# The Medical Security System: A Proposal To Ensure Health Insurance Coverage For All Americans

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## System Overview

This paper sets forth a proposed Medical Security System (MSS) that would provide health insurance coverage to all non-elderly Americans.

*System Design*

The Medical Security System combines funds from a payroll tax, existing government funding sources, and additional appropriations to provide a basic insurance plan to all individuals. Private health insurance exchanges structure the insurance market, allowing individuals to select a basic plan at no charge or pay an additional amount to obtain enhanced coverage. A medical savings account option is also available. Employers can avoid the payroll tax (their own and their employees') if they provide and pay for a significant portion of a comprehensive insurance option for their employees and their dependents. All legal residents, regardless of employment status, who do not obtain coverage through their employer have free access to a plan through an exchange, and can purchase higher-cost coverage if they desire. Waivers of cost sharing are available to low-income families through a state-administered system.

The Medical Security System is financed primarily through a payroll tax. Tax rates are set originally to approximate current private insurance spending. For illustration, tax rates of 7.7 percent for employers and 3.3 percent for employees applied to the Social Security wage base would generate approximately the amount spent on private insurance premiums and would distribute the costs between employers and employees in accordance with the national average contributions for family coverage. A portion of existing state and federal Medicaid and State Children's Health Insurance Program (S-CHIP) funds for poverty-related eligible populations, along with additional general revenues, will also be required.

A set of nationally standardized model benefits packages will be developed (for example, tightly managed with limited copayments,less tightly managed with higher copayments). One benefit option will be structured as a medical savings account (MSA), with a high-deductible health plan combined with mandatory contributions to a savings account that can be used only for medical costs. The standard benefits package with the lowest actuarial value (other than the MSA) is referred to as the benchmark package. The value of the benchmark package determines the revenue necessary to provide universal coverage under the MSS. This amount, less other funding streams, will ultimately determine the actual payroll tax rate.

The MSS operates through health insurance exchanges that serve to organize the insurance market. Exchanges operate in defined geographic areas designed to encompass one or more health care markets. Exchanges are assumed to be private, but there are no requirements as to their form of governance or ownership. Any exchange that meets basic requirements can obtain a license to operate,meaning that multiple, competing exchanges may exist within any given market. Exchanges have no regulatory power.

Exchanges bear no insurance risk; instead, they contract with licensed health plans. To operate, an exchange must offer all standard benefits plans; however, exchanges may also offer additional plan designs. All products must be offered to all partici-

pants on a community-rated basis. At least one plan must be offered free-of-charge. Through the MSS, exchanges receive a fixed amount per enrollee adjusted for the age and gender composition of the enrollees. On average, the MSS provides each exchange with sufficient funds to offer the benchmark plan at no cost to the enrollee. As a practical matter, the specifics of the no-cost plan in any exchange will be determined by the bids the exchange receives. It is important to emphasize that the actual design of the no-cost plan may or may not match the benchmark plan, and it may vary across exchanges. Exchanges also collect premium payments from individuals who select enhanced plans, and they provide information to participants about their plan options.

The notion of a health insurance exchange is borrowed loosely from the stock exchange. Stock exchanges create a marketplace for highly regulated goods (securities). To succeed,these exchanges must attract buyers and sellers (firms and shareholders). While exchanges impose significant contractual requirements on buyers and sellers,they do not have any regulatory authority themselves. This analogy has its limits, but it does suggest the type of role envisioned for the exchanges.

Employers may be exempt from the payroll tax system if they provide all part-time and full-time employees with a health insurance package equal to or greater than one of the standard benefits packages described above. Employers must contribute a minimum of 85 percent of the cost of individual coverage and 75 percent of the cost of dependent coverage, and employees are required to participate in coverage offered by exempt employers. Employer exemptions are given for three-year periods and cannot be revoked during that time. The continuation coverage requirement under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is eliminated.

Every legal American resident, regardless of work status or earnings, may obtain any no-cost insurance package through any exchange operating in his or her area (unless the resident is covered by an exempt employer). At the time of enrollment,the person may select a plan that requires a premium payment, in which case premium billing is handled by the exchange. Non-payment results in the exchange moving the person into a no-cost plan. Enrollment cycles are annual, with exceptions for people who move into or out of the region. Health care providers may arrange with exchanges and health plans to provide for enrollment at the point of service for anyone who has not gone through the enrollment process. Any person may elect the medical savings account option, but the election is irrevocable for five years.

Families with income below current mandatory Medicaid eligibility income standards qualify for a copayment waiver, allowing them to obtain medical services without making copayments or deductibles and to obtain certain otherwise uncovered services. Waiver applications are processed by states based on recent earnings data. Copayment waivers are valid for one year and must be renewed annually.

The low-income child and adult components of Medicaid are eliminated, as is the State Children's Health Insurance Program (S-CHIP). Medicare remains intact. The portion of Medicaid that serves people with disabilities is reconfigured as wrap-around coverage beyond the basic benefits available through the MSS.

*System Principles*

The Medical Security System is built on three principles.

UNIVERSALITY

Health insurance coverage should be universal. Putting this principle into effect requires two important conceptual shifts within the health care system.First, we must acknowledge that no amount of public coverage, whether in the form of public programs such as Medicaid or financial support such as tax credits,can expand from the base of our existing voluntary, employer-based insurance system into a universal system. Efforts to build from the voluntary employer-sponsored insurance base have yielded many innovative approaches, such as sliding premium scales, waiting periods for enrollment in public programs, and tax credits to purchase coverage in the non-group market or to apply

toward the employee's share of the health insurance premium. While each incremental step is important and can benefit many people, this approach cannot reach universality. Substantively, the two systems cannot mesh to provide true universal coverage, and, politically, sharing financial responsibility between the government and employers without clearly defined roles for each creates a constant battle to shift costs to the other payer.

Second, we must separate financing from enrollment. A variety of financing sources must be called on to support the health care system. In addition, effective enrollment mechanisms must reach all people. But the two systems must be separated, so that income tests and applications with cumbersome verification requirements are no longer barriers to program enrollment. Similarly, we should encourage the separation of enrollment and health benefit administration from the workplace, thereby facilitating more efficient labor markets and eliminating employers' access to personal health information about their employees.

INDIVIDUAL CHOICE

The MSS is built around the critical American value of choice, which is available at three levels. First, in contrast to the circumstances facing most Americans today, individuals are able to choose their health plan and delivery system. Second, individuals are able to choose their health care provider. They can choose a plan based at least in part on whether that plan includes the providers on whom the individual relies. They may always obtain services outside of the MSS if they are willing to pay for those services. Third, individuals can determine the level of financial risk they are willing to bear. Individuals can choose from a range of insurance structures, from catastrophic to comprehensive. They pay according to the risk they are willing to take, and they are able to join a risk pool with others with similar tastes for risk.

APPROPRIATE RESOURCE ALLOCATION

The political process will determine the parameters of the benchmark plan and the funds necessary to support universal access to that plan. The definition of the guarantee is fundamentally a social decision that should be made in the political arena. The combination of individual choice and competition among health plans will yield efficiencies within that core system. Spending decisions beyond the core are made by individuals, without tax subsidies, reflecting their desire to obtain more health insurance coverage than the MSS provides. The MSS retains the third-party payment system. While third-party payment is inherently inflationary, it provides a very real value to people by reducing the financial risks they face.

## Coverage and Eligibility

The Medical Security System is universal for legal residents of the United States under age 65. The system fully uncouples financing and enrollment, making a basic health insurance package available to every American, regardless of employment status or income. Some people will continue to receive their insurance coverage through their employer. Others will obtain coverage through new health insurance exchanges that structure the market for health insurance. Everyone will have an insurance option available at no charge, but will also be able to use his or her own money to purchase a higher-cost, more comprehensive product.

### *Design*

HEALTH INSURANCE EXCHANGES

All Americans (except those covered by an exempt employer) will have the option of obtaining health insurance through new entities called health insurance exchanges. A health insurance exchange is a market organizer for health insurance products. The exchange receives funds (as described below) and enters into contracts with multiple insurance companies. Exchanges can take any ownership or governance form (for example, private, public, corporate, not-for-profit). Health insurance exchanges are licensed by the federal government.

Each exchange must offer all standard plans (as described below) and at least one health plan that can be obtained free-of-charge by the enrollee. The exchange may also offer additional benefit designs. All plans, standard or otherwise, must be offered at

**All Americans will have the option of obtaining health insurance through new entities called health insurance exchanges. Each exchange must offer at least one health plan that can be obtained free-of-charge by the enrollee.**

a community rate to all exchange participants with no underwriting. Exchanges may not tie participation in the exchange to purchase of any other goods or services,and exchanges may not sell any goods or services other than health insurance.

The federal government will define a set of geographic regions, known as catchment areas, designed to approximate health care markets. An exchange that wishes to operate within a catchment area must serve the entire area. A single exchange can serve one or more catchment areas, or even operate nationwide. There is no restriction on the number of exchanges that may operate; in fact, competing exchanges may operate in any given catchment area. An exchange operating in a catchment area must accept enrollment from any resident in that catchment area.

Exchanges contract with health plans and pay them for each enrollee in the exchange who selects that plan. The exchange bundles the funds it receives through the Medical Security System with the premium contributions made by individuals and passes them along to health plans.

An exchange that performs its functions well—contracts with a variety of plans, informs enrollees of their choices, handles premium collections—should obtain a sufficient enrollment base to be financially self-sustaining. However, since the MSS cannot function without the exchanges, states will be required to create an exchange if none exists in the state.

### BENEFIT OPTIONS

A national board will create a series of standard benefits plans. These plans will reflect a range of options with respect to delivery system (for example, tightly managed,loosely managed,unmanaged) and cost sharing. As noted above, all health exchanges must offer all standard plans.

Based on the funds available to it through the MSS, each exchange must also offer at least one no-cost plan.A no-cost plan is one in which any person may enroll without being required to make any premium payment from his or her own funds. A no-cost plan may or may not correspond with one of the standard plans. As a practical matter, the exchange, knowing the funds it will receive per member, will solicit bids from participating health plans at a price that matches those funds (less administrative costs absorbed by the exchange). The benefit design of the received bids will determine what the exchange can offer at no cost. Given this method, it is important to note that the specifics of the no-cost plan may vary among exchanges.

Every exchange must offer an MSA option. Under this option,a high-deductible plan is provided, with the balance of the funds placed into a savings account. Funds in the account roll forward indefinitely and are available only for medical costs. The MSA option is available to all MSS participants, but a participant who elects that option must remain in the MSA for five years.

No rebates are permitted for below-cost plans; that is, exchanges may not offer plans that cost less than the funds they have available, and then refund those excess funds to the enrollee. The only exception to this is the MSA. In the MSA option,all funds other than those used to purchase the high-deductible insurance are deposited into the MSA, which is available to the enrollee only for health-related purposes.

### EMPLOYER PLANS

Employers may continue to provide health insurance to their employees. An employer that provides all part-time and full-time employees with a health insurance package equal to or greater in value than one of the standard benefits packages, and con-

tributes a minimum of 85 percent of the cost of individual coverage and 75 percent of the cost of family coverage, can become exempt from the MSS. This exemption means that the employer does not pay the payroll tax into the MSS. Exempt employers must make employee participation in the company's health plan automatic and mandatory. Employer exemptions are granted for renewable three-year periods, and the employer must abide by the terms of the exemption for the entire period.

*Rationale*

The MSS relies heavily on health insurance exchanges because of the demonstrated value of pooled purchasing arrangements. These arrangements pool risk, offer a choice of plans, and organize the insurance market in a manner that increases competition. The limited success of purchasing pools in the current health insurance system is primarily a reflection of the environment in which these pools must operate. The MSS offers these pools a large number of members and a set of market rules under which they do not face any competitive disadvantages. Under these conditions, health insurance exchanges can provide value and choice.

In the MSS,health insurance exchanges can take any organizational form, and any number of exchanges can exist side-by-side with identical or overlapping catchment areas. There is no reason to restrict organizational form or create monopsony purchasers as long as all exchanges are required to follow appropriate market rules. Competition among exchanges will occur on the basis of information provided to enrollees,the range of insurance options offered to enrollees, and the overall quality of service provided. In the short run, exchanges will be created and some will fail, imposing a cost on the health care system. Over time, a limited number of exchanges are likely to survive. The process of exchange competition, and the possibility of new entrants if existing exchanges do not meet the needs of their customers, should yield good-quality service. A natural corollary of having multiple, competing exchanges is that those exchanges have no government or regulatory power.

The series of standard benefits packages is designed to enhance the efficiency of the market. The goal is to create sufficient standardization that consumers can evaluate the relative value of various options. One alternative would have been to permit only standard benefits plans to be sold. This option was rejected because the process that defines these plans will inevitably be political and potentially slow-moving and could prevent the adoption of innovations (such as the emergence of point-of-service plans).

To ensure the viability of the standard plans,the MSS requires that all benefit designs offered by the exchange, standard or not, be offered on a community-rated basis without underwriting. One alternative would have been to permit risk rating for non-standard products. This option was rejected because of the concern that a health plan could offer a minor variation on a standard plan, underwrite the plan, and offer it at a low cost while higher-risk populations are placed in the almost identical standard plan. This would yield the sort of risk segmentation the MSS must avoid to be successful.A more appealing option would be to permit underwriting for any plan with a premium of, for example, more than 50 percent above the benchmark plan, as long as the plan is guaranteed renewable. This option would allow people who want to bear less financial risk to enroll in a more comprehensive plan without facing the risk that premiums for this plan will be artificially high because of people switching into the plan at the last minute when they anticipate needing health care services. If stable, such a structure could segment people with a low tolerance for financial risk without fully segmenting health care risk. This option was rejected for its complexity, but is worth more exploration as a vehicle for offering more insurance options. Nothing in the MSS explicitly bars the continued existence of the non-group insurance market. If state regulations permit it, that market could offer Medigap-style coverage without conforming to the precise requirements of the MSS.

In the MSS, neither exchanges nor health plans are permitted to refund to the individual any funds that may be available because the enrollee selected a low-cost plan. This provision is designed to create a true floor for insurance coverage. This provision

does limit the extent of health plan competition in a very low-cost market. That is, since rebates are not available, all an efficient plan can do is add benefits, which may have an inflationary effect on overall health care spending. Despite this risk,the provision was adopted to ensure that competitive pressure does not result in poorer people, who may prefer cash in hand to better insurance coverage, from becoming concentrated in a very low-cost, very low-quality plan that refunds a large portion of the premium to the enrollee, but offers little in the way of health insurance protection.

The MSA option offers a realistic insurance option for people who are willing to take significant personal financial risk, while limiting the likelihood of risk segmentation. Strong opponents of MSAs argue that people willing to accept financial risk have disproportionately high incomes, and, because income is correlated with health status, they are likely to have lower-than-average costs. Removing this population from the larger risk pool yields higher premiums for everyone else. Strong proponents of MSAs argue that they are the only realistic mechanism for creating price sensitivity and full choice of provider among individual users of health care services. While MSA proponents claim that MSAs have not shown great success in the market because of the regulatory burdens associated with the existing MSA demonstration, evidence from the rest of the health insurance market suggests that the more likely reason is that only a relatively small portion of the population is willing to bear the amount of financial risk inherent in the MSA structure. The MSS includes an MSA option because it is believed that the cost to the rest of the population is small compared with the gain that will accrue to MSA participants. The five-year lock-in requirement for MSAs is designed to reduce their risk segmentation aspects,although the requirement will not eliminate such aspects entirely.

Employers may continue to offer health insurance benefits to their employees even after establishment of the MSS for the same reasons that they choose to do so today: to gain a competitive advantage when recruiting employees, or to pursue particular wellness goals among their workforce. Employers should be encouraged to play this role if they can offer their employees benefits that go beyond those available from health exchanges. Some of these benefits could include improved health plan selection, oversight, and information, or reduced employee cost sharing.

Employees working for exempt employers are barred from the health insurance exchange system. This provision exists to prevent employers from encouraging their highest-cost employees to shift their costs to the publicly financed program, either through the structure of their employee subsidies or through more direct pressure on the employee. This restriction on employee choice is unfortunate, but it is necessary to protect the integrity of the system. The existence of this restriction provides a strong justification for enforcing the standards imposed on employers that wish to be exempt. It also creates a need for individual premium subsidies, discussed below.

## Financing

The Medical Security System relies on three sources for financing. The primary source of funding is a payroll tax. Additional government revenues supplement the payroll tax, and individual premium contributions by some participants also finance the system.

### *Design*

#### PAYROLL TAX

The payroll tax forms the core of MSS financing. It is designed to emulate the current system by having employers collect the portion paid by employees and combine that amount with the employer's contribution. However, as a tax, the system operates in an equitable manner by requiring the participation of all firms, in contrast to the current voluntary structure.

The precise structure of the payroll tax is not critical to the design. To illustrate, a financing system is presented with the split between employer and employee contributions divided 70 percent/30 percent, approximately the same division that exists today for family coverage at the typical firm. Again,

for illustration, the proposal applies the tax to the current Social Security wage base. A combined employer/employee tax rate of 11 percent applied to the Social Security wage base in 1996 would yield approximately the $334 billion spent on private health insurance premiums that year. While participation in part of the Social Security system is currently optional for state and local government employees, that would not be the case for the MSS, thereby providing a larger tax base. Consistent with how Social Security taxes currently operate, self-employed persons would pay the combined employer and employee rate.

#### PUBLIC FINANCING

Public financing beyond the payroll tax will be necessary to generate sufficient funds to provide coverage to all Americans. If the payroll tax generates approximately the resources currently spent on private coverage, additional resources will be needed to cover those currently without health insurance and those covered through public programs.

One source of public financing is a portion of current expenditures on Medicaid and the State Children's Health Insurance Program (S-CHIP). Since coverage for these populations comes through the MSS, appropriations to these programs can be redirected to the MSS. Some current public expenditures will be needed for special subsidies, discussed below. Thus, current spending on Medicaid and S-CHIP, less the amount needed to provide other subsidies, will be available to fund the MSS.

#### INDIVIDUAL FINANCING

The MSS provides every individual with the opportunity to participate in any health plan offered by any health exchange. However, only some insurance options available through the exchange will be available at no cost. For higher-cost plans, individual contributions will be necessary. These funds will be paid to the exchange and passed on to the appropriate health plan.

#### *Rationale*

The MSS fully uncouples financing from enrollment in health insurance. Thus, the MSS could function using any funding source, ranging from a portion of general tax revenues to a per capita assessment. The decision to rely primarily on a payroll tax is an effort to balance various implications of these different funding mechanisms.

The payroll tax has the advantage of emulating the current system of financing health insurance reasonably closely. Most non-elderly Americans receive coverage through work, meaning that we already rely on an employment-based financing system. Despite the view of most economists that employees pay the full cost of insurance provided through the workplace, as a practical matter employees perceive that they share costs with their employer. To minimize disruption,the MSS emulates this division.

The MSS includes a major shift by imposing a flat tax rate on a capped portion of earnings. This stands in contrast to how health plans charge firms, which varies by employee age and family structure, but not by income. It also stands in contrast to how employees observe their payments, which are generally based only on family structure, with no variation in employee (or employer) contribution based on the employee's salary. How the underlying costs of health insurance are actually borne by employees within a firm depends at least on labor market conditions, the complex tax treatment of health benefits, and, probably, on the market for the firm's goods. It is impossible (and not necessarily desirable) to determine the precise incidence of health care costs today and create a tax system that emulates it. In the MSS, the goal is to approximate the current structure while achieving the added goals of equity and universality.

Setting aside the problem of disruption, and, therefore, of likely political opposition, some would argue that all funding for the MSS should come from general revenues, generated from the relatively progressive federal income tax. This funding option has the advantage of greater vertical equity (higher-income people pay a much larger share of total income taxes collected than they do of total Social Security taxes collected). It also presumably has less of a negative effect on job creation than a significant payroll tax. Yet, it is difficult to imagine this large a shift in the financial burden associated with health

insurance. The salary base of the MSS payroll tax is capped for the same reason: concern that a new financing system with dramatically increased costs for high earners is not politically viable.

All payments into the MSS are based on earnings and decisions about the type of coverage an individual desires; none is based on the enrollee's health status. Some people believe this is an inefficient design, because it reduces the financial incentive for people to adopt healthful behaviors. The MSS rejects incorporating health status into the financing mechanism, based on the notion that other financial consequences associated with unhealthful behavior remain,and that individuals should not be penalized for incurring health care costs that are not attributable to individual behavior.

Total funding for the MSS is determined by the cost of providing the benchmark plan to all eligible people. The amount of revenue the payroll tax generates will vary with the cycles of the economy. Since general tax revenues must make up the balance, the MSS design creates some uncertainty in projecting future federal budget demands.Given the size of the MSS, even a modest degree of error could have significant implications for the overall federal budget.

The MSS retains a significant role for individual expenditures for health insurance. This design feature is important for two reasons.First, while health insurance exchanges can exert some bargaining pressure on health plans and providers to hold down costs, real pressure for efficiency will come from individuals selecting from among their plan options to obtain their preferred combination of price and quality. Second, to be affordable,a universal coverage system must guarantee to everyone a level of coverage that is less generous than some people will desire. The individual purchasing option allows those who wish to spend more than average on health care to do so.

## Relationship between Financing and Benefits

From among the standard benefits plans, the one with the lowest actuarial value is termed the benchmark plan. The total resources necessary to pay premiums for all Americans enrolled in the MSS are determined by multiplying the cost of the benchmark plan (including health care and administrative costs) by the number of Americans under age 65, less those covered by exempt employers. The premium dollars are allocated to each health exchange based on the number of enrollees in that exchange, with allocations weighted to reflect the age and gender mix of each exchange's enrollees.

Knowing the per capita premium dollars available, each exchange contracts with participating health plans. The exchange must offer at least one no-cost plan, so the exchange must solicit bids that exactly equal the per capita premium dollars available. By design, the no-cost bids on average should precisely match the benchmark plan. However, depending on health care costs in that market and the efficiency of the plans that operate there,the no-cost bids could be for a plan somewhat richer or somewhat leaner than the benchmark plan. Plans will also bid to offer higher-cost benefit designs, with the individual enrollee required to pay the cost differential between the benchmark and the higher-cost plan.

It must be emphasized that the MSS operates with a defined contribution design. That is, while various benefit packages are defined,and the level of funding is designed to be sufficient to cover the benchmark package for everyone, the actual coverage available to any person will be whatever health plans can offer, given the premium payments they receive on behalf of their enrollees.

## Other Subsidies

Two groups will find that a standard package of insurance benefits does not meet their needs. One is made up of people with very low incomes for whom the modest copayment and deductible provisions of a standard package create barriers to access to care. The second group includes people with disabilities who need services that go beyond those provided by traditional health insurance benefits. The MSS includes separate subsidy systems to address the needs of these two groups. In addition, the tax system subsidizes low-income employees of exempt

employers whose premium burden may be more than they can afford to bear.

*Design*

Since at least one plan in every exchange is offered at no cost,there are no premium subsidies to individuals based on income. However, in the MSS, states will administer a system that permits individuals in low-income families to obtain a copayment waiver, allowing them to obtain medical services without making copayments or meeting deductibles. Eligibility for waivers is guaranteed for everyone with income below poverty and all other current mandatory Medicaid eligible populations, but states may adopt broader eligibility standards.Eligibility is for one year and must be renewed annually.

While individuals who qualify for the waiver will likely be concentrated in no-cost plans, some may choose to enroll in plans that charge premiums. These plans could have larger cost-sharing requirements than the no-cost plan. Complete forgiveness from cost-sharing requirements could create a windfall to the enrollee and add incentives for plan design and selection. Therefore, the waiver will be designed based on its application to the benchmark plan. For qualifying individuals in other plans, the waiver will be a credit against cost sharing designed to have the same actuarial value as the complete waiver for the benchmark plan. All administration of the cost-sharing waiver will be the responsibility of the health plans and the state, with no financial risk to or involvement of the provider or the exchange.

Under Medicaid, low-income children are currently eligible for a broader range of health care services than are found in a typical private insurance plan. As a part of the MSS,all children in families that receive the cost-sharing waiver will also receive state-administered fee-for-service coverage for that additional set of services.

People who qualify for Medicaid on the basis of disability currently receive a set of medical and supportive services that are not found in private insurance plans. This portion of the Medicaid program will continue to exist. However, since everyone will be eligible to participate in the MSS, the disability component of Medicaid will function as a wraparound to the core set of benefits.

Financing for all of these subsidy programs will retain the existing Medicaid matching structure between the federal government and the states. Matching funds are available to states that extend copayment subsidies beyond the mandatory populations. Matching funds (for premium costs only) are also available if a state chooses to offer premium subsidies to low-income individuals, even though the MSS has no provision for such subsidies. Beyond these requirements, states may use their own funds to offer whatever subsidies they wish to low- and moderate-income individuals or people with special health care needs.

Low-income employees of exempt employers are required to participate in their employer's health plan. While an exemption is available only if the employer pays a large portion of the premium, the employee may still face a significant financial burden to pay for coverage—a burden that low-income employees whose firms are not exempt do not face. Therefore, the MSS includes a refundable tax credit for these employees. The credit would cover 100 percent of the actual cost to the employee of enrolling in the employer's plan for people with adjusted gross incomes below the poverty line, with the amount of the credit phasing out to zero when income reaches 200 percent of the poverty line.

*Rationale*

The goal of these provisions is to ensure that low-income populations can participate in the mainstream health care delivery system. Underlying the MSS design is the notion that all Americans should have access to a good health insurance plan,and that empirical evidence shows that all Americans are sufficiently price sensitive that a relatively heterogeneous group of people will select a no-cost plan. Cost-sharing exemptions and wraparound benefits permit low-income populations to participate in the same health plans as the rest of the population. These provisions create some administrative complexity and raise concerns about coordination of benefits and service delivery systems. However, those risks are viewed as less substantial than the

risk of an inadequate or substandard health care system for low-income people and/or for people with disabilities if these groups are segregated from the general system.

The decision to fold Medicaid and S-CHIP into the MSS is sure to be controversial. There has always been a tension within the Medicaid program based on whether it should seek to provide mainstream health care to its enrollees or cultivate relationships with a limited set of providers that have the experience and cultural competence to serve a financially disadvantaged population. A case can be made for either approach; however, in the context of true universal coverage, the former approach is more sustainable and defensible. In a universal system, a special set of rules for a needy group will always be under attack. The MSS seeks to eliminate these boundaries and keep the entire population in one system. It is likely that within the MSS, groups of what we now think of as safety net providers will form health plans, as they have done in the Medicaid program, to compete for the population accustomed to obtaining services from them. This is consistent with the benefits of keeping the entire population in a single financing system.

Of particular importance is the decision to have no direct special subsidies of premiums for low-income individuals. Isolating such subsidies from the rest of the health care system creates serious risks that the subsidy will decline over time or in times of budget pressure, leaving this group in a de facto segregated system. It creates arbitrary distinctions among people with different incomes who must be deemed deserving of the subsidy, often on the basis of very limited information about their real health care needs or the real costs they face purchasing health care. If they are large, such subsidies can also create the risk of significant work disincentives as income increases and the subsidy is phased out. Such subsidies also create tremendous administrative burdens.

The decision to include a refundable tax credit for low-wage workers in exempt firms is an effort to make the best out of a difficult challenge. For risk-selection reasons, employees in exempt firms are not permitted to participate in the health exchange. However, they will then face premium costs that may be prohibitive. Subsidizing employees based on their salary is inefficient, because it adds an administrative burden for the employer, and an individual's salary may not reflect his or her family resources. Therefore, the tax system is used to transfer funds to truly needy families who are required to purchase coverage through their employers.

## The System as Viewed by Various Actors

*Individual Enrollees*

Individuals may choose to obtain their coverage through any exchange operating in their area, and they may choose from among any of the plans offered by the exchange. There will always be at least one no-cost option, but other plans will require a premium payment on the part of the consumer.

Most people will presumably take active steps to select an exchange and a source of insurance coverage from among the various options available. However, some people will fail to follow this process. Health care providers will have the option (and the strong financial incentive) to enter into an arrangement with one or more exchanges and health plans to permit people who present for services and are not yet enrolled in a plan to be enrolled at the time of service. Unlike existing public programs, the MSS has no recertification or reapplication processes. Enrollment in an exchange and a health plan are continuous until an active step is taken to enroll elsewhere. Therefore, over time, enrollment in the system will be essentially universal.

While this paper uses the term, "individuals," to refer to enrollees, most people will enroll as families. A series of issues arises when a family has one member who works for an exempt employer, and another member who either does not work or works for a firm without an exemption. I have not attempted to work out the details of the family choices and cash flows in such a circumstance; however, this is an important area for further work.

*Employers*

Employers must choose whether to seek an exemption. The system is designed to make exemption a

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reasonably attractive option, as large employers can serve as innovators in the health care system. Employers may also wish to offer a higher level of benefits than the MSS does, and there should be no barriers to a firm that wishes to do so.

Non-exempt employers must collect and pay the payroll tax. This function will be similar to the activities currently performed in the Federal Insurance Contributions Act (FICA) system, and will add administrative and financial burdens to firms. Exempt employers may contract with health plans or self-insure, as they may do today.

*Health Plans*

Insurance plans face a very different environment under the MSS than they do today. The MSS brings into the insurance system the tens of millions of Americans who are currently uninsured and whose demand for health care services is not fully known. Guaranteed issue and community rating for all products is an environment unfamiliar to most plans. Contracting with many potential health insurance exchanges creates new responsibilities. The possibility of large swings in plan enrollment in the early years creates significant risks. At the same time,plans operating in a universal-coverage system have a large new pool of potential customers. Disruption could be significant in the short run. The variety of new risks taken on by health plans comes at a cost, suggesting the need for relatively generous assumptions about program financing in early years.

After a transition period, it is reasonable to expect that the MSS actually would reduce the risk health plans face. Churning of enrollees should decline substantially as insurance provision is uncoupled from the workplace. Continuous insurance coverage should reduce the cost health plans face because the build-up of demand for services during spells without insurance should disappear, and increased disease severity due to delayed medical treatment should decline. Movement toward community rating should force plans that rely heavily on underwriting out of the market, leaving a more heterogeneous risk pool for the remaining plans.

In the early years, plans can expect their contracts and negotiations with health insurance exchanges to be similar to current practices among purchasing pools. For example, payments to the exchanges through the MSS will be adjusted for age and gender, so plans will submit bids to health insurance exchanges that emulate the age and gender categories used by the MSS. If plan bids are higher than the amount available through the MSS, the balance will be charged to the individual enrollee as a premium.

Over time these relationships may change. For example, one could imagine exchanges developing a cost-neutral risk-adjustment payment system for health plans. If effective, such systems would benefit the plans, since premium payments received would reflect expected costs more accurately. The value of this benefit would be reflected in lower bids for coverage through the innovative exchange, attracting more enrollees and ultimately benefiting the consumer.

*Federal and State Governments*

The federal government has five responsibilities in the MSS. First, it must collect payroll taxes. With a structure parallel to that used in FICA,it seems natural to give this task to the Social Security Administration, or a partner agency operating in conjunction with the SSA. Tax receipts would function in essentially the same manner as Social Security receipts.

Second, the government must define distinct geographic areas that serve as the catchment areas for health insurance exchanges. This is an extremely

complex and important task. The goal is to balance two competing interests: On the one hand, all insurance products are community rated within the area, and, as discussed below, payments to exchanges may be adjusted by region. Therefore, the areas must correspond somewhat with existing health care market boundaries. On the other hand, exchanges benefit from scale and a minimum number of borders with other areas. This argues for relatively large regions.

Third, the government must license health insurance exchanges. While the formal requirements for exchanges are limited, they can create tremendous problems if they fail, misappropriate funds, or use risk-segmenting behaviors. Therefore, oversight of the exchanges will be required. A federal license will be necessary to receive any funds from the MSS.

Fourth, the government must define the process for making payments to licensed exchanges. Among other items, the government must determine the relative payments to be made for enrollees in each age and gender grouping used to define payments. Fifth, the government must grant exemptions to qualifying firms.

State governments have roles, as described above, in operating subsidy systems for low-income enrollees and people with disabilities. State governments are responsible for establishing one or more health insurance exchanges if the private market does not do so. In addition, states retain their existing authority to license health plans that operate in their states and enforce market conduct, solvency, and network adequacy rules.

*Health Care Providers*

As a modification of the financing system, the MSS has no direct effect on health care providers, but many implications flow from the system. Under the MSS, levels of uncompensated care should fall significantly, affecting the financial strength of many health care institutions. By uncoupling financing from enrollment, changes in health insurance coverage should be less frequent, thereby creating more stable medical and financial relationships between patients and providers. The MSS raises the possibility of increased consolidation in the health plan market with its attendant benefits of reduced complexity, but perhaps lower reimbursement rates because of the reduced relative negotiating power of providers.

## System Calibration

While the paper thus far has set forth the general structure of the Medical Security System, certain details are crucial to the program's success. In addition, in a dynamic economy and health care environment, the MSS must have built into it balancing tensions that will ensure the system's proper functioning. This section examines in more detail three aspects of the MSS: the benchmark benefits package, the balance between payroll tax and other funding sources, and regional variation.

*The Benchmark Benefits Package*

The various standard benefits packages exist to create a series of comparable options that facilitate an effective market for health insurance. These packages will be most helpful in this role if they represent typical plans that people obtain today through their place of employment or in the individual market. Beyond that, the details of each package are unimportant, because plans are free to offer any benefit design. Failure to specify these plans well will have limited effect on the overall MSS.

The one standard package that serves as the benchmark plan plays a very substantial role. The cost of this plan for an average-risk person multiplied by the number of people in the MSS determines the total funding necessary to support the system. On average, the benchmark plan is what participants in the MSS will receive at no cost.

Proper definition of the benchmark plan is critical for political reasons. It is not credible to propose a universal health insurance plan where the guaranteed coverage is far below what most people experience today. Even if, in the end, the payroll tax were set lower than the current contribution toward coverage through employer-sponsored insurance, and individuals had sufficient resources left over to buy their way into a plan comparable to what they have

today, the politics of a scaled-back standard package would be unacceptable.

An adequate benchmark plan is also critical for substantive reasons. If the benchmark plan is too lean, most Americans will want to purchase a richer plan, leaving the lowest-income group that cannot afford to pay for premiums out of their own pockets segregated in inadequate, no-cost plans. An inadequate benchmark plan also creates concerns about risk selection, discussed below.

Similar problems arise if the benchmark plan is too rich. The political problem is that the tax levels necessary to support the MSS will be high—more for many people than they are paying for premiums today. Substantively, an excessively rich benefits package will stifle competition among plans and allocate society's resources toward health care above the value those resources provide.

Between these two bounds, the appropriate level of benefits in the benchmark plan is a matter of social choice: How much of the cost of health care should be spread across all Americans, and how much should be borne by the individual? At the outset, the benchmark plan and its actuarial value must be determined through an administrative process. But the political process must be relied on to maintain the appropriate balance between the extremes. The benchmark package is very visible. Failure of the MSS to provide most Americans with benefits at least as good as the benchmark package will create political pressure to expand the resources available to purchase the package. Health plans will compete to offer the most desirable no-cost plan, helping to maintain the strength of the package available to enrollees at no charge. Yet, as the package becomes richer, there will be strong pressures to reduce the payroll tax. The universality of the system, in terms of benefits received and taxes paid, helps prevent significant erosion or expansion of the benefits.

*Balance Across Funding Sources*

Most firms that choose to be exempt are likely to make this decision based on negotiated benefits in a labor contract or a desire for greater control over benefit costs. However, two groups of employers could select exempt status for simple financial reasons: firms with a healthier-than-average workforce and firms with higher-than-average salaries. For the first group, insurance purchased on the open market will cost less than average. Since the payroll tax assessment is based on broad averages, there is a cost advantage to having an exemption. For the second group, the payroll tax assessment will impose a higher-than-average burden that can be avoided if the firm purchases its own coverage.

For both groups, the problem is the gap between the cost of participating in the payroll tax-based system and the benefits the firm's employees gain from the insurance provided in that system. Of course, a firm takes on substantial administrative costs when it administers its own health insurance benefits, and the three-year lock-in for the exemption means the firm must be confident that its status is fairly stable. Still, if a significant number of firms are in either of these positions, they could start a death spiral in the MSS in which lower-risk and higher-revenue populations withdraw, leaving high-cost and low-revenue people in the system.

The best mechanism to prevent this dynamic is to set the payroll tax to collect only a portion of the program's costs and rely on general revenues to fill in the balance. Under this design, a firm that chooses to be exempt avoids the cost of the payroll tax, but gives up a benefit that is greater than the cost to the average firm. The proper mixture of revenue sources is difficult to determine in advance. If a large number of employers seek to change their exemption status, that may be a sign that the system is out of balance, and the funding mixture needs to be adjusted.

*Regional Variation*

As described thus far, the funding provided to health insurance exchanges for the average-risk enrollee is the same around the country. While the system could work this way, the result would be a no-cost plan that is much richer than the benchmark plan in low-cost regions, and a very lean no-cost plan in high-cost areas. This outcome has political and practical problems. One solution is to adjust payments to exchanges by region based on variation in health care costs. This would lead to

more comparable benefits around the country. An alternative is to adjust payment to exchanges based on general salary levels. This provides regional equity, since each region in essence keeps the funds it raises through the payroll tax.

While either solution assures some comparability of benefits around the country, neither addresses a more complex issue: the possibility that people in different regions place a different value on health care spending. These different values could reflect the wealth of the region—people in wealthier regions may feel they can devote more of their resources to health than to other priorities. Alternatively, these values could reflect the efficiency of the health care system, with people in some regions feeling that an inefficient health care delivery system does not yield solid value for the money. If there were an effective political process that could capture these regional variations, it would make sense for the payroll tax rate to vary by region to reflect these differences. As a practical matter, this process could be undertaken by states, but state boundaries generally do not correspond with health insurance market boundaries. Therefore, while desirable in theory, it may not be possible in practice to design a system that varies taxing and spending levels around the country.

Thus, the MSS as proposed provides area-adjusted payments to health insurance exchanges. This is not a perfect solution to the dilemmas discussed above, but it does assure a reasonable amount of equity until a better design emerges.

## Other Issues

*Risk Selection*

One purpose of a universal health care system is to spread the risk of health costs across a broad population. If the system leads to a concentration of relatively high- or low-risk groups into one health plan, the benefits of that risk sharing are lost.

One opportunity for risk selection is through selective marketing of insurance products and/or benefit packages designed to appeal particularly to certain low-risk populations. Through these techniques, a health plan, or a plan in conjunction with an exchange, could direct low-risk populations to specific plans where they would have low premiums, forcing higher premiums on participants in other plans.

Three features of the MSS are designed to reduce this risk. First, all products offered by all exchanges must be community rated and must be offered on a guaranteed-issue basis. At the outset, this feature prevents explicit underwriting that would guide only certain populations into certain plans. In addition, it creates instability for any successful risk segmentation endeavors. If an effort to select favorable risk succeeds,the benefits of that selection are available to anyone who wishes to enroll. This reduces the incentive for plans to select, because their benefits are transitory, and it reduces the likelihood that such efforts would succeed even if they were to be undertaken.

Second, a plan is limited in how much financial reward it can provide its enrollees as a result of successful risk selection. That is,no rebates are available to program participants, so a plan with very low costs can reward its low-risk enrollees with lower premiums only to a certain point. But that point is not likely to be particularly low, because the benchmark plan will represent a decent benefits package for a mixed-risk population. Beyond that point, all the plan has to offer its enrollees is richer benefits—precisely the sort of behavior that runs counter to its risk-selecting objectives. Of course, the plan can benefit from selection, by making profits on the gap between the premiums it receives and the health care costs it incurs. But it is not clear why even healthy people would choose a lean benefits package over a richer one. Thus, even though plans have an incentive to obtain low-risk enrollees,plans will find it difficult to target this population.

Third, size requirements argue against extensive risk-selection activities. It is reasonable to project that a modest number of fairly large health plans will dominate each health care market under the MSS. These plans require such a large number of enrollees to succeed that it is difficult to imagine them having significant, effective risk-selection efforts. Smaller plans, to succeed, will need to differentiate themselves. While marketing based on net-

work quality or service might be successful for a small plan,it is difficult to imagine a successful risk-segmentation campaign on behalf of a small plan.

A related concern is that a health insurance exchange could become a front for an aggressive risk-selecting health plan. While complying with exchange requirements by offering a full range of plans, the exchange could market very selectively, perform some informal underwriting activities, and channel low-risk people to a preferred health plan. As with the plans themselves, exchanges would find that the potential rewards of this behavior are quite small, yielding very little incentive to seek out low-risk enrollees.

Aside from intentional efforts by plans or exchanges to find low-risk enrollees, selection can occur as a natural event when enrollees are offered different health plans. People with greater health care needs have good reason to select plans with more comprehensive benefits. Evidence from the Federal Employees Health Benefits Program (FEHBP) and other large employers confirms that health plans offering more comprehensive benefits experience adverse risk selection.

The best buffer against these risk-selection problems is to develop and maintain a strong benchmark plan. The benchmark plan must represent good enough coverage that a heterogeneous profile of individuals will enroll in it. While it is unavoidable that some share of higher-risk individuals will seek more comprehensive coverage, the incentives to do so must not be so great that they result in total risk segmentation in the market.

Annual open enrollment creates some barrier to people moving to richer plans when they anticipate having higher health care costs. However, beyond annual enrollment and a good benchmark, the MSS has no formal mechanism to prevent risk selection or to compensate plans or enrollees for risk selection taking place. Despite the likelihood that this will occur, no obvious alternative presents itself. Given the state of the art in risk-adjustment techniques,the administrative complexity of operating such systems for a large population, and their susceptibility to political manipulation,I conclude that no mandatory risk-adjustment system should be imposed as part of the MSS. (The incentive for health insurance exchanges to develop risk adjustment systems voluntarily is discussed above.) If the MSS succeeds in providing universal coverage at a cost to the individual that is primarily, but not entirely, separated from his or her personal risk of incurring health care costs, it will represent a significant step forward that can be improved on over time.

*Transition*

The MSS is a comprehensive insurance system that differs fundamentally from the current health care system in the United States. As such, movement to the MSS would require a substantial transition. The MSS was designed to illustrate a model, not to offer a straightforward path from the current system to one like it. There are two incremental steps that could be taken, however, that would represent significant movement toward the MSS, thereby smoothing the prospects for the transition.

First, incremental steps could be taken to encourage the creation of entities like health care exchanges. Specifically, new requirements could be placed on employer-sponsored health insurance payments for them to retain their tax-exempt status. Modest steps would include requirements that employers offer standardized benefits packages or a choice of plans. A more substantial step would be permitting the tax exemption only if firms purchased insurance through some sort of a pooled purchasing arrangement. Alternatively, if a new system of individual tax credits for health insurance were developed, those credits could be made larger for people who purchase insurance through a pooled arrangement.Of course, obtaining support for these measures would be difficult, but they would begin to restructure the market in a manner consistent with how it would function under the MSS.

Second,incremental steps could be taken to create a more equitable financing system for employer-sponsored health insurance. Employers could be rewarded for offering a larger subsidy to their lower-wage employees than they do to their higher-wage employees. Employers could be required to pay at least a specific portion of the cost of insurance for any of their expenditures to retain their tax-exempt

status. Employers that do not provide health insurance to their employees could face other requirements, such as a higher minimum wage.

Setting aside incremental steps, a few features of the MSS are designed to minimize the disruption involved in the transition. Specifically, the level and split of the employer and employee payroll taxes are designed to emulate the dominant practice in the marketplace. The use of age- and gender-adjusted premium payments to exchanges, and then passing them along to health plans,is designed to retain the approximate structure of risk in the group insurance market. The employer exemption provisions are designed to encourage continuity among employers that are adding significant value to the health care system, not only by providing their employees with coverage, but also by promoting quality, choice, and information.

These provisions, however, leave a substantial transition burden. Three major (and many minor) areas of risk arise in the transition.

First, as noted above, in the early years of the MSS substantial risks are associated with premium and enrollment levels for health plans. Aside from the cost implications of these risks,there are broader system implications that create the possibility of program failure. The system will require sizable administrative systems to manage the many tasks associated with the program.

Second, projections of tax revenue could be erroneous. Financing certainty is essential for effective operation of the system. Health plans must know what resources are available when constructing their bids. The government may need to use general appropriations to cover the possibility of errors in this area. However, very large potential costs and much budgeting uncertainty are associated with the government taking on this responsibility.

Third, the MSS shifts the cash flow of hundreds of billions of dollars in the health care system. Rather than making direct, monthly payments to health plans, employers will pay taxes to the government, which will transfer those funds to exchanges, which will then pass the funds to health plans. These additional steps introduce time and, given the sums involved,significant cash flow costs.Once the system has been operating for a time, cash flow expectations can be adjusted. However, at the outset, the potential delay in cash flow could create significant costs.

*Cost Containment*

The MSS relies on two types of forces to contain costs. Political forces will determine the funds devoted to the guaranteed benefits package, with tax rates and appropriations to the program set through the political process. The program is designed to create broad interest among the general population that will ensure its continued political support. The expectation is that a large number of Americans will enroll in no-cost or very-low-cost plans, thereby ensuring that the value of the benchmark plan does not erode. In addition, the benchmark plan will form the base for people purchasing more expensive coverage, so all participants will have an interest in retaining a solid base. At the same time, aggressive competition among plans to serve that group will ensure that the benchmark plan is valued appropriately. With a defined contribution design,there is no direct translation between loading up the benchmark benefits package with additional services or providers and having those providers receive any benefit.

Market forces will determine people's willingness to pay for coverage beyond the basic package. This will be a large, contested market with plans charging premiums ranging in cost from zero to substantial. Competition among plans to provide an attractive no-cost plan will be intense. The limited evidence available today suggests that employees at all income levels are quite sensitive to price when selecting health plans if they have to bear the full cost of their decisions. All funding for health insurance beyond the no-cost plan will come from individuals making their own choices about the relative value of an additional bit of health insurance compared with their other priorities.

Total health care spending will reflect the outcome of a political process that probably has somewhat expansionary tendencies, combined with a market process that creates much greater price sensitivity among individuals than exists today. It is impossible to know whether this total is larger or smaller than current health care spending.

*Political Feasibility*

It is difficult to evaluate the political feasibility of the MSS in the current environment, in which serious health reforms are not even being discussed. Based on recent history, opposition to the plan would be strongest from the employer community, which would resist the payroll tax-based financing system. In the political debates, it would be easy to demonize the proposal by portraying it as highly disruptive to people's current coverage, as representing a federal takeover of the health care system, and as encouraging employers to drop coverage, leaving people at the mercy of an untested government program.

These rhetorical devices simply show that any serious reform of the health care system can be criticized. In fact, the MSS was designed with an eye toward minimizing disruption, while pursuing principles, such as equity and choice, that Americans value. Whether it has achieved these goals is a reasonable question.

One area of political feasibility requires a bit more attention: the creation of horizontal equity. In the current voluntary, employer-based insurance system, employers can offer their employees anything from no coverage to very comprehensive coverage. A payroll tax shifts all employers to an equal financial burden (except those that choose to be exempt, but they retain a significant financial burden, as well). Proponents of market-based efficiency should applaud this move toward equity, because it will prevent one firm from gaining a competitive advantage in its product market at the expense of imposing a social burden by leaving its employees without health insurance. However, despite the logical argument behind horizontal equity, we can expect significant opposition to this change in practice.

One reason for the opposition is the fear that firms have of moving from a system where they can control their health expenditures, scaling them up in good economic times and when the labor market is tight,and scaling them down when the opposite is the case. Unfortunately, data on the range of costs employers incur for health care are limited. Based on the available data, we can say that the average insurance cost per employee across various measures, such as firm size, industry, and average wage, rarely varies from the national mean by more than 10 percent. These data do not tell us how much variance there is around the mean within any category. However, they do offer some evidence that, despite the control employers have over their costs, employers that offer coverage tend to spend (combining employer and employee contributions) within a reasonably narrow range. This suggests that enforced horizontal equity, while having a very real effect on those firms that do not offer coverage at all, will have a modest effect on firms that already provide coverage.

*Equity, Efficiency, and Choice*

A fair system has horizontal equity—people in like circumstances are treated the same—and vertical equity—people with more ability to bear a burden take on a larger share. Equitable systems, however, often come at the cost of efficient use of resources. And when discussing health insurance where certain actors can benefit financially from risk segmentation, it is tempting to achieve equity at the cost of reducing or eliminating choice.

No single plan can achieve perfect equity, efficiency, and choice, but the MSS is designed to maximize all three values. The system has horizontal equity by requiring financial participation from all actors. It has vertical equity through the payroll tax financing system. Efficiency emerges from the economic pressures inherent in health plan and health insurance exchange competition for enrollees, and individual price sensitivity for benefits beyond the benchmark level. Choice is constrained in some regards, but most people will observe much greater health plan and provider choice than they have today.

*Quality and Access*

The MSS is structured around health plans. I consider this a positive step for pursuit of health care quality. Despite heated debates about HMOs and the quality of care they provide, it is difficult to dispute the notion that organized systems of care are essential to creating data and systems that have the potential to improve health care quality. These systems are

a necessary, although not a sufficient, condition for improving quality. Because the MSS encourages development of those systems, it encourages the conditions that support quality improvement efforts.

By structuring market competition around health plans,the MSS does more to promote quality than do reforms that rely on market forces at the point of service. With extremely poor data currently available on individual providers, reforms that expect individuals to make value-sensitive choices every time they select a provider are certain to encourage competition almost exclusively on price. While we are far from the potential in this area, it is possible that competitive health plan selection could occur on the basis of quality as well as price.

A uniform payroll tax applied around the country with proceeds directed locally will tend to push health care spending to a uniform proportion of the economy. Other funding sources, such as general federal appropriations and federal matching funds to assist people with low incomes and with disabilities, may have a more skewed distribution. Still, the payroll tax base could be a significant force for generating more equitable distribution of health care resources.

In the end, the MSS is designed as a health care financing system, not as a mechanism for directly addressing the distribution of health care resources. Eliminating the problem of uninsurance, and dramatically reducing the phenomenon of underinsurance, should yield substantial improvements in access and quality. However, these areas require additional attention beyond reform of the health care financing system.

## Conclusion

The Medical Security System is offered as a proposal for achieving true universal health insurance coverage in the United States. It is an imperfect proposal, with many complex areas still to be defined. The tremendous importance people place on health security makes any transition from the current system difficult to achieve. Yet, a vision of a fair and efficient system can help us think about the direction incremental steps should take today, and help prepare us for a time when universal coverage returns to the center of the American political agenda. ■

## Weil Proposal

### Key Elements

**Alan R. Weil** proposes creating a Medical Security System (MSS) to provide health insurance coverage to every legal resident under age 65. His plan would:

GUARANTEE ALL NON-ELDERLY AMERICANS access to a basic health coverage package at no cost to them, by requiring employers either to provide coverage or pay a payroll tax to finance coverage purchased through insurance exchanges.

LICENSE HEALTH INSURANCE EXCHANGES designed to organize the insurance market. The exchanges would operate in defined geographic areas and contract with health plans that would offer all their products on a guaranteed-issue, community-rated basis.

ENABLE INDIVIDUALS TO OBTAIN INSURANCE through a health insurance exchange or their employer. At their option, employers could opt out of the MSS financing system by providing part- and full-time employees with a health plan equal to or greater in value than one of the standard benefits packages.

ELIMINATE THE STATE CHILDREN'S HEALTH Insurance Program (S-CHIP) and the low-income and adult components of Medicaid, folding those beneficiaries into the MSS, while waiving copayments and providing wraparound coverage for services not included in the basic package.

RELY ON A PAYROLL TAX, existing government funding sources, individual premium payments, and additional appropriations for financing.

## About the Author

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