Covering America

REAL REMEDIES FOR THE UNINSURED

VOLUME 3

ECONOMIC AND SOCIAL RESEARCH INSTITUTE

DECEMBER 2003

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SOCIAL RESEARCH
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Additional *Covering America* Publications

Covering America: Real Remedies for the Uninsured, Volume 1. June 2001, Elliot K. Wicks, ed.

Covering America: Real Remedies for the Uninsured, Volume 1, Proposal Summaries. June 2001, Elliot K. Wicks, ed.

Covering America: Real Remedies for the Uninsured, Volume 2. November 2002, Elliot K. Wicks, ed.

Covering America: Real Remedies for the Uninsured, Volume 2, Proposal Summaries. November 2002, Elliot K. Wicks, ed.

Cost and Coverage Analysis of Ten Proposals to Expand Health Insurance Coverage, October 2003, John Sheils and Randall Haught.

ISSUES IN COVERAGE EXPANSION DESIGN SERIES:

Decision Points and Trade-Offs in Developing Comprehensive Health Coverage Reforms. February 2003, by Elliot K. Wicks.

Coping with Risk Segmentation: Challenges and Policy Options. February 2003, by Elliot K. Wicks.

Building Quality Improvement into Health Coverage Expansion Proposals. March 2003, by Jack A. Meyer and Sharon Silow-Carroll.

Options for Financing Health Coverage Expansion. April 2003, by Jack A. Meyer and Elliot K. Wicks.

OCCASIONAL PAPER

Tax Credits for Individual Health Insurance – Effects on Employer Coverage and Refinements to Improve Overall Coverage Rates. August 2002, by Rick Curtis and Ed Neuschler, Institute for Health Policy Solutions.

CURRENT POLICY SERIES PAPERS

Health Insurance for Laid-Off Workers: A Time for Action. February 2003, by Lynn Etheredge and Stan Dorn.

Nine Billion Dollars a Year to Cover the Uninsured: Possible Common Ground for Significant, Incremental Progress. October 2002, by Stan Dorn and Jack A. Meyer.

Pros and Cons of Stimulus Package Options for Promoting Health Insurance Coverage. Issue Alert No. 1, November 2001, by Elliot K. Wicks, Jack A. Meyer, and Todd Kutyla.

What Health Coverage Would Laid-off Workers Obtain under Recent Tax Credit Proposals? Issue Alert No. 2, March 2002, by Stan Dorn and Jack A. Meyer.

Health Coverage for Laid-off Workers: Searching for Common Ground. Issue Alert No. 3, May 2002, by Stan Dorn and Jack A. Meyer.

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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 third, and last, in a series that presents comprehensive proposals to extend health insurance to uninsured Americans and to move the country toward universal coverage. The objective of publishing these proposals—and the commentaries that are included in this volume—is to maintain interest in comprehensive health reform and to provide a forum where new innovative approaches can be developed, debated, and exposed to a large audience. When this project commenced, the political prospects for comprehensive reform were dim. Today, the worsening crisis of escalating health care costs and employer cuts in benefits, along with the upcoming Presidential campaign, seem to have revived interest in finding major solutions to the problems of the uninsured. Thus the proposals presented in this series are especially relevant. We think the proposals and the other products of the *Covering America* effort can be valuable resources as the nation struggles to solve this long-present but inadequately addressed problem.

Proposals to Extend Coverage

As was true for the 13 previously published proposals, the reform ideas presented here represent the work of authors with widely different philosophical perspectives and contrasting views about how to cover the uninsured. Although the ideas and opinions expressed in this document are entirely the authors, each proposal was reviewed and critiqued by our advisory panel of expert health researchers and analysts, as well as the staff of the Economic and Social Research Institute, before the final version of the proposal was prepared. (Panel members were not asked for endorsements of any proposal; none was given, and none should be inferred.)

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 proposals included in the previous two volumes of this series.

Michael Calabrese would put in place a mandate that all individuals maintain a minimum level of health coverage, with employers contributing to the cost through a limited payroll tax or an employer-sponsored plan and the federal government making tax credits available that would limit premium contribution to no more than 10 percent of household income.

Helen Halpin envisions a reform that would result in most people getting coverage through a new, state-administered CHOICE entity that would contract with all willing licensed health providers and group practice and staff model HMOs. No one would have to enroll, but premium subsidies would be available only to those who chose this form of coverage. Employers could offer their own health plans, as many do now, but for any employees not in the employer plan, the employer would pay a payroll tax not to exceed 6.5 percent of payroll.

Paul Seltman proposes an employer-based approach that would ultimately require all employers to offer and pay for coverage, but he develops an elaborate mechanism to give employers flexibility in deciding when to meet that requirement. Adopting ideas from the Clean Air Act, the approach would have the federal government issue "allowances" that employers could use to postpone the time when they had to cover all employees. The

number of allowances issued nationally would decline as the deadline approached for 100 percent coverage, but employers seeking to extend their individual deadlines could buy allowances in a market that would promote trading between employers with excess allowances and those needing them.

Eugene Steuerle criticizes both the present system of subsidizing health coverage and many of the proposed approaches for new subsidies. Steuerle argues that the present system—especially the tax provision which does not count employer-paid health premiums as taxable income for employees—is very expensive to government and very inefficient because it encourages excess purchase of insurance and because little of the subsidy goes to people who need it most. In addition, neither providers nor consumers have financial incentives to economize in using health services. He proposes an alternative that would allow people to choose between a tax credit or the tax exclusion, but with a fixed "cap" on the amount of employer premiums that could be excluded. He also would mandate that households buy coverage, with the penalty for non-compliance being disqualification for certain tax relief provisions such as the personal exemption.

Commentaries on Coverage Expansion Issues

This document also includes two essays that are commentaries on proposals and issues related to comprehensive reform.

The first essay, by Michael Chernew, compares, analyzes, and assesses three of the proposals published in the first volume of this series, specifically those he characterizes as "voluntary insurance pool proposals" that rely on managed competition. The three are: A Private/Public Partnership for National Health Insurance, by Jonathan Gruber; Expanding Health Insurance Coverage: A New Federal/State Approach, by John Holahan, Len Nichols, and Linda Blumberg; and Near-Universal Coverage Through Health Plan Competition: An Insurance Exchange Approach, by Sara Singer, Alan Garber, and Alain Enthoven. Chernew finishes by suggesting how he would select from and combine elements of these proposals to create an optimal managed competition approach to coverage reform.

The second essay is by Katie Merrell. It reviews characteristics of public policy and private health insurance markets to understand how they affect the cost of insurance at different income levels. She argues that policy makers typically do not acknowledge that the regressive way employment-based health insurance is taxed, combined with its enhanced value, effectively make private market health insurance most expensive for lowest-income purchasers. Merrell's essay illustrates the net effect of public and private factors on the after-tax price per actuarial value of insurance, creating a framework that can be used to assess proposals for expanding insurance coverage in the United States. ■

Section 1

Proposals

A Comparison of Reform Plan Features

The first two pages of the following material provide a side-by-side comparison of the features of the reform plans summarized in the preceding narrative. The subsequent pages summarize features of the plans included in Volume I and Volume II. The plans are identified by the names of the authors.

	Calabrese	Halpin
General approach	Individual mandate, federal tax credits to limit medical expense, employer pay or play, insurance pools.	Incentives to encourage people to enroll in a public plan that would ultimately be a single payer. Employers offer coverage or pay 6.5% payroll tax. Subsidies to limit premiums to 2.5% of income.
Target population	All the uninsured.	The entire population.
Form of public programs	Refundable, advanceable, income-related tax credits; medical expenses limited to 10 percent of income except 0 percent when income below 150 percent of federal poverty level.	Premiums reduced on a graduated basis for those choosing coverage through new public plan; no family would pay more than 2.5% of income; those below 150% of poverty would pay nothing.
Mandates for coverage	Individuals must buy; employers must pay 6% of payroll.	None.
Sources of funding	6% employer payroll tax and 4% employee tax, cap on tax exclusion.	Employer payroll taxes, new federal "sin" taxes, state savings from public program reductions, tax on cross-border transactions between U.S. and Mexico.
Major tax changes	Tax exclusion remains for premiums (paid by employer and employee) for minimum benefit package, but premiums for additional benefits are taxable as income.	Employers not offering coverage would pay 6.5% payroll tax (5.5% for small employers).
Level of benefits	Adequate but not "luxury" coverage, determined by a commission.	Initially equal to benefits of Kaiser Permanente with reduced co-payments for low-income people.
Role of federal government	Fund tax credits, some grants to states.	Fund subsidies, update benefit package, collect payroll tax, monitor state administration, develop risk-adjustment system.
Role of state government	With grant from federal government, must establish Community Insurance Pools (CIP) to facilitate purchase of coverage.	Pay subsidies for Medicaid and SCHIP enrollees who switch to new public program; administer new program; contract with HMOs.
Effects on existing public programs	Medicaid (except long-term care and the disabled) and S-CHIP eliminated.	Would continue to be available, but many eligible people would choose to enroll in new public plan instead.
Role of insurers/ health plans	Largely as now, but would also sell through CIPs.	Could continue to offer coverage, but strong incentives encourage people to enroll in new public plan, which would offer only HMOs or new HMO-like plans.
Role of employers	Pay 80 of premium for minimum benefit package or pay tax equal to 6% of payroll. Withhold employee premium and transfer to health plan.	Required to pay 6.5% payroll tax or offer and pay for coverage. Many would find it less costly to pay tax rather than offer employer-paid coverage.
Risk share/ purchasing pools/ insurance regulation	Community rating required.	Federal government bears risk for those choosing fee-for-service providers, and HMOs bear risk for their enrollees. In essence, community rating.

	Seltman	Steuerle
General approach	All employers required to offer coverage, but can postpone deadline by buying government-issued "allowances" to not cover. Coverage "floors" rise each year.	Modest, but gradually increasing, tax credit available as an alternative to a capped tax exclusion. Modest tax penalties for those not buying coverage. Employers required to offer but not pay for coverage.
Target population	Workers in firms not offering coverage.	The entire non-Medicare population.
Form of public programs	State subsidies cover 100% of employee premium share for workers below 100% of the federal poverty level (FPL) and 80% for those under 200% of FPL. Federal government provides much of financing for subsidies.	Modest federal tax credits available to all, growing over time. The present unlimited tax exclusion for employer-paid premiums would be reduced and capped at a fixed level.
Mandates for coverage	All employers must provide coverage, but some firms might take 20 years by acquiring allowances.	Individuals failing to acquire coverage would be denied certain tax benefits otherwise available.
Sources of funding	Employers, state, and federal governments.	Revenues generated from a reduction in tax exclusion and tax penalties on persons not buying coverage.
Major tax changes	None.	The present tax exclusion is capped at a fixed level.
Level of benefits	Actuarially equivalent to the most popular FEHBP plan. Employer must pay at least 50% of premium.	Not specified.
Role of federal government	Set yearly coverage floors; issue allowances; collect user fees per allowance; fund state subsidies; monitor and enforce compliance with coverage requirements.	Fund tax credits; administer tax penalties.
Role of state government	Provide subsidies to low-income workers; establish mandatory purchasing pools/cooperatives for smaller firms.	Unchanged.
Effects on existing public programs	Essentially unchanged.	Essentially unchanged.
Role of insurers/ health plans	Essentially unchanged.	Essentially unchanged.
Role of employers	Required to offer coverage, pay at least 50% of premium, or acquire allowances to postpone the time when full coverage is required.	Required to offer at least one state-approved plan but would not have to pay any of the premium. Adjust employee income withholds in accordance with tax credits. Enroll employees in health plan unless they opt out.
Risk share/ purchasing pools/ insurance regulation	Community-rated mandatory purchasing pools for firms with fewer than 25 employees.	Unchanged.

The table on this page and the next summarize the features of the proposals in Volume II.

	Kendall/Levine/Lemeiux	Miller
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.	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.
Target population	Low- and middle-income individuals and families.	Working uninsured, including individuals, and people who decline public coverage.
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.	Medicaid, S-CHIP, and Medicare would continue for the time being. Better-funded high-risk pools.
Mandates for coverage	After five years, a commission would decide whether to establish an individual mandate.	None.
Sources of funding	Not specified; presumably general revenue, but alcohol and tobacco tax mentioned.	Reductions and other federal health and non-health spending.
Major tax changes	None apart from tax credit for coverage.	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.
Level of benefits	Not regulated, but states have responsibility to prevent underinsurance; after five years, a commission would assess adequacy of benefits.	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.
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.	Fund tax credits, help fund high-risk pools, and additional funding for safety net. Require guaranteed renewable options for coverage eligible for tax credits.
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.	Would compete for insurers by adopting an attractive insurance regulation.
Effects on existing public programs	Continue largely unchanged.	Medicaid, S-CHIP, and Medicare continue for the time being.
Role of insurers/ health plans	Essentially unchanged.	Similar to present but with greater flexibility to sell MSAs and other new insurance products.
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.	Essentially unchanged.
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.	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 bypassing favorable insurance regulations.

	Morone
General approach	"Single-payer" approach. All legal residents covered by Medicare, with expanded and rationalized benefits package and no co-payments. Particular emphasis on community medicine. States could choose to opt out for residents under age 65 by designing their own system under federal guidelines.
Target population	All legal residents.
Form of public programs	Medicare covers all legal residents, but Medicaid remains as a source of long-term care, disability coverage, and wraparound coverage for Medicare. Many other programs (maternal and child benefits, for example) would be subsumed under new program.
Mandates for coverage	All legal residents covered by Medicare or state alternative.
Sources of funding	Earmarked value added tax (VAT).
Major tax changes	Medicare payroll taxes and premiums abolished and replaced with VAT. Medicare's claim on general revenues (Part B) ends. Tax relief for state Medicaid programs.
Level of benefits	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.
Role of federal government	New Department of Health organizes and runs expanded Medicare program. Oversees optional state waiver programs. IRS designs and implements a value-added tax. The earned income-tax credit expanded to offset regressive effects of VAT.
Role of state government	Long-term care portion of Medicaid remains. Have the option of designing and paying for 25% of costs to operate federally approved and modern alternative to federal Medicare.
Effects on existing public programs	Medicare vastly expanded to all legal residents with expanded benefits. Medicaid continues for long-term care. Many other programs replaced by new Medicare.
Role of insurers/ health plans	Can offer supplementary coverage to expand benefits beyond Medicare level.
Role of employers	Do not contribute toward Medicare coverage but could pay for supplemental benefits (with continued tax exclusion for employees).
Risk share/ purchasing pools/ insurance regulation	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.

Calabrese

Key Elements

Michael Calabrese has proposed a tax-credit based plan with the following key features:

AN INDIVIDUAL INSURANCE MANDATE provision would require every American to maintain a minimum level of coverage.

FEDERAL TAX CREDITS would be available to ensure that coverage is affordable—accounting for no more than 10 percent of household income.

EMPLOYERS WOULD BE REQUIRED either to offer and pay for qualifying coverage or to pay a 6 percent payroll tax.

STATES WOULD ESTABLISH COMMUNITY INSURANCE POOLS (CIPS) to offer every American a choice among competing private insurance plans.

INSURERS PARTICIPATING IN THE CIP would be required to offer the minimum required benefits package on a guaranteed-issue and community-rated basis.

THE CURRENT TAX EXCLUSION FOR EMPLOYER-PAID HEALTH PREMIUMS WOULD BE CAPPED at the national median cost of the basic benefits plan sold through the CIP.

MEDICAID, S-CHIP, AND OTHER PUBLIC PROGRAMS for basic coverage would be eliminated (except for the disabled or chronically ill).

About the Author

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Universal Coverage, Universal Responsibility: A Plan to Make Coverage Mandatory and Affordable for Individuals

by Michael Calabrese

America's voluntary and increasingly fragmented health insurance system fails to deliver essential, continuous, or affordable health care coverage to all citizens. There is a growing realization that the current system's problems are systemic; that they burden everyone, not only the uninsured; and that they are increasingly harmful to our economy as well as to our health. As a result, momentum for fundamental reform to achieve universal coverage has been building, fueled by support from the general public as well as from a surprisingly diverse range of stakeholders, including politicians and interest groups on opposite sides of the battle over the aborted Clinton administration proposal in 1994.[1] Yet, while the public and these powerful stakeholders largely agree on the problem, they remain widely divided over a reform path to solve it.

The most promising and politically feasible way forward, we believe, is to make a minimum level of insurance both mandatory and affordable for individuals. The grand bargain underlying compulsory health insurance is *universal coverage in exchange for universal responsibility*. By making both the insurance mandate and subsidy *citizen-based*,[2] the nation can achieve universal coverage, expanded choice among private plans, and continuity of coverage and care regardless of employment status. Every legal resident should be able to choose his or her own insurance provider and level of coverage from among competing private plans—and receive a refundable tax credit, if needed, to make a basic level of coverage affordable. Households above the poverty line should be required to contribute a manageable share of their income, on a sliding-scale basis, but in no case exceeding 10 percent of household income. Although employer-sponsored coverage should remain voluntary, it is most practical to require employers to choose between providing at least the minimum level of coverage, as most do now, or to contribute to its cost (based on a modest and fixed percentage of payroll). Employers could administer health plans, but most would find it more efficient to facilitate enrollment in plans through regional Community Insurance Pools. In addition, most Medicaid participants and the unemployed would join the medical mainstream.

The major goals and advantages of the approach proposed here include:

- *Universal coverage*. Like state auto insurance requirements, every American would maintain basic insurance coverage and contribute to its cost based on ability to pay.
- *Affordability regardless of job status.*

[1] The AFL-CIO, U.S. Chamber of Commerce, American Medical Association, Health Insurance Association of America, AARP, and Business Roundtable are among the many groups participating in the bipartisan Alliance for Health Reform; see http://www.coveringtheuninsured.org.

[2] "Citizen" is used here in a generic sense; we assume that all permanent legal residents would be covered under the new system. Emergency medical costs imposed by uninsured foreign visitors and illegal residents would be reimbursed through a Default Payment Fund maintained by each state's insurance purchasing pools (described further below).

Whether or not a worker or family is covered under an employer-sponsored plan, every individual would have guaranteed access to basic coverage at a cost that does not exceed a fixed share of household income.

- *Expanded consumer choice*. Each state would establish one or more insurance purchasing markets where every individual and employer could choose from among a variety of competing private insurance plans.
- *Complete portability and continuity of coverage*. Insurance purchased through the Community Insurance Pools would be fully portable and renewable, allowing workers to change jobs or reduce hours without worrying about either losing coverage or being forced to change insurers or doctors.
- *Improved incentives for cost containment*. Instead of today's costly policy churn, continuity of coverage creates incentives for insurers to invest in preventive care, improves the quality of care, and reduces administrative costs for both employers and insurers. Minimizing cost shifting and uncompensated care, while bringing millions of relatively young and healthy individuals into the insurance risk pool, would reduce average premium costs for everyone.
- *Reducing the social benefit burden on business*. The burden of administering plans and subsidizing low-wage workers and their families would shift from responsible employers to society as a whole.

The key features of the proposal described in more detail below include:

- An individual insurance mandate requiring every American to maintain a minimum level of coverage and contribute to its cost based on ability to pay.
- Contributions and subsidies would flow from a combination of three sources: a mandatory employer contribution; individual payments not to exceed a modest percentage of family income; and a refundable federal tax credit, payable directly to health plans (including to employer plans), to make up the difference.
- States would establish Community Insurance Pools (CIP) to offer every American a choice among competing private insurance plans, much as federal employees do through the Federal Employees Health Benefits Program (FEHBP).
- Insurers participating in the CIP would be required to offer the minimum required benefits package on a guaranteed-issue basis and at community-rated premiums, with individuals free to purchase more comprehensive coverage or supplemental services with their own funds (or with additional employer contributions). Employers would have access to plans in the pool, and insurers would be free to manage care and set premiums and reimbursement rates based on market forces.
- Tax credit subsidies would be based on the median national cost of the minimum required benefits package purchased through the CIPs; the current tax exclusion for health benefits compensation would be similarly capped at the median cost of a basic benefits plan sold through the CIP.
- Medicaid, S-CHIP, and other public programs for basic coverage would be eliminated, and participants (except for the disabled or chronically ill) would be enrolled in private plans through the CIP.

Reform Goals and Background

Universal Coverage and Responsibility

This proposal springs from the premise that the best way to ensure that every individual and family has a minimum level of coverage is to require it. A recent report from the Robert Wood Johnson Foundation estimates that 75 million Americans, or nearly one-third of the non-elderly population, were uninsured during some portion of the last two years. Eight of each 10 uninsured Americans are in working families, and an estimated 60 percent of uninsured adults own or work for small businesses. These coverage gaps among even

middle-class workers suggest that the inability to sustain adequate and continuous coverage afflicts a much larger segment of the population than was previously thought. Double-digit premium increases since 2001 are pushing firms to drop coverage or shift costs to employees, who, in turn, decline offered coverage at increasing rates. And even when workers maintain coverage, they typically must change health plans and doctors when they change jobs, at an average turnover rate of less than five years.[3]

Just as most states require drivers to self-insure, every American should be required to maintain coverage and contribute to its cost based on ability to pay. The responsibility to avoid imposing uncompensated health costs on society must be elevated from a voluntary to a mandatory duty of citizenship. Just as the nation requires workers and employers to share a payroll tax deduction to anticipate the basic health and living expenses guaranteed through Medicare and Social Security, respectively, every working American should contribute a reasonable portion of his or her income to pay for health care. Moreover, the outbreak and spread of deadly viruses in recent years (for example, AIDS) has increased awareness of the public health risks of having large segments of the population without regular access to health care.

Affordability Regardless of Job Status

A second key reform goal is to make access to a choice of affordable health plans available regardless of job status—that is, to make basic coverage fundamentally *citizen-based* rather than *job-based*. America's uniquely hybrid public-private benefits system relies on a combination of tax "carrots" (excluding health benefit compensation from taxable income) and regulatory "sticks" (eligibility and anti-discrimination rules) to prod employers to cover most of the full-time rank-and-file. In the current fiscal year, the federal government alone will provide at least $130 billion in tax subsidies for employment-based health insurance.[4] Despite these costly subsidies for employer-sponsored coverage, 25 percent of working-age adults lack work-based health insurance. Some of these adults have no connection to the workforce and, thus, lack access to the tax-subsidized health insurance available only through employers or to the self-employed. Others are part of the growing numbers of Americans with non-traditional work arrangements—part-time, contingent, or contract workers, who are rarely offered benefits. Others, as mentioned above, opt out of coverage because of rising costs. While the government operates public programs like Medicaid for the poor and disabled, significant and persistent gaps between the public and private systems remain. As a result, our health insurance system is far more fragmented, costly, unfair, and inefficient than it needs to be.

The current voluntary, employer-based system also creates significant labor market distortions, burdening families and decreasing the efficiency of the economy. In the family setting, it is necessary for one parent to have a top-tier job with benefits—but the inflexibility of that job often forces the other parent into a second-tier job or out of the workforce alto-

[3] Job stability has declined sharply among all age groups since 1987. In 2000, workers aged 25–34 had a median 2.6 years of job tenure, while workers aged 35–44 and 45–54 stayed in the same job an average 4.8 years and 8.2 years, respectively; see L. Mishel, J. Bernstein, and H. Boushey. *The State of Working America: 2002-03*. Ithaca, NY: Cornell University Press, 2002, pp. 264-66.

[4] Employer-paid health insurance premiums are excluded from compensation for both income tax and payroll tax purposes, resulting in a revenue loss to the federal Treasury that is estimated (for fiscal 2003) to be at least $120 billion (using the income tax expenditure estimate done for Congress by the Joint Tax Committee) or as much as $160 billion (using the estimate done by the Treasury's Office of Tax Analysis). Roughly one-third of these totals represent payroll tax expenditures. An additional $9 billion in tax expenditures subsidize various other health benefits, including premiums paid by the self-employed, continuing coverage for terminated employees (COBRA), Flexible Spending Accounts, and Medical Savings Accounts; see L. Burman, C. Uccello, et al. "Tax Incentives for Health Insurance." Discussion Paper No. 12. Washington: Urban Institute, 2003.

gether. A growing share of workers relies on coverage offered by a family member's employer—a form of cost shifting that encourages yet more firms to drop coverage or increase co-premiums.[5]

In the larger economy, the current voluntary system distorts labor market signals to both employers and employees. On the demand side, the all-or-nothing nature of eligibility rules imposes a high fixed cost on employers for each eligible employee on their payroll. This creates financial disincentives for firms to cover non-standard, part-time, or low-wage workers and, in some cases, deters employers from taking on new full-time employees. As health costs rise faster than wages, offering health benefits to lower-wage workers becomes increasingly untenable to employers. On the supply side, employees who risk losing health insurance are deterred from reducing their hours or switching jobs. Job lock, labor market sorting, and a two-tier workforce are among the economic distortions that result, reducing labor market flexibility and economic efficiency.

This proposal for mandatory insurance delinks coverage from employment by giving every individual and adult access to a choice of competing private plans through a Community Insurance Pool. Every individual would have guaranteed access to basic coverage at a cost that does not exceed a fixed share of household income, and all but the poor would have a responsibility to contribute to the cost of coverage, but based on ability to pay.

[5] Between 1979 and 1998, the share of private-sector employees receiving health coverage from their own employer fell from 66 percent to 54 percent, a drop of 12 percentage points. Most of this decline occurred after 1988, when 64.6 percent of all employees received coverage as a benefit at work; J. Medoff, M. Calabrese, et al. "The Impact of Labor Market Trends on Health Coverage and Inequality." New York: The Commonwealth Fund, 2001.

Expanded Choice, Portability, and Continuity of Coverage

A third general goal is to achieve a more portable and coherent system of coverage, one characterized by consumer choice and continuity of coverage and care. Today's coverage gaps and disruptions in the continuity of care adversely affect quality of care and, consequently, health outcomes for the insured and uninsured alike. In contrast, a system of portable and continuous coverage is likely to result in substantial improvements in health outcomes and cost containment. First, it will end the widespread gaps in coverage that result in preventable sickness, death, and lost productivity. The uninsured often lack access to quality primary and preventive care. Without regular checkups, routine medical screening, and lifestyle counseling, minor health problems become major ones. When the uninsured do access the health care system, they do so disproportionately through hospitals and emergency rooms that are far more expensive alternatives to ongoing primary and preventive care.

Second, by enabling individuals to stay with a single insurer for life, a system of portable and continuous coverage would increase insurers' incentives to invest in disease prevention and long-term preventive care.

While the system proposed here would most obviously benefit the uninsured and families struggling to afford coverage, it would also be a major improvement for those who currently purchase health insurance through their employer. Most important, workers would no longer need to worry that losing a job means losing coverage. They would always have access to a choice of plans best suited to their needs through the CIP—and at a premium tied to their current income. In addition, even workers at firms with employer-sponsored plans would have the option to select their own policy and level of coverage from among health plans competing through the CIP, instead of being limited to

the plan selected by their employer. Individuals choosing to enroll through the CIP would then be assured the option of keeping the plan and medical professionals of their choice as they move from job to job, as Americans do with increasing frequency.

Improved Incentives for Cost Containment

A fourth goal of the system of universal coverage proposed here is to reduce the rate of increase in health insurance premiums, particularly by reducing unproductive administrative costs and by realigning financial incentives that influence both individual consumers and insurers. Health insurance premiums have risen at double-digit rates over the past three years, a trend that further undermines the ability and willingness of employers to offer and pay for coverage. One contributor to rising premiums is cost shifting. Companies offering good family coverage subsidize family members who work at other firms, but who are not offered or decline coverage from their own employer. In addition, uncompensated care, to a large degree, is passed along in higher prices to private payers. The inefficient use of hospital emergency room services as a means of primary care among the uninsured further inflates costs. Requiring everyone to maintain and contribute to the cost of coverage will minimize cost shifting and lower the average cost of coverage, particularly for individuals and small employers.

Another costly side effect of America's fragmented health coverage policy is related to high turnover because individuals typically switch plans and providers when they change (or lose) their job. As noted above, insurers would have a greater incentive to encourage preventive care and disease prevention if policy holders could stay with the same plan provider indefinitely. Policy churning is also a major contributor to the more than $110 billion the United States spent on private insurance and government administrative costs last year. This does not even include administrative costs absorbed by employers or the cost of lost productivity due to preventable illness and job lock. More generally, creating a large CIP clearinghouse offers the potential for participating private insurers to streamline and reduce the cost of administering enrollment, premium collection, and claims payment processes.

Individual consumer choice among competing private health plans could also better align supply with demand. Because workers typically have little choice over the scope or price of their health insurance benefits at work, individuals often end up with more or less coverage than they need or are willing—or able—to pay for. These choices are further distorted by excluding employer-paid health benefits from taxable income, since the tax subsidy encourages discretionary health care consumption in excess of what individuals might choose to purchase with after-tax dollars. By subsidizing only basic coverage and requiring that supplemental coverage and services be offered and priced separately, we expect individuals to make more economically rational choices about health care utilization.

Reducing the Social Benefit Burden on Business

Another important objective of the self-insurance mandate proposed here is to shift the burden of subsidizing basic benefits for low-wage workers from employers to society as a whole. Because health insurance can represent 25 percent or more of a low-wage worker's total compensation—and because below-median-wage workers receive little if any tax benefit from the exclusion—firms with a predominantly low-wage workforce have a strong disincentive to pay for health coverage. The approach proposed here reverses this disincentive. Any required employer contribution would be a modest and fixed share of the worker's wage (for example, 6 percent). And since employer-sponsored plans would be eligible to receive the tax credit subsidy,

low-wage workers would become relatively *less* expensive to cover rather than more.

By extending tax credit vouchers and a choice among competing plans through a Community Insurance Pool to all workers *as individuals*, the plan proposed here would enable employers to get out of the business of administering complex health plans without reducing their employees' after-tax compensation. Purchasing pools and refundable tax credits would allow companies to decide purely for business reasons whether to sponsor a benefits plan for coverage above the required minimum—while still providing incentives for employer contributions to the cost.

In addition to the tax credit subsidy for low-wage workers, a mandatory system would lower health insurance costs faced by employers that choose to continue administering a company plan by ending cost shifting. Employers providing health benefits already are paying a substantial share of the cost of treating the uninsured as well as the poor. These costs are disguised—shifted onto unwitting private purchasers and taxpayers—and considerably larger than they would be in a system of mandatory coverage and universal responsibility. These hidden costs include the cost of uncompensated care: Doctors and hospitals charge higher rates to cover unpaid bills and inadequate payments by Medicaid and other public programs. Another category of avoidable cost results from "policy churning" among the insured. A third hidden cost is related to the shrinking number of workers who receive health coverage from their own employer: Roughly 20 million workers are covered by an employer other than their own, typically their spouse's, a form of cost shifting that exacerbates "job lock" and encourages other firms to drop or not adopt health benefits. While the first two types of hidden costs artificially increase the price of insurance, the third creates a "free-rider" problem among employers.

Features of the System

Individual Insurance Mandate

The essential starting point for this proposal is a new social bargain: guaranteed access to affordable basic coverage in exchange for personal responsibility. Just as most states require drivers to self-insure, every American should be required to maintain coverage and contribute to its cost based on ability to pay. There are several reasons to make an individual mandate the centerpiece of a universal coverage system. First, it avoids the politically untenable alternatives of a single-payer public program or of an employer plan mandate. Even the option of offering employers a large enough subsidy to increase voluntary compliance would leave at least 25 percent of the population—particularly the unemployed, part-time, and contingent workforce—exposed to the problems of the individual insurance market or dependent on medical welfare programs. In an increasingly global, competitive, and volatile economy, companies should focus on their business, not on managing health benefits. Employer-based approaches also typically leave the poor segregated from the medical mainstream, in stigmatized public "welfare" programs. Universal access to a regulated market of competing private health plans best optimizes the objectives outlined above.

Second, it is critical that the public perceive the subsidies necessary to achieve universal coverage as part of a reciprocal obligation, not as welfare for the uninsured. It is critical to emphasize that a central purpose of the new system is to ensure individual choice and to protect workers who currently have coverage from losing it. Decoupling coverage from employment guarantees continuity of coverage for everyone, while also greatly reducing the cost to employers of covering low-wage workers.

Third, making the purchase of private insurance mandatory will minimize cost shifting

and lower the average cost of coverage, particularly for individuals and small employers. More than one-third of the uninsured live in households earning over $40,000 per year, and 6.6 million live in households with incomes exceeding $75,000. Since the uninsured are also disproportionately young, requiring them to contribute premium dollars to the insurance risk pool would reduce the average cost of basic coverage and lower the total public cost of universal coverage.

Finally, bringing everyone into the social risk pool is necessary to ensure that nonemployer purchasing groups could avoid problems of adverse selection. The Community Insurance Pool proposed below—based on guaranteed issue and community-rated premiums—can provide a cost-effective alternative comparable to a large employer group precisely because risks are widely distributed and because individuals cannot opt to buy coverage only when they need expensive care.

Limit the Mandate to Basic Coverage

Considering the enormous public expenditure associated with an entitlement to health insurance, we believe it is most practical to require (and subsidize) an adequate but minimal level of coverage. If the required benefits package is too inclusive, then either the share of household income or the share of the already strained federal budget devoted to this goal will be viewed as prohibitive. Indeed, an important part of the overall logic of cost containment relies on creating a clear distinction between medically necessary (and hence required) coverage and discretionary health care "consumption." All available public subsidies should be targeted to make the former (basic coverage) as affordable as possible—and to make discretionary purchase of the latter ("luxury" coverage) compete equally with other consumer demands. While most employers and individuals are likely to purchase a supplemental package of services above the required minimum, these offerings should be priced separately and should remain largely unregulated with respect to deductibles, copayments, and other restrictions.

Presumably the required basic benefits package would be defined with an emphasis on preventive care, acute care, catastrophic coverage, and at least a partial prescription drug benefit. Beyond such very general coverage categories, we recommend that Congress establish either an independent regulatory body or a commission of medical professionals—with input from consumer, business, and labor representatives—to determine the specific scope of a basic benefits package and to monitor the program's ongoing costs and quality. The expert agency or commission should also determine the range of allowable deductibles and copayments for various services. Although copayments for most nonpreventive services would be important to discourage overutilization, copayments for services in the basic tier should not be set at a level that would deter lower-wage families from seeking appropriate treatment. For example, although federal premium subsidies could extend well into the middle class, required copayments might be minimal for families below a certain income threshold. We assume the expert panel also would allow substantial variations with respect to the delivery of services and the degree of managed care, but that participating plans would offer a basic benefits package that is roughly comparable, meets the social goal of minimally adequate coverage, and competes primarily on price, quality, and convenience.

Congress could either give the expert agency or commission a global budget to work within or, preferably, authorize it to report its recommendations for an up-or-down vote along the lines of the congressional military base-closing commission. The body should remain in business and meet periodically as an expert oversight and advisory adjunct to the responsible executive branch department and congressional oversight committees. It would

be particularly important for the agency or commission to independently assess and report back annually on the health outcomes of the system, recommending appropriate changes in the mandatory tier of medical services.

Enforcement

Every adult would be required to maintain, individually and on behalf of his or her dependents, health insurance coverage at least as comprehensive as the required minimum benefits package. Verification of coverage could efficiently piggyback the annual income tax filing process. Indeed, because the reconciliation of eligibility for the tax credit subsidy is based on income, proof of coverage by a qualified plan is almost necessarily tied to the annual tax reporting process. If a worker receives qualified coverage through an employer, this could be indicated on the IRS Form W-2 with no extra burden to employers.[6] The self-employed and other individuals who purchase coverage directly through the Community Insurance Pool (described below) would receive each January a simple form (similar to an IRS Form 1099 used by firms to report payments of non-wage income) certifying the number of months they were covered by that plan during the previous year. To prove coverage, individuals would simply enclose the coverage form along with their W-2, which they already are required to attach to their tax return.

Since the IRS receives its own copies of both forms, it would be reasonably straightforward for the government to identify and contact individuals who fail to file proof of coverage. Anyone who fails to certify coverage would be randomly assigned to a private plan offered through the Community Insurance Pool that is priced at or below the median for that region. Although Medicare, or what remains of Medicaid, could be used as the default assignment for individuals who fail to enroll or who default on their portion of the premium, we prefer to keep the largest possible share of the population within the community-rated pool of competing private plan offerings. This would avoid the possibility that competition from the government program would distort the CIP risk pool or reduce the incentives for private plans to compete for the most price-sensitive (and low-wage) consumers.

Individuals not required to file an income tax form, who virtually by definition are very low income, would be required to submit the proof-of-insurance form (or equivalent) each year to maintain their qualification for subsidies. Although the tax credit vouchers would be paid directly to qualified plans, all individuals (including non-filers) would need to annually report their total household income to maintain eligibility. Any health plan that suspends an individual's coverage due to nonpayment would be required to report this to the local CIP administrator.

The appropriate penalty for failing to obtain qualified coverage would likely be a contentious issue. Since an individual with lapsed coverage would be randomly assigned to a plan in the local CIP that is priced at or below the median, the IRS would assess the individual that amount (which is the median price figure used to calculate the tax credit) for each unpaid month. The individual's assessment would be reduced by the amount of the payroll contribution made by the individual's employer during that year (since, presumably, the employer did not provide qualifying coverage, or the worker was not eligible for it).

[6] Employers that offer and pay for a level of coverage at least as comprehensive as the minimum required package would receive the tax credit due to employees qualifying for a credit and would apply that amount to the cost of coverage. Information necessary to monitor the qualification of employer plans could be collected and audited at little cost by using the annual Form 5500 filing required by most employer-sponsored plans to remain qualified for tax-exempt status.

Contributions and Subsidies

With insurance mandatory, there is a strong rationale for means-tested subsidies to make coverage affordable for everyone. All but the poor would have a responsibility to contribute to the cost of coverage based on ability to pay. Contributions and subsidies should ideally be divided among the three current sources of today's private employer-based health insurance system: federal tax subsidies, an employer contribution (based on a fixed percentage of payroll), and individual payments that would never exceed a modest share of a family's adjusted gross income. Although this proposal could be implemented without a mandatory employer contribution, for reasons outlined below, it would be more practical to divide this responsibility between employers and employees. Thus, as we conclude that the maximum personal responsibility should be 10 percent of household income, we propose below that employers contribute up to 6 percent of workers' wages, and that individuals contribute up to 4 percent of adjusted gross income.

Tax Credits

If the median cost of a basic plan exceeds the individual's required contribution, the difference would be made up by a federal tax credit (in the form of a voucher) paid directly on behalf of the subsidized household to the household's health plan or self-insured employer. The tax credits would be refundable (eligibility does not depend on having an income tax liability to offset), advanceable (estimated credits are advanced quarterly to health plans), and calculated on a sliding-scale basis according to income. The tax credit bridges the gap between the personal responsibility requirement and the cost of an essential benefits plan. There would be no income limit on eligibility, although to the extent that health costs continue to escalate faster than incomes, Congress would need to revisit the personal contribution limit from time to time.

The maximum tax credit amount would be equal to the national median cost of the required minimum benefits plan offered through CIPs. However, the amount of the credit due any particular individual initially would be reduced by his or her employer's required contribution.[7] The employer's contribution would be forwarded to the CIP for payment to the plan the employee has selected, although it would be retained by employers that provide the required minimum coverage through the company's own plan. To the extent that the remaining cost exceeds 4 percent of a household's adjusted gross income, a refundable credit would close the gap and would be advanced quarterly by the government to whatever qualifying insurance provider is indicated on the employee's Form W-4.[8] The final credit for each year (which might be greater or less than the estimated credit, depending on other non-wage income) could be reconciled subsequently through the annual income tax process.

The premium contributions for the basic level of coverage, whether paid by employers or individuals, would be excluded from taxable income, as employer-paid health benefits are today, but any additional health benefits compensation would be reported as income on the IRS Form W-2. This has the overall effect of preserving the current tax exclusion for employer-paid health benefits, but capping its cost. Today's unlimited exclusion of health benefits compensation from both the payroll

[7] Because individuals receive credit for the employer's contribution (6 percent of compensation), high-income individuals would be unlikely to owe any additional payment for the required level of coverage, but they could choose to purchase additional coverage at their option through or even outside of the CIP.

[8] The IRS Form W-4, which is already in use to calculate income tax withholding, could be used with little extra burden to estimate the credit. Employers sponsoring plans could simply subtract the credit from other tax withholdings and transfer it to their qualified plan. Similarly, the self-employed could estimate and subtract the credit using the current quarterly income tax withholding process. The state's CIP clearinghouse would receive a copy of the W-4 for all other workers and bill the Treasury directly for each participant's estimated credit, which would be transferred quarterly (or monthly) as a single premium subsidy payment to health plans.

and income tax subsidizes basic and discretionary medical consumption and is a major contributor to rising health care costs. Although high earners disproportionately benefit from any exclusion, we believe that adding the entire employer contribution to taxable income would be too abrupt a change, and that there would be less political resistance if *every* taxpayer continued to receive a significant (but capped) tax subsidy for health coverage.

Households earning less than 150 percent of the federal poverty level (FPL) would be eligible for a credit equal to 100 percent of the median cost of the minimum benefits plan offered through their Community Insurance Pool. They would not actually receive the credit, however, since it would be paid directly to the plan in which they choose to enroll (or to which they were randomly assigned if they failed to enroll). The federal government's cost for this credit, though, would be offset by the 6 percent payroll tax contribution contributed on any wage income during the year—an amount the CIP clearinghouse (which collects and routes all payments on behalf of participating insurers) would refund to the government. For households earning between 150 percent and 250 percent of the FPL, the personal contribution should incrementally increase from zero to a maximum of 4 percent.[9] Thus, a family at 200 percent of the FPL (roughly $35,000) would be required to contribute up to $700 (2 percent of income) if the employer contributed only the 6 percent minimum.

Another important feature of the tax credit proposed here is that it is *citizen-based*—by which we mean that the tax credit is attached to the individual, regardless of whether coverage is obtained through the employer's health plan or purchased directly through the CIP. The subsidy is therefore neutral with respect to the choice of coverage and promotes horizontal equity among households with similar ability to pay. It also substantially reduces the implicit "tax" imposed by the current anti-discrimination requirements in ERISA, which generally mandate firms to make the same dollar expenditure on health coverage for low- and high-wage employees (rather than requiring parity as a percentage of income, as ERISA does for pension contributions). Currently, if a firm wants to fully pay for family coverage on behalf of high-wage employees, it must do so for low-wage employees as well. Because health insurance can represent 25 percent or more of a low-wage worker's total compensation—and because workers below median wage receive little if any tax benefit from the exclusion—firms with a predominantly low-wage workforce have a strong disincentive to pay for health coverage.

The approach proposed here reverses this disincentive. The employer would be required to contribute no more than 6 percent of a low- to middle-income worker's wage. Moreover, since employer-sponsored plans would be eligible to receive the tax credit subsidy, low-wage workers would become relatively *less*, rather than more, expensive to cover. For this reason, even if Congress decided that only individuals (and not employers) should be required to contribute to the cost of basic coverage, we believe that employers would have no additional incentive to stop offering insurance coverage as an employee benefit. Indeed, whereas employers with a very highly skilled workforce would continue to feel the need to offer coverage for purposes of labor market recruitment and retention, employers with predominantly low-wage or older workforces would receive far larger tax subsidies for providing basic coverage than they do today. Whether or not this mitigates small-business opposition to *any* mandated health benefits cost, it does allow a large number of firms not

[9] For example, for each additional 10 percent increment of income, the required level of contribution would increase by 0.4 percent. Such a gradual phase-in would be unlikely to deter additional work effort. Jonathan Gruber adopts a similar approach in his proposal; see J. Meyer and E. Wicks. *Covering America: Real Remedies for the Uninsured*. Washington: Economic and Social Research Institute, 2001, p. 62.

currently offering coverage to level the labor market playing field by facilitating health care coverage for a modest and fixed share payroll.

Employer Contribution

Although employer provision of health benefits should remain voluntary, because the current financing of health insurance flows primarily through employers and payroll deduction, it appears to be most practical to maintain (and universalize) the employer's role as a source of and conduit for premium payments. We would require employers either to maintain coverage at least as comprehensive as the required basic level of coverage (and pay at least 80 percent of the premium for those basic benefits), *or* to contribute a premium payment equal to a flat percentage of payroll. If the maximum personal contribution is 10 percent, then employers should contribute 6 percent and individuals 4 percent. Like current contributions for Medicare and Social Security, the contribution would apply to all wages, including wages paid to part-time and contingent workers not otherwise eligible for coverage under the employer's own benefits plans. It is essential that these non-standard workers, who disproportionately number among today's uninsured, accumulate automatic contributions to offset the cost of their coverage in proportion to their work effort and earnings.

When the individual does not receive basic coverage at work, the employer contribution would be submitted to the Internal Revenue Service, along with other tax withholdings, as now, and forwarded to the state CIP clearinghouse for payment to the insurance plan. Employees would receive credit for this payment up to the median cost of the required benefits package offered through their state CIP; any excess contribution would be retained by the CIP to offset the cost of the tax subsidy and to reimburse local providers for the cost of any remaining uncompensated care. ERISA nondiscrimination requirements could be repealed with respect to essential benefits coverage, since employers meet their entire responsibility with the 6 percent contribution. Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation requirements would be repealed as well, since workers would maintain their access to guaranteed coverage, based on income, through the CIP.

The contribution requirement would have no practical effect on the vast majority of firms. Most employers already sponsor coverage, for which the average employer spends between 7 percent and 10 percent of payroll.[10] Only employers that currently do not offer coverage would see an increase in their outlays for health benefits. With our approach, employers that now pay for health benefits should find it very attractive to simply enroll their workforce through a menu of plans administered by the CIP. Health benefits costs would become fixed and predictable, and there would be no burden of administering a plan. And, as noted above, the availability of the tax credit subsidy for qualified employer plans would *reduce* current benefits costs in proportion to the share of low-wage workers who participate in the company plan. Even today, many firms that do not offer coverage might do so if their low-wage workers were subsidized.

Most economists maintain that the ultimate cost of any payroll tax (or fringe benefit) is borne by the employee, since firms make their personnel decisions based on total compensation and the marginal productivity of labor. Therefore, we would expect this requirement to have virtually no impact on aggregate employment since it can be offset far more easily than a 6 percent increase in the minimum

[10] The typical employer's contribution varies by firm size and industry or occupation group. Firms with more than 500 employees spend, on average, 7 percent of total employee compensation on health insurance benefits. State and local government employers spend closer to 10 percent of employee compensation on health insurance.; U.S. Department of Labor. Bureau of Labor Statistics. "Employee Costs for Employee Compensation Summary." USDL 03-297. Washington, DC. June 11, 2003. .

wage.[11] This does not mean that the increase in fringe benefits costs will not be disruptive for many employers that do not currently provide health coverage. Firms are likely, over time, to adjust wages and expenditures on other fringe benefits to compensate. For example, firms that simply cannot afford a *real* increase in compensation might choose to reduce nominal wage growth over a period of years to offset the health benefits increase. Because this adjustment could take some time, Congress may want to phase the employer contribution in over at least three years for firms not currently providing health benefits. Congress also might decide initially to exempt the smallest employers (for example, fewer than 15 employees).

Although there is a strong political rationale for relying solely on the individual insurance mandate—and, therefore, avoiding knee-jerk opposition to an "employer mandate"—there also are practical reasons to require employers to pay in a large share of the personal contribution requirement. While a 6 percent contribution is unlikely to have any long-term economic impact on firms, it has the virtue of being an automatic payment that reduces the amount individuals would have to pay in on their own. It reduces the perceived out-of-pocket burden of the individual mandate and makes collection of a majority of private premium payments certain, predictable, and automatic (thereby also reducing the budgetary cost to the government). It is also a less radical departure from the current system, where the vast majority of workers are accustomed to their employers paying for the majority of premium costs.

More critical, to the extent that employers choose to help workers enroll in plans offered through the CIP—and stop administering a company health plan—there is no guarantee firms would continue contributing to the cost or, as an alternative, adjust wages upward to compensate. We believe most employers will conclude that writing a check to the CIP is more attractive than administering their own health plan. Because the tax subsidies in the new system would be limited for higher-paid workers and available to workers below the median wage, whether or not the employer sponsors a plan, we would expect employers to reduce the share of compensation dedicated to health benefits, if not immediately, then over time. Yet, there is great uncertainty concerning the extent to which employers would fail to adjust wages to compensate for the reduction in health benefits compensation. This would most adversely affect the wages of low-skill workers, who also have the least bargaining power, a risk that would be greatly mitigated by an automatic 6 percent employer contribution.

Finally, a flat-rate contribution puts all employers on a level playing field. All employers would contribute on behalf of their own workers, ending the inefficient premium shifting onto firms that cover all family members. This cuts both ways. Although many small and low-wage employers would need to adjust their compensation mix to absorb this cost, they would face no competitive disadvantage, since every employer would contribute at the same rate. And by making a flat dollar contribution and facilitating enrollment via the W-4 process, employers could effectively avoid the onus of *not* providing health benefits.

Community Insurance Pools

It is well known that individuals and small groups face special problems in finding affordable, high-quality health insurance. Small employers cannot adequately spread the risks of high medical claims, achieve economies of scale in administration, offer choices among

[11] Indeed, recent studies suggest that moderate increases in the minimum wage have little impact on employment levels in low-wage, low-benefit industries such as food services; see D. Card and A. Krueger. "Minimum Wage and Employment: A Case Study of the Fast Food Industry in New Jersey and Pennsylvania: Reply," *The American Economic Review* (December 2000).

health plans to their employees, or manage competition among accountable health plans. They typically face substantially higher premium charges than large firms. Individuals seeking coverage are, of course, in an even more vulnerable position and more so if they have a potentially costly pre-existing condition. Not surprising, the uninsured rate among wage earners who are self-employed or work in firms employing fewer than 25 employees is roughly double the uninsured rate for wage earners in medium and large firms.[12]

It is likewise well accepted that one potential remedy to the dysfunction of the small group and individual insurance market would be to facilitate health insurance purchasing cooperatives that duplicate, or even improve on, the advantages of a very large and sophisticated employer group. By pooling small groups into larger ones, it was thought that health insurance purchasing cooperatives (HIPCs) could bargain for lower premiums, increase access to coverage, and offer choice to employees of small firms, since fewer than one in 10 employer plans at firms with fewer than 200 employees offers choice.

Two key barriers have stymied the growth and success of purchasing pools in the small-employer market: the inability to reach a critical mass (which creates greater purchasing power and lowers administrative costs) and the presence of adverse selection (where there is no requirement or strong incentive for relatively low-risk groups to join or remain in the pool).[13] The approach proposed here takes direct aim at these barriers by:

- requiring and subsidizing every uninsured adult to acquire and maintain coverage;
- funding states to create one or more publicly subsidized, large-scale CIPs;
- restricting tax credit subsidies to minimum benefits plans purchased through the CIP, or to employer plans that pay for equivalent coverage;
- providing employers of any size with incentives to purchase at least the minimum benefits coverage through the CIP at the community rate; and
- standardizing and separately pricing the minimum benefits package, which would be exempt from state coverage mandates or other regulations that apply to plans sold outside the CIP.

Establishing State Purchasing Pools

Perhaps the biggest challenge for a mandatory insurance system would be to create a market mechanism to replicate the benefits of large employer-based risk pools for individual citizens. Making basic coverage mandatory for individuals necessitates making such coverage available and affordable to all. If an individual mandate delivers and subsidizes coverage of the young and relatively healthy uninsured, then at a minimum a guaranteed-issue requirement is necessary to force insurers to cover the sick. However, without mechanisms (such as community rating) to spread the cost of higher risks among the broadest possible group of purchasers, those costs would default to the government, making an already expensive program prohibitive. And for community rating to work, it would be necessary to limit the eligibility for tax credit subsidies primarily to consumers and insurers within the pool.

To achieve this, we propose that each state receive a federal grant, allocated roughly on the basis of population, to establish and oper-

[12] Among uninsured wage earners, nearly half (46 percent) are self-employed or work for private-sector firms with fewer than 25 employees. The uninsured rate among this group is 28 percent, while the uninsured rate for wage earners employed at medium and large firms ranges from 12 percent to 16 percent. *See* Fronstin, Paul. "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2000 Current Population Survey." Issue Brief No. 228. Washington, DC: Employee Benefits Research Institute. 2000.

[13] For a summary of lessons learned from the experience of small-group purchasing cooperatives, see Elliot Wicks. "Health Insurance Purchasing Cooperatives." Issue Brief. New York: The Commonwealth Fund, November 2002.

ate one or more Community Insurance Pools. States should be given considerable flexibility with respect to whether local CIPs are public agencies or contracted to private sector operators. The pools could be statewide or based on metropolitan areas that might even cross state lines. Pools could even compete within the same state, although this is likely to increase administrative costs considerably. After an initial period, the federal operating subsidy could be phased out or reduced by assessing an administrative fee on plans in proportion to premiums earned through the pool.

Plans made available through CIPs would be subject to minimal insurance regulation. Participating insurers would be required to offer and separately price the nationally mandated minimum benefits package on the basis of guaranteed issue and guaranteed renewability. Insurers could offer more comprehensive options, or supplemental coverage, but these add-ons could not be tied to sales; they would have to be offered and priced separately on an actuarially fair basis. If participating insurers could offer only very comprehensive (and expensive) options, they would likely attract consumers who did not reflect the risk profile of the pool as a whole. Requiring plans to offer and price the standardized minimum package separately focuses competition on price and quality. Although health plans must provide and separately price the minimum benefits package to be eligible for federal subsidies, they should be free to manage and deliver care based on consumer demand. This means that health maintenance organizations (HMOs), preferred provide organizations (PPOs), and indemnity plans would offer the same scope of tier-one coverage, but would compete on price, quality, and service to attract individual (and group) subscribers.

The other critical category of regulation relates to pricing and risk adjustment. Participating plans would have to price the mandatory benefits package on a community-rated basis by family type (single, married without children, single with children, and married with children) and possibly by broad age category. Community rating would make the average cost of coverage as low as possible, reduce public subsidy expenditures, and avoid the costly administrative process of risk rating. Younger and healthier individuals would typically prefer risk rating because, if the market is segmented by risk, their premiums would be lower. However, that concern is mitigated in this context, since the sliding-scale tax credits ensure that nobody pays more than a modest share of income for the mandatory level of coverage.

One problem with community rating is that it increases the incentive for insurers to avoid high-risk populations. It also can penalize insurers that offer supplemental coverage or ancillary services that attract individuals with more expensive health needs. Therefore, to deter risk selection strategies and to compensate for inadvertent risk sorting among plans, some degree of retrospective risk adjustment (or additional public subsidy) is likely to be necessary. Since participating insurers, as a group, cannot avoid bad risks in a mandatory system, efforts to market or shape benefits packages to do so are wasteful and undermine the goals of the system. We therefore suggest that the same commission of medical experts and business, consumer, labor, and insurance industry representatives established by Congress to define the mandatory minimum benefits package, also study and recommend to the state CIPs one or more risk-adjustment methods.

Enrollment

Whether or not they are eligible for an employer-sponsored plan, all legal residents could purchase the plan of their choice through the local CIP—and have both the employer's contribution and any tax credit paid directly to the plan (including to their employer's own plan, if they do not opt out). En-

rollment would occur in one of three ways: through an employer (by filing or amending a Form W-4), directly through the CIP or individual plan, or by default assignment.

Workplace enrollment. Because employers already are required to have employees complete a Form W-4 to calculate income tax withholding, it would be fairly easy to extend this process to include designation of the employee's health plan. The form should be completed at the time of initial employment, as now, but updated each year as well during the CIP's open enrollment period. The annual update would be important, since the form (or an attachment) could extend the income tax withholding calculation to estimate the employee's tax credit eligibility and estimated monthly payment for whatever coverage is indicated (whether through the employer or through the Community Insurance Pool). The form would authorize payroll withholding and the transfer of the worker's estimated credit voucher to the plan. Employers could be required to make CIP enrollment material available, which would include descriptions and comparisons of plans available through the pool.

Direct enrollment. Although employers could offer "one-stop shopping" (and frequently valuable advice), individuals less attached to a well-organized workplace (for example, the unemployed and self-employed) should have an easy opportunity to enroll directly in plans offered through the CIP. Just before the annual open enrollment period, the state CIP administrator should mail plan descriptions and enrollment material to every household within its jurisdiction. Enrollment (or switching from one plan to another) could occur by mail, by Internet, or by telephone through the CIP clearinghouse. In addition, individual insurers should be allowed to advertise or market their plans directly to consumers, or through sponsorship arrangements with non-profit constituency organizations (for example, religious groups, consumer groups, unions). However the individual or family enrolls, the information submitted (and updated each year) would be essentially the same as on the Form W-4 extension described above. The CIP (or enrolling insurer) would need an estimate of current year income to calculate the anticipated tax credit and payment due. With this, and authorization for payroll deduction, the CIP could notify the employer of the enrollment and the amount that would need to be forwarded by payroll deduction to the CIP clearinghouse.

Default enrollment. Of course, some individuals would fail to enroll, particularly those who were not attached to a stable job or residence (for example, the homeless, indigent, itinerant), but also others seeking to shirk the personal payment obligation. Individuals who failed to certify enrollment on their Form W-4 and/or income tax form would be randomly assigned to a plan offered through the CIP—one priced at the median or below. Current Medicaid enrollees who did not affirmatively select a plan, after a transition period, would be similarly assigned. An additional channel for identifying the remaining uninsured would be medical providers, particularly emergency rooms, when they provide uncompensated care for persons unable to show coverage.[14] Individuals assigned to plans presumably would be billed for the entire premium, which they would owe until such time as they provided information sufficient to collect contributions from any employers (through the CIP) and the government (for any tax credit or additional state-paid subsidies).

[14] As noted above, each state CIP would establish a Default Reimbursement Fund to compensate health care providers for uncompensated care. Providers would have access to an online database that could immediately determine if the patient is enrolled in a health plan in that state, or through the CIP in some other state. If not, and if the patient cannot pay, the provider could fall back on the Fund. To be eligible for reimbursement, a doctor, emergency room, or other provider could be required to collect and supply information about the patient (for example, name, address, driver's license number, place of employment) to facilitate ongoing CIP outreach and enrollment efforts.

Role of Employers

The system proposed here is fundamentally citizen-based, as it de-links both affordable group plan coverage and tax subsidies from the employment relationship. As noted, every American should be able to choose from among plans competing through the CIP, whether or not his or her employer sponsors a plan. Both the tax credit subsidy and employer contribution, if there is one, could be applied to any qualified plan.

This leaves two roles for employers, one mandatory and one voluntary. The required role is to facilitate enrollment and the payroll deduction of premium payments; the voluntary role, as it is today, is to administer a company-sponsored health plan.

Employers as intermediaries. As described above, the employer's current responsibility to remit payroll and income tax withholding, based on IRS Form W-4, would be expanded to include withholding health premium payments for workers who enroll in plans through the CIP. When workers are first hired, and once annually during the CIP open enrollment period, employers would be required to collect plan enrollment and expanded W-4 information from all employees. They could also be required to make a package of information from the local CIP, describing the menu of available plan options, available on request. Based on this information, the employer would transfer automatic payroll deductions to the plan provider selected by the employee. If the worker remains in the company plan, all payments—the employer's contribution, the tax credit, and any premium payment due from the employee—would be retained by the firm (and transferred to its qualified plan). Indeed, eligible employees should be automatically enrolled in the company plan unless they affirmatively enroll in another qualified plan through the CIP.

If a worker chooses to enroll (or remain in) a plan offered through the CIP, or to enroll in a family member's employer-sponsored plan, the worker's employer would deduct and transfer both the employer's contribution and the employee's premium payment to the CIP clearinghouse (for payment to the particular plan the employee indicated on the W-4). Although employers sponsoring plans could immediately receive a worker's estimated tax credit—by subtracting it from the employee's income tax withholding—if the worker were enrolled through the CIP, it would be less burdensome on firms if the CIP itself calculated and advanced the tax credit to insurance plans with funds from the federal government.

Employers as plan sponsors. Employers can limit their role to facilitating enrollment through the CIP, as described above, or they can maintain a company plan. However, to be eligible for the tax credit voucher, an employer-sponsored plan should conform to a number of the basic principles in line with the overall goals of a system of universal and affordable coverage. The plan must be at least as comprehensive as the minimum benefits package offered by plans competing through the CIP. If the employer pays the entire premium, then no additional regulation should be required. For coverage or services above the minimum benefits level, any plan would be free to charge any actuarially fair premium and to decide what deductibles or copayments are appropriate.

However, if any copremium is imposed on employees (or their dependents) for the required minimum coverage, then an employer-sponsored plan (whether or not it is self-insured) must: (a) define, price, and offer the minimum level of coverage separately, as plans are required to do within the CIP; (b) charge copremiums only to the extent that the cost is greater than 6 percent of the employee's covered wages (since employers are required to make this minimum contribution); and (c) remit both employer and employee contributions to the CIP if, during the annual enrollment window, an employee opts to enroll in a

plan through the CIP or through a family member's qualified plan, rather than in the company plan. This final requirement would be critical in the context of a system premised on mandatory self-insurance, since it ensures that individuals have the ultimate choice over what arrangement and cost best suits their family's medical needs and economic situation.

Integrating Medicaid into the Mainstream

One particularly important design issue concerns the extent to which the Medicaid and S-CHIP populations should be integrated into the mandatory system of choice among competing private insurers. Medicaid spending has surged over the past two decades—driven, among other factors, by the 20 percent increase since 1988 in the share of the non-elderly population without health insurance. The federal share alone exceeds $150 billion—more than 10 percent of the federal budget. Medicaid recipients among the non-elderly fall into two broad pools: the financially needy (namely, low-income women with dependent children) and the medically needy (namely, low-income people with long-term physical and mental disabilities). The financially needy comprise three-quarters of Medicaid's 51 million recipients, but account for less than one-third of program expenditures.

We propose that the financially needy now covered by Medicaid should be enrolled in private plans through the CIP. Once each state's CIP becomes well established, Medicaid enrollees could be assigned randomly to a basic benefits plan at or below the median cost. Like other individuals, former Medicaid recipients would then be free to switch to another plan during the open enrollment period, to upgrade their coverage with their own resources, or to drop coverage if they gain employment at a firm that provides qualified coverage. In essence, once the financially needy population is enrolled through the CIP, they are treated like everyone else. To the extent that their household income remains below 150 percent of the poverty line, the state CIP would collect the full premium amount from the federal government (reduced by any employer contributions for earnings) and pay it out to the private insurance provider.

While the majority of adults and children now eligible for Medicaid or S-CHIP would be mainstreamed, Medicaid would continue to enroll and fund care for those persons eligible for the long-term care portion of the program. Medicaid covers more than 12 million disabled and elderly people at a cost that exceeds $12,000 per enrollee—more than six times the average cost of the program's 39 million non-disabled participants.[15] Because the federal government would be assuming the total cost of covering the financially needy, we assume the states should take greater responsibility for financing the medically needy, particularly the elderly and others requiring long-term nursing care services.

While there are many advantages to bringing nearly all Americans into a single, seamless system, because Medicaid itself serves very divergent populations under state-determined eligibility and benefits criteria, it is important to examine the degree to which integration would be desirable as well as its costs and tradeoffs. For example, although the basic benefits package guaranteed under a mandatory system is likely to be somewhat less comprehensive than the current entitlement, research suggests that the more generous fee schedules and lack of stigma associated with enrollment in mainstream health plans can lead to improved participation and access to quality physicians—and, ultimately, to better health outcomes.

At the same time, federal assistance should continue to be available for state programs addressing special needs of this population

[15] The Kaiser Commission on Medicaid and the Uninsured. "Medicaid: Fiscal Challenges to Coverage" The Henry J. Kaiser Foundation, May 2003.

that would not normally be included under the basic health benefits package. Today, Medicaid coverage and eligibility varies significantly from state to state. Services such as in-school immunizations, eyeglasses, and speech therapy are provided through Medicaid by some states—and should, at the option of the states, continue as "wraparound" services for those who would now be eligible for Medicaid. Similarly, Medicaid enrollees today pay extremely low copayments for basic services, with children paying none at all, so as not to unduly deter routine and preventive care. We assume that the cost-sharing requirements that would apply to very low-income individuals enrolled through the CIP (for example, persons below 200 percent of poverty) would be considerably lower than for other participants.

Moreover, automatic enrollment of the Medicaid population into mainstream plans through the CIP would reduce the problems created when low-income people churn between the public and private systems as well as the "crowd-out" effects that occur if the continued expansion of Medicaid eligibility remains the nation's primary means to expand coverage. The continuity of coverage and care accessible through the CIP might even be more important to a very low-income, at-risk population.

Finally, because the system makes means-tested coverage affordable to *all* Americans, it would create an even greater level of stigma to *disenrolling* individuals and families from private coverage because their income (and hence ability to contribute) fell below a certain threshold. Forcing the low-income population to shift back and forth between the mainstream system and Medicaid as their ability to pay fluctuates would be wasteful and unfair and would undermine other reform goals.

Financing

Under the proposal here for mandatory coverage, the cost of health insurance would continue to be shared in roughly the same proportion among individuals, employers, and government. However, there would be several significant changes in the distribution of the financial burden, primarily because all employers and all but the lowest-income individuals and families would be expected to contribute to the cost of the required minimum level of coverage.

Although census data show that two-thirds of the uninsured earn less than $10 per hour—and would have all or most of their insurance premium subsidized—as many as one-third of the uninsured would be required to contribute a modest share of household income (for example, up to 4 percent), unless their employer provides basic coverage. Other low-income workers who may be paying a larger portion of their income today for coverage would likely pay less, at least for basic coverage. Similarly, employers that currently buy comprehensive coverage for a large number of relatively low-wage workers would see a substantial reduction in their health costs, since we assume the maximum employer contribution to the cost of basic coverage is a flat 6 percent of the individual worker's wage. Conversely, employers currently making no contribution would begin paying 6 percent of payroll, phased in over three years or more. The federal government would completely fund the premiums of the vast majority of non-disabled adults and children currently eligible for Medicaid and S-CHIP because they are poor, although presumably the states would then assume a larger share of the cost of long-term care for the medically indigent remaining in the public program.

While overall health spending by the federal government would increase substantially,[16] the net cost would be reduced by at

[16] Two comparable proposals released during 2003 by The Commonwealth Fund and by Blue Shield of California estimated the net additional cost to the federal government at $70 billion and $75 billion, respectively. Both would insure virtually all Americans on a mandatory basis and rely on a combination of individual, employer, and federal tax credit

least three changes: first, by capping the tax exclusion for employer-paid premium at the median cost of the minimum benefits package; second, by eliminating Medicaid, S-CHIP, FEHBP, and other separately administered public programs providing basic health coverage through private providers; and third, by requiring all employers not providing coverage to deduct and submit a premium contribution equal to approximately 6 percent of covered payrolls. Fourth, by eliminating disproportionate hospital share (DSH) and related federal payments, the insurance mandate would minimize uncompensated care, and any remaining reimbursements would come from a Default Payment Fund financed by excess employer payments for very high-wage workers. Finally, although making basic coverage affordable should increase the demand somewhat for primary and preventive health care, the mandatory nature of the system would help to reduce the *average* cost (and subsidy) for a basic plan by bringing in premium dollars from the uninsured who are able to pay. For example, the nearly 7 million uninsured adults living in households earning more than $75,000 should add $15 billion or more to the private insurance premium pool.

Incentives for Cost Containment

The system of mandatory self-insurance proposed here does not anticipate any form of rationing, premium caps, or other mechanisms that would force cost control directly. The proposal is, in part, premised on a belief that our society is affluent enough to ensure the affordability of an essential level of quality care for all, and that the consumption of health services above that level should be a matter of competing consumer preferences—neither subsidized nor constrained. While cost containment will be an increasingly important health policy issue, we believe that achieving universal coverage is a more pressing—and sufficiently daunting—policy challenge that can provide the foundation for subsequent reforms focused on both the supply and demand sides of the market. Nevertheless, the system proposed here is structured to include a number of features that should help to reduce administrative costs, make consumers more cost conscious, and encourage insurers to place more emphasis on preventive care.

Most important, a truly *citizen-based* model of universal coverage enables continuity of coverage and care. Unlike today's system, distinguished by the enormous waste and discontinuity of policy churning, individuals would be able to remain with the plan and doctors of their choice as they move from job to job. This should reduce administrative costs *and* increase the incentive for insurers to invest in disease prevention and long-term preventive care. Insurers and health care providers spent $112 billion on administrative costs in 2002, a large portion of which is attributable to individuals moving in and out of plans and changing their medical providers frequently.[17] While continuity of coverage and the economies of scale inherent in a large Community Insurance Pool would reduce administrative costs, over the longer term enabling individuals to remain with a single plan for life should increase insurers' incentives to focus more on preventive care.

Second, the incentives to purchase coverage through the Community Insurance Pool would greatly increase competition in the small-group and individual insurance market. There would be more choice among more plans offering a standardized basic benefits package that would be easier for consumers to

contributions for financing; see K. Davis and C. Schoen. "Creating Consensus on Coverage Choices." *Health Affairs* Web Exclusive (April 23, 2003); Kenneth E. Thorpe. "An Analysis of the Costs and Coverage Associated with Blue Shield of California's Universal Health Insurance Plan for All Americans" (mimeo). Atlanta: Emory University, June 11, 2003.

[17] See Karen Davis. "American Health Care: Why So Costly?" Testimony before Senate Appropriations Subcommittee on Labor, Health and Human Services, June 11, 2003.

compare. The plans competing through the CIP would, in turn, put competitive pressure on employer-sponsored plans, since workers could opt out of employer coverage and transfer their subsidies to offset the cost of outside plans. In addition, we anticipate that the national agency or commission proposed above, when it recommends the scope of the required minimum level of coverage, would bring the best research to bear on such issues as how to set copayments not primarily to reduce short-term costs for a plan, but to improve health outcomes and reduce long-term costs to society as a whole.

Third, more consumer choice would better align demand with supply. Since the essential tier must be defined, offered, and priced separately, consumers could more readily select the coverage they need and are willing to pay for. Comparative information on the costs and performance of these plans would be made widely available through the local CIP clearinghouse.

Fourth, the open-ended tax subsidy for health care consumption would be capped at the median cost of the minimum benefits package. Although guaranteeing the affordability of coverage for all Americans would, by itself, increase utilization, removal of today's sizable tax subsidies for non-essential services would place health benefits on a level playing field with other types of compensation and consumption preferences. As a result, individuals and firms would likely move toward less comprehensive plans, with more services consumed on an à la carte basis. With no tax subsidy for "luxury" coverage, employers should be more inclined to increase wages or pension benefits (which have fallen steadily as a share of compensation as health care has risen).

Finally, the approach here anticipates substantial administrative savings for both insurers and employers. In addition to the significant reduction in policy "churning" mentioned above, institutionalization of a CIP clearinghouse to route enrollment information and forward routine premium payments (nearly all by automatic payroll deduction), suggests significant savings in overhead. Employers opting to simply enroll their workforce through the CIP would save considerable sums on internal benefits management and consulting services. In addition, creation of state CIP clearinghouses and standardization of the essential benefits package would be likely to lead to a standardized, electronic claims payment system, at least for tier one services. The CIPs could use this system to compile data to measure service utilization and determine risk adjustment. A more standardized, electronic claims payment system also would reduce overhead costs not only for insurers, but for medical providers who today must navigate a frustrating variety of rules and forms to receive reimbursements from insurers.

Political Feasibility

The current system, with its persistent coverage gaps, cost shifting and other problems, is convincing policy makers and a broad array of constituencies of the urgent need for an alternative means to make basic health coverage universally accessible and affordable. Yet none of the standard policy remedies rises to this challenge or meets the test of political feasibility. Requiring every American to obtain at least a basic level of health insurance from a private provider is a policy that defies the usual political spectrum. The coverage guarantee and means-tested tax credit subsidy should appeal to liberals, while the reliance on private insurance markets and consumer choice and the easing of the social benefits burden on employers should appeal to conservatives.

Most employers should support the individual mandate approach described here: it reduces the health benefits costs of most firms and allows employers to get out of the busi-

ness of administering health benefits. Employers would not be required to offer or administer a health plan, only to contribute a modest and flat percentage of payroll and to facilitate enrollment through an annual Form W-4 process. For those firms that continue to offer a plan, or to pay the premium for employees enrolling through the CIP, the burden of subsidizing low-wage workers would shift from employers to society as a whole. Employers could provide very comprehensive coverage as a fringe benefit to their highly paid employees without bearing the full cost of covering low-wage employees, as is currently required. Although some small or low-wage employers may object to any required contribution, we believe that on balance the vast majority of firms would find the division of payment and responsibility to be very favorable compared to the current system and compared to any other proposal capable of ensuring universal coverage.

Similarly, insurance companies that chafed at the premium growth caps and regulatory role of the purchasing Alliances proposed during the Clinton administration appear to be, a decade later, considerably less resistant to the healthmart approach assumed here, which is more akin to the way millions of federal employees choose among competing private health plans today. Participation in the CIPs would be voluntary, and, although many for-profit insurers could well oppose insurance regulation (such as community rating and guaranteed renewability), they would also benefit immediately from a huge expansion of the private insurance market as 40 million Medicaid enrollees, and an additional 40 million uninsured Americans, would become customers for private coverage. Medical professionals should likewise support a system where every patient would arrive with insurance coverage, where the Medicaid population would be treated at standard insurance rates, and where any otherwise uncompensated care would be reimbursed through the state CIP.

In some respects the greatest unknown may be the perception of individual Americans, particularly those who currently receive health benefits through their employer. In 1994 the perception that those with good coverage had little to gain and, in fact, might lose their choice of doctors helped to turn public opinion against the risk of reform. A decade later, however, the public is reconciled to a degree of managed care and appears far more worried about losing coverage—either because of a change in employment or because rising premiums and employer cost shifting makes it unaffordable. Although there is no obvious remedy to medical cost inflation, the proposal here may be appealing to the extent it addresses three sources of public anxiety: first, individuals and families would be able to keep their coverage even if they lose their job; second, the worker's premium cost would never exceed a modest share of family income; and third, every individual would always have a choice of among a variety of competing plans whether or not his or her employer provides coverage.

In short, the principle of universal coverage in exchange for universal responsibility within the existing market system may well be the most feasible and politically centrist foundation on which to build a political consensus around comprehensive health reform. ■

Helen Ann Halpin

Helen Ann Halpin has proposed a program that emphasizes voluntary choice but which includes incentives that are likely to produce a state-based, single-payer system over time. It has the following elements:

A CHOICE PLAN THAT WOULD CONTRACT with all willing (presumably most) licensed providers and group model or staff model HMOs and offer comprehensive coverage to most of the population should they choose to enroll.

CONTINUATION OF MEDICAID, S-CHIP, MEDICARE, EMPLOYER-BASED PLANS, and private insurer plans as alternatives to CHOICE for those who prefer to stay with current forms of coverage.

A REQUIREMENT THAT EMPLOYERS EITHER OFFER COVERAGE (though neither the type of plan nor the amount of premium contribution would be regulated) or pay a payroll tax of no more than 6.5 percent for each employee not covered under the employer's health plan.

SUBSIDIES AVAILABLE ONLY TO PEOPLE ENROLLING IN CHOICE that would limit premium payments to a maximum of 2.5 percent of annual income, depending on income and family size.

FINANCING FOR CHOICE from individuals (premiums), states (replacing some current public program subsidies), the federal government (some new "sin" taxes), employers (payroll taxes), and a new assessment on cross border transactions between Mexico and the United States.

About the Author

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Getting to a Single-Payer System Using Market Forces: The CHOICE Program

by Helen Ann Halpin

Overview

The CHOICE program is a new approach to health care reform that very quickly achieves nearly universal access to a single-payer health insurance system for all U.S. residents without any individual mandates or new regulations for employers or health insurers. It accomplishes this goal by offering all U.S. residents a new choice for their health insurance coverage that better meets their preferences as health care consumers, providers and employers. CHOICE offers Americans the option of unrestricted access to nearly all licensed health care professionals and facilities in their state for comprehensive, affordable, high-quality health care without eliminating any of their current health insurance options. The simple beauty of the CHOICE program is that it achieves these goals through economic incentives, competition with the existing system, and ultimately transitioning the entire system as a result of the voluntary choices of individuals, businesses, and health care providers. The result is increased access, equity, efficiency, choice, and security for all.

CHOICE is a shared responsibility between the federal and state governments, with states having flexibility in how they design and administer their programs. CHOICE recognizes the differences in the public programs and delivery systems operating within each state, as well as the varying needs of their populations, and gives states the opportunity to tailor their programs within federal guidelines. Financing is a mix of public and private, and each state contracts directly with private and public health care providers and organized delivery systems in the state to provide covered health care services. All U.S. residents who enroll in CHOICE will have two major options for affordable, comprehensive health insurance coverage:

- *The CHOICE Single-Payer Network:* CHOICE enrollees may receive their medical care from any licensed health care professional or facility that contracts with the statewide CHOICE fee-for-service network to provide covered services. It is anticipated that nearly 100 percent of all health care providers (except those who practice in group- or staff-model HMOs) will elect to contract with their statewide CHOICE Network. All providers in the network will be paid Medicare payment rates for all enrollees, regardless of their sources of financing (for example, employer, Medicaid, Medicare).
- *Organized Delivery Systems:* CHOICE enrollees may select among all state licensed organized delivery systems (ODSs), which include both group- and staff-model HMOs, that elect to contract with the CHOICE program in their state. ODS will be paid an age-, sex-, and risk-adjusted capitation payment for each CHOICE enrollee. In addition, health insurance carriers and health plans will be offered federal tax incentives to develop new partnerships with large multi-specialty groups in exclusive arrangements, creating more ODS options that will compete with each other and

with the CHOICE Network for enrollees.

CHOICE makes coverage affordable by basing the amount that enrollees pay toward CHOICE coverage on their annual wages and family size. Employers contribute by paying a payroll tax of 5.5 percent or 6.5 percent, depending on firm size, which is substantially less than many now pay for coverage. An employer that continues to offer workers health coverage will be credited for the full amount of the tax for each worker enrolled in the employer's plan. States and the federal government will contribute to CHOICE financing when people move from existing state or federally subsidized programs to CHOICE.

Objectives of the CHOICE program

The CHOICE program has five major objectives:

1. To Increase Coverage

The primary objective of the CHOICE program is to guarantee access to affordable, comprehensive health insurance coverage for all non-elderly adult workers (regardless of their immigration status) and their non-working dependents as well as all Americans who are currently eligible for Medicaid, the State Children's Health Insurance Program (S-CHIP), or Medicare. A "worker" is broadly defined to include full-time, part-time, seasonal, contractual, and temporary workers as well as the self-employed.

It is expected that the CHOICE program will increase coverage to at least 95 percent of all U.S. residents within one year of adoption. The CHOICE program will extend eligibility for coverage to nearly all currently uninsured U.S. residents and their families. It also will increase coverage, through mass media campaigns and extensive community outreach, for U.S. residents who are eligible for S-CHIP and Medicaid but are not enrolled, and it will provide for more comprehensive and affordable coverage for elderly Medicare beneficiaries who elect to enroll in the CHOICE program through a federal Medicare Demonstration Program.

2. To Increase Choice

All working, non-elderly U.S. residents and their non-working dependents, as well as Medicaid, S-CHIP, and Medicare beneficiaries, will retain all of their current health insurance coverage options, but they will be offered a new option in the form of the CHOICE program. For example:

- Workers and their families will retain the option of getting their coverage through their employer (if offered), public programs (if eligible), the individual market (if affordable), or the new CHOICE program.
- Elderly Medicare beneficiaries will have the option of getting their coverage through the traditional Medicare program, Medicare+Choice plans, or the new CHOICE program.
- Individuals eligible for Medicaid, S-CHIP, and other state-administered and -financed health insurance programs will have the option of continuing their coverage in these public programs or enrolling in the new CHOICE program.
- Employers will have the option of deciding whether to offer employer-sponsored coverage and will remain free to decide what shape and form that coverage will take without any regulation of the benefits they offer.
- CHOICE enrollees will have the option of choosing from their statewide CHOICE Network of health care providers or enrolling in an organized delivery system (ODS) for their medical care.
- CHOICE enrollees will have the option of choosing their own doctors and hospitals from among all health care providers who contract with the statewide CHOICE Network.
- Health insurance brokers will have the option of offering the CHOICE program to individuals and small firms.
- Health insurance companies and health

plans will have the option of continuing to sell coverage in the group and individual markets and will be offered incentives to partner in new exclusive arrangements with multi-specialty medical groups to form new ODSs.

- Health insurance companies and health plans will also have the option of developing and selling supplemental products that cover services not included in the CHOICE benefits package as well as contracting with the CHOICE program to perform administrative functions.

3. To Increase Equity

An objective of the CHOICE program is to ensure that *everyone pays a fair share of the cost* to support access to comprehensive, affordable coverage for all U.S. residents and their families. The CHOICE program achieves financial equity by requiring all parties (individuals, employers, and state, county, and federal governments) that currently support the health care system financially to continue to do so at a level that is affordable and necessary to provide comprehensive, high-quality health care services. The CHOICE program also increases equity by:

- Making premium contributions affordable for individuals and families by tying them to wage levels up to a maximum annual wage. There is no out-of-pocket premium for individuals and families with annual incomes below 150 percent of poverty. On average, U.S. residents with incomes above 150 percent of poverty will pay 2 percent of their annual income applied up to the maximum wage subject to the Social Security tax (approximately $87,000 per year in 2003) to enroll in the CHOICE program.
- Setting employer contributions to help finance health insurance coverage so that all employers operating in the United States pay into the CHOICE program for any employees who do not take up employer-sponsored coverage. The payroll tax under the CHOICE program is considerably less than what employers now pay to buy coverage in the small- and large-employer group health insurance markets.
- Providing a reasonably comprehensive standard set of benefits to all CHOICE enrollees.
- Providing fair payment to all health care providers in the CHOICE Network through 100 percent Medicare payments, regardless of patients' source of financing.
- Providing each participating ODS with an age-, sex-, and risk-adjusted capitation payment for all covered services for its CHOICE enrollees.

4. To Increase Efficiency

Another objective of the CHOICE program is to increase efficiency in administering health insurance coverage and to purchase greater value with U.S. health care dollars. This means maintaining and improving the quality of health care, while at the same time keeping costs reasonable. This objective will be achieved by:

- Taking advantage of electronic processing capabilities for all administrative functions, including claims processing, auditing, and quality review and improvement.
- Bulk purchasing of pharmaceuticals and medical equipment through the Federal Supply Schedule (FSS).
- Coordinating administration of the CHOICE program with other state-administered health insurance programs.
- Permitting any requirements for enrollment, including residency, work status, family status, and income, to be determined by a self-certification process with random paperless verification.[18]
- Permitting automated enrollment of patients in CHOICE by health care professionals at the site of care.
- Contracting directly with licensed health

[18] Ana Montes. Latino Issues Forum. Memo to Norma Garcia of Consumers Union re: Self-Certification (April 20, 1999).

care professionals and facilities in the statewide CHOICE Network, whose performance will be assessed on quality and value.

- Restricting contracts with ODS to only state-licensed group- and staff-model HMOs, whose performance will be assessed on quality and value.[19]

5. To Increase Security

Ultimately, the goal of the U.S. health care system under the CHOICE program will be to maintain and improve the health of all people living in the United States and to meet their medical care needs. This means preventing disease and disability, promoting health, managing chronic conditions, treating illness and injury, and giving priority coverage to those services that have been demonstrated to be effective in improving health outcomes. This objective will be achieved by:

- Providing coverage for those services and treatments that have been demonstrated to be effective and relatively cost-effective in the prevention, diagnosis, treatment, and management of a medical condition.
- Returning medical care decision making to health care providers and their patients with no preauthorization requirements.
- Holding health care providers accountable for the quality and cost of the care they deliver.
- Increasing the number of insured individuals, thereby providing a reliable source of new revenue for safety net providers and, at the same time, increasing per capita state funding for indigent medical care for persons who remain uninsured.[20]

Coverage/Eligibility

1. Eligibility Criteria

U.S. residents who meet the following criteria are eligible to enroll in the CHOICE program, regardless of their race, age, gender, religion, ethnicity, sexual orientation, legal status, health status, family status, or income.

Non-elderly (0–64 years) U.S. residents who meet *all three* criteria below are eligible to enroll in the CHOICE program:

- Currently reside in the United States with the intent to remain.[21]
- Are not covered by Medicare.
- Meet *one* of the following criteria:
  - —Worked in the United States (or is the non-working dependent[s] of an eligible worker) for at least three months out of the last 12. A "worker" is defined to include full-time, part-time, seasonal, temporary, and contractual workers and the self-employed.
  - —Are eligible for Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefits.
  - —Are receiving state unemployment benefits.
  - —Are eligible for S-CHIP.

Elderly U.S. residents are eligible if they meet the following conditions:

- Are 65 years of age or older.
- Currently reside in the United States with the intent to remain.
- Are eligible for Medicare.

Non-working, non-elderly U.S. residents and uninsured elderly U.S. residents can buy into the CHOICE program by paying the full premium. However, persons enrolled in military/CHAMPUS/Veterans Administration (VA) programs are not eligible for the CHOICE program. In addition, *non-working* adult (18 and older) U.S. residents who are eligible for or enrolled in the Medicaid program will not be eligible in the first phase of implementation to enroll in the CHOICE program, but they will remain covered under Medicaid. Non-elderly Medicare enrollees also will not be eligible to enroll in CHOICE ini-

[19] UC Berkeley Annual Survey of Health Plans (1997).
[20] California LAO analysis (2001).
[21] The language of "present with intent to remain" is used to determine Medicaid eligibility.

tially. Once the CHOICE program is up and running and covering the majority of the U.S. population, the non-working Medicaid and non-elderly Medicare populations will become eligible to enroll in the program. This phased approach avoids adverse selection of these high-risk, high-cost populations into the risk pool too early in the program's development. By first establishing a very large and relatively healthy risk pool, it will be easier to absorb a relatively small but higher-risk population later without substantially changing the average costs of offering coverage to the entire population.

2. Guaranteed Annual Renewal

Individuals and families who elect to enroll in the CHOICE program will have coverage for one full year. Once an individual or family has enrolled, annual renewal is guaranteed, conditional on continued payment of the income-based share of the premium (if any is required).

Subsidies

The CHOICE program offers subsidies to individuals, based on their annual income and their family size, and to firms, based on the number of employees (size of firm). No subsidies are offered to anyone who purchases coverage outside the CHOICE program, with the exception of subsidies offered as part of existing public insurance programs, including Medicaid, S-CHIP, and Medicare.

1. Subsidies for Individuals and Families

For those who enroll in CHOICE, the subsidy for individuals and families is based on both annual wages and family size, gradually increasing as income decreases and family size increases, with limits on out-of-pocket costs capped along both dimensions. Individuals and families who enroll in the CHOICE program pay, at a minimum, nothing toward the monthly premium (for those in families with an annual income below 150 percent of the federal poverty guideline) and, at a maximum, 2.5 percent of their annual income up to the annual wage cap for Social Security taxes (about $87,000 in 2003), or a maximum of $181 per month for a family of any size.

Individuals with incomes between 151 percent and 250 percent of the poverty guideline pay 0.5 percent of their monthly wage toward the premium; those with incomes between 251 percent and 350 percent of the federal poverty guideline pay 1.5 percent; and those with annual incomes above 350 percent pay 2 percent (applied up to the annual wage cap for Social Security taxes). For each non-working dependent who is also covered under CHOICE, an additional 0.5 percent of monthly wages is paid toward the premium, up to a maximum of 2 percent of monthly wages for families with an income between 151 percent and 350 percent of poverty, and up to a maximum of 2.5 percent of monthly wages for families with an income above 350 percent of poverty, again applied only up to the annual wage cap for Social Security taxes. The subsidies are only offered to individuals and families who enroll in the CHOICE program and are not available for any other source of coverage.

2. Subsidies for Employers

Firms are also subsidized relative to their current costs in the group market or as self-insured employers. The subsidy, however, is greater for small firms (1 to 50 employees) than it is for larger firms (more than 50 employees). Under CHOICE, small firms will pay a quarterly tax of 5.5 percent of total payroll, with large firms paying at a marginal rate of 6.5 percent for the 51st employee and beyond. Firms with employees who elect to get their coverage through the firm's plan will receive a tax refund equal to the amount of the payroll tax paid on the wages of those employees.

Financing

The CHOICE program is financed by existing private and public (state and federal) funding for health insurance and new sources of funding.

1. Existing Funds

State Funding

The state will pay its share of cost for:

- workers and their dependents eligible for Medicaid who enroll in the CHOICE program;[22]
- persons eligible for S-CHIP who enroll in the CHOICE program;[23]
- workers eligible for other state-subsidized health insurance programs who enroll in the CHOICE program.

Federal Funding

The federal government will pay its share of cost (federal match) for persons eligible for S-CHIP and Medicaid who enroll in the CHOICE program as well as the Medicare+Choice premium for elderly Medicare beneficiaries who elect to enroll in their state's CHOICE program.

2. New Sources of Funding

Worker's Share of Premium

The CHOICE program does not require workers to take coverage under either their employer's plan (if offered) or the CHOICE program. Thus, workers retain the option of not taking health coverage and not paying a premium, with no individual mandate to buy coverage. All workers and their families, regardless of whether their employer offers health insurance coverage, will have the option of enrolling in the CHOICE program. Persons who take employer-sponsored coverage are responsible for their share of the premium as determined by their employer; it is not subsidized. Workers who take coverage under the CHOICE program pay only the subsidized, wage-based share of the CHOICE premium (if any); they do not pay the premium for the employer's plan.

Table 1 presents the share of the monthly premium each worker who elects to enroll in the CHOICE program will be required to pay as a function of his or her monthly wage relative to the federal poverty guideline and the number of non-working dependents in the family.

Thus, a worker with annual wages of less than $13,000 will be fully subsidized under the CHOICE program and will not be required to contribute anything toward the premium. The same is true for a family of four with an annual income below $26,000. At the other extreme, individual workers who earn more than $87,000 per year will pay $145 per month for themselves, while a family of two or more with an annual income greater than $87,000 will pay a maximum of $181 per month under CHOICE.

Rationale. One of the biggest barriers to health insurance coverage for most uninsured Americans is affordability. Thus, one mechanism for expanding coverage is to tie individual and family premium contribution levels to workers' wages (up to the maximum annual wage subject to Social Security tax), making health insurance affordable for all U.S. residents and their dependents.

Workers who elect to enroll in the CHOICE program will pay a fair share of the cost of the monthly premium, which varies as a function of their monthly wage and the number of non-working dependents in their family. The premium is structured so that those who can afford to pay more are asked to pay a larger share of the premium than those with lower incomes. No individual or family enrolled in the CHOICE program will be asked to pay more toward the annual premium than 2.5

[22] HCFA Final Management Report for FY 2000. Available at hcfa.gov/meidcaid/fmr00.zip.
[23] "State Children's Health Insurance Program Allotments for Federal Fiscal Year." *Federal Register* 65, no. 101 (24 May 2001).

TABLE 1

Worker Out-of-Pocket Monthly CHOICE Premium

WORKER ANNUAL WAGE AS A PRECENT OF THE FEDERAL POVERTY GUIDELINE [1, 2,3]	PERCENT OF MONTHLY WAGE PER WORKER	ADDITIONAL PERCENT OF MONTHLY WAGE FOR EACH NON-WORKING DEPENDENT	MAXIMUM PERCENT OF MONTHLY WAGE PER WORKER
Up to 150% of poverty	0%	0%	0%
151%-250% of poverty	0.5%	0.5%	2%
251-350% of poverty	1.5%	0.5%	2%
Above 350% of poverty	2%	0.5%	2.5%

[1] Individuals enrolled in the CHOICE program who are eligible for Medicaid or S-CHIP will be required to pay only the premium that is required under these programs, if any.
[2] Based on the worker's monthly wage up to the annual wage cap for Social Security payroll taxes (approximately $87,000 annual wage in 2003).
[3] The same rates and restrictions would apply to income of elderly Medicare beneficiaries who voluntarily enroll in CHOICE through the demonstration program of the Centers for Medicare and Medicaid Services (CMS).

percent of total wages, applied up to the maximum annual wage per worker subject to the Social Security payroll tax. Workers with wages below 150 percent of the federal poverty guideline will not be required to pay any out-of-pocket monthly premium.[24] Workers who are eligible for Medicaid or S-CHIP will not be required to pay a premium that exceeds the requirements of those programs in their state. The self-employed pay the worker's share of premium for themselves and their non-working dependents.

Employer Payroll Tax and Tax Refund

All firms operating in the United States will pay a quarterly payroll tax to help finance the CHOICE program based on firm size and total payroll. The self-employed are treated as small firms of one employee for the purposes of the payroll tax. The tax, levied on all wages, tips, and salaries, applies to the total quarterly payroll across all workers. Firms are categorized by size, with smaller firms (those with 1 to 50 workers) paying at a lower rate than larger firms, as shown in Table 2.

State government will pay the payroll tax to cover state employees under CHOICE, and all municipal and county governments will pay the payroll tax for their employees. The federal government will continue to offer Federal Employees Health Benefits Program (FEHBP) plans to federal employees; however, we expect federal workers will do whatever minimizes their costs and meets their needs (either remain in FEHBP or move to CHOICE).[25]

All U.S. employers who hire foreign workers residing in the United States, both documented and undocumented, will participate in financing their health care coverage by in-

TABLE 2

Employer Quarterly Payroll Taxes under the CHOICE Program

FIRM SIZE	MARGINAL TAX RATE
1st to 50th worker	5.5%
51st worker and beyond	6.5%

[24] Individuals/families with incomes below 150 percent of the federal poverty guideline will pay no out-of-pocket share of premium to enroll in the CHOICE program and no co-payment for services or pharmaceuticals. Enrollees in the CHOICE program through no-cost Medicaid will also face no premium cost or copayments if enrolled in the CHOICE program. Premiums and copayments for persons enrolled in the CHOICE program through S-CHIP or share-of-cost Medicaid will not exceed the requirements under these programs.

cluding the wages of these workers in their total payroll, which is subject to the CHOICE employer payroll tax.

While all employers are required to pay the tax, an employer that continues to offer its workers health insurance benefits will be credited with the full amount of the tax for each worker who accepts coverage under the employer-sponsored plan. The tax is also credited for workers with qualified coverage under CHAMPUS or Medicare (for those elderly beneficiaries who do not enroll in CHOICE). However, there will be no recovery of tax payments for other persons not covered under the employer's plan, including workers who are covered under a spouse's employer's health plan.

Rationale. While firms are not required to offer employer-sponsored coverage under the CHOICE program, nor is such coverage regulated by the state, employers are required to pay a modest payroll tax that is significantly less than the average cost of coverage in the group market—on average a 15 percent savings for firms that now offer coverage.[26] Thus, all workers and their non-working dependents in all firms will have the option of enrolling in the CHOICE program when the payroll tax goes into effect or getting their coverage through their employer, if it is offered. This differs significantly from traditional "play or pay" programs, as there are no rules or restrictions on what firms may offer and even if an employer offers coverage, their employees always retain the option of enrolling in the CHOICE program—thus is it not an either/or proposition to the employer.

Most non-elderly Americans with health insurance receive their coverage through their employer (67 percent); yet, in 2002, only 61 percent of smaller firms (with 3 to 199 workers) offered their workers health insurance coverage.[27] In addition, approximately 76 percent of non-elderly adults who were uninsured in 2000 were employed either full- or part-time. While employment is the most important route to coverage, with employers subsidizing on average 84 percent of the premium cost for single coverage and 73 percent of the premium cost for family coverage, employment in the United States certainly does not guarantee coverage.[28] The probability of being offered employer-sponsored insurance varies significantly as a function of firm size, industry, and employment status (full- or part-time, contractual, temporary, seasonal). The CHOICE program seeks to eliminate all of these inequities by guaranteeing all U.S. workers and their families access to comprehensive and affordable health insurance coverage, regardless of their work status or their employers' characteristics.

Recent estimates suggest that, among firms that offer coverage, the employer share of premium is the equivalent of about a 7 percent to 8 percent payroll tax. The payroll tax under the CHOICE program is considerably less costly for nearly all U.S. firms that currently offer coverage (5.5 percent tax for small firms; 6.5 percent tax for large firms). Thus, it is expected that most firms will stop offering their own coverage, pay the tax and encourage their workers to enroll in CHOICE rather than continuing to steer them into employer-sponsored health plans.[29] The firms least likely to pursue this strategy are very-high-wage firms, for whom the payroll tax might represent an increase over their costs of self-insuring or purchasing coverage in the group market.

Lower payroll taxes for small firms recognize the difficulty these firms have in affording coverage in the group market as well as

[26] Ibid.
[27] Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 2002

[28] Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 2002
[29] A similar idea of a payroll tax low enough to encourage many employers to choose a public coverage option rather than continuing to offer coverage themselves was developed independently in another paper in this series. See Jacob S. Hacker. "Medicare Plus: Increasing Health Coverage by Expanding Medicare." *Covering America: Real Remedies for the Uninsured*, Vol. 1. Economic and Social Research Institute, 2001.

their reported desire to be able to offer health benefits to their workers. Using a marginal payroll tax rate lessens the impact of firm expansions on employer health care costs and reduces the likelihood of negative responses to the payroll tax among firms.

The CHOICE program is also structured to reduce employers' potential to "game" the system. For example, an employer could offer coverage but not contribute toward the cost of it, thus avoiding all costs. Similarly, employers could choose to offer coverage with only minimal benefits to reduce costs (there are no minimum benefits requirements for employer-sponsored coverage under CHOICE). However, if employers make coverage look less attractive than that available under the CHOICE program, and their employees elect not to take that coverage and enroll in CHOICE instead, the employer will still be responsible for the payroll tax for these workers. As a result, the health plans that employers continue to offer to their employees are expected to be similar to those they currently sponsor and to be competitive with the CHOICE program.

Because the payroll tax rates that help finance the CHOICE program are so reasonable, it is expected that most firms will find the cost of the payroll tax to be considerably less than the cost of paying for health insurance for their workers and will encourage their workers to enroll in CHOICE.

Financing for Medicare Beneficiaries

In addition to the federal Medicare+Choice capitation payment from CMS, the premium for elderly Medicare beneficiaries who voluntarily elect to enroll in the CHOICE program will be funded in two ways:

- An income-based share of premium (see worker share of premium above for rates), not to exceed 2.5 percent for a couple in the highest income brackets and applied to an annual income capped at the Social Security tax maximum annual wage.
- For those who have retiree health benefits, the amount the employer pays to purchase retiree health benefits will be paid to the CHOICE program for each eligible Medicare beneficiary who voluntarily enrolls in CHOICE.

Public Health Taxes

Three public health taxes also will be used to help finance the cost of providing health insurance coverage to U.S. residents. They include:

- A federal tobacco tax of $1 per pack of cigarettes, with a proportionate increase on other tobacco products, which will be earmarked exclusively as revenue for the CHOICE program.
- A new federal tax on alcoholic beverages earmarked exclusively as revenue for the CHOICE program.
- A new federal tax of ten cents per 12 ounces of sweetened soda/soft drinks earmarked exclusively as revenue for the CHOICE program.[30]

Rationale. The specific items to be taxed were selected based on analysis of the leading causes of disease and years of life lost in the United States, which include use of tobacco products, alcohol consumption, and obesity.[31]

Safety Net Savings

Under the CHOICE program, 80 percent of per capita state safety net spending on medical care for the indigent and uninsured will be redirected to the CHOICE program for each previously uninsured person who enrolls in the program. The safety net will retain 100 percent of federal disproportionate share hospital (DSH) funds, 100 percent of current per capita safety net spending on medical care for persons who remain uninsured, plus the 20 percent of current per capita spending for

[30] Jacobson MF, Brownell KD. Small Taxes on Soft Drinks and Snack Food to Promote Health. American Journal of public Health. 2000 90(6):854-857.
[31] McGuiness JM, Foege WH. Actual Causes of Death in the US. JAMA 1993;270(18):2007-12.

each previously uninsured person who enrolls in CHOICE.

Rationale. Federal and state governments spend billions of dollars on the safety net each year; however, not all of this funding will be available to help finance the CHOICE program for the previously uninsured. It is critical that funding to DSH facilities be maintained, and that funding is not only maintained but increased as well to pay for health care for the 4 percent to 5 percent of the population who remain uninsured after CHOICE is fully implemented.

The CHOICE program will quickly reduce the number of uninsured people in the United States, and, commensurately, fewer people will need indigent medical care. Under the CHOICE program, Medicare payments will replace indigent care funding for previously uninsured people. This approach will provide the safety net with a much more stable source of financing in the long run by offering higher payments for covered services, and it will enable all safety net providers to deliver more comprehensive, high-quality health care to all of their clients. In addition, the amount the state spends to fund the safety net per uninsured person will be increased under CHOICE by increasing the per capita funding for those who will remain without coverage.

NAFTA Social Integration Fund

Under a new provision of the North America Free Trade Agreement (NAFTA), health insurance for Mexican workers who live and work in the United States will be financed in part by a social contribution from bilateral trade between the United States and Mexico. A bilateral side agreement will be negotiated to create a NAFTA Social Integration Fund that will require a 2 percent contribution on all cross-border transactions. In the United States, the NAFTA Social Integration Fund will subsidize the cost of coverage in the CHOICE program for Mexicans living and working here. The amount of bilateral trade between the United States and Mexico in 2000 was estimated to be $174 billion.[32] Two percent of this would yield $3.5 billion toward financing comprehensive health insurance coverage under CHOICE for all Mexican workers and their families who reside in the United States.

Rationale. NAFTA is the free trade agreement among the United States, Mexico, and Canada to eliminate all tariff and non-tariff barriers to trade by 2005. Under NAFTA, United States-Mexico bilateral trade has more than doubled, growing from $82 billion in 1993, to $130 billion in 1996, to $174 billion in 2000. Before NAFTA was enacted, duty on products and services averaged 10 percent in Mexico; by 1996, this had decreased to less than 6 percent. In the United States, average tariffs fell from 4 percent to about 2.5 percent over this same period.

The reduction in trade barriers and tariffs has allowed many smaller U.S. firms to export their goods. Both the Bush administration and President Fox of Mexico favor "regularizing" Mexicans who are in the United States illegally—that is, taking the steps necessary to make it legal for them to live and work in the United States as citizens of Mexico. Mexico recognizes that its citizens who work in the United States are not only important political constituents, but also that the remittances they send to Mexico constitute the second- or third-largest source of Mexican income.

NAFTA has already negotiated two bilateral side agreements on the environment and safety and labor issues. As part of adoption of the CHOICE program, another side agreement will be negotiated to address social investments, including public health and health care. Adoption of a Social Integration Fund with Mexico will greatly reduce the burden on the United States to subsidize the cost of emergency, maternity, and indigent care for

[32] Personal communication with Joe Kafchinski, U.S. Census Bureau, Foreign Trade Division (Feb. 6, 2002).

Mexicans and their families who live and work here.

This expansion will be modeled on the European Union's Maastricht Treaty developed in 1993.[33] The participating countries developed a strategy that pursues "a high level of human health protection by encouraging co-operation between the member countries" and, if necessary, by lending financial support to their action. In terms of health insurance coverage under European Union regulation, a cross-border worker is entitled to medical care benefits in both the member country in which the worker is employed and the member country in which he or she lives.

Insurance Risk

The federal government will bear the insurance risk for enrollees in the CHOICE Network in each state. State-licensed group- and staff-model HMOs that contract with the CHOICE program in each state will bear the insurance risk for their enrollees.

Administration and Regulation

1. Administration by a Designated State Agency

A state agency designated by each state's governor will administer the CHOICE program and will coordinate with other state agencies to streamline and simplify enrollment in S-CHIP and Medicaid, regulate providers, assess quality, collect and report data, and reach out to the community. The designated state agency will provide or arrange for a centralized electronic clearinghouse for claims processing, benefits coordination, payments to providers, utilization review, quality management, and other administrative functions. Administrative costs for the ODS contracting with the CHOICE program are expected to be about 5 percent, similar to costs for large-group health plans. Program administration for CHOICE is estimated to be 3 percent.

2. Enrollment

Workers will enroll in the CHOICE program through their employer. The wage-based employee share of the monthly premium for workers enrolled in the CHOICE program will be collected through automatic payroll deductions and sent by electronic funds transfer to the designated state agency. The quarterly employer payroll tax will also be collected by the CHOICE program by electronic transfer of funds. Medicare beneficiaries will enroll in CHOICE through the CMS demonstration program or through the employer that administers their retiree health benefits.

3. Self-Certification and Automated Verification

To further reduce barriers to enrollment, all requirements for residency, work, and income will be determined through a self-certification process, whereby individuals verify their information by signature, with a random paperless online verification process. Self-certification with periodic auditing has been found to be cost effective and results in very little fraud. The cost of more extensive verification does not produce enough savings in decreased fraud to make it cost-effective.[34] Implementation of an automated eligibility determination system has the potential to reduce Medicaid and S-CHIP administrative costs by at least 20 percent.[35]

4. Electronic Claims Submissions

All providers in the statewide CHOICE Network will be required to submit all claims electronically. We assume the CHOICE program will not be fully operational until 2005, at which time it is expected that more than 90 percent of health care providers and medical facilities and organizations will have elec-

[33] The European Commission. Communication on the Development of Public Health Policy. Available at http://europa.eu.int/comm/health/ph/grneral/phpolicy2.htm.

[34] Ana Montes, op. cit.

[35] The Lewin Group (March 2002), op. cit.

tronic claims processing capability. Additional federal funding to facilitate adoption of electronic claims processing should be appropriated for the remaining 10 percent of health care professionals and facilities without this capability. Electronic review of claims submission will be ongoing to prevent fraud and identify providers in the CHOICE network with utilization profiles that are statistical outliers. Claims will be reviewed to assess quality and costs as well.

5. Bulk Purchasing

Costs of prescription drugs and durable medical equipment will be significantly lower under the CHOICE program, because they will be purchased using the Federal Supply Schedule (FSS). It is estimated that the savings generated from bulk purchasing using the FSS will amount to about 40 percent for prescription drugs now purchased in the private sector and about 30 percent for drugs now purchased through Medicaid.[36] Similar savings will be realized from bulk purchasing of medical equipment under the FSS.

6. Statewide CHOICE Network

All state-licensed health care providers and health care facilities will be eligible to participate in the statewide CHOICE Network to provide covered services, but as part of their contracts they will be required to provide data on quality and costs and to participate in quality studies. The designated state agency will coordinate regulation of health care providers participating in the CHOICE Network with regulation of providers participating in other state-administered health insurance programs. Enrollees will be covered only when services are received from providers in the CHOICE Network, with the exception of coverage for emergency care by non-network providers.

Rationale. We anticipate that nearly all physicians, other health care providers, medical groups, hospitals, and other health care facilities will elect to contract with the CHOICE Network because of higher payment rates, lower administrative costs, less uncompensated care, and the millions of U.S. residents enrolled in the CHOICE program. We also anticipate that providers will actively encourage their patients to enroll in CHOICE, so providers can receive higher payments than have been available from HMOs and Medicaid. Under CHOICE, providers will be less burdened with paperwork and administration, and they will have the freedom to refer patients to specialists and other ancillary and rehabilitative services as they deem necessary, without any requirements for preauthorization, approvals, or referrals.

7. Provider Payments

All health care providers and facilities will be paid at rates equal to 100 percent of Medicare payment rates (for example, RBRVS for physicians and DRGs for hospitals). No physicians, medical groups, or hospitals contracting with the CHOICE Network will be paid capitation payments.

Rationale. Providing all providers with 100 percent Medicare payments will result in increased payments to providers for patients now covered under Medicaid and S-CHIP. Uncompensated care for health care providers and facilities will decline, and payments to physicians and hospitals for CHOICE enrollees who are eligible for Medicaid will increase substantially. This approach achieves equity in payment to providers, regardless of patient's source of financing. It will also help to ensure an adequate supply of providers to serve all CHOICE enrollees, regardless of their source of financing, which has been a significant problem under Medicaid.

[36] Ibid.

8. PCP Selection

The CHOICE Network allows enrollees to select any participating provider at any time. Enrollees will be required to select a primary care physician (PCP) who will be held accountable for provision of recommended preventive care and chronic disease management. Enrollees will not be required to obtain a referral/authorization from their PCP to visit a specialist or receive any other covered services. Enrollees may change their PCP at the beginning of each calendar year, and the new PCP must notify the CHOICE program of the change.

9. Contracts with Organized Delivery Systems (ODSs)

Under the CHOICE program, the only ODSs with which a state may contract are group- and staff-model HMOs. Participating ODSs will be required to offer the CHOICE program standard benefits package to CHOICE enrollees, but they may offer additional coverage as well. States also may elect to contract with Medicaid managed care plans operating in their state.

While the CHOICE program will not contract with any independent practice associations (IPAs)/network-model HMOs, point-of-service (POS) plans, or preferred provider organizations (PPOs), all state-licensed U.S. disability insurers or health plans will be encouraged, through federal tax incentives, to create new group- or staff-model HMOs that may contract with the CHOICE program in each state. For purposes of this proposal, a group-model HMO is any health services plan that offers an exclusive multi-specialty network of physicians (who provide services only to that one carrier's enrollees). ODSs will be paid an age-, sex-, and risk-adjusted capitation payment to address any adverse selection in the market. Self-funded employer plans will be exempt under the Employee Retirement Income Security Act (ERISA) from the risk-adjustment process.

Formation of these new partnerships will require time to implement. Carriers and multi-specialty groups that partner to form new group-model HMOs will be required in year one to have at least 30 percent of the multi-specialty group's enrollment be through the partner carrier's plan, increasing to 50 percent at the end of two years, 70 percent at the end of four years, and 100 percent at the end of five years, thereby achieving exclusivity.[37]

We also assume that disability insurers and health care services plans will develop supplemental products to offer additional coverage beyond what is provided in the CHOICE standard benefits package and will try to develop and market low-cost products to compete with the options available under CHOICE. In addition, it is expected that many states will contract with private health insurers to perform administrative functions under CHOICE, including claims processing, benefits coordination, and payments to providers.

Rationale. The ultimate goal of these provisions is to retain the option of organized delivery systems under the CHOICE program and to establish competing exclusive multi-specialty groups of physicians who practice in ODSs and who see only patients who are enrolled in the partner carrier's plan. It is through their ability to increase benefits beyond those offered through the CHOICE Network that ODSs will best be able to compete against each other and the CHOICE Network in the reformed market. To the extent that Medicaid recipients would like to continue to receive their medical care through Medicaid managed care plans, and other individuals and families living in their service areas would like to be able to enroll in them, the CHOICE program will give states this option in designing their programs.

[37] S. J. Singer and A. C. Enthoven. "Structural Problems in Managed Care in the U.S. and Some Options for Ameliorating Them." *The U.S. Management Review 43* (1) (Fall 2000): 50–65.

The CHOICE program will not contract with IPA and network-model HMOs and other forms of managed care because they have been shown to be associated with a number of problems with respect to the efficient delivery of high-quality care.[38] Major efficiency problems with IPA/network-model HMOs include their inability to negotiate with or select high-quality, efficient medical groups; their lack of physician loyalty, cohesion, and leadership; their redundant and often contradictory rules and processes; their lack of investment in the health care delivery system; and the insulation of medical groups from efficiency-enhancing market competition.[39]

A random sample survey of consumer experiences in managed care in California found that individuals enrolled in IPA/network-model HMOs reported significantly more problems in getting needed care than those enrolled in group-model HMOs or PPOs.[40] In another survey of callers to California's Ombudsman Service, consumers in IPA/network HMOs reported problems at a rate three times higher than that for consumers enrolled in group-model HMOs or PPOs. [41] As a result of the problems inherent in IPA/network-model HMOs, there is also substantial dissatisfaction among physicians contracting with these plans.[42]

Under CHOICE, the federal government will use tax incentives to encourage formation of new group- and staff-model HMOs, giving Americans more options for getting their health insurance and medical care through ODSs. These new partnerships between carriers and exclusive multi-specialty groups will relate to one another in a way similar to that of the Kaiser Foundation Health Plan and the Permanente Medical Groups. In this type of arrangement, insurer and the physician incentives are better aligned, so they work in partnership to match resources to the needs of the population served; to offer comprehensive services in the most appropriate setting; to integrate and share information systems; to improve care processes; to conduct evidence-based utilization management, formulary development, and continuous quality improvement; and to manage cost-benefits trade-offs.[43]

The goal of the CHOICE program is not to put insurance companies and health plans out of business but, rather, to try to redesign the system so the products they offer provide accessible, comprehensive, coordinated care as well as to take advantage of the expertise of health insurers in performing specific administrative functions. Both the group and individual health insurance markets will continue to operate and sell their products under the CHOICE program, but they will have to compete with options under CHOICE that will be available to all U.S. residents.

10. Community Outreach

The federal government will develop materials and buy media time for a national mass media campaign on the CHOICE program. In addition, states will conduct extensive community outreach through schools, health care providers, and facilities to enroll eligible persons in Medicaid, S-CHIP, or the CHOICE program. As stated earlier, any uninsured individual may be enrolled in CHOICE at the site of care through an automated verification system; and health care providers will be paid 100 percent Medicare payments for the care they provide. The CHOICE program in each

[38] Ibid.
[39] Ibid
[40] H. H. Schauffler et al. "Differences in the Kinds of Problems Consumers Report in Staff/Group Health Maintenance Organizations, Independent Practice Association/Network Health Maintenance Organizations, and Preferred Provider Organizations in the U.S." *Medical Care 39*_(1) (2000): 15–25.
[41] "Real Problems and Real Solutions: Making the Voices of Health Care Consumers Count." Health Rights Hotline (1999).
[42] Chebab et al. "The Impact of Practice Setting on Physician Perceptions of the Quality of Practice and Patient Care in the Managed Care Era." *Archives of Internal Medicine 161* (2): 202–211.
[43] Singer and Enthoven op cit

state will coordinate with other state-administered health insurance programs in implementing their outreach programs to enroll all U.S. residents in eligible programs. To this end, the CHOICE program will work with employers as well to inform all workers about their eligibility.

The CHOICE program will work with other state-administered health insurance agencies in the state in contracting with hospitals, physician offices, medical groups, and clinics, as well as pre-schools and elementary and secondary schools, to ensure that persons seeking medical care who are eligible for state programs enroll and receive health insurance benefits. All licensed hospitals, clinics, and other health facilities will be prepared to instruct any uninsured patient to apply for the CHOICE program as well as Medicaid and S-CHIP. The individual can self-certify his or her eligibility and may allow an application for enrollment to be submitted while he or she is in the hospital, clinic, or facility. Women who give birth at a hospital, clinic, or facility will be similarly informed and provided an opportunity to submit an application for themselves and their child.

Additionally, pre-schools and public elementary and secondary schools will inform the parent or primary caretaker living with each child at least once each year about the CHOICE program, Medicaid, and S-CHIP. Information will include eligibility requirements, and an application may be submitted at the education facility. There will be a simple, uniform mail-in application and enrollment process as well as an electronic enrollment option for CHOICE, Medicaid, and S-CHIP.

Rationale. The CHOICE program will permit health care providers to make eligibility determinations for a patient using an automated eligibility system. Providers will receive payment for all services provided to patients enrolled in this way, even if the patients are later deemed to be ineligible. Since about 55 percent of uninsured persons seek medical care each year, it is conservatively estimated that half of them will acquire coverage through this process.[44] This would result in a 28 percent reduction in the number of uninsured adults and children in non-working families who are eligible for Medicaid and S-CHIP but are not enrolled.

11. Regulation of Employers and Health Insurers

Regulation of employer-offered coverage will not be affected by adoption of the CHOICE program. Existing state agencies charged with this responsibility will continue to regulate HMOs and disability insurers.

Benefits

1. Initial Standard Benefit Package

The Kaiser Foundation Health Plan standard benefits package in the large-group market in California will be the benchmark for health benefits under the CHOICE program. These benefits include, but are not limited to, coverage of hospital care, outpatient care, prescription drugs, preventive care, chronic disease management, maternity care, mental health care, supplies and supplements, ambulance services, dialysis care, alcohol, tobacco and/or drug dependency treatment, durable medical equipment, emergency care and out-of-area urgent care, family planning, hospice care, vision care, health education, hearing care, home health care, imaging, lab tests and special procedures, ostomy and urological supplies, physical, occupational and speech therapy, multidisciplinary rehabilitation, prosthetic and orthotic devices, reconstructive surgery, skilled nursing facility care, and transplants.

2. Wrap-Around Coverage

To ensure that no one will lose any benefits for which he or she is eligible under current pub-

[44] The Lewin Group, Inc. Analysis of 1998 MEPS data.

lic programs (for example, long-term care under Medicaid and dental care for children under S-CHIP), supplemental or wrap around coverage is provided for anyone who is eligible for a state or federal insurance program with benefits beyond those covered under CHOICE.

3. Payments for Covered Services

Payments for covered services will only be made to health care providers that contract with the Statewide CHOICE Network and to ODSs that contract with the CHOICE program. Payments for out-of-network providers will be made for CHOICE enrollees only for emergency and out-of-area urgent care.

4. Experimental Treatments

The CHOICE program seeks to encourage the development of new treatments and therapies that advance the practice of medicine. As such, it will cover experimental treatments, as long as the treatments are being provided within the context of an Institutional Review Board -approved randomized controlled clinical trial.

5. Pharmacy Benefits

Pharmacy management is a critical aspect of both cost and quality of care. A federal pharmacy and therapeutics committee, comprising independent physicians, pharmacists, consumers, and others, will oversee the CHOICE formulary process. Prescription drugs under the CHOICE program will be purchased through the FSS, which will make them much more affordable compared to current market prices.

6. Copayments

No copayments will be required for receipt of covered clinical preventive services (screening, immunization, or counseling services) in the CHOICE program. There will also be no copayment requirements for enrollees who select the CHOICE Network and whose annual wages are less than 150 percent of the federal poverty guideline. For enrollees in the CHOICE Network whose coverage is financed in part through Medicaid or S-CHIP, copayments will not exceed the requirements under these programs.

Copayments for enrollees who select the CHOICE Network and whose annual wages are above 150 percent of the federal poverty guideline (and whose coverage is not financed by Medicaid or S-CHIP) will be set initially at $10 per outpatient visit.[45] Emergency room copayments will be $35 per visit. There is no copayment, deductible or coinsurance for inpatient care.

Drug copayments for enrollees who select the CHOICE Network and whose annual wages are above 150 percent of the federal poverty guideline (and whose coverage is not financed by Medicaid or S-CHIP) will be $10 per prescription per month. Copayments for those enrolled in CHOICE Network with incomes below 150 percent of the federal poverty guideline will be waived. Participating ODSs may design their own copayment requirements for prescription drugs.

7. Updating Benefits over Time

An independent federal panel of experts composed of physicians representing the major specialties will be established to advise the CHOICE program on coverage for specific interventions, treatments, or drugs that should be added to or removed from the standard benefits package. The panel will meet at least annually to consider new drugs and treatments and to review scientific evidence on their efficacy, effectiveness, relative cost-effectiveness, and impact on the public's health. Only those drugs and devices that have received U.S. Food and Drug Administration (FDA) approval will be eligible for consideration.

[45] Fifty percent of covered workers in HMOs in 2001 had a copayment requirement of $10; see KFF/HRET Employer Health Benefits 2001 Annual Survey.

Rationale. A comprehensive standard set of benefits is one of the keys to the CHOICE program. Health benefit design sits at the center of the debate over trade-offs among access, choice, quality, and costs. Health benefit design is the determination of what is covered by insurance and what is not. The Kaiser Permanente Health Plan group-market benefits package was selected as the initial benchmark because it is relatively comprehensive, was determined through a clinical review process, and was designed to promote the health and meet the medical care needs of the covered population.

One of the primary drivers of improvements in health care quality and growing health care costs is the increasing availability of new technology and pharmaceuticals, including diagnostic and therapeutic interventions. For example, direct-to-consumer advertising has increased patient demand for specific drugs and treatments, as have the actions of political advocates who have pressured state governments to mandate coverage of specific services or prescription drugs for groups with particular conditions.[46] The result is often an irrational process for determining which services and treatments are covered.

CHOICE offers a more rational framework for determining what new technologies and pharmaceuticals will be covered. To preserve affordability and prevent erosion of comprehensive benefits, selection of benefits will be based on evidence that establishes the likelihood that a given procedure, intervention, or drug will produce genuine health benefits. CHOICE also must enable coverage of interventions based on the cost-effectiveness of the procedure, intervention, or drug compared to other comparably effective therapies for the same condition or symptom complex. The decision-making process also needs to exclude from coverage treatments deemed to be inappropriate for insurance coverage because the benefit of including them is limited or is far outweighed by the cost and the effect on the affordability of the benefit package.

The CHOICE program would achieve nearly universal coverage (95 percent) while ensuring stable aggregate risk pools and an evidence-based approach to covered benefits. Under these circumstances, it is feasible to provide broad access to a comprehensive benefits package that is likely to produce desired health outcomes in a cost-effective manner. Such a benefits package would minimize obstacles to receiving effective treatments and would promote access to appropriate health-value-added care, including primary prevention, early disease identification and treatment, and management of chronic conditions.

This approach is highly preferable to using the blunt policy tools of higher and higher deductibles, coinsurance, and copayments. The research shows that these tools do reduce utilization, but they are indiscriminate—reducing the use of both appropriate services and marginal, low-value services to the same degree. The CHOICE program would enable ODSs and health care providers to compete based on effectiveness and efficiency of care delivery and health status improvement, rather than on underwriting, risk avoidance, cost shifting and risk pool manipulation, all of which the current system encourages.

Quality and Data Incentives

1. Patient Care Management

Disease Prevention

The CHOICE program covers all evidence-based clinical preventive services.[47] CHOICE Network providers will agree to implement patient education efforts and reminders to ap-

[46] H. H. Schauffler. "Politics Trumps Science: Rethinking State-Mandated Benefits. *American Journal of Preventive Medicine 19* (2) (2000): 136–137.

[47] US Preventive Services Task Force. Guide to Clinical Preventive Services. Second Edition. (Baltimore, MD: Williams and Wilkins). 1996.

propriate segments of the population (for example, women 18 and older for Pap smears every three years). PCPs in the CHOICE Network, and ODSs that contract with the CHOICE program, will be encouraged to ensure their patients receive all recommended preventive services at recommended intervals and, at a minimum, record that the services were provided. Physicians in the CHOICE Network will be required to submit claims electronically for each preventive service provided, which will enable analysis of claims data for quality assessment. In addition, preventive services utilization will be included in quality performance measures that are linked to provider incentives.

Management of Chronic Conditions

The CHOICE program will notify its enrollees and network providers of those provider organizations that sponsor approved disease management and self-care programs. Patients will be encouraged to participate in disease management programs through reductions in or waivers of copayments. The CHOICE program also will evaluate the option of carve-out disease management programs that have a proven record of success (for example, care for patients with AIDS). The CHOICE program will encourage patient participation in these programs by using similar incentives as those for provider-sponsored disease management programs. Additional incentives may be offered for patients who continue in a given program for a specified period. For example, a patient with cardiac disease who continues to follow a provider group's approved protocol for three years may receive a premium discount.

Centers of Excellence. All enrollment materials will highlight hospital centers of excellence for high-volume, high-cost procedures for which the literature indicates a correlation to quality. The CHOICE program will contract in-network only with those facilities that meet or exceed evidence-based standards for these select services. Where outcomes are not yet available, volume data will be used when appropriate, and network hospitals will be required to participate in any scientific outcome studies. Examples of conditions for which there are existing data for Centers of Excellence include transplants, coronary artery bypass graft surgeries, and neonatal care. Approved trauma centers (for example, burn units) and centers of excellence will also be used for catastrophic care.

2. Provider Performance Measurement and Improvement

Quality Performance and Improvement

High-value providers will be recognized during enrollment, at annual renewal, and throughout the year for their performance on quality performance measures (see below for provision of such information and bonus incentives). In areas for which several years of comparative data are available, high-value providers will be recognized. In the interim, providers will be recognized for improvements as well as for participating in quality measurement programs.

Data and Information

There is a paucity of comparative provider performance information. Such studies often take several years to produce meaningful results and require substantial resources. As a requirement for in-network selection for the CHOICE program, providers will submit relevant electronic data to participate in a study or studies related to their practice.

3. Patient Incentives

Financial Incentives

Plan design is one of the most effective means of influencing patient behavior. Certainly, limiting coverage to in-network providers (except in emergencies) will encourage enrollees to see providers who are willing to provide cost and quality data. As mentioned above,

copayments can be waived or reduced for patients who elect to participate in disease management or self-care programs. Copayments will be waived for all preventive services.

Other Incentives

Additional patient incentives related to quality will include aggressive promotion of educational opportunities. All media, including print, the Internet, phone, and in-person discussions, will be used as appropriate. The patient's condition, language, cultural perspective, health literacy, disabilities, and preferences will be taken into consideration. For example, rather than require a newly diabetic teenager to modify his or her eating habits dramatically, the teen can learn how to count the number of carbohydrates in whatever he or she wants to eat and adjust the level of self-injected insulin accordingly.

Several off-the-shelf, highly regarded educational products will provide patients with evidence-based treatment option comparisons and structured clinical decision support. These include consumer videotapes from the Dartmouth Outcomes Project, condition-specific disease management materials, and commercial software from Healthwise. This type of information can be made available through a nurse advice line, in addition to print and Internet materials.

4. Provider Incentives

Financial Incentives

After the first year of participation, bonus incentives will be paid to providers based on (1) their performance on quality and performance measures, (2) improvement on quality and performance measures, and (3) participation in quality-of-care studies. A bonus scheme will be developed with advice from the provider community and will be paid on top of the Medicare payment rates. It is anticipated that the bonus will reach 10 percent over a three-year period.

Other Incentives

Other incentives include year-round recognition through press releases, an annual recognition event, and publicity during enrollment. This recognition, in conjunction with financial incentives, will strive to provide enrollees with information on "best of class" providers when they need to make decisions about care.

Rationale. Measurement of quality at the physician group, individual physician, and hospital levels is still in its infancy. The quality measurement tools available today across all levels focus on patient satisfaction with care and perceived quality. Physician group measures in the United States include population health status and measures across select diseases/conditions as well as utilization of preventive care. Hospital measures include C-section and perinatal mortality rates, coronary artery bypass graft (CABG) mortality rates, and several Medicare quality indicators. The CHOICE program will work with organizations across the country that provide comparative provider performance information to make such information interactive and available in a variety of media for enrollees all across the country.

The above approach differs from traditional fee-for-service care because of the way cost and quality are factored into the CHOICE program. First, physicians participating in the statewide CHOICE Network will be required to report on both quality and cost measures and to participate in quality studies. Second, the CHOICE Network will include incentives for patients to migrate to relatively high-quality providers and to actively manage their own health. Creation of consumer and provider incentives for both cost and quality—that is, value—as part of the CHOICE Network distinguishes delivery of care in this model from others available in today's U.S. marketplace. In addition, all health plans offered by the CHOICE program will be required to meet any applicable standards issued by the National Committee on Quality

Assurance, to provide quality data, and to participate in quality studies.

Implementation and Transition to the Future

No federal waivers are required to implement the CHOICE program, no ERISA waiver is required to adopt a new federal payroll tax, and there is no individual or employer mandate to have health insurance coverage.

1. Implementation Steps for States

Implementation of the CHOICE program will require each state to:

- Designate a state agency to administer the CHOICE program.
- Contract with licensed health care providers and facilities that elect to participate in the statewide CHOICE Network.
- Contract with ODSs (licensed staff- and group-model HMOs) and develop an age-, gender-, risk-adjusted capitation payment.
- Simplify and coordinate an administrative process for enrollment and eligibility, including self-certification with paperless verification and electronic application.
- Institute a system for collecting the monthly worker share of premium.
- Develop and implement a community outreach strategy to inform residents about CHOICE and how to enroll and to increase enrollment in Medicaid and S-CHIP for those who are eligible.
- Develop an electronic application that will enable providers to enroll patients at the site of care.
- Implement an electronic claims processing and review system.
- Develop a process for review of claims with respect to quality and costs.
- Institute a system for processing claims electronically and a payment system for health care providers in the CHOICE Network.
- Develop a fee structure for licensed insurance brokers who enroll those who are self-employed and small firms (fewer than 50 workers) in the CHOICE program.
- Submit a proposal for review and approval by the U.S. Department of Health and Human Services that demonstrates all of the above conditions have been met.

2. Implementation Steps for the U.S. Department of Health and Human Services

- Develop a national media campaign to increase awareness, knowledge, and understanding of the CHOICE program and how to enroll, including a national media buy over a six-month period on all major network and cable outlets.
- Review and approve a CMS national Medicare demonstration project to permit elderly Medicare beneficiaries to enroll voluntarily in CHOICE and pay their income-based share of premium.
- Appoint a CHOICE National Benefits Panel to review, at least once a year, new treatments, drugs, and technologies that have been demonstrated to be effective and relatively cost-effective in improving health and maintaining and increasing quality of life. Based on this review, update the CHOICE benefit package to reflect the best and most current evidence-based science.
- Institute a system for collecting the quarterly employer payroll tax, distribute each state's revenue to the appropriate administrative agency, and issue tax refunds to eligible firms.
- Collect and distribute the federal taxes from tobacco, alcohol products and soft drinks to the states.
- Develop an age-, sex-, risk-adjusted capitation payment for ODSs.
- Arrange for bulk purchasing of prescription drugs and medical devices through the FSS.
- Review and approve each state's program's regarding its compliance with the provisions of the CHOICE program prior to before releasing federal money to the states, and

monitor state compliance with program rules over time.

Changes to the Existing System

1. Impact on Existing Coverage and the Health Care Market

Adoption of the CHOICE program does not automatically replace any existing coverage. However, it does provide all non-elderly U.S. workers and their non-working dependents, including those who are eligible for S-CHIP and Medicaid, as well as elderly Medicare beneficiaries with the option of replacing their current coverage with the CHOICE program, if they choose.

The CHOICE program leaves in place Medicare, Medicaid, S-CHIP, employer-sponsored coverage, and the private group and individual health insurance markets. However, through the voluntary actions of workers and their families and health care providers, and as a result of outreach to individuals eligible for but not enrolled in S-CHIP and Medicaid, the CHOICE program is likely to increase overall coverage rates to approximately 95% percent of all U.S. residents, regardless of their legal status, within one year of implementation. At the same time, the CHOICE program offers employers strong economic incentives to move much of their covered population into the CHOICE program.

We anticipate that following the implementation of the CHOICE program, the number of persons covered by commercial PPOs and IPA/network -model HMOs will decline, and the number of employers who offer health benefits will decline. Within a year of implementation, it is estimated that the number of persons receiving their health insurance through their employer in the group market will decline dramatically. In addition, the number of U.S. residents purchasing private health insurance in the individual market will also decline, as individuals understand that coverage under CHOICE is both more affordable and more comprehensive, with a much broader choice of providers. The individual health insurance market will try to compete with the CHOICE program, but it may not be able to do so effectively unless the health plans can develop and sell a product that is less expensive than and competitive with the benefits, out-of pocket monthly premium costs, and co-payments under the CHOICE program. It is estimated that enrollment in Medicaid and S-CHIP will also drop as well (although financing through these programs will continue), as individuals eligible for these programs move into the CHOICE program.

In addition, the CHOICE program offers federal tax incentives to health insurance carriers and health plans to partner with multi-specialty groups in exclusive arrangements to create new group-model HMOs in the United States. It is likely that the group-model HMO market will grow through the formation of new ODSs to compete with the existing group- and staff-model HMOs in each state. Commercial health plans will also have the opportunity to develop and market supplemental products for coverage that exceeds the standard CHOICE benefits package.

2. Impact on the Safety Net

Safety net providers will be less dependent on direct state subsidies for indigent care, because they will be providing services to a predominantly insured population. They will also be paid at a higher rate for indigent care for the remaining uninsured population. Each state will maintain its commitment to safety net providers through continued state and federal funding for indigent care programs for those who remain uninsured. In addition, safety net providers will be strongly encouraged to participate in the CHOICE Network in their state. Those who do so will be reimbursed at Medicare payment rates, which are more than 50 percent higher than rates currently paid by Medicaid and considerably

higher than is currently available through indigent care funding.[48] In addition, states have the option of permitting Medicaid managed care plans to contract with the CHOICE program. Thus Medicaid recipients now enrolled in managed care plans could stay in them, and the plans would be newly accessible to others in the areas they serve. In addition, they would receive risk-adjusted capitation payments that are significantly higher than Medicaid payment rates.

Political Feasibility

Like any proposal that seeks to accomplish major reform of the U.S. health care system, there will be winners and losers. Though the potential losers can be expected to oppose the CHOICE proposal, it may be unique in that it is likely to find much broader support than previous proposals because of its voluntary approach and the absence of restrictions on individuals, employers, health insurers, and health care providers. However, it will face strong opposition from at least two very powerful interests—the private health insurance industry and the pharmaceutical and medical device industries, whose profit margins are likely to be negatively affected once the CHOICE program is fully implemented.

There is probably nothing that can be done about opposition by the health insurance industry in particular because, even though it will still be able to sell its products in both the individual and group markets, it will lose substantial market share to the CHOICE program in both markets. However, there will be new opportunities for industry members to partner with large multi-specialty groups to form new ODSs as well as opportunities to develop and market supplemental products that offer coverage beyond that included in the CHOICE standard benefits package. In addition, health insurers will have the opportunity to contract with states to serve as third-party administrators in processing claims and payments, coordinating benefits, and performing other administrative functions. However, none of this is likely to temper the industry's opposition to the CHOICE program. In defending CHOICE against attacks, proponents need to stress that it offers Americans much broader access to choose any doctor or hospital they want, with much more comprehensive benefits, at a cost that is affordable and reasonable, and their health care providers will be compensated at a fair rate and will be able to practice medicine without interference by managed care administrators. It is a win-win situation for them and their doctors.

However, health care providers may be split in their support of CHOICE. While many may welcome a single administrative structure and single set of rules for providing services and receiving payments, as well as the freedom to make their own medical decisions about what is in the best interests of their patients, others may be concerned that a single payer may reduce their payments over time. Instead, most health care professionals, particularly physicians who serve Medicaid patients and currently serve a substantial proportion of managed care enrollees, will be much better off, not only financially, but also in terms of reduced administrative burden, as a result of returning medical decision making to their hands and eliminating prior approval, authorizations, or appeals of denied services. In addition, reporting requirements, particularly for quality measures, will be simplified enormously as a result of fee-for-service payments and electronic claims processing. Not only are Medicare payments likely to be much higher for many of their patients, but bad debt and uncompensated care will be virtually eliminated.

There is likely to be some opposition among health care providers who fear the federal government will have too much power in determining Medicare payment schedules.

[48] The Lewin Group (March 2002), op. cit.

However, historically, Medicare has been a much more generous payer than the state-run Medicaid programs. In addition, the political coalition of consumers likely to develop as a result of adopting the CHOICE program is expected to be even more powerful than AARP, which developed following enactment of Medicare, and should be able to exert a tremendous amount of political pressure, along with the health care provider interest groups, to keep Medicare payment rates reasonable and equitable.

Most hospitals are also likely to look favorably on the CHOICE program because they will receive higher payments for Medicaid-eligible patients, will not receive any capitation payments, will have nearly all bad debt and uncompensated care eliminated, should see drastic reductions in the use of emergency rooms for non-emergency conditions, will be able to finance operation of their trauma centers, and will be recognized for the acute care areas where they excel. In addition, hospitals will face less of an administrative burden because they will be working primarily with a single payer in submitting claims and receiving payment, and quality assurance and assessment will be easier as a result of electronic submission of claims data, facilitating review of quality and costs. In addition, public hospitals will greatly benefit because the vast majority of their clients will be insured under CHOICE, and they will have a stable source of revenue to meet their patients' medical care needs.

Academic medical centers are likely to favor the CHOICE program because it will cover experimental treatments, as long as they are conducted within the context of an IRB-approved randomized controlled clinical trial. Thus, a substantial new source of revenue to support research and innovation in medical care will be available following adoption of the CHOICE program.

Opposition by the pharmaceutical and medical device industries is likely to be strong because all covered prescription drugs and medical devices will be purchased through the FSS. However, it may be possible to soften some of this opposition if the prices paid under CHOICE still enable these industries to make a reasonable profit. Since the quantity of products purchased under the CHOICE program is likely to increase substantially given nearly universal coverage, it does not seem unreasonable that their margins should decline commensurately. The key to gaining their support will be to set prices in such a way that they will continue to deliver a return on investment to their shareholders.

The vast majority of the business community is also likely to favor the CHOICE program. Those who currently offer coverage may continue to do so, but the CHOICE program gives them the opportunity to get out of the business of administering health benefits and bearing the associated financial risks. In most cases, the CHOICE program will offer a firm's employees an option for comprehensive health insurance coverage with much greater choice, with coverage as rich as, if not richer than, that they currently have, and with much lower patient cost sharing, at a reasonable price. The coverage is also a bargain for the employer.

However, there may be substantial opposition from the Chamber of Commerce and the National Federation of Independent Businesses with respect to imposition of a payroll tax on small firms. Even though the majority of U.S. firms, including small firms, offer their workers health benefits, and the CHOICE program will enable these firms to provide more comprehensive benefits for their workers at a lower cost than they pay now, organizations representing small-business interests are likely to view any scheme that imposes new taxes on firms as unacceptable. Under the CHOICE program, small firms will be subject to a 5.5 percent tax on total payroll, but it is not clear how this will play out. Many small employers would like to offer their workers

health insurance coverage but cannot afford the prices. The payroll tax is substantially less than the cost of coverage in the small- and large-group markets. In addition, as previously mentioned, high-wage firms are likely to continue to offer their workers health benefits that are more attractive than the CHOICE program to avoid paying more through the payroll tax for health care than they do now through self-insurance or purchasing group products. Firms also may worry that as costs increase, the payroll tax will creep up, but their costs are likely to increase regardless of how they participate in employer-sponsored health benefits. Their premiums in the group-health insurance market are increasing now at double-digit rates. In addition, any increased costs imposed on employers under CHOICE will be tempered by the ability to spread them across the many different sources of revenue for the CHOICE program, including the employee share of the premium and the state and federal sources of revenue as well as new sources of revenue, including new public health taxes. Under the current system, when health insurers increase group premiums, there is no way for employers to share the burden of increased costs except to shift them onto employees.

Compared to a uniform federal program, a federal-state model of shared responsibility in achieving universal coverage is much more likely to be politically acceptable both to state legislators and to Congress. The success of S-CHIP suggests that the federal government can play an important role in defining the framework and options for broad expansions and reform of the health care system, including eligibility determination, outreach, and enrollment, leaving the details regarding administration, interagency coordination, regulation, and quality assessment and assurance to each state. In fact, individual state programs might look quite different under CHOICE. In some states, the CHOICE program, once fully implemented, may resemble a single-payer plan, where the state contracts with all private and public providers in the state as part of the CHOICE Network with no ODS options. This scenario is particularly likely to occur in states where there are no staff- or group-model HMOs and no large multi-specialty groups facilitating their creation. In other states, once fully implemented, the CHOICE program may resemble Alain Enthoven's original vision of managed competition[49], with many organized delivery systems made up of exclusive groups of providers in partnership with an insurer competing against each other for enrollment of the population living and working in their service area, with the majority of providers in the state participating in one ODS. Most state programs probably will fall somewhere in between these extremes, with a choice of several ODSs, but with the majority of the health care providers contracting with the CHOICE Network.

Many states are likely to welcome the program because it enables them to solve an enormous problem without requiring that they raise any new state revenue, and to streamline administration and reduce costs associated with existing public insurance programs. In addition, states will be eligible for considerable amounts of federal revenue generated from the payroll tax, public health taxes, and the NAFTA Social Integration Fund to solve what has been an intractable problem—reaching near-universal health insurance coverage and offering comprehensive and affordable coverage to all residents in their state. However, states also will face a number of new administrative challenges, which some states will be able to meet better than others.

It is unlikely that any comprehensive national health care reform proposal will be enacted in the foreseeable future, despite the fact that the number of uninsured is growing,

[49] Enthoven, AC. Health plan : the only practical solution to the soaring cost of medical care. (Reading, Mass: Addison-Wesley Pub. Co.) 1980.

health care is becoming more expensive, and the issue is increasingly on the public agenda. However, given the current revenue shortfalls at the federal and state level and the attention being given to fighting terrorism at home and abroad, Congress is unlikely to tackle the problem of the uninsured and underinsured, with perhaps the exception of working to pass some kind of pharmacy benefit under Medicare. While it is likely that comprehensive national health care reform will become a more dominant issue in the 2004 presidential election, until the U.S. economy improves and there is a change in leadership at the national level, the problem of the uninsured is likely to continue to worsen and to be excluded from the formal policy agenda. However, this political reality does not mean that we should stop working on new proposals to solve this ongoing problem. One of the important lessons from the failed Clinton health care reform effort was that there was not a viable and acceptable policy solution ready to go with a broad base of support when the policy window opened.[50] In addition, strategies for responding to opposing interests and framing the debate were not well developed, and the battle to win public opinion was ultimately lost. Understanding where is the most likely a strong base of support on which to build a broad-based coalition and anticipating the sources of opposition and how they will try to reframe the debate will be key in winning this war.

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[50] Kingdon, JW. *Agendas, Alternatives and Public Policies.* (New York. NY: Harper Collins) 1984.

Seltman

Key Elements

Paul A. Seltman proposes to build on the current employer-based system to expand insurance coverage to all private sector workers. The proposal includes the following elements:

ESTABLISH ANNUALLY INCREASING, NATIONAL COVERAGE FLOORS specifying the percentages of workers that employers must insure.

ESTABLISH AN ALLOCATION AND TRADING SYSTEM IN "ALLOWANCES," which permit employers not to insure limited percentages of their workforces, consistent with the national coverage floors.

MINIMIZE EMPLOYERS' COMPLIANCE COSTS by giving them flexibility in meeting coverage deadlines and designing health benefits packages.

PROVIDE PREMIUM SUBSIDIES for employees up to 200 percent of the federal poverty level.

ESTABLISH STATE-BASED, MANDATORY PURCHASING POOLS for firms with fewer than 25 employees.

ENFORCE COMPLIANCE THROUGH MONITORING AND PENALTIES implemented by the Department of Health and Human Services.

FINANCE THE POLICY WITH FEDERAL GENERAL REVENUES, "SIN" TAXES, USER FEES, AND PENALTIES, distributed to the states with matching requirements.

About the Author

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From Clean Air to a Clean Bill of Health: Using Allowance Trading under the Clean Air Act as a Model for Covering All Private-Sector Employees

by Paul A. Seltman

Across the political spectrum, there remains widespread agreement that the failure to insure tens of millions of Americans is one of the largest problems facing the U.S. health care system. Unfortunately, the health policy universe of solutions to this problem is predominantly divided into two camps. One relies heavily on direct government intervention in the form of public insurance and regulation of the private insurance market, and the other relies on financial incentives and a reduction in government regulation to stimulate private market forces to "fix" the market. These camps have been dug into their positions for quite some time; this paper seeks to show both sides a way out.

Bridging the Gap between Two Paradigms

In the U.S. health care system, private employers finance most individuals' health insurance policies. Employers, however, are under no obligation to provide health insurance for their employees. In fact, more than 80 percent of uninsured Americans are either workers or live with workers, and among uninsured workers, 40 percent are employed by businesses with fewer than 25 employees.[51] While the lack of insurance coverage is not exclusively a small-firm problem, small businesses generally have fewer resources on which to draw to pay for such coverage. Therefore, a major policy question for our health care system is how to encourage and enable more employers—and small employers in particular—to offer health care coverage to their employees.

Some policy makers believe that if so many employers truly wanted or were able to cover more employees, workers would not comprise such a large portion of the uninsured population. Therefore, they favor an expanded Medicare- or single payer-type solution. But I strongly prefer an approach that would build on the good that so many employers in this country are already doing. Over time, through working with insurers and employee benefits managers, many employers have developed health insurance packages that are both attractive to their employees and reasonable in cost for themselves. Employers also have been a driving force behind health care quality improvement. Retaining innovative employers as key players in the health care system likely would be crucial to the success or failure of any large-scale effort to increase the number of insured workers.

Of course, building on the employer-based model to cover all private-sector employees would require some level of compulsory cov-

[51] Garrett, Bowen, Len M. Nichols, and Emily K. Greenman. *Workers Without Health Insurance: Who Are They and How Can Policy Reach Them?* Washington: The Urban Institute, September 1, 2001, pp. 2, 5. All of the data compiled in this study are based on an examination of "non-self-employed workers ages 18–64 from a combined sample of the February and March 1999 Current Population Survey (CPS). Like the study, this proposal would apply only to non-self-employed workers (see footnote 12).

erage by employers, which would likely be met with the now customary blend of skepticism, protest, and threats of wage and job losses. Nonetheless, I believe this resistance could be overcome with the right policy.

To bridge the gap between the two paradigms of universal coverage and move from voluntary employer-provided insurance toward mandatory employer-provided insurance, a market-based framework should be created, with flexible rules that pay homage to the differences among employers as well as a long implementation period. This solution would not only reverse the current trend of static or shrinking employer-based coverage and cost shifting to employees; it also would expand insurance coverage more broadly to all private-sector employees and possibly further. It would give some employers, whose business sectors historically do not offer health benefits to their employees, the opportunity to do the right thing for their workers without leaving themselves at a competitive disadvantage.

To find this potential solution, one need only look to the Clean Air Act for guidance and precedent, transferring (with appropriate adaptations) its logic and lessons learned to the health care sector for the benefit of all working Americans.

The Clean Air Act's Acid Rain Control Program and Allowance Trading

The Clean Air Act, codified as 42 U.S.C. 7401 *et seq*., was enacted to protect the environment and human health from emissions that pollute the air. Amendments to the Act in 1990 included establishment of an acid rain control program (title IV), which sets national goals for reducing annual sulfur dioxide emissions from power plants, by far the largest contributors to such emissions.

These emissions reductions have been imposed in two steps, with facilities generating larger amounts of sulfur dioxide having to meet specific emissions caps beginning in 1995 and all facilities having to meet a more stringent cap by 2000. As of the beginning of 2001, compliance had been close to 100 percent.[52]

The acid rain control program adopted a unique approach to emissions reduction.[53] First, it established an overall emissions cap that sets a nationwide limit on pollutant emissions. Second, it allocated those emissions to individual sources and allowed trading between them. As described by the General Accounting Office (GAO):[54]

> Unlike the traditional command-and-control approach, in which the regulator specifies how to reduce pollution or what pollution control technology to use, title IV gives utilities flexibility in choosing how to achieve these reductions…. Title IV also allows trading in emission allowances. Based on formulas in the law, each utility receives a fixed number of allowances. Specifically, an allowance is an authorization to emit 1 ton of SO_2. Once the allowances are allocated, the act requires that annual SO_2 emissions not exceed the number of allowances held by each utility plant. To meet this requirement, a utility can buy allowances, in effect paying other utilities to reduce SO_2 emissions below their allowed levels. For some utilities, buying allowances costs less than other approaches.

Utilities also can "bank" extra allowances for future sale or use.

Sound Theory Behind Cap-and-Trade Programs Underlies Success

Emissions cap and allowance trading programs achieve social goals while providing businesses with flexibility that traditional forms of regulation do not. The mandatory emissions cap achieves the social benefits by requiring firms to reduce pollution. The trad-

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[52] *Acid Rain Program: Annual Progress Report, 2000*. Environmental Protection Agency, Document EPA-430-R-01-008, 2001.

[53] A similar approach has been adopted for greenhouse gas emissions in legislation authored by U.S. Senator Joseph Lieberman (D-CT) and John McCain (R-AZ). See S. 139, "Climate Stewardship Act of 2003".

[54] General Accounting Office. *Allowance Trading Offers an Opportunity to Reduce Emissions at Less Cost*. Washington: GAO, December 1994, p. 2.

ing provisions allow firms to minimize their compliance costs.

More direct regulation results in higher compliance costs because it imposes identical or similar requirements on businesses without regard to their varying sizes, economic sectors, geographic areas of operation, or financial positions.[55] In contrast, cap-and-trade approaches respect these differences among firms by providing an environment in which national goals are set, but allowing firms to achieve these reductions in a variety of ways and by different timetables.

Cap-and-trade programs generally work as follows: First, an overall cap is established to set a national goal. In the context of this proposal, the goal is to increase the number of privately employed workers who have health insurance. That goal is expressed here as a decreasing cap on the number of uninsured workers and a corresponding increasing floor in the percentage of covered workers.[56]

Second, allowances are allocated to businesses. Each firm is allotted a certain number of allowances per year, according to a statutory formula and a firm's individual experience. An allowance is defined as an authorization not to do something—in this proposal, an authorization not to provide health insurance for one employee for one year. Once allowances are allocated, the annual number of uninsured, private-sector employees nationwide cannot exceed the number of allowances distributed to private-sector employers. If an employer is not able to insure a sufficient number of its employees to comply with its allowance allocation, the employer can buy allowances from other employers, effectively paying other firms for the right to insure fewer employees than the employer is required to by law.

The intended effect of allowance trading is to minimize compliance costs for employers. Trading allows firms whose financial position is relatively weak to literally buy time through the purchase of allowances and delay their compliance with statutory targets when the cost of an allowance is cheaper than insuring an employee. This flexibility for employers in allowance holdings and timing is the linchpin of this proposal.

Under this proposal, employers also would have the freedom to design health benefits packages. However, these benefits packages would be required to equal a specified minimum actuarial value, and employers would be required to cover at least 50 percent of employees' premiums. Furthermore, to help small firms pool their risk and increase their purchasing power in the private insurance market, state-based mandatory purchasing pools would be established for firms with fewer than 25 employees.

Of course, employees would be the real beneficiaries of this proposal. Workers earning up to 200 percent of the federal poverty level (FPL) would receive premium subsidies on a sliding-scale basis to cover some or all of their employee share of premiums, and, ultimately, all private-sector employees would be insured. Moreover, if employer compliance costs were lower than expected, more employees likely would receive benefits more quickly.

Translating Allowance Trading for the Private Health Insurance Market

Obviously, utility emissions are not the same as uninsured employees, and the strategies that utilities and other types of businesses may use to abate these problems also are very different. Moreover, emissions are acts of commission, not omission, as is the case with an employer that does not provide health in-

[55] *Overview and Issues on Emissions Allowance Trading Programs*. Statement of Peter F. Guerrero, Director, Environmental Protection Issues, Resources, Community, and Economic Development Division, General Accounting Office, July 9, 1997, p. 2.

[56] I have chosen a "negative" approach to constructing the cap—that is, the number of uninsured workers—because the traditional concept of allocating allowances to businesses is inherently "negative." Allowances are given to businesses to permit them to continue certain behavior that the government is otherwise attempting to moderate.

surance for its employees. Nonetheless, translated appropriately for the health care arena, a national allowance trading system has the potential to give private employers the financial and design flexibility to ultimately cover 100 percent of their employees with comprehensive health insurance.

Such a system would have multiple benefits. First, it would help employers to pay for the costs of insuring their workers. Second, it would help level the national health care playing field by reducing regional and economic sector differences in health care coverage. Third, the system could trigger behavioral responses that result in insurance coverage progressing faster than expected under this proposal. Fourth, the market's incentives should stimulate innovations in how employers finance and design employee health plans.

This proposal offers more hope to uninsured employees than many of the alternatives do. The status quo is not sustainable. In today's uncertain economic climate, with rising health insurance premiums, many employers are either dropping health coverage or shifting more health care costs to their employees. But an immediate employer mandate with little flexibility for employers on financing and benefits also would be unworkable and disruptive. This proposal attempts to find a market-based middle ground that would attract supporters across the political spectrum.

The proposal's major features are described below. In writing this proposal, I have attempted to confront a number of major questions that likely would be raised during the course of implementation. However, I have by no means covered all of them. In addition, because this is the first time that such a model has been presented in the health care context (to my knowledge), significant quantitative work must be done to determine the exact levels of funding needed to reach the proposal's stated objectives.

While I believe the allowance-trading model has the potential to provide the nation with a unique solution to the health care conundrum, I do not intend to present this proposal as the only way in which one might use allowance trading successfully. For example, this proposal's approach could be merged with so-called play or pay proposals, in which employers are required either to purchase health insurance for their employees or to pay into a public fund that would finance "fallback" health plans for uninsured workers.[57] Adding the additional option for employers to purchase allowances not to insure their employees would create a new "play, pay, or buy" approach. Allowance trading also could be used in proposals that would make states responsible for designing and administering health care financing systems that provide universal health insurance.[58] Under that type of model, allowances could be distributed to states instead of employers, and states would use and trade allowances during a long implementation period until they ultimately were required to cover 100 percent of their legal residents. As a final example, proponents of an individual mandate approach to providing universal health insurance could fold the allowance-trading concept into their model as well. Individuals could be permitted a transition period before they were required to insure themselves, and, in the meantime, they could purchase allowances through a government-sponsored auction instead. The proceeds from this auction would be used to pay for uncompensated care in the health care system. Thus, my true aim in writing this proposal is to introduce the allowance-trading concept into the mainstream of political and policy debate over health care reform.

[57] For instance, one could use the State Children's Health Insurance Program (S-CHIP) as the basis for a fallback plan.

[58] See Kronick, Richard, and Thomas Rice. "A State-Based Proposal for Achieving Universal Coverage." In *Covering America: Real Remedies for the Uninsured*. Washington: Economic and Social Research Institute, June 2001, pp. 121–34.

Building on Employer-Provided Coverage

This proposal to cover all private-sector workers builds on employer-based coverage by enabling all private employers to eventually afford health insurance for their employees after a long implementation period. During the implementation period, firms would be required to gradually lower their numbers of uninsured workers, according to declining capped levels, to meet minimum employee coverage rate targets. These minimum targets, or "floors," would increase every year. To help firms meet the floors, each year the U.S. Department of Health and Human Services (HHS) would distribute a declining number of "allowances" to firms not to insure specific percentages of their workforces. To the extent that a firm still could not meet such a floor, it could purchase more allowances from other firms or buy them at auction to avoid enforcement penalties. (The allowance allocation and trading system is described in the next section.)

Under this proposal, businesses would not be expected to provide health insurance for their employees any sooner than other firms with similar profiles. However, they would be required to put together health insurance benefits packages that are affordable and attractive to their workers.

While private employer participation would be mandatory, this proposal would give businesses far more flexibility and lower compliance costs than other employer-based proposals would. It would create a market-based mechanism for phasing in universal coverage for private-sector workers. While it may not silence all critics of employer mandates, the proposal would be far less disruptive to the economy than an immediate mandate or other comprehensive reforms would be.

National Coverage Floors

All private employers would be subject to national coverage floors, which would be effective beginning two years following the date of enactment. In the first year of program implementation, the national coverage floor would equal the average number of insured, privately employed individuals over the period 1996–2000 (using the Current Population Survey [CPS][59]). The national coverage floor for the year also would equal the coverage floor for "average-coverage" employers, and corresponding coverage floors for "low-coverage" and "high-coverage" employers would be calculated based on averages in these two groups over the same period. (These three categories of employers are defined and explained below.) HHS would calculate all floors, both as numbers of insured, privately employed individuals and as percentages of the private workforce.

After the first year of implementation, all coverage floors would increase every year by 1.5 percentage points. They would continue increasing until they reached 100 percent, at which point all private employers in a 100 percent coverage category would be required to cover all of their employees without exception.

Using a recent five-year period as a starting point for national coverage floors accomplishes two important policy goals. First, by using past years as a base, it prevents firms from gaming the system through purposely lowering their coverage levels as preparations are made to implement the new program. Second, by using a five-year average, it accommodates for the normal up-and-down swings

[59] While the Current Population Survey (CPS) is not the only source of federal data on the uninsured, it is widely used because it has the largest household sample size and provides credible state-level estimates. Also, among competing federal surveys, the CPS is most often criticized for overcounting the uninsured. Therefore, in the context of this proposal, using the CPS results in greater flexibility for employers: higher numbers of allocated allowances and a longer time frame in which to achieve 100 percent coverage of their employees.

of the business cycle that can affect employer-based coverage.

Based on CPS analyses, one could anticipate that employers would have somewhere between seven ("high-coverage" firms) and 20 ("low-coverage" firms) years to cover all of their employees.[60] For example, looking at national patterns, small firms likely would have a longer transition period than large firms, retail businesses a longer period than manufacturers, and Texas firms a longer period than Pennsylvania firms. All firms also would have the flexibility not to comply with annual coverage floors by buying the right to insure fewer employees, either from other firms or at an annual auction.

Under this proposal, provisions of the Health Insurance Portability and Accountability Act (HIPAA), Employee Retirement Income Security Act (ERISA), and state laws related to employer-provided health insurance would continue to apply. As an important example with particular relevance here, HIPAA's employee non-discrimination rules would remain in effect. Therefore, in deciding which employees to cover each time its floor increases and requires it to cover more employees, an employer would not be permitted to deny an employee eligibility for health insurance due to health factors such as health status and medical history. However, as current law allows, an employer could, in the short term, exclude from coverage part-time workers or workers with fewer than six months on the job. Ultimately, when its coverage floor reached 100 percent (or possibly sooner, since non-discrimination rules likely would not permit the employer to cover some part-time workers and not others), the employer would have to cover these workers, too. But in the short run, the employer could make the same eligibility distinctions allowed today. While these inequities are not ideal, they would be temporary, and they offer a distinct improvement over freezing current inequities in place.

Leveling the Playing Field for Businesses

One important barrier to employers offering health insurance coverage to their employees is that their direct business competitors might not do so. Lowering profit margins for the sake of employee benefits may not be wise if such an action places a business at a competitive disadvantage. Therefore, any employer-based plan to expand health insurance coverage must find a way to level the playing field for businesses of similar size that compete against each other in the same economic sectors or in similar geographic regions.

To achieve this goal, the proposal would group businesses into one of the following categories of employee health insurance coverage: "low-coverage," "average-coverage," or "high-coverage." By definition, "average-coverage" firms would be those groups of firms that provided health insurance for a percentage of their employees that was close (that is, within a certain range higher and lower) to the national average of coverage among all private employers in the years 1996–2000 (using the CPS[61]). "Low-coverage" and "high-coverage" firms would be those groups of firms that provided insurance for either a significantly lower or higher percentage of their employees relative to the national average of coverage among all private employers over the same period. In the future, all three of these categories of employers would be required to cover higher and higher percentages of their employees until they achieve 100 percent coverage. However, firms in the "low-coverage" category, by having a lower level of coverage as a starting point, would have a significantly longer transition period to 100 percent coverage than would firms in the "high-coverage" category.

[60] See, generally, Garrett, Nichols, and Greenman.

[61] See footnote 9.

Firms would be grouped for placement in these categories based on their common sizes, industries, and geography. For size, businesses would be divided into those with 100 or more employees, 25 to 99 employees, 10 to 24 employees, and fewer than 10 employees. For industry type, businesses would be divided based on the classifications of the Current Population Survey Annual Demographic Supplement (excluding "Government"): agriculture, forestry, and fishing; construction; trade; services; mining; transportation and public utilities; manufacturing; and finance, insurance, and real estate. For geography, businesses would be divided by either their state of incorporation or the primary state in which firms conduct their business.

For example, one might find that all construction firms with fewer than 25 employees operating in southern states fall into the "low-coverage" category. In that case, all of these similarly situated businesses would be subject to the same, initial employee health insurance coverage floor (expressed as a percentage of a firm's total number of employees) and the same year-by-year increases in that floor. They would not be disadvantaged relative to each other.

While one could create narrower categories than the three I have chosen, maintaining eight, 16, 32, or more categories with coverage targets increasing into the future could prove to be an undue administrative burden. Three categories should provide adequate flexibility, even to "low-coverage" employers. Also, the progress three categories of employers make in covering their employees over time not only would be easier for regulators to watch but also easier for the public to observe and understand, which would be crucial for engendering popular support for the program. Moreover, establishing where different types and sizes of firms fall among these three categories at the outset is vital for proper categorization of new firms established after the first year of program implementation. Adding more categories would further complicate this process.

Defining "Coverage"

To allow employers to comply with the employee coverage floors and to clarify the program's goals, the meaning of "coverage" should be defined as clearly as possible.

"Employee" for purposes of "coverage" means a full-time, part-time, or contingent (temporary or contract) employee.[62] "Employee," however, does not include dependents of employees. But employers could choose to cover dependents and, in some circumstances, as described below, would be required to cover dependents at the option of the employee.

Covering full-time workers is a major goal of this proposal, since they comprise 71 percent of uninsured workers.[63] But the importance of also requiring businesses to cover their part-time and contingent workers should not be underestimated. Only 73 percent of part-time workers are insured, compared to 88 percent of their full-time counterparts.[64] Despite the fact that their take-up rates are similar to those of regular workers, contingent workers with less than six months of experience are less likely to be eligible for their employers' insurance than recently hired regular workers (41 percent, compared to 70 percent).[65] Moreover, requiring employers to

[62] Under this proposal, the term, "employee," does not include the self-employed, defined as "[s]omeone who is working in a small family business as the owner, or who is working in the family business without pay…." (Garrett, Nichols, and Greenman, p. 4, fn 1). However, self-employed workers would have a one-time option to join the health insurance purchasing pools described in the section on financing.

[63] Garrett, Nichols, and Greenman, p. 6.

[64] Garrett, Nichols, and Greenman, p. 15. The authors also note, "Sponsorship [by employers] is lower for those working less than full-time, but the reason for low coverage is less tied to sponsorship than to eligibility and take-up." Under this proposal, employers could continue to use eligibility rules as a means to determine which employees are covered during program implementation years. However, employers would be judged as being in or out of compliance with coverage floors on the basis of employee take-up rates, not employer sponsorship rates.

[65] Garrett, Nichols, and Greenman, p. 16.

cover full-time employees but not part-time or contingent employees could result in a significant shift in preference among employers from full-time to part-time or contingent workers, with a likely corresponding negative impact on family incomes and benefits.

In this proposal, "coverage" is defined in terms of employee take-up rates, not employer sponsorship, because employer sponsorship only solves about half of the problem. Fifty-nine percent of *uninsured* employees work for employers that do not offer health coverage.[66] However, roughly 21 percent of uninsured employees are ineligible for their employers' health plans (for example, waiting periods for new employees, no coverage for temporary workers), and 20 percent are offered coverage but decline it.[67] Therefore, this proposal deals with both sides of this equation: Employers would be required to sponsor health insurance for their employees but would not have to offer it to all of them at once, and, over time, increasing numbers of employees would have to take up their employers on their offers.[68]

Data from the CPS point to affordability as being the most significant factor in determining employee take-up rates. Take-up rates among employees rise steadily with increases in both income and wages.[69] Moreover, it is difficult to argue that most workers do not want health insurance. As Garrett, Nichols, and Greenman note in their report for the Urban Institute, "The fact that 70 percent of poor workers who are offered coverage take it up would seem to indicate substantial demand for health insurance, since an average employee premium would be a considerable share of their income."[70]

For those employees working less than full-time (fewer than 35 hours per week), employer sponsorship is lower, "but the reason for low coverage is less tied to sponsorship than to eligibility and take-up."[71] According to Garrett, Nichols, and Greenman, "Only 63 percent of those working 20 to 34 hours per week were eligible for coverage, and only 58 percent of those who were offered coverage took it."[72]

This proposal would enable take-up rates to rise over time in two ways. First, since employer compliance with coverage floors would be judged on the basis of employee take-up rates, employers would have a strong incentive to structure health benefits packages with their employees' needs and pocketbooks in mind. Second, employees earning up to 200 percent of the FPL would receive subsidies on a sliding-scale basis to cover some or all of their employee share of premiums. These subsidies would be publicly financed as described in the section on financing.

Employee Coverage from Other Sources

Employees with health insurance from other sources would be deemed to be "covered" by their employers (but not those employees who decline coverage without having other coverage). If an employee were offered coverage through a spouse or partner, the employee could choose whether to receive coverage through the spouse or partner or through his or her employer. Employers would be prohibited from discriminating on the basis of an employee's coverage status when making hiring and firing decisions.

As under current law, employers could not deny eligibility for employer-sponsored insurance based on an employee's eligibility for Medicaid or the State Children's Health Insurance Program (S-CHIP). If an employee's immediate family members were enrolled in different health insurance plans, including Medicaid or S-CHIP, the family could elect to re-

[66] Ibid., p. 7.
[67] Ibid.
[68] As discussed earlier, however, employers would be prohibited from "cherry-picking" among employees on the basis of health factors when deciding which employees to insure.
[69] Garrett, Nichols, and Greenman, pp. 11–15.
[70] Ibid., p. 14.
[71] Ibid., p. 15.
[72] Ibid.

ceive its coverage through either the public program or employer-sponsored insurance. Financial responsibility would be apportioned between the public program and the employer. For example, if the employee chose employer-sponsored insurance for his family, he and his family would receive the same financial contribution from the public program toward health coverage that they otherwise would have received. However, if this contribution fell short of the amount necessary to pay the employee's share of the family's premium, the employee would be responsible for the shortfall. This would encourage employees to pay attention to the price and value of their health insurance options. If the employee were due to receive more funds than necessary to pay the family's premium, the excess amount would flow to HHS for redistribution among the states in accordance with the distribution formula specified in the section on financing.

Employee Benefits and Contributions

Employers would have the freedom to structure employee health benefits packages. However, this freedom would be limited by two important constraints. First, for an employee to be deemed as "covered" by an employer, the employee must take up a health plan with an actuarial value at least as high as the most popular Federal Employees Health Benefits Program (FEHBP) plan among federal workers, inflation-adjusted annually.[73] Second, the employer's share of the health insurance premium must equal at least 50 percent. These requirements aside, employers still would have a strong incentive to craft health benefits that meet employees' reasonable expectations, since employers' compliance with coverage floors would be judged on the basis of employee take-up rates.

To further encourage employers to offer high-quality, reasonable-cost plans, employers would receive allowance "bonuses" for every employee who took up a health plan with the following additional characteristics: the employer's share of the premium equals at least 70 percent; employees' annual out-of-pocket costs are limited to $1,500 for employees earning up to 200 percent of the FPL and $3,000 for employees earning 200 percent of the FPL or more, inflation-adjusted annually[74]; and the benefits package includes a list of certain minimum benefits, such as preventive and developmental screening and treatment services (as determined by a bipartisan, congressionally appointed commission, with this minimum benefits list submitted to Congress under a fast-track procedure requiring an up or down vote without amendment). Two and a half percent of annual allowance allocations would be withheld from employers for the purpose of distributing these bonus allowances. Any of these allowances not distributed as bonuses would be returned on a pro rata basis to the employers from which the allowances were withheld.

Coverage Rules after Full Implementation

After this proposal has been implemented fully, and all private-sector employees have health insurance, the basic coverage rules would continue to apply to preserve the benefits—for employees and the nation's health care system—of reducing the number of uninsured Americans by roughly 80 percent. Employers would have to ensure that all of their employees were covered with health insurance plans with actuarial values at least as

[73] After the first year of implementation, the actuarial value would be inflation-adjusted annually to the Consumer Price Index (CPI) plus two-thirds of the differential between the CPI and Health-CPI over the most recent five years. Doing so would impose greater cost discipline on the health care system than simply using the Health-CPI and would better accommodate the costs of new technologies and scientific breakthroughs than simply using the CPI. In addition, every five years, there would be a new determination of which FEHBP plan is the most popular among federal workers, thereby resetting the base actuarial value from which inflation adjustments would be made.

[74] After the first year of implementation, these caps would be inflation-adjusted annually to the CPI plus two-thirds of the differential between the CPI and Health-CPI over the most recent five years.

high as the most popular FEHBP plan among federal workers. Employers also would be required to cover at least 50 percent of each employee's health insurance premium. In addition, the coverage rules related to coverage from other sources still would apply.

Allowance Allocation and Trading System

At a minimum, an allowance allocation and trading system would, over time, enable businesses to afford the cost of health insurance coverage for their employees. More than likely, it also would help to equalize regional health care differences by providing a national market in trading; trigger behavioral responses that lead to higher rates of insurance coverage sooner than expected under this proposal; and encourage employers to be innovative in the financing and design of employee health plans.

Allowance Allocation

Under this proposal, an "allowance" would be defined as a limited authorization for a private employer not to insure one employee for one year.[75,76] HHS would distribute allowances to private employers annually based on the system described here.

Allowances would not expire until they were used. If not used by the employer to which the allowance was distributed in the year in which it was distributed, the employer could save or "bank" the allowance for future use or sale.

Allowances would be distributed to private employers every year until the coverage floor for their category reached 100 percent. After that point, employers would have to insure 100 percent of their employees without exception. However, any remaining banked allowances these employers had could still be traded until the coverage floors for all categories of businesses reached 100 percent; but once that occurred, all allowances would cease to be valid and marketable. In addition, allowances would be valid only as long as an employer remained in business. When a business is acquired by another entity, thereby forming a new firm, both the market value and obligations attached to the allowances held by the original business would be passed on to the acquiring entity. But HHS would keep a watchful eye for those businesses attempting to structure sham deals for the sole purpose of gaining an advantage under the new system. For instance, the creative shuffling of employees and business operations among subsidiaries to enable a particular subsidiary to be re-classified as a "new" firm in a more favorable category (that is, with a longer implementation period) would be prohibited.

In the first year of program implementation (two years after the date of enactment), all private firms in the same category (that is, "low-," "average-," or "high-coverage") would be allocated the same number of allowances, based on the 1996 to 2000 average numbers of uninsured, privately employed individuals in their categories.[77] Firms would receive allowances irrespective of whether they have sponsored insurance in the past. The total number of allowances available to be allocated would be equal to the average number of uninsured, privately employed individuals over the period 1996 to 2000, likely requiring a pro rata adjustment of allowances

[75] No value distinction between allowances for full- and part-time employees would be made since the cost of insuring an employee does not vary based on his or her full- or part-time status. Also, for accounting and trading purposes, allowances would be divisible into twelfths since health insurance premiums (and thus changes in the status of employees' coverage) are generally paid monthly.

[76] The statute would state clearly that allowances are not property rights to avoid any takings issue if the government were to decide to change the coverage floors in the future. According to the Environmental Law Institute, this provision under the Clean Air Act's acid rain program did not have a dampening effect on the allowance market. Environmental Law Institute. *Implementing an Emissions Cap and Allowance Trading System for Greenhouse Gases: Lessons from the Acid Rain Program.* Washington: Environmental Law Institute, September 1997, p. 60.

[77] See Environmental Law Institute, pp. 37—40.

across the three categories. As mentioned earlier, using a recent five-year period as a starting point would prevent firms from gaming the system in advance, while accommodating for swings in the business cycle that can affect employer-based coverage.

This initial allowance-distribution scheme, operating in conjunction with the coverage floors, also would serve two other important purposes. First, it would function as a quasi maintenance of effort provision. The starting benchmarks for all future, annual increases in the numbers of covered employees would be derived from recent, average coverage levels in the three different categories of firms. Second, by allocating allowances to all employers, the initial distribution scheme would not just help employers offering coverage to their employees for the first time. It also would award allowances to employers that were good corporate citizens in the past by providing health insurance to their employees when they were not required to do so.[78]

After the first year of program implementation, each employer would be allocated a fixed number of allowances at the beginning of every calendar year based on that employer's average number of uninsured employees over the previous five years, that is, on the basis of a five-year moving average.[79] Allowance allocations would be reset every year on this basis and adjusted according to a pro rata share system that matches the total number of newly available allowances in the system in a given year with the national coverage floor and the corresponding categorical coverage floors to be reached. Until they have five years of history under the new program, existing employers would be allocated allowances based on a modified, five-year moving average: one year of actual experience plus a four-year average based on 1997 to 2000 experience of employers in the same category, two years of actual experience plus a three-year average based on 1998 to 2000 experience of employers in the same category, and so forth. New firms entering the system after the first five years of implementation would be allocated allowances in their first year based on the five-year moving average of the number of uninsured employees among firms in the same category during the most recent five years. After their first year, they would be allocated allowances based on a modified, five-year moving average (until they have five years of history under the program): one year of actual experience plus a four-year average based on the most recent experience of firms in the same category, two years of actual experience plus a three-year average based on the most recent experience of firms in the same category, and so forth.

The moving average approach has the advantage of avoiding the political struggles that tend to accompany any attempt to write permanent allocations into law.[80] This approach also would treat new businesses more fairly by allowing them to transition into the system on an equal footing with similarly situated business competitors, receive an allowance allocation, and not be forced to purchase all of their allowances from existing employers to comply with the national coverage floors. A more static model in this context of expanded health care responsibilities for employ-

[78] One could make an argument for eliminating the categories of businesses created in this proposal, favoring instead a simpler distribution of allowances to firms based on their individual historical coverage rates alone. One could contend that, in the context of such a market incentives system, all firms would face a uniform "cost" of compliance in the form of the allowance price. Therefore, regardless of their variations in size, industry, and geography, and regardless of variations in coverage history, firms would be similarly situated competitively because the cost of insuring one more employee would be the same for all of them—that is, the cost of buying an allowance on the market. But there are two problems with this argument. First, in the long run, all employers must buy insurance policies for all of their employees, and the costs of those policies will vary widely from business to business, depending on a business's size, industry, geography, and other factors. Second, an approach based solely on individual firms' coverage histories would effectively penalize those firms that have been good corporate citizens and provided health insurance to their employees when the law did not require them to do so.

[79] See Environmental Law Institute, pp. 41–4.

[80] Ibid., p. 42.

Allowance Allocation and Trading: How the System Would Work in Practice

Jake Jones owns a small business, "Just Jake's," which employs nine workers but does not provide health insurance for any of them. Just Jake's is a small delicatessen located in Athens, Georgia. As a restaurant with fewer than 10 employees located in a state with lower levels of insured workers than the U.S. national average, Just Jake's (and similarly situated restaurants) likely would fall into the "low-coverage" category of businesses under this proposal. Assume that the national coverage floor for that category in the first year of implementation would be 70 percent of employees—the lowest coverage floor and corresponding to the most generous percentage distribution of allowances, relative to the "average-" and "high-coverage" categories. Just Jake's would receive sufficient allowances in the first year of implementation to avoid purchasing insurance for three of its nine workers (33 percent, not 30 percent, since one would round up to whole numbers because one could not insure a portion of an employee). Just Jake's would then have a series of options: the restaurant could buy health insurance for all of its workers and save ("bank") its three employees' worth of allowances for future use or sale; buy health insurance for just six of its workers, for whom it does not have allowances; or purchase six more employees' worth of allowances from other firms or at auction, at a significantly lower cost than purchasing health insurance for six employees. Since the 70 percent floor would rise by only 1.5 percentage points per year, it would be six years before Just Jake's health insurance coverage responsibility increased by one more employee to seven employees, giving the delicatessen ample time to implement business strategies to meet the rising challenge.

Jack Beyer owns a medium-size business, "Hard Sell," which employs 20 workers and provides health insurance for all of them. Hard Sell is a lobbying firm located in Bethesda, Maryland. As a medium-size lobbying firm located in a state with higher levels of insured workers than the U.S. national average, Hard Sell (and similarly situated lobbying firms) likely would fall into the "high-coverage" category of businesses under this proposal. Assume that the national coverage floor for that category in the first year of implementation would be 90 percent of employees—the highest coverage floor and corresponding to the least generous percentage distribution of allowances, relative to the "average-" and "low-coverage" categories. Despite its history of 100 percent employee coverage, Hard Sell still would receive sufficient allowances in the first year of implementation to avoid purchasing insurance for two of its 20 workers (10 percent). Like Just Jake's, Hard Sell would have numerous options. Hard Sell could continue to purchase health insurance for all of its employees and bank its two employees' worth of allowances for future use or sale. It also could lower its employee coverage percentage to 90 percent and use its allowances (or lower its coverage percentage below 90 percent and purchase additional allowances) if Hard Sell unexpectedly lost some clients and decided to save money by dropping some or all of its employees' health insurance as a short-term measure. Nonetheless, Hard Sell would have to plan ahead and be prepared to cover 100 percent of its employees on a permanent basis within seven years.

ers—with a precise formula written into law that allocates allowances to existing firms, as was the case with the acid rain program—could create economic barriers to starting new businesses and negatively affect job creation.

One could argue that a moving average system nonetheless has possible disadvantages. For example, it could reduce the incentive for employers to increase the number of insured workers and bank extra allowances for the future. In theory, that could happen, since allowance surpluses created by employers insuring more workers than required "would be progressively reduced as the allowance allocation is gradually lowered under the moving average system."[81] However, such a result is highly unlikely. The primary factor motivating an employer to insure more employees would be the steadily increasing national coverage floors, not the opportunity to trade surplus allowances, and that has been the experience under the acid rain program.[82]

Another possible disadvantage of a moving average system is the potential to "discourage the trading of…allowances by reducing the predictability of future allocations."[83] However, a five-year averaging period would create "reasonable certainty," since 80 percent of the allowances would be

[81] Ibid., p. 43.
[82] Ibid.
[83] Ibid., p. 44.

guaranteed in the next year, followed by 60 percent, and so forth.[84]

Allowance Trading and Auctions

If unable to reach a statutory coverage floor with its distributed allowances, an employer would be required to either acquire allowances from another employer (or broker or advocacy organization) or purchase allowances at auction. An employer would be in violation of the law and subject to penalty if it did not take either of these remedial actions under such circumstances.

A vigorous market in allowance trading is key to the success of this proposal. Trading would allow firms to literally buy extra time for compliance by purchasing allowances from other firms. Trading also would make compliance cheaper, since buying additional allowances to cover more employees likely would be significantly cheaper than buying more insurance policies. That is because businesses with excess allowances would have a strong financial incentive to sell most of them—allowances would be marketable only as long as the program was in effect, and these businesses would not need more than small numbers of allowances in reserve to protect themselves from potential economic downturns. These businesses would have to sell their allowances at levels low enough below market prices for employee insurance policies to attract buyers. Otherwise, potential buyers, facing annually climbing employee coverage floors, would choose to purchase health insurance for their uninsured employees. Businesses also would need to sell their allowances at levels low enough to compete with sales prices offered by other firms. For example, if the private health insurance premium for a firm to cover one of its employees for one month were $250, the firm might be able to buy an allowance on the market instead for $70.

For an active market in allowance trading to develop, it should operate on a national and not a state-by-state basis for the following reasons: First, national trading would ensure the presence of an active market in allowance trading due to lower transaction costs and the predictability of having one regulator. If each state were allowed to set up its own coverage floors, regulations, and allowance-trading systems, companies would have far greater difficulty assessing the value of allowances, since that value would vary from state to state, depending on the regulatory environment.

Second, national trading eventually would help to even out pre-existing disparities in coverage levels among the various states and regions of the country. For example, Texas firms that have traditionally not covered their employees could buy excess allowances from Pennsylvania firms that have. These Texas firms would still have to move in the direction of higher coverage levels, but they could buy time and flexibility along the way from the Pennsylvania firms. If instead states had their own programs, and trading occurred exclusively within state boundaries, states with relatively low levels of covered employees would likely have weak trading markets with insufficient numbers of firms with excess allowances to trade. That would make it far more difficult for firms in these states to take advantage of the flexibility offered by this proposal to increase coverage for the uninsured at a pace of implementation that is comfortable for them.

Third, national trading would avoid a "race to the bottom" in which firms could rush to relocate to states with the least stringent regulations and most generous implementation periods. Such a result either would exacerbate pre-existing disparities in coverage levels among states or create new ones.

While at first glance this proposal for a national market in allowance trading would seem to leave state governments out of the regulatory scheme entirely, that is not the

[84] Ibid.

case. States would have significant roles to play and a real stake in the program's success. With a combination of federal and state funds, states would have primary responsibility for providing health insurance premium subsidies for privately employed workers earning up to 200 percent of the FPL. They also would establish mandatory purchasing pools for small businesses with fewer than 25 employees.[85] In addition, state governments would have the opportunity to use excess funds to purchase allowances from employers in their state and retire them to reduce their state's number of uninsured workers ahead of schedule. These roles are discussed briefly in the section on financing.

This national market in tradable allowances would be largely unencumbered. Since coverage floors would apply to all categories of employers from the beginning of implementation, all employers could begin trading immediately, which would help foster early trading. Starting some categories (for example, "low-coverage") later would otherwise leave fewer buyers in the market, since employers in those categories would lack the same urgency of other employers to cover their workers.[86] Moreover, anyone could trade in allowances, including states, health care advocacy organizations, and brokers. Such a wide variety of players would enhance the market's dynamism and effectiveness in achieving this proposal's goal of increasing coverage for the uninsured. For instance, over time, health care advocacy groups could purchase allowances from employers and bank them indefinitely (that is, "retire" them), thereby quickening the pace of achieving universal coverage. Employers donating excess allowances to nonprofit health care groups and taking a tax deduction for the contribution could achieve the same effect.

At the beginning of each calendar year, there would be a 90-day reconciliation period during which firms could buy allowances to cover any shortfalls in coverage below their coverage floors in the preceding year. Trading among firms and other entities could occur throughout the year but would be expected to be more intense during the reconciliation period.

In addition, an annual auction would be held in March—before the end of the 90-day period—to help ensure the availability of allowances for small businesses and new firms.[87] The annual auction, planned and coordinated by an organization designated by HHS, would help to provide price signals to the market and stimulate trading in the early years of the new program. Five percent of all allowances would be withheld from employers each year for sale at this auction, and proceeds from the auction would be returned on a pro rata basis to the employers from which the allowances were withheld. Entities holding excess allowances also could sell them through this auction, and any other employer, individual, advocacy organization, or state could buy these allowances.

At auction, private sellers could specify the minimum sales price for their allowances, but the HHS designee would set a minimum asking price for the rest of the allowances. (Under the acid rain program, for example, the Chicago Board of Trade was the Environmental Protection Agency's designee for the first couple of years.) That would enable HHS to "determine the price at which it offers its allow-

[85] Firms of this size employ 40 percent of all uninsured workers and have the lowest rates of employer-sponsored insurance; see Garrett, Nichols, and Greenman, pp. 5, 8.

[86] General Accounting Office. *Allowance Trading Offers an Opportunity to Reduce Emissions at Less Cost*. Washington: General Accounting Office,, December 1994, pp. 63–4.

[87] In the acid rain program, auctions are now virtually irrelevant. Private allowance markets are very active with year-round trading, and prices have never reflected market power by large businesses. Concerns at the time of the program's inception that big firms would "horde" most of the allowances proved to be unwarranted; see Swift, Byron. "How Environmental Laws Work: An Analysis of the Utility Sector's Response to Regulation of Nitrogen Oxides and Sulfur Dioxide Under the Clean Air Act." *Tulane Environmental Law Journal* (Summer 2001): 342–43.

ances with the assistance of market experts, in much the same way that a privately held company arranges the price for its initial offering of stock with a 'market maker' or expert."[88] HHS thus could ensure that its "asking prices were not so low as to encourage potential buyers to bid less than they would in a competitive market."[89,90,91]

Allowance-Tracking System

HHS would establish an automated allowance-tracking system to conduct or track all allowance issuances, deductions, and transfers. The system would track allowances held by all employers, individuals (for example, brokers), organizations, and states. It would give HHS the ability to monitor compliance with coverage floors and thus ensure that actual uninsurance levels do not exceed available allowances.

To help HHS accurately track coverage levels, employers would be required to report additional, standardized information as part of their quarterly federal tax returns.[92] Employers would report all trades and the prices at which allowances were traded so that market participants could operate in an informed market. They also would report employee hires, terminations, and resignations, since the number of employees would have a direct impact on employer compliance with required employee coverage levels. The Internal Revenue Service (IRS) would be required to share this additional information from the returns with HHS.

In addition, individuals (for example, brokers), organizations, and states would be required to report all allowance trades and prices directly to HHS. They would submit this information quarterly in a standardized, electronic format developed by HHS.

Allowance-trading information gleaned from individuals, organizations, states, and employers (but not information about hires, terminations, and resignations) through the allowance-tracking system would be made public. In combination with the penalty provisions (discussed below in the section on enforcement), this public information would aid in creating a compliance system that is transparent and virtually self-enforcing.[93] Making the trade prices of allowances public also would help to ensure an active market.

HHS would use the allowance-tracking system as the basis for action at the end of the annual 90-day reconciliation period. At that time, HHS would deduct allowances from an employer's allowance holdings in an amount equal to its recorded level of uninsurance. HHS would take enforcement action when employers do not meet their coverage floors.

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[88] GAO, p. 64.

[89] Ibid.; see also Environmental Law Institute, p. 48.

[90] Under the acid rain program's auction, the EPA was not allowed to set a minimum price, creating a situation in which winning bidders paid amounts they actually had bid, generating a range of winning prices. (In contrast, for example, securities auctions "have a single, market-clearing price paid by all winning bidders and received by all sellers" [GAO, p. 53]).) The resulting behaviors of buyers and sellers led to lower prices for allowances than expected. According to the GAO, "Sellers [had] an incentive to place offers as low as possible in order to obtain the highest price. Meanwhile, buyers bid lower, knowing that most allowances offered [would] be very cheap, particularly EPA's zero-priced allowances… .According to utilities active in the market, the prices paid at the auction discourage[d] potential trades or unnecessarily delay[ed] allowance transactions because buyers want[ed] to obtain allowances at the low prices reflected in the auction, while sellers [found] those prices unrealistic and below their costs of reducing emissions" [GAO, p. 54].

Thus, the lesson learned from the early years of the acid rain allowance auction was that without one winning auction price, there is market uncertainty, lower trade volume, and less potential to reduce the costs of compliance with the law. That is why different auction rules are proposed here.

[91] Some lawmakers now view auctions as the best allowance allocation approach in the context of some of the environment's most stubborn pollutants. U.S. Senator James Jeffords (I-VT) has introduced the "Clean Power Act of 2003" (S. 366), which would auction 100 percent of the available allowances. This approach is popular with economists and environmentalists, because it avoids any need for allocation formulas and creates revenue that can be used for other purposes. However, the approach has not gained broad support, since businesses dislike the idea of needing to buy all of their allowances instead of having some distributed to them for free. For the same reason, businesses also likely would reject this approach in the health care context.

[92] Most employers would include this information on Internal Revenue Service Form 941 (Form 943 for agricultural employers).

[93] See Environmental Law Institute, pp. 53–5.

HHS would establish user fees to help the agency cover the costs of operating this tracking system and to further support achievement of this proposal's coverage goals. Employers would pay a set fee to HHS for each allowance distributed to them by the agency. The user fees would be sufficient to handle the heavy trade volume at the end of the year. Efficient and accurate tracking not only would improve compliance monitoring but also would reassure market participants.[94]

The fact that allowance tracking and trading would occur on a national level does not mean the program would become an undue administrative burden. The allowance-tracking system for the acid rain program, after which this proposal is modeled, has been implemented by fewer than 10 EPA employees, and the entire program by fewer than 100.[95]

Tax Treatment and Allowance Trading

During the 1990s, the IRS ruled that EPA's allocations of allowances under the acid rain program were not taxable.[96] That meant that an allocated allowance had a zero cost basis, leading to a large capital gains tax liability for firms when that allowance was later sold. The zero-cost-basis ruling might have been a contributing factor to low trading volume in the early years of the acid rain program, though the General Accounting Office (GAO) believes it was a minor one.[97]

This proposal would permit the market to assign a cost basis to the allocations. Doing so would provide sources with a tax deduction on the fair market value of their allowances when they donate the allowances to nonprofit, health care advocacy organizations.[98] Many of these organizations would be interested in collecting donated allowances for the purpose of retiring them. This policy thus would encourage allowance donations and almost certainly help to buy down uninsurance levels ahead of schedule. Five years after enactment of the acid rain program, for example, 35,000 allowances already had been donated—without the encouragement of tax deductions.[99]

If this approach were adopted, there would be a downside: On distribution, allowances would become federal tax expenditures.[100] Nonetheless, this approach should be considered seriously due to its potential benefits of fostering early, active trading and encouraging early buy-down of uninsurance levels.

Regulatory and Enforcement Authority

HHS would promulgate nearly all regulations necessary to implement this proposal.[101] It also would have the authority to monitor and certify compliance with the new law and conduct on-site visits in an investigative capacity. Moreover, it would have the authority to issue orders requiring compliance and to impose penalties for violations of the law's requirements.

As mentioned earlier, there would be a 90-day reconciliation period at the beginning of each calendar year, during which firms could buy allowances (directly from other firms or at auction) to compensate for any shortfalls in coverage below their coverage floors in the preceding year. If there were insufficient allowances to cover a floor shortfall at the end of the reconciliation period, an employer would be subject to an automatic penalty per employee not insured below the coverage floor. This penalty would equal three times the average annual cost (during the calendar

[94] GAO, p. 65.
[95] Environmental Law Institute, p. 55.
[96] Ibid., p. 60.
[97] GAO, pp.57–8; according to the GAO and the Environmental Law Institute, the major cause of low market activity in the early years of the program was the lack of market transparency and information.
[98] Environmental Law Institute, p. 61.
[99] Ibid.
[100] To address this concern, it would be possible to draft the law so that no cost basis attaches to an allowance until after the federal government has distributed it.
[101] The IRS would design new forms to accommodate the information requirements of this proposal and would be required to consult with HHS in doing so.

year in question) of insuring an employee in the state in which the firm is located with insurance that meets the requirements of the new law. In addition, employers not meeting their coverage floors would have their allowance holdings reduced in the next year by one-twelfth of one allowance for each employee per month not insured below the coverage floor. Similar penalties under the acid rain program have been very effective in promoting compliance. Even in the first two years of the program (1995 to 1996), when the trading market was not particularly active, all utilities complied with the emissions cap.[102]

HHS also would impose penalties on firms that try to game the system with methods that cause "leakage." For example, when firms permanently shut down all or some of their operations, or lay off employees, a corresponding number of allowances would be confiscated and retired. This provision would remove any incentive firms otherwise would have to behave badly and then reap a windfall. Larger firms also would be penalized for breaking up into smaller firms for the primary purpose of enjoying a lower coverage floor and a longer phase-in period. Additionally, HHS would have the authority to assess penalties on employers that discriminate on the basis of an employee's coverage status when making hiring and firing decisions.

In addition to HHS action, citizen suits would be permitted, against both employers alleged to have violated the coverage floors and HHS when the agency is alleged to have failed to perform an action that is not discretionary under the new law (for example, to promulgate required regulations).

Financing

To make states true partners in this national effort and give them a stake in a positive program outcome, a portion of federal user fees (the portion remaining after covering the costs of establishing, implementing, and maintaining the allowance-tracking system, but not covering the costs of any new full-time HHS employees), all revenues from penalties and increased or new federal "sin" taxes, and an amount from general revenues specified by statute would be distributed annually to the states on the basis of their relative numbers of uninsured, private-sector workers. In accepting these funds, states would agree to match them at their Federal Medical Assistance Percentage rates.

States would be required to use as much of these funds as necessary to subsidize the employee share of health insurance premiums on a sliding-scale basis for low-income workers earning up to 200 percent of the FPL. States would use remaining funds to establish state-based, mandatory purchasing cooperatives for small businesses with fewer than 25 employees. If there were still funds available, states could develop ways to insure non-working adults and children who are ineligible for Medicaid or S-CHIP. They also could buy excess allowances from firms in their state and retire them to reduce their state's number of uninsured workers ahead of schedule.

Since 59 percent of uninsured workers have incomes below 200 percent of the FPL,[103] revenues from user fees and penalties would not be sufficient to fully fund this proposal. In the first year of implementation, when only small numbers of employees likely would be added to the rolls of the insured, user fee and penalty revenues might be adequate. But as employers were slowly required to cover higher and higher percentages of their workers, additional sources of funding would be necessary to help employees below 200 percent of the FPL afford coverage, perhaps $40 billion to $55 billion a year for these employees' shares of premiums.[104] That is why a core

[102] Environmental Law Institute, p. 59.

[103] Garrett, Nichols, and Greenman, p. 6.

[104] The high end of the $40 to $55 billion range is a rough estimate based on employers covering only 50 percent of

amount from general revenues would provide the majority of financing for this proposal—to ensure the existence of a stable and sustainable funding stream.

However, significantly increasing or creating new federal "sin" taxes could reduce the amount from general revenues required to fund this proposal. For example, a $2 per pack increase in the federal cigarette tax (from $0.39 to $2.39), as recommended in February of 2003 by the HHS Interagency Committee on Smoking and Health, would generate $28 billion a year. Such a tax would have the added potential benefit of improving public health.

User Fees

HHS would charge user fees on a per allowance basis upon distribution to each employer receiving allowances. While either Congress or HHS could determine the exact amount of the fee per allowance, the fee should be low enough to ensure that "low-coverage" firms could afford it without undue hardship.

Low-Income Subsidies

States would have to ensure the availability of sufficient funds to help low-income workers earning up to 200 percent of the FPL pay for their employee share of health insurance premiums on a sliding-scale basis before spending resources from this program on small-business purchasing pools or other activities. States would subsidize 100 percent of the employee share of premiums for workers with earnings below 100 percent of the FPL, 90 percent for workers with earnings 100 percent to 149 percent of the FPL, and 80 percent for workers with earnings 150 percent to 199 percent of the FPL.

Low-income subsidies are established as a priority in this proposal because, as discussed earlier, employer eligibility rules and employee take-up rates contribute to employees' lack of insurance as much as employer sponsorship does, particularly among lower-income workers. Moreover, as Garrett, Nichols, and Greenman conclude in their study for the Urban Institute, the most efficient health insurance subsidies in the employment context are targeted to low-income workers, not their employers. The authors found that to be the case for two reasons: one, employer benefits are spread over all firm employees, regardless of need, and, two, giving the lion's share of workers "stronger demand for health insurance and the wherewithal to trade wages for tax-preferred employer contributions" encourages more firms to sponsor health insurance.[105]

Numerous states already have experience providing subsidies to low-income workers to help them afford the costs of their employer-sponsored insurance. For example, Iowa, Massachusetts, Mississippi, Pennsylvania, Texas, and Wisconsin operate federally authorized Health Insurance Premium Payment programs, which subsidize enrollment in employer-sponsored health insurance for Medicaid-eligible employees and their families.[106]

Health Insurance Purchasing Cooperatives

After ensuring the availability of sufficient funds to subsidize low-income, privately employed workers, states would use remaining funds to establish state-based, mandatory purchasing pools for firms with fewer than 25

employees' premiums. The low end is a rough estimate based on employers covering 70 percent. Given current employer premium contribution data and incentives provided under this proposal (that is, bonus allowances), the lower end of the cost range may be more realistic. Moreover, covering the full 30 percent share of employee premium costs (in the case of employees earning less than 100 percent of the FPL)—or even the 50 percent maximum allowable employee share—would not be a bad deal for the federal and state governments. Currently, when individuals with similar incomes are enrolled in low-income programs for the uninsured, federal and state governments pay 80 percent to 100 percent of their premium costs. (For current employer coverage data related to premium contributions, see Gabel, Jon et al. "Job-Based Health Benefits in 2002: Some Important Trends." *Health Affairs* [September/October 2002]" 143–51].)

[105] Garrett, Nichols, and Greenman, p. 27.

[106] Silow-Carroll, Sharon, Emily K. Waldman, and Jack A. Meyer. *Expanding Employment-Based Health Coverage: Lessons from Six State and Local Programs.* The Commonwealth Fund, February 2001.

employees. Firms of this size employ 40 percent of all uninsured workers and have the lowest rates of employer-sponsored insurance.[107] Purchasing pools would help these firms to gain purchasing clout and potentially leverage a choice of health plans for their employees. Making the purchasing cooperatives mandatory for these businesses also would enable them to spread their risk without the opportunity for firms with the healthiest employees to abandon the pool in favor of testing market waters on their own.

In addition, self-employed individuals, who are not otherwise covered by this proposal, would be given a one-time option to join these purchasing cooperatives.[108] This option would allow the self-employed to take advantage of the purchasing power and risk pooling inherent in the mandatory cooperatives in exchange for agreeing not to disrupt the cooperatives' stability by cycling in and out to their individual benefit.

Conclusion

This proposal represents a novel approach to achieving health insurance coverage for all privately employed workers. While all employers would be required to participate in this new program, the proposal would give them the tools, flexibility, and long implementation period needed to meet the target goals.

This is a realistic proposal, but like any policy model, it has potential weaknesses. First, while the public could easily understand the program's ends (that is, coverage floors), the means (marketable allowances) would be more difficult to explain. Relative to the Clean Air Act's program to reduce acid rain, this program to increase health insurance coverage would affect individuals more directly, particularly their pocketbooks. Therefore, most Americans would want to understand the details and what impact those details would have on them and their employers. Policy makers would need to make a concerted effort to engage and educate the public about the new mechanisms that could deliver on the promise of health coverage for every private-sector worker.

Second, the public would need to be willing to live with disparities in equity in the short term. All workers would end up in the same place. But along the way, just like today in America, whether one would have health coverage, and how good or expensive that coverage would be, would depend on for whom one worked and where one lived. Again, a strong public information campaign, to ensure that Americans understood the program and to counter political opposition that could develop during the long implementation period, would be of the utmost importance.

Third, as mentioned at the outset, the exact levels of funding needed to reach the proposal's objectives are unknown. This is a fresh proposal in the health care context, requiring significant quantitative work to achieve a proper cost estimate.

With these possible drawbacks in mind, Congress and the President could consider piloting the proposal in a limited number of states that wished to participate. However, such a pilot program would need to involve a representative sample of states from all geographic regions to give policy makers an accurate glimpse of the real potential of a national, allowance-trading program.

As stated earlier, the promise of allowance trading does not rest on the specific design of this proposal. Under a "play, pay, or buy" approach, small firms could decide to pay into a public fund to finance "fallback" health plans for their uninsured workers instead of shopping for additional allowances from other em-

[107] See Garrett, Nichols, and Greenman, p. 5.

[108] Individuals who are self-employed on the effective date of this proposal would be required to make this election within 30 days following the effective date. Those who become self-employed after the effective date would be required to make the election within 30 days of their change in employment status.

ployers or brokers. Under a state-based approach, states, not employers, would receive allowances, using and trading them until reaching universal coverage for their residents. Under an individual mandate approach, individuals would have the option of purchasing allowances through a government-sponsored auction as a transitional measure until they were required to buy insurance. Proceeds from the auction would pay for the uncompensated care in the health care system that would exist until universal coverage is achieved. No matter which of these approaches a policy maker might favor, allowance trading has the potential to deliver on the promise of significantly increasing coverage for the uninsured.

Allowance trading would offer more hope to uninsured workers than many of the alternatives would. Neither our current system nor an immediate mandate of any kind is an economically or politically sustainable method of providing employees with health insurance. This plan thus seeks to find a market-based middle ground that would generate support across the political spectrum.

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Steuerle

Key Elements

C. Eugene Steuerle has developed an incremental coverage expansion proposal that is designed to mitigate perverse incentives in the present system that discourage cost consciousness and encourage ever-larger private and public spending for health coverage—spending that is often not directed to areas of greatest need or to improving quality of care. The proposal includes the following elements:

THE PROVISION OF THE TAX CODE that allows employees to not pay tax on employer-paid health insurance premiums would be changed: the exclusion would be capped at a fixed-dollar amount, which would not change over time as health insurance premiums increase.

PEOPLE AT ALL INCOME LEVELS could choose to take advantage of a modest tax credit as an alternative to the tax exclusion; the size of tax credit would increase over time.

EMPLOYERS WOULD BE REQUIRED TO OFFER, but not necessarily pay for, at least one state-approved health insurance plan for employees.

AN "INDIRECT" MANDATE WOULD BE ESTABLISHED and enforced through the federal tax system: individuals who failed to get coverage would lose some tax benefit, such as the personal exemption, credits to help pay higher education expenses, etc.

THE INITIAL SOURCES OF FINANCING for the tax credit would be tax revenues from the portion of employer-paid premiums that are newly taxable and the tax penalties imposed on people who fail to arrange coverage.

EMPLOYERS WHO OFFER COVERAGE would be encouraged to adopt the practice of automatically enrolling employees in the employer's health plan unless they specifically chose to opt out.

About the Author

C. EUGENE STEUERLE, PH.D., is a Senior Fellow at The Urban Institute and co-director of the Urban-Brookings Tax Policy Center. He is the author, co-author, editor, or co-editor of ten books, and over 150 reports and articles, 600 columns, and 50 Congressional testimonies or reports. Among many other positions, he has served as Deputy Assistant Secretary of the Treasury for Tax Analysis, President of the National Tax Association (2001 to 2002), chair of the 1999 Technical Panel advising Social Security on its methods and assumptions, President of the National Economists Club Educational Foundation, and Resident Fellow at the American Enterprise Institute. Between 1984 and 1986 he served as Economic Coordinator and original organizer of the Treasury's tax reform effort, for which Treasury and White House officials have written that tax reform "would not have moved forward without your early leadership" and the "Presidential decision to double the personal exemption...[is] due to your insightful analysis." Dr. Steuerle has published articles on such issues as the financing of health care, the use of mandates, and the economic effect of health insurance subsidies. He has provided Congress with testimony and served as faculty at health reform retreats by both the Senate Finance Committee and the House Ways and Means Committee. He has promoted health reform proposals to focus on children and to provide both “carrots and sticks” to encourage the purchase of health insurance.

A Workable Social Insurance Approach to Expanding Health Insurance Coverage

by C. Eugene Steuerle

Introduction

The federal government's health budget is expanding by leaps and bounds even as the number of uninsured increases and average out-of-pocket costs for Americans rise faster than income. Does this seem incongruous? It shouldn't. Federal policy toward health care operates like a man running with a blindfold on: that he trips, falls over cliffs, and generally fails to reach his objective shouldn't be surprising. What is questionable is the federal government's continual exhortation to run faster under these circumstances. If the blindfold comes off, then policy can be "run" at a more sustainable and efficient pace.

The task here, to identify ways to expand health insurance coverage and reduce the number of uninsured, cannot be achieved without squarely facing the constraints and dilemmas of health policy. Here, the non-health side of the wider market and the financing side of government must be given their due. That is, government expenditures on health care are one part of a broader balance sheet; the other parts of that sheet change simultaneously when health policy is reformed. Ignoring them will not make them go away.

The growth in federal expenditures on health care is so large today that it claims a major share of all new revenues to the government and has led, over time, to a decline in the share of almost all non-health functions, other than retirement, relative to both total expenditures and gross domestic product (GDP). Spending more on new health programs on top of the automatic growth in existing programs *does* mean less to spend on education, homeland security, community development, and everything else—in the aggregate and, often, separately. The high level of current expenditures helps to make reform very difficult, because change can be very expensive and affects a wide range of interest groups.

Even if one wants to argue that tax increases can meet demands for new public interventions (that is, that privately paid-for goods and services, rather than other public goods and services, are what should decrease), this scenario still gives health care priority to use those government revenues and weakens the ability of other functions to maintain their current resource shares, much less capture some higher future share.[109]

This situation is not as bleak as it might first appear. Although the high, automatic, growth rate in existing health care entitlement programs—a growth requiring no new legislation—greatly constrains achieving legislative reforms, those constraints are more political than economic. Indeed, the political problem is how to move off a path of unsustainable promises, but the economic problem is how to

[109] Higher tax rates raise the efficiency cost, even for the same level of expenditure on other functions. That is, economic theory suggests that at the margin, the efficiency cost of taxes rises with the tax rate. Hence, if education programs require tax rates to rise from 35 to 36 percent, they are more costly in terms of efficiency than if they require tax rates to rise from 25 to 26 percent. Even if one does not accept the economic logic, it is fairly clear that taxpayers reduce their support for government functions at higher tax rates. Either way, large amounts spent on health care weaken legislators' ability to tap taxpayers yet again for non-health purposes. Trade-offs are real.

capture some of the sustainable portion of public health expenditure growth and steer it toward more optimal use. Here, much can be achieved.

While some components of the reform package set out here are similar to those in other proposals, this paper approaches the task by recognizing up-front all parts of the health care balance sheet. Thus, many health care proposals start from a health needs assessment that includes inadequate health insurance coverage. Then they blithely ignore all the dilemmas and constraints embedded in current health policy, ranging from large budgetary cost to high implicit and hidden tax rates. The approach here is, first, to identify the constraints and dilemmas and then see how a reform plan might be developed that recognizes and addresses them.

The Dilemmas and Constraints

The Budget

In the United States, government at all levels now spends a percentage of GDP on health care that is similar to that spent by government in other developed countries, although private costs are much higher in the United States. For the government simply to take over the costs of the private portion of the health care system would soon require a tax increase of about 8 percent of GDP (and more over time without a strict set of cost controls). This could translate into either 16 additional percentage points in a tax rate on earnings similar to Social Security or close to a doubling of the individual income tax. In addition, the growth rate in public health expenditures, including tax subsidies, is inexorable: projected costs of public health care subsidies and systems indicate that they will continually absorb larger shares of GDP.[110]

This growth in existing health programs is so great that it cannot be absorbed easily: facing their own budget crunch, for instance, state governments today are wary of Medicaid expansions even when a significant share of the additional cost is paid out of federal funds. Education, national defense, homeland security, and a variety of other needs create budgetary pressures that inevitably are going to force the federal government to constrain health cost growth, one way or the other. *Any simple expansion in government health expenditures sooner or later will only add to the requirement to constrain the growth of total government health care expenditures.*

Average Health Care Spending

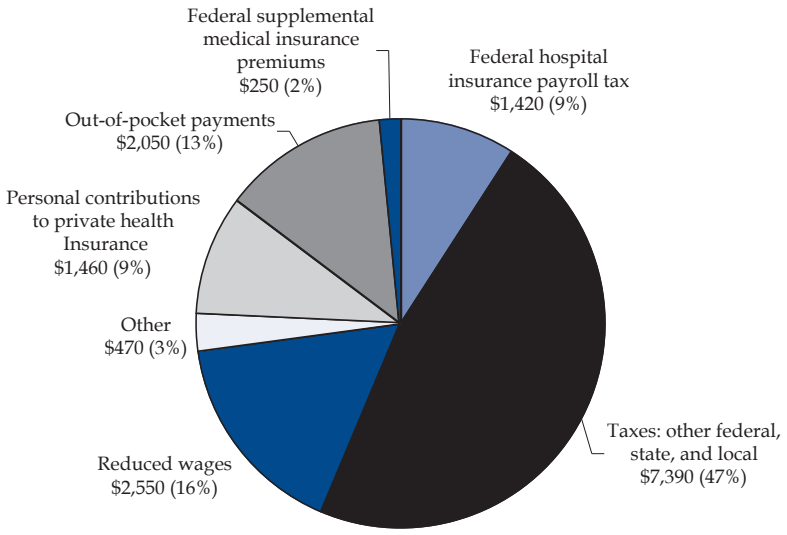
For 2003 average health care spending per U.S. household was approximately $15,600, of which less than $4,000 was paid directly out-of-pocket or as personal contributions to health insurance (see figure 1). Approximately $8,800 per household is paid through federal, state, and local taxes to fund government health programs and to compensate for revenues lost due to the special tax treatment of certain health-related income. More than $2,500 per household was paid indirectly through lower wages in return for employer-provided insurance, and around $500 was paid for through such non-patient revenue as charitable donations, hospital parking, and gift shops. *It is simply not possible to continue the myth that $1,000 or $2,000 will purchase meaningful catastrophic health coverage for a household when $15,600 is the average household health spending.*[111]

[110] See for instance Budget of the United States Government, FY 2004, Historical Tables, Table 16.1—Outlays for Health Programs, 1962-2008, p. 299; and 2003 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, p. 7.

[111] These calculations were first made for 1992 in C. Eugene Steuerle, "The Search for Adaptable Health Policy through Finance-based Reform," in Robert. B. Helms (ed.). *American Health Policy: Critical Issues for Reform*. Washington: AEI Press, 1993, and for 1996 in C. Eugene Steuerle and Gordon B. T. Mermin. "A Better Subsidy for Health Insurance." In Grace Marie Arnett (ed.). *Empowering Health Care Consumers through Tax Reform* (Washington, DC: the Galen Institute, Alexandria, VA: 1999). During that period, average costs rose from about $8,000 in 1992 to $11,000 in 1996 to more than $15,000 for 2003. The notion that there

FIGURE 1

Average Health Care Costs per Household by Source, 2003 (Total = $15,590)



Source: C. Eugene Steuerle, Urban Institute, 2003. Based on data from the Centers on Medicare and Medicaid and the Budget of the U.S. Government, FY 2004.

Infinite Demand at a Zero Price

Crucial to the design of health insurance has been a feature that has plagued health costs, both private and public, to this day: most individuals receive, and most health care professionals provide, services without either having to pay more than limited attention to cost. Essentially, the patient and doctor negotiate over what is paid for by *other* members of the insurance plan—in the case of Medicare, the taxpayer. In effect, public benefits have expanded without any real cap on cost except as laws and regulations (public and private) attempt to limit the services eligible for reimbursement or the reimbursement rate. Efforts to limit payments through managed care, managed competition, and capitation payments have not yet succeeded in breaking through this incentive system. Meanwhile, the higher costs lead to more people and employers opting out of insurance. *The budget burden of existing government health subsidies grows at an unsustainable rate largely because the design of health insurance often leaves decision-makers indifferent to added costs for society and discourages ratcheting down the price of existing services in ways that are common to other growth industries.*

Bang per Buck on Incremental Expansion

A variety of incremental expansions of the existing health care system are often proposed. Economists put these expansions into their various economic models, and then typically conclude they have limited bang per buck:

- Patched onto an existing labyrinth, the incremental expansion typically tries to target a harder-to-engage population.
- A new government subsidy often reduces incentives to engage in other private coverage arrangements, such as existing employer-provided health insurance. This crowd-out ef-

is no money available for reform is belied by the costs imposed simply by staying on the current path.

fect leads to a further shift from private funding to public, thus weakening the net impact of any additional public funding on provision of additional health care.

Because they are typically accompanied by shifts from the private to the public sector, most incremental expansions in government programs cost government much more than the cost of any net additional health insurance or health care received.

Who Should Be Subsidized? Who Should Pay?

If a new government subsidy system is designed so that all households with moderate incomes are to be heavily subsidized, then the cost of the program will be quite high, and a large share of that cost will go to subsidize those already insured. If, on the other hand, all moderate-income people are to be only modestly subsidized, then the complaint is that those in this income group who are currently uninsured still cannot afford to buy insurance. To complicate matters more, most moderate-income insured individuals already spend amounts that many reformers consider too high to impose on those who are not insured. Those paying already usually pay through a reduction in cash wages (at least according to most economic theory) when receiving employer-provided health insurance. *To save on costs, many proposals opt to heavily subsidize moderate-income individuals without insurance, but then they deny some or all benefits to equally deserving moderate-income taxpayers who already buy their own insurance, usually through their employers.*

Growth and Productivity within the Health Sector

Investments in health ideally should be targeted to meet the greatest need per dollar spent. Over time, constantly readjusting to new needs and new opportunities requires attention to health sector productivity. Alone among major growth sectors, the U.S. health sector maintains significant increases in quantity of production not matched by declines in relative prices.[112] (Consider, for instance, how prices drop for existing products in other growth industries, such as computers and telecommunications.) The result is very high-cost growth, which leads to more demand for public cost controls. In turn, these cost controls threaten new technologies, partly because vested interests fight to maintain higher prices for existing goods and services, thereby reducing directly or indirectly what regulators might make available to spend on newer items. Even today, we under-invest in some services that may significantly improve health and over-invest in some services with minimal, if any, positive impact on health. For instance, many forms of unsubsidized preventive health are known to yield higher returns than many forms of subsidized acute care that have little if any positive impact on health.

Within one or two decades, half of all spending on health care will be for products and services not available today. A gigantic bargaining session with government bureaucrats or elected officials, however, simply is not going to be able to determine easily what those new products and services should be in that doubly large market. The decision over what new items to produce must be determined in part by a private sector that tries to balance the costs against the benefits of the goods and services they will receive.

Put another way, if an economy is to grow optimally, resources have to be allocated to areas of production where they yield the highest net return. Under ideal conditions, freely operating markets tend to produce that result, because prices adjust so that resources command the highest price where they are most valued. But when government makes resource allocation decisions, or when buyers pay prices that are different from market-determined prices—both of which are true for many health care services—resources do not

[112] See Figure 3 in Rudolph Penner and C. Eugene Steuerle, "Budget Crisis at the Door," (Washington, DC: The Urban Institute), forthcoming.

necessarily flow to areas of greatest value. We should therefore strive, where practical, to create a structure where consumers are aware of the true resource cost and bear the burden of deciding to consume additional health resources. Of course, this is easier said than done, and we have to combine such a strategy with policies that ensure people can afford to have adequate access to high-value health services. *Health reform proposals cannot ignore the difficult requirement to choose the best health goods and services in the future—a requirement that forces individuals to face directly some of the costs of their decisions, particularly the costs of the insurance they buy.*

Engaging the Market and Adverse Selection

If direct cost controls cannot be used fully to restrain cost, then the only other real option is somehow to let individuals—or intermediaries acting on behalf of individuals—make more choices within an incentive structure that encourages economizing. However, when people are allowed choices among benefits packages, delivery systems, levels of cost sharing, and so forth, some risk segmentation almost inevitably arises. The healthy always have an incentive to pursue other healthy individuals to join with them in common risk pools, leaving the less healthy behind with much higher insurance costs or the inability to buy insurance at all. By allowing individuals to recognize cost and match benefits to prices, however, more output can be produced at a smaller cost, and market production can better match consumer preferences about how the same amount of money should be spent. Thus, productivity/efficiency and risk selection go hand in hand, a conclusion that neither proponents nor opponents of market-based reform like to admit. *Greater market efficiency through private decision making leads to some adverse selection, thus requiring a delicate balancing act.*

The Welfare Dilemma

Often what appears to be the simplest solution to expanding health insurance coverage is to adopt a welfare model and put all the money at the bottom of the income distribution, where people are least likely to have insurance on their own or to be able to afford it. Actually, to get the most at the bottom and achieve maximum progressivity means continual expansion of a system like Medicaid, with fixed income points for determining eligibility. Any alternative scheme of phasing out benefits means that a larger share of the money is spent at income levels above, and a smaller share below, some notch point where benefits are suddenly taken away. This classic welfare dilemma arises from the tax systems implicit in transfer programs. *Substantial means testing in health programs, whether through notches or phase-outs of benefits, entails many of the problems associated with welfare systems: large penalties for additional work (often one more dollar means the loss of thousands of dollars of benefits) and huge marriage penalties for groups of people for whom marriage is a route out of poverty.*

What to Do?

In sum, any proposal must operate in a world with:

- government health care costs that must be constrained;
- average health care spending well in excess of what most people (and members of Congress) think is average;
- infinite demand when health insurance offers services at zero or close-to-zero prices;
- poor bang per buck for most incremental expansions;
- subsidies for the uninsured often not granted to or proposed for other equally deserving taxpayers who get insurance from their employers or buy it on their own;
- beneficial long-term effects when people face choices and are engaged in recognizing costs along with benefits and differentiating services that make them healthy and produc-

tive versus those of lesser value;

- adverse selection and market efficiency that go hand in hand; and
- the classic welfare dilemma that: any system of phasing out benefits creates a tax system unto itself with its own set of distortions that must be addressed.

Health care proposals often ignore or fail to deal with one or more of these dilemmas or constraints. No proposal is fully developed if it ignores the existing health care budget or what people spend now, creates large adverse selection, or implicitly builds a new, large, crazy quilt tax system.

Facing up to a dilemma, however, does not mean finding an easy way around it. It simply means that one has a better chance of choosing feasible policies. Here is one example:

Research on the incremental value of any modest legislative expansion in publicly provided health coverage often shows little bang per buck. This research is not consistent, however. It is not the analysis that fails, but what is analyzed. In particular, there appear to be no studies of the marginal impact on coverage of expansions that take place *automatically.* Consider the increasing amount of tax revenue spent to cover the existing, uncapped, employee tax exclusion for employer-provided insurance. Here is an expansion that *reduces* the number of insured and costs taxpayers more each year. That is, the uncapped tax exclusion helps promote higher costs for health insurance, which in turn causes fewer people to buy insurance. If the incremental tax dollars foregone because of the employee exclusion were transferred to a more universal credit that was capped, there could be a net reduction in the number of uninsured at no additional cost. Put another way, the "bang per buck" analysis can be used to guide *relative* shifts in priorities even if most absolute increases in health care spending can be shown to yield very modest net gains per dollar of additional cost.

In simplest terms, I believe one must engage the dilemmas, recognize the validity of concerns that drive each side of each dilemma, and then tackle the trade-offs that are required.

In a world of trade-offs:

- expenditure-neutral and revenue-neutral options are considered;
- the marginal impact of automatic growth is not ignored but juxtaposed with policy alternatives;
- carrots and sticks are considered simultaneously, taking into account various inequities (those who pay more than others who are in equal circumstances);
- the constraints of limited resources and limited ability to create perfect equality or avoid all adverse selection are recognized; and
- the regulatory nature of any insurance scheme, private or public—its effects on the demand for health insurance, market growth, adverse selection, and tax systems—is engaged, not disdained.

A Reform Package

The package of reforms offered below is directed at taxpayers at all income levels but is not meant to be an all-encompassing solution to providing universal health care. Nor is it meant to be a replacement for a Medicaid or a welfare-type system for those with low incomes, although one could build on the basic package to develop a replacement. Moreover, it extends its reach to many low- and moderate-income people who fall through the cracks of all systems. For instance, Medicaid leaves out large numbers of single people and households that, although eligible, simply do not apply for Medicaid (either directly or by way of cash assistance programs like Temporary Assistance to Needy Families (TANF), whose administrators often tie beneficiaries into the Medicaid system).

What this proposal seeks to do is gradually replace the principal existing system of sup-

port now provided largely to moderate- to high-income people in a way that increases insurance coverage, leads to greater cost constraints, and otherwise creates market incentives for a more efficient, yet growing, health market. This approach also recognizes the need to engage people in the broad middle class in the ways they receive most health care and pay for most health insurance, whether through taxes, reduced wages, or direct purchase. It seeks to engage them more actively in making decisions, especially about purchasing insurance, in ways that would improve the efficiency of the health market for everyone. Improvements in the base system that applies to most taxpayers make it easier to integrate a reformed Medicaid system with the type of credit-based system suggested here.

Finally, this proposal is perhaps unique in showing that it is possible to improve the efficiency and equity of the system without adding to cost, although it may be desirable to incur some additional costs under the reformed model to increase the size of subsidies.

Social Insurance and Mandates

The crux of this reform package is its attempt to move health insurance subsidies into a system of social insurance in a consistent and coherent way. Unlike a welfare approach, social insurance deals directly with the obligation to pay, not just the need to receive. There is not enough room here to engage fully this important distinction.[113] Nonetheless, some brief comments are in order.

Although health reformers often advocate subsidizing health insurance, especially for low-income individuals, such a policy really involves two separate goals. The first is helping individuals have enough income to purchase health insurance, and the second is requiring individuals to purchase health insurance (since the subsidy cannot be used to purchase any other good or service). Each goal—greater progressivity (achieved by subsidies) and mandated health insurance coverage—must be justified in its own right. Even in the case of an insured Medicaid enrollee, it is not automatic that the amount spent on health insurance has greater societal value than other uses of the funds, such as a better education or more clothing.

Similarly, subsidizing health insurance at moderate- to high-income levels mixes two goals, the subsidy and the mandate that it be spent on health insurance. When these goals are separated, it becomes obvious that the employee exclusion for employer-provided health care is not progressive at all, since it distributes much more to the rich than the poor. Moreover, a little-known but telling fact is that it is becoming more regressive over time as more moderate-income individuals fall out of the employer-provided insurance market. Yet, one may still want to coax, through subsidies or mandates, insurance coverage at middle- and high-income levels. In effect, income redistribution as a goal of policy can be separated from requiring or encouraging people to buy health insurance.

The ability of some individuals to ride free on others' tax and insurance payments is a problem that applies to all income levels. Those who are not insured, even if they have average incomes, bear some risk that they will be unable to pay a large or catastrophic expense. This expense may then be met out of public funds (for instance, if the expense makes them eligible for Medicaid) or private funds (if private insurance helps cover the cost of uncompensated emergency care in hospitals). Hence, not all the "uninsured" are entirely uninsured: many effectively have a backup insurance policy that is paid for either by the insured or other taxpayers. For people with low to moderate income levels, the cost of buying insurance is high relative to income, while their lack of private resources means that the value of the backup insurance policy

[113] See, for instance, Eugene Steuerle and Jon Bakija. *Retooling Social Security for the 21st Century*. Washington: The Urban Institute, 1996.

(the chance that they will become eligible for assistance) is greater. Hence, while mandates common to social insurance may be harder to enforce at lower income levels, it is at those income levels that the greatest inequity exists between those with equal financial resources who purchase and do not purchase insurance.

As an example, economists would assert that employees with $20,000 in wage income and $5,000 in a health insurance policy from an employer essentially earn $25,000 in income, 20 percent of which goes to buy health insurance. If other employees earning $25,000 a year do not purchase health insurance, they may have a backup policy with an expected value of, say, $2,000, and they ride free on the contributions of those who do purchase insurance or pay taxes. This creates an equity problem known formally as "horizontal inequity," "unequal treatment of equals," or "unequal justice before the law."

Social insurance solutions recognize that these inequities must be tackled; at the same time, they may approach the progressivity issue separately by providing greater subsidies for those having less income.[114] Here, unlike the current health insurance system, concerns over horizontal equity are met through a system of mandates. The requirement that individuals buy automobile insurance or pay into a Social Security system are examples of how social insurance is used to deal with similar considerations of equity. Thus, motorists capable of buying insurance are not allowed to remain uninsured, thereby shifting costs onto others; nor are those with the ability to make contributions to a retirement system allowed simply to fall back on public support in old age without making contributions along the way.

[114] Social Security, for instance, was intended to be progressive. Even though annual benefits are higher for higher-income taxpayers, their annual taxes are higher still. Whether Social Security has achieved that goal (largely due to different mortality rates) is another matter.

With this social insurance setting, here then is the package of reform elements that might be put into a reform plan:

Summary of the Reform Package

- A simplified, moderate subsidy to purchase insurance, available for use in either the employer-provided or the individual market.
- The subsidy would be a flat dollar credit amount offered in lieu of the employee exclusion for employer-provided insurance, available to people at all income levels, whether taxable or not.
- The subsidy would not be meant simply to be a low-income subsidy but to replace existing middle-class and upper-income subsidies.
- An indirect mandate on individuals: if they do not obtain health insurance coverage, they would be denied the benefit of some subset of federal tax preferences such as the child credit, personal exemption, higher education subsidy, or itemizing deductions.
- Note that the poor generally would not be subject to the mandate since they do not pay federal income taxes; moreover, many are eligible for Medicaid.
- A fixed (but unindexed) cap on the value of employer-provided health insurance that can be excluded from taxation enforced through some liberal or simplified "safe harbor" rules for calculating whether the cap has been exceeded.
- As the cap becomes more restrictive (as health care costs escalate), more individuals and employers would move to the credit-based system; eventually the cap would become low enough that the exclusion of employer-provided health benefits would effectively be replaced by the credit.
- A requirement that employers (perhaps with some additional, front-end modest subsidy) at least offer health plans that employees could buy, and that the purchase cost of such plans be deducted from wages to the extent costs are paid directly by employees.

- A parallel requirement that any individual subsidy offered by the government would be reflected in wage withholding.
- An option for employers who provide insurance: insurance can be automatically provided and charged to the employee unless the employee formally opts out of coverage.

The Credit

Until more revenues can be raised, the size of the subsidy might need to start out small, say, an average of $1,000 per household (more for larger households, less for smaller ones, based on household size). To simplify and encourage coverage of children, I suggest not varying size of the credit by age. However, determining the credit on a per capita basis need not be a crucial element. I have suggested in the past that a credit-based system might first apply only to children, and then be expanded later to cover adults. If this were the case, then the mandates discussed below (removal of some tax preferences) would have to apply only to child-related preferences.[115]

While the cap on employer-provided insurance might raise only modest amounts of revenue at first, these added revenues would grow considerably over time, because the cap forestalls automatic growth in the annual cost of this exclusion, which, as currently structured, is estimated to grow by more than $50 billion after only five years. Extrapolating further shows yields over $100 billion annually after eight to 10 years. *This proposal suggests taking a significant share of that growth and converting it to a credit offered equally to all those insured.*[116]

The credit would be available for privately purchased health insurance, or insurance purchased through an employer with either employer or employee money.

The Mandate

Mandates on individuals to buy health coverage are not a new idea. The version I prefer is not a complete mandate, but one that relies on penalties that can reasonably be assessed. During the early 1990s, when President Clinton proposed health reform, mandates on employers were considered. This is the wrong locus for imposing a mandate, however; the logic of social insurance requires that the mandate be imposed on individuals. When placed on employers, the mandate does not apply to large segments of the population and operates more like a minimum wage requirement that could adversely affect employment.[117]

But this raises an additional set of issues. How can an individual mandate be enforced? I do not believe that a *complete* mandate to buy insurance can be enforced—the Achilles heel of many proposed reforms. After all, what would one do with scofflaws? Throw them in jail? In addition, the mandate must apply at many moderate-to-middle-income levels where some people buy insurance and others do not. At those income levels, there are often inadequate resources available to pay any large penalty, even if it were desirable to impose and possible for the Internal Revenue Service (IRS) to hire enough enforcement personnel. I am led to believe that the proper form of a mandate should be a simple penalty—eliminating the ability to benefit from some items of tax relief, such as a child credit, personal exemption, itemization of deductions, or educational tax benefits. (Indeed, re-

[115] See, for instance, C. Eugene Steuerle and Jason Juffras. "A $1,000 Tax Credit for Every Child: A Base of Reform for the Nation's Tax, Welfare, and Health Systems." Working paper prepared for the National Commission on Children, Changing Domestic Priorities Project, Urban Institute, April 1991, and C. Eugene Steuerle. "Beyond Paralysis in Health Policy: A Proposal to Focus on Children." *National Tax Journal* (September 1992): 357-68.

[116] Note that the increase in costs will not equal the revenues made available by a cap, since some share of the increased cost is caused by those policies whose costs grow, but which are still below the cap. Also note, however, that the tax expenditure budget ignores the tax subsidies provided through both Social Security taxes and state individual income taxes.

[117] See C. Eugene Steuerle. "Implementing Employer and Individual Mandates." *Health Affairs* (Spring 1994): 54-68, and Mark V. Pauly. "A Case for Employer-Enforced Individual Mandates." *Health Affairs* (Spring 1994): 21-33.

cent child credit expansions could have been designed in such a way as to lead to substantially increased health insurance coverage. An enhanced child credit might still be used for this purpose.)

Reduced public costs for covering the uninsured could be used to offset the loss of tax subsidies (such as the child credit). Moreover, the money raised by the mandate could be spent in the same income classes from which it came. In that way, any overall progressivity goal could be maintained. Or it could be spent on further subsidies to states to help low-income households obtain health care, in which case progressivity would be enhanced. The point, again, is that distributional (progressivity) issues could be resolved in ways that still recognize the importance of horizontal equity issues in social insurance (that people at equal levels of income or well-being have equal obligations).

The Cap

To help pay for this package of benefits, as well as to help reduce health care costs over time, there would be a cap on the value of employer-provided health insurance that would be tax-excluded.

One objection to this cap has often been that it is difficult to calculate the amount of benefits provided in excess of a cap. Accordingly, this cap would operate with some fairly liberal safe-harbor rules, such as a monthly limit of, say, $500 per employee with family coverage and $250 per employee with some form of individual coverage. The safe harbor might not require separate calculations even if employees choose from among different plans that in the end have different values (for example, if an employer provides $400 for half of employees' families and $550 for the other half, it would still comply with the $500 on average safe harbor). Employers operating within the spirit of the rule could also propose other safe harbors to those regulating the system. It is important to remember that the cap becomes tighter as health costs rise relative to its fixed nominal amount, while the value of the credit rises as the revenues from the tighter cap are shifted toward the credit-based subsidy. Slight inequities in the value of tax subsidies around the cap value are small compared to the current inequities between those who are subsidized for expensive insurance and those who get no subsidy at all.

To ease their own administrative responsibilities, employers likely would gravitate toward the type of plan operated for decades by the federal government. Under this plan, employees paid out of after-tax income for any cost of insurance above some limit. For instance, if they wanted the Blue Cross high-cost option, they might pay $100 extra a month, whereas if they accepted the Blue Cross low-cost option, they paid only $10. The $100 or $10 in this example was essentially taxable. The calculation was clean, straightforward, and easy to administer. No one complained about the administration or possible difference in value of insurance, which generally would be far more important than any small difference in the value of the tax break surrounding the insurance.

Flexible payment, cafeteria, and other plans offering individuals options to put aside money tax-free also would be restricted to ensure that the cap is not exceeded.

After a period of time, I expect employers would generally adopt a defined contribution approach to the purchase of health insurance since that fits in easily with a credit-based system. They might make employer contributions or rely on employee contributions or both, but the design and administration of contributions would resemble that of 401(k) retirement plans.

As the credit grows in value and the exclusion remains fixed, more employers would switch to the credit-based subsidy option. Thus, the cap would provide increased revenues that would be used for the credit (which might also be indexed at a minimum to grow

with inflation or, for awhile, with wages). Also, I expect that Congress might even periodically decide to bump up the value of the credit. As the credit grows, and the cap does not even keep up with inflation, more employees and employers will opt for the credit rather than the exclusion. Eventually, the exclusion itself might be eliminated.

As employees see more directly the net effect of health insurance purchases on their total compensation, they would also likely begin to push employers to offer lower-cost health plans. Many employers would likely see some advantage to making costs more explicit when the time comes to bargain with labor over total compensation packages. Retirement plans have been moving in this direction for some time, for similar reasons.

Engaging the Employer

A system with individually based credits that is badly designed could disrupt the market in which employees purchase insurance directly or indirectly from employers. Employer involvement eases administration and decision making for individuals, so it should continue to be encouraged—although not at the cost of discriminating against those who are not offered employer-based plans. Some advocates of individual credits have discounted or deprecated the value of employer participation. I do not. Indeed, I suggest that there are ways to build on and expand employer participation.

Accordingly, employers would be involved in this package of benefits in three different ways: (1) through a requirement to offer plans; (2) through tax withholding adjusted for both size of credit subsidy and withdrawal of some tax benefits for those who do not declare themselves insured; and (3) through an option whereby employees can be placed into a health insurance plan unless they opt out.

The Requirement to Offer Plans. All employers would be required to offer (but not necessarily pay for) coverage. Thus all employers, large or small, would eventually be involved directly or indirectly in encouraging their employees to purchase health insurance. An employer that is contributing to the coverage premium would have to decide between using the employee exclusion tax benefit and converting to the credit-based system. An employer that does not contribute to health coverage would still have to offer coverage, for which employees could claim the tax credits.

This health reform package avoids both mandating that employers buy insurance for their employees and limiting the credit to only employer-provided insurance. The proposal envisions an individually based system in terms of both mandates and subsidies. At the same time, it seeks to engage employers in implementing this system, taking advantage of their natural ability to organize, communicate with employees, and, if the employer is large enough, create a natural insurance pool.

There is substantial evidence in the field of retirement plans that individuals save much more when offerings are made through employers. For instance, although individual retirement accounts (IRAs) are freely available to most individuals, less than 10 percent of eligible individuals invest money into such accounts each year. Yet, when employers offer retirement plans, participation rates by individuals making their own deposits are much higher, often ranging from 30 percent to 80 percent (even when there is no employer match). Merely offering plans, I believe, will substantially reduce the numbers of uninsured. This requirement dovetails nicely with the requirement to reflect various individual subsidies and mandates in wage withholding, discussed next.

Withholding. The employer would administer both the credit subsidy and the mandate (a penalty for those who do not declare themselves insured) in the same way other taxes or contributions for United Way are administered. Note that this combined effect on incentives could be significant, even though the

subsidy and the mandate, each by itself, might only be modest.

Suppose, for instance, that the subsidy (the carrot) would reach $1,000 over time, and that the loss of other tax benefits for those who remain uninsured (the stick) would also be $1,000. Together, that provides a net incentive of $2,000 for an individual to buy an insurance policy for his or her family, a sum not obtainable if the reform were to use only carrots or only sticks. Approximately $170 a month would not be enough to purchase a good policy outright, but for many households it might cover more than half the cost of a policy with some basic protections, including catastrophic care and normal checkups.

Opting Out Rather than Opting In. The final point of employer involvement takes advantage of yet another facet of the employee benefit world. It turns out that participation in retirement plans appears to be much higher when employees are automatically enrolled unless they opt out, rather than requiring them to opt in. The same should be true in health care.

This reform package would not *require* employers to offer participation on an "opting out" basis, but I suspect that many might decide to do so. In addition to encouraging better insurance coverage for employees, the "opting out" strategy might make it easier to increase tax withholding on employees, because these employees could be asked to declare at the same time that they opt out whether they have coverage elsewhere for their families.

Minimizing the Administrative Burden on Employers

How can these requirements and options be designed to minimize administrative burdens placed on employers, especially small employers? To start, each employer could offer as many plans as it desired, but the requirement to offer any plan at all would apply only if at least one plan was available to the community and approved by the state. (States would have to face some trade-offs in deciding how comprehensive the plan must be, but some catastrophic element probably would be required in all cases.) The availability of a credit almost guarantees that over time different insurers would try to offer plans and would lobby the state to approve the plans. Meanwhile, the state would want to get the best health care value for its citizens and, thereby, would have an incentive to make sure some plan was offered, so as to garner federal money into the state. As with many elements of this package, it would take time for these developments to take place, and the small employer might not be able to offer a plan until the state made sure at least one was available. But the incentives of this reform structure likely would result in most employers of all sizes eventually offering plans.

Any changes in tax withholding would also be very simple. For proof of insurance, the employer could rely on evidence that an employee had accepted some health insurance plan the employer offered. For other health insurance, the employer could be allowed to rely on a statement by the employee that the employee and his or her family were insured. This means that compliance would depend on self-reporting by the individual, but the formal requirement to make a statement, with its perjury implications, often goes a long way toward minimizing cheating. The employer's primary burden would be to approach those not insured through an employer-provided plan periodically—say, twice a year—perhaps at the same time that employees are approached with the option to buy into an employer-offered plan. This periodic questioning of employees would reinforce the need to buy insurance and the personal cost of not doing so—as much as it would help to make withholding more accurate.

Since the credit amount would not phase out with income, its exact value each month would be known in advance. The withholding

would be easy and exact. As for the penalty, it would use the same formulas that already are implicit in tax withholding schedules for number of dependents and so forth. The IRS would provide the same type of alternative look-up schedules already used by employers. Depending on the exact nature of the mandate adopted, the change in withholding might entail nothing more than changing to zero the number of personal exemptions and child credits that could be claimed.

The final point of employer involvement entails an option to enroll employees automatically unless they specifically ask to be excluded (and indicate that they have insurance elsewhere to ensure correct withholding). There would be no additional requirement on employers at all, and the administration of this option likely would not be any more difficult than the opposite approach, whereby employees elect into (rather than out of) an employer-based health insurance system. In any case, there is no extra administrative burden unless the employer chooses to use this particular system.

Back to First Base: How the Package Approaches the Dilemmas and Constraints

With this package, I would take money that actually contributes to a decline over time in health insurance coverage (because of its effects on rising costs) and redirect it in a way that should expand coverage. Moreover, this plan reallocates the money in a more progressive manner. At the same time, I have tried to make costs and benefits explicit to improve the decisions about future health care. Thus, I believe that as the credit and mandate system takes hold, and employers move toward a defined-contribution approach, often combined with a fixed-dollar premium contribution per employee, the costs of insurance would be made much more explicit. And as those costs are made explicit, workers would grasp more completely how much they are willing to pay for insurance, or get in employer benefits, relative to the cash wages they receive. Moreover, with a capped subsidy and recognized costs above the subsidy, individuals would have a significant incentive to bargain to add features to plans that limit costs over time. The improved market for health insurance, in turn, would reduce health costs for everyone over time, thus leading to increased insurance coverage (or lower rates of drop-out from private coverage). In a sense, this part of the plan is a variation on the "managed competition" approach to health reform, but one that recognizes that the main goal is to get the incentives lined up correctly, not to pick some one-size-fits-all approach such as managed care, preferred provider organizations, or system with larger co-payment rates.

At this point, it is worth stepping back and asking how well this package addresses the dilemmas posed at the beginning of this essay. In my view, all reform plans—as well as current law—should be forced to run this gauntlet to see how they stack up against each other. Let me be clear. There are costs associated in any approach to resolving a dilemma; that is why it is a dilemma. This package expands health insurance coverage at zero cost (or modest cost, depending on size of the subsidy) to the government, but it does not solve the problem of providing universal health care, nor does it avoid all adverse selection. Along with expanded coverage, therefore, the package seeks to provide a viable way of improving significantly the existing market at a reasonable cost.

The Budget. A share of the existing resources spent on health care would be frozen and then re-spent on a gradually improving set of options for individual purchase of health care. Over time, Congress could add to the subsidy side of the ledger, but by discretionarily increasing the value of the credit as opposed to automatically increasing the value of an inefficient exclusion that is becoming

more regressive over time. Here, I have concentrated on restrictions on the employee exclusion of employer-provided health care, but I believe this type of budgetary model can also be extended to areas like Medicare in ways that induce more cost consciousness and help to increase insurance coverage. But that is another subject. Paying for some or most changes, as well as improving the incentive structure to reduce costs over time, would go a long way toward resolving the budget dilemma.

Average Health Care Spending. In applying restrictions on the existing subsidy, employers would calculate under various alternatives the cost of the health insurance they provide. More and more these costs would be stated explicitly on the health policy itself, and purchases of insurance above some cap would be recognized explicitly as coming from after-tax income. Eventually the system would convert to one for which accounting is done on a contribution basis where employees see fairly explicitly the value of the government subsidy, the value of the employer payment, and the total cost of the insurance. They would gradually come to recognize their costs, both in out-of-pocket payments for insurance and in reduced cash wages. They would start making decisions that could lead to a health insurance system that provides both lower growth in average health care costs and better health care per dollar spent on insurance.

Infinite Demand at Zero Price. The credit amount offered to most middle-income taxpayers would not be sufficient to cover the cost of health insurance. However, since it applies only to the first dollars of insurance purchased, at least the price of additional insurance becomes more explicitly recognized. To cover costs not met by the subsidy, I would expect that plans would make even greater efforts to offer better coverage at lower cost through a variety of techniques. These include the use of co-payments that force the purchaser to bear some of the cost of various decisions, such as whether to purchase generic drugs, and still newer approaches to preferred-provider and health-maintenance types of options. Such options, I believe, would expand simply as a matter of economics, despite their disagreeable aspects that relate directly to making costs explicit. Nonetheless, the reform package suggested here does not entail specifying how they will evolve; new market experiments are continually required.[118] At the same time, the reform plan does not anticipate stopping individuals from buying wrap-around policies, nor does it attempt to regulate such efforts.

Bang per Buck per Incremental Expansion. The expansion in health insurance coverage is done in a way that entails little or no net increase in government health costs. That is, much or all of the expansion would be paid for through a cap on the existing exclusion, through a credit to many who do not now receive any subsidy, through some redistribution of subsidies from higher- to moderate- and middle-income households, and through the tax penalties imposed on those who fail to comply with the mandate. Moreover, the growth rate in costs likely would fall over time with greater consumer awareness of those costs. Even if the subsidy or credit amount is greater than what can be financed through other cutbacks—that is, if some new budget outlays would be required—I still expect a remarkable improvement over current law and most other reform options. One reason is that a variety of cost-improvement mechanisms are built into the policies, including the cap on tax-free employer-provided benefits and the movement toward a defined contribution system where people see

[118] Uwe Reinhardt recently demonstrated that chronic activity is inherent in health reform since payers and providers view each other with permanent suspicion. One implication, I believe, is that reform has to be developed in a way that channels this activity, rather than seeks some permanent solution to an ever-evolving health marketplace. See Uwe E. Reinhardt, "Churchill's Dictum and the Next New Thing in American Health Care," Business Economics (July 2003): pp. 38-52.

and bear more fully the full cost of health insurance expansions. Over time these not only should lower the cost of insurance from what it would otherwise be, but in the process, help to expand the numbers of those who can afford to buy health insurance. Of course, the tax penalty imposed on middle-income taxpayers who do not purchase health insurance also would raise revenues that could be used for health insurance expansion at no budgetary costs.

Who Should Be Subsidized? Who Should Pay? This proposal produces parity among taxpayers with roughly equal incomes. No one would be penalized with denial of a credit simply because he or she had already purchased health insurance. Of course, adherence to the equal justice principle also meant that no attempt was made to allow the government to offer some new subsidy only to those who don't have health insurance. At the same time, the penalty for not purchasing health insurance would improve horizontal equity over current law.

Economic Growth and Productivity of the Health Sector. The proposal leaves a wide range of decisions to individuals or to intermediaries such as firms operating on their behalf. This decision-making is especially important for growth to occur in an evolving market where the basket of goods and services offered over time is going to change rapidly in ways that cannot be foreseen or controlled by some government bureaucracy.

Engaging the Market and Adverse Selection. Again, the proposal relies heavily on individual decision making and recognition of the cost of insurance as a way of improving the market for health care. That does not mean that adverse selection cannot become an issue. I believe, however, that it is a mistake to try to write some one-size-and-time-fits-all regulation to try to limit such selection. States would retain some flexibility in what they offer in the way of assistance, and the credit could be restricted to plans covering some minimum number of individuals (thus, effectively creating some minimal amount of "community rating"). However, many employers operate in many states, and individuals cross state lines all the time. Therefore, I do not want to impose multiple levels of state regulation that may be difficult to administer and enforce across state boundaries.

The Welfare Dilemma. Partly for administrative reasons, the credit suggested here does not phase out with income. Thus, there is no new implicit tax system created and no notches where one suddenly loses all benefits. Moreover, to the extent that people now face a notch in Medicaid, it will be smaller, as they will immediately be eligible for the credit when they earn one more dollar and lose their Medicaid. As noted, Medicaid itself could be reformed to take advantage of this credit base, although I have not dealt with that issue here.

Conclusion

Through careful design, it is possible to expand health insurance coverage at little net cost to government. A social insurance approach to health insurance reform is superior in many ways to a welfare approach, because the former explicitly de-couples the issues of who should be subsidized with who has some obligation to pay for benefits received. Thus, the social insurance approach works separately but simultaneously on both the subsidy issue and the mandate or requirement to buy insurance. The credit-based subsidy proposed here creates better incentives to buy insurance and is more progressive than the employee exclusion that grows increasingly regressive over time. At the same time, any mandates arising out of a social insurance scheme should be imposed on individuals, not employers, and they should be practical and easy to administer. The proposal suggested here adopts a partial mandate because of practicality constraints, but it will also expand insurance coverage and improve equity between

those who do and do not purchase insurance. Finally, health insurance coverage can be expanded by taking advantage of employer involvement in offering employee benefits, including what we have learned about how to increase participation in employer-sponsored, defined contribution, retirement plans.

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Section 2

Commentaries

Chernew

Commentary Abstract

Michael Chernew examines three of the proposals prepared for Volume I of this project. The proposals—by Jonathan Gruber; John Holahan, Len Nichols, and Linda Blumberg; and Sara Singer, Alan Garber, and Alain Enthoven— can be categorized as "voluntary insurance pool proposals." After summarizing the three proposals, the author evaluates their effectiveness in terms of how they would affect the number of insured, their costs, and their effect on the distribution of financial benefits and burdens across income classes. He also assesses how they implement the theory of managed competition. The paper concludes with the author's views about some of the key design decisions that must be made in devising a coverage expansion plan of this sort.

About the Author

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Covering America: A Commentary on Three Approaches

by Michael Chernew

Introduction

In 2000, 15.8 percent of non-elderly Americans were not covered by health insurance, up from 13.7 percent in 1987.[119] This rise in the share of individuals without health insurance coverage occurred during a period of strong economic growth and expansions in public programs designed to cover the uninsured. For example, gross domestic product (GDP) per capita, adjusted for inflation, rose on average 2.1 percent per year over this period, and the share of non-elderly covered by public coverage rose from 13.4 percent to 14.1 percent. Moreover, forecasts suggest further declines in coverage if health care costs grow as predicted.[120]

There is a large body of literature examining the health consequences associated with being without coverage. Recent literature reviews conclude that despite serious shortcomings with that literature, the preponderance of evidence suggests serious health consequences associated with not having coverage.[121] In particular, Hadley[122] suggests extending coverage to all Americans would reduce mortality rates by between 10 percent and 15 percent among the uninsured. We would also expect significant impacts on morbidity and, perhaps, productivity.

The discouraging trends regarding coverage and the growing evidence of adverse health consequences of not having coverage have generated substantial interest in policy options that might increase coverage rates. In this spirit, The Robert Wood Johnson Foundation (RWJF) has funded a number of initiatives to promote increasing coverage of the uninsured. One of those is the *Covering America* project, directed by the Economic and Social Research Institute (ESRI). As part of that project, ESRI commissioned 13 individuals (or teams) to design policy initiatives that would increase coverage rates. This commentary examines three of those proposals. They are:

- A Private/Public Partnership for National Health Insurance by Jonathan Gruber
- Expanding Health Insurance Coverage: A New Federal/State Approach by John Holahan, Len Nichols, and Linda Blumberg
- Near-Universal Coverage Through Health Plan Competition: An Insurance Exchange Approach by Sara Singer, Alan Garber, and Alain Enthoven

These three proposals share many basic similarities. All are based on voluntary purchase of coverage without government mandates that individuals or employers purchase coverage. Each is built on a system of insurance purchasing "pools" that govern, with varying degrees of specificity, the market in which health plans compete. The regulations governing the purchasing pools are designed

[119] P. Fronstin. "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2001 Current Population Survey." EBRI Issue Brief (2001): 1–31.
[120] M. Chernew, D. M. Cutler, and P. S. Keenan. "Increasing Health Insurance Costs and the Decline in Insurance Coverage," working paper; R. Kronick and T. Gilmer. "Explaining the Decline in Health Insurance Coverage." *Health Affairs 18* (2) (1999): 30–47.
[121] J. Hadley. "Sicker and Poorer: The Consequences of Being Uninsured." The Kaiser Commission on Medicaid and the Ininsured, May 2002; Institute of Medicine. "Care Without Coverage: Too Little, Too Late. Washington: May 2002; H. Levy and D. Meltzer. "What Do We Really Know About Whether Health Insurance Affects Health?" ERIU Working Paper 6 (2001).
[122] Hadley, 2002, op. cit.

to create a managed competition setting and remove barriers to coverage through provisions such as guaranteed issue and community rating. Because each proposal relies on voluntary participation, each proposes a system of incentives, largely subsidies, to encourage the uninsured to purchase coverage. The managed competition/purchasing pool portion of these proposals can largely be thought of as independent of the subsidy/regulatory schemes. Subsidies and community rating could be implemented without these purchasing pools.

Because of the common features, these three plans can be categorized as "voluntary insurance pool proposals." The other 10 RWJF-funded proposals fall outside of this category and are not discussed here. Section 2 of this commentary outlines the key features of these proposals. Because of space constraints, the proposals are not described in great detail. More complete specifics of these proposals can be found in *Covering America: Real Remedies for the Uninsured* published by ESRI, June 2001. Shorter summaries and comparisons can be found in *Covering America: Real Remedies for the Uninsured*, Volume 2, published by ESRI, November 2002.

Section 3 reports estimates of the impact of the proposals on coverage and costs. These estimates are largely derived from a microsimulation model constructed by the Lewin Group.[123] Section 4 provides an overview of the managed competition system all three of these proposals rely on, examining implementation issues and what we might expect in a managed competition environment, including challenges that may arise in such a system. The final section concludes with an assessment of how proposal attributes might be most advantageously combined.

[123] John Sheils and Randall Haught. *Cost and Coverage Analysis of Ten Proposals to Expand Health Insurance Coverage.* Washington, D.C.: Economic and Social Research Institute, October 2003.

Proposal Summaries

Gruber

In the Gruber proposal the federal government oversees 51 mutually exclusive purchasing pools, one for each state and the District of Columbia. After a transition period, Medicaid and S-CHIP are folded into the purchasing pool. Any health plan may participate, provided it meets criteria specified by the federal government. Prices for enrollees are set on a community-rated basis within the pool, adjusted by family type, where the community rate reflects the set of enrollees in the pool. Any individual on his or her own, or acting through his or her employer, may purchase coverage through the pool and is eligible for a range of subsidies, discussed below. Employers choosing to enroll their employees through the pool must have *all* employees participate in the pool.

The incentives to join the pool vary by income level. Lower-income individuals are provided a plan "near" the median premium free of charge. The subsidy phases out at 300 percent of the poverty line. Employers are not explicitly subsidized, but their employees can qualify for the subsidy if the employer offers coverage through the pool. Consolidated Omnibus Budget Reconciliation Act (COBRA) requirements are also eliminated for employers purchasing coverage for their employees through the pool. All individuals face 100 percent of the marginal cost of plans with premiums above the median, though their employers can offset this contribution. Individuals in families above 300 percent of the poverty line save the full marginal cost if they choose a plan with a premium below the median. Individuals with family incomes between 150 percent and 300 percent of the poverty line receive only half of the marginal savings, and individuals in families below 150 percent of the poverty line have no incentive to choose plans with below-median premiums. Healthy, high-income individuals have the lowest in-

centive to join the pool, which suggests the pool is likely to attract a less healthy workforce on average.

Like the other two proposals, Gruber's requires risk adjustment. It specifies that risk adjustment between plans serving the pool will be based on prospective and retrospective factors. The prospective factors are based on survey data of enrollees to ascertain traits such as age, gender, and major illnesses. The risk-adjustment factor is a weighted average of expenditures predicted from these traits and actual expenditures.

The proposal creates a new federal agency to oversee pool operation (Private/Public Partnership Health Insurance Agency [PPPHIA]), which agency sets minimum benefit requirements. Plans may vary in terms of benefits offered above the core set of benefits (for example, inpatient, outpatient, and physician services). They may also vary in their cost-sharing provisions, network composition, and the set of managerial tools designed to manage care (for example, utilization management and provider reimbursement rules). Individuals report income every six months, but there is no "reconciliation" process. For individuals participating through their employers, the employers are responsible for income verification and other administrative activities for individuals who qualify for subsidies. Individuals can enroll during an annual open enrollment period. The PPPHIA (or, perhaps, the local pools or an independent commission) decides what information will be distributed at open enrollment.

The proposal is financed in part by placing some restrictions on the ability of individuals to exclude the costs of insurance premiums (above a threshold) from taxable income. Any costs above that are financed through state and federal general revenue.

Holahan, Nichols, and Blumberg

Like the Gruber proposal, Holahan et al. propose a system of state-based purchasing pools that would be open to all non-elderly in the state. There are several distinctions between this system of purchasing pools and the Gruber proposal. First, state participation is voluntary, and states are given greater flexibility regarding how the pools will operate, though, as in the Gruber proposal, the pools are designed to replace Medicaid and S-CHIP. Pools can also be more active purchasers than envisioned in the Gruber proposal. For example, they can negotiate with plans and opt to exclude some from participation in the pool. Second, enrollees are charged a *state* community rate, which is set independent of the set of individuals who select into the pool. Third, the state pools are required to offer a managed fee-for-service (FFS) plan. Fourth, employers may purchase coverage for some of their employees through the purchasing pool and may purchase coverage for others from insurers outside the pool. Fifth, while each area of a state will be covered by one (and only one) pool, there can be multiple pools, each serving different areas in the state. For example, there could be an insurance pool in Northern California and another in Southern California.

In the Holahan et al. proposal, states are given a higher Medicaid match if they participate in the program. Subsidies to households vary by income. Individuals in families below 150 percent of poverty are fully subsidized. Partial subsidies are given to individuals between 150 percent and 200 percent of poverty such that total copremium and cost sharing cannot exceed 7 percent of income. The maximum out of pocket rises to 12 percent of income for individuals between 200 percent and 250 percent of poverty. States select the "benchmark" plan, and individuals choosing a more expensive plan pay the excess premium. Employers are charged the state community average rate.

Like the Gruber proposal, Holahan et al. require risk adjustment for plans within the pools (exchanges). In this case states choose

the risk-adjustment method from a menu of federally approved approaches.

The Holahan et al. proposal does not explicitly set up an administrative structure to manage the pools, but the states will each need to do so in some fashion. Moreover, the federal government will be required to undertake certain activities, such as determining the state community rates. States will decide on the benefits package (above a federally set minimum). Individuals can enroll during an open enrollment period, or afterward with a 25 percent penalty, and, like the Gruber proposal, eligibility for subsidies follows the welfare model that checks eligibility periodically, but does not require transfer of funds to individuals or reconciliation at a later date as a system that relied on tax model might. The proposal is financed through state and federal general revenues. The pool incorporates S-CHIP matching rates, which are higher than Medicaid matching rates.

Singer, Garber, and Enthoven

Singer et al. propose a system of purchasing pools, labeled "exchanges." Exchanges can be operated by employers or other private entities. Each area (maybe a state or locality), will have at least one pool open to low-income individuals and firms with fewer than 50 employees. If, after a period of time, no other exchange emerges in an area, a default pool run by the federal government will serve the area. Unlike the other two proposals, the pools in the Singer et al. proposal may compete against one another. Non-employer exchanges must accept all individuals, at a community rate, but can set criteria for accepting employers who wish to purchase coverage for their employees through the exchange. Waiting periods are allowed, and exchanges can dictate when open enrollment is permitted. Exchanges must offer at least two plans. Public programs are not folded into the exchanges system, though beneficiaries of those programs qualify for a tax credit if they opt to purchase coverage through an exchange.

Individuals with less than $31,000 annual income and families with less than $51,000 annual income receive a tax credit equal to 70 percent of the cost of a median-cost plan. For individuals who do not choose a plan, states are paid half of the subsidy to enroll the individual in a default plan. A reduced subsidy is available for individuals with incomes between $31,000 and $41,000 and for families with incomes between $51,000 and $61,000. These subsidies, only available through the exchanges, are administered through the tax system. The income thresholds are indexed for inflation.

As is the case with the other two proposals, risk adjustment is required among plans within an exchange to prevent them from profiting by risk selection. Because this managed competition system has multiple exchanges within geographic areas, there is also risk adjustment between exchanges. For example, exchanges that attract healthier individuals must transfer funds to those that attract less-healthy individuals. Because employers may qualify to be exchanges, this will entail some employers paying subsidies to other employers with less-healthy workers. The Singer et al. proposal does not specify how risk adjustment will be conducted; it requires only minimal risk adjustment initially. However, the proposal also requires exchanges to use "other methods to limit risk selection among plans."

The Singer et al. proposal sets up a federal organization, the Insurance Exchange Commission (IEC), to monitor exchanges. Exchanges have considerable discretion in how they operate. They perform key functions such as determining the benefits package, and exchanges must provide participants with information about plan performance. Incentive payments are provided for states meeting clinical performance goals (for example, achieving high rates of childhood immuniza-

tion). The Singer et al. plan also creates the U.S. Insurance Exchange (USIX) to serve as a purchasing pool where no private exchanges exist. Like the Gruber proposal, the Singer et al. proposal requires, after a transition, that employees consider the portion of their health care benefits above a fixed threshold (105 percent of the median plan premium) as taxable income. The system of subsidies is financed through state and federal general revenue.

Evaluating the Effects

These proposals are evaluated based on three criteria:

- Effectiveness at improving access to health care services, measured largely by the effectiveness at decreasing the number of uninsured.
- Costs, measured by changes in aggregate expenditures.
- Equity, represented by the distribution of financial burden and benefits across income classes.

Much of the evaluation is based on analysis performed for RWJF by the Lewin Group, which was commissioned to provide a microsimulation of the cost and coverage impacts of these proposals.[124] The Lewin analysis estimated aggregate costs and coverage impacts, the key summary statistics. It also estimated the impact of each proposal on a variety of subgroups, including households of different types; federal, state, and local governments; employers; and health care providers. These estimates were made under a common set of assumptions, but the task was daunting for a variety of reasons. Specifically, the forecasting model had to estimate how individuals, employers, insurers, states, and health care providers would respond to different incentives and changing market environments.

There are many gaps in the existing research on a variety of relevant parameters, suggesting that estimates will be imprecise Although in general it is unclear whether this will bias estimates in favor of or against any specific proposal, it is unlikely that changes in modeling assumptions would affect all proposals equally. For example, one of the crucial parameters is the impact of managed care penetration on health care costs and cost growth. The proposals that encourage greater participation in managed care will be favored by assumptions of greater impact of managed care penetration on health care cost inflation. Despite these issues, and ongoing sensitivity analysis, the following preliminary estimates from the Lewin model are the best available common basis for comparing the proposals.

Coverage and Access to Services

The primary benefit associated with these proposals is increased coverage. When considering this, it is important to remember that insurance is an intermediate good. Some of its value is in providing financial protection against the costs of illness; however, policy interest in this topic is largely motivated by the relationship between coverage and health. The impact of insurance on health likely varies across individuals, although evidence regarding the nature of this relationship is scant. One might believe that less-healthy, higher-risk individuals will benefit more from coverage than will healthy, low-risk individuals. If so, any proposal that insures large numbers of high-risk individuals will have a greater health effect than will a program with comparable coverage effects but which enrolls relatively low-risk individuals. Of course, such a proposal may also be more costly if premiums accurately reflect expected expenditures. Alternatively, if screening and preventive services are important contributors to health, insuring individuals who perceive themselves to be healthy and low risk may yield large benefits. In any case, more research on the health consequences of covering different subpopulations is important. Despite strong suspicion

[124] Sheils and Haught.

that the benefits of coverage vary with health status, without such research, we cannot know which patterns of coverage will lead to the greatest, and most cost-effective, health benefit. Moreover, if the health benefits are concentrated in particular clinical areas (such as hypertension) or if they accrue largely to specific populations (such as the near elderly), then reforms targeted to these diseases or populations may be preferable to reforms which achieve broad coverage. Research can inform such targeting.

The Lewin model estimates that the Holahan et al. proposal generates the greatest amount of increased coverage, with an estimated 15.2 million people gaining coverage. As one might expect, the impact on coverage is greatest in the lower-income groups: about 50 percent of the uninsured with family incomes below $20,000 obtain coverage, whereas only about 20 percent of the uninsured with incomes between $50,000 and $75,000 receive coverage. The pattern of coverage gains for adults by age is somewhat U-shaped, ranging from a 30 percent to a 45 percent reduction in coverage. Children (those younger than age 19) have about a one-third decline in the number of uninsured.

The Gruber proposal is estimated to increase the number of insured by 14.5 million. Again, the effects are greatest on the lowest income groups (though slightly below the effects in the Holahan et al. proposal). The effects diverge mildly at higher incomes, but the patterns are very similar. The effects by age category are also very similar to those in Holahan et al. They are almost identical at the extremes of age distribution, but the effects are smaller in the Gruber proposal for the middle age categories.

The Singer et al. proposal is estimated to increase coverage by 11.8 million individuals. It is important to recognize that the Lewin tabulation of uninsured for the Singer et al. plan considers individuals enrolled in the default plan as "uninsured." This is done to be consistent with the treatment of Medicaid-eligible individuals not enrolled in Medicaid, who are also considered to be uninsured. The central question is whether individuals in this "uninsured" group appear to consume health care services as if they were uninsured or insured. For certain acute services, such as treatment for heart attacks, they may behave as if they are insured. Their use of preventive services may be more like the uninsured, however. For example, relative to Medicaid recipients, uninsured but Medicaid-eligible children are twice as likely to report unmet medical need, not having seen a doctor, and having spent more than $500 on medical care in the past year.[125] It is important to note that the gap in coverage improvements between the Singer et al. proposal and the other two is driven almost entirely by lower coverage rates in the low-income groups that would largely fall into the default plan. The age profile of effects in the Singer et al. proposal is similar to that of the other two, with considerably fewer effects in the lower age ranges. However, it is unclear how inclusion of individuals in the default plan would affect this distribution.

The Lewin model is not constructed to measure health status effects, which would entail a large expansion in the model and associated assumptions. In each proposal community rating encourages high-risk individuals to purchase coverage. If the health effects of coverage are greater for high-risk individuals, this will lead to greater health gains than if coverage were distributed randomly (though at a greater cost).

Financially, community rating creates a subsidy that flows from relatively healthy, low-risk individuals to relatively less-healthy, high-risk individuals. This type of subsidy encourages those most likely to use health care services to purchase coverage, while simultaneously encouraging the relatively healthy in-

[125]Kaiser Commission on Medicaid and the Uninsured. 'Enrolling Uninsured Low Income Children In Medicaid and CHIP.' The Henry J Kaiser Family Foundation. March 2001.

dividuals to try to opt out of the financing system. Holahan et al. take a unique approach to this latter aspect of community rating. In contrast to setting the community rate as a function of participants in the public pool, the rate is set as a function of the health status of *all* state residents. The system is financed by general revenues, so healthy individuals must pay this subsidy through their taxes *regardless* of whether they participate in the public pool.

Singer et al. add another set of provisions to augment the "health effects" associated with their proposal. Specifically, they include a variety of provisions to improve health outcomes, even for individuals who remain "uninsured." In particular they encourage providing funds to public hospitals and clinics with open access policies. This direct subsidization of care may increase access to care even in the absence of coverage. It gives health care providers some control over allocating and rationing services in a way that might minimize some of the overconsumption associated with insurance coverage.

Under the Singer et al. plan, states are also given financial incentives to improve their performance on various quality indicators related to health outcomes. This feature of the proposal should not be overlooked. The RAND Health Insurance Experiment demonstrated that much of the health benefit associated with insurance coverage might be traceable to a relatively small set of services, for example, screening for and treating hypertension.[126] Though insurance may improve health, it tends to bring with it overconsumption of care. Directly providing certain types of care may allow the system to achieve a significant portion of the health benefit with less of the associated overconsumption.

Costs/Efficiency

Although each of these proposals relies on a system of subsidies, the subsidies are not a cost from a societal perspective, though policy makers focused on federal budgets may view them as such. The cost of the subsidy would be related to any economic inefficiencies stemming from the taxes used to finance them. More important, the subsidies provide a mechanism to transfer money from some population groups to others and are probably best thought of in the context of equity.

The societal "costs" of each proposal reflect several factors. The first is the costs associated with increased utilization of health care services arising because individuals gain coverage or shift to more comprehensive coverage. It is important to recognize that, although treated as a cost, this increased utilization is the motivation for the entire endeavor. Insuring individuals without altering their care-seeking behavior would not produce the benefits advocates are seeking. Setting aside the important distributional issues, the portion of this increased use that we should be concerned about is only the portion of use that would not be justified by the marginal benefit of care. The RAND Health Insurance Experiment, based on linear demand curves, estimated that about 20 percent of total medical spending, and a considerably higher share of incremental spending, could be considered to be welfare loss.[127] Nyman[128] alters some of the assumptions used in Manning to compute welfare loss and suggests the figure is significantly smaller. Moreover, in the case of each of these proposals, the welfare loss would be reduced by any cost sharing or managed care features of insurance. Because of the managed competition nature of the markets envisioned under these proposals, one would expect health plans to be relatively more efficient at

[126] W. Manning et al. "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment." *American Economic Review 77* (3) (June 1987): 251.

[127] Manning et al., 1987, op. cit.

[128] J. A. Nyman. "The Value of Health Insurance: The Access Motive." *Journal of Health Economics 18* (2) (April 1999): 141–52.

reducing welfare loss than plans operating in many environments common today would be. The Lewin model loosely builds cost savings into the model as "managed competition savings" but cannot directly examine welfare loss.

The second cost factor arises because payment rates to providers rise when individuals shift from Medicaid to private coverage. From a financing prospective, this is a cost. From a welfare economics perspective, it is a transfer from consumers to providers. As Pauly[129] notes, higher spending on a good or service only represents an "opportunity cost" if it requires more resources devoted to production of that good or service. Higher reimbursement for the same service should be thought of as a transfer, assuming the quality of care associated with the service does not change. More than a third of the costs of these plans recorded in the Lewin model reflect this "transfer cost."

A third cost incorporated into the model is the administrative costs associated with setting up the various purchasing pools and regulatory bodies. These costs are difficult to estimate, but the Lewin model does a reasonable job based on applying various ratios of administrative costs to benefits observed in practice. Costs for managing the subsidy program are also included, but they are based only on best-guess estimates.

A fourth cost issue, common to each of these proposals, relates to the impact of competition on cost growth induced by the formation of purchasing pools. Evidence suggests that insurers' competition and selective contracting for health care services can reduce health care costs or cost inflation.[130] There have been few direct evaluations of purchasing cooperatives. An Enthoven and Singer[131] study of several purchasing cooperative initiatives for brief periods in the early 1990s reports that managed competition was associated with reduced health care cost growth. The Lewin model builds a reduced rate of cost growth into its model to reflect this.

The Holahan et al. proposal was estimated to cost $34 billion per year. Given that the number of uninsured is reduced by of 15.2 million, this corresponds to $2,237 per newly insured person. Financing this $34 billion requires $127.4 billion in federal expenditures, because a lot of such expenditures represent subsidies (which are largely transfers, as opposed to costs) to households or employers that would have purchased insurance without the subsidies. States save $12.5 billion in aggregate, before any changes in state tax law.

The comparable estimates for the Gruber proposal suggest it is a bit more expensive ($36.7 billion) and has a somewhat higher cost per newly insured person ($2,548). Federal expenditures ($190.5 billion) are again much higher than the net cost, and the states save $10 billion. Unlike the Holahan et al. proposal, which had very small costs for employers, the Gruber proposal is estimated to generate a windfall for employers of $1.6 billion because of reduced payments for retirees' health care.

Scoring of the Singer et al. proposal is again complicated by treatment of eligible individuals who are not enrolled; the model does not assume increased utilization for these individuals. The aggregate costs of the proposal were estimated to be $23.0 billion. Given the reduction of 11.8 million uninsured, this corresponds to $1,949 per newly insured per-

[129] M. V. Pauly. "U.S. Health Care Costs: The Untold True Story." *Health Affairs* 12 (3) (1993): 152–59.

[130] G. A. Melnick, J. Zwanziger, and A. Verity-Guerra. "The Growth of Hospital selective Contracting." *Health Care Management Review 14* (3) (1989): 57–64; M. A. Morrisey. "Competition in Hospital and Health Insurance Markets: A Review and Research Agenda." *Health Services Research 36* (1) (2001): 191–222; J. C. Robinson and H. S. Luft. "Competition, Regulation, and Hospital Costs, 1982 to 1986. *Journal of the American Medical Association 260* (18) (1988): 2676–81; J. Zwanziger and G. A. Melnick. "The Effects of Hospital Competition and the Medicare PPS Program on Hospital Cost Behavior in California." *Journal of Health Economics 7* (1988): 301–30; J. Zwanziger, G. A. Melknick, J. Mann, and L. Simonson. "How Hospitals Practice Cost Containment with Selective Contracting and the Medicare Prospective Payment System." *Medical Care 32* (11) (1994): 1153–62.

[131] A. C. Enthoven and S. J. Singer. "Managed Competition and California's Health Care Economy." *Health Affairs* (Millwood) *15* (1) (Spring 1996): 39–57.

son. Before taxes, this is financed with $102.8 billion in federal expenditures. States save a bit more than they do in the other plans ($14.6 billion), and the windfall to employers is comparable to that of the Gruber plan ($1.3 billion, compared with $1.6 billion).

Equity

Equity is a complex concept to put into practice. As in all three proposals, there are complex sets of cross-subsidies with regard to costs and benefits that do not accrue equally to all individuals. Equity regarding financing is discussed in the context of the progressive nature of the financing system, though one should note it is not clear how "progressive" the financing system should be to be considered equitable. Specifically, is it equitable if wealthier individuals pay a disproportionate share? How disproportionate should the share of financing be? This commentary does not take a position on that question.

Yet, these distribution issues are important, regardless of one's views on the "equity" of the distribution of benefits and financial burdens. They are crucial in assessing the political support for these initiatives. Ultimately, citizens as a whole pay for extra costs, but some groups may pay more than others. The larger the cross-subsidization, the more likely that the individuals paying the cross-subsidy will oppose the plan.

To compute distribution effects, the Lewin model assigns costs to households with two exceptions. First, costs to state government are not assumed to be financed through increased taxation (or, if states save money, the model does not assume savings are passed back to citizens in the form of lower taxes). Second, savings for retirees' health insurance are assumed to be windfalls for employers and not allocated back to individuals who own the firm (for example, stockholders or private owners). All federal costs are passed along to households via income tax, and wages are assumed to adjust to reflect changes in private/public financing. Similarly, households assume all costs of coverage and care.

Equity in distribution of benefits is related to the relationship between coverage and health status. Ignoring financing, the greatest beneficiaries will be high-risk individuals in poor health who are currently uninsured, or even low-risk individuals who would otherwise have been uninsured and happen to suffer a serious adverse health event. These may not be low-income individuals, though such individuals are more likely to be uninsured. Because the Lewin model does not relate health status to coverage or access, the distribution discussion focuses on financing. Coverage changes by income class are discussed above.

The distribution consequences of each of these proposals is largely a function of the system of subsidies, specifically, who gets the subsidies and how they are financed. They are all targeted to individuals based on income and funded largely through the income tax system. Thus, the financing scheme for each proposal is progressive. However, it should be recognized that the current system has complex cross-subsidies that result in transfers across income categories. Existing cross-subsidies arise from public programs such as Medicaid and S-CHIP, which the Holahan et al. and Gruber proposals replace, and in the care delivery process, in which care for the uninsured is financed from payments from the insured (and some transfers to providers through various programs to support such care). Ultimately, the progressive nature of the subsidy system depends on the proposed subsidy schedule, the limits placed on the ability of employees to exclude the value of insurance benefits from taxable income, and how restructuring the health care market place alters the current set of cross-subsidies.

The Lewin model strives to capture all of this, and from that analysis we should conclude that this system of subsidies entails higher-income individuals financing the extra

care delivered to largely lower-income individuals currently uninsured. Moreover, higher provider payments are needed in the Gruber and Holahan et al. proposals because the power that exists in public programs such as Medicaid to pay reduced fees is lost. Increasing the subsidies, either by raising the share of coverage provided by the subsidy or by raising income thresholds below which the subsidies are provided, would increase participation and increase the progressive nature of the financing system.

The Lewin model indicates that all proposals are very progressive in their financing. In the Holahan et al. proposal, on average, households with annual incomes below $50,000 receive savings. The cost is borne largely by households with annual incomes over $150,000, which are estimated to pay $4,236 each per year. Households with incomes between $100,000 and $150,000 are estimated to pay $1,786 on average. These numbers would be a bit lower if one assumes savings to the states are passed on as lower state taxes.

Like the Holahan et al. proposal, Gruber estimates savings for households with annual incomes below $50,000. Households with annual incomes over $150,000 are estimated to pay $5,705 each per year (before state tax law changes, but after predicted wage offsets), and average payments for households with incomes between $100,000 and $150,000 are estimated to be $2,452.

The progressive nature of the Singer et al. proposal is more similar to the Holahan et al. proposal than it is to the Gruber proposal. Specifically, households with annual incomes below $50,000 receive savings. Households with annual incomes over $150,000 are estimated to pay $4,186 each per year, and households in the next lowest income category are estimated to pay an average of $1,861 before state taxes are taken into account.

Managed Competition: Theory and Implementation

One's opinion of these proposals, as a group, will depend largely on one's opinion of managed competition. The managed competition model is predicated on the recognition that individuals have different tastes and needs for coverage, cost-containment provisions, and medical care. The idea is to allow individuals to choose the coverage option that best suits their preference. Competition among insurers is intended to drive competition among health care providers (for example, physicians and hospitals). Insurers should have incentives to seek advantageous prices from health care providers and adopt care-management techniques that encourage provision of only valued care. Thus, even though there may not be competition at the time of service delivery, fundamental aspects of service delivery, such as price, reflect a competitive process.

Despite their common reliance on this model, each proposal implements the various components in slightly different ways. There are several key features in the functioning of a managed competition model. The first is competition among insurers. This competition may occur either directly, for enrollees from the purchasing pool, or indirectly, for the opportunity to be offered by the purchasing pool. All of the proposals strive to ensure such competition exists, though they do so in slightly different ways. The Gruber proposal does this by mandating that the pool offer all plans meeting a pre-defined set of criteria, if the plan wishes to be offered. Purchasing pool administrators have very little discretion about which plans are offered. This type of guaranteed free entry into the exchange may be the strongest way to promote competition. However, the Gruber proposal does not devote much attention to what happens in geographic areas where an insufficient number of plans exists. Moreover, certain details of the Gruber proposal would likely have to be clarified because of the reliance on state pools.

Specifically, individuals eligible for free coverage are provided with a plan near the statewide median premium. In certain areas there may not be a plan near the median, so it is likely that modification would be needed to account for geographic variation.

The Singer et al. and Holahan et al. proposals allow pools to operate over areas smaller than the state and would allow more discretion by purchasing pool administrators with regard to which plans to offer. Health plans may face real or perceived barriers to entry if gaining access to the purchasing pools is costly. However, in both of these cases, the authors examine contingencies related to an insufficient number of competitors emerging. In the case of Holahan et al., pools are required to offer a default managed FFS plan, which could compete with existing insurers but may be the only plan offered by the pool. It is run by the state essentially as a backup plan, so one need not be overly concerned that such a plan would charge enrollees monopoly prices in non-competitive regions. However, the state plan could exercise monopsony power against health care providers. This is no different from existing situations when competition is scarce (of course, the absence of competition among insurers likely correlates with a lack of competition among health care providers, so it is not clear whether insurers or providers wield excessive power). The Singer et al. proposal requires that exchanges offer at least two plans and proposes a backup system for geographic areas where such competition does not emerge. Again, this backup system is publicly managed.

The second key managed competition feature is that individuals should be charged the incremental costs associated with higher-cost health plans. Individuals facing the incremental costs of coverage would purchase higher-cost coverage only if they sufficiently valued the benefits. The Gruber proposal requires individuals (including those with low incomes) to pay the incremental costs of more expensive plans. However, it does allow employers to subsidize this incremental payment if they desire. By providing low-income individuals with free access to median-price plans, the Gruber proposal limits concerns that low-income individuals will be forced into excessively low-quality plans. By limiting refunds if low-income people choose lower-than-median-premium plans, however, Gruber limits to some extent their incentive to choose what may be the most appropriate health plan once benefits and premiums are considered.

The Holahan et al. proposal is very similar in that individuals pay the increment between the premium for the plan they choose and the premium for a state-designated benchmark plan. Employers can decide to pay some of the incremental costs of more expensive plans. Moreover, relative to the Gruber plan, there is more flexibility for refunds if less-expensive plans are chosen, and more flexibility for how the benchmark plan is chosen, but conceptually these approaches are very similar. The Singer et al. proposal does not mandate such pricing policies, allowing exchanges to decide for themselves how to set individual contributions. One might anticipate that competition among exchanges would encourage efficient design of contribution policies in the public exchanges. Employer-sponsored exchanges may behave differently (as employers now do) in part because, unlike public exchanges, they have labor market reasons to attract certain types of employees. But the authors envision that, by capping the ability of employees to exclude the value of health insurance from taxable income, there will be a trend toward all exchanges requiring incremental payments.

The third key feature of the managed competition model is information. All of the proposals would promote provision of performance information to potential enrollees. The proposals vary in the attention they devote to this endeavor, however. For example, the Singer et al. proposal has a formal committee

devoted to quality improvement and monitoring and explicitly charges one of the new administrative structures with disseminating information. The Gruber plan envisions such information being disseminated during open enrollment. Yet, we should note that the performance measures used currently are limited at best and generally do not include measures of caregivers' technical competency. Nevertheless, as performance measurement improves—which each proposal should encourage—information dissemination could become more valuable, and markets would become even more effective.

The fourth feature of these managed competition models is general reform of the insurance market, including mandates for guaranteed issue and risk-adjustment provisions to minimize the adverse consequences of adverse selection. Requirements such as guaranteed issue and community rating will fill an important existing gap in insurance markets: coverage against the risk of becoming high risk. As more diseases become treatable, the number of diseases thought of as chronic conditions, as opposed to acute illnesses, will grow. Coverage for the longer-term costs of these illnesses is important and is facilitated by community rating and guaranteed issue.

Related to this reform of the insurance market is the creation of a more efficient channel for insurance purchase outside the employer-based system. Specifically, another aspect of efficiency that arises from the availability of common purchasing pools is the removal of various barriers to the efficient operation of labor markets. The current health care financing system relies heavily on employer-provided coverage. This has a variety of labor market effects, including potential reductions in the mobility of workers, labor supply, and labor demand. Because insurance costs vary by firm size, the current system may put small firms at a competitive disadvantage, thereby affecting job creation and growth. By changing the role of employers, or the constraints they face, in the health care financing system, the proposals have the potential to affect economic outcomes.

Allowing individuals to purchase coverage directly through the pools, at reasonable prices, increases job mobility more than a system in which insurance is tied to employment. Scale economies can be exploited so small firms can participate without paying all of the additional loading fee commonly charged in the small-group market.

The Lewin model does not quantify the gains from this efficiency, but two implementation details are important in this regard. The first is free entry of plans into the pool. If all plans in an area are offered through the pool, individuals will not find themselves in a situation where the plan they desire is not offered. The Gruber plan mandates that pools allow *all* qualified plans to be offered through the pool. Thus, it may be reasonable to expect all plans would be available in the public pool. The Holahan et al. plan allows the states more flexibility in this regard, but mandates that, at a minimum, a managed FFS plan be available through the pool. The Singer et al. plan relies on employers the most and allows competing exchanges in a single geographic area. One could still envision, therefore, the greatest potential for continued labor market inefficiencies because some plans may not be offered by all exchanges, but one would expect most large plans to be offered by at least one public exchange.

The second feature that might impede labor market flexibility would be differential prices charged within the pools. Each proposal tries to minimize this by mandating community rating and risk adjustment. The Holahan et al. proposal is the strongest in this regard, mandating that the benchmark premium be based on state risk profiles, so any adverse selection into the pool by health risk or employer size will not affect premiums. The Singer et al. proposal would be most subject to this concern if public exchanges attracted

mostly small firms and they were more costly to serve. Under that proposal, insurers are not constrained to offer the same premium rate to different exchanges. Nevertheless, in practice, given competition and risk adjustment, one would expect the system of public exchanges, even in the Singer et al. proposal, to enhance job mobility.

Existing research provides some insight regarding the effects of the managed competition model. Despite inertia in health plan choice, empirical evidence indicates that individuals are responsive to copremiums, suggesting the market will tend to reward relatively inexpensive plans, all else being equal.[132] There is also empirical evidence consistent with the notion that individuals will gravitate toward plans with better scores on performance measures.[133]

The response to relative prices and performance measures supports arguments for managed competition. We have no basis to assess whether the empirically observed responsiveness to price and quality is "optimal" or whether various informational or market barriers distort optimal switching. But, given the market reforms inherent in these proposals, it is reasonable to expect that individuals will be better able to make health plan choices suitable to their preferences and economic conditions.

However, several challenges might arise in a system of managed competition. First, despite the responsiveness of individuals to relative prices, the system of subsidies may encourage an increase in average premiums. In models of perfect competition, prices are driven by costs in the long run, not by demand, because competition constrains prices, even in the face of growing demand. However, in markets with imperfect competition, subsidizing premiums could lead to higher ones. There is little empirical evidence about this point, and the changes in the system related to encouraging individuals to pay the incremental costs may offset any inflationary impact of the subsidies. Nevertheless, the effects of subsidies on premium equilibrium is an important area for research.

Second, though competitive markets will likely reduce the rate of premium cost growth, we should not expect a system of managed competition to constrain cost growth to a rate below the rate of inflation, or even below the rate of real income growth. Historically, the development and adoption of new medical technologies has driven health care cost growth.[134] On average, individuals have desired access to these technologies[135], and despite the interconnection between coverage and technology development, it seems unlikely that a system of competing health plans will change those relationships. A review of the evidence examining managed care and health care cost growth concluded that while markets with more managed care experienced lower cost growth, the reduction in cost

[132] T. C. Buchmueller and P. J. Feldstein. "The Effect of Price on Switching Among Health Plans." *Journal of Health Economics* 16 (2) (1997): 231–47; D. M. Cutler and S. Reber. "Paying for Health Insurance: The Tradeoff Between Competition and Adverse Selection." Working paper 5796. Cambridge, MA: National Bureau of Economic Research, 1996; B. Dowd and R. Feldman. "Premium Elasticities of Health Plan Choice." *Inquiry 31* (1994/95): 438–44; A. Royalty Beeson and N. Solomon. "Health Plan Choice. Price Elasticities in a Managed Competition Setting." *Journal of Human Resources 34* (1) (1999): 1–41; D. P. Scanlon, M. Chernew, C. McLaughlin, and G. Solon. "The Impact of Health Plan Report Cards on Managed Care Enrollment." *Journal of Health Economics 21* (2002): 19–41; B. A. Stromborn, T. C. Buchmueller, and P. J. Feldstein. "Switching Costs, Price Sensitivity and Health Plan Choice." *Journal of Health Economics 21* (1) (January 2002): 89–116.

[133] N. D. Beaulieu. "Quality Information and Consumer Health Plan Choices." *Journal of Health Economics 21* (1) (January 2002): 43-–63; Scanlon et al., 2002, op. cit.; G. J. Wedig and M. Tai-Seale. "The Effect of Report Cards on Consumer Choice in the Health Insurance Market." *Journal of Health Economics 21* (2002): 1032–48.

[134] M. E. Chernew, R. A. Hirth, S. S. Sonnad, R. Ermann, and A. M. Fendrick. "Managed Care, Medical Technology, and Health Care Cost Growth: A Review of the Evidence." *Medical Care Research and Review 55* (3) (1998): 259–88; D. M. Cutler. "The Incidence of Adverse Medical Outcomes Under Prospective Payment." *Econometrica 63* (1) (1995): 29–50; J. P. Newhouse. "Medical Care Costs: How Much Welfare Loss?" *Journal of Economic Perspectives 6* (3) (1992): 3–21.

[135] Newhouse, 1999, op. cit.

growth was not sufficient to halt the rise in income devoted to health care.[136]

Of course, technology-driven cost growth is not necessarily a bad thing. Cost growth arising from a system in which individuals make informed choices may be preferable to a system with cost growth administratively constrained. Yet, in a system of subsidies to individuals financed through a progressive tax system, we must recognize that, over time, subsidies will need to increase as health care costs increase. Political support for this system may become strained (as it might for any system aiming to cover the uninsured). Moreover, if it functions as envisioned, this system will result in multiple tiers of coverage. Some of the variation in coverage generosity will be driven by variation in preferences and will likely be viewed as positive. Some of the variation in coverage generosity will also likely reflect income heterogeneity. The relationship between coverage generosity and income is nothing new, and all proposals may lead to more equity in coverage. However, variation in coverage by income class may be problematic in a public-sponsored program. Some observers may be troubled if lower-income individuals are subject to more narrow benefit offerings, tighter physician networks, or stricter utilization review. From an economic standpoint, such variation is probably a good thing, although admittedly it will force policy makers to ponder which benefit/plan attributes should be non-negotiable. Each proposal has administrative mechanisms for examining such issues.

A Composite Proposal

The three plans discussed above illustrate some of the trade-offs encountered when designing a proposal to reduce the number of uninsured. One might think the most basic decision is whether the proposal relies on voluntary participation or mandates coverage. While there are important policy ramifications associated with whether a reform proposal relies on mandatory or voluntary action, design features may reduce this distinction. For example, by increasing eligibility income thresholds and subsidies and, perhaps, by specifying a default plan, as in Singer et al., voluntary plans could achieve coverage akin to mandatory plans. Similarly, though systems of purchasing pools are typically associated with voluntary participation proposals, proposals that mandate coverage could also rely on pools. In fact, the Holahan et al. proposal allows states, after a period of time, to mandate coverage. The choice about the mandatory or voluntary feature will have distribution consequences. Voluntary proposals generally require incentives for participation that tend to lead to progressive financing. Mandates could be much less progressive, depending on how they were financed, because they could be used to force individuals to purchase coverage even when they otherwise would not.

Perhaps the more central questions that distinguish proposals is the extent to which they allow/encourage heterogeneity in insurance products and how they reform the market for choice of health plans. The system of purchasing pools allows substantial heterogeneity; individuals can purchase what they are willing to pay for.

Purchasing pools have several other advantages as well. Relative to models with incentives or mandates, but no pools, the "pool" approach facilitates market regulation. It also facilitates a system in which incentives for efficient purchase of coverage could occur as well a structure in which search costs and transactions costs associated with switching plans are reduced. Ultimately, what matters is whether these advantages are worth the administrative costs and any inefficiencies attributable to pool management.

The proposals discussed illustrate a variety of ways the pools could be structured. One of

[136]Chernew et al., 1998, op. cit.

the key questions is whether pools should offer all plans meeting pre-specified criteria, as in the Gruber proposal, or whether pools should have the freedom to refuse to offer certain plans, as in the Singer et al. and Holahan et al. proposals. In either case, competition could occur among all plans, and the option to refuse access to the pool might strengthen the bargaining power of the purchasing pool administrators and reduce premiums. Yet, restricted plan choice is likely to create entry barriers, which could reduce the effectiveness of competition in constraining premiums. Restricted plan choice may also increase costs associated with joining or leaving purchasing pools. Thus, it is probably better to have free entry into the pools and allow competition within the pool among plans offered.

A second question about the pools is whether they should be local monopolies, as in the Gruber and Holahan et al. proposals, or there should be competing pools, as in the Singer et al. proposal. The advantages of competition are well known. Organizations have incentives to find the administrative structures and rules that most appeal to consumers, and they can exploit administrative efficiencies to the fullest.

Nevertheless, it is likely that in this case the monopoly approach is preferable, at least for "public" pools. The monopoly approach, when combined with mandates that pools offer all eligible plans, will simplify the search process because there will not be multiple organizations offering the same plans, perhaps at different premiums and perhaps with different benefits. In a world with well-informed consumers this mass of information and heterogeneity may well be ideal. But in the existing insurance market, some limits are likely useful. A large, publicly run pool might be able to better undertake outreach and, thereby, facilitate take-up among populations unlikely to search among multiple pools. Moreover, all proposals emphasize the value of plan performance information. Monopoly pools will promote a common message about plan performance that may be more salient than conflicting messages or presentations that might otherwise exist. Essentially, the size associated with a monopoly pool may add needed credibility. Moreover, until risk adjustment is refined, allowing competing purchasing pools may lead to various types of activities aimed at managing selection as opposed to setting the foundation of a well-functioning market. Finally, if a proposal does not allow free entry of plans into each pool, a system of competing pools will likely not take full advantage of the ability of pools to enhance labor market mobility and facilitate bridging coverage as individuals move within the labor market.

Each of the proposals discussed implants a system of community rating and guaranteed issue as well as risk adjustment. These features, though separate from the pool structure, are important aspects of insurance market reform. They help healthy individuals insure against the financial risk associated with contracting a chronic disease, and they provide added incentives for less-healthy individuals to purchase coverage. This added incentive is important because many of the benefits of coverage will accrue to the less healthy. The Holahan et al. proposal adds a novel provision in this regard, basing the community rate on *statewide* health risks. Assuming this is administratively feasible to compute, the system provides a stronger cross-subsidy to the less healthy than do community rating systems, which base the community rate only on pool participants. In general, this is a good feature of the Holahan et al. proposal, though one might worry that if risk adjustment were insufficient and the public pool becomes too heavily skewed toward less-healthy individuals, health plans might alter their offerings to pool participants or decline to participate in the pool altogether. This might prevent individuals from having access to the plan that best suits them.

The emphasis in each of the proposals is generally on increasing coverage, and evaluations of the proposals focus on their effect on coverage. However, the Singer et al. proposal reminds us of the fundamental motivation for these proposals, to improve access to care for the purpose of improving health. By providing financial support for safety net providers, and by providing access to a default plan, Singer et al. try to diminish the costs associated with not taking up insurance. The focus on health is further enhanced by giving states incentives to meet certain clinical targets. The advantage of focusing on direct provision of care is that insurance tends to encourage overconsumption of health care services. Direct provision of care and focus on high-value services may help the system realize many of the gains in health status while minimizing insurance-induced inefficiency (which would also be reduced by competition within the pools).

There are several drawbacks to proposals such as these, which rely on a heterogeneous model of competing plans, compared to a system with stronger governmental management. First, government-run systems could exploit their buying power to set lower prices for health care services in a way that these plans might not be able to achieve. For example, the Lewin model assumes that prices paid by plans participating in the purchasing pool will be higher than those paid by Medicaid. Of course, these savings are really transfers from health care providers to consumers. Moreover, low prices may not be sustainable over the long term and may result in some rationing of care to beneficiaries. Additionally, if a large share of the public were enrolled in such plans, political pressure to maintain access to care and fairness for providers might diminish the ability of government systems to obtain lower prices than the market might generate.

A second cost of this heterogeneous competitive model is that, inevitably, the fragmentation leads to administrative costs. These costs are not valueless; individuals appreciate the diverse choices with regard to plan traits and provider networks. However, the administrative costs associated with such a system might be reduced in a system with less plan choice and less reliance on competing private plans.

More important, regardless of which proposal is adopted to reform the health care system, pressure for health care costs to rise will likely continue well into the future as medical technology advances. Improved clinical outcomes are valuable, but financing systems must be evaluated in part on how they will adapt to this increasing pressure. The fundamental issue is the extent to which they allow heterogeneous coverage and access. The proposals discussed above have the virtue of allowing markets to regulate cost growth. Market imperfections may constrain the ability of these market systems to generate optimal cost growth, but these systems share a philosophy of value combined with trust in markets that makes them appealing in an era of cost growth. To economists, part of that appeal reflects the likely heterogeneity in plan choices that will occur and, very likely a "tiering" of access to care. However, these systems will generate fundamental questions about the equity of coverage and access. Such a debate is sorely needed, because, regardless of the financing systems chosen, society will be faced with the sometimes challenging blessing of how to manage access to the ever-increasing array of medical services at physicians' disposal.

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Merrell

Commentary Abstract

Katie Merrell reviews characteristics of public policy and private markets for personal health insurance to understand how they affect the cost of insurance at different income levels. While policy makers worry that expanding public insurance programs will "crowd out" private insurance, they typically do not acknowledge the reality of the private insurance market faced by low-wage workers nor the public subsidy enjoyed by higher-wage workers who purchase insurance through their employers. The regressive tax treatment of employment-based health insurance, combined with its enhanced value, make private market health insurance most expensive for lowest-income purchasers. This paper illustrates the net effect of public and private factors on the after-tax price per actuarial value of insurance, creating a framework that can be used to assess proposals for expanding insurance coverage in the United States.

About the Author

KATIE MERRELL has been a Senior Analyst at the Center for Health Administration Studies at the University of Chicago for over a decade. Her current projects range from an analysis of the Medicaid careers and service utilization of various subgroups of program participants to the feasibility of using hand-held computers to collect real-time information from informal caregivers of community-based geriatric and pediatric patients. As an instructor at the University's School of Social Service Administration, she teaches graduate level courses in data analysis and the U.S. health services system. Ms. Merrell was a senior staff member at the Physician Payment Review Commission for eight years, where she was responsible for topics such as practice expense payment under the Medicare Fee Schedule, geographic adjustment of fee schedule payments, insurance market reform, and Medicare managed care payment policy. She has been invited to speak about Medicare and payment policy by academic, medical professional, and government groups in the United States and Europe.

When Worlds Collide: Public Policy, Private Markets, and the Price of Health Insurance

by Katie Merrell

The health insurance market in the United States is shaped by a number of public policies and private market characteristics that create the insurance choices faced by those under age 65. Proposals to expand health insurance coverage differ in the degree to which they take account of the public and private aspects of the market and the likely effects of changes in one arena on the other. Indeed, the notions of public versus private insurance and insured versus uninsured oversimplify the U.S. health insurance market.

One of the challenges in understanding how public policy and private markets interact is that the concept of "health insurance" is poorly defined. As the growing body of literature on "underinsurance" suggests, there are people covered by health insurance who nonetheless have to pay for more of their personal health expenditures than they expect to. Insurance policies vary in both price and comprehensiveness of benefits. As a result, analyses based on reported premiums paid, whether for the employee share of group benefits or for individually purchased nongroup policies, are not like price analyses in markets where the good studied has essentially the same function across the product models available; for example, all cars provide transportation, albeit with different amenities and fuel efficiency. Without detailed information about what benefits are included in an insurance policy, premium data are difficult to interpret. Being insured is not associated with a specified level of coverage in every case, limiting the meaning of discussions of "the insured" versus "the uninsured" and challenging analysts to account for differences in benefits when comparing premium data.

The U.S. health insurance market offers an array of products that vary in price and value, which suggests that this market functions much like other goods and service markets, where one can buy Yugos or Mercedes-Benzes and can spend the night at a Motel 6 or at the Ritz-Carlton. As the result of public policy, private market characteristics, and the interaction of the two, however, there are important differences between health insurance and other markets. Anyone with enough money to buy a Mercedes-Benz can walk into a dealership, hand over the cash, and drive away in a new car. Conversely, someone with enough money to pay the premiums of a comprehensive policy provided by a firm at which the potential purchaser does not work cannot necessarily buy that level of coverage at that price. As a result of the U.S. employment-based insurance system, publicly provided insurance, the tax treatment of health insurance premiums, and the price difference between individual and group-sponsored policies, people face different price and value combinations depending on whether and where they work, factors highly associated with both their health status and income level.

This paper explores the effect of key public policy and private market characteristics on the price of insurance, standardized for the actuarial value of benefits, across income lev-

els[137] and discusses the factors that drive the price per value available to consumers. The analysis builds directly on conventional wisdom, data, and analyses of the U.S. insurance system presented by others. The first section explores the notions of price, value, and consumer choice in the health insurance market. The second section explores key aspects of public policy—publicly provided insurance and tax-subsidized private insurance—and is followed by a section reviewing the price and value of private insurance in the individual and group markets. The fourth section examines the combined effect of public and private features on the effective price of health insurance across the income levels, and the final section explores the relationship between after-tax price and income as a means for comparing alternative proposals to expand insurance.

This analysis focuses on the price of health insurance and the actuarial value of different insurance products in an effort to create a policy analysis tool that integrates public and private effects on the net price of insurance to consumers. The closely related, and arguably more important, questions of the relationships among insurance status, health service use, service prices, health status, and individuals' total health expenditures are not addressed.

The Price and Value of Health Insurance

An individual facing the choice of whether to buy health insurance and which policy to choose presumably weighs the cost of whatever policies are available, the probability of needing health care services, the cost of expected care under each policy, and what health care would cost without any insurance.[138] Balancing the cost and value of alternatives in this market is not inherently different from making the same calculation in other markets. Whether the added safety features of a Volvo, for example, are worth the higher price raises similar issues: what are the odds that my family will really ever benefit from those features, and does that benefit justify the additional cost?

The price (premium) of a particular insurance product is inversely related to the likely out-of-pocket costs of care: comprehensive policies that ensure low out-of-pocket costs even when high levels of care are used are more expensive than those that absorb less of the financial burden of illness. At the same time, some service needs such as routine preventive office visits, are predictable and relatively inexpensive, while the use of other potentially life-saving services, such as live-donor liver transplantation, are rare but very costly. As a result, the insurance consumer is faced with a broad array of options that differ in both price and value, depending on the specific services covered.

In the traditional context of fee-for-service care, plan value is inversely related to how much a policy holder expects to pay out of pocket when services are used—people in high-value plans expect to pay little beyond their premiums for health-related services, but for those in low-value plans, premiums account for relatively less of total health spending. Plan value is determined largely by cost-sharing requirements, including annual out-of-pocket caps, and by benefits package design, including lifetime benefits caps. There are more subtle factors that increase plan value, however, such as whether the insurer has negotiated rates with providers, which

[137] Income distribution, rather than health status, is used as the organizing principle because it has a tradition as the basis for public policy making in the United States. With few exceptions, such as pregnancy and end-stage renal disease, health status has not been used to identify people as eligible for public programs.

[138] The insurance value of insurance (that is, insulation from risk) is more important to risk-averse consumers than it is to risk-neutral or risk-taking consumers. It can be thought of as either an additional aspect of this decision or as included by individuals in their assessment of the probability they will need care, the cost of care, and the proportion of these costs covered by different policies.

lower not only the insurer's cost but also the dollar cost of a percentage-based copayment. Ironically, as a result of the prevalence of such negotiated rates, those without insurance typically face the highest provider prices. In general, the notion of plan value becomes more complicated in the case of managed care, where this traditional insurance concept must be applied to the combination of insurance and service value represented by different plans. Ease of access to specific services and providers may be a better indicator of plan value than out-of-pocket costs, although they may be highly correlated if those individuals in plans with tight access control end up paying directly for out-of-plan services to circumvent plan limits.

The actuarial value of insurance policies provides, at least theoretically, a summary of the value of all aspects of a policy, allowing for comparison of different insurance policies through a single measure rather than having to assess the relative importance of, for example, prescription drug coverage compared to a specified annual out-of-pocket cap. Analysts have used the actuarial value of plans to assess whether policy holders are "underinsured" compared with some benchmark,[139] as a tool for modeling consumer choice of plans in Medicare managed care,[140] and as a way to think about defining a minimum benefits package.[141] Health plan actuarial value can be thought of as a scale from 0 to 100, where 100 equals first-dollar coverage for all conceivable health services with no limits. Lack of (or limited) coverage for particular services, lifetime caps, limited provider panels, and cost-sharing provisions all reduce the actuarial value from this maximum value.

Economists argue that a limitation of using the actuarial value of insurance products as an indicator of their value to consumers is that it does not measure *insurance* value. In other words, risk-averse individuals derive more value from a particular insurance product than do risk-taking individuals, regardless of the product's actuarial value. Risk-averse individuals are more likely to buy even a high-price, low-value plan if it is the only one available to them, while risk-neutral or risk-taking individuals may be more likely to go without insurance in this instance. This is not a critical problem, however, to the extent that it is related to the heterogeneous personal preferences that underlie consumer choice—not everyone who can afford the high-end Mercedes-Benz in fact buys one.

The analysis below uses the concept of the price per actuarial value unit to explore how public policy and private market characteristics affect individuals at different income levels. The measure can be thought of as a summary of the price of insurance plans faced by consumers grouped by income level, where the actual premiums have been adjusted for differences in benefits. The main advantage of the price per value is that it avoids defining some package of benefits as appropriate for everyone or more desirable than other packages. The increasing concern that people are underinsured is not proved with information about lower premiums (suggesting less extensive coverage) but rather with data showing continued high or increasing premiums despite eroding benefit packages. For example, the Center for Studying Health System Change reports that small employers in 12 studied communities have both high premium increases (14.5 percent for those with 3 to 49 employees, compared to 10.2 percent for those with 200+ employees) and are reducing the value of offered plans to employees through increased cost sharing and reductions in serv-

[139] P. F. Short. "Hitting a Moving Target: Income-Related Health Insurance Subsidies for the Uninsured." *Journal of Policy Analysis and Management 19* (3) (Summer 2000): 383–405.
[140] K. Merrell. "Medicare+Choice Benefits and Premiums: How Do They relate to One Another and to Enrollment?" Office of the Assistant Secretary for Planning and Evaluation, Office of Health Policy, December 2001.
[141] S. Glied, C. Callahan, J. Mays et al. "How Comprehensive are Standard Private Health Insurance Plans?" Prepared for the Commonwealth Fund, February 2003.

ices covered, among other measures.[142] Therefore, data on premiums without information about value are difficult to understand. When consumers and advocates claim that certain forms of coverage "aren't even available" in the individual market, economists conclude that they really mean "for an amount within anyone's budget," based on the assumption that for enough money, an insurer would issue any policy. Actually analyzing price per actuarial value unit of insurance, however, is difficult because data about actual insurance coverage held by individuals typically do not include sufficient benefit details to calculate plan value. Consensus that there is less value in the individual, non-group market suggests that reported premium differences understate the difference in price per unit value across different parts of the insurance market. As a result, simulations of alternative proposals to expand insurance based only on premiums may misstate the potential costs of improving the nation's insurance status as well as the interactions between public policy and private market characteristics.

The price per unit of actuarial value provides a helpful tool for exploring public policy and private health insurance markets. By normalizing for variation in the value of benefits, it provides a single measure for thinking about supply in the U.S. health insurance market from the consumer's perspective.

Health Insurance: Public Policy

Publicly financed insurance is the most prominent health insurance-related public policy in the United States. Through Medicaid and the State Children's Health Insurance Program (S-CHIP), federal and state governments provide insurance to nearly one-fifth of the nation's non-elderly population.[143] Reflecting the typical private-public dichotomy of insurance provision, policymakers considering Medicaid expansions during the late 1980s and S-CHIP in the late 1990s were concerned that raising the income cutoff for Medicaid eligibility would cause large numbers of people just above the then-current income eligibility levels to switch from the private market into publicly provided insurance. An extensive body of literature has evolved assessing the potential magnitude of this "crowding-out" effect.[144]

In its simplest form (shown in figure 1), this notion suggests that raising the income level for public insurance eligibility will move everyone with incomes between the old and new eligible income levels out of the private market, where insurance costs $\$P_P$, into the public program, where insurance costs $0. The final version of S-CHIP allows states to establish sliding-scale premiums for those at higher eligible income levels, so the price of public insurance increases gradually with income among those eligible (see figure 2). For example, there were three premium levels for California families of four in 2000: those at the poverty level paid $8 monthly; at 150 percent to 185 percent of poverty, they paid $14; and at twice the poverty level, they paid $27 a month. The actual slope of this sliding-scale premium for expanded public coverage is state-specific, as are the income levels at which the price of coverage jumps to the market price and the actual size of the insurance price difference for those whose incomes are just above the maximum eligibility level.

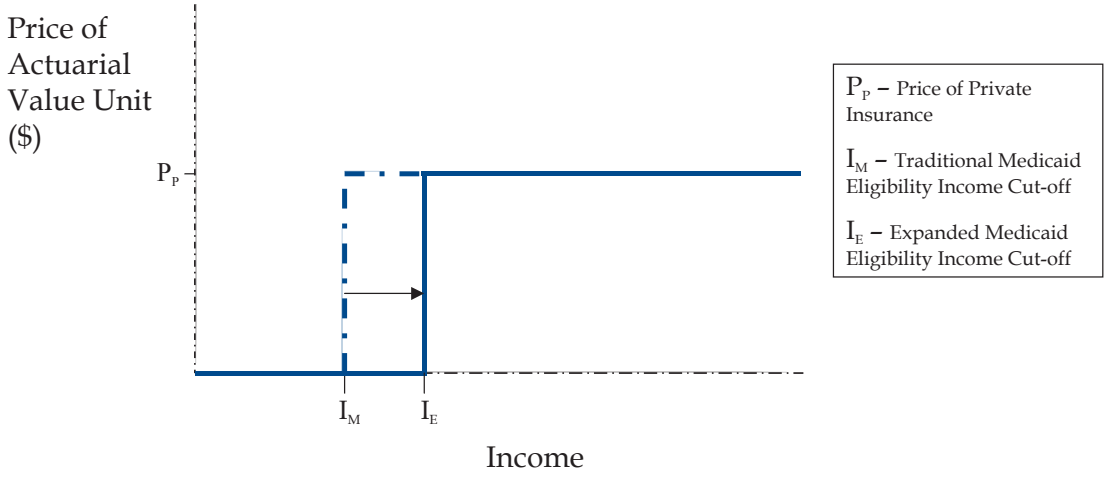
[142] Center for Studying Health System Change. "Cutting Back But Not Cutting Out: Small Employers Respond to Premium Increases." Issue Brief No. 56, October 2002.

[143] Institute of Medicine. *Leadership by Example: Coordinating Government Roles in Improving Health Care Policy*. Washington: National Academies Press, 2002.

[144] D. M. Cutler and J. Gruber. "Medicaid and Private Insurance: Evidence and Implications." *Health Affairs 16* (1) (Jan.–Feb. 1997): 194–200; L. Dubay. "Expansions in Private Health Insurance and Crowd-out: What the Evidence says." Kaiser Family Foundation, October 1999, http://www.kff.org/content/1999/19991112m/dubay.pdf; L. Shore-Sheppard, T. C. Buchmueller, and G. A. Jensen. "Medicaid and Crowding Out of Private Insurance: A Reexamination Using Firm-Level Data." *Journal of Health Economics 19* (1) (January 2000): 61–91.

FIGURE 1

Effect of Raising the Eligibility Limit of Income-tested Public Insurance Program on the Price of Insurance by Income



The price drops from $P to $0 for those between the traditional eligibility level and the new level.

FIGURE 2

Effect of a Sliding-Scale Premium Public Insurance Program on the Price of Health Insurance by Income

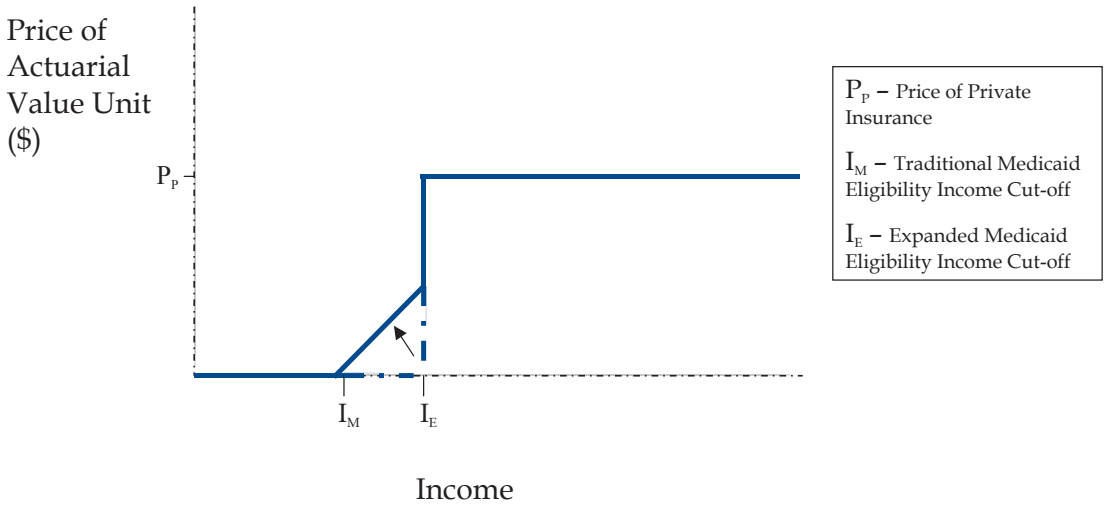
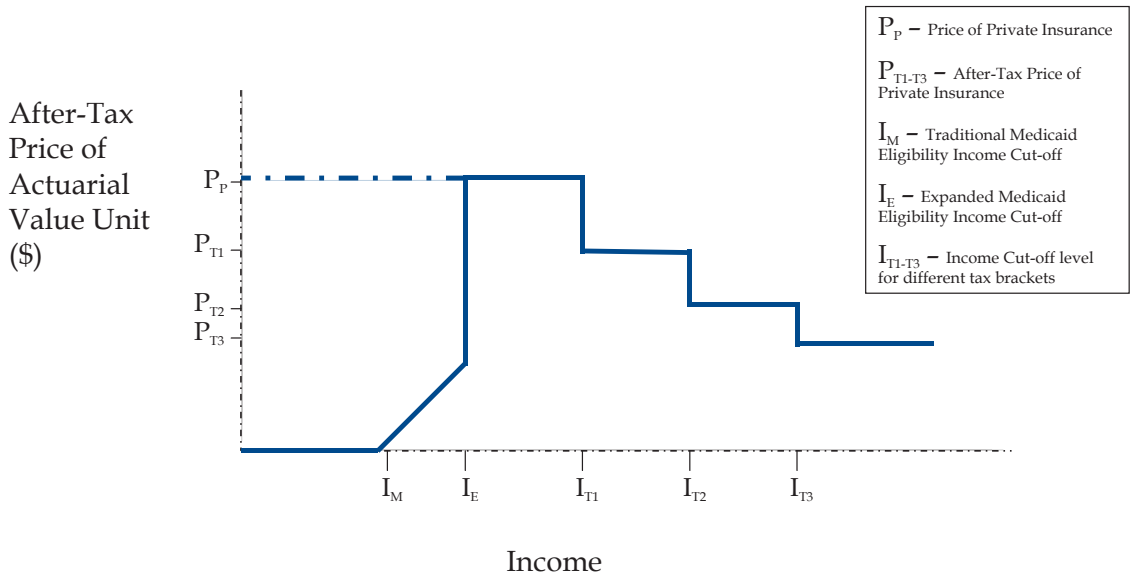


FIGURE 3

Combined Effect of Public Policy on the Price of Health Insurance by Income



In addition to providing insurance to low-income people, the income tax code encourages certain forms of insurance. In particular, employer-based insurance is tax advantaged for the firm and its employees, who can also use pre-tax dollars to pay their share of premiums. According to Sheils and Hogan,[145] federal tax collections were $111.2 billion lower than they would have been in the absence of the tax advantage given to employer-based health insurance.[146] As a result of the tax treatment of health insurance premiums, the effective after-tax cost of a particular health insurance policy drops as the marginal tax rate increases with income.

From a public policy perspective only, therefore, the effective after-tax price of a particular amount of health insurance coverage is zero for those below the income eligibility level for public insurance (assuming they meet other program criteria); it peaks for those just above the maximum income level for publicly provided insurance; and it drops at income levels where the marginal tax rate increases (see figure 3). This simple view ignores the fact that many people below the income eligibility level are *not* eligible for public insurance because they fail to meet non-income criteria. As a result, low-income people face one of two prices—the private insurance price (P_P) or $0—depending on the non-income eligibility requirements of public insurance. Tax subsidy proposals aim to use federal tax policy to reduce the after-tax price from P_P for low earners, presumably those with incomes below or possibly slightly above I_E.

[145] J. Sheils and P. Hogan. "Cost of Tax-Exempt Health Benefits in 1998." *Health Affairs 18* (2) (March–April 1999): 176–81.

[146] Historically, self-employed individuals who buy themselves insurance enjoyed half the tax advantage of those in group plans, but current policy now provides 100 percent deductibility for these taxpayers. Others who buy policies in the non-group market receive no tax break, paying after-tax dollars for their entire premium.

In summary, the key public policies that affect the consumer's price of insurance are the income (and non-income) eligibility requirements for public insurance and the tax-advantaged treatment of spending on health insurance. The primary effect of these policies is directly on after-tax prices, rather than on the value of insurance products. These factors have a secondary effect, through the incentives they create in the private market, that affects both premiums and value.

Health Insurance: Private Markets

The price/value relationship in the private market is driven primarily by whether products are purchased individually or through groups such as unions and employers. The price per actuarial value (or, similarly, product value for a given price) differs widely between these two, with prices substantially higher in the individual, non-group market. Glied et al.[147] document the difference in actuarial value between individual and employer-sponsored plans held by individuals to be about 5 percent at the median. This observed difference understates the difference in value *faced* by people in the two groups, since the probability of being insured differs between those with access to employment-based coverage and those without such access. Among group-sponsored plans, there appear to be differences in price and value by group size, with smaller groups facing higher price per actuarial value than larger groups. The small-market reforms implemented by most states in the mid-1990s were designed to reduce the price-value differences between the small- and large-group markets, largely by reducing the variation in premiums across groups.[148]

Lower-income people are less likely to have access to group coverage. For example, Pauly[149] estimates that among the uninsured, only 12 percent with incomes below the poverty level have access to group insurance (directly or through a family member); in contrast, 36 percent of those with incomes at 100–200 percent of poverty have such access. As a result, low-income individuals not eligible for public insurance are more likely to face the non-group market's high prices than are high-income people (see figure 4). The share of people with access to lower-price group products increases with income, so the mean income-specific price per value unit falls as income rises. Among those with private insurance of any type for the entire year, low-income people are more likely to report they face financial or insurance-related barriers to care, again suggesting that the actuarial value of insurance that people buy increases with income.[150]

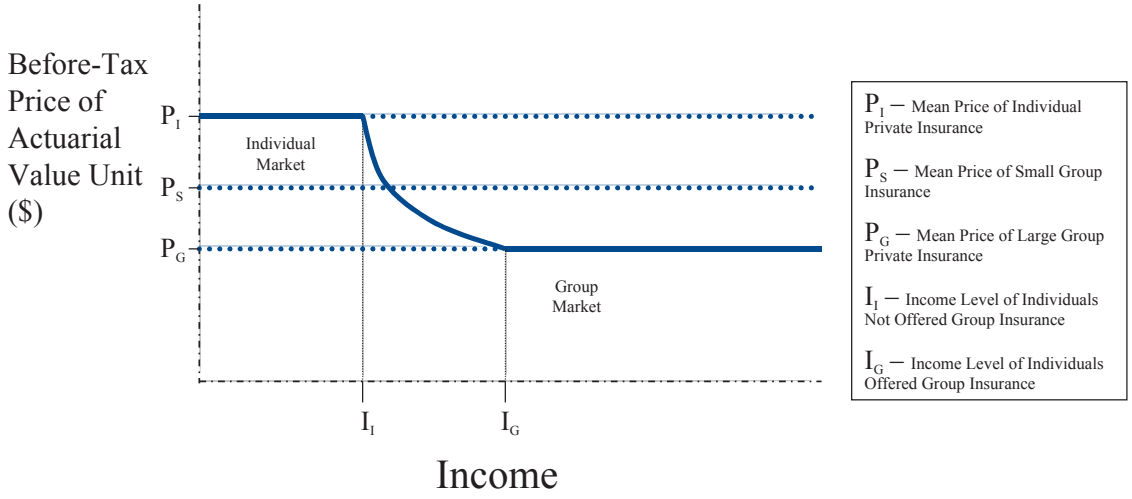
Relative to the non-group market, the price per unit value is lower for employer-sponsored coverage for three reasons: employer subsidy of premiums, risk selection, and administrative costs. The size of the employer subsidy has dropped steadily since the postwar period, when employers typically paid the entire premium, but it still represents an important reduction in the price actually paid by the insured in most group-sponsored products. The size of the price difference due to risk selection has been studied widely but remains difficult to quantify. Strategies such as excluding coverage for pre-existing conditions and limiting certain types of benefits exist largely as risk-selection tools for insurers, since the value reduction they represent is of more importance to high-risk individuals than

[147] Glied at al., 2003, op. cit.
[148] Physician Payment Review Commission. *Annual Report to Congress, 1995*. Washington: Author, 1995.

[149] Pauly M. Herring B. "Expanding Coverage via Tax Credits: Trade-offs and Outcomes." *Health Affairs*. *20* (1):9-26, 2001 Jan-Feb
[150] Based on analysis of individual data from the Medical Expenditure Panel Survey (MEPS) 1999 household survey data, where the financial and insurance-related reasons respondents did not receive care included "could not afford care," "insurance company would not approve/cover/pay," "pre-existing condition," "insurance company required referral—could not get," and "doctor refused family insurance plan."

FIGURE 4

Effect of Correlation between Income and Source of Private Insurance on Mean Price of Available Insurance by Income



At incomes below I_I, few people have access to group-sponsored insurance, so the average price they face is P_I. Access to group products grows with income and is virtually universal for incomes greater than I_G, where the price levels off at P_G.

to those at low risk. As discussed at length when many states instituted insurance market reforms in the mid-1990s, legislative efforts to lower premiums for high-risk individuals and small groups through fewer opportunities for risk selection must be weighed against the likelihood that higher premiums will cause low-risk individuals and groups to drop coverage. Essentially, this means that efforts to improve the value of these products comes with a price tag that will chase away low risks, thereby raising premiums further for those who remain in the insurance market.

Finally, non-group insurers argue that their administrative costs are higher because they incur marketing and application processing costs that are borne by the human resource departments of firms offering group products. Pauly[151] argues that these costs in the non-group market may be unnecessarily high, citing the drop in administrative costs of automobile insurance that occurred when national firms began bypassing insurance agents and offering direct-to-consumer products.

In addition to these direct effects on the price per unit value, employment-based insurance likely has a number of secondary effects on the insurance market. First, when total compensation includes a mix of wages and benefits such as health insurance, nominal wages act as an imperfect price signal in the labor market. This creates the potential for selection effects that lead to inefficient labor allocation and health risk pooling. Second, this system makes employers become health insurance agencies, a role for which they may be poorly suited.

The mean price per unit value as a function of income (figure 4) reflects the mix of people buying in each of the three markets at a particular income level and the actual levels of P_I, P_S, and P_G. The fact that these different prices

[151] M. Pauly, A. Percey, and B. Herring. "Individual versus Job-Based Insurance: Weighing the Pros and Cons." *Health Affairs 18* (6) (Nov.–Dec. 1999): 28–44.

reflect at least in part the risk selection that has occurred into each of the three suggests there is a complicated relationship among the three. To understand the price per unit value across the income distribution, how it has been changing over time, and how policy affects it, the key question is to understand the effect on price per unit value of risk selection into and out of the individual and small-group markets relative not only to uninsurance but also to group products. As discussed below, some reform proposals express the direction and magnitude of these selection effects; others do not.

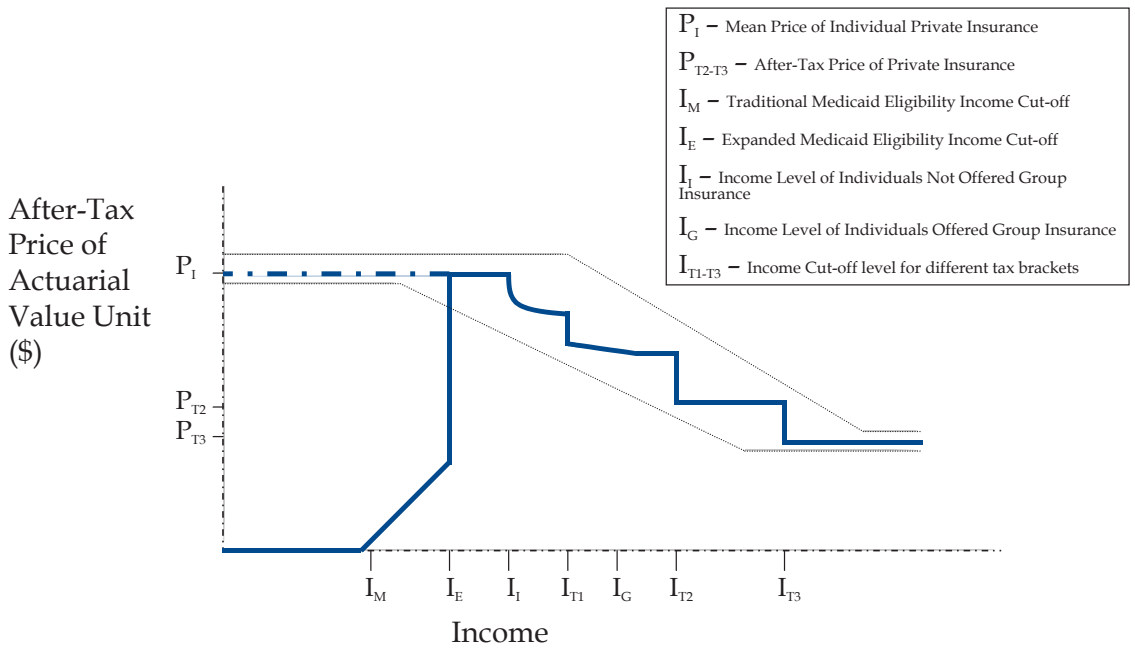
Within the private market, then, the key factors that affect the price per value borne by the consumer are the share of the premium paid by the employer, risk selection, and administrative costs. The first and third factors appear to affect premiums directly, while the second may affect the value of offered products more directly in different segments of the private market.

After-Tax Price as a Function of Income and Its Role in Insurance Purchase

This individual-versus-group private market exists within the public policy regimes described earlier. As a result, some low-income consumers who do not have access to group products are able to choose the free or sliding-scale public program while others are not (see figure 5). Those with incomes above the public program's eligibility level operate exclusively in the private market. Those closest to the eligibility level are those people in the private market least likely to have access to a group product. As a result, within the lowest income tax brackets, the mean after-tax price per actuarial value unit falls as the share of people at each income level with access to group products increases. This within-tax-bracket effect

FIGURE 5

Combined Effect on Public Policy and Private Markets on Mean Price of Insurance by Income



Note: Dotted lines indicated two standard deviations around the mean.

likely disappears in higher tax brackets, where access to group products is widespread. At these higher income levels, consumers benefit from the tax treatment of their spending on health insurance, the explicit subsidy provided by their employers, and the risk selection and administrative cost savings associated with group products.

The actual shape of the after-tax price per value unit function depends on several public policy and private market characteristics. The after-tax price as a function of income as represented in figure 5 is based on several assumptions about the relationship between key publicly determined income levels, such as the maximum eligibility for expanded public programs (I_E) and income-tax bracket cutoffs (I_{T1-T3}), and market-determined levels, such as the income levels at which individual and group products are relatively more prevalent (I_I and I_G). In particular, as drawn, key income levels are assumed to ascend from expanded eligibility for public insurance, individual-dominant private market, tax bracket change, and, finally, the group-dominated private market, after which only tax bracket changes continue to occur. If, instead, the expanded eligibility level (I_E) equals (or exceeds) the level at which individual policies dominate the private market (I_I), then the after-tax price would begin to decline from P_I (or some P between P_I and P_G) immediately at I_E. The variance around the mean is driven primarily by the shares of people in the non-group, small-group, and large-group markets at each income level. For those with incomes below the public insurance eligibility level, the variance shown is only for those *not* eligible for public coverage; the price and variance for those eligible is zero.

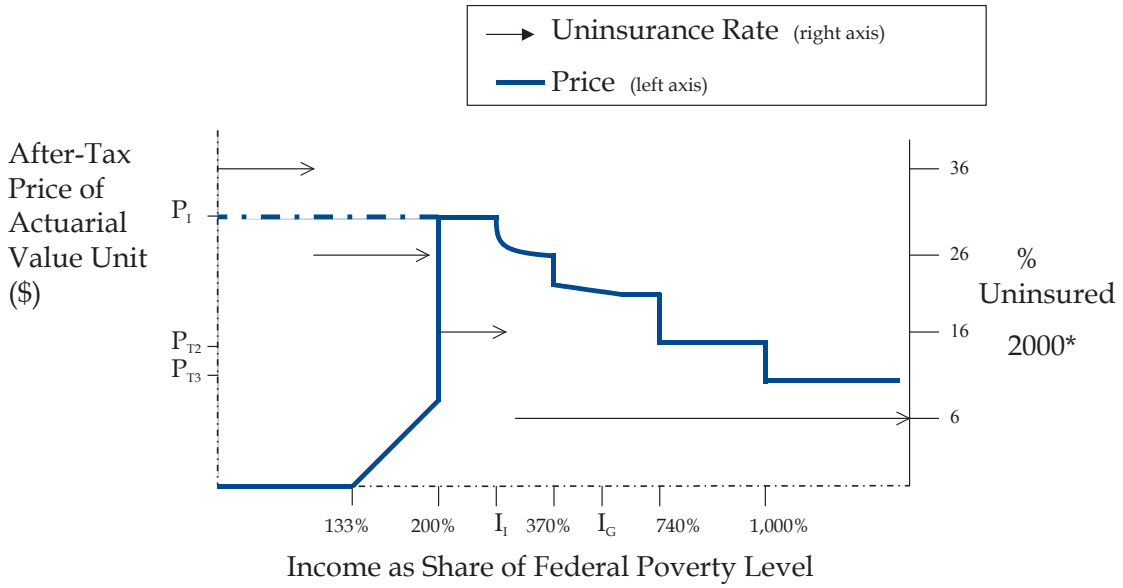
To reflect public and private policy accurately, it would be necessary to construct figure 5 separately by state and by population subgroups explicitly recognized by policy, such as eligibility levels for children compared to those for adults. In fact, other dimensions besides income might yield an even more noticeable price differential among groups, such as age and health status. For example, the ratio of the non-group price per value for someone with a costly chronic condition and that of a healthy person is likely to be larger than the ratio of the price for low-income people to high-income people as represented here.

The price function is also affected by how the actuarial value of plans is conceived. As described above, the maximum value was based on the notion of first-dollar coverage for all health services.[152] This avoids making any assessment of appropriate levels of coverage, or picking those dimensions in which coverage characteristics are more important to consumers. However, this definition may lead to a biased measure of price per value across income for analyses of policies that *do* make such choices, to the extent that there are particular benefits whose marginal price differs in different parts of the private market. For example, the price per value in the individual market (P_I in figure 4) may be higher than that in the small-group market (P_S) because, say, coverage for infertility treatment is extraordinarily expensive in the individual market, while the price for coverage for all other services is not that different. In this case, the difference between P_I and P_S is larger than it would be if the definition had been "price per actuarial value unit for all but infertility services." As a result, using the price per value measure as defined here might be misleading when analyzing a policy aimed at promoting access to a particular benefits package. Again, such distortions exist only if the marginal cost of coverage for particular services differs across the income distribution. If this is an important issue, then it may be appropriate to define alternative price-per-value measures for particular analyses. This issue should not

[152] In fact, as represented here, the benefits offered through Medicaid effectively constitute the maximum value, since those eligible for Medicaid are shown as facing an after-tax per value price of $0.

FIGURE 6

Mean Price of Insurance and Uninsurance Rates by Income



*Uninsurance rate is reported for income ranges (Kaiser Commission, 2002)

change the overall *shape* of the price function, but it will affect the distances between key prices, such as P_I and P_G in figure 4.

Unfortunately, the difficulty in putting actual values on the different income levels at which the price changes, and the actual prices at these cut points, prohibits us from making a precise comparison of price per value by income directly with uninsurance rates by income. Nonetheless, national guidelines and summaries can be used to draw the relationship among price, uninsurance, and income. Medicaid's income eligibility level differs among eligibility groups, but for these purposes, 133 percent of the poverty level was used. Similarly, states differ in how much they have expanded eligibility under S-CHIP, but most have approved plans for covering those up to 200 percent of the poverty level.[153] This simple set of key income level estimates allows for a direct comparison between price per value and uninsurance rates across the income distribution (see figure 6). As expected, uninsurance rates drop with price per value along the income distribution.

Policies for Expanding (or Redistributing) Insurance

The after-tax price per actuarial value as a function of income provides a tool for comparing alternative strategies for expanding insurance coverage. As evidenced by the growing crowd-out literature, such analyses typically lead to particular concern for under-

[153] These estimates are for a family of four that includes two children and files jointly. Standard deductions and exemptions were added to the taxable income level at which tax rates change to convert to gross income. The resulting sum was then converted to a share of the federal poverty level for a family of four. These estimates are imprecise because they ignore the effect of the earned income tax credit, itemized deductions, and other aspects of the tax code that affect the relationship between gross and taxable income.

standing market alternatives for those below through just above the eligibility level for public programs.

Before focusing on that part of the income distribution, however, the fact that after-tax price *declines* with income above this point merits comment in terms of equity and efficiency. The regressive nature of the way our current employment-based system is taxed is likely inefficient, leading those at high income levels to be "overinsured," which, in turn, may be an important contributor to medical cost growth.[154] Similarly, the falling price as income increases due to public policy alone is arguably inequitable by some simple, intuitive notions of equity (figure 3). As a result, the tendency to focus on policies aimed at individuals with income levels around I_E may lead us to ignore the larger question of whether public policy is directing resources in this market as appropriately as possible through the implicit public spending on tax-advantaged employer-based insurance. In other words, discussions of covering the uninsured are often couched as expanding public spending, which begets the crowding-out concerns described above. A quick glance at figures 3 and 5 suggests that it may be just as appropriate to ask if rather than *expanding* the amount of government spending on insurance, public policy's effect on the price of insurance could be redirected to *reallocate* public spending, both explicit and implicit, on insurance. It may be appropriate to ask whether the downward-sloping part of figure 3 should be eliminated, and whether the additional tax revenues generated could be used to subsidize insurance for those with low incomes. In other words, at a minimum, eliminating the publicly generated downward-sloping part of the price function could be both efficient and equitable; at the same time, additional tax revenues would be generated that could be used to modify the steep ascending part of the curve at I_E (and the high price for those in private market earning less than I_E).

Currently, modifying the steep gradient at the maximum public insurance eligibility income limit is at the heart of efforts to reduce uninsurance (and the high price to those below this income cutoff who are ineligible for public insurance), since this is the part of the income distribution where uninsurance rates are highest and premiums appear to be most "unaffordable." The analysis presented here suggests that working through taxes alone, such as with refundable tax credits, may be an expensive way to provide everyone with some minimal value of coverage, since people at this income level are more likely to shop in the expensive non-group market. Some discussions of this type of solution, like the graph in figure 3, fall into the trap of considering a "private price" (P_P in figure 3) as the operand for tax arithmetic, when in fact multiple private prices (simplistically P_I, P_S, and P_G in figure 4) are not uniformly distributed across income levels. If the intent of tax-based reforms is to lower the effective price of insurance, this could be achieved through tax credits directly or through some combination of tax credits and insurance market reform (or subsidy). In other words, tax credits alone affect only the tax treatment of whatever premium is paid (figure 3), and market reform affects the before-tax market prices faced (figure 4), while some combination might be the most cost-effective way to produce the after-tax price that will expand insurance coverage.

It may be that changes in one sphere lead naturally to desired changes in the other. For example, Pauly[155] asserts that refundable tax credits for low earners will, in essence, level the public-policy playing field across income levels *and* revitalize the individual non-group market. In the framework presented here, he argues that balancing the tax treatment of employment-based insurance with refundable

[154] Sheils and Hogan, 1999, op. cit.

[155] Pauly, Percy, and Herring, 1999, op. cit.

credits for low-income people will level P across incomes in figure 3 and, subsequently, in figure 4. If he is correct with regard to the effect of public policy and private markets, the resulting after-tax price per value would no longer vary with income, except for those eligible for public insurance (with incomes below I_E). Presumably, the effect would be the same if the tax advantage to employment-based coverage were eliminated, since it would greatly reduce the incentive for employed people to restrict themselves to the group market. If Pauly is overly optimistic about the nature and magnitude of this effect, then the size of the tax credit would have to be larger than he estimates if it is to be large enough to enable those with low incomes to buy insurance.

The market reforms passed by most states in the 1990s were largely aimed at changing the price/income gradient in the private market, moving P_I, P_S, and P_G in figure 4 toward one another, mostly by reducing the role of risk selection in inflating and creating variance in P_I and P_S. To the extent that states focused on the small-group market rather than the individual market, the fact that small firms could opt out created the possibility that P_I could decline as the result of declines in P_S, if relatively high-risk small groups dropped out but lowered the risk of those subsequently in the individual market.[156] (The opposite could happen as well, with P_I increasing if the new risks in the individual market exceed the previous level of risk and price continues to reflect risk.) There seems to be consensus at this point, however, that these reforms have not had important effects.[157]

Proposals to expand insurance through mandated purchase of a minimum benefits package or other approaches that do not explicitly involve tax policy, public program eligibility, or market reform are amenable to analysis through the after-tax price per value. To analyze such a proposal, the after-tax price per value would first be estimated based on a maximum actuarial value equal to that of the required benefits package. Within this somewhat constrained benefits universe, the curve in figure 4 is presumably flatter (as are the within-tax bracket slopes of figure 5), but without other policy changes, those at low-income levels would still face the highest after-tax price per value. Multiplied by the required package value, these individuals would pay the highest dollar value to satisfy the new insurance mandate.

The after-tax price per value by income level is a fairly simple measure for considering alternative proposals for reforming the U.S. health insurance system. It is the product of all the key factors in the system—publicly financed insurance, the tax code, employer subsidies, risk fragmentation, and administrative costs—and can help us understand how changes in one area may or may not have significant net effects from consumers' perspective.

Acknowledgements

Jonathon Hess provided excellent research assistance for this project. All opinions and errors are the author's. ■

[156] This would happen if the average risk in the small-group market was lower than the average risk in the non-group market. If small firms withdrew coverage, and their employees reverted to the non-group market, then the average risk in this market would fall, possibly lowering P_I.

[157] Marquis, MS and SH Long. "Effects of 'Second Generation' Small Group Health Insurance Market Reforms, 1993-1997." *Inquiry* 38(4):365-380, 2001/2002 Winter; Jensen, GA and MA Morrisey, "Small Group Reform and Insurance Provision by Small Firms, 1989-1995." *Inquiry* 36(2): 176-187, 1999 Summer.