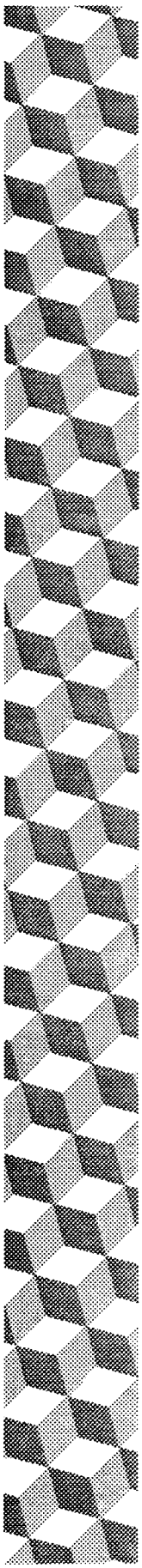

FAMILY HEALTH ACCOUNTS

UNDER A MODEL OF MANAGED COMPETITION WITH EMPLOYER-MANDATED PREMIUMS

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HEALTH CARE FINANCING REFORM
MAY 1993

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Introduction

Managed competition is a concept that has risen from virtual obscurity in the recent past to become a model for health reform which may reduce the gridlock that has paralyzed development of a national health plan. A form of managed competition was first proposed by Alain Enthoven, a health economist, in the late 1970's and has continued to be advocated by him, and others, throughout the 1980's.[1] In 1991, a group of health policy and industry experts, including Enthoven - dubbed the Jackson Hole Group because they met to struggle with health reform issues over a period of several years in Jackson Hole, Wyoming - introduced a comprehensive plan for reform based on managed competition, called the *Twenty-First Century American Health Care System.*[2,3] Managed competition appears, finally, to have gained the nation's attention through adoption by President Bill Clinton of a modified version of the Jackson Hole plan during his campaign as his model for national reform.[4] With the creation of the White House Task Force for Health Care Reform, chaired by Hillary Rodham Clinton, managed competition could be poised to become the foundation for the nation's health care system.

Managed competition attempts to relieve many of the problems which have contributed to rising health care costs by taking advantage of the tendency for competitive markets to reduce costs. However, unlike traditional markets, managed competition provides a structured competitive environment in which health purchasing alliances obtain qualified health plans for consumers. The supply and quality of health insurance and provider plans are managed by regulation, bid processes, contracting or other mechanisms to maximize the dynamics of competition and ensure optimal plan accountability and performance.

Employer-mandated premiums

Many of the current models of managed competition rely on employer-based financing of employee health plans, either through mandated premiums or payroll taxes, up to a benchmark premium. Under these models, employees are responsible for payment of premiums above the benchmark plan if they choose to purchase more expensive coverage.

There are those who argue that subsidization of employee premiums by employers places an unfair burden on businesses. However, the provision of health insurance by employers, especially large companies, has become an accepted employee benefit, is often the easiest and most effective way to ensure that employees have coverage and is perceived by companies as simply one of the costs of doing business. Employer-based payment of premiums seems to be the mechanism which provides the greatest assurance that the largest group of health care consumers - employees and their dependents - will have financial access to necessary health services. However, many businesses, particularly small businesses, are concerned about the potential financial impact of mandated employer premiums. Some fear they will be forced to downsize their workforce if they are required to provide insurance to their employees. Others believe they will not be able to survive at all. These are legitimate concerns which must be addressed by the architects of any system of reform which places the responsibility for financing premiums primarily on employers. However, for the purposes of this paper, we assume a system in which employers are required to pay a percentage of the total premiums for their own employees, as opposed to a system in which there is no mandate or one in which employers participate through payroll taxes or wage-based premiums which are aggregated to pay for employees and other persons who are unable to pay for their own coverage.

A system of managed competition in which employee health plans are financed primarily through the workplace is likely to establish requirements that contributions be assessed according to the number of hours worked by employees in a given time period, although it is unlikely that employees who work some minimum level of part-time hours would be subsidized through their employment. Under this type system, the determination of an employer's premium liability might not be particularly difficult to calculate for employees with only one full-time job who were unmarried or whose spouses did not work. However, tracking of employment and calculations of appropriate employer contributions would be administratively much more complex in situations where individuals had multiple employers or families had more than one family member who was employed.

A number of issues arise when multiple employers are potentially liable for premium contributions to individual or family health plans. In the case of an individual employee who had multiple jobs, determining which employers would pay premiums, and what percentage each would contribute if there was more than one, could require fairly significant tracking of employment data. Where employers for more than one family member were contributing premiums to the same family health plan, unless a sufficient mechanism was available to monitor employment data for all employers within a family, tracking issues could become overwhelming, particularly if one or more family members had multiple employers. In addition, unless families paid their portions of premiums through a personal lump-sum payment, tracking of payroll deductions for employees would also be necessary.

Tracking of individual and family employment data to determine government subsidies for low-income workers and their employers who are unable to pay their portions of the premiums would also be essential. Again, in situations where an individual had only one full-time job, monitoring would be relatively straightforward. However, with multiple employed family members or jobs, tracking would become more complex.

Family Health Accounts in a system of employer-mandated premiums

Family Health Accounts offer an efficient mechanism for consolidating employment information about individuals and families to facilitate collection of premiums. Accounts could be administered through health purchasing alliances. Administration of the Accounts would include collection of data regarding all employers of family members within each household, salary or wages earned, hours worked and other relevant information.

Changes in employment status or retirement would not affect family health coverage since accounts would not be linked to the place of employment, but only to the health purchasing alliance. With a job change, the funding source for the Accounts would change, but coverage would continue uninterrupted.

This paper will discuss the integration of Family Health Accounts into a system of managed competition which mandates employer and employee payments of percentages of employee health plan premiums. It will offer a model in which health purchasing alliances could administer the Accounts as a public trust.

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Legal Structure of Family Health Accounts within health purchasing alliances

There are several models for entities which could successfully serve as health purchasing alliances. For the purposes of the system proposed in this paper, one particular structure, a public authority model, will be discussed. In a system of managed competition, one or more public authorities could serve as purchasing cooperatives or health purchasing alliances for the state.

A public authority acting as a public trust could effectively administer Family Health Accounts within a health purchasing alliance. A public authority operates somewhat like a state agency, with agency powers, but with much less political control. Public authorities can also carry out business operations in a more efficient manner than most other state agencies. For example, in many states public authorities may own and convey property, both real and personal, and are legally authorized to enter into contracts and leases. However, public authorities acting as public trusts are largely limited only to those activities that are expressly authorized in the instruments or articles that establish the trust.[5] Public authorities may ordinarily engage in any business in which the state may engage, with a few enumerated exceptions.[6]

The public authority structure readily lends itself to managing the financial aspects of the Family Health Accounts with trust functions already built into the structure. The use of Family Health Accounts in managing the myriad complexities of a state-wide health care purchasing system with employer-mandated premiums could be accomplished with relatively minor changes to existing public authority statutes and enactment of enabling legislation. A public authority under this model could potentially be established under existing state public trust acts.[7]

It is anticipated that changes in tax laws allowing deductions for premiums paid up to a benchmark level, refinement of the public trust acts, and comprehensive legislation establishing the use of Family Health Accounts and the governance thereof would be required. For example, implementation of Family Health Accounts in this system would involve the legal establishment of the accounts themselves, as well as changes in tax and related state statutes to allow tax-deferred treatment of money deposited in the accounts.

The accounts would be governed and administered by health purchasing alliances, with individual tracking for each household's account, but the funds in the accounts would be held in aggregate, possibly within the state treasurer's office. Excess funds (those not needed for premium payments or administrative costs in the current month) could then be invested in short-term money markets in a lump sum. Some state retirement systems currently use this model in holding and administering pension funds that are paid monthly to their retirees.[8] Using a model that has an established history and legal precedent such as this simplifies the implementation of this model considerably.

Operation of Family Health Accounts

Contributions for premiums could be made from each family's primary employers and might also be made from the secondary employers. Employers would pay a percentage of the amount of a benchmark premium. For example, an employer for a full-time worker might pay 80 percent of the premium. Through payroll deductions, families would contribute an amount equal to the difference between the amount provided by the employer(s) and the cost of the health care plan chosen by the family. The funds would be transferred from the employer to

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the health purchasing alliance for deposit into Family Health Accounts.
The health purchasing alliance would be responsible for administration of the Family Health Accounts. The health purchasing alliance would collect and retain copies of all forms necessary for each family's selection of an accountable health plan. Administration would include verifying that contributions are received in correct amounts from all appropriate employers and tracking contributions within the Accounts. The health purchasing alliance would verify that sufficient contributions have been received to pay for the health plan selected. The health purchasing alliance would transfer to the appropriate accountable health plans the monthly premiums for each family.

Under the model proposed here, the minimum balance required in the Family Health Accounts would be equal to one month's premium. This would give the health purchasing alliance a one-month cushion or window to enable them to pay all premiums to the health plans on the first of the month while using the remainder of the month to verify that appropriate payments were received and checks were cleared. The funds to maintain this positive balance could be assessed incrementally against employers and employees; for example, the cushion could be phased in at 5 percent a month over 20 months until a one-month excess balance had accrued. Since it would be necessary to maintain a cushion, the health purchasing alliance could hold the balances in trust and invest them in a money market account. Investment income from the money market account would be used to offset expenses of administering the Family Health Accounts.

Overview of the model:

Investment income from the accounts could be used under this model to offset expenses of administering the Accounts. Income in excess of administrative expenses could be used elsewhere in the system, such as, to finance premiums for families with inadequate incomes. In developing this model, it was necessary to use current premium rates as estimates of rates which would exist within a system of managed competition. Premium rates for individuals and families were obtained from a group of managed care health maintenance organization plans with similar benefits offered by the Employee Group Insurance Plan for the State of Oklahoma. The lowest-cost plan was selected as a benchmark premium for calculating the potential amount of income which could be generated through the Accounts.

All individuals or families participating in a health purchasing alliance would be required to have a Family Health Account. For purposes of this discussion only, it is assumed that persons who would have Accounts would be employees in firms of less than 1000 workers, public employees and persons on public assistance, excluding Medicare. It will also be assumed that this constitutes 75 percent of Oklahoma's 1,207,235 households and that each of these households has a family health account.[9] Through data supplied by the Urban Institute, Oklahoma households can be divided into family status; i.e. 22 percent are married without children; 52 percent are married with children; 12 percent are single with children; and 14 percent are single.

FAMILY STATUS	% OF POPULATION	PREMIUM
MARRIED WITHOUT CHILDREN	22%	$274.97
MARRIED WITH CHILDREN	52%	$401.72
SINGLE WITH CHILDREN	12%	$282.42
SINGLE	14%	$155.67

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Based on sample premiums from the Oklahoma managed care plan, the monthly benchmark premium would be $274.97 for those married without children, $401.72 for those married with children, $282.42 for those single with children and $155.67 for single individuals. (The rates used for this calculation were based on two or more children for each category with children.) Multiplying the number of households times the monthly benchmark premium determines the minimum balance which could be anticipated in the Accounts. This formula predicts that one month's balance, equal to $294,328,641, would be available for investment. Investment of this balance for 25 days per month (allowing five days for the receipt of monthly premiums and checks to clear) in a money market account yielding 5% would earn $12,095,698 annually.

905,426 HOUSEHOLDS WITH ACCOUNTS **X** % OF POPULATION WITH SPECIFIC FAMILY STATUS **X** MONTHLY PREMIUM RELATIVE TO FAMILY STATUS **=** MINIMUM ACCOUNT BALANCES

$$\frac{\text{ALL MINIMUM ACCOUNT BALANCES FOR EVERY FAMILY STATUS} \times 5\% \text{ YIELD}}{365 \text{ DAYS}} = \text{DAILY YIELD}$$

DAILY YIELD **X** 25 DAYS **X** 12 MONTHS **=** ANNUAL INVESTMENT INCOME OF $12,095,698

Under this model, the health purchasing alliance would keep separate records on each Family Health Account. The health purchasing alliance would calculate the amount of funds available in excess of its needs on a daily basis. The actual funds would be held in the aggregate in an agency charged with holding public funds. For example, in the State of Oklahoma balances within the accounts could initially be deposited in a single account held at the State Treasurer's Office. Excess funds could be wired from the State Treasurer's Office to the money market fund for investment. The use of a money market fund for investment purposes would allow daily liquidity needs of the health purchasing alliance to be met. Monthly distribution from the health purchasing alliance to the accountable health plans would be made through the State Treasurer's Office.

Family Health Accounts administered by the health purchasing alliance would track all sources of funding for the accounts including primary and secondary employer contributions and family contributions. The accounts would also track and pay monthly premiums to the accountable health plan selected by each family. Parameters would need to be set up to flag Accounts which did not post contributions large enough to cover premiums. Employers would submit the funds to the health purchasing alliance detailing which funds were contributed by the employer and which funds were contributed, through payroll deduction, by the employee. It would be the responsibility of the health purchasing alliance to merge the contributions received from multiple employers within a family into the appropriate Family Health Account.

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Conclusion

Family Health Accounts may be an important mechanism for monitoring and tracking employment data essential to efficient collection of health premiums. It is unlikely information necessary to administer a system of mandated employer premiums can be effectively tracked without a mechanism like the Accounts in which data about employment is integrated with the actual flow of premium funds.

Family Health Accounts have been developed as part of the Oklahoma Family Choice Health Plan. Their use as the tracking mechanism for employer premiums is only one of a number of functions they would perform within a reformed health care system of managed competition.

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Funds for the printing of this document have been provided through a grant from the Robert Wood Johnson Foundation

NOTES

1 See A. Enthoven, "Consumer Choice Health Plan," *New England Journal of Medicine* 298 (1978): 650-658, 709-720. See also; A. Enthoven and R. Kronick, "A Consumer-Choice Health Plan for the 1990s (First of Two Parts)," *New England Journal of Medicine* 320(1) (1989): 29-37 and A. Enthoven and R. Kronick, "A Consumer-Choice Health plan for the 1990s (Second of Two Parts)," *New England Journal of Medicine* 320 (2) (1989): 94-101.

2 Jackson Hole Initiatives, The *Twenty-first Century American Health System*, (1991).

3 P. Ellwood, A. Enthoven and L. Etheredge, "The Jackson Hole Initiative for a Twenty-first Century American Health Care System," *Health Economics* (1992): 149-168.

4 B. Clinton, " Clinton Health Care Plan," *New England Journal of Medicine* 327(11) (1992): 804-806.

5 See, e.g., the Oklahoma Public Trust Act, 60 O.S. 1991, §§ 176 et seq.

6 In Oklahoma, these exceptions are found in 60 O.S. 1991, §§ 178.4 (the trust functions may not include a wholesale outlet, unless part of the trust industry, a retail outlet, unless operated in conjunction with trust facility, or residential enterprise, except public housing).

7 See, note 5.

8 For example, the Oklahoma Teachers' Retirement System has several revolving funds which are either invested or held in the treasurer's office for administrative expenses or monthly payment to the retired teachers.

9 1990 Census of Population and Housing, Oklahoma State Data Center - Oklahoma of Department of Commerce