Policy Environment for Health Benefits: Implications for Employer Plans

Anna M. Rappaport

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INTRODUCTION

Traditionally, employers have been the main source of funding and plan sponsorship for citizens' health benefits in the United States. However, the government also plays a major role in insuring Americans. Health care currently accounts for 15 percent of the Gross Domestic Product, and it will reach 18 percent if the current rate of spending increase continues\(^1\) For example, in 1991, the government paid 44 percent of all health care costs,\(^2\) while insurance companies, businesses, and individuals paid the remaining 56 percent.\(^3\) Of that 44 percent paid for by the government, the bulk was distributed through the Medicaid and Medicare programs.\(^4\) These programs aid the poor, elderly, and those who are likely to be overburdened by health care costs.

Because not all employers provide health insurance for their employees, and not all those who are uninsured qualify for government assistance, there are gaps in coverage. In fact, the number of uninsured Americans is estimated at thirty-five million.\(^5\) Steadily increasing health care costs are one reason for this high number of uninsureds.

Although the use and development of new technologies leads many to believe that the United States health care system is the best in the world, it is only good — or even useful — to those who have access to the system or the means to pay for care on their own. For many Americans, a serious personal injury or illness is not only physically debilitating, but it can lead to financial disaster.

\(^*\) Managing Director, William M. Mercer, Inc., Chicago, IL.
2. Id.
3. Id.
4. Id. at 110.
President Clinton has made health care reform a policy priority and has introduced legislation in an attempt to revamp the costly and often ineffective current system. Because the majority of uninsured individuals are employed, most proposals to increase access have focused on building or expanding coverage through employment. This article focuses on the issues and concerns of employers with regard to health care reform, concentrating on how such reform will impact their businesses and their livelihood. In order to better understand this impact on business, it is first necessary to discuss the concerns of both employers and individual employees with respect to health care reform.

I. Issues and Problems from the Employer Perspective

Employers face different problems with respect to employee health care provisions depending on, for example, their size, geography, number of locations, union status, the type and level of benefits provided to active employees and retirees, their sophistication as health benefit purchasers, and the health of the business. Some employers have high benefits and costs, while others offer far more moderate benefits, excluding part-time workers and others from coverage. Still others provide no benefits at all. Large national employers are concerned about complying with many different state regulations, whereas small employers are most concerned with obtaining coverage at a reasonable price.

Although employers' interests and perspectives vary greatly, an overwhelmingly common problem is that current employee demand for health care coverage exceeds available resources. For example, global competition, debt service, and tightened budgets both in non-profit and government organizations have led to decreased resources. Increased health care costs only exacerbate this problem. Yet regardless of this common dilemma, employers are not a homogeneous group, and health care reform will impact each one differently. This section outlines certain provisions of the Clinton proposal and discusses how, if enacted, they will affect different types of

7. EMPLOYEE BENEFITS RESEARCH INSTITUTE, HEALTH CARE REFORM: TRADEOFFS AND IMPLICATIONS 10 (1992) (explaining that 84.4 percent of uninsured Americans are employed).
9. Id.
One main provision of the Clinton proposal is a mandate that employers provide health insurance coverage for employees. Clearly, this places a heavy financial burden on all employers of all types, especially since federal and state mandates regarding coverage already exist. In 1993, the Family and Medical Leave Act and the Omnibus Budget Reconciliation Act imposed federal mandates on employers. Under the Clinton proposal, the federal government would set the basic framework, but the states would implement the system and impose additional requirements. Therefore, although existing state mandates generally apply to insured programs only, the new system could create new problems for employers. For example, the role of the states and preemption under the Employee Retirement and Income Security Act ("ERISA") is a key concern for large national employers. If the states are allowed to regulate self-insured programs, the management of those programs becomes far more complex and costly. Another controversial feature of the Clinton proposal is an employer mandate to provide coverage to part-time workers. Many employers offer few or no benefits based on an employee's part-time status. Therefore, those employers who hire more part-time workers in order to reduce costs might be forced to restructure the way they do business.

For small employers, insurance coverage is a primary concern. Many small employers have no practical way to get needed coverage. Even small businesses that are able to obtain coverage often have difficulty obtaining and maintaining coverage if one or more employees have a serious health problem. These businesses may find themselves "locked in" with an insurance company and consequently subject to large increases in premiums year after year. They may also find that their group coverage has been canceled or that they are not eligible for renewal. In this case, the small business would have to exclude sick employees from coverage before obtaining other coverage. Although insurance market reform addressing small employer issues is a goal of virtually all health care reform

10. H.R. 3600, §§ 1601-08.
15. Id. § 1606(B)(a)(1)(c).
16. Rappaport, supra note 8, at 512.
proposals, small employers as a group do not uniformly support reform, as many simply say they cannot afford coverage of any kind. Consequently, employers face significant concerns regarding health care reform. As clear and sound as their stance on several issues may be, their employees express equally ardent and convincing opinions.

II. THE INDIVIDUAL’S PERSPECTIVE

Many individuals do not comprehend the value or cost of their health care coverage. If offered coverage at a fair premium, they might choose not to buy it, or they may not be able to afford it. At the same time, many individuals are aware of the potential impact of catastrophic illness, and thus fear lack of coverage. For this reason, employer-provided health benefits are a major concern for most individuals.

For example, many individuals today are very concerned about keeping their jobs in order to maintain their current health benefits and access to retiree benefits. Employees also worry about maintaining the ability to choose their own physicians. When major illness strikes, individuals often seek the best possible care from the best possible physician. Many employer plans limit physician choice or put significant financial penalties on out-of-network choices. Moreover, in some rural areas there are virtually no doctors available and access, rather than choice, is therefore an issue. As a result, any effect that health care reform legislation has on these areas is of great concern to individuals today.

Although the various reform proposals differ in how they address the concerns of the individual, each does deal with the issue of access to coverage, and each provides the uninsured individual with the resources needed to obtain coverage. Generally, reform proposals also offer some subsidy to a wider definition of "the poor" than is currently covered by Medicaid. However, many individuals find that access and affordability are not the same thing, and most will be surprised at what coverage costs.

Having discussed the concerns of both employers and individuals, this article now outlines some of the most significant proposed reform bills and their main provisions regarding employer-provided

III. THE HEALTH CARE DEBATE

Public policy perspectives on the appropriate role of employers vary greatly. Because employers play a major role in providing benefits, and public programs play a major role in working with and taxing the benefits plans, employer issues and public policy issues often intertwine. Some of the most serious problems with respect to health care are increased costs; the number of uninsured citizens; the aging population and their access to and use of the system; the tax preferred status of employee benefit plans; and Medicare and Medicaid issues concerning cost-shifting, reimbursement, and their impact on the delivery system.

As the proponents of reform attempt to address these issues, they face conflicting interests: those individuals who currently possess generous coverage do not want their coverage to decrease, while those individuals who lack such coverage want to obtain it. By the time Congress adjourned late in 1993, several major health reform bills were formally introduced. The three most significant bills are discussed below, as well as the regulatory issues that will result from any reform legislation. Appendix I provides a summary of the competing proposals described here, as well as two other proposals.

A. President Clinton's Health Security Act of 1993

In the Senate, the Health Security Act ("Act" or "Clinton plan") was introduced by Majority Leader George Mitchell (D-Me.) and has thirty-two sponsors, including one Republican, Senator Jim Jeffords (R-Vt.). One hundred Democrats sponsored the House version, which was introduced by Majority Leader Richard Gephardt (D-Mo.).

The Clinton Plan requires employers to provide insurance to all workers and pay 80 percent of the weighted average premium. Individuals not covered by an employer plan would be required to purchase insurance, and there would be subsidies for low-income in-
individuals and small businesses. Health care would be delivered through regional and corporate alliances that would serve as purchasers, negotiate prices, and manage administration. The plan would also place an overall cap on national health care spending, enforced through limits on premium increases. Exhibit I provides an overall schematic to show how the proposal works.

**EXHIBIT I**

**The Clinton Plan**

<table>
<thead>
<tr>
<th>Employer Contributions</th>
<th>Employee Contributions</th>
<th>Government subsidies for low-income subscribers</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>REGIONAL HEALTH ALLIANCE (Governed by employers and consumers)</td>
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<tr>
<td></td>
<td></td>
<td>HMOs</td>
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</tbody>
</table>

**B. The Managed Competition Act of 1993**

Introduced by Representatives Jim Cooper (D-Tenn.) and Fred Grandy (R-Iowa) in the House,23 and Senators John Breaux (D-La.) and Dave Durenberger (R-Minn.) in the Senate,24 the Managed Competition Act is a more theoretical, managed competition approach than the Clinton Plan. If passed it would require small employers (those with fewer than one hundred employees) to offer health insurance to their employees, but would not require them to pay for coverage. Overall, this proposal, supported by a bipartisan,

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centrist coalition of members, involves less regulation and more reliance on market competition than the Clinton plan. Although it does not ensure universal coverage, it does offer universal access.

C. *The Health Equity and Access Reform Today Act of 1993*

Developed by the Senate Republican Task Force on Health Care Reform, the Health Equity and Access Reform Today Act\(^2\) was introduced by Senator John Chafee (R-R.I.) and Representative Bill Thomas (R-Cal.). Considered the moderate Republican alternative, it has the support of Minority Leader Bob Dole (R-Kan.). This proposal is similar to the Managed Competition Act in that it relies more heavily on the market than does the Clinton proposal. Unlike the Managed Competition Act, however, it would require individuals to purchase coverage. It contains a federal voucher system that would provide subsidies to low income individuals, and it would require universal coverage to be phased in by 2008.

D. *Regulation of Employer-Sponsored Programs*

Currently, the states regulate insured plans and the federal government regulates self-insured plans. While state insurance laws include many different mandates, a proposed minimum benefits package can be viewed as the equivalent of a new set of mandates. For employers who are not currently subject to state mandates, the idea of being subject to both federal and state regulation under a reformed system is not welcome.

If federal legislation is passed, implementation of health reform is likely to be shared by the states and federal government. The Clinton proposal provides for a National Health Board to have specific responsibilities,\(^2\)\(^6\) and for the states to have most of the responsibility for implementing the legislation.\(^2\)\(^7\) The National Health Board would update and interpret the minimum benefits package, issue budget regulations, and implement the quality management system.\(^2\)\(^8\) States would be free to add additional requirements and or-

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26. H.R. 3600, §§ 1151-54, 1501-06 (establishing a National Health Board and describing its responsibilities).
27. Id. § 1511 (requiring the board to approve a state health care plan if it meets certain requirements).
28. Id. § 1503.
ganize alliances, and would be required to implement guaranty funds for Associated Health Programs ("AHPs") in the state.

The Clinton plan proposes that states be permitted to substitute a single-payer approach for managed competition. In that case, the state could mandate that all persons be covered under the single-payer program. The plan's proposed role for the states overlaps with functions currently performed in the regulation of insurance; therefore, there are also proposed amendments to ERISA.

Many states have already made significant strides in the area of health care reform. If Congress takes a long time to debate the federal proposals, it is likely that many more states will take independent action. Under either scenario, regulatory issues — both state and federal — are crucial to all employers.

IV. IMPLICATIONS FOR EMPLOYERS

Any of the proposed health care reform legislation will impact employers on many different levels. On a global level, health care reform influences human resources strategy, and even overall business strategy. At the next level, health care reform influences the provision of health benefits. Exhibit II provides an overview of some of the primary human resources issues.

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29. Id. § 1204(c).
30. Id. § 1221 (outlining the states' responsibilities).
31. Id. § 8402(a).
32. Id.
33. See id. §§ 901-04 (discussing the Act's relation to ERISA).
EXHIBIT II

What Will It Mean to Employers?
Health Care Reform

Human Resource Strategy

Labor Force Alternatives
- Part-time vs. full-time?
- Overtime for full-time?
- Fewer part-time?
- Outsource?
- Automate?

Corporate Culture
- Benefits a right?
- Reduced employer control?
- Prevention emphasis?

Compensation Package
- Effect on pay?
- Effect on benefits?
- Effect on staffing?

A. Human Resources Strategies and the Provision of Health Benefits

Employee benefits play a major role in determining the number of part-time versus full-time workers that a company will hire. Because part-time workers often do not receive the same benefits as full-time workers, many organizations use significant numbers of part-time employees in order to reduce costs. If reform legislation mandates that organizations provide and pay for coverage for these workers, they may elect to use more full-time employees, allow for more overtime, increase automation, or relocate work outside of the United States.

For example, benefits administration includes enrolling employees, answering questions, providing balances in savings plans, processing savings plan loans, and processing claims. Increasingly, companies are using automated "voice response" mechanisms rather than benefit representatives for automatic enrollment and to answer
routine questions, provide balances, and process loans. As a consequence, many of the routine functions previously handled by benefit representatives are now handled by machine. Similarly, many companies are sending their claims outside the United States to be processed. This work was traditionally performed in the United States, but if employment costs increase, the economic attractiveness of this option may increase.

Moreover, because health care reform legislation may define health benefits as a right, employers may also lose control of their benefit packages and the ability to design packages to fit their specific needs. For example, many employers attempt to promote employee wellness and healthy behaviors by making investments beyond the benefit package. These investments often boost morale and reduce long-term health costs, absenteeism, and disability. If health reform imposes a standard benefit package and set of incentives, corporate motivation to make such investments will be reduced.

Health care reform will also impact labor relations. In the last few years, health benefits have been a major issue in labor negotiations. Health care reform could take the issue off the table, or at least vastly reduce its importance. If adopted, the Clinton proposal would leave open only a few issues for negotiation, including adoption of a supplemental plan or added benefits, decisions about outsourcing, and — for large employers — a major decision with regard to the formation of corporate alliances. Furthermore, workforce management may suffer as a result of any reform since health benefits are of utmost importance to employees.

At this point, there are many questions but few answers regarding the impact that reform may have on human resources strategy. These issues are very important to both individual companies and to the economy as a whole. Organizations considering lobbying in favor of health care reform should look at the alternative proposals, analyze how each one may impact their business, and conduct a detailed evaluation as early as possible. For others, a wait-and-see attitude is more appropriate. As legislators reach a consensus about an approach to health care reform, it will be important for these companies to begin planning.

B. Effect on Different Types and Sizes of Employers

The nature of the mandates imposed by reform legislation will be critical in determining the impact on employers. Universal coverage,
a cornerstone of the Clinton proposal, is to be achieved through a combination of employer and individual mandates. Employers are required to provide coverage for employees and their families,\textsuperscript{38} while individuals who are not employed get coverage directly through the regional alliances.\textsuperscript{38} Employers would be required to pay for 80 percent of the cost of coverage for full-time employees under the Clinton proposal,\textsuperscript{39} with other proposals calling for:

- Individual rather than employer mandates.\textsuperscript{38}
- Employer mandates of a different type — employers are required to offer coverage but not pay for it.\textsuperscript{39}
- Market reform, but no mandates, so that anyone can buy coverage, although no individual is required to purchase coverage.\textsuperscript{40}

The Clinton proposal would also establish Health Alliances, both corporate and regional, that would provide health care coverage for all citizens.\textsuperscript{41} Larger employers, those with over five thousand full-time employees nationally, would be given a choice of either participating in these regional alliances or offering their own plans to employees. The Managed Competition Act\textsuperscript{42} calls for employers with 100 or more employees to continue corporate programs, but with a required benefit package.\textsuperscript{43} Employers who do not participate in the general purchasing pools probably will have to make a payment of some sort to reflect the fact that the purchasing pool has a higher risk mix than the employee group. The Clinton proposal calls for a payroll tax of one percent for employers with their own alliances,\textsuperscript{44} plus an additional payment to a national guaranty fund covering employer-sponsored alliances,\textsuperscript{45} and it also permits some additional taxation by the states.\textsuperscript{46}

\textsuperscript{35} H.R. 3600, § 1601-09 (listing employer responsibilties).
\textsuperscript{36} Id. § 1004.
\textsuperscript{37} Id. § 1006 (a)(2)(C)(ii).
\textsuperscript{38} See infra Appendix I (discussing the Chafee-Dole proposal).
\textsuperscript{39} See infra Appendix I (discussing the House Republican Task Force proposal).
\textsuperscript{40} See infra Appendix I (discussing the Cooper-Grandy proposal).
\textsuperscript{41} See generally Mary Case, Mixed Effect of Health Care Reform on Larger Employers, \textit{1993 Benefits L.J.} 525 (describing the responsibilities that employers will have under the Clinton plan).
\textsuperscript{43} Id. § 1005 (describing the responsibilities of employers).
\textsuperscript{44} H.R. 3600, § 1223 (d)(1).
\textsuperscript{45} Id. § 1552(b).
\textsuperscript{46} Id. § 1204(a)(3).
Employers eligible to sponsor their own programs will have a difficult decision to make. At first glance, most eligible employers may assume that they should continue their own plans, particularly those who have strived to do an effective job of purchasing. Ultimately, however, this is likely to be a difficult decision, and one that requires careful consideration. Based on the Clinton proposal, employers should consider the following issues in their decision:

- Which taxes will increase costs beyond the current cost of employer coverage?
- Which factors will make an employer's cost higher or lower within a corporate alliance than in a regional alliance? This analysis requires consideration of how the employer's risk pool compares to that in the various regional alliances in which the employer would participate.
- What problems will be created for multiple locations and the requirements with regard to choice, even in small locations?
- Because part-timers will have to be covered through the regional alliances, to what extent must the employer maintain a duplicate administrative system?
- What will be the relative disadvantage of joining a regional alliance later?
- With which state and federal regulations will the employer have to comply, and what will be the cost of compliance?
- What management structure and costs will be required to maintain the corporate alliance?
- Will employees be better or worse off in the corporate alliance or the regional alliance? How will their plan choices and/or benefits differ?
- How will unionized groups respond to the decision? Are there bargaining implications?
- Will the employer want to offer supplemental coverage above the minimum benefits package? Will this be easier with one approach rather than another?
- How many different health plans would the employer have to deal with? What bargaining power would the employer have with these plans?
- What responsibilities will the employer have if employees are covered through regional alliances?
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- Would the decision about the form of health benefits management make future corporate transactions such as acquisitions and/or divestitures easier or more difficult?
- Would the decision affect marketplace competition?
- Would the need to manage benefits by geographic location create a need to change corporate organizational structure?

Consequently, employer practices and costs will differ greatly. Industries with high costs, such as the auto industry, are likely to be winners under reform, whereas those with lower costs and benefits, like retail operations, may be big losers. Most larger employers already offer health care coverage, but usually not to all employees. Smaller employers may not offer coverage at all, and if they do, they are likely to pay a smaller portion of the cost. For those smaller employers offering coverage, purchasing through a pool will prove to be far more beneficial than purchasing individually. However, because some small employers do not have access to pools, reform should offer easy access to care and favorable purchasing, similar to that already available to large employers. Therefore, the impact on employers will reflect a mix of their current practices and what they would be required to do under any reform legislation.

C. Impact on Plan Design

Health care reform legislation will have a substantial impact on the design of employer benefit plans, including what benefits are offered through what networks, who is covered, and who pays. For employers receiving coverage through a regional alliance or other purchasing cooperative, the options for plan design are linked to what is available both through the alliance and as supplemental coverage.

The minimum benefits package mandated under the Clinton proposal is considerably more generous than what is currently offered in Medicare. Exhibit III provides a very broad overview of the package’s design under the Clinton plan.
The minimum benefit package also defines what services are covered. It resembles many of the more generous benefit structures available today, but with some important differences: there would be more severe limitations on mental health initially, an emphasis on preventive care, and no initial dental coverage for adults. There is also likely to be controversy over the concept of a complete benefits package versus catastrophic coverage, as well as other specific benefits. A final controversial issue, particularly with respect to large employers, is a proposal to permit states to mandate additional benefits.

The Clinton proposal would also permit supplemental coverage to fill in the gaps in the minimum program. In contrast, the other proposals call for mandatory catastrophic coverage only, or do not include very specific coverage. With respect to the tax treatment of benefits, the Clinton proposal "grandfathers" the favorable tax treatment of benefits offered on January 1, 1993 for ten years. It is possible that the value of any benefits provided in excess of the minimum benefits package will be taxable income to the employee, or alternatively, not deductible by the employer.

Under the Clinton plan, an individual's doctor selection is limited

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<th>Fee-for-Service</th>
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<td></td>
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<td>Non-Network</td>
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to those offered by the particular "health plans" in which he or she is enrolled. Under many employer plans today, the same situation exists, but under most plans other than HMOs, the employee can go out-of-network by paying a greater share of the cost. The Clinton plan provides the same option. However, it is unclear how this would work in practice since many doctors are already tied to HMOs and other networks, and the number of ties will only increase under the Clinton plan. Therefore, because it is increasingly difficult for a physician to practice privately, it is unclear whether, in reality, an individual will be capable of selecting an out-of-network physician under a reformed health care system.

Another plan design issue concerns family coverage. Employers generally cover both employees and dependent family members. However, in today's family both spouses often work. Therefore, employers have adopted strategies to make it attractive for employees to cover all or part of the family with a plan purchased through the other spouse's employer. These strategies include significant contributions as well as choices which allow an employee to substitute cash or other benefits for health coverage foregone. Under the Clinton proposal, such strategies are no longer viable, and in effect every employer would pay for its own employees and a share of the cost of families reflecting family structures with both spouses working. If one or both employers offer corporate alliances, the Clinton proposal would allow the family to elect the plan in which it wishes to enroll.

For employers, a choice of networks is a major concern affecting both access and quality. Multi-location employers face special problems, and they may opt to use plans with multi-location networks, buy locally, or use a combination thereof. Reform alone will not resolve this issue; rather, the marketplace will drive the options available.

The Clinton minimum benefits package will affect the design of each employer's plan differently, depending on their current plan design. Some of the issues to consider in evaluating benefits compared to a present plan include:

53. H.R. 3600, §1402(F) (explaining the provision of services and defining in and out of network).
54. Id. § 1402(F)(2).
55. Id. § 1342.
56. Id. § 1012(D)(4).
• Comparison of specific services currently covered with the minimum benefits package.
• Comparison of cost-sharing provisions.
• Comparison of how managed care is currently handled versus the administration proposal. The administration proposal requires out-of-network options for HMOs.
• Comparison of provisions with regard to provider choice.
• Comparison of current versus proposed cost-sharing.
• Comparison of types of choices available.
• Comparison of eligibility provisions for both employees and family members.

Therefore, employers need to be aware of the potential effects that health care reform will have on their benefit plan design. Not only may substantive requirements be added, but employers may also face several new administrative mandates.

D. Benefit Plan Administration Issues

The Clinton proposal adds new administrative requirements for some parties and reduces requirements for others. There will be numerous changes for employers, including:

• If employers with employees covered by regional alliances are involved in the enrollment process, the administrative burden might increase at this point since the employees would have more options. If the employer's only job is to report the employees to the alliance, then enrollment would be made easier.
• Small employers would simply remit premiums and information to the regional alliances. However, if they had employees in areas covered by different alliances, they would have to deal with multiple alliances. For example, a company with three facilities in different areas plus a sales force in the fifty states might end up dealing with sixty or more different alliances. Since the premium for each employee is based on family status, and caps are based on percentages of payroll, the premium calculations could be quite complex.
• New hires and employee terminations would need to be promptly reported to each alliance. In addition, events leading to a change in family status, such as the birth of a first
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child and a divorce, would require prompt reporting and some processing of premium changes as a result of the change.

- Because it is proposed that premiums vary for full- and part-time employees, where there are employees whose work schedules change, the premiums might have to be adjusted monthly (or on some other schedule). There might also need to be work schedule reporting.

- Large employers who develop their own corporate alliances would probably have to comply with state regulations in all of the states where they do business. They would be mandated to offer employees choices in those states, so that they would need to select multiple plans in each area where the employees reside. It appears that they could no longer offer a single national program.

- Large employers would need to remit premiums to the regional health alliances for any employee who is not covered on a plan through their spouse. They would, therefore, have to deal with regional alliances in all areas where they have employees.

- COBRA compliance would cease to be necessary if the goal of universal, portable coverage is obtained. This would be a major relief to many employers.

There are also a number of issues relating to claims, utilization management, change of plans by employees, and the alliances themselves. These will not directly affect employers, except for those with corporate alliances.

**E. How Will Employer Costs Compare**

Under the Clinton proposal, there are several factors which may increase costs, and other factors which will decrease costs. Key factors tending to increase costs are:

- More people will be covered. Groups to be covered that are not covered now include part-timers, employees in other groups who are not eligible for benefits, and employees currently paid for by their spouses' employer.
- Benefits financed by the employer will be more generous because the current benefit plan is below the minimum benefit package adopted.
- The share of costs paid by the employer will go up because the employer is currently paying less than 80 percent of the plan cost.
- The employer will be in a more expensive risk pool.
- There is community rating and the costs are higher because the employer has more favorable risks than the pool.
- The employer was previously able to take advantage of attractive purchasing opportunities individually or through a pool which is no longer available in the new environment.

Key factors which may reduce costs include:

- Cost-shifting from other programs, particularly Medicaid and indigent care, will be eliminated.
- An increase in managed care.
- Medical practice pattern changes.
- The share of costs paid by the employer is reduced because currently the employer is paying more than 80 percent of the plan cost, and the employer chooses to pay 80 percent.
- The fact that an employer ends up in a less-expensive risk pool.
- There is community rating, and the costs are lower because the employer has less favorable risks than the pool.
- The fact that an employer will be able to take advantage of more favorable purchasing opportunities than were available previously.

In general, the higher-cost employers will substantially reduce costs, whereas the lower-cost employers may have major increases in cost. Industries such as retail, which employ many part-time workers without benefits, will be forced to drastically reduce benefits. Similar factors will apply in any proposal involving purchasing cooperatives, community rating, and minimum standards for benefit coverage and cost-sharing.

Also, reform financing will have a major impact on employer costs over time. Under the Clinton proposal, financing is based on balancing requirements on employers, in the form of required benefits, required cost-sharing, additional taxes with subsidies for some persons from other taxes, and changes in Medicare and Medicaid. Much of the cost of additional coverage will be paid by reducing costs, eliminating waste, and reducing payments to health providers.
Whether or not the program will actually achieve this goal is questionable.

In any case, financing is likely to be difficult because covering those who are currently uninsured will prove to be expensive. For employers, key issues include the extent to which the total program costs will be assessed against them, and how those costs will be distributed.

V. SPECIAL ISSUES FOR EMPLOYERS

A. Flexible Benefit Plans

Many employers currently offer flexible benefit plans which include a variety of options and great variations in benefit levels. The Clinton minimum benefits package eliminates many of these options. Therefore, it is relatively likely that there will be only two levels if the Clinton proposal is adopted — the basic level and a supplemental level, although there would be a choice of health plans offered.

B. Retiree Coverage

Many employers cover both active employees and retirees in their benefit programs. In some cases, when a company promises benefits before the employee actually retires, this is considered to be a contract with the employee. Under current accounting rules, the cost of this coverage accrues as employees continue to work.

The Clinton proposal would provide substantial relief to employers with regard to retiree coverage. Early retirees would be covered under regional alliances, even if the employer maintains a corporate alliance. The cost of early retirees would be subsidized both through community rating and through a premium subsidy. The federal government would pay 80 percent of the weighted average premium for early retirees, and employers with existing contracts paying 100 percent of early retiree coverage would pay the additional 20 percent. Employers offering coverage now would be required to repay, over a three year period starting in 1998, a portion of their savings. Retirees over age sixty-five would continue to be covered by Medicare, and the Clinton proposal would add long-term care and prescription

57. Id. § 1608(c)(2).
58. Id.
drug coverage to Medicare.\textsuperscript{59} It is unclear whether there would be any change in the employer responsibility for post-sixty-five benefits. At a minimum, it would seem that coverage now provided by Medicare would not be needed in employer plans. Retiree coverage is an area where the Clinton proposal has changed many times, and it will probably be controversial. It is unclear how the other proposals would affect retiree coverage.

Under the Clinton proposal, there are certain anomalies in coverage. That is, people are treated differently according to circumstance or group, as follows:

- Those eligible for Medicare will continue to be covered by Medicare, but the benefits will be enhanced.
- Those not eligible for Medicare will be covered under regional or corporate alliances; employers will pay 80 percent of the cost for full-time employees and a pro-rated portion for those working more than ten hours per week.
- Individuals who are not employed (or spouses or dependent children of those who are employed) will pay their own premiums, except that the poor are subsidized, as are early retirees.
- Early retirees, those over age fifty-five with future eligibility for Social Security retirement based on quarters of coverage, will be eligible for subsidies equal to 80 percent of the cost of the coverage.
- Those eligible for Medicaid are covered under the regional alliances, with Medicaid paying the cost.

The Clinton proposal, with regard to coverage, leaves some questions unanswered, such as:

- Why should an individual over fifty-five who is not currently working but has forty quarters of Social Security coverage be subsidized, while a nonworking individual at a younger age is not subsidized?
- Why should individuals eligible for Medicare receive less coverage, and perhaps pay higher premiums, than retirees over fifty-five?
- If Medicare continues to cover disabled persons, why should a more seriously disabled person eligible for Medi-
care get less coverage than a less disabled person not eligi-
ble for Medicare?

C. Worker's Compensation

At the present time, health care coverage for work-related inju-
ries is covered under worker's compensation statutes. Generally, this
is entirely separate from a company's health benefit program, al-
though some companies integrate coverage. This is an area of in-
creasing concern because if companies are managing their health
benefits and not their worker's compensation, costs will shift to
worker's compensation for two reasons: (1) injuries and illnesses will
be classified as worker's compensation, thus increasing the incidence
of worker's compensation claims; and (2) providers will shift the
cost to worker's compensation when there is no restriction on what
they can charge.

VI. WHAT SHOULD EMPLOYERS DO NOW?

There are some immediate issues that employers need to address
with regard to health care reform, and others that will appear fur-
ther down the line. Immediate needs include:

- Decisions About Lobbying. During the period when many
  competing proposals are on the table, employers or groups
  of employers may choose to lobby. There are some topics
  which may be of great importance to employers that are
  currently not well-defined. These are areas where it is par-
  ticularly important to decide whether lobbying may be
  helpful. Because there is substantial activity at the state
  level, organizations may wish to lobby at the state level as
  well.
- Information Needs of the Organization. Senior manage-
  ment needs to be able to answer questions from board
  members and the investment community. Employees may
  also have questions.

In the meantime, organizations need to maintain programs to
manage health care benefits. Because it is unclear which legislation
will pass, when it will pass, and when it will be effective, it is most
important not to let efforts die. In the meantime, the marketplace is
changing, creating both new hazards and new opportunities. As
more and more purchasers are using effective purchasing strategies,
those who are not focused on purchasing strategies are increasingly vulnerable to cost-shifting and higher prices. New programs and networks are also creating new opportunities for those employers who are working on purchasing strategies.

Data is also a major concern. In the absence of reform, data provides the foundation for identifying areas where purchasing strategies can help and for evaluating them once they are in place. For the organization considering a corporate alliance, data will be important in that evaluation. If reform is implemented on a state level, and employers are in the situation of responding differently in different states, data may also be very important. It is difficult to predict what will be lost without adequate data, but a great deal can potentially be gained by those employers who have good data.

Several types of data are suggested:

- Detailed historical claims data to permit extensive analysis.
- Good enrollment data to enable linking of claims and historical data.
- Data on employees not covered, as a cost analysis will depend on knowing how many there are and what their demographics are.

**Conclusion**

Health care reform is at center stage at the federal and state levels. If enacted, reform will have a major impact on employers. This article has reviewed major implications of the federal proposal for employer plans, focusing on both the Clinton plan and other reform proposals. If comprehensive reform is adopted, the impact will be great on both companies and individuals. Some will be winners, and some will be losers.
## Alternative Health Reform Proposals

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<thead>
<tr>
<th></th>
<th>Clinton Moderate Democrats</th>
<th>Chafee-Dole Senate Republicans</th>
<th>Cooper-Grandy Conservative Democrats</th>
<th>Single Payer McDermott-Wellstone Liberal Democrats</th>
<th>House Republican Task Force</th>
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<tbody>
<tr>
<td><strong>COVERAGE</strong></td>
<td>Universal coverage by end of 1997. Achieved by requiring all employers to contribute to their workers’ health insurance, and giving financial assistance to unemployed and people with incomes below 150% of the federal poverty line. Also gives federal subsidies to small, low-wage businesses.</td>
<td>Universal coverage by 2000. Achieved by requiring all individuals to obtain health coverage. Offers vouchers to people with incomes below 240% of poverty line to cover some or all of premium.</td>
<td>Does not achieve universal coverage. Increases coverage by providing subsidies to people below poverty level.</td>
<td>Universal coverage upon enactment. Federal government pays most health bills, virtually eliminating private insurance. Medicare and Medicaid and other government health programs would be folded into the new system.</td>
<td>Doesn’t guarantee universal coverage. Requires employers to offer a federally approved health plan for their workers, but doesn’t require them to pay for it. Federal subsidies to provide health plans for the poor.</td>
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<tr>
<td><strong>FINANCING</strong></td>
<td>Employers must pay 80% of regional average health insurance premium for each full-time worker. Raises taxes on cigarettes by 75 cents per pack and increases tax on other tobacco products. Payroll assessment of 1% on big corporations that opt out of regional insurance pools. Caps Medicare and Medicaid spending.</td>
<td>Uses savings gleaned from placing spending caps on Medicare and Medicaid. Taxes employer-provided health benefits exceeding a certain value.</td>
<td>Caps the amount of worker health benefits employers can deduct for tax purposes. Abolishes Medicaid and replaces with subsidies to help poor people buy private insurance.</td>
<td>Increases corporate and individual income taxes, places a tax on hospitals. Such taxes would replace the insurance premiums companies and individuals now pay. States would have to fund 15% of the new program.</td>
<td>Uses savings from phasing out subsidies for wealthy people’s Medicare premiums and raising minimum federal retirement age to 62 from 65.</td>
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<td></td>
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<tr>
<td><strong>BENEFITS</strong></td>
<td>Government sets standard benefits package guaranteed to all Americans. Covers most medically necessary services, including mental health treatment, prescription drugs and many preventive services. A separate program would cover home care and community-based care.</td>
<td>Two standard packages of benefits set by the federal government. One provides only catastrophic coverage. The other will be a comprehensive package, but narrower than the Clinton plan.</td>
<td>A national health board would establish a uniform benefits package.</td>
<td>Covers all medically necessary services, including nursing home and other forms of long-term care, mental health and substance abuse services. Doesn’t cover cosmetic surgery or over-the-counter drugs.</td>
<td>Health plans must meet a defined standard of coverage, including medically necessary services and preventive care.</td>
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<tr>
<td><strong>COST CONTROL</strong></td>
<td>Caps allowable annual increase in private health insurance premiums. Establishes regional insurance buying pools — called health alliances — of businesses and individuals to bargain with health plans. Employers with fewer than 5,000 workers must join Medicare and Medicaid spending caps.</td>
<td>Medicare and Medicaid spending caps. Caps the tax-deductibility of employer health benefits at the average price of the least expensive one-third of the health plans offered by a regional purchasing pool. Workers also pay tax on value of health benefits exceeding that amount. Sets up optional, competing insurance-purchasing pools for employers with fewer than 100 workers.</td>
<td>Relies on market forces to hold down costs. Sets up insurance purchasing pools to help increase consumer muscle. These would be smaller and have less regulatory authority than the Clinton health alliances; employers with 100 or fewer workers must join.</td>
<td>State governments would negotiate annually with doctors, hospitals and other providers to establish a cap on payments for medical services.</td>
<td>Limits on increases and rate variations in health insurance premiums charged to small businesses. Aims to generate market forces to hold down costs.</td>
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### Alternative Health Reform Proposals (Continued)

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<tr>
<th>IMPACT OF EMPLOYERS</th>
<th>Clinton Moderate Democrats</th>
<th>Chafee-Dole Senate Republicans</th>
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<td>Mandate: Must pay for 80% of average coverage cost. Large employers have option of providing coverage through corporate alliance, but small employers must participate in regional alliances.</td>
<td>Employs cooperatives for employers with under 100 employees.</td>
<td>Employers with under 100 employees must join purchasing cooperatives.</td>
<td>Gets employers out of health benefits; everyone is covered by a government program.</td>
<td>Mandates that employers offer coverage.</td>
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<td>Employers with under 75 employees have caps on cost.</td>
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**NOTE:** A plan by Sen. Phil Gramm (R., Texas) would allow people to put the money their employers now spend on their health coverage into a tax-free account to pay doctor bills or buy coverage. Special tax credits would help the poor buy coverage.