Covering America: A Commentary on Three Approaches

by Michael Chernew

Introduction

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

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

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

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

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

[119] P. Fronstin. "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2001 Current Population Survey." EBRI Issue Brief (2001): 1–31.

[120] M. Chernew, D. M. Cutler, and P. S. Keenan. "Increasing Health Insurance Costs and the Decline in Insurance Coverage," working paper; R. Kronick and T. Gilmer. "Explaining the Decline in Health Insurance Coverage." *Health Affairs* *18* (2) (1999): 30–47.

[121] J. Hadley. "Sicker and Poorer: The Consequences of Being Uninsured." The Kaiser Commission on Medicaid and the Ininsured, May 2002; Institute of Medicine. "Care Without Coverage: Too Little, Too Late. Washington: May 2002; H. Levy and D. Meltzer. "What Do We Really Know About Whether Health Insurance Affects Health?" ERIU Working Paper 6 (2001).

[122] Hadley, 2002, op. cit.

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

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

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

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

Proposal Summaries

Gruber

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

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

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

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

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

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

Holahan, Nichols, and Blumberg

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

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

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

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

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

Singer, Garber, and Enthoven

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

grams qualify for a tax credit if they opt to purchase coverage through an exchange.

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

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

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

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

Evaluating the Effects

These proposals are evaluated based on three criteria:
• Effectiveness at improving access to health care services, measured largely by the effectiveness at decreasing the number of uninsured.
• Costs, measured by changes in aggregate expenditures.
• Equity, represented by the distribution of financial burden and benefits across income classes.

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

There are many gaps in the existing research on a variety of relevant parameters,

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

Coverage and Access to Services

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

[124] Sheils and Haught.

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

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

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

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

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

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

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

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

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

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

Costs/Efficiency

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

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

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

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

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

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

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

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

A fourth cost issue, common to each of these proposals, relates to the impact of competition on cost growth induced by the formation of purchasing pools. Evidence suggests that insurers' competition and selective contracting for health care services can reduce health care costs or cost inflation.[130] There

have been few direct evaluations of purchasing cooperatives. An Enthoven and Singer[131] study of several purchasing cooperative initiatives for brief periods in the early 1990s reports that managed competition was associated with reduced health care cost growth. The Lewin model builds a reduced rate of cost growth into its model to reflect this.

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

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

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

[129] M. V. Pauly. "U.S. Health Care Costs: The Untold True Story." *Health Affairs* 12 (3) (1993): 152–59.
[130] G. A. Melnick, J. Zwanziger, and A. Verity-Guerra. "The Growth of Hospital selective Contracting." *Health Care Management Review 14* (3) (1989): 57–64; M. A. Morrisey. "Competition in Hospital and Health Insurance Markets: A Review and Research Agenda." *Health Services Research 36* (1) (2001): 191–222; J. C. Robinson and H. S. Luft. "Competition, Regulation, and Hospital Costs, 1982 to 1986. *Journal of the American Medical Association 260* (18) (1988): 2676–81; J. Zwanziger and G. A. Melnick. "The Effects of

Hospital Competition and the Medicare PPS Program on Hospital Cost Behavior in California." *Journal of Health Economics 7* (1988): 301–30; J. Zwanziger, G. A. Melknick, J. Mann, and L. Simonson. "How Hospitals Practice Cost Containment with Selective Contracting and the Medicare Prospective Payment System." *Medical Care 32* (11) (1994): 1153–62.
[131] A. C. Enthoven and S. J. Singer. "Managed Competition and California's Health Care Economy." *Health Affairs* (Millwood) *15* (1) (Spring 1996): 39–57.

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

Equity

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

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

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

vate/public financing. Similarly, households assume all costs of coverage and care.

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

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

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

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

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

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

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

Managed Competition: Theory and Implementation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

able to their preferences and economic conditions.

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

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

[132] T. C. Buchmueller and P. J. Feldstein. "The Effect of Price on Switching Among Health Plans." *Journal of Health Economics* 16 (2) (1997): 231–47; D. M. Cutler and S. Reber. "Paying for Health Insurance: The Tradeoff Between Competition and Adverse Selection." Working paper 5796. Cambridge, MA: National Bureau of Economic Research, 1996; B. Dowd and R. Feldman. "Premium Elasticities of Health Plan Choice." *Inquiry 31* (1994/95): 438–44; A. Royalty Beeson and N. Solomon. "Health Plan Choice. Price Elasticities in a Managed Competition Setting." *Journal of Human Resources 34* (1) (1999): 1–41; D. P. Scanlon, M. Chernew, C. McLaughlin, and G. Solon. "The Impact of Health Plan Report Cards on Managed Care Enrollment." *Journal of Health Economics 21* (2002): 19–41; B. A. Stromborn, T. C. Buchmueller, and P. J. Feldstein. "Switching Costs, Price Sensitivity and Health Plan Choice." *Journal of Health Economics 21* (1) (January 2002): 89–116.
[133] N. D. Beaulieu. "Quality Information and Consumer Health Plan Choices." *Journal of Health Economics 21* (1) (January 2002): 43–63; Scanlon et al., 2002, op. cit.; G. J. Wedig and M. Tai-Seale. "The Effect of Report Cards on Consumer Choice in the Health Insurance Market." *Journal of Health Economics 21* (2002): 1032–48.

[134] M. E. Chernew, R. A. Hirth, S. S. Sonnad, R. Ermann, and A. M. Fendrick. "Managed Care, Medical Technology, and Health Care Cost Growth: A Review of the Evidence." *Medical Care Research and Review 55* (3) (1998): 259–88; D. M. Cutler. "The Incidence of Adverse Medical Outcomes Under Prospective Payment." *Econometrica 63* (1) (1995): 29–50; J. P. Newhouse. "Medical Care Costs: How Much Welfare Loss?" *Journal of Economic Perspectives 6* (3) (1992): 3–21.
[135] Newhouse, 1999, op. cit.

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

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

A Composite Proposal

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

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

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

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

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

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

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

Nevertheless, it is likely that in this case the monopoly approach is preferable, at least for "public" pools. The monopoly approach, when combined with mandates that pools offer all eligible plans, will simplify the search process because there will not be multiple organizations offering the same plans, perhaps at different premiums and perhaps with different benefits. In a world with well-informed consumers this mass of information and heterogeneity may well be ideal. But in the existing insurance market, some limits are likely useful. A large, publicly run pool might be able to better undertake outreach and, thereby, facilitate take-up among populations unlikely to search among multiple pools. Moreover, all proposals emphasize the value of plan performance information. Monopoly

pools will promote a common message about plan performance that may be more salient than conflicting messages or presentations that might otherwise exist. Essentially, the size associated with a monopoly pool may add needed credibility. Moreover, until risk adjustment is refined, allowing competing purchasing pools may lead to various types of activities aimed at managing selection as opposed to setting the foundation of a well-functioning market. Finally, if a proposal does not allow free entry of plans into each pool, a system of competing pools will likely not take full advantage of the ability of pools to enhance labor market mobility and facilitate bridging coverage as individuals move within the labor market.

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

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

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

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

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

Chernew

Commentary Abstract

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

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