A Plan for Achieving Universal Health Coverage

Combining the New with the Best of the Past

by Elliot K. Wicks, Jack A. Meyer, and Sharon Silow-Carroll

No Americans should be denied access to needed medical care because they lack health insurance coverage, and no health care providers should go unpaid because they treat people who lack the means to pay for care. This proposition is the guiding principle underlying the proposal for universal health coverage that we develop in this paper. We have designed a system that achieves universal coverage by (a) providing generous subsidies in the form of tax credits for those with limited ability to pay, (b) mandating that everyone buy coverage from one source or another, (c) establishing Medicare as a temporary backup payer for those who fail to purchase coverage, and (d) establishing aggregate purchasing arrangements. The system is built on the foundation of current private health plans and employment-based coverage. Our plan addresses only the non-elderly population; the Medicare program for the elderly would remain as a separate program.

Objectives

Our approach is based on a vision of the way health care financing should look. It seeks to achieve the following objectives.

Universal Coverage

Large numbers of Americans are without health coverage—about 43 million by the latest count—and this number has been rising, even in the face of the longest period of sustained prosperity in U.S. history. Many other citizens have inadequate coverage that does not protect them from incurring unaffordable medical bills in the case of a serious illness or injury or does not encourage use of cost-effective preventive and primary care services. Many people lose coverage when they lose or change jobs. Although there are programs to cover poor children and families, many low-income individuals and working families are not eligible for public subsidy programs and cannot afford to buy coverage privately.

We are proposing a plan to correct these problems. We believe that any plan to achieve universal coverage must include two features: a federal mandate that everyone have coverage, and substantial subsidies to make coverage affordable for everyone. Those features are already embodied in Medicare, the plan that covers essentially everyone over the age of 65. In enacting Medicare, we decided as a society that ensuring access to needed medical care for the elderly population was so important that we were willing to impose a degree of compulsion to achieve universal coverage. Using the same rationale, we believe that a mandate for coverage can be justified as a way to ensure access for people of all ages and to achieve fairness—by eliminating "free-riders," those who do not buy coverage but use the medical system's resources in emergencies. Our plan would ensure that no one is ever "between" coverage or otherwise falls through the cracks. This objective is achieved by establishing an individual mandate and by making Medicare the default payer for those who nevertheless fail to get coverage (with disincentives for individuals to rely permanently on Medicare coverage).

Reduced Fragmentation, Duplication, and Inequities of Public Subsidy Programs

The current public financing system is highly fragmented and unduly complicated. There are many different types of subsidy programs, each with dif-

ferent eligibility criteria and benefit structures. As people's circumstances change, they become ineligible for one program but may not be eligible for others, or they may be eligible but not know they are. Some people are reluctant to enroll because of the stigma associated with public programs. As a consequence, people fall through the cracks. The subsidy system is far from seamless. Few people can keep track of all the system's features, especially because of constant policy changes, and it inevitably is bureaucratic, duplicative, and expensive to administer.

Current subsidies are also unfair. Because the major public financing programs, especially Medicaid, permit substantial local discretion in setting eligibility standards, inequities abound. People in equal circumstances are not treated equally. Needy people in some parts of the country have no coverage, while similarly situated people in other parts of the country have comprehensive coverage. We have a multi-tiered system of care based in part on income and in part on where people live and their state's eligibility and benefits standards. If the objective is to provide access to appropriate care to all needy people, it is hard to defend the current system.

In addition, the subsidy system for the non-poor—the income tax provisions that allow employer-paid health premiums to be excluded from employees' taxable income—favors higher-income people over lower-income people. Higher-income people often work for employers who pay more toward coverage, so more income is tax-exempt; and because they have higher marginal tax rates, the tax exclusion is worth more to them. Government's tax-expenditure cost is very high—$125.6 billion in federal money and $15.3 billion in state tax losses in 2000.[1]

The approach we propose eliminates the patchwork of subsidy approaches and multiple public programs, the burdensome and expensive administrative procedures for determining eligibility, and the myriad complicated and constantly changing regulations. This objective is achieved by replacing most subsidy programs with a tax credit, basing eligibility for the credit on income alone.

Simplified Administration

The current administrative system for private health insurance is unnecessarily inefficient, wasteful, and burdensome for patients and providers. Time and resources are wasted because there is no centralized system for determining eligibility, identifying benefit limits, submitting claims for payment, and coordinating benefits. Many of the costs are borne by patients as they try to wend their way through the maze of claims submission and administration, and surely many costs that are legal obligations of insurers are actually paid out of pocket by patients because claims are never submitted or are not settled accurately. The system we propose would substantially reduce the burdens and costs borne by providers and patients related to determining the limits on benefits, filing claims, and coordinating benefits. This objective is achieved by establishing a national centralized electronic mechanism for paying claims and coordinating benefits.

Maintaining the Role of Private Health Plans and Insurers as Sellers of Health Insurance Coverage

The current system of private health plans and insurers works well for most Americans. Competition among health plans and insurers for business helps to promote efficiency and better service. In addition, recent changes in state and federal laws governing the sale of insurance to small employers have improved some aspects of performance. Though further changes may be needed, there seems to be little reason or political desire to abandon the basic structure of a private insurance system, and there is no obvious alternative on the horizon. The case for retaining the basics of the current system is strong.

Continued Reliance on Employer-Sponsored Coverage and the Role of Employers as Poolers of Risk

Employers play a major role in pooling risk; that is, they bring together people with different levels of risk who all pay a similar premium. Avoiding seg-

[1] John Sheils, Paul Hogan, and Randall Haught. *Health Insurance and Taxes: The Impact of Proposed Changes in Current Federal Policy.* Report of The National Coalition on Health Care, October 18, 1999.

mentation of risk is a major challenge for any system, so it seems wise not to abandon a system that meets the need for risk pooling for a large portion of the population. In addition, much of the pressure and many of the ideas for cost control and quality improvement have origins in the employer community. The case is strong for continuing to have employers be advocates for employees in purchasing coverage that offers good value.

Features of the System

Subsidies

THE PROVISIONS

Every (non-elderly) American would be eligible for a health coverage subsidy in the form of a "refundable" tax credit that could be used to offset costs of coverage, whether the premium is paid by the insured person (including those buying individual coverage) or by an employer on behalf of an employee. That is, a family's income tax liability would be reduced by the amount of the credit, as long as the total of the employer and employee premium was equal to or greater than the credit. However, any premiums paid by the employer would be considered taxable income to the employee. Although the size of the tax credit would be larger for lower-income people, everyone would be eligible for the minimum credit. That minimum credit would be equal to the average value of the current federal income tax exclusion to those who have employer-sponsored coverage, or approximately $700 per year for an individual or $1,500 per year for a family.[2] Larger subsidies would be available to people below the median family income (currently about $50,000 per year). People with incomes at or below the federal poverty level would get a total tax credit sufficient to pay the full premium for coverage comparable to the costs of efficiently provided Medicaid benefits.[3] For those between the poverty level and the median income, subsidies would be reduced gradually as income rises so that those at the median income would receive the minimum subsidies indicated above.

The tax credit subsidy needs to be "refundable" and payable in advance. That is, people whose income tax liability is less than their credit would receive the difference in the form of a "refund." And because premiums have to be paid monthly beginning more than a year before tax time,a mechanism is needed to make coverage affordable during the year as premiums come due. We propose that the amount of the subsidy be based on the previous year's reportable income. People whose reportable income is low enough to qualify them for advance payments would receive a federal voucher every month that could be applied to the cost of coverage. Vouchers could be transferred to and redeemed by either employers or insurers, depending on whether the person has coverage through an employer or in the individual market. (This voucher process and redemption generally would be handled electronically through the centralized administration system described later.) If a family that is not receiving vouchers experiences a decline in income that would make it eligible for advanced payments, it could apply for eligibility at that time. Any government overpayments would be reconciled at the next tax filing, with minor amounts (for example, under $100 per year) being forgiven.

An important issue is how to adjust the subsidies over time as the cost of medical services increases. For people below the poverty level, the subsidy should be adjusted so that it is always adequate to purchase coverage equivalent to current Medicaid benefits. We propose that the Office of the Actuary in the Health Care Financing Administration be assigned the task of developing an appropriate

[2] In 2000 the average employer premium contribution was about $4,600 a year for family coverage and about $2,100 for single coverage. (Computed from Jon Gabel et al. "Job-Based Health Insurance in 2000: Premiums Rise Sharply While Coverage Grows." *Health Affairs* 19 [5] [September/October 2000]: 147). For someone in the 32 percent marginal tax bracket, the tax savings are about $1,500 for family coverage and $700 for single coverage.

[3] Because Medicaid-covered services vary from state to state, the federal enabling legislation would define a uniform benefits package. But the intent is that the covered services would be equivalent to what is now typically available to Medicaid enrollees. Any changes in benefits over time would be defined by changes in federal law or regulations.

The most compelling reason for mandating that everyone be covered is that this requirement is necessary to ensure universal coverage.

index to increase the subsidy over time. For people earning above the median income, we would propose that the subsidy not be indexed to increase automatically but could be increased at the discretion of Congress. For those between the poverty level and median income, the subsidy would increase automatically when it was increased for those below the poverty level.

THE RATIONALE

The current tax policy that excludes employer premium contributions from employees' taxable income is widely acknowledged to be an inequitable and inefficient way to subsidize the purchase of health insurance. It is inequitable because many low-income people do not have employer-sponsored coverage, so they get no benefit; higher-income people tend to have more comprehensive coverage and thus more excludable income; and higher-income people have higher marginal tax rates, so they benefit more from every dollar that is excluded from tax. The subsidy is inefficient—that is, its cost is high relative to the objective—because much of the forgone tax revenue pays for subsidies to people who could afford to pay for coverage out of pocket. It is also inefficient because it encourages people to consume more health care services relative to other goods and services than they would if employer-paid premiums were not "tax sheltered."

Substituting a tax credit for the tax exclusion substantially reduces the inequity, especially because the credit we propose is larger for lower-income people but fixed for those with incomes above the median. Though a case could be made for entirely phasing out the credit for higher-income people on equity and efficiency grounds, this would produce a large tax increase for politically influential middle- and high-income people. Retaining a substantial subsidy for these income groups should lessen political opposition to the change, although high-income people whose employers contribute generously to comprehensive coverage would still have a higher tax liability with the tax credit than with the tax exclusion.

The current Medicaid program provides comprehensive medical coverage to families that qualify. (It also includes coverage of some non-medical services, about which more is said later.) We believe that such comprehensive medical coverage should be subsidized fully for all families below the poverty level, and that substantial though gradually decreasing subsidies should be available to families up to the median income level. Without such subsidies, many will find the cost of paying for the now-mandatory coverage to be burdensome if not impossible. The graduated phasing-out of low-income subsidies is justified on the grounds of ability to pay and to ensure that the system does not include strong work disincentives. If the subsidy were reduced too quickly, some people would be reluctant to take higher-paying jobs that would make them ineligible for the low-income subsidy because they actually might have lower net incomes after paying more for health insurance.

The feature of the proposal that may need more explanation is the provision that allows the credit to be applied not only to premiums paid by employees or individuals but also to those paid by employers. This provision would appear to make the budgetary cost of the subsidy higher, but that is not likely to be the case in the long run. Since employer-paid premiums would be taxable income to employees, there is no reason for employees to prefer being compensated in the form of employer-paid premiums rather than money wages. If the tax credit could not be applied to employer-paid premiums, employees would urge employers to stop paying the premium and give them the equivalent in money wages. Employees then could pay for coverage themselves and use the tax credit to offset the cost, leaving them

with more net income. Over time employers likely would stop paying anything for premiums because doing so would benefit their employees without adding to the employers' costs. (Economists argue that employers are largely indifferent to the form of compensation; what counts is the cost of the total compensation package,including money wages plus employee benefit costs.) At the point where employees pay all of the premium, the credit could be applied to the entire premium;so the budgetary cost is the same as if the credit could be applied toward both the employer and employee portions of the premium. But if employers stopped paying for premiums, they might be tempted simply to abandon entirely their role as purchasing agents acting on behalf of their employees. For reasons noted earlier, we think this would be a bad result. But if the credit applies equally to employer-paid or employee-paid premiums, employers may continue to pay a portion of the premium and to pursue good value in purchasing health coverage for their employees.

Regarding changes in the subsidy over time, the rationale for increasing the subsidy for impoverished people as medical costs rise is straightforward: We want to ensure that they can afford the coverage they are required to buy. For the group between the poverty level and median income, the same rationale justifies increasing their subsidy, which would happen more or less automatically, since it is tied to the subsidy for those below the poverty level, with a phase-out as income rises. We do not propose,however, to automatically increase the tax credit subsidy for people above median income. The main reason for creating the credit for them in the first place was not because the subsidy was needed to make coverage affordable, but to avoid the political objections that would occur if this group had to give up its current tax exclusion subsidy without having anything else in its place. On equity grounds, a case could be made for having the real (after-inflation) value of the tax credit subsidy decline over time. If the credit is increased for this higher-income group, we favor having Congress explicitly decide to raise it rather than having it increase automatically as medical costs rise.

Individual Mandate

THE PROVISIONS

Every individual and family would be required to have health coverage—that is, at a minimum, as comprehensive as Medicare benefits (Parts A and B) with the addition of a drug benefit and well-child care.[4] To ensure that such plans are available, all insurers offering health coverage would be required to offer a policy that includes the services covered by Medicare plus prescription drugs and well-child care and to price the policy on an actuarially defensible basis.

A mandate without effective enforcement would not achieve the desired result. We propose that everyone be required to show proof of purchase of coverage as part of his or her annual filing of federal income tax forms. In the case of families, proof of coverage would be required for the person filing the return, his or her spouse, and all dependents listed on the tax return. Insurers, health plans, and self-insured employers would be required to issue a standard form to all policy holders that serves as the proof of purchase and is attached to income tax returns (comparable to W-2 forms now issued by employers to show earnings). The forms would indicate the months during which each person is insured. Individuals who have no taxable income and, therefore, do not now file a tax return, still would be required to send in proof of coverage when federal tax returns are due.

Those who fail to show proof of coverage incur the following penalty: for every month they are without coverage, they would be required to pay a fee, to be included with their tax return, that is equivalent to the monthly cost of coverage for Medicare benefits plus a 10 percent surcharge. The fee would be levied whether or not the individuals use any medical services during the time they are uninsured. The fee would be based on the actuarial cost of providing the augmented Medicare benefits package to a non-Medicare population under age

[4] In referring to Medicare benefits, we are referring only to the services covered, not to the kind of system that delivers these services. An individual could meet the mandate requirement by choosing an indemnity plan, a preferred provider organization (PPO), a health maintenance organization (HMO), etc., as long as the benefits were as extensive as those covered under Medicare.

65. The premium assessment would be adjusted to reflect family size and composition and regional differences in medical costs, but not age of the adults (explained under "Insurance Regulation" below). The tax credit applicable to the family or individual (discussed in the previous section) can be applied against this liability.

THE RATIONALE

To achieve the objective of universal coverage requires that one of two conditions be met: either everyone must be required to purchase coverage, or a mechanism must be in place that automatically covers everyone (as is the case with social insurance systems). In a sense, we have chosen to build in both conditions. We would mandate that everyone buy private coverage, but, in addition, we propose that anyone who is not privately covered, for whatever reason, would default into Medicare coverage and pay a premium for the time he or she is covered under that system. In a sense, this approach can be thought of as an individual (as contrasted with an employer) "play or pay" mandate: one either "plays" by purchasing private coverage or "pays" by being assessed for Medicare coverage. (The mechanism by which this is accomplished is discussed in the next section.)

The most compelling reason for mandating that everyone be covered is that this requirement is necessary to ensure universal coverage. But there are other reasons, as well. Even if they have the means to buy coverage, some people will choose not to do so if there is no mandate; yet when they need expensive care for life-threatening or emergent conditions, society is not willing to deny them access to essential services. They then become "free-riders" who do not bear their fair share of the costs. Our approach prevents this.

In addition, no one has been able to devise a practical mechanism for making the individual insurance market work well without mandating that everyone have coverage. The individual market falters without a mandate because individuals can predict when they will need certain expensive kinds of medical care—for example, elective surgery or maternity benefits. Some people will choose to buy coverage only when they expect to need care, which creates severe problems of adverse selection. The ability to buy coverage only when the insured person is likely to incur expenses negates the insurance principle, which involves pooling of risk among individuals who cannot predict when they will need expensive services. Moreover, it is not fair to require people who want to stay insured permanently to pay for the costs of care provided to individuals who become part of the insurance pool only when they know they will be incurring major medical expenses. Individuals who go in and out of coverage on that basis are not paying their fair share.

Since our approach includes the "mandate" that everyone who does not buy private coverage is automatically covered by Medicare and must pay a premium for that coverage, why, then, do we also propose to mandate the purchase of private coverage? Without such a mandate, the number of people who default into Medicare coverage would almost surely be greater (even though they must pay a premium plus a penalty for the time they are covered by Medicare). Because we seek to encourage coverage acquired in the private market rather than having large numbers of people defaulting into Medicare, we propose a mandate to buy private coverage to promote that objective. On the other hand, our proposal would still achieve universal coverage, even without this requirement. The mandate to purchase private coverage is desirable but not necessary.

We propose to use the federal income tax filing mechanism to enforce the mandate because it is a relatively simple approach and would be an add-on to a process that most people complete routinely each year. Of course, some people who do not file returns now would have to do so, but they also would be required to do so to verify the amount of tax credit subsidy for which they are eligible (explained above). Because virtually all of these people would have very little income, the form could be very short and easy to complete. Some people would fail to comply, and they would be subject to the same penalties as people who do not file returns: if they owed an obligation—in this case, if they failed to buy coverage, and the cost of coverage exceeds their tax credit—they would be subject to

interest penalties identical to those for unpaid or overdue taxes. Some people—for example, the homeless—might fail to file, but because of their very low income, they normally would have no premium obligation anyway.

The 10 percent penalty above and beyond the actuarial cost of coverage for those who fail to get coverage on their own is imposed to create incentives to buy private coverage. Because we want to maintain the privately based insurance system, we want to make the default position of having Medicare pay the bills more expensive than getting coverage through the private system. The base premium amount is based on a community-rated premium, with adjustments for family size and differences in regional costs. The rationale is to make the rate comparable (not counting the surcharge) to what could be purchased privately in the region. (As we explain later, we propose that community rating be required in the private insurance market for individuals and small groups.)

A requirement that individuals be insured must be coupled with a definition of a minimum benefit package that fulfills the requirement. We have chosen Medicare coverage (Parts A and B) plus a drug benefit and well-child care. We add drug benefits because we believe that prescription drugs should be covered, and because there seems to be strong support for adding such a benefit to Medicare. We add well-child care because it is cost-effective coverage that is not applicable, and therefore not covered, under Medicare. We favor this definition of minimum benefits for several reasons. First, this is a benefit package that already applies to the elderly population. If it is good enough for the elderly, it should be good enough for everyone else. It would be inappropriate to have a benefits package minimum for the non-elderly that was more comprehensive than that available under Medicare for seniors. Second, the Medicare benefits package reflects a political decision about what constitutes an appropriate level of services. Relying on that decision avoids going through the very controversial and politically charged process of defining a new benefits package, with the inevitable intense lobbying from disease-specific advocates and provider groups. Third, Medicare benefits are not so comprehensive as to make the cost of the minimum package very high, nor is the coverage so generous as to encourage "excess" consumption of medical services. Fourth, having the minimum benefits package be the same as Medicare benefits simplifies administration of the "fallback" coverage system for people who fail to get private coverage (explained later). Procedures related to claims review, reimbursement of providers, cost-control measures, etc., would be identical for the fallback system as for the existing Medicare system. No new mechanisms or bureaucracies would be required.

Even though we favor using Medicare benefits as the minimum standard for everyone, our approach would work well even if some other benefit standard were adopted. The merits of our approach do not depend on using Medicare coverage to define minimum benefits for the individual mandate. If it is decided that the peculiarities of the Medicare benefits package, even with the additions we suggest, make it unsuitable for use as the standard, a number of alternatives could be substituted. For example, the minimum coverage package could be based on the services covered under the Federal Employees Health Benefits Plan (FEHBP). Or Congress could devise an entirely new set of benefits just for this program. If it is simply the association with Medicare that carries negative political connotations, the program could be identified with an entirely different name.

Medicare as a Source of Backup Coverage

THE PROVISIONS

Anyone who lacks coverage at any point for whatever reason would be automatically covered by Medicare. The benefits package available would be identical to the minimum benefits required under the individual mandate, which in this proposal are the equivalent of Medicare coverage plus drug coverage and well-child care. People who default into this arrangement do not become Medicare enrollees, but Medicare is responsible for any (covered) medical expenses they incur during the time they lack other coverage. Medicare pays providers on the same basis and through the same mecha-

nisms that are used currently, but the money does not come out of the present Medicare trust fund. Instead, a new fund would be established for this purpose. This fund would be financed primarily by the assessments imposed on people for the months they lack coverage and that are paid as part of the federal income tax filing process, as explained earlier. Even though the assessment is equal to an actuarially determined premium plus a 10 percent penalty, some funding shortfall is likely because some people covered through this system will not actually pay any assessment. Their income will be so low that the tax credit for which they are eligible will fully offset the full cost of their assessment. Funds to cover this shortfall would have to come from other sources, essentially general tax revenues.

THE RATIONALE

Even when everyone is required to have coverage, some people inevitably will not be enrolled in a health plan for some period of time. They will be between jobs and fail to get individual coverage, they will fail to pay a premium and subsequently will be disenrolled, or they simply will fail to sign up, even though they are required to by law. These people still need to have a source of coverage if they are to get the care they need, and if providers are to be paid for the services they provide to them. Having Medicare provide backup coverage solves this problem. We would not make these people Medicare enrollees because we want to encourage them to get private coverage. That is also the reason for imposing the 10 percent penalty above and beyond the actuarial cost of coverage. Some people probably will default into Medicare coverage for long periods—the homeless, for example—and they are likely to be people of above-average risk. But this is probably an appropriate way to spread risk.

We propose Medicare benefits as the coverage package available to those who default to the fallback system, but there are obviously other alternatives. The coverage could be more or less generous. For example, the FEHBP benefits package could be used as a model. But whatever the benefits, they should be identical to the minimum benefits package required for the individual mandate. The coverage should be no less comprehensive because the notion of universal coverage implicitly requires that everyone have access to a societally determined minimum set of benefits. On the other hand, if the fallback benefits were more generous, people would have incentives to default to the fallback system rather than buying coverage on their own.

Even under our preferred option of using the Medicare benefits package, it would be possible to choose an administrator for the default system other than Medicare—for example, FEHBP—if that is thought to be politically desirable. The advantage of having Medicare as the administrator is that the program already has contractual agreements with nearly all providers and has mechanisms in place for administering claims,setting reimbursement amounts, and making payments. Thus, no new bureaucracy and few administrative changes would be necessary to administer the system.

We would not propose to cover undocumented immigrants through this system. The incentives for people to enter the country illegally to get access to treatment would be too strong. We understand that some undocumented people,especially children,are covered by Medicaid or the State Children's Health Insurance Program (S-CHIP), even though they are not officially eligible for these programs. Some of them would lose coverage if this proposal were adopted. We acknowledge that meeting the health needs of undocumented people, especially for primary and preventive care, deserves attention and that better ways need to be found to cope with the problem. But finding a solution is beyond the scope of this proposal, because the problem has many dimensions other than those related to health coverage.

Employer Mandate to Offer (But Not Pay for) Coverage

THE PROVISION

We would require employers to *offer* coverage to their employees and employees' dependents, but they would not be required to pay anything toward the premium, though many would choose to do so just as they do now. Employers would be free to design any benefits package they thought appropri-

ate, as long as the coverage was at least as comprehensive as Medicare coverage plus a drug benefit and well-child care. The requirement to offer coverage could be met by offering it through an aggregate purchasing arrangement (APA) that would be available in each state (as explained below) and would offer benefits packages equivalent to Medicare and Medicaid, among others.

Employers that offer their own plan rather than purchasing through the APA would be required to allow employees who are eligible for the lower-income tax credit (those with incomes below the family median) to purchase coverage equivalent to Medicaid coverage through the APA. That is, if eligible lower-income employees request it, employers would be required to withhold premiums from paychecks and send the withheld amount to the APA, along with the same dollar contribution that the employer makes for the firm's standard plan.

THE RATIONALE

Inclusion of this mandate to offer coverage ensures that every employee would have the option of being covered by an employer-sponsored plan, with the risk-pooling advantages and administrative economies of scale that group purchasing achieves. Employers would have a reason to seek a good value for their employees' benefit, even if the employer pays nothing. And having the employer withhold premiums from paychecks and pay the insurer or health plan is more efficient and less expensive for health plans and relieves employees of the burden of doing this themselves. Having a plan available through an employer makes it easy for most people to meet the requirement that they buy coverage. They avoid the need to incur burdensome transaction costs—finding a plan for themselves or finding an agent who will help them do so, making difficult judgments about the value of various plans, and then paying individual premiums to the plan they choose.

We see no substantial advantage to requiring employers to *pay for* coverage. Economists generally believe that employers offset the cost of paying insurance premiums by paying lower money wages than they otherwise would. If that is so, there is no advantage to requiring employers to nominally pay the cost of the premium (now that employer-paid premiums would not be tax-excludable income). Moreover, a requirement to pay for coverage likely would cause some employers who pay only the minimum wage to lay off some workers because the workers' contribution to productivity would not be great enough to justify paying the now-higher total compensation.

We allow employers to choose the aggregate purchasing arrangement (described next) as the vehicle for offering employees coverage. This makes it easy for employers that do not offer coverage now to meet their obligation, but still ensures that employees are not forced into the less efficient and potentially confusing individual market. We require employers to allow lower-income employees to purchase coverage equivalent to Medicaid coverage through the APA because the employer's own benefit package may not be suitable for lower-income employees. For example, the deductibles and co-payments may be unaffordable, or primary care services may not be covered adequately.

Aggregate Purchasing Arrangements

THE PROVISIONS

Each state would be required to establish an aggregate purchasing arrangement that would serve small employers and individuals (though larger employers could opt to purchase coverage through this mechanism). The federal government would establish general guidelines for these organizations, but states would be given wide flexibility in deciding what kind of arrangement to establish. For example, they could establish a traditional health purchasing cooperative, a HealthMart, or a similar organization of their own design. They could establish just one or as many as they thought feasible. They could be private, quasi-public, or public entities, at the state's option. As an alternative, the state could allow employers and individuals to buy into the state's existing employee plan or a different state plan designed for this purpose.

Each aggregate purchasing arrangement would be required to offer, at a minimum, a benefits package equal to Medicare benefits plus drug coverage

and well-child care and another equal to Medicaid coverage. Each participating health plan would be required to offer at least these two benefits packages. No insurer or health plan offering insured plans in the state could refuse to offer coverage through the APA, but the APA (under state-determined regulations) would establish its own criteria for deciding which plans to include.

People getting coverage through the APA, whether individuals buying for themselves or employees in a group, would *individually* be able to choose any health plan that offers coverage through the APA. Each insurer selling through the APA would price coverage on a community-rated basis (with the minimal adjustments explained below), and that coverage would be available at that price to all individuals and all groups with 100 or fewer employees. The rates health plans charge inside the APA could be no higher than the rates they offer for comparable coverage to groups outside the APA. But the APA could negotiate with insurers for a lower price than their outside price, reflecting administrative savings, volume discounts, or other efficiencies that insurers and health plans realize by selling coverage through the APA. Insurers contracting with the APA would be subject to all the rules that apply in the small-group and individual markets, as explained below.

Employers with 10 or fewer employees would be required to offer coverage exclusively through the APA. Groups of any size could participate, but the state would have the option of choosing to establish a mechanism for the APA that would allow insurers and health plans to charge groups with more than 100 employees a premium that reflected the specific group's risk and administrative costs. Individuals could also buy coverage through the APA. No group or individual seeking coverage through the APA could be excluded; the APA and all participating insurers would have to accept all applicants.

THE RATIONALE

When individuals and small employers want to purchase health coverage on their own, they are at a disadvantage. They lack the specialized knowledge and resources that large employers can allocate to this task, so they are not in a good position to determine whether they are receiving good value and buying a plan that best fits their needs. In addition, because of the diseconomies that health plans face in serving small groups and individuals, most notably high marketing and administrative costs, these buyers pay more for coverage than large employers. Aggregate purchasing arrangements have the potential for giving individuals and small employers some of the advantages that large employers enjoy—not only lower administrative costs, but also the power to negotiate with health plans to ensure that purchasers are buying high-value coverage. Further, APAs could provide the kinds of cost and quality comparisons that individuals and employees need to choose wisely among health plans.

But previous experience with purchasing cooperatives and similar organizations has been discouraging. For the most part, they have not realized the expected economies, and they have had trouble attracting sufficient numbers of employers and maintaining health plan participation. Most observers agree that the problems of aggregate purchasing arrangements would be largely solved if they could become big enough, and if they could be assured of health plan participation. We attempt to solve the first problem by requiring all very small employers to participate. These are the employers least capable of buying cost-effective health coverage on their own, but there are enough of them to create a large pool of business when all of them participate and all their employees get coverage, as required. The size of this market might be sufficient by itself to attract many health plans, but to ensure continued participation, we would require that all plans participate if asked to do so by the APA. States might decide to establish criteria for limiting the number of plans that participate in the APA, because, if all plans were to participate, administrative costs might be excessive and the range of choices might be overwhelming. Further, APAs might want to limit participation as a negotiating ploy: they could bargain with plans to give all of their business to the few health plans that offer the best deal.

We propose to allow every individual or employee buying coverage through the APA to choose any

The problems of aggregate purchasing arrangements would be largely solved if they could become big enough, and if they could be assured of health plan participation.

plan that participates in the APA. Especially in the era of managed care, we think people should be able to select the plan that best matches their needs, and they should be able to switch plans periodically (for example, once a year) if they become dissatisfied. This individual-choice provision also puts competitive pressure on plans to perform well. Moreover, when employees can choose their own plan, they will often be able to stay in the same plan when they change employers.

We allow groups of any size to buy coverage through the APA if they wish to do so. Having larger groups be part of the APA could help it to achieve greater economies of scale and give it more negotiating clout when dealing with health plans. The APA would also serve as a convenient vehicle for providing coverage for those employers that wish to adopt a defined-contribution approach to paying for health coverage. But if large groups are community rated with the smaller groups in the plan, there is a danger that the APA will be adversely selected against: higher-risk, larger groups would have an incentive to join the APA to get a lower premium rate. We therefore propose that these larger groups be separately rated if the state chooses to take this approach.

Insurance Regulation

THE PROVISIONS

Federal law would require all health plans to accept all individual and small-group applicants (a guaranteed-issue requirement) and to provide immediate and full coverage for all covered benefits. In other words, there could be no waiting periods, exclusions for prior conditions, or other limits on coverage that would be applied differently for new enrollees.

Insurers and health plans selling coverage to individuals and groups with 100 or fewer enrollees would be required to price premiums on a community-rated basis. Adjustments would be permitted only for family size and composition and for regional differences in medical expenses. In other words, each insurer would put all individuals and groups of 100 or fewer in a single pool for a defined geographic area, and the insurer's premium would be based on the medical claims experience of all of the people in that pool.

THE RATIONALE

The guaranteed-issue requirements are consistent with current federal policy in the small-group market, but, more important, are absolutely necessary to ensure universal coverage. Justification for any of the current limits on coverage having to do with prior conditions, waiting periods, coverage portability, and so forth is negated by the individual mandate requirement. Insurers traditionally have included these provisions to protect themselves against people who would wait to buy coverage until they knew or suspected they would be incurring major medical expenses. This problem has been acute in the individual market, but insurers believe it is also a problem in the market composed of very small groups (those with no more than four or five employees). Under our proposal, however, everyone will have coverage because of the individual mandate, so this justification for limiting coverage for new enrollees disappears. Insurers, however, could be permitted to establish reasonable waiting periods for conditions not covered under the Medicare-based minimum benefits package but covered by an optional, more comprehensive benefits package. Since coverage for these additional benefits would be voluntary, adverse selection problems could arise if insurers were not allowed to impose any restrictions on access to coverage. In the interest of avoiding churning and associated administrative costs, it also would make sense to limit plan switching to an open enrollment period or at the time of some change in job status or family condition, such as

marriage or the birth of a child.

The decision to require community rating is based in part on a value judgment and in part on efficiency grounds. The value judgment is that people should not be rewarded or penalized (in the form of premium differences) for risk characteristics over which they have little or no control. People cannot change or influence their age, gender, or genetic predisposition, all of which make them more or less vulnerable to illness and injury. They cannot affect their past medical experience and associated medical expenses. They can influence current behavior, which can affect future medical expenses and,therefore, risk, but health insurers seldom consider personal behavior, aside from smoking, in assessing risk. And if they were to consider personal behavior and life choices, the practice would raise difficult ethical issues about what is "good" behavior and what is "bad." (For example, should overweight people and sky divers be charged higher rates than thin people and long-distance runners or skiers, and would that be fair?)

On the whole, it seems more fair to use community rating than risk rating if there are no practical reasons not to do so. The essence of the insurance principle is to share risk—those who do not need expensive medical care during a period subsidize those who do. If the risk is not shared "at the front end" through community rating, then it has to be shared "at the back end"through some other mechanism, such as a more direct subsidy to those who have incurred very high medical expenses. But the cost of financing that subsidy has to come from the people who do not incur high medical expenses in either case. Community rating is simpler and fairer than the alternative ways of sharing risk.

Objections to community rating that have merit in today's insurance market are largely negated by the provisions of our approach. People argue that community rating raises rates for low-risk populations (as it undoubtedly does to some degree), and that, as a result, some of these people find that the higher price exceeds the value they attach to having coverage. So they drop coverage, which increases the number of uninsured. But our proposal would require that everyone buy coverage and would help them to do so with subsidies based on financial need.

People also argue that the current age-rated system achieves a kind of rough equity: low-risk people are more likely to be young, and younger people have lower incomes, on average; so it is fair that they should pay less, because they have less ability to pay. But our approach addresses this concern by linking subsidies to income so that everyone has the ability to pay.

The efficiency argument for community rating and against risk rating is that risk rating is a wasteful process. It requires expenditure of resources to segregate people into risk categories, a process that does nothing to enhance the welfare of insured people. It does not expand the amount of medical care, improve quality, or enhance efficiency.

If risk rating were allowed, some higher-risk groups and individuals would face rates that could make coverage unaffordable unless the subsidies were varied according to risk. Linking the size of subsidies to the level of risk would pose immense administrative complications and would be an expensive undertaking.

On the other hand, a practical argument for risk rating is that it allows individual insurers to offset at least partially the effects of drawing a population whose risk is not representative. Insurers that happen to attract higher-risk people can afford to cover the higher medical costs they incur by charging enrollees above-average premiums. But this is not a practical long-run solution because, as they raise their premiums, insurers will lose the lower-risk people they cover because those people will switch to less expensive health plans. This practical argument needs to be addressed through a risk-adjustment process that somehow compensates insurers that cover a disproportionate number of higher-risk people.

We would allow premiums to be adjusted for family size and composition, a provision that is virtually a universal practice now and is presumably not controversial. The other rating factor we would allow is for differences in regional medical costs. This also follows current practice and is entirely consistent with the *community* rating principle. The very term implies that uniform rates should apply to

a limited geographic area. Most purchasers tie the rates they pay HMOs to local medical costs. Since medical costs vary significantly from region to region,and insurers' business is concentrated in different regions, insurers need to be able to protect themselves by charging rates that reflect those regional differences. Further, it could be argued that people who live in higher-cost areas should have to pay more so that they have incentives to seek ways to hold costs down. Their costs should not be subsidized by people who live in lower-cost areas.

Although the more common practice is to define small groups as firms with 50 or fewer employees, we choose to include groups with 100 or fewer employees within the community rating pool. The inclusion of larger employers broadens the risk pool substantially, which means that the costs of covering higher-risk individuals and small groups is spread over a larger portion of the population. It is also questionable whether groups of between 50 and 100 employees are large enough to be risk rated separately or to self-insure and be at risk for the costs of their employees' medical expenses.

Elimination of Medicaid, S-CHIP, and Other Public Programs as a Source of Coverage

THE PROVISIONS

Medicaid, S-CHIP, and similar programs to fund coverage for low-income people would be eliminated and would be replaced with subsidies in the form of refundable tax credits (described earlier) that allow people who otherwise would be eligible for these programs to purchase coverage in private markets just as everybody else does. (The important exception would be that Medicaid would continue to fund and administer the long-term care portion of the program. States would have increased responsibility for financing long-term care, as described later.)

We recognize that not all low-income people will be well equipped to deal with the private market, especially because some will be unemployed and thus will not have coverage through their jobs. For these people, the APAs that each state must establish can serve as an appropriate source of coverage. In fact, the state may decide to make an APA responsible for negotiating with health plans, perhaps through a competitive bidding process, to offer managed care coverage that is specially tailored to the needs of this population, but open to anyone who chooses it.

States would be required to continue to have mechanisms to integrate services, provide case management, and otherwise meet the unique needs of many of the people with disabilities receiving Supplemental Security Income (SSI) cash assistance and Medicaid. They also would need effective outreach programs to identify these special populations — which might be somewhat more difficult, because they could no longer be identified as they enroll in Medicaid. In most instances, existing Medicaid program structures would continue to serve these functions, but Medicaid would no longer be the source of funding. Some supplemental funding might be necessary from the states to cover services that normally are not considered to be medical in nature but that these people need if they are to improve their health. Examples include speech therapy and transportation services.

THE RATIONALE

Because our proposed system provides low-income people with tax credits adequate to purchase coverage equivalent to the benefits provided by Medicaid, there is no ongoing need for Medicaid, S-CHIP, and other similar programs that subsidize care for the poor. An argument could be made for phasing out these programs in stages, especially Medicaid, to ensure a smooth transition for vulnerable populations that may not be well equipped to find private coverage in a private system that may not be fully prepared to meet their needs. On the other hand, phasing out one system while phasing in another adds a layer of complexity—for example, the need to establish a mechanism to let people choose between getting tax credits or temporarily retaining coverage under Medicaid or S-CHIP.

Programs providing highly specialized services that aid very specific populations, such as Maternal and Child Health Block Grants and the Ryan White program, could be retained.

The tax credit subsidy makes private market-based coverage affordable for low-income people.

Having them purchase coverage just as higher-income people do eliminates the stigma often associated with medical "welfare," and it gives these people access to the same providers available to the rest of the population. The multi-tiered arrangement that characterizes our current system is eliminated. Low-income people get "mainstream" care in the same way that elderly people do. They will not face the discrimination from providers and lack of access that is now often the lot of Medicaid recipients, because, as far as providers are concerned, they will be indistinguishable from the population that receives smaller subsidies (the tax credit available to everybody).

Elimination of these low-income programs also eliminates the expensive and burdensome process of determining and redetermining eligibility and moving people from one insurance system to another as their eligibility status changes. Everyone is eligible for tax credits, and the amount of the credit is determined through the income tax reporting system. Low-income people are like everybody else except that they receive a larger tax credit.

Substituting private insurance for Medicaid coverage will increase the budget cost, at least in the short run, because providers will be reimbursed at market rates rather than lower government-constrained rates—though presumably health plans and employers will negotiate vigorously to keep provider rates as low as possible throughout the system, just as they do now. But in terms of equity and ensuring access, there is no defensible justification for paying providers less for serving the low-income population than for serving any other population.

The extra cost associated with higher provider reimbursement rates may be at least partially offset, for two reasons. First, providers currently try to recoup some of the fee discounts they have to accept from Medicaid by charging other payers more. Such attempts at cost shifting will no longer be necessary, which should benefit current non-Medicaid payers. Second, people who are now uninsured will get better care, which should have a favorable impact on costs. They will have access to primary care and preventive services, which not only will improve their health status, but also reduce costly use of hospital emergency rooms and prevent simple problems from developing into acute problems that are expensive to treat.

Centralized Electronic Administration

THE PROVISIONS

Determination of eligibility, claims submission, coordination of benefits, and similar administrative processes would be channeled through a centralized electronic clearinghouse that would serve all insurers and health plans. The role of this entity would be analogous to the role the Federal Reserve System fills for the nation's banking system plus the role served by centralized administration of credit card transactions. All health plans and insurers would be required to participate, to accept the common data format and procedures of the system, and to share in the costs of the clearinghouse.

All transactions would be handled electronically. Every person enrolled in a health plan would be issued a card (comparable to an automatic teller machine [ATM] card or "smart card") with electronically embedded information sufficient to serve the functions of the system. Every health care provider would have a card reader connected to the centralized system (just as most retailers are connected to a centralized administration for credit card transactions), and every patient encounter would begin with reading the patient's card. That reading would provide all necessary information about eligibility, covered benefits, amount of copayment, whether the deductible has been met, etc. Any payments made by the patient at the time of the visit would be entered. Although it might be desirable to include information of a medical nature as part of this smart-card mechanism, this raises important privacy and confidentiality issues that are beyond the scope of this analysis.

Patients who misplace, forget, or lack an identifying card would be entered into the system by name, Social Security number, and mother's maiden name. Services could not be denied to patients because they lack a card, and Medicare would guarantee that providers are paid for covered services if no other insurer can be identified for the patient.

Federal legislation would be required to put this

system in place to ensure that the infrastructure is created and that health plans and providers comply with the requirements for standardization. We have no strong preference about whether the organization that carries out these activities is government or private. We noted that somewhat analogous institutions are the Federal Reserve check-clearing system, which is public, and the credit card clearing system, which is private. Both seem to work well. In either case, the ongoing costs of operating the system should be recovered through fees levied on health plans, insurers, and other risk-bearing entities, including self-insured employers. The federal government probably would need to appropriate funds to cover some of the initial costs of establishing the system.

THE RATIONALE

The current system for administering submission of claims, determining eligibility, calculating copayment obligations, and coordinating benefits is woefully deficient, duplicative, and inefficient. Patients often are responsible for keeping track of and submitting claims from many different providers for each serious episode of care. They get billed for services that are obligations of insurers, and they neglect to submit many claims that insurers should be paying. Providers waste huge amounts of time and money submitting and resubmitting claims and billing patients and insurers, processes that are especially inefficient when the patient is covered by multiple insurers. Insurers have to send multiple reports to patients and providers indicating what has been paid and what is the patient's obligation.

Using a centralized clearinghouse along with electronic submission of information would greatly reduce these administrative burdens and costs borne by patients, providers, and insurers. Administration still would be complicated and expensive: insurers still would have to approve treatment plans, authorize services, etc. But much of the inefficiency and cost and many of the hassles of the current system could be eliminated. In particular, patients would be relieved of the administrative burdens that now rest on them.

Financing

THE PROVISIONS

Health care coverage would continue to be financed by employers, individuals and families, and government, but the ways in which the federal and state governments finance subsidies would change radically. Programs of medical coverage for specific population groups now subsidized by federal and state governments—most notably, Medicaid and S-CHIP—would be eliminated, with the important exceptions of Medicare for the elderly and Medicaid for long-term care. Medicaid and S-CHIP would be replaced with tax credit subsidies, as explained earlier.

The revenues to finance tax subsidies (which are available to everyone but at different levels, depending on income) would come from two federal sources—general tax revenues and the special tax assessments on individuals defaulting to Medicare coverage. The general revenue money would not be primarily new net spending, however. The federal government would experience large revenue increases by eliminating the tax exclusion of income that employees receive in the form of employer-paid health insurance premiums. Both income tax and payroll tax revenues would rise when the exclusion provision is removed. In addition, the federal government would no longer finance Medicaid or S-CHIP. These changes would result in more money in the general fund, which would go far toward financing the new income tax credits. Some additional new public resources probably would be required, however—a political challenge that is easier to manage in a period of large budget surpluses.

Eliminating Medicaid and S-CHIP would relieve states of substantial funding burdens. We would propose that, in exchange, states be required to assume greater responsibility for current long-term care services provided under Medicaid. States initially would be required to finance the costs of this program fully, with the benefit limits as currently defined, if they can do so without exceeding their present Medicaid and S-CHIP obligation. They also would be required to finance certain non-medical but medically related services now covered by Medicaid for special needs populations and the near-poor elderly. Initially states would be required

to maintain their current level of Medicaid effort, and, if the cost exceeded that level, the federal government would make up the difference. Over time, states' obligation would be phased gradually to a system in which their share is based on some measure of ability to pay, such as state per capita income, rather than on previous levels of funding. The effect would be to cap their obligation, with the federal government assuming costs beyond the states' levels of obligation.

THE RATIONALE

The changes in funding proposed are based on two judgments: (1) that income redistribution activities (which any subsidy program is) should be the responsibility of primarily the federal government, and (2) that the levels of subsidies should be based on need, not on the recipient's place of residence. We take the position that, for equity reasons, the amount an individual contributes in the form of taxes to fund the subsidy program should be based on ability to pay (that is, income), not on the state where the individual lives. Likewise, the amount of subsidy provided to an individual should be based on that person's ability to pay for coverage, not on where he or she lives or on a state's ability and willingness to provide such subsidies. The capacity of states to fund subsidies varies widely, and their ability to pay is likely to fluctuate widely with changes in state or regional economic conditions. This proposition leads to the conclusion that establishing subsidy standards and funding the cost is primarily a federal responsibility.

It is not unreasonable, however, to require states to maintain some level of effort rather than experiencing a large windfall gain, with all of the subsidy cost falling on the federal government. Thus we propose increased state responsibility for long-term care, but, consistent with our earlier line of reasoning, we would propose a gradual transition from requiring states to maintain current levels of effort to contributing according to their citizens' ability to pay, which we measure by state per capita income. States may be wary of accepting the responsibility for funding long-term care, because, given the aging of the population and other trends, long-term care costs are likely to rise more rapidly than most other parts of the health care system. A federal cap on states' long-term obligation, with the federal government picking up the excess, may be a reasonable trade for states' continued acceptance of meeting federal standards for quality and other aspects of long-term care.

Risk Adjustment

Because our proposal requires insurers to use community rating for the individual and small-group markets, they cannot use rate adjustments to protect themselves against getting a disproportionate number of high-risk enrollees. Under these circumstances, a strong case can be made for developing a mechanism to compensate insurers operating in these markets for differences in the risk profiles of the people they insure. The public interest requires that insurers be rewarded for being efficient in administering and providing high-quality medical services, not for being skillful in selecting and attracting low-risk populations and avoiding high-risk populations. Without some method for compensating insurers for differences in the risk of the populations they cover, insurers have strong incentives to risk-select; and experience suggests that it is very difficult to prevent risk selection through legislative prohibitions. But even if insurers did not intentionally seek to attract low-risk people and avoid high-risk people, some would get more than their fair share of high-risk people, partly because of random factors and partly because certain kinds of plans appeal to people with certain kinds of risk profiles. Health plans that gain a reputation for being particularly skilled at treating people with certain kinds of severe medical conditions, for example, could be especially vulnerable to adverse selection. Insurers drawing higher-risk people would be at a competitive disadvantage unless a mechanism were in place to compensate them, essentially through some kind of money transfer from insurers with a relatively high proportion of low-risk enrollees to insurers with a disproportionate share of high-risk enrollees.

The problem is that the state of the art in risk adjustment is still in the developmental stage. Much conceptual work is being done, and a number of

experiments are underway, but there is still some question whether these techniques are sufficient for the job. There is no way to predict risk completely so that insurers can be compensated fully and accurately before the fact, and techniques that compensate on the basis of after-the-fact incurred expenses decrease incentives for health plans to contain costs. We are not prepared to endorse any particular risk-adjustment mechanism or approach; we leave that task to people with expertise in this area. But we do think that efforts to develop workable approaches should be continued and accelerated.

It is uncertain how critical a risk-adjustment process is to the success of our approach (or, for that matter, to most other approaches that depend on private insurers). Most of the market operates now without risk adjustment, with at least some success. The fact that everyone would be required to have coverage under our plan helps in some respects, because it ensures that everyone, both high- and low-risk people, will be in some pool. The problem of having people buy insurance only when they anticipate needing expensive care also is eliminated.

Transition

The reform proposed here is not an incremental change. It does not build on existing programs of public coverage. It requires some major restructuring, particularly at the government level, and imposes new obligations on individuals, employers, and health plans. Designing a gradual transition from the current system to the new system is not an easy task because many of the changes must become operational at the same time.

Some steps can be taken before the program is implemented fully. The APAs can be established in each state, and, once they are ready to begin operations,all small employers with fewer than 10 employees could be required to use them as the vehicle for offering coverage. Those that provide coverage already would switch to the APA when their existing health plan comes up for renewal. At the same time, the requirement that all employers offer (but not necessarily pay for) coverage for their employees could be implemented.Employers with 10 or fewer employees would be required to use the APA, and many others probably would choose to do so.

The requirement that all health plans price premiums on a community-rated basis for employers with 100 or fewer employees can and should be implemented gradually. States vary considerably in the extent to which they limit health plans' ability to vary premium rates for small employers, and it would be too disruptive to require them all to move from their current position to full community rating over a short period of time. In fact,implementation of full community rating should not begin until the individual mandate is in place. Otherwise, premium rates for low-risk groups may rise to such an extent that significant numbers of them would drop coverage. Thus the requirement for community rating should be phased in over a period of several years for the small-group market. Any movement toward community rating and guaranteed-issue requirements for the individual market, however, probably will have to wait until the individual mandate and tax credits are in place. Otherwise, health plans likely would suffer adverse selection because sicker people would take advantage of the community rates to buy coverage, while healthier people would wait until the individual mandate required them to do so.

A number of the most important features of the reform must become operational at the same time to avoid creating severe problems. They include the individual mandate, full community rating, tax credit subsidies, elimination of the tax exclusion of employer-paid premiums,health plan premium risk adjustment,and requirements that individuals show proof of coverage as part of the tax-filing process. It would be highly desirable to implement the electronic system for paying and reconciling medical claims at the same time these other features of the system are put in place, but it probably would be possible to begin the rest of the new program without having the electronic system fully operational.

Cost Containment

Because this proposal would extend coverage to everyone currently without insurance, it likely

would increase the demand for medical services and raise the total level of health expenditures. But apart from that, nothing in the proposal should be a strong force to increase costs. Nevertheless, private funders of insurance coverage obviously would continue to be concerned about costs, and cost escalation would have special implications for the federal government,since rising costs would create pressure to increase the size of the tax credits and, thus, the revenue loss associated with this form of subsidy. Without tax credit increases, coverage would become unaffordable for many people if health costs rose appreciably. Clearly, continued attention will need to be directed to efforts to contain medical cost escalation. The proposal does not include any new forms of cost control, but it does incorporate features that should strengthen existing competitive market forces and create stronger incentives for consumers to be cost-conscious.

One necessary condition for market forces to work to contain costs is the presence of incentives that encourage cost-conscious behavior. This proposal helps to create appropriate incentives by eliminating the tax exclusion for employer-paid health premiums, which encourages people to buy more comprehensive health insurance than they would otherwise. The current tax exclusion subsidizes any level of health coverage paid for by the employer and, thus, encourages employees to prefer extensive coverage, making it almost costless for them to consume any well-insured health care services. The proposed reform provides subsidies only for purchasing the standard coverage package; that is, individuals who choose to buy more comprehensive coverage would pay all of the cost difference between that benefit package and the standard coverage package. As a consequence, they would be more likely to carefully weigh the benefits against the costs,and fewer people would buy very comprehensive coverage. Because they would be paying more out of pocket than they do now for at least some services, people are likely to reduce their rates of utilization, especially for services that are only marginally beneficial.

For the same reason that people would tend to choose less comprehensive plans, they also would have strong incentives to choose plans that are efficient and offer high value. The new tax credit subsidy would be a fixed amount unaffected by the cost of the health plan chosen. Thus people who chose a plan that costs more than their subsidy (which would be most people) would have to pay the full extra cost out of pocket. That is a strong incentive not to choose an inefficient, costly plan.

Of course, incentives to choose a higher-value plan have little effect when people have few plans from which to choose, as is often true today. The proposed approach would give many people more plan options: everyone acquiring coverage through the APA could choose from a number of plans. To a greater extent than currently, health plans would be in head-to-head competition for consumers' business,so they would have stronger incentives to offer plans that provide high value. Moreover, health plans would not have the option available to them now of being able to compete on the basis of risk selection, because for employers with fewer than 100 employees, premiums would be determined on a guaranteed-issue, community-rated basis; and the risk-adjustment process, to the extent that it is accurate and effective, would greatly reduce the rewards associated with being skillful at risk segmentation. Fewer resources would be devoted to finding ways to avoid high-risk enrollees, an effort that produces no real social benefit. The only remaining basis for competition would be to offer good-quality care and high levels of service at reasonable prices.

Apart from the fact that people previously uninsured would use more medical services than before, there is nothing obvious in this proposal that is likely to cause cost escalation. It is true that a significant portion of medical payments now subject to government price administration—namely, for services covered through Medicaid—would be reimbursed at market rates, which are likely to be higher than administered-price rates. A one-time price increase is a likely result, but over the longer term, reimbursement rates are not likely to rise at a greater rate than they would under an administered-price arrangement, because even administered prices have to rise at roughly the same rate as market prices to induce providers to offer services.

Whether market forces will be adequate to contain costs remains to be seen, but nothing in this proposal is likely to reduce the prospects for success—quite the contrary. But if additional cost containment strategies have to be pursued, it is likely that they would have been necessary even in the absence of the implementation of this proposed reform.

Quality of Care

Implementation of this proposal is likely to have a positive effect on quality of care in two ways. First and most obvious, by ensuring that everyone is covered, the reform eliminates financial barriers to access. People who now defer or deny themselves care because they lack coverage will no longer have any reason to do so, so problems can be detected sooner, when treatment is more effective and less expensive. People now enrolled in Medicaid and similar public programs often have difficulty finding providers willing to accept them, either because the providers do not participate or because they already have a full roster of public-program patients. This constraint would be greatly reduced. Now covered by private insurance, these people would have access to the wider range of providers serving their area.

Second,the increased head-to-head competition among health plans just described will force them to prove that they provide good-quality care as part of their efforts to convince potential enrollees that the plans offer a high-value product.

Implementation of this reform is likely to leave largely unchanged the other forces that influence quality. Employers still will have reason to be concerned about quality, since they will be the source of coverage for much of the population. Medicaid no longer will fund care for low-income people (apart from long-term care),so government's responsibility for quality will need to be extended beyond concerns about low-income populations to the entire population. Activities of government organizations such as the Agency for Healthcare Research and Quality will be even more vital than they are now. Special attention should be directed to the effects of the reform on low-income populations formerly served by Medicaid and S-CHIP to ensure that the new system meets their needs,as well as those of the general population.

Political Feasibility

Like any proposal that represents a major departure from the status quo, this approach to reform would not be free of opposition. Nevertheless, the proposal does offer a number of significant political advantages.

Advantages

The reform model presented here should appeal to traditional conservatives for several reasons. First, it puts everyone into the mainstream medical system rather than into a government-run "bureaucratic" system. Second, it eliminates existing government-run programs like Medicaid and S-CHIP, which, because they are subsidy programs directed essentially at the poor, are often perceived negatively as "welfare" programs. In place of these programs, the proposal substitutes tax credits, which conservatives tend to favor over direct government-financed programs and which can legitimately be sold as a form of tax reduction. Third,the proposal places few constraints on employers. Apart from being required to allow their employees to opt into the aggregate purchasing arrangement and to offer *but not pay for* health coverage, employers' role in providing coverage for their employees remains largely unchanged. Fourth, the proposal relies on competitive market forces to contain health care costs, rather than introducing new forms of government-administered price regulation or cost controls. Moreover, by eliminating the tax exclusion for employer-financed health premiums, the proposal would require people to bear more responsibility for their health care costs.

Major stakeholders who are often threatened by proposals that would extend coverage broadly may find that this proposal is more attractive than other reform alternatives. Insurers and health plans would continue to play the role they do now, and, in fact, they would have as new customers large numbers of people who currently are covered by government

programs. Providers, too, should find many aspects of this proposal appealing. Most notably, providers that now serve large numbers of Medicaid patients would be paid at market rates rather than at the normally lower government-determined reimbursement rates. In addition, there would no longer be any uncompensated care, because everyone would be required to have insurance coverage, and even those individuals who failed to meet the requirement would have their medical bills paid by Medicare. Providers who now serve recipients of public programs also would be freed from the administrative burdens of dealing with the government bureaucracies that administer programs for low-income patients. And all providers would be freed of many administrative burdens when the integrated electronic claims handling system is in place.

Advocates for low-income and disadvantaged populations obviously would find the universal coverage feature of this program to be highly desirable. They also would likely look favorably on the feature that provides tax credit subsidies to everyone, so that there is no income test for eligibility and, therefore, no stigma for the poor in accepting such subsidies. The multi-tiered system of care that characterizes our current system would be eliminated. Everyone would be served by "mainstream" providers, and providers would be unable to distinguish among patients according to the subsidy they receive. Access for low-income people also would be improved. Those whose access is now limited to providers who accept patients from public programs would benefit by being able to choose from the same range of providers as the rest of the population. Extension of choice is obviously desirable for its own sake, but the greater choice of providers also should enhance the quality of care available to people who are now served by public programs.

Disadvantages

Although the proposal is likely to appeal to many groups, it also faces formidable political obstacles. First, the program involves a large tax expenditure. Even though the tax credits that subsidize purchases of health coverage for the entire population can be characterized as a form of tax reduction, it is still true that the subsidies under this program would cause large losses in tax revenue. While it is probably easier for politicians to defend off-budget tax expenditures than on-budget appropriations, people who look with disfavor on policies that expand the role of government are not likely to be mollified. And, of course, to the extent that this proposal reduces tax revenues, it reduces the revenue available to spend on other public programs. Offsetting the negative effects of increased tax expenditures for tax credit subsidies is the fact that other changes, particularly taxation of employer-paid health insurance premiums and elimination of Medicaid and S-CHIP, will have a large positive effect on the budget position of the federal and state governments (and, incidentally, alleviate some of the revenue problems of Medicare and Social Security, since payroll tax revenues will also increase).

Some people will view this program as more "big government." Even though it requires no significant buildup of new government bureaucracy or personnel, relies on private-sector forces, and actually increases the number of people who will be buying coverage in the private sector, it will be characterized by some as a major expansion of government's role and influence. Some will criticize the idea of using Medicare as a fallback for those who have no coverage, even though, in most cases, this would be a temporary arrangement. Vexed by the current rules and regulations of the Health Care Financing Administration, they would not eagerly greet the idea of having the agency administer coverage for even more people. Critics with this perspective also may fear that if cost increases begin to appear in the health care sector, government cost controls will not be far behind.

This approach also involves a degree of compulsion that some will find objectionable. The requirement that everyone purchase health care coverage is a restriction on individual liberty, and while it is certainly possible to marshal persuasive arguments to justify this level of compulsion, the arguments will not convince everyone. The proposal also requires employers to take certain actions. Specifically, they are required to offer (but not pay for) coverage to all employees and to allow individual employees to opt

into the aggregate purchasing arrangement. Employers that do not offer coverage now, or those who have well-established insurance programs of their own, will have to make changes that may appear burdensome to them.

Like any major reform, this proposal creates various kinds of financial redistribution that are likely to be opposed by people who view themselves as being worse off as a result of the change. Eliminating the tax exclusion for employer-paid premiums is likely to cost higher-income people with comprehensive employer-paid coverage more than they gain in the way of a tax credit. Thus, they may oppose this change in the approach to financing subsidies for health coverage. Opposition to eliminating the tax exclusion is likely to be particularly strong from labor unions that have bargained successfully for generous health coverage programs. The requirement that all firms with fewer than 100 employees be part of a single risk pool will raise the cost of health coverage for lower-risk employers and their employees: Because all employers in the pool will be charged the same community rate, low-risk employers and their employees will no longer be able to realize their current risk advantage.

Although insurers and health plans would play a larger role in the revised system, some will still object to specific provisions. In general, insurers are not enthusiastic about community rating because they believe that constraints on their ability to adjust rates in accordance with the risk of the populations they insure can jeopardize their ability to remain profitable. Even if an appropriate risk-adjustment process is in place, as proposed, it may be hard to convince insurers that their worries are groundless. Moreover, some insurers have carved out a profitable niche for themselves that is based on their effectiveness in selecting low-risk populations. Since their competitive advantage up to now has been attributable to their being more skillful in selecting risk, rather than in being cost-effective in managing care, these insurers and health plans may oppose the changes envisioned in this proposal.

Advocates for low-income populations may be wary of the proposal because it does away with much of Medicaid. They have worked long and hard to ensure that Medicaid incorporates features to protect lower-income populations and to be attentive and responsive to their special needs. Even though we propose retaining certain elements of Medicaid to meet these special needs, advocates may still worry that placing these vulnerable populations into mainstream care may leave them without all the protections and special services they need. ■

Wicks, Meyer, and Silow-Carroll Proposal

Key Elements

Elliot K. Wicks, Jack A. Meyer, and **Sharon Silow-Carroll** have outlined a proposal to achieve universal health coverage while maintaining a market-based system and simplifying administration. Key elements of the proposal include the following:

REFUNDABLE TAX CREDITS, payable in advance, for all households, with the credit varying by income, sufficient for those below the federal poverty level to cover the full cost of coverage comparable to Medicaid and gradually reduced for higher-income people.

A REQUIREMENT THAT EVERYONE BUY COVERAGE at least as comprehensive as Medicare plus drugs and well-child care. Those not meeting the requirement would be automatically covered by Medicare as a backup but would have to pay a premium plus a penalty (at tax time) for every month without private coverage.

A REQUIREMENT THAT ALL EMPLOYERS OFFER (but not necessarily pay for) a minimum benefits plan no less comprehensive than Medicare.

ELIMINATION OF THE FEDERAL TAX PROVISION that permits employees to exclude from their taxable income the amount that their employer pays for health coverage.

ESTABLISHMENT OF PURCHASING POOLS, or aggregate purchasing arrangements, to serve as a source of health coverage for individuals and small employers. Insurers are required to participate and offer a standard benefits plan comparable to Medicare.

CENTRALIZED ADMINISTRATION OF ALL CLAIMS, coordination of benefits, etc., to reduce administrative duplication and inefficiency.

About the Authors

ELLIOT K. WICKS, PH.D., is Senior Fellow at the Economic and Social Research Institute and Senior Consultant with Health Management Associates. Dr. Wicks specializes in analysis of policy reforms to help bring affordable health coverage to more Americans,especially workers in small firms. He has extensive knowledge of arrangements of pooled purchasing of health coverage and recently directed a project to investigate the barriers to the success of health purchasing cooperatives. Other recent research includes a study of small-group market reform and employers' and consumers' use of health plan report cards. Dr. Wicks is the author of numerous articles and monographs on these and other subjects related to health care financing and delivery. Dr. Wicks has worked for health care consulting firms, policy research institutes,a trade association, and state government, and he was formerly a faculty member at Michigan State University. He has a Ph.D. in Economics and Social Policy from Syracuse University and an M.A.in Economics from Northwestern University.

JACK A. MEYER, PH.D., is the founder and President of the Economic and Social Research Institute. Dr. Meyer has conducted policy analysis and directed research on health care issues for several major foundations as well as federal and state government. He has led projects developing policy options for reforming the overall health care system and directed research on community-wide reforms covering all regions of the U.S. Many of these projects have highlighted new strategies for overcoming barriers to health care access and innovative designs for extending health insurance coverage to the uninsured. Dr. Meyer is the author of numerous books, monographs, and articles on topics including health care, welfare reform, and policies to reduce poverty. He has also directed recent studies on the viability of safety net providers, Medicaid managed care for people with disabilities, the conversion of public hospitals to private status, and assessments of reform proposals to extend health coverage to workers in small firms. Dr. Meyer holds a Ph.D. in Economics from Ohio State University.

SHARON SILOW-CARROLL, M.S.W., M.B.A., is Senior Research Manager at the Economic and Social Research Institute. She has conducted health policy analysis for more than ten years, specializing in assessing health care reform strategies that expand coverage to vulnerable populations. Recent projects include examining employers' attitudes about their current and future involvement in providing health coverage, reviewing community-based health plans for uninsured individuals, and profiling state and local initiatives to expand employer-based health coverage among the working uninsured. Ms. Silow-Carroll is the author of *In Sickness and In Health? The Marriage Between Employers and Health Care,* which analyzes the corporate/employer role in providing health care coverage from economic, social and cultural perspectives. She has written numerous reports and articles reviewing public and private sector programs aimed at enhancing access, containing costs, and improving quality of care. Ms. Silow-Caroll received an M.B.A. in Health Care Management from the Wharton School, and an M.S.W. from the University of Pennsylvania School of Social Work.