Expanding Health Insurance Coverage

A New Federal/State Approach

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Overview

We propose a new consolidated federal-state health insurance program based on five principles:

1. *Substantial new federal subsidies* to finance expansion of coverage *with state discretion* to participate and to modify rules.

2. *Equity* among individuals with similar incomes and among states in a new program that would also end the complexity in current public programs.

3. *Spread excess health risks broadly* across the general population.

4. *Organize the purchasing of subsidized health insurance.*

5. *Choice*—all privately insured can keep their current arrangement if they prefer.

These principles would be implemented in the following ways.

Substantial new federal subsidies to finance expansion of coverage with state discretion. In those states that choose to participate,full subsidies are provided for those with incomes below 150 percent of the federal poverty level (FPL), and partial subsidies are made available for those with incomes between 150 percent and 250 percent of FPL. Within minimal federal standards—for example, minimum benefit packages—states are given broad leeway to design and organize purchasing arrangements that work best for their local conditions. Our federalism model is the current State Children's Health Insurance Program (S-CHIP), with high federal contributions and considerable state flexibility. The federal share of the total subsidy in our plan is 30 percent higher than today's Medicaid matching rates. Our model would differ from S-CHIP in that there would be no fixed budget allocations and states could not limit enrollment arbitrarily. State participation is voluntary, and,after five years,states are free to impose an individual mandate if they choose. Participating states also receive the higher match on their residual Medicaid program,including long-term care benefits to the elderly, and wraparound benefits for the nonelderly. As discussed below, participating states can keep their disabled residents in the residual Medicaid program or bring them into the new program (under special arrangements). Non-participating states would continue to receive their current Medicaid and S-CHIP matching rates. The higher federal share of expenditures in the proposed program is designed to ensure that the net incremental cost to states is relatively low and, thus, is intended to give strong incentives for state participation.

Equity. All people at the same income levels in each participating state are eligible for equal subsidies, whether they are currently enrolled in Medicaid, S-CHIP, or private plans, or they are uninsured. This simplifies complex and conflicting eligibility rules that discourage coverage expansion. The primary condition for receiving subsidies is to purchase insurance through a state-organized purchasing pool. States receive the same federal matching funds for all of their enrollees,unlike the current system, which provides higher federal shares for higher-income S-CHIP children than for lower-income Medicaid children. Finally, individuals with incomes below 150 percent of FPL are treated equally in every participating state,and those between 150 percent and 250 percent are treated similarly across the states as well. The federal government imposes a floor on the subsidy levels between 150 percent and 250 percent of FPL.

Spread excess health risks broadly. No one,

regardless of his or her personal health risk, is charged more for insurance than the hypothetical (and computed) statewide community rate,and this guarantee is financed with public (federal plus state) dollars. The statewide community rate is the rate that would be charged by a competitive insurer for a person of average risk for the standard benefits package. This is a key new concept, and we devote considerable attention to it. This explicit subsidy for higher-risk individuals is available only to those who purchase through the new state-organized purchasing pool. At the same time, private insurers would be free to price products outside the pool as they see fit. The key design feature is that the financial consequences for higher-than-average risks are shared across all citizens, because those inside and outside the state pool pay taxes, the source of financing for our proposed subsidies.

Organized purchasing of subsidized health insurance. The primary new institution is a purchasing pool composed of Medicaid and S-CHIP recipients and all others who choose to join. Federal law requires this pool to be open to all at community rates. Administrative efficiencies, risk pooling, bargaining power, and data collection for risk adjustment and community rate determinations are all enhanced through this kind of purchasing entity and risk pool. States have broad discretion to design their purchasing pools within federal guidelines, and they can choose to enroll all state and local employees in the pool as well, or give them the choice of enrolling, as might any other employer. Certainly the uninsured, but those with private insurance who might prefer to purchase standardized benefits packages through this pool at a statewide community rate as well, are free to join, or they can maintain their existing arrangements. This choice—to join the state pool or make their own private arrangement—is a central element in our plan and our fifth principle, explained below. The state-organized purchasing pool—which can be operated by a private vendor—is required to operate (or contract for) its own managed fee-for-service (FFS) health plan and may choose to manage competition among private plans as well. The purpose of requiring a state FFS plan is to ensure sufficient enrollment capacity and to provide the state with a basis of comparison for premium rates submitted by private insurers who wish to sell their plans through the pool. The state assumes the insurance risk for this FFS plan.

Choice. All of the privately insured who want to can keep their current arrangements may do so. No new regulations are imposed on insurers outside the state's risk pool, and states are free to repeal insurance market regulations not required for compliance with the Health Insurance Portability and Accountability Act (HIPAA). Employers are free to offer coverage or not. If they do, they can offer their coverage exclusively through the state pool, or they can offer it both inside and outside the state pool. In either case,the employer selects its preferred contribution level. All workers must have access to the pool because subsidies will be available only to pool enrollees. In addition, anti-discrimination rules require that firms offering coverage inside and outside the pool must make equal contributions to both. Any individual in the state is always free to join the state pool during open enrollment.

Rationale

Our proposal is based on the premise that a purely federal expansion of coverage is politically impossible. In our view, broad expansions based on a federal-state partnership are much more likely to earn political support. The enthusiastic response to the S-CHIP program suggests that public support for coverage expansions should follow a joint federal-state model.

This plan also recognizes that individual and small-group insurance markets have serious flaws that are difficult to overcome and plague all proposals that rely on the private market to expand coverage. Simply put, insurers and managed care organizations have strong incentives to market to the healthy and avoid the sick. State efforts to reform small-group and individual insurance markets may have been somewhat successful at spreading risk, but they have not expanded coverage. Guaranteed issue improves access for high risks, but may increase premiums, thereby reducing the

attractiveness of coverage for low risks. Efforts to force community rating reduce premiums for the sick, but increase them for the healthy, leading to possible reductions in the overall numbers covered under a voluntary system.Our proposal spreads the costs of high-risk individuals more broadly and uncouples that support from premiums paid by the relatively healthy.

Our program is explicitly designed to recognize that the system of coverage for low-income Americans has become increasingly complex and highly inequitable. Medicaid eligibility rules are unfathomable to all but a handful of experts. Medicaid eligibility has become even more complex with the delinking of Medicaid and cash assistance following welfare reform.Enactment of S-CHIP with different rules for income eligibility has added to the complexity that potential eligibles must navigate.

The current subsidy system is highly inequitable because higher-income S-CHIP children receive greater federal support than do lower-income children and their families who receive Medicaid. These differentials have provided incentives for states to favor S-CHIP enrollees or try to maximize S-CHIP participation at the expense of Medicaid. Moreover, within S-CHIP, states that have adopted broad expansions (for example, Minnesota and Washington) could get a higher S-CHIP matching rate only if they extended coverage further. In effect, there is a financial penalty for having already enacted a broad expansion. Our proposal eliminates this feature and treats all states with similar income levels identically.

Finally, while no doubt providing some fiscal benefits, current efforts in S-CHIP to prevent displacement of private coverage have led to significant inequities. By limiting eligibility to the uninsured,S-CHIP denies subsidies to families paying considerable amounts for individual coverage or for the employee's share of an employer's plan,even though their incomes are low enough by the program's standards to merit assistance. By providing subsidies based on income and regardless of current coverage, this proposal provides financial relief to those low-income individuals who pay a lot for coverage in addition to those we hope to encourage to purchase health insurance for the first time. At the same time, we preserve incentives for employers to continue offering and helping to pay for coverage.

We have consciously decided against using tax credits to expand coverage for four reasons.First, we believe that subsidies for expansions of coverage should be income-related. The administrative barriers to effectively providing income-related tax credits are tremendous when credits are provided at the same time that required payments to insurers and advance payments are reconciled with year-end taxable income. Credits would have to be provided at the beginning of the year to ensure that low-income persons had the liquidity necessary to purchase health insurance. Because the credit amount would be based on taxable income, advance payments would have to be based on current or expected income. If these estimates of actual full-year taxable income were incorrect,the Internal Revenue Service (IRS) would need to reconcile the amounts at the end of the year. This "recapture" of overpayments of credits would be costly, because low-income families tend to be inconsistent in filing income tax returns.[1] In fact, the cost of reconciling the credits is likely to exceed the amount of money actually recouped. In addition, the risk that the credits or a portion of them might have to be returned at year-end is a significant disincentive for low-income individuals to participate. Second,and related to the first issue, tax credits are particularly difficult to administer for low-income individuals and families. Such people are more likely to change jobs and have gaps in employment, and may not be consistent tax return filers. Thus, it is difficult to reach them with advanced payments of credits made through employers. Consequently, alternative administrative structures would be required to serve this purpose, but the need for such additional structures diminishes any efficiency to be gained by implementing such a subsidy through the tax system.

Third, part of the subsidy we have designed is

[1] Experience with the earned income tax credit shows that individuals using the advanced payment feature of the credit have high rates of non-filing of tax returns and not reporting receipt of the advanced payment if they do file tax returns. If this experience is consistent with what would occur under a health insurance tax credit, the administrative costs of correcting such errors and attempting to recover even modest underpayments from low-income persons may be significant.

explicitly related to individual health risk. Determination of health care costs relative to the state average is outside the scope of Treasury Department activity and expertise. Appropriate premium contributions by individuals and appropriate payments to insurance plans are best determined by administrative entities at the state/local level, aided by specific insurer, provider, and enrollee data and information that our proposed state purchasing authority would collect.

Fourth, most tax credit proposals allow people to use their tax subsidies only in unorganized insurance markets. Indeed, this lack of interference in markets is often viewed as a strength. We believe that some structuring of the market in which subsidies are used is necessary to ensure efficiency, equity, and access.

Coverage and Subsidies

In this program all participating states agree to provide full subsidies to all of those living below 150 percent of poverty who enroll in the state purchasing pool. Further, participating states extend partial subsidies to those between 150 percent and 250 percent of FPL. For those in this income range, states can set the premium schedule, up to federal limits, on overall cost-sharing burdens—that is, premiums plus deductibles and coinsurance. These limits on cost sharing are no more than 7 percent of family income for those between 150 percent and 200 percent of poverty, and no more than 12 percent of income for those between 200 percent and 250 percent of poverty. (Limits on cost sharing for children's only coverage are limited to 5 percent of income, as in S-CHIP). States can use their own funds to subsidize individuals or families above 250 percent of poverty if they choose. Participating states also permit anyone, regardless of income, to buy into the state pool at a premium that reflects a statewide community rate.[2] No subsidies (beyond the current tax exemption for employer-sponsored insurance) are extended to anyone purchasing coverage outside of the pool.

Participating states can choose to keep their disabled residents in the residual Medicaid program or bring them into the new program. As participating states, they receive the 30 percent higher federal matching rate in either case. In the new program, states are required to provide access for the disabled to the state fee-for-service plan or to special managed care plans designed for the disabled.

The state program has to provide for guaranteed issue—that is, anyone can sign up during open enrollment. Anyone who does not sign up can enroll retroactively by paying a full year's premium plus a 25 percent penalty. (Note that those below 150 percent of FPL face no premiums and, thus, have no retroactive obligation, and those between 150 percent and 250 percent of FPL face reduced penalties). The intent here is to avoid the severe adverse selection problems that result when an an individual signs up after being diagnosed with a serious illness. Given our income-based subsidy scheme, this penalty is less serious than a 12-month pre-existing condition exclusion and, in most cases, is less burdensome than the medically needy provisions of Medicaid. Therefore, the medically needy path to eligibility is eliminated for participating states.

Employer and Employee Behavioral Responses and Crowd-Out

The crowding out of private insurance can be thought of in a number of ways:

- employers dropping or not beginning to offer employer-sponsored coverage given the availability of public alternatives;
- workers dropping employer-sponsored coverage to enroll in public alternatives; or
- public spending on health care replacing current private spending.

Obviously, all of these are interrelated; however, it is helpful to keep each one in mind, because our program has different implications for each.

While some employers may drop coverage as a result of our program, we do not expect that many will. The current tax exemption for employer-sponsored insurance coverage continues to apply only to those enrolling in insurance coverage through their

[2] The specific meaning of the statewide community rate is explained in detail in the section on the state pool.

The administrative costs of plans offering coverage inside the pool will be significantly below the administrative costs of existing non-group policies, and such savings alone will likely be sufficient to induce the vast majority of those in the non-group market to enroll.

employers, maintaining the incentive for workers to purchase their insurance through their existing group arrangements (if employers do drop coverage and wages are increased as a consequence, those increased wages become taxable income, while the contributions to health insurance were not). Competition for higher-wage workers who have strong demand for employment-based tax preferences for health insurance will keep most firms offering health insurance to be competitive in the labor market. Although subsidies are available only to those purchasing coverage through the state insurance pool, employers are permitted to buy coverage for their employees in that pool. The state pool premiums charged to employer groups are based on a statewide community rate; the level of the employer contribution to the premium is left up to the employer. Firms competing for workers have to maintain reasonably high employer shares to attract workers who are ineligible for subsidies.

These provisions serve two purposes with regard to the crowd-out noted above.First,they ensure that there is no incentive for individuals to drop out of employer-sponsored insurance arrangements. Second,they limit the amount of private dollars displaced by public dollars, particularly in firms with workers who earn vastly different amounts. In firms with high-wage and low-wage workers, high-wage workers will continue to want employer-sponsored coverage to take advantage of the current system's tax subsidy, in addition to the convenience and administrative economies of scale and risk-pooling advantages of employment-based insurance coverage. Their interests have to be taken into account by employers when the employers set their premium contribution levels for the employer-sponsored plans they offer (including plans in the state pool).

We do not purport to have developed an ironclad approach to avoiding crowd-out; this was not our intent. We do believe, however, that our approach creates a reasonable balance between maintaining much of the existing employer-based system and generating much more equity by income class.

WHO WOULD SIGN UP—THOSE WITH INCOMES BELOW 250 PERCENT OF POVERTY

Below 250 percent of poverty most individuals and families have an incentive to join the state pool. Most of those with incomes less than 250 percent of FPL who currently have employer-sponsored coverage will receive subsidies. Because of the offer of at least partial subsidies, they will choose to obtain coverage inside the pool. For those workers whose firms drop coverage, presumably small firms with low-wage workers,many will also enroll in the plans offered by the pool.

Those currently in Medicaid and S-CHIP are enrolled automatically. If the state chooses, state employees can be automatically enrolled, as well. Among the low-income uninsured, incentives to join are strong. Lack of information and indifference to health insurance are the greatest barriers; there is plenty of evidence of non-participation by those eligible for current public programs. With all state residents eligible for enrollment, however, we expect the stigma witnessed under the Medicaid program to be reduced substantially.

Those who currently have private non-group coverage are also likely to sign up because the pool will offer more comprehensive coverage at lower cost. The administrative costs of plans offering coverage inside the pool will be significantly below the administrative costs of existing non-group policies, and such savings alone will likely be sufficient to induce the vast majority of those in the non-group market to enroll. The income-related subsidies available to this population increase the incentives to join even more. Seasonal workers and those who

tend to change jobs frequently also may find the pool attractive, because participating in it means that changing jobs does not mean changing insurance plans. However, some non-group purchasers who are eligible for only partial subsidies, and who can obtain coverage at low rates due to excellent health and/or the desire for less generous benefit packages, may continue to purchase coverage outside the pool.

WHO WOULD SIGN UP—THOSE WITH INCOMES AT OR ABOVE 250 PERCENT OF POVERTY

Those with incomes at or above 250 percent of FPL, and who face high health insurance premiums either because of above-average administrative costs (in small groups or for individuals) or above-average health risks due to poor health status, will find the state plan to be attractive. This includes individuals in firms with employer policies that have high premiums for either reason. They are able to purchase some plans inside the state purchasing pool at a price no higher than the statewide community rate. Those benefiting from good experience rating or who are willing to purchase less generous benefits packages are less likely to enroll. Finally, while it is unclear how many of the non-income-subsidized uninsured will enroll, many of the uninsured are likely to find the plans in the state pool more attractive than what is available in the current non-group market, with its extensive underwriting and high costs of comparing benefits across insurers and plans

INDIVIDUAL MANDATE

After a period of five years, states are permitted to mandate that each individual obtain health insurance coverage, either inside or outside the state pool, individually or through an employer. This delay is necessary to establish enrollment procedures, ensure efficient operation of the pools, refine procedures for determining the statewide community rate, etc. The federal government will support the mandate with the same schedule of subsidies outlined above.

A mandate, or any serious expansion of coverage, permits the federal government to scale back its support of acute-care activities that are now performed outside the insurance-based system (for example, disproportionate share hospital payments [DSH]). We discuss this more fully in the section on financing. In addition,a mandate is not likely to cost substantially more than if a state adopted the voluntary version we have outlined. This is because, after some years of the voluntary program's operation, most of those brought into coverage by the mandate will be in households with incomes of more than 250 percent of poverty, and thus would not receive income subsidies. Those below 250 percent who would come in only under a mandate are likely to be the healthiest members of this group, so their per capita cost should be lower than average, as well.

Federal/State Relations

States obviously have considerable responsibility under this program in exchange for a large amount of federal funding. States are required to meet federal standards for eligibility determination, outreach, and enrollment.States have to incorporate Medicaid and S-CHIP recipients into the purchasing pools (which are described in detail below), along with subsidized low-income individuals, employer groups,and others who choose to enroll.States may choose to incorporate state employees into these pools, as well, or they can maintain a separate system. As with any other employer, states must offer access to the pool and make the same contribution to coverage in the pool. In addition, their workers are eligible for low-income subsidies only inside the pool. We expect that states will find it most efficient to integrate current administrative structures for purchasing insurance for state employees with the new state purchasing entity. In some states,however, this integration will take time to achieve politically. To counter this,the federal government can provide financial incentives for states to integrate their employees early in the implementation of the program.

States have to establish procedures for informing enrollees about their choices of plans and establishing standards of quality, provider payment,and risk adjustment. States also have to develop a standard benefits package that meets or exceeds federal bene-

fits package requirements. Federal standards will include local flexibility in the spirit of the S-CHIP program. For example, under S-CHIP, states must establish a benefits package equal in actuarial value to one of several benchmark plans, such as the standard Blue Cross and Blue Shield plan offered under the Federal Employees Health Benefits Plan (FEHBP),the health plan offered to state employees, or the benefit plan offered by the health maintenance organization (HMO) with the largest market share in the state. This flexible standard gives states a great deal of leeway.

States are responsible for establishing fair and equitable subsidy schedules so that premiums do not exceed established maximum payments for individuals of particular income groups.States are responsible for organizing purchasing pools, establishing reporting and dissemination requirements, and negotiating with plans over price or establishing competitive bidding mechanisms.States are required to operate (or contract for) a discounted fee-for-service plan to further ensure beneficiary choice and provide an outlet for those worried about managed care plans' quality. States are not required to pay the full cost of the discounted fee-for-service plan for low-income enrollees if enough capacity and choice is available in managed care arrangements.

Finally, states are responsible for operating a residual Medicaid program. This would continue to cover all groups (the elderly and,if the state chooses, the disabled) and benefits (for example, nursing home care) now required as part of Medicaid that are not incorporated into the new program. Optional groups and optional benefits can still be provided at state discretion at the new higher matching rate.

The federal government monitors state compliance with program rules. This includes ensuring that states are meeting federal standards for eligibility determination, outreach and enrollment, and some provider payment levels. The federal government monitors state procedures for calculating the statewide community rate to ensure that it is fair to beneficiaries—that is,not too high—and fair to the federal government—that is, not too low (further detail about the statewide community rate is provided in the next section). The federal government also monitors state efforts to organize markets and engender efficiency in their competitive bidding processes or negotiations with health plans. This again is necessary to ensure that the federal government does not pay more than necessary to obtain the coverage it seeks, and to disseminate lessons learned by the federal government to inform other states and improve performance nationwide.

The federal government monitors state spending, including supervision of subsidy calculations for low-income people and for those with above-average risk. The federal government also strictly enforces provisions to avoid the financial manipulations that have occurred in Medicaid.[3] For example, the federal government might have to establish rules on the maximum payments that can be made to particular classes of providers. It may also be necessary to monitor payments made by health plans to specific classes of providers. Both of these strategies are possible mechanisms for preventing states from encouraging providers to set their charges high, thereby allowing the state to leverage more federal matching funds. There is one natural limit to the ability of states to engage in these arrangements: payments by plans to providers have to be covered by a plan's capitation rate. If the capitation rate is too high,the plan has to charge premiums in excess of the amount subsidized by the state. Given the sensitivity of lower-middle-class individuals to premiums, plans should be reluctant to raise rates.

Why Rely on States?

There are several problems with a model that relies so heavily on states.First,states differ widely in their performance of current programs under current arrangements. Among the 13 individual states represented in the National Survey of America's Families (NSAF), uninsurance rates for low-income children vary from a low of 7 percent in Massachusetts to a high of 37 percent in Texas, and, for low-income

[3] These include disproportionate share hospital payments, supplemental payments made to public hospitals and nursing homes financed with intergovernment transfers, and other arrangements that have had the effect of obtaining federal funds with little or no state and local matching funds.

adults, from 19 percent in Massachusetts to 47 percent in Texas.[4] According to the Current Population Survey, Medicaid coverage varies from 5 percent of low-income adults in Nevada and 6 percent in Idaho to 29 percent in Tennessee and 30 percent in Vermont. In 1998, Medicaid spending per child enrollee varied from $2,542 in New Hampshire to $794 in Mississippi.[5] Eligibility standards for children under S-CHIP ranges from a maximum of 140 percent of poverty in South Dakota and North Dakota to 350 percent of poverty in New Jersey.[6] Reliance on states alone can result in Americans with comparable incomes being treated quite differently.

Second, as referenced above, a range of financial abuses, including disproportionate share hospital (DSH) payments and, more recently, supplemental payment programs, have allowed states,at their discretion, to increase their effective matching rates. These financing abuses have led to widespread skepticism about state discretion at the federal level, and have threatened the viability of federal-state financial relations.

Third, there is extreme variation in administrative capacity at the state level. States such as New York, Massachusetts, Minnesota, and Washington have far more health policy expertise than do many of the smaller states in the south and west.

Despite these problems, we believe that it is politically unrealistic to enact a broad expansion of coverage at the federal level at this point in time. Right or wrong, the momentum in the nation is toward greater reliance on state government. We also believe that S-CHIP offers a fundamentally different model from Medicaid.S-CHIP has combined higher federal matching payments with more state flexibility. The higher federal matching rates have made coverage expansions for children much more financially attractive to states, and state governors have been able to receive credit for reducing the number of uninsured children. All states have adopted S-CHIP (and the majority have extended coverage to at least 200 percent of poverty),and several have expressed interest in extending coverage to include parents. With a high level of federal matching funds it will be hard for states to walk away from the opportunity to expand coverage to low-income and high-health-risk individuals. For all these reasons, we believe that S-CHIP provides a good model of federalism to follow.

One concern with state stewardship is inadequacy of funding. However, with about 40 percent of a state's population enrolled in the program, program beneficiaries should have sufficient political power to avoid chronic underfunding. While there is more state flexibility under S-CHIP than under Medicaid, a range of federal standards is essential. For example under S-CHIP, there are rules for minimum benefits packages. As described above, we believe the federal government will need to set rules for benefits packages,minimum provider payment standards, operation of the pools, and to avoid the financial abuses of Medicaid. A different concern is that states will not be able to control the growth of costs. However, because state expenditures will still be large compared with other state spending, states will have an incentive to control costs.

Organization of the State Purchasing Pools and the General Insurance Market

Development of State Health Insurance Purchasing Pools

Under our reform proposal,each state is required to construct a single purchasing authority and risk pool through which insurance coverage is provided for those who are subsidized because of low incomes or above-average health risks and for those with higher incomes who want to take advantage of the choices and efficiencies inherent in large-group purchasing mechanisms. Those subsidized because of income include most of those currently eligible for or enrolled in Medicaid or S-CHIP and many who are not currently eligible for those programs.

[4] Urban Institute tabulations of 1999 National Survey of America's Families data. Details of all Urban Institute calculations are available on request.

[5] Urban Institute calculations based on Health Care Financing Administration (HCFA) 2082 data and the March Current Population Survey. Form 2082 financial and enrollment data are supplied by the state to HCFA.

[6] F. Ullman, I. Hill, and R. Almeida. *CHIP: A Look at Emerging State Programs,* New Federalism Issue Brief Series A, no. A-35, Washington: Urban Institute, 1999.

To the extent that a state has existing state-only comprehensive insurance coverage programs (for example, Washington State's Basic Health Plan), we expect that these states will integrate these programs into the state purchasing pool to secure the large federal share of subsidy dollars for this population. Our equity principle requires that all subsidized enrollees with equivalent incomes be treated in the same manner inside the pool—that is, the distinctions between Medicaid and S-CHIP and other types of enrollees are erased. In addition, individuals exceeding the income eligibility cutoffs for subsidies and private employer groups may purchase coverage through this pool. All purchasers/enrollees in a given geographic coverage area have access to the same health plans and enrollment options, regardless of whether they are subsidized (for some plans, additional payments will be required—see below).

States have the option to contract with private insurers and managed care plans to provide coverage through the state pool. However, even if private insurers are used in this manner, each state is required to operate its own managed FFS plan. The state can either run this plan directly or contract with an insurer or a third-party administrator for this purpose. In addition to FFS being an increasingly popular option for Medicaid managed care programs, one important benefit of this managed plan is that it serves as a safety valve and as a check on proprietary health plans' bidding and contracting strategies. For example, if plans all submit relatively high bids, the state may be able to operate a managed fee-for-service program, one that monitors use and negotiates fee discounts from providers, at a lower cost. Our vision of this new health insurance program is sufficiently general that one could imagine a state qualifying for the subsidy payments with just this managed FFS plan—that is, without trying to manage competition among proprietary health plans. An FFS plan may also be essential in states or substate areas where sparse populations prevent managed competition from developing. The state purchasing pools can build on existing structures for state employees' plans, Medicaid, S-CHIP, or other state purchasing programs, or entirely new entities may be created at the state's discretion.

As noted earlier, the new program provides two types of subsidies. The first provides premium subsidies to those below 250 percent of poverty, with those in families below 150 percent of poverty receiving subsidies sufficient to cover the full cost of a comprehensive plan. The second subsidizes individuals with above-average health risks so that the premium they face is equivalent to a community rate calculated over the entire insured population in the state. Both subsidies are available only to those enrolling in coverage inside the state purchasing pool to minimize administrative complexity.

General Features of State Pools

Once the state determines the benefit package, subject to federal minimum requirements, private insurers may decide to sell supplemental benefits in the pool. But these benefits must be priced separately and treated as add-ons to, not replacements for, the standard package. Those enrollees who are entitled to additional benefits because of Medicaid eligibility under current law (for example, children with special needs and the disabled) continue to receive those benefits as wraparounds through a residual Medicaid program (which also continues to provide long-term care as under current law). The state purchasing pools operate under guaranteed issue and guaranteed renewal for all groups and individuals. Each year the state purchasing pool holds an open enrollment period at least one month long. Enrollment will be permitted at non-open enrollment times; however, late enrollees (regardless of the month they enroll) will be required to pay what they would have paid in premiums for one full year plus a 25 percent penalty. As described above, for workers with employer offers, the income subsidy inside the pool can be applied only to the employee share. No additional insurance market reforms are required outside the state purchasing pool. We assume that HIPAA remains in place in non-participating states,and that participation in the program satisfies HIPAA's requirements for an individual market mechanism.

Premium Payment Details

We have four goals for our premium payment mechanics: (1) spread excess health risk broadly throughout the population; (2) provide subsidies for those with low incomes; (3) create incentives for efficiencies in care delivery and insurance administration; and (4) ensure that private insurers remain willing sellers—that is, that they collect enough money for the risks they are bearing. This section and the more technical appendix explain the pricing mechanics through which we achieve these goals.

One of our core principles is to set premium payments so as to spread excess (above-average) health risk across all taxpayers. No person enrolling in the state purchasing pool has to pay more than he or she would under a statewide community rate for the state-determined standard benefits package. Low-income persons are subsidized either completely or partially, depending on their income.

To show how this works, we present two examples. The simplest case is represented by a state using only a managed FFS arrangement for its risk pool—that is, there are no competing private health plans. In this case, the state determines the premium it charges all enrollees, based on expected use of an average person *in the entire state* as well as negotiated price and utilization management incentives it has agreed to with participating providers. In this case, the FFS plan is the benchmark plan, by definition. Those with incomes below 150 percent of FPL can enroll in this plan without cost. Those with incomes between 150 percent and 250 percent of FPL pay a share of the statewide community rate according to the schedule determined by the state. Individuals with incomes above 250 percent of FPL are able to buy into this managed FFS plan by making a payment equal to the statewide community rate, which could entail some premium variation by age at the state's discretion.

Federal and state governments share in the costs of the low-income subsidy, according to the relevant matching rate. The governments also jointly bear the difference between the statewide average cost and the expected cost of providing care to those enrolled in the state pool's FFS plan. This includes the higher costs due to the pool's attracting higher-than-average-risk enrollees.

The managed competition regime, under which competing private health plans join the state-run FFS plan as an option for enrollees, is somewhat more complicated. Its details are laid out in the technical appendix. In this case, the state must perform four key functions to determine appropriate payment amounts.

1. Elicit "bids" from plans interested in participating in the pool.
2. Choose and implement a risk-adjustment mechanism from the choices approved by the federal government.
3. Set the benchmark within-pool rate.
4. Determine the statewide community rate.

We describe these functions in the following paragraphs.

Elicit bids from plans. Insurers that want to compete for the substantial business inside the purchasing pool must submit premium bids for a standard risk enrollee—that is, a healthy young adult male. The healthy young adult male is chosen so that insurers do not base their bids on different expectations about the people who are likely to enroll in the state pool. There are two advantages to having plans bid this way. First,it is standard procedure for insurers to determine premiums for the standard risk. Second, it allows the state to have a uniform measure for comparing plan bids to non-pool rates, because plans typically file rates for standard risks with state insurance departments. While competitive bidding is one clear mechanism for eliciting such bids, the state does not have to use this approach. It can also set or negotiate standard rates with the plans. In addition, insurers include an administrative load in their standard risk bids.

Choose and implement a risk-adjustment mechanism. The state must also establish a risk-adjustment system to compensate plans appropriately if they enroll above- or below-average-risk individuals. The federal government provides a list of acceptable risk-adjustment methods from which states select one. States can also request approval for their own risk-adjustment method. The approval process is intended to guarantee some consistency and quality control across the nation. States use the

risk-adjustment mechanism to compare average risks enrolled in each plan with average risks throughout the state. These relative risk rankings are necessary to determine premiums to be paid by enrollees and the state and federal governments,and to be received by plans.

Set the benchmark within-pool rate. We expect plans to submit or negotiate a range of bids. The government then determines or selects a benchmark bid. This can either be the median bid or it can be set at a pegged level—for example, 110 percent of the lowest bid. The benchmark bid must be set high enough to engender sufficient plan capacity to ensure that those who are fully subsidized have some choice of plans, and low enough so that all plans have incentives to become efficient and bid low. The benchmark bid is used in setting the level of the full income-related subsidy, the excess risk subsidy, and the statewide community rate. Because the government cannot commit financially to providing low-income persons a complete subsidy for any plan that they might choose, the benchmark is used to define a reasonably efficient premium level. If any plan's bid is above the benchmark, the individual choosing to enroll in that plan (regardless of income) is responsible for paying the excess.

Determine the statewide community rate. The state must compute the expected average premium that is sufficient to cover health services plus administrative loading costs as if all those insured in the state were enrolled in the in-pool benchmark (efficient) plan. This premium is what we refer to as the statewide community rate. It is calculated by adjusting the benchmark bid for the standard-risk person to the level of average risk of all those insured throughout the state (not just in the pool). This requires insurers to report average risk scores both inside and outside the state pool. Because this is a difficult calculation and necessarily an approximation, it may be necessary for the states to supplement insurer reports with other information. Two representative data sources come readily to mind: the Medical Expenditure Panel Survey of employers collects state-specific premium data for most states, and actual provider revenue data collected to support the Commerce Department's estimates of gross domestic product (GDP) are used in HCFA's ongoing state and national health expenditure estimates. Both of these sources can be used to develop alternative ways to calculate the statewide community rate for adults and children. It may also be politically necessary to use panels of experts,including actuaries, plan representatives, beneficiary advocates, and representatives of federal and state government, to decide on the reasonableness of the statewide community rate estimate.

Calculating the statewide community rate reasonably accurately is important. If it is estimated too high, potential beneficiaries will have to pay more to enroll in a state pool than we intend, and too few will want coverage inside the pool. If it is estimated too low, cost to the federal and state government will be higher than necessary with more enrollees coming into the pool for the subsidies, and the per capita excess risk subsidy being too large.

Because calculating the statewide community rate is so politically charged, it is probably desirable to err on the high side in the beginning; this maximizes the chances that the system will be up and running without implacable insurer opposition. The extra cost this imposes will be low in the early years because only a few states are likely to implement the program initially. Once calculation of the statewide average cost is institutionalized, fluctuations and uncertainty in this estimate will be reduced, and lessons learned in the early years can be applied in the bulk of states that will implement the program at a more measured pace, and in all states over time.

When these calculations are completed, we have several pieces of essential information. We have bids from each plan, risk adjustments reflecting the health status of enrollees of each plan in the pool, as well as in the entire state, and calculations of the statewide community rate. The state can then determine the required contributions from beneficiaries, payments to plans, and payments by government.

What enrollees will pay. Enrollees in the state pool are responsible for paying the statewide community rate,less any applicable income-related subsidies. Employer contributions count toward an enrollee's obligation. In addition, if the beneficiary

chooses to enroll in a plan whose bid exceeds the benchmark bid, he or she will also have to pay the difference between the two bids. If the beneficiary chooses a plan whose premium falls below the benchmark, the plan may choose to rebate the difference to the enrollee as an incentive. The enrollee's payment is never affected by the mix of risks in the plan he or she selects.

What plans are paid. Plans receive a premium payment equivalent to their bid for the standard risk, adjusted for the relative risk of those individuals actually enrolling in their plan. If a plan's bid is below the benchmark bid, the plan can offer a discount to the beneficiary. Thus, plans receive the full costs they expect to incur and that their competitive bids reflect. But, in general, it is important to note that plans get part of their payment from enrollees and part from the government in the form of income subsidies, excess risk subsidies, and risk-adjusted premium payments.

What the government pays. The government is responsible for paying two types of subsidies. These subsidy dollars flow directly to plans; they are not transferred through enrollees themselves. First, the government pays all of the applicable low-income subsidies attributable to enrollees in each plan. Second,the government pays the difference between the benchmark standard-risk bid, adjusted for the relative risk of those enrolling in a particular plan, and the statewide community rate. This second type of payment compensates plans for the difference in the health risk of their enrollees compared to all insureds in the state. This payment does not subsidize a plan's inefficiency, however, because the health risk subsidy is based on the cost of the plans' enrollees as if they were enrolled in a plan priced at the benchmark. Pure inefficiency—higher bids than the benchmark bid for the standard risk—must be recouped from enrollees.

State options. Each participating state has a number of choices that are sometimes limited by federal floor or minimums. Nevertheless,there is considerable state discretion to affect the character of the purchasing pool. In addition to choosing whether to contract with private plans, some of these choices result from asking the following questions:

• Will employers choose a plan on behalf of employees, or will employees have full choice of plans in the pool?

• Will state and local government employees be incorporated fully into the pool, or will they maintain separate coverage with the option for workers to enroll in the pool?

• Will the pool be publicly managed, or will it be run through a public-private partnership?

• What will the premium structure be—single vs. family; single, couple, single-parent, two-parent (from a menu, or with federal approval)? Each state will be required to offer a child-only premium.

• Will any age adjusters be used for setting the unsubsidized premiums within the pool?

• What will be the pool's approach to private insurer premium determination within the pool? Will the state rely on pure competitive bidding, negotiation, or some hybrid? (All pools will have the power to exclude plans deemed unacceptable by reason of quality and/or price.)

• What will be the exact risk-adjustment method (from a menu or with federal approval)?

• How large a geographic area will be served by each pool (statewide, substate, etc.)?

Financing—Who Will Pay?

This program is paid for through a combination of federal and state funds. The proposal is expensive, to be sure, as is any serious proposal to expand coverage. There are currently 63 million non-elderly adults and 39 million children living below 250 percent of poverty. Of these, 24 million adults and 15 million children currently have employer-sponsored coverage. Another 4.8 million adults and 1.7 million children have private, non-group coverage.[7] Even though many of these individuals currently have coverage, they can receive subsidies, if they choose to join the state plan. Another 8.6 million adults and 12.9 million children have Medicaid; under our proposal the federal government pays a higher share of expenditures on this population.

[7] Urban Institute analysis based on data from the 1998 March Current Population Survey.

We are not substantially increasing the total number of dollars spent on health care services; rather, we are changing the financing source of those dollars to be more heavily weighted to federal, progressive income taxes.

Finally, 22.6 million low-income adults and 8.7 million low-income children are uninsured and can begin receiving coverage.

The large number of low-income adults and children who already have coverage but can nonetheless join the state pool means that the price of achieving equity—that is, treating individuals with similar incomes the same—is high. It is important to remember, however, that we are proposing to change the ways in which health insurance is paid for with regard to low-income people and people with above-average health risks. We are not substantially increasing the total number of dollars spent on health care services; rather, we are changing the financing source of those dollars to be more heavily weighted to federal, progressive income taxes.

Our proposal involves considerable expenses attributable to health risk subsidies for those above 250 percent of poverty. Because health expenditures are very unevenly distributed (that is, a large share of expenditures is attributable to a small percentage of the population), a relatively small proportion of the population benefits greatly from the risk-related subsidy, but this subsidy is likely to account for a large share of premium dollars.

These costs are borne by both federal and state governments, but primarily the former. Compared to proposals that would be completely federal (for example, refundable tax credits that could achieve the same degree of coverage, if generous enough), the federal expenditures for our proposal are lower because of the state contribution. The federal share is paid for through federal general revenues—and by cuts in existing programs,the need for which would be reduced under such a reform. The increase in federal expenditures is also limited by the strong incentives for employers to continue contributions to their employees' coverage. These incentives include the tax advantage to higher-wage workers, market pressures to compete for workers who demand health insurance at most or all jobs, and anti-discrimination rules that make it difficult to exclude subsets of workers from health benefits that some workers value highly enough for the firm to offer.

We fully expect that some time after full implementation of the program, the federal government and the participating states will be able to begin to reduce other direct payments made directly to providers (for example, DSH payments) to fund care for the uninsured and low-income populations. While the need for such extra sources of funding should be lower under the proposed program, we do not anticipate eliminating these payments completely. Even in states that do adopt an individual mandate, a residual number of uninsured are sure to persist,and some support for providers in particularly high-need areas, such as inner cities, may still be necessary. In those states not choosing to participate in the program, the costs associated with providers in high-need areas can be expected to continue to grow. Changes in federal programs will have to be sensitive to the different needs in participating and non-participating states.

Under our proposal, states pay lower matching rates than they do under Medicaid, but they will pay on many more lives. At the same time,they get more federal dollars for those they currently cover under Medicaid. Moreover, they receive the higher federal match on residual Medicaid benefits. This is a large substitution of federal funds for existing state obligations. But federal contributions for those above 250 percent of poverty under the current S-CHIP program are eliminated; therefore, those states that have extended S-CHIP coverage to higher-income levels lose some federal benefits. Still, remembering the savings states get from higher matching rates across the board in Medicaid, states are free to use some of their savings to maintain or increase subsi-

dies for those above 250 percent of FPL with state-only money, or to supplement the federal subsidies between 150 percent and 250 percent if they prefer. In addition,states that have existing high-risk insurance pools can eliminate them and send enrollees into the new state combined pool.

There are several sources of potential savings to different groups that offset much of the necessary tax increase. Many individuals and businesses will pay lower premiums because of lower administrative costs that result from switching into the pool from the current small-group and non-group markets. In addition, many of those who remain in the private market will pay lower premiums because many above-average risks will enter the pool because of the community rate. To the extent that insurers currently price small-group and individual policies at inefficiently high levels because of fears of adverse selection that do not actually come to fruition,this means real system savings. The consolidated purchasing power of the new pool should engender new efficiencies among health plans and throughout the health care delivery system. Lower premium payments will also lead to higher wages and more tax revenue than would have been the case at the same income and payroll tax rates.

Political Feasibility

This proposal has a number of political strengths, and its share of weaknesses. From the perspective of federal executive and congressional policy makers, the plan offers a way to attack a major national problem. Political leaders will receive credit for offering a solution to the problem without a major expansion of the federal bureaucracy. On the other hand,leaders at the federal level will have to bear the political burden of using surplus revenues or raising taxes to finance the program. Further, while federal political leaders will provide general oversight, most of the credit for the program's success will go to state political leaders.

At the state level, political leaders have the opportunity to receive the credit for solving a serious issue for their constituents with very little increase in state revenues. They have the luxury of building consensus and adopting a program only after that consensus exists. However, there will be some increased financing at the state level. Moreover, states will have a large number of new administrative challenges, and state leaders will bear the brunt of criticism for operational failures.

Liberals are likely to applaud the coverage expansion that will result, but they will be dissatisfied that the proposal leaves us short of universal coverage and grants so much state discretion. There may be opposition to segmentation of low-income and less-healthy Americans into state purchasing pools, separate from plans serving higher-income and healthier Americans. There is also likely to be distrust and lack of confidence in states' ability to administer such a complex program and concerns about chronic underfunding.

Conservatives will oppose a large government initiative and the introduction of what is essentially an expanded entitlement program. They will view the large amount of spending on those who currently have coverage as inefficient. Conservatives are likely to find favor with the large state role,and they cannot argue that it is a "one size fits all" program. The fact that any individual or family can continue to choose a private plan should mollify some conservative critics.

The business community should clearly benefit. No firm will be worse off, and many will have new, less expensive options. The administrative burdens on many smaller firms will be reduced,and the costs of coverage will fall because of the movement of above-average risks into the pool. Some of the savings, however, might be offset with wage increases over time.

Insurers and providers are likely to find the plan a mixed blessing. While it will greatly increase the number of covered lives, insurers are likely to be concerned about so many lives being within the scope of the state-organized pool. They are likely to fear what organized purchasing and bargaining power can do to their traditional discretion to segment markets and earn very healthy profits. The fact that a voluntary market outside the state pool is not regulated beyond current law will be viewed as a positive, however. Similarly, providers will also see

the benefits of more covered lives, but they will be concerned about government bargaining power being used to lower capitation rates, which can affect their revenues.

Health insurance consumers would either be better off or, at least, no worse off. They can retain existing arrangements, which may become cheaper, or seek a new offering in the state pool. People with low incomes, those in poor health, and those in small firms would clearly benefit. To the extent that increased competition holds down the cost of premiums, those working for employers that offer coverage will see higher wages in the long run. Of course, taxes will be higher than otherwise, offsetting these benefits to some extent.

Transitions

Our general principle is to leave the pace of the transition to the new subsidy and pooling structure to the individual states, with financial incentives to start early. We offer two-year planning grants to states that are willing to start the first year. These planning grants include enough money to fund development of standardized reporting formats for risk adjustment and statewide community rate calculation purposes. One advantage of our system is that it builds on existing institutions: state Medicaid agencies, S-CHIP, and state employee health insurance programs all perform many, if not all, of the functions we have in mind, except for calculating the statewide community rate. Several states—for example, Minnesota, Washington, and Massachusetts—have many of the features of the system we are proposing already in place. We anticipate that other states will choose to participate in the program at varying rates. An advantage of delayed state entry is the opportunity for those entering later to learn from the experience of the pioneers. Our recommended pace is two years of planning, combining Medicaid and S-CHIP in year two, and then adding free choice of the pool in year three.

At least five years of state operation under the new system are required before the state could opt for an individual mandate. This waiting period serves two functions: first, it ensures that the state's pool is operating effectively and efficiently; and,second, it permits federal and state governments to generate more accurate estimates of the cost of the mandate for budgeting purposes. Enforcement mechanisms are up to the states to devise, and they need to be approved by the federal government.

Technical Appendix

Premium Payment Details, Managed Competition Case

This appendix explains how we determine beneficiaries' obligations, government payments, and net payments to health plans,and achieve our objectives of equity and efficiency. Initial bids will be requested from all private plans participating in the state pool; bids would reflect the insurer's price for a standard risk, including administrative load. "Standard risk" is used to define the premium cost for an individual of a specified age group and gender, usually a young adult male, the lowest-cost insured adult. It does *not* mean the average risk for the population insured in the pool. Expected health costs and administrative costs are embedded in this bid for the standard risk.

A given plan's bid is denoted as SR_i. From the distribution of bids, the state purchasing authority will determine a benchmark bid, SR_b. As noted in the text, states may decide to set premiums through a pure competitive bidding process, they may use a more interactive negotiation approach, or they may set the "bid" unilaterally and then accept only those plans willing to accept that rate, or some alternative method. This standard risk bid will be converted to a premium level by using a risk adjuster that takes into account the difference in expected health costs

between actual enrollees in an insurer's plan within the pool and the expected cost of the standard risk. In general,the premium for the i-th plan is $P_i = SR_i * (1 + RA_i)$, where P_i is the premium, SR_i is the i-th plan's bid for a standard risk enrollee, and RA_i is the risk adjuster or risk score for all the enrollees in plan i, relative to the standard risk. $RA_i = 0$ implies that the i-th health plan has drawn all standard risks,and $RA_i = .12$ means that the plan's enrollees are expected on average to be 12 percent more costly than the standard risk.

We do not have strong opinions about which risk-adjustment method states decide to use, though the federal government should approve the method chosen to guarantee some consistency and quality control across the nation. Any number of specific techniques will produce risk scores relative to the 1.0 standard risk that is bid,and it is these relative scores that make up RA.Each person, given his or her characteristics and recent medical history, has an RA score, and average RAs can be computed for any group of persons.

Two other concepts are prerequisites to a full explanation of our payment mechanics. The first is the risk adjuster score that reflects the average risk in the state as a whole, RA_{st}, and the other, which builds on this, is the statewide community rate, or $CR_{st} = SR_b * (1 + RA_{st})$. That is, the statewide community rate is the product of the benchmark bid and the average risk statewide, incorporating those both inside and outside the pool.

Now, to remain in business, each health plan must collect its expected costs, given the actual average health risk it happens to enroll, or $P_i = SR_i * (1 + RA_i)$. Our equity principle says that no person should pay more than the statewide community rate CR_{st}, except for an inefficient plan, one that bids above SR_b. This CR_{st} is also the amount of the full income-based subsidy, so that an enrollee in a household living at less than 150 percent of poverty can choose an efficient plan and pay nothing out-of-pocket. Partial income subsidies are fractions of 100 percent, s, ($s \leq 100$ percent), times CR_{st}.

Thus, the community-rated premium for plan i would be $CR_i = SR_i * (1 + RA_{st})$. This is the standard risk bid by plan i, adjusted for the risk of all insured individuals in the state. CR_i is the premium facing an individual enrollee in plan i who is *not* eligible for an income-related subsidy. Those who are eligible for low-income subsidies would pay:

$CR_i - sCR_{st} = SR_i * (1 + RA_{st}) - s * SR_b * (1 + RA_{st}) = (SR_i - s * SR_b) * (1 + RA_{st})$.

When s = 100 percent,and $SR_i = SR_b$, those with incomes below 150 percent of poverty pay nothing. If a plan bids above the benchmark, or enrollees' income exceeds 150 percent of poverty so that $s < 1.0$, then they must pay something out-of-pocket for that plan.

The government must pay the income subsidy and make sure the plan is adequately compensated for the risk profile it actually attracts. The simplest way to accomplish both these goals is to set the government amount as a residual, the difference between what the plan requires to stay in business and what the enrollee pays. The government then would pay:

$SR_i * (1 + RA_i) - (SR_i - s * SR_b) * (1 + RA_{st})$,

which can be rearranged to yield:

$SR_i * (RA_i - RA_{st}) + s * SR_b * (1 + RA_{st})$.

The first term in the government obligation is the combination risk-adjustment and risk subsidy payment that compensates plan i for its enrollees' risk relative to that in the state as a whole. The second term is the income subsidy amount appropriate for an enrollee with a particular subsidy level, s. Obviously, aggregate government payments will be determined by the average risk and subsidy levels of in-pool enrollees, in addition to the efficiency of plans that compete in the pool. Thus, both governments and beneficiaries gain if most plans are efficient and, therefore, have strong incentives to foster a competitive climate and bidding mechanism that encourages health plan efficiency. Health plan efficiency is key to minimizing the cost of achieving our goals of coverage expansion and equitable access for the low-income and the high-risk. ■

Holahan, Nichols, and Blumberg Proposal

Key Elements

John F. Holahan, Len M. Nichols, and **Linda J. Blumberg** have outlined a new proposal to cover the uninsured that would extend the subsidized coverage that is available under the State Children's Health Insurance Program (S-CHIP) to all lower-income people. The proposal is built on the following key elements:

THE FEDERAL GOVERNMENT WOULD PROVIDE financial incentives to states to expand health coverage subsidies to all families and individuals with incomes below 250 percent of the federal poverty level and those facing higher-than-average health expenses, regardless of income. Subsidized coverage could be purchased only through purchasing pools, which states would have broad discretion to design.

FEDERAL FUNDING WOULD BE IN THE FORM of a match amounting to 30 percent more than the current Medicaid match, provided to states in exchange for meeting minimum federal standards. States choosing to participate would have to provide coverage to those meeting the eligibility rules, but could specify a minimum benefits package consistent with federal guidelines, as in the S-CHIP program. Non-participating states would continue their Medicaid and S-CHIP programs.

THE NEW PROGRAM WOULD EFFECTIVELY REPLACE Medicaid and S-CHIP. People below 150 percent of poverty would get full subsidies, while those between 150 and 250 percent of poverty would get partial subsidies, and the high-risk (regardless of income) would be subsidized as well. A set of uniform federal rules would apply nationally.

ALL INDIVIDUALS, INCLUDING THOSE with high health costs, could buy insurance through a state-designed purchasing pool at a premium no higher than a statewide community rate for a standard benefit package. Employers must offer employees the state pool coverage as an option, but they could choose whether to buy coverage exclusively through the pool.

THE STATE PURCHASING POOL would combine existing Medicaid, S-CHIP, state employees' purchasing programs, and willing participants from the private sector to create administrative efficiencies, pool insurance risks, and improve bargaining clout for those within the pool.

About the Authors

JOHN F. HOLAHAN, PH.D., is Director of the Health Policy Research Center at The Urban Institute. He has authored numerous publications on the impact of public policy and market forces on the health sector, with a particular focus on effects on low-income populations. These include analyses of the recent growth in Medicaid expenditures, variations across states in Medicaid expenditures, and the implications of block grants and expenditure cap proposals on states. He has also published research on the effects of expanding Medicaid on the number of uninsured and the cost to federal and state governments. He directs the health policy component of the Assessing the New Federalism project which has produced several reports on health policy for low income populations. Other research interests include health system reform, changes in health insurance coverage, and managed care payment arrangements. Dr. Holahan has a Ph.D. in economics from Georgetown University.

LEN M. NICHOLS, PH.D., is an economist and Principal Research Associate at the Urban Institute who studies private health insurance markets and how they work in response to decisions by employers, individuals, regulators, and public insurance programs. He has written extensively on these and other issues under the general rubric of health reform at both the national and state levels. He has also been a consultant on health policy for the World Bank and the Pan American Health Organization. Dr. Nichols is currently a member of the Competitive Pricing Advisory Commission (CPAC) for the Medicare program as well the Technical Review Panel for the Medicare Trustees Reports. He was the Senior Advisor for Health Policy at the Office of Management and Budget (OMB) during the development of and debate over the Clinton health reform proposals of 1993–94. Prior to OMB, Dr. Nichols was a visiting Public Health Service Fellow at the Agency for Health Care Policy and Research, and prior to that he was an Associate Professor and Economics Department Chair at Wellesley College. He received his Ph.D. in economics from the University of Illinois in 1980.

LINDA J. BLUMBERG, PH.D., is Senior Research Associate at the Urban Institute. She is currently working on a variety of projects related to private health insurance and health care financing: estimating the coverage and risk pool impacts of tax credit proposals, estimating employer price elasticities of offering health insurance, the effects of insurance market reforms on the risk pool of the privately insured, and a series of analyses of the working uninsured. While at the Urban Institute, she has also done research on insurance market reforms, the effects of the Medicaid expansions for children on private health insurance, tax credits as tools for expanding health insurance coverage, provision of health insurance coverage by small employers, the Health Insurance Portability and Accountability Act of 1996, the District of Columbia's Medicaid program, reform of the Medicare AAPCC, and health insurance purchasing cooperatives. From August 1993 through October 1994 Dr. Blumberg served as health policy advisor to the Clinton Administration during its initial health care reform effort. She received her Ph.D. in economics from the University of Michigan.