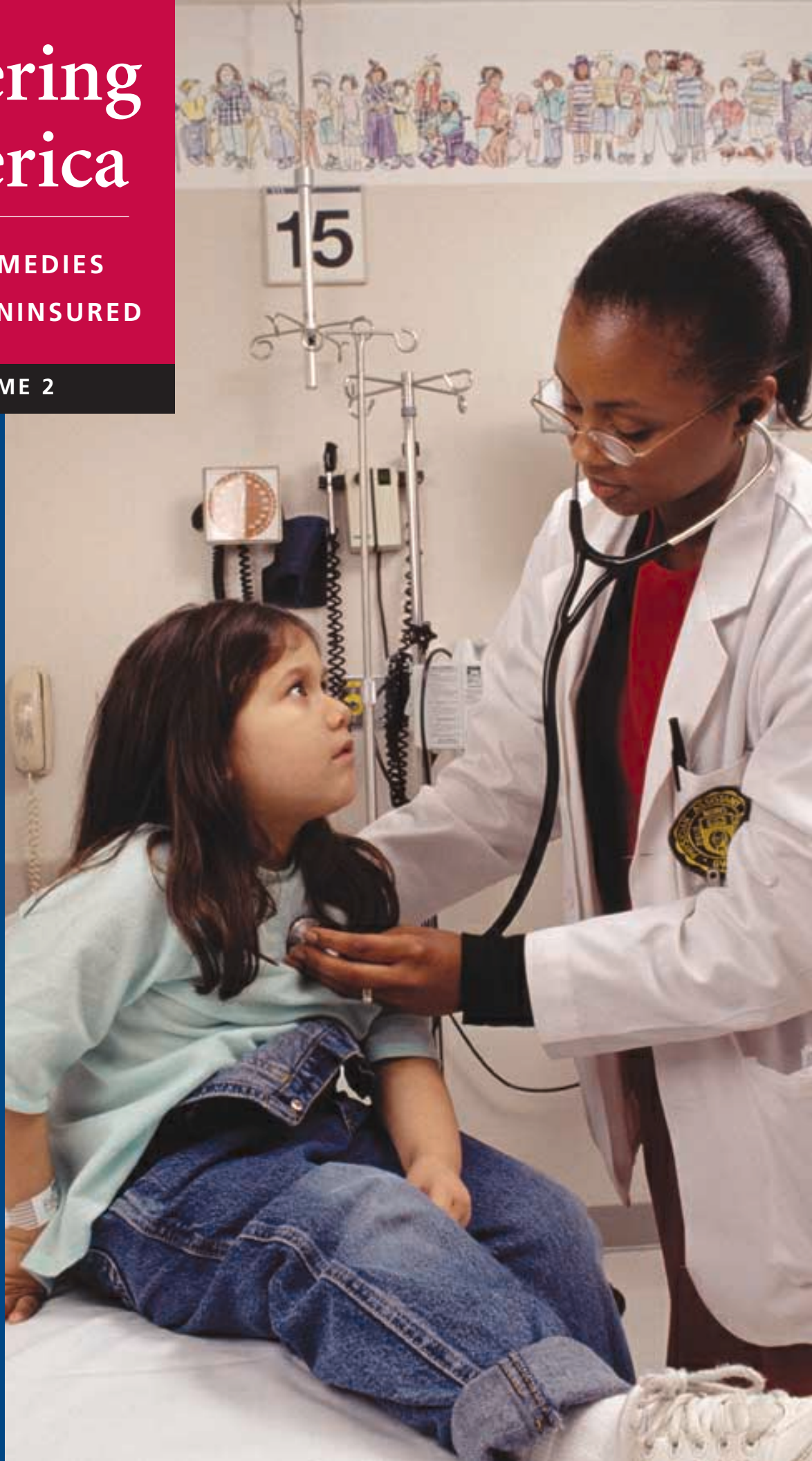
Covering America

REAL REMEDIES FOR THE UNINSURED

VOLUME 2



ECONOMIC AND SOCIAL RESEARCH INSTITUTE

NOVEMBER 2002

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ECONOMIC AND
SOCIAL RESEARCH
INSTITUTE

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About the Economic and Social Research Institute

The Economic and Social Research Institute (ESRI) is a nonprofit organization that conducts research and policy analysis in health care and in the reform of social services. ESRI specializes in studies aimed at improving the way health care services are organized and delivered, making quality health care accessible and affordable, and enhancing the effectiveness of social programs.

Overview

by Elliot K. Wicks and Jack A. Meyer

This volume is the second in a series that presents comprehensive proposals to extend health insurance coverage to most, if not all, Americans. Since the first volume was published in June 2001, the problem of the uninsured has, if anything, grown worse. The downturn in the economy has caused large numbers of people to lose their jobs and, in the process, their health insurance. Nothing on the economic horizon suggests that market forces alone will enable more people to get coverage in the near future. The need for imaginative, far-reaching proposals to reform the way we make health insurance available and affordable for all Americans remains as strong as ever.

The purpose of this volume, and the *Covering America* project, is to help supply that need. While the authors as well as the sponsor and staff of this project realize that the current political climate does not make achievement of universal coverage likely in the immediate future, we are convinced that it is important to keep that objective alive by creating a forum where new and creative ideas can be developed, dissected, debated, and refined. The project seeks to do this by convening leading experts representing the full range of philosophical and political perspectives and developing diverse, comprehensive proposals and careful analyses designed to lay the groundwork for future progress in covering the uninsured. What distinguishes the proposals produced as part of this process from most of those that have appeared in the last several years is their emphasis on achieving universal or near-universal coverage. This document presents a portion of the creative work produced as a result of these efforts.

Proposals to Reduce the Number of Uninsured

The first narrative section of this document includes summaries of three new proposals to protect Americans against the financial burdens of paying for expensive medical care. Like the 10 proposals published in the previous volume in this series, the new reform proposals were prepared by distinguished health analysts representing diverse philosophical perspectives and very different ideas about the direction reform should take. Although we place no constraints on the authors regarding the approach they devise, we do ask them to put their ideas to the test of presenting their proposal in person before our advisory panel of expert health researchers and analysts for their review and critique. (Panel members were not asked for endorsement of any proposal; none was given, and none should be inferred.) After reflecting on the comments of the advisory panel as well as those of the Economic and Social Research Institute staff, the authors prepared the final versions of their proposals, which appear here.

The three proposals in this volume differ markedly in their approach to improving coverage for the uninsured. The first uses tax credits but retains most of the features of the present system, while adding new ones to improve accountability and incentives for good performance. The second also uses tax credits but relies very heavily on reforms that would greatly strengthen market forces and incentives for individual consumers to economize on utilization of health resources. The third proposal departs dramatically from the other two, proposing that the nation adopt a single-payer system that would automatically cover all citizens with no cost sharing at the point of service use and no payment of premiums. The proposals are summarized briefly in the following paragraphs and in a feature-by-feature comparison in the table that immediately follows this introduction, which also summarizes the features of the proposals included in the first volume of this series.

David Kendall, Jeff Lemieux, and S. Robert Levine have prepared a plan that, while relying heavily on

the basic structure of the present system, adds new federally financed, refundable tax credits to make coverage affordable. Families with an annual income up to $50,000 and no employer-sponsored coverage would receive a full credit of $3,750 a year, while those with employer-sponsored coverage would get $1,500. Employers, including those not paying for coverage, would be responsible for helping workers to enroll in a health plan at the work site, passing along federal tax credits, and deducting the cost of coverage from employees' paychecks. States would be required to establish purchasing groups (similar to the federal employees' plan) or other purchasing options that would allow every individual and business to choose from a variety of competing health plans. After five years, a commission would decide whether the federal government should mandate that everyone have coverage; people failing to get coverage would not be allowed to claim the personal exemption on their federal income tax. The authors are especially concerned that decision makers be held accountable for achieving good results. They assign state governments major responsibility for improving coverage rates, access to care, health care quality, outcomes, and public health. Consistent with the emphasis on accountability, the grants that support these activities would be tied to states' ability to achieve specified performance levels. States would use the grants to supplement tax credits, strengthen the safety net, assure health plan choice, and measure quality and outcomes. Finally, the authors would establish a health information infrastructure to improve communication, enhance secure information exchange among stakeholders, and enable continuous improvement of health care safety and quality and cost-effective use of health care resources.

Tom Miller proposes reforms that place more emphasis on the end of achieving access to health services than on the *means* of expanding insurance coverage. He would redesign incentives to promote efficiency and economy, especially by assigning more responsibility for health spending decisions to individual consumers and less to third-party payers. Everyone would be eligible for tax credits to cover 30 percent of the cost of coverage, but the credits could be used to purchase only high-deductible "catastrophic" plans. Miller also would eliminate legal restrictions that limit the sale and attractiveness of medical savings accounts (MSAs) and other individual health savings accounts. These forms of coverage incorporate strong incentives for individual consumers to economize on the purchase of care because they would be spending "their own" money to cover front-end costs. These changes, Miller contends, should help to bring down the price of coverage and make it more affordable, thereby improving coverage rates. Efforts to publicize provider prices should be encouraged so consumers would have information that allows them to bargain individually to get better prices from their providers. Miller would eliminate the tax provisions that now encourage choice of employer-based plans over individual coverage. He would put greater emphasis on expanding the safety net system as an alternative to covering all of the uninsured and would increase funding for and accessibility to high-risk pools for the uninsurable. He sees a need for greater flexibility in health insurance regulation, so that states would compete to attract insurers by designing less onerous regulations. Finally, he would institute tax incentives to encourage voluntary contributions to aid the uninsured, allowing people to get a 100 percent tax credit for contributions to approved agencies that provide coverage for low-income uninsured people.

James A. Morone proposes abandoning the employer-based approach to coverage and replacing it with a single-payer model that would guarantee universal coverage. He says that, although our current work-based system may have made sense at a time of unionized industrial-based employment, stable and often lifelong jobs, and only limited foreign competition, that is no longer the case. Now few workers stay in a single full-time job for long, and the new economy requires that employers be able to quickly adjust the size of their workforces, with consequent disruptions of insurance coverage. A better alternative to an employer-based system is to cover all Americans under Medicare. All legal residents, young and old alike, would be covered automatically under an augmented Medicare program that would add coverage for prescription drugs, durable medical

equipment, home health care, and treatment for drug addiction and would have no premium payments or cost sharing. Morone sees a need for renewed emphasis on primary care. Thus Medicare would fund primary care in non-traditional settings, such as schools, and would expand delivery of home health services. The entire Medicare system, including coverage for those over age 65, would be funded solely by a new earmarked federal value-added tax; the current Medicare payroll tax would be abolished. Although clearly a federally centered approach, the plan would provide some flexibility and room for experimentation. States could opt out (for residents under age 65) by implementing an alternative program that meets federal guidelines and by paying 25 percent of the cost of that program. Further flexibility would be permitted by allowing employers to provide coverage to supplement the Medicare benefit package. Morone argues that costs would be kept under control because taxes would have to be raised if expenses increased.

Commentaries and Strategies for Overcoming Barriers to Success

The second section of this document includes three essays reflecting on the 10 proposals produced in the previous volume. Although the commentaries were written in response to the earlier proposals, many of the observations are applicable to the three proposals contained in this volume as well. These commentaries are prepared by people with the kinds of insight, experience, and expertise that allow them to look at reform from a broad perspective. The authors address various factors that impede initiatives to reduce the number of uninsured and offer suggestions for overcoming them. The highlights of the essays are presented here.

In their paper, "Medicaid: What Any Serious Health Reform Proposal Needs to Consider," *Christine Ferguson, Patricia Riley, and Sara Rosenbaum* argue that reformers who would replace or significantly change the structure of Medicaid need to understand and consider carefully the crucial roles that Medicaid plays in state government. Failure to do so could jeopardize key activities of state government and leave many people without social services that are vital to their well-being. The authors' first major point is that Medicaid funding has come to represent a very large portion of every state's budget for social services, and that these funds partially finance agencies, particularly their administrative and oversight functions, that serve populations in addition to Medicaid enrollees. Taking away all Medicaid funds as a result of a transfer of Medicaid functions to some new program would threaten states' capacity to provide social services for an array of needy groups of people. The authors' second major point is that a high proportion of Medicaid funds go to provide services that are not defined as "medical services" by conventional insurance standards—for example, special-education services, services for people with physical and developmental disabilities and the frail elderly, and home- and community-based services. These services go to the sickest, neediest people who are considered uninsurable in conventional health insurance terms and who require services that conventional insurance is not structured to support. Medicaid is based on a social welfare model that cannot be adequately replaced by simply giving everyone the means to buy conventional coverage in the health insurance market. Reformers must recognize this fact and design their reforms to ensure that neither the financial health of states nor the social needs of vulnerable groups are jeopardized.

In their commentary, "Mobilizing, Framing, and Leading: Three Policy Thought Experiments for *Covering America,*" *Edward Lawlor and Ann Dude* look at three successful non-health-related policy reforms to see what lessons can be learned about reformulating health reform strategies to enhance the chances for achieving universal coverage. The three initiatives are the efforts by Mothers Against Drunk Driving (MADD) to pass legislation to curb alcohol-related driving injuries; the 2002 education reform act known as "No Child Left Behind"; and the 1993 North Atlantic Free Trade Agreement (NAFTA). The authors conclude that MADD's success illustrates the importance of attention to bottom-up policy development, the passion and personal investment of committed individuals and

local and state organizations, and the establishment of links between the technical policy reformers and social movement players outside Washington, D.C. The success of the education bill, the authors say, shows the importance of the interplay among compromise, presidential stewardship, and careful framing of the issue in terms of common symbolic ground. NAFTA illustrates success in achieving major policy enactment in spite of strong opposition by powerful interest groups and shows the importance of technical and institutional policy moves, the power of leadership, and the positive influence of sophisticated framing and reframing of the issues in the face of partisan differences and ideological barriers.

Bruce Vladeck, in "Ends and Means in Health Insurance Policy," provides a general critique of the reform proposals in the first volume in this series. He begins by arguing that too many of the authors have falsely assumed that access to the kind of insurance they propose will ensure access to adequate health care. Vladeck says that, in a desire to constrain costs, many of the proposals would provide people with coverage that is too limited to allow them to afford the care they need. Low-income people in particular need coverage that does not include substantial cost sharing in the form of deductibles and copayments; otherwise, they will be deterred from getting medically necessary outpatient services—a fact that Medicaid recognizes and the proponents of bare-bones, high-deductible plans do not. Vladeck goes on to suggest that the authors may be incorrect in concluding that the only way to achieve universal coverage is through incremental steps toward that goal. The nation has been pursuing an incremental strategy to expand health coverage for 20 years, yet the number of uninsured people has grown steadily during that time. Vladeck contends that some real experiences—for example, the "Reagan Revolution" and the "Contract with America"—show that non-incremental strategies are more likely to be successful in achieving the ultimate goal, even if not all at once. Vladeck also notes that many of the proposals try to create health insurance markets that match those of economic theory. They seek to create a structure that would give consumers economic incentives to choose an efficient, cost-effective health plan from among a range of options, which, in turn, is expected to induce health plans to compete to control costs and maximize consumer preferences. The problem, Vladeck contends, is that average consumers do not want that kind of choice and rationally prefer to avoid the transactional and information costs of purchasing health insurance as individuals. Moreover, he argues, a large body of evidence shows that competition in health markets does not control costs over the long run. Vladeck closes by offering the outlines of a reform he favors. The guiding principle is that, once covered, no one should lose health insurance. Existing Consolidated Omnibus Budget Reconciliation Act (COBRA) mechanisms could be built on to implement the principle. People who do not file tax returns would be eligible for Medicaid or subsidies adequate to fully finance previous coverage. Anyone else whose job or family status changes, and who is not immediately protected by new coverage, would be covered under COBRA, with the costs paid for by a combination of public funds and individual contributions tied to income. ■

Section I

Proposals

A Comparison of Reform Plan Features

The first two pages of this table provide a side-by-side comparison of the features of the reform plans that are described in detail in the following chapters. The subsequent pages of the table summarize the features of the reform plans presented in the previous volume. The plans are identified by the names of the authors.

	Kendall/Levine/Lemeiux
General Approach	Tax credits to low- and middle-income individuals and families to be used in either individual or group market. States receive performance-based grants to improve coverage rates, access, quality, and outcomes.
Target Population	Low- and middle-income individuals and families.
Form of Public Programs	Advanceable and refundable tax credits for low- and middle-income people. Medicaid, S-CHIP, and Medicare would continue. Federal government provides grants to states to improve coverage, access, quality, and outcomes. States subsidize costs of coverage when credits are not large enough to make coverage affordable; may use purchasing pools or high-risk pools.
Mandates for Coverage	After five years, a commission would decide whether to establish an individual mandate.
Sources of Funding	Not specified; presumably general revenue, but alcohol and tobacco tax mentioned.
Major Tax Changes	None apart from tax credit for coverage.
Level of Benefits	Not regulated, but states have responsibility to prevent underinsurance; after five years, a commission would assess adequacy of benefits.
Role of Federal Government	Finances and oversees tax credits. Provides performance-based grants to states. Establishes commission to study health benefits and technology and a federal information exchange/clearinghouse to report and disseminate information on quality and outcomes.
Role of State Government	Uses federal grants to supplement tax credits, strengthens safety net, assures health plan choices (e.g., through pools), and measures quality and outcomes. Continues operating Medicaid and S-CHIP.
Effects on Existing Public Programs	Continue largely unchanged.
Role of Insurers/Health Plans	Essentially unchanged.
Role of Employers	Required to offer (but not pay for) a menu of health plans, facilitate an annual enrollment for employees, withhold premiums, and administer tax credits.
Risk Share/Purchasing Pools/ Insurance Regulation	Purchasing pools are an option to meet the requirement that states assure that everyone has a choice of plans available at reasonable cost. States could use federal grants to subsidize high-risk people in the pool. Alternatively, states could impose community rating to spread risk.

Miller	Morone
Tax credits available to all to provide 30% subsidy for high-deductible coverage. Strengthen safety net and establish high-risk pools for the uninsurable. Strong incentives for consumers to economize.	"Single-payer" approach. All legal residents covered by Medicare, with expanded and rationalized benefits package and no copayments. Particular emphasis on community medicine. States could choose to opt out for residents under age 65 by designing their own system under federal guidelines.
Working uninsured, including individuals, and people who decline public coverage.	All legal residents.
Medicaid, S-CHIP, and Medicare would continue for the time being. Better-funded high-risk pools.	Medicare covers all legal residents, but Medicaid remains as a source of longer-term care, disability coverage, and wraparound coverage for Medicare. Many other programs (maternal and child benefits, for example) would be subsumed under new program.
None.	All legal residents covered by Medicare or state alternative.
Reductions in other federal health and non-health spending.	Earmarked federal value-added tax (VAT).
Advanceable tax credits as an option to exclusion of employer premium. More flexible tax treatment of MSAs and IRA-type health savings accounts to encourage growth.	Medicare payroll taxes and premiums abolished and replaced with VAT. Medicare's claim on general revenues (Part B) ended. Tax relief for state Medicaid programs.
Minimum equal to services covered in minimum-cost FEHBP plan but with significant front-end deductible (e.g., 5% of income) and maximum out-of-pocket obligation; thus catastrophic coverage.	Similar to Medicare but with addition of prescription drugs, maternal and child health services, mental health services, emphasis on primary care, including neighborhood health centers and extensive new home health benefits.
Fund tax credits, help fund high-risk pools, and additional funding for safety net. Require guaranteed-renewal option for coverage eligible for tax credit.	New Department of Health organizes and runs expanded Medicare program. Oversees optional state waiver programs. IRS designs and implements a value added tax. Earned Income Tax Credit expanded to offset regressive effects of VAT.
Would compete for insurers by adopting attractive insurance regulation.	Long-term care portion of Medicaid remains. Have the option of designing and paying for 25% of costs to operate federally approved and monitored alternative to federal Medicare.
Medicaid, S-CHIP, and Medicare continue for the time being.	Medicare vastly expanded to all legal residents with expanded benefits. Medicaid continues for long-term care. Many other programs replaced by new Medicare.
Similar to present but with greater flexibility to sell MSAs and other new insurance products.	Can offer supplementary coverage to expand benefits beyond Medicare level.
Essentially unchanged.	Do not contribute toward Medicare coverage but could pay for supplemental benefits (with continued tax exclusion for employees).
Purchasing pools could accept all employers and individuals and risk-rate new entrants for two years. To further offset adverse selection, pools could require multi-year contracts of customers and impose penalties for early exit from pool. States would compete to be the single legal domicile for insurers by passing favorable insurance regulations.	Medicare is the single pool and the only insurer for all citizens for the standard benefits package, so there are no risk-sharing issues.

A Comparison of Features of Reform Plans in Volume I

	Butler	Feder/Levitt/O'Brien/ Rowland	Gruber	Hacker	Holahan/Nichols/ Blumberg
General Approach	Would make refundable tax credits available to working households. States would get grants to expand health coverage to more residents and make insurance more affordable. Coverage obtained at work or from a range of other organizations such as churches or unions.	Expand Medicaid and the State Children's Health Insurance Program for low-income people. Possible combination with tax credit to small, low-wage firms to expand employer offerings.	Establishment of purchasing pools in every state through which households with incomes up to 300% of the federal poverty level would be eligible for no-cost or reduced-cost coverage on a sliding-scale basis; automatic plan enrollment for lowest-income households.	A modified "play or pay" approach that creates incentives for workers and employers to buy into "Medicare Plus," a national program based on Medicare.	Extend the type of subsidized coverage that is currently available under S-CHIP to all lower-income people and subsidize insurance for the highest risk.
Target Population	Working uninsured individuals and families; the plan would achieve near-universal coverage for all working households of legal U.S. residents.	People below 150% of poverty level covered at no cost; those between 150% and 200% of poverty would pay some premiums and cost sharing. Higher-income people could buy-in to public coverage and pay a sliding-scale premium. Employees of small, low-wage firms benefit from tax credit.	Individuals and households under 300% of the federal poverty level would receive subsidies. Households with incomes below 150% of poverty level would be eligible for no-cost coverage.	All Americans not covered by Medicare or employer-sponsored insurance.	Individuals with incomes under 250% of the federal poverty level and those at high health risk. Subsidies available only to those who enroll through the state purchasing pool.
Form of Public Programs	Refundable tax credit, funded via repeal of federal income tax provision that makes employer contributions to employees' health insurance non-taxable income; federal tax revenues would fund grants to states to help low-income families buy coverage.	S-CHIP expansion, federally subsidized, with some state match, for those with limited incomes, and a federal tax credit subsidy for small employers to help cover workers.	Household income determines eligibility for no-premium plans (for households under 150% of poverty level) or reduced-premium plans (for households under 300% of the federal poverty level on a sliding-scale basis but premium not more than 10% of income).	Premiums for those buying into Medicare Plus would be scaled to income, with lower-income citizens paying only a small percent of income. Employers would be eligible for transitional subsidies and for reductions in their contribution rate based on firm income.	Increased federal-funding match to participating states; full subsidies to people below 150% of poverty; cost-sharing up to 7% of income for people between 150% and 200% of poverty and to 12% for people between 200% and 250% of poverty. Higher-risk individuals, regardless of income, pay no more than a statewide community rate.
Mandates for Coverage	None, but to receive tax credit, individual or family would have to buy a health plan that included a minimum set of benefits. High-level of voluntary compliance expected among most workers since employees required to tell employers which health plan they wished to join.	None.	None.	None initially but individual mandate would apply eventually if a nontrivial share of Americans remained uninsured.	After five years, states could mandate that everyone be covered.
Sources of Funding	Savings from elimination of existing tax exclusion, and federal general tax revenues.	Federal general revenues, with state matching payments.	Federal general revenues, savings from replacement of Medicaid and S-CHIP health programs, and limits on tax exclusion for employer-provided insurance.	Payroll contributions and premiums, general revenues, and other smaller sources.	Federal general revenues, and cuts in existing programs since the need would be reduced as health reform is implemented.

Kronick/Rice	Pauly	Singer/Garber/ Enthoven	Weil	Wicks/Meyer/ Silow-Carroll
All non-elderly legal residents would be guaranteed comprehensive health insurance as a "right" (at no direct cost) through a public insurance approach designed by each state and monitored by the federal government.	A refundable tax credit/voucher system would make some level of coverage affordable to lower-middle-income people who currently have no health insurance. Very-low-income households would initially be eligible for publicly financed zero-premium comprehensive insurance.	Combines refundable tax credits and insurance exchanges to promote lower-cost, higher-value health coverage while allowing employers and individuals to continue current arrangements if they desire.	A new Medical Security System would be created to provide universal coverage, making coverage a "right."	Tax credits for all households, varying by income. Universal coverage achieved by mandating that everyone have or buy health coverage and having Medicare automatically cover anyone temporarily uninsured. Builds on present system of private health plans and employer-based coverage.
All non-elderly legal residents.	Principal target group is lower-middle income families and individuals with incomes above the federal poverty line, or about half of the uninsured. Very low-income families covered publicly, at least initially.	Low and moderate-income people who are not eligible for Medicare.	All legal U.S. residents under age 65.	All of the uninsured.
Federal subsidies to states to finance availability of no-cost coverage to all legal residents.	A voucher or tax credit large enough to cover one-half to two-thirds of the premium for moderately comprehensive coverage. The credits would be in the form of coupons worth $1,500 for individual coverage and $3,500 for family coverage. No-cost publicly financed coverage for very low income households.	Continuation of Medicaid/ S-CHIP for eligible individuals and families who choose to stay in these programs; refundable tax credits equal to 70% of median-cost health plan; federal payments to states equal to 50% of the tax credit to cover the costs of running "default plans" for people who do not enroll.	Payroll tax, Medicaid, and S-CHIP funds.	Refundable tax credits for all households but varying according to income—minimum credit approximately $700 a year for an individual and $1,200 a year for a family. People below 100% of poverty would get credit sufficient to buy coverage comparable to Medicaid. Those above that level up to median income would get gradually reduced subsidies.
All legal residents under age 65 automatically covered by comprehensive benefits. Everyone would have at least one health insurance option that would not require payment of premiums. There would be a mandatory payroll tax.	None.	None.	All employers and employees would pay a new payroll tax. All people would have to enroll or be enrolled by default.	Every individual and family would have to have health coverage at least as comprehensive as Medicare's, plus prescription drugs and well-child care. Those who fail to show proof of purchase would pay a premium plus a penalty for Medicare backup coverage for every month without other coverage.
Primary revenue source would be a payroll tax levied on employers and employees, supplemented by federal general revenues, state revenues, and, in some states, premium payments from individuals.	Federal budget revenues; those who buy more expensive coverage would pay out-of-pocket. Full coverage for those with incomes below 125% of the federal poverty level would be financed through a combination of state and federal revenues.	Phased-in cap on current federal tax exclusion; general revenues; and savings over time from changing consumer behavior and increasing health plan competition.	Payroll tax, premiums, and federal subsidies.	Federal general revenues, but partially offsetting savings would be realized from the elimination of Medicaid and S-CHIP and from making employer-paid health premiums taxable income for employees.

A Comparison of Features of Reform Plans in Volume I

	Butler	Feder/Levitt/O'Brien/ Rowland	Gruber	Hacker	Holahan/Nichols/ Blumberg
Major Tax Changes	Repeal of the federal income tax provision that makes employer contributions to employees' health insurance a non-taxable form of income.	Explores tax credits to individuals or employers, the latter to subsidize the offering of coverage to uninsured workers with modest incomes.	Limits the tax exclusion for employer-provided insurance equal to no more than the cost of the median-cost plan in each purchasing pool.	Cap on tax exclusion of employer-provided health insurance at level of twice the average premium of Medicare Plus coverage.	Federal taxes would be increased if surplus not available.
Level of Benefits	To qualify for the tax credit, families would have to enroll in a health plan that included at least the minimum insurance package, which would be primarily catastrophic coverage.	Comprehensive but not specifically delineated.	Physician services, inpatient and outpatient hospital, prescription drugs, nominal payments for well-child care, prenatal care, and immunizations.	A defined benefit package similar to Medicare plus outpatient prescription drugs, preventive services, mental health benefits, and maternal and child health care.	States determine a new standard benefit package—within federal guidelines—for everyone under 250% of poverty and those at high health risk.
Role of Federal Government	Would establish a default system of health insurance regulation to encourage availability of affordable insurance; would establish a benchmark health plan with basic features and catastrophic protection. Would monitor state compliance and work with states on a plan to eliminate uninsurance.	Would make federal funds available at enhanced Medicaid matching rates to states willing to cover targeted uninsured.	Funds subsidies, sets minimal rules, provides oversight of purchasing pool administration.	The Health Care Financing Administration would have primary responsibility for administering Medicare Plus. In addition to offering standard fee-for-service coverage, Medicare Plus would also allow beneficiaries to enroll in private health plans that contracted with the program.	Financial support, monitor state compliance of minimum rules, oversee state spending and enforcement.
Role of State Government	Would develop a mechanism to supplement federal tax credit for eligible workers and help cover those who did not purchase minimum insurance. Would have to use additional federal funds to expand existing or develop new programs to achieve target levels of coverage. Would work with health insurers on insurance reform that keeps benefits affordable.	Would provide coverage to low-income uninsured residents, consistent with federal rules affecting eligibility, benefits, administration, and other program aspects.	Not addressed, except for continued responsibility for remaining parts of Medicaid.	Would transform from provider of insurance to a portal for coverage under the new Medicare Plus system. States would continue to finance care for the eligible aged, blind and disabled. In addition, they would have to reach out to and enroll non-workers, provide wraparound coverage for those who would have been in Medicaid, and subsidize premiums for unemployed people.	Increases role of states significantly while granting more flexibility.

Kronick/Rice	Pauly	Singer/Garber/ Enthoven	Weil	Wicks/Meyer/ Silow-Carroll
Payroll tax substitutes for employer and employee premiums, which has implications for tax exclusion provision of employer premium contributions.	No major tax code changes, but tax credits in the form of coupons would help people purchase qualified health insurance. The new vouchers would be viewed and treated as tax reductions for those who use them.	Phased-in cap on current federal tax exclusion for employer-paid premiums.	New payroll tax would be established for employers and employees.	The tax exclusion for employer-paid health premiums would be eliminated.
A federally-defined standard benefit package. Benefits would include prescription drug coverage; dental and long-term care would not be required.	To qualify for the credit, the plan would have to cover effective medical and surgical services, prescription drugs, and medical devices based on a standard definition. Patient cost sharing would be permitted, as would managed care.	Generally determined by the market, with minimum standards set by the Insurance Exchange Commission, including goods and services known to be medically effective and provided at reasonable cost.	Guarantee is for basic coverage, but individual may supplement with own funds to buy more comprehensive.	A package of benefits comparable to Medicare's plus a prescription drug benefit and well-child care coverage.
Would impose payroll taxes on employers and employees, calculate money needed and provide funds to each state health care system, monitor state implementation of expansions, measure quality and health outcomes, determine and update standard benefit package, monitor and regulate quality of care in states.	Would make information about insurance purchasing and plans available, including price and quality and could subsidize the production and distribution of such information. It also would be (or contract with) an insurer of last resort.	Establish the Insurance Exchange Commission to oversee insurance exchanges, distribute tax credits and make default plan payments. Establishes U.S. Insurance Exchange as backup in markets without private exchanges.	Would set up and regulate insurance exchanges, forward tax revenues, and determine size of payroll tax.	Would fund all tax credits. Would establish general guidelines for states setting up the aggregate purchasing arrangements (APA). Would continue to operate Medicare, for the elderly and as a temporary back-up plan for people who do not have proof of private coverage.
States would have much flexibility in designing a system—how to pay health care providers (e.g., single payer vs. competing health plans), be responsible for raising revenue to supplement federal financing, meet federal requirements, and enroll residents in health plans. Would provide information on enrollment options and procedures, negotiate with health plans and providers, regulate health plans, and collect data to evaluate the system.	Would have primary role of selecting or managing the public plan for poor people not currently covered by Medicaid. Could continue to regulate individual insurance and regulate risk-rating. In addition, states could choose to provide payments for people with high medical expenses, possibly allowing smaller deductibles or less-constraining upper limits in low-cost plans.	Continue to provide Medicaid and S-CHIP; use new federal funds to pay for care under default plans by reimbursing safety-net providers.	States would continue to pay some Medicaid costs to keep coverage at current levels; would subsidize copayments under basic plan for low-income residents.	Each state would be required to establish an aggregate purchasing arrangement through which small employers and individuals would purchase coverage. In exchange for no longer financing the acute portion of Medicaid or S-CHIP, states would assume greater responsibility for long-term care services under Medicaid.

A Comparison of Features of Reform Plans in Volume I

	Butler	Feder/Levitt/O'Brien/ Rowland	Gruber	Hacker	Holahan/Nichols/ Blumberg
Effects on Existing Public Programs	Medicaid and S-CHIP would continue as now.	Medicaid and S-CHIP would continue and be expanded.	Gradual phase out of Medicaid and S-CHIP (and accompanying federal subsidies) for those families who qualify on income alone. Medicaid remains in place for the elderly and disabled.	Would eventually replace existing public programs for the uninsured with a single national program based on Medicare. Medicaid and S-CHIP would be phased out with eligibles automatically enrolled in the new Medicare program or employer-sponsored plans.	Participating states would receive enhanced federal S-CHIP matching rate for all current Medicaid and S-CHIP beneficiaries under 250% of poverty; all states must continue smaller, residual Medicaid program for children and adults with special needs as well as all long term care services; would eliminate federal payments to states covering individuals with incomes above 250% of poverty. No change in non-participating states.
Role of Insurers/ Health Plans	Would continue to be a major source of coverage. Would have to bring premium rates into line with federal or state underwriting and benefit requirements, but would benefit from administrative savings associated with the automatic enrollment system.	Would stay the same as today, although some market reforms might be necessary.	Could participate in state-established purchasing pool or continue to operate outside of such arrangements.	Would stay the same as today; would compete for business from Medicare Plus system.	Health plans participating in the new state plan would be required to accept all applicants, with premiums set at a statewide community rate. Payments to plans would be risk adjusted. Insurers would not be subject to any new federal market regulations outside the state purchasing pool.
Role of Employers	Similar to present but would have to inform employees about the tax credit program and deliver the tax credit. Would serve as a clearinghouse, creating automatic enrollment mechanisms for insurance, setting up payroll deduction and payment systems for employees and providing proof of insurance for each worker.	Similar to present. If tax credit were pursued, small low-wage employers would be encouraged to offer insurance to their employees; employers would receive the tax credit if they provided insurance.	Would continue to offer health coverage to workers, but could do so within the purchasing pool or outside of it.	Employers would enroll workers at workplace. They could choose to sponsor coverage at least as generous as the new program's or pay a modest payroll-based contribution to fund public coverage.	Would continue to have choice to offer health coverage to their workers. If they offer, they must make state plans available, but they can also offer plans outside the state pool.
Risk Share/ Purchasing Pools/ Insurance Regulation	Insurance industry and states would have to work together to develop a means for adjusting risk among plans.	Possible reforms in the individual insurance market unless tax credits could be applied to a publicly managed insurance product.	Purchasing pools are foundation of proposal: subsidies are available only for coverage purchased through the pools.	To avoid adverse selection, measures are imposed to make it more difficult for employers to shift between public and private coverage. 50% to 70% of the population might eventually enroll in Medicare Plus, providing strong bargaining leverage and broad pooling of risk. No new regulations are imposed on private insurance, and there are no insurance pools.	State-established purchasing pools are foundation of proposal. Medicaid (except the disabled and elderly) and S-CHIP enrollees and state employees would be included in the pool. The pool would be open to individuals and employers, and insurers could offer standard benefit package at a statewide community rate, plus add-on products priced separately.

Kronick/Rice	Pauly	Singer/Garber/ Enthoven	Weil	Wicks/Meyer/ Silow-Carroll
Would vary by state, but new state program could replace S-CHIP and portions of Medicaid.	Medicaid and S-CHIP would continue, and more low-income people would be subsidized to enroll in these programs or some other public program.	Medicare remains intact; people enrolled in Medicaid and S-CHIP may stay in these programs or opt instead for tax credits to be used in the private market.	S-CHIP would be subsumed; Medicaid would be mostly subsumed.	S-CHIP and Medicaid largely replaced, except for disabled and elderly.
In some states, plans would compete for business from states and would have to include services specified in a federally-defined benefits package. Some states might choose to pay providers directly and eliminate the role of insurers/health plans.	Would continue to be major source of coverage. Would be required to guarantee renewability in the individual market and to set premiums on modified community-rating basis in the small-group market. Insurers would redeem vouchers or certificates.	Would compete to provide low-cost, high-quality care; collect and report quality of care and health outcomes data.	Plans would contract with health insurance exchanges to offer range of plans, including a "no-cost" plan (that is, no enrollee contribution); would market plans and monitor quality of care.	Would continue to be major source of coverage but would be required to offer a policy that covers the services comparable to Medicare plus prescription drugs and well-child care, to participate in purchasing pools, and to community rate in individual and small-group markets.
Employers would no longer provide or buy health coverage for their workers. Although employer role would be eliminated, both employers and employees would have to contribute to financing coverage.	Similar to current role.	May become their own insurance exchange; continue to offer benefits to employees; or purchase coverage from exchanges.	Employers would collect payroll tax but could opt out by offering own generous plans to employees.	Employers would be required to offer (but not necessarily pay for) coverage for employees and dependents. Benefits must be at least comparable to Medicare plus a prescription drug benefit and well-child care. Employers with 10 or fewer employees would have to offer coverage through the purchasing pool.
Since coverage in no-cost plan is automatic, everyone is pooled together, though states would have latitude to decide specifics.	Few restrictions would be placed on qualifying coverage. But all policies must have a guaranteed renewability clause, and low-cost policies must be sold under modified community rating. Plans with more generous coverage could charge higher premiums to high-risk people. Insurers could impose modest waiting periods for people who did not enroll during open season.	The Federal Insurance Exchange Commission would develop risk- adjustment strategies. Payments would be risk-adjusted both between health plans within an exchange and across exchanges.	Insurers selling through insurance exchanges would be required to offer guaranteed-issue, community rated standard benefit packages.	All health plans would have to accept all individual and small-group applicants and provide immediate and full coverage for all covered benefits with no waiting periods or exclusions for prior conditions. Insurers selling individual and small-group coverage would have to price premiums on a community-rated basis. Purchasing pools (APAs) open to all individuals and groups.

Kendall, Lemieux, and Levine

Key Elements

David B. Kendall, **Jeff Lemieux**, and **S. Robert Levine** have outlined a plan for a performance-based approach for achieving near-universal coverage. It establishes universal coverage as a national mission and has the following elements:

FEDERAL INCOME-RELATED, refundable, advanceable tax credits to individuals and families.

PERFORMANCE-BASED GRANTS to states linked to improvements in coverage rates, access to care, health care quality, outcomes, public health, and protection from financial hardship for their residents.

STATE-ESTABLISHED PURCHASING GROUPS (similar to the federal employees' plan) or other purchasing options that would allow every individual and business to choose from a variety of competing health plans.

EMPLOYER RESPONSIBILITY to permit workers to enroll in a health plan at the work site, pass along federal tax credits, and deduct the cost of coverage from employees' paychecks.

AFTER FIVE YEARS, AN INDIVIDUAL MANDATE enforced through disallowance of the personal exemption for federal income tax.

ESTABLISHMENT OF A HEALTH INFORMATION INFRASTRUCTURE to improve communication and enhance secure information exchange among stakeholders and enable continuous improvement of health care safety and quality and cost-effective use of health care resources.

About the Authors

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S. ROBERT LEVINE, MD, is a national leader in efforts to promote wider use of information technologies to empower consumers and improve health care access and quality. He is Chairman of the Board of Chancellors of the Juvenile Diabetes Research Foundation, the world's top non-profit funder of diabetes research, where he has helped develop its highly effective grassroots advocacy program as well as lead efforts to help its research funding program be more responsive and focused on its mission—a cure for diabetes and its complications. In 1998, he was a recipient of Research!America's Research Advocacy Award for his leadership in generating broad-based support for the doubling of federal biomedical research funding. As Chairman of the Progressive Policy Institute's Health Priorities Project, he has co-authored core papers on an Information Age health system, covering the uninsured, and Medicare reform. Dr. Levine also serves on the Boards of the Center for the Advancement of Health and the Foundation for Accountability. He is a graduate of Cornell University and the Loyola-Stritch School of Medicine. He completed his Internal Medicine and Cardiology training at the Mount Sinai Medical Center, New York, where he later joined the full-time faculty as the founding Director of its Cardiac Health and Rehabilitation Program.

JEFF LEMIEUX is the Senior Economist for the Progressive Policy Institute (PPI). A health economist, he is responsible for studies of overall economic and federal budget, tax, and entitlement issues, as well as health care. Mr. Lemieux was an author and issues editor for the Spring 2000 *Blueprint* magazine published by the Democratic Leadership Council (DLC): *Health Care, Igniting a Consumer Revolution.* Some of his recent publications on health care are "A Progressive Path Toward Universal Health Coverage" (PPI, December 2000), "A New Medicare for the New Economy" (DLC, February 2001), "Transitional Health Coverage: A Tax Credit for COBRA" (PPI, August 2001), and "The New Health Care" (DLC, September 2001). Prior to joining the PPI, Mr. Lemieux was the Staff Economist for the National Bipartisan Commission on the Future of Medicare. He was responsible for the long-term baselines for Medicare spending used by the Commission and the budgetary estimates of the Commission's proposals. From 1992 through 1998, Mr. Lemieux was with the Congressional Budget Office (CBO), where he estimated the cost of national health reform plans and, later, the impact of Medicare reforms enacted in the Balanced Budget Act of 1997 and other laws. He formed CBO's projections of national health expenditures in 1992. Those projections were updated in a series of CBO publications between 1992 and 1998. Between 1990 and 1992, he was with the Office of the Actuary at the Health Care Financing Administration (HCFA), and prior to HCFA, worked for DRI/McGraw-Hill, an economic forecasting firm.

A Performance-Based Approach to Universal Health Care

by David B. Kendall, Jeff Lemieux, and S. Robert Levine

Overview

For as long as health insurance rates have been measured systematically in the United States, there has been no progress in reducing the number of uninsured. Even after slight improvements in coverage rates at the tail end of arguably the strongest economy in the nation's history, coverage rates are still lower now than they were in 1987. Failure is all too common in health care policy and reform efforts.

Covering the uninsured requires a new approach to health policy. Current policies are based on propagating rules and manipulating behavior, rather than on achieving results. For example, Medicaid provides substantial federal funding in exchange for compliance with federal requirements. Yet, even where federal law requires coverage for certain categories, such as low-income, pregnant women and children, there is no automatic assessment of how effective state efforts are to enroll people. Not surprising, large gaps between eligibility and enrollment rates persist, especially in the case of children.

Rules and incentives are necessary and important tools, but they are more useful in helping to set the conditions for success than as ends in themselves. Health policy needs to include real-time assessment of performance and continuous recalibration of methods to achieve the desired outcome. *Describing success* so everyone can help to pursue it is more likely to inspire progress than merely *prescribing behavior* based on an incomplete theory or an inappropriate model.

Our vision of success is that nearly all U.S. residents have health care coverage, which they select for themselves and which provides them with a level of coverage that is appropriate to their health status and income level. Health care would be delivered safely without waste and with the best possible individual and population-based outcomes. People who remain uninsured for whatever reason would be assured access to community-based outpatient and preventive care services rather than having to rely on emergency room and hospital-based care only, often delivered too late in the course of illness to be effective.

In general, the government would ensure that everyone has the opportunity to get coverage, and individuals would be responsible for obtaining it and using resources wisely. We seek broad recognition that as a community, decisions about the use of health care resources affect our common health and our common wealth.

There can be no real progress or success without clearly defined accountability. Our framework for accountability is straightforward: The federal government provides a basic level of subsidy to everyone according to need and supports the research and encourages the information flow necessary for high-quality, cost-effective use of health care services. The states make sure that coverage is affordable and a choice of health plans is available to people in diverse circumstances. Employers act as conduits for enrolling and paying for coverage (even if they choose to make no contribution themselves), and individuals are responsible for securing coverage and paying their fair share.

Here, then, are the key ingredients of our proposal that are necessary for success:

Tax credits for employer-sponsored and individual health insurance to improve affordability. Our tax credits would apply to both employer-sponsored

coverage and individually purchased coverage. They would be available to the uninsured as well as people who are struggling to afford coverage they already have. The existing tax exclusion for employer-sponsored coverage would not be repealed. Therefore, the tax credits would not disrupt employer-sponsored coverage. In addition, the credits would be refundable, which means that low-income workers can use them even if they pay no income tax. They would also be advanceable so workers could use the credit at the time they purchase coverage.

Workplace focus to make coverage easy to get. People are accustomed to getting coverage at work, and our proposal would enable all uninsured workers to do so. However, it would not require employers to sponsor or contribute to coverage.

Voluntary purchasing groups or other options to make choices widely available. As a condition for receiving new federal grants, states would ensure that all employers and individuals could choose among competing group insurance plans through at least one, but preferably several, private purchasing groups. Alternatively, a state could issue a menu of options to make choosing coverage convenient. A modified version of the federal employees' system would be made available to individuals and small businesses as a backup if a state did not follow through.

Performance-based grants to assist states in improving coverage and health care for all their citizens, and to reward those that succeed. All states would receive a base amount to help them improve insurance options in the state, disseminate information about obtaining coverage, advertise the importance of coverage, protect people with high health care costs, and help assure basic care for those who lack coverage. To reward states that succeed, the federal government would give additional grants to states that could document increases in coverage rates. These new state grants would not require state spending to receive federal funding as current programs like Medicaid require. Moreover, these grants would not dictate the means for making improvements. Instead, the federal government would reward states that improve coverage rates so that coverage is equally available and affordable to the young and old, sick and healthy, poor and rich. A portion of the base grant would be set aside for states to participate in national collaborative efforts to develop and test measures of health care quality, access, outcomes, and public health. Those measures would become the basis for additional performance-based grants to states when the data become available.

Information networks to assess state performance, improve quality, and inform policy. In order to fully assess the performance of states, much more data about health care processes and outcomes will be needed. This very same kind of data is important to health professionals, hospitals, and patients in order to avoid costly medical mistakes and to improve quality generally. The same data is also important for research on "the benefit of benefits," which is the subject of controversies involving insurance coverage decisions in the private and public sectors. The federal government would catalyze the creation of information networks that can economically produce this data while keeping patients' medical records private.

Individual responsibility to obtain coverage. With State Children's Health Insurance Program (S-CHIP), Medicaid, tax credits, purchasing groups, and the new state grants, coverage for children would be universally available and affordable. A few years after enactment, parents would be denied the personal exemption—a small tax benefit—for any of their children who remained uninsured. As it becomes clear that coverage is more affordable and easy to obtain, adults remaining uninsured would lose their personal exemption as well.

Our plan is divided into two phases to encourage adjustments in federal policy based on a systematic, objective assessment of experience and to allow for an evolution in the political dynamic surrounding issues related to health care coverage.[1] The focus of Phase One is simply getting people coverage through tax credits and performance grants,

[1] For a similarly staged implementation of a tax credit, see Mark Pauly. "An Adaptive Credit Plan for Covering the Uninsured." In Jack A. Meyer and Elliot K. Wicks (eds.). *Covering America: Real Remedies for the Uninsured.* Washington: Economic and Social Research Institute, 2001, pp. 135–52.

because some coverage is better than no coverage. Phase One would set in place the accountability framework, rules, and incentives described above. Focusing on the relationship between work and coverage would help correct the misperception that the uninsured are non-workers (most are not). It also would help bind together the interests of the middle class with those who are trying to enter the middle class by making health care coverage more secure for everyone.

The focus of Phase Two is solving the problem of *under*insurance (inadequate benefits for a given health condition or income level) and enforcement of an individual mandate for coverage for all adults—explicitly shifting the burden of responsibility for having coverage to the individual. Five years after our proposed tax credits and other reforms went into effect, we propose a commission to study the impact of the credits and performance grants, to recommend changes if necessary, and, most important, to recommend whether to deny uninsured adults the personal exemption on their taxes. Because any coverage mandate must decide what level of coverage is sufficient, the commission would also need to examine the prevalence of underinsurance. Ultimately, the remaining uninsured must take responsibility for their own health coverage. But before we take that final step, we must make health insurance considerably more affordable and easier to acquire than it is today.

Assessing Performance: The Missing Link in Health Policy

A generation ago, health care financing only involved making sure people were reimbursed for their doctor and hospital bills. Indeed, the government appeared to be as capable as insurance companies of managing such a basic kind of transaction.

Today, health care is dramatically different. Scientific advances in screening and diagnostic tools, pharmaceuticals, and surgery techniques have dramatically increased our ability to detect and treat disease at its earliest stages. The possibilities for care are complex and seemingly endless. Knowledge is exploding, and no single doctor can be an expert about you, all the health problems you may face, and the many treatment options available. Health care increasingly requires patients to become active participants in their care, often involving multiple health professionals. Health care is moving from a focus on episodes of acute intervention to meeting the expanding need for care that is integrated and has continuity, especially for people with chronic conditions. In response to new knowledge and new challenges, policy makers need to let what we have termed the "new health care" flourish.[2]

The old policy levers are not working. Centralized, bureaucratic systems cannot keep track of an ever more complex care delivery system. The efforts by HMOs to control costs centrally produced a backlash, which prompted a general retreat from controls on physician and patient behavior. As an alternative, HMOs and other health plans have begun to deploy a wide variety of evolving tools that can empower physicians and patients: disease management, case management, pharmacy benefit management, self-care support, nurse hotlines, decision-support technology, provider and facility evaluations, and network contracts.

Given the growing importance of access to integrated care, especially for people with chronic conditions, health insurance, including federal and state health care programs, should consist of more than financial support for people who cannot afford health care. Such insurance must be a ticket to accessible, high-quality, cost-effective care that seeks to achieve the best possible outcome for everyone in every circumstance.

Managing an increasingly complex health care system requires a focus on performance. Performance is also a key ingredient in cost restraint because medical mistakes can be expensive, and waste cannot be identified without continuous and systematic assessment of medical effectiveness.

Both health care policy and coverage itself should be subject to ongoing performance assessment. Consider the relatively simple act of signing

[2] David Kendall, Jeff Lemieux, S. Robert Levine, and Kerry Tremain. "The New Health Care." *Blueprint: Ideas for a New Century 12* (September/October 2001): 58–59.

up people for free coverage. At a time when mortgage applications and other complex financial transactions commonly occur on the Internet, it has taken a partnership between a health care foundation and government officials in California to develop the nation's first online application, known as health-e-app, which permits community organizations and applicants themselves to check eligibility for Medicaid and S-CHIP.[3]

In areas other than health care, the federal government demands accountability from states for using federal funds. The recently enacted reauthorization of the Elementary and Secondary Education Act granted more flexibility to states and school districts in exchange for more rigorous performance measures. Formulas for performance rewards, however, need to be devised carefully. Some performance rewards in the 1996 welfare reform act have been criticized as wasteful. For example, the District of Columbia "won" a bonus for reducing teenage pregnancies for reasons that remain unclear even though it had made no efforts to do so. Performance-based grants in health care should be aimed at improvements that are not attributable to larger demographic or economic trends.

Any health care policy that runs on autopilot needs to be challenged, even when it is fairly successful. For example, health insurance tax policy—which consists mostly of excluding employer-paid insurance premiums from personal taxation—requires minimal government intervention. To be sure, the current tax exclusion for employment-based coverage has been extraordinarily successful in creating a fairly stable private health insurance system. It has created a joint public and private health care financing system that covers most Americans with virtually no public bureaucracy. But outside the occasional congressional hearing, there is no formal scrutiny of this public expenditure, which is the third most expensive federal health care program after Medicare and Medicaid. This tax policy has remained nearly the same for 55 years, despite being highly regressive, inflationary, and unfair to workers whose employers do not offer coverage; to workers between jobs; and to workers who might prefer coverage other than the health plan chosen by their employer. Tax credits can compensate for many of the weaknesses of the existing tax exclusion.

[3] See http://www.healtheapp.org/.

Expanding Coverage with Tax Credits

We propose fixed-dollar tax credits as a base subsidy to help low- to middle-income workers purchase health coverage. The maximum credits would be $1,500 for single coverage and $3,750 for a family plan for taxpayers who do not have an employer-sponsored plan, or $600 for individuals and $1,500 for families that do have employer-subsidized coverage. The higher tax credit for people without employer-sponsored coverage reflects the fact that people with employer-sponsored health coverage already get a substantial tax break under current law. In subsequent years, the tax credits would increase by the average annual increase in the premiums of plans. The credits would be refundable—that is, they would be fully available even to those who otherwise would not pay any income tax.

The tax credits would be available to people or families whose incomes fall below certain levels. For taxpayers using the tax credit to help purchase family coverage, the top income for the full credit would be $50,000 a year. The tax credit for families would phase down to zero at incomes of $75,000 and above. For people using the tax credit for single coverage, the top income for the full credit would be $25,000 a year; the credit would be available in smaller amounts for single coverage for taxpayers with incomes up to $37,500 a year. (Of course, people whose incomes are too high to qualify for the tax credit could still receive the tax breaks for health coverage already available under current law.)

The phase-out ranges for tax credits begin at levels above the point where the phase-out ranges of the Earned Income Tax Credit end. Therefore, the tax credits should not create troublesome disincentives for additional work or higher earnings. In fact, the employment focus of the proposed program is intended to strengthen the connection between working and health benefits.

Extending the tax credits to people who have coverage at work is essential for two reasons: stability and fairness. The current tax system favors employment-based coverage, especially for high-wage workers. Making substantial tax credits available only for coverage purchased in the individual market, however, would tilt the tax incentive toward individual coverage. That could destabilize the employment-based system by giving some employers—especially those with low-wage workers—an incentive to drop coverage. While individual choice of coverage is one of the goals of our proposed system, we believe it will work better in the context of group coverage.

Tax credits at the levels we propose would create a similarly sized tax benefit for coverage in either the individually purchased or employment-based market, at least for most people, which would reduce the potential for tax policy to distort decisions about where to get coverage. We believe our tax credit proposal would expand both employer-based and individual coverage.

These tax credits are designed to induce those not covered to purchase insurance and to reward those who already have coverage for making the sacrifice. Economists widely agree that employer-provided benefits are a substitute for wages or other forms of employee compensation. That is why we have proposed tax relief to people who already make sacrifices to get coverage at work, a policy known as horizontal equity. Denying tax credits to those who have worked hard and played by the rules would be unfair. Moreover, it would disrupt health care delivery as people sought to change insurance coverage in search of the highest possible subsidy.

A final design issue is whether the tax credit should be a flat dollar amount or a percentage of the insurance premium price. Each option has advantages and disadvantages, so whichever one is chosen, additional measures are needed to compensate for its weaknesses.[4] We have chosen a flat dollar tax credit primarily because it is easier for employers to administer than a percentage tax credit would be. A flat dollar credit would remain the same regardless of employee's choice of health plan, unlike under a percentage tax credit, which would require employers to calculate a separate tax credit for each employee. A flat tax credit, however, is not fair to older and sicker people because they often must pay significantly more for insurance. Our proposal for performance grants would require states to choose between requiring insurers to charge everyone the same insurance rate regardless of age or health status (a practice known as community rating) or providing supplemental subsidies for older, sicker people (or a combination of the two).

Using Tax Credits at Work

The next element of our proposal asks employers to handle enrollment in health plans and payroll deductions and adjustments for workers with health coverage—even if the employer does not pay a part of the cost.

We propose that all employees, on their first day on the job and each year thereafter, receive an enrollment form for health insurance. At the very least, the enrollment form would contain the coverage choices available under a state-arranged menu of options or purchasing group. Employees who do not select a plan and do not have coverage from another source would have to sign a form stating that their choice not to have insurance is deliberate; those forms would be forwarded to the state, which could target the worker for additional outreach efforts.

Employers that *do* sponsor coverage would deduct premiums from employees' paychecks, as they do now. In addition, they would add on to an employee's pay the tax credit for which the employee was eligible, up to the amount of the employee's share of the premium. In effect, companies would transfer tax credits to their employees right on those employees' paychecks, providing an automatic federal subsidy, and making private health insurance more affordable. The federal government would pay employers back contemporaneously, through bookkeeping adjustments in the amounts withheld and sent to the federal government for employees' tax payments. At the end of the year, the company

[4] See Stuart Butler and David B. Kendall. "Expanding Access and Choice for Health Care Consumers Through Tax Reform." *Health Affairs 18* (6) (November/December 1999): 45–57.

would show the amount added to workers' pay from the tax credit on their W-2 forms. Then workers would file for the tax credit on their tax returns, which would be the final determination of exactly how much they would receive. It is important to note that workers whose employers pay a large share of the premium are still eligible for the full amount of the tax credit for which they qualify. The credit advanced on their paychecks would be limited to the employee's share of the premium, but any remainder would be claimed through the tax filing process as described above.

Employers that *do not* sponsor coverage nevertheless would give their employees enrollment forms for at least one menu of health plans offered by a state-sanctioned purchasing group or another menu developed by the state insurance commissioner. (Those employers could provide options from other insurance companies or groups as long as they also supplied the insurance commissioner's menu.) Like firms that sponsor coverage, these employers would be required to handle payroll deduction of premiums and forward those payments to the purchasing group. They would also add back to employees' paychecks the tax credits for which employees were eligible. Again, the company would be reimbursed for the tax credits via its business tax arrangements. Health policy analyst Lynn Etheredge has shown that the cost of making such transactions is minimal, and the practice is common, given the widespread use of electronic payroll processing services for many payroll-withholding functions, ranging from taxes to pensions to charitable contributions.[5]

How would employers know whether an employee was eligible for a tax credit? The employer would not need to know precisely, because the final tax credit would be determined on each employee's individual tax return, but the employee's hourly wage could be used as a guideline. For wages below $12 an hour, employers would assume employees were eligible for the full credit for either individual or family coverage. For wages up to $18 an hour, employers could adjust employees' pay for the full tax credit for family coverage. The Internal Revenue Service could add a worksheet on the W-4 form so that employees with multiple jobs or a spouse who works could figure an appropriate amount to add to their pay. But in any case, employees taking the credit at work—as long as their wages were within the guidelines—would not be subject to interest or tax penalties on tax credits received in advance if it turned out at the end of the year that they did not qualify for the credit.

[5] Lynn Etheredge. "Health Insurance Tax Credits for Workers: An Efficient and Effective Administrative System." Washington: Health Insurance Research Project, George Washington University, 2001.

Pooling Insurance Risk and Grants to the States

Our plan would establish a federal grant program that would require the states to provide everyone who lacks employer-sponsored coverage with a menu of reasonably priced health plan choices. The menu of choices could be as formal as one offered by a purchasing group similar to the Federal Employees Health Benefits Program (FEHBP) plan or as informal as a list of insurance products compiled by the state insurance commissioner, as described above. "Reasonable" means that someone who is sick and has a low to moderate income would not have to pay more for insurance than someone who is healthy. Community rating laws would be one of several ways for the state to satisfy the requirement for reasonable prices. States could also create and subsidize local purchasing groups (similar to the federal employees plan), negotiate with local insurers for options available to everyone in the state, risk-adjust or reinsure health plans or groups with a high proportion of older or sicker enrollees, or directly subsidize high-risk residents.

The state grants would total $12 billion a year and would consist of two portions: (1) a base amount of about $2 billion, allocated to each state based on a state's population, to create and administer a menu of reasonably priced choices, and (2) a performance-based amount for the rest of the grant, which would be divided between improvements in the state's insurance coverage rates and improvements in health care quality, access, and outcomes; public health; and the adequacy of benefits

throughout the population. (The performance-based portion is described in the next section.) The state grants would not depend on matching funds from the states, as do Medicaid and S-CHIP.

Although the menu of choices is aimed primarily at people without job-based coverage, it could also benefit employers too small to offer workers a choice of health plans. States would ensure that all businesses, as well as individuals without employer-sponsored coverage, receive a menu of health plan options from at least one source each year. If, after two years, a state failed to ensure that at least one such menu was available to its residents, individuals and small employers would be able to sign up for a modified version of the federal employees' program directly. That state's grant money would go toward financing the costs of setting up and administering an FEHBP-like program.

These state grants are a critical addition to our proposal, because a tax credit by itself would not guarantee that everyone would be able to find affordable coverage in a stable marketplace. Premiums for individual coverage can be much higher than group rates offered to employers for a given set of benefits, and individual coverage may not be readily available to people with severe health problems. Furthermore, lower-income people need financial assistance at the time they purchase insurance, not after the fact, and tax credits for individual coverage cannot be provided easily in advance. (Advancing tax credits directly to individuals or their insurance companies could prompt some people to purchase nearly worthless or fraudulently marketed insurance, which would be difficult to regulate and audit. The market for employment-based coverage, by contrast, is more readily regulated and defined.)

Health insurance would become more portable with these new purchasing options. The combination of letting people switch between individually purchased policies and creation of a purchasing group that includes multiple employers would make it possible for a high proportion of individuals to keep their coverage for long periods even if they changed jobs or dropped out of job-based coverage. Another advantage of purchasing groups is that employers, especially small firms, would have an easier time offering employees a choice of competing health plans. By making good choices of coverage easy to arrange, and by boosting the tax advantage to employees, we hope a great many more employers will decide to sponsor and/or contribute to employee health insurance. Good choices of health insurance, we believe, will be a key to maintaining employee satisfaction.

Finally, unlike past proposals for purchasing groups that have met with strong opposition from some health insurers and their agents, our proposal permits alternatives that might be acceptable. For example, states could combine a menu of existing insurance products with subsidies to individuals targeted by health status, age, and income level. This approach would be more comprehensive than a standard high-risk pool, but it would not require a state to adopt community rating or to to create a purchasing group. Although we favor purchasing groups, we recognize that each state needs the flexibility to adapt federal policy to its local political culture, market conditions, and existing regulatory structure.

Health Care Improvements through Performance-Based Grants

The larger portion of the state grants would be performance-based. Of the $12 billion total, $10 billion would be divided between improvements in coverage and improvements in health care quality, access, and outcomes; public health; and the adequacy of benefits. States would have the flexibility to use the performance-based grants to expand public or private coverage or both. They would receive the funding, however, only after the uninsured rate for low- to moderate-income families and individuals has actually dropped. The funding would continue while the uninsured rate remained at that rate or decreased. The funding would be capped on a per person basis, although it could be adjusted for state-level insurance premium variations. States would not be required to match federal funding with their own funds, but they would need to file a plan with the Secretary of Health and Human Services that

describes how they intend to respond to the basic grant conditions.

The distribution of the grants would depend primarily on the degree of improvement in each state. There would be an adjustment for economic conditions so that during a recession, when some people might drop coverage, the state would continue to receive performance-based grants, despite having declining coverage rates. Such payments might only be partial, however, so that states have an incentive to keep coverage rates high even in times of economic distress.

States would be required to maintain current eligibility levels for Medicaid and S-CHIP. This requirement would prevent states from substituting the more generous funding from performance grants for current spending on Medicaid and S-CHIP, which require state matching funds.

The data required and the formulas for calculating the performance-based grants would be complex. Research is underway to develop prototypes for these formulas based on existing data, but better state-level data would be required for proper implementation.[6] The Department of Health and Human Services (HHS) would be charged with working collaboratively with an expert advisory panel to develop formulas and identify data needs. HHS and this panel would have to consider a wide range of issues, including the standards for performance that should be achieved to receive the grants, the causality of a state's action on a given outcome, the need for accountability even in the absence of clear-cut accountability, and adjustments, if any are needed, to make the measures of improvement fair across states without undermining the performance standard.

In addition, states would set aside a portion of their grants to participate in national collaborative efforts to develop and test measures of health care quality, access, outcomes, and public health. Those measures would become the basis for additional performance-based grants to states when the data become available.

One model for such a collaboration is the Child and Adolescent Health Measurement Initiative (CAHMI). CAHMI includes more than 50 state and federal agencies, consumer organizations, researchers, and health care professionals. Its work helped develop the quality measures that were mandated as part of S-CHIP.[7]

In general, performance grants would create a new bargain with the states. Instead of being financial partners with the federal government, which creates an incentive to limit access and coverage, states would focus on increasing coverage rates. Since the grants are based on success in reaching measurable objectives, not the methods used to reach those objectives, states would be free to choose whether to expand private insurance or public programs, or some combination of the two. Thus, the grants could flow into wherever coverage gaps existed in the state. Moreover, this flexibility would prevent federal policy from unintentionally destabilizing existing coverage by favoring one source of coverage over the other.

This framework of flexibility and accountability would create a wide variety of possible actions by states. They could build on the federal tax credit with a supplemental state tax credit or grant, so that low-income workers could choose mainstream private coverage at work or individually. The states could use S-CHIP funds to allow workers to buy job-based coverage for their children. Alternatively, workers could use the federal tax credit to buy into S-CHIP or Medicaid programs.

Improving the Safety Net through Performance Grants

A final condition for receiving grants is that states have a safety net that can provide coordinated outpatient and preventive care services for people who remain uninsured for whatever reason. States would specify how they intend to provide care for the remaining uninsured as part of their state plan. They would also measure and disclose the health care quality, outcomes, and health status of the

[6] The Progressive Policy Institute is researching prototype formulas for performance-based grants.

[7] "The Child and Adolecsent Health Measurement Initiative," www.facct.org/cahmi.html.

uninsured according to the same measures used to judge the performance of all health plans and providers. (The process for determining these measures is specified in the quality of care and cost restraint section below.)

Given the additional financing to cover the uninsured provided under this proposal, the current financial strain on the safety net should be dramatically reduced. That would free up resources for improving the safety net. If necessary, however, states could use a portion of the performance grants to help pay for such improvements.

An active safety net is important for three reasons. First, no matter how successful implementation of this proposal might be, there will still be a significant number of uninsured in the short term before mandated coverage takes effect, and a small number of uninsured in the long run made up of those who slip through the cracks for one reason or another (including being underinsured). Second, the existing entitlement to emergency room care creates a perverse incentive for the uninsured to seek non-emergency care in a very high-cost setting. Third, opportunities for health improvement are often greatest among those who do not have regular access to care.

One way for states to improve the safety net is to give the uninsured the same opportunities that are available to the insured. For example, the uninsured could be given access to a health care services discount card, and/or obtain low-interest health care credit cards. Otherwise, they will have to pay high retail prices because they do not have a health plan that negotiates wholesale prices on their behalf. Some areas of the country have created networks of doctors to function as a health plan for the uninsured. For example, in Asheville, North Carolina, low-income uninsured residents qualify for such a network.[8] Physicians donate their time, and hospitals cover the cost of prescription drugs, thus realizing savings from eliminating preventable hospitalization that has turned into bad debt.

States that maintain high-quality care for the uninsured through community health networks would be rewarded through performance-based grants. First, participants in such care systems may identify themselves in surveys of the uninsured as having coverage, thereby letting states qualify for a coverage bonus in the performance-based grants to the states. Improvements in health care quality for the uninsured would also be rewarded through the peformance-based grants.

The Critical Role of States

Why give the states such a significant role with such wide-ranging responsibilities? Successful political movements to increase coverage rates have occurred in only a handful of states. Still, states like Minnesota, Oregon, Massachusetts, Rhode Island, Wisconsin, and Tennessee have provided inspiration (and hard-won lessons) by demonstrating what is possible and what is problematic. Many states want to do more, and have done so with S-CHIP, which gives them more flexibility than Medicaid. But they are frustrated in general by the complexity of federal policies and their own lack of resources. Indeed, the success of high-performing states has been partly due to federal waivers from Medicaid regulations, and such states are likely to be enthusiastic about taking greater responsibility for achieving results.

States that have not yet responded aggressively to federal incentives to cover the uninsured through Medicaid and S-CHIP will likely be energized by a new relationship with the federal government. Performance grants would let state-elected officials take credit for covering the uninsured with little or no additional financial responsibility as long as the state maintains its current eligibility levels for Medicaid and S-CHIP.

A requirement for states to maintain eligibility may seem unfair to some states that already have gone well beyond minimal federal requirements for coverage in Medicaid. Presumably, however, these states have already realized the benefits of their past expenditures. And given that high-spending states will likely want to continue to be leaders, performance grants will give them a new opportunity for more progress and acclaim if they achieve near-uni-

[8] Fran Carlson. "What Works: Pooling Resources for the Poor." *Blueprint: Ideas for a New Century 6* (Spring 2000): 28.

versal coverage ahead of the national schedule anticipated by our proposal. Still, equitable sharing of federal funds will be an issue and should be debated, along with remedies for abuses of the disproportionate share program and other Medicaid loopholes.

Another reason to give states a key role is the issue of regulating insurance rates. Setting an adequate subsidy for insurance requires that the subsidy be related to the cost of insurance. Regulation of insurance rates ranges widely from state to state, from pure community rating in New York to full-risk rating in other states. That makes it difficult at best to set a fair federal subsidy. By aiming the tax credits toward job-based coverage, we have minimized, but not eliminated, some of the individual variation in pricing workers face. As long as states have the primary responsibility for regulating insurance rates, they also need to be responsible for ensuring that all residents can afford coverage.

Of course, the federal government could preempt state insurance regulation. We believe, however, that a political consensus on insurance regulation is far less likely, at least in the short run, than a consensus on financing coverage.

It is important to note that returning insurance regulation completely to the states is also unlikely. Large employers avoid state insurance regulations by self-insuring under the Employee Retirement Income Security Act (ERISA). At the same time, large employers have achieved near universal coverage for their workers and families. Indeed, many large employers require employees to show proof of other coverage before they are allowed to decline the company's health benefits.

Interaction with Medicaid and S-CHIP

The performance grants are designed to give states neutral choices in expanding coverage through government programs or tax credits. Some analysts would prefer to favor one or the other. We believe that it is critical to blend the advantages of both approaches in a framework of flexibility and accountability.

The biggest advantage of Medicaid and S-CHIP is that they deliver an appropriately rich set of benefits to individuals targeted by income. These programs avoid the problem of benefits that are too rich for the general population.

The biggest disadvantage of these programs is the lack of accountability for performance. States that comply with federal rules are eligible for funding, but there are few guarantees that beneficiaries will actually get coverage or access to care. For certain populations, such as pregnant women and children, states are mandated to offer coverage. But access to care is not guaranteed, because there is no common yardstick for measuring it. Many states pay health providers very little under Medicaid, which restricts access to and choice of providers. While some providers are willing to accept such low payments because they consider it part of their mission or professional duty, mainstream providers have a substantial incentive to shun or severely limit acceptance of Medicaid patients in low-payment states.

Another problem is that optional expansion of Medicaid and S-CHIP varies widely. Some states simply take greater advantage of federal funding than others, which is inequitable for people who live in the states that skimp.

A related problem is that the per capita spending levels vary widely by state, with results that range from inequitable to abusive. The most notorious example is the disproportionate share program, which is supposed to compensate states with high rates of uninsured, but, instead, is sometimes used by states to fund non-health care portions of the state budget.

If tax credits and S-CHIP were to evolve side by side, many new possibilities might emerge. People would have the chance to bundle funds that might be available from multiple government programs to help them buy one insurance policy. For example, families whose children qualify for S-CHIP coverage would have a choice: Parents could use S-CHIP to cover their children and then use the tax credits to help purchase employer-based or individual coverage for themselves. Or they could combine the money from the tax credit with additional funds from the S-CHIP program to purchase one health policy for the whole family. In the latter case, S-CHIP rules would apply to any purchases of private

insurance that were supported by S-CHIP funds. If necessary, the caps on federal outlays for S-CHIP could be raised to accommodate this new option.

Possible State Uses of State Grants and Tax Credits

By focusing on states' performance instead of on program design, the federal government can create a wide range of options for state action. Such flexibility is critical, given the variation in the states' political cultures and the difficulty of achieving consensus and coalitions that can drive change. As mentioned earlier, the performance grants set four key conditions for each state: (1) funding is directly linked to lowering the rate of uninsured, with adjustments made for adequacy of coverage levels by income, evenly distributed gains in coverage across age and health status groups, and economic and social factors that are beyond the control of the state's health care system; (2) additional performance-based grants are awarded for improvements in the population's health status and for the quality of care; (3) a menu of choices must be available to every person without employer-sponsored coverage at a reasonable cost; and (4) a safety net must be in place that guarantees access to primary care and coordinated specialty care for chronic illnesses. Some of the ways states might respond to these conditions follow.

Subsidized purchasing groups. Purchasing groups can offer community-rated insurance premiums without disrupting the existing insurance market. Some states may want to ensure broad access to coverage through community rating, but might not be able to enact community-rating regulations, as New York has done. The performance grants would give states funding to ensure the success of purchasing groups under that circumstance. The funding would be used to subsidize premiums in the purchasing group, whose lower community rate for older, sicker people would draw some of them away from the small-group or individual markets. States would have to watch carefully to ensure that insurance rates stabilized in *and* outside the purchasing groups after an initial adjustment period. If need be, a state could impose some restrictions on how often people could join the purchasing group, so that when they got sick, they could not immediately join the purchasing group to get lower rates and thereby drive up premiums, which could cause a spiral of ever-rising premiums due to adverse selection. In any case, community-rated insurance premiums would be the most direct way to ensure that the flat amount of the federal tax credit was as valuable to the sick and old as to the young and healthy.

High-risk pools. States that prefer to avoid community rating could use the performance grants to target subsidies at people with higher health risks. A high-risk pool is an example of targeting people who have been turned down for insurance and, therefore, are deemed to be uninsurable. A majority of states have high-risk pools, but many of them are underfunded. Performance grants offer a new source of financing high-risk pools, but high-risk pools by themselves would not be sufficient to ensure equitable access to coverage and care. States would need to offer subsidies targeted to older, sicker, and lower-income people who are nonetheless insurable. This could be done through supplemental tax credits or payments directly to insurers on behalf of workers or individuals who qualify for assistance.

Expanding public programs. Another general approach would be for states to use the performance grants to expand Medicaid and S-CHIP. The base level of funding of performance grants could be used to increase provider payment rates under Medicaid and S-CHIP to increase beneficiaries' access and choices. Such performance-based funding would allow program expansion without a state match. The challenge for such expansions would be to connect the uninsured who are mostly workers and their families to public programs. One way would be to work with employers to help with outreach and enrollment. States like Wisconsin and Massachusetts have already taken steps in that direction. States also could use public programs to supplement employer-based coverage, which would ensure adequate coverage for lower-income workers, which, in turn, would be rewarded as part of the performance payments. Such a policy direction

could lead to a seamless integration of state and private purchasing and coverage.

Civic ventures to boost coverage rates and improve public health. Having health insurance is a seldom-promoted public health message. As obstacles to coverage diminish under this proposal, a sense of personal responsibility will increase. Indeed, part of creating a dynamic approach to health policy is recognizing that the commitment to and importance of health insurance must be renewed continuously as a public mission. Just as with public health campaigns like the one against cigarette smoking, the nation's civic capacity should be tapped for this mission. For example, the AmeriCorps program could be a source of organizing support for small businesses and individuals to obtain health care coverage. Just like the many volunteer tax advisors at seniors' centers, AmeriCorps's "enrollment advisors" are needed to help people with complex health insurance issues. A similar kind of effort can work in other areas of public health as well. For example, Massachusetts uses AmeriCorps to promote health and prevention in low-income communities, where the need for reliable information and connections to personalized health resources is greater and less likely to be met.[9]

Financing and Budgeting

The cost of this proposal will be significant, as would any other major effort to reduce the number of uninsured. Much of the cost would be for tax credits, but a significant amount ($10 billion to $12 billion a year) would be appropriated for performance-based grants to the states.

Not all of the costs of our proposal should be considered new spending on health care, however; a significant portion amounts to tax relief for low- and moderate-income families who are already struggling to afford health insurance. Furthermore, the cost to the government does not include any potential savings from reductions in health premiums for people who already have coverage.

Although covering the uninsured through tax credits is expensive, it could reduce costs for those who already have insurance, because most of the uninsured are relatively young and healthy. Adding them to large insurance pools would reduce the average premium for the group. Furthermore, uninsured people usually get at least some treatment if they are ill or injured. The costs of that care are spread to government programs and to those with insurance, sometimes directly and sometimes in subtle ways. Therefore, reducing the number of uninsured would allow governments and insurers to reduce the portion of their payments that essentially subsidize hospitals and doctors for treating those who cannot pay.

There are a host of financing possibilities, many of which are not health-related and, therefore, difficult to prioritize. Health-related revenue raisers that are worth mentioning include alcohol and tobacco taxes and a tax cap on the tax exclusion for job-based coverage, which would also help to restrain costs by ending subsidies for expensive and inefficient health plans.

Mandatory Coverage

The new tax credits, combined with the current S-CHIP program and other initiatives, should eliminate any excuse for children going without health coverage. All but seven states have enacted eligibility for S-CHIP coverage for up to 200 percent of poverty.[10] The performance grants would ensure that all states have the necessary additional funds to make child coverage affordable for all families. Furthermore, families could also get tax credits to finance their children's health care coverage. Given that level of affordability, we recommend requiring that all children be covered within three years of enactment of our proposal.

Enforcement of this requirement would deny parents of uninsured children the personal exemption for those children they list on their tax forms. That would barely penalize parents in the lowest tax

[9] See "Health Services Corps." Washington: Democratic Leadership Council, July 7, 2001, http://www.ndol.org/.

[10] Kaiser Family Foundation State Health Facts Online, http://www.statehealthfacts.kff.org.

brackets—for whom the personal exemption matters little to their final tax bill—but it would have an important symbolic impact (and a real financial impact on middle- and upper-income families that chose not to cover their children). Public and private health plans would be required to make available to the IRS their lists of enrollees for verification purposes.

Even with tax credits and convenient group-purchasing options, some adults still may choose to remain uninsured. However, that choice places a burden on the rest of society, which must pick up the tab when uninsured people are hospitalized or need extensive medical care. For that reason, and to promote the public health, society has an interest in prodding all Americans to protect themselves with health care coverage.

Under Phase Two of our proposal, about five years after initial enactment, a commission would be established to study the impact of the credits, recommend changes if necessary, and, most important, recommend whether to deny adults who remain uninsured the personal exemption on their taxes.

Benefits

Phase Two of our proposal would also include an assessment of the problem of underinsurance. There are two reasons to believe that the problem would have been partially solved during Phase One, however. First, group insurance tends to produce a wide scope of coverage because it must satisfy a range of health care needs. Second, states would be rewarded through performance grants for ensuring that everyone has coverage, especially older people, poorer people, and people with chronic health conditions. Still, since subsidies for the non-poor require some sharing of premium costs, there is a chance that people may skimp on their benefits beyond a reasonable level of risk taking.

Furthermore, states might be tempted to allow the sale of insurance with substandard benefits as a way to increase coverage of the uninsured as cheaply as possible, and possibly draw down significantly more performance-based grant income than it cost the state to cover the uninsured. That is why the performance grants must be based on health care quality, outcomes, and access to care; public health; and adequacy of benefits in addition to coverage rates. States that allowed substandard benefits, or whose public programs effectively funneled enrollees to low-quality providers, would not show as much improvement in these other areas as states with better benefits and better-paid health providers.

The important point here is not to overanticipate problems, but rather to prepare a range of innovative solutions, test them, review their impact, and adjust them to sustain progress toward achieving a set of pre-determined goals. For that, the federal government, the states, and the public will need good information about benefits provided over time and across regions of the country. Therefore, we propose a new federal commission to study health benefits, including current benefit practices, the cost and clinical appropriateness of benefits, the extent and nature of benefit mandates (specific benefits that are required by law or regulation, either nationally or locally) and their cost and clinical effectiveness, and so on. Benefit controversies are certain to continue to drive the health care debate as new technologies and treatments confront concerns about affordability and access to health care. Solid data on what is happening across the nation, the actual measured health impact of certain benefits, and what the trade-offs are will be more essential than ever.

A Health Information Network

The real-time exchange of personal health information and medical records is critical to the delivery of safe, high-quality, cost-effective health care. The federal government needs to take a more active role in encouraging the formation and optimal use of a secure health information network, and in helping to build public confidence in such a network.

The benefits of systematic data collection, aggregate analysis, and health information exchange will be felt throughout the health care system. A health information network also may provide a platform for the creation of "personal health accounts" through which the uninsured (and insured) can learn about their eligibility for assistance with obtaining cover-

age, "bank" benefits from multiple sources, and use these various subsidies to purchase plans best suited to their needs. The network also can become the secure means through which patients can communicate with their providers and plans and the world's health knowledge base, helping them to gain access to best practices in care opportunities as well as providing a convenient means to resolve disputes.

By having a rich flow of information about health care and health outcomes, caregivers and researchers can develop greater understanding of what is effective. Additional benefits include better communication between doctors and patients, more customization of care based on patients' needs and preferences, fewer medical errors, low-cost assessment of provider performance, and a more finely honed sense of the value of health care and the need for coverage for that care.

Ongoing federal efforts have focused on setting standards for transmitting data, including privacy protections as part of the Health Insurance Portability and Accountability Act (HIPAA). The core problem in setting such standards is effectively linking together different sources of data on individual patients and populations, and providing this information to those who need to know, when they need to know it, and in a fashion that respects the interests and privacy expectations of individuals while contributing to the enhancement of individual and population health outcomes. The key problem is not technological; software solutions are widely available. The problem is how to create trust in a system that handles the most personal information about individuals.

Privacy protection requires more than the passive legal protections that are part of HIPAA. It requires a dynamic system that continuously assesses and customizes each person's preferences and privacy needs. For example, AIDS patients, who often understand the benefits of participating in clinical trials in exchange for timely reports on results, may be surprisingly willing to share personally identifiable data electronically if they know they can choose the security system themselves and control and audit who has access to their information. This example is not hypothetical, but is an actual research project at the New England Medical Center.[11]

The federal government should encourage and take part in cooperative health information network development ventures that seek to build public trust. The Patient Safety Institute (PSI) is one example.[12] PSI is designed to engender trust by giving patients control over their medical records, and by a board of directors that is controlled equally by representatives of patients, doctors, and hospitals. Such networks can provide patients the tools they need to gain the comfort and control necessary to benefit fully from sharing personal health information. Patients need that comfort and control to allow information about themselves from multiple, disparate sources (including information they themselves can contribute) to be linked. Performance-based grants would encourage states to adopt such networks that produced measurable improvements in health care quality.

Quality of Care and Cost Restraint

To improve quality *and* restrain costs, we propose a federal information clearinghouse—patterned after the Securities and Exchange Commission (SEC)—that would report on health quality and outcomes, not just in health plans, but also among individual health providers, including hospitals and physician groups. Comparative information would help consumers make good choices and allow consumer advocates to make sound recommendations. It also would create new incentives for quality improvements in the health industry.

As envisioned by the Jackson Hole Group, the role of an SEC-like organization would be to require disclosure of performance information about health plans.[13] The standards for measurement would apply to public and private health plans as well as to safety

[11] Brad Miskell. "If Silence = Death, Will Numbers = Answers? Information Activism on the Net." *Journal of the International Association of Physicians in AIDS Care* (December 1998).

[12] See Patient Safety Institute, http://www.ptsafety. org.

[13] Paul Ellwood, Alain Enthoven, and Lynn Etheredge. "The Jackson Hole Initiatives for a Twenty-First Century Health Care System." *Health Economics 1* (1992); see also Regina Herzlinger. "Protection of the Health Care Consumer." Washington: Progressive Policy Institute, March 1, 1999.

net providers who care for the uninsured. Unlike the ongoing evolution toward tougher corporate accounting standards, a health care SEC would be launched with tough standards from the start.

Some progress has already been made through the National Committee for Quality Assurance, and, more recently, provider-level performance information is becoming more common. For example, auto companies and unions have joined to provide workers with online ratings of local hospitals.[14] Another example is Medicare, which has contracted with the National Quality Forum, a broad-based membership organization, to develop extensive quality indicators for nursing homes. Basic information on the quality of nursing homes, health plans, and dialysis centers is currently available at www.Medicare.gov.

Assessment of health outcomes and health care safety are key parts of the performance-based state grants program. Not only would such measures focus state governments on collective actions for improving quality (for example, public investments in health information exchange), they would also spur states to require providers and facilities to report their performance so the states can devolve responsibility for quality where appropriate.

Working in conjunction with the National Quality Forum and other interested parties, the Department of Health and Human Services, which would oversee the performance grants, should envision an "ideal" of where quality measurement should be in five years; determine what can be accomplished first; and take steps to build the infrastructure, culture, and responsibility for moving toward the ideal.

Quality measurement is critical for cost restraint. Without systematic quality assessment, cost restraints risk being penny-wise and pound-foolish or a shell game of shifting costs from one part of health care to another.

Finally, by expanding choices, competition, and information for health care consumers, our proposal would create the framework for tougher measures to restrain costs, such as limits on open-ended subsidies for health care coverage through the tax code.

[14] "Hospital Profile Consumer Guide," www.hospitalprofiles.com.

Political Challenge

As health care costs rise, so does insecurity about coverage. People will lose part or all of their health benefits or they may hear about others who do. This insecurity gave rise to the health care debate in 1993 and 1994 as well as earlier debates.

While coverage for the uninsured is an appropriate response to this feeling of insecurity, it is neither a complete nor an all-encompassing response. While people may feel more insecure, they also realize that reform could make the situation worse. That is what caused the public to reject President Clinton's proposal, even in the face of wide support for universal coverage. The harsh truth is that Americans—most of whom had coverage—were not prepared to risk what they already had to achieve universal coverage for someone else.

That is why any expansion of coverage to the uninsured must minimize disruption to people with existing coverage. Our proposal, for example, would not undermine job-based coverage by eliminating the tax exclusion. Instead, it would expand the use of tax policy to help the uninsured through tax credits. It would not eliminate or fold Medicaid and S-CHIP into larger programs, but, rather, encourage states to make government programs work in concert with private-sector choices.

Finally, our proposal would facilitate broad political support by expanding public financing through each of the three key health care markets: individually purchased coverage (favored by conservatives), job-based coverage (favored by centrists), and state-based government programs (favored by liberals). A broad coalition is necessary, not so much to reach a consensus at the beginning of debate, but to ensure there will be enough common ground to bring people together at the end of debate.

Conclusion

The pursuit of universal coverage should be a national mission to unleash the energy needed to build support for legislation and to make sure the job gets done after enactment. A performance-based system plays to the strengths of each element of the

health care system. The federal government is best equipped to provide significant funding for the uninsured and to catalyze creation of the basic infrastructure for health care purchasing and health information exchange. The states are best at working with local health care markets and ensuring that no one falls through the gaps between public and private health care systems. Employers are best equipped to be the registrars and transfer agents for expanded health coverage because they already serve that role for taxes, pensions, and other types of insurance. Finally, all Americans must assume final responsibility for their own health care coverage and that of their family, once the opportunity to obtain coverage has greatly improved.

The political battles over health care are often waged as if a single act of Congress could solve the problem of health care coverage once and for all. Health care financing is too closely linked to health care delivery, however, to expect a single policy on coverage to be valid for very long. For example, Medicare has failed to develop a prescription drug benefit because action depends on Congress, while most private health plans have a prescription drug benefit to answer consumer demand. Still, it would be a mistake to expect minimalist government intervention to set the nation on a course toward universal coverage. Instead of pursuing the false promise of a one-time universal entitlement "solution," or acting on a false belief in the "invisible hand" of the market, health policy makers should embrace a dynamic process of systematic, ongoing assessment and revision of policies to achieve the desired outcome. Universal coverage is a mission that should succeed or fail based on its impact on the lives and health of everyone in the United States. ■

Miller Proposal

Key Elements

Tom Miller has provided a detailed blueprint for a reformed health care system that would try to promote efficiency and economy by re-designing incentives, especially by assigning more responsibility for health spending decisions to individual consumers and less to third-party payers. The plan would put more emphasis on achieving access to health services than on expanding insurance coverage. It includes the following elements:

TAX CREDITS AVAILABLE to everyone that could be used to purchase high-deductible insurance coverage.

GREATER EMPHASIS ON EXPANDING the safety net system as an alternative to covering all of the uninsured.

IMPROVED FUNDING FOR and accessibility to high-risk pools.

GREATER FLEXIBILITY in health insurance regulation, provided by promoting inter-state regulatory competition to attract insurers.

CHANGES IN THE INCENTIVES that now encourage choice of employer-based coverage over individual coverage.

TAX INCENTIVES TO ENCOURAGE voluntary contributions to agencies serving the uninsured.

About the Author

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Improving Access to Health Care without Comprehensive Health Insurance Coverage: Incentives, Competition, Choice, and Priorities

by Tom Miller

Vision

A reformed health care system would restore control of health spending decisions to the individual consumer and reduce the role of third-party payment for ordinary health care expenses. Third parties would compete in private markets to be agents of consumers, rather than maneuvering through the political system to acquire their own shares of health care spending. Health care would be decentralized, depoliticized, diverse, and dynamic. When health care is delivered in this manner, it will be less expensive, more accessible, provide greater value, and better match the needs and preferences of individual consumers.

Market-based reform begins with more neutral tax treatment of health insurance purchasing options, emphasis on protection against major risks, and deregulation of health care suppliers. Instead of more regulation and litigation, such reform restores the vital role of voluntary contracts and market prices. It also:

- reintegrates public program beneficiaries into the choices offered by the private, competitive health care system;
- accelerates the transition from the current set of defined benefit group health plans controlled by employers and government agencies to defined contribution health financing that responds to individual consumers' needs and preferences;
- harnesses the potential of greater convergence between health care financing and financial services; and
- facilitates the consensual flow of health information.

Overview of Major Objectives

Improving health outcomes and health status for lower-income individuals should be the primary goal of health care system reform. Increasing health insurance coverage levels per se remains at best an imprecise tool of limited effectiveness in achieving that objective. It may well be more efficient, on balance, to selectively target expansion of safety net care than to subsidize expansion of conventional health insurance coverage to reduce the number of uninsured Americans.

To achieve better health outcomes, we need to provide individual health care consumers with stronger incentives to be cost-conscious in using scarce medical resources. Making the market-based cost of care more transparent to all parties involved in health spending decisions will encourage its more efficient consumption and delivery. Reducing the long-term rate of growth in the cost of health care remains more important than (and, beyond a certain point, operates at cross-purposes to) expanding the scope and scale of subsidized health insurance coverage. Health insurance subsidies increase not just the demand for health care but also the total *cost* of health care, creating net welfare losses estimated at 20 percent to 30 percent of total insurance spending.[1] In the opposite direction, access to "free" care dampens the demand for private health insur-

[1] Martin Feldstein. *Hospital Costs and Health Insurance.* Cambridge, MA, and London: Harvard University Press, 1981, pp. 99, 201–03, 239–44; Martin Feldstein. "The Welfare Loss of Excess Health Insurance." *Journal of Political Economy 81* (2) (1973): 251–80. See also Edgar A. Peden and Mark S. Freeland. "A Historical Analysis of Medical Spending Growth, 1960–1993," *Health Affairs 14* (2) (1995): 236–47 (finding that about half the growth in real per capita medical spending from 1960 to 1993, and two-thirds of its growth from 1983 to 1993, resulted from either the level or growth of insurance coverage).

ance.[2] In striking the necessary balance, the net effects of comprehensive third-party insurance (raising costs and thereby limiting access to health care) substantially outweigh any disincentives to obtain insurance protection that may be caused by direct provision of charity care. When rising health care expenditures outpace wage increases, their strongest effect is to reduce health insurance coverage for low-income workers.[3] Hence, at the margin, increasing incentives to purchase less-comprehensive health insurance and filling in urgent gaps in direct delivery of health care through safety net mechanisms may produce more affordable and accessible health care.

Target Population

To expand access to health care, we should focus primarily on the working uninsured (and their dependents): those workers who currently decline the employer-sponsored insurance coverage offered to them, workers in smaller firms that do not provide insurance coverage, workers prone to frequent job turnover and short-term employment, and self-employed individuals. Other targets would include Medicaid-eligible individuals who currently decline such coverage, State Children's Health Insurance Program (S-CHIP)-eligible families that currently decline such coverage, and workers dissatisfied with the terms of their existing employer-sponsored coverage. A market-based reform approach for *all consumers* would not only reduce the future cost of health care (that is, at least lower its rate of growth), but also improve its quality through enhanced accountability to purchasers in a more competitive, value-conscious environment.

Expanding Access to Care by Empowering Workers with Better Incentives and New Options

This proposal would rely on new incentives, rather than explicit mandates, to expand availability of market-enhancing health care options. Rather than destabilize current arrangements, it would structure a menu of alternatives that trade off somewhat lower subsidies in return for greater choice and flexibility, more economizing opportunities, and long-term sustainability. The tools include a new tax credit option available to purchasers of non-employer-group, high-deductible insurance; medical savings accounts; defined contribution health plans; voluntary purchasing pools; a competitive federalism approach to insurance regulation; and a strengthened safety net system that includes federal subsidies for high-risk pools and tax incentives for charitable contributions to non-profit providers of safety net health care.

Tax Policy—Moving toward Parity

The primary vehicle for accomplishing various market-strengthening reforms that lower future health care costs and expand access to health care would be a new federal tax credit option. The tax credit would amount to 30 percent of the cost of qualified insurance coverage (see "Subsidies," below, for an explanation of why that specific percentage was chosen). Essentially, individuals could subtract this portion of their insurance costs directly from their federal income tax liability.[4]

The tax credit is an *option;* it would not eliminate the current tax exclusion that is available for workers insured by employer-sponsored insurance (ESI) plans. (A similar federal income tax deduction also is available on a partial basis—70 percent of the

[2] Bradley J. Herring. "Does Access to Charity Care for the Uninsured Crowd Out Private Health Insurance Coverage?" Yale University Institution for Social and Policy Studies working paper. September 7, 2001; Bradley J. Herring. "Access to Free Care for the Uninsured and Its Effect on Private Health Insurance Coverage," Dissertation on Health Care Systems, University of Pennsylvania, 2000.

[3] Richard Kronick and Todd Gilmer. "Explaining the Decline in Health Insurance Coverage, 1979–1995." *Health Affairs 18* (2) (1999): 30–47 (observing that "persons with few assets to protect will get no greater benefits from insurance when health care prices are higher than when they were lower... .").

[4] It would be approximately comparable to "excluding" from one's income that is subject to federal income taxes and federal payroll taxes an amount equal to what one spends on qualified private insurance coverage in a given year—except that rather than applying one's marginal federal tax rates to the excluded amount to determine one's net saving on taxes, a taxpayer would reduce his net federal income tax liabilities by 30 percent of that amount.

cost of qualified health insurance—for the self-employed, and it will become 100 percent deductible from federal taxable income in 2003.) Instead, it would provide a competitive alternative to the tax exclusion for those workers to opt for in place of the tax exclusion. It would encourage a more gradual transition toward other forms of private insurance coverage. Workers who choose to enroll in an ESI group plan would continue to use the current tax exclusion. Employees who choose to decline ESI coverage and not take advantage of the current tax exclusion could use the tax credit option instead to purchase other forms of health insurance coverage.

The tax credit also would be made available to other individuals and families that currently do not qualify for the tax exclusion because they lack access to employer-sponsored insurance coverage. The tax credit option would move policy closer to tax treatment parity (horizontal equity) for those workers and other federal taxpayers with non-ESI coverage.

Employers that continue to provide ESI coverage would be required to report the value of the employer-financed share of that coverage to individual employees on their regular periodic pay statements and annual W-2 forms. In the event that employers were not allowed to charge different employees different prices for their share of group insurance coverage (that is, no repeal of the non-discrimination rule for health status under the Health Insurance Portability and Accountability Act), employers would report the periodic equivalent of the per-employee Consolidated Omnibus Budget Reconciliation Act (COBRA) premium, minus the administrative charge allowed for COBRA. Disclosure of this information would assist individuals in choosing between the tax benefits of the current system and those provided by a new tax credit option.

The new 30 percent tax credits would be assignable (to insurers providing coverage). They also would be advanceable, in the sense that an eligible taxpayer purchasing health insurance could receive a 30 percent tax credit "discount" at the time of payment. In the event that an eligible individual wished to pre-pay his or her health insurance premiums for periods beyond a month and up to a full year, the individual could receive the full 30 percent credit up front and apply it to those insurance premiums. However, the maximum tax credit available for any eligible individual would be no greater than that individual's total federal income tax and Federal Insurance Contributions Act (FICA) tax liability (including both the employer and employee shares of the payroll tax) for the previous calendar year. In other words, only taxpayers would receive tax credit "relief" for health insurance costs.

Because the maximum amount of an advanceable tax credit is determined by an individual's tax liability for the previous year, concerns about year-end reconcilability (to recapture excess tax credit payments relative to annual taxable income) should be reduced. Nevertheless, it may be necessary to ensure more predictable tax relief for individuals with fluctuating amounts of annual taxable income. If these latter individuals choose to use the tax credit option, then they also would be allowed to use three-year income averaging for federal income tax returns (subject to maximum annual taxable income eligibility caps, to limit excessive tax arbitrage). Such income averaging also would help individuals adjust the maximum amount of their tax credit for a given year, to deal with unusually higher health insurance expenses.

Even if an employer were no longer "paying" directly for an employee's insurance coverage under an employer-sponsored group plan, the employer still could facilitate delivery of health tax credit assistance through several mechanisms.

An employer could choose to include in an employee's gross wages an amount equivalent to what the employee otherwise would have received as the non-taxable employer's contribution to the employee's applicable share of any group coverage offered under the employer's health benefits plan.

An employer could "list bill" and allow employees using the tax credit option to pay their individual insurance premiums through payroll deduction (that is, an insurer bills the employer for a list of designated employees who have opted for non-employer-sponsored coverage). In the latter case, the workers would bear the entire premium, but apply their tax credit to reduce the net payment due.

An employee could request that the employer adjust income tax withholding, to reflect the likely value of the health tax credit.

An employer and his or her employee simply could renegotiate a new salary level (reflecting non-participation in the employer-sponsored group plan and the accompanying non-use of the tax exclusion) and let the employee pay insurance premiums and use the tax credit on his own.

The net effect of these reforms would be to encourage workers and their families either to move from employer-based coverage to individually purchased insurance, or to ensure that the ESI coverage they select represents the best competitive value they can find.

To be eligible for this tax credit option, employees and other individual health care consumers must purchase an insurance package that covers a minimum set of health services and includes a minimum, but significant, front-end deductible. The minimum covered services would be defined as those health services covered by the local market area's least expensive plan for federal workers under the Federal Employees Health Benefits Program (FEHBP) or the particular state government's least expensive health plan offered to its employees. Insurers could offer a wider variety of benefits at higher prices, but all plans eligible for the tax credit must be catastrophic plans, that is, they must include a minimum deductible level and a maximum out-of-pocket (stop-loss) level. A likely figure for minimum deductibles for single coverage might be the lower of $2,000 or 5 percent of taxable income. The likely maximum stop-loss level (the maximum out-of-pocket cost) would be the lower of $5,000 or 10 percent of taxable income.[5]

Of course, eligible plans could set even higher deductible levels, or lower stop-loss levels, as long as the two paths did not cross (that is, the stop-loss level could not be lower than the deductible).

Funds available through the tax credit could not be used to purchase more comprehensive insurance coverage with less cost sharing (that is, with deductibles below minimum levels). Insurers selling more comprehensive coverage to individuals using tax credits first must offer them a separately priced policy at the same time with deductible and stop-loss levels that comply with catastrophic coverage cost-sharing limits.

However, individuals using health tax credits for insurance coverage also could make other tax-advantaged contributions to individual health savings accounts, with a choice of two types of tax treatment.

1. *Pre-tax, regular individual retirement account (IRA)-style tax treatment.* Contributions would be deductible/excludable against federal income and payroll taxes, with tax-free inside buildup on investment income, until they are withdrawn. If withdrawn for Internal Revenue Code (IRC)-eligible health spending purposes before the recipient is age 65, they would be subject to federal income taxes and deferred collection of federal payroll taxes only to the extent of the original amounts contributed (that is, no tax recapture of the inside buildup of investment income). Withdrawals of funds before age 65 for other purposes would be fully subject to federal taxes. At age 59½ and later, accumulated funds could be rolled over tax-free into individual IRAs or into contributions to Medicare medical savings accounts (MSAs).

2. *Post-tax, Roth IRA-style tax treatment.* Post-tax contributions would receive inside buildup on investment income, with no further taxes on any withdrawals for IRC-eligible health spending purposes. No additional federal taxes would be imposed on the applicable investment income share of any non-health withdrawals, as long as an individual, after any such withdrawals, still retained funds in the health savings account that equaled or exceeded 75 percent of the applicable annual deductible in any accompanying qualified insurance policy.

Deposits to an individual health savings account for any single year could not exceed the amount of

[5] Minimum deductibles and maximum stop-loss levels, of course, would be higher for family coverage. Adjusted gross income for the previous federal income tax filing year would provide the most likely measure of one's "taxable income." There is a trade-off between administrative simplicity and sensitivity to ability to pay in setting minimum deductible levels and maximum out-of-pocket cost limits. Pegging such levels to vary with adjusted gross income would require private insurers either to offer a wider range of deductible and stop-loss levels or to become more engaged in monitoring income levels of their customers. On the other hand, simply setting a single, fixed numerical level for minimum deductibles or maximum stop-loss limits would undershoot or overshoot the financial ability of many customers to handle them.

the annual deductible in one's accompanying qualified insurance policy.

Using the Tax Credit Option to Leverage Other Reforms

Health insurance coverage purchased with funds from the federal tax credit would have to meet several additional criteria. Such policies would have to provide a separately priced guaranteed renewal option (but they would be otherwise exempt from HIPAA's guaranteed renewal requirements for other group health care plans). They would be exempt from individual state benefit mandates.[6] When approved, either by the insurance department in a state in which the issuing insurer is both domiciled and receives at least 25 percent of its total health insurance premium revenue, or by a "default" federal health benefits regulator at the Department of Labor, any such insurance policy would have to be given reciprocal approval in any state in which an individual purchaser chooses to purchase that policy. The default federal regulator would charter nationwide high-deductible catastrophic care policies in the event that individual state regulators failed to approve them.

Health insurance coverage purchased with federal tax credits could also be provided by voluntary purchasing pools that meet certain minimum criteria that include capital and solvency requirements. Such pools would have to provide annual open seasons and be open to all willing purchasers who use the health tax credit option.

Purchasing pools have the potential to provide an efficient mechanism for workers to gain a wider choice of health plans than many employers (particularly smaller ones) can offer on their own. Indeed, they may provide effective alternatives to poorly performing employer-selected health plans. For that reason, pool participation should not be limited just to business firm buyers making collective decisions for all their employees. Membership in "voluntary" purchasing pools should reflect the preferences of individual workers and other health care consumers, not just the interests and convenience of employers.

The role of purchasing pools would be to provide a single, stable source of ongoing coverage. They would ease the burden of choosing and buying coverage, particularly for people seeking insurance without the assistance of an employer. Pool administrators would help design benefits packages offered to individual pool participants. They would negotiate contracts and premiums with the health plans choosing to sell to pool members. In short, pool administrators would and should be effective purchasers and advocates on behalf of their members.

But the record for most such purchasing pools in the recent past has been disappointing. Early experiments with association health plans, health marts, and other health insurance purchasing cooperatives (HIPCs) have failed to attract a critical mass of customers needed for bargaining leverage and economies of scale. They also have been plagued by operating rules (community rating, state-level limits on risk classification and rate differentials, curbs on multi-year lock-in commitments) that increase adverse selection. The most likely pool customers have been those most likely to have greater long-term health care claims costs. Low-risk individuals and employer groups are less likely to join, and they are most likely to leave early, once they learn of their relative risk status within the pool in any event.[7]

Hence, any pools accepting funds from tax credit beneficiaries would be allowed to operate under the following ground rules:

• Tax credit-eligible purchasing pools would be allowed to require those buying insurance to commit to multi-year contracts—either to a particular health plan or to the pool in general.

• To deal with adverse selection concerns, yet still provide long-term protection against health risk redefinition, eligible purchasing pools could indi-

[6] State-mandated laws that require insurance coverage of particular types of health providers or services also increase the cost of health insurance and reduce covered workers' wages. Gail A. Jensen and Michael A. Morrisey. "Employer-Sponsored Health Insurance and Mandated Benefit Laws." *Milbank Quarterly 77* (4) (1999): 425–59. As many as 20 percent to 25 percent of the uninsured lack health insurance due to state mandates. Frank A. Sloan and Christopher J. Conover. "Effects of State Reforms on Health Insurance Coverage of Adults." *Inquiry* 35 (1998): 280–93.

[7] Tom Miller. "A Regulatory Bypass Operation." *Cato Journal 22* (1) (2002): 85–102.

vidually rate new entrants for their first two years in the pool, based on pre-announced underwriting rules, to the extent that those entrants present significantly heterogeneous risk profiles. People who remain with the same health plan for more than two years thereafter would be subject only to annual premium increases that reflect overall plan experience within the pool (in effect, a modified form of guaranteed renewability protection after year two).[8]

• To discourage low-risk customers from being enticed away from their pools by other insurers offering lower premiums to them, pools could attach "early exit" disincentives or other types of binding mutual constraints that encourage customers to remain in the pool on a long-term basis. For example, pool administrators and participating plans could structure annual premiums in two tiers—leaving the retained, second-tier portion of an individual's premium payment at risk of forfeiture upon early exit from the pool. (Or, more positively, the second-tier funds would be held in reserve as a potential "bonus payment" or rebate for continuous participation in the pool for a pre-specified duration.) Second-tier payments also could be subject to transfer or "settling up" in the event individual pool participants switch health plans during annual open seasons. Individuals demonstrating superior health risk profiles would leave some money behind in their old plans when they switch, whereas higher-risk individuals would transfer some of those funds over to their "new" plan. Pool administrators could negotiate with participating plans to determine the parameters of such "time-consistent" health insurance arrangements and contingent "severance payments," as first proposed by Cochrane.[9]

The above incentives and disincentives could be needed to discourage self-identified low-risk individual participants from selectively leaving the purchasing pool early, thereby raising average pool costs. However, adverse selection concerns might be dampened to some degree by the lack of an upper dollar limit on tax credit assistance to high-risk, high-cost individuals. As their premiums rise, so, too, would their 30 percent tax credit discount on insurance costs.

Effective voluntary purchasing pools would need several other new tools. They should be allowed to offer benefit packages that are exempt from state benefit mandates. Any state fictitious group laws[10] or state rating laws that would interfere with operations of eligible purchasing pools would be subject to federal pre-emption. Health plans competing within such purchasing pools would be allowed to set their own overall premiums based on their claims experience with the pool.

Pool administrators could enhance their effectiveness by using authority to contract selectively with particular health plans and by organizing employer-based enrollment and payroll deduction services for pool participants. Ensuring that purchasing pools serving federal tax credit recipients receive "charitable purpose" federal tax status would enhance their ability to attract start-up funding from private foundations.

Unless and until voluntary purchasing pools reach sufficient size to achieve competitive clout, they might need to balance risk redefinition protection objectives against desires for a broader menu of health plan choices for pool participants. Benefits standardization and limits on the numbers of eligible plan sponsors reduce the magnitude of adverse selection and the need for risk adjustment, but at the cost of consumer choice and market competition. The only honest answer will come from trial and error entrepreneurial experimentation in a less-

[8] See, for example, Bryan Dowd and Roger Feldman. "Insurer Competition and Protection from Risk Redefinition in the Individual and Small Group Health Insurance Market." *Inquiry 29* (1992): 148–57.

[9] John H. Cochrane. "Time Consistent Health Insurance," *Journal of Political Economy 103* (3) (1995): 445–73. See also Mark Pauly, Andreas Nickel, and Howard Kunreuther. " Guaranteed Renewability with Group Insurance." *Journal of Risk and Uncertainty 16* (1998): 211–21. Other exit disincentives might include greater use of front-loaded contracts to enhance the sustainability of long-term protections and minimize adverse selection incentives. Igal Hendel and A. Lizzeri. "The Role of Commitment in Dynamic Contracts: Evidence from Life Insurance." Cambridge, MA: National Bureau of Economic Research Working Paper No. 7470, January 2000.

[10] Such laws generally aim at preventing any fictitious grouping of a firm, corporation, or association of individuals from combining risks to obtain a preferred insurance rate or premium. For example, a law may require that private associations that purchase health insurance for their members must have a bona fide professional or trade purpose.

regulated marketplace. In any case, the combination of expanded purchasing options and long-term risk protection that finds the most buyers would begin to narrow the significant administrative cost differential between larger-employer group plans and other insurance purchasing choices.[11]

Tax-Advantaged Savings Vehicles for Individualized Health Care

Other tax policy reforms (apart from the optional federal tax credit) include universal availability of permanently authorized tax-advantaged MSAs and multi-year rollovers of section 125 flexible spending account balances ("use it or keep it").

The potential of current-law Archer MSAs has been hampered by eligibility limits, a narrow range of permissible insurance deductible levels, and a low numerical cap on individuals eligible for what has been a demonstration project of limited duration under HIPAA. Instead, MSAs should be authorized permanently (rather than temporarily authorized through December 31, 2003). The tax benefits for such accounts would be available to anyone covered by qualified high-deductible insurance—including workers insured under group health plans sponsored by employers with more than 50 employees and any individuals purchasing qualified high-deductible insurance on their own or as part of a non-employer group arrangement. Current law would be revised further to remove enrollment caps and maximum deductible limits, allow MSA account holders to fully fund their MSAs each year (up to 100 percent of the accompanying catastrophic insurance policy deductible), allow employers and employees to combine their contributions to MSAs at any time within a given year, and pre-empt first-dollar state-mandated benefits that would otherwise apply to HIPAA-qualified MSA plans.[12]

Because MSA plans already are linked to high-deductible insurance that covers health claims that are more catastrophic in nature, they can make the cost of insurance coverage more affordable for most Americans. Less-comprehensive coverage means lower insurance premiums for a larger fraction of people with low incomes—particularly those low-risk people who may want less than full coverage and, therefore, may decide not to purchase higher-priced, standardized insurance policies.[13]

Current tax treatment of Internal Revenue Code section 125 "flexible spending" health accounts (FSAs) would be revised to allow year-end, tax-free rollovers of accumulated balances, up to the amount of the annual deductible in the accompanying employer group plan for the applicable year. By ending the current tax treatment of "use it or lose it" for year-end balances, FSA funds could be saved for higher-value use in succeeding years.[14] However, withdrawals for non-health-spending purposes would be subject to income taxes.

Facilitating Defined Contribution Employer Health Benefits

A growing number of employers are beginning to offer defined contribution (DC)-style health benefits plans, in which the employer purchases less-comprehensive, high-deductible group insurance coverage for workers covered by the plan and then makes cash contributions to those workers' individual health accounts. DC plans help employers cope with rising health insurance costs by capping their total health benefits contributions, increasing employee cost sharing, and empowering workers to handle more routine health care decisions.

Fewer than half (43 percent) of ESI-covered

[11] For a more comprehensive analysis of risk pooling, administrative costs, and public policy options in various segments of the health insurance marketplace, see Mark Pauly and Brad Herring. *Pooling Health Insurance Risks.* Washington: AEI Press, 1999, pp. 81–89.

[12] See Victoria C. Bunce. "Medical Savings Accounts: Progress and Problems under HIPAA." Washington: Cato Institute Policy Analysis No. 411, August 8, 2001.

[13] Ibid. See also Katherine Swartz. "Rising Health Care Costs and Numbers of People without Health Insurance." Prepared for the Council on the Economic Impact of Health System Change conference, "Renewed Health Care Spending Growth: Implications and Policy Options," Washington, January 11, 2001. Swartz notes that the majority of standardized policies currently available are "generous and expensive—making them unaffordable to low-income people." Catastrophic insurance for less-predictable health care expenses would force consumers to bear the full marginal costs of health care up to the point where their use of health care exceeds the deductible. (Swartz recommends that health insurance coverage should define "catastrophe" relative to an insured customer's income.)

[14] The Bush administration has proposed a limited tax-free rollover of FSA balances at the end of a calendar year, but only up to a maximum amount of $500.

workers are satisfied with the overall performance of their current health plan. Fewer than half (48 percent) trust their employer to design a health plan that will provide the coverage they need, and approximately the same number of employees (47 percent) think better health plans are available for the same cost. Almost four out of 10 employees (39 percent) want their employer to contribute a fixed-dollar amount toward the premium for any health plan—even if it means the employees have to find their own health plan.[15]

DC plans allow employers to purchase less expensive, less comprehensive group health insurance coverage for their workers, yet still fund individual health spending accounts to handle the workers' more routine health care needs—so-called "two-tiered" health benefits plans. A "purer" form of defined contribution plan would even allow employees to select their own individual insurance coverage, with the assistance of their employer's original contribution. Whether individual employees pay just the extra cost of additional out-of-pocket health spending or the extra cost of more generous insurance coverage as well, DC plans provide incentives to compare the value of the health care they receive to other goods and services they might want.

DC plans might provide a halfway house in the transition from comprehensive ESI to high-deductible MSA plans. Value-conscious employers and employees could insist that insurers "spin off" (not insure) items about which little uncertainty exists or for which the typical treatment cost is relatively low compared to the paperwork required to process the claim.[16] Possible examples include orthodontics, regular checkups (medical, dental), vaccinations, maternity care, eyeglasses, etc. Whereas MSA plans rely on much higher deductible levels for accompanying catastrophic insurance policies and treat all insured services equally, two-tiered DC plans could provide certain "preventive care" health services with first-dollar coverage, while others might not be covered at all.

To the extent that either tax-preferred FSA accounts (with year-end rollovers) or individual health savings accounts in two-tiered DC plans would reduce the reliance on more expensive comprehensive insurance coverage, they would benefit the less healthy, since these individuals tend to have higher out-of-pocket costs than those who are healthy.

Despite the potential benefits of two-tiered DC plans, as well as the recent tax guidance issued by the Internal Revenue Service clarifying how accumulated balances in an individual employee's health reimbursement accounts may be treated when rolled over at the end of a year,[17] several regulatory barriers to the future growth of DC plans still need to be removed.

First, "pure" DC plans for fully insured employer groups, in which an employer distributes defined health benefits contributions to each eligible employee and allows them to purchase their own individual or non-employer-group insurance coverage, run the risk of being regulated inconsistently. They might be treated both as employee welfare benefit "group" plans and as "individual" health plans under state law.[18]

To clarify the regulatory treatment of this kind of DC plan, any plan or fund under which medical care is offered to employees by an employer solely through provision of a monetary payment or contribution to a participant or beneficiary and that is used exclusively to purchase individual health insurance coverage should not be considered an "employee welfare benefit plan" for regulatory purposes under the Employee Retirement Income Security

[15] Watson Wyatt Worldwide. *Maximizing the Return on Health Benefits: 2001 Report on Best Practices in Health Care Vendor Management.* Washington: 2001.

[16] See James H. Cardon and Mark H. Showalter. "An Examination of Flexible Spending Accounts." *Journal of Health Economics* (November 2001): 953.

[17] Employer contributions to such accounts would not be treated as taxable income, as long as they were spent for IRS-eligible health items or "saved" in the account and rolled over beyond the end of a calendar year for future use in paying health care expenses. The accumulated funds would be subject to income taxes and deferred payroll taxes in the event they are withdrawn for other reasons, with the exception of rollovers into other tax-advantaged retirement accounts.

[18] See Department of Health and Human Services, Health Care Financing Administration. "Insurance Standards Bulletin Series—INFORMATION." Program Memorandum Transmittal No. 00-06, November 2000 (conveying position of HCFA that coverage characterized as an individual policy under state law may nonetheless be subject to group market requirements of the Public Health Service Act, as added by HIPAA, if coverage is provided in connection with a group health plan).

Act (ERISA). However, such plans or funds would retain their "group" tax exclusion benefits under the Internal Revenue Code. Such hybrid treatment (group for tax purposes, individual for regulatory purposes) would be premised on the conditions that (1) only the employer, rather than individual employees, may decide to provide health benefits through defined contribution payments, and (2) such defined contributions must be provided to all employees or all members of a class of employees based on work-related distinctions.[19]

Second, the defined contributions employers make to individual employees in pure DC plans, to be used to purchase individual health insurance coverage, should be allowed to vary on the basis of health status in the event the employer uses an approved risk-adjustment mechanism. That is, employers would be allowed to make larger contributions to workers with poorer health status to offset the higher premiums they would face when they seek to purchase individual coverage. However, state insurance regulators would need to approve this exemption from HIPAA non-discrimination rules.

Third, recent IRS guidance regarding the tax-free rollover status of employer contributions to health reimbursement accounts still does not allow accumulated funds to become vested for other non-health-spending purposes. Nor does it allow employees to contribute their own money to such tax-advantaged accounts. To a large extent, increasing the ceilings for annual rollovers of FSA fund balances, or expanding the availability of MSAs, would bypass most of this problem.

Enhanced Market Pricing Information and Consumer Disclosure Reforms

Once individual consumers are empowered by more equitable and flexible health financing options, how will they obtain sufficient market information to make better choices? Federal government agencies (primarily the Centers for Medicare and Medicaid Services) could help by aggressively disclosing and publicizing, particularly through Internet-based platforms, the various fees for coded medical services authorized under the Medicare program. Physicians and other health care providers should be allowed to cross-reference their own basic Medicare conversion factor with official Current Procedural Terminology (CPT) codes, Resource-Based Relative Value Scale (RVRBS) weighting factors, and geographic practice cost indexes (GPCIs) to effectively make their undiscounted fee schedules for various services and procedures more readily available to cash-paying customers.[20]

Although the American Medical Association (AMA) has been reluctant to allow broad access to some of this "proprietary" information for third-party commercial activities, some version of limited disclosure for consumer information purposes appears to be possible. Indeed, last February, the AMA began offering a free resource on its web site[21] for patients to look up CPT codes and the related Medicare payment information. Patients can enter either the CPT code or the medical procedure description to receive search results that describe the particular CPT service and Medicare fee information by geographic area. The AMA site helps patients research cost estimates of various health care procedures. There is a limit of 10 searches for each individual per day.[22]

Building on this type of information, medical providers should be able to tell potential cash customers, "My conversion factor is x percent of the Medicare conversion factor, and you will be responsible for paying the difference between it and any available third-party means of payment." In this manner, a more competitive market for out-of-pocket health care spending can thrive. In essence, private plans and providers could announce and post voluntarily their uninsured "cash prices" for

[19] The proposed Health Care Account Act of 2001 (H.R. 2658), introduced on July 26, 2001, takes a similar approach. It selectively excludes "health care expenditure accounts" from the definitions of group health plans to which HIPAA group health plan requirements would otherwise apply, but it also treats eligible defined contributions to those accounts as excluded from gross income for federal tax purposes.

[20] Health care payers use CPT codes to categorize physician and other health care services on medical claim forms. Bureau of National Affairs, Inc. "AMA Offers Patients Access to CPT Code Data." *BNA's Health Care Policy Report (*February 11, 2002): 222.

[21] http://www.ama-assn.org/cpt

[22] Ibid.

various diagnosis-related groups (DRGs), CPTs, and other services and procedures as a percentage of Medicare-authorized prices. At that point, further individual bargaining would be possible from this standard baseline.

Market-Driven Deregulation via Competitive Federalism

Empowering consumers with a greater diversity of affordable health benefits choices will require exposing exclusive state health care regulation based on geography to competition from market-friendly regulation across state lines.

Lower-income workers in small firms bear the brunt of excessive state health insurance regulation, because their employers generally are unable to self-insure and, thereby, gain ERISA protection from state benefit mandates, restrictions on rating and underwriting, and other regulatory burdens. In general, increased state regulation has raised the cost of health insurance and limited the range of benefits package design. A wide assortment of small-group regulatory measures imposed by many states during the 1990s failed to improve levels of insurance coverage and, in some cases, priced low-risk consumers out of the small-group market. Various state government regulatory attempts to force low-risk insureds to subsidize high-cost insureds through devices like modified community rating and guaranteed issue often were counterproductive, because they triggered premium spirals that drove younger, healthier, and lower-income workers out of the voluntary insurance market. In other words, state health insurance regulation has been part of the problem, not part of the solution.[23]

Rather than try to solve state-based regulatory failure with a new round of heavy-handed federal rule making or pre-emption, the better route to restoring a market-friendly, consumer-empowering environment at the state level is to facilitate competitive federalism—revitalized state competition in health insurance regulation that reaches across geographic boundary lines. (The closest successful model for such competitive federalism involves corporate law and the business of corporate charters, in which Delaware has specialized and excelled by consistently producing benefits to its "customers"—investors.[24]) Such regulatory competition would limit the excesses of geographically based monopoly regulation. Currently, insurance consumers (at least in the non-self-insured market) are subject to a single state government's "brand" of insurance product regulation. Solely by virtue of where they live, they are stuck with the entire bundle of their home state's rules. Short of physically moving to another state, they are unable to choose ex ante the type of health insurance regulatory regime they might prefer and need as part of the insurance package they purchase.

Competitive federalism could facilitate diversity and experimentation in health insurance regulatory approaches. It would discipline the tendency of insurance regulation to promote inefficient wealth transfers and promote individual choice over collective decisions driven by interest group politics.[25] In short, it would improve the quality of health insurance regulation, thereby enhancing the availability and affordability of health insurance products.

Insurers facing market competition across state lines would have strong incentives to disclose and adhere to policies that encouraged consumers to deal with them. Employers and individuals purchasing insurance would migrate to state regulatory

[23] See, for example, Frank A. Sloan, Christopher J. Conover, and Mark A. Hall. "State Strategies to Reduce the Growing Numbers of People without Health Insurance." *Regulation 22* (3) (1999): 24–31; Melinda L. Shriver and Grace-Marie Arnett. "Uninsured Rates Rise Dramatically in States with Strictest Health Insurance Regulations." Heritage Foundation Backgrounder No. 1211, August 14, 1998, Washington, DC; Employment Roundtable. "Personally Owned Health Insurance Policies: A Solution for the New Economy?" Washington, DC, March 2001; Jensen and Morrisey, op cit.

[24] See Roberta Romano. "Law as a Product: Some Pieces of the Incorporation Puzzle." *Journal of Law, Economics, & Organization 1* (2) (1985): 225–83; Jonathan R. Macey. "Federal Deference to Local Regulators and the Economic Theory of Regulation: Toward a Public-Choice Explanation of Federalism." *Virginia Law Review 76* (March 1990): 265–91.

[25] Tiebout pioneered an economic theory of federalism that argued that competition among local jurisdictions allows citizens to match their preferences with particular menus of local public goods: Charles M. Tiebout. "A Pure Theory of Local Expenditures." *Journal of Political Economy 64* (5) (1956): 416–24. Qian and Weingast noted that inter-jurisdiction competition, along with decentralization of information and authority, can provide credible commitment to secure economic rights and preserve markets: Yingyi Qian and Barry R. Weingast. "Federalism as a Commitment to Preserving Market Incentives." *Journal of Economic Perspectives 11* (4) (1997): 83–92.

regimes that did not impose unwanted mandates but, instead, fit the needs of their consumers. State lawmakers would become more sensitive to the potential for insurer exit. At a minimum, interstate regulatory competition would provide an escape valve from arbitrary or discriminatory regulatory policies imposed at either state or federal levels. Key design requirements for regulatory competition in health insurance would include:

1. Only one sovereign has jurisdiction over a particular set of health insurance transactions, and its law controls the primary regulatory components of the regime governing them. Other states provide regulatory reciprocity (also known as the "principle of mutual recognition" in the European Union), by respecting and enforcing that state's insurance charter and its accompanying rules. Such reciprocity works through private arbitrage of jurisdictional competition, rather than politically mandated harmonization that suppresses competition.

2. Health insurers can choose their statutory domicile, or otherwise determine the applicable forum and applicable law, and make it part of the purchasing option they present to consumers. Insurers and their consumers can exercise the right of free exit: they can vote with their feet and their pocketbooks. Insurers can choose their domiciles, the markets where they prefer to operate, and the bundle of laws and regulations attached to the products they sell. They can relocate to alternate jurisdictions at relatively low cost. Consumers may choose not only the state in which they live but also the legal rules attached to the insurance products they buy.

3. States must receive some benefits, such as tax revenues, from competing in the production of specific laws and regulations that reduce insurers' business costs and increase the value of insurance products. Conversely, states also must feel within their own borders a sufficient number of any negative consequences of the regulatory regimes they choose to adopt and "export" to consumers in other states.

4. Competition for the marginally informed consumer must operate to protect other consumers who are not aware or informed of the particular regulatory regime.

5. Rather than present a single set of contract terms on an all-or-nothing basis, insurers can offer consumers a menu of alternative policies that are priced to reflect different regulatory approaches.

6. Solvency regulation should remain decentralized and kept at the state level, to avoid federal domination over other regulation in the name of protecting consumers and taxpayers. Regulatory competition for insurance product design, pricing, and pooling could be accommodated within the current state-based guaranty fund system in a manner that limits an individual state's opportunities to impose costs on other jurisdictions.

Several mechanisms or paths could lead to vigorous interstate competition in health insurance regulation. A more indirect, but sustainable, approach would involve strategic use of choice of forum clauses, and perhaps choice of law clauses, in health insurance contracts. Insurers would condition sales of a particular policy on a consumer's consent to the designated litigation forum. That forum would be matched to the state whose regulatory law was selected. This choice of forum would need to be adequately disclosed and executed at the beginning of the contractual period, not just at the time of litigation. Insurers could increase the likelihood that the agreement would be enforced and regulatory competition enhanced by linking the designated forum to their company's domicile—rather than to the site of the sales transaction.[26]

Federal law could provide some shortcuts—such as a statute mandating enforcement of choice of forum contracts under the commerce or full faith and credit clauses of the Constitution. Congress also could provide uniform disclosure requirements for choice-of-forum and the insurer's domicile in insurance contracts.

A more direct federal statutory approach might set an "insurer domicile" rule, in place of a "site of transaction" rule, for determining applicable state law and regulatory authority—at least as a default rule for multi-state transactions where the respective parties do not otherwise designate operative

[26] Larry E. Ribstein and Bruce H. Kobayashi. "A State Recipe for Cookies: State Regulation of Consumer Marketing Incentives." American Enterprise Institute Federalism Project Roundtable, January 30, 2001 (www.federalismproject.org/masterpages/ecommerce/cookies.pdf).

law. For example, Rep. Ernest Fletcher (R-KY) recently introduced the "State Cooperative Health Care Access Plan Act of 2002" (H.R. 4170), which would authorize a health insurer offering an insurance policy in one primary state (the primary location for the insurer's business) to offer the same policy type in another secondary state. The product, rate, and form filing laws of the primary state would apply to the same health insurance policy offered in the secondary state.[27]

Another route to interstate competition in insurance regulation might be built on decisions by individual states to grant regulatory "due deference" to determinations by out-of-state insurance regulators that a particular insurance company is qualified to conduct such business. Once an insurer submitted evidence of good standing in its domestic jurisdiction and (if different) in the jurisdiction where it conducts the largest share of its health insurance business, it would qualify for licensure in the state granting such regulatory deference.[28]

Involving Congress in structuring interstate regulatory competition may be necessary to defuse threats of retaliation and exit restrictions by individual state insurance regulators. However, it remains unlikely that Congress would relinquish a great deal of current and future regulatory authority over health insurance (HIPAA; mandates for mental health parity and minimum maternity stays in the hospital; proposed patients bill of rights legislation [PBOR]) without asking for something in return. For that reason, the contractual choice of forum approach would be preferable to other more targeted statutory fixes requiring costly political side payments.

Any move to full-fledged regulatory competition in health insurance, whether attempted through a legal or a legislative strategy, will require mobilization of political constituencies that see its benefits and need them. The most likely future candidates for reinvigorated state regulatory competition might well be large, self-insured, multi-state firms. Most versions of proposed PBOR legislation would target them for the greatest liability risks, particularly if those firms administer their own workers' health benefits in-house. If enacted into law, PBOR also would strip away many of the benefits of current ERISA protections against state regulation by imposing a multitude of new federal mandates on self-insured companies. (As of this writing, it appears unlikely that negotiators ultimately might revive and revise the latest version of such proposed legislation to ease some of the new liability burdens on large, self-insured employers by transferring lawsuits against them to federal court.) Multi-state, self-insured firms still may seek the uniformity of a single regulator, but seeking exclusive regulation at the federal level may not provide a deregulatory haven much longer. If large firms begin to see self-insured status as more of a liability-increasing risk than a regulation-reducing benefit, they may consider the virtues of linking their plans to a single market-friendly regulatory regime at the state level. If state insurance regulatory systems could compete on an interstate basis, the better ones might find a new customer base in multi-state firms seeking consolidated regulation of fully insured products at the state level.

Another possible block of customers for competitive federalism-style insurance regulation includes purchasers of individual insurance on the Internet. The current lines of regulatory jurisdiction for Internet sales remain fluid. Congress might consider a special carve-out to minimize the growth of new regulatory burdens on this promising channel of distribution. Matching regulatory jurisdiction to an insurer's state of incorporation might simplify the regulatory branding for Internet insurance products. It also would allow an insurer to offer potential Internet-based purchasers a more uniform insurance product, regardless of where they live. Recent

[27] See also Employment Roundtable, op cit., pp. 20–21.

[28] Regulators in secondary states would be most likely to treat proof of licensure and good standing in the primary state as prima facie evidence of qualification for licensure in the secondary state, while still requiring additional routine documents and fees and compliance of the primary state's insurance department with broadly accepted accreditation standards, such as those maintained by the National Association of Insurance Commissioners. (For one creative "draft" proposal outlining how regulatory due deference might operate at the state level, see Lawrence Mirel. "Regulatory 'Due Deference': A Proposal for Recognition and Deferral to Fellow Insurance Regulators under Certain Conditions." Exposure Draft. Commissioner of Insurance and Securities for the District of Columbia, January 1, 2002.) Initially, an individual state's decision to grant regulatory due deference would be similar to a declaration of unilateral free trade in health insurance products. The state would be eliminating or reducing its own regulatory restrictions on out-of-state insurance to benefit its citizens and to provide a model for other states to emulate.

individual insurance price quotes for Internet-marketed products suggest that such distribution already has great potential to make low-cost insurance more available to lower-income consumers.

An additional block of potential buyers for competitive federalism-style health insurance could be sponsors of voluntary purchasing coalitions. To gain a firmer foothold in the health insurance marketplace, buyers' groups will need to find state-based regulation that does not overpower them with rating restrictions and pooling requirements (to the extent they are not pre-empted by other federal legislation). These groups also are likely to operate beyond a single state's boundaries, and they would prefer dealing with a single insurance regulator.

Finally, if optional federal tax credits are made available to purchasers of non-ESI policies, Congress could consider crafting special regulatory treatment for policies serving this new clientele.

Of course, proposing interstate competition in state health insurance regulation will face predictable "race to the bottom" warnings. However, those who prefer the existing set of choices within the existing health insurance regulatory system can continue to use them. Other consumers who believe there are advantages in new and different regulatory approaches should be allowed to try them.

Reputational concerns will provide both constraints and incentives for the choice of regulatory regimes by established insurance firms. There is little to be gained on a long-term basis in contracting for a law and forum that many consumers are likely to know unduly favors insurance sellers over buyers.

Normal competitive pressure would discourage private insurers from repeatedly switching their state insurance regulator on an opportunistic, short-term basis. Insurers would be more likely to issue a credible promise not to remove to another state, in order to reduce doubts about the enforceability of certain provisions of its insurance contracts.[29] By accepting this restriction voluntarily, a private insurance company might improve its market value. Insurers also would tend to incorporate in states that had an established tradition of regulatory stability and in states whose economy was more dependent on the insurance industry.

State regulators could coordinate their law enforcement activities to deal with interstate problems. They also could require compliance with the standards of a centralized body to assist necessary uniformity in certain areas. Or Congress could establish a default rule for enforcement of certain actions (such as those involving consumer fraud or other improper market conduct) that affect consumers in a secondary state but involve insurance policies regulated by a primary state. The rule would authorize insurance regulators in that secondary state to treat the insurer involved as if it were primarily licensed there.[30]

Defenders of the current regulatory structure and skeptics of regulatory competition need to answer the "Compared to what?" challenge. They cannot just assume that a hypothetically perfect, well-designed system of more and more state (or federal) health insurance regulation will materialize in the future. They need to demonstrate its measurable benefits over a more decentralized system of regulatory competition—a system much more likely to deliver the contractual assurances, services, and features for which buyers are willing to pay.

After all, we have already been running a different race to the "bottom" with too much regulation. The losers end up uninsured—because they can't afford coverage or refuse to overpay for it. The race to the "market top" needs a full field of state regulators running in each other's markets.

Summary

The tax incentives and deregulatory initiatives above would be aimed at increasing overall insurance coverage levels for catastrophic protection, encouraging more stable and longer-term private insurance arrangements, providing a better match between individual consumer preferences and available products, and expanding the pool of personal savings available to finance more routine and discretionary

[29] Henry N. Butler and Jonathan R. Macey. "The Myth of Competition in the Dual Banking System." *Cornell Law Review 73* (May 1988): 677, 715.

[30] See, for example, the State Cooperative Health Access Plan Act of 2002 (H.R. 4170): § 101.

health care spending choices. New voluntary pooling options also may lower the administrative costs and improve the qualitative choices available to certain health care purchasers employed by small firms, self-employed, and/or lacking access to employer-sponsored insurance coverage. The overall objective is to help make less-comprehensive levels of private insurance coverage more available and more affordable for more customers.

Safety Net Reforms

The above reforms focus in large part on restructuring and expanding financial assistance via the tax code to empower and provide incentives to *taxpayers* to purchase at least basic levels of catastrophic health insurance coverage. The additional combination of deregulatory reforms, personal savings incentives, and reduced subsidization of discretionary health spending would increase the availability of more affordable health care options for all purchasers. Nevertheless, lower-income individuals and families ineligible for Medicaid coverage still would need to rely to a great extent on the mixture of safety net mechanisms (state uncompensated care funds, public hospitals, community health centers, mandated emergency room care, and other uncompensated care provided by private hospitals and physicians) that provide a market for "free care."

The uninsured in general pay out-of-pocket for only about one-third of the care they receive. Even more of that charity care is available to low-income uninsured individuals in particular. According to Herring, high-income uninsured individuals receive more than half (53 percent) of their medical care in the form of charity care, whereas low-income uninsureds receive just over two-thirds (68 percent) as free care. The average uninsured person consumes at least 50 percent, and perhaps as much as 60 percent, of the annual health care used by the average insured individual.[31]

In deciding whether it's best to subsidize insurance coverage or additional "free" health care for the low-income uninsured, several points stand out. The current market for charity care operates quite rationally in mimicking the effects of private catastrophic insurance policies. The proportion of health care paid out-of-pocket by the uninsured decreases considerably as utilization and total "spending" increases. Proportionately more charity care is available for uninsured individuals who incur larger medical expenses. And the low-income uninsured with high medical bills (above $10,000) pay about half as much out-of-pocket for their care as do high-income uninsured individuals with similarly sized bills. (The low-income uninsured with such high bills receive 90 percent of their care for free.)[32]

At the same time, availability of charity care for uninsured individuals has a modest negative effect on their decision to purchase private health insurance. In effect, the supply of free care lowers the "reservation price" value of insurance for the uninsured when they consider the *net* cost to them of paying for insurance premiums versus remaining uninsured. If the supply of free care expands, tax credit subsidies will need to become even larger to induce the uninsured (particularly those with low incomes) to purchase insurance.

However, the relative crowd-out effects of expanded free care that reduce insurance levels are modest compared to its benefits in improving a low-income uninsured individual's direct access to health care (as opposed to health insurance).[33] This suggests strongly that, dollar-for-dollar, investing in safety net assistance to the low-income uninsured is more effective and productive than trying to coax them to purchase health insurance with tax subsidies.

Although increased federal subsidies to local uncompensated care pools and to community health centers may bolster those important components of the overall safety net, two higher-priority items should be targeted first: financial assistance to high-risk pools for the medically uninsurable, and expanded tax incentives for charitable giving that helps deliver health care services to the low-income uninsured.

[31] Herring, 2001, op cit., pp. 9–10; see also Herring, 2000, pp. 27–37.

[32] Herring, 2001, p. 10.

[33] Ibid., pp. 29–30.

Medicaid Coverage for State High-Risk Pools

Medically uninsurable individuals represent a small percentage of the uninsured population (roughly no more than 1 percent to 2 percent of the uninsured have ever been denied health coverage for medical reasons).[34] But they present the strongest case for public assistance. To some degree or another, at least 30 states currently operate high-risk pools that make insurance coverage available to them and subsidize their premiums.

States with well-structured and adequately financed high-risk pools are more successful in keeping their individual health insurance markets competitive and insurance rates affordable. Such pools allow the individual insurance market to operate efficiently, while carving out for special treatment those high-cost individuals who are beyond the capacity of the individual market to handle on an unsubsidized basis.[35]

However, not all state high-risk pools are adequately financed (ideally, the funding should come from general revenues rather than through taxes on insurers within the state), and many states do not provide such subsidized coverage at all. Using the rationale that the "medically uninsurable" (at least to the extent that the unsubsidized price to insure them privately far outstrips their ability to pay) should be considered "medically needy," mandatory Medicaid coverage and matching federal assistance should be extended to this class of beneficiaries, provided that the funds are channeled through state-operated high-risk pool programs that meet certain minimum criteria (for example, premium ceilings, waiting periods, rejection by at least one insurer, catastrophic conditions allowing automatic pool acceptance without prior carrier rejection) already in practice, but not "new" ones. The scope and scale of this Medicaid-financed high-risk pool coverage for the medically uninsurable would be capped at an upper ceiling that equals the higher amount of all individuals in a state facing private insurance premiums that are at least 200 percent of standard rates (plus those who cannot obtain any coverage at all, for medical reasons) or 2 percent of all people covered in a state's individual insurance market.

Citizen Appropriations for Charitable Health Care

To bolster financing for charitable safety net care and ensure that it is delivered with private-sector efficiency, a new 100 percent, dollar-for-dollar federal income tax credit (above the line) would be provided for certain charitable contributions to provide health care services to the low-income uninsured. These "citizen appropriations" would be modeled in part on the Arizona tax credit for education "scholarships."[36] The maximum individual credit amount allowed would be no greater than 10 percent of an individual's federal income tax liability in a given tax year. Eligible donations would have to be made to approved organizations that provide health insurance coverage, health care services, or payment of medical bills to uninsured individuals who are not eligible for optional federal health tax credits or Medicaid assistance. Organizations eligible to receive the donations must either be a non-profit, in accordance with section 501(c)(3) of the Internal Revenue Code, or, in the case of hospitals, physicians, insurers, and other health care providers that wish to receive direct donations, a separate non-profit subsidiary created by them to receive and distribute such funding. Eligible organizations could spend only as much of their donations as they could document was directed toward paying the health care expenses of qualified uninsured individuals. Taxpayers could designate the institution to which their donation would be directed, but they could not pinpoint the individual beneficiary.

[34] Karen Beauregard. "Persons Denied Private Health Insurance Due to Poor Health." Agency for Health Care Policy and Research publication no. 92-0016. Rockville, MD, December 1991; Pauly and Herring, op cit., pp. 88, 90–91.

[35] Elizabeth White. "Risk Pools Aim to Cover Uninsurable, Stabilize Insurance Markets." BNA's Health Policy Report, August 27, 2001, pp. 1338–41; Conrad F. Meier. "Extending Affordable Health Insurance to the Uninsurable." Heartland Policy Study No. 91, August 27, 1999.

[36] See, for example, Carrie Lips and Jennifer Jacoby. "The Arizona Scholarship Tax Credit: Giving Parents Choices, Saving Taxpayers Money." Washington: Cato Institute Policy Analysis No. 414, September 17, 2001; Lisa Snell. "The Arizona Tax-Credit Program Paradox." Reason Public Policy Institute Policy Update 18, April 4, 2002.

Thinning Out the Emergency Room—Rethinking EMTALA

Hospital emergency rooms increasingly are plagued by overcrowding, unfunded care deficits, and arbitrary federal regulatory mandates. Behind a good many of those problems is the Emergency Medical Treatment and Active Labor Act (EMTALA), originally a largely symbolic law but now one with increasingly pernicious consequences.

EMTALA essentially prohibits discrimination against individuals seeking treatment (frequently high-cost) in hospital emergency rooms based on ability-to-pay criteria. It has been interpreted and expanded through the past decade to essentially provide broad, unfunded access not just to emergency care, but, potentially, inpatient care as well. As David Hyman notes, hospital emergency room personnel cannot delay treatment or examination to inquire about patients' ability to pay or their insurance status.[37]

As an unfunded federal mandate imposed on hospitals, EMTALA has created free-rider problems. First, managed care organizations cut back on emergency care coverage, and then their insured patients bypassed their health plans' contractual restrictions on access to emergency departments and arrived there for "free treatment" anyway. By the late-1990s, EMTALA essentially mandated access to 24-hour, just-in-time, emergency care at levels well above what many insured individuals were willing to pay for in their managed care plan contracts. With hospital emergency departments already disproportionately serving patients covered by Medicaid and those who are uninsured, increasingly unable to "make up their losses on volume," and finding their proportion of paying insured patients declining, EMTALA's unrestricted entitlement for utilization up to ER capacity provided strong incentives for hospitals to constrain, rather than expand, their emergency department capabilities. As too many patients lined up for federal free lunches in the ER, overcrowding, queuing, and declining quality of care hurt the uninsured most.

A first-stage remedy would be to repeal EMTALA's application to insured patients. ER personnel should be given leeway to sort prospective patients initially into "insured" versus "uninsured" categories, with the former then explicitly informed that they will be held personally responsible for unreimbursed care and asked to provide modest refundable deposits (returned in the event of true emergencies that are eligible for health plan reimbursement).[38]

Second-stage relief to ER overcrowding would involve new federal assistance to *all health care providers* delivering disproportionate shares of uncompensated *emergency* care to the *uninsured* (in effect, DSH-E, or disproportionate share-emergency care, rather than the current DSH, or disproportionate share, payments that are made to providers with high levels of services to lower income patients), instead of continuing to impose unfunded emergency care mandates. Reimbursement would be pegged to Medicaid payment levels, but it would be based only on actual levels of otherwise uncompensated care to the uninsured.

Beyond limiting EMTALA emergency room mandates to individuals without insurance coverage, we also would consider allowing emergency care providers to charge uninsured individuals who, upon preliminary screening, present no obvious emergency symptoms a refundable copayment at the time of such emergency room care (limited in amount, returned in the event that ER staff later certifies that an emergency condition in fact existed, and federally subsidized for low-income individuals not otherwise eligible for Medicaid or federal tax credits).

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[37] This section draws heavily on the work of David A. Hyman. "Patient Dumping and EMTALA: Past Imperfect/Future Shock." *Health Matrix: Journal of Law-Medicine 8* (Winter 1998): 29–56.

[38] For evidence that increased cost sharing could discourage patients from inappropriately using hospitals' emergency departments, see Kevin F. O'Grady, Willard G. Manning, Joseph P. Newhouse, and Robert H. Brook. "The Impact of Cost Sharing on Emergency Department Use." *The New England Journal of Medicine 313* (August 22, 1985): 484–90 (finding that a 25-percent level of cost sharing deterred emergency department utilization for less serious conditions but did not deter utilization for more serious conditions). See also Joe V. Selby, Bruce H. Fireman, and Bix E. Swain. "Effect of Copayments on Use of the Emergency Department in a Health Maintenance Organization." *The New England Journal of Medicine 334* (March 7, 1996): 635–41 (concluding that a small co-payment resulted in a 15 percent reduction in emergency department utilization but did not affect conditions classified as "always an emergency").

Medicaid Opt-Out Vouchers for Other Private Insurance Coverage

To help provide a transitional step from Medicaid coverage to longer-term private coverage under the various options outlined above, federal Medicaid waiver authority would be expanded for states that already provide private managed care alternatives to Medicaid fee-for-service coverage and use capitated per-beneficiary payments to do so. States could allow individual Medicaid-eligibles (not including the blind and disabled, or the medically needy elderly) to claim their "share" of annualized capitated payments as a private health insurance voucher. This option would be at the initiative of beneficiaries (no mandatory assignment). These opt-out beneficiaries, whose Medicaid eligibility would be annualized to reduce administrative costs and complexities, then could use the vouchers to purchase other eligible forms of HIPAA-qualified private insurance coverage.

States would be allowed to waive certain mandatory Medicaid benefits package requirements for these private insurance alternatives to allow beneficiary cost sharing and economizing incentives. For example, private opt-out plans could combine greater cost sharing with first-dollar coverage of preventive care services—most likely two annual primary care physician office visits. Plans that combine high-deductible catastrophic coverage with individual health spending accounts would be specifically authorized. Private opt-out plans also would be authorized to provide rebate incentives for beneficiaries using covered services in amounts totaling less than 30 percent of annual premiums, or for those not using emergency room benefits, in a given year. Apart from this enhanced cost-sharing flexibility, minimum covered benefits would be similar to those required for the optional federal tax credits, as described previously.

States using this waiver authority could choose to risk adjust voucher amounts for participating beneficiaries, but they would not be required to do so.

Coverage/Eligibility

Apart from existing Medicaid program criteria for coverage of the non-elderly, non-disabled poor, eligibility is not directly pegged to income. Tax credit assistance requires federal tax liabilities, but it is provided proportionately (30 percent of eligible expenses) rather than laddered or phased out according to one's income level. It would not be available to individuals taking advantage of the current tax exclusion for ESI (no double-dipping). MSA options are available to anyone who purchases HIPAA-qualified catastrophic health insurance (ideally with fewer restrictions on the permissible range of deductible levels). Tax-free rollover treatment of year-end FSA balances is available to employees offered and using FSA benefits in ESI plans. Any employer may offer a defined contribution health benefits plan with individual health savings accounts, provided the employer pays for the health insurance (either directly or when presented by a participating employee with a request for reimbursement of a paid insurance coverage invoice).

Safety net assistance via "citizen appropriations" charitable tax credits will be distributed according to the rules set by eligible non-profit intermediaries. Although it theoretically could be distributed directly to the insured (for example, to subsidize the employee share of ESI premiums), standard priority setting as well as likely Internal Revenue Service (IRS) rules for charitable purposes would make that unlikely. EMTALA-mandated "free" emergency care would be limited to the uninsured. The only mandatory coverage would be that under current law that is not otherwise eliminated above (Medicaid, Medicare, military care, and other miscellaneous federal health programs).[39] Purchase of private coverage would remain voluntary, but be more widespread as the "value" of that coverage improves. Individuals who believe they can improve their overall well-being by spending their money on other items than health insurance (for example, investment in education has a higher payoff in terms of improved health outcomes than does the purchase of health insurance, all things being equal) should remain free to do so. The ultimate objective is to

[39] Reform of those public programs is outside the immediate scope of this paper. For the author's thoughts on those issues, see Tom Miller. "Public Health Care." In *Cato Handbook for Congress: 108th Congress.* (Washington: Cato Institute, forthcoming 2003).

improve health outcomes for more people, and, secondarily, to facilitate their access to necessary *health care.* Greater health insurance coverage is only one of several means to accomplish that objective, not an end in itself.[40]

Opportunities to accumulate long-term savings in MSAs, FSAs, individual health savings accounts within two-tiered DC plans, and even Medicaid opt-out rebates would provide a further financial buffer to weather insurance coverage disruptions during transitional periods (job switches, unemployment, early retirement, welfare to work). Labor market competition should limit incentives for employers to abandon current ESI coverage offers, although employers may need to restructure their plans to deal with federal tax credit competition.

Subsidies

The primary subsidies for health insurance and health care spending would remain tax subsidies, unless and until it is politically feasible to pull all of them up from the tax code by their roots and branches.[41] Individual states may continue to set different income phase-out levels for Medicaid assistance. High-risk pool subsidies are pegged to the degree by which individual insurance premium quotes exceed standard rates, although states may wish to consider setting some secondary income criteria that link eligibility for such subsidies to private insurance premium levels that exceed a particular minimum percentage of one's annual income.

The optional federal tax credit is designed to "crowd in" workers who seek alternatives to current ESI offers, as long as they are willing to make the necessary cost-sharing trade-offs. The 30 percent tax credit is also designed to be more appealing to workers in lower marginal income tax brackets (the 15 percent bracket, plus a discounted portion of the full 15.3 percent employer/employee FICA payroll tax), and less appealing to higher-income workers who would benefit more from the current tax exclusion for ESI coverage.

Various deregulatory reforms that open up new private coverage options might crowd out some portion of current ESI coverage, to the extent that the former offer higher-value alternatives. Covered individuals currently benefiting disproportionately from regulatory cross-subsidies might need to rebalance their personal health spending with their personal health care costs in a more competitive, risk-sensitive pricing environment.

Removing access to free emergency room care (under EMTALA mandates) from insured individuals would reduce "free riding" by managed care plans, restore and perhaps expand emergency care capacity, and improve access to emergency care for the uninsured.

The optional federal tax credit is based on one's previous calendar year federal tax liabilities, authorized to be advanceable and transferable, and able to be administered through payroll deduction and/or list billing—all to reduce cash flow problems. Limited forms of multi-year income averaging may help to address beneficiary concerns about year-end reconcilability and recapture.

The Medicaid opt-out vouchers provide a slight opportunity to mainstream low-income beneficiaries with non-subsidized people in private insurance plans. However, there is nothing wrong with a little "welfare" stigma to the extent that it provides incentives to individuals to seek higher-paying employment, better insurance coverage, and economic independence. The medically uninsurable in state high-risk pools, on the other hand, are only partially subsidized because they still would pay approximately 150 percent to 200 percent of standard insurance rates.

Most of the proposed subsidies herein would come from the tax expenditure side of the federal budget ledger. Federal matching payments for state high-risk pools and disproportionately mandated emergency room care to the uninsured would flow through the Medicaid entitlement, rather than the annual appropriations, process.

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[40] See Cato Institute. "Will More Health Insurance Improve Health Outcomes?" Policy Forum, June 19, 2002 (http://www.cato.org/events/020619pf.html).

[41] See Tom Miller. "Health Care." In *Cato Handbook for Congress: 107th Congress.* Washington: Cato Institute, 2001, pp. 311, 313–17.

Financing

Necessary funding would be acquired through a combination of spending reductions within both current federal health programs and other federal non-health programs (a lengthy set of recommended budget cuts is available on request from the Cato Institute, and Congress continues to supply new opportunities to expand it on a regular basis), as well as reprogramming of current Medicaid spending. To the extent that the total amount of reduced federal tax revenue (due to individual tax credits) still remains greater than the reduced expenditure levels, we suggest that it would represent a more productive form of publicly held federal government debt than other, much larger amounts of currently "implicit" long-term debt for health care expenditures (Medicare). Incentives aimed at reducing the long-term trend in the growth rate of health care costs also would help any given level of spending to deliver more, and better, health care.

A portion of funding for high-risk pools would shift from the state level to the federal government, and the overall amount of such funding for assistance to the medically uninsurable would be likely to increase with more liberal eligible criteria.

Providing federal disproportionate share assistance to emergency care providers for the uninsured would shift some of that burden from the private sector (unfunded EMTALA mandates) to federal taxpayers.

We view private ESI benefits as job-based compensation by non-wage means. In that sense, the employee bears the ultimate cost of such insurance. Carving back regulatory cross-subsidies and reducing the tax bias favoring employer group insurance coverage would better match individual workers' personal health care consumption decisions with what they are willing and able to pay.

Insurance and Risk

We remain unperturbed by hypothetical concerns about adverse selection and risk segmentation in a more competitive, market-based private health insurance system. There is little evidence that individuals and families can identify and anticipate most of their future medical expenses in ways their potential insurers cannot. A recent study by Cardon and Hendel finds little empirical evidence of information asymmetries, market failure, and adverse selection in health insurance markets.[42] Differences in health expenditures between the insured and uninsured are mostly due to observable differences in demographics (age, gender) and price sensitivities (higher-income workers capture more tax subsidies for insurance coverage), rather than unobservable factors related to health status.

Private insurers do not need to remain helpless and clueless regarding potential adverse selection problems. In competitive markets, they may use a number of tools: set periodic limits on plan switching, vary premiums according to the amount of insurance purchased, underwrite and rate based on risk categories, create more homogeneous risk pools, or rely on the law of large numbers to diversify risks in large pools. Consumer inertia and individual differences in aversion to risk further limit the applicability of adverse selection theory to the real world.

Many difficulties we observe in health care insurance markets are due to government intervention rather than adverse selection or other market failures. If insurers are not allowed to charge different premiums to different risks, price predicted risk appropriately, and match their policy configurations to market demands, they will be more likely to resort to higher uniform prices, less savory practices like excluding or discouraging coverage of high risks, and, ultimately, market exit. Cream skimming

[42] James H. Cardon and Igal Hendel. "Asymmetric Information in Health Insurance: Evidence from the National Medical Expenditure Survey." *The Rand Journal of Economics 32* (3) (2001): 408–27. See also Stephen H. Long, M. Susan Marquis, and Jack Rodgers. "Do People Shift Their Use of Health Services Over Time to Take Advantage of Insurance?" *Journal of Health Economics 17* (1) (1998): 105, 112–15. Long et al. find little support for the hypothesis that people anticipate changes in their insurance status and arrange their health care consumption accordingly. The authors also find no evidence that people choose to purchase or drop insurance coverage in anticipation of change in their overall health care needs and conclude that insurer selection is an unlikely explanation for this failure to find quantitatively important transitory demand. However, they observe that recent state reforms aimed at eliminating or limiting some insurer restrictions on coverage of pre-existing conditions ironically might increase the ability of patients to adjust their treatment patterns for chronic conditions in anticipation of insurance changes.

(selecting only the best risks) becomes the insurers' mirror image of adverse selection by insurance customers. Political interventions fail to alleviate underlying differences in risk across customers or eliminate insurers' knowledge of such differences. They only force insurance companies to cope in inefficient ways and create new problems.

It is preferable to allow private insurers to do what they do best—evaluate risk and price it accordingly—and then deal with remaining outlier problems (for example, the medically uninsurable) through explicit, transparent public subsidies rather than more camouflaged regulatory cross-subsidies. We should separate support for societal objectives of income redistribution and protection against prohibitively expensive, but predictable, health risks from the competitive operations of commercial insurance markets.

Health status information is most likely to be asymmetric when it is scarce and costly. While government mechanisms prefer to ignore, hide, or shift those information costs, markets create proper incentives to discover efficient ways to signal relevant private information and put it to use.[43]

Deregulating insurance choices and providing greater tax parity for all insurance purchasers can fill the real gaps in private insurance coverage, by providing breathing room for further market innovations, such as new forms of voluntary risk pooling and long-term insurance contracts. The growing availability of online health information and insurance products further strengthens the case for empowered consumers.

Market mechanisms cannot eliminate every unfortunate human experience in health care access, affordability, and quality. Private charity and a backup safety net of transparent, direct subsidies have necessary roles to play. Unlike centralized government "solutions," markets do not promise perfect outcomes, just better ones.

[43] Stephen Shmanske. "Information Asymmetries in Health Services: The Market Can Cope." *The Independent Review 1* (2) (1996): 191–200.

Administration and Regulation

In most cases, administration and regulation of health insurance arrangements would remain predominantly at the state level (subject to the ERISA pre-emption for self-insured employer group plans, and new pre-emption protections for certain voluntary purchasing pools and insurance purchased with new federal tax credits). Consumer flexibility, rather than state flexibility per se, would be increased through greater interstate regulatory competition and arbitrage (competitive federalism). The Internal Revenue Service and the Treasury Department would play a large role in administering new forms of tax-code-based assistance and in regulating charitable care intermediaries handling "citizen appropriations" tax credits used for charitable health care purposes.

High-risk pools for the medically uninsurable should continue to be administered by states, but some degree of federal monitoring would creep in as a corollary to matching federal Medicaid funds.

A new federal administrative apparatus (hopefully modest) would be needed to handle federal matching payments for disproportionate uncompensated emergency room care provided to the uninsured.

Benefits

Apart from a generic list of the minimum "types" of benefits that must be included in private insurance eligible for optional federal tax credits, benefits could vary widely for different covered individuals. The most important component of such variation would be in the range of cost-sharing mechanisms and levels. Deregulated health insurance options should operate as "magnet health plans" that increasingly draw consumers away from more traditionally regulated insurance plans (in particular, fully insured employer group plans still subject to substantial state-level regulation).

Fit and Feasibility

The new system is designed to be evolutionary, based on incentives and market-opening opportu-

nities for a wider range of health care financing and delivery alternatives. The respective market shares for the latter would be determined by the preferences of empowered individual consumers, controlling more of their own money and responsible for the consequences of their decisions. We do not tear up the employer-based system, but we subject it to new competition on a more level playing field. To be clear, most of the "new" economic signals would point in the direction of greater cost sharing, less-comprehensive insurance coverage, and more individual consumer responsibility. But consumers seeking more security or more predictable long-term arrangements would be able to join together in particular health financing mechanisms that facilitate those preferences. (They just would find it harder, through political means, to force others to disproportionately subsidize their particular tastes.)

Individual workers, more so than employers, would be presented with expanded voluntary options rather than political mandates. The pace of change largely would be determined by their decentralized, pluralistic choices.

The current climate of annual double-digit percentage increases in health care costs, dissatisfaction with the mature version of managed care, and remaining political resistance to centralized command-and-control mechanisms points to greater acceptance of the last remaining, relatively unexplored health care reform option—putting choices back in the hands of individual consumers and competitive free markets.[44]

Equity

To a larger degree under the new system, you would get what you pay for, unless someone else wanted to pay for it voluntarily on your behalf. Income redistribution issues should be debated separately and resolved in the larger political arena, while we finally allow health insurance markets to operate more efficiently for the purposes for which they are best suited. The optional federal tax credit, designed as an uncapped percentage of insurance costs, is better adapted for coping with regional market cost differences as well as variations in the ex ante risk profile of individual customers.[45]

By focusing on safety net assistance that delivers health care, rather than health insurance, aid to those most in need could be targeted better, and at lower cost.

Quality of Care and Non-Financial Access

The ultimate arbiter of the quality of care should be the person who receives it and pays for it. Patients have more at stake regarding quality than any other party in the health care system. By more effectively combining consumption of care with its purchase (that is, less third-party payment), we are more likely to arrive at the optimal mix of access, cost, and quality.

A necessary role remains for separately targeted public assistance for special or vulnerable populations. But the proposed experiment in citizen-directed appropriations for charitable care via dollar-for-dollar tax credits is more likely to deliver legions of new, involved players on the compassion front, who actually know the type of people they are helping and care deeply about them.

The new system increasingly would distribute medical resources toward the places where individual consumers wish them to go, instead of where various medical providers, health industry vendors, and "enlightened" experts prefer to receive them. "Patient-directed" and "consumer-driven" health care would operate under new sets of directions. ■

[44] See James C. Robinson. "Renewed Emphasis on Consumer Cost Sharing in Health Insurance Benefit Design." *Health Affairs* (web exclusive March 20, 2002) (http://www.healthaffairs.org/WebExclusives/Robinson_Web_Excl_032002.htm).

[45] In using a 30 percent tax credit that is proportional to the cost of one's health insurance premium, instead of a fixed-dollar tax credit, we place greater emphasis on assisting a smaller number of higher-risk individuals in financing insurance coverage, rather than aiming simply to sign up as many lower-risk individuals as possible for less expensive, but perhaps also less necessary, insurance coverage. For a discussion of the trade-offs between these different approaches to insurance subsidies, see Mark Pauly, Bradley Herring, and David Song. "Tax Credits, the Distribution of Subsidized Health Insurance Premiums, and the Uninsured." NBER Working Paper No. 8457. Cambridge, MA: National Bureau of Economic Research, September 2001, p. 17.

Morone Proposal

Key Elements

James A. Morone has proposed a single-payer approach to provide universal coverage with the following elements:

THE MEDICARE PROGRAM with expanded benefits, including no cost sharing, would provide automatic coverage for all legal residents of every age.

FUNDING WOULD COME SOLELY from revenues raised by a new federal value-added tax.

STATES COULD OPT OUT (for residents under age 65) by proposing a program that meets federal guidelines and by paying 25 percent of the cost.

EMPLOYERS COULD OFFER COVERAGE for additional benefits, with the employer-paid premium not subject to income tax.

About the Author

JAMES MORONE is Professor of Political Science at Brown University. His *Democratic Wish: Popular Participation and the Limits of American Government* (Basic, 1990; Yale, 1998) won the American Political Science Association's 1991 Gladys Kammerer Award for the best book on the United States and was named a "notable book of 1991" by the *New York Times.* His *Hellfire Nation: The Politics of Sin in American History* is forthcoming in February 2003. Morone co-edited *The Politics of Health Care Reform* (Duke University Press, 1994) and *Health, Wealthy and Fair* (Westview, forthcoming). He has written more than 100 articles on American politics, history, and health care policy. Professor Morone received his B.A. from Middlebury College and his Ph.D. at the University of Chicago. He has been on the faculty of The University of Chicago, Yale University, and the University of Bremen (Germany). The Brown University classes of 1993, 1999, and 2001 voted Professor Morone the Barret Hazeltine Citation as teacher of the year. Professor Morone has testified before Congress numerous times. He was a secretary and member of Governor Cuomo's task force on Universal Health Care for all New Yorkers (UNY*CARE) and a member of the National Academy of Sciences Committee on the Social and Ethical Impacts of Developments in Biomedicine. He is on the editorial board of six scholarly journals and chairman of the board of *PS: Politics and Political Science* and *The Journal of Health Politics, Policy and Law.* He is a founding member of the Health section of the National Academy of Social Insurance. He is currently president of the New England Political Science Association and immediate past president of the Politics and History section of American Political Science Association. Professor Morone has won multiple grants, including an Investigators Award from The Robert Wood Johnson Foundation.

Medicare for All

by James A. Morone

Overview

Medicare for All proposes a sharp break with both the current health care system and with conventional wisdom. The proposal begins with the assumption that the problems of American health care—most notably the problem of the uninsured—will not be fixed by tinkering at the margins. Nor will they be fixed without popular agitation, without a movement.

This is not a proposal geared to the current Congress, but it does build on and improve one of the nation's most popular public policies. It is easy to understand. It is a proposal that citizens could rally around. And, given the trends in the American economy and the health care system, it might eventually prove to be more politically feasible—and effective—than programs lodged more securely in conventional wisdom.

The proposed program would improve the Medicare program and extend it to all legal residents. *Medicare for All* would cover a broad range of health care services: acute care, prescription drugs, mental health services, maternal and child health, and other services detailed below.

The proposed program addresses our health care delivery systems by placing strong emphasis on primary care. *Medicare for All* would fund primary health care in non-traditional settings. For example, it would foster community health centers and school-based health centers. More important, it would rethink and vastly expand the delivery of home health services, especially to the elderly and disabled. A generation ago, the medical profession resisted these kinds of innovations in care settings; today, the managed care revolution has prepared the way for such alternative practice settings.

Medicare for All would break with current financing arrangements. Medicare payroll taxes would be abolished. Medicare would not draw from general revenues. There would be no cost sharing. The current benefit limits (which force some elderly to spend down their life savings) would be eliminated. Providers could not bill their patients for covered services.

The system would be financed by a value-added tax (VAT) specifically earmarked for the new program. Today, the VAT is championed by a range of political bedfellows. In the United States, many fiscal conservatives seek to replace the income tax with a VAT; some tax specialists would combine the VAT with an income tax paid only by relatively wealthy people. And the VAT is the major tax used (in fact, required) by the European Union. In short, this is a familiar tax with a substantial track record. Turning to the VAT cuts through the Gordian knot of health care finance. The VAT's potentially regressive effects could be offset by graduated income tax reductions for low- and moderate-income taxpayers.

Employers could continue to offer health benefits by providing wraparound coverage that fills in the gaps in *Medicare for All* (such as dental insurance, expanded mental health benefits, or amenities such as private hospital rooms). These would be equivalent to contemporary Medigap policies. The tax advantages that accrue to employer-sponsored health benefits would remain in place.

Medicare for All would permit states to experiment—essentially mirroring Medicaid waivers. Any state could opt out of the Medicare program for residents under age 65. States that chose to opt out would design their own alternatives—under simple

federal guidelines. State plans would be required to guarantee universal coverage, they would have to offer health options with no cost sharing, and they would be required to organize their plans in a simple and transparent way. While Medicare would be fully funded from the VAT, state plans would get 75 percent of costs, matched by funds raised at the state or local level.

Medicare for All puts special emphasis on organizing an efficient bureaucracy. It would establish a new cabinet-level Department of Health, which would be charged with creating a simple, transparent, user-friendly health care system. By putting an end to multiple payment sources and extensive patient cost sharing, the proposed system would end some of the major sources of complexity in the American health care system. The new program would operate with electronic billing and payment. Major organizational initiatives would include a benefits board that would review, evaluate, and update the benefits package and a division for community health.

The existing Medicare program would be streamlined—for example, we would eliminate the arbitrary division between Part A (hospital) and Part B (physician services). Medicaid would become a smaller program focused largely on long-term care benefits.

Breaking with the Old Logic

Medicare for All introduces two sharp changes from current practice. It breaks the link between coverage and employment—a great American innovation rendered increasingly obsolete in the new global economy. And it limits the long, futile American effort to run a system with competing health care payers.

First, consider the link between employment and health insurance. The idea developed during World War II when health care benefits sidestepped wartime wage limits. It got a further boost from post-war policy, especially the seminal Taft-Hartley Act (1947). The approach was well geared to an industrial sector marked by stable (often lifetime) employment, relatively predictable domestic markets, and regular labor-management relations. By 1979, more than four out of five full-time employees got their health care from their employers. The numbers have declined ever since (with a brief uptick in the 1990s).[1] Rising health care premiums take a steady toll on the employment-based systems; and the apparent return of relentlessly rising costs (employer health insurance premiums increased three times faster than the rate of general inflation in 2001) have eroded a long-standing faith that corporate America would have the will and skill to rein in its health care costs.[2]

More important, the old industrial economy is sinking into history. People shift jobs frequently—lifetime employment with a single firm has become unusual. Global trade and fierce equity markets put enormous pressures on firms (and on their employee benefits). Contingent and part-time workers, consultants, and other flexible arrangements all undermine the kind of long-term commitment to employees that nourished the old system of health benefits. Of course, the pressures on companies vary by sector and firm—most large companies still offer health benefits; most small firms no longer do. However, the numbers are declining in every category. Efforts to reform the system by shoring up employer health care confront the new realities of an emerging global economy. As the quicksilver economy of the 21st century gathers velocity, the mid-20th century employment-based health system will be increasingly difficult to defend—or revive. It offers patchy coverage, it offers few footholds for expanding coverage to the uninsured (or the underinsured), and it places a heavy burden on many companies. Put bluntly, its days are numbered. As that becomes clear, *Medicare for All* may stand out as an appealing reform alternative.

Second, this plan largely rejects one of the great

[1] See Marie Gottschalk. *The Shadow Welfare State.* Ithaca: Cornell University Press, 2000, for a fine description of Taft-Hartley and, more generally, the rise of the employment health care state. See also Michael Graetz and Jerry Mashaw. *True Security: Rethinking American Social Insurance.* New Haven: Yale University Press, 1999, chapter 7.

[2] *Employer Health Benefits: 2001.* The Henry J. Kaiser Family Foundation and HRET, pp. 3, 13, 14; Lawrence Brown. "Dogmatic Slumbers: Business and Health Care Policy." In James Morone and Gary Belkin (eds.). *The Politics of Health Care Reform.* Durham, NC: Duke University Press, 1994.

health care reform standards: consumer choice of health plans. (States that opt for their own health plans may keep the idea alive.) In theory, American health care offers two different kinds of consumer choice: the choice of provider is one of the great—and unassailable—values in American health care. That is not the same as choice of insurers. The idea of competing insurance packages has been a kind of holy grail for health reformers; the idea is intuitively appealing, because it more or less fits with traditional economic models. Consumers choose among competing plans, selecting the mix of price and services they most value.

However, the reality has rarely met expectations. In the real world, the choice of insurance packages is a source of confusion and frustration. People have no idea how to cut through the complexities. They do not understand what exactly they are buying or what trade-offs they are making. A full range of options is rarely available to them in any case (nine out of 10 small employers offered just one plan in 2001).[3]

Worse, the two kinds of choice often conflict: choice among competing health plans leads to limits on the choices that really matter to most people, a choice among health care providers. That, in turn, has led to the political backlash against managed care. *Medicare for All* challenges the conventional wisdom: competition among insurance plans is an idea that has never worked except in special circumstances. Medicare's current beneficiaries do not miss it, nor will the rest of the population when Medicare is extended to them.

Benefits and Coverage

Fixing Medicare

The first step for the proposed program involves fixing Medicare itself. The program's organization and benefits package (introduced in 1966) makes little sense today. Medicare is divided into two parts: Part A covers hospital costs and is financed by a payroll tax; this was the package that Medicare's proponents originally proposed. Part B (Supplementary Medical Insurance) was originally a voluntary program covering physician services and out-of-hospital expenses; it was proposed as a Republican answer to Medicare and dramatically added onto the package in the House Ways and Means Committee. Part B is funded 25 percent by beneficiary premiums and 75 percent from general revenues. Today, almost all Medicare beneficiaries participate in both parts of the program.

Medicare for All would abolish Parts A and B. A general benefits package would be available to all Americans. The financing mechanisms for both A and B would be abolished.

The benefits package would begin with current Medicare services: inpatient hospital services, physician services, short-term nursing care, home health services, hospice care, and post-hospital skilled nursing care and rehabilitation services.

Medicare operates with some gaping benefit holes that would be closed under the proposed plan. For example, outpatient prescription drugs and durable medical equipment would be covered. More generally, a careful review of the benefits package would be undertaken (and updated every two years, as described below). In part, Medicare services would have to be tailored to the entire population. Such benefits as maternal and child health care costs would be covered by the program.

Today, reformers often criticize Medicare for not protecting beneficiaries from catastrophic costs. People over 65 who do not have good supplemental insurance run a real risk of being impoverished by their medical expenses. That risk would be eliminated by abolishing patient cost sharing altogether.

Community Medicine

Medicare, like most of the American health care system, emphasizes highly technical sickness insurance. The closer a patient gets to the operating theater, the more sophisticated—dazzling is not too strong a word—American medicine generally gets. *Medicare for All* would make a strong commitment to the other end of the health care spectrum. The program would emphasize full access to primary care and early intervention.

Medicare for All would create a special Office for Community Medicine, which would oversee a new

[3] *Employer Health Benefits, 2001,* p. 7.

initiative in community-based programs. In some cases, this would mean returning to old efforts such as community health centers; in others, it would involve major new initiatives. Take four important examples: community health centers, school-based health centers, home health services, and drug treatment facilities.

In the mid 1960s, the Office of Economic Opportunity launched a national network of community health centers (CHCs). The centers were meant to overcome the shortage of services in poor neighborhoods. They were originally conceived as a companion to Medicaid: Medicaid would overcome financial barriers to health care, and the CHCs would address other barriers by rethinking service delivery systems. Reformers expected the two programs to grow at roughly the same rate and predicted 1,000 centers serving some 25 million poor people by 1973. Of course, Medicaid grew, while the CHCs, which proved to be too sharp a departure from the existing models of medical care delivery, faded. The medical profession resisted the idea of working in health clinics that were not organized on a fee-for-service basis. Ironically, the managed care revolution has largely broken the professional resistance to what was once a radical service delivery innovation. Physicians routinely work in clinics and are often salaried. *Medicare for All* would return American medicine to the clinic model, funding a network of community health centers through state departments of health.

The program would also offer funds (on a per capita basis) for any school district that established a school-based health center. This is a popular intervention; over 1,000 school health centers have sprung up in the past decade. The idea is to get primary care to children and youths by going to where the kids are. The school-based clinics seem especially effective at getting care to teenagers—a population that is difficult to reach, especially in poor and immigrant neighborhoods. The centers offer annual physicals, mental health services, and reproductive health services, among others.[4]

Finally, one of the great, silent innovations in American medicine lies in the army of home health workers that has sprung up to care for the elderly, disabled, and very sick. Three-quarters of a million dedicated, low-wage workers are offering care and compassion in American communities. The Office of Community Medicine would place home health services in an entirely new framework. Currently, Medicare's home health services operate as an alternative to skilled nursing facilities. Eligibility is tied to hospital discharge and acute symptoms. However, a rapidly aging society is going to require far more extensive, but less intensive home health care. Old people need a vast range of help in the simple activities of daily living. Some of these activities are not medical: getting dressed or getting in and out of bed, for example. Other services involve very minor medical interventions: changing bandages, administering eyedrops, giving drugs, monitoring blood pressure, caring for skin wounds.

Today spouses and children provide much of this care. However, by all accounts, it is exhausting; aging spouses, in particular, often require help to care for their partners. Recent studies document the extraordinary contortions home health workers go through to qualify elderly clients for Medicare (looking for skin sores, for example). Under current rules, Medicare calls that fraud. Scholars like Deborah Stone counter that it looks to them a lot more like simple decency. In any case, an aging society is going to require enhanced home health care—and simple care that helps elders get through their daily activities while assisting with routine medical tasks fits the emphasis on community care that characterizes *Medicare for All.*[5]

Another important benefit is drug addiction treatment. The United States has, in the words of former Clinton drug czar Gen. Barry McCaffrey, "some five million people chronically addicted to drugs [who] are a total mess." Since the mid-1980s, the policy response has emphasized police action—incarcerating addicts at extraordinary rates. Drug policies have fueled an expensive (and extensive) penal regime; one in 33 Americans is now in jail or prison,

[4] See James Morone, Elizabeth Kilbreth, and Kathryn Langwell. "Back to School: A Health Care Strategy for Youth." *Health Affairs* (January/February 2001): 122–36.

[5] See Deborah Stone. *Reframing Home Health-Care Policy.* Cambridge, MA: Radcliffe Public Policy Center, 2000.

on parole, or under probation, about a third of them for drug offenses. *Medicare for All* would offer states treatment funds for first- and second-time drug users. The goal would be to shunt addicts from incarceration to treatment, a strategy now stirring in New York, California, and other states.[6]

The Benefits Commission

The benefits package would be overseen and updated by a commission. The Medicare experience offers a warning—echoed by the experience of national health insurance in some other nations. Political systems often freeze a benefits package into place; they rarely keep up with new health care technologies as efficiently as market systems do. The result of this program would be growing inequity: people with good wraparound policies would enjoy a more flexible and up-to-date benefits package. The problem tends to grow more acute in the generations after the program has been put in place—Medicare's failure to cover prescription drugs is a good example.

To begin to address the problem, *Medicare for All* would empower an independent national commission that would include representatives of provider groups, consumer groups, public officials, and local representatives. The commission would issue a biannual report on health care benefits proposing adjustments to keep up with medical technology.

The commission would report to the Secretary of Health, who, after review, would submit a proposal to Congress under fast-track authority. Congress would then vote the benefit changes up or down without amendment.

Cost Sharing

The proposed program would operate without any cost sharing, a perennial issue among health specialists. On the one side, analysts argue that cost sharing brings the discipline of economic calculation to bear on people's health care choices. On the other side, critics contend that cost sharing leads people to put off needed care; it discriminates against poor people, leads to worse health at lower income levels, and gets gamed by medical providers who often influence the use of services. There is good evidence for both sides of the argument—indeed, the two views are not incompatible.

However, the entire cost-sharing debate is not central to the current proposal. A single-payer, tax-based, health care system such as the one proposed here does not require cost sharing to control costs; it has a more formidable cost-control mechanism (tax resistance, discussed below). Almost all industrial democracies operate with few (if any) cost-sharing mechanisms.[7]

Without cost sharing, another trouble with contemporary Medicare could be addressed: its maddening complexity. Forms and statements could be kept brief and simple. Likewise, providers ought to be freed from the tyranny of billing that plagues every medical practice. An advisory committee of consumer and provider representatives, selected for three-year terms, would offer an annual report on program transparency.

Option Two: State Plans

The proposed system would offer states the option of forming a health care alternative for citizens under 65. States would apply for waivers and, following federal guidelines, organize and operate their own health care financing systems.

The guidelines could be kept relatively simple and would include the following:

• States would be required to guarantee universal coverage to all legal residents.

• States would be required to at least offer all residents a benefit package equivalent to *Medicare for All.*

• States would offer at least one plan without any cost sharing (again, equivalent to *Medicare for All*). Of course, states might choose to organize systems that also offered other choices—for example, front-end rebates with higher cost sharing for people who fell ill.

• All plans offered in a state must safeguard against catastrophic costs.

[6] James A. Morone. *Hellfire Nation.* New Haven: Yale University Press, 2003, chap. 15.

[7] My discussion of cost sharing follows Richard Kronick and Thomas Rice. "A State-Based Proposal for Achieving Universal Coverage" In Jack Meyer and Elliot Wicks (eds.). *Covering America: Real Remedies for the Uninsured.* Washington: Economic and Social Research Institute, pp. 123–4; see also the essays in *Journal of Health Politics, Policy and Law (*October 2000 and Fall 1995).

• The states would guarantee portability by reimbursing the federal Medicare program for care delivered to residents traveling in other states.

The state plans would be vetted for simplicity and transparency; they would be monitored and rated for costs, quality, and access to care. Plans that experienced significantly higher inflation rates or substantially lower access to care would not be renewed after five years.

Federal funds would provide 75 percent of the cost of the state program; states would find other sources for the remaining 25 percent. If state health care taxes were levied for the remaining 25 percent, individuals would receive limited exemptions on their income taxes, though the rebates would not cover the full tax burden.

For proponents of *Medicare for All,* this will seem an odd twist to the system. After all, to its partisans, the proposed plan's biggest difficulty will be overcoming the political hurdles to its realization. Once those victories are finally won, why raise all the complications of state alternatives? After all, there has been no popular outcry for waivers from the current Medicare program—despite all the problems the program has developed over the years.

The answer lies in the politics of innovation. State-level experiments would try out fresh ideas and innovations. Those that prove successful could be imported to the national programs. Many (perhaps most) successful social programs have their origins in innovative state efforts. A handful of state-level experiments, overseen and largely funded by the federal government, would foster innovation and creativity in the national program.

If the federal program began to falter over the years (by not keeping up with innovations in medicine, for example), ambitious politicians in innovative states might find it appealing to try and organize their own alternatives. The prospect would pressure federal policy makers to remain responsive, especially after the program has been running for some time.

Still, state programs would prove difficult to sustain over time. Successful programs would require skillful oversight and administration; the most successful state officials often move up to better positions in the federal government or the private sector. Moreover, states cannot engage in deficit spending, so economic downturns are likely to pressure states to participate in the national program. Finally, *Medicare for All* is likely to prove extremely popular with the public—like Medicare and Social Security. National administrators may very well need to tinker with the incentives to state policy makers if they are to keep a handful (say three to five) of states experimenting with health plans. Failing that, of course, the state option would simply fall into disuse.[8]

Skeptics of *Medicare for All* will have far more positive predictions about the prospects for state plans. It might be politically useful to let the states try to do better than *Medicare for All.*

Financing

Medicare for All introduces a sharp break with current health care financing. Today, Medicare (Part A) is financed by a payroll tax currently pegged at 2.9 percent and split between employers and employees. Part B is funded largely (75 percent) out of general revenues, with the rest coming from monthly premiums paid by enrollees.

For middle-class Americans, tax-subsidized employment plans are the most important source of insurance. More than 80 percent of households earning $50,000 or more are offered coverage by employers; in contrast, only a third of households earning between $15,000 and $20,000 are offered insurance coverage by employers.[9]

Medicare for All puts an end to this patchwork. Medicare payroll taxes are abolished. So are Medicare premiums. General revenue funds are freed for other uses. Employers can offer supplemental and wraparound policies, but workers are not reliant on them for basic medical care coverage.

Instead, the proposed program would be funded by a value-added tax (VAT), mentioned earlier. The value-added tax is a kind of national sales tax. However, rather than simply apply the tax to retail

[8] See Harvey Sapolsky, Jamie Aisenberg, and James A. Morone. "The Call to Rome: Obstacles to State Level Innovation." *Public Administration Review 47* (2) (April 1987).

[9] Graetz and Mashaw, p. 139.

sales, the VAT is paid every time a product is sold. For example, a VAT is added when a manufacturer sells a product to a wholesaler, when the wholesaler sells to a retailer, and when the retailer sells to the consumer. Put differently, the difference between a business's purchases and its sales is its value added. A portion of the tax is applied to every stage in the production process.[10]

The VAT is the official tax of the European Union. All but two nations in the Organization for Economic Cooperation and Development (OECD) rely on it. (The European single market has not gotten its member countries to agree on the VAT rate, however, which still varies from nation to nation.) In the United States, the VAT is championed by fiscal conservatives who would replace the entire income tax with a VAT. Former Rep. Sam Gibbons (D-FL) and Sen. Ernest Hollings (D-SC) have proposed the most recent shift to a national VAT.

Why a VAT? Because health care comprises the largest sector of the American economy. Nationalizing the funding has many advantages—as most other nations have discovered (and as I discuss in the last section, below). There is no question, however, that it would be extremely expensive. We are not likely to fund the American health care system by squeezing a bit more out of our businesses, juggling payroll taxes, or turning to general revenues. Instead of the usual pastiche, a VAT offers a clear, transparent, familiar way to cut through the conundrum of health care financing. This is not a theoretical idea but a practical source of revenue that can be studied in action across the industrial world before being put into place to fund American health care.

In short, consumer spending—the motor of the American economy—would provide the funds that finally solve the seemingly endless crisis in American health care.[11]

Two criticisms of the VAT are worth noting:

First, VATs are usually criticized for being sharply regressive. People earning $15,000 a year typically spend all their income on consumption items. Those earning $150,000 typically spend less on consumption, so they pay a smaller percentage of their income in taxes. There are many ways to relieve VATs of this regressive quality, however. *Medicare for All* would not tax food, medicine, or shelter. Moreover, the tax would be linked to an expansion of the earned income tax credit. That is, income tax relief could render the tax burden neutral for people earning less than $30,000 a year; the tax credit would gradually phase out for individuals earning between $30,000 and $45,000 a year.

Second, critics caution that a federal VAT might compete with state revenues. The states have traditionally relied on the sales tax, while the federal government has used the income tax (at least since the 1920s). But things have been changing in the states. By 1997, less than half of total state revenue (48 percent) came from sales taxes. In fact, the states themselves increasingly rely on incomes taxes (they now account for 39 percent of total state revenues). Moreover, *Medicare for All* solves the problem of health care finance—in many ways, the largest challenge facing state budget directors. On balance, the *Medicare for All* is a good deal for the states.[12]

Of course, any new tax system will take time to implement. The Internal Revenue Service (IRS) studied the implementation burden of converting the whole tax system to a VAT (in 1982) and estimated that the tax would apply to 20 million firms and would take some 18 months to put in place. Implementation of *Medicare for All* would require enough time (and attention) to get the tax changes right.[13]

Existing Programs

Employers

Medicare for All would end the longtime practice of relying on employers as the primary provider of

[10] See Michael Graetz. *The Decline (and Fall?) of the Income Tax.* New York: Norton, 1996.

[11] Though it is beyond the scope of this discussion, I would propose using the VAT to fund the two great American social problems: health care and education. A per capita grant to states for education funding (tied to per capita income) would also offer a way to solve the education funding dilemma and promote a basic and equitable floor for all students. Covering both health care and education would reflect American values by offering all Americans a real opportunity. I develop this plan elsewhere.

[12] Data computed from U.S Census Bureau. *Statistical Abstract of the United States* 1999 (119th ed.). Washington, DC, 1999, pp. 325–7.

[13] Graetz, p. 200.

health care insurance. As noted above, those practices developed in a very different social and economic context. If health premiums continue to rise faster than the general rate of inflation, employer-based health care will rapidly erode. But if the United States turned to *Medicare for All,* many companies would still want to offer some health benefits to employees. Some, for example, would find those benefits a good way to recruit and maintain valued workers.

The proposed program would encourage employers to continue offering health benefits. Employers could offer coverage that wraps around the *Medicare* benefits package. Such coverage might include dental benefits, enhanced mental health benefits, or hospital amenities such as private rooms. Even in the early years of Canadian Medicare (as they call their national health insurance), private insurers thrived by filling the gaps in what was back then a very generous package of benefits.

To encourage employer health benefit packages, the tax subsidies for employer health insurance would remain in place. This issue raises another difficult choice for supporters of a *Medicare for All* system: just how egalitarian a system should we be aiming for? Looking cross-nationally, even single-payer systems vary enormously on the level of equity designed into the system.

The argument against subsidizing employer benefits is simple: it fosters a multi-tier, unequal system from the start. As cost constraints begin to clamp down on the public system (discussed below), these differences will tend to grow. Over time, individuals with good wraparound coverage will have access to better facilities, new forms of treatment, and so forth. Encouraging supplemental policies will only hasten the development of inequalities. From this perspective, basic equality of opportunity—simple justice—requires treating people in equal circumstances in equal ways.

Although these are powerful arguments, there are compelling reasons to encourage employer supplementary policies. The United States is a markedly unequal society. *Medicare for All* addresses health inequities in dramatic ways. However, wealthier people will always seek better care and more amenities, and private insurers will find and offer services that Medicare does not cover. In this context, encouraging companies to offer supplemental health benefits has numerous advantages: it increases the number of people with access to enhanced benefits, it accommodates the relentless American quest for "business class" upgrades, and it creates a market for innovation and luxury that is often missing in nationally funded health care systems.

The great trade-off lies in creating a first-rate health care system for all Americans on the one hand, and accommodating demands for different tiers of care and service on the other hand. To make the balance work, *Medicare for All* would not permit providers to extra-bill patients for covered services; the program itself would fully reimburse providers. On the other side, private insurance markets would pick up and develop benefits not covered by *Medicare for All.* Making this balance work will take careful oversight.

The Medicare Benefits Commission would be required to report to Congress on the state of the benefits package every two years. One of the commission's important tasks would be to scan the private insurance markets to ensure that important health care services were not migrating from public to private systems. This would be a significant danger as decades pass: medical progress introduces new therapies, program cost constraints grow, and private insurance markets stand ready to take up the slack. A well-run system would keep a close eye on private-sector innovations to keep Medicare up to date.

Medicaid

Medicare for All would replace a significant part of Medicaid. The new program would cover acute care benefits for every age group. Most of the services covered by the State Children's Health Insurance Program (S-CHIP), for example, would be turned over to the new program. Medicaid would also be relieved of paying Medicare premiums and copayments for low-income elders (since *Medicare for All* would operate without cost sharing). The new program's community health benefits and home health benefits would offer additional health coverage for

low-income and older people. Taken together, these changes would offer enormous budget relief in many states.

Some important features of the Medicaid program would remain. Most significant, Medicaid is currently the single largest expenditure source for nursing homes (covering just under 40 percent of total costs for the elderly). Though it is beyond the scope of this chapter, reduction of Medicaid's responsibilities (along with budget relief to most states) would offer an opportunity to finally rationalize funding for long-term care.

Administration

Health would be removed from the Department of Health and Human Services (HHS), carefully reorganized, and elevated to a cabinet-level department. Organizational details do not attract much media scrutiny, but, at the end of the day, a plan such as this one can thrive only with a sensibly organized, reasonably financed, and well-motivated bureaucracy.

Classic bureaucratic theory suggests that organizations with a bold new mission and adequate resources tend to attract more motivated workers. There is supposed to be a life cycle to bureaucratic agencies—the peak comes early on when the agency faces large challenges and forges new routines. Looking back on Medicare's implementation, for example, Lyndon Johnson described it as the greatest organizational mission the nation had undertaken since the invasion of Normandy. But effective organizations do not spring up spontaneously; they have to be assembled with care.[14]

In the high drama of winning health reform, the shape of the bureaucracy is overlooked—a detail, an afterthought. Ignoring the details early on will produce chaos during implementation.[15]

Planning for the new organization should begin very early in the political life of the proposed program. (That should be true for every proposal in this collection, incidentally.) Before *Medicare for All* is even introduced, a small bipartisan panel of former health officials (to include the last eight Health Care Financing Administration [HCFA] administrators) would develop an organizational plan for the new Department of Health, the administrative agency responsible for the proposed program. Those details may actually matter more for the health of this (or any) reform, than far more visible questions such as the details of the benefits package.

The committees already noted in this proposal signal some of the most important organizational elements of the proposed program. They include:

- an Office of Community Health;
- a Benefits Board to oversee the benefits package and keep it up to date over time; and
- a paperwork and simplification board, made up of both consumers and providers. As Medicare developed, it became extraordinarily complicated for both beneficiaries and providers. The new program should make a commitment to simplicity and transparency—and vest that commitment in a visible part of the agency.[16]

Simplicity is an especially important issue for the American health care system. A half-century of health care inflation, all the programs designed to deal with that inflation, a vibrant market for health insurance products, and a host of other factors have produced an extraordinarily complicated and inefficient system. Enormous resources are squandered in determining eligibility or negotiating reimbursements from multiple sources. A single-payer system with no out-of-pocket costs can bring a welcome simplicity—but only if policy makers are committed to achieving it.

A single-payer regime could be organized around a simple, national, centralized, electronic method of paying claims. A swift, efficient, and simple reimbursement regime would be the greatest spur to medical system productivity in recent history—it

[14] For a classic summary of the literature on bureaucracy, see Anthony Downs. *Inside Bureaucracy.* Boston: Little Brown, 1967; Lyndon Johnson. *The Vantage Point.* New York: Holt, Rinehart and Winston, 1971, p. 220. See also Judith Feder. *Medicare: The Politics of Federal Hospital Insurance.* Lexington, MA: Lexington Books, 1977.

[15] This, incidentally, was one of the most serious flaws with the Clinton health proposal, though it never got much press. See James A. Morone. "Organizing Reform." *The American Prospect* (Spring 1994): 11–12.

[16] On Medicare's growing complexity, see T. R. Marmor. *The Politics of Medicare.* New York: Aldine, 2000, p. 107; and John Oberlander. *Medicare and the American State.* Ph.D. Dissertation, Yale University, 1995.

would release medical providers from their paperwork, and it would yield enormous cost savings; estimates range as high as 25 percent of health care costs.[17]

Practical Considerations

Political Feasibility

By the standards of contemporary politics, this is not a practical proposal. It would not be taken seriously, for example, in the current Congress.

However, American political history is full of far-reaching changes—both liberal and conservative—that seemed chimerical when first proposed.[18] The key to successful change lies in at least two factors: first, advocates have to develop a plan, publicize it, and push, push, push. Second, they have to find a following—a movement—that mobilizes and demands the change. Solving the American health care puzzle (with 40 million uninsured people *and* runaway costs) will take precisely that combination. Really fixing American health care will require one of the great reform efforts in American history. And that is not likely to happen without a popular outcry, a movement.

Medicare for All does not make much sense if measured simply by contemporary Beltway politics. But few other proposals are as well geared for generating a populist uprising. In that sense, it may ultimately prove more feasible than proposals that try to cover 40 million people with elaborate (and, to the layperson, incomprehensible) compromises, complications, and concessions.

Political History

The issue of feasibility can usefully be put in the larger context of policy change over time. Political historians often describe American political development as a process of punctuated equilibrium. Under normal conditions, the fragmented political system—with checks and balances everywhere—seems designed for stalemate. Only relatively small, incremental changes successfully negotiate the political process. Most of the time, American politics is the politics of tinkering on the margins. Most reform proposals sensibly reflect that reality. But over time, demands for larger change build up. Those underlying demands eventually are met in recurring moments of vast, tectonic change—like the New Deal or the Great Society. *Medicare for All* is based on the premise that fixing America's health care dilemma will take a comparable change.

Reformers who agree with that assessment ought to set their sights on the longer term. Leave others to work for incremental improvements and, instead, begin rallying support for a plan that is likely to address our health problems in a systematic and popular way. Medicare's supporters pushed for more than a decade (without much to show for it) before their opportunity came.

Cost Control

Though many Americans will find it hard to believe, the cross-national experience is unambiguous: single-payer systems (featuring monopsony buyers) offer the most effective methods of health care cost control. Indeed, over time they tend to create the opposite problem, they control costs too tightly. Why? Because public funding means that every rise in health care costs is very visible—it translates more or less directly into a rise in taxes. And there is no greater spur to cost control than tax resistance.

In 2002, many private corporations experienced double-digit health care premium increases. Some universities, for example, faced a 50 percent rise in premiums. Such increases pose serious problems for employers and workers, of course. But spread over thousands of institutions, the problems are local and dispersed. In contrast, a large premium increase in a single-payer system creates a crisis, because meeting the higher costs requires raising taxes. That dispersed problem becomes highly concentrated. Of course, employees are going to pay the premium increases, either directly or indirectly. In a nationalized system, however, those increases immediately become political. There's nothing like the prospect of

[17] See Elliot Wicks, Jack Meyer, and Sharon Silow-Carroll. "A Plan for Achieving Universal Coverage." In *Covering America,* p. 196.

[18] For examples—from the abolition of slavery to the prohibition of liquor, from racial desegregation to welfare reform, from social security to gender equality—see Morone. *Hellfire Nation;* Morone. *The Democratic Wish.*

a big rise in taxes to focus the public mind on effective cost-control measures. The chronic American health care problem—rising costs—would suddenly become politically unacceptable.

Is there anything comparable to a single-payer health system in American politics? Arguably, defense spending. Here is another highly technical industry performing services simultaneously vital and baffling to the layman. Health care providers are asked to square the circle among quality, access, and costs; likewise, defense contractors are asked for timeliness, high performance objectives, and low cost. There are many other similarities and one great difference. Defense is funded—as *Medicare for All* will be—by the government. And in contrast to health care, defense spending remained under tight control throughout the entire Cold War. Even with the American way of life at stake, defense spending never rose more than five years in a row as a percentage of gross domestic product (GDP). And, after the 1950s, it consumed a steadily diminishing portion of the American economy despite occasional rises (in 1965–67 and 1974–75). The Reagan administration's defense spending perfectly illustrates the syndrome of government-controlled expenditures: a popular politician articulates a new demand for spending; Congress allocates a large increase in funds; spending rises relative to other national priorities. However, the growth soon runs up against competing national goals, other programs, tax resistance, and alarm over the deficit. After the early and mid-1980s, defense spending flattened out and, once again, began to decline again as percentage of GDP.[19]

In short, for a nation that especially hates tax increases, the problem with a plan like this one is likely to be *too much* cost control.

Access to Care

The proposed plan would solve the problems of access to care. All legal residents would have health insurance, and they would pay no costs at the point of service. Providers would not be permitted to extra-bill their patients; Medicare would pay the costs in full. Moreover, the plan also addresses other barriers to access: community health centers, school clinics, home health benefits. Each feature of the plan would help ensure broad—and unprecedented—access to health care.

Innovation

Broad access and lower costs come at a price. *Medicare for All* would very likely dampen the fast pace of innovation in American health care. National systems are slower to adopt new organizational forms and new technologies. Today, the American system is marked by nothing so much as the proliferation of new insurance products, new medical technologies, and new organizational models (that fly rapidly in and out of favor—remember managed care?). This feature of the American system would diminish even as we solved cost and access problems.

One reason to continue encouraging employer-sponsored health insurance is to maintain a market (albeit a smaller one) for innovative services and technologies not covered by the new national program. On balance, I have argued, the risk of injecting inequality back into the health system is worth taking in exchange for the innovations the private market is apt to stimulate. The key, again, is to organize *Medicare for All* to monitor and adopt the best innovations of the private insurance sector.

Quality of Care

Nothing will improve the quality of care for more Americans than extending health insurance to the 40 million people who do not have it (or the 30 million more who do not have enough). That said, the proposed plan marks a shift in American health care priorities. This plan emphasizes primary care and low-technology interventions—home health workers are a good example.

On the other side, the grip of cost control will loosen the irresistible march of high technology. This plan is likely to force hard choices about heroic measures undertaken on the very sick and the very old. Americans will be much slower to perform heroic measures that prolong life for a matter of weeks. Does that diminish quality of care? In some

[19] For the defense spending analogy, see James A. Morone. "Beyond the N Words: The Politics of Health Care Reform." *Bulletin of the New York Academy of Medicine* 66 (4) (July–August 1990): 344–65.

ways it does. And yet, anyone who has recently watched a dying loved one run the gauntlet of high technology may very well think not.

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Section II

Commentaries on *Covering America* Proposals

Ferguson, Riley, and Rosenbaum

Commentary Abstract

Christine Ferguson, **Patricia Riley**, and **Sara Rosenbaum** argue that reformers who would replace or significantly change the structure of Medicaid need to understand and consider carefully the crucial roles that Medicaid plays in state government. Failure to do so could jeopardize key activities of state government and leave many people without social services that are vital to their well-being.

About the Authors

CHRISTINE C. FERGUSON has served in the highest levels of state and federal government with honor and distinction for more than two decades. As the Director of Human Services in the State of Rhode Island from 1995 to 2001, Ms. Ferguson managed the largest agency in the state as an appointee of Governor Lincoln Almond. She oversaw nearly one-third of the state's annual budget, providing critical programs for veterans, senior citizens, low-income families, children, and the disabled. As a result of her innovative and progressive approach, Ms. Ferguson has been applauded as a national leader in human services policy. Prior to serving in Governor Almond's cabinet, Ms. Ferguson was counsel and deputy chief of staff to the late U.S. Senator John H. Chafee. She spent a total of 13 years working for the Senator, eventually managing his entire legislative agenda from defense budget priorities to health care.

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Medicaid: What Any Serious Health Reform Proposal Needs to Consider

by Christine Ferguson, Patricia Riley, and Sara Rosenbaum

Introduction: Medicaid—Not Just Medicare's Second Cousin

For the first time in history, total state and federal expenditures under the Medicaid program have exceeded those of Medicare. In 1998, Medicaid insured more than 40 million persons. Medicaid spending constituted between 15 percent and 20 percent of all state expenditures[1] and is slated to grow at an average annual rate of 8.5 percent between 2002 and 2012.[2] In 2001, Medicaid spending amounted to more than half of all national expenditures on means-tested entitlement programs.[3] Based on a specified formula tied to state financial conditions, the federal government contributes between 50 percent and 83 percent of state medical assistance expenditures[4] and between 50 percent and 90 percent of program administration costs.

Despite a considerable body of research, the full dimension of Medicaid's importance as a source of financing for state health care activities actually remains relatively little understood. In fact, Medicaid's very structure means that it has come to assume a seminal role in paying for health services that are essential to the success of numerous other state health and health-related programs; many of these services, particularly for children and adults with long-term and chronic health problems, lie beyond the limits of even the most generous private insurance plans. Careful examination suggests that Medicaid's unique legislative design has allowed the program to evolve into a central structural underpinning for health initiatives that transcend the bounds of conventional health insurance and extend into the broadest reaches of health care. Medicaid's very scope and elasticity complicates federal health reform efforts, since changes in federal Medicaid policies can have a significant impact on a broad range of state health and health-related services and programs as well as a wide array of provider groups.

Part I of this paper describes Medicaid's role in state health policy with regard to revenues, health care spending (particularly on populations whose needs extend beyond traditional health insurance), health care infrastructure support, and state and local government administrative support.

Part II examines how Medicaid's eligibility, coverage and benefits, and program administration costs distinguish the program from conventional health insurance.

Part III illustrates Medicaid's unique qualities by examining one state's use of the program to maintain its health activities.

Part IV concludes with a discussion of key issues raised by Medicaid that comprehensive health reform would need to address.

Part I: Medicaid's Role in the States

For nearly 40 years, Medicaid's broad program structure and federal financial contributions have made it the central vehicle for transforming state health care activities. In the early 1960s, states made

[1] National Governors Association. *The Fiscal Survey of States,* June 2001. http://www.nga.org (accessed January 10, 2002).

[2] Congressional Budget Office. *The Budget and Economic Outlook: Fiscal Years 2003–2012*, chap. 4. Washington, 2002. http://www.cbo.gov/showdoc.cfm?index=3277&sequence=0& (accessed February 8, 2002).

[3] Congressional Budget Office. 2001. *The Budget and Economic Outlook*.

[4] Family planning services and supplies are financed at a 90 percent contribution level.

modest investments in health care services for the poor, the elderly, and persons with disabilities; by 2000, states were administering health insurance programs that collectively insured more than 40 million persons and supported comprehensive health systems. Medicaid now accounts for 15 percent to 20 percent of state budgets, second only to spending on K–12 education. In fact, over the past decade, state and local governments have relied increasingly on the revenue Medicaid brings into a state to support government functions related to health care for millions of persons as well as the health care infrastructure. Over the years, some states have undertaken aggressive efforts to elevate federal contributions beyond their statutory limits through what have been termed "creative" financing schemes; at times, these efforts have tended to overshadow the important contributions to American health policy made by state Medicaid investments aimed at the nation's most vulnerable populations.

Congress established Medicaid as a shared responsibility of the federal government and the states. Because virtually all states, unlike the federal government, are obligated to balance their budgets annually, this shared arrangement has created a natural series of checks and balances on program size. Although Medicaid is an entitlement, states' budget balancing obligations create a brake of sorts on overall program expenditures (although Medicaid revenue maximization efforts have at times pushed federal expenditures upward at a far more rapid rate than state expenditure growth alone would indicate). At the same time that state budget constraints act as a check on overall program size, Congress has encouraged major program growth through creation of numerous options to expand program coverage. The very existence of these options has not only permitted expansion but in some cases has served to pressure states to adopt popular program expansions.

The state/federal Medicaid relationship has been challenging, particularly as federal program policy has expanded. State Medicaid expenditure data, when reported nationally, often tend to lag behind actual state experience, thereby creating an incomplete picture of state program conditions. States have reacted, particularly in times of tight budgets, against the breadth and depth of Medicaid's sometimes unpredictable growth. In such an environment, states have sought new ways to generate federal revenues beyond levels otherwise permissible under the federal financing formula, especially through intergovernmental transfer and provider contribution arrangements. Such Medicaid maximization activities were designed within the construct of Medicaid law and regulation but generally were seen as loopholes by the federal government and were quickly constrained. While most states used funds so generated for legitimate Medicaid purposes, a few used the revenue for non-Medicaid purposes and were the subject of well-publicized audits and penalties.

Expenditures and Revenues

Medicaid's role in state economies is best illustrated in a recent report by the Urban Institute that chronicles changes in state spending over the 1990s and in the process sheds important light on Medicaid's overall importance to state financial health.[5] Table 1 shows that over the 1988–1997 period, state governments' overall real per capita spending increased by almost 30 percent; within this overall increase, real public welfare expenditures grew by 71 percent, far exceeding any other spending category. Of this growth, medical payments to vendors (most of it through Medicaid) grew by more than 100 percent and accounted for over 80 percent of public welfare spending growth. Table 2 shows the role played by federal public welfare and health and hospitals grant funding in the rise in overall state revenue over this same time period while tables 3 and 4 underscore the magnitude of the increase of Medicaid revenues considered alone. Taken together, these statistics suggest that Medicaid has been the largest single source of direct federal funds transfers to states and has in turn driven a major increase in state investment in health care over the past decade. Over the 1988–1997 period, federal inter-governmental revenue accounted for 40 percent of the total increase in state revenue, and the primary source of these revenues was Medicaid.

[5] David Merriman. *What Accounts for the Growth of State Government Budgets in the 1990s?* Series A, No. A-39 Washington: Urban Institute, 2000.

TABLE 1

Real Per Capita Expenditures by State Governments, FY 1988 through FY 1997 (1992 Dollars)

YEAR	TOTAL EXPENDITURES	ELEMENTARY & SECONDARY EDUCATION	HIGHER EDUCATION	PUBLIC WELFARE	CORRECTIONS	HEALTH AND HOSPITALS	HIGHWAYS	INTEREST	OTHER GENERAL EXPENDITURES
1988	$2,034	$430	$271	$396	$63	$164	$191	$91	$427
1989	2,116	452	278	418	68	174	193	92	442
1990	2,164	448	285	447	74	182	188	92	449
1991	2,267	457	293	508	79	187	192	96	455
1992	2,419	477	305	618	80	190	193	97	459
1993	2,468	484	307	642	79	203	196	92	464
1994	2,533	484	309	683	85	209	199	88	476
1995	2,601	506	317	691	92	213	203	87	491
1996	2,595	520	319	673	94	213	200	87	488
1997	2,624	534	323	676	97	210	200	88	496
Percentage Change, 1988–1997	29%	24%	19%	71%	54%	28%	5%	-4%	16%

Sources: Expenditure data from U.S. Bureau of the Census, State Government Finances. Population data from U.S. Bureau of the Census, Population Estimates Program, Population Division. Data deflated using state and local government implicit price deflators from national income and product accounts; David Merriman. *What Accounts for the Growth of State Government Budgets in the 1990s?* Series A, No. A-39 Washington: Urban Institute, 2000.

Note: Rows may not add due to rounding.

Thus, Medicaid occupies not only a singular place in health policy but a singular role in the economies of state and local governments as well. It is the biggest single revenue producer for state governments, in part because of the federal financing formula that governs the program and, in part (as has become evident in recent years), because of states' ability to further enhance their nominal, statutorily defined federal contribution rate through such techniques as favored payment rates to governmental health facilities. But regardless of whether states are receiving revenues at the statutory rate or at artificially enhanced levels, there is no question that the program funds overwhelmingly are invested in states' efforts to sustain vast and complex health services related to a wide array of public programs for children and non-elderly and elderly adults. Medicaid's greatest contribution from a state vantage point lies in the degree to which the program is structured through its eligibility, coverage, payment, and administrative provisions to recognize services and costs that transcend conventional insurance and reach into the broader levels of health spending to support overall social welfare goals.

Infrastructure Investment

Two clear examples of Medicaid's investment in a state's health care infrastructure are disproportionate share hospital (DSH) payments and enhanced reimbursement for federally qualified health centers (FQHCs). The DSH program allocates federal funds to all states to support the cost of hospitals that treat a higher number of uninsured and low-income patients—regardless of their potential eligibility for Medicaid. In 1998, Medicaid DSH payments amounted to approximately $10 billion, or 9 percent of total program spending.

A second principal form of infrastructure support is the enhanced payment system (based on the concept of reasonable cost per encounter) for federally qualified health centers (FQHCs) and rural health clinics (RHCs) to support the mission of these two classes of health providers as a source of care for uninsured and underserved persons. Feder-

TABLE 2

Real Per Capita State Government Expenditures for Public Welfare, FY 1988 through FY 1997 (1992 Dollars)

		COMPONENTS OF THE STATE PUBLIC WELFARE EXPERIENCE			
YEAR	ALL PUBLIC WELFARE EXPENDITURES	MEDICAL VENDOR PAYMENTS	CATEGORICAL CASH ASSISTANCE	CATEGORICAL ASSISTANCE—INTER-GOVERNMENTAL TO COUNTIES	OTHER PUBLIC WELFARE
1988	$396	$202	$46	$38	$110
1989	418	217	45	41	116
1990	447	239	45	42	120
1991	508	287	49	46	126
1992	618	370	53	62	132
1993	642	388	55	61	138
1994	683	416	54	65	149
1995	691	427	50	64	151
1996	673	418	44	61	149
1997	676	426	39	59	152
Percentage Change, 1988–1997	71%	111%	-14%	54%	38%

Sources: Expenditure data from U.S. Bureau of the Census, State Government Finances. Population data from U.S. Bureau of the Census, Population Estimates Program, Population Division. Data deflated using state and local government implicit price deflators from national income and product accounts; David Merriman. *What Accounts for the Growth of State Government Budgets in the 1990s?* Series A, No. A-39 Washington: Urban Institute, 2000.

Note: Rows may not add due to rounding.

al Medicaid expenditure data alone do not permit calculation of the national value of the reasonable cost payment method (which was updated in 2000 by replacing the earlier retrospective cost-based system with a prospective formula); but its value presumably would equal the difference between the amount of Medicaid compensation received for covered services by FQHCs and RHCs and the amount states might receive were they to use their standard fee schedules to purchase the same services. However, separate data on state Medicaid payment supplements to federally funded health centers as part of the cost-based payment reconciliation process suggest that this increment is considerable. In 2000, it amounted to $350 million, or 26 percent of the $1.343 billion in total Medicaid payments received by health centers.[6] This amount reflects both reconciliation up to reasonable cost levels for payments made directly by state agencies and supplemental payments made by state agencies that represented the difference between health centers' managed care contractual payments and their reasonable costs.

State and Local Government Administrative Support

A critical dimension of Medicaid spending is the extent to which program administration functions are carried out by other state and local agencies with formal interagency relationships with the Medicaid agency. For example, Medicaid agencies purchase quality assurance services from health agencies, as well as administrative health care case management services from numerous public agencies services to children and adults with special needs (for example, children in the child welfare system, children with illness and disabilities who receive special education services, adults with physical or developmental disabilities, and the frail elderly). In all of these cases,

[6] Uniform Data System; calculations by Daniel R. Hawkins, Vice President for Federal and State Affairs, The National Association of Community Health Centers, Washington D.C., 2002.

TABLE 3

Real Per Capita State Federal Inter-governmental Revenues, FY 1988 Through FY 1997 (1992 Dollars)

		COMPONENTS OF THE STATE PUBLIC WELFARE EXPERIENCE				
YEAR	TOTAL FEDERAL INTER-GOVERNMENTAL GRANTS TO STATES	EDUCATION	HEALTH AND HOSPITALS	HIGHWAYS	PUBLIC WELFARE	OTHER
1988	$473	$85	$20	$63	$226	$80
1989	488	88	22	65	234	79
1990	504	91	23	59	253	78
1991	551	95	25	58	294	79
1992	629	102	27	57	360	83
1993	677	107	31	63	388	88
1994	708	111	33	66	408	90
1995	718	113	37	69	408	92
1996	715	117	38	65	406	89
1997	719	112	39	64	410	93
Percentage Change, 1988–1997	52%	32%	99%	2%	82%	16%

Sources: See Expenditure data from U.S. Bureau of the Census, State Government Finances. Population data from U.S. Bureau of the Census, Population Estimates Program, Population Division. Data deflated using state and local government implicit price deflators from national income and product accounts; David Merriman. *What Accounts for the Growth of State Government Budgets in the 1990s?* Series A, No. A-39 Washington: Urban Institute, 2000.

Note: Rows may not add due to rounding.

TABLE 4

Real Per Capita Federal Inter-governmental Grants to State Governments for Public Welfare

	FY 1997	FY 1988
Total	$410.00	$226.00
Medicaid	315.00	141.00
Non-Medicaid total	96.00	84.00
DETAIL ON NON-MEDICAID TOTAL		
AFDC	32.00	50.00
Food Stamp Administration	8.00	5.00
Low-income Energy Assistance	4.00	7.00
Social Services Block Grant	9.00	12.00
Community Services Block	0.08	1.79
Work Incentive Program	0.0	0.57
Other Non-Medicaid	43.00	7.00

Sources: Federal grant data by program is from the U.S. Bureau of the Census. *Federal Expenditures by State by Fiscal Year 1997 and 1998.* Population data from U.S. Bureau of the Census; David Merriman. *What Accounts for the Growth of State Government Budgets in the 1990s?* Series A, No. A-39 Washington: Urban Institute, 2000.

Note: Numbers may not add due to rounding. Data deflated using state and local government implicit price deflators from national income and product accounts.

other public agencies are conducting activities and carrying out responsibilities that arise out of their essential governmental functions for state residents. But a portion of their administration and oversight budget derives from Medicaid payments made to support that aspect of a public agency's undertaking whose costs are attributable to the Medicaid population. The relationships between Medicaid agencies and other agencies that carry out complementary activities for the Medicaid populations underscore a practical truth: despite the fact that federal Medicaid law requires that each state establish a "single state agency," in fact, in nearly all states, multiple public agencies are involved in program administration through inter-governmental contracts. Indeed, the programs under which these other agencies operate (such as federal child welfare and special education laws) contain virtually no federal spending authority for medical care and instead assume the existence of Medicaid to finance medical and medical support services for eligible populations.

Covered Services and Populations Outside of Conventional Insurance

The Medicaid program contains a number of coverage mandates and options reflecting federal policies that aim the program in great part at individuals and families whose health status or family circumstances place them outside a conventional health insurance environment and within the classes of persons for whom states historically have assumed responsibilities. To be sure, in recent years, Medicaid has been expanded (through both direct amendments and the complementary State Children's Health Insurance Program [S-CHIP]) to more actively reach lower-income workers and their families. But this aspect of public coverage—health insurance for working families—is only one of Medicaid's numerous roles. The very concept of coverage under Medicaid bears only limited resemblance to the coverage principles that guide private insurance. From its inception (and with the notable exceptions of the exclusion of expenditures for inpatient mental illness and expenditures for persons who are inmates of public institutions), the term, "medical assistance," was shaped to reflect the realities of state social welfare spending imperatives for poor, disabled, and medically at-risk populations. The definition of medical assistance has evolved considerably over the past 35 years, with numerous expansions in the definition of medical assistance at the urging of state and local public officials whose social welfare obligations compelled various types of health care spending that fall outside the realm of private insurance. Whether the issue was special education-related services, home and community-based services for persons with physical and developmental disabilities or the frail elderly, services in smaller residential settings for persons with mental illness, community treatment for persons with tuberculosis, insurance for disabled workers, treatment of uninsured women with breast and cervical cancer, emergency services for undocumented aliens, or other health care imperatives, state and local officials have played a role over the years in reshaping Medicaid to effectively serve the sickest and most disabled persons in the most flexible settings possible.[7] The states have sometimes responded to federal mandates; at other times, states have initiated innovations through policy and programmatic waivers.[8]

Part II: Populations and Services Covered under Medicaid

In many respects, the basic structure of Medicaid has not changed in 35 years, despite the most profound changes in health care organization, delivery, and finance in a century. States have jury-rigged reform through a series of waivers, making the program idiosyncratic by state. States struggle with program requirements and cost, and program scope and design vary considerably among states. It is essential that proposals to reform Medicaid (either standing alone or as part of a broader national health reform effort) proceed only with a full understanding of the unique "policy space" Medicaid has come to occupy.

To be sure, Medicaid's role parallels private, employer-sponsored insurance for working-age adults and children. At the same time, Medicaid is the means by which states insure "uninsurable" populations, such as disabled workers, and finance medical and health services that conventional health insurance, which depends on medical risk avoidance and carefully circumscribed rules of coverage,[9] simply is not structured to support.

But this deceptively simple characterization of Medicaid masks a program of uncommon complexity, subtlety, and flexibility (particularly for one of its size). Medicaid coverage rules are legendary in their complexity. Federal law designates certain categories of individuals as mandatory coverage groups for participating states.[10] These groups consist mainly of families with children that satisfy eligibility criteria

[7] See, for example, the Medicaid Resolutions of the National Governors Association. http://www.nga.org.

[8] Sara Rosenbaum, "Health Policy Report: Medicaid." *New England Journal of Medicine 346* (8): 635–9.

[9] Deborah Stone. "The Struggle for the Soul of Health Insurance." *Journal of Health Politics, Policy, and Law* (5): 187–204; Alain Enthoven and Richard Kronick. "A Consumer Choice Health Plan for the 1990s: Universal Health Insurance in a System Designed to Promote Quality and Economy." *New England Journal of Medicine 320* (2): 29–37; Mark Pauly and Sean Nicholson. "Adverse Consequences of Adverse Selection." *Journal of Health Politics, Policy, and Law* (Special Issue: The Managed Care Backlash) *24* (5): 930–931.

[10] Op. cit. at note 9.

under states' 1996 Aid to Families with Dependent Children (AFDC) programs; elderly, disabled, and blind persons who receive federal Supplemental Security Income (SSI) benefits; "poverty-level" children and pregnant women; and (for limited assistance) Medicare beneficiaries with incomes at or below the federal poverty level (known as qualified Medicare beneficiaries). Indeed, eligibility varies significantly among states, in part because of federal law and regulations that allow states to set different eligibility levels for some populations and to use different strategies to define eligibility. For example, federal law allows states to disregard certain types of family income (for example, child support payments) or expenditures (work-related expenditures) in calculating family income, and there is variability in how states do so. Moreover, states' economies vary considerably, and Medicaid policies reflect that. A family living at 185 percent of the federal poverty level in a high cost-of-living state may face a different situation from one living in a state in which the cost of living is relatively low.

Medicaid's unique flexibility rests in its essential characteristics and, more important, in its roots, which lie not in private insurance, but in social welfare spending aimed at addressing the health needs of the sickest, neediest, and least insurable residents and services.[11] In recent years, as the gaps in and limitations of private health insurance have become more visible, particularly for lower-income workers and their families,[12] Medicaid reform has focused on this particular program role, most notably through amendments enacted in 1996 and 1997 that offer states expanded options to cover lower-income working families[13] as well as near-poor children who are uninsured but are ineligible for basic Medicaid coverage.[14] But federal financing still is not available to cover non-disabled adults without children, for example, unless a state receives waivers to extend coverage under Section 1115 demonstration authority.[15]

But in recent years, equal public policy focus has been on Medicaid's other roles as the principal funder of chronic care, companion health care systems aimed at high-risk populations, and the safety net. Examples of these reforms are expansion of state eligibility options for uninsurable persons (for example, uninsured women with breast and cervical cancer and working-age adults with severe disabilities who seek to return to work), expanded support of the health care safety net (for example, FQHC payment reforms), and expanded coverage of low-income Medicare beneficiaries.[16] The Bush administration has proposed using Medicaid as the legislative vehicle to expand outpatient prescribed drug coverage for lower-income elderly persons,[17] still further evidence of Medicaid's role in accommodating national priorities that do not lend themselves easily to a commercial insurance market. Thus, while in certain respects Medicaid resembles conventional insurance, in fact, in its structure it extends far beyond commercial bounds, thereby according states the power to address complex health policy problems that require unique interventions.

Figure 1, which displays Medicaid enrollment and expenditures, suggests that rather than thinking of Medicaid as a single program, it is more useful in a public policy context to approach the program as a legislative "vessel" holding several distinct and very large population groups.[18]

Families with Children

The first component of this legislative vessel is a

[11] Robert and Rosemary Stevens. *Welfare Medicine in America.* New York: Basic Books, 1975; Paul Starr. *The Social Transformation of American Medicine.* New York: Basic Books, 1982.

[12] Ellen O'Brien and Judy Feder. *Employment-Based Health Insurance Coverage and Its Decline: The Growing Plight of Low Wage Workers.* Washington: Kaiser Commission on Medicaid and the Uninsured, 1999.

[13] Sara Rosenbaum and Kathleen Maloy. "The Law of Unintended Consequences: The 1996 Personal Responsibility and Work Opportunity Reconciliation Act and its Impact on Medicaid for Families with Children." *Ohio State Law Journal 60:* 1423–78.

[14] The State Children's Health Insurance Program 42 U.S.C. §1397. See Pernice, K. Wysen, T. Riley, N. Kaye. *Charting CHIP: Report of the Second National Survey of the State Children's Health Insurance Program.* Portland, ME: NASHP, 2001. http://www.nashp.org.

[15] In 2001, the Bush administration announced the Health Insurance Flexibility and Accountability Demonstration, which permits states to use program savings to expand coverage to the uninsured, encouraging coordination with the private sector. But states have been hard-pressed to secure funds for such expansions and have found that the federal rules related to using Medicaid to purchase employer-sponsored insurance are difficult to implement.

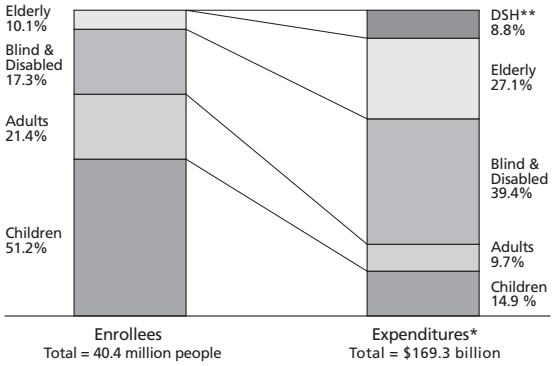
[16] Health Policy Report: Medicaid, op cit., note 9.

[17] The Budget of the United States, 2002. http://www.omb.gov

[18] "Health Policy Report: Medicaid op. cit., note 9.

FIGURE 1

Medicaid Enrollees and Expenditures, by Enrollment Group, 1998



*Total expenditures exclude administrative expenses.

**Disproportionate Share Hospital payments.

Source: Kaiser Commission on Medicaid and the Uninsured. "The Medicaid Program at a Glance." *Medicaid Facts,* Jan. 2001, www.kff.org/content/2001/2004b/2004b.pdf.

mechanism for providing health insurance to low-income, working-age individuals and their family members. In fact, however, spending on "acute care services" for individuals who fall into this general description (for example, families headed by non-disabled parents and other caretaker relatives and their children, poverty-level children, and pregnant women) amounts to a small portion of total program spending. Figure 2 shows that in 1998, acute care spending for mandatory and optional coverage groups made up of non-disabled adults and children, amounted to slightly less than 25 percent of total program spending.

The Elderly and Adults with Disabilities

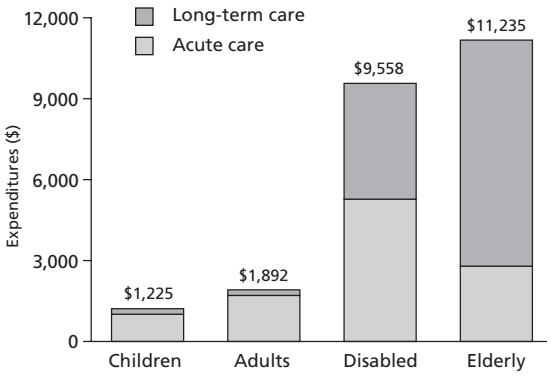
Medicaid's second and third coverage components focus on groups and services that lie almost completely outside the commercial health insurance markets: the program funds both acute and long-term care services for persons with disabilities and the elderly poor, two groups with virtually no access to private health insurance, whose needs place them outside of any market that most private health insurers would seek to develop. Figure 1 shows that in 1998, less than 28 percent of all Medicaid enrollees were elderly or persons with disabilities, but expenditures on these populations amounted to more than two-thirds of total program spending.

Figure 2 underscores that significant levels of acute care spending occur for elderly individuals and persons with disabilities. It also shows that the per capita rate of acute care spending on these two groups vastly exceeds per capita spending levels for non-disabled children and adults who more closely approximate covered individuals in the commercial market. In other words, were persons with disabilities and the elderly to be covered in the commercial market and only for a standard commercial package, their resource demands would far surpass standard actuarial norms.

An important consideration in Medicaid is the health status of its beneficiaries. In isolation, expenditures on persons with disabilities appear to consume about 40 percent of the program, as Figure 1 indicates. But this figure understates Medicaid spending on persons with chronic illness and disabilities, since the proportion of children and adults with chronic illness and disability who are enrolled in Medicaid far exceeds the percentage who technically gain eligibility based on a formal finding of disability. For example, it has been estimated that only 14 percent of children enrolled in Medicaid who

FIGURE 2

Medicaid Expenditures per Enrollee, by Acute and Long-term Care, 1998



Source: Kaiser Commission on Medicaid and the Uninsured. "Medicaid Role for the Disabled Population Under Age 65." *Medicaid Facts,* April 2001, www.kff.org/content/2001/2171/2171.pdf.

have a chronic illness or disability enrolled in the program on the basis of a formal disability determination; the overwhelming majority receive Medicaid based on their status as "poverty-level" or "AFDC-related" children.[19] Medicaid's role for elderly and disabled Medicare beneficiaries is similarly unique. Medicaid not only pays premiums, deductibles, and coinsurance for low-income Medicare beneficiaries, but, in the case of the poorest beneficiaries, supplements Medicare's coverage with additional coverage for services that are basic but omitted from Medicare, most notably prescribed outpatient drugs and long-term care services.

Children (and Some Adults) with Special Needs

Medicaid's fourth component—and the one that is the least well studied or understood—is the program's role as the principal funder of medical care services for individuals (typically children) who may or may not have standard insurance but who are at high medical risk and who are receiving a blend of medical and social services through other systems of care. Most of these population groups are distinguished by health status factors that an individual private market would consider uninsurable: severe pre-existing physical and mental health conditions, permanent disability or impairment, age, institutional status, and other characteristics that would virtually exclude them from the individual insurance market.[20] Not only do their health conditions place them beyond the limits of conventional coverage, but their service needs extend beyond the range and scope of benefits found in a conventional insurance plan.

In any state, there may be numerous companion health and health-related systems of care that coexist with Medicaid. Examples are state child welfare systems, medical and aftercare programs for children with special health care needs, school health programs, mental health and developmental disabilities programs for children and adults, special education and early intervention programs, state juvenile justice programs, state public health agency-operated programs designed to address and control public health threats such as the transmission of disease or the treatment of lead exposure in children, and programs for the frail elderly. The children and adults who receive medical care and clinical case management services through these other systems are disproportionately poor and Medicaid-dependent. All of these programs have an obligation to address not only the social/educational but also the medical needs of clients and patients, yet their funding for necessary medical care is either very low in relation to need or virtually non-existent (for example, the federal special education program bars states from using funds to pay for necessary medical care, provoking a demand at the state level for Medicaid support).

As a result, Medicaid is the primary means by which states finance and carry out these other essential health and health-related services. Even in states in which managed care enrollment is extensive, these services typically are "carved out" of state managed care contracts and remain under the direct administrative control of state Medicaid programs and other state agencies.[21] These expenditures show up in aggregate national data on medical assistance expenditures, but, given the structure of the Medicaid expenditure reporting system and the absence of specialized studies, it is impossible to accurately disaggregate these special expenditures from the broader program spending data. Recent negotiated federal/state settlements in the hundreds of millions of dollars for Medicaid payments related to medical care for children in special education is a fair indicator of just how essential Medicaid is to a range of medical and health-related social welfare programs.[22]

Benefits Covered for These Population Groups

While Medicaid creates enforceable rights and bene-

[19] Ibid., p. 637; Center for Health Care Strategies. *The Faces of Medicaid.* Princeton, NJ, 2000. http://www.chcs.org

[20] Karen Pollitz, Richard Sorian, and Kathy Thomas. *How Accessible Is Individual Health Insurance for Consumers in Less than Perfect Health?* Washington: Georgetown University Institute for Health Care Research and Policy, 2001.

[21] Sara Rosenbaum et al. *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracting.* Washington: George Washington University Medical Center, 2000. The full study can be viewed at http://www.gwhealthpolicy.org.

[22] Kaiser Daily Health Reports (May 22, 2002).

fits that resemble those found in private insurance policies, in certain fundamental respects Medicaid coverage design rules and options are unlike private plans. Indeed, not only in whom it covers but what it pays for, Medicaid is the antithesis of private insurance in both theory and operation.

Private insurance benefits are structured to impose strict contractual limits on what is considered medical care and the circumstances under which benefits will be covered and paid.[23] Even in employment-based insurance, pre-existing condition limitations and waiting periods are common.[24] Benefit plans are structured for a population of workers and family members without serious underlying health conditions, with an emphasis on preventive and acute services and just enough institutional and home care to permit an otherwise healthy person to "recover" to "normal function." Within the typically modest constraints of state insurance law and federal laws governing employee health benefit plans, insurers and issuers have discretion to design limited coverage plans, restricting or excluding otherwise available coverage by condition (for example, less coverage for mental illness, lower lifetime coverage limits for persons with human immunodeficiency virus [HIV]).[25]

Insurers and health plans also have the flexibility to adopt restrictive definitions of when otherwise covered benefits will be considered medically necessary, by building in limitations based on whether a service or intervention will allow an individual to "recover" lost functioning. This type of definition effectively excludes coverage when the individual who requires it needs the benefit to prevent deterioration, maintain functioning, or "recover" to levels that might be expected in a person with a disability rather than an individual with no underlying health conditions.[26] Finally, in private insurance, cost sharing can be considerable and lifetime payment rules restrictive.

Medicaid operates under highly different rules, even as it maintains a basic medical necessity test. The Medicaid program provides federal funds to states to offset the cost of "medical assistance" furnished to eligible persons by qualified providers. However, the term, "medical assistance," only superficially resembles a conventional insurance benefit plan. It includes such services as long-term institutional care; long-term case management; personal attendant services; long-term rehabilitation and habilitation services; special medical, personal, and environmental services and supports needed to maintain severely disabled children and adults in their homes; and other services not typically found in private insurance plans. States have considerable flexibility in benefit design and, indeed, more than two-thirds of all state Medicaid spending can be attributed to optional services.[27] At the same time, certain classes of benefits (including nursing home and home health benefits) are mandatory,[28] and in the case of children under age 21, mandatory coverage includes the full range of federally defined medical assistance services.[29]

Federal law also sets certain limits on states' discretion over terms such as medical necessity; a preventive standard of coverage is required in the case of children.[30] Pre-existing condition exclusions and waiting periods are not allowed. Furthermore, feder-

[23] Rand Rosenblatt, Sylvia Law, and Sara Rosenbaum. *Law and the American Health Care System.* (New York: Foundation Press, 1997); 2001–02 update.

[24] The Health Insurance Portability and Accountability Act (HIPAA) limited but by no means prohibited the use of waiting periods and pre-existing condition limitations.

[25] The Employee Retirement Income Security Act (ERISA) gives employers near total discretion over health plan benefit design. Subsequent laws have limited this discretion only in the most modest ways. The Mental Health Parity Act of 1996 (which expired in 2001) prohibited only annual and lifetime dollar caps on mental health benefits but permitted ongoing coverage limits stated in terms of defined benefits. Furthermore, to the extent Congress anticipated that diagnostic-based discrimination would no longer exist following enactment of Title I of the Americans with Disabilities Act (which prohibits discrimination against persons with disabilities in employment or employment-related benefits), this expectation has not been borne out; courts have ruled virtually uniformly that diagnostic-based limits are lawful as long as they are applied uniformly to all covered individuals; Law and the American Health Care System, op cit., note 25.

[26] Law and the American Health Care System, op. cit., note 25.

[27] Kaiser Commission on Medicaid and the Uninsured. *Summary of Mandatory and Optional Services,* 2001. http://www.kff.org/medicaid.

[28] 42 U.S.C. §§1396a(a)(10)(A) and 1396d(a) (2002).

[29] 42 U.S.C. §§1396a(a)(10)(A), 1396d(a), and 1396d(r) (2002).

[30] For additional information on coverage standards for children, see Sara Rosenbaum and Colleen Sonosky. *Federal EPSDT Coverage Policy,* December 2000. http://www.gwhealthpolicy.org/downloads/epsdt_execsum.pdf

al "amount, duration, and scope" standards require that state coverage levels meet certain tests of reasonableness and prohibit state programs (at least in the case of required services) from discriminating on the basis of particular conditions).[31]

Certain types of exclusions typically found in insurance contracts, such as "educational" or "social" exclusions in the case of medical care furnished to children in school or foster care, are not permitted in Medicaid. For example, private insurance typically excludes "educational" services (that is, otherwise covered medical care that is furnished during the school day as part of a special education plan); federal Medicaid law specifically prohibits this type of exclusion.[32] Finally, even where permitted, cost sharing is circumscribed to nominal levels as a matter of federal law, in view of the financial situation of the eligible population.[33]

State Medicaid agencies also have flexibility over compensation methodologies and payment rates. Federal law sets certain substantive compensation standards in the case of federally qualified health centers and rural health clinics and for payments to state- and county-operated health care providers. Federal law also requires certain payment adjustments in the case of managed care organizations and disproportionate share hospitals and establishes certain procedural requirements in the case of rate setting for nursing home and hospital payments. But the level of federal incursion into Medicaid payment standards and methodologies is relatively modest.

Beyond these requirements, state agencies are free to devise payment methodologies and rates that meet the needs of their providers. For example, a state can use a reasonable cost payment methodology in the case of public hospitals, health department clinics, and other public providers, thereby ensuring that these providers (and thus the public agencies or entities of which they are a part) are compensated at favorable rates that reflect the full reasonable cost of care to the Medicaid population. Budget pressures constrain states in their ability to invest through Medicaid. Faced with difficult choices in times of budget austerity to eliminate or restrict eligible populations, reduce services, or restrict provider payments, states have placed limits on provider reimbursement. A recent report shows only eight states paid average Medicaid provider fees equal to or above Medicare rates; the remainder paid less than Medicare, ranging from 41 percent to 127 percent of Medicaid rates.[34]

Program Administration

States have considerable flexibility in how they administer their programs. They can elect to administer their programs on a traditional fee-for-service basis or through the use of limited or comprehensive managed care arrangements, including primary care case management systems and networks of preferred institutional and specialty providers overseen by a state agency as well as full-service managed care organizations furnishing both general and specialized care.

As of 2001, all states used some form of managed care. Over the past decade, state Medicaid programs have become extremely sophisticated purchasers of managed care services, buying coverage through managed care products for both non-disabled and disabled beneficiaries.[35] States' managed care purchasing practices span a broad range of approaches, including buy-ins to employer-sponsored plans and the direct purchase of managed care products through individual enrollment of children and adults enrolled in Medicaid and S-CHIP.

However, to equate this trend toward use of managed care with what is actually covered under state Medicaid programs would be misleading.

[31] This type of discrimination (that is, singling out certain conditions such as AIDS or mental illness for lesser treatment) is common in conventional insurance. See Law and the American Health Care System, op cit., note 25., chap. 2F.

[32] 42 U.S.C. §1396b(e) (2002).

[33] In fact, cost sharing can be considerable for medically needy persons who "spend down" to eligibility levels by incurring high medical expenses. Even with special spousal impoverishment rules enacted under the Nursing Home Reform Act of 1987, the protected income and assets of families with medically needy persons are relatively modest.

[34] "Comparing Physician and Dentist Fees Among Medicaid Programs." The Lewin Group, Medi-Cal Policy Institute, June 2001. http://www.medi.cal.org.

[35] Negotiating the New Health System, op cit., note 22.

Despite the fact that all state programs now buy private health insurance and managed care products to some degree, these arrangements continue to be supplemented by services and benefits covered under state Medicaid plans but extending beyond the outer limits of insurance. Some states have begun to experiment with more organized approaches to this supplementation through articulation of carefully defined "wraparound" plans for both Medicaid- and S-CHIP-enrolled children as well as disabled adult workers.

Part III. Medicaid's Multiple Roles in Operation: The Case of Rhode Island

Perhaps the best way to understand the Medicaid program in operation is through the example of a single state, Rhode Island. It is important, however, to recognize the considerable variability among states. Over the years, Rhode Island has become known as an innovator in Medicaid through its broad efforts to insure lower-income families and workers with disabilities and because of the breadth of its programs for children and adults with physical and mental disabilities and the frail elderly. In this regard, Rhode Island offers a particularly pronounced example (and one that cannot be said to be indicative of all states) of what a state can do in Medicaid, by both exercising of coverage and financing options and using federal demonstration authority.

At the same time, Rhode Island is an exemplary model of what state Medicaid programs throughout the country do in their efforts to shape their coverage and activities to meet multiple responsibilities related to the health care needs of the entire population, both those who need Medicaid as a form of basic insurance and those who require the more complex and long-term services that only Medicaid ensures.

Rhode Island's annual Medicaid report presents a clear picture of the program's reach and importance.[36] In FY 2000, Rhode Island's Medicaid program covered 14 percent of all state residents, a higher proportion than all but 14 states. As of 2000, the state's total uninsured population stood at 6 percent, the lowest in the nation.[37] Much of this progress can be attributed to Medicaid reforms. The state's total average monthly caseload approached 150,000 persons, with considerable growth between 1999 and 2000, even in the face of a strong economy.

But as is true generally, the proportion of Medicaid spending devoted to creating public insurance alternatives for working families without access to employer-sponsored arrangements accounts for only a small proportion of overall program activities. The qualities that make Medicaid unique show up in Rhode Island's special initiatives aimed at uninsurable persons and services. Adults with disabilities and the elderly made up 26 percent of enrollees but accounted for 69 percent of total program spending; children with special health needs and children in sponsored foster care accounted for 9 percent of the total caseload and 13 percent of total expenditures. Thus, Medicaid spending on health coverage for working-age adults and their children accounted for only a small part of the state's overall program.

Even a cursory examination of the initiatives described in the state's annual Medicaid report, supplemented by discussions with state Medicaid officials,[38] underscores the range of activities in which Medicaid is involved. Indeed, Rhode Island Medicaid officials estimate that some 40 percent of total program spending is tied to initiatives for special populations undertaken in collaboration with other public agencies responsible for the care and management of certain populations:

- Medicaid collaborates with the state's agencies on aging and disabilities to develop and support an expanded assisted living network, including homemaker services; personal care and case management services; and other services and supports aimed at populations with serious activity limitations.
- Medicaid offers special insurance and health

[36] http://www.dhs.state.ri.us/dhs/reports/ma2000.

[37] Kaiser Family Foundation State Health Facts Online. *Population Distribution by Insurance Status 1999–2000.* http://www.kff.org (accessed June 21, 2002).

[38] Interview with Tricia Leddy, Administrator, Center for Child and Family Health, Rhode Island Department of Human Services), February 13, 2002.

support programs for individuals making the welfare-to-work transition as well as adults with disabilities who are transitioning into the workforce and who will need continuous access to comprehensive public insurance during employment.

• Medicaid funds expanded case management services for high-risk pregnant women, including home visiting, intensive therapies, and comprehensive preventive services.

• Medicaid is involved in health promotion activities such as school-based lead screening and treatment programs.

• Medicaid is the principal source of funding for children and adolescents with special health needs, such as juvenile drug court treatment programs, special "CEDARR" family centers for families with special needs children, and special services for children in foster care.

In collaboration with Rhode Island's Department of Mental Health, Retardation and Hospitals, the state Medicaid program supports a full continuum of services for enrollees, beginning with detoxification and complemented by rehabilitative support services. The program funds comprehensive treatment and rehabilitation services for enrolled adults with mental illness, including—but not limited to—counseling and therapy, crisis intervention, residential services, multi-disciplinary treatment planning, and assertive community treatment.

As a result of the landmark U. S. Supreme Court decision in *Olmstead v L.C.*[39], the state has expanded its institutional and community placement services and is one of the few states without a waiting list for community-based waiver placements.

Special programs have been created for persons suffering from traumatic brain injury and those with multiple sclerosis and other long-term physical disabilities.

The state financed health care for some 5,500 children in foster care and special adoption placements; for children in foster care, behavioral health represented 86 percent of total per child per month expenditures, underscoring the unusual nature of health care for special needs children.

The state's "Ticket to Work and Rhode to Independence" program, funded by both Medicaid and special grants, furnished employment assistance, case management, and Medicaid "buy-in" programs for employed persons with disabilities.

Part IV. Issues Reformers Must Address

This paper has examined Medicaid's role in the American health care system from the perspective of states' overall role in the financing and provision of health services for their populations. Originally, Medicaid was structured to reach only populations such as women and children on welfare, persons with profound disabilities, and the elderly, who fell outside the workforce with its presumed access to employer-sponsored coverage. State Medicaid activities were aimed exclusively at these populations, although even in Medicaid's earliest days, several states used their own funds to cover their poorest workers.

As evidence mounted regarding the weakness of the employment-based health insurance system (particularly related to coverage of workers with chronic illness and disabilities), a series of congressional amendments to Medicaid made it possible for and sometimes required states to significantly expand covered populations and services and to experiment with alternative delivery systems. Over the years, states have taken significant advantage of these options, particularly in the case of children.

The heightened attention focused on some states' efforts to manipulate federal financial arrangements to maximum funding advantage has tended to obscure Medicaid's essential role in helping states to meet their essential health care obligations to low-income, vulnerable, and special needs populations. Over the decades, Medicaid has permitted states to fundamentally reconceptualize their role in American health care. The state vision of Medicaid today spans both health insurance for lower-income families and long-term care and services to promote community integration and support children and adults with disabilities and special needs. Finally, many states tend to define as part of their Medicaid-

[39] 119 S. Ct. 2176 (1999); see also Health Policy Report: Medicaid, op. cit., note 9.

financed mission an obligation to maintain an essential health care infrastructure of clinics, inpatient facilities, and special-purpose services and programs, ranging from community mental health services to school-based clinics and adult day treatment facilities.

In reconceptualizing their health roles, states also have modernized their thinking about how to approach the task. For example, in furthering access to health insurance for working families, many states have sought to build their initiatives around the public purchase of private coverage, either through subsidizing enrollment in employer-sponsored health plans where available or, more commonly, sponsoring beneficiaries in privately administered managed care arrangements. Thus, to the extent that reform advocates emphasize use of premium support systems and greater reliance on private insurance arrangements, it is fair to say that state Medicaid programs have pursued these goals steadily over the years.

But this paper also documents Medicaid's numerous other roles, all of which pertain to the responsibility of state governments to provide health care for persons who, by virtue of their health status and need for services, lie beyond the farthest reaches of even a strong private market. Indeed, in many respects, Medicaid makes a vibrant private market possible precisely because it offers a means of coverage for millions of persons with disabilities and chronic illness who otherwise would have no coverage or would obtain insurance only through heavy market regulation and at considerable expense.

The data presented in this paper suggest that most Medicaid expenditures are for services and populations tied to the program's unique role as a form of health insurance that departs from commercial insurance principles and norms. While reforms for working families have been notable, their overall impact on total Medicaid spending has been modest: most Medicaid expenditures are tied to the program's historic mission of supporting persons with disabilities, the elderly, and the health service obligations of public agencies generally. These costs are high, rise at a significantly greater rate than the general rate of inflation, and would be untenable in terms of state budgeting in the absence of Medicaid. As the Urban Institute study suggests, Medicaid is the single most important source of state revenue and expenditure growth.

Any federal health care reform proposals must therefore take into serious consideration the consequences of such reform on Medicaid and state financial health. This issue of how to ensure that states can continue their basic role in shaping health care for all populations is central to national health reform and cannot be dismissed through a single-minded focus on debates over whether states are getting more than their so-called fair share of federal financial contributions.

Because the Medicaid program is most certainly not a single, monolithic health care financing mechanism, any proposals to reform it or to make it part of a larger national reform must carefully consider the breadth and depth of Medicaid's financing and service delivery, which varies by state and by community. Any reform proposal addressing Medicaid must be able to answer four questions:

1. Will the open-ended nature of the federal financing system continue as long as states make reasonable investments in their programs? In light of overall financial constraints in state governments and the impact of these financial realities on states' abilities to invest, is it time to recalibrate the federal contribution level, with special incentives built into federal financial arrangements for state investments that further national policies such as de-institutionalization and community integration, investments in working families, use of employer-sponsored arrangements when available, and positive utilization controls that promote efficiency without adversely affecting necessary health care access among low-income persons?

2. How will the proposal affect the trend toward increasing state-federal investment in the health care infrastructure designed to support uninsured and non-eligible populations as well as Medicaid eligibles?

3. How will the proposal affect the extensive use of Medicaid funds to support a variety of state and local direct care and administrative functions outside of the single state agency?

4. How will the proposal affect populations and services that fall outside conventional insurance products? Does the proposal address how each of the four major population groups, and the services provided through Medicaid for them, will be handled?

- Families with children
- Adults with disabilities
  - Those disabled before age 21
  - Those disabled after age 21
- The elderly
- Children with special health care needs

The Future of Health Care Reform and Medicaid

In theory, it might be possible to untangle Medicaid and alter a series of other federal programs to permit the types of expenditures that Medicaid now supports. Special education and early child development laws could be re-drafted to include health spending authority and guaranteed funding. Programs to aid persons with mental illness and developmental disabilities and the frail elderly could be dramatically expanded. The Medicare program could be restructured to improve coverage of workers with disabilities who otherwise would lose assistance when they return to the workforce. Medicare also could be expanded to cover prescriptions and long-term care services. Separate insurance programs could be established for persons with HIV, women with breast and cervical cancer, and persons with tuberculosis. A special federal safety net enhancement program could be created. For each proposal, state and federal financing responsibilities and formulas must be outlined.

Medicaid has evolved into one of our most important health care programs at both the state and federal level. It is not a stagnant program: a host of federal legislative and regulatory reforms and initiatives over the years have dramatically expanded the program's importance to people, health care providers, and state governments. Program variability among states has increased to a point where Medicaid is a radically different program in every state, meeting state-defined needs within expenditure levels states may be willing and able to commit to. How this complex and complicated program can be made more efficient to face changing health policy priorities remains an open question. Its size and rapid growth suggest that the time for a reform that balances state, federal, consumer, and provider interests is upon us—and it is a task that requires a full understanding of Medicaid's many roles and complex financing to assure success. Whether federal and state policy makers have the vision and political will to come together around a common vision for what Medicaid needs to be in the 21st century is one of the great "unknowns" in national health reform. ■

Lawlor and Dude

Commentary Abstract

Edward Lawlor and **Ann Dude** look at three successful non-health-related policy reforms to see what lessons can be learned about reformulating health reform strategies to enhance the chances for achieving universal coverage. The three initiatives are the efforts by Mothers Against Drunk Driving (MADD) to pass legislation to curb alcohol-related driving injuries; the 2002 education reform act known as "No Child Left Behind"; and the 1993 NAFTA trade act.

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Mobilizing, Framing, and Leading: Three Policy Thought Experiments for *Covering America*

by Edward F. Lawlor and Ann Dude

Background

Seven years after the Clinton health reform saga, the political environment for health policy is best described as one of stalemate and pessimism. The long economic recovery of the 1990s (and the fiscal resources that went with it) appears to be over; incremental efforts at expanded coverage, such as the Medicare prescription drug benefit and the State Children's Health Insurance Program (S-CHIP) expansions, have struggled; and federal priorities have shifted to national security (defense), homeland security, and tax relief. The fiscal constraints imposed by recession, scheduled tax cuts, and the proposed ramp-up of defense and security spending leave little room for expansionary domestic policy, much less the political time and attention needed to enact major reform. Strong ideological currents also press against the prospects for significant initiatives to expand coverage. The health policy and health politics literature provides an extensive and sophisticated account of the obstacles to and constraints on enacting comprehensive health reform in the United States. The Clinton reform experience itself spawned much literature documenting both its history and the contemporary obstacles to reform.[1] In the aftermath of this experience, a number of arguments make up the conventional wisdom about the stalemate of U.S. health reform, both at a moment in time and historically. Students of agenda formation emphasize the need for political and contextual factors to come together to produce the right chemistry for reform.[2] Agenda formation involves having policy ideas and interests lined up for the right moment when the political environment is ready, when the classic "window of opportunity" exists. The role of public opinion in agenda formation, as well as influencing the President and Congress to act, has received significant attention in the literature, though, as observers like Lawrence Jacobs have illustrated, public opinion in health has its own complexities of interpretation and connection to actual congressional behavior.[3]

Students of institutions emphasize the structural impediments—for example, the realities of congressional committees and behavior—in shaping the possibilities for reform ideas to make their journey from political will to actual legislation.[4] Other structural arguments look more closely at the influence of existing policy, the bureaucracy, programs, and infrastructure on the opportunity set for reform. The idea here is that existing policy creates its own future policy possibilities, and that reform opportunities are path dependent. Students of health care's political economy emphasize the tremendous role that money, power, and influence—the medical industrial complex—play in protecting insurance, provider, pharmaceutical, and

[1] Haynes Johnson and David S. Broder. *The System: The American Way of Politics at the Breaking Point.* Boston: Little Brown, 1996; Theda Skopol. *Boomerang.* New York: W. W. Norton, 1997; Jacob S. Hacker. *The Road to Nowhere.* Princeton, NJ: Princeton University Press, 1997.

[2] John W. Kingdon. *Agendas, Alternatives, and Public Policies.* New York: Harper Collins, 1984.

[3] Lawrence Jacobs. *The Health of Nations: Public Opinion and the Making of American and British Health Policy.* Ithaca, NY: Cornell University Press, 1993; Lawrence Jacobs and Robert Shapiro. "Don't Blame the Public for Failed Health Care Reform." *Journal of Health Policy, Politics, and Law 20* (2) (Summer 1995): 411–23.

[4] Sven Steinmo and Jon Watts. "It's the Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America." *Journal of Health Policy, Politics, and Law 20* (2) (Summer 1995): 329–72.

professional interests. For example, the Center for Responsible Politics estimates that pharmaceutical interests spent $19 million on campaign contributions and $68 million in lobbying activities in 1999–2000, creating undeniable influence over the prospects and feasible options for Medicare prescription drug coverage.

In addition to these formal explanations for America's health policy stasis, a number of more casual explanations are found in the lore of U.S. health care reform efforts. Some observers believe in the historical cycles phenomenon of health policy: every 30 years or so, a confluence of ideological commitments and political pressures produces a significant comprehensive reform effort. Others believe in the power of a single charismatic and committed leader as the key explanation for policy failure and the key requirement for advancing universal coverage. Others have likened health care reform debates to competing "theologies," with little possibility for rational and open-minded deliberation.

The Plan of this Chapter

As The Robert Wood Johnson *Covering America* project demonstrates, there is no shortage of good ideas and analytic support for significant reform. The 10 proposals represent reasoned, analytically defensible approaches that take due account of the evidence and institutions that lie in the background of health care reform. However, the ongoing and daunting question that remains is how to reformulate or reframe the reform project to achieve universal coverage so it stands some positive chance of legislation and implementation.

This chapter looks to examples of policy making and political organization from outside the world of health reform for lessons and insights that are applicable to contemporary health reform. The idea is to step outside the usual confines of health policy and politics discussion and see if ideas for reframing health care coverage can be garnered from successful examples of policy making elsewhere. Can directions for policy design, political strategy, and evaluation of reform alternatives be developed from examination of other policy domains? Are there different ways to think about the existing set of reform proposals that recast them in political terms?

Such an exercise is obviously fraught with political naiveté and analytical risk, but the goal is to stimulate some fresh thinking about the design and strategy of health care reform. Such an exercise also runs the risk of trivializing or oversimplifying what are very complex politics and policy processes.[5] But it also holds the promise of changing some of the policy formulation mindset. This chapter is meant to be deliberately provocative. The idea is to create the kind of self-awareness among health policy analysts and economists that John Kingdon created in his comparative analysis of transportation and health care in the 1980s. For example, by looking carefully at the narratives of transportation and health care, Kingdon observed the mantra of "access, cost, and quality" that so drives the conceptual frameworks and analysis of health care was nowhere present in any of the discourse about transportation policy.

The examples take the form of several mini-case studies of recent policy that, by some measure, have been "successful," meaning that significant legislation and commitment of public resources has occurred, in spite of the obstacles and pessimism that characterized these issues ex ante.[6] We have chosen examples of policy development at three levels of scale and ambition, from down-on-the-ground social movements to, arguably, the most significant example of economic policy making in the last decade.[7] The criteria for selection of these

[5] For an extended discussion of these hazards, see Richard Rose. *Lesson Drawing in Public Policy: A Guide to Learning Across Time and Space.* Chatham, NJ: Chatham House, 1993.

[6] One of the obvious observations coming out of this exercise is the absolute paucity of "big policy" accomplished in the two decades. Unlike the Johnson or, arguably, the Nixon administrations, there simply are few examples of significant domestic legislation committing substantial resources to a public purpose. Contrast this era with the policy making of the Johnson administration: on the walls of the Johnson Presidential Museum in Austin is an exhibit of the 100 major pieces of legislation passed during his term, including Medicare, the Voting Rights Act, the Clean Air Act, etc.

[7] It is interesting to note that the search for examples of significant federal legislation that might serve as useful analogies or heuristics for envisioning health reform actually produced few good candidates. The "War on Drugs," which has captured some $30 billion of federal resources and a cabinet-level appointment, mostly directed at interdiction activities, is a possibility and may be worth further discussion. (One of my

cases include the scale of their impact (either in resources or potential behavioral change) and their extension of the reach or capabilities of the state (as opposed to legislation that could be interpreted as taking away federal or state benefits or authority). Each case study comes from recent political history. For these reasons of selection, we examined and rejected for inclusion in this chapter creation of the Office of National Drug Control Policy (the so-called drug czar), the 1996 welfare reform legislation, and the Adoption and Safe Families Act of 1997.

It is worth noting that the analysis of "unsuccessful" policy initiatives can be useful as well to develop new strategy for universal health coverage. Jacob Hacker's analysis of the Clinton health reform experience, for example, provides an effective counterbalance to the literature in the aftermath of that experience that concludes, in one way or another, that significant health reform in the United States is "doomed" or preordained to fail.[8] Although the Clinton experience provides an always-tempting and relevant stockpile of political analogies and lessons, this chapter purposefully looks elsewhere for evidence that the health reform project is necessarily deterministic, static, or bounded by the certainties that seem to rain down from the many post hoc explanations of reform failures. As Hacker concludes,

> Retrospective certainty has, of course, also been a prominent feature of the prolific commentary on the health care reform debate. The burial of health care reform in 1994 prompted a barrage of "defeat was inevitable" arguments from the nation's political scientists, many of whom implied, without much subtlety, that anyone who really understood politics would have known that the Clinton plan and its alternatives were doomed from the start. These arguments go beyond the claim that the health care reform was unlikely to pass to the more suspect claim that it was destined to fail. In doing so, they degenerate into mechanistic and static characterizations that fail to capture the uncertainties and strategic complexities of the debate.[9]

The concept of this chapter is to provide heuristics, not necessarily formal analogies or determinative lessons from other policy developments, but with an eye toward countering the deterministic and even fatalistic mindset of most political analysis of contemporary health reform. The goal is to stimulate some reframing of the sources of political action and change, to reconsider the sources of political influence in health reform, and to challenge some of the political truisms that have taken hold in the backwaters of the Clinton reform effort.

The case studies include the following: (1) The dramatic commitment of regulatory and law enforcement tools to reducing the incidence of drunk driving, and its related injuries and deaths, as a result of significant grassroots social mobilization. This case illustrates the existence and potential role of social movements in producing reform "under the radar," but with potentially significant results. (2) The recent federal education legislation, "No Child Left Behind," which illustrates the most recent example of policy framing and compromise across ideological and partisan lines at the federal level. (3) The North American Free Trade Agreement (NAFTA), which profoundly altered the terms of trade in North America, despite the vigorous opposition of organized labor, particular industries, and an apparent lack of public opinion mandate.

The plan of the chapter is as follows: The case studies are interspersed with discussions of mobilizing, framing, and leading the campaign for universal coverage, taking account of all the well-known constraints and obstacles. The goal of these exercises is not to pass judgment on the underlying merits of the resulting education, drunk driving, or trade pol-

colleagues calls this achievement the triumph of criminalization and militarization in framing a policy agenda.) Welfare reform, which also may deserve more thinking for this paper, may be more an example of "takings," in Richard Epstein's parlance, than it is a positive assertion of new policy and entitlement that is helpful for understanding health care reform. Federal child welfare legislation, namely, the Adoption and Safe Families Act, embodied a set of goals for family re-unification and swift movement to permanent adoptive homes—a philosophy of service—as well as a strong model of delegation and financing to state administration. Its politics and design reflect many idiosyncrasies of the substance and populations involved in child welfare.

[8] Jacob Hacker. "Learning from Defeat? Political Analysis and the Failure of Health Care Reform in the United States." *British Journal of Political Science 31* (2001): 61–94.

[9] Ibid., pp. 93–4.

icy, but rather to look briefly at the political anatomy of these recent or relatively recent policy initiatives for ideas about new ways to construct and "market" health care coverage. In the case of drunk driving legislation and regulation, we are exposed to the underground phenomena of social movements—also lurking in states as potential players in promoting models of health care coverage. In the case of education reform, we become sensitized to the possibilities for bipartisan compromise around a set of vague but important notions of school accountability, as well as the pathways around important ideological symbols such as vouchers. Finally, by examining the anatomy of NAFTA, we come back full circle to realpolitik and consider the power and possibilities of legislation (actually ratification) in spite of what appears to be overwhelming opposition from organized, populist, and special interest forces, and even initial policy ambivalence by the President.

Mobilizing: Mothers Against Drunk Driving, Social Movements, and Health Care Coverage

Many progressives look to bottom-up social movements as potential vehicles for health reform. Examples from the civil rights movement, the women's movement, the movement for support of HIV/AIDS research and coverage, and the environmental movement all have salience in thinking about engagement of the public in issue advocacy and political influence. Discussion of national health care reform has been surprisingly immune from broad-based, value-driven, social movement politics. The language and rationale of rights has never taken serious hold in U.S. health care, identification of health coverage with particularly compelling and visible populations has never occurred, and an organized advocacy with "voice" has arguably never really developed. But, as this section demonstrates, organizing around health care coverage is occurring in cities and states, though almost without connection to the reform ideas trafficking in Washington.

As a heuristic for understanding the role and behavior of social movements, consider the remarkable evolution, visibility, and policy consequences of the movement to reduce the incidence of drunk driving, largely mobilized by the group, Mothers Against Drunk Driving (MADD). The origins of MADD can be traced back to two tragic accidents in 1979 that severely injured one child and killed another. The mothers of these children, Cindy Lamb and Candy Lightner, sought out key leadership in Congress and simultaneously began a national grassroots organizing campaign. The movement was publicly launched in October of 1980 at a press conference convened by then Congressman Michael Barnes (D-MD), during which the two founding mothers called for the creation of a Presidential Commission and a broad-based campaign at the federal and state levels to raise the minimum drinking age to 21.

The tactics and institutions that MADD (and its affiliated organizations) have subsequently used are mulitifaceted: the original Presidential Commission evolved into the permanent National Commission on Drunk Driving, the policy emphasis on a minimum drinking age broadened as zero-tolerance standards were implemented for teenagers, more stringent blood-alcohol limits (0.08) were adopted in states, aggressive measures such as checkpoints became accepted law enforcement tools, and financial incentives were directed at states to change the minimum drinking age when direct federal jurisdiction over drunk driving is not available. MADD and its affiliated organizations have also promoted technological interventions, such as sobriety monitors on cars and sophisticated electronic scanners for identification (ID) cards.

The campaign against drunk driving has morphed and grown along with its success and visibility. For example, beginning in 1999, MADD embraced prevention of youth alcohol abuse as a defining program area and set about to create the grassroots support and policy advocacy to move an agenda of legislation and intervention directed at teenage drinking, not drunk driving per se. MADD has introduced educational programs in high schools and colleges and has begun to monitor and counter advertisements and marketing.

The movement against drunk driving is even

more interesting for its effects on the hearts and minds of citizens than for its considerable legislative and regulatory accomplishments. Informal practices, such as designated drivers, have clearly changed behavior on a broad scale and influenced social norms. The idea of the designated driver, which has now become inculcated into the social life of the nation, was created by this movement. The idea of the designated driver is reinforced in the advertising campaigns of beer distributors. On holidays, public transportation agencies and even private taxi associations have taken up this idea with free or subsidized transportation as a socially sanctioned and convenient substitute for driving while drunk.

Advocates claim that the policy to raise the minimum drinking age to 21, as well as the various sanctions on drinking and driving, have reduced highway deaths due to alcohol by 1,000 per year, a reduction of about 40 percent from 1980 through 1996. All told, advocates take credit for saving 18,000 lives. All of this occurred without necessarily a politically supportive or ideologically compatible environment. Ronald Reagan, for example, a strong proponent of state's rights and devolution, became a champion of the movement against drunk driving and a supporter of federal legislation imposing a minimum drinking age of 21 across states.[10] These changes have occurred despite the expectations we have of young people to serve in the military, to vote, to be married, and to be treated as adults in virtually all other aspects of life and responsibility at the age of 18. If one steps back from this movement, its effectiveness in changing norms and policy is quite remarkable.

Are there analogous movements in health care? Many movements in health care and health services are defined by interests in particular diseases and domains of health care: cancer, reproductive health, AIDS/HIV, alternative health, etc. Sherry Glied has described how ACT UP and the AIDS lobby transformed research into and coverage of HIV care from traditional disease-specific lobbying to a movement basis, in some ways providing a political road map for other causes and coverage, such as coverage of experimental autologous bone marrow transplantation for breast cancer.[11] In national health coverage, the best example of a large-scale movement to enhance coverage is found in the history of the End Stage Renal Disease Program, where, again, the political concern and the nature of coverage turn out to be disease-specific. The translation of concern, motivation, and even congressional theater is much more direct when constituents bring the experience of struggling with a disease into the political process. The most recent example of this phenomenon, albeit with less fanfare and congressional involvement, is the extension of Alzheimer's coverage in Medicare.

However, the movement for universal coverage in health care, per se, has been extremely diffuse and fragmented. Pockets of organization lie in professional groups, such as public health professionals, religious communities, and community-based organizations. At a minimum, it is curious that organized medicine has not mobilized more effectively in the last two decades to secure universal coverage. With the exceptions of relatively small groups and movements, such as Physicians for a National Health Plan, the organized efforts of physicians have largely been directed at reimbursement, regulation (for example, patient's rights in managed care), or specific domains of coverage that go along with specialty interests. Some specialty groups, such as the American Academy of Pediatrics, have engaged in public policy work and issue advocacy around topics of concern, but this activity has not reached a scale and level of organization across medicine to be a force for promoting health care coverage.

More grassroots organization around health issues does exist in states and cities, but often without a connection to national organizations or policy discussions. One such organization in Illinois illustrates its version of a social movement approach to universal coverage, albeit seemingly out of sight of the development of national reform proposals in Washington.

In 1999, a coalition of activists sponsored an advisory referendum in state elections, called the

[10] Michael Barnes. "Complacency Is Largest Threat: War Against Drunk Driving Enters Third Decade." *Washington Post,* no date.

[11] Sherry Glied. *Chronic Condition, Why Health Reform Fails.* Cambridge: Harvard University Press, 1997, pp. 167–68.

Bernadin Amendment after the beloved late Cardinal of the Archdiocese of Chicago. The amendment was dedicated to Bernadin and tied to his 1995 pastoral letter, *A Sign of Hope.* In his letter, Bernadin wrote,

> I was deeply disappointed by our inability as a nation to move forward with systematic reform of our nation's delivery of health care. While now is not the time to attribute blame, I am troubled that our constitutional process for decision-making seems increasingly incapable of addressing fundamental issues. . . . If justice is a hallmark of our community, then we must fulfill our obligations in justice to the poor and the unserved first and not last.

After his death, a group of activists took up Bernadin's call for universal coverage and began a statewide movement for a constitutional amendment. As it appeared on the state ballot, the Bernadin Amendment had the following text:

> Health care is an essential safeguard of human life and dignity, and there is an obligation for the State of Illinois to ensure that every resident is able to realize this fundamental right. On or before May 31, 2002, the General Assembly by law shall enact a plan for the universal health care coverage that permits everyone in Illinois to obtain decent health care on a regular basis.

The amendment was supported by an average of 71 percent of the electorate in counties (83 percent in Cook County) in the April 1999 Illinois elections.

This movement for a constitutional amendment has been reinforced by classic organizing and a model of a social movement approach to universal coverage, known as the Gilead Campaign in Illinois. Gilead (taken from the traditional hymn, "There is a balm in Gilead, to make the wounded whole") is organized by a coalition of 330 churches, community organizations, labor unions, hospitals, and clinics known as United Power in Action. The Campaign receives financial support and leadership from mainstream provider associations, such as the Metropolitan Chicago Health Care Council, and major systems, such as Advocate Healthcare and Blue Cross/Blue Shield of Illinois. The Campaign itself is an amalgam of practical programs and services designed to get families registered for existing insurance (for example, S-CHIP, Veterans Administration programs), expand availability of low-cost primary and preventive care, and expand insurance coverage using both public and private insurance products. As it has evolved, the Campaign has brought together a broad spectrum of interests in health care coverage and efficiency in health care delivery, from business interests, to providers, to insurers, to grassroots organizers. Its focus has largely been practical initiatives, such as expansion of KidCare at the state level, that elicit broad support within the coalition. Not surprising, the Campaign has struggled for resources, struggled to balance the often conflicting interests of its members, and struggled to maintain the leadership and policy infrastructure that high-level influence on health policy requires.

While in many respects, social movement activity for coverage in health care is a humble enterprise, without anything like the resource base of the pharmaceutical or insurance industries, it is interesting to observe how disconnected this movement is from the concepts and strategic thinking about how to achieve universal coverage. This is a two-way street: many in the health policy community are virtually unaware that this strata of political activity even exists, and many organizers are completely unaware of the thinking and design work going on in the professional and academic health policy community. It is worth asking whether, as part of the program to promote reform, some effort and resources should be devoted to better understanding and, perhaps, closing this gap. At a minimum, it suggests that renewed attention should be paid to the city, county, and state levels of health care politics and their organization.[12] It also may be worth asking again whether there are ways to engage physicians, other professionals, and providers in new and creative ways to be effective constituents when health reform reappears on the agenda.[13]

[12] For an extensive description and analysis of health politics at these levels see John E. McDonough. *Experiencing Politics.* Berkeley: University of California Press and the Milbank Memorial Fund, 2000.

[13] See, for example, David Rothman and Tom O'Toole. *Redefining the Dimensions of Care: Physicians and the Body Politic.* Baltimore: Open Society Institute, 2001.

Education Reform: The Role of Framing and Compromise

In December 2001, Congress passed the "No Child Left Behind" Act, which President Bush signed into law in January 2002. This education reform bill shepherds in a new era of regulation and accountability in public education, along with increased levels of federal government funding for education (a projected $22.6 billion for 2002).

The education bill is an interesting case for this project because it asserts new federal authority in education, presents an interesting example of policy framing, and illustrates successful political tactics in the most recent presidential/congressional environment. Politically, the bill serves as a good example of bipartisan compromise on an issue that has been a vexing federal problem over the course of several administrations, with these latest reforms representing the most wide-reaching federal initiatives since the Johnson administration.

The bill itself provides new federal funding for education, requirements for testing students and reporting school performance, plans at the individual school level for students to achieve "proficiency" on a national test, and provisions for addressing the performance of "failing" schools. In exchange for removing the block grant and voucher proposals advocated by some Republicans, the bill includes a more modest provision to pilot block grants in only 150 school districts. The legislation features significant targeting of federal funds to low-income students and schools. To satisfy the diverse ideological and program interests in education, the legislation included an unusually large number of special provisions, from hate crimes prevention to school computer Internet filters.

One major reason the bill was able to pass through both chambers of a tightly balanced Congress was that it attracted a few key sponsors in both the Senate and the House, supporters who represented moderates of both parties. Critics of the bill, however, maintain it achieved full bipartisan support only because moderate influences allowed the most controversial initiative—and the reform with arguably the greatest potential for true change—vouchers, to be excluded from the final version. Vouchers would have provided funding for children in failing schools to transfer to any other school, public or private, thus injecting a sense of competition into the public system. While voucher schemes are already in place in several locales, the proposal proved to be too controversial at the national level.

The background, processes, and outcomes of this recent education bill present some intriguing parallels for health reform. Wholesale education reforms have run into opposition from powerful groups heavily invested in maintaining the status quo, including state governments, that fear more regulation from the federal level without additional funds, and the teachers' unions. While the role of the federal government in education, relative to health, is a small one, changes at the federal level involve shifts in inter-government responsibility and tilt against established interests and educational philosophies. The education bill that resulted bears out some of Chubb and Moe's analysis of the inevitable ingredients of reform in a mature educational system.[14] In brief, they argue that educational reform inevitably will involve a mixture of institutional, political, and economic incentives, as well as increased systems of accountability that include reading, testing, and teacher proficiency.

One important implication for health reform that follows from the experience of "No Child Left Behind" is the treatment of controversial and ideologically charged issues that can doom reform efforts: how to use policy ambiguity and finesse to move along the path of reform.[15] In the recent education debate, voucher schemes maintained support from conservative congressional members who sought to inject market competition into inefficient education bureaucracies and from the grassroots—some parents and local education boards, especially

[14] John Chubb and Terry Moe. *Politics, Markets, and America's Schools.* Washington: Brookings Institution, 1990.

[15] For an extended discussion of the uses of ambiguity in striking compromise, see Deborah Stone. *Policy Paradox: The Art of Political Decision Making.* New York: W.W. Norton, 2002, pp. 157–62.

in certain large cities. While President Bush had a strong commitment to choice and to vouchers, he chose to compromise in the face of opposition from Democrats (who feared a backlash from the teachers) and from others who worried about the potential for a Supreme Court challenge based on issues surrounding the separation of church and state. The measure was left out of the final version, but the bill still allows room for this particular innovation to be implemented at the state level.

One wonders if a similar strategy could be used for health care: broadly defining the goals of reform at the national level, then leaving states room to work out the details, especially regarding controversial issues such as employer mandates, which Congress could encourage by relaxing ERISA strictures. Several *Covering America* proposals represent opportunities for some level of federal ambiguity and state variation in design and implementation. This approach might make it more likely that Congress could pass something at the national level, despite opposition regarding controversial topics. The major political obstacle to this approach would be the opposition of national firms that provide coverage and purchase health care across many states. For these interests, variations are a costly aspect of doing business, and standardization itself is a major goal of reform. Because the federal government plays a larger role in health care than in education, it might arguably have more influence on states in matters of health than in matters of education, and thus could pass more substantial changes as long as reformers avoided the most controversial topics. The danger in this logic, however, can be seen in the major criticism of the education bill: federal reformers, trying too hard to avoid controversy, passed a bill that does not really fix anything.

Another proposal that failed to make the final version of the education bill was the effort spearheaded by Senator Jim Jeffords (I-VT) to establish funding for special education as an entitlement. This proposal elicited resistance from states and from conservative members of Congress fearful of a potentially expensive, uncontrollable spending mandate.

The context of the 2002 election year was probably also important in promoting action on education this year. Education receives intense and ongoing media scrutiny and still sits at the top of most polls as a concern of voters. Federal reform served as a cornerstone of both presidential candidates' election platforms in 2000. The new bill provides one opportunity for a legislative success this election year, and for President Bush to fulfill his promise to "change the tone" in Washington. School reform and vouchers also had the express support of President Bush, who had pursued similar (largely successful) reforms in Texas.

Finally, it is worth reflecting on what turned out to be the conceptual core of the education bill: promoting accountability, standards, and performance in the educational system. Many of the resources, and much of the framework, of the bill are devoted to state and national testing in reading and math; a program of financing, remediation, and accountability for "failing" schools; and standards and resources for upgrading the quality of teaching. Thus, the bill is framed around a concept of accountability and a philosophy of school reform that enjoys widespread support, if not some controversy within educational circles. This approach may be contrasted with many proposals for increasing health care coverage that lack clearly developed provisions for quality improvement, performance, and accountability. In political terms, education reform exploited the symbolic value of accountability, choice, and quality without the ideological baggage of vouchers. As a matter of strategy, health reformers may also want to invent and emphasize such symbols to go along with the benefits of expanded coverage, per se.

NAFTA: Economics, Power, and Leadership

A third example, leading to a profoundly different perspective on the crafting and management of the legislative process, is the ratification of NAFTA in late 1993. Perhaps more than any other recent piece of legislation, NAFTA revealed the power of strong-arm, classical horse trading. It also demonstrated the assertion of presidential will in spite of strong

opposition by labor, particular industries (especially agriculture), environmental groups, and critics of globalization. This was all done under the specter of coming elections facing members of Congress. NAFTA was ratified in spite of the drumbeat of a broad-based populist campaign, which included such visible and diverse figures as Ross Perot, Patrick Buchanan, and Ralph Nader.

NAFTA was passed after an extended period of trade negotiation with Canada and Mexico, a hand-off of the bill across administrations—from George Bush to Bill Clinton, and an often bitter ideological and regional debate that crossed party lines.[16] Certain business interests, especially those organized around the group USA*NAFTA, invested considerable political and financial capital in the effort to get NAFTA ratified. This included the work of executives from such major U.S. firms as Allied Signal, General Electric, and Kodak.

NAFTA was ratified with support from many diverse points of view in the political spectrum—many finding common ground and justification in the merits of free trade—and some engaged in game-theoretic strategy over a broad political calculus.[17] In the end, for example, the NAFTA vote in the House included 132 Republicans and 102 Democrats in favor, and 156 Democrats, 43 Republicans, and one independent opposed. In this case, the administration sided with Newt Gingrich and was opposed by key party stalwarts, especially in the Midwest and South.

NAFTA is interesting for our purposes because it illustrates the significance of technical and institutional policy moves, the potential power of stewardship and leadership (in spite of organized opposition and public opinion), the role of political economy in modern congressional and presidential policy making, and the power of an important symbol—in this case free trade—in overcoming apparent partisan and ideological barriers. NAFTA was ratified in an era during which Congress had become increasingly assertive over trade policy, and, in theory, had created numerous structural obstacles to presidential policy leverage over trade policy. In all of the accounts of NAFTA's negotiation and enactment, the granting of an extension of fast-track authority in 1993, allowing presidential latitude in trade negotiation, is regarded as crucial. In other words, a seemingly technical and obscure change in the institutional environment—in the rules of the road—opened the possibility for such a large-scale and comprehensive trade bill. Frederick Mayer describes the significance of this extension of fast-track authority:

> As formulated by E.E. Schattschneider, and as explicated by the mainstream literature on trade policy ever since, the core problem in international trade policy is overcoming the tendency of concentrated interests in protection to overwhelm the more general interest in free trade. If policy is made piecemeal, establishing the level of protection one sector at a time, for example, gains to protection will be concentrated for firms in that sector, while the losses will be diffused among the unorganized consumers. Given the much greater problem of collective action for the many small losers, the concentrated protectionists' interests will be more successful in bringing political pressure to bear on trade policy makers. Attempts to negotiate away these barriers one by one encounter the same problem: Concentrated interests are thus often able to prevent international agreement. Comprehensive trade negotiations, those that deal with the many sectors simultaneously, help balance the contest of interests by adding together the many small benefits from each sectoral liberalization. But if Congress can subsequently revisit the terms of an agreement one sector at a time, the comprehensive agreement will unravel as concentrated insiders block pieces of the agreement one by one. . . .
>
> The fast track process largely solves this problem.[18]

NAFTA is also interesting for us because it reveals sophistication in framing and reframing. The issues raised by NAFTA were wide-ranging: immigration, environment, public health, drugs, human rights, and, of course, the economy. For

[16] For a detailed analysis of the crafting of the NAFTA agreement itself among Canada, Mexico, and the United States, see Maxwell Cameron and Brian Tomlin. *The Making of NAFTA: How the Deal Was Done.* Ithaca, NY: Cornell University Press, 2000.

[17] This interpretation is presented in Frederick Mayer. *Interpreting NAFTA.* New York: Columbia University Press, 1998.

[18] Ibid., p. 95.

many of these issues, analyses and evidence could be marshaled on either side of the question. Some of the controversy over these issues was effectively deflected merely by creating other avenues for discussion—for creation of a separate "Action Plan" for environmental concerns—and some of these issues were effectively discounted by analysts and NAFTA advocates. Many issues were defused with the argument that the consequences of NAFTA were minimal in the context of activity in the whole macro economy. Much of the debate about NAFTA focused on the question of net jobs and their migration. While this question is controversial enough, political opposition to other dimensions and consequences of the agreement never gained momentum.

The contest for public and congressional support centered on these questions of employment effects and the benefits of free trade. Both sides created imagery and examples. Rarely was the concept of free trade an abstraction in the debate leading up to NAFTA's passage. In a famous exchange during the 1993 debate between Al Gore and Ross Perot, Gore provided the example of a firm (and its executive, Norm Cohen) that had moved its production from North Carolina to Mexico to avoid trade barriers. "If NAFTA passes, Norm Cohen has plans right now to shut that factory in Mexico down and move 150 jobs back to Charlotte, North Carolina."[19] This imagery was reinforced, of course, by examples of benefits to particular industries, such as automobiles, as well as references to selected studies showing significant benefits in employment (for example, 200,000 net jobs added to the U.S. economy in each of the first two years), balance of trade, and prices.

The movement of the Florida congressional delegation, for example, from virtually unanimous opposition to grudging support, occurred because special deals were struck to protect sugar, citrus, and winter vegetable crops from Mexican competition. Presidential leadership and management of this process of political bargaining were aggressive and sophisticated. Mickey Kantor, the trade representative; Bill Daley, the brother of Chicago Mayor Richard Daley; Bill Frenzel, a former congressman and trade specialist; and other administration leaders were engaged to lobby and make deals with members.

NAFTA illustrates political success in spite of opposition from many different sources. Although President Clinton came to support ratification grudgingly, in the end, he put enormous personal energy and leadership into its enactment. NAFTA illustrates political dynamics and tactical success at the opposite end of the political food chain from such grassroots efforts as the Gilead Campaign. The success of NAFTA required the most sophisticated political management and strategy, as well as effective use of media, symbols, and imagery. NAFTA's support cut across traditional party and ideological lines; it mobilized some of the most powerful commercial and economic interests in the country.

As a model for thinking about health reform and coverage, the NAFTA experience raises all the high-game questions of the political economy that surrounds the health sector. As the prolonged prescription drug debate has illustrated, without good answers and strategy for responding to the interests of the health care industry, and without power, political will, and political resources to engage the industry, it is hard to overcome its resistance. The implication of this heuristic for filtering and considering the *Covering America* proposals is to analyze very carefully the industry interests in play across these proposals. In many respects, health care reform should be thought of in the same terms as NAFTA, as one of the most significant pieces of economic policy that can be envisioned, with vast consequences for the economy of insurers, providers, suppliers, and other stakeholders that make up the sector.

Discussion

In an era of divided government, widespread cynicism, and unfavorable economic conditions, it is useful to look at the counterfactuals: examples of policy or policy development that cut against the grain of the recent legislative and policy stalemate. This chapter has attempted to provide three very different examples that imply different strategies for framing reform. These heuristics provide significantly differ-

[19] Quoted in Paul Blustein. "NAFTA: Free Trade Bought and Oversold." *Washington Post,* September 30, 1996, p. A1.

ent touchstones for prospectively analyzing universal coverage proposals. A social movement approach implies greater attention to bottom-up policy development, looking to both the values and concepts expressed in state and local initiatives. The illustration of MADD is instructive, because it highlights the possible roles of motivated leadership, innovation, and tactics, particularly as they operate in subterranean policy contexts. MADD and other successful movements have made use of the passion, the personal investments and commitments, and the broad-based support of community, advocacy, professional, and other organizations.

It is interesting that universal coverage movements—such as the Gilead initiative described earlier—in the United States are so disconnected from academic, professional, and policy discourse. It would be interesting to connect the dots between developing proposals for expanding coverage and the values and concerns of social movement players in health care. At the same time, it would be useful to envision how social movement players in health care can be better connected to the technical and formal discussion of health policy emanating mostly from Washington. National health policy initiatives (with the significant possible exception of Medicare) have not been particularly adept at or astute in relating to social movements.

The motivations and politics of social movements tend to operate in a middle ground between the large-scale (and often diffuse) goals of universal coverage proposals and the felt need of individuals, families, and providers who encounter risks, difficulties, and hardships in providing access to care. This is why movements tend to coalesce around particular risks or diseases—such as AIDS/HIV, multiple sclerosis, or Alzheimer's disease—or groups, such as children, who have been the focus of S-CHIP expansions. Indeed, some of the patchwork of the U.S. entitlement to health care reflects exactly the disproportionate pressure that has been exerted when individuals and groups experience direct and dramatic consequences from a lack of coverage. Although many of the goals and tactics of comprehensive reform are in significant tension with this form of disease-specific entitlement, it is worth asking how the passion and investment that lie in movement politics can be mobilized toward the agenda of universal coverage. Large contemporary groups (for example, persons with diabetes, dislocated workers under age 65), as well as their families and caregivers, have the motivation for social movement engagement in health reform, but do not have obvious vehicles for political action.

The recent education reform experience highlights the interplay among framing, compromise, and presidential stewardship, if not leadership in a successful congressional strategy. The final bill capitalized on important symbolic common ground between Republicans and Democrats, finessed the ideologically charged issues of vouchers and choice, and featured the most visible examples of political compromise, including the joint appearance of Senator Ted Kennedy and President Bush in Boston promoting the legislation. As a work of inter-governmental design and negotiation, the Education Bill conceptually has issues in common with health coverage proposals that seek to integrate with Medicaid, state insurance initiatives, and safety net providers. Alas, health care coverage does not appear to engender the same commitment and personal interest from President Bush as education reform.

Clearly, the success in producing education reform raises the question of the role and importance of bipartisanship in promoting health reform. Political scientists have much debated the importance of bipartisanship in producing large-scale legislative wins, especially in the modern era. As both the education reform and NAFTA experiences recounted in this chapter demonstrate, however, bipartisanship can take many forms and occur at different moments of the political process. It is helpful to have symbols (for example, accountability, free trade) that can be embraced across ideological lines, as well as leadership that is willing to make compromises on programmatic and technical issues. While bipartisanship has been difficult to achieve in recent health policy, including legislation for patients' rights in managed care and prescription drug coverage, it is worth noting that these other policy heuristics involve some of the same principals (and principles) as health reform. Education reform, for

example, involved the leadership and compromise of President Bush and Senator Kennedy.

The successful enactment of NAFTA is interesting because it reveals the ingredients of big policy enactment against the odds, and against significant and passionate opposition. Again, NAFTA was built around the presumed benefits of free trade, and it exhibited extraordinary bipartisan and ideological mixing. NAFTA represents, among other things, an exemplar of power politics, worth considering as a counterexample to the presumed stranglehold by the powerful economic interests of insurance, providers, pharmaceuticals and medical suppliers, and even state governments on reform efforts.

Several final observations for the coverage proposals in The Robert Wood Johnson project emerge out of this excursion into alternative policy development. *Health care proposals read as if coverage is a sufficient justification for policy.* What if a broader social justification or motivation is required to elicit bipartisan consideration and consensus? It is worth asking whether, at this late hour in the development of U.S. social policy, a more robust justification is necessary to motivate action and achieve consensus. Human capital or human potential benefits of coverage? Efficiencies in the health sector? Accountability and outcomes? Has the proposal been framed, positioned, and articulated with all due respect to the symbolic and political touchstones of our time? Are there ways to think about universal coverage as a contributor to individual and family opportunity, personal responsibility, transitions, or other contemporary values receiving widespread expression in other arenas of social policy? To be more pragmatic, is it possible to think of universal coverage, at least in part, in the context of security, or a strengthened public health system? Even recently, examples of framing of health initiatives appear to exploit the symbols and rhetoric of the time. Edwin Park and Leighton Ku's proposals for Medicaid reform qua stimulus package fit almost perfectly Kingdon's idea of attaching policy approaches to the "problem environment" that presents itself. Their proposal is tailored in both its public finance and coverage features to complement the larger agenda of economic stimulus and recovery of the moment.[20] In the current environment, framing many issues around the federal preoccupation with security is another example. Policy strategists have even joked about ways to reframe the Medicare prescription drug benefit as a key element of national security. In Chicago, for example, the City Department of Public Health is literally going through a process of reformulating the "paradigm" (its word) of public health, to capture resources and opportunity provided by the current emphases on bioterror, emergency preparedness, and security.

A clearly important element in the political success of coverage proposals will be the degree to which an issue is constructed in symbolic, rhetorical, and public interest terms. The balance for health care between symbols that promote the cause and possibilities for reform and symbols that elicit the traditional ideological and "theological" responses is tricky. Deborah Stone has written about the need to find symbols that both bring together disparate interests and provide sufficient ambiguity to allow consensus to form around an initiative.

A number of symbols can be observed in recent legislation in social welfare and the human services. The idea of "opportunity," usually meaning mobility and employment, is a core feature of recent welfare reform, housing policy, child welfare, and employment and training. Closely related to the symbolic ideal of opportunity is the concept of transitional assistance, which is either explicit or implicit in much of recent social policy. In the federal HOPE VI housing initiative, for example, much of housing assistance is to be "transformed" from building and maintaining a stock of public housing, to giving residents the wherewithal to move (soon) into private housing. The wraparound services in this model (for example, employment, service connectors) have the goal of supporting residents in their transition, not necessarily supporting their long-term tenure in public housing. This philosophy is obviously fundamental to the time limits in Temporary Assistance to Needy Families (TANF) and can be seen in the philosophy and design of modern child welfare policy,

[20] Edwin Park and Leighton Ku. *Temporary Medicaid Improvements as Part of a Stimulus Package.* Washington: Center on Budget and Policy Priorities, October 9, 2001.

where the primary goal is to move children quickly either to family reunification or to a permanent adoptive situation—what is called "permanency planning" in the jargon of the child welfare field.

Also closely related to opportunity in the modern construction of social policy are notions of responsibility, voluntarism, and normative ideas about what makes for a civil society. Welfare reform was framed around the concept of personal responsibility; the President now asserts that every citizen has the responsibility to provide the equivalent of two years of voluntary service. The public intellectuals promoting versions of a civil society have been creating a larger construct for social policy that may yet have implications for how health policy is interpreted.

Clearly, the importance of framing health care reform has not been lost on the architects of earlier attempts. Indeed, the imagery of the Clinton plan around health "security" is an illustration of this strategy, and the President's rhetoric and use of symbols (for example, the health security card) revealed appreciation of the importance of symbolically framing reform, at least initially.

From the perspective of other domains of social policy, it is interesting to note how seemingly little attention is being paid to the symbolic construction and framing of health care reform, despite the sophistication of policy design and economic analysis under way. Many possibilities exist: Universal coverage can be framed in human capital and/or human potential terms; in terms of distributional justice, rights, or responsibilities; in terms of public accountability (as education reform has most recently been framed); or in efficiency terms (cost effectiveness, mobility of labor, etc.). It may be worth considering the *Covering America* proposals more explicitly in these symbolic terms, or through these symbolic lenses.

As a final observation from these three case studies, it is worth asking about the state of advocacy and political organization for health reform. The MADD experience suggests there is power in commitment and mobilization, however quaint and naive those ideas may appear in the modern political economy. Very few vehicles exist for mobilization of political support for health reform. The grassroots examples, such as Gilead, described in this chapter, operate at a considerable distance from the machinery of federal reform and the debates of the academic policy community. A proposition that comes out of this chapter is that the sources and potential impact of advocacy and political organization for health reform—outside the Beltway—may not be sufficiently appreciated, or certainly supported, in terms of requisite resources. It may not be enough to try to reach the public with advertising and such large (diffuse) political interests as labor and AARP. Intermediate organizations, often operating at the state and local levels, may be worth further investigation and support in the name of building a robust political agenda for reform.

The *Covering America* proposals are clearly strong in their conceptual development, specificity, and articulation of potential benefits. Indeed, the framework of the project has imposed a kind of discipline that requires descriptions of the approach, interactions with government and health stakeholders, funding, etc. The proposals emphasize the rational and structural features of reform. Largely missing from the public presentation of these proposals are ties to politics, social, and ideological undercurrents for reform and the symbols or meanings that might be attached to the ways in which health reform is undertaken or to the features of specific proposals. ■

Vladeck

Commentary Abstract

Bruce Vladeck provides a general critique of the reform proposals in the first volume in this series. He argues that too many of the authors have falsely assumed that access to the kind of insurance they propose will ensure access to adequate health care. He suggests that the authors may be incorrect in concluding that the only way to achieve universal coverage is through incremental steps toward that goal. He criticizes the proposals for trying to create health insurance markets like those of economic theory in spite of the evidence that this is inconsistent with consumer preferences and probably will not work. He closes by offering the outlines of a reform he favors based on the principle that no one, once covered, should lose health insurance.

About the Author

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Ends and Means in Health Insurance Policy

by Bruce C. Vladeck

As the ratio of discussion and analysis to actual health policy change continues to grow, we seem increasingly at risk of running afoul of two of the most dangerous, and closely related, confusions in rhetoric: the one between means and ends, on the one hand, and the confusion between is and ought to be, on the other. *Covering America: Real Remedies for the Uninsured* is itself not immune from these problems, which is especially distressing given the amount of thought, effort, concern, and real goodwill that went into its production. One hesitates to criticize by name any of the 20 contributors, who certainly cannot be faulted for a lack of seriousness, sincerity, or sophistication—but individual criticism is largely beside the point. While there are many important and substantive differences among them, all of the chapters in *Covering America* occupy space within the same intellectual and political construct. And that framework, I would suggest, is very much a reflection of the problems of ends and means and is and ought to be.

In this paper, I try to identify and explore the three principal shortcomings of that framework—the confusion between means and ends in the discussion of health insurance; the confusion between means and ends in the discussion of incrementalism; and the confusion between is and ought to be in the discussion of health care costs and markets—and try to identify some of the consequences. In fairness to the spirit of the enterprise, however, I think it would be inappropriate to engage solely in criticism. Therefore, I will try to suggest some alternate ways of thinking about things that might be more conducive to moving policy in the direction everyone says they want to go—or, alternatively, to smoking out some of the profound conflicts and fundamental disagreements that the current discourse conceals, and that in fact may constitute more significant barriers to policy change than any shortcomings of the analytic process.

My own view is that, when real, non-incremental change, good or bad, comes to American health policy, it will do so as a result of a process in which analytic discourse will be largely irrelevant—in which, indeed, the process and products of analytic discourse become a weapon in the fight against change. Such a view, of course, exposes its proponent to accusations of anti-intellectual nihilism, to which I can respond only by reference to the historical record, and by re-emphasizing the difference between means and ends.

Means and Ends in Health Insurance

In the very first sentence of their chapter, Wicks, Meyer, and Silow-Carroll write,

> No Americans should be denied access to needed medical care because they lack health insurance coverage, and no health care providers should go unpaid because they treat people who lack the means to pay for care. This proposition is the guiding principle underlying the proposal for universal health coverage that we develop in this paper.

This is a worthy principle, and one to which I certainly subscribe, as I am sure do all the authors in *Covering America.* But then, like the other authors, Wicks, Meyer, and Silow-Carroll proceed to devote most of their discussion to health *insurance,* not access to health care.

It is easy to confuse the two. The syllogism is pretty straightforward: in the contemporary United States, health insurance coverage is generally a necessary, if not always sufficient, condition for access to the kind of "mainstream" health care that most of us expect. The evidence is overwhelming that individuals without health insurance have less access, and less satisfactory access, to the health care system than the rest of us, a particularly important point to make in the current political climate, in which the notion that "no one in America is denied access to medical care" has taken on considerable currency, although it is demonstrably untrue. Most of those without insurance are, in Uwe Reinhardt's particularly apposite phrase, "beggars at the health care feast," a phenomenon that few would condone openly.

But not all health insurance is the same. And not everyone with health insurance has "the means to pay for care" as a result. Indeed, as several of the authors in *Covering America* do acknowledge, a growing number of Americans have health insurance that is inadequate as a tool for insuring the means to pay for care. More important, most of the contributors would encourage the proliferation of health insurance policies that would increase the numbers of Americans who had nominal health insurance, but lacked the ability to afford services they need.

The underlying problem, of course, is that health "insurance" is at least partially a misnomer. One could spend a lot of time in the debate over whether health insurance is insurance at all, but the ways in which it differs from property and casualty or automobile or life insurance are particularly important for the issues at hand. Since Kenneth Arrow, health economists have tended to focus on the extent to which insured events in health care take place at the discretion of the insured—a concern that I think is much overrated, and that has contributed significantly to the confusion about health insurance—and the extent to which "moral hazard" exists. But even more important is the fundamental fact that insured events happen quite often. The average American with health insurance has more than four covered physician visits a year, along with claims for prescription drugs and other services.

Much of what consumers want from their health insurance is precisely what economists do not want them to have: protection from out-of-pocket costs at the point of service and decoupling of financial and clinical transactions. We used to call some of what we now lump under "health insurance" "health care prepayment plans," and that is what health insurance represents for many consumers. Policy makers keep trying to shift coverage from the front end to the back end, but actual consumers keep buying more front-end coverage than would be rational if they were primarily interested in buying insurance.

More important than prepayment as a unique characteristic of health insurance is the extent to which such insurance is redistributive. It redistributes resources from the healthy to the sick. Most of the authors in *Covering America* seek to maintain or expand insurance pools such as those provided by most large employers to avoid the complex risk-adjustment methods that must be adopted otherwise to prevent risk selection from overwhelming the redistributive power of health insurance.

The simple arithmetic requires such redistribution. If the purpose of health "insurance" in a society like ours is to assure, or help assure, that people will have the necessary financial resources to pay for necessary medical care when they get sick, then the brute fact is that the cost of treatment for one serious illness can easily exceed the total gross annual income of an average household. And the probability of encountering such expenses is not randomly distributed among the population, but not distributed in entirely predictable ways either: healthy 30-year-olds get hit by cars and develop cancers, but at a much lower rate than 60-year-olds or 80-year-olds. So most of the authors in *Covering America* require community rating of insurance pools to ensure that the health insurance market does not work like a real insurance market, by concealing subsidies from the healthy to the sick. And as several contributors note, the practical and political advantages of maintaining a system of employer-based health insurance are counterbalanced by the fact that working people are systematically healthier than are non-workers.

This would not be such a big deal if it were not for the fact that the risks of needing expensive medical care are distributed not just by demographic characteristics, but by income as well. The less income one has, the more likely one is to be sick (which is cause and which is effect is an interesting but insoluble question). At the same time—in an often overlooked obvious point—the less income one has, the less one has to spend either on purchasing health insurance or paying out-of-pocket costs. So if health insurance is to be an effective means toward the end of access to medical care, it has to subsidize people of modest incomes quite extensively. Doing so, however, costs a lot of money, since even without the tax exclusion, people with more money will continue to demand extensive insurance. As a result, many of the contributors to *Covering America* end up recommending subsidization of moderate-income people at a level that provides them the opportunity to obtain health insurance that almost certainly will be inadequate to provide them with access to mainstream health care. This is not just a theoretical assertion: in multiple-choice, defined-contribution employer plans in both the public and private sectors, there is a powerful correlation between income and plan choice, and unless health insurance prices have absolutely no economic meaning, this means that lower-income employees are getting less valuable health insurance, even though they are more likely to need it.

For very low-income people, we know very clearly that copayments deter medically necessary outpatient utilization. The effective prohibition on copayments for most services is what makes Medicaid so unusual in American health care, and is why folks like Feder et al. cling so desperately to preserving Medicaid as a means of assuring access to care for low-income people. But in this and other ways, Medicaid thus really is not insurance at all; it is a mechanism to funnel money to providers of service on behalf of people with effectively no disposable income of their own. Of course, just because Medicaid is not really health insurance does not mean that it actually guarantees access: while Medicaid beneficiaries, in general, have significantly better access to needed medical care than do the uninsured, their access is often inferior to that of more affluent people with private insurance.

The ultimate confusion between means and ends in the discussion of health insurance is reflected in the growing number of proposals—including several in *Covering America*—to encourage bare-bones, high-deductible policies exempt from mandatory coverage laws. Since such policies presumably will be much cheaper than most of what is now on the market, it would require substantially less subsidy to expand the number of nominally insured people. Widespread adoption of such policies also would be a financial boon to providers who give expensive services in emergency situations, who presumably would be paid something for some cases for which they now are not paid at all. But such widespread adoption could also significantly increase the number of people with health insurance without increasing access to most needed care.

Means and Ends in Political Strategy

In describing the process through which the papers in *Covering America* were developed, Elliot Wicks explains, "Although political feasibility is important, we wanted authors to consider approaches that involve fundamental reform . . . . Writers were told not to assume the present political climate." It appears that almost all of them ignored that advice. Either explicitly or implicitly, *all* of the authors talk about incrementalism as a political necessity, and all describe what are essentially incremental strategies.

In the political science literature in which the term, "incremental," originated, there are in fact two senses in which the concept is used. The first is descriptive (incrementalism as an "is"), a way of characterizing the processes through which social policy in the United States generally is made. The Madisonian division of powers, it is argued, along with the naturally pragmatic, non-ideological character of American culture, produce political processes that normally solve problems a little piece at a time. The evolution of the Social Security System, including its Medicare component, generally is adduced as the prototypical example. In the history of American

social policy, incrementalism is an observable empirical fact—though not an unvarying one.

But there is also a normative ("ought to be") theory of incrementalism, which advances it as a cognitive strategy in a world full of unknowns and unintended effects. In this guise, incrementalism is a way of coping with uncertainty and minimizing adverse consequences. In his essay, Mark Pauly explicitly adopts the latter strategy, but most of the other authors in *Covering America* argue that their proposals are inherently incrementalist, not because that is optimal, but because they have no other choice. We cannot get to universal coverage in one fell swoop, it appears; the most we can hope for in the foreseeable future is limited, incremental change. Given the consequences for real people of not having health insurance, it is irresponsible to hold out for utopian change when incrementalism offers the most realistic hope of actually accomplishing something.

That argument is fundamentally a tactical argument, a statement about ends and means. We know where we want to get, and incrementalism will get us there.

But that argument may be wrong, and I believe it is. We have been pursuing incrementalist strategies for expanding health care coverage for more than 20 years now, and the number of uninsured people has increased dramatically during that period. We are now approaching an economic period during which some of the more direct results of incremental strategies—such as the non-entitlement status of State Children's Health Insurance Program (S-CHIP) eligibility and the expensiveness of COBRA (Consolidated Omnibus Budget Reconciliation Act)—are likely to accelerate the process of health insurance loss. And just because a single example of non-incrementalist policy effort, the Clinton administration's Health Security Act, failed dramatically does not imply that incrementalist efforts have not failed as well.

In my own view, the lessons of the Reagan Revolution of 1981 and the Contract with America Congress of 1995–96 are that non-incrementalist strategies may be much more effective: even if the changes they produce are fundamentally incremental, change does occur, and in the direction the proponents of the non-incremental strategies desire. We may be re-learning the same lessons now. If you really want to change social policy in this country, it may be that you have to take advantage of a post-election honeymoon, regardless of how broad or narrow the electoral outcome actually was, to go for broke. There may be subsequent political penalties for overreaching, but in the meantime, one may get closer to one's goals. We are no closer to universal insurance today than we were 20 years ago, but during that time we have abolished the statutory commitment to full employment, federal efforts at school desegregation, and entitlements to cash assistance for single mothers.

The point, though, is that these are, or should be, fundamentally tactical arguments, arguments about means, not ends. It may well be that the only way to bring about even incremental change in the right direction is to advocate for non-incremental change. Effective political rhetoric, and effective political strategies, may require depiction of a preferred end-state that may never be attainable, but that at least can serve to define the goals of policy change, and provide a metric by which to evaluate that change. You can't always get what you want, but if you do try (to ask for all you want), you may just get what you need.

Is and Ought to Be in Health Insurance

By my count, half the contributors to *Covering America* had some involvement with creation of the Clinton administration's health reform proposal, as did I. I thus found it particularly astonishing that no fewer than five of the proposals therein involved purchasing pools or insurance exchanges—although I hasten to note that there was not a one-to-one correlation between Health Security Act alumni and pool advocates. As best I can tell, insurance exchanges are what we used to call health insurance purchasing cooperatives (HIPCs), and then, thanks to the White House spinmasters, "health alliances." No feature of the Health Security Act evoked more ridicule, mockery, or disdain. One might even suggest that the political unattractiveness of health

alliances contributed to the non-incremental policy changes of the Contract with America.

Whatever the political implications, the issue is that real health insurance markets refuse to behave like perfect theoretical markets, and real health insurance consumers refuse to behave like abstract consumers, and health policy analysts continue to devote enormous time and effort to trying to make reality look more like theory. The analytic means—the application of theoretical constructs to assist in the description and comprehension of empirical phenomena—thus becomes an end in itself.

In most cases, the relative risk characteristics of an insured population are a far more powerful predictor of actual claims expense than anything one can do about policy design. Thus, unless health insurers are especially dumb (a possibility that should not be rejected out of hand, at least as a broad generalization) or altruistic to a theory-defying degree, they will do everything they can to maximize their ability to select risk. Community rating can dampen some of these behaviors a little, and risk adjustment can level the playing field after the fact, but creating a totally artificial market may be necessary. That is especially the case if one's objective is not to eliminate risk selection but to manipulate it, so that the extent of subsidies to relatively high-risk individuals and households can be minimized and, optimally, concealed.

In a few instances, involving enormous effort and considerable investment, insurance exchanges or similar pooling devices have been able to provide a small number of small businesses with access to group insurance in a form that would not otherwise have been available to them. But, as several of the contributors to *Covering America* note, voluntary insurance exchanges suffer from the generic problem that firms that are good risks—and can demonstrate to insurers that they are good risks—have little incentive to participate over time, thus making likely, in the absence of significant subsidy, the kind of self-reinforcing "death spiral" that has afflicted so many of the individual high-risk pools established by the states.

One can design all sorts of facilities to counteract some of the inefficiencies and inequities in the small-group health insurance market, although just how far that would get us in increasing the number of insured people is a very good question. The underlying problem, however, is more systemic. Most of the authors in *Covering America* seek to transform individual American households into consumers of health insurance. The rhetoric is that doing so will give people more choice and permit insurance plans to be tailored more closely to individual preferences.

In fact, the devolution of choice to individuals serves two other, more important, compelling purposes: first, it helps to conceal the already accelerating shift of health care costs from employers and other third parties to individual households by creating the impression that maintaining current levels of coverage is a whimsical luxury for which families should pay a punitive amount. Second, by fragmenting the purchasing power of consumers, it moves the health insurance market closer to the theoretical model of neoclassical microeconomics, which is easier to talk and make assertions about.

The problem with this line of reasoning is that most individuals want no part of being health insurance consumers, and their wariness may be quite rational. A recent Commonwealth Fund survey reinforced the long-standing findings of other public opinion research that people prefer employer-provided health insurance largely because they have more confidence in their employers' ability to deal with health insurers than in their own. Data collected about Medicare beneficiaries since the advent of The Balanced Budget Act are hardly very encouraging about the ability or enthusiasm of most beneficiaries for even a very highly structured choice process, and health insurance has a higher salience for Medicare beneficiaries than for younger people. In addition, Medicare beneficiaries have far more time on their hands.

Of course, there will always be some people who prefer to have greater opportunities for choice in purchasing health insurance; one suspects that the proportion is significantly higher among academics, especially social scientists, than any other group in the population, but empirical data are scanty on this topic. And it is probably a good idea to give them

opportunities to exercise that choice, as long as we can prevent the tail from wagging the dog. But there are good reasons why individual health insurance has never accounted for more than a small fraction of the basic health insurance market in this or other countries—although it may be quite functional in a choice-driven, supplemental market that serves primarily to offer an escape valve for the more affluent. For the average consumer, though, the information and transactional costs of health insurance purchasing may far outweigh the benefits of individually tailored policies, even if one can effectively prevent the choice process from becoming an opportunity for risk selection.

In another instance of preferring theory over reality, almost every contributor to *Covering America* suggests, implicitly or explicitly, that competition among health plans is a necessary vehicle to control health care costs, especially because of the political unacceptability of direct government constraints on prices or expenditures. The rejection of government-administered cost containment represents, of course, another instance of converting the empirical, contemporary "is" into an analytic "ought to be," but we certainly have a considerable body of evidence to suggest that greater competition in health care, as a means to control costs over time, simply does not work. It may work for a very short period, or it may appear to work if people confuse the operations of the underwriting cycle for more substantive secular change, but competition among health plans, or among providers, whatever its other merits may be, does not save money over time.

In response to evidence about the absence of any clear-cut link between competition and efficiency in health care, competition proponents tend to cite either so-called design flaws in public policy or political backlash against, say, successful managed care efforts. But those are just another way of saying that, if reality fails to conform to theory, reality must be changed.

Formulating Alternatives

If the ends—the goals—of health policy should be to ensure access to needed health care for all individuals in this society, regardless of their economic circumstances, and if health insurance provides at least a partial means to that end, then there may be some other ways of thinking about some of these issues that will be of some help in moving forward. I propose to accomplish significant change—in incremental steps, but quite non-incremental in total—by proposing a non-incremental idea.

To start with, incrementalist efforts to solve the problems of the uninsured continually run into a particular difficulty: however many individuals become newly insured as a result of those efforts, others (perhaps even greater numbers) are losing insurance at the same time. We keep struggling to fill a glass that has a major hole in the bottom. Apart from the fact that, during any given period, many people are losing their health insurance, this also means that many of the still-insured face considerable anxiety or even "job lock" for fear of losing coverage, while the simple churning of so many households into and out of the system also creates enormous administrative and organizational costs for all concerned.

But if everyone ought to have health insurance, and it is hard to keep finding new ways to supply it to the uninsured, we might think about approaching the problem by starting with the proposition that *no one should lose* insurance. We should quickly adopt the absolute principle that, once a household has health insurance, it keeps it forever (or at least for as long as the household continues to exist). When people change jobs, or relocate, or experience changes in family status, they should keep the health insurance they already have until they get something new.

The unseemly haste with which employers, affinity groups, Taft-Hartley plans, and Medicaid agencies discontinue coverage for people the moment their status changes (or in the case of at least some Medicaid agencies, when their status does not change but the bureaucratic hurdles for continuing enrollment are not surmounted) arises, of course, from their concern about the financial liability they will experience for people for whom they are no longer responsible. But any policy that works to reduce the number of uninsured will surely

require a new set of public subsidies. We just need to think about targeting those subsidies to help people *keep* insurance, rather than *regain* it.

The basic structural mechanisms for implementing this approach *already exist.* People who lose jobs with large and medium-size employers are eligible for COBRA, for which administrative mechanisms are in place; developing methods to extend or socialize those mechanisms for smaller employers should be relatively straightforward. Federal law requires every state Medicaid agency to maintain a subrogation unit to collect from workers' compensation and auto insurance carriers, and to cross-match enrollment tapes with employment data. Finding out, with a high degree of confidence, who gets new health insurance is not extremely difficult; getting the right subsidies to the right places will be more complicated. But allocating the costs of maintaining insurance between government and individual households could be accommodated easily through the tax system.

My own instinct would be as follows: every household that legally qualifies as non-tax-filing, and has no health insurance of at least some minimum quality, gets a full subsidy either to keep a previous policy or to receive Medicaid or S-CHIP. Whether the household keeps the previous policy or receives Medicaid should be determined entirely by which is cheaper, for equivalent benefit packages. All households that file returns should be assessed a surtax of some fixed percentage of adjusted gross income. This surtax would fund a sizable proportion of the cost of the new government subsidies embodied in this proposal. Additional funding may need to come from general revenues or other means if the surtax is not sufficient to cover program costs. All current deductions and exclusions for health insurance and health services should remain, and the employee share of premiums for employer-provided insurance should be fully deductible, regardless of itemization. In that way, we can subsidize health insurance for the more affluent segment of the population just as we now do, through the income tax system (without running quite as much new revenue through the federal government), while continuing to provide employers with an incentive to offer health insurance, with the concomitant efficiencies of large-group plans. When individuals' job or family status changes, if they do not immediately receive new insurance from a new employer or new family, payment of COBRA will be automatic, with the relative split between public subsidy and individual contribution tied to income.

In essence, everyone's health insurance would be financed by a combination of private funds—from individual households or on behalf of individual households by employers who provide compensation in the form of health insurance rather than wages—and public subsidy, *as is now the case for everyone except some fraction of the people who are unfortunate enough to be forced to buy individual policies.* As people have noted for years, a subsidy is a subsidy, whether it takes the form of a Medicaid benefit or a tax expenditure for employment-based health insurance. The difference is, under this proposal, potential loss of health insurance would trigger a new subsidy, tied to the household's annual income determined as is now the case after the end of the year, and equally available for public and private insurance.

Since the policy goal is to provide everyone with access to health care, we should be prepared to pay now and collect later, particularly since so small a fraction of health insurance in contemporary America involves assumption of real insurance risk by intermediaries or insurance companies. Cash flow might become a problem for some of the smaller players in the system, but it would not cost very much, comparatively speaking, to subsidize appropriate working capital loans.

Over time, the administrative complexities and horizontal inequities arising from perpetuation of an unsatisfactory, pre-existing status quo might create considerable pressure for still further changes in the system. Adjustments would need to be made for firms that go out of business or drop their health insurance coverage altogether. It might become necessary to find a more sophisticated and equitable risk adjuster for COBRA than simply paying 102 percent of the average premium. If the ultimate goal of policy is kept clearly in focus, then we might respond to some of the costs and irritations arising

from cumulative incremental change by finally adopting some non-incremental improvements.

All we need to apply these principles—along with some additional subsidy to individuals who have had no insurance at all for a while—is the necessary political will and a rather substantial amount of money. Covering all of the uninsured is going to cost a lot, and I personally believe it is important not to repeat the Clinton administration's mistake and attempt to sidestep or finesse the issue of costs.

While in a more perfect world it certainly would be possible to finance care for all of the currently uninsured in America by simply eliminating a fraction of the waste and inefficiency in the current system for the insured, we do not seem to know how to do that, and even if we could make the system a whole lot more efficient, we do not have very good mechanisms for capturing and reallocating the savings. On the other hand, political and economic events of the last several years have reminded us how essentially wealthy this nation is, and how the ability to afford even tens of billions of dollars a year in additional public expenditures is a matter of political choice, not economic constraint. My particular proposal imposes the greatest cost on upper-income taxpayers while providing the greatest benefits to lower-income taxpayers, which is a conscious policy choice.

By my back-of-the-envelope calculations, full implementation of this particular proposal would reduce the number of uninsured by at least half within two years. I believe that is at least as fast as any of the proposals in *Covering America,* and much faster than anything now being discussed in Washington. Increasing enrollment of Medicaid- and S-CHIP-eligible children, and expanding coverage to their parents, would cover some of the remainder. For everyone else, I would personally favor Jacob Hacker's enhanced Medicare proposal, at least in part, since they all will eventually become Medicare beneficiaries anyway.

Non-incremental expenditures require non-incremental politics. And while most of the political and opinion elites seem to favor incremental change that clings to the center of perceived public opinion or policy choices, one certainly could argue that the most effective advocates in the American political system over the last several decades have been those who rejected that approach. Ironically, given our notions of "radicalism" and "conservatism," it has been those on the right who have been least tolerant and least accepting of consensual, incrementalist politics, and I think it is very hard to argue against the belief that they have been astonishingly successful on matters of economic and social welfare policy, and only slightly less successful on so-called social issues. Indeed, given the divergence in tactical orientations between proponents and opponents of dramatically expanding government subsidies to permit greater access to health insurance, the more practical political bet will be that we move backward rather than forward in the immediate future. The alternative most grounded in recent political experience, I believe, would be for those who believe in universal coverage to demand the whole ball of wax.

Postscript: A Word from Our Sponsors

For good reasons, most of the contributors to *Covering America* have relatively little to say about Medicare beneficiaries. People over age 65, along with recipients of Social Security Disability Income and those with end-stage renal disease are, after all, the only categories of Americans with universal health insurance coverage. But those, such as Hacker and Wicks, Meyer, and Silow-Carroll, who would extend Medicare coverage to others in the population acknowledge that, in doing so, it should be necessary as well to improve the existing Medicare benefits package.

If our criterion, again, is improved access to needed medical care, then Medicare as it is now constituted increasingly fails that test for a growing proportion of its beneficiaries. On average, it now covers barely half of the total health care expenses of the people it covers, and its generosity of coverage compares unfavorably to almost every other health insurance policy now available in the market. An ever-growing number of beneficiaries go without needed services because of economic barriers.

If we are going to move to universal insurance as a mechanism for universal access, then, taking the

existing Medicare program for granted is inadequate. We need to bring its coverage up to par, beginning, at a minimum, with a decent prescription drug benefit and some limitation on total out-of-pocket liabilities for beneficiaries. Doing so, of course, would be very expensive, and the resources available for insurance expansion are presumably finite in the short run. But if we are going to reject incrementalism as a goal, and perhaps as a tactic as well, then the simple fact is that equity demands that everyone be covered, and that those with the greatest health care needs be covered at least as well as the rest of us. A society this wealthy really can afford both. In fact, I would personally argue, it is hard to see how, ethically, we could afford to do one but not the other.

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