a result, premiums for groups that represent good health risks would rise with the implementation of community rating, while premiums for groups representing bad risks would fall. Some of the healthier individuals would choose not to purchase health insurance as a result of the premium increase, while more of those individuals who are poorer health risks would purchase health insurance. The result would be an increase in the pool’s average risk, increasing premiums and potentially creating a vicious cycle that would end in an unviable health insurance market. The likelihood of this scenario actually occurring depends on the sensitivity of the demand for health insurance to changes in premiums among individuals who represent good and bad risks and on the ability of individuals to determine their own risk status.

One mechanism for preventing adverse selection is to develop a reinsurance mechanism for health insurance. A number of proposals include measures that would encourage the creation of either public or private reinsurance pools to reduce the effects of adverse selection. These pools would allow individual insurance plans to cap the costs of the poorer risks, allowing them to offer premiums closer to those offered to good risks.

Another issue addressed by most proposals is the guarantee that group policies cannot be canceled by the insurer due to changes in the health status of individuals in the group. Many carriers currently refuse to renew high-risk groups or only offer to renew policies at significantly higher rates.

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4 Medical underwriting refers to the practice of requiring a potential purchaser of health insurance to undergo a physical examination or submit other evidence of good health before being allowed to purchase insurance.
Some insurers charge low rates initially and then raise premiums substantially when small groups renew (durational rating). Small groups often change insurers frequently to avoid these increases. This process subjects small businesses to repeated medical underwriting and works against companies with less healthy employees by raising premiums even higher and constantly imposing new waiting periods for individuals with preexisting conditions. Other insurers use tiered rating to establish renewal rates for groups too small to be experience rated. Tiered rating sets renewal rates based on an analysis of each enrollee who incurred high medical expenses and the likelihood of continued high expenses. Rating practices such as these have reduced the premium rates for some small groups but overall have increased segmentation in the small group market (George Washington University Health Policy Forum, 1991).

Most proposals would limit annual premium increases to eliminate durational rating. Industry advocates recommend that carriers limit premium increases to the rates established for new businesses plus an adjustment factor of up to 15 percent. However, congressional bills generally do not allow for such an experience adjustment and limit renewal rates to those established for new policies.

Because nearly one-half of all uninsured workers are self-employed or working in firms with fewer than 25 employees, proposals of all types have included as part of their package a set of small group insurance market reform proposals. Small group reform advocates argue that small employers would purchase health insurance if it were offered at the right price. However, it is likely that at least some small employers would not be willing to purchase coverage in the absence of substantial federal or state subsidies.

Researchers evaluating the Robert Wood Johnson Foundation (RWJ F) projects for the medically uninsured found that small employers’ primary reason for not offering health insurance was the high cost of coverage—85 percent of employers not offering insurance cited high premiums as an important reason (McLaughlin, 1991). Although the RWJ F demonstration projects did not reform local small group insurance markets the way that current national proposals would, their goals are similar: to stabilize the cost of insurance to small businesses and distribute these costs more equitably. Previously uninsured small employers began to offer insurance to their employees during the enrollment phase of the demonstration projects. However, only 17 percent of employers who previously did not offer insurance enrolled even in the most successful RWJ F project targeted at small employers (McLaughlin, 1991). If the experience of these projects is representative of national experience, small group insurance market reform may result in a minority of small employers choosing to purchase health insurance.

The effect of insurance market reform on national health expenditures will depend on the program’s success in increasing health insurance coverage. The removal of preexisting condition exclusions would make health benefits more portable and lower costs for some employers. However, restricting premiums by imposing community rating or limiting premiums within bands would likely increase some employers’ costs. Many economists have found that subsidizing groups by altering prices is less efficient than subsidizing those same groups through a direct transfer of income (Feldman, 1987). However, the administrative costs of identifying individuals needing an income transfer may outweigh the costs of an inefficient insurance market.

The development of reinsurance markets, state risk pools, or other methods to subsidize the insurance costs for poor risks may alleviate some concerns about restrictions on premiums. However, public and private reinsurance schemes distribute the cost burden differently. If a private reinsurance market develops, the costs of providing expanded access to poorer risks will be borne by the purchasers of insurance. The premium paid by individuals and employers for health coverage will include the premium paid by insurers for the reinsur-
ance of poorer risks. On the other hand, the burden of the costs of a public risk pool will depend on that pool’s financing mechanism. Most state risk pools are now financed by state insurance premium taxes. Courts have ruled that employers who self-insure are exempt from these taxes under the Employee Retirement Income Security Act of 1974 (ERISA). As a result, the cost of risk pools is borne by individuals and employers who purchase commercial insurance. There are ways to spread the costs of the risk pool in a different manner, for example, by financing through general revenues. Most proposals do not specify any financing mechanism for reinsurance pools.

Managed competition would fundamentally alter the health insurance market. It incorporates many elements of small group health insurance reform but goes beyond those changes to restructure the entire market. However, there are many issues that must be addressed before a managed competition model could be implemented. How these issues are resolved will determine not only the structure of the health insurance and health services markets but also the speed and costs of the transition from our present system to a managed competition system.

Minimum Benefit Package

One of the potentially most politically difficult issues in implementing any health care reform proposal is likely to be defining the minimum standard benefit package. President Clinton and others have asserted that health care is a right to which all Americans are entitled. It is the minimum standard benefit package that determines and defines that right. It will determine the costs society bears, the incomes of providers, the health of many individuals, and the attributes of a workable health care reform package.

Under most managed competition proposals, the sponsor manages competition based on the price of a standard benefit package that is considered to be the minimum to which all Americans are entitled. This package determines the tax preferences given to individuals and employers in the purchase of health insurance benefits. Determining the basic benefit package will have important consequences for the income of physicians and other health care providers and for the type of care available to Americans. The richer, more inclusive the package, the wider the range of benefits available to the individual patient, the more health care individuals will have access to, the higher the costs to private payers and taxpayers and consequently the greater the income to providers.

Looking at how the political process has determined benefit levels in the past may yield some insights on the outcome of the present debate on the minimum benefit package. Defining a minimum benefit package has proven to be a difficult problem in other countries with universal coverage. Most countries have found it difficult to decide what not to cover, so they have pushed the decisions down to local levels (Employee Benefit Research Institute, forthcoming).

In the United States, state insurance mandates, which require that certain benefits be included in either group or individual health insurance plans, may provide some insight into the political difficulty involved in defining a standard benefit package. Benefit mandates became widespread in the early 1970s. By 1991, there were 992 state mandates. These mandates together could be viewed as representing what the state governments have determined to be a basic minimum benefit package. The mandates have required coverage for procedures such as in vitro fertilization; diagnoses such as mental health and substance abuse; and the services

Issues in Implementation
of various providers such as psychologists, podiatrists, or chiropractors. Many critics of state mandated benefits believe they raise the costs of health insurance to levels that are unaffordable for small employers. The provider groups and service specialists who have lobbied aggressively in the states for inclusion of their services in insurance packages can also be expected to apply pressure as federal policy is formed.

Perhaps a starting point for defining a basic benefit package would be the Medicare program. Medicare offers a relatively poor set of benefits compared with most private health plans. Defining a basic benefit package more generous than Medicare may require changes in the Medicare program that could considerably increase the costs of health care reform to the federal government. Currently, most Medicare beneficiaries do not rely on Medicare alone; less than 13 percent of elderly Medicare beneficiaries have no supplemental coverage.

Hospital Insurance (HI), or Medicare Part A, provides benefits for inpatient hospital care, skilled nursing care, home health care, and hospice care. Beneficiaries are subject to a deductible for each hospital admission. The amount of the deductible ($676 in 1993) is generally indexed to the average cost of hospital days. If the hospital stay exceeds 60 days, the beneficiary is also subject to a copayment. HI provides no coverage after 150 days.

Supplementary Medical Insurance (SMI), or Medicare Part B, finances 80 percent of the cost for most outpatient services for Medicare beneficiaries. A wide array of physician services is covered under Medicare Part B, including visits in the home, office, and hospital. This program also finances various miscellaneous health services, including outpatient services received in hospitals and in rural health, community health, and renal dialysis centers. Part B coverage also includes physical and occupational therapy services.

Medicare provides limited coverage for extended inpatient hospital care and care received in a skilled nursing facility. It does not cover long-term care, nursing home care, or home health care that is determined to be unrelated to rehabilitation or is purely custodial. In addition, Medicare does not cover prescription drugs.

The other major public program that defines benefits is the Medicaid program. While this program generally offers more generous benefits than Medicare, especially with respect to copayments, provider reimbursement under Medicaid is usually less generous. As a result, a large number of studies indicate that the care received by Medicaid recipients and by the uninsured differs markedly from that received by privately insured individuals. A recent report by the U.S. Office of Technology Assessment reviewed this literature and found that Medicaid recipients “are up to 2.5 times more likely than privately insured patients to experience potentially inadequate health services, and up to 4 times more likely to experience an adverse health outcome.”

The difference between the minimum benefit package and the benefits currently offered by public or private plans will determine the impact of the minimum benefit package on the health care delivery system. Currently, private plans generally include coverage for care associated with an episode of hospital care, including hospitalization, in-hospital professional care, and surgery, and many outpatient services. Fee-for-service plans are less likely than alternative delivery systems to offer preventive services and services that are predictable or not considered medically necessary. Deductibles are generally much lower than those faced by individuals with Medicare coverage alone, and there are often limits on an insured individual’s out-of-pocket expenditures. Finally, lifetime maximum benefits for privately insured individuals are generally much higher than those offered under the Medicare program (table 2).

The comprehensiveness of the minimum benefit package obviously would affect the costs to individuals and to taxpayers. Under most managed competition models, subsidies would be provided to low-

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### Table 2: Beneficiary Cost Sharing and Coverage for Selected Benefits Among Public and Private Health Plans

<table>
<thead>
<tr>
<th></th>
<th>Medicare (HI)</th>
<th>Medicaid (SMI)</th>
<th>Medicare/Medicaid (Dual Eligibles)</th>
<th>Medigap&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Private&lt;sup&gt;b&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td>Days 1–60: $676 inpatient hospital deductible</td>
<td>No deductibles or copays, but eligibility is limited to a specified low-income population with specified limited resources</td>
<td>Medicare SMI requires payment of the monthly premium. State Medicaid programs pay this premium, deductibles, and certain coinsurance</td>
<td>Days 1–60: $676 inpatient hospital deductible</td>
<td>$100 annual</td>
</tr>
<tr>
<td><strong>Copays</strong></td>
<td>Days 61–90: $169 daily copayment</td>
<td>No deductibles or copays, but eligibility is limited to a specified low-income population with specified limited resources</td>
<td>Medigap plan pays the $169 a day coinsurance amount for days 61–90 and $338 a day for 60 additional days</td>
<td>Medigap pays the 20% coinsurance for doctors’ bills after the $100 deductible has been met</td>
<td>20% (most common)</td>
</tr>
<tr>
<td><strong>Lifetime Limits</strong></td>
<td>Limited to 150 hospital days</td>
<td>None</td>
<td>Medigap plan pays 100% of hospital costs, up to the Medicare limits, for an additional 365 days of hospitalization</td>
<td>Medigap pays 100% of hospital costs, up to the Medicare limits, for an additional 365 days of hospitalization</td>
<td>$1 million (most common)</td>
</tr>
<tr>
<td><strong>Coverage for Selected Benefits</strong></td>
<td>Covered</td>
<td>c</td>
<td>Covered</td>
<td>Covered</td>
<td>Core benefits</td>
</tr>
<tr>
<td></td>
<td>Covered</td>
<td>Not covered</td>
<td>Optional&lt;sup&gt;e&lt;/sup&gt;</td>
<td>Optional</td>
<td>Covered under plans H, I, and J</td>
</tr>
<tr>
<td></td>
<td>Covered</td>
<td>Covered</td>
<td>Optional&lt;sup&gt;f&lt;/sup&gt;</td>
<td>Covered</td>
<td>Covered under plans D, G, I, and J</td>
</tr>
<tr>
<td></td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Core benefits</td>
</tr>
<tr>
<td></td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not Covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>


<sup>b</sup>Not applicable.

<sup>c</sup>Represents percentage of employees with coverage: 98%<sup>d</sup>

<sup>d</sup>Represents full-time employees from medium and large private establishments participating in health care plans in 1989.

<sup>e</sup>Covered in all 50 states and in American Samoa, Guam, Hawaii, and the N. Mariana Islands.

<sup>f</sup>Covered for those aged 65 and over and for those under age 21 in 40 states.

<sup>g</sup>Mental health and drug abuse benefits are commonly subject to special limitations, including higher deductibles and copays and lower maximums. Plans also commonly limit the duration of hospital stays for mental health and drug abuse, as compared with other illnesses.
income individuals either directly or through the tax code. However, for individuals with income above a certain level most managed competition models would alter the tax code to remove incentives to purchase health insurance. These models usually tie the tax preference to the cost of the basic benefit package. Thus, the distribution of health care costs would vary, depending on the definition of the minimum basic benefit.

**Administration**

Defining a minimum benefit package is only the first step in the operation of a managed competition model. Once that minimum benefit package is defined, the sponsor would also negotiate with the insurer or the health plan for packages that are richer than the basic benefit. A richer benefit package will leave less of an opportunity for insurers to offer differentiated products. A less generous minimum benefit package might induce many individuals to purchase additional coverage. Insurers might have an opportunity to affect the characteristics of the population they insure by their choice of the attributes of the plans they offer above the minimum package. Standardizing the benefit packages that insurers could offer above the minimum package might alleviate this problem.

There are several other issues in the administration of a managed competition system. These include the organization of the sponsors; the size of the market served by a sponsor, both geographically and in terms of covered individuals; and the sponsors' role in allocating risks across insurers or health plans.

One concern with managed competition models is the organization of the sponsor. Enthoven's original proposal described these sponsors as public entities. Later he broadened the definition to include large employers or any other purchasing cooperative. Other proposals have characterized the sponsors as public utilities. The CDF proposal allows large employers to act as the sponsors for their employees and dependents and sets up nonprofit organizations (HICPs) to act as sponsors for all others. These nonprofit organizations may have publicly appointed boards or may simply be regulated by the states or the federal government.

The organization of the sponsor may have important consequences for local health care delivery. Publicly appointed boards may have different objectives from those of large employers or a privately organized regulated utility. If there are multiple sponsors within a single health market, these differences in objectives might present providers and insurers with unintended incentives that could thwart the goals of managed competition.

The size of the population served by each sponsor would affect both the health insurance market and the health care services market. If multiple sponsors are operating in a local health care market, insurers might be able to manipulate the system to avoid insuring the poorer risks. If it is less costly to avoid insuring poorer risks than managing health care, insurers might attempt to create a niche for themselves insuring the healthier groups.

Under a managed competition model, health plans or insurers contract with or hire providers and facilities to provide health care to the plans' enrollees. The theory of managed competition is that the competition among health plans along cost and quality dimensions will lead them to negotiating with providers to either attract cost-effective providers or alter the treatment patterns of providers to remove any waste or inefficient practices. To be effective, health plans have to have sufficient market power within the local health care services market to affect provider behavior, and they need the competition from other health plans to give them an incentive to exert that market power.

The size of the local market thus becomes an

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issue in implementing managed competition. How large a market is necessary to support competing health plans? A recent study estimated that it would take a population of 450,000 to support a single HMO that owned its own tertiary care hospital. Thus, a market population of at least 1.2 million would be necessary for three completely independent health plans to compete in the same market. The authors estimate that only about 42 percent of Americans live in market areas of 1.2 million or more people. Conversely, the authors estimate that a plan with 60,000 enrollees could provide primary care and most of the specialists necessary for tertiary care but would need to share cardiology and urology services and hospital services. Seventy-one percent of Americans live in markets with more than 180,000 people.

It is not clear how sharing facilities such as hospitals or specialists would affect competition among plans. One of the benefits of competition is the incentives provided for private entities to spend resources on research and development of cost-effective methods for delivering care. If health plans share facilities, the incentives for individual health plans to fund this research may be limited if their competitors share the benefits. This may be less of a problem if there is public investment in the development of treatment protocols and quality measures.

The organization of the sponsors becomes crucial to assessing the minimum size of the market. If multiple sponsors are allowed to operate in a single market, it is conceivable that a single health plan could be negotiating with several sponsors, which could limit the sponsors’ ability to negotiate.

Table 3 looks at the percentage of Americans who would be in a HIPC in 1991, assuming that individuals who are not covered by a plan sponsored by employers with more than 1,000 employees purchased health insurance through a HIPC. North Dakota would have the largest proportion of its citizens in a HIPC, followed by Montana, Maine, and Alaska. These states would also be unlikely to support a sufficient
number of competing health plans for the market to work as envisioned by most models of managed competition. If an individual sponsor is responsible for all care in a large enough geographic area, the sponsor could negotiate with health plans over the whole area rather than within a local market. The sponsor could then compare costs and quality across markets and apply these standards to health plans that, because of size constraints, are the sole providers in a given market. In that sense, the bids from all the plans in the sponsor’s geographic area, or even bids from potential sponsors who have not yet entered the market, could be used to determine costs. In essence, the plan may be competing in an area larger than the market area from which the plan actually draws enrollees. The health plan would essentially be a regulated monopoly in those markets too small to sustain more than one health plan. If that is the case, the sponsor’s role changes considerably, because competition among plans would no longer assure that the plans are responsive to enrollees’ needs. Moreover, given the present situation in which the organization of the health care services market varies considerably across local markets in the same state, it may well be the case that data on costs from one area may not be relevant to another.

For areas too thinly populated to support competition, the sponsor’s role would become very important in determining the costs and quality of care for that market. The organization of that sponsor would be even more critical in shaping the health care system for such markets than for markets in which competition helps regulate provider and insurer behavior. One of the most important tools the sponsor and the consumer would have is the measurement of the quality of care provided by a health plan.

Defining Quality of Care

Managed competition is intended to foster competition among health plans on the basis of cost and quality. Defining and measuring health care quality are controversial and costly endeavors. Quality of care is a multidimensional concept: it can be viewed narrowly (as clinical effectiveness) or broadly (as all the attributes of medical care that patients value). The difficulty with any multidimensional concept is weighting the disparate components. Even if individuals agree on the attributes of care that determine its quality, they may disagree about the relative importance of each attribute.

An important question is who is going to develop the definition of quality used to assess health plans and providers? The different participants in the health care delivery system have different interpretations of quality. The measures of quality actually employed in the health care system will determine in large part the incentives faced by insurers, providers, and consumers. Once a definition of quality is developed, health plans will be required to provide the sponsor with specific information that will be used to ascertain the quality of care, and the plans will then compete along the dimensions of quality defined by the system. The definition of quality may therefore be as important as the definition of a minimum benefit package in determining the overall costs of health care, the distribution of these costs, and the rate of health care cost inflation.

Distribution of Risks

In addition to defining the quality of care, definitions of the risks facing individual health plans are needed to fully implement a managed competition model. In most managed competition proposals a mechanism is provided to redistribute premium income across insurers on the basis of risks. This mechanism is intended to remove risk selection as a barrier to cost competition among insurers. Insurers of health plans that have a healthier than average enrollee population would be required to trans-
fer some funds to plans with a less healthy population. This requirement would limit the rewards of attempting to attract a healthier population.

Several potential issues must be addressed in using this mechanism. First, over what population is the transfer to be made? If transfers are made only over local health care markets, theoretically the sponsor could administer that transfer, unless there were multiple sponsors within an area. Transfers made over a larger region might reward some insurers solely for their location if populations differ by those risk factors used to determine the transfer payment.

A second issue is what factors are used to determine the risks of each insurer’s populations. These factors may introduce unintended incentives if they do not completely capture the observable differences in characteristics associated with health care services utilization across enrollee populations.

Moreover, there is a question of whether these factors should be applied prospectively, that is, without any adjustment for actual utilization, or retrospectively, after it is clear that one insured group has incurred more costs than another. In the first case, a set of demographic characteristics would be identified as risk adjusters, and an insurer who attracted a healthier group based solely on these characteristics would be required to transfer some of its premium income to another insurer whose risk profile based on these characteristics was poorer. Retrospective adjustment would transfer income based on actual utilization by plan enrollees. If prospective risk adjusters accurately predict the risks faced by the insurer, they preserve the incentive for the health plan to manage care efficiently. Because they are based on actual utilization, retrospective adjustments may be a more accurate measure of the differences in risks faced by competing health plans, but they may also mitigate the incentive to practice cost-effective medicine.

While adverse selection among health plans may be an issue, another major issue in implementing a managed competition proposal is adverse selection for the entire system. The issue becomes a question of whether individuals or groups should be required to participate. To contain health care costs, managed competition relies on individuals to make choices among health plans on the basis of costs and quality. In order to give individuals the incentive to choose cost-effective plans, they must feel the financial consequences of their choices. Imposing increased costs on individuals by changing the tax preferences, limiting employer contributions to health plans, or changing the insurance market so that premiums are no longer based on individual risk means that some individuals may choose not to purchase health insurance. To the extent that these individuals tend to be healthier, the remaining participating population will tend to be less healthy, driving up the average costs of providing health insurance, forcing others out of the system, and potentially making the system unsustainable.

Although a number of proposals would mandate that employers or individuals purchase health insurance, such a mandate presents a difficult political problem for policymakers. For example, the CDF proposal requires that employers with fewer than 1,000 employees who offer health benefits do so through the HIPC but does not require either employers to offer health benefits or employees to participate if the employer offers them. Moreover, individuals not connected to the work force need not participate, although lower-income individuals are given subsidies and reduced premiums.

The problem of adverse selection is potentially the most important issue in reforming the health insurance market. Insurers and health plans price their products on the basis of the risks they face. As noted above, in Enthoven’s model of managed competition transfers are made among health plans to avoid rewarding plans that attract lower risk enrollees. Setting aside the important issue of how this transfer is to be imple-
mented, the transfer alone cannot prevent the problems that adverse selection presents to the managed competition model. If individuals can opt to not purchase health benefits, poorer risks will be more likely to purchase health insurance than good risks, and at minimum the price of these benefits will be higher than would otherwise be the case.

Mandating that all employers offer health benefits alleviates the problem somewhat. Offering health benefits through an employer lowers the transaction costs for individuals and may capture more of the good risks. If employees can choose between cash or health benefits, an employer mandate may not completely alleviate the problem of adverse selection. That is, if employees can receive the cash equivalent of the health benefit rather than the health benefit, more of the good risks are likely to opt for the cash. If employees cannot make the tradeoff between cash and health benefits, then more of the good risks are likely to opt for coverage, making the issue of adverse selection less important.

**EBRI simulated the impact of an employer mandate on coverage, assuming that the mandate covered all employees who worked more than 19 hours a week for an employer with more than 10 employees and that it included family coverage. Under this mandate, all but about 14.4 million of the currently 36.3 million nonelderly uninsured would have coverage** (tabulated from table 4).

The EBRI analysis also found that the cost of an employer mandate would be borne primarily by small employers and their employees. EBRI estimated that an illustrative employer mandate would increase spending by employers on employer-sponsored health benefits by $33 billion to $86 billion. The wide range between the estimates is related to assumptions about the costs of the mandated benefit package. If employers with fewer than 25 employees were exempt from the mandate, spending would increase by $12 billion to $33 billion. Costs for

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Employer</td>
<td>28.4%</td>
<td>32.8%</td>
</tr>
<tr>
<td>Indirect Employer</td>
<td>28.0</td>
<td>29.7</td>
</tr>
<tr>
<td>Other Private</td>
<td>7.1</td>
<td>5.6</td>
</tr>
<tr>
<td>Medicare</td>
<td>12.9</td>
<td>12.6</td>
</tr>
<tr>
<td>Medicaid</td>
<td>7.8</td>
<td>7.2</td>
</tr>
<tr>
<td>CHAMPUS&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1.0</td>
<td>0.7</td>
</tr>
<tr>
<td>Uninsured</td>
<td>14.7</td>
<td>11.1</td>
</tr>
</tbody>
</table>

<sup>a</sup>Civilian Health and Medical Program of the Uniformed Services.

Individuals not connected to the work place may still make their decision on whether to purchase health benefits based on their own assessment of their risks of needing health care (which is likely to be more accurate than an insurer’s assessment of that individual’s risks). There are two issues that make this group important to the success of a managed competition model. One is the adverse selection problem described above. It is unclear how unstable the market would be without an individual mandate, especially if those not connected to the work force constitute a greater health risk than workers. The second issue is how to provide individuals who choose not to purchase health insurance with health care should they need it. One of the criticisms of our present system is that care for the uninsured is funded by hidden subsidies and cost shifting. Without an explicit source of funds for care for those who remain uninsured, those hidden subsidies may remain.

**Tax Changes**

Managed competition requires that individuals share at least some of the financial consequences of their choices among health plans. As a result, most managed competition proposals change the tax code with respect to health care. Most tax-based approaches focus on limiting the exclusion of employer

**Table 4**

| Coverage Effects of Illustrative Mandates That Employers Offer Health Benefits |
|---|---|---|
| Present System | Mandate Full Time More Than 25 employees | Mandate More Than 10 Employees |
| Direct Employer | 28.4% | 32.8% | 42.9% |
| Indirect Employer | 28.0 | 29.7 | 29.9 |
| Other Private | 7.1 | 5.6 | 3.6 |
| Medicare | 12.9 | 12.6 | 12.1 |
| Medicaid | 7.8 | 7.2 | 5.2 |
| CHAMPUS<sup>a</sup> | 1.0 | 0.7 | 0.4 |
| Uninsured | 14.7 | 11.1 | 5.8 |

<sup>a</sup>Civilian Health and Medical Program of the Uniformed Services.
contributions to health insurance from workers' taxable income and expanding individual tax credits. Because no employer contributions to health insurance are currently included in employees' taxable income, proponents of this type of reform argue that neither employers nor employees have any incentive to choose the most cost-effective plan. They suggest that if contributions are limited to a maximum dollar amount or to the average cost of a basic health plan in a geographic area, employers and employees would be more likely to choose cost-effective providers. By expanding individual tax credits, advocates hope that low-income individuals would be more easily able to purchase health protection for themselves and their families.

Currently, employer contributions to health insurance are excluded from employees' taxable income. This tax preference is intended to expand access to health care by encouraging health insurance coverage. Many analysts have concluded that the tax preference leads to the purchase of too much health insurance, insulating insured individuals from the financial consequences of their health care service purchases and at least contributing to health care cost inflation.

Additionally, the tax preference is often said to be regressive because the value of the exclusion is greater for higher-income individuals. This occurs for two reasons. First, although the value of the benefit is generally the same for the lowest- and highest-income individuals within the same employer, higher-income workers face a higher marginal tax rate. The same dollar exclusion is thus worth more to them. This advantage was substantially reduced when the tax rate structure was condensed by the Tax Reform Act of 1986 (TRA '86). The second reason that the tax preference is regressive is that the probability that an individual has employer-based health insurance decreases as his or her income decreases. Low-income individuals are less likely to have coverage and are therefore less likely to benefit from the exclusion.

However, for those individuals who receive coverage through an employer and whose employer contributes to that coverage, the exclusion of that contribution from taxable income may be progressive. The costs of providing health coverage do not generally vary by income, so if tax rates were proportional (with everyone paying the same percentage of income in taxes), the exclusion would be a larger percentage of the low-wage worker’s income than of a higher-wage worker’s income. As tax rates become more progressive (so higher-income individuals pay a larger proportion of their income in taxes), the value of the exclusion increases for higher-income individuals and the tax preference becomes less progressive. The flattening of the tax rates in the TRA '86 made the exclusion more progressive.

As an example, take the three families in table 5, each of whom has health care benefits through an employer. The employer’s contribution for each family is $3,000, so the employer’s contribution to the benefits is 15 percent of the first family’s income, 6 percent of the second family’s income, and 3 percent of the third family’s income. Currently, the first family faces a 15 percent marginal tax rate, while the marginal tax rates for the second and third families are 28 percent and 31 percent, respectively. So while the value of the exclusion is greater for the families with higher incomes, the value of the exclusion as a percentage of each family’s income is less for the higher-income families. For families that presently receive health benefits, including the employers’ contribution to the benefits in the families’ taxable income would likely be regressive.

Although most researchers agree that this tax preference has affected the provision of health insurance benefits by employers, it is not clear how much of the increase in private health insurance coverage, and thus on health care costs, results from tax policy. In general, the tax preference for health benefits has increased both the number of individuals with health insurance and the breadth of coverage, although its effects differ by employee group.

Changes in tax policy without other health system reforms will clearly affect the cost of health

| Table 5 | Value of Exclusion of Employer Contribution of $3,000 to Three Families of Different Income Levels |
|------------------|---------------------------------|-----------------|-----------------|-----------------|
| Family Income  | Employer Contribution as a Percentage of Family Income | Marginal Tax Rate | Value of Exclusion | Exclusion as a Percentage of Family Income |
| $20,000         | 15%                                           | 15%             | $450            | 2.3%             |
| $50,000         | 6                                             | 28%             | $840            | 1.7%             |
| $100,000        | 3                                             | 31%             | $930            | 0.9%             |
| Source: Employee Benefit Research Institute. |
benefits and workers’ income. Including the value of health benefits as taxable income reduces the total net (of taxes) compensation of workers who receive these benefits. The reduction in compensation will depend on the worker’s taxable income, with high-income workers facing the largest dollar drop if health benefits are included as taxable income. Some workers may feel that, absent the tax preference, they would rather have cash than health benefits. Employers trying to attract these workers may be less likely to offer health benefits.7

Removing the cost of health benefits as a tax deductible business expense for employers (but not including it as part of employees’ taxable income) increases employers’ labor costs. Employers may respond to such a change by reducing or dropping health benefits, reducing the provision of other benefits or cash compensation, or reducing employment. Because the cost of providing health benefits does not generally vary by income for employees within a plan, changing the tax preference in this way will increase the costs of employing high- and low-wage employees by the same dollar amount, although the percentage increase in costs for high-income workers will be less. A $3,000 dollar increase in the cost of employing a highly skilled (and therefore high-income) worker may not reduce the demand for these workers very much, whereas the same increase in the cost of employing a less skilled worker may have a large impact on the demand for such workers.

Most large employers who offer health insurance would likely continue to offer it in the absence of a tax preference. Group insurance is less expensive than individual policies because of the costs of administration and the problem of adverse selection. Employers are thus able to provide more insurance per dollar than the employee could purchase individually. Employer-sponsored health insurance may also decrease employee turnover and increase productivity.

Small employers and employers with a large number of low-wage workers may decide not to offer health insurance in response to the elimination of favorable tax treatment for health benefits. Moreover, changes in the tax treatment of employer health benefits are likely to change the nature of these benefits. Employers may not desire coverage of marginal health care services. Some coverages, such as dental insurance, may be dropped, and coverage for basic care may be reduced through higher deductibles and copayment rates. More employers may institute cafeteria plans to accommodate differences in the demand for health insurance among their employees.8

The effect of changes in tax policy on national health care expenditures is unclear. It is clear that, by itself, removing the exclusion from individual taxable income of an employer’s contribution to health benefits would reduce the number of individuals with employer-sponsored health insurance and reduce the breadth of services for those with employer-sponsored coverage. The magnitude of that change is unknown. Research into the relationship between tax policy and the demand for health insurance and between insurance and the demand for health care services suggests that the magnitude may be small. However, the impact of insurance coverage on technological advances and the quality and intensity of care are not well understood.9 It may be that over time changes in health insurance induced by changes in tax policy could have profound impacts on the health care delivery system.

A number of attempts have been made to estimate the effect of limiting the amount of employer contributions to health insurance that is excluded from

employees’ taxable income. A Health Insurance Association of America (HIAA) analysis of such a proposal advanced by the U.S. Department of the Treasury found that the effect of such a cap on individual taxable income would vary by region, firm size, and income (Health Insurance Association of America, 1985). For example, a worker earning $15,000 in a small firm in Los Angeles with fully employer-paid insurance would have to pay an additional $718 in federal income and Social Security taxes under the proposal—a 36 percent increase in tax liability under 1985 tax law, compared with a 17 percent tax increase for higher earners.

EBRI used its Tax Estimation Analysis Model (TEAM) to estimate the impact of capping tax-exempt employer contributions to health plans at $2,940 for family coverage and $1,080 for individual coverage in 1991 (table 6). The analysis found that the imposition of a tax cap would be regressive in the sense that lower income filers would pay a larger percentage of their income than higher income filers toward the new tax. This effect is mitigated if lower-income individuals are not subject to the cap.

Along with shifting the distribution of the tax burden, capping the tax exemption of employer contributions to qualified health plans would also generate additional federal revenue. A cap of this size would have gathered $18.7 billion in 1991 assuming that there were no changes in employer or employee behavior as a result of the change in tax preference. This clearly is implausible. In fact, as discussed above, the major reason for changing the tax treatment of health benefits, other than to raise revenue, is to induce a change in behavior. These estimates should thus be considered the maximum that could possibly be raised; the actual amount is likely to be less (table 7).

The greatest increase in tax revenue would come from taxpayers with annual incomes of $20,000–$50,000—$8.3 billion in additional tax revenue. If the cap were phased in by income so that individuals with incomes of less than $10,000 and families with incomes of less than $20,000 were not subject to the cap, the total revenue raised would be $13 billion, with the largest share coming from those with incomes between $50,000 and $100,000.

### Table 6

<table>
<thead>
<tr>
<th>Income Class</th>
<th>Average Adjusted Income per Return</th>
<th>Average Change in Taxes per Return</th>
<th>New Taxes as a Percentage of Income per Return</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>$27,673</td>
<td>$140</td>
<td>0.50%</td>
</tr>
<tr>
<td>Less Than $5,000</td>
<td>348</td>
<td>5</td>
<td>1.40</td>
</tr>
<tr>
<td>$5,000–$10,000</td>
<td>7,701</td>
<td>20</td>
<td>0.25</td>
</tr>
<tr>
<td>$10,000–$15,000</td>
<td>12,730</td>
<td>54</td>
<td>0.42</td>
</tr>
<tr>
<td>$15,000–$20,000</td>
<td>17,854</td>
<td>123</td>
<td>0.69</td>
</tr>
<tr>
<td>$20,000–$30,000</td>
<td>25,217</td>
<td>174</td>
<td>0.89</td>
</tr>
<tr>
<td>$30,000–$50,000</td>
<td>40,193</td>
<td>234</td>
<td>0.58</td>
</tr>
<tr>
<td>$50,000–$100,000</td>
<td>68,651</td>
<td>364</td>
<td>0.53</td>
</tr>
<tr>
<td>$100,000–$200,000</td>
<td>142,450</td>
<td>517</td>
<td>0.36</td>
</tr>
<tr>
<td>More than $200,000</td>
<td>444,966</td>
<td>767</td>
<td>0.17</td>
</tr>
</tbody>
</table>

Source: Employee Benefit Research Institute Tax Estimation Analysis Model.

### Table 7

<table>
<thead>
<tr>
<th>Income Class</th>
<th>$1,080 Individual No Phase In</th>
<th>$1,080 Individual Phase In $10,000/$20,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $20,000</td>
<td>$2,569.4</td>
<td>$497.8</td>
</tr>
<tr>
<td>$20,000–$50,000</td>
<td>8,339.0</td>
<td>5,246.4</td>
</tr>
<tr>
<td>$50,000–$100,000</td>
<td>5,683.9</td>
<td>5,274.5</td>
</tr>
<tr>
<td>$100,000–$200,000</td>
<td>1,419.3</td>
<td>1,419.2</td>
</tr>
<tr>
<td>More than $200,000</td>
<td>695.3</td>
<td>695.3</td>
</tr>
<tr>
<td>Total</td>
<td>$18,706.9</td>
<td>$13,133.0</td>
</tr>
</tbody>
</table>

Source: Employee Benefit Research Institute Tax Estimation Analysis Model.

### Distribution of Costs and Benefits

While each health care reform proposal would have different distri-
Table 8
Employee Benefit Research Institute Simulations of Federal Expenditures, Adjusted Premiums, and Total Premiums under H.R. 5936 If It Were in Effect in 1991

<table>
<thead>
<tr>
<th>Family Income as a Percentage of Poverty</th>
<th>Total Federal Assistance ($ billions)</th>
<th>Total Income Adjusted Premiums&lt;sup&gt;a&lt;/sup&gt; ($ billions)</th>
<th>Total Premiums ($ billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 100%</td>
<td>$44.6</td>
<td>$44.6</td>
<td>$75.8</td>
</tr>
<tr>
<td>100% to 200%</td>
<td>26.6</td>
<td>73.3</td>
<td>92.2</td>
</tr>
<tr>
<td>Greater than 200%</td>
<td>0</td>
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<sup>a</sup>Asumes premiums that average $2,340 but vary by region and age.

Distributional effects, the CDF proposal provides a framework for examining how changes in the tax code would affect the distribution of costs and benefits in health care reform. The largest single expense in the CDF proposal would be the assistance given to low-income individuals for the purchase of health insurance. The value of this assistance depends on the minimum benefit package, which has not yet been determined, and the factors determining the AHPs’ premium. While the services covered under the minimum basic benefit package are the most important determinants of that premium, the AHPs will also have to consider local market demographics and develop a formula for sharing the burden of their share of the subsidy to low-income individuals.

EBRI simulated the CDF plan’s expenditures as if it were in place in 1991. It was assumed that the minimum benefit package would resemble the average coverage currently given to privately insured individuals. Premiums were assumed to vary by age and region in the same manner as they do now. These variations were simulated using data from A. Foster Higgins and Blue Cross. The premiums ranged between $1,380 and $3,670, with an average premium of $2,340. This compares with Medicaid per enrollee medical expenditures (excluding Medicaid payments for nursing home care), which ranged from $1,280 to $3,847 with an average expenditure of $1,996. This is the crucial assumption in determining the effects of the CDF proposal; other assumptions may give very different results.

Table 8 illustrates the relative burdens of the subsidy on the federal government and AHPs. Total federal assistance for those below poverty would be $44 billion. It is estimated that, if every individual whose family income was between the federal poverty level and twice the federal poverty level purchased health insurance, the federal assistance for that group would be just under $27 billion. However, some of these individuals may not choose to purchase health insurance despite the

subsidy. Using a mid-range estimate of the sensitivity of an individual’s demand for insurance to changes in the cost of that insurance, EBRI estimated that about 50 percent (5.5 million out of 11 million) of the currently uninsured with family incomes between the poverty level and twice the poverty level would opt to purchase health insurance, given the subsidies in this plan.

The second column in Table 8 gives the total premiums AHPs would be allowed to charge to individuals. The final column gives the total estimated premiums that would be charged without the requirement to adjust these premiums for low-income individuals. Subtracting column two from column three gives the total subsidy incurred by the AHP for low-income individuals. For individuals in families with incomes below the poverty level, the total AHP subsidy would be about $31 billion. The plan provides that funds would be exchanged among AHPs to prevent any individual AHP from losing due to a disproportionate share of low-income individuals. However, the premiums negotiated by the HPPC and the AHP will have to reflect the subsidies paid by the AHP to low-income individuals due to reduced premiums.

The primary revenue sources for the CDF proposal are the funds currently used as the federal contribution to the Medicaid program, the revenue gained from removing the cap on income subject to the Medicare payroll tax, and the revenue from the excise tax on the portion of employer contributions that exceed the minimum premium for the basic benefit package.

- In 1991, the total federal expenditures for the Medicaid program were $53.6 billion.
- Using the EBRI TEAM, assuming a basic benefit premium of $2,000, and assuming that employers did not change the amount they contribute to their employees’ health benefits, the excise tax on private employers would raise $12 billion in 1991.
- It is estimated that the revenue gained from remov-
ing the cap on income subject to the Medicare payroll tax would be about $5 billion in 1991.

The total for these revenue sources is slightly more than $70 billion. Given the assumptions made in the simulations, the revenue sources identified in the CDF plan would almost pay for the low-income assistance provisions. However, the assumption that employers would continue to provide that same contribution to their employees’ health plan in the face of a 34 percent excise tax seems dubious at best. More likely they would cut back their contribution to the amount of the cap and pay their employees the difference in cash. If that is the case, that money would then be taxable income, and revenues from the individual income taxes would increase. If all employers took that action, the effect would be identical to a cap on the exclusion of employer contributions from the employees’ taxable income in terms of influencing consumer behavior, although lower marginal tax rates would mean less revenue for the federal government. The political difference between these two actions is that, with the cap, policymakers could claim that no individual taxes were raised.

Most of the proposal’s revenue comes from the Medicaid program, which currently covers about one-half of the population below poverty. The plan proposes to spread Medicaid’s funds over the larger population of individuals below 200 percent of poverty by requiring AHPs to reduce their premiums to low-income individuals. As a result, the standard nonadjusted premiums would have to increase to pay for that subsidy. This has the effect of both increasing the federal assistance and reducing the number of the uninsured above the poverty level who will choose to purchase health insurance, exacerbating the adverse selection problem.

There are no requirements that individuals purchase health insurance coverage or that employers help finance that coverage. One of the concerns of a voluntary system of health insurance is that the AHPs will suffer from adverse selection. While the CDF proposal specifies that payments will be made across AHPs so plans with poorer risks will receive payments from plans with better risks, there is concern the entire system might face selection problems in that, as costs increase, better risks will choose not to purchase insurance. To the extent that occurs, the premiums charged for the minimum basic plan would need to increase to reflect the risks represented by those actually purchasing insurance. The result would be an increase in the pool’s average risk, increasing premiums and potentially creating a vicious cycle that would end with an unviable health insurance market. The likelihood of this scenario actually occurring depends on the sensitivity of the demand for health insurance to changes in premiums among good and bad risks and on individuals’ ability to determine their own risk status.

Changing the health insurance market, mandating employer health benefits, and changing the tax code may have significant effects on the health care delivery system, but they are unlikely to reduce health care cost inflation in the near term. One of the proposals for restraining the growth in health care costs is the imposition of a budget on the amount spent on health care services. How this budget would be implemented, what services would be subject to the budget, and whether the budget would be global or limited to government purchases of health care services, have not yet been addressed.

The most limited approach would be to cap the amount the federal government spends on health care. This approach would affect the Medicare and Medicaid programs at a minimum and perhaps the federal employees health benefits program and the veterans health...
system as well. While such an approach has the benefit of controlling federal expenditures, it may exacerbate the problems faced by the health care delivery system as a whole. The history of health care cost management has demonstrated that reducing the amount an individual payer spends for care redistributes the cost burden across other payers. In the federal government’s case that redistribution will mean that some providers earn less income but also that private payers—especially those with limited market power in local health care markets, the states through the Medicaid program, and individuals without health insurance—are going to bear a substantial portion of the reduction in expenditures in the form of cost shifting.

Placing a budget cap over the entire health care delivery system would require that price controls be implemented on the system. Without those controls, the budget cap would simply be a target. A target is distinct from a cap in that a target has no enforcement mechanism. Simply setting a target may have some benefits, but it seems unlikely that it would substantially reduce health care expenditures. One of the benefits of imposing a budget cap or a target is that the amount society wishes to spend for health care is determined by the political process rather than an informal market.

A target can be used to determine future regulatory action, for example, by triggering the imposition of price controls in the future. The issue is whether these nonbinding targets have much of an effect on individual provider behavior. If individual health care providers believe their own actions have little impact on the system as a whole, the presence of a target may not have much effect even if exceeding that target would lower reimbursement in the future.

Conversely, a budget cap implies the existence of a mechanism for enforcing that cap. That enforcement mechanism has to be the regulation of prices in the health care system. Employing a system of administered prices (i.e., prices that are determined by regulators rather than by market forces) in the health care services market as an enforcement mechanism raises a number of issues. In general, administered prices are inferior to prices determined in an efficient market because they do not necessarily reflect the underlying costs of producing a service or the demand for that service. In practice, administered prices are often used in industries characterized by monopoly power, such as public utilities. As the number of interrelated services increases, it becomes increasingly difficult to administratively set prices that accurately reflect underlying costs and demands. Setting efficient prices in the health care services market, which is currently characterized by large differences in costs that are determined by provider type, region, and patient type, may prove to be much more difficult. Conversely, if health care service prices do not now accurately reflect costs and demands as a result of provider monopoly power, administered prices may in fact be an improvement. Whether a system of administered prices would be an improvement over prices as currently determined depends on the mechanism used to generate regulated prices and the degree to which the fees currently charged in the health care delivery system are different from those that would be charged in an efficient market.

There are several different ways to organize the financing and delivery of care with a binding budget cap. One way is to retain a private delivery system but impose an all-payer system in which providers are reimbursed by all payers according to a common fee schedule. One way to implement price controls is to apply Medicare’s reimbursement system to the entire system. Medicare prospectively sets a per admission fee schedule for hospitals, adjusted for diagnosis, and a per service fee schedule for physicians. Since the Medicare population is predominately elderly, some adjustments would have to be made for diagnoses and services for younger populations, but the basic methodologies could be directly applied.

One advantage of this approach is that it eliminates price discrimination and cost shifting. Currently, there are wide differences in the prices paid by
public, small private payers and large private payers for health care services. It is often asserted that these price differences reflect cost shifts from public payers to private payers. To the extent that this is true, the cost of care provided to those in public programs and those who are uninsured is subsidized by higher costs in the private sector.

It has been proposed that budget caps could be imposed in a managed competition system by regulating the maximum amounts that can be charged for the basic benefit package (Starr, 1992). In his campaign President Clinton also suggested that global budgets be used in conjunction with managed competition. Conversely, Alain Enthoven has suggested that global budgets would rob managed competition of its major cost management feature: price competition (Enthoven, 1993). Because the intention of managed competition is to develop a mechanism that would allow the market for health care services to operate efficiently, imposing price controls on that market means that the market will not determine the allocation of health care resources.

Controlling prices alone may not be enough to control total expenditures. If providers are able to increase utilization or to recode procedures to maximize their incomes, price controls may be ineffective in the short run. To the extent that they are effective, they may affect the quality of care. Over time, the fees paid for health care services may become considerably different from those that would have been charged in the marketplace. Practice patterns that exist when the controls were developed might be frozen in place. The mix of physician specialties may not reflect the mix that would be most cost effective or provide the highest quality of care.

President Nixon imposed wage and price controls on the health care system in the early 1970s. These controls were considered an abject failure in controlling health care cost inflation. The lifting of the controls led to rapid increases in the prices of health care services and in health care expenditures. A similar result might be avoided if budget caps are imposed in the short term until the markets for health insurance and health care services are reformed. Then market forces might restrain health care cost inflation if the caps are removed.

The arguments for or against price controls come down to a debate on the efficiency of the market for health care services and health insurance. If those two markets fail, administered prices might actually improve the allocation of resources. However, if the markets are efficient enough to represent the desires of consumers and the costs faced by providers better than regulators, administered prices result in a less efficient allocation of resources.

If the primary goal of health care reform is to contain costs in the near term, binding budget caps seem to be inevitable. No other mechanism will have as immediate an effect on health care costs. To have significant effects on health care costs, budgets must be accompanied by price controls and some constraint on utilization. Simply setting targets for health expenditures may not have much of an impact. In the short run, the excess capacity of the U.S. health care system would probably mitigate some of the adverse effects on the quality of care that many analysts have suggested would be the result of binding budget caps.

The combination of the constraints placed on federal governmental action by the budget and the significant political problems involved in reaching a consensus on the important elements of health care reform may limit the ability of the federal government to implement national health care reform in the near term. As a result, individual states may be encouraged by the federal government to continue to experiment with their own
### Table 9

**State Small Group Market Reform**

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a Lower limit on group size for basic plan.
b With limits on carrier share of total market.
c Maine’s continuity law applies to all groups regardless of size.
d Limited use of demographic rating.
e Limits rate increases to one per each six months.
f For basic benefit plan with employer paid premium.
health reform programs. Many states are actively considering a variety of approaches to health care reform. These proposals vary according to the type of system used to provide health care coverage and the population covered; how the system will be financed; the types of health care services provided; and how the system will be administered. Even if individual states are able to reach a consensus on an approach to implement, most proposals still face a number of barriers in attempting to expand access or reduce health care cost inflation.

Most health care reform proposals reallocate the costs of health care services in order to expand access to care. As a result of the reallocation, some groups would face higher costs in the form of increased labor costs, higher insurance costs, or higher taxes. Therefore, state health care reform provides an incentive for employers who face higher costs to move out of the state. While this is also true of national health care reform, there are language, cultural, and technical barriers that may limit movement out of the country, but these barriers are much less of a factor in movement among states. Moreover, individual states may not have a sufficient tax base to implement and sustain comprehensive health care reform measures. Finally, the interaction of state and federal law places important constraints on states’ ability to regulate the health care delivery system. ERISA authority is of particular significance to state health care reform.

ERISA

ERISA establishes uniform standards that employee benefit plans must follow to obtain and maintain their tax-favored status. ERISA section 514(a) provides that ERISA generally supersedes or preempts all state law otherwise applicable to pension and welfare plans covered by ERISA, with the exception of state law regulating insurance, banking, and securities. The exception covering insurance in effect allows certain indirect state regulation of insured health plans. Recent court decisions have affirmed that ERISA exempts employers who self-insure their health insurance benefits from many such state laws. Many employers choose to self-insure because they are exempt from state mandated benefit laws, which specify certain types and levels of coverage the group policies must include. Moreover, self-insured plans have been able to invoke ERISA preemption protection to avoid paying taxes on insurance premiums or taxes that fund state pools to insure poor risks.10 As a result, ERISA preemption has limited states’ ability to finance health care proposals. Many state reform efforts face the risk of being overturned in court because they would cause some impact to employee benefit plans.

A New Jersey federal district court ruled in May 1992 that ERISA preempts a New Jersey hospital rate-setting law that would have required self-insured health plans to pay surcharges to cover the costs of care provided to the poor.

More recently, fully insured plans have begun to successfully challenge states’ financing mechanisms. On February 3, 1993, a federal judge struck down a large part of New York’s payment system that added surcharges to hospital bills paid by commercial insurance companies and HMOs. The surcharges were meant to be used to help nonprofit insurers, which did not have to pay the surcharges, compete more evenly with the for-profit companies. The court found that the surcharges violated ERISA because they involved the use of employee contributions to benefit funds to subsidize the

10 Congressional interest in ERISA preemption of self-insured plans has increased in the light of the McGann vs. H&H Music Company case, which involves a company that moved from a traditionally insured to a self-insured arrangement and subsequently lowered its lifetime health benefits for AIDS cases from $1 million to $5,000. In November 1992, the U.S. Supreme Court declined to review a lower court opinion that ruled in favor of the company. For further details on the case, see Sarah Snider, “Features of Employer-Sponsored Health Plans,” EBRI Issue Brief no. 128 (Employee Benefit Research Institute, August 1992).
The History of ERISA’s Preemption Provision and Its Bearing on the Current Debate over Health Care Reform

Michael S. Gordon, esq.


A curious myth has arisen in connection with the application of ERISA preemption provision to private-sector health plans. The myth is that what is now perceived by many as the adverse consequences of ERISA’s preemption provision on state efforts to regulate such plans were unintended by the Congress that enacted ERISA and were unforeseen. This myth received a sort of semiofficial blessing when in the late 1970s Hawaii sought specific legislation to exempt its Prepaid Health Care Act from ERISA’s preemption provisions. Leading the charge was Hawaii Sen. Daniel Inouye (D), who said that ERISA’s preemption regarding state regulation of private health plans was the product of “inadvertent legislative oversight.”1 Sen. Lloyd Bentsen (D-TX), who had been a conferee on ERISA, no doubt out of sympathy for his colleague, contended that the issue had never come up in hearings before the Finance Committee, which somehow seemed to imply that Senator Inouye was correct.2

The myth was reinforced to some extent in 1983, when Hawaii obtained a sharply limited exemption from ERISA’s preemption clause for its health statute. Outside the Washington Beltway it probably looked like Congress had corrected its unintended oversight; inside the Washington Beltway, the reluctance of Congress to give Hawaii the complete exemption it sought signified that maybe it had meant it when it enacted sweeping preemption in 1974.3

In my view, the debunking of this myth is essential if all of us are to arrive at a sound and realistic appraisal of what can or should be accomplished at the State level in order to bring about meaningful health reforms. There are many in the health reform culture who have a great deal of fondness for the myth because it seems to fortify their case for state initiatives. However, fictionalizing the very difficult federal-state dilemma that confronted the ERISA legislators in 1974 hurts rather than helps the current efforts to achieve needed health reforms. Such an outlook needlessly trivializes the concerns that led to sweeping preemption and makes it highly problem-

2 Ibid.
3 The 1983 Hawaii exemption only saved the Hawaii health statute as it existed in 1974 and did not save subsequent amendments to that statute that were enacted in 1976. The 1983 Hawaii exemption also contained a warning that “[t]he amendment made by this section shall not be considered a precedent with respect to extending such amendment to any other State law.” Id. at 59.

To give states more flexibility in designing health care reform plans, bills were offered in the 102nd Congress to give states limited exemptions from ERISA. Sens. David Pryor (D-AR) and Patrick Leahy (D-VT) introduced legislation that would have streamlined and expanded the ERISA waiver process. The bill would have allowed qualifying states to tax ERISA plans to equalize contributions across health care plans and to subsidize the uninsured. It also would have established standard benefit packages requirements for employer-sponsored plans. Self-insured plans would have been exempt from the standard benefit requirements if they met a minimum per-employee dollar value standard. Rep. Ron Wyden (D-OR) introduced similar legislation, but his bill would have only allowed states to tax plans if all employers in the state were taxed under a comprehensive health care financing system. Sen. Dave Durenberger (R-MN) introduced legislation that would...
eral, the proponents of state reforms will be able to reconcile successfully their differences with opponents of state action.

The fact is that the key legislators involved in enacting ERISA’s all-inclusive preemption provision did realize and understand its essentially adverse effect on state regulation of health plans. Some of them, like former Sen. Jacob Javits, the foremost architect of ERISA, but also an impassioned advocate of national health insurance, not only knew and understood, but were exceedingly troubled by the implications of ERISA’s broad preemptive scope.

In order to appreciate what troubled many ERISA legislators, like former Sen. Jacob Javits, but which, nonetheless, led to the much criticized preemption provision that we confront today, it is necessary to turn the clock briefly back to the situation that existed at the time of the Senate-House conference on ERISA in 1974. The Senate and House passed versions of preemption that prevented the states from legislating about the matters regulated by the law. Since, in contrast to the extensive regulation imposed on pension plans, the then pending legislation imposed only fiduciary and disclosure requirements on health and welfare plans, the then pending legislation imposed only fiduciary and disclosure requirements on health and welfare plans, this meant that states were generally free to legislate content requirements for such plans—exactly the situation that proponents of health plan reforms currently regard as preferable.

However, during the ERISA conference, three dramatic instances of state action affecting health and welfare plan development in a potentially injurious way were brought to the attention of the conferees. Needless to say, these examples did not surface as a result of some accidentally uncovered academic research project, but were introduced to the conferees through the form of intense lobbying pressure on the part of politically potent interest groups. These interest groups did not necessarily advocate the sweeping preemption provision ultimately adopted by the conferees; they merely wished to make sure that States were blocked from taking the particular actions that they opposed.

The three problem areas (not necessarily listed in the order of their importance) were (a) the Monsanto decision, (b) Hawaii’s prepaid Health Care Act and California’s threatened imitation of that model, and (c) pending state restrictions on prepaid legal service plans.

In the Monsanto decision, a Missouri lower court had held that the Monsanto company’s noninsured health plan for its employees, a portion of which was collectively bargained, could not pay out benefits until it had satisfied the licensing requirements governing insurance companies in Missouri. Business and organized labor groups objected to the notion that a state could treat such a noninsured health plan trust fund as if it were an insurance company subject to the regulation of commercial insurers under the supervision of the state’s insurance commissioner. The case was perceived by them as a prelude to a revenue grab by Missouri so as to rationalize the imposition of a premium tax on employer contributions to noninsured employee benefit trusts. It was also perceived as having the collateral purpose of inducing such trusts to switch their operations to commercial insurers.

Moreover, that segment of the labor movement that operated joint labor-management multipurpose health plans, the so-called Taft-Hartley plans, feared that if the Monsanto decision was embraced by other state courts, it would put the Taft-Hartley plans out of business. After all, what was the point of having a noninsured trust fund if the practical effect was to obliterate the distinction between insured and noninsured plans and treat the latter as if they were for-profit insurance companies? Thus, both business and labor concluded that if the pre-conference version of ERISA’s preemption clause permitted states to adopt the Monsanto approach, then such a clause had to be modified to short-circuit such a development. Parenthetically, the Monsanto decision was reversed after ERISA’s enactment.

Similarly, just prior to ERISA’s enactment, in Missouri v. Monsanto Co., Cause No. 259774 (St. Louis City, Cir. Ct., Jan. 4, 1973), rev’d, 517 S.W. 2d 129 (Mo. 1974). For further details, see Justice Steven’s dissent in FMC Corp. v. Holliday, 111 S.Ct. 403, 413; 12 EBC 2689, 2696-98 (1990).

6 Technically speaking, this result was accomplished not under the broader statement of preemption adopted by the conferences in sec. 514 (a) of ERISA, but under the so-called “deemer” clause in sec. 514 (b) (2) (B), 29 U.S.C. sec. 1144 (B) (2) (B), which stated that an employee welfare plan shall not be deemed to be an insurance company for purposes of State insurance laws. Nonetheless, the Monsanto decision played a vital role in generating the sweeping preemption language adopted in sec. 514 (a) because it stimulated fear that failure of federal authority to occupy the field under ERISA could lead to other forms of State action that, intentionally or otherwise, could undermine private benefit plans.
Hawaii had passed its Prepaid Health Act and California was threatening to do something along the same lines. While Hawaii’s labor unions had supported the Hawaii health law, the AFL-CIO feared (as did big business) that a series of state laws with varying health plan requirements would impose impossible compliance burdens on large multistate plans.

Moreover, in the case of collectively bargained plans, allowing states to determine the appropriate health benefits instead of the collective-bargaining parties, appeared to intrude on a critical federal labor law principle that labor unions had struggled for decades to vindicate. At the time, it was understood that from the perspective of many multistate unions, only a federal program of national health insurance justified the modification of that principle.

The last of the triumvirate of concerns that led to sweeping preemption had to do with prepaid legal services plans. A number of labor unions had invested heavily in the establishment of collectively bargained prepaid legal service plans, but there was an acrimonious dispute between the AFL-CIO and American Bar Association over whether the panel of lawyers available to provide their services under these plans should be open or closed. The American Bar Association was lobbying state legislatures to enact laws forbidding the type of legal services plans the AFL-CIO favored, which were closed panels.

Employer-union prepaid legal services plans were a type of welfare plan that fell under ERISA’s jurisdiction. However, since the pre-conference version of ERISA would have permitted states to prohibit the AFL-CIO favored legal services plan, the AFL-CIO insisted on the modification of the preemption clause to assure the survival of its approach.

In my view, it should be clearly understood that the failure to modify preemption to deal with all the concerns I have just described would have resulted in a failure to enact ERISA altogether. The combined political firepower of those insisting on broader pre-emption was too great to run the risk of ignoring or downgrading their concerns. No doubt, the failure to enact ERISA would have left states free to enact the type of health reforms that the enactment of ERISA prevented them from accomplishing, but in those days pension reform, not health reform, was the top priority. Thus, expanding ERISA’s preemption provision to assure that states could not enact the type of health system reforms that are at the top of today’s agenda was a decision the ERISA conferees were compelled to make, even though many of them knew and were made uncomfortable by the knowledge that it could set back the cause of health system reforms for the then foreseeable future.

That future has clearly and painfully arrived. In the last analysis, the choice of whether health reforms should be legislated at the federal or state level, or some combination thereof, is not an ERISA preemption issue but one of the ultimate substantive policy decisions that must be confronted by the health reform culture.

Recent State Actions

On April 16, 1992, the Minnesota legislature passed the Health Right bill with small employer insurance reforms. These reforms include guaranteeing the issue and renewal of health insurance plans to small employers (defined as those with 2–29 employees). In addition, carriers would be required to offer two basic benefits plans that would be exempt from state mandates (except continuation of coverage and dependent care mandates), with maximum out-of-pocket costs of $3,000 per individual and $6,000 per family. General premium rates must not vary more than 25 percent on either side of the index rate by July 1, 1993. These variations can be based only on health status, claims experience, employer’s industry, and the length of time that the small employer has been covered. To spread the risk among a state’s carriers, the bill calls for the creation of a health coverage reinsurance association to share and transfer high risk groups among the state carriers.

The plan is funded by a 1 percent tax on premiums paid to HMOs and nonprofit health service corporations; a 2 percent tax on the revenues of hospitals, health care providers, and wholesale drug

7 Note 5, supra.
distributors; and a 5 cent per pack cigarette tax (Minnesota House of Representatives, 1992). These costs will be passed on at least in part to all payers. There is some question as to whether this feature of the plan is affected by ERISA preemption.

Implementation of the bill is projected to cost the state $254 million annually by 1997 in subsidies and is estimated to cover 160,000 Minnesotans, a little under one-half of the estimated number of uninsured in the state. The actual costs of the plan and the number of people who would gain coverage will depend on how sensitive the demand for health insurance is to changes in premiums.

In examining the likely impact of subsidies provided to individuals to purchase health insurance, EBRI found that, even assuming a very strong price sensitivity, which is unlikely for low-income families, fewer than 30 percent of those currently uninsured and eligible for the subsidy were likely to become insured as a result of the subsidy. That result is consistent with what has actually happened in Minnesota. The Health Right Act is an expansion of Minnesota’s Children’s Health Plan (CHP), which was enacted in 1988. Of the current 80,000 children eligible for CHP, 21,651 were enrolled in the program as of October 1991.

A self-insured union health plan brought a suit against Minnesota’s Health Right Plan, challenging the provision of the plan allowing hospitals to pass the provider tax through to payers. The case was dismissed by the court on the grounds that the tax was not in place at the time of the suit. The tax became effective January 1, 1993.

Other states are contemplating even more comprehensive reforms. Governor Chiles of Florida announced on January 4, 1993, a plan for reforming the state’s health care system. The plan, entitled “A Blueprint for Health Security,” is the fulfillment of legislation passed in March 1992, requiring a committee of providers, consumer groups, insurance representatives, and others to develop such a plan. The plan is based on managed competition. The centerpiece being state-chartered, nonprofit organizations (community health purchasing alliances (CHPAs)) pooling businesses, individuals, and local governments in exclusive geographic territories. Health care services would be purchased from accountable health partnerships (AHPs). The AHPs would be required to enroll all individuals regardless of current health status or medical history. Other components of the plan include basic benefit standards, Medicaid expansion to cover the working poor, private health insurance reform, and various measures designed to fundamentally reform the health care delivery system.

Aside from large scale reforms, a number of states have enacted health insurance reforms that determine how insurers price their product (table 9):

• New York enacted community rating in July 1992, effective April 1, 1993, for all policies issued to groups of 50 or fewer individuals and Medicare supplemental policies. The law allows for no rate variation. An advisory committee was set up to establish regulations to stabilize the small group market. On November 4, 1992, the Insurance Department published the regulations developed by the committee.

• Maine enacted in the spring of 1992 a law, effective July 15, 1993, that affects the small groups market of 25 or fewer covered individuals. The law allows carriers to vary rates by family status, smoking status, and participation in a wellness program as well as age, gender, occupation, and industry.

• Vermont enacted a law, effective July 1, 1992, that allows rates to vary by 20 percent based on factors approved by the Vermont Insurance Department. One of the key elements to the plan’s success is a “safety net” program proposed by Blue Cross of Vermont. The program offers premiums at 15 percent above previous rates to individuals who lose their coverage if their carrier leaves the market. According to the Vermont Insurance Department, only two carriers with a sizable portion of the market, Golden Rule and American Public, have left the market. The individuals covered by these two carriers were able to obtain
coverage from Blue Cross of Vermont’s “safety net.”

Although a number of states have implemented, or seem close to implementing, significant reform measures, many states have not seriously considered these proposals. Given the barriers facing individual states, it seems likely that most states will not take major action on health care reform in the near future without significant incentives from the federal government.

However the national debate on health care reform is resolved, the diversity across states is likely to influence the implementation of any national reform. In the absence of national reform, individual states will continue to affect their local health care delivery system through regulation of health insurance and health providers. Employers and other purchasers of health care services who are active in more than one state are likely to find increasing diversity across local health care service markets.

There are significant unanswered questions that must be addressed before health care reform can be implemented. These questions include what health care services are all Americans entitled to as a right? How would the health insurance market be regulated? If a managed competition model were implemented, how would the sponsors be organized? How would their respective market areas be allocated? What quality of care measures would be used to evaluate health plans? Would employers or individuals be mandated to procure health insurance? How would differences in risks faced by competing health plans be rewarded? How would the tax treatment of health insurance change and how would these changes affect coverage, costs, and quality? Are global budgets desirable and what form would they take?

Who would bear the costs of health care reform? This Issue Brief attempted to examine the issues surrounding these and other questions.

However these questions are ultimately addressed, it is clear that health care reform is going to have significant impacts on the health care financing and delivery systems. Changes in the market for health insurance are likely to decrease the numbers of health insurers. Changes in the tax code may provide an incentive for individuals to choose more cost-effective plans, which may accelerate the growth of organized systems of care such as HMOs and other managed care networks.

Regardless of the way in which the political debate over health care reform is resolved, fully implementing these reforms is likely to be a prolonged process. Some of the reforms and their impacts will be felt immediately, but it is more likely that the issues of health care cost inflation and limited access to health care services will be with us for some time.


Employee Benefit Research Institute. “Rationing: Making
Choices and Allocating Resources in the Health Care Delivery System.” EBRI Issue Brief (Employee Benefit Research Institute, forthcoming).


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