



The Rolling Hills Group Health Reform Proposal Overview

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Overview and Goals for Reform

Inherent in the discussions of the Rolling Hills Group was an understanding of the limits of state policy making in health care and the impact of federal tax policy, that underwrites employer sponsored health insurance and the Employee Retirement Income Security Act (ERISA), which creates plans that do not have to meet individual state regulatory requirements.

The overall goal was to establish a reform plan for Tennessee that can serve as a structural model for other states and the nation. The Rolling Hills Group agreed that states, like Tennessee, should serve as a testing ground for the federal government to determine what proposals could gain bipartisan support and work best to expand coverage and control costs. The federal government should watch carefully and help fund the states' reform efforts before attempting to provide coverage to 47 million uninsured and reform a \$2.2 trillion dollar healthcare system.

The Rolling Hills Group determined the overarching goals of reform should be:

1. Universal insurance employing a mix of private and public structures and funding.
2. Health system reforms that produce a higher value for the dollars spent on care and increase the use of best practices and evidence-based decision making.
3. Funded through changes to the US tax code and the better use of existing funding and resources without adding new costs.

Universal insurance is health care coverage extended to every citizen, and can utilize a variety of structures. *In the case of the Rolling Hills Group recommendations, it is intended to be an improved mix of private and public structures and funding.*

Assuring a higher value for the dollars spent on health care and increasing the

use of best practices are key goals. To simply provide coverage will not ensure better outcomes, lower costs and improve health. Demonstration projects to address key health issues, as well as payment reform, are some ways to further these goals.

The U.S. spends more than any nation per capita on health care, but does not demonstrate consistent quality or improved outcomes for those dollars. Outcomes and quality vary enormously by state, without correlation to spending. Thus, the Group concluded that many of these goals can be reached through reform at the state level.

Part One: Tennessee Reform

Steps Towards Universal Coverage via a Structured Private Insurance System

- Tennessee should create a state risk pool, and phase in as many employers and individuals as possible over a period of ten years. (ERISA plans would not be eligible until federal reforms occurred.) Under the risk pool, a choice of competing private plans would be offered, operating under new reforms.
- Tennessee should enact insurance reforms including requiring guarantee issue, eliminating pre-existing condition exclusions, and using modified community rating to price policies for plans participating in the pool.
- Tennessee should create a basic health plan to serve as a model using a \$750 individual deductible, indexed to inflation, and permit actuarially equivalent plans to be offered within the pool.
- A “Connector”- like entity should serve to link employers and individuals to health insurance products. In addition, as the pool size grows, the connector could also serve as the point for providers to refer individuals who present without insurance. The Rolling Hills Group believes this function could be privatized so that new additional government bureaucracies are not created.
- By 2010, all Tennesseans in families with incomes above 400% of poverty would be required to have at least the basic health plan offered through the insurance pool or have other public services disallowed (licenses, benefits, etc.)
- By 2010, children in families with incomes up to 250% of the federal poverty

level would be required to enroll in Tennessee's CoverKids program.

- Financing for subsidies would be dependent upon Federal reforms (see Federal reform financing.)

Health System Changes

- Develop demonstration projects to test how Tennessee could adopt payment and care models that emphasize health and wellness.
- Develop demonstration projects to test payment models that align payments across providers similar to the Centers for Medicare and Medicaid Services Acute Care Episode (ACE) project.
- Develop mechanisms through which patients and payers can choose providers based on quality standards, and consumers can choose insurers based on quality and other standards.
- Provide cost information to patients in addition to purchasers.
- Make insurer loss ratios public so comparisons can be made regarding the relative value for consumers and providers. Loss ratios should be based on the insurers' total premium revenue and total medical payments for all products.
- Require insurers to submit claims data showing all utilization and payments for members of a purchaser's insured group to a purchaser at least annually.
- Collect provider specific data to assist individuals and families in determining which providers are likely to follow their wishes for end of life care, and continue to stress patient education about the need to document their wishes about end of life care.
- Use Tennessee's universities and medical schools to enhance provider knowledge of best practices and comparative effectiveness information, evaluate aspects of the Tennessee health care system and make recommendations. In particular, evaluations should examine provider payment and its effect on care and pharmacy and medical supplier costs and make recommendations for state-based cost containment and transparency.
- Tennessee should develop and adopt standardized administrative processes for claim payment, appeals and other similar functions for plans participating in the pool.

Part Two: Federal Reforms

Federal reform is essential, in conjunction with state reform, to truly create a sustainable health system. The Rolling Hills Plan would allow Tennessee to create the basic mechanisms that could then be folded into national reform.

- Using the Federal Employees Health Benefits Plan (FEHBP) structure, overseen by a Federal Reserve-like regional regulatory mechanism, the Federal Health Reserve (FHR), individuals and employers would purchase private plans through state or regional risk pools.
- A system of subsidies or “transfer payments” made to qualified plans through the tax code (refundable tax credits) will guarantee payment of premiums and coverage under a basic insurance benefit for the lower income uninsured who cannot afford to buy coverage.
- Under a phased in “individual insurance requirement” all Americans will be required to have insurance by 2019, with higher income Americans required to have insurance by 2012. Enforcement will be through the federal tax code, with those failing to buy insurance being “randomly assigned” to qualified plans, and unpaid premiums would become a federal tax liability.
- Many different plans can be offered, but tax subsidies will be limited to the “actuarial value” of a Blue Cross Standard Option PPO, with a fairly high deductible — (\$750 for an individual policy and a similar deductible for family policies, indexed to inflation) guaranteeing insurance under a basic insurance benefit, while capping the current tax benefit wealthy people get to the actuarial value of that same benefit.
- A Federal Health Reserve Board (FHR), insulated from politics, would establish a basic plan design, benefits and coverage, and could act as a “connector.”
- ERISA plans could continue to operate outside of the Federal Health Reserve system or state regulatory schemes, but would participate in risk pools via “risk adjustment” methodologies – to avoid systemic medical underwriting. Plans with higher risk patients, including ERISA plans, would receive payments from the pool to lower premiums. Those plans with relatively lower risk would make additional payments to the pool.

- Beginning in 2010, only the actuarial value of the estimated cost of the basic FHR benefit would be excludable from income to individuals and only that value would be deductible as a business expense to employers. The additional tax revenue generated from this change would be used to subsidize coverage for low income residents. From 2010 to 2019, the deduction to employers would be further phased down to 50% of the actuarial value of the FHR base plan.
- As uninsured levels fall, spending on existing public subsidies for indigent care (Medicare DSH, Medicaid DSH, etc.) should also fall and be recaptured to buy insurance for low income beneficiaries.
- In 2012, all Americans with income below 100% of poverty and those with income above 350% of poverty would be required to enroll in at least the FHR basic plan, or an actuarial equivalent—or have other public services disallowed (licenses, benefits, etc.) Those encountering the health system (hospitals, etc) would be randomly assigned to a qualifying FHR plan if they were uninsured. Their premiums would be IRS tax liabilities if they did not pay. Also, anyone with income below 100% of poverty would get a full subsidy for the basic plan cost, and therefore would also be randomly assigned to a plan upon encounter with the health system, if they are not insured.
- As revenue increases from the tax code changes and spending on existing indigent care programs is shifted to fund the pool, subsidies would be phased in for all lower income purchasers.
 - By 2019, full subsidies will be available for those with income less than 150% of poverty and partial subsidies for those with income between 150% and 350% of poverty.
 - To be eligible for subsidies individuals must have been uninsured and not have had health insurance for the 12 month period prior to receiving the subsidy.

Additional Reforms

- Return to the original rules concerning direct-to consumer advertising for prescription drugs, which effectively limited television and other electronic media advertising.

- The Federal Health Reserve Board should make drug coverage recommendations that would guide plan formularies for cost and effectiveness. States and the federal government should make comparative effectiveness research a priority and assist providers and consumers in accessing objective information about drugs and medical devices.
- Pharmacy Benefit Managers should provide increased transparency concerning drug costs and utilization.
- Health Information Technology initiatives to create an interoperable system should be implemented.
- The Federal Health Reserve Board and other agencies of the federal government, including CMS, should develop payment methodologies that better align incentives for care.

PART ONE

The Plan for Tennessee

Towards Universal Coverage via A Structured Private Insurance System

According to the Kaiser Family Foundation, nearly 14 percent of the residents of Tennessee were uninsured in 2007: 845,728 Tennesseans. Nationally, 15 percent of the population is uninsured. Among other reforms, better payment incentives, transparency and other systems reform are needed to improve quality and create sustainability. Tennessee must take three initial steps in order to move towards universal coverage through a structured private insurance system. Those steps are (1) the creation of a state-based risk pool; (2) insurance reforms; and (3) the creation of a basic health plan platform from which a variety of “actuarially equivalent” plans may be designed.

Creating a Tennessee Risk Pool

Beginning in 2010, Tennessee should create a risk pool, offering individuals and employers competing plans. Universal insurance, using private and public structures, must be achieved within 10 years of the enactment of reform. Both federal and state reforms need to be phased in over a period of time to permit for sustainable rates of change and correction of unintended consequences. As part of the phase-in, geographic demonstration projects for best practices, disease management, provider payment alignment, and other issues should be included in order to improve quality, provide access to information to improve outcomes and improve the health status of individuals. The recommendation to create a state risk pool envisions that the risk pool would offer plans in a manner patterned after the Federal Employees Health Benefit Program (FEHBP). They would provide access to a variety of well regulated private sector insurance choices.

Because state reforms cannot supersede federal law, ERISA plans will continue to operate independent of state reform. If ERISA plans want to participate in a state risk pool, because they are governed by federal law they would have to

reconstitute themselves and cease being ERISA plans. ERISA plans, however, could be included through federal reform efforts. (The Rolling Hills Group recommendations include reforms that would enable ERISA plans to both continue and be part of broader health reform.)

Insurance Reforms

As part of the first steps in creating a structured private insurance system, Tennessee should enact insurance reforms. The way in which the private insurance market operates disadvantages small groups, individuals with health problems and older individuals. Reforms should work to achieve accessible and affordable insurance. Those reforms are:

- a) *Require guarantee issue and prohibit pre-existing condition exclusions -*
As a pre-requisite for being able to provide plans through the pool, insurers must be required to issue insurance to anyone who applies and individuals with pre-existing conditions should not be penalized by having those conditions excluded from coverage.

- b) *Use modified community rating to determine pricing –* Variations in price should be limited to defined rate bands by geography, age and health behaviors. By using modified community rating, individuals and small groups would be less likely to be priced out of obtaining insurance.

- c) *Establish guidelines for participating payer profits, and make medical loss ratios and other information to characterize payer performance public –*
By allowing the pool to negotiate plan design, and clearly defined administrative costs, the risk pools could establish effective guidelines for profit. In the FEHBP, net margin is about 3-4 percent and about 5 percent for private plans in the Medicare Advantage program. By making information about medical loss ratios public and making other performance measures public, the public would be able to determine which plans were spending more or less on direct medical care.

- d) *Provide employers annual plan and group utilization reports –*
This information will allow employers to easily shop for the best coverage for their employees at the lowest cost.

- e) *Create administrative simplification* – Tennessee should adopt administrative simplification for claims forms, payment processes, and appeals that must be used by plans participating in the state risk pool.

Benefits and Plan Design

Plans offered through the risk pool must provide benefits that provide coverage for inpatient and outpatient services and encourage prevention services. Plans would be based on the actuarial value of a minimum benefit package that allows plans to create co-payments, deductibles and other benefit designs to allow consumers choice of plans best suited to their needs. The Group recommended having a standard plan with a deductible rate of \$750 for individual policies and a corresponding deductible for family policies, indexed to inflation.

Individual Insurance Requirement and Enforcement

Tennessee should require that all individuals have coverage. Enforcement of the insurance requirement should be through an individual's or family's normal interaction with government, without creating a new bureaucracy. For example, enrolling a child in school, applying for a driver's license or other services could be denied to those without coverage. Individuals without coverage could then be referred to the risk pool to obtain coverage or be randomly assigned to a participating plan.

- a) By 2010, all Tennesseans in families with incomes above 400% of poverty would be required to have at least the basic health plan offered through the insurance pool or have other public services disallowed (licenses, benefits, etc.)
- b) By 2010, children in families with incomes up to 250% of the federal poverty level should be required to enroll in Tennessee's CoverKids program.

Health Care Delivery System Reform

An important part of reform that must work in tandem with universal coverage, and insurance reforms, is health systems reform. These reforms should increase quality and produce better health outcomes.

Outcomes and Quality

1. Use of evidence-based guidelines should be encouraged throughout the system. To encourage the use of evidence based guidelines, participating plans should be required to adopt incentives for providers in their networks to use current guidelines.
2. Assist in provider education and adoption of best practices through demonstration projects that can be completed and incorporated into reform as coverage through a risk pool is phased-in.
3. Leverage Tennessee's medical schools and universities to develop ongoing review of all elements of the health care system. Because health care payment coverage, delivery of services, and site of care can impact health status and outcomes, it is important that Tennessee develop a resource that can contribute to cultivating continued improvement while reform is phased in and once reform has been implemented. In addition, these unique state resources can be used to further comparative effectiveness research at the state level.

Payment Reform

1. Incentives to ensure that the healthcare system provides the most appropriate care should be incorporated as the risk pool is phased in. Risk pools should not mandate a specific payment structure. However, insurers and plans should begin to develop mechanisms to pay for care that produces better outcomes. New models of payment that better align incentives among providers should be adopted. Payment reform also should include an emphasis on incentives for providers who successfully treat chronic care patients, including a medical home model.

2. Payers should be required to have plans evaluated periodically to ensure payment is not deterring the use of primary care or services that assist in disease management. Demonstration projects should assess how Tennessee is adopting payment and care models that emphasize health and wellness. This includes using Tennessee's medical schools and universities to be part of an ongoing review of the factors that impact delivery of care and health status.

Transparency

Developing and encouraging the use of comparable quality standards, and providing consumers with information concerning cost, and quality of providers and insurers, allows providers and insurers to compete on quality and price measurements. These steps coupled with medical loss ratio transparency will provide the consumer with vital new tools.

1. Develop mechanisms through which patients and payers can choose providers and insurers based on quality standards.
2. Provide cost information to patients in addition to purchasers.

End of Life Care

There may not be one answer that is easily adoptable concerning end of life care and following patient wishes. But, health reform must address patient education issues and work to facilitate conversations between patients and providers before end of life decisions arise. On June 8, 2004 Tennessee Governor Phil Bredesen signed into law the Tennessee Health Care Decisions Act (HCDA). The legislation marked a significant development in Tennessee law and established Tennessee as a leader in relation to the way health care decisions are made by patients who want to give advance instructions and the way decisions are made for patients who do not give advance instructions. The statute include provisions on advance directives, filled a long-standing gap in Tennessee law on health care surrogacy, and updated the law concerning what the HCDA calls "universal" do-not-resuscitate orders.

1. Evidence-based medical research should emphasize assisting providers so they have better information and understanding about end of life care.

2. Tennessee should have an ongoing education effort concerning living wills, advance directives and health proxies and the provisions included in the HCDA.

Tort Reform

Tort reform should be studied as part of Tennessee reform and at a national level plans and providers should be incentivized to follow evidence-based guidelines.

PART TWO

Federal Reform

The Rolling Hills group realizes that real reform in Tennessee is not possible without national structural reform. Changes to the federal tax code are required to better use funds and provide subsidies for low income residents. ERISA plans cannot participate in state based reforms because they operate under federal law. Therefore, only statutory changes at the federal level hold the promise for true systemic change.

UNIVERSAL INSURANCE VIA A STRUCTURED PRIVATE INSURANCE SYSTEM

- Over 10 years, 2010-2019, the plan would phase in a redesigned system that will provide universal insurance for all Americans
- The Federal Employees Health Benefits Plan (FEHBP) structure, overseen by a Federal Reserve-like regulatory mechanism, the Federal Health Reserve (FHR), is the basic template for the system.
- A system of subsidies, or “transfer payments” to certified health plans, via the tax code (refundable tax credits) will guarantee payment, and coverage, for the lower income uninsured.
- Under a phased in “individual insurance requirement” all Americans will be required to have insurance by 2019, with the lower and higher income Americans required to have insurance by 2012. Enforcement will be through the tax code, with those failing to buy insurance being “randomly assigned” to qualified plans, and incurring tax liability for unpaid premiums.

- Many varying plans can be offered, but tax subsidies will be limited to the “actuarial value” of a FEHBP Blue Cross Standard Option PPO, with a fairly high deductible—guaranteeing insurance under a basic insurance benefit, while limiting subsidies for higher income Americans for that same benefit.

STRUCTURE

State or regional health pools, hereinafter called the Federal Health Reserve (FHR) system, would organize and negotiate a range of health plans for individuals and families to purchase in each state or region. (There may be 15 regions; or 34 regions, tracking the functioning Medicare Part D structure; or 50 regions — one for each state. The Rolling Hills Group has no strong preference).

The FHR Board, insulated from politics, would establish plan design, benefits and coverage, as the U.S. Office of Personnel Management (OPM) does for federal employees, and track the participating insurers for compliance with insurance reforms. Plan benefits would track:

- The Blue Cross FEHBP Standard Option plan, with a \$750 deductible for individuals, indexed to inflation from 2009; or,
- An “actuarially equivalent” benefit as identified by the FHR.
- Regional FHR Boards as well as the national FHR could make coverage determinations within parameters of the basic health plan.

By 2019, all health insurance, including self funded plans, in the U.S. would be required to operate either:

- a) within the FHR system;
- b) as a health plan independent of the FHR marketing system, but fully participating in FHR “risk adjustment” and pooling of risk mechanisms; or
- c) as an independent self funded ERISA plan exempt from state insurance regulations, but fully subject to the FHR “risk adjustment” and pooling of risk mechanisms.

INSURANCE REFORMS

All FHR plans will be required to offer insurance with guaranteed issue, with no preexisting condition exclusions, and at modified community rates.

- Modified community rates could include age, sex, geography and health behavior factors. No beneficiaries within any age band could have premiums vary more than +/- 25% of the mean price of the product due to other risk factors.
- FHR plans will disclose medical loss ratios, and targets for margins will be under 4% - 5%, as is the case with FEHBP. This will be a high volume, low margin product for insurers.
- ERISA plans could continue to operate outside of FHR or state regulatory schemes, but would participate in risk pools via “risk adjustment” methodologies – to avoid systemic medical underwriting.
- In each FHR region (as Medicare does in Part C and Part D), the FHR would collect risk adjustment data from all plans, including ERISA plans.
 - Plans with relatively higher risk patients (including ERISA) would receive payments from the pool (lowering premiums);
 - Plans with relatively lower risk patients (including ERISA) would make additional payments to the pool (raising premiums).

This system significantly reduces insurance “cherry picking” or risk selection and results in insurers focusing on plan design and services—rather than insurance underwriting of health risk.

FINANCING THE PLAN

Tax Code Changes

Beginning in 2010, only the actuarial value of the estimated cost of the basic FHR benefit would be excludable from income to individuals and deductible as a business expense to employers. From 2010 to 2019, the deduction to employers would be further phased down to 50% of the actuarial value of the FHR base plan.

Refundable tax credits (effectively direct transfer payments to insurers from the U.S. Treasury for payment of low income individuals’ and families’ health plans) would provide subsidies for low income beneficiaries on an income related basis. This will allow all low income earners to afford basic coverage which becomes mandatory for all Americans by 2019.

The result will be a slow transition to lower cost plans, with higher deductibles for most higher income Americans. This is estimated **to increase tax revenues by \$70 billion a year in 2010 dollars, when fully phased in.**

As uninsured levels fall, public spending for existing public indigent care subsidies should also fall—and be recaptured to buy insurance for low income beneficiaries. But these subsidies, mainly Medicare and Medicaid Disproportionate Share programs (DSH) and Medicare Bad Debt, should ONLY be recaptured as it is proven that uninsured rates are falling. Still, at least \$50 billion per year in 2010 dollars is spent on these costs for uncompensated care today. In a system with far fewer uninsured, **\$30 billion a year could be recaptured for financing coverage for the uninsured**

THE ESTIMATED COST OF UNIVERSAL INSURANCE FOR A BASIC PLAN IN 2010 dollars is \$100 Billion (IOM report adjusted for Inflation; Also see Moran estimate)

Low Income Coverage—and Individual Insurance Requirement

Beginning in 2012, all Americans with income below 100% of poverty and those with income above 350% of poverty would be required to buy at least the FHR basic plan — or have other services disallowed (licenses, benefits, etc). Those encountering the health system (hospitals, etc.) would be randomly assigned to a qualifying FHR plan if they were uninsured. The premiums for those with income above 350% of poverty would be IRS tax liabilities if they did not pay. For those with income less than 100% of poverty, the cost of the insurance would be paid directly to the FHR plan by the U.S. Treasury.

- As revenue rises from reduced tax expenditures, and indigent care costs decrease, subsidies would be phased in for lower income purchasers.
 - By 2012, all individuals up to 100% of poverty would have a subsidy for the cost of the basic plan.
 - By 2019, purchasers with income below 150% % of poverty would have full subsidies and those with income from 150% to 350% of poverty would have an income related subsidy for at least part of the costs of the FHR plan.

Random Assignment

Under an “individual insurance requirement” ALL Americans not signing up for an FHR plan — or equivalent -- would be randomly assigned to an FHR plan (just as Medicare “dual eligibles” are today in Medicare Part D). As discussed above, lower income individuals would have rates subsidized, or fully covered, with payments made directly to FHR health plans—not to the beneficiaries—to ensure the subsidy is used for insurance.

- Payments to insurers would come via an “individual refundable tax credit” and any unpaid premiums would become a federal tax liability to the individual.

RESULTING SYSTEM: “Everyone in the Pool”

An individual insurance system, covering all Americans not eligible for Medicare or Medicaid, with PRIVATE, well structured insurance products, in a modified community rated system.

- Uncompensated care rates would be expected to fall below 2% (some aliens and unpaid deductibles) and providers would be compensated for the bulk of care.
- Expensive tax subsidies that create incentives for excessive insurance for high income workers will be reduced — and redistributed as subsidies to lower income Americans.
- Coverage and utilization decisions will be depoliticized via the Federal Health Reserve Boards — resulting in a better allocation of our resources.
- Universal PRIVATE insurance would be provided to all not eligible for Medicare, Medicaid or SCHIP— with a rational level of public oversight.

All of these reforms can be accomplished with no new spending in the system. Preliminary estimates are that this plan is budget-neutral to the U.S. Treasury.

APPENDIX

THE ROLLINGS HILLS GROUP'S REFORM PROPOSAL

SAMPLE BENEFICIARY IMPACT at full phase in:

1) *Low Income Family, 100% of Poverty* (\$10,400 single/\$21,200 for family of four): Remains on Medicaid in virtually every state. Auto enrolled via Medicaid at any health provider, should they not be enrolled. Those categorically ineligible for Medicaid would be covered under the FHR without being charged premiums.

2) *Low Income Family above Medicaid levels (ex. 150% of poverty)* (\$15,600 single/\$31,800 for a family of four):

In states that Medicaid covers, either enrolled or randomly assigned to Medicaid. In non-covering states, the beneficiary would enroll in an FHR plan or, if not enrolled, would be randomly assigned to an FHR plan in their region (much as Part D does today in Medicare for dual eligibles).

The premium would be subsidized. At 150% of poverty, the entire premium would be paid via a transfer payment (or refundable tax credit) that would go directly to the FHR participating insurer (much as Medicaid premiums do).

At higher income levels from 150% - 350% (\$15,600 individual/ \$31,800 family of four to \$36,400 individual/ \$74,200 for family of four), the premium would only be partially subsidized on a sliding scale, based on income, and the beneficiary would be required to pay a part of the costs. (see below #3)

3) *Lower Income Uninsured (ex. 300% of poverty -- \$31,200 individual/\$63,600 for family of four)*

The individual or family would be required to have coverage either via a) employer or b) FHR. They could enroll in an FHR plan or be randomly assigned to a plan by the FHR. They would be required to pay a portion of the premium, and cover deductibles and co pays.

At this income level, the percent of premium paid by the individual or family would likely be about 75% of premium costs. Any individual or family that is randomly assigned to a plan (or otherwise in an FHR), and did not pay the premium to the plan, would have that premium amount referred to the IRS as a tax liability, collectable via all IRS authorities.

4) *Lower-Middle Income Family* (example: 350% of poverty -- \$36,400 individual/\$74,200 family of four)

Again, would be required to buy at least the FHR plan via a) an employer; b) enrollment in an FHR; or c) assignment to an FHR plan. The family would be above the income level for any subsidy, and would be required to pay the full amount of the premium. Non payment would be a tax liability.

5) *Middle Income Family via ERISA plan* (example 400% of poverty \$41,600 individual/\$84,800 family of four)

Could be covered via their employer plan. They would be taxed, as income, on the marginal cost of the plan, should its actuarial value exceed that of the base FHR plan. The employer would only be eligible to deduct 50% of the cost of the FHR base plan value by 2019. None of the employer costs of benefits exceeding the base FHR plan value could be deducted. The ERISA plan would be included in a regional risk adjustment system to ensure its inclusion in community risk pools.

6) *Higher Income Family* (e.g., \$300,000 per year)

Again could be covered through the employer plan, (likely ERISA) or via the FHR. As in example #5, the tax treatment would be the same. These higher income earners are likely to use extra benefits. If the employer provides them, it is taxed as income, and the employer may not deduct them as a business expense after 2010.

The resulting incentive is a slow, gradual movement of higher income earners away from ERISA plans, and into the FHR system — voluntarily.

