The Hidden Costs of Domestic Partner Benefits

by Michael E. Hamrick

Executive Summary

Corporate executives often hear that health care for domestic partners costs no more than it does for married couples. That may be true for some companies. But executives at many companies can expect that the cost of health care for domestic partners will be higher—and perhaps significantly higher—than for married couples. One bit of evidence comes from a small group plan in California that paid 17.1 percent more last year for same-sex couples than for opposite-sex couples.

Generally, a lack of data makes the cost of domestic partner benefits difficult to predict. The benefit is new, there is no published actuarial data, no guide to how many employees will choose to accept the benefits, virtually no tracking of the specific costs involved, and no uniformity in the definitions of what constitutes an eligible domestic partner. Estimates of health-care costs for domestic partners are either unreliable or outright guesswork because they ignore the disproportionate number of high-risk people enrolling in the benefits program and the increased medical costs associated with same-sex couples.

Taking high-risk enrollees and same-sex medical costs into account, some employers can expect 3 to 5 percent higher costs if only 1 or 2 percent of their employees choose domestic partner benefits.

The Hidden Costs of Domestic Partner Benefits

Introduction

Advocates of domestic partner benefits contend that the cost of offering such benefits to cohabitating couples is the same as for married couples. But what little data exist today argue against that view. WellPoint, which owns Blue Cross of California and a number of other major insurers, reviewed a pool of small California employers with approximately 700,000 employees in 2001. WellPoint found that costs for same-sex couples were much higher than for opposite-sex couples: "The loss ratio (health-care costs as a percent of premiums paid) for same-sex domestic partners was 17.1 percent HIGHER than for the remaining two-party members [meaning opposite-sex couples]."[1]

No american insurance company has made health insurance available to cohabiting couples on the same policy at any price outside of the corporate employee-benefit platform. The reason is that insurers avoid unpredictability. Because they cannot reasonably forecast the health-care costs for cohabitating couples, insurers are unwilling to risk the profitability of individual domestic partner insurance policies.

I. The Difficulty of Projecting the Costs of Domestic Partner Benefits

Insurers build their actuarial tables—and set their prices—using years of historical data. Without such data, their forecasts become less certain and their pricing more volatile. There are five reasons why insurers have insufficient data.

First, domestic partner benefits are a fairly new benefit. A 1999 Hewitt Associates survey found that most domestic partner benefits plans were launched within the last six years.[2]

Second, estimates of domestic partner benefit enrollment vary widely. Some proponents estimate rates of between 0.5 and 3 percent.[3] The Hewitt survey reports that in 37 percent of companies, between 1 and 5 percent of employees elected domestic partner benefits for a partner. In 5 percent of the companies surveyed, more than 5 percent of employees eligible for benefits elected domestic partner benefits. The average enrollment shift—the number of domestic partners added to the insurance plan—for all companies was 1.2 percent.[4] The wide difference might result from the broad variety of definitions about what constitutes an eligible plan participant.

Third, definitions relating to domestic partners are inconsistent. Pricing models require clearly defined assumptions for determining the profit or loss associated with a particular group within an insurance pool. Every risk manager understands what the phrase "employee and spouse" means, but the definition of domestic partnership varies considerably from firm to firm.[5] Indeed, at least one organization that argues for domestic partner benefits recommends permitting the definition to vary from employee to employee. It proclaims that the "ideal" domestic partner policy is one that:

> covers a *wide range of family types*. If possible, an employer should offer benefits to same- and opposite-sex couples, *both romantic and non-romantic*, as well as partners' children. By crafting an inclusive policy such as this, the employer *allows the employee to define his or her own family* and responds to that family's needs.[6]

Most corporations have not adopted such a broad policy. Fifty-two percent of companies require a signed affidavit only (i.e., a form certifying the relationship). Fifteen percent of employers require an affidavit plus other proof. The least restrictive employer plans (13 percent) require no proof at all. Only 5 percent require domestic partner registration with local government. The remaining firms (15 percent) require various combinations of certification and designated types of evidence.[7]

From an actuarial point of view, the more the definition of what constitutes a domestic partnership varies, the less valuable the classification becomes as a predictor of future costs. With little or no historical data upon which to rely and no consistency across firms in the definition of what

constitutes a domestic partner relationship, it is virtually impossible to predict, and therefore, profitably price, this new category of insureds.[8]

Despite the difficulty in predicting the costs of insurance for domestic partners, the vast majority of firms (95 percent) require the same contribution from employees with domestic partners as they require for spousal benefits.[9] The assumption is that domestic partnerships are the same, and therefore will have a similar claims/utilization of insurance benefits in the future. Under scrutiny, that assumption does not hold.

Fourth, in order to study the cost dynamics and effectively price insurance benefits for domestic partnerships, it is essential that domestic partners be classified in a separate pool or insurance class. By creating a unique class of insured persons, the cost of insuring such couples could be tracked and compared with the premiums collected for this new risk class, as was done by WellPoint for 2001. Over time, higher claims or utilization of benefits would be reflected in higher premiums charged to domestic partner couples, unless prohibited by law (as it currently is in California). However, if additional tracking and differentiation is not done, the higher costs will be shared by the rest of the pool, specifically, married couples with "two party" or "Family" coverage.

Finally, the very nature of domestic partnerships increases the difficulty in predicting costs. Because domestic partnerships may begin or end without legal consequences, there is no external pressure helping to hold such relationships together. Consequently, domestic partnerships tend to be unstable. A recent survey in Great Britain found that "a third of live-in relationships last less than a year . . . . Only one in ten lasts longer than five years."[10] An older U.S. study found similar results: "Two-fifths of cohabiting unions do not continue as cohabitations for more than 1 year, only one-third lasts 2 years, and only 1 in 10 are still cohabiting after 5 years."[11]

In addition, many cohabiting employees may add a beneficiary during any open enrollment period, if not more often, with no proof of good health required. Indeed, a cohabiting employee can wait to choose insurance for his or her partner until discovering that the partner has a serious illness. This creates an ever-shifting pool of insured individuals. By contrast, married employees may ordinarily add beneficiaries to their group insurance plan without proof of good health only within 30 days of a life-event, such as marriage, birth or adoption, thereby creating a more stable base of insured individuals.

II. How Insurance Works

Insurance, like any other business, must be profitable over time. State regulators require insurers to demonstrate that they can protect their policyholders by having sufficient funds to cover potential costs. Otherwise, policyholders could suddenly lose coverage if an insurer fails, and be unable to secure replacement coverage. So when claim costs exceed the premiums charged, insurers have three options: (1) limit coverage; (2) impose loss controls by attempting to change behavior (e.g., require use of safety equipment); or (3) simply raise the premiums.

Health insurance plans are profitable when the factors that drive costs are well known and very predictable. Costs are predictable not only because of experience with defined categories of insured individuals; they are also predictable because insurance companies can safely assume that most people are generally healthy. As a rule, 92 percent of the individuals covered by health insurance plans are generally healthy. The balance—8 percent—account for 71 percent of the costs in a given year.[12] When determining the premiums to be charged for coverage under a health insurance plan, actuaries assume that these proportions will hold true for the sample population—the group of individuals covered by the plan. An insurance plan in which the percentages are consistent with those of the population as a whole is said to have **random selection**. The advantage of larger employer group insurance plans is that the large number of people included in a pool that is created solely as a result of employment generally results in random selection.

Changes in underwriting guidelines, classifications or employer administrative policies that allow an unusual number of individuals with known (or pre-existing) high-risk health conditions to enter group health insurance plans leads to

adverse selection, which can have a dramatically disproportionate effect on costs. For example, a 1percentage-point increase in the *unhealthy* population group due to adverse selection could result in an 8.56 percent increase in utilization/claims costs.[13]

Impact of Adverse Selection Illustrated

	Random Selection	Adverse Selection	% Chg.
Ratio of Healthy/Unhealthy	92/8	91/9	-1/+1
% Losses from Unhealthy Group	71.00%	79.88%	8.88%
% Losses from Healthy Group	29.00%	28.68%	-0.32%
Impact on Total Plan Costs	100.00%	108.56%	8.56%

Advocates of domestic partner benefits claim that most firms experience a proportional increase in costs related to enrollment shifts.[14] In other words, if 1 percent of employees enroll a domestic partner in the benefits plan, claims costs will rise roughly 1 percent. The problem is that domestic partners will cost more to insure than the general population. As a result, the employer's insurance costs will increase at a higher rate than the rise in the number of employees, and in most cases, the employer will not recognize that domestic partners account for the disparity.[15]

III. The Inescapable Adverse Selection Associated with Domestic Partner Benefits

A. Fluidity and Adverse Selection

Approximately 43 million Americans have no health insurance, and given insurers' experience with contestable claims, it would be surprising if some uninsured persons did not try to take advantage of easy access to domestic partner benefits plans.[16] A study in the mid-1990's found that more than half of those with serious medical needs knew as much as one year in advance of their declining health.[17]

According to a recent survey, 32 percent of the employers that offer domestic partner benefits have no waiting period for replacing one domestic partner with another. Twenty-six percent require a minimum period of six months during which a domestic partner couple must reside together.[18] In view of the instability of domestic partnerships and the apparent ease of adding a domestic partner to a benefits plan at any time, such policies practically invite abuse.[19] Employers should anticipate adverse selection in the domestic partners added to their insurance plans.

B. The Unique Case of Same-Sex Relationships

The risk of adverse selection is increased by the unique health-care problems associated with gay sex. The high level of sexually transmitted diseases among gays, lesbians and bisexuals has been well documented.[20] Within the gay community, the rate of new HIV infections has again risen to rates comparable to the first years after AIDS was discovered in the early 1980's. A 3-year study recently completed by the Centers for Disease Control (CDC) found that 4.4 percent of men who had sex with men became infected with HIV each year during a 3-year period from 1998 to 2000.[21] The CDC estimates that these numbers underreport by as much as one-third the number of new but undiagnosed HIV infections. At this rate, total new HIV infections would affect approximately 6.6 percent of men who have sex with men per year.[22]

AIDS likewise continues to be a serious health risk for men who have sex with men.[23] According to the CDC, 63.5 percent of the cumulative AIDS cases in men have occurred in men who had sex with men.[24] Eighty-two percent of the cumulative AIDS cases among white, non-Hispanic males involve men who had sex with men.[25] Prior to the development of newer AIDS drugs, epidemiologists estimated "that 30 percent of 20-year-old gay men will be infected with HIV or dead of AIDS by age 30, and that a majority will become HIV-infected during their lifetimes."[26]

Advocates of domestic partner plans claim that employers with domestic partner benefits have

not experienced an increase of cost because of HIV/AIDS.[27] However, the numbers of HIV infections and AIDS cases consistently reveal that HIV/AIDS affects gay men disproportionately. In fact, one observer estimates that "the incidence of AIDS among 20- to 30-year-old homosexual men is roughly 430 times greater than among the heterosexual population at large."[28] At a minimum, domestic partner benefits plans should expect to have higher percentages of HIV/AIDS among their participants than in non-domestic partner benefits plans. And employers should anticipate significant increases in health-care costs. Some estimate that HIV treatment alone costs $10,000 to $12,000 per person annually, and when you add the costs of full-blown AIDS cases, the aggregate costs to health insurers—and therefore employer plans—will be in the billions of dollars.[29]

The increased health-risk concerns are not limited to the HIV/AIDS issue. Gays and lesbians have increased likelihood of alcohol abuse, domestic violence, mental illness and contracting other sexually transmitted diseases.[30] Many of these illnesses or problems are expensive to treat and will add costs to numerous components of an employer's benefits plan.[31]

Given the health consequences of gay sex, it is reasonable to be concerned about the impact on health-insurance costs. If gay and lesbian individuals contract the flu, diabetes, cancer and heart conditions (etc.) at the same rate as the general population (and there is no evidence to the contrary), all things being equal, gay men and lesbians will cost more to insure overall.[32]

IV. The Inadequacy of Current Cost Projections

An advocate for domestic partner benefits has developed a model supporting the belief that costs rise proportionately at various enrollment rates.[33] But that model is flawed. The pro-advocacy model looks at insurance costs as static and ignores the issue of adverse selection. The model includes the cost of FICA taxes to the company because the portion of health insurance premiums paid by the corporation is subject to FICA taxes. But because it does not account for adverse selection, even with FICA taxes the model computes a cost to the employer that is less than the percentage of new enrollees. The pro-advocacy model in Table 1 in the Appendix shows that with 20,000 employees and an enrollment rate of 0.5 percent for domestic partnership benefits, the total cost to the employer increases only 0.36 percent. With a total enrollment shift of 2 percent, the total cost to the employer rises only 1.44 percent.

The model in Table 1 reflects a relationship between *current* premium costs paid by employers on behalf of employees and the growth in employees covered under the plan *at the same cost*. This is an incorrect basis for analyzing the relationship between domestic partner benefits and the cost to employers because it assumes that *new enrollees* to domestic partner plans will represent a cross section of society. But as shown above, inherent characteristics of domestic partnerships and current statistics on disease and health problems in the gay and lesbian community demonstrate that there will be adverse selection in domestic partner benefits plans. The only question is how much. Again, if 71 percent of insurance claims come from 8 percent of the plan participants, and individuals are added with higher likelihood of illness, costs will rise dramatically.

Given the millions of uninsured persons in the United States, the ease of entering domestic partnerships and obtaining health-care benefits, the number of gay men with HIV/AIDS, and the increased risk of additional diseases for other gays, lesbians and bisexuals, it is reasonable to estimate that a significant number of domestic partners will have known, high-risk health conditions when they join a domestic partnership health-care plan. If a domestic partnership plan brings one extra enrollee in 10 with a high-risk health condition into the risk pool (10 percent adverse selection), costs begin to rise disproportionately with enrollment at all levels of enrollment shift. With an enrollment shift of 0.5 percent, the additional cost to the employer would be 0.8 percent; with an enrollment shift of 2 percent, the additional cost would be 3.21 percent; and with an enrollment shift of 5 percent, the increased cost would be 8.03 percent.[34] If the plan gains one in four high-risk enrollees (25 percent adverse selection), the cost is much worse: with an enrollment shift of 0.5 percent, the additional cost to the employer would be 1.47 percent; with an enrollment shift of 2 percent, the additional cost would be 5.87 percent; and with an enrollment shift of 5 percent, the increased cost would be 14.68

percent.[35] Finally, if one in two enrollees are high risk (50 percent adverse selection), the cost increase is over five times the enrollment shift: with an enrollment shift of 0.5 percent, the additional cost to the employer would be 2.58 percent; with an enrollment shift of 2 percent, the additional cost would be 10.31 percent; and with an enrollment shift of 5 percent, the increased cost would be 25.78 percent.[36]

The problem with adverse selection is that it is impossible to know how high the cost will go until the company pays it.[37] In view of the likelihood of adverse selection in domestic partnership plans, no model predicting costs is reasonable without taking adverse selection into account. When adverse selection is included in the analysis, it is clear that adding domestic partners to an insurance plan will cost far more than the proportionate cost that the proponents predict. Even if the enrollment shift is small, and the resulting increase in costs is insignificant to an employer, the costs will be disproportionate. This conclusion is consistent with the results of WellPoint's experience in its California small group-insurance pool in 2001.

V. The Potential Impact of Domestic Partner Benefits on Rising Health-Care Costs

Health-care costs appear to be spiraling out of control. According to a 2001 survey, monthly premiums for employer-sponsored health insurance rose 11 percent from spring 2000 to spring 2001. The report also indicated that "premium equivalents for self-insured plans—which are a reflection of underlying health-care costs"—rose 9.5 percent during the same period. The report suggests that the rise in self-insured plan costs indicates that employers can expect higher premium increases in the coming years.[38] Preliminary data for 2002 indicate that this year's increases will be more extreme.

Prescription drugs are a major driver of the growth in health-care costs. The cost for prescription drugs rose an average of 15.5 percent scross all plan types from 2000 to 2001.[39] And there can be no doubt that the increase in HIV/AIDS cases had something to do with it. The Human Rights Campaign's estimate of from $10,000 to $12,000 annually to treat HIV does not even include the cost of viral load tests that "can cost from $80 to $300 each and must be administered every few months."[40]

The unavoidable adverse selection associated with domestic partner benefits plans will exacerbate health-insurance costs for participating firms. Instead of an 11 percent increase in costs, an employer with a 1 percent shift in enrollment and only 25 percent adverse selection will face an increase of nearly 14 percent in health-care costs. Given this outlook for health-insurance costs, employers should not lightly assume that a decision to adopt domestic partner benefits is inexpensive.

Conclusion

Until health-care costs for domestic partners are tracked separately, as in WellPoint's 2001 review, no one can know for sure how domestic partner benefits policies will affect companies financially. The cost of domestic partner health insurance is almost certain to exceed the cost of insurance for married employees because adverse selection is unavoidable. That excess cost will be passed along to employers and other employees as well.

The bottom line is that a company should not adopt domestic partner benefits without conducting its own analysis. If a company does choose to extend domestic partner benefits, it should track at least the following:

1. The loss ratio for marriages;
2. The loss ratio for domestic partnerships;
3. The loss ratio for same-sex partners compared to opposite-sex partners;
4. The length of time between adding a partner to an employee's benefits plan and the first major medical expense.

ENDNOTES

[1] Mark (Denny) Weinberg, "Domestic Partners and the Uninsured Issue," March 1, 2002, e-mail to distribution list. Mark Weinberg is Executive Vice President and Chief Development Officer of WellPoint, Inc.

[2] *Survey Findings: Domestic Partner Benefits 2000*, Hewitt Associates, p. 10.

[3] Sally Kohn, *The Domestic Partnership Organizing Manual for Employee Benefits* ("*Manual*"), p. 1, The Policy Institute of the National Gay and Lesbian Task Force (1999), www.ngltf.org/downloads/dp/dp_99.pdf. Employers who offer benefits to same-sex and opposite-sex domestic partners will experience an enrollment shift at the higher end of the range. Human Rights Campaign Worknet (HRC), *How to Achieve Domestic Partner Benefits in Your Workplace*, www.hrc.org/worknet/dp/dptool.pdf.

[4] *Domestic Partner Benefits 2000*, p. 27.

[5] *Ibid*., p. 15.

[6] *Manual*, p. 6 (emphasis added).

[7] *Domestic Partner Benefits 2000*, p. 15.

[8] Indeed, when WellPoint reviewed the cost of domestic partner benefits for all couples in 1998, the loss ratio was only 2 percent higher than for married couples. Weinberg e-mail.

[9] *Domestic Partner Benefits 2000*, p. 16.

[10] Steve Doughty, "How Live-in Love Doesn't Last," *Daily Mail* (London), January 16, 2002, p. 7.

[11] Larry L. Bumpass and James A. Sweet, "National Estimates of Cohabitation," *Demography*, 26(4): 615-625, p. 620 (1989).

[12] These results are from a private morbidity study of various population cohorts in the mid-1990's.

[13] Because 8 percent of a randomly selected population accounts for 71 percent of medical claims, each 1 percent of unhealthy individuals accounts for 8.875 percent of total claims, while each 1 percent of healthy individuals accounts for approximately 0.32 percent of claims.

[14] M. V. Lee Badgett, Ph.D., "Calculating Costs with Credibility: Health Care Benefits for Domestic Partners," *Angles*, 5(1): 1-8, p. 1 (November 2000).

[15] Even if domestic partners were classified as a separate group, it would take years to fully understand the financial impact of offering domestic partner coverage because higher claims occur after the new enrollees are added to the plan. Without tracking those costs separately, it is impossible to determine the full cost of domestic partner insurance.

[16] For example, in the late 1980s insurance companies were receiving a surprising number of AIDS-related claims. Lincoln National Reinsurance Company reviewed 125 life insurance claims where AIDS was the cause of death and found that 36.8 percent (46) of the claims were *contestable*—a legal process by which an insurer attempts to deny payment of a claim due to misrepresentation, fraud or change in medical condition prior to becoming insured. During the same period of time, only 21 percent of all claims were contestable, thus showing that individuals with known health conditions were apparently seeking insurance benefits. At that time record-keeping was poor because of privacy concerns and because of hesitancy by some physicians to identify AIDS as the cause of death. Lincoln National's medical and research staff said that they did not recognize half the AIDS-related claims. Gabriel L. Shaheen, "AIDS: Pricing and Reserving Considerations," *Record of Society of Actuaries*, 14(3): 1360-1367, p. 1367 (1988).

[17] See endnote 12.

[18] *Domestic Partner Benefits 2000*, p. 17.

[19] Amanda May, "Odd Couples: Wait, are those really straight-looking guys actually together? Nope, they're just fake domestic partners," *New York Magazine*, July 8, 2002, www.nymag.com/page.cfm?page_id=6182. Advocates of domestic partner benefits claim there is no evidence employees have registered domestic partners fraudulently. The fact is that if a domestic partner benefits policy does not limit the reasons for cohabiting, it is not fraudulent to cohabit for the purpose of enabling a friend or partner to obtain benefits. Moreover, in view of the resistance to employer scrutiny of domestic partnerships, it would be surprising if an employer were able to discover that a domestic partner had been registered because of known health issues. *Ibid*. ("The [New York] city clerk's office wouldn't comment on the possibility of fraud. 'We don't know people's personal lives,' snapped one spokesperson").

[20] Gabriel Rotello, *Sexual Ecology: AIDS and the Destiny of Gay Men*, New York: Penguin, 1998; John R. Diggs, Jr., M.D., *The Health Risks of Gay Sex* (Corporate Resource Council, 2002).

[21] Elianna Marziani, "AIDS Infection Back at '80s Level," *The Washington Times*, June 1, 2001, p. 1.

[22] *Ibid.*

[23] Eighty-three percent of AIDS cases among adults and adolescents occur in men. "Basic Statistics," Centers for Disease Control—Division of HIV/AIDS Prevention, June 2001, www.cdc.gov/hiv/stats.htm (total of 784,032 adult and adolescent cases, with 649,186 cases in males).

[24] *Ibid*. Eight percent of this total number of AIDS cases in men includes men who also inject drugs.

[25] "HIV/AIDS Surveillance Report: U.S. HIV and AIDS cases reported through December 2000 (year-end edition)," Centers for Disease Control and Prevention, 12(2), p. 18, Table 9, www.cdc.gov/hiv/stats/hasr1202.pdf.

[26] Walt Odets, Ph.D., "Psychosocial and Educational Challenges for the Gay and Bisexual Male Communities," a report to the American Association of Physicians for Human Rights, AIDS Prevention Summit, Dallas, Texas, July 15-17, 1994.

[27] Badgett, pp. 3-4 (citing a report from 1992, when there were very few employers offering domestic partner benefits).

[28] Jeffrey Satinover, M.D., *Homosexuality and the Politics of Truth*, p. 57, Grand Rapids: Baker Book House, 1996.

[29] HRC, *HIV/AIDS Drugs,* October 2001, www.hrc.org/issues/hiv%5Faids/background/drugs.asp. With an average period of 8-11 years from HIV infection to development of AIDS-related symptoms, it is likely that costs may exceed $90,000 for each person who undergoes HIV treatment. The CDC estimates that there are approximately 40,000 new HIV infections in the United States each year, and that 42 percent of those infections—16,800—occur in men who have sex with men. CDC HIV/AIDS Update as of December 2000. Therefore, future HIV treatment expenditures of $1.5 billion are accruing each year just for men who have sex with men (math: $90,000 lifetime HIV treatment costs X 16,800 new HIV infections for men who have sex with men per year).

[30] Diggs, 2002. The increased risk of domestic violence applies to heterosexual domestic partners as well. Linda J. Waite and Maggie Gallagher, *The Case for Marriage: Why Married People are Happier, Healthier and Better-Off Financially*, pp. 155-56, New York: Doubleday, 2000.

[31] Domestic violence costs corporations from $3 to $5 billion annually. Beth McConnell, "Bill Would Guarantee Abused Workers' Rights," *HR News*, 20(10): 1,13, p. 1 (October 2001).

[32] The likely increased cost is highlighted by the Gay and Lesbian Medical Association's publication of a 481-page manual that describes health problems unique to gays, lesbians, bisexuals and transgendered people. *Healthy People 2010, Companion Document for Lesbian, Gay, Bisexual, and Transgender (LGBT) Health*, Gay and Lesbian Medical Association, available at www.glma.org. The one area where married employees' spouses may have higher medical costs is pregnancy. However, pregnancy costs for married women certainly did not equal the costs of insuring same-sex couples in WellPoint's California small group pool in 2001.

[33] Badgett, p. 4.

[34] Appendix, Table 2.

[35] Appendix, Table 3

[36] Appendix, Table 4.

[37] Richard K. Kischuk, "Dealing with Unexpected Changes in Health Care Environment," *Record of Society of Actuaries,* 13(1): 404-413, p. 408 (1987).

[38] *Survey of Employer-Sponsored Health Benefits: 2001 Summary of Findings*, p. 1, Kaiser Family Foundation and Health Research and Educational Trust.

[39] *Ibid.*

[40] HRC, *HIV/AIDS Drugs*, October 2001.

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APPENDIX

Table 1

Model Ignoring Adverse Selection[1]

Enrollment Rate	New DPs (20,000 EEs)	Premium Pd. by Co.	Impact on Plan Costs	Total Cost (Incl. FICA tax)	% Change in total costs
0.50%	100	$4,250	$425,000	$457,513	0.36%
1.00%	200	$4,250	$850,000	$915,025	0.72%
1.50%	300	$4,250	$1,275,000	$1,372,538	1.08%
2.00%	400	$4,250	$1,700,000	$1,830,050	1.44%

Table 2

Model Showing Impact of Adverse Selection Rate @ 10%[2]

Enrollment Rate	New DPs (20,000 EEs)	Anti-Selection Percentage	Assume 10% Anti-Selection	Impact on Plan Costs[3]	Total Cost[4] (incl. FICA tax)	% Change in total costs
0.50%	100	10%	10	$565,781	$1,023,294	0.80%
1.00%	200	10%	20	$1,131,563	$2,046,588	1.61%
1.50%	300	10%	30	$1,697,344	$3,069,881	2.41%
2.00%	400	10%	40	$2,263.125	$4,093,175	3.21%
5.00%	1000	10%	100	$5,657,813	$10,232,938	8.03%

Table 3

Model Showing Impact of Adverse Selection Rate @ 25%

Enrollment Rate	New DPs (20,000 EEs)	Anti-Selection Percentage	Assume 25% Anti-Selection	Impact on Plan Costs	Total Cost (incl. FICA tax)	% Change in total costs
0.50%	100	25%	25	$1,414,453	$1,871,966	1.47%
1.00%	200	25%	50	$2,828,906	$3,743,931	2.94%
1.50%	300	25%	75	$4,243,359	$5,615,897	4.40%
2.00%	400	25%	100	$5,657,813	$7,487,863	5.87%
5.00%	1000	25%	250	$14,144,531	$18,719,656	14.68%

Table 4

Model Showing Impact of Adverse Selection Rate @ 50%

Enrollment Rate	New DPs (20,000 EEs)	Anti-Selection Percentage	Assume 50% Anti-Selection	Impact on Plan Costs	Total Cost (incl. FICA tax)	% Change in total costs
0.50%	100	50%	50	$2,828,906	$3,286,419	2.58%
1.00%	200	50%	100	$5,657,813	$6,572,838	5.16%
1.50%	300	50%	150	$8,486,719	$9,859,256	7.73%
2.00%	400	50%	200	$11,315,625	$13,145,675	10.31%
5.00%	1000	50%	500	$28,289,063	$32,864,188	25.78%

APPENDIX ENDNOTES

[1] This model (based on M.V. Lee Badgett's assumptions) of a firm with 20,000 employees shows the relationship between enrollment rates (number of people enrolling their domestic partners in the plan) and the change in total costs. The model assumes that the employer is paying 85 percent of the premium costs annually ($5,000 est.) and paying the 7.65 percent FICA tax on employer-paid health insurance premiums. The portion of employer-paid health insurance premiums is considered taxable income to the employee (domestic partner employee) and is subject to the company FICA contribution on 100 percent of the imputed income. It also assumes that the cost for married employees is "individual-plus-one," or the cost of two single people, and that one half of the employees are married.

[2] The adverse selection models are based on the same assumptions as the model that ignores adverse selection.

[3] Impact on Plan Costs formula = [(Enrollment Rate %/1%) X 8.875%] X (Total Plan Premiums) X (percentage of individuals with existing health issues added to plan).

[4] Total cost projections (Models Showing Impact of Adverse Selection at various rates) include three components – company portion of premiums paid on behalf of domestic partner employees, FICA tax paid by company related to imputed income to employee and increase in claim costs due to adverse selection.