

ODP/DPC office
Chris Jennings

BOX 2:

REQUESTS

Meetings/Event Invitations	Oct 99 – Feb 00
Meeting	Apr./May/June/98-99
Event Invitations	Nov 98 – Feb 99
Speaking Engagements	April 99 – June 99
Speaking Engagements	Feb 98 – July 98
Speaking Engagements	Jan 99 – Aug 99

ENCLOSURES FILED OVERSIZE ATTACHMENTS

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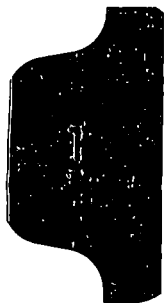
Out of Chaos and Gridlock
Building Leadership and Consensus for Universal Access to Health Care

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Out of Chaos and Gridlock Building Leadership and Consensus for Universal Access to HealthCare

Meeting Overview

Despite a robust economy for almost a decade and low unemployment, the number of non-elderly Americans without health insurance continues to grow. In 1999, 44 million Americans were uninsured, up from 36 million in 1990. The growth of the uninsured poses serious challenges to efforts that improve the health of Americans and the productivity of the nation, and is prompting increased political and media attention to address the problem.

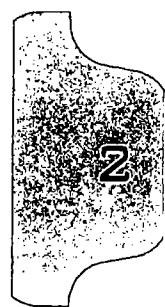
Out of Chaos and Gridlock is a two-day meeting of approximately 20 national leaders from health care policy and economics and the stakeholder communities. Participants will discuss the sociological, political, and economic factors related to the growing number of uninsured, examine potential models and solutions, and begin building leadership and broad consensus for principles to guide health system reforms.

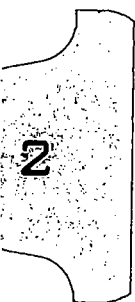
This effort supports and complements the growing number of efforts by a variety of groups and public policy makers to address universal access to health care. A distinguishing characteristic of this effort is participation by a small group of thought leaders in a highly interactive and intensive forum where they can engage in candid discussions of challenges and solutions. A desired outcome of the meeting is commitment from a core group of the participants to continue to work together on a national framework for regulatory and market efforts.

The meeting format includes brief presentations that will frame discussion and debate about the various aspects of reform to the health care delivery system. Meeting goals are to:

- Discuss service system reform, addressing quality and infrastructure issues.
- Consider health care financing in a realistic context, i.e., there will not be significant new resources, and with the assumption that universal access and quality care can be achieved within current expenditures.
- Debate ideas that conceptualize health system reforms in new ways to stimulate new thinking and approaches.
- Consider emerging tools, such as the Internet and digital technologies, that have the potential to improve persistent public policy concerns of access, safety, and efficiency, and consumer demand for high quality, customer friendly, and cost conscious care systems.

The meeting, hosted by the Washington Business Group on Health and the Bazelon Center for Mental Health Law, is supported by a consortium of public and private entities: the California Health Care Foundation, the MacArthur Foundation, the National Institute of Mental Health, and the Substance Abuse and Mental Health Services Administration.





Out of Chaos and Gridlock

Building Leadership and Consensus for Universal Access to Health Care

April 30 – May 2, 2000
Belmont Conference Center
6555 Belmont Woods Road
Elkridge, MD 21075

Preliminary Agenda

Sunday, April 30, 2000

- 5:00 p.m. Arrival and check-in at the Manor House
- 5:30 p.m. **Welcoming Reception and Dinner** (Manor House)
Mary Jane England, M.D.
President, Washington Business Group on Health
- Robert Bernstein, Ph.D.
Executive Director, Bazelon Center for Mental Health Law

Monday, May 1, 2000

- 7:00 a.m. Early coffee
- 7:30 a.m. Breakfast at the Manor House
- 8:30 a.m. **Introductions and Meeting Overview** (Carriage House)
Mary Jane England, M.D.
President, Washington Business Group on Health
- Each participant will share what they believe are the greatest challenges and opportunities for realizing a national framework for universal access to health care*
- 10:30 a.m. Break
- 10:45 a.m. **Organization Out of Chaos: Four Systems in Health Care**
Lawrence Casalino, M.D., Ph.D.
Professor, Department of Health Studies, University of Chicago
- Discussants: David Mechanic, Ph.D.
Professor, Institute for Health Policy and Aging, Rutgers University
- Michael Hogan, Ph.D.
Director, Ohio Department of Mental Health
- 12:00 p.m. **Luncheon/Walk the Belmont Center Grounds**
- 1:30 p.m. **Breaking Through Long-Held Assumptions: Principles for Reform**
Paul Starr, Ph.D.
Professor, Sociology, Princeton University
- Discussants: Judith Feder, Ph.D.
Research Professor of Public Policy, Georgetown University
- David Lansky, Ph.D.
President, Foundation for Accountability

- 3:00 p.m. **Break**
- 3:15 p.m. **Challenges to Predicting Economics of Reform Through the Lens of Prescription Drug Benefits**
 Richard Frank, Ph.D.
 Professor of Health Economics, Harvard Medical School
- Discussant: Constance Horgan, Sc.D.
 Professor, Heller School, Brandeis University
- Navigating the Political Landscape**
 Christopher Jennings
 Special Assistant to the President for Health Policy
- Discussant: Ronald Pollack
 Executive Director, Families USA
- 5:30 p.m. **Adjourn Day One**
- 6:00 p.m. **Reception/Dinner** (Manor House)

Tuesday, May 2, 2000

- 7:00 a.m. Early coffee
- 7:30 a.m. Breakfast at the Manor House
- 8:30 a.m. **System Reform Model: Transferable Tax Credit Proposal** (Carriage House)
 Lynn Etheredge
 Senior Consultant, Health Insurance Reform Project, George Washington University
- Discussant: Susan Dentzer, Ph.D. (invited)
 The News Hour
- 10:15 a.m. **Break**
- 10:30 a.m. **System Reform Model: Public Utility Proposal**
 William Goldman, M.D.
 Senior Vice President, United Behavioral Health
- Discussants: Paul Harrington
 Health Policy Director, Majority
 US Senate Committee on Health Education, Labor and Pensions
- John M. Colmers
 Executive Director, Maryland Health Care Commission
- 12:30 p.m. **Luncheon**
- 1:30 p.m. **Conclusions and Next Steps**
 Mary Jane England, M.D.
- 3:00 p.m. **Adjourn**



Out of Chaos and Gridlock
Building Leadership and Consensus for Universal Access to Health Care

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Organization Out of Chaos: Four Systems in Health Care

Lawrence Casalino

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Washington Business Group on Health

May 1, 2000

How should universal access to medical care be financed? That is the question with which many discussions of providing health care for all begin and end. It is an appropriate and necessary question, but focussing on it alone is not enough. Four systems function together in health care. Changing one while ignoring others is likely to lead to unintended consequences, uneven quality, and difficulty in controlling costs. Every finance system requires payors, payment methods, and providers of care. The ways in which these are organized limits the types of finance system that are can be implemented, while the finance system in turn strongly affects the evolution of payor, payment method, and provider systems.

The provider system is the final common pathway in health care. It profoundly affects the costs and quality of care. Rather than beginning, as usual, with the finance system, it might be productive to reverse the usual order of discussion and begin by considering what type of provider system might be desirable. This means asking: what kind of provider system is likely to meet the goals we have for health care? One would then work backward and ask: what types of finance, payor, and payment systems are likely to encourage the development of such a provider system?

In this paper I suggest a model of population-based care for the U.S. health care system. This model would be based on making physician groups – medical groups and Independent Practice Associations (IPAs) – responsible for caring for populations of patients.¹ The groups would be clinically integrated with hospitals, would be paid through a “blended” payment system which would combine elements of prospective and retrospective payment, and would contract with private and/or public “sponsors” which would structure quality and cost-based competition among the physician groups.

There are three cogent objections to this suggestion.

First: it could be argued that neither government nor employers as purchasers of medical care should “pick winners and losers” among providers. But this cannot really be avoided: any

¹ Population-based care would require clinical integration of physicians with hospitals and with other parts of the provider system. For simplicity, I write only of physicians in this paper; including hospitals does not change the essential arguments.

finance system does just that. It is better to start with consciousness of this fact than to proceed unconsciously, letting the chips fall where they may.

Second: it might be argued that the most important thing is simply to get health insurance for everyone, and that adding reform of the payor, payment, and provider systems could introduce difficult and unnecessary political complications. Yet it is not clear that these political complications would truly be unnecessary. To create a system of universal access which doesn't work – for example because it can't control costs or provides poor quality care – is not desirable. If the Medicare system had been designed in a way that it could control costs, perhaps the U.S. would have universal health insurance by now. (It may also be that any such design was politically impossible, and that there would be no Medicare program if the legislation's promise had not been to leave the provider system unaffected.)

Finally, some might believe that focussing on the provider system is utopian, not only because of the political difficulties it would entail, but also because of the paucity of capable medical groups and IPAs that presently exist. But if it is true that such groups are required if costs are to be controlled and quality improved, then it is important to consider how the creation of more such groups could be encouraged.

I begin by suggesting a set of goals for the health care system and discussing obstacles to achieving these goals. I then describe a configuration of provider, payment, payor, and purchaser (finance) systems which might achieve these goals, and conclude by outlining some public and private policies which would promote movement toward this configuration.

Five Goals for the U.S. Health Care System:

Universal access to care, control of costs, and improvement of quality are widely shared goals. Two other possible goals are perhaps less obvious, but are equally important. Continuous innovation in the processes through which care is provided is critical if costs are to be controlled and is necessary for continual quality improvement. Population-based care is also important for quality and probably for costs as well.

What is population-based care and why is it desirable? Population-based care would make groups of physicians and hospitals responsible for the care of populations of patients – not

just those individuals who present themselves for care, but all people in a given population. These provider groups, supported by state-of-the-art information systems and by professional managers, would be given incentives to allocate dollars where they would have the biggest impact, to provide preventive care and coordinated care of chronic diseases, and to continually develop new organizational processes to contain costs and to improve quality. This vision of population-based care is not new; it goes back – under the name of “prepaid group practice” to the Committee on the Costs of Medical Care of the 1930s and was invoked by supporters of the federal HMO Act of 1973, but has largely been lost in the bitter public and physician opposition to “managed care”.

What Systems Would Promote Access, Cost-Control, Quality Improvement, Innovation, and Population-Based Care?

Universal access can only result from changes in the system of financing health care. Possible financing changes will be discussed by others at this workshop; I will not discuss them in detail in this paper except to point out the impact they might have on the other three systems, particularly the provider system. Here I will simply note that there are at least two reasons why the U.S. provider system is not well-suited to provide universal access to care. First, the very uneven geographic distribution of physicians means that access to care would be difficult in many central cities and rural areas, even for patients who have insurance. Solving this problem would require offering financial incentives to physician groups to serve these areas. Second, the solo and very small medical group practices which still predominate in the U.S. (and elsewhere) are not well-suited to controlling costs or to increasing quality (more on this below). Changing the finance system without changing the provider system means either signing a blank check or resorting to heavy-handed means of controlling costs.

There are five ways to control health care costs:

1. Rationing:
 - the supply of providers

- the supply of services (through utilization management and/or through paying for less than all medically appropriate services, as in the Oregon Medicaid plan)

- by ability to pay.

2. Controlling the price paid per service
3. Competition
4. Increasing the cost-consciousness of patients and/or of providers
5. Innovation/re-engineering the processes of care.

When they are well-structured, competitive markets encourage innovation, making it possible to control costs while simultaneously increasing quality. Attempts to create competition in health care in the U.S. have met with mixed success: cost increases were temporarily slowed during the 1990s, but the system as structured encourages competition on the basis of market power, stinting (on delivering care), and shirking (avoiding sick patients), rather than competition on the basis of efficient delivery of high quality care.

Rationing and price controls can be reasonably effective in controlling costs, as Canada and Great Britain, for example, have shown. However, these methods are heavy-handed, introduce economic distortions, and do not in themselves lead to innovation or quality improvement.

Moderate incentives for physicians and patients to be aware of the costs of care would be useful (what would happen to U.S. restaurant costs if we all had “restaurant insurance” and, for a \$5 co-pay, could eat as much of whatever foods we wanted at any restaurant we desired?). Overly strong incentives would lead some patients – particularly poorer ones – to fail to seek appropriate care and some physicians to fail to provide it. Moderate incentives for cost-consciousness would be one important component of a competitive system, but are not enough in themselves to structure productive competition.

Quality in medical care has traditionally been understood as the quality of care which an individual physician provides for whichever individual patients happen to appear in his or her office. This kind of quality will always be important, but the concept of population-based care

suggests a complementary, and equally important, understanding of quality: quality as the care that a group of physicians provides to a population of patients. This kind of quality – and population-based care in general – can only be provided through organized processes. These processes would be directed toward identifying patients who need preventive care and care for chronic diseases, following-up over time with these patients, coordinating chronic disease care and patient education, providing physicians with resources to help them manage particularly difficult cases, and providing performance data and clinical education to continually improve the performance of individual physicians.

But what populations am I speaking of? By "population" I mean the set of patients for whom a physician group is responsible at any given time. There is a potential contradiction between population-based care and consumer choice. If patients are free to choose physicians and hospitals (and/or are forced to switch because of changing jobs or because their employer changes health plans) how can they be cared for as populations? There are two ways of mitigating this problem. First, if patients choose their physician group through a sponsor which offers all medical groups and IPAs in the area which meet a minimum standard of quality (see below), then the problem of involuntary switching of physician group will disappear. Second, quality measures can be used which give physician groups an incentive to provide population-based care (eg. to provide diabetic patients with annual retinal exams) even though the savings from some elements of this care may accrue to other groups in the future.

There may be more than one way to structure a health care system which provides high quality, population-based care at a reasonable cost. It might be possible, for example, to encourage physicians to develop organized processes for innovation, quality improvement, and population-based care within a largely government-financed and administered system which relies primarily on rationing the supply of providers and on regulating prices as means of controlling costs. I will not discuss this route further, but will focus on changes that would be needed in the provider, payment method, payor, and purchaser (finance) systems if an alternate route – that of structuring market competition - were chosen.

Market competition in health care would work best with organized groups of physicians, blended payment methods, payors who function as sponsors, and purchasers who require that payors function as sponsors.

Physicians:

Organized processes, not surprisingly, are best provided through organizations – that is, at the provider level, through groups of physicians. These can be Independent Practice Associations (IPAs), composed of physicians who remain in solo and small group practices, or medical groups of at least moderate size.

A provider system composed of physician groups, rather than of individual physicians, would also make it possible to structure competition much more effectively. Competition over controlling costs and improving quality in health care, rather than over stinting and shirking, requires both risk adjustment and incentives for better performance. The latter cannot be reasonably done without the former. It is possible to adequately adjust for risk at the level of a moderate sized medical group or IPA, but very difficult or impossible to do so for small groups and individual physicians. It is, therefore, much more reasonable for a payor (eg. a health plan) to give performance incentives to a group of physicians than to individual physicians.

The traditional Medicare and Medicaid programs, which pay fee-for-service to individual physicians, do not encourage physicians to form groups, nor do they provide organized processes for improving care at any level. Health plans do claim to provide such processes. My purpose here is not to discuss the degree to which they actually do so, but rather to point out that health plan processes for improving care can be a useful complement to – but not a substitute for – the processes of physician groups. The reason for this is simple: health plans do not actually provide care; physicians do. Health plans can never be as close – physically or emotionally – to patients as physicians.

Unfortunately, there are relatively few physician groups in most areas of the United States, and fewer still which currently have the capability to create innovations which improve medical care. There are many obstacles to the creation and survival of physician groups. These include health plan strategies; inadequate or misdirected incentives, payment models, and

payment levels; physician culture; government regulations; and the fact that it takes time to create effective organizations. Physician groups, which suffer from the joint liabilities of newness and smallness, don't have much time.

Health plan strategies: There are two models of health plan-physician contracting in the U.S.: the individual contracting model and the group contracting model. In the individual contracting model, the health plan (HMO or PPO) contracts with individual physicians. Organized processes for controlling costs and improving quality, if any, are developed at the health plan level, far from patients and physicians. In the group contracting model, HMOs contract with groups of physicians – IPAs and moderate sized and large medical groups. The physician groups, as well as the HMOs, ideally develop organized processes for improving care. It is very difficult to know whether health plans simply contract opportunistically with individual physicians or groups, depending upon which are available, or whether some health plans prefer the individual contracting model, which gives them powerful negotiating leverage with physicians and enables plans to develop capabilities for managing care which purchasers increasingly see as being the value-added component of the product they are buying.

Inadequate or misdirected incentives: Medical groups and IPAs typically accept financial risk for the costs of physician services for their population of patients (professional capitation) and share risk for the costs of hospital services. The obvious routes to profit – or, at least, to survival – are two: 1) become big enough to negotiate reasonable rates with HMOs; 2) avoid patients who are ill or likely to become so. It is important to become big because payment rates are determined by negotiations between a medical group or IPA and a health plan. Physician groups that are large enough are more difficult for a health plan to drop from its provider network. It is important for physician groups to avoid sick patients because risk adjustment for both payment rates and quality measures is rudimentary, and does not adequately compensate groups who develop a reputation at being good at taking care of classes of patients who are costly.

Capitated medical groups which are cost-efficient are rewarded for this efficiency to the degree that they profit from any surplus remaining in their professional capitation payments or the hospital risk pool after their patients' costs are paid. Unlike in other industries, however, efficient

groups are not able to attract more patients by offering lower prices. Patients pay the same—health-care-premium-regardless of whether they choose a high or a low cost medical group. Efficient groups thus subsidize inefficient groups.

Physician groups which have a reputation for high quality are able to attract more members and, if the demand for them is very strong, to negotiate higher capitation rates with health plans. To date, however, direct payment from health plans for scoring well on quality measures has been minimal and poorly risk-adjusted.

A different set of problems comes into play when physician groups are paid fee-for-service. In this case, the groups have no incentive to invest in quality improvement (and cost-saving) processes such as case management programs to keep patients with left ventricular dysfunction out of the hospital. The savings generated will all accrue to the payor (the health plan) and/or the purchaser (eg. Medicare), while the costs of the quality improvement processes are all borne by the physician group (which may also cut its fee-for-service income by keeping patients healthy).

Inappropriate payment models: Capitation, particularly if it involves substantial risk for hospital and/or pharmaceutical costs, is a problematic method for paying physician groups. Essentially the physicians are given a pool of money; it is very easy to spend it all before all the bills for services to the group's patients have been received. This failure to deal with IBNR (Incurred But Not Received bills) leads to bankruptcy for the group and/or non-payment to the providers of those services. Handling capitation requires having large numbers of patients among whom to spread risk, having a well-managed group with excellent information systems, and having adequate capital. Most physician groups are weak in all of these areas. Furthermore, it seems counter-intuitive for the larger entity – the health plan – to pass insurance risk to the smaller – the physician group.

Inadequate payment levels: Their own efficiency in lowering the costs of care plus consolidation among employers and among health plans in California in recent years have led to capitation rates which are more than 20% lower than in other heavily populated states. Meanwhile, *patient protection regulations* aimed at health plans have had the unintended

consequence of raising costs for physician groups. California has been the prime example of the group contracting/delegation of financial risk and care management responsibility; this model is now threatened as even some of the most highly regarded groups in the state are struggling to stave off bankruptcy.

Payment Methods:

Pure fee-for-service payment gives physicians an incentive to provide too many services and fails to encourage population-based care. Pure capitation gives physicians an incentive to provide too little care and, as just described, raises the specter of bankruptcy. Economic theory suggests that payment methods that blend retrospective and prospective elements – eg. fee-for-service and capitation – should be a more effective way of paying physicians. Some physician groups have moved to blended payment methods through trial and error (cf. Robinson in *JAMA*, 1999, vol. 282, no. 13), but payors have yet to do so, with the notable exception of the Buyers Health Care Action Group, a coalition of large employers in the Minneapolis area.

BHCAG contracts directly with approximately 25 “care systems”. These systems, each of which must provide or contract for care for the population of patients that choose it, range from a small pediatrics group to large physician-hospital organizations. Annually each care group, with actuarial assistance from BHCAG, estimates its costs to provide virtually all health care services to a standard population of patients in the coming year. In other words, rather than negotiating payment rates with a health plan or with BHCAG, each group essentially names its own price. On the basis of these estimates BHCAG places each group into a high, medium, or low cost category. BHCAG employees who select groups in the high or medium category pay proportionately more for their health insurance. BHCAG collects quality information about the groups and distributes it to employees, who then make their decision based on cost and quality.

BHCAG uses a blended payment system. It pays each group fee-for-service using risk-adjusted RVRBS with the dollar value of each service calculated using a conversion factor based on the price that the group named as its price to provide care. BHCAG adjusts the conversion factor quarterly for each group; the group earns more per service during the next quarter if the costs of care for its population have been less than expected, and vice-versa.

The BHCAG model has many features which should promote cost-containment, quality improvement, innovation, and population-based care. It encourages the growth of physician groups, but because BHCAG does not pass insurance risk to the groups by placing them at risk for the costs of patient care and giving them a pool of money to pay these costs, the BHCAG model minimizes the risk of financial disruption. It gives physicians and patients moderate incentives for cost-consciousness while rewarding cost-effective groups with more patients and high quality groups with more patients and/or higher payment rates. Sophisticated risk adjustment at the group level makes it possible for groups to actually try to gain a reputation for high quality in the care of chronically ill patients. More subtly but no less importantly, the BHCAG model eliminates the incentive for physician groups to grow beyond their optimal size in an attempt to gain at least some negotiating leverage with health plans. Groups can remain at the size that they feel makes it possible for them to take good care of their patients.

Implications for the payor and purchaser systems:

BHCAG, which acts as both purchaser and payor for its employees, structures competition: that is, it functions as a sponsor. It pools the healthy and the sick, aggregates purchasing power, designs the benefit package and payment method, collects and distributes cost and quality information, gives employees moderate incentives for cost-consciousness, provides incentives at the physician group level for both cost-containment and quality improvement, and sets minimum standards for the type of groups with which it will contract.

The BHCAG model requires both a large, capable sponsor and the presence of physician groups. Most areas in the U.S. have neither. What kinds of organizations could serve as sponsors? Very large employers and employer coalitions of large and/or small employers could act as sponsors. Quasi-public regional organizations created especially for the purpose could also do so. Finally, health plans could conclude that acting as sponsors makes sense for them as a long-term business model, or they could be forced by purchasers to give up their drive to gain negotiating leverage through growing ever larger and to begin acting as sponsors.

The lack of competent medical groups and IPAs in most areas is a serious obstacle to this proposal, but sponsors could begin by contracting with those which do exist, using BHCAG's

method. This could provide a strong impetus for the creation of new groups and IPAs, and for improving the capabilities of those which already exist.

The role of purchasers should be to serve as sponsors themselves, as BHCAG has done, or to provide strong incentives for other organizations to act as sponsors. This has implications for the structure of the purchaser/finance system. Individuals – perhaps purchasing their care through Medical Savings Accounts – would not be able to foster the emergence of sponsors. At the other extreme, the federal and most state governments are too large to act as sponsors themselves, but have sufficient purchasing and regulatory power to create sponsors and/or to encourage existing organizations - health plans, very large employers, and employer coalitions – to act as sponsors.

Policy Implications:

Change in the U.S. health care system will most likely result from a combination of public and private policies: federal and state regulatory decisions, federal and state purchasing decisions (eg. for Medicare, Medicaid, public employees), the purchasing decisions of large employers and pension funds (eg. CALPERS), and the purchasing decisions of consumers. What policies – involving the purchaser, payor, payment, and provider sitmaps might structure competition on the basis of quality and costs and help create a system of population-based health care?

Federal and state regulatory policies:

1. Consider unintended consequences on physician groups when crafting legislative, regulatory, and judicial actions targeted at health plans (eg. patient protection laws).
2. Consider a program of loans to nonprofit medical foundations which could serve as capital for the creation and strengthening (eg. through better information systems) of medical groups and IPAs.
3. Consider a program of income subsidization (based on performance) for physician groups which locate in underserved areas.

4. Reject the Campbell bill and other attempts to allow non-employed physicians to bargain collectively. Not only would this be a violation of anti-trust law, but it would eliminate an important reason for physicians to create and join medical groups and IPAs.
5. Vigorously enforce anti-trust law against health plans.
6. Support the development of employer purchasing coalitions for small and medium-sized businesses.

Federal and state purchasing policies:

1. Encourage HMOs which contract with HCFA to act as sponsors (using the BHCAG model) and/or create quasi-public regional sponsors for the Medicare program. HCFA could encourage health plans which act as sponsors not only for Medicare patients but for all enrolled patients.
2. Medicaid, the Federal Employees Health Benefit Plan (FEHBP) and state employee pension funds could take analogous actions
3. Federal and state programs aimed at increasing the number of people with health insurance should encourage enrollment in health plans which support population-based care. Tax credits, for example, could encourage such enrollment; medical savings accounts would not.

Employer Purchasing Policies:

1. Employers should form purchasing coalitions and promote the sponsor model, either by acting as sponsors themselves, by requiring that health plans act as sponsors, or by making use of regional quasi-public sponsors.

Consumers:

A brief concluding word about consumers: consumer choice will be and should be an important part of our evolving health care system. But it is a mistake to think that consumer choice and the Internet will magically bring order to the chaos in U.S. health care. Information is never a substitute for organization. Indeed, there will be little information without organization, and no population-based or high quality individual care without organized processes in physician groups.

The "managed care" – in reality mainly managed cost – system of the 1990s will not survive. Consumers don't like big insurance companies, and they particularly don't like big insurance companies telling them they can't have health care services which they desire. A health care system based on physician groups, sponsors, and population-based care would look, feel, and be quite different.





Health Care Reform and the New Economy Old Principles, Emerging Realities¹

By Paul Starr

Since the national debate about health care reform in the early 1990s, American society has changed far more than anyone expected in so short a time. The looming deficits, persistent inflation, relatively high unemployment, concomitant economic anxiety, and diffuse cultural foreboding are gone, at least for now. The change seems to be more fundamental than a mere cyclical turn. While the exceptionally low unemployment and inflation of recent years may prove ephemeral, the “new economy” rooted in information technology is not a temporary phenomenon. Fundamental changes in communications and economic and social relationships are in the making; entire new industries are taking shape. New technologies are contributing 8 percent of employment and 35 percent of growth, according to Commerce Department reports. Rather than lagging behind Japan and other countries, as Americans feared a decade ago, the United States has taken a dominant role in the emerging global information economy, and America seems likely to sustain its comparative advantage for the foreseeable future. Economic inequality has not abated; indeed, inequalities in wealth are greater than ever. But with unemployment among blacks and Hispanics lower than at any time in recent history, the poor also seem to be benefiting from the new economy – though their position is more precarious, especially given time-limits in welfare reform, declining Medicaid enrollment, and the likelihood that they would be the first to lose their jobs in a recession.

How do these new circumstances affect health care reform? In the early 1990s, the economic and political context decisively shaped the reform debate. Economic insecurities raised concerns about “health security,” while projected budget deficits and inflation focused attention on cost containment. The opponents of reform had many of the same worries about jobs and the deficit, except that they thought the government would make the problems worse. General anxiety that something fundamental had gone wrong in America may have intensified emotions on both sides.

Although today’s easing of economic worries might be expected to facilitate consensual change, the effects run in contrary directions. Rising surpluses make new expenditures more feasible, while prosperity takes some of the felt urgency out of reform. Bill Bradley’s proposal to use the surplus to expand health coverage suggested that at the least the Democrats might be ready to return to large-scale redistributive programs. But not only did Bradley’s proposal fail to ignite his candidacy; even on the issue of health care, Gore continued to enjoy more support in polls throughout the primaries, despite his more limited proposal to expand CHIP. The difficulties that Bradley’s plan encountered suggest how hard it continues to be to produce a consensus even among those who might be most sympathetic to reform—Democratic primary voters.

Rising budget surpluses have dramatically altered the debate about Social Security reform and, to a lesser extent, about Medicare (we would not be considering

¹ Preliminary (April 25, 2000) draft for discussion at conference, “Out of Chaos and Gridlock: Building Leadership and Consensus for Universal Access to Health Care,” May 1, Elkridge, Maryland.

prescription drug coverage if the overall budget picture hadn't changed). According to opinion polls, more Americans support using the surplus to expand health care than to cut taxes, but the new fiscal environment has not inspired a groundswell of interest in universal coverage. In a shift that may come back to haunt him, Gore has effectively set the bar higher for all social programs by saying that we must not only first balance the budget, but also pay off the national debt. Hoover might feel a belated vindication. The projected surplus has, nonetheless, had an effect of far-reaching importance on the health care debate that is apparent in all the major proposals for expanded coverage introduced in the presidential campaign this year—Gore's and Bush's as well as Bradley's.

The expansion of coverage is now being detached, once again, from the rationalization of the health care system. "Evolution in Defeat" was the title of an article I published in 1982 about the history of national health insurance proposals.² The original proposals introduced before World War I were as much concerned with providing cash payments during illness (sick pay) as with covering the costs of treatment, and they were chiefly aimed at helping urban workers. Reformers introduced the proposals at the state level, and that is where the battles were fought—and lost. By the 1930s, the focus had shifted to the costs of medical care, the debate had moved to the federal government, and coverage was conceived more broadly, though it was still not yet universal. From the New Deal through Truman's national health insurance plan and the original Medicare legislation, reformers continued to assume that federally provided health insurance would mean channeling increased resources to health care and that this was a good and necessary thing.

By the 1970s, however, rising costs began to preoccupy health policy, and proposals for expanding coverage were increasingly conceived as a means of rationalizing the system and reducing its inefficiencies. It was in this context that the debate emerged between regulatory and market strategies. The Clinton plan, which attempted a synthesis of those strategies, was, in a sense, the culmination of the "comprehensive" approach that tried to put the rationalization of the system and the expansion of coverage into one program.

Now we are seeing further evolution in defeat as the political logic of the comprehensive approach unravels. Because of the fiscal austerity and anti-tax fervor that dominated policy debates from the mid-1970s to the mid-1990s, there seemed no other way to finance coverage expansion in the short or long run except by aggressive cost containment. And because business was also seeking new means of controlling the cost of health benefits, the comprehensive approach had the potential to bring together the business community with advocates of universal health insurance. Neither of these political premises seems valid today. The budget surplus opens up a politically more attractive path for financing. And the rise of managed care in the private sector has directly addressed the interest of business in containing its own costs. Loading stringent cost containment on to policies aimed at expanding coverage seems like taking on a lot of excess political baggage. Pursuing coverage expansion alone simplifies the tasks of

² "Evolution in Defeat: The Changing Objective of National Health Insurance, 1915-1980," *American Journal of Public Health* (January 1982). Much of this material appeared a year later in my book, *The Social Transformation of American Medicine* (New York: Basic Books, 1983).

public communication and persuasion and avoids the kind of provisions that were used to demonize the Clinton plan as a threat to liberty.

Piecemeal expansion of coverage has another appeal: it invites compromise. If one party supports a program expansion and the other a tax credit, why not do some of both? In a highly toxic political environment, this is unlikely, but in a milder climate with growing surpluses, it seems quite possible. Such piecemeal measures might seem small but have long-run implications because they could become the basis of policy development in future administrations or by reform-minded states. The CHIP program, for all its limitations, may be a step toward public assumption of the health costs for dependents of low- to moderate-income parents. That could reduce the magnitude of any future requirements for employer coverage. It would lay the groundwork for an employee-only mandate or, as I would prefer to conceive it, a health-care minimum wage (an increase in the minimum wage earmarked for health benefits). Coverage of nonworking spouses could be addressed through a combination of tax credits and subsidized buy-ins. The culmination of an incrementalist approach of this kind could be an individual mandate—beginning with the provision that Bradley recommended requiring parents to see that their children have health coverage.

The promised bounty of the new economy makes such a path imaginable; the persistent income inequality of the new economy may make such a path necessary. But does the new economy require any different vision of health reform? What are the implications, if any, of the information revolution for the principles and mechanics of reform as well as its political feasibility? A great deal of health care commerce is migrating to the Internet—should the infrastructure of reform also migrate to the Net? I organize my discussion around some of the principles of reform widely discussed in the debate about the Clinton plan.

Choice. One of the paradoxes of the managed care revolution is that it has run in the opposite direction from other trends toward more individual choice in American society. A few decades ago, most Americans had just one option for savings—a passbook savings account; everyone used to have the same black telephone and the same telephone service. Now we choose among a wide array of alternatives for financial services and telecommunications. Consider the increase in the size of new supermarkets and other retail stores and the expanded variety of products they carry. Information technology has facilitated this growth in “mass customization” and consumer choice, and the Internet and electronic commerce are further extending that trend.

As organizations, health insurance plans are more diverse than they used to be, but that is not how consumers see the rise of managed care. Under the traditional fee-for-service system, consumers enjoyed an unrestricted right to choose their providers. Managed care plans not only constrain those choices; our system for purchasing coverage limits the consumer’s ability to choose a plan. Because most employers offer only a single insurer, they are effectively determining which doctors and hospitals their workers and families can use unless they pay out-of-plan rates. This is an anomalous situation in an age when Americans reasonably expect to have more choices, not fewer.

Part of the answer to that anomaly is to give the choice of health plan to the individual employee. But how to do that in a system where employers cannot contract with all available plans? The managed-competition proposals of the early 1990s envisioned a health insurance purchasing cooperative -- or HIPC, pronounced “hippic,”

not “hiccup”-- that would aggregate employee groups and enable individual employees to choose among the plans in an area. The Clinton plan called this mechanism a “regional health alliance” and required that at least three types of plans be offered – fee-for-service as well as HMO and PPO. Some Republican proposals have called their voluntary versions of purchasing alliances “health marts.”

New information technology does not help overcome the obstacles to aggregating risk pools. It does, however, address the objection that these proposals would add another “layer” of bureaucracy. A HIPC, an alliance, or a health mart – whatever you call it – can now be conceived of as an electronic marketplace. Like electronic commerce generally, it can cut out intermediaries – in this case, in benefits offices -- cheaply and conveniently disseminating information to consumers and relaying online enrollment decisions to plans. Not all people will use an electronic marketplace immediately. But it could become the site where a growing proportion of consumers make their annual enrollment choice and also find (or link to) data on consumer satisfaction and other relevant information. In other words, it can put the decision-making information together with the decision. It can also provide a way for members of plans to communicate with each other and compare experiences. Even if only a minority of consumers use the opportunities for better information and communication, they can have a positive effect in sensitizing the health plans and providers to key cost and quality issues.

Quality. Broadly speaking, quality has two dimensions: (i) the objective, technical aspects of care (the accuracy of diagnosis and effectiveness of treatment) and (ii) service and patient satisfaction. Most of the discussion about information technology and quality has focused on the development of outcomes measures for improving the technical dimension of care. Presumably, as more health care activities become computer-mediated, it should become cheaper to build databases; and as more health care providers use electronic networks on a regular basis, broader collaboration in research should get easier, as it has in the academy and the technology industries. New knowledge about outcomes should improve not only clinical judgment, but also organizational processes, reducing mistakes and iatrogenic disease.

The impact of the digital revolution on customer service and patient satisfaction may be equally important. In other industries, new information technology has improved service – for example, by making it easier and more convenient to perform transactions and providing quicker turnaround times on customer orders. As yet, health care has been little affected. Much consumer dissatisfaction with health care, however, stems from poor service. Improvements in other industries may have only accentuated irritation with the long waits and difficulties in getting questioned answered that patients regularly experience in the health system.

This has been the context for the spectacular growth in the use of the Internet for consumer health. Many patients and their families have turned to the Internet to get advice and information about health problems more quickly and to learn about options that their doctors or health plans might not otherwise provide. Most of this surge in communication occurred completely outside the mainstream health system; it was spontaneous, informal, and at first noncommercial. Health information networks were developing on two separate tracks. The industry was preoccupied with building data networks to link hospitals and hospital suppliers, pharmaceutical wholesalers and retailers, and providers and insurers. In the past decade, health care organizations have

invested heavily in enterprise-wide networks to overcome the fragmentation of their own information systems. But on a separate track that the industry hardly thought worth its attention, popular health communication was exploding, and, ironically, this is turning out to be the basis of electronic health commerce. In effect, the “system” is coming to the “people” as health plans and providers establish Web sites and begin opening up online avenues of communication with patients and each other.

These developments may seem unrelated to reform; some critics may say they are also unrelated to quality because so much of the information on the Internet is unreliable. But today’s developments may be the beginning of a major reconfiguration of health care. Telemedicine has generally been thought of as an exotic service for such situations as emergency care in remote rural areas. But especially as the Internet turns to broadband, a large part of the population will routinely consult providers via computer, not just using e-mail as we know it, but with full video and data links. Patients with chronic conditions may be continuously linked to the network, their conditions monitored by sensors and computers that they carry around as part of their clothing or themselves. The “physician visit” or “encounter” in the conventional sense may be an increasingly less relevant measure of a unit of medical care (this will make capitation even more logical than it is now). The Internet generally makes us less place-dependent -- and that will increasingly be the case with health care.

For some people, the development of these options may be an improvement in service. Electronic consultations may economize on their time—an efficiency that is not registered in any health statistics, though it is real enough to them. Other patients may never want to use electronic consultations and prefer to pay for more personal, face-to-face service. In health care, as in other industries, one of the effects of the information revolution may be a greater variety of service options. That widened array will be an improvement in quality if consumers have choice among them, but it will be experienced as a decline in quality if one option is imposed on them.

Cost, Affordability, and Innovation. Hoped-for savings from computerization have so often proved illusory that policy analysts are deservedly skeptical about using technology to make health care more affordable. Technology will not reverse the long-run growth in health care expenditures, but it may be a significant source of greater efficiency. Expenditures will likely continue rising because technological innovation makes possible new services and products that didn’t exist before. Innovation, however, can also blunt some of this effect through improvements in productivity. Such improvements may come about in at least two ways. The first is through the reduction of transaction costs – particularly business-to-business transactions where e-commerce is generally showing the fastest growth. The second is through an increase in competition – particularly long-distance competition, which can help break up local monopolies, for example, in radiology and other specialized services. The full benefit of these developments hinges on public policy. The absence of shared standards for data communication have long limited savings in transaction costs, and although the Health Insurance Portability and Accountability Act (HIPAA) has set in motion a standard-setting process, progress is painfully slow: no standards are yet in force, and the act deals only with administrative, not clinical, data. The potential for long-distance competition is limited by state licensing laws that often make online consultations across state boundaries illegal.

Dwarfed by other issues, these obstacles to the development of the new economy in health care have been of little interest to health care reformers. But if there is significant benefit in both quality and cost from the development of computer networks and other new technology, reformers ought to make such issues a more central part of their agenda. Hardly anyone, for example, has wanted to take up the issue of state licensing as a barrier to competition, but if the Europeans can establish a continental system of licensing, why is it inconceivable that the United States establish a national one? The current licensing system is a form of protectionism that ought now to be seen as an unconstitutional interference with the interstate commerce. It's time to attack it head on.

Simplicity and Transparency. One criticism of the Clinton plan that came even from its supporters was that it was too complex, and its opponents ridiculed the proposal by quoting opaque sections of the legislation and holding up a diagram of its proposed architecture that looked like a Rube Goldberg contraption. Of course, the existing system is an incredibly complex contraption, and every serious health bill in Congress includes technical language that ordinary citizens (and even experts!) find incomprehensible. Reform should be simpler, but it can never be simple.

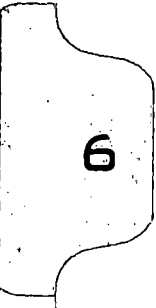
Incrementalism is itself a step toward political simplification. Decoupling rationalization from the expansion of coverage implies doing fewer things at once. The real issue, however, should not be the complexity of legislative or regulatory provisions, but whether the public can understand what is fundamentally at stake, what the proposed changes would mean for them, and ultimately how to negotiate the system to get the care they want and need.

Here "transparency" may be a better ideal than "simplicity." Our health care system will always be complicated, but consumers will feel more confidence in it if they have access to full information about its operation. The Internet today creates higher expectations of transparency than existed in the past – why shouldn't information be posted on web sites? The cost is trivial. Why shouldn't consumers be able to know about arrangements between health plans and their providers – aren't they properly concerned with such arrangements?

To be sure, it's the organizations that need to become more transparent to the consumers, not the other way around. Just as consumers want to be assured they have full access to information about their health care, so they want to be assured of the privacy and confidentiality of their own personal health information. One concern is the flip side of the other. If we want to derive all the benefits that new technology can provide, we are going to have to pay the cost that privacy protection entails. It a precondition of public trust.

No one knows for certain where new technology and the new economy will take us. I do not believe that they have any bearing on the fundamental moral concerns that lie behind the interest in universal health coverage. Nor do I expect that they will alter many of the political impediments that have prevented America from achieving that goal. But if the new economy continues to bring about more rapid increases in productivity and growth than we experienced during the 1970s and '80s, it will change the context of our thinking about nearly everything in public life, including health policy. For years the ratio of health care expenditures to GNP seemed to grow uncontrollably, and we assumed that

to slow it down, we needed an increasingly harsh prescription for health care. But, by definition, any ratio also depends on the denominator – in this case, the GNP. A sluggish economy sets in motion one kind of health politics; a dynamic one, another. A new economy with higher growth and innovation won't necessarily bring us universal coverage, but we will have to think differently about it.





Lessons for Expanded Insurance Coverage: Prescription Drugs

- Benefit Design
- Cost Containment
- Crowd-Out
- Eligibility

Benefit Design: Insurance or Walking Around Money

- Insurance Principles
 - Market Offers Limited Coverage--Selection?
 - Few Prescription Drug Proposals Adhere
- Cost Control
 - Uncertainty: Methods Other Than Benefit Design
- Fairness and Cost Sharing
 - Cost, Distribution and Targets of Policy
 - People w/Income < \$10K Spend 8% Drugs

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Cost Control

- Compatible Institutions
 - What Works With Traditional Medicare
 - Role of Government
 - Regulation --Price Controls
 - Competition--For What by Whom
 - Tough Competition or Managed Care-Light
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Crowd-Out

- Roughly 30% of Elderly Have Employer Sponsored Drug Coverage
 - Coverage for All Elderly by Medicare Will Result in Cost Shifting
 - Large Subsidies Required to Limit Shifts
 - Models Used To Date--Overstate Impact
 - Conclusion--Crowd-Out is Still Very Costly
- • • • • • • •

Eligibility

- Crowd-Out Appears to Make Broad Prescription Drug Coverage (with generous benefit) Prohibitive
- Subsidies Aimed at Population Targets Can Solve Much of the Problem
- Fairness is helped--Politics are Hurt
 - Remember Catastrophic

Possible Implications

- Crowd-Out --Big Deal
- Poorest First Limits Crowd-Out and Helps Main Problem
- Institutions for Expansion and Cost Control Important
 - PBMs in Medicare
- Medicaid Expansions Look Pretty Good





**"Transferable" Health Insurance Tax Credits --
Questions & Answers**

The paper "Tax Credits for Uninsured Workers" (Health Insurance Reform Project, September 1999, available at www.hirp.gwu.edu) proposed use of "transferable" tax credits for workers who do not have employer-sponsored insurance. The following questions and answers address major features of "transferable" tax credits.

1. What is a "transferable" health insurance tax credit? A transferable health insurance tax credit is a tax credit that is made available to assist eligible individuals in purchasing health insurance. If the eligible person chooses a private plan, the tax credit amount is paid to that health plan. If the eligible person decides not to purchase private health insurance, the tax credit amount is transferred to state government, which will use the tax credit to provide a basic benefit plan for that individual.
2. What is the key advantage of a "transferable" tax credit? Many analyses of tax credit proposals for the uninsured project low take-up rates for purchase of private health plans. In contrast, with a transferable tax credit, all eligible individuals will have health insurance coverage - a private health plan (if they so choose) or a government-sponsored plan.
3. How would a transferable tax credit work? As proposed, a worker whose employer did not offer health insurance would be given an opportunity to sign up for health insurance coverage at his or her workplace and to have automatic payroll deductions of premium contributions. If an eligible worker chose a private health plan, government would pay the tax credit to the health plan. To decline this tax credit, an eligible worker would sign a form indicating he/she had made such a decision. For these individuals, the transferable tax credit would be paid to state government, which would provide a basic benefit plan for that individual.
4. Would transferable tax credits be income-related? As proposed, the tax credits would be a flat amount per individual, sufficient to purchase basic (Medicare-type) benefits, when supplemented by an individual premium comparable to the Part B premium paid by Medicare enrollees. In addition, children in lower income families would be eligible for CHIP children's benefit. Income-relating of CHIP eligibility and benefits would adjust total assistance (tax credits +CHIP) to a family's needs.
5. How do transferable tax credits differ from block grants? The tax credits are intended to assist eligible individuals. Each eligible worker decides whether or not to use his or her tax credit to purchase private health insurance. If a state receives a tax credit, it is responsible for providing basic health insurance coverage for the eligible individual. A state's benefit would have to at least match the actuarial value of the tax credit.

Tax Credits for Uninsured Workers -- Medicare Benefit
Financing Options

1. General strategy

- Affordable, bipartisan incremental plan, either

Stand-alone
Tax bill amendment

- Assures basic coverage for 33 M full-time workers (3days/wk or UI) w/out employer benefits available; also protects 160M with employer coverage if they lose employer benefits. Complements CHIP children's coverage

2. Basic financing

Premium: \$1,400/worker, split

\$780 - federal tax credit
\$ 95 - state contribution
\$525 - worker (voluntary) contribution
\$1,400

note: \$525 is same as Medicare premium (SMI/Part B) paid for Medicare benefits
federal/state split (89%/11%) is current split of health insurance tax subsidies

Federal cost \$22.2 B
(33mx\$780=\$25.7, minus \$3.5 federal DSH savings = \$22.2B)

3. Employer financing options

- Could be a required contribution to the program's costs if an employer does not make at least the same level of health insurance premium payment

Options

<u>- Employer contribution</u>	<u>Net federal costs</u>
0	\$22.2B
10¢/hr (\$200)	\$16.3B
20¢/hr (\$400)	\$10.5B
25¢/hr (\$500)	\$7.5B

note: economists would generally believe that 85% (or more) of such employer contributions would eventually be paid by workers through reduced wages

4. State financing options

<u>Federal/state shares of \$875/worker</u>	<u>Net federal costs</u>
89%/11%	\$22.2B
75%/25%	\$18.1B
60%/40%	\$13.2B
50%/50%	\$10.9B

5. Combination options

<u>Employer contribution</u>	<u>Net Federal costs</u>		
	<u>Federal/State shares</u>		
	<u>75%/25%</u>	<u>60%/40%</u>	<u>50%/50%</u>
10¢/hr	\$13.2B	\$9.9B	\$7.6B
20¢/hr	\$ 8.3B	\$5.9B	\$4.3B
25¢/hr	\$ 5.8B	\$3.9 B	\$2.6B

Net Federal cost	DSH adjustment	Gross federal cost	Workers	Federal premium	State premium 11%	Government premium	Private premium	Worker premium	Employer premium	Employer rate
22.2	3.5	25.7	33M	\$ 778.79	\$ 96.25	\$ 875.04	\$ 524.96	525	\$ (0.04)	\$ (0.00)
22.2	3.5	25.7	33M	\$ 778.79	\$ 96.25	\$ 875.04	\$ 524.96	500	\$ 24.96	\$ 0.01
22.2	3.5	25.7	33M	\$ 778.79	\$ 96.25	\$ 875.04	\$ 524.96	400	\$ 124.96	\$ 0.06
22.2	3.5	25.7	33M	\$ 778.79	\$ 96.25	\$ 875.04	\$ 524.96	300	\$ 224.96	\$ 0.11
22.2	3.5	25.7	33M	\$ 778.79	\$ 96.25	\$ 875.04	\$ 524.96	250	\$ 274.96	\$ 0.14
22.2	3.5	25.7	33M	\$ 778.79	\$ 96.25	\$ 875.04	\$ 524.96	200	\$ 324.96	\$ 0.16
22.2	3.5	25.7	33M	\$ 778.79	\$ 96.25	\$ 875.04	\$ 524.96	100	\$ 424.96	\$ 0.21
Net Federal cost	DSH adjustment	Gross federal cost	Workers	Federal premium	State premium 15%	Government premium	Private premium	Worker premium	Employer premium	Employer rate
22.2	3.5	25.7	33M	\$ 778.79	\$ 137.43	\$ 916.22	\$ 483.78	525	\$ (41.22)	\$ (0.02)
22.2	3.5	25.7	33M	\$ 778.79	\$ 137.43	\$ 916.22	\$ 483.78	500	\$ (16.22)	\$ (0.01)
22.2	3.5	25.7	33M	\$ 778.79	\$ 137.43	\$ 916.22	\$ 483.78	400	\$ 83.78	\$ 0.04
22.2	3.5	25.7	33M	\$ 778.79	\$ 137.43	\$ 916.22	\$ 483.78	300	\$ 183.78	\$ 0.09
22.2	3.5	25.7	33M	\$ 778.79	\$ 137.43	\$ 916.22	\$ 483.78	250	\$ 233.78	\$ 0.12
22.2	3.5	25.7	33M	\$ 778.79	\$ 137.43	\$ 916.22	\$ 483.78	200	\$ 283.78	\$ 0.14
22.2	3.5	25.7	33M	\$ 778.79	\$ 137.43	\$ 916.22	\$ 483.78	100	\$ 383.78	\$ 0.19
Net Federal cost	DSH adjustment	Gross federal cost	Workers	Federal premium	State premium 20%	Government premium	Private premium	Worker premium	Employer premium	Employer rate
22.2	3.5	25.7	33M	\$ 778.79	\$ 194.70	\$ 973.48	\$ 426.52	525	\$ (98.48)	\$ (0.05)
22.2	3.5	25.7	33M	\$ 778.79	\$ 194.70	\$ 973.48	\$ 426.52	500	\$ (73.48)	\$ (0.04)
22.2	3.5	25.7	33M	\$ 778.79	\$ 194.70	\$ 973.48	\$ 426.52	400	\$ 26.52	\$ 0.01
22.2	3.5	25.7	33M	\$ 778.79	\$ 194.70	\$ 973.48	\$ 426.52	300	\$ 126.52	\$ 0.06
22.2	3.5	25.7	33M	\$ 778.79	\$ 194.70	\$ 973.48	\$ 426.52	250	\$ 176.52	\$ 0.09
22.2	3.5	25.7	33M	\$ 778.79	\$ 194.70	\$ 973.48	\$ 426.52	200	\$ 226.52	\$ 0.11
22.2	3.5	25.7	33M	\$ 778.79	\$ 194.70	\$ 973.48	\$ 426.52	100	\$ 326.52	\$ 0.16
Net Federal cost	DSH adjustment	Gross federal cost	Workers	Federal premium	State premium 25%	Government premium	Private premium	Worker premium	Employer premium	Employer rate
22.2	3.5	25.7	33M	\$ 778.79	\$ 259.60	\$ 1,038.38	\$ 361.62	525	\$ (163.38)	\$ (0.08)
22.2	3.5	25.7	33M	\$ 778.79	\$ 259.60	\$ 1,038.38	\$ 361.62	500	\$ (138.38)	\$ (0.07)
22.2	3.5	25.7	33M	\$ 778.79	\$ 259.60	\$ 1,038.38	\$ 361.62	400	\$ (38.38)	\$ (0.02)
22.2	3.5	25.7	33M	\$ 778.79	\$ 259.60	\$ 1,038.38	\$ 361.62	300	\$ 61.62	\$ 0.03
22.2	3.5	25.7	33M	\$ 778.79	\$ 259.60	\$ 1,038.38	\$ 361.62	250	\$ 111.62	\$ 0.06
22.2	3.5	25.7	33M	\$ 778.79	\$ 259.60	\$ 1,038.38	\$ 361.62	200	\$ 161.62	\$ 0.08
22.2	3.5	25.7	33M	\$ 778.79	\$ 259.60	\$ 1,038.38	\$ 361.62	100	\$ 261.62	\$ 0.13
Net Federal cost	DSH adjustment	Gross federal cost	Workers	Federal premium	State premium 40%	Government premium	Private premium	Worker premium	Employer premium	Employer rate
22.2	3.5	25.7	33M	\$ 778.79	\$ 519.19	\$ 1,297.98	\$ 102.02	525	\$ (422.98)	\$ (0.21)
22.2	3.5	25.7	33M	\$ 778.79	\$ 519.19	\$ 1,297.98	\$ 102.02	500	\$ (397.98)	\$ (0.20)
22.2	3.5	25.7	33M	\$ 778.79	\$ 519.19	\$ 1,297.98	\$ 102.02	400	\$ (297.98)	\$ (0.15)
22.2	3.5	25.7	33M	\$ 778.79	\$ 519.19	\$ 1,297.98	\$ 102.02	300	\$ (197.98)	\$ (0.10)
22.2	3.5	25.7	33M	\$ 778.79	\$ 519.19	\$ 1,297.98	\$ 102.02	250	\$ (147.98)	\$ (0.07)
22.2	3.5	25.7	33M	\$ 778.79	\$ 519.19	\$ 1,297.98	\$ 102.02	200	\$ (97.98)	\$ (0.05)
22.2	3.5	25.7	33M	\$ 778.79	\$ 519.19	\$ 1,297.98	\$ 102.02	100	\$ 2.02	\$ 0.00
Net Federal cost	DSH adjustment	Gross federal cost	Workers	Federal premium	State premium 50%	Government premium	Private premium	Worker premium	Employer premium	Employer rate
22.2	3.5	25.7	33M	\$ 778.79	\$ 778.79	\$ 1,557.58	\$ (157.58)	525	\$ (682.58)	\$ (0.34)
22.2	3.5	25.7	33M	\$ 778.79	\$ 778.79	\$ 1,557.58	\$ (157.58)	500	\$ (657.58)	\$ (0.33)
22.2	3.5	25.7	33M	\$ 778.79	\$ 778.79	\$ 1,557.58	\$ (157.58)	400	\$ (557.58)	\$ (0.28)
22.2	3.5	25.7	33M	\$ 778.79	\$ 778.79	\$ 1,557.58	\$ (157.58)	300	\$ (457.58)	\$ (0.23)
22.2	3.5	25.7	33M	\$ 778.79	\$ 778.79	\$ 1,557.58	\$ (157.58)	250	\$ (407.58)	\$ (0.20)
22.2	3.5	25.7	33M	\$ 778.79	\$ 778.79	\$ 1,557.58	\$ (157.58)	200	\$ (357.58)	\$ (0.18)
22.2	3.5	25.7	33M	\$ 778.79	\$ 778.79	\$ 1,557.58	\$ (157.58)	100	\$ (257.58)	\$ (0.13)

\$1400 Premium, \$20 B Net Federal Cost

Net Federal cos	DSH adjustment	Gross federal c	Workers	Federal premium	State premium 11%	Government premium	Private premium	Worker premium	Employer premium	Employer rate
20	3.5	23.5	33M	\$ 712.12	\$ 88.01	\$ 800.14	\$ 599.86	525	\$ 74.86	\$ 0.04
20	3.5	23.5	33M	\$ 712.12	\$ 88.01	\$ 800.14	\$ 599.86	500	\$ 99.86	\$ 0.05
20	3.5	23.5	33M	\$ 712.12	\$ 88.01	\$ 800.14	\$ 599.86	400	\$ 199.86	\$ 0.10
20	3.5	23.5	33M	\$ 712.12	\$ 88.01	\$ 800.14	\$ 599.86	300	\$ 299.86	\$ 0.15
20	3.5	23.5	33M	\$ 712.12	\$ 88.01	\$ 800.14	\$ 599.86	250	\$ 349.86	\$ 0.17
20	3.5	23.5	33M	\$ 712.12	\$ 88.01	\$ 800.14	\$ 599.86	200	\$ 399.86	\$ 0.20
								100	\$ 499.86	\$ 0.25
Net Federal cos	DSH adjustment	Gross federal c	Workers	Federal premium	State premium 15%	Government premium	Private premium	Worker premium	Employer premium	Employer rate
20	3.5	23.5	33M	\$ 712.12	\$ 125.67	\$ 837.79	\$ 562.21	525	\$ 37.21	\$ 0.02
20	3.5	23.5	33M	\$ 712.12	\$ 125.67	\$ 837.79	\$ 562.21	500	\$ 62.21	\$ 0.03
20	3.5	23.5	33M	\$ 712.12	\$ 125.67	\$ 837.79	\$ 562.21	400	\$ 162.21	\$ 0.08
20	3.5	23.5	33M	\$ 712.12	\$ 125.67	\$ 837.79	\$ 562.21	300	\$ 262.21	\$ 0.13
20	3.5	23.5	33M	\$ 712.12	\$ 125.67	\$ 837.79	\$ 562.21	250	\$ 312.21	\$ 0.16
20	3.5	23.5	33M	\$ 712.12	\$ 125.67	\$ 837.79	\$ 562.21	200	\$ 362.21	\$ 0.18
								100	\$ 462.21	\$ 0.23
Net Federal cos	DSH adjustment	Gross federal c	Workers	Federal premium	State premium 20%	Government premium	Private premium	Worker premium	Employer premium	Employer rate
20	3.5	23.5	33M	\$ 712.12	\$ 178.03	\$ 890.15	\$ 509.85	525	\$ (15.15)	\$ (0.01)
20	3.5	23.5	33M	\$ 712.12	\$ 178.03	\$ 890.15	\$ 509.85	500	\$ 9.85	\$ 0.00
20	3.5	23.5	33M	\$ 712.12	\$ 178.03	\$ 890.15	\$ 509.85	400	\$ 109.85	\$ 0.05
20	3.5	23.5	33M	\$ 712.12	\$ 178.03	\$ 890.15	\$ 509.85	300	\$ 209.85	\$ 0.10
20	3.5	23.5	33M	\$ 712.12	\$ 178.03	\$ 890.15	\$ 509.85	250	\$ 259.85	\$ 0.13
20	3.5	23.5	33M	\$ 712.12	\$ 178.03	\$ 890.15	\$ 509.85	200	\$ 309.85	\$ 0.15
								100	\$ 409.85	\$ 0.20
Net Federal cos	DSH adjustment	Gross federal c	Workers	Federal premium	State premium 25%	Government premium	Private premium	Worker premium	Employer premium	Employer rate
20	3.5	23.5	33M	\$ 712.12	\$ 237.37	\$ 949.49	\$ 450.51	525	\$ (74.49)	\$ (0.04)
20	3.5	23.5	33M	\$ 712.12	\$ 237.37	\$ 949.49	\$ 450.51	500	\$ (49.49)	\$ (0.02)
20	3.5	23.5	33M	\$ 712.12	\$ 237.37	\$ 949.49	\$ 450.51	400	\$ 50.51	\$ 0.03
20	3.5	23.5	33M	\$ 712.12	\$ 237.37	\$ 949.49	\$ 450.51	300	\$ 150.51	\$ 0.08
20	3.5	23.5	33M	\$ 712.12	\$ 237.37	\$ 949.49	\$ 450.51	250	\$ 200.51	\$ 0.10
20	3.5	23.5	33M	\$ 712.12	\$ 237.37	\$ 949.49	\$ 450.51	200	\$ 250.51	\$ 0.13
								100	\$ 350.51	\$ 0.18
Net Federal cos	DSH adjustment	Gross federal c	Workers	Federal premium	State premium 40%	Government premium	Private premium	Worker premium	Employer premium	Employer rate
20	3.5	23.5	33M	\$ 712.12	\$ 474.75	\$ 1,186.87	\$ 213.13	525	\$ (311.87)	\$ (0.16)
20	3.5	23.5	33M	\$ 712.12	\$ 474.75	\$ 1,186.87	\$ 213.13	500	\$ (286.87)	\$ (0.14)
20	3.5	23.5	33M	\$ 712.12	\$ 474.75	\$ 1,186.87	\$ 213.13	400	\$ (186.87)	\$ (0.09)
20	3.5	23.5	33M	\$ 712.12	\$ 474.75	\$ 1,186.87	\$ 213.13	300	\$ (86.87)	\$ (0.04)
20	3.5	23.5	33M	\$ 712.12	\$ 474.75	\$ 1,186.87	\$ 213.13	250	\$ (36.87)	\$ (0.02)
20	3.5	23.5	33M	\$ 712.12	\$ 474.75	\$ 1,186.87	\$ 213.13	200	\$ 13.13	\$ 0.01
								100	\$ 113.13	\$ 0.06
Net Federal cos	DSH adjustment	Gross federal c	Workers	Federal premium	State premium 50%	Government premium	Private premium	Worker premium	Employer premium	Employer rate
20	3.5	23.5	33M	\$ 712.12	\$ 712.12	\$ 1,424.24	\$ (24.24)	525	\$ (549.24)	\$ (0.27)
20	3.5	23.5	33M	\$ 712.12	\$ 712.12	\$ 1,424.24	\$ (24.24)	500	\$ (524.24)	\$ (0.26)
20	3.5	23.5	33M	\$ 712.12	\$ 712.12	\$ 1,424.24	\$ (24.24)	400	\$ (424.24)	\$ (0.21)
20	3.5	23.5	33M	\$ 712.12	\$ 712.12	\$ 1,424.24	\$ (24.24)	300	\$ (324.24)	\$ (0.16)
20	3.5	23.5	33M	\$ 712.12	\$ 712.12	\$ 1,424.24	\$ (24.24)	250	\$ (274.24)	\$ (0.14)
20	3.5	23.5	33M	\$ 712.12	\$ 712.12	\$ 1,424.24	\$ (24.24)	200	\$ (224.24)	\$ (0.11)
								100	\$ (124.24)	\$ (0.06)

\$1400 Premium, \$15 a Net Federal Cost

Net Federal cost	DSH adjustment	Gross federal cost	Workers	Federal premium	State premium 11%	Government premium	Private premium	Worker premium	Employer premium	Employer rate
15	3.5	18.5	33M	\$ 560.61	\$ 69.29	\$ 629.89	\$ 770.11	525	\$ 245.11	\$ 0.12
15	3.5	18.5	33M	\$ 560.61	\$ 69.29	\$ 629.89	\$ 770.11	500	\$ 270.11	\$ 0.14
15	3.5	18.5	33M	\$ 560.61	\$ 69.29	\$ 629.89	\$ 770.11	400	\$ 370.11	\$ 0.19
15	3.5	18.5	33M	\$ 560.61	\$ 69.29	\$ 629.89	\$ 770.11	300	\$ 470.11	\$ 0.24
15	3.5	18.5	33M	\$ 560.61	\$ 69.29	\$ 629.89	\$ 770.11	250	\$ 520.11	\$ 0.26
15	3.5	18.5	33M	\$ 560.61	\$ 69.29	\$ 629.89	\$ 770.11	200	\$ 570.11	\$ 0.29
15	3.5	18.5	33M	\$ 560.61	\$ 69.29	\$ 629.89	\$ 770.11	100	\$ 670.11	\$ 0.34
Net Federal cost	DSH adjustment	Gross federal cost	Workers	Federal premium	State premium 15%	Government premium	Private premium	Worker premium	Employer premium	Employer rate
15	3.5	18.5	33M	\$ 560.61	\$ 98.93	\$ 659.54	\$ 740.46	525	\$ 215.46	\$ 0.11
15	3.5	18.5	33M	\$ 560.61	\$ 98.93	\$ 659.54	\$ 740.46	500	\$ 240.46	\$ 0.12
15	3.5	18.5	33M	\$ 560.61	\$ 98.93	\$ 659.54	\$ 740.46	400	\$ 340.46	\$ 0.17
15	3.5	18.5	33M	\$ 560.61	\$ 98.93	\$ 659.54	\$ 740.46	300	\$ 440.46	\$ 0.22
15	3.5	18.5	33M	\$ 560.61	\$ 98.93	\$ 659.54	\$ 740.46	250	\$ 490.46	\$ 0.25
15	3.5	18.5	33M	\$ 560.61	\$ 98.93	\$ 659.54	\$ 740.46	200	\$ 540.46	\$ 0.27
15	3.5	18.5	33M	\$ 560.61	\$ 98.93	\$ 659.54	\$ 740.46	100	\$ 640.46	\$ 0.32
Net Federal cost	DSH adjustment	Gross federal cost	Workers	Federal premium	State premium 20%	Government premium	Private premium	Worker premium	Employer premium	Employer rate
15	3.5	18.5	33M	\$ 560.61	\$ 140.15	\$ 700.76	\$ 699.24	525	\$ 174.24	\$ 0.09
15	3.5	18.5	33M	\$ 560.61	\$ 140.15	\$ 700.76	\$ 699.24	500	\$ 199.24	\$ 0.10
15	3.5	18.5	33M	\$ 560.61	\$ 140.15	\$ 700.76	\$ 699.24	400	\$ 299.24	\$ 0.15
15	3.5	18.5	33M	\$ 560.61	\$ 140.15	\$ 700.76	\$ 699.24	300	\$ 399.24	\$ 0.20
15	3.5	18.5	33M	\$ 560.61	\$ 140.15	\$ 700.76	\$ 699.24	250	\$ 449.24	\$ 0.22
15	3.5	18.5	33M	\$ 560.61	\$ 140.15	\$ 700.76	\$ 699.24	200	\$ 499.24	\$ 0.25
15	3.5	18.5	33M	\$ 560.61	\$ 140.15	\$ 700.76	\$ 699.24	100	\$ 599.24	\$ 0.30
Net Federal cost	DSH adjustment	Gross federal cost	Workers	Federal premium	State premium 25%	Government premium	Private premium	Worker premium	Employer premium	Employer rate
15	3.5	18.5	33M	\$ 560.61	\$ 186.87	\$ 747.47	\$ 652.53	525	\$ 127.53	\$ 0.06
15	3.5	18.5	33M	\$ 560.61	\$ 186.87	\$ 747.47	\$ 652.53	500	\$ 152.53	\$ 0.08
15	3.5	18.5	33M	\$ 560.61	\$ 186.87	\$ 747.47	\$ 652.53	400	\$ 252.53	\$ 0.13
15	3.5	18.5	33M	\$ 560.61	\$ 186.87	\$ 747.47	\$ 652.53	300	\$ 352.53	\$ 0.18
15	3.5	18.5	33M	\$ 560.61	\$ 186.87	\$ 747.47	\$ 652.53	250	\$ 402.53	\$ 0.20
15	3.5	18.5	33M	\$ 560.61	\$ 186.87	\$ 747.47	\$ 652.53	200	\$ 452.53	\$ 0.23
15	3.5	18.5	33M	\$ 560.61	\$ 186.87	\$ 747.47	\$ 652.53	100	\$ 552.53	\$ 0.28
Net Federal cost	DSH adjustment	Gross federal cost	Workers	Federal premium	State premium 40%	Government premium	Private premium	Worker premium	Employer premium	Employer rate
15	3.5	18.5	33M	\$ 560.61	\$ 373.74	\$ 934.34	\$ 465.66	525	\$ (59.34)	\$ (0.03)
15	3.5	18.5	33M	\$ 560.61	\$ 373.74	\$ 934.34	\$ 465.66	500	\$ (34.34)	\$ (0.02)
15	3.5	18.5	33M	\$ 560.61	\$ 373.74	\$ 934.34	\$ 465.66	400	\$ 65.66	\$ 0.03
15	3.5	18.5	33M	\$ 560.61	\$ 373.74	\$ 934.34	\$ 465.66	300	\$ 165.66	\$ 0.08
15	3.5	18.5	33M	\$ 560.61	\$ 373.74	\$ 934.34	\$ 465.66	250	\$ 215.66	\$ 0.11
15	3.5	18.5	33M	\$ 560.61	\$ 373.74	\$ 934.34	\$ 465.66	200	\$ 265.66	\$ 0.13
15	3.5	18.5	33M	\$ 560.61	\$ 373.74	\$ 934.34	\$ 465.66	100	\$ 365.66	\$ 0.18
Net Federal cost	DSH adjustment	Gross federal cost	Workers	Federal premium	State premium 50%	Government premium	Private premium	Worker premium	Employer premium	Employer rate
15	3.5	18.5	33M	\$ 560.61	\$ 560.61	\$ 1,121.21	\$ 278.79	525	\$ (246.21)	\$ (0.12)
15	3.5	18.5	33M	\$ 560.61	\$ 560.61	\$ 1,121.21	\$ 278.79	500	\$ (221.21)	\$ (0.11)
15	3.5	18.5	33M	\$ 560.61	\$ 560.61	\$ 1,121.21	\$ 278.79	400	\$ (121.21)	\$ (0.06)
15	3.5	18.5	33M	\$ 560.61	\$ 560.61	\$ 1,121.21	\$ 278.79	300	\$ (21.21)	\$ (0.01)
15	3.5	18.5	33M	\$ 560.61	\$ 560.61	\$ 1,121.21	\$ 278.79	250	\$ 28.79	\$ 0.01
15	3.5	18.5	33M	\$ 560.61	\$ 560.61	\$ 1,121.21	\$ 278.79	200	\$ 78.79	\$ 0.04
15	3.5	18.5	33M	\$ 560.61	\$ 560.61	\$ 1,121.21	\$ 278.79	100	\$ 178.79	\$ 0.09

Net Federal cos	DSH adjustment	Gross federal c	Workers	Federal premium	State premium 11%	Government premium	Private premium	Worker premium	Employer premium	Employer rate
10	3.5	13.5	33M	\$ 409.09	\$ 50.56	\$ 459.65	\$ 940.35	525	\$ 415.35	\$ 0.21
10	3.5	13.5	33M	\$ 409.09	\$ 50.56	\$ 459.65	\$ 940.35	500	\$ 440.35	\$ 0.22
10	3.5	13.5	33M	\$ 409.09	\$ 50.56	\$ 459.65	\$ 940.35	400	\$ 540.35	\$ 0.27
10	3.5	13.5	33M	\$ 409.09	\$ 50.56	\$ 459.65	\$ 940.35	300	\$ 640.35	\$ 0.32
10	3.5	13.5	33M	\$ 409.09	\$ 50.56	\$ 459.65	\$ 940.35	250	\$ 690.35	\$ 0.35
10	3.5	13.5	33M	\$ 409.09	\$ 50.56	\$ 459.65	\$ 940.35	200	\$ 740.35	\$ 0.37
10	3.5	13.5	33M	\$ 409.09	\$ 50.56	\$ 459.65	\$ 940.35	100	\$ 840.35	\$ 0.42
Net Federal cos	DSH adjustment	Gross federal c	Workers	Federal premium	State premium 15%	Government premium	Private premium	Worker premium	Employer premium	Employer rate
10	3.5	13.5	33M	\$ 409.09	\$ 72.19	\$ 481.28	\$ 918.72	525	\$ 393.72	\$ 0.20
10	3.5	13.5	33M	\$ 409.09	\$ 72.19	\$ 481.28	\$ 918.72	500	\$ 418.72	\$ 0.21
10	3.5	13.5	33M	\$ 409.09	\$ 72.19	\$ 481.28	\$ 918.72	400	\$ 518.72	\$ 0.26
10	3.5	13.5	33M	\$ 409.09	\$ 72.19	\$ 481.28	\$ 918.72	300	\$ 618.72	\$ 0.31
10	3.5	13.5	33M	\$ 409.09	\$ 72.19	\$ 481.28	\$ 918.72	250	\$ 668.72	\$ 0.33
10	3.5	13.5	33M	\$ 409.09	\$ 72.19	\$ 481.28	\$ 918.72	200	\$ 718.72	\$ 0.36
10	3.5	13.5	33M	\$ 409.09	\$ 72.19	\$ 481.28	\$ 918.72	100	\$ 818.72	\$ 0.41
Net Federal cos	DSH adjustment	Gross federal c	Workers	Federal premium	State premium 20%	Government premium	Private premium	Worker premium	Employer premium	Employer rate
10	3.5	13.5	33M	\$ 409.09	\$ 102.27	\$ 511.36	\$ 888.64	525	\$ 363.64	\$ 0.18
10	3.5	13.5	33M	\$ 409.09	\$ 102.27	\$ 511.36	\$ 888.64	500	\$ 388.64	\$ 0.19
10	3.5	13.5	33M	\$ 409.09	\$ 102.27	\$ 511.36	\$ 888.64	400	\$ 488.64	\$ 0.24
10	3.5	13.5	33M	\$ 409.09	\$ 102.27	\$ 511.36	\$ 888.64	300	\$ 588.64	\$ 0.29
10	3.5	13.5	33M	\$ 409.09	\$ 102.27	\$ 511.36	\$ 888.64	250	\$ 638.64	\$ 0.32
10	3.5	13.5	33M	\$ 409.09	\$ 102.27	\$ 511.36	\$ 888.64	200	\$ 688.64	\$ 0.34
10	3.5	13.5	33M	\$ 409.09	\$ 102.27	\$ 511.36	\$ 888.64	100	\$ 788.64	\$ 0.39
Net Federal cos	DSH adjustment	Gross federal c	Workers	Federal premium	State premium 25%	Government premium	Private premium	Worker premium	Employer premium	Employer rate
10	3.5	13.5	33M	\$ 409.09	\$ 136.36	\$ 545.45	\$ 854.55	525	\$ 329.55	\$ 0.16
10	3.5	13.5	33M	\$ 409.09	\$ 136.36	\$ 545.45	\$ 854.55	500	\$ 354.55	\$ 0.18
10	3.5	13.5	33M	\$ 409.09	\$ 136.36	\$ 545.45	\$ 854.55	400	\$ 454.55	\$ 0.23
10	3.5	13.5	33M	\$ 409.09	\$ 136.36	\$ 545.45	\$ 854.55	300	\$ 554.55	\$ 0.28
10	3.5	13.5	33M	\$ 409.09	\$ 136.36	\$ 545.45	\$ 854.55	250	\$ 604.55	\$ 0.30
10	3.5	13.5	33M	\$ 409.09	\$ 136.36	\$ 545.45	\$ 854.55	200	\$ 654.55	\$ 0.33
10	3.5	13.5	33M	\$ 409.09	\$ 136.36	\$ 545.45	\$ 854.55	100	\$ 754.55	\$ 0.38
Net Federal cos	DSH adjustment	Gross federal c	Workers	Federal premium	State premium 40%	Government premium	Private premium	Worker premium	Employer premium	Employer rate
10	3.5	13.5	33M	\$ 409.09	\$ 272.73	\$ 681.82	\$ 718.18	525	\$ 193.18	\$ 0.10
10	3.5	13.5	33M	\$ 409.09	\$ 272.73	\$ 681.82	\$ 718.18	500	\$ 218.18	\$ 0.11
10	3.5	13.5	33M	\$ 409.09	\$ 272.73	\$ 681.82	\$ 718.18	400	\$ 318.18	\$ 0.16
10	3.5	13.5	33M	\$ 409.09	\$ 272.73	\$ 681.82	\$ 718.18	300	\$ 418.18	\$ 0.21
10	3.5	13.5	33M	\$ 409.09	\$ 272.73	\$ 681.82	\$ 718.18	250	\$ 468.18	\$ 0.23
10	3.5	13.5	33M	\$ 409.09	\$ 272.73	\$ 681.82	\$ 718.18	200	\$ 518.18	\$ 0.26
10	3.5	13.5	33M	\$ 409.09	\$ 272.73	\$ 681.82	\$ 718.18	100	\$ 618.18	\$ 0.31
Net Federal cos	DSH adjustment	Gross federal c	Workers	Federal premium	State premium 50%	Government premium	Private premium	Worker premium	Employer premium	Employer rate
10	3.5	13.5	33M	\$ 409.09	\$ 409.09	\$ 818.18	\$ 581.82	525	\$ 58.82	\$ 0.03
10	3.5	13.5	33M	\$ 409.09	\$ 409.09	\$ 818.18	\$ 581.82	500	\$ 81.82	\$ 0.04
10	3.5	13.5	33M	\$ 409.09	\$ 409.09	\$ 818.18	\$ 581.82	400	\$ 181.82	\$ 0.09
10	3.5	13.5	33M	\$ 409.09	\$ 409.09	\$ 818.18	\$ 581.82	300	\$ 281.82	\$ 0.14
10	3.5	13.5	33M	\$ 409.09	\$ 409.09	\$ 818.18	\$ 581.82	250	\$ 331.82	\$ 0.17
10	3.5	13.5	33M	\$ 409.09	\$ 409.09	\$ 818.18	\$ 581.82	200	\$ 381.82	\$ 0.19
10	3.5	13.5	33M	\$ 409.09	\$ 409.09	\$ 818.18	\$ 581.82	100	\$ 481.82	\$ 0.24

\$1400 Premium, \$5.8 Net Federal Cost

Net Federal cost	DSH adjustment	Gross federal cost	Workers	Federal premium	State premium 11%	Government premium	Private premium	Worker premium	Employer premium	Employer rate
5	3.5	8.5	33M	\$ 257.58	\$ 31.84	\$ 289.41	\$ 1,110.59	525	\$ 585.59	\$ 0.29
5	3.5	8.5	33M	\$ 257.58	\$ 31.84	\$ 289.41	\$ 1,110.59	500	\$ 610.59	\$ 0.31
5	3.5	8.5	33M	\$ 257.58	\$ 31.84	\$ 289.41	\$ 1,110.59	400	\$ 710.59	\$ 0.36
5	3.5	8.5	33M	\$ 257.58	\$ 31.84	\$ 289.41	\$ 1,110.59	300	\$ 810.59	\$ 0.41
5	3.5	8.5	33M	\$ 257.58	\$ 31.84	\$ 289.41	\$ 1,110.59	250	\$ 860.59	\$ 0.43
5	3.5	8.5	33M	\$ 257.58	\$ 31.84	\$ 289.41	\$ 1,110.59	200	\$ 910.59	\$ 0.46
5	3.5	8.5	33M	\$ 257.58	\$ 31.84	\$ 289.41	\$ 1,110.59	100	\$ 1,010.59	\$ 0.51
Net Federal cost	DSH adjustment	Gross federal cost	Workers	Federal premium	State premium 15%	Government premium	Private premium	Worker premium	Employer premium	Employer rate
5	3.5	8.5	33M	\$ 257.58	\$ 45.45	\$ 303.03	\$ 1,096.97	525	\$ 571.97	\$ 0.29
5	3.5	8.5	33M	\$ 257.58	\$ 45.45	\$ 303.03	\$ 1,096.97	500	\$ 596.97	\$ 0.30
5	3.5	8.5	33M	\$ 257.58	\$ 45.45	\$ 303.03	\$ 1,096.97	400	\$ 696.97	\$ 0.35
5	3.5	8.5	33M	\$ 257.58	\$ 45.45	\$ 303.03	\$ 1,096.97	300	\$ 796.97	\$ 0.40
5	3.5	8.5	33M	\$ 257.58	\$ 45.45	\$ 303.03	\$ 1,096.97	250	\$ 846.97	\$ 0.42
5	3.5	8.5	33M	\$ 257.58	\$ 45.45	\$ 303.03	\$ 1,096.97	200	\$ 896.97	\$ 0.45
5	3.5	8.5	33M	\$ 257.58	\$ 45.45	\$ 303.03	\$ 1,096.97	100	\$ 996.97	\$ 0.50
Net Federal cost	DSH adjustment	Gross federal cost	Workers	Federal premium	State premium 20%	Government premium	Private premium	Worker premium	Employer premium	Employer rate
5	3.5	8.5	33M	\$ 257.58	\$ 64.39	\$ 321.97	\$ 1,078.03	525	\$ 553.03	\$ 0.28
5	3.5	8.5	33M	\$ 257.58	\$ 64.39	\$ 321.97	\$ 1,078.03	500	\$ 578.03	\$ 0.29
5	3.5	8.5	33M	\$ 257.58	\$ 64.39	\$ 321.97	\$ 1,078.03	400	\$ 678.03	\$ 0.34
5	3.5	8.5	33M	\$ 257.58	\$ 64.39	\$ 321.97	\$ 1,078.03	300	\$ 778.03	\$ 0.39
5	3.5	8.5	33M	\$ 257.58	\$ 64.39	\$ 321.97	\$ 1,078.03	250	\$ 828.03	\$ 0.41
5	3.5	8.5	33M	\$ 257.58	\$ 64.39	\$ 321.97	\$ 1,078.03	200	\$ 878.03	\$ 0.44
5	3.5	8.5	33M	\$ 257.58	\$ 64.39	\$ 321.97	\$ 1,078.03	100	\$ 978.03	\$ 0.49
Net Federal cost	DSH adjustment	Gross federal cost	Workers	Federal premium	State premium 25%	Government premium	Private premium	Worker premium	Employer premium	Employer rate
5	3.5	8.5	33M	\$ 257.58	\$ 85.86	\$ 343.43	\$ 1,056.57	525	\$ 531.57	\$ 0.27
5	3.5	8.5	33M	\$ 257.58	\$ 85.86	\$ 343.43	\$ 1,056.57	500	\$ 556.57	\$ 0.28
5	3.5	8.5	33M	\$ 257.58	\$ 85.86	\$ 343.43	\$ 1,056.57	400	\$ 656.57	\$ 0.33
5	3.5	8.5	33M	\$ 257.58	\$ 85.86	\$ 343.43	\$ 1,056.57	300	\$ 756.57	\$ 0.38
5	3.5	8.5	33M	\$ 257.58	\$ 85.86	\$ 343.43	\$ 1,056.57	250	\$ 806.57	\$ 0.40
5	3.5	8.5	33M	\$ 257.58	\$ 85.86	\$ 343.43	\$ 1,056.57	200	\$ 856.57	\$ 0.43
5	3.5	8.5	33M	\$ 257.58	\$ 85.86	\$ 343.43	\$ 1,056.57	100	\$ 956.57	\$ 0.48
Net Federal cost	DSH adjustment	Gross federal cost	Workers	Federal premium	State premium 40%	Government premium	Private premium	Worker premium	Employer premium	Employer rate
5	3.5	8.5	33M	\$ 257.58	\$ 171.72	\$ 429.29	\$ 970.71	525	\$ 445.71	\$ 0.22
5	3.5	8.5	33M	\$ 257.58	\$ 171.72	\$ 429.29	\$ 970.71	500	\$ 470.71	\$ 0.24
5	3.5	8.5	33M	\$ 257.58	\$ 171.72	\$ 429.29	\$ 970.71	400	\$ 570.71	\$ 0.29
5	3.5	8.5	33M	\$ 257.58	\$ 171.72	\$ 429.29	\$ 970.71	300	\$ 670.71	\$ 0.34
5	3.5	8.5	33M	\$ 257.58	\$ 171.72	\$ 429.29	\$ 970.71	250	\$ 720.71	\$ 0.36
5	3.5	8.5	33M	\$ 257.58	\$ 171.72	\$ 429.29	\$ 970.71	200	\$ 770.71	\$ 0.39
5	3.5	8.5	33M	\$ 257.58	\$ 171.72	\$ 429.29	\$ 970.71	100	\$ 870.71	\$ 0.44
Net Federal cost	DSH adjustment	Gross federal cost	Workers	Federal premium	State premium 50%	Government premium	Private premium	Worker premium	Employer premium	Employer rate
5	3.5	8.5	33M	\$ 257.58	\$ 257.58	\$ 515.15	\$ 884.85	525	\$ 359.85	\$ 0.18
5	3.5	8.5	33M	\$ 257.58	\$ 257.58	\$ 515.15	\$ 884.85	500	\$ 384.85	\$ 0.19
5	3.5	8.5	33M	\$ 257.58	\$ 257.58	\$ 515.15	\$ 884.85	400	\$ 484.85	\$ 0.24
5	3.5	8.5	33M	\$ 257.58	\$ 257.58	\$ 515.15	\$ 884.85	300	\$ 584.85	\$ 0.29
5	3.5	8.5	33M	\$ 257.58	\$ 257.58	\$ 515.15	\$ 884.85	250	\$ 634.85	\$ 0.32
5	3.5	8.5	33M	\$ 257.58	\$ 257.58	\$ 515.15	\$ 884.85	200	\$ 684.85	\$ 0.34
5	3.5	8.5	33M	\$ 257.58	\$ 257.58	\$ 515.15	\$ 884.85	100	\$ 784.85	\$ 0.39

Tax Credits for Uninsured Workers

Prepared by
Lynn Etheredge

Abstract: The recently passed legislation that allocates \$792 billion of projected surpluses to tax cuts did not contain major initiatives to assist the 43 million persons without health insurance. This paper outlines an incremental reform proposal—based on federal tax credits—that could be included in revised versions of that legislation and would assure basic benefit coverage for 33 million adults in working families who do not have employer-sponsored benefits. The proposal uses federal tax credits as core financing to provide these individuals with competitive choices in a well-functioning individual insurance market. It incorporates elements from the Armey-Stark tax credit proposal, the Breaux-Thomas "premium support" design for Medicare beneficiaries, and the new state-federal CHIP programs. The paper provides a rationale for a basic benefit package that would cost about \$1,400 per individual, with financing shared among federal tax credits (\$780 per person), individual premiums (\$525 per person), and state tax credits (\$95 per person). States would have major policy-setting and implementation roles. Individuals with employer-sponsored coverage would have assurance that these basic benefits would be available if they lost their employer coverage. Federal costs for assisting 33 million adults in working families would be about \$22 billion in 2000.

Federal budget surpluses and prosperity now create a unique opportunity for assisting the 43 million uninsured. Without agreement on a proposal for extending health insurance coverage, however, the projected surpluses may be spent for tax cuts and other purposes. It would be regrettable to miss this opportunity.

Three leading reform ideas—tax credits, consumer choice, and federalism—have proven useful foundations for recent bipartisan health initiatives. The purpose of this paper is to discuss how these elements can also be used for a legislative initiative to

assure basic health benefits for the 33 million adults in working families who do not have access to employer-sponsored coverage.¹

The key provisions of the proposal are the following:

- The federal government would establish a legislative policy framework and finance tax credits for basic benefits.
- State governments would have lead policy-setting and implementation roles, using the CHIP model for federal-state cooperation.
- Eligible individuals would be able to choose among competing health plans.

There is growing support for *federal tax credits* as a way to resolve tax code inequities and assist the uninsured. Recently, Reps. Dick Armey (R-Tex.) and Pete Stark (D-Calif.), who often espouse different policies, jointly advocated the use of tax credits to assure health insurance coverage for all Americans.² Among the growing numbers of other proposals advocating tax credits (or deductions) are the one sponsored by Reps. Jim McDermott (D-Wash.) and James E. Rogan (R-Calif.) and those sponsored by Reps. Nancy Johnson (R-Conn.), John Shadegg (R-Ariz.), and Sen. Barbara Boxer (D-Calif.). Interest groups now supportive of tax-financed proposals include the American Hospital Association, the Blue Cross and Blue Shield Association, the Health Insurance Association of America, and the American Society of Internal Medicine/American College of Physicians. A major factor in this support of tax code reforms is the question of equity: workers without employer coverage do not participate in the \$125 billion of tax subsidies (1998) for workers with employer benefits.³ Federal tax assistance has recently been enacted to allow self-employed individuals, on a phased-in basis, to deduct their full premium expenses from taxable federal income.

Consumer choice among competing health plans is also proving an attractive political formula. The federal government has long provided an organized system of choices for its workers (the Federal Employees Health Benefits [FEHB] program), as have most state governments and many large employers. In the Balanced Budget Act of 1997, federal decision-makers expanded the opportunities for Medicare's 38 million enrollees to choose from among traditional fee-for-service Medicare benefits and private health plans. The recent Bipartisan Commission on the Future of Medicare proposed new policies for improving this market. Many state Medicaid programs have also been reformed to enroll more beneficiaries in managed care plans. Various ideas for health marts and purchasing alliances are being discussed to offer more choices and economies for small employers and their workers.

Federalism is also proving a successful formula for bipartisan legislation. The state-federal CHIP program targets uninsured children in low-income working families, provides state options with respect to benefits and implementation, and allocates federal funds based on numbers of eligible persons, a standard benefit policy, and geographic cost adjustments. Increasingly, the political challenges for comprehensive reform legislation seem to grow in light of the health system's size, complexity, acrimonious relations, and comprehensive reform costs. Several scholars of national health care reform have suggested that, after five failures to enact comprehensive health reform in this century, a "federalist option" may now be the best course to deal with the political impasse.⁴ States now vary widely in their share of the uninsured problem (from less than 5% of the under-65 population uninsured in some states to nearly 25% uninsured in other states), health insurance

markets and regulation, in state programs (Medicaid, CHIP, state assistance), political philosophies, and other characteristics.

Table 1
Recent Health Initiatives

Tax Credits/Deductions

Enacted: Self-employed premium deductions
Proposals: Armey-Stark, McDermott-Rogan, Johnson, Shadegg, Boxer

Consumer Choice

Enacted: Medicare+Choice, state Medicaid reforms
Proposals: Breaux-Thomas, health marts

Federalism

Enacted: CHIP, HIPAA

The following sections develop an outline for a proposal, discuss major national legislative policy questions, and propose their resolution. The first section deals with tax credits; the second deals with state policies and insurance markets. The paper does not aim for a comprehensive redesign of the national health system, but for an enactable, workable compromise that will assure basic benefits for 33 million individuals without employer coverage. Advocates for comprehensive reform will find that many items from their agendas would remain.

TAX CREDITS

In designing federal tax credits for coverage of uninsured workers, the first issues that need to be considered deal with the amount of the tax credit and how the federal government, workers, and state governments will share premium costs. At least three major critiques of tax credit-based proposals also need to be addressed.

Tax Credit Amount

If there is going to be a federal tax credit, how large should it be? Current proposals reflect a range of options: (a) basic benefits; (b) average benefits; or (c) comprehensive benefits.

There are a number of reasons for preferring a basic benefits plan for an incremental proposal. Federal costs escalate with higher tax credits. Higher tax credits also increase risks of unravelling employer coverage, if workers can receive benefits better than those available from employer-sponsored policies. There are also equity issues if some workers pay taxes to finance benefits for uninsured workers that are greater than those they receive.

For illustrative purposes, Medicare's benefits—adjusted to include maternal and child health benefits and preventive services for an under-65 population—are a useful prototype for a basic health insurance package. Medicare's benefits are well below the norms of employer-sponsored benefits. They are only a "10th percentile" plan, due to high deductibles, lack of catastrophic or stop-loss protection, and absence of prescription drug coverage. This is, however, probably about the right benefit level to avoid unravelling employer coverage or generating complaints from insured workers. At the same time, Medicare offers a good health insurance package, one that has been well-accepted over 30 years, and it is a very popular benefit. It also seems questionable whether public policymakers would enact a tax credit for workers that provides more generous benefits than are now available for Medicare beneficiaries. The estimated premium for a basic benefit modelled on the Medicare program would be about \$1,400 per adult in 2000.⁵

Worker Premium

How much of a \$1,400 premium should be paid by enrollees, and how much should be financed by a tax credit? One way to think about this question is that Medicare enrollees now pay \$525.60 (\$43.80 per month) for a comparable benefit package. If retirees, many living on Social Security checks and without work income, are expected to pay this amount, it would seem reasonable to expect as much from full-time workers. On this basis, the government premium support would be \$875 per person, and individuals would pay about \$525 for basic benefits, depending on the actual cost of the plan they select.

State Tax Credit Share

If a government tax credit is set at \$875, how much of this amount should be paid by state governments? States' tax policies mirror the same inequities for workers without employer health benefits as federal tax policies, and states can afford to contribute. With tax credits financing coverage for 33 million workers, the states' eligible residents will benefit; state and local governments will save on Medicaid disproportionate share hospital (DSH) payments for the uninsured; and the states' employers should realize premium savings (from less cost-shifting). Since a number of administrative functions would fall to state governments, it is also prudent that some state funds should be at risk for their actions.

In 1998, an estimated \$13.6 billion of the total \$124.8 billion government tax expenditures for employer health benefits came from state governments, about an 11% state share.⁶ Using this ratio, government tax credit expenses would be shared \$780 per person (federal) and \$95 per person (state).

The federal and state tax credit costs would be reduced by lower Medicare and Medicaid DSH payments for the uninsured. A rough estimate of federal savings would be \$3.5 billion in 2000; they would offset federal tax credits of \$25.7 billion, for a net federal cost of \$22.2 billion.^{7, 8}

Table 2
Tax Credits

Benefits:	Basic
Amount:	\$1,400 /adult premium
Premium shares:	Federal \$780/person Individual \$525/person State \$95/person
Effectiveness:	Federal/state subsidies Workplace sign-up, payroll contributions Automatic enrollment Safety-net benefits
Efficiency:	Flat credit per adult Allocated to states for payment to insurers
Geographic flexibility:	"Premium support" adjustments

Issues

Three issues are often raised about the use of tax credits to expand health insurance coverage: effectiveness, efficiency, and geographic flexibility.

Effectiveness

Since tax credits support voluntary purchase of insurance, but are not mandates, one of the key questions is whether eligible workers will use them to buy insurance coverage. Obviously, good benefits and lower premiums make it more likely that an individual will sign up. The proposed benefits—Medicare-based—

would be widely recognized as valuable, and individuals would be receiving a benefit of \$875. Even for a worker with \$10,000 of wages (full-time work at \$5 per hour), the \$525 annual premium would be only about 5% of income. Enrollees would also benefit from provider price discounts available through health plans. Given that the new market would have 33 million people, there would likely be significant advertising and marketing to encourage eligible persons to enroll.

Eligible workers would find purchasing health insurance more affordable than they do currently. As well, there are two methods for encouraging voluntary enrollment that are now used in the FEHB program and Medicare that would also be helpful; their use is proposed for this incremental initiative.

Workplace sign-up and payroll contributions—Employer-based insurance (including the FEHB program) typically allows workers to sign up at their work place and to have their premium contributions automatically deducted from paychecks. This is convenient, facilitates enrollment, and sharply reduces administrative costs. Medicare hospital insurance (Part A) contributions—as well as Social Security, unemployment insurance, and the income tax system—also use payroll withholding.⁹ Employers should not object to offer this service, as it makes health insurance coverage available for their workers.¹⁰ Arrangements could be made for firms to submit premiums to a clearinghouse if submission to individual plans was too burdensome.

Automatic enrollment—A second measure to increase voluntary coverage, effective for the Medicare program, would be to establish an automatic enrollment system for eligible individuals. Employers that did not offer health insurance (and unemployment insurance offices) would be required to with-

hold the worker's premiums and submit that amount as premiums for health insurance coverage to a worker-specified plan (or to a state-designated health plan, absent a worker selection) unless the worker explicitly declined coverage. Workers would have to decline in writing, after reading a statement that explains the tax credits and the benefits of basic health insurance. In the Medicare supplementary medical insurance program (Part B), such automatic enrollment and deductions from Social Security checks have produced over 95% sign-up rates.¹¹

An administrative arrangement that features workplace sign-up, payroll contributions, and automatic enrollment would also sharply reduce both government and individual costs. In today's individual insurance market, insurers' administrative charges—including medical underwriting, collection costs, and other load factors—expressed as a percentage add-on to benefits, range from 18% to 20% for HMO and Blue Cross/Blue Shield individual policies to 78% for individual commercial insurance policies. These are markups for typical insurance benefits; for basic benefits, the administrative charges would be an even larger mark-up percentage. Estimates for the proposed arrangement are for administrative costs of 7.5%.

What should happen if an individual who is eligible for a tax credit decides not to use it to purchase private coverage? He or she could receive no benefits, but that would not be consistent with across-the-board progress on insurance for all workers. In this proposal, tax credits that individuals do not use for private insurance would be used by state governments to finance whatever "safety-net" coverage could be purchased on their behalf for the \$875 federal-state tax credits.¹² With workplace sign-up and premium payments, automatic enrollment—and this safety-net provision—all 33

million eligible individuals would be assured of at least some coverage.

Administrative efficiency

A second issue in the use of tax credits is how to administer them efficiently. Three specific concerns that can arise are (a) it is complicated (and expensive) to calculate income-related tax credits for 33 million eligible persons and to issue individual vouchers or rebates; (b) a number of the individuals eligible for a tax credit would not be filing tax returns; and (c) since income tax returns are filed after the year in which the income is earned, it is difficult to match income-related tax credits with current incomes. These concerns can be addressed through the following measures:

- The proposed tax credits would be a flat credit per adult. To be eligible, an individual would need to certify that he or she met work requirements and was not eligible for employer-sponsored health benefits but would not have to file an income tax return. This would vastly simplify administration and make it easy to use the employer-based sign-up and contribution system described above. There would be no need to calculate new tax credits from tax returns for 33 million individuals or to adjust tax credits for changing incomes. It seems difficult to justify such administrative complexity and expense for a tax credit which is such a limited amount—and when many high-income workers receive far more generous tax benefits that are not income-related. In 1998, federal health insurance tax benefits for families with incomes over \$100,000 averaged \$2,357 and totalled \$26.2 billion.¹³
- To provide a much simpler and less expensive way to administer tax benefits than using millions of checks or

vouchers, the Arney-Stark tax credit proposal suggests that tax credits be payable to insurance companies or other entities rather than to individual taxpayers. The proposal developed here adopts this approach and would allocate the federal tax credits to state governments. States would then pay private insurance companies (or another entity) the combined federal-state tax credits due for the individuals they enrolled, and the balance would be available for tax credit financing of the state-sponsored plan (if there was one) or for the minimal benefits payable for individuals who did not sign up for health insurance.¹⁴

Geographic flexibility

A third issue that arises with using tax credits to purchase health insurance is that health insurance premiums can vary a great deal among geographic regions. A nationally uniform tax credit would buy more benefits in some areas than in others and would not assure basic benefits that are comparable for all eligible persons. Should the federal tax credit be a "defined contribution" or support a "defined benefit"?

The recent plan supported by Sen. John Breaux (D-La.) and Rep. Bill Thomas (R-Calif.), based on work of the Bipartisan Commission on the Future of Medicare, proposed a creative way to deal with this issue for Medicare's beneficiaries. Using a "premium support" concept, the Medicare program would calculate a national average premium for a defined benefit (a modified Medicare benefit package) and then adjust this amount for geographic cost variations. The federal government would pay this adjusted premium contribution on behalf of enrollees who signed up for private health plans in each area.¹⁵ Using the premium support concept, the national average tax

credit per person (\$780) could also be adjusted for geographic cost variations. To simplify the federal administrative role, the tax credits for each state's residents (allocated to states for payment to health plans) would be adjusted for state cost differences. Since health insurance premiums would vary within a state in ways that are influenced by a state's health policies (discussed in the next section), states would be responsible for adjusting the tax credit amounts payable to health plans within a state.

STATES AND INSURANCE MARKETS

The foregoing discussion dealt with tax credits and their administration. What else does a legislative policy framework need to include for a tax credit initiative to work well?

Two other major tasks for legislative policy-making are to assure that benefit plans are available for eligible persons in all areas and assure that eligible individuals can purchase these plans. Assurance that eligible individuals can purchase plans involves (a) setting market rules (guaranteed issue, no pre-existing condition exclusions) and (b) adjusting tax credits, using the same factors insurers will be allowed to use to adjust premiums in this market. These tasks fall within the broad scope of state health insurance market regulation and programs on which recent legislation built the federal-state CHIP program and HIPAA legislation. For this tax credit proposal to work, federal and state governments will also need to work together. Beneficiaries should be able to expect that they will be able to purchase basic benefits for the tax credits. And if federal decision makers are going to allocate some \$22 billion annually of taxpayer funds to extend coverage for workers and their families, they need to assure that the funds accomplish this objective.

Availability of the basic insurance benefits for eligible persons should not be a widespread problem. The size of the new market, with over \$46 billion of premiums (\$1,400 x 33 million eligibles), should be attractive to insurance brokers and insurance companies. They would be able to offer the basic benefit plan, with the \$875 tax credit sweetener, to all eligible persons without medical underwriting.¹⁶ Nevertheless, the Medicare+Choice experience illustrates that legislative policy needs a contingency plan if some areas do not have basic health insurance available. While Medicare health plan enrollment has continued to grow, more than 800,000 individuals will be dropped from coverage because it was not profitable enough to serve the counties in which they lived.

If there are no rules or tax credit adjustments in this new insurance market, eligible persons could find that they are denied health plan coverage, are subject to pre-existing condition exclusions, or that health plan premiums are priced unaffordably, even with the government tax credit. The current variation in state individual insurance markets illustrates the need to address this issue. As of 1998, for example, 11 states had community rating requirements for the individual coverage market, and an additional 8 states had rate band limits. Thirteen states had guaranteed issue for the individual coverage market, and 31 states limited pre-existing condition exclusions.¹⁷

In the bipartisan HIPAA legislation, national standards (state-administered) have already been established for guaranteed issuance of insurance and pre-existing condition exclusions in the group health insurance market. These HIPAA provisions should simply be extended to this new tax-credit eligible group.¹⁸ The HIPAA extension would benefit the 33 million individuals eligible for tax credits directly. Quite importantly, it would also benefit the more

than 160 million workers and family members with employer group coverage (now covered by HIPAA) by assuring that—if they did lose employer-based coverage in the future—they would be able to purchase basic health insurance, with the same portability protections, in this new market.¹⁹ For dealing with the remaining issues, such as insurance availability in all areas and health insurance premium variations, the CHIP legislation offers a recently enacted model.

The CHIP Model

In the CHIP program's model for federal-state relations, the federal legislative framework specifies an objective (e.g., coverage of a defined population group), key policy parameters (e.g., financing), and state model standards that would accomplish that objective (e.g., a "benchmark" benefits package). States have options to propose equivalent arrangements that they prefer or that would work better in their state.

Benefits and premiums

As discussed in the previous section, the federal government would determine its payment to states based on a "benchmark" plan, the numbers of persons eligible, and geographic cost adjustments. As a model standard for within-state adjustments, the federal tax code could require that all private health insurance products, as a condition for participating in this new market and receiving tax credits, offer the benchmark health benefits for all eligible persons in their service areas (on a guaranteed-issue basis, without pre-existing condition exclusions,) and set premiums using community rating methods for this group. These are the same kind of requirements that large payers, e.g., the FEHB program, CalPERs, and Medicare+Choice, usually establish in structuring individual choice markets for their enrollees.^{20, 21}

While these legislative provisions would be a model state standard, states could propose—as in CHIP—actuarially equivalent approaches for health benefits and premium adjustment factors. For example, a state might specify a basic benefit package for eligible adults that is actuarially equivalent to the model benefit package but which better integrated with its CHIP benefits for low-income children. Or a state might elect a strategy of allowing premiums to be adjusted for age and sex and between large urban areas and rural areas—and propose that the tax credits it pays be adjusted by the same factors. Some states (e.g., California and Florida) have fostered health alliances or purchasing cooperatives and may want to use them. States that help to pay for COBRA coverage (e.g., Massachusetts) might design ways to combine tax credits with state assistance. States may also supplement basic benefits or safety-net benefits from their own funds. There are many creative ideas that could be tried by leadership states.

Availability

The other legislative objective—access to insurance if it is not available from the private market—could be accomplished through a model provision that states sponsor a health plan for areas where the health insurance market was not adequately serving the eligible populations in terms of costs or quality of care.

Should the model state standard for this objective be that states cover the eligible individuals through separate state-sponsored programs or through their Medicaid programs? Medicaid is available nationwide and offers broad benefits; welfare reform legislation provided new Medicaid options for covering working populations (Section 1931). Nevertheless, there are a number of other factors to be considered.

Most importantly, Medicaid has a means-tested "welfare program" reputation among politicians, health plans, and providers—and among the tax-credit beneficiaries. Among other concerns are that Medicaid's benefits are more generous than the basic benefits that could be financed by tax credits, and it has many regulatory and procedural requirements that would hamper flexible administration of a tax-credit financed program.²² This proposal is thus that the legislative model for states be to assure health insurance coverage, where market performance is not satisfactory, through a state-contracted plan rather than through enrolling workers in Medicaid programs.

Table 3
State Insurance Markets

Objectives:	Health plan available in all areas Eligibles able to purchase using tax credits and self-paid premiums
Basic rules:	Extend HIPAA group standards Guarantee issue No pre-existing condition exclusions
State regulation:	CHIP model (legislative standard, state flexibility) Community rating (or actuarial equivalent) State assures availability if market fails
Federal role:	HIPAA model (federal regulation if state declines)

As with the insurance plan standards, states could develop equivalent arrangements for assuring availability of insurance products. States governments, working with insurance companies, may be able to assure availability of good insurance products, in a competitive insurance market, for all locales and eligible individuals. States may also find better ways to integrate tax credits and CHIP for families that qualify for both benefits. Some states have already inte-

grated Medicaid and state-funded programs to assist working families (e.g., Mass-Health and Wisconsin's BadgerCare), and other states have state-funded assistance programs for low-income adults (e.g., MinnesotaCare, Oregon's Family Health Insurance Assistance Program, and Washington's Basic Health Plan); they may wish to build on those foundations.

Other Insurance Coverage

Another set of state health policy concerns relates to the potential of tax credits for workers without employer-sponsored coverage to reduce insurance coverage in the small group market. This could be a problem if there were large new tax credits. But the potential effects of a \$875 tax credit for financing basic benefits are likely to be modest. Most workers would see themselves as worse off if they lost employer group benefits and employer-paid premiums.²³ The basic health plan is designed to have a limited benefit package (10th percentile, no prescription drugs) and individual premium share (over 30%), that would make it an unattractive alternative to most employer group health insurance. Insurance brokers and insurance companies would be able to offer better benefits for the small group market. Problems could also arise if states allowed wide premium variations in their small employer market (resulting in more high-cost firms that might have a cost advantage in dropping coverage). Regulatory tools are already in use in most states, however, to reduce premium variations in the small group market; in 1998, forty-six states had rating bands or community-rating that limited premium variations in their small group market.²⁴ Nevertheless, this is one of the issues each state would need to consider in developing implementation proposals for the tax-credit program.²⁵

State Participation

This tax credit proposal, with its flexible state policy and implementation roles, should prove very attractive to state governments. But what should legislative policy provide if a state did not participate or, more likely, proposed to do so selectively? Traditionally, these are uncommon occurrences, but a complete legislative policy should address them.²⁶ The recent HIPAA statute for federal-state health insurance regulation includes provisions that address this issue. Under HIPAA, if a state declines to take on a specific responsibility, the federal government takes it on. This approach would assure that the federal tax credits for the 33 million eligible adults would be available nationwide so that all of them would have health insurance coverage.

Table 4
Proposal's Benefits

Opportunity:	Projected budget surpluses Bipartisan support for tax credits, consumer choice, federalism
Beneficiaries:	33 million adults in working families eligible for tax credits Workers with employer-based coverage, if they lose those benefits
Employers:	No employer mandates Coverage for all full-time workers
Insurance brokers/ companies:	\$46 billion new market
States:	Lead state role, flexibility Fewer uninsured Limited state costs
Hospital/ physicians:	Reduced bad debt/charity care
Federal government:	No large federal bureaucracy or new taxes Affordable (\$22 billion in 2000)

CONCLUSION

Federal budget surpluses, prosperity, and bipartisan support for key reform strategies create a unique opportunity for a major incremental proposal to assist the uninsured. Building on broadly supported ideas for tax credits, federalism, and consumer choice, the legislative policy proposed in this paper would assure basic benefits for 33 million adults in working families without employer coverage and correct serious tax code inequities. Given the size of the \$792 billion tax cuts now being considered (over ten years), the proposal's \$22 billion annual cost (in 2000) would be affordable. New taxes, employer mandates, or a large federal bureaucracy are not required. The proposal is intended to be attractive to 33 million eligible persons, 160 million individuals who could lose employer-sponsored benefits, state governments, insurance brokers and insurance companies, hospitals and physicians, and employers. Major technical issues concerning tax credits (effectiveness, administrative efficiency, geographic adjustment), health insurance standards, and health insurance availability can be resolved using recently enacted legislative models and bipartisan proposals. We should not miss this opportunity.

Support for this paper was provided by a grant from the Robert Wood Johnson Foundation to the Health Insurance Reform Project at George Washington University. The author thanks Stanley Jones, Judith Moore, and Sandra Foote for comments on this paper and also thanks participants in an HIRP-*Health Affairs*-sponsored meeting of December 11, 1998, and an HIRP-sponsored meeting on April 6, 1999, to discuss tax credits for the uninsured, insurance market reforms, and state roles.

ENDNOTES

1. The 33 million number refers to adults in working families in which (a) at least one adult is a full-time employee (at least three days per week) or a worker receiving unemployment insurance (UI) benefits and (b) no family member is eligible for employer-sponsored health insurance. Fewer than one-quarter of these individuals are now estimated to purchase individual coverage policies. A rationale for targeting working families, estimates for eligible population, benefit and administrative costs, and discussions of related reform issues can be found in Lynn Etheredge, Stanley Jones "Affordable Health Benefits for Workers without Employer Coverage," Research Agenda Brief, Health Insurance Reform Project, George Washington University, February 1998; available at <http://www.hirp.gwu.edu>.
2. Dick Armey and Pete Stark, "Medical Coverage for All: The Ultimate Congressional Odd Couple Weighs In," *Washington Post*, June 18, 1999.
3. John Sheils and Paul Hogan, "Cost Of Tax-Exempt Health Benefits in 1998," *Health Affairs*, March/April 1999, 176-181.
4. Theodore Marmor, Jerry Mashaw, and Jonathan Oberlander, *National Health Reform: Where Do We Go From Here?* in *Health Policy, Federalism, and the American States*, Robert Rich and William White (eds.) (Washington, D.C.: Urban Institute Press, 1996).
5. These estimates are based on extrapolating 1998 estimates of \$1,382 per adult. They assume an efficient administrative load factor (7.5%). For comparison, national average HMO benefits for 1998 would be about \$2,037 per adult in the individual coverage market, with estimates using a typical 18.5% load factor for that market.
6. Sheils and Hogan, "Cost of Tax-Exempt Health Benefits."
7. In 2000, Medicaid DSH payments are estimated to be \$11.8 billion (CBO) and Medicare DSH payments \$4.5 billion (projected from MedPac data). DSH savings would require revised payment calculations.
8. If the 16 million children in these families were eligible for a federal tax credit of \$490, the added federal costs would be \$7.8 billion. Estimated premium costs would be \$880 per child. Using the matching shares for adult coverage, these premiums would be split \$490 (federal), \$330 (individual), \$60 (state). State CHIP programs, since their eligibility

can extend to 200 percent of poverty, may cover many of these children.

9. The cost estimates for this proposal assume such economies.

10. Providing sign-up information and premium remissions is proposed as an employer requirement, but employers could be allowed to take a small administrative charge as a tax credit. Individuals could also sign up for plans with health insurance brokers and with health insurance plans directly and inform employers of the plan to which their premium contribution should be remitted.

11. Enrollment also could be encouraged by a provision that (a) offered a "one-time" regular sign-up period when an individual first became eligible and (b) imposed a late-enrollment surcharge. The Medicare SMI program now applies a premium surcharge for late enrollment.

12. Legislative policy guidance should be provided for a state model benefit, with state options to offer actuarial equivalent coverage, but was not developed for this paper. States can supplement either (or both) of the basic benefits and safety-net benefits from their own funds. This state flexibility can be used to calibrate a balance of benefit generosity, individual premiums, and voluntary sign-up rates.

13. Sheils and Hogan, "Cost of Tax-Exempt Health Benefits."

14. Initial federal payments would be based on estimated numbers of eligibles with adjustments based on actual numbers of eligibles (audited).

15. A similar concept is also applied in the CHIP legislation which allots funds to states based on number of uninsured children and a geographic cost factor.

16. With the \$875 tax credit, health insurance brokers and companies could also encourage eligible individuals who already purchase health insurance to improve their benefits.

17. Susan Laudicina, Jacqueline Yerby, and Katherine Pardo, *State Legislative Health Care and Insurance Issues*, Blue Cross and Blues Shield Association, December 1998.

18. See Karl Polzer "HIPAA as a Regulatory Model" National Health Policy Forum, Issue Brief #735, George Washington University, April 1999. In general, HIPAA requires that an insurer take all members of a group who apply without new waiting periods or bans on pre-existing conditions.

19. The automatic coverage for basic benefits should be particularly useful in dealing with transitional, short-term problems in health insurance. About 50% of the uninsured are without coverage for six months or less, e.g., because of unemployment (See Robert Bennefield, "Who Loses Coverage and for How Long?" *Current Population Reports*, U.S. Bureau of Census, May 1996, 70-54). Although COBRA now allows insured workers to continue coverage when they leave their jobs, they need to pay the full premiums for the employer-offered benefits, and most elect not to incur this level of out-of-pocket expense.

20. Insurers could offer supplemental benefits and coverage, e.g., coverage of children, Medigap-type options.

21. A critique of community-rating for the individual coverage market is that there would be many losers among insured experience-rated individuals whose premiums would rise. In this instance, however, the new tax credit of \$875 per person would offset any premium increases for persons who faced a rate increase. As well, the market for individuals eligible for tax credits would be distinct from the individual coverage market for other individuals; averaging of high-cost nonworking populations with the working population into one community rate would not be required by this standard.

22. This general discussion should be qualified for some Medicaid programs and subpopulations. TennCare uses a Medicaid waiver; Medicaid is being reformed in other states, e.g., to include outreach, eligibility expansions, and private insurance buy-ins and to enroll the CHIP population. For some sub-populations that move from welfare to work (e.g., those eligible for TANF) or that have Medicaid eligibility that changes month-to-month with earnings variations, a Medicaid-integrated option may also make sense.

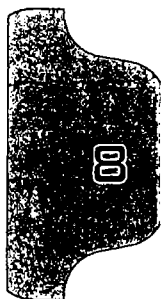
23. Economic theory and studies suggest that workers, on average and over the long term, pay employer premium contributions through a reduction in their wages, so that they would be better off to forego employer-paid premiums if they could get a bigger tax break. But it is also clear that workers generally do not see the matter this way; a \$5,000 family health insurance policy, with \$4,000 employer contribution, so a worker need only pay \$1,000 for a \$5,000 benefit is a different option than having to pay a \$5,000 premium for the same benefits out of one's own pocket. It is also difficult for an employer to "gross up" wages for all workers, who differ in single/family, age/sex, health status, availability of spousal coverage, income and tax brackets,

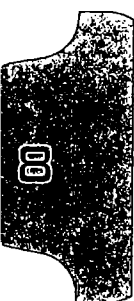
and other ways in amounts that would compensate them equivalently for their loss of employer contributions and cover the premiums they would be charged in the nongroup health insurance market. Workers would owe income (15% or more) and Social Security taxes (7.65%), and employers would owe higher Social Security taxes (7.65%) on premium contributions that are converted to workers' wages.

24. Laudicina, Yerby, and Pardo, *State Legislative Health Care*. Thirty-six of 38 states using rate bands had adopted NAIC model standards for the small group market.

25. As an incentive against employers dropping childrens' coverage, many state CHIP plans impose a six-month waiting period for eligibility after loss of employer coverage. A similar waiting period could be applied for tax credit eligibility of workers who lose employer coverage.

26. Arizona did not participate in Medicaid for a number of years, and HCFA will need to administer some HIPAA requirements in California, Missouri, and Rhode Island.





THE PUBLIC UTILITY EXPERIENCE AS IT APPLIES TO HEALTH CARE

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San Francisco, CA

Washington Business Group on Health
April 30 - May 2, 2000

**THE PUBLIC UTILITY EXPERIENCE
AS IT APPLIES TO HEALTH CARE**

The contemporary struggle over health reform in the United States pits two powerful myths against one another. The first established and entrenched myth reifies the illusion that the existing health care nonsystem allows broad freedom of choice and access to uniformly available, compassionate, competent health providers. The second reformist myth posits a new illusion. It suggests that competing organized care systems, under economic pressures for cost containment, will assure broad freedom of choice and access to uniformly available, compassionate, competent health providers.

Both myths deny reality. Both myths serve a similar function: namely, to obscure that the goal can only be reached through massive change and the political and economic struggles inherent in that process. The new myth is reinforced by uncomfortable recognition that the old myth of self-correcting universal care was never true. This old illusion has increasingly lost its power.

A COMPARISON WITH PUBLIC UTILITIES

The shared goal might be reached, however, within a regulated and accountable public or quasi-public structure. One way to realize how it might be formed would be to examine a conceptual and structural analogue, for example, public utilities¹. The public policy conflict over accepting that health care is a necessity for the economic well-being of the society at large is on a par with water, power, and communications. The public today takes for granted that when they turn on the tap the water will flow and that it will be of good quality; that when they flip the switch, the light will come on immediately and stay on; and that when they lift the receiver, the dial tone will be present and the transmissions clear. This took over a century to accomplish across the entire United States. At various times, industries such as railroads, natural gas, communications and waste disposal have also been viewed as public utilities. (See Addendum)

If an industry meets the criteria to fit a public utility, it must undergo regulation². There are three areas for such regulation: quality of service, public accountability and universal access. Rate setting is also addressed. The quality of service may include both technical and non-technical components of the industry. Technical components include the availability of service, managing excess capacity,

adequate facilities to meet demand and the appropriateness of services rendered.

Non-technical components refer to areas such as service problems or the ability to contact the company regarding bills or making payments. The government may choose to regulate any one or all three of the areas of service.

This model is specific to industries “affected with the public interest”³. Since the pressures driving health reform are economic, the challenge for the reformers in making the mythological goal a reality is to discover the means by which access can indeed be universally assured to available, appropriate and affordable care. Early on, the term “broad freedom of choice” however, needs to be addressed. Public utilities do not provide such broad choice. Where choices exist (e.g., long distance telephone), they are limited as are most things in life. In mitigation of what might be perceived as a popular loss (i.e., choice) it might be useful to reflect that in health care only a small portion of Americans have, or have ever had, “broad freedom of choice.” Unlimited choice is restricted to those who are unusually knowledgeable, go to great lengths to be informed, and who have unrestricted resources. (See attached chart on central and local government regulatory roles.)

In the context of health reform, consider mental health care as a paradigm for inadequate insurance coverage. The mental health benefit is usually restricted,

access is often problematic, and utilization is usually low and sometimes dangerously low. Another historical paradigm, nostalgically pined for, is the less-limited, inpatient hospital-oriented, unmanaged approach of traditional insurance indemnity policies. The first approach spends too little and the second too much. Neither model ever had either a theoretical or an empirical basis, but were ensconced actuarially over time. They became legitimized only by virtue of their presence in the accumulated databases.

SYSTEMS OF CARE

In the relatively brief few years that managed health care has become an element of the medical-industrial complex, it has exercised a significant influence on the shape, size, and delivery of health care. Providers see managed care as a euphemism for restricting care to save money at their expense; managed care advocates and payors see it as a means to enhance benefits and provide more care at less cost.

Physicians have historically been the object of the “willing suspension of disbelief” by the general public and government. This entailed delegating executive

functions to physicians and abdicating critical cognitive faculties in order to suppress fears and contain anxiety about health risk decisions. These attitudes, understandable and useful under certain specific (usually acute) clinical circumstances for individuals, have the opposite effect when institutionalized as laissez-faire public policy. The suspension of disbelief has no place in organizing, monitoring, and financing a public utility. It likewise has no place in considerations of the public health. Only in organized systems of care-monitored and overseen jointly by the public and professionals -can quality, cost effectiveness and uniform access be reasonably assured.

Bibliography

1. Goldman, W. Myths and Potentials. *Managed Care Q* 1994; 2 (2):51-52.
2. This model is explained in detail by Roger Colton, Kenneth B. Frisof and Eugene R. King in their article 'Lessons for the Health Care Industry from America's Experience with Public Utilities.' *Journal of Public Health Policy*. 18.4, 389-400.
3. In 1877, the Supreme Court, in *Munn v. Illinois*, 94 U.S. 113(1877), Chief Justice Morrison Waite wrote, "when used in a manner to make it of public consequence and affect the community at large" property becomes affected with a public interest and can be submitted "to be controlled by the public for the common good".

Addendum

The following little paper illustrates some of the complexities in developing a new regulatory model for electric power. This refutes the argument, often made, that health care is so much more complex than other industries, and therefore so much more difficult to manage and regulate effectively. All industries are complex, the difficulties may seem insurmountable when you examine any one, but in fact these goals are accomplished.

Electric power is basic to modern life and directly contributes to high standards of living. The electric utility is unique in that it sells a product that must be generated at the instant it is to be used. With existing technology, it is impossible to build up an appreciable stockpile of electric power, so that the utility must be ready to generate enough electricity to satisfy the demand at any time. If the utility has excess generating capacity, it can usually cover any anticipated demand; but an overabundance of excess capacity would mean that too much of the plant would be idle too much of the time, thereby increasing cost. At the same time, few products have a greater need for quality and reliability.

Electric utilities can operate only by the grant of a special privilege or franchise from the national or local government that permits use of streets, subsurfaces, and other local property. A single concern in any given area, creates a monopoly. If duplication of service to one area is permitted, the streets would be cluttered with facilities. A franchise, therefore, gives the utility certain rights and imposes corresponding duties, namely, to charge and obtain a reasonable rate for the service and to establish and enforce reasonable rules and regulations under which it, (1) provides service to all who apply for the service, (2) provides power up to maximum capacity and is prepared to meet future increases in demand; (3) provides service that is adequate and safe; (4) does not discriminate unfairly among customers (though it may serve different categories of customers at different rates); (5) does not obtain more than a reasonable price for its service.

A utility technical department is responsible for planning, construction and transmission, the day-to-day operation of the system and maintenance.

Social patterns and events may require monitoring so as to make most efficient use of the system facilities. Electronic information exchange online must be employed to determine the best allocation of resources.

Operational reserves must be available immediately while arranging for whatever repair work is necessary.

The history of electric power goes back to 1878. Electric power generation, transmission and distribution has been a story of invention and technological innovation and development and is a work in progress.

Regulatory Partnership

Federal Government

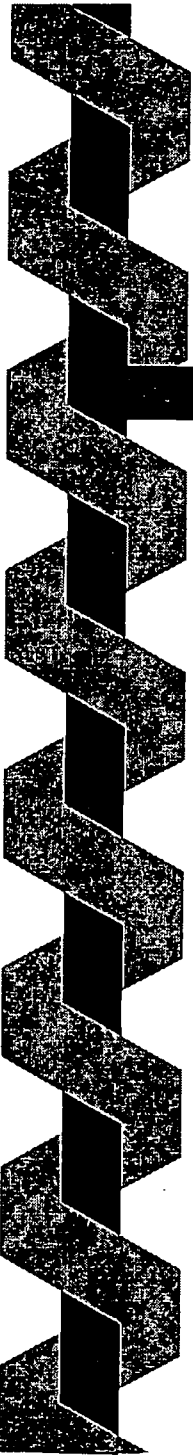
- Articulates Values
- Sets Principles of regulation
- Establishes regulatory standards re: universal accessibility and quality
- Establishes measures and data and reporting requirements
- Sets perimeters of competitive and (quasi) monopolistic arrangements
- Establishes requirements for customer complaint and provider conflict resolution
- Promulgates confidentiality, privacy and safety guidelines

Local Government

- Implements principles of regulation
- Explores beneficial variations and innovations
- Assures consistency, accountability and compliance with standards
- Decides distribution and mix of for-profit and non-profit providers
- Selects mix of benefit variations and delivery configurations
- Determines rates, means for raising capital, solvency requirements, protection for investors

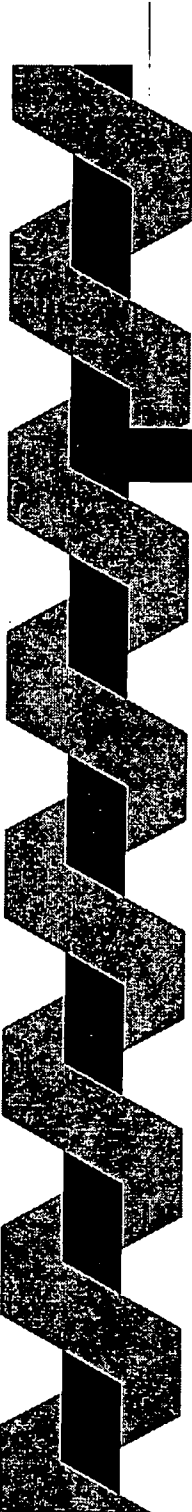
**OVERHEADS FOR
PRESENTATION BY DR. WILLIAM GOLDMAN**

- (1) Drawing A Parallel Between Public Utility Regulatory Approaches &
Necessary New Directions for Health Care, and
- (2) Some Questions for Those Interested in Formulating New Policies



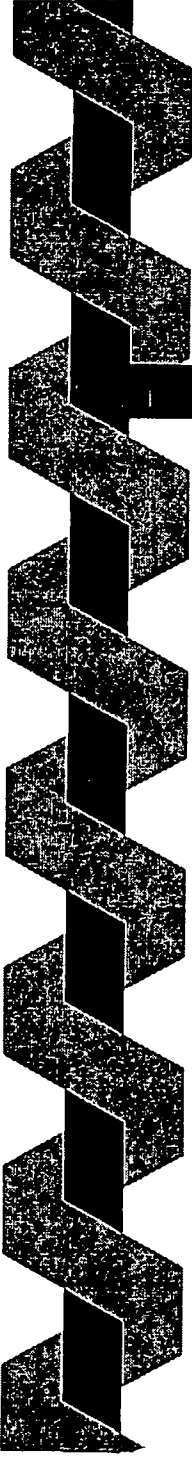
Necessary Shared Values

- **Health care affects the public good**
- **Health care should be available to all**
- **Our economic well being is affected by
health status for individuals and business**



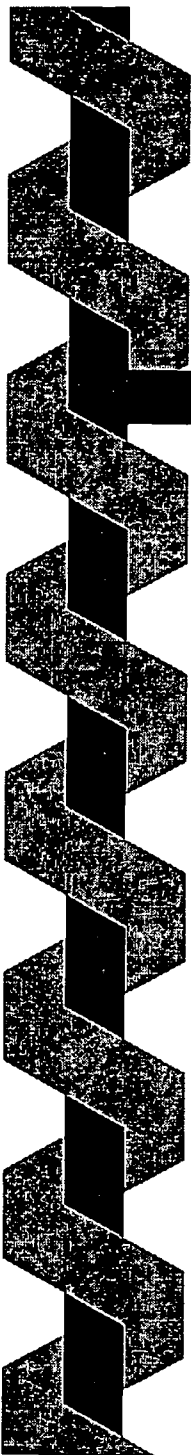
Social Axioms

- **Hybrid models are intrinsically American, i.e.; public services, private capital and regulation should assure a reasonable return;**
- **State, substate or regional level variation and social experimentation is good**
- **Sustained profitability is good**
- **Pluralism is good**



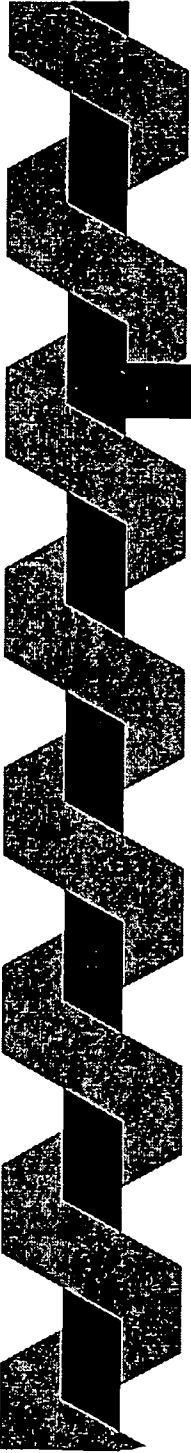
Preconditions for Providing Universal Healthcare Coverage

- **Equity of access**
- **Financial predictability of services**
- **Choice Assured**
- **Information availability**



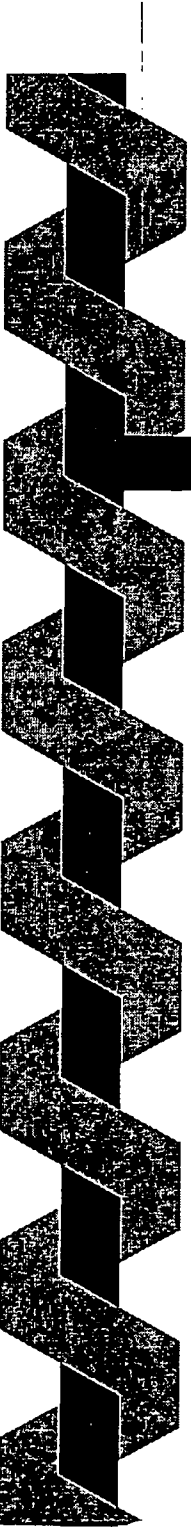
Preconditions for Providing Universal Healthcare Coverage

- **Expectation of accountability**
- **Not result in increase in tax burden for public**
- **Common open accounting practices**
- **Profitability needs to be protected**



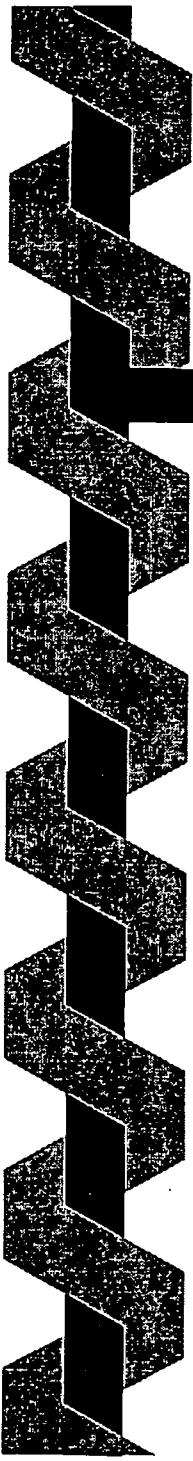
Essential Public Utility Measures:

- **Does it effect the public good?**
- **Does it have a great concentration of economic power?**
- **Will monopolistic conditions be necessary for it to fulfill it's mission?**



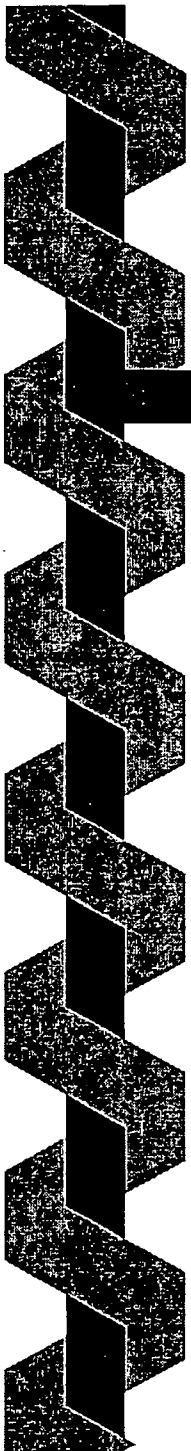
Essential Public Utility Measures:

- **Are its products necessary to sustain life?**
- **Does it possess sufficient planning capabilities and excess capacity?**
- **If mismanaged can great harm occur?**



Current Contradictions Relevant to Healthcare

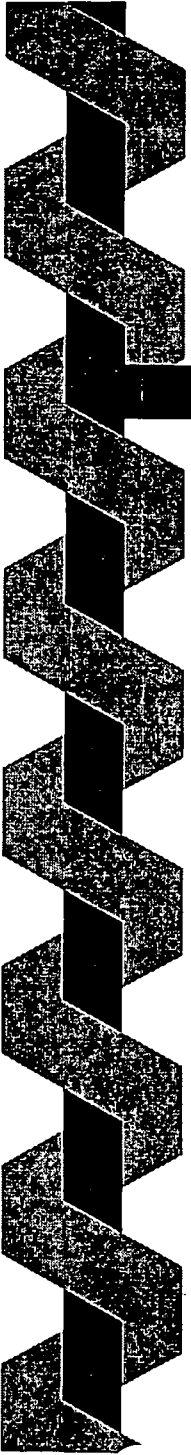
- 1. Central Government is bad; regulation is good**
- 2. Progress can only be made through systems of care; current systems are gridlocked**
- 3. A laissez-faire zeitgeist v: are providers and products safe**
- 4. Ineffective and inappropriate services are compensated equally with best practices**



Some Questions:

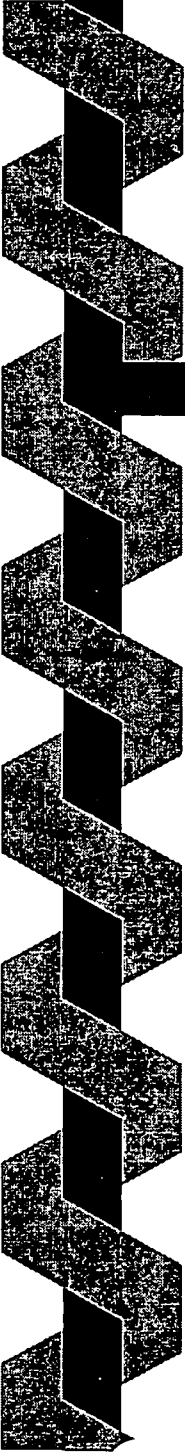
Re Quality :

- **Is the principle of zero fault tolerance in healthcare possible without no-fault (delivery of care) insurance**
- **Is there a learning curve?**
- **How much will a data dependent, accountable, care system impact waste and fraud?**



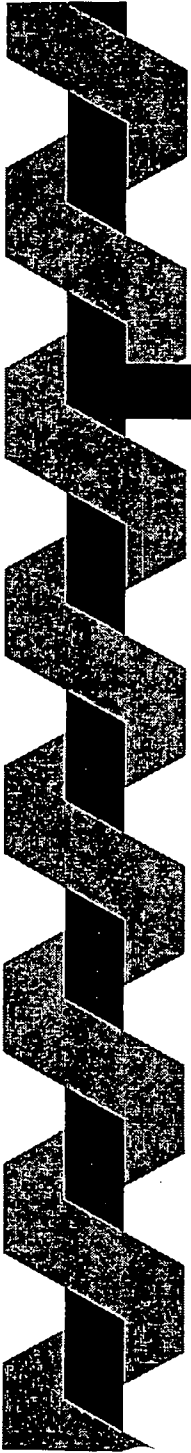
Some Questions:

- **If medical costs reinflate, a la 1989, would that drive labor costs up sufficiently to tip employers to relocate outside of the U S leading to increased unemployment and job insecurity?**
- **If affordability is subjective for payers (dependent on culture, perception of need, resource availability, etc.), might rate setting be approached differently?**



Some Questions:

- **How will the genome, the internet and integrated data warehouses be regulated?**
- **Is it true that health care is a commodity? And if it is, should it be subject to speculative trading?**
- **Will “making it up in volume” satisfy medical - industrial complex stakeholders to sufficiently soften opposition to regulation?**



Caveats

“Lower costs, after all, are not the sole measure of public good”.

Craven Crowell

Chairman, TVA

1998



A Profile of the Uninsured

Two part series on solving the problem of the uninsured

Part One

Despite a robust economy and low unemployment, the number of non-elderly Americans without health insurance grew from 35.6 million in 1990 to just over 43 million in 1997. The continued growth of the uninsured poses serious challenges to efforts to improve the health of Americans and has prompted a spate of policy proposals to address the “problem of the uninsured.”

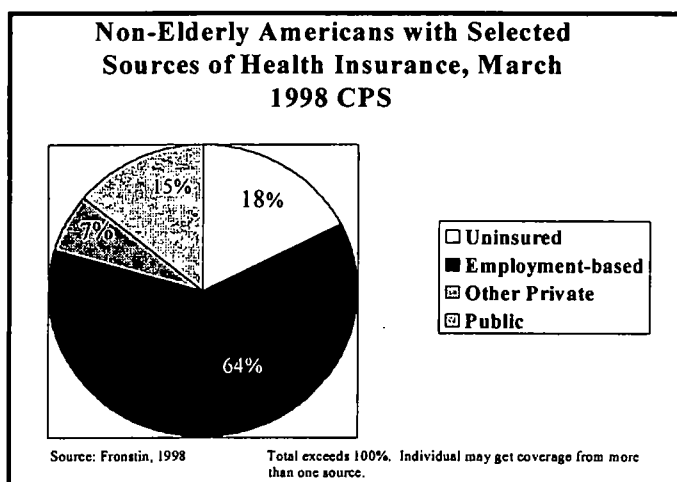
The growth of the uninsured is worrisome for a number of reasons. First, the uninsured are less likely than those with insurance to receive preventive and basic health care and more likely to delay treatment until expensive services are required. As a result, they are generally less healthy than the insured and experience a poorer quality of life. Second, their productivity may be compromised as a result of their poor health. And third, their lack of coverage means that the costs associated with their care may be shifted to other payers through higher premiums or through taxes to pay for uncompensated care.

In this issue of *Policy and Marketplace Trend Report*, we provide a profile of the uninsured and explore the reasons behind the continued growth of this population. In next month’s issue, we’ll describe and discuss the various legislative proposals that have been advanced to expand coverage for the uninsured.

The Uninsured: Who Are They?

Of the 236 million civilian, non-institutionalized, non-elderly Americans in 1997, 43.1 million, or just over 18%, were uninsured. In contrast, 193.1 million Americans had health insurance, with 64.2% covered through private employers, either in their own name or as a dependent. Another 6.7% had other private coverage and 14.8% received insurance through public programs such as Medicaid, Medicare (for the disabled), or other public programs.

There is no single, or simple, answer to the question “Who are the uninsured?” In terms of sheer numbers, they are predominately low-to-middle income white adults who work in small wholesale and retail trade firms. A picture of the “average” uninsured does not tell the whole story, however. Nearly 5 million of the uninsured work in firms with 1,000 or more employees. Just over 18% live in families with incomes of \$50,000 or more. And one in four is a child under 18.

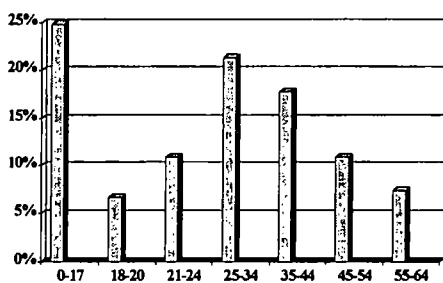


Averages also mask the vulnerability of some populations to the risk of being uninsured. For example, while whites represent the greatest number of uninsured (23 million out of 43 million), the likelihood of being uninsured is over twice as great for Hispanics as for whites: 36% of Hispanics are uninsured compared to 14% of whites. Similarly, while only 22% of uninsured workers are employed in the smallest firms (fewer than 10 employees), nearly 35% of individuals in these firms are without insurance. In contrast, nearly 20% of

uninsured workers are employed in firms with 1,000 or more employees, but only 12.3% of workers in large firms are uninsured.

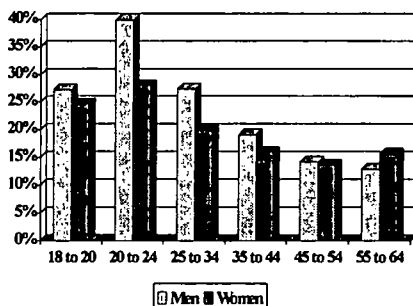
As these examples show, it is important to keep in mind what “lens” is being used to view the uninsured—the characteristics of the total uninsured population or the likelihood of individuals with specific characteristics being uninsured. Below, we use both “lenses” to create a fuller picture of the uninsured.¹

Distribution of Uninsured by Age,
March 1998 CPS



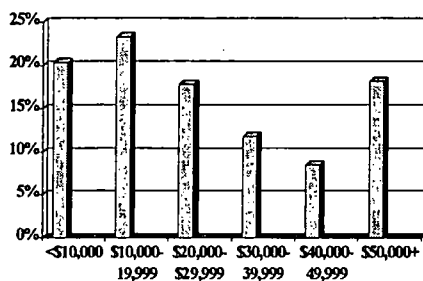
Source: Fronstin, 1998

Likelihood of Being Uninsured by
Age, March 1998 CPS



Source: Fronstin, 1998

Distribution of Uninsured by
Family Income, March 1998 CPS



Source: Fronstin, 1998

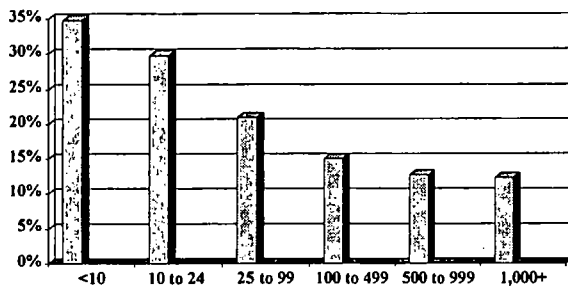
❖ **Work Status:** The majority of the uninsured, 57%, are employed adults. Non-working adults make up another 18% of the uninsured and children under 18 account for the remaining 25%. Non-workers are at the highest risk of being uninsured: 26% of such individuals lack insurance.

❖ **Age:** Of the 43.1 million uninsured in 1997, 10.7 million—or one in four—were children, a figure that represents 15% of *all* children. Most of these children lived in low-income families (200% of the poverty level or below) and in families where the head-of-household worked full- or part-time all year. Only 14.7% of uninsured children lived in families headed by a nonworker.

Among adults ages 18 to 64, nearly 20% were uninsured in 1997. After children, individuals ages 25 to 34 accounted for the largest segment of the uninsured. Individuals under 25 were most likely to be without insurance, however; 34% of those ages 20 to 24 lacked coverage with young men more likely to be uninsured than young women (40% versus 28%). With the exception of women ages 55 to 64, the likelihood of being uninsured decreases with age.

❖ **Income:** Although lower income families are more likely to be uninsured than higher income families (37% of those with family incomes between \$10,000 and \$15,000 versus 7.8% of those with family incomes over \$50,000), the uninsured are found at *all* income levels. For example, among the uninsured, 38.5% had family incomes of \$30,000 or above; 18.2% had family incomes above \$50,000.

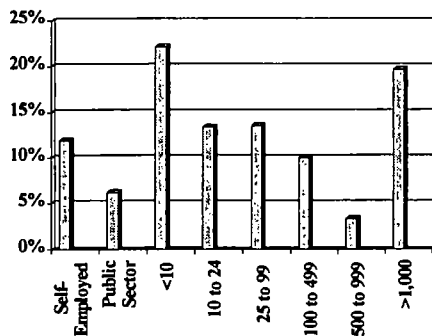
Likelihood of Being Uninsured by Size of Firm, March 1998 CPS



Source: Fronstin, 1998

❖ **Firm Size:** It is well known that the incidence of coverage increases with firm size. Over one third of workers in firms with fewer than 10 employees were uninsured, compared to 15.8% of those in firms with 100 to 499 employees, and only 12.3% of workers in firms with 1,000 or more workers. Just under a quarter of the self-employed were uninsured. Among uninsured workers, 22% were employed in firms with 10 or fewer employees and nearly an equal number, 19.6%, were employed in large firms with 1,000 or more employees.

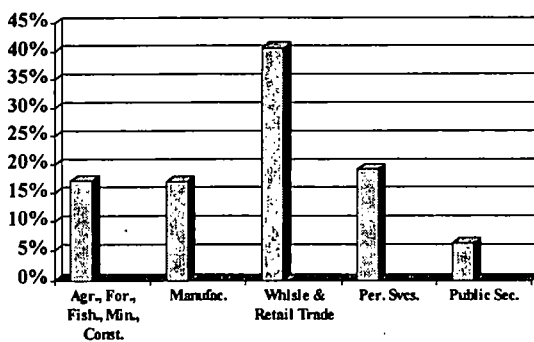
Distribution of Uninsured by Firm Size, March 1998 CPS



Source: Fronstin, 1998

❖ **Hours of Employment:** Access to insurance also varies by hours of employment, with full-time workers more likely to be in firms that offer insurance than workers who are employed part-time. In addition, part-time workers are less likely to be eligible for coverage, even if their employer offers insurance. Although most workers who are not eligible for coverage through their employer are insured through other sources, a significant portion—25 to 66% depending on the reason for ineligibility—lack insurance (Thorpe & Florence, 1999).

Distribution of Uninsured by Industry, March 1998 CPS



Source: Fronstin, 1998

❖ **Industry:** Industry type also plays a role in determining the likelihood of being insured. Only 8% of those employed in the public sector were uninsured, compared to 33% of those working in agriculture, forestry, fishing, mining, and construction jobs. However, the uninsured are concentrated in the wholesale and retail trades which employed 2 out of 5 of the uninsured in 1997. In contrast, 17% of the uninsured worked in manufacturing.

❖ **Race and Origin:** Of the 43.1 million uninsured in 1997, 23 million were white, 7.1 million were black, 10.5 million were Hispanic and the remaining 2.5 million were classified as “other.” Only 14% of whites were uninsured compared to 30% of blacks and 36% of those of Hispanic origin.

❖ **Family Structure:** Individuals who are married, with or without children, are more likely to have coverage than single individuals with or without children. Nearly 29% of singles without children were uninsured in 1997, compared to only 13.6% of married couples with children.

How Long Are People Uninsured?

Many economists believe the estimates of the uninsured developed from the Current Population Survey (CPS) may overstate the number of uninsured (Lewis, Ellwood & Czajka, 1998). Although individuals are asked to report their coverage for an entire year, some who are uninsured at the time of the survey may not remember they were insured earlier in the year. To account for this problem, analysts have turned to other surveys where information is collected more frequently in order to develop estimates of “spells without insurance.”

Using data from the Survey of Income and Program Participation (SIPP) for 1994 and 1995, EBRI estimates that the median spell without insurance is about 7 to 8 months (Copeland, 1998). That is, half of all spells without insurance last less than 8 months; half last longer than 8 months. About two thirds of all “spells without health insurance” last less than a year; the other third last longer than a year and represent the chronically uninsured. The chronically uninsured: are ages 25 to 34; have incomes below or just above the poverty level; lack a high school diploma; have lost Medicaid coverage; are of Hispanic origin; and reside in rural locations.

A somewhat bleaker picture emerges from a survey conducted by the Kaiser Family Foundation (KFF) and the Commonwealth Fund in 1997. At the time of the survey, one-in-three working-age adults was uninsured or had a recent gap in coverage. Moreover, 64% of these individuals said they had been without coverage for more than a year (KFF, 1998).

Why Does the Number of Uninsured Continue to Grow?

There is no shortage of explanations as to why the number of uninsured continues to grow. Many analysts use coverage data to suggest that employers are at least partly to blame. A recent study for the KFF points out, for example, that while 69% of the population had employment-based coverage in 1987, only 64% had such coverage in 1995. Similarly, 35.4% of the non-elderly population had job-based dependent coverage in 1987, a figure that dropped to 31.1% in 1995 (KFF, 1998).

An analysis by EBRI, however, shows that the number of individuals covered by employment-based insurance actually *increased slightly* between 1993 and 1997 from 63.5% to 64.2%. EBRI concludes that the *more recent* increase in the number of uninsured is due largely to a decline in *public sources* of insurance, notably military programs and Medicaid (Fronstin, 1998). For example, as people left the welfare rolls, the percentage of non-elderly Americans covered by Medicaid dropped from 12.1% in 1996 to 11% in 1997.

According to a new analysis by the Families USA Foundation (1999), welfare reform will have an even greater impact on increasing the ranks of the uninsured in the future. The study reports that 675,000 individuals, 419,000 of them children, were uninsured in 1997 as a direct result of welfare

reform and that “millions” more will become uninsured when they run up against caps on the time they can receive welfare benefits.

While analysts may quibble about who’s to blame for the loss of coverage, there is no lack of agreement that individuals who are eligible for insurance but do not take it do so for *financial reasons*. In a 1995 KFF survey of the uninsured, 55% said the main reason they didn’t have insurance was because they couldn’t afford it (KFF, 1998). Similarly, 68% of workers who were eligible for, but rejected, employer-sponsored insurance cited cost as the primary reason for doing so (Thorpe & Florence, 1999).

Solving the Problem of the Uninsured

Finding a solution to the problem of the uninsured will not be easy. As the foregoing shows, the population is diverse and the reasons for being uninsured are varied. Most individuals are without insurance for relatively short periods of time; a worrisome minority are chronically uninsured. Short of wholesale reform that imposes an individual or employer mandate, a single policy solution is unlikely to solve the problem of the uninsured. Rather, various approaches, including expanding access through new purchasing arrangements or risk pooling mechanisms and improving the affordability of coverage is likely to be needed.

In next month’s *Policy and Marketplace Trend Report*, we’ll take a closer look at how the debate over the uninsured is shaping up on Capitol Hill. We’ll also review some of the policy proposals—particularly those that use tax credits and deductions to improve the affordability of insurance—being advanced at the federal level to “solve the problem of the uninsured.”

¹Unless otherwise noted, the data in this section are based on the March 1998 Current Population Survey, as reported in Fronstin, 1998.

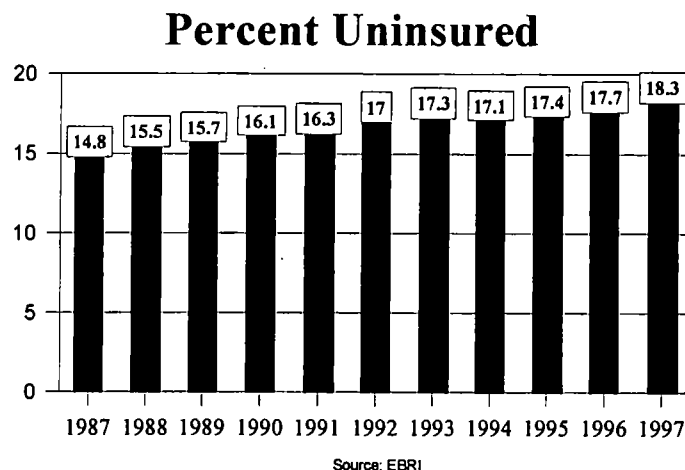
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Increasing Affordability and Access to Health Insurance

Part Two

The U.S. economy has boomed over the past ten years, yet the number of uninsured individuals has steadily increased. If the number of uninsured is increasing in good economic times, analysts worry that in a downturn, many more will lose their health insurance. Against this backdrop, it's not surprising that health policy analysts and lawmakers are looking for ways to increase the affordability and access to health insurance.



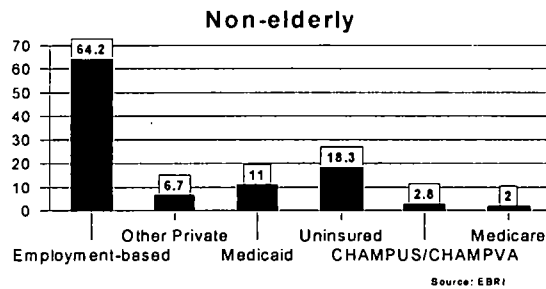
Several proposals targeting the insured have already been introduced this congressional session; more plans are on the way. Many use the tax system to incent currently uninsured individuals to purchase health insurance, primarily in the private market. While the impetus for most proposals seems to be reducing the number of uninsured, broader concerns about tax inequities and inefficiencies, or the lack of health plan choice and frustrations with managed care also appear to be fueling some plans. As a result, proposals run the gamut from supplementing the employment-based insurance system to scrapping it altogether.

To help frame the debate, this article reviews the shortcomings and strengths of the existing employment-based health insurance system and identifies the broad approaches that have been suggested to reduce the number of uninsured. In a future issue of *PMTR*, we'll take a closer look at the implications of these proposals for reducing the number of uninsured and for the future of an employment-based insurance system. (A side-by-side comparison of bills that have been introduced to date is enclosed with this issue of *PMTR*.)

Concerns about an Employment-based System of Health Insurance

Critics of an employment-based insurance system charge that plans are no longer affordable for many workers because employers have shifted more of the costs of insurance to employees; that such a system does not provide an adequate choice of health plans; that the current tax treatment of employer-sponsored insurance is unfair and inefficient; and that the current arrangement encourages over consumption of insurance and services resulting in higher overall health care costs.

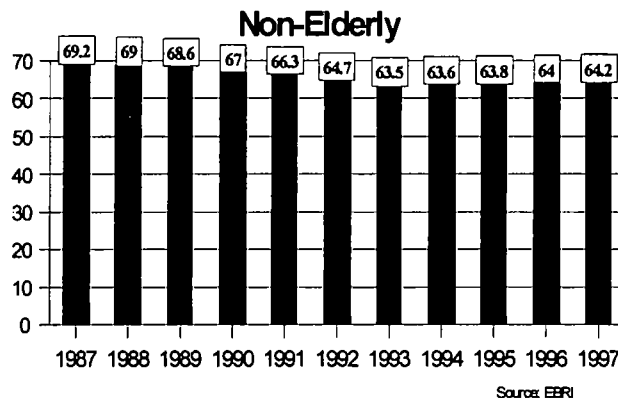
1997 Insurance Coverage



❖ *Eroding Affordability:* Currently, the vast majority of the non-elderly insured get health coverage through their employer. Nonetheless, the percentage of those with employment-based coverage has decreased over the last ten years.

Studies show that while the number of employers offering health insurance has actually increased, the number of individuals turning down the offer of employer-sponsored insurance has also increased.¹ Many of the uninsured report that they decline coverage because they cannot afford their share of premiums, co-pays, and deductibles (see *Policy and Marketplace Trend Report*, May 1999).

Employment-Based Coverage

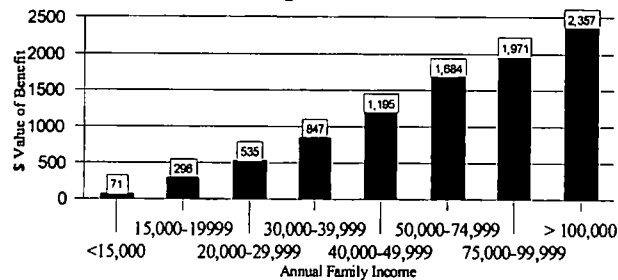


❖ *Limited Choice:* The lack of health plan choice is another perceived shortcoming of the employer-sponsored insurance market and one of the factors underpinning the managed care backlash. A 1998 poll by Louis Harris & Associates found that 58 percent of individuals have no real choice of health plan. Thirty-six percent literally had one plan offered. Twenty-two percent said they had a choice between plans that were so similar that there was no real choice.²

❖ *Tax Treatment Inequities:* Analysts agree that the tax treatment of employer-sponsored health insurance is regressive. Because employer contributions to health insurance are not taxed as income, individuals in higher tax brackets receive more benefit from this arrangement than do those in lower brackets. The average tax expenditure for the ten percent of the population in families with annual incomes above \$100,000 was \$2,357 in 1998. In contrast, the 64 percent of the population in families with annual incomes below \$50,000 received an average tax expenditure of only \$71.³ Those with higher incomes receive a disproportionate share of the tax benefits associated with the \$252.3 billion that employers spent on health insurance in 1998.⁴ The tax benefit received by those with employer-sponsored coverage is not available to the uninsured and only partially available to the self-employed.

Federal Health Benefit

Tax Expenditures



❖ *Over Consumption:* Lastly, in an employment-based health insurance system most employees do not pay the total cost of their health insurance. As a result, they are unaware of the true price and will tend to over-consume health insurance. Similarly, since they pay only a portion of the total cost of specific services, the insured are likely to use more health care services than necessary. This leads to higher overall spending for health care.

Strengths of an Employment-based System of Health Insurance

Proponents of an employment-based system point to its ability to pool risk; the proactive role that employers play as intermediaries between plans and employees; and the ability of employers to drive the market to improve quality and keep costs in check.

❖ *Natural Risk Pooling:* One of the most obvious strengths of an employment-based system is that employers provide a natural mechanism to pool risk. If the employer group is large enough, underwriting is unnecessary since costs are spread across the group. In contrast, premiums in the individual market are underwritten based on the historical claims for people of the same gender, age, geographic location, etc. Individual rates are almost always higher than group rates because each person's premium is expected to cover his claims.

❖ *Intermediaries with Health Plans:* The employer's role as intermediary between the health plan and the employee is another positive feature. Employers screen plans based on cost and quality, educate their employees on health plan choices, distribute comparative information, and enroll employees in the plans. Employers also often act on behalf of employees in disputes with health plans.

❖ *Market Drivers:* Lastly, through their market clout and push for greater efficiency and accountability, employers have helped keep cost increases down. They've also led the drive for improved quality through such initiatives as HEDIS and FACCT. More recently, they have begun prodding health plans to demonstrate the value of their outputs through new measures such as improved functional outcomes and increased productivity.

The positive aspects of the employer-based health insurance system have lead most policy makers to support keeping the employer-based system intact, at least for the short term, supplementing it with measures targeted to specific groups of the uninsured. However, if health care costs continue to rise, dissatisfaction with managed care remains strong, and health plan liability expands, a number of analysts believe it is only a matter of time before employers embrace an individual-based insurance system.

Increasing the Affordability of Health Insurance

The tax code has emerged as the central tool of most proposals to make health insurance more affordable for the uninsured. The most basic proposals supplement the employer-sponsored insurance market through tax incentives for individuals, usually those who don't have access to employment-based coverage, to participate in the individual market. Other proposals follow this basic approach but also include structural reforms, such as new pooled purchasing entities, to increase access. The most radical proposals alter the tax treatment of insurance with the apparent goal of shifting from an employment to an individual-based insurance system. Regardless of the specific approach, any proposal involving the tax code must address numerous structural issues such as the type and amount of the tax incentive, the target of the incentive, eligibility, and opt-out provisions.

❖ *Tax Credit vs. Tax Deduction:* A tax-based approach to increase affordability can use either a credit or deduction. The tax deduction would allow individuals to deduct all or a portion of the cost of their health insurance. Critics of this approach point out that a deduction, which reduces taxable income, is regressive because it is worth more to individuals in higher tax brackets. In contrast, a tax credit, which is applied to taxes owed or refunded if no taxes are due,⁵ is worth the same to everyone who uses it, no matter the tax bracket. Some analysts argue that a credit would be more likely to encourage the uninsured population to purchase coverage because it would be worth more to them than a deduction. One challenge of either approach is cash flow: how to implement the deduction or credit so that low-income individuals have enough cash up-front to purchase coverage.

❖ *Amount of the Incentive:* The level of participation, or the number of individuals taking advantage of a tax credit or deduction, relies heavily on the amount of the incentive. Economist Kenneth Thorpe estimates that with a tax credit of \$2,800, about 75% of the uninsured living at or near the poverty line would purchase insurance. Take-up rates would fall off sharply, however, as the size of the credit declines.⁶ Analysts agree that changes in the tax code are unlikely to bring about universal coverage; some individuals will decline insurance no matter how much it is subsidized. Finding the right amount will be a delicate balancing act because the larger the incentive, the more likely it is to displace currently sponsored insurance.

❖ *Target of the Incentive:* Tax incentives can be targeted to individuals or employers. Most large employers already offer insurance to their employees, but many small firms do not. Some analysts have suggested providing special incentives to small firms to encourage them to offer insurance to their employees. While this approach might help moderate and higher income workers who can afford to purchase insurance if they have access, it is unlikely to have a significant impact on low-wage workers for whom cost is still the most important barrier to coverage. Critics also point out that targeting small employers does nothing to help low-wage workers in large firms who decline coverage because they cannot afford their share of insurance premiums or the uninsured who are not connected to the workforce. For these reasons, many economists recommend targeting incentives to individuals rather than to firms.⁷

❖ *Eligibility:* Eligibility is another key issue that must be addressed in any tax incentive proposal. Tax incentives could be limited to those with no employment-based access to insurance or they could also be used to purchase employer-sponsored insurance. The latter approach would help employees who have turned down employer-sponsored insurance because they could not afford their share of the premium. Thus, tax incentives could be used for the employee portion of insurance or for insurance purchased on the individual market, or both. Since group insurance is usually more affordable than insurance purchased in the individual market, helping employees purchase through an employer could help keep overall costs down.

❖ *Opt-out Provisions:* Much more difficult issues arise if employees with employer-sponsored insurance are permitted, with the employer's approval, to opt-out of their employer program and use the employer contribution, along with any additional tax incentive, to purchase another health insurance plan. On the one hand, increasing consumer choice is a laudable goal. As noted earlier, the majority of employees enrolled in employer-sponsored plans have no discernable choice between health plans.⁸ Moreover, people who had real choices were happier with their coverage.⁹ On the other hand, if only healthy employees opted-out, this approach could seriously distort the employer's risk pool. The potential consequences of such an approach suggest that few employers would permit voluntary opt-out, leaving employees with the same choices as before.

Increasing Access to Health Insurance

Increasing the affordability of health insurance is clearly one half of the battle to reduce the number of uninsured. Improving access to insurance is the other. Once individuals previously unable to access the system have the means to enter the market, they must be able to actually purchase an insurance product. For some individuals, particularly those who do not have access to employer-sponsored insurance, finding a product in the market may actually be the tougher part of the battle. Insurance in the individual market is more expensive than insurance purchased through a large group. Thus, many analysts believe that proposals to assist individuals with the purchase of their own health insurance also need to include small market reforms that would increase access.

❖ *Pooled Purchasing:* One approach to expand access that has garnered some support in Congress is pooled purchasing arrangements, especially the "HealthMart." A HealthMart is a private, voluntary organization that would offer multiple insurance products to small employers and/or individuals. Other pooled purchasing arrangements include association health plans, community health organizations, individual membership associations, and multiple employer welfare arrangements.¹⁰

In theory, insurance purchased through a HealthMart (or other similar arrangement) would be cheaper than insurance purchased in the individual or small group market because the HealthMart would be able to spread risk across a larger pool and perform administrative and information gathering functions more cheaply. Some proposals also would exempt HealthMarts and other pooled purchasing groups from state benefit mandates in an effort to make coverage more affordable.

❖ *Buy-in Options:* Allowing the uninsured to buy-in to existing insurance programs such as Medicare, Medicaid, or the Federal Employees Health Benefits Program (FEHBP) is another approach that has been suggested from time-to-time to improve access. In his 1998 State of the Union Address, President Clinton proposed giving individuals ages 55 to 64 the option to buy into the Medicare program, and Medicare and Medicaid buy-ins are an integral part of proposals to help the disabled return to work. Some states have used their Children's Health Insurance Program dollars to buy coverage for uninsured children through Medicaid.

❖ *Guaranteed Access Pools:* A guaranteed access pool, a safety net program to allow "the uninsurable" to purchase insurance at more reasonable prices, is another approach to expand access. Because it focuses on high cost individuals who cannot get insurance in the individual market, this approach has higher costs associated with it than other pooling methods. It typically features higher tax incentives for participants to buy-in and expanded funding to keep the pool viable. Some proposals use a combination of federal and state funding to establish the guaranteed access pool, with shortfalls in premiums made up by other assessments and revenue raisers.

Solving the Problem of the Uninsured: A Complex Problem

As the foregoing discussion suggests, designing policies to reduce the number of uninsured will not be an easy task. Most who seek solutions to the problem of the uninsured do not want to disrupt the employer-based system that voluntarily provides coverage to most Americans. Nonetheless, tools used to incent the uninsured to purchase health insurance could create market distortions that adversely affect the employer-based system. The challenge is how to improve access for the uninsured without displacing existing coverage.

Difficult issues, such as the size of the incentive, who to target to get the most bang for the buck, and how to ensure access to products in the marketplace, must be resolved. Finding the revenue to finance a major reform effort also will be difficult and contentious. Moreover, many analysts believe that without an **individual mandate** to purchase insurance—a highly controversial provision—the impact of any proposal to reduce the number of uninsured will be limited.

Whether these issues can be resolved in the short term remains to be seen. Pressure in Congress to “do something” about the uninsured is mounting, however, and the growing number of uninsured is sure to be an issue in the upcoming presidential campaign. For employers, perhaps an even more important question than *when* we solve the problem of the uninsured is *how*. Many observers believe that how we solve the problem of the uninsured may well determine whether we take the next step of moving from an employment to an individual-based insurance system. With that in mind, employers should take a close look at the impact of proposals to increase affordability and access on their employee populations and on their overall benefits strategies.

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³Sheils, John and Paul Hogan. “Cost of Tax-Exempt Health Benefits in 1998.” *Health Affairs*, Volume 18, Number 2, March/April 1999, p. 179.

⁴*Ibid.* p. 178.

⁵Brunce, Victoria and David Lack. *Snapshot: Health Insurance Tax Credits in the 106th Congress*. Council for Affordable Health Insurance Policy Brief, Volume 3, Number 5, April 20, 1999, p.7.

⁶Thorpe, Kenneth E. *Changes the Tax Treatment of Health Insurance: Impacts on the Insured and Uninsured*, paper prepared for the EBRI Spring Policy Forum, “Severing the Link Between Health Insurance and Employment: What Happens if Employers Stop Offering Health Benefits, May 5, 1999.

⁷Brunce and Lack, *op.cit.*

⁸Louis Harris & Associates, Inc. and the Harvard School of Public Health poll. *How Many People with Employer-sponsored Health Plans Have Choices?* Conducted between June 30 and July 17, 1998.

⁹“Industry Insights: Employee Choice of Health Plans.” *Managed Care Outlook*, March 26, 1999.

¹⁰Wicks, Elliot K., Ph.D. and Jack A. Meyer, Ph.D. *Small Employer Health Insurance Purchasing Arrangements: Can They Expand Coverage?* National Coalition on Health Care Report, May 1999, p. 19.

**Washington Business Group on Health
Proposals to Expand Access to Health Insurance through the Tax Code**

Proposals	Type of Tax Incentive: Credit and/or Deduction	Amount	Who's Eligible	Funding	Administration of Tax Incentive	Individual/Small Group Market Reforms	Other Relevant Provisions
Agenda to Improve Health Care for America's Working Families Al Gore	Refundable tax credit.	Tax credit (refundable in certain cases) for 25 percent of health insurance costs.	Individuals without access to employer-sponsored health coverage and who purchase coverage in the individual market, who buy into CHIP or who buy into Medicare are eligible for the refundable tax credit. Employees of small businesses who buy insurance through purchasing coalitions are eligible for the tax credit.	Does not provide for funding in this proposal.	Not outlined in proposal.	Will strengthen individual market. Allows small businesses to band together in purchasing coalitions.	Extends CHIP eligibility to 250 percent of poverty. Allows families without access to employer-sponsored health insurance to buy into CHIP or Medicaid. Allows those 55 to 64 to buy in to Medicare. Investments in community health. Work Incentives Improvement Act, Patient's Bill of Rights and privacy protections included.
The New Prosperity Initiative George W. Bush	Refundable tax credit.	Tax credit of \$1,000 to cover up to 90% of the cost of insurance for individuals with incomes of \$15,000 or less; tax credit of \$2,000 to cover up to 90% of insurance for families with incomes of \$30,000 or less. Credits phase out at higher income levels	Individuals and families that do not receive employer-sponsored coverage and that are not eligible for public programs.	Funding not specified in proposal.	Can be advanced to insurer when premiums are due.	Supports the creation of Association Health Plans that allow small businesses to band together to purchase from bona fide trade associations	Permits employees to rollover up to \$500 of unspent health FSA funds. Makes MSAs permanent and lifts the cap on the number of accounts; allows all employers to offer an MSA, including as part of a cafeteria plan; permits both employee and employer contributions; lowers the minimum deductible to \$1,000 for an individual and \$2,000 for families; and allows contributions up to the deductible.

Proposals	Type of Tax Incentive: Credit and/or Deduction	Amount	Who's Eligible	Funding	Administration of Tax Incentive	Individual/Small Group Market Reforms	Other Relevant Provisions
Health Coverage, Access, Relief, and Equity (C.A.R.E.) Act S. 2320 Sens. Jim Jeffords (R-VT) and John Breaux (D-LA) H.R. 4113 Reps. Dick Armey (R-TX) & Calvin Dooley (D-CA)	Refundable tax credit.	Tax credit of \$1,000 for individuals with incomes of \$35,000 or less and a credit of \$2,000 for families with incomes of \$55,000 or less for the purchase of qualified health insurance including COBRA coverage. Credits phase out at higher income levels.	Individuals and families who do not receive subsidized employer-sponsored insurance and who are not eligible for Medicare, Medicaid and certain other public programs. Self-employed who do not take a deduction for health insurance. Individuals who contribute to MSAs; amount of the credit not allowable as a deduction.	Funding not specified.	Payments may be advanced to issuers of qualified health insurance.	None	Benefits provided through cafeteria plans or flexible spending accounts do not qualify.
American College of Physicians-American Society of Internal Medicine	Refundable tax credit for individuals.	Tax credit to a maximum of \$2,800 for individuals at 100% of poverty phasing out \$2,400 at 150% of poverty.	Adults at 100-150% of poverty level without existing coverage.	Budget surplus and savings of Medicaid disproportionate share money.	Available at year-end through income tax filing or monthly vouchers paid to enrollee or directly to plan.	None specified.	Funding for state-level outreach efforts. Federal subsidies for COBRA coverage for those up to 250% of poverty level. Expand Medicaid to individuals below 100% of poverty level.
American Medical Association	Refundable tax credit for individuals.	Tax credits would be inversely related to income.	Individuals with health insurance or other health expense coverage are eligible for tax credits.	Eliminating the tax exclusion of employment-based insurance would equal the value of the tax credits making the	Available at year-end through income tax filing or monthly vouchers paid directly to the plan by welfare agency or other appropriate entity for	Establishes voluntary choice cooperatives.	Employer contributions for health insurance would be reported as compensation and then offset by tax credit. Employer contribution

Proposals	Type of Tax Incentive: Credit and/or Deduction	Amount	Who's Eligible	Funding	Administration of Tax Incentive	Individual/Small Group Market Reforms	Other Relevant Provisions
American Medical Association, cont.				proposal budget neutral.	lower-income individuals.		tax deductible to employer. Encourages the establishment of state risk pools.
Council for Affordable Health Insurance	Refundable tax credit for individuals.	Credit for individuals in households with income more than \$14,500 receive a \$750 credit. Households with income of \$14,500 to \$6,500 receive a credit of \$1,250. Households with income less than \$6,500 receive a credit of \$1,900. Credit for high-risk individuals in households with income over \$14,500 receive a credit of \$1,125. High-risk individuals in households with income of \$14,500 to \$6,500 receive a credit of \$1,875. High-risk individuals in households with income less than \$6,500 receive a credit of \$2,850. Credits will receive annual COLAs.	Excludes all those covered by federal programs including Medicare, FEHBP, military health care and Indian health programs. Medicaid population is eligible.	Proposal is budget neutral, it pays for the tax credits through Medicaid savings.	Everyone receives a tax credit based on income. The employer can manage employed individuals' tax credits through the payroll system. The unemployed can receive monthly or quarterly refunds. Low-income individuals receive a voucher based on last year's tax return to purchase privately or through a state Guaranteed Access Program. Those not qualifying for private coverage, the "uninsurable," receive 150 percent tax credit.	High-risk individuals would be allowed to participate in a state-run Guaranteed Access Program, a safety-net risk pool. If a state chooses not to operate a Guaranteed Access Program the federal government can enact legislation to allow the insurance industry to set one up for the state. Funding for the pool would come from assessments on state insurance carriers. Funding could be expanded through other means.	The value of employer-provided benefits is reported and taxable on employees' W2s and then offset by tax credit. Employer contribution tax deductible to employer.

Proposals	Type of Tax Incentive: Credit and/or Deduction	Amount	Who's Eligible	Funding	Administration of Tax Incentive	Individual/Small Group Market Reforms	Other Relevant Provisions
Health Insurance Association of America Insure USA	Tax credit, deduction and vouchers.	CHIP-style, federal/state program for adults below 100% of poverty. For those between 100-200% of the poverty level a \$2,000 federal voucher (75% of the average FEHBP premium) to purchase insurance either in the individual market or to cover the employee contribution of employer-sponsored coverage. Tax credits for small firms: 40% for employers with <10 employees, 25% for employers with 10-25 employees, and 15% with employers with 26-50 employees. Full deductibility of health insurance premiums for creditable coverage for individual purchasers and self-employed.	Those in Medicare, Medicaid and military health programs are NOT eligible.	Not specified. Looking for broad-based funding.	Voucher administered periodically during the year through a designated federal agency, i.e., HCFA, similarly to the food stamp program. Payment could be assigned to a health plan. Credit/deduction administered through tax code filings.	Federal government provides seed money and block grants to help set up risk pools, matching funds to underwrite losses on premiums down to 150% of the standard rate, and reinsurance to cover 75% of claims over \$1 million. Federal government funds risk pools sponsored by private industry and allows antitrust exemptions and tax credits.	Employee contributions to health insurance are not taxable. Federal government will help defray costs of risk pools with seed money and block grants. Federal government will match funds to help with underwriting losses, provide reinsurance, and assist with the creation of risk pools sponsored by private industry. Expand MSAs by simplifying rules. Deduction not available unless taxpayer itemizes. Lessen mandates and regulations.
National Association of Health Underwriters	Refundable tax credit for individuals.	Tax credit to a maximum of \$2,400 per family or \$800 per adult and \$400 per child	Individuals not covered by the Medicare program or military health plan.	Treating employer-paid health insurance and unearned taxable income to employees	Credit advanced by employer to employed individual each pay period and then deducts credit from wage and tax report. Credit advanced by insurance carrier to unemployed individual	None specified.	Additional subsidies available for low-income.

Proposals	Type of Tax Incentive: Credit and/or Deduction	Amount	Who's Eligible	Funding	Administration of Tax Incentive	Individual/Small Group Market Reforms	Other Relevant Provisions
National Association of Health Underwriters, cont.					and then deducted from insurance carrier's federal taxes.		



Participant Biographies

Robert Bernstein, Ph.D.

Dr. Bernstein is the Executive Director of the Bazelon Center for Mental Health Law in Washington, D.C. A nationally recognized expert on public mental health service systems and serious mental illness, he was the architect and, for 19 years, director of an innovative system to serve older adults with persistent mental illness in integrated community-based settings. He holds a doctorate in psychology from Wayne State University in Detroit, Michigan and is an experienced clinician, working with primarily adolescents and young adults.

Dr. Bernstein has applied his first-hand knowledge of the combined effects of mental illness and the social/political environments in which people with mental disabilities live to system reform advocacy on behalf of this population. As an expert witness in the 1995 trial of the landmark case of *Wyatt v. Poundstone*, in the United States District Court for the Middle District of Alabama, he toured wards of the state's psychiatric hospitals and testified about the neglect of older people confined in these facilities and their need for quality treatment that is respectful of their rights. He has also provided expert testimony in pivotal cases establishing the fair housing rights of people with mental disabilities and mandating their access to the least restrictive mental health services consistent with their needs.

Dr. Bernstein joined the Bazelon Center, the leading national legal advocacy organization for people with mental disabilities, in April 1997. He articulates his mission as Executive Director as the establishment of policies and systems that will foster the integration and empowerment of consumers of mental health services – beyond “deinstitutionalization” and toward “community membership.” This philosophy guided his work in Michigan, where the programs he headed, Geriatric Screening and Outpatient Service, developed and supported successful community-living arrangements for hundreds of older adults with mental illness or dementia, many of whom had lived for decades in state psychiatric institutions.

Lawrence Casalino, M.D.

Lawrence Casalino practiced for twenty years as a family physician in the San Francisco area; he has recently moved to the Department of Health Studies at the University of Chicago. While working as a family physician, he obtained a Ph.D. in Health Policy and organizational sociology at the University of California, Berkeley. With the help of a Robert Wood Johnson Investigator Award, Dr. Casalino is currently studying the effects of public policies and of public and private purchasing decisions on the organization of physician practice and on the structure of physician-health plan relations. His work has been published in the *New England Journal of Medicine*, the *Journal of the American Medical Association*, and *Health Affairs*.

Hal Cohen, Ph.D.

Hal Cohen is President of Hal Cohen, Inc., a health care consulting firm and is an associate of Phoenix HealthCare Consulting. Hal was Executive Director of Maryland's Health Services Cost Review Commission from 1972 to 1987. He has been appointed to three federal panels,

being a member of the Prospective Payment Assessment Commission (ProPAC) from 1983 to 1989 where he served as Chairman of the Subcommittee on Hospital Productivity Cost Effectiveness and has also been a member of the National Advisory Committee on Rural Health and the National Committee on Vital and Health Statistics.

In Maryland, Hal served as a member of the Health Care Access and Cost Commission from 1993 to 1998. Prior to coming to Maryland, he taught government regulation at the University of Georgia for eight years. Hal received his Ph.D. in economics from Cornell University and is the author of several articles on hospital costs.

John M. Colmers

John M. Colmers has played a major role in Maryland's efforts to provide its citizens with access to quality health care at an affordable price. Effective October 1, 1999, Mr. Colmers was appointed Executive Director of the Maryland Health Care Commission (MHCC) which was created as a result of a merger of two existing health regulatory commissions. The MHCC is charged with the combined responsibilities of the former Health Care Access and Cost Commission and the Health Resources Planning Commission. In addition to the health care reform activities performed by the HCACC, the MHCC will also be responsible for the development and adoption of the State Health Plan, administration of the Certificate of Need Program, and the compilation and analysis of health care data sets.

From July 1993 to September 1999 he was Executive Director of the Health Care Access and Cost Commission (HCACC), one of the preceding organizations. The HCACC has developed the Comprehensive Standard Health Benefit Plan for the small group insurance market; developed a medical care database of non-hospital services; creation of "report cards" on the quality and performance of health maintenance organizations; established standards for the operation of electronic health networks; implementation of a payment system for all health care providers; and the development of an Advisory Committee on Practice Parameters to develop recommendations on the use of statewide practice parameters.

From 1987 through 1993, Mr. Colmers was the Executive Director of the Health Services Cost Review Commission – the agency that oversees Maryland's unique all payor hospital rate setting system.

Mr. Colmers is currently the Chairman of the Steering Committee of the Reforming States Group, a bipartisan group of senior state health leaders from the legislative and executive branches of over 40 states. Mr. Colmers is also currently serving on two Institute of Medicine Committees.

Mr. Colmers completed his undergraduate work at the Johns Hopkins University and he received his Masters of Public Health degree from the University of North Carolina in 1977. He has completed course requirements for a Doctorate of Science degree in health services research at the Johns Hopkins University School of Public Health.

Mary Jane England, M.D.

Mary Jane England, M.D. is president of the Washington Business Group on Health, a nonprofit national health policy organization of the nation's major employers. Dr. England serves on the Board of Allina Health System, NSF International, The Health Project and is the chair of the advisory committee for the Robert Wood Johnson Foundation's program, Making the Grade: School-Based Clinics.

Before joining WBGH, she was vice president, Group Medical Services at The Prudential Insurance Company of America where she was responsible for the development of mental health policy and programs. Prior to Prudential, Dr. England was associate dean and director of the Lucius N. Littauer Master in Public Administration (MPA) Program at the John F. Kennedy School of Government, Harvard University. As the first commissioner of the Massachusetts Department of Social Services (DSS) from 1979 to 1983, she helped establish and administer a new state agency for children and their families.

A psychiatrist with a M.D. from Boston University School of Medicine, Dr. England served as president of the American Psychiatric Association and the American Medical Women's Association in 1995. She currently serves on the DHHS Substance Abuse and Mental Health Services Administration National Advisory Council and the National Institute of Mental Health Advisory Council, and the President's Quality Forum Planning Committee.

Dr. England is the chair of the Board of Visitors of Boston University School of Public Health and a member of the Board of Visitors of Boston University School of Medicine. Dr. England holds honorary degrees from Regis College, Boston University, the Massachusetts School of Professional Psychology and the University of Texas. She is also a recipient of the 1995 Boston University Distinguished Service to the Community Award.

Lynn M. Etheredge

Lynn Etheredge is an independent consultant specializing in health policy and retirement issues and he is also senior consultant to the Health Insurance Reform Project at George Washington University.

Mr. Etheredge's career started at the White House Office of Management and Budget, where he served as a fiscal economist developing multi-year projections of the federal budget and the U.S. economy. During the Nixon and Ford administrations, he was OMB's principal analyst for Medicare and Medicaid and led its staff work on national health insurance proposals. After a detour to the Department of Energy as head of a strategic planning office, he returned to OMB as a senior career executive and headed its professional health staff in the Carter and Reagan administrations.

Since leaving government service, Mr. Etheredge has worked in many capacities with the public and private sectors, in consulting, academic positions, and policy think tanks. During the last several years, he has authored a number of policy studies about Medicare reform, expanding Medicare's benefits to include prescription drug coverage, and using tax credits to assist uninsured workers. Mr. Etheredge is author of more than 70 publications and is a graduate of Swarthmore College.

Judith Feder, Ph.D.

Judith Feder, Ph.D., a political scientist, is Dean of Policy Studies at Georgetown University. In addition to directing and teaching in the Georgetown Public Policy Institute, Feder is conducting policy research with particular attention to health and long term care financing. From 1993-1995, Feder served in the Department of Health and Human Services (DHHS) as Principal Deputy Assistant Secretary for Planning and Evaluation, leaving as Acting Assistant Secretary. At DHHS, she played a key leadership role in formulating the Administration's health policy.

Before joining the Clinton Administration, Feder was a widely published health policy researcher at Georgetown University and, prior to that, at the Urban Institute. She also served as staff director of the Congressional Pepper Commission. Currently, Feder holds a senior advisory position with the Kaiser Commission on Medicaid and the Uninsured, serves on the boards of prominent health services organizations and journals, and is an elected member of the National Academy of Public Administration and of the National Academy for Social Insurance. She holds a Ph.D. in political science from Harvard University.

Richard G. Frank, Ph.D.

Richard G. Frank, Ph.D., is the Margaret T. Morris Professor of Health Economics in the Department of Health Care Policy at Harvard Medical School. He is also a Research Associate with the National Bureau of Economic Research. Prior to his arrival at Harvard in 1994, Dr. Frank was a Professor in the School of Public Health and the Economics Department at Johns Hopkins University. Dr. Frank is engaged in research in three general areas: 1) the economics of managed care arrangements for mental health and substance abuse care; 2) the economics of the pharmaceutical industry; and 3) the organization and financing of physician group practices.

Richard Frank and his colleagues are examining competing strategies for organizing and financing mental health and substance abuse care. In related research, under a National Institute for Drug Abuse-sponsored Center grant to Brandeis and Harvard Universities to study the impact of managed care arrangements on the treatment of individuals with addictive disorders, Dr. Frank is examining the impact of several different approaches to managing substance abuse services. His work in the area of pharmaceuticals has focused on drug pricing and the dynamics of competition in that large and controversial market. Another area of activity involves understanding the economic and organizational factors that influence the performance of medical group practices. As part of the research of the Sloan Center for the Study of Managed Care, of which he is the Deputy Director, Dr. Frank and his colleagues are studying the organizational, managerial and financial factors that explain variation in the performance of medical group practices.

Dr. Frank serves on the Advisory Council of the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services. He advises several state mental health and substance abuse agencies on issues related to managed care and financing of care. He recently was the co-recipient of a Senior Investigator Award from the Robert Wood Johnson Foundation to support work on reforming financing of mental health and substance abuse care. Dr. Frank was awarded the Georgescu-Roegen prize from the Southern Economic Association for his joint work on drug pricing. He is an associate editor on the Journal of Health Economics and on the Journal of Mental Health Policy and Economics, and a member of the American Economic Association and the International Health Economics Association.

Dr. Frank graduated from Bard and holds a doctorate in economics from Boston University. He served as a Commissioner on the Maryland Health Services Cost Review Commission from 1989 to 1994. During 1993, he served as a staff member on the President's Task Force on Health Reform. He was also elected to the Institute of Medicine, NAS in 1997.

Howard H. Goldman, M.D., Ph.D.

Howard H. Goldman, M.D., Ph.D. is Professor of Psychiatry at the University of Maryland School of Medicine, where he is the Director of Mental Health Policy Studies and the Co-Director of the Center for Mental Health Services Research. Dr. Goldman received a joint M.D. – M.P.H. degree from Harvard University in 1974 and a Ph.D. in social policy research from the Heller School at Brandeis University in 1978, while completing a residency in public psychiatry in a unique National Institute for Mental Health (NIMH) training program.

Dr. Goldman served as Assistant Institute Director at NIMH from 1983-1985. Over the past twenty years he has worked on three “national plans” for services and research produced by the NIMH. Dr. Goldman is also the author of 200 publications. A great deal of his time is spent in editorial roles: Currently, he serves on Health Policy and Economics and The Journal of Behavioral Health Services and Research. He served previously on the editorial board of the American Journal of Psychiatry, Health Affairs, and Evaluation Review. Dr. Goldman also edits a textbook Review of General Psychiatry, now entering its 5th edition.

Dr. Goldman has received awards in mental health services research from the American Public Health Association, the American Psychiatric Association, and the Cecil Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill. He has given the Schorr Family award lecture at the University of Arizona, the Emily Mumford medal lecture at Columbia University, and the Lundbeck lecture in Sweden. He consults to public and private organizations on mental health care in the United States, the United Kingdom, and Sweden. He served as the Senior Scientific Editor of the Surgeon General's Report on Mental Health, published in 1999.

WILLIAM GOLDMAN, M.D.

United Behavioral Health - 425 Market Street, 27th Floor, San Francisco, California 94105
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RESUME SUMMARY

CURRENT POSITIONS:

- Senior Vice President for Behavioral Health Sciences, United Behavioral Health, San Francisco
- Clinical Professor of Psychiatry, University of California, San Francisco;
- American Psychiatric Association, Council on Economic Affairs;
- UCLA/Rand Research Center on Managed Care for Psychiatric Disorders Advisory Board;
- NIMH National Worksite Program Research Advisory Group;
- NIMH Parity Workgroup;

PREVIOUS POSITIONS:

- Medical Director, US Behavioral Health/United Behavioral Health, San Francisco, California;
- Medical Director, Contra Costa Health Plan, Martinez, California;
- Associate Medical Director for Mental Health Services, HealthAmerica, Inc.;
- Medical Director, HealthAmerica/Rockridge, Oakland, California;
- Director of Mental Health, Drug and Alcoholism Services, City and County of San Francisco;
- Massachusetts Commissioner of Mental Health and Mental Retardation;
- Director, Westside Community Mental Health Center, San Francisco;
- President, National Council of Community Mental Health Centers;
- Visiting Scholar, Kennedy School, Harvard University;
Heller School, Brandeis University; Department of Psychiatry;
Albert Einstein School of Medicine;
- Chair, American Psychiatric Association Committee on Financing Mental Health Care;
- National Institute of Mental Health, National Advisory Mental Health Council,
- Board of Directors, American Orthopsychiatric Association;
- Founding Fellow, College of Mental Health Administration;
- Fellow, American Psychiatric Association and American Orthopsychiatric Association.
- Member, American College of Psychiatrists

EDUCATION:

- M.D., Columbia University;
- Psychiatric Residency, Mt. Zion Hospital, San Francisco, California;
- Fellowship, Langley Porter Neuropsychiatric Institute, San Francisco, California;
- Fellowship, Berkeley Center for Training in Mental Health Administration.

Nikki Heidepriem

Nikki Heidepriem, co-founder of the Firm, and native of Miller, South Dakota, brings to the firm over 20 years experience in government, law, and the political arena.

In 1978, she left a law practice in Chicago to become special assistant to Secretary of Health, Education and Welfare, Joseph Califano, Jr. In January 1980, she joined the Washington, DC law firm of Verner, Liipfert Bernard & McPherson where she practiced commercial litigation and public policy representation. While at Verner Liipfert, Heidepriem wrote the first report of the Citizens Commission on Civil Rights entitled, "There is no Liberty..."

From 1983 through 1984, Heidepriem served on the national political staff of the Mondale for President Campaign. In November 1984, she joined Carol Tucker Foreman in business.

Heidepriem served as director of communications for Barbara Mikulski's successful bid for the United States Senate. In 1988, she advised the campaigns of Democratic presidential nominee Michael Dukakis and Senators Lloyd Bentsen and Max Baucus on targeting women's vote and on reaching organized constituency groups. She was also a key strategist for the campaign to defeat the nomination of Robert Bork to the United States Supreme Court. In 1992, she served as a consultant for the primary and general election campaigns of Bill Clinton for President.

Heidepriem is a director of the National Partnership for Women & Families, the Jacobs Institute of Women's Health, the Bazelon Center for Mental Health Law and the Macalester College Alumni Association. She serves on the steering committee of EMILY's List. She is a member of Georgetown Presbyterian Church.

Heidepriem graduated from Macalester College in St. Paul, Minnesota, and from the law school at New York University, which she attended on a Root-Tilden Fellowship. At NYU, she was the managing editor of the Annual Survey of American Law.

Michael F. Hogan, Ph.D.

Dr. Michael Hogan has served as Director of the Ohio Department of Mental Health since March 1991. In the past two decades, Dr. Hogan has held leadership positions and led reform in the mental health systems of three states. Serving in the Massachusetts Department of Mental Health from 1976 to 1984, he developed innovative community mental retardation and mental health services, and served as Regional Administrator and Superintendent of Northampton State Hospital. Western Massachusetts became one of the only regions of the U.S. which serves mentally retarded and mentally ill citizens in a completely community based system.

Dr. Hogan served from 1984 to 1987 as Deputy Commissioner, and from 1987 to 1991 as Commissioner of Mental Health in Connecticut. He was credited with leading Connecticut to fourth place ranking among the state mental health systems in 1990 – tied with Ohio. During his tenure, Connecticut reduced state hospital use and costs, expanded and improved community services, and implemented purchase of service and information system reforms.

Coming to Ohio in 1991, Dr. Hogan has guided Ohio's public mental health system through broad, challenging reforms initiated via the Mental Health Act of 1988. This legislation unified mental health care and leadership at the community level. To implement the legislation successfully, ODMH has reduced state operations faster than any other state agency, and increased community mental health resources by over \$700M since 1990. This has been achieved within an ODMH budget that has grown less than inflation. To accomplish this, under Dr. Hogan's leadership, ODMH has carefully and successfully closed four state facilities, privatized one, and consolidated administrative services and costs. The quality of care in the remaining hospitals is rated above national norms for private and public sector care. ODMH has also piloted improvements in Quality Improvement, interagency collaboration, and outcome funding.

Dr. Hogan holds a bachelor's degree from Cornell University and a doctorate from Syracuse University. He served from 1994 to 1998 on the National Advisory Mental Health Council and is president of the board of the National Association of State Mental Health Program Directors Research Institute. He has authored a book and numerous chapters and articles. He is married and has three sons.

Constance Horgan, Sc.D.

Constance Horgan (Sc.D., Johns Hopkins University) joined the Heller Graduate School in July 1984. She is currently a Professor at the Heller School and Director of Health Services Research within its Schneider Institute for Health Policy. She has over twenty-five years of experience in health policy analysis and health services research in both academic and government settings. In 1990, Dr. Horgan started the Substance Abuse Group at the Institute for Health Policy which has

become one of the leading groups in the country on the financing, organization, and cost of substance abuse services. As Director of Health Services Research, Dr. Horgan is responsible for developing and supervising four areas: financing and reimbursement, program evaluation, long term care, as well as substance abuse and mental health.

Dr. Horgan has focused her attention on how mental health and substance abuse services are financed, organized and delivered in the private and public sectors. She has directed several studies for the Federal government (AHCPR, HCFA, NIAAA, NIDA, MINH, and SAMHSA) and foundations, including the Robert Wood Johnson Foundation. Dr. Horgan directs the doctoral training program in health services research funded by the NIAAA. She also teaches child health policy and the substance abuse policy courses. She has written numerous articles and served on expert panels and advisory committees for federal agencies, professional associations, and academic and community task forces.

Edward F. Howard

Ed Howard is executive vice president of the Alliance for Health Reform, a nonpartisan effort formed to educate America's opinion leaders about the urgent need for universal access to affordable, quality health care and long-term care.

Until November 1990, he served as the general counsel for the U.S. Bipartisan Commission on Comprehensive Health Care and the "Pepper Commission," which has reported to Congress on ways to assure access to health care and long-term care for all Americans.

Before joining the staff of the Pepper Commission, he served as public policy coordinator for the Villers Foundation (now the Families USA Foundation), a Washington-based, non-profit organization helping to empower older persons, with an emphasis on those with low and moderate incomes.

He has written and lectured across the country, and testified before Congress, on a range of topics related to aging and health, including long-term care, the uninsured, Social Security, Medicaid, Medicare, age discrimination in the workplace and services for the elderly.

Mr. Howard was general counsel for the House Select Committee on Aging under the chairmanship of the late Representative Claude Pepper, and played a key role in passing legislation to protect older workers beyond age 65.

He has been a member of the American Bar Association's Commission on Legal Problems of the Elderly, and a fellow of the Brookdale Center on Aging at Hunter College. He is a member of the National Academy of Social Insurance.

Mr. Howard holds a juris doctor degree from the Harvard Law School.

Chris Koyanagi

Chris Koyanagi is Policy Director for the Judge David L. Bazelon Center for Mental Health Law in Washington, DC. The Bazelon Center is a legal advocacy organization concerned with the rights of children and adults with mental impairments. Chris is responsible for the legislative and policy advocacy agenda of the Bazelon Center. The Center prioritizes policy changes to ensure community membership for persons with mental illness, including access to community-based services and protection of individual rights. Chris works on policy regarding financing, particularly Medicaid, policy on the use of advanced directives for mental health care, consumer

rights under public sector managed care plans and access to housing, income support, education, rehabilitation and other essential community services for adults and children with mental disorders.

Chris has over 30 years of Washington experience working on human service issues and in addition to her work at the Bazelon Center, serves on several mental health policy and advisory committees and has authored numerous articles and other publications on mental health policy.

David Mechanic, Ph.D.

David Mechanic is the Rene Dubos University Professor of Behavioral Sciences and Director of the Institute for Health, Health Care Policy, and Aging Research at Rutgers University. His research and writing deal with social aspects of health and health care.

David Mechanic received his Ph.D. from Stanford and joined the University of Wisconsin faculty in 1960, where he was chair of the Department of Sociology (1968-1970), the John Bascom Professor of Sociology (1973-1979) and Director of the Center for Medical Sociology and Health Services Research (1972-1979). He moved to Rutgers University in 1979, was Dean of the Faculty of Arts and Sciences (1980-1984), and established the Rutgers Institute for Health, Health Care Policy, and Aging Research (1985), which he directs. He also directs the NIMH Center at Rutgers for Research on the Organization and Financing of Care for the Severely Mentally Ill.

Dr. Mechanic is a member of the National Academy of Sciences, the American Academy of Arts and Sciences, and the Institute of Medicine. He has served on numerous panels of The National Academy of Sciences, federal agencies and non-profit organizations.

David Mechanic has received many awards including the Health Services Research Prize from the Association of University Programs in Health Administration and the Baxter Allegiance Foundation, the Distinguished Investigator Award from the Association for Health Services Research, the First Carl Taube Award for Distinguished Contributions to mental Health Services Research from the American Public Health Association, and the Distinguished Medical Sociologist Award and Lifetime Contributions Award in Mental Health from the American Advanced Study in the Behavioral Sciences at Stanford.

He has written or edited 24 books and approximately 400 research articles, chapters and other publications in medical sociology, health policy, health services research, and the social and behavioral sciences.

Paul Starr, Ph.D.

Paul Starr is Professor of Sociology at Princeton University and author of *The Social Transformation of American Medicine*, winner of the 1984 Pulitzer Prize for Nonfiction, the C. Wright Mills Award, the James Hamilton Prize of the American College of Healthcare Executives, and the Bancroft Prize in American History.

He is also co-editor of *The American Prospect* – a liberal magazine about American politics and society, public policy, and ideas – which he founded in 1990 with columnist Robert Kuttner and Robert Reich.

Through *The American Prospect*, he helped to organize the Electronic Policy Network and to create its "virtual" publication, *Idea Central*.

Professor Starr has written extensively on American society and public policy, particularly health care. His book *The Logic of Health Care Reform* (1992, reissued in a revised and expanded edition in 1994) laid out the case for a system of universal health insurance and managed competition. During 1993, Professor Starr worked at the White House on President Clinton's health plan. He is currently working on a book on the politics of information and the information age.

Veronica V. Goff

Veronica Goff is Vice President for the Washington Business Group on Health (WBGH), a nonprofit health policy organization representing the nation's largest employers. Ms. Goff oversees all facets of administration and day to day operations for WBGH. She also leads the Health and Productivity Management Initiative and Depression Awareness, Recognition, and Treatment (D/ART) National Worksite Program, a cooperative initiative of WBGH and the National Institute of Mental Health to identify workplace and health system practices that reduce the costly impact of depression.

Before joining WBGH in 1989, Ms. Goff was a Research Associate at the University of Virginia Health Sciences Center. She worked for AT&T, supervising a Chicago-based corporate health promotion facility and was marketing director for a shared-used corporate health promotion facility in Richmond, VA. Ms. Goff holds a Master of Science degree and a Bachelor of Science degree in education from Southern Illinois University.

Ronald H. Weich

Ronald Weich is a partner in the Washington, D.C. law firm of Zuckerman, Spaeder, Goldstein, Taylor & Kolker, LLP, and a member of the Board of the Bazelon Center for Mental Health Law. A native New Yorker, Mr. Weich received his undergraduate degree from Columbia University in 1980 and his law degree from Yale University in 1983. He began his legal career as an Assistant District Attorney in New York County and in 1987 joined the staff of the United States Sentencing Commission. From 1989 to 1997, Mr. Weich served in a series of senior staff positions in the United States Senate, notably as General Counsel to the Labor and Human Resources Committee and as Chief Counsel to Senator Edward M. Kennedy on the Judiciary Committee.

In his years on Senator Kennedy's staff, Mr. Weich was responsible for a variety of health care issues, including substance abuse, mental health, tobacco policy and medical malpractice. In this capacity he served on the 1993 White House task force that produced President Clinton's health care reform legislation, and then participated in the Labor Committee's consideration of that bill the following year.

At Zuckerman Spaeder, Mr. Weich has represented a number of health-related organizations including the American Psychological Society, the National Board for Certification in Occupational Therapy, the National Center for Tobacco-Free Kids, and the United States Pharmacopeia. He also represents the American Civil Liberties Union on medical privacy issues and in 1999 testified before Congress on this issue.

Raymond B. Wertz

Ray Wertz was named President of the Consumer Health Education Council (CHEC) in May 1999. CHEC's mission is to reduce the number of uninsured Americans and improve the health of the general public through information and research that helps individuals and plan sponsors understand the value and uses of private and public insurance.

Previously, Ray was Vice President of Compensation and Benefits for Whitman Corporation in Rolling Meadows Illinois where he was a strong proponent of health and financial education for employees and their families. In addition to his over thirty years' experience as a human resources executive, Ray has been active on many Boards, including the Washington and Midwest Business Groups on Health, and in other private and public sector organizations established to address community-wide health care delivery, quality, education and access.

Ray, a native of Chicago, has a BA and MA in History and Philosophy from De Paul University and a JD from John Marshall Law School.