A State-Based Proposal for Achieving Universal Coverage

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Overview

We propose that the United States adopt a health care financing system that provides comprehensive health insurance to all legal residents. The system will be administered by the states and overseen by the federal government.Employers will no longer be involved in providing health insurance coverage, although both employers and employees will contribute. Other sources of financing include the federal and state governments and, in some instances, individuals and families. The proposed system will replace most of the major components of the U.S. health care financing system; the two exceptions are Medicare and Medicaid-financed long-term care.

Each state will administer its own delivery and financing systems. The federal government will contribute to a state's system as long as several requirements are met, including coverage by and access to at least one zero-premium plan that includes a standard benefits package for nearly all legal residents. Beyond that, states will have wide latitude in crafting their own particular systems. For example, a state can choose to establish a "Canadian-style" single-payer system, in which hospitals are paid based on a negotiated budget and physicians on a fee-for-service basis (presumably with an aggregate expenditure cap). Alternatively, and perhaps more likely, a state can contract with health plans that compete for enrollees through low premiums, high quality, and/or service, with individuals who choose more expensive plans paying for them with additional premiums.

All health insurance choices offered must include the services specified in a federally defined benefits package that states may choose to augment. Services to be included are inpatient and outpatient care, skilled nursing and home health care, mental health care, preventive services, prescription drugs, and durable medical equipment. To receive coverage, individuals and families will enroll with their states. They only need to provide evidence that they are legal residents of the state; no income verification is required. People living in states that choose to contract with private health plans also must choose a plan. Those failing to do so will be placed in a plan requiring no premium payment.

The plan will be financed through a variety of sources. The primary revenue source, a payroll tax levied on both employers and employees, will be supplemented by general federal revenues,state revenues, and, potentially, by individual contributions for certain plans and/or benefits beyond those included in the standard benefits package. Employers with predominantly low-wage workers will pay a lower tax rate than other employers. The proposal provides a number of assurances that important constituency groups, such as states, larger employers, small employers, and families, will pay no more, on average, than they currently do for their health insurance coverage.

The proposal will help ensure that the United States meets health care access, cost, and quality goals. All Americans under age 65 who live in the country legally will be provided with health insurance that includes coverage for all major health care services except long-term care. Those eligible will have at least one health insurance option that does not require them to pay any premiums. Thus, neither financial considerations nor burdensome application processes will present barriers to obtaining health insurance, thereby ensuring that the goal

of universal coverage is met.

Costs are likely to be contained because nearly all participants in the health care marketplace will have an incentive to control them.States will receive an annual fixed-dollar contribution from the federal government; thus they are at risk for additional spending and will have a strong incentive to spend wisely. If they rely on competing health plans to provide insurance packages,these plans will vie with each other for enrollees, recognizing the strong role that premiums play in consumer health plan choice. The plans, in turn, will continue to pay providers in ways designed to reduce excessive and unnecessary use of services.

A major challenge will be ensuring that good-quality care is provided. Markets, by themselves, cannot ensure this, particularly in light of the difficulties consumers have in obtaining and evaluating the necessary information. The federal government will need to invest substantial resources in measuring health care quality and health outcomes across states, with a special emphasis on vulnerable populations. As part of the proposal, the federal government will closely monitor the quality of the care provided under each state system, and provide financial rewards to states that improve quality.

A second challenge is that states will be taking over a number of responsibilities for administering health insurance that previously were carried out by employers. Depending on how a state chooses to organize, these responsibilities may include, for example, outreach, enrollment, negotiations with health plans and providers, data compilation, and quality assurance. States will need technical and financial assistance to carry out their enhanced roles.

Detailed Description of Proposal

Federal Requirements

To receive federal contributions, states must demonstrate that they have met and continue to meet specific criteria. There are two aspects to this: having their initial program approved,and continuing to meet coverage and quality requirements. This section addresses the initial requirements. Ongoing requirements are addressed later. To obtain approval for their initial plans, states must submit their proposal to a federal agency.[1] The proposal will have to demonstrate the following:[2]

• Nearly all (at least 98 percent) of the legal residential population[3] in the state will be enrolled.

• All localities will offer at least one plan that does not require any premiums, and that, like all plans, includes the federally mandated benefits package.

• New state residents will be covered in a timely fashion.

• A plan is in place to monitor and ensure the quality of services provided to all state residents.

• There is also a plan in place for collecting and compiling the data necessary to evaluate the system; this is likely to include information on enrollment, utilization (perhaps through encounter data), costs, quality, and satisfaction.

• The state has a reasonable plan for carrying out all of the necessary activities to implement its proposed system.

States are not required to implement universal coverage; such approval is necessary only if the state wishes to obtain federal contributions. But given the fact that the vast majority of revenues will come from the federal government through the payroll tax and general revenues,it is anticipated that states will be anxious to obtain timely approval of their proposals. Nevertheless, a state may choose not to participate, in which case it forfeits the federal money that would have been available.[4]

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[1] We assume that this would be an executive branch agency, but we do not take a position on which one; it could be the Health Care Financing Administration, another agency in the Department of Health and Human Services, or a newly established agency.

[2] This is not unlike the system established in Canada. Under the 1984 Canada Health Act, provinces must demonstrate that the following five provisions are met to receive federal health contributions: public administration, comprehensiveness, universality, portability, and accessibility.

[3] The residential population excludes prisoners, those residing in institutions, and the homeless. Although states are encouraged to enroll individuals in these populations, we recognize that this will be a difficult task. Some safety net system of care will still be necessary to care for some of these individuals, as well as those who do not reside legally in the United States.

[4] A state that chooses not to participate could continue to receive federal matching money for the Medicaid and State Children's Health Insurance Program (S-CHIP).

Eligibility

All legal residents of a state are eligible for the state's program.[5] To sign up, they simply have to demonstrate that they live in the state and are residing legally in the United States. No intrusive information, including income, will be solicited. One exception, discussed below, is if states chose to supplement federally mandated benefits with additional ones based on such criteria as low income.

Each state will be responsible for enrolling its residents in a particular health insurance plan. Under a system such as single-payer, there probably will be a single plan for which everyone in the state is eligible. Services could be received from any certified provider simply by showing one's eligibility card. Under systems that contract with private plans, individuals will need to enroll in a particular plan. This can be done when a person registers for coverage or, alternatively, within a designated period of time after registration.

Benefits will be fully portable. A person who is visiting another state will be eligible to be reimbursed for urgent and emergency services during that visit, and those moving to another state will also be covered during the period in which their eligibility is being transferred from one state to another.

Benefits

There will be a federally determined standardized benefits package to which all states, and all plans within states, must conform. We propose that this include such elements as medically necessary acute inpatient care, outpatient care, acute nursing and home health care, mental health care (in parity with physical health care), preventive services, prescription drugs, and durable medical equipment. Specifically excluded are dental care and long-term care (both of which states may choose to provide to certain residents). In general, the benefits package should be similar to that currently provided by most large employers.

In those states relying on competing health plans, determination of medical necessity will be carried out by the plans initially. As noted below, however, states will oversee the quality of care provided by plans.A second "check and balance" is that the federal government will monitor and, when necessary, regulate the quality of care provided in the state—including whether plans in the state are defining medical necessity too narrowly.

As experimental therapies and technologies are developed, we foresee a multi-level decision-making process. In states that contract with competing health plans, decisions about whether and when to provide the new therapy will likely be made by the health plans initially, although certainly in consultation with the state. The state will have the option of being more prescriptive and requiring each plan to provide coverage. In states that make direct payments to doctors and hospitals, the state certainly needs to be directly involved in deciding whether to pay for new therapies. The federal government will have the option of intervening and being more prescriptive if it does not like the choices made collectively by states and health plans.

The exact set of benefits to be covered will be established by Congress. Of major importance will be how these are to be updated over time. We suggest that recommendations for updating the benefits package be made by the Medicare Payment Advisory Commission (or a new agency) for Congress,and by the Health Care Financing Administration (or a new agency) for the President.

We anticipate that states may wish to provide more benefits than those included in the standardized package—for example, Title V services to children with special health care needs. As with the status quo, states could establish their own eligibility criteria for such additional services, with funding largely provided by the federal government.

One key issue concerns patient cost-sharing requirements under the standardized benefits package. Some advocate substantial cost sharing to make

[5] It would be desirable to grant eligibility to all state residents, legal or not, but we have not proposed this because of the political difficulties inherent in granting full benefits to those living in the country illegally. Nevertheless, there are several reasons to cover them: (a) they have health needs like everyone else; (b) their inclusion will lead to true universality, removing the need for a safety net system that could be quite expensive in areas with many such residents; and (c) their inclusion could improve social cohesiveness. As an alternative to covering these individuals, we suggest that the federal government make direct payments to states with significant concentrations of undocumented persons, with the stipulation that these monies be used by the states to support those providers that serve this population.

people think twice before using services, while others believe that this is inequitable and will reduce the use of necessary services. Our proposal follows the lead established by the great majority of developed countries: they have instituted low or no copayment requirements on basic services such as inpatient, outpatient, and preventive care. Low copayments also follow the precedent established in most employer-sponsored insurance.

Cost-sharing requirements should be kept low for several reasons:

• Cost sharing represents a larger share of income for those individuals with lower incomes, thus it is regressive.

• Similarly, low-income people are, on average, in poorer health, so requiring them to pay a good deal for services is doubly inequitable.

• There is evidence to indicate that the health of low-income families is adversely affected by cost sharing.[6]

• There is also evidence that cost sharing is indiscriminate in that it reduces the use of necessary *and* unnecessary services.[7]

• Low copayments will obviate demand for supplemental insurance that covers these copayments. Such policies may be viewed as undesirable by states because, by increasing utilization, program costs will rise, as well.

• Although it is clear that an individual facing substantial copayments will use less health care than an individual for whom care is nearly free, it is far from clear that a health care system in which many people face copayments (but are fully insured for care beyond some catastrophic limit) will provide less care than a system in which copayments are low. In the absence of supply side constraints, if providers are paid more for delivering more services, then they are likely to respond to lower levels of consumer demand by adjusting standards of care.

We propose that copayments under the standard benefits package be similar to those in policies currently offered by typical large employers. Even these relatively low copayments will disadvantage those who are currently covered by Medicaid and, therefore, now have no copayments. States may choose to provide supplemental coverage for low-income persons; this supplemental coverage might cover copayments as well as other services not included in the standard benefits package, such as dental care.

Financing

The system will be financed according to the following principles:

ESTIMATING HEALTH CARE EXPENDITURES AFTER UNIVERSAL COVERAGE, BY STATE

The federal government will estimate the cost of providing the standard benefits package to all legal residents in each state. First, it will estimate current health expenditures in each state using data from the National Health Accounts, supplemented by survey data on employer health insurance costs and health maintenance organization (HMO) premiums. The estimate of current expenditures will be adjusted upward for expected utilization increases from insuring the uninsured (and underinsured).[8] It will be adjusted downward for expected efficiencies that will result from universal coverage.

STATE GOVERNMENTS' FINANCIAL RESPONSIBILITY

State governments will be expected to contribute 90 percent of their current Medicaid and S-CHIP spending on services that are included in the standard benefits package for covered populations (that

[6] R. H. Brook et al. "Does Free Care Improve Adults' Health?" *New England Journal of Medicine* 309: 1426–34; M. F. Shapiro. "Effects of Cost Sharing on Seeking Care for Serious and Minor Symptoms." *Annals of Internal Medicine* 104: 246–51; R. O. Valdez. *The Effects of Cost Sharing on the Health of Children,* Santa Monica, CA: RAND Corp., 1986.

[7] K. N. Lohr, "Effect of Cost Sharing on Use of Medically Effective and Less Effective Care." *Medical Care 24* (supplement): S31–S38.

[8] Under the proposal, acute care services currently paid for by Medicaid will be folded into the standard benefits package. Average unit payment rates to providers are likely to be higher under the standard benefits package in many states than the rates currently paid by Medicaid; however, we do not suggest adjusting current expenditure levels upward to account for the difference. Rather, we suggest assuming that average payment rates for non-Medicaid services will decline slightly, resulting in overall average unit payment rates (combining Medicaid and non-Medicaid) that will be similar after universal coverage as they are under the status quo. To the extent that there is strong evidence that utilization rates of current Medicaid recipients will change when they are covered by so-called mainstream plans, modelers might want to assume some utilization response; however, we are doubtful that such evidence exists.

All legal residents of a state are eligible for the state's program. To sign up, they simply have to demonstrate that they live in the state and are residing legally in the United States.

is, state Medicaid spending on dental services,long-term care, undocumented persons, and the elderly would not be included in this amount).

FEDERAL GOVERNMENT'S FINANCIAL RESPONSIBILITY

The federal government will pay to state governments that operate a qualified plan an amount equal to the estimated cost of providing the standard benefits package to all residents (estimated as discussed above) minus the state government financial responsibility amount. The state government financial responsibility is not a "maintenance of effort" requirement. If states can provide the standard benefits package to all legal residents at lower-than-expected cost, the state contribution will be smaller than expected. Alternatively, if more money is needed, it is state governments' responsibility to raise a portion of the necessary revenues.

If we could be confident that the state-specific estimates of expected expenditures after universal coverage would closely approximate the expenditures needed to maintain the status quo in the health care system,then we would be comfortable placing financial responsibility for the marginal health care dollar entirely in the hands of state governments. State governments will be making important decisions about health care financing, and they should be accountable for the outcomes of these decisions.

However, uncertainties in the accuracy of the state health accounts data and the adjustments needed to move from the status quo to universal coverage create uncertainty about the precision of the estimates of state-level post-universal coverage expenditures. As a result, it is possible that expenditures in a given state will be substantially greater than expected expenditures, not because the state has chosen to be generous in its payments to providers, but rather because the expected expenditures were an underestimate of the expenditures needed to maintain the status quo in the state's health care system.

If a state's expenditure for services included in the standard benefits package differs substantially from the expected state government financial responsibility amount, we suggest that the federal and state governments share in the surplus or deficit.A reasonable approach would be to make the state fully responsible for spending that is 20 percent more or less than the expected state government responsibility; have the state and federal governments share the next 30 percent surplus or deficit 50-50, and have the federal government be responsible for 80 percent of the surplus or deficit if state spending is more than 150 percent of the expected amount, or less than 50 percent of the expected amount. For example, if a state is expected to spend $1 billion but actually spends $1.5 billion, the federal government would increase its contribution to the state by $150 million—that is, 50 percent of the difference between actual state spending and 120 percent of expected spending.

Inevitably, there will be disagreements between the federal and state governments about which state expenditures should be included in this calculation.[9] In the long term, a system in which the federal contribution is fixed and states are financially responsible for their decisions is preferable to a system that encourages disputes about matching payments. However, in the short term some sharing of financial responsibility for deviations from projections is sensible. We suggest below that Congress appoint a commission to make recommendations on realigning federal contributions across states; the work of

[9] Witness the disagreements in the Medicaid program about disproportionate share hospital payments, and, more recently, about payments to nursing homes and hospitals under the Upper Payment Limit regulations.

this commission would facilitate the transition to full state financial responsibility.

payroll tax

The federal government will raise most of the money needed to finance its contribution to state programs through a payroll tax on employers and employees. The amount of money raised by the payroll tax will be equal to 95 percent of the total amount currently spent by employers and employees for health insurance for covered benefits (that is, it would not include amounts spent for dental care or other services not included in the standard benefits package). This amount would include expenditures for non-group coverage and out-of-pocket payments for health care, to the extent that payments for these services are expected to be included in the standard benefits package. The tax rate will be uniform throughout the country.

Following the model of the Medicare payroll tax, we suggest that the health care payroll tax be applied to all wages; however, if there is a desire to limit the progressivity of the financing system, the payroll tax could be imposed only on wages up to the Social Security wage base.

In a full proposal,a payroll tax rate will be specified. Rather than providing our own back-of-the-envelope estimate of what this tax rate will be, we leave this to the modelers. For purposes of discussion below, we assume that the total payroll tax will be 8 percent—that is, we assume that an 8 percent tax will generate an amount equal to 95 percent of what is currently spent by employers and employees (including non-group coverage and out-of-pocket payments that would be covered).

The total payroll tax will be divided between employers and employees based on the current distribution of spending between employers and employees. If, for example, the modelers estimate that 75 percent of current spending is done by employers, and if the total tax is 8 percent, then employers would pay a 6 percent tax,and employees would pay a 2 percent tax. We propose that the employee portion of the payroll tax be treated as pre-tax income, as much of employee spending for health insurance is now.

To increase the progressivity of the financing system and minimize negative effects on the level of employment, we propose a lower tax rate for employers with predominantly low-wage workers. For example, employers whose average employee makes less than $8 per hour would pay 4 percent of covered payroll rather than 6 percent of covered payroll. Self-employed persons will pay both the employer and employee portions.

federal general revenue responsibility

The difference between the amount of money the federal government is obligated to pay to the states and the amount raised by the payroll tax raised will be financed by general revenues. We expect that much of the general revenue obligation will be a transfer from federal Medicaid funds currently used to support Medicaid and S-CHIP. However, some of the general revenue obligation will require new federal funds, presumably drawn from the anticipated budget surplus.

growth rate of federal payments

The federal payment to the states will grow at a rate to be specified annually by Congress, after receiving a recommendation from the President and the Medicare Payment Advisory Commission (MedPAC) or a new advisory agency to be established. In making its recommendation, the advisory agency will consider factors similar to those that MedPAC considers in recommending payment updates for Medicare. In addition, the agency must consider the effects of any changes in the standard benefits package. To provide some protection to state governors and health care providers, the five-year growth rate of per capita federal payments to the states will not be less than the five-year growth rate of per capita Medicare expenditures, unless compelling rationales are advanced that health care needs are increasing much more quickly in the over-65 population than in the under-65 population.[10]

[10] The rationale is that if Congress has the political will to get tough with providers in the Medicare program, then it is reasonable to ask governors to be similarly hard-nosed; alternatively, if Congress decides that Medicare needs additional funds to provide high-quality care to seniors, it is not reasonable to ask governors to be significantly more frugal for their states' under-65 population.

POTENTIAL REALIGNMENT OF PAYMENTS AMONG THE STATES

The proposed financing system is intended to leave the status quo largely intact for health care providers—revenues to the health care financing system in each state after universal coverage is implemented should be similar to current revenues (adjusted for the expected effects of universal coverage, as discussed above). In addition, state government payments are intended to be similar to the current system—with a 10 percent savings in each state to encourage governors and state legislatures to support the proposal. As a result, there will be wide disparities across states in the amount of federal support; in states that have high per capita health care costs, federal support will be greater than in states with low per capita cost health care costs.

This is likely to be seen as unfair by those people living in states that historically have spent relatively little on health care. We suggest that Congress appoint a commission to make recommendations on long-term realignment of federal contribution levels.[11]

FEDERAL PENALTIES FOR PARTIAL NON-COMPLIANCE

Federal government payments to the states will be contingent on the states satisfying basic requirements. To the extent these requirements are not satisfied, graduated financial penalties will be applied. For example,if a state does not provide the standard benefits package to 98 percent of its legal residents, the federal contribution is reduced—certainly by the per capita contribution amount and, we propose, with an additional penalty. A state that fails to meet quality standards or to provide required information will also be subject to financial sanctions.

RECAPTURING RETIREE HEALTH WINDFALLS

To avoid a large windfall to shareholders of companies with retiree health obligations, a tax on corporations that show Federal Accounting Standards Board Section 125 obligations on their balance sheets will be enacted. The government would estimate the portion of a corporation's Section 125 liability that would be assumed by the states under reform. Employers would be assessed 70 percent of this amount, and would pay a special "retiree health assessment tax." The total retiree health assessment would be paid over 30 years.

Administration and Regulation

Once the new system has been implemented, it will be necessary to monitor its performance and make necessary corrections. There is a trade-off, of course, between accountability and state autonomy. On the one hand, consumer protection is especially critical in health care, where much is at stake and consumers face severe information problems. On the other hand, for a proposal like this to be successful, states need to tailor a system that best fits their particular circumstances.

The main concern is quality—whether the average quality is sufficiently high and whether disadvantaged populations face particular quality barriers. Most parties will have strong incentives to control costs, which obviously raises issues about sacrificing quality. These concerns are discussed in the following section.

As noted, the federal bureaucracy envisioned is minimal. The executive branch will be advised by the Health Care Financing Administration or a new agency, and Congress by the Medicare Payment Advisory Commission or a new agency. Once the system has been implemented, some of the ongoing duties of these two agencies will include making recommendations on:

- updating the benefits package;
- revising the formula for allotting contributions to each of the states; and
- deciding how much federal contributions will increase over time.

[11] A number of factors should be considered in thinking about equity. Federal contributions might be compared to the amount of payroll tax revenue coming from the state; one might focus only on the federal per capita contribution from general revenue as the amount to be concerned with when considering fairness. Alternatively, if we think of current federal Medicaid spending as an entitlement to the states (or, at least, as part of the status quo), then the federal contribution to focus on might be simply the new general revenue payments (that is, treating the displaced Medicaid funds, like the payroll tax, as belonging to the states). One also might want to consider the size of the per capita state contribution in considering equity, as well as the contribution of the state to medical education, and, potentially, research.

Quality Assurance

The major concern with the proposal is ensuring that high-quality services are provided. There are two somewhat independent aspects to this. First, plans—particularly in states that emphasize price competition—are likely to be under strong pressure to keep costs down, potentially threatening quality. Second, even if plans do attempt to provide good-quality care, they may lack the tools to do so.

Regulatory oversight is necessary to address the first issue, because in markets where full consumer information is problematic, there is no assurance that the services provided will be of the quality sought by consumers. Furthermore, some states may not meet their responsibilities to ensure the provision of good-quality care. This is particularly a concern for services delivered to vulnerable groups such as racial and ethnic minorities and the poor. As a result, quality assurance is the only major area of the proposal in which strong federal regulation is called for.

We propose that a quasi-independent, bipartisan federal quality commission be established to monitor the quality of health care delivered in each of the states, and to provide financial incentives to states to improve quality. (Quality will be defined as encompassing access and quality.) The commission needs to be given a sufficient budget for staffing adequately and collecting the data necessary to fulfill its mission, which will include assessment of:

- whether nearly all individuals have health insurance;
- whether the most vulnerable individuals face any unduly significant barriers to accessing necessary preventive and acute care services;
- the technical quality of care provided to patients through assessments of appropriate processes and desirable health outcomes;
- patient satisfaction; and
- state-provided data to evaluate access, costs, and quality. As noted earlier, these data would likely include information on enrollment, utilization (perhaps through encounter data), costs, quality, and satisfaction.

In addition to measuring quality, we propose that the quality commission be empowered to financially reward states that perform the best in improving quality of care. A portion of the federal payments to states would be deducted from the direct federal payments and provided to the quality commission to distribute as a "quality bonus" to states that improve their performance. The bonus pool might begin at 0.5 percent of federal support, and grow to 5 percent after 15 years. The proposed growth in the size of the pool reflects anticipated improvements in our ability to measure meaningful aspects of quality. The movement of funds to the quality improvement pool should lag the implementation of universal coverage—perhaps by three to four years, to give the quality commission time to implement measurement tools and establish baseline performance levels.

Of course, some aspects of a health system (for example, adequately trained physicians and other personnel, well-staffed and equipped hospitals) are critical to the provision of quality care. These structural aspects, however, are left to the states to regulate.

The second issue is that many states, health plans, providers, and consumers lack the necessary tools to ensure adequate quality of care. The "free-rider effect" will result in too small an investment in the necessary data and research on quality. States will want to take advantage of investments made by other states, and health plans of investments made by other health plans. To illustrate, suppose that one health plan is considering investing in a system that evaluates the quality of primary physician care, feeding back information to providers so they can improve. In most cases, however, providers are enrolled in many managed care plans. If one plan invests in improving quality, the other plans in which the provider participates will gain without making a concomitant investment. As a result, all plans will underinvest in quality improvement.

The best way to deal with this problem is to treat research on quality as a public good and have the federal government invest in it. This is done in clinical care through the National Institutes of Health and, to some extent, in health services research. But the amount of investment in the latter is much too low. In 1998, the United States spent $1.15 trillion on

health care.[12] In contrast, the budget of the Agency for Healthcare Research and Quality (AHRQ), the federal agency mainly responsible for the accumulation and dissemination of this knowledge, was only about $200 million—a mere 0.02 percent of health care dollars spent.[13] We believe that this figure should be at least 1 percent of total health spending, although this enhanced funding should be phased in.

Some of the actions to be emphasized in this research and dissemination effort should include:

• reducing medical errors;

• ensuring that providers in all medical specialties use state-of-the art technologies;

• enhanced measurement of health care processes and outcomes;

• focusing on the health status of disadvantaged population groups; and

• creating the necessary databases to accomplish these tasks.

Integration with the Current Health Care Financing System

MEDICAID

The Medicaid program for long-term care services would remain. For aged or disabled persons who meet Medicaid financial eligibility standards, reimbursement for institutional and home and community-based long-term care would continue, with the current federal formula for matching payments.

Two areas deserve special consideration—a variety of services outside the standard benefits package that are currently provided under Medicaid to children, and non-long-term care payments currently made for those who are dually eligible for Medicaid and Medicare (for example, prescription drugs, copayments, deductibles, Part B premium payments.)

For children, there are a variety of services—dental care is a prominent example—currently provided by Medicaid that are not part of the standard benefits package. There are at least two options here: first, maintain Medicaid financing for dental services under current Medicaid rules, or, second, provide funds under a block grant to the states, with the stipulation that the funds be used to support health care for low-income children. While maintaining the Medicaid entitlement and open-ended matching funds may sound attractive to advocates, we doubt that it is a good idea. First, some services—such as dental care—are currently optional for states under Medicaid. More important, in most states access to dental care is extremely problematic. Even under the current system, most states have done a very poor job in providing dental services to low-income children.

There are other federal programs—such as Title V (providing funds for services for children with special health care needs), Section 330 funds for community health centers, support for community mental health centers, and support for rural and migrant health centers—that should continue, even under universal coverage. Eventually the need for these funds might be reassessed, but this is not included in the proposal. Similarly, although on a much larger scale, the Department of Veterans Affairs health care system might eventually change in response to an environment of universal coverage for the standard benefits package, but changes to the VA are not part of the proposal.

Medicaid currently pays for prescription drugs, copayments, deductibles,and Part B premiums for a variety of low-income Medicare recipients. Under this proposal, the federal government will administer this Medigap-like coverage directly, rather than relying on the states to fill gaps in a federally run program. Ninety percent of the financial burden lifted from the states by federal assumption of current Medicaid responsibilities would be added to states' financial responsibility.

MEDICARE

The standard benefits package for persons under age 65 will be richer and deeper than the benefits currently available under Medicare. This will add to the already existing pressure to improve the Medicare benefits package, but changes to Medicare are not included as part of this proposal.

[12] www.cdc.gov/nchs/products/pubs/pubd/hus/00tables.htm# National Health Expenditures

[13] www.ahrq.gov/about/profile.htm

We have chosen to rely on states to make major decisions about health care financing and delivery because we think they are the appropriate locus of financial and political decision making.

SAFETY NET PROVIDERS

Protecting safety net providers would be largely a state responsibility. As discussed above, a variety of Health Resources and Services Administration (HRSA) programs in support of providers such as community health centers and rural and migrant health centers would be expected to continue. However, since the Medicaid acute care program would be folded into the universal coverage system, Medicaid disproportionate share hospital (DSH) payments would end. Consistent with the federal requirement to provide the standard benefits package to all state residents, state governments could choose to continue direct payments to hospitals currently receiving DSH funds; however, these payments would compete directly with money that might be used to pay for health insurance premiums (in a system with competing health plans) or to support other providers (in a single-payer system). These are problems for the states to work out, although state plans submitted for approval to the federal government must demonstrate that the needs of traditional community providers have been taken into account in designing the state financing system.

The Central Role for States

As the title of this paper suggests, this is a "state-based proposal." This section discusses some of the advantages and disadvantages of a state-based proposal, and indicates why we have chosen this direction.

We have chosen to rely on states to make major decisions about health care financing and delivery because we think they are the appropriate locus of financial and political decision making. We see three major substantive problems with a system run solely by the federal government.First,it will be difficult for the federal government to do a good job of figuring out, in total, how much money should go into health care. Providers will always argue for more and complain that quality will suffer without more resources. Some providers will go out of business. Decision makers in Washington are so far away from local conditions that it will be difficult for them to determine whether the providers are correct and how much to be concerned that some providers may go out of business. Imagine, for example, that Medicare was expanded to cover the entire population. Suppose now that some hospitals or physicians in Boston or St. Louis have negative margins and face the prospect of cutting back services or, perhaps, closing their doors entirely. Alternatively, these hospitals might argue that they are unable to adopt quality-enhancing technology because of inadequate reimbursement. The providers will certainly appeal to the federal government for help. How are decision makers in Washington going to determine whether such help is needed? It is difficult to imagine that they will do a good job. We have concerns about the ability of state governments to make good decisions here, as well, but there is greater financial and political accountability with decisions made closer to the bedside (and closer to patients and providers and taxpayers!).

Second, the federal government, under intense scrutiny and pressure, has a very difficult time experimenting with new forms of finance and delivery, while states are able to move somewhat more nimbly. For example, the federal government has tried unsuccessfully a number of times to implement a competitive bidding demonstration for Medicare. In contrast, state governments, in purchasing benefits for both state employees and Medicaid beneficiaries, have been able to adopt innovative purchasing practices with much less political resistance. Federal government control is likely to lead to a system that is less innovative and flexible over time than a system in which state gov-

ernments have major responsibility for financing and delivery decisions. Related to this point, state diversity and experimentation will allow for the dissemination of best practices.

Third, we continue, collectively, to disagree about whether "competitive" or "regulatory" approaches to health care financing will produce the desired combination of quality and economy. These fights are unlikely to be resolved any time soon, and preferences are likely to differ across states. A state-based approach allows for diversity, while a federal approach would be likely to impose a uniform solution. (One could imagine a federal approach with substantial waiver authority to allow state diversity, but this is likely to be difficult to implement if state governments do not have financial responsibility, as well.)

We have justified our choice of state rather than federal control of major health care financing decisions. In the concluding section, we present our rationale for proposing increased public-sector involvement in health care financing and eliminating the role of employers as middlemen in our financing system.

In this proposal, states will have substantially expanded roles and responsibilities, including:

• choosing the financing and service delivery systems used (for example, single-payer, competing private health plans) to provide health insurance coverage to nearly all state residents;

• providing information on enrollment options and procedures to all state residents;

• carrying out the enrollment process, which will often entail having all residents choose a health plan;

• negotiating with health plans and providers over services, payments, and quality;

• ensuring that the necessary data are collected, both for estimating the cost of the system and for evaluating its performance;

• ensuring that insurers and providers do their part to provide good-quality care; and

• sharing with the federal government in the financial risk associated with financing health care services for the population.

This reliance on states undoubtedly is controversial; it was not chosen as the basis of our proposal lightly. There are two major concerns about placing such key responsibilities with the states. First, until now they have not had the main responsibility for administering health insurance for their populations. This lack of experience will be costly if they are not able to carry out the many roles listed above. Second, it can be argued that some states have not been as "trustworthy" as others in implementing their primary health insurance program, Medicaid, and that some states have done a poor job of protecting disadvantaged groups such as racial minorities. In the case of Medicaid, some states have extremely stringent eligibility criteria and pay providers so poorly that few want to treat patients in the program.

With respect to the first problem—lack of experience—there is no doubt that most states will need both technical and financial assistance to carry our their enhanced roles. Congress needs to allot sufficient funding for these activities. Nevertheless, one should not be too pessimistic about states' abilities to carry out these roles because they are already have a great deal of experience in regulating private insurance and HMOs; enrolling state residents in programs such as Medicaid and S-CHIP; contracting with health plans and third-party administrators as part of Medicaid; and operating public health systems.

The second problem is more worrisome: some states have done a poor job of providing health insurance coverage in the past, and these problems could be magnified under the proposal, which provides strong financial incentives to states for controlling costs. Aggressive cost control, in turn, could harm quality.

Several aspects of the proposal address these potential problems. First, all non-Medicare-eligible state residents will be part of the system. State officials whose systems provide poor-quality or inefficient care will be under strong political pressure to improve them. Second, states will find it difficult to skimp on providing adequate access because this is a federal government requirement. Those states that do not enroll at least 98 percent of their population will face severe financial penalties. Third, only those state plans that are initially approved by the federal

government will become operational. Fourth, there is a strong federal quality monitoring system built into the proposal (with special emphasis on quality and outcomes for vulnerable groups), coupled with financial incentives that will reward states that offer good-quality care and penalize those that do not.

Transition

The following steps need to be followed in implementing the proposal. We also provide a suggested timetable for the transition from our current hodgepodge to the reformed system.

1. Congress passes a law enacting the reforms on July 1, 2002.

2. The federal agency responsibility for oversight of the new system, in consultation with governors and other interested parties, develops guidelines for the state plans. Guidelines are promulgated by July 1, 2003. The federal government makes planning grants to the states.

3. States enact enabling legislation, and submit state plans to the federal government no later than December 31, 2004. The federal government makes funds available to the states for transitional assistance and provides technical assistance and training.

4. On January 1, 2006, the federal government starts collecting new payroll taxes. States with approved state plans start receiving payments from the federal government and providing coverage to all under-65, non-Medicare residents of the state. Employers presumably stop providing health benefits to employees for services included in the standard benefits package.

If a state does not implement a plan, then employers and employees will be paying a substantial payroll tax, but not receiving federally subsidized health benefits. This is likely to create extremely strong pressure on state governments to design and implement acceptable plans.

Impact of Proposal on Society's Goals

Access

The proposal will help ensure that the United States attains the three major policy goals of universal access, cost control, and good quality of care. With regard to access, all Americans who live in the country legally will, as a right, be provided with health insurance that includes coverage for all major health care services except long-term care. Everyone will have at least one health insurance option that does not require payment of any premiums. Thus, financial considerations will no longer be a barrier to obtaining health insurance, nor will stigma be an issue because everyone will receive coverage through the state. States will be given strong financial incentives from the federal government to ensure that they meet coverage requirements. Combined, these should ensure that the goal of universal coverage is met.

This is not to imply that access issues will be solved. There are many barriers to access, and financial impediments are only one. In addition, to the extent that there are some copayments under the standardized benefits package, some individuals currently enrolled in Medicaid may find themselves worse off. Similarly, the benefits package excludes various services covered by state Medicaid programs, which could also impede access. States may wish, therefore, to consider providing additional coverage to poor and vulnerable individuals to compensate for this shortfall.

Costs

Costs are likely to be contained because nearly all participants in the health care marketplace will have an incentive to control them. Because states will receive an annual fixed-dollar contribution from the federal government, they are at risk for additional spending, so they have a strong incentive to spend wisely. If they rely on competing health plans to provide insurance packages, these plans will vie with each other for enrollees, recognizing the strong role that premiums play in consumer health plan choice. The plans, in turn, will continue to pay providers in ways designed to reduce excessive and unnecessary use of services.

As in the case of access, cost control is hardly guaranteed, nor should it be. In fact, as medical therapies become more efficacious and the population ages, the United States may wish to spend more on health care.

Some elements of the proposal will almost certainly increase health care costs. These include universal coverage and comprehensive benefits (the latter will increase utilization for those who are currently underinsured).

Quality

The biggest challenge will be ensuring that good-quality care is provided. We do not believe that markets, by themselves,can assure this,particularly with the difficulties consumers have in obtaining and evaluating the necessary information. Nor can states—some of which may be under tight fiscal constraints—necessarily be depended on. If the federal government is going to turn over large amounts of revenue to the states, it will need to invest substantial resources in measuring health care quality and health outcomes across states, with special emphasis on vulnerable populations. The types of investments and oversight needed to accomplish this goal were discussed above.

Political Feasibility

We are aware that our proposal represents a substantial departure from the status quo and will face significant political opposition. Two main features of the proposal are likely to create opposition: first, transforming current voluntary employer and employee payments into a mandatory payroll tax, and, second, turning over the money and the responsibility to state governments. We address each of these concerns below.

There are two reasons to propose a payroll tax. First and most important, we know of no way to get to universal coverage, or anywhere close to it, without required contributions. The main alternatives to the payroll tax for the required contributions are a value-added tax or an increase in the income tax (accompanied by an individual mandate). The payroll tax is closer to the way the United States currently finances health care and is arguably politically more palatable than either of these alternatives. Proposals for expanding subsidized coverage (for example, expanding S-CHIP to parents in families with incomes less than 250 percent of federal poverty level) are not likely to do much to reduce the number of uninsured. The S-CHIP-like expansion proposals may be the best we can hope to accomplish, but we should be clear about how far they leave us from universal coverage.

The second reason we propose public-sector decisions about health care financing is that we think employers have added relatively little value to health care purchasing. Employers are in business to make a product or provide a service,not to purchase health care. Since most actions that employers might take in an attempt to purchase better health care will only be effective if they are joined by many other employers, they face a significant collective action problem. While a few employer groups, such as the Pacific Business Group on Health, have made some progress in overcoming the collective action problem, progress has been limited, and effective purchasing coalitions are the exception,not the rule. Certainly the tribulations of Medicare and state Medicaid programs give us pause, as well, but these organizations have the potential, partially actualized, to be prudent intermediaries in health care finance.

Some who support public financing and the elimination of the employer role in purchasing care will be upset that our proposal calls for state governments to set the rules of health care financing, rather than simply expanding the federal Medicare program to cover all Americans. Certainly Medicare is an extremely popular program and has the advantage of an existing and concrete framework. Our proposal envisions new state structures and suffers from uncertainty—what exactly will health care look like in my state after Congress passes universal coverage legislation? The answer must await state action. However, the difficulty of having a uniform set of federal rules to respond flexibly to the needs of the residents and providers in each state outweighs, in our judgment, the potential advantages of simply expanding Medicare.

We are aware that our approach relies on substantially more public-sector involvement in health care financing and delivery than the country has been comfortable with in the past. There is likely to be concern about this proposal from a variety of

important constituencies—some employers with relatively young and highly paid employees might end up paying more in payroll tax than they now pay for health insurance, as would employers who currently do not offer health benefits at all. Some providers and insurers will be nervous about concentrated purchasing power in the hands of state government; some governors will be reluctant to absorb substantial new responsibilities and the political demands these responsibilities create; and some citizens will be concerned about giving state governments greater control over the financing and delivery of health care. However, the proposal will have appeal, as well: The left should find mandated universal coverage with no required premiums attractive, and the right should like the opportunity for states to tailor their own health care system, and the likelihood that many of these state systems will embrace market-based approaches over administered pricing approaches. As we approach 50 million uninsured (the 2000 Current Population Survey results showing a decline in the number of uninsured are most likely a short-term blip in a longer-term trend), rising costs (again) for employers and employees, increasing dissatisfaction among physicians and hospitals, managed care backlash from patients, and a poor outlook for profit growth for health insurers reveal at least the potential that the country might be ready to experiment with approaches that are more revolutionary than evolutionary. Our proposal provides a sensible policy prescription that could be successfully implemented if the political window opens more widely than its customary narrow slit.

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Kronick and Rice Proposal

Key Elements

Richard Kronick and **Thomas Rice** propose that the United States adopt a health care financing system that would:

GIVE ALL LEGAL U.S. RESIDENTS a "right" to comprehensive health insurance coverage. Health insurance would be a social insurance program, not a means-tested program.

MAKE STATES RESPONSIBLE for designing and administering the health care financing system, allowing them the flexibility to create systems that meet the needs of their residents. To receive federal funding, states would need to assure that nearly all legal residents would be covered and have access to at least one zero-premium plan that includes a federally defined standardized benefits package.

REPLACE THE CURRENT HEALTH CARE FINANCING SYSTEM, which largely relies on employment-based health insurance, with one relying on a payroll tax levied on employers and employees. This tax would be supplemented by federal general revenues, state revenues, and, possibly, individual contributions for plans or benefits beyond those in the standardized benefits package.

RETAIN MEDICARE AND MEDICAID-FINANCED long-term care.

MONITOR STATE IMPLEMENTATION and make a substantial investment in measuring quality and outcomes, particularly for vulnerable groups.

About the Authors

RICHARD KRONICK, PH.D., is Associate Professor in the Department of Family and Preventive Medicine at the University of California at San Diego. His work focuses on understanding how and whether markets can be made to work well in health care,particularly for vulnerable populations. He recently co-authored, with Joy de Beyer, *Medicare HMOs: Making Them Work for the Chronically Ill* (Health Administration Press, 1998). He has developed and helped state Medicaid programs implement risk-adjusted payment systems. In 1993–94 he was a Senior Health Policy Advisor in the Clinton Administration, where he contributed to the design of the Administration's health care reform proposal. In the late 1980s he co-authored, with Alain Enthoven,a proposal to achieve universal coverage in the U.S.,and contributed to the theory of 'managed competition'. Prior to that he served as the Director of Policy and Reimbursement in the Massachusetts Medicaid program. Dr. Kronick received his Ph.D. in Political Science from the University of Rochester.

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