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

by Michael Calabrese

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

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

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

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

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

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

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

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

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

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

Reform Goals and Background

Universal Coverage and Responsibility

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

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

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

Affordability Regardless of Job Status

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

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

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

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

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

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

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

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

Expanded Choice, Portability, and Continuity of Coverage

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

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

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

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

Improved Incentives for Cost Containment

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

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

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

Reducing the Social Benefit Burden on Business

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

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

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

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

Features of the System

Individual Insurance Mandate

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

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

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

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

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

Limit the Mandate to Basic Coverage

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

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

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

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

Enforcement

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

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

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

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

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

Contributions and Subsidies

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

Tax Credits

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

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

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

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

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

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

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

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

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

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

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

Employer Contribution

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

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

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

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

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

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

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

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

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

Community Insurance Pools

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

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

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

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

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

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

Establishing State Purchasing Pools

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

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

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

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

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

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

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

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

Enrollment

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

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

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

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

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

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

Role of Employers

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

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

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

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

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

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

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

Integrating Medicaid into the Mainstream

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

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

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

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

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

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

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

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

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

Financing

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

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

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

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

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

Incentives for Cost Containment

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

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

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

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

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

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

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

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

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

Political Feasibility

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

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

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

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

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

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

Calabrese

Key Elements

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

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

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

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

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

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

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

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

About the Author

MICHAEL CALABRESE is Vice President of the New America Foundation, a nonpartisan public policy institute in Washington, D.C. He previously served as General Counsel of the Congressional Joint Economic Committee, as an employee benefits counsel at the national AFL-CIO, and as director of domestic policy programs at the Center for National Policy. He has co-authored, with Harvard Economics Professor James Medoff, several studies on trends in the provision of employer-paid health care and pension benefits since 1979. He is currently at work on a book that proposes a system of universal and portable retirement saving accounts. Mr. Calabrese is an attorney and graduate of Stanford Business and Law Schools, where he completed the joint JD/MBA program in 1984. He received a B.A. in Economics and Government from Harvard College in 1979. Mr. Calabrese has published opinion articles in many of the nation's leading outlets, including *The Wall Street Journal*, *The New York Times*, *The Washington Post* and *The Atlantic Monthly*.