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Plan Competition For Health System Efficiency

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I. Introduction

In recent decades, leading "mainstream" proposals for health care reform have featured elements of health plan competition. President Clinton's health-care reform proposal was built upon a foundation of plan competition, and a majority of members of the bipartisan Medicare Reform Commission endorsed a plan competition approach, labeled at the time "premium support," for the largest governmental health insurance program in the United States. Presidential candidates of both parties in the lead-up to the 2000 and 2004 elections incorporated plan competition into their health care reform proposals. Plan competition is not merely a feature of failed health reform proposals, but exists today in several important forms. In the world of private health insurance, federal employees have access to a competitive health insurance market in the form of the Federal Employees Health Benefits Program. Medicare beneficiaries can participate in the Medicare Advantage program, an alternative to the traditional Medicare fee for service program that offers choice among competing health plans. Various forms of nationwide plan competition models are in use by the Netherlands, Germany, and Israel. Thus neither the concept nor the implementation of plan competition is new. And for millions of federal employees, employees of large firms, and state employees, choice among competing health plans is familiar and, according to some evidence, is something they value highly.

Plan competition is often contrasted with another frequently discussed approach to reform of health care financing, single-payer. Single-payer ordinarily is used to mean that a single government agency is responsible for paying health care bills. The Canadian health-care system and, in the United States, Medicare, are frequently offered as models for single-payer. Most single-payer advocates favor only the traditional fee for service component of Medicare, and many are actively opposed to Medicare Advantage. They claim that such an approach to financing is better able to control expenditures, is more amenable to universal coverage, and avoids administrative inefficiencies and waste. According to them, such systems ensure equal access to medical care and offer the strongest assurance that patients will have an unrestricted choice of health care providers. A full discussion of the merits of such claims is outside the scope of this paper, but it is important to note that one of the principal reasons for adopting a plan choice scheme is a belief that competition among plans offers superior incentives for improving the quality and efficiency of care, and can facilitate exploration of alternative modes of delivery and financing. Since 1978, Alain Enthoven has been a leading proponent of this view that if individuals bear the costs of choosing more expensive plans, health plans will compete for enrollees by lowering their costs and tailoring their services to better address consumer needs (Enthoven 1978; Enthoven 1978; Enthoven 2004.; Enthoven and Tollen 2006). The very uniformity that single-payer advocates admire is a substantial drawback from this perspective.

A. Plan choice and delivery system

Plan competition proposals recognize that the incentives embedded in the reimbursement system help shape the care delivery system. Traditional Medicare reimburses most

services on a fee-for-service basis. Like the relatively unrestricted fee-for-service commercial health insurance that was common more than 20 years ago, it has few restrictions on service volume or requirements like pre-certification, which private managed care plans routinely use to limit utilization of some procedures. Reimbursement on a per-service basis, particularly when there are relatively few checks on volume, can support a wide variety of organizational forms that would struggle under other reimbursement forms. Even Medicare is no longer a pure fee-for-service system; initiatives in recent years have added performance incentive payments and payments for disease management programs, and for nearly 25 years Medicare has reimbursed hospitals on a per-admission basis, with an adjustment for the particular diagnosis and treatment that was the principal reason for hospitalization (the DRG, or Diagnosis-Related Group). But for most other services and products, like specific tests and office visits, reimbursement is for narrowly defined forms of care. Payment at such a disaggregated level creates incentives very different from those that result from payment for service bundles, like management of an entire episode of illness or of a hospitalization. Disaggregated payments place less pressure on physicians, for example, to deliver care as part of an integrated group. The individual physician typically bears little or no financial risk for the care of his or her patients, since any service provided will predictably result in an incremental reimbursement. For an office visit, a physician seeing a patient enrolled in traditional Medicare may bill for the visit itself, along with associated laboratory tests, and in some circumstances for other services and procedures. Not only does this financing arrangement tend to promote the utilization of billable items

and services, but it is particularly congenial to physicians practicing independently or as part of small groups.

The incentives embedded in other forms of payment encourage alternative forms of organization of care. Kaiser Permanente is the classic example of a health maintenance organization in which the providers receive payment on a capitated basis. Capitation creates incentives for using fewer services, and it does not favor the provision of tests and procedures that offer high margins in a fee-for-service environment. In addition, because the capitation payment is independent of the number or type of services provided, in such a payment system it is possible to use services that would not be eligible for reimbursement under a typical fee-for-service arrangement, but which improve patient well-being. Thus, in the absence of a specific payment for a disease management program, it is very difficult for patients enrolled in traditional Medicare to receive services that are unreimbursed, such as patient education services, dietary counseling, and other forms of non-physician care. In a capitated arrangement, the provider needs only to find the most efficient way to deliver the desired forms of care.

Under capitation, providers also bear risks that health plans bear under fee-for-service arrangements. A capitated provider might receive no more reimbursement for a patient with a prolonged ICU stay and multiple surgical procedures than for a healthy patient that rarely visits the doctor. Under a fee for service arrangement, the physician would typically receive more reimbursement for the sicker patient. This allocation of risk means that full capitation is only an option for relatively large groups of providers, who can pool their risks. Thus full capitation is largely a phenomenon of large multi-specialty groups, who are often tightly linked financially. Fee-for-service reimbursement, on the

other hand, can work well for individual physicians in small groups. Thus, although small practices can exist in capitated environments, especially if they bear risk for only a subset of medical expenses, such as outpatient services, the health insurance reimbursement arrangement can shape the organization of care.

B. Why patients care about choice

Too much choice, according to some authors, can be costly to consumers and patients. There was a common perception that the number of Medicare Part D options was so overwhelming that many of the elderly found it hard to make a choice (Schwartz 2004). But limited choice may be a greater danger, because it there is ample evidence that not everyone wants to choose the same health plan. Particularly when health plans differ in fundamental ways, such as the difference between a PPO-type health plan and a more heavily managed, capitated plan, satisfaction depends on choice. Individuals who choose to be in an HMO when given the choice of other plans are much more satisfied than individuals who enroll in an HMO simply because it is the only option their employer offers.[3]

C. Learning by competition

There are many uncertainties about the best ways to organize health services and to ensure that high quality care receives appropriate rewards. Although studies have compared the quality of care in managed care plans and in more loosely organized health plans, such as PPOs and service benefit (often termed indemnity) plans, there is not yet a

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[3] Ullman, R., J. W. Hill, et al. (1997). "Satisfaction and choice: a view from the plans." Health Aff (Millwood) **16**(3): 209-17.

consensus that a particular form of organization of care is superior. Organization of care and its financing are often considered to be two distinct issues, but the incentives embedded in payment mechanisms can strongly influence both the type and quality of health services delivered. A commitment to a particular mode of financing, such as traditional Medicare for all, will therefore strongly influence the organization of care before there is enough evidence to commit to conclude that a particular form of organization is best. Furthermore, longstanding debates about the incentive effects of managed care and fee-for-service reimbursement have never gone away. Many physicians, along with members of the public, claim that capitated payment and similar features of managed care plans lead to systematic under provision of care, while others note that fee for service reimbursement tends to promote over utilization, along with a distortion in the service mix that tilts toward overuse of procedures with under use of cognitive services, such as office visits. These incentives influence care that is provided in large multi-specially groups, as well as care provided as part of hospital based practices and solo independent practices.

Agnosticism toward specific forms of organization of care or toward methods of payment is a strong reason to favor competition among health plans. These benefits extend beyond the value of choice to consumers; experience with plan competition, if it is directly linked to systematic efforts to track health outcomes and evaluate plan and provider performance, can enable us to learn what the consequences of health plan choices are. We can learn a great deal simply by observing which health plans succeed and which fail when large numbers of consumers are given diverse choices. The potential to learn is a unique benefit of plan choice approaches, and they do not presume

that we already know all that we need to know to promote quality and efficiency of resources. Plan choice offers both opportunities to innovate, then, and opportunities to learn which innovations work.

D. Costs of plan competition

Critics of plan competition note that it has several disadvantages, relative to a single payer system. First is the possibility of greater administrative costs. There is no generally accepted definition of administrative costs, which are frequently measured as residuals after accounting for expenditures for various categories of services and capital costs, so the very measurement is problematic. Furthermore, what is labeled as administrative cost in one accounting system is often embedded in other cost measures in different cost systems, making comparisons of administrative costs across systems problematic. But flawed as existing comparative measures of administrative costs may be, they consistently show that the federal Medicare program costs less to administer than commercial health plans[4]. Similarly, Canada is often cited as an example of a single payer system with lower administrative costs than commercial plans in the United States[5].

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[4] One common assertion in the debate over U.S. health care policy is that Medicare administrative costs are about 2 percent of claims costs, while private insurance companies' administrative costs are in the 20 to 25 percent range. Merrill Mathews of CAHI and Mark Litow of Millman Inc. find Medicare's actual administrative costs are 5.2 percent, when the hidden costs are included.Merrill, M. (2005). "Medicare's Hidden Administrative Costs." Council for Affordable Health Insurance.

[5] Private insurers take, on average, 13% of premium dollars for overhead and profit. Overhead/profits are even higher, about 30%, in big managed care plans like U.S. Healthcare. In contrast, overhead consumes less than 2% of funds in the fee-for-service Medicare program, and less than 1% in Canada's program. (Himmelstein and Woolhandler, PNHP 2006)

As a source of information to consumers, marketing encourages price and quality competition. But to the extent that marketing resources are funneled toward selecting high-paying but low cost enrollees, they are inefficiencies unique to private health plan competition. Note that it can similarly be argued that governmentally produced goods and services in general might not bear the costs associated with marketing and selling private goods and services that are characteristic of most of the economy. These costs are real, but are generally accepted because of the belief that choice has value and that open competition promotes efficiency.

There are also many people who claim that choice is confusing and, for a service as important and confusing as health insurance, too much choice is undesirable. Yet evaluations of the Medicare Part D drug benefit, a complex benefit with many drug plans to choose among, indicate that the choice process in its first year worked well, and that the majority of Medicare beneficiaries were able to make rational choices (Winter, Balza et al. 2006).

Another, more serious, objection to plan competition is that it is subject to adverse selection. Profitability for a health plan depends on the difference between the premiums collected and expenditures, which are directly related to the health of enrolled members. One of the most straightforward ways to ensure profitability is to enroll individuals and families who use little care. Without adequate compensation for enrollment of high-cost individuals, a health plan has strong incentives to design its benefits and market to select healthy members, not the chronically ill and others with the greatest need for health insurance. This topic is discussed in much greater detail below, but it is important to note

that with universal enrollment in a single health plan, there is no possibility of adverse selection, since there is no selection at all – everyone is in the same plan.

Finally, claims are often made that single payer systems are better able to control expenditure growth than plan choice schemes. A single payer, for example, is a monopsonist in the market for health services, and can therefore exert greater pricing pressure on hospitals and physicians than can even the largest private plans. What such arguments often fail to acknowledge is that since the single payer is a government agency, its use of seemingly unlimited monopsony power is constrained by political considerations. Medicare, for example, has been unable to implement scheduled cuts in payments to providers because Congress – responding in large measure to powerful groups of providers – has blocked them. A government agency is unlikely to exercise monopsony power the same way that a large private entity – such as Wal-Mart – does. These limits make it hard for a government agency to precipitously limit expenditures the way that it does so well in theory. Nonetheless, over three decades, private insurance has seen a higher cumulative growth in per enrollee payments than Medicare.[6,7]

For the remainder of this paper, we proceed from a premise that plan choice is desirable, but we will return to the advantages and disadvantages of the specific approach to plan choice that we develop. In particular, we will discuss how that approach addresses the

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[6] The difference is a couple of percentage points in average annual growth rate in payments since 1970. Annual growth rate in payments by Medicare enrollees average 9.6 percent in contrast to 11.1 percent by private insurers prior to 2000. One caveat to this comparison is that benefits offered by private insurers have expanded while Medicare's have stayed relatively constant over the time period (Antos King 2003) Boccuti, C. and M. Moon (2003). "Comparing Medicare and private insurers: growth rates in spending over three decades." Health Aff (Millwood) **22**(2): 230-7.

[7] Employer-sponsored benefit packages have changed in response to less stringent cost-sharing requirements.

inevitable problem of adverse selection, inherent in a competitive health insurance marketplace.

Our general arguments pertain both to Medicare and to the commercially insured population, so much of our discussion does not make a distinction between the two programs. But there are important differences in the populations covered, in the laws and regulations governing private and public health plans, and in the modes of financing. Where relevant, we discuss how plan competition would work differently in Medicare and in other health insurance settings.

II. Strategies for Containing Adverse Selection

In most contexts, consumer welfare is best served by a large number of firms competing to deliver the highest-quality product at the lowest-possible cost. In principle, the same reasoning applies to health insurance. In practice, however, informational problems frequently hamper competition between health insurance providers. The typical outcome is some variety of "adverse selection." As discussed above, this is likely to be the most critical hurdle for plan competition, because unfettered markets alone may not be sufficient to guarantee consumer welfare. We begin by outlining the nature of these problems, as well as laying out the most well-known solutions.

Regulations that restrict the use of information, often coupled with the absence of some information altogether, preclude the ideal outcome. First, most societies believe that the price of health insurance should be lower than its competitive level for the sickest, and thus most expensive patients. This social preference is fostered in large part by extreme inequality in health spending, and thus in the cost of providing insurance. For example, allowing insurers to charge different actuarially fair premiums — on the basis

of demographic variables alone — would lead to premiums that differ by a factor of ten or more. Further allowing premiums to differ by past medical costs would cause the variation to reach a factor of 100 or more (van de Ven and Ellis 2000). This form of price-discrimination may lead to an efficient outcome—that is, no waste[8]--but societies frequently object to the inequalities of access generated by this structure. As a result, health insurers are often explicitly or implicitly barred from charging different premiums on the basis of all known information.

A side effect of this desire for equity is competition among health insurers for the healthiest patients. This competition is wasteful from a social welfare perspective. For example, if health insurers are not allowed to discriminate on the basis of past medical costs, it pays to enroll individuals with histories of low expenditures, and to screen out sicker patients. Competition between firms for the healthiest patients does not increase total social welfare, but simply leads to the reassignment of insured individuals across firms. This type of competition actually harms efficiency.

A related problem arises due to the imperfect availability of information about health risk. When insurers cannot perfectly observe the health of their patients, they must structure their policy offerings to avoid attracting the sickest, most expensive patients. Viewed from the consumer side, patients also have incentives to seek out the insurance policies that offer them the highest value, and thus exploit insurers who inadvertently structure contracts that appeal to the heaviest consumers of health care. Again, the result can be an unstable market where insurers seek to attract the healthiest patients, but pass

[8] Here we mean waste in the economic sense that there is no way to make someone better off without making someone else worse off. In the current system, there is almost surely a way to redistribute resources so that everyone would be better off.

off the sickest to their competitors. This leads to a variety of undesirable outcomes -- continuous exit of the relatively generous insurers, the inability of low-risk consumers to buy preferred insurance coverage, and high prices for high risks (Rothschild and Stiglitz 1976; Wilson 1977; van de Ven and Schut 1995; Newhouse 1996; Schut and Van de Ven 2005; Van de Ven and Schut 2007).

In light of these problems, regulators must seek a balance between the cost-containing benefits of competition, and the harmful effects of competing for the healthiest patients, or "adverse selection." Many types of regulation are intended to accomplish this balancing, but most fall in two categories: regulations that decrease the incentives of firms to attract healthy patients, and regulations that directly prohibit or hamper the mechanisms through which adverse selection operates. It goes without saying that all these regulations temper the efficient incentive to lower loads, even as they temper the inefficient incentive to attract healthier patients. This typifies the central trade-off in the design of health plan choice.

III. Incentive-Based Regulations to Mitigate Adverse Selection

Insurers' incentives to select patients by risk type depend upon *predictable* losses and gains. Patients' incentives and ability to locate financially beneficial plans depend upon losses and gains that are *unpredictable* to the insurer, but predictable to the patient. Regulators have often attempted to limit both kinds of incentives by imposing risk-sharing among health plans.

To address the predictable losses that motivate insurers to seek out healthy patients, regulators often subsidize plans that take on sick patients, and "tax" those taking on healthy ones. They are limited in their efforts to the characteristics that they can

observe easily, like age, gender, and disability status; they cannot readily ascertain other characteristics that might affect health care consumption, like general ill health or "frailty", risk-taking behaviors, or preferences for costly services. The regulators promote this "observable risk-sharing" in an effort to reduce the incentives of insurers to seek out the healthiest patients. While such regulations limit adverse selection, they generate the typical trade-off with insurers' motives for cost-containment (Feldstein 1973).

To address the unpredictable losses that motivate patients to exploit favorable plans, regulators sometimes compensate plans that suffered higher losses than observables would predict, and correspondingly "tax" the plans that suffered lower than expected losses. We call this "unobservable risk-sharing." This reduces the cost of being saddled with patients whose claims are excessively high even with risk adjustment, and helps to prevent adverse selection from destabilizing an insurance market.

1. Observable Risk-Sharing: Risk Adjustment

Several governments offer risk adjusted subsidies to the insurer. In other words, the government will pay higher premiums (or premium subsidies) to insurers who enroll sicker and hence riskier patients. The subsidy will match the predictable risk only to the extent that available risk-adjustment models work. The ideal risk-adjustment formula is not an exact science. Determining which costs should be shared by everyone is largely subjective. For example, few would argue that a particular taste for care should be covered in a publicly subsidized risk adjustment scheme. Similarly, questions arise as a result of patient health behaviors (should the cost of lung cancer be shared by society if the patient actively chooses to smoke?), and provider behavior (should regional variation

be subsidized if it results from different practice styles?). Moreover, agreement upon the health *problems* that are to be covered is only the first set of subjective decisions; the adjuster must then determine the appropriate treatment and expense (Newhouse, Buntin et al. 1997). These guidelines must be updated regularly to reflect current ethics, understanding, and technology. As one might expect, the long lists of acceptable costs in Germany and the Netherlands – two countries that practice risk-adjustment -- seldom look similar.

Previous research suggests that the most sophisticated risk-adjustment technology will only explain a third of the variation in predicted expenditures, roughly 5 percentage points more than where we stand currently (Newhouse, Buntin et al. 1997). An advanced model today incorporates demographic variables, prior year expenditures, hospital diagnoses, drug prescriptions, and sometimes self-reported health. Moreover, many of the mechanisms for adjusting risk are tied to actual spending patterns, which cannot isolate taste for care or bad luck streaks. Accounting for overuse or unpredictable losses will only reduce incentives to be more efficient. In risk adjustment, the goal is to account for all of the individual characteristics that give rise to variation in spending for which we do not want to hold the individual responsible. In other words, we want to subsidize insurance purchase if a person is born with a nasty genetic defect. We do not want to subsidize those who have a penchant to see very high-priced specialists frequently because they are hypochondriacal. An ideal risk adjustment measure could explain little variance as long as the unexplained variance is due to genuinely random stuff, such as the unpredictable accidents.

Despite a long list of characteristics that can be used to predict and adjust risk, the most common risk-adjusters in the market only utilize age and gender, known to explain 6.5 percent of predicted variation in costs while systematically underestimating the costs of high-risk individuals and overestimating the costs of low-risk individuals. Large purchasing pools, such as the FEHBP and CalPERS, use these rudimentary risk adjusters. Their failure to adopt more sophisticated risk-adjustment technology may be surprising. However, lack of data is an important obstacle. Germany, Israel, and Russia lack data that link individual consumer characteristics with individual healthcare expenditures. Health plans typically have more information than their sponsors. Privacy issues are central, as are the administrative costs of advanced risk-adjustment models. Perhaps a better question is: what is the cost of forgoing an extra 10 percentage points of explained variation? Given known and unavoidable biases of the most sophisticated of risk-adjusters, one cannot discount the possibility that other regulations, in combination with crude risk-adjusters, are equally effective at minimizing selection incentives while sustaining healthy competition. These issues are discussed in more detail below, when we lay out the experiences of countries with managed competition.

2. Unobservable Risk-Sharing: Plan Reimbursement

In a world with imperfect risk-adjusters, and a persistent threat of risk-selection, simply reimbursing "unlucky" plans may be a substitute or helpful complement for risk-adjustment. Even if sick patients look similar to healthy patients according to observable characteristics, it is still possible to reimburse more heavily those insurers who suffer larger losses. This transfers resources to the insurers who experience more illness in their insured population. This risk-sharing mechanism reduces incentives for efficiency, but

promotes the stability of the market by reducing the losses from high risk patients, and hence the incentive to screen them out.

Three approaches to unobservable risk-sharing are most common: *proportional risk-sharing* (retrospective reimbursement of a fixed percentage of all costs) *outlier risk-sharing* (retrospective reimbursement of a percentage of expenses per enrollee above a specified annual threshold), and *risk-sharing for high risks* (each health plan is allowed to designate *ex-ante* a specified percentage of its members for whom they are reimbursed retrospectively). With all forms of risk-sharing, premiums can be reduced proportionally to keep the total outlay to insurers the same. A useful index of an insurer's incentives for efficiency is "financial risk," or the percentage of total costs for which the health plan is completely at risk.

Later, we compare the Dutch, German, and Israeli systems. The Dutch system employs outlier and proportional risk-sharing; German health plans only transfer ex-post losses or gains according to the proportion of outliers enrolled in each plan; Israel does not use unobservable risk-sharing at all. Van Barneveld et al (1998) shows that, in hindsight, reimbursing the costs of fewer than 4% of the members, chosen ex ante by the insurer based on the previous year's medical expenditures, would have reduced predicted losses by 51 percent[9] more than proportional or outlier risk-sharing, which reduced losses by 20 and 41 percent respectively. Keeler et al (1998) showed in a simulation that condition-specific risk sharing – a hybridized approach that compensates plans ex post, based on the observed characteristics of their patients -- reduced over- and under-

[9] This is relative to predicted losses without any risk sharing.

payment to insurers by two-thirds, which was also an improvement over the use of proportional and outlier-sharing.[10]

Empirical experience suggests that agreements made up front about ex-post risk-sharing reduce variation in predicted losses by more than reimbursement amounts determined retroactively. Weighing the moral hazard implications of each method may also lead one to prefer ex-ante contracts that cover expenses of particular treatments or individuals. However, it is crucial to ensure that high-risk members selected for risk-sharing face the appropriate premium, and to prevent "diagnosis inflation" of conditions to be reimbursed.

B. Direct Regulation of Adverse Selection

As discussed earlier, community-rating or prohibitions on pricing by certain risk factors can lead to adverse selection. A more extreme restriction on premium contracts, found in Israel, Colombia, and Russia, is the requirement that a health plan accept the individual's risk-adjusted premium subsidy, determined by the sponsor, as the full premium. As mentioned before, this encourages plans to seek out low-risks through unwelcome modifications of the benefit package—for example, artificially increasing wait times for patients with heart failure.

1. Regulating Market Functioning and Plan Offers

Mandating a minimum basic health plan, and forbidding selective contracting (e.g., "any-willing-provider") are direct attempts to limit the ways in which insurers can

[10] Newhouse argues, on theoretical grounds, that the ideal risk-sharing arrangement would be one which pays a prospectively set marginal cost and a capitation rate such that the plan breaks even on that case. Though moral hazard concerns remain, this addresses both selection and quality-skimping (assuming that patients can observe quality to some extent). A practical drawback to this approach is the difficulty of observing marginal cost.

appeal selectively to low-risk consumers. Of course this comes at the expense of possible efficiency-enhancing innovations, such as contracting with cost-effective providers. Mandating that everyone purchase some basic insurance package prevents low-risk consumers from dropping out of the market, or from choosing very cheap but skimpy benefit packages. This comes at the cost of consumer choice, and possibly moral hazard that the insurer is unable to reduce through innovation.

Another type of regulation limits the enrollment period and the opportunity to switch plans (e.g., "one-year-lock-in"). Such regulations reduce the ability of consumers to seek out and exploit favorable plans. Guaranteed renewable insurance (in recent California legislation) serves the same function on the insurer side, by preventing insurers from dropping patients selectively. Similarly, when health insurance is partially or wholly tied to an employment contract, the employee's ability to switch plans is also thwarted. This is one argument in favor of employer-based systems of competition. The obvious cost of such an approach, however, is a limit to choice and to the price-reducing competition it inspires.

C. Broader Implications of Market Restrictions

Though these regulations are discussed in terms of their impact on risk-selection and competition incentives, the primary motivations behind adopting such regulations and the extent of their influence need not be limited to selection and efficiency concerns. Politically important yardsticks of plan performance -- such as a nation-wide spending limit, equitable access, and minimized administrative costs -- also depend on regulations like fixed premiums, minimum service packages and employer contributions. At this

nexus, the central aims of a single-payer and tightly regulated competition can be attained.

Healthcare reforms in Israel offer an important example. Even after the effective integration of managed competition in 1995, the government maintained its tight control over insurance premiums. The purpose of this rigidity was to enforce a cap on expenditures but, as discussed earlier, the regulation also had the beneficial effect of keeping low-risk individuals in the insurance market. Evidence on successful pooling of low risks with high risks suggests that both primary and secondary effects of this regulation contributed to Israel's control over spending at the national level.

Israel's Ministry of Health also resolved to set a minimum standard of care and coverage in reaction to civilian activist groups (Chinitz 2000). The combination resulted in a level of government oversight in the insurance market that induced lobbying activity, multiplied administrative tasks, and hindered efficiency in so far as it restricted individual choice. But importantly, a minimum package barred health plans from deterring sick patients through severe restrictions on coverage and ultimately helped achieve the desired equity in coverage.

We also learn something about marketing activity that arises in spite of uniformity in the healthcare package, a lesson equally applicable to a single-payer system. In both the Netherlands and Israel, allowing providers to differentiate themselves through narrowly defined supplemental packages led insurers to redirect their advertising resources to less significant distinctions in their products. In Israel, budgets for marketing rose from 51.4 million (1994) to 62.6 million (1995) and 91.2 million (1996)

despite legal restrictions on advertisements. In the Netherlands, too, advertising of supplemental packages became the preeminent information source on which consumers based their choice of health plan.

IV. Lessons from Experience

There are several sources of empirical evidence that shed light on the successes and failures of the various regulations discussed above. We begin by discussing evidence for the United States, and then offer several examples from the recent experiences of several countries that have enacted managed competition regimes.

A. The U.S. Experience

Average premiums are sometimes a misleading indicator of consumer welfare. Adverse selection can induce the continuous exit of generous plans resulting in welfare losses, despite the lower premiums of surviving plans. Several case examples, as well as a holistic view of managed competition in the U.S., are informative.

1. Industrial Purchasing: The Norm

In a survey of all Fortune 500 companies health care purchasing practices, James Maxwell and Peter Temin (2004) show that, in general, companies are not bidding to increase the number of plans they offer, but rather to drive prices down: 93% percent decreased the number of carriers they offered in their region over five years (1998-2003); no employer increased choice.[11] Furthermore, managed companies providing a

[11] The employers of most insured Americans do not offer a choice of health insurance carriers. Less than 4% of the Fortune 500 companies use tactics to promote managed competition among health plans. Presence of choice, defined contribution, and information dissemination define a "managed competition company."

fixed contribution to health insurance—managed competition companies in their terminology—were even more likely to drop carriers than industrial purchasers, who bear a fixed fraction of given premiums or equivalent coverage. Single carrier strategies appeared to hold down costs more than the alternatives (Maxwell, Briscoe et al. 1997). One possible explanation is that employers contracting with only one health plan are better able to monitor the plan, and hence choose the "most efficient."[12] No differences in employee satisfaction were found. The argument that commonly follows (and is made by Maxwell and Temin) is that "managed competition does not offer clear financial advantages over industrial purchasing."

But these conclusions are based on a limited view of employer-based managed competition. Heterogeneity in the choice of plans offered to employees and the sundry cost-sharing arrangement between the employee and her employer hampers the effectiveness of isolated networks of managed competition. For example, plans' investments in efficiency may pay off in a competitive environment where demand is allowed to respond to quality and price, but may fail to be rewarded in a context where the employee does not enjoy the full amount of the savings. In this latter case, efficient reductions in cost can lead to private losses for insurers who are unable to realize corresponding increases in volume. Needless to say, this is a strong disincentive to invest in efficiency-enhancement. As providers in the U.S. often contract with multiple employers, mostly industrial purchasers, the real financial advantage to managed competition cannot be realized.

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[12]A more plausible explanation is that health plans discount their rates much more deeply for a single carrier employer than when they have to compete. Purchasing coalitions can offset this discount to some degree. That is why this observation has little relevance to the competition scheme we propose.

2. Health Plan Cooperatives

The US has seen several examples of health plan cooperatives, which are organizations designed to bring in competing health plans and foster managed competition. In the case of a cooperative, attracting competitive plans is only the first step to attracting a competitive membership (with reasonable risk profiles); in the absence of high-visibility health plans, cooperatives attract only those who cannot get health insurance elsewhere—on average, a riskier group; the beginning of a selection death spiral. Unsurprisingly, only certain health plans are willing to negotiate with so-called managed-competition companies or cooperatives, and ensuing behavioral changes resulting from competition are tempered by external market forces that originate beyond the cooperative itself.

Health Insurance Purchasing Cooperatives (HIPC). Their objective was to achieve economies of scale that would increase purchasing power and lower administrative costs. Failure ensued. Florida, Texas, North Carolina, and Colorado Alliances all closed when enrollment fell sufficiently. Only the California HIPC adjusted for the risk of its members; nevertheless, transfers were not large enough to keep PPOs in the system. In 2005, the largest insurer's market share increased from 33 to 43 percent of the market for small groups insurance. Small businesses face fewer options and higher prices than ever before.

There are several explanations for the failure of HIPCs. First, due to the high-risk profile of micro-groups – which, like people in the individual insurance market, buy when someone needs care and drop out after care is delivered--- plans would either raise premiums for HIPCs, making the HIPC noncompetitive for average or low-risk

businesses, or, where law required community-rating inside and outside the HIPC, the health plan would withdraw. A second, oft-cited reason for health plan departure was the fear of competing against oneself in the outside market. Ultimately a plan preferred to contract directly with employers. Finally, administrative costs of agents, which proved essential to attracting small employers, did not diminish as HIPCs grew in size (except for the case of COSE where one plan dominated). These costs prevented HIPCs from offering price discounts to attract enrollees (Wicks and Hall 2000; Wicks 2002). Of course, it is likely that none of the HIPCs approached efficient scale. It is a chicken-and-egg problem; costs were too high, so they couldn't attract enough enrollees; without enough enrollees, could not lower costs.

Of the employers that follow a reasonably good approximation of the managed competition model -- Stanford University, the University of California system, Harvard University, American Management Systems, Wells Fargo Bank, and Hewlett-Packard -- none avoided the exit of the most generous plans (Enthoven and Talbott 2004). There were some moderate transfers from health plan profits to consumers (Cutler and Reber 1998). Gray and Seldon (2002) were able to exploit variation in the real value of the subsidy cap in different cities to show that the FEHBP capped premium subsidy was at least *reducing* the adverse selection observed. To the further credit of FEHBP's well-defined contribution plan and effective coinsurance payments (based on plan-specific negotiated prices), in 2004, 183 private health insurance plans continued to vie for patronage, including local HMOs and national PPOs. Nearly 75 percent of FEHBP beneficiaries were enrolled in national PPOs in 2004, whereas other managed competition employers could hardly retain a single PPO as a viable option for employees. CalPERS, like FEHBP, had success with relatively low premiums between 1993 and 2001, after

which counties with younger populations began to drop out (Darmiento 2003). Double digit inflation in premiums followed, outpacing other private employers. Medicare, prior to establishing CMS-HCC 64 group risk-adjustment scheme in 2004, documented significant differences in expenditures of new enrollees in HMOs and people who disenrolled from Fee-For-Service (35% above average versus 60% below average costs in 1998). Conspicuously, more than half of 346 health plans that contracted with Medicare+Choice in 1998 exited the market by 2002. Plans that remained reduced their benefits substantially. Those offering any form of drug coverage dropped from 73 to 66 percent, half of these covered generic drugs only. This early spiral is commonly attributed to the reality that crude risk adjustment and favorable selection into HMOs led Medicare to overpay managed care plans, whose windfall profits were later used to lure low-risk beneficiaries and drive away competition. The insurance-claim based risk-adjustment scheme used today continues to underestimate the costs of high-risk individuals (MEDPAC 2007, Pope 2004), but Medicare is experimenting with the state of the art; utilizing a "risk sharing for high risks" policy in Medicare Part D and phasing in differential payment schemes among providers based on measures of quality and resource use.[13,14]

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[13] On an optimistic note, Thomas Rice and coauthors Rice, T., R. E. Synder, et al. (2002). "Who switches from Medigap to Medicare HMOs?" Health Serv Res **37**(2): 273-290. demonstrates that switching rates from Medigap to Medicare do not signal adverse selection.

[14] Medicare Advantage and Part D: (MedPAC report, March 2007). There were 30% more stand alone prescription drug plans (PDPs) and 25% more Medicare Advantage Prescription Drug Plans in 2007, compared to 2006. The range of Part D premiums for basic benefits narrowed over two years. The average premium offered by basic plans is lower, but the average for enhanced plans is higher. The overall average premium has risen, to 25$ in 2007, from 23$ in 2006 (weighted for enrollment). There is a larger proportion of PDPs with the defined standard benefit structure and supplement, a smaller proportion of benefits with the same average value as the standard benefit but with alternative benefit designs.

Enthoven argues that the specifics of these private employer plans were ill-configured and precluded their success. For example, neither CalPERS nor FEHBP use regional and diagnosis-based risk adjustments, or a true fixed-dollar contribution policy. As a voluntary program, CalPERS would ideally have a risk-adjusted employer contribution to the pool as well as risk-adjusted payments to health plans to prevent adverse selection. CalPERS also lacks a mechanism to reconfigure benefits in response to a rapidly changing market.

B. International Experiences

The U.S. examples raise the question of whether *widespread* managed competition would function better than isolated pockets of it. To analyze markets fully saturated with managed competition, or something approximating it, we turn our attention to international examples of nationwide managed competition.

Three country case studies -- Israel, Germany, and the Netherlands -- offer insight into the consequences of regulating competition using different tools to share risk and directly restrict free market competition. The Netherlands provides an extreme case of redistribution among insurers and successful eradication of risk-based selection, at the expense of competition for greater efficiency. Germany and Israel permit varying degrees of risk-based selection and indeed encourage insurers to compete: in Israel, insurers compete by providing different kinds of supplemental insurance packages; in Germany, insurers are allowed to compete more broadly, and reap more of the gains from selecting the healthiest individuals. A striking commonality is the success of more stringent restrictions on the free market, and its ability to contain adverse selection without substantially reducing the benefits of competition.

1. The Netherlands

Starting in 1992, the Netherlands gradually incorporated aspects of Enthoven's model of managed competition into their public health insurance system. By 2002, the Dutch had adopted a sophisticated health-based risk-adjustment technique, relying at first on pharmacy-based cost groups (PCGs) computed from outpatient prescription drugs, and by 2004, diagnostic cost groups (DCGs) computed from hospital diagnoses as well. Today there are 30 groups altogether, including age and a self-employment indicator, which can predict 22.8% of the variation in health expenditures.[15] Additionally, the Netherlands employs proportional risk-sharing[16] and outlier-risk sharing[17], though both forms of risk-sharing have been steadily reduced as risk-adjustment techniques improve. According to several studies, the cost of pursuing a risk-selection strategy in the Netherlands, given threats of poor public relations, outweighs any residual financial incentive to select low-cost members (Greb 2006).

The result of this scheme has been similar pricing among health plans described by one author as "indistinguishable pricing." Despite the existence of 24 different health insurance organizations, the difference between the cheapest and most expensive plan falls within the narrow range of 100-150 Euros each year.**[18] What differences there are can be attributed primarily to competition over supplemental package premiums;

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[15] By comparison, CMS-HCC, used by Medicare, uses 64 health-based groups and explains about 25% of the variation. Prospective models at best can explain 30%.
[16] Sickness funds are reimbursed retroactively a fixed percentage of all costs.
[17] Sickness funds are reimbursed retroactively a certain percentage of the expenses for each member that is above an annual threshold (or certain deviation away from mean).
[18] Important to note here is the extent to which consumers can realize the full benefits of switching to a less costly fund. In the Netherlands, a portion of the basic benefit-package premium is uniform (income-dependent and paid by employers and employees). A second part is a flate-rate premium (community rated) determined by individual funds and financed by the insured person only. Typically 2.2% of costs of basic benefits vary. Supplementary insurance premiums and supplementary services are also determined by individual funds. 95% of the compulsory insured have bought supplemental insurance.

consumers are much more sensitive to premiums for supplemental benefits (Kerssens 2003). This conclusion is supported by interviews with consumers who acknowledge that their primary reason for switching funds is the supplementary insurance (1/4 switch for reasons related to their flat-fund, their basic healthcare package); the interviewees confess to being aware only of "small differences" between insurance funds, supplemental or basic; the perceived magnitude of differences does not vary between those who switch, or stay in any given year. Only 2% of insured Dutch switch at all, in any given year.[19] A favorable interpretation of this equilibrium is one in which the "law of one price" prevails, and competition has erased the financial weaker and less efficient plans. A less generous interpretation, however, would focus on the lack of plan choice, perhaps engendered by the degree of risk-adjustment and risk-sharing.

2. Germany

By contrast, 40% of insured Germans[20] switched between 400 active sickness funds in 2004, demonstrating a strong willingness to change plans in response to premium changes. We examine key regulations: competition was introduced into the statutory health insurance market of Germany in 1996 (enactment of The Health Care Structure Act of 1993). This allowed all insured Germans to choose among public sickness funds (regional or substitute) and company-based funds (BKKs) freely.[21] Risk-adjusted capitation rates (transfers from government to insurer) were calculated using

[19] Healthier and younger people are the most likely to switch, but this could be entirely explained by differential costs of switching, plus habit formation.
[20] 90% of the German population is insured with statutory sickness funds.
[21] Previously, each person above an income threshold was assigned to a sickness fund or could opt into a company-based fund if employed by the company that the fund was designed for (company funds had better risk structures).

age, gender, sick pay claims, and incapacity to work[22] that together predict 8% of the variation in individual health care costs. Insurers are reimbursed for outliers[23] (preserving competition to select for low-risk members around the mean). An important distinction between the Netherlands and Germany is the degree to which consumers realize the benefits of switching to a lower cost plan: in Germany employers and employees share equally the (community-rated, income-dependent) premium contribution determined by the sickness fund. Though the consumer is half as sensitive to price changes, the employer has an incentive to influence employee decisions.

Perhaps as a result of less accurate risk-adjustments and reduced risk-sharing, the primary instrument of competition between sick funds in Germany is the selection of healthy members.[24] Health plan premiums today reflect the risk structure of its members; no evidence suggests that lower premiums additionally reflect improved efficiency. The number of funds fell from 1209 in 1991 to 396 in 2001 due to mergers and market exits; those remaining are not more efficient or effective (Nuschsler 2005).

3. Switzerland

Switzerland, applying a more "German" strategy to mitigate adverse-selection, also suffers from competition among insurers for the young and healthy, although adverse-selection has not spiraled the way it has in Germany. Potential explanations for this difference include: the differential cost of switching, which seems lowest for the

[22] And income, to "offset different income structures." (I don't quite understand, see Buchner, Wasem 2003).
[23] No mention of whether funds are penalized for particularly low-risk members.
[24] Put differently, risk-selecting is more profitable than managing care.

healthy and poor in Germany, but not so in Switzerland; and differences in the way information about price and quality circulate (Greb 2006).

4. Israel

Age is the only proxy used by the Israeli Ministry of Health to risk-adjust for the health costs of individuals. Moreover, no risk-sharing scheme is in place to attenuate selection. Nevertheless, Israel enjoys a regulated competition scheme that has steadily increased the efficiency of the health system. How? In one critical respect, Israel deviates from Enthoven's vision: the government does not allow variation in premium and scope of services for the basic insurance package, only in supplemental insurance.[25] This is to encourage the four private non-profit sick funds[26] to compete by reducing expenditures and increasing membership through improved quality of services (increasing the profit margin per person and number of persons)(Gross 2001).[27]

As a result, the income of sick funds has remained stable, and expenditure per capita declined by 3% (1995), a trend that essentially continued for three years. All plans improved access and availability (*visible* services*)*, increased internal supervision of physician referrals and external supervision of provider services, negotiated for better purchasing terms, and closed less profitable facilities. Within a year researchers

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[25] A rigid fixed budget is set for the basic package, which is governed by the Ministry of Finance and Health; and the Health Price Index. There is a uniform health care premium tax equal to 4.8% of income; reductions are granted to poor and elderly.

[26] These four funds insure 96% of the Israeli population.

[27] There is one potentially inefficient feature of the Israeli system. The four sick funds can all offer supplemental insurance to their members, but not to non-members. However, independent commercial firms can also offer supplemental coverage to any sick fund member Shmueli, A. (1998). "Supplemental health insurance ownership in Israel: An empirical analysis and some implications." Social Science & Medicine **46**(7): 821-829.. This can create externalities, if some consumers choose supplemental coverage from a different firm, which now has incentives to shift costs onto the basic insurer. In practice, 40% of the insured population chooses its own sick fund's supplemental plan.

documented an impressive rise in patient satisfaction, particularly among targeted populations, such as the young, the healthy, Arabs (who use fewer services), large families (to retain more members), and rural dwellers (a previously untapped population).[28] Selection evidently remained an issue in this environment.

Though the Ministry of Health spending deficit fell from 1.5 billion to zero (2000) as a consequence of managed competition, insurers diverted substantial private resources toward competing over the premium fees and benefits of the supplemental package. Budgets for marketing rose from 51.4 million (1994) to 62.6 million (1995) and 91.2 million (1996). Moreover, insurers continued to target less-costly individuals. The average switch rate remained constant at 4% before and after the reform, but the changing demographics of those who switched signaled increased adverse selection: 1% of those aged 54 to 74 switch, while 8% of those aged 15 to 25 switch. Finally, the number of antitrust cases rose; small funds set similar restrictions, negotiated as a larger group with providers, and jointly opened clinics (Chinitz 2000; Gross R 2001; Gross 2003)

C. Implications of International Experience

Despite persisting concerns, Israel uniquely reaps benefits from regulated competition and dampens adverse-selection through one of the most radical market restrictions: a fixed premium and basic health plan determined by the sponsor.[29] The Dutch, who ardently pursue price-based strategies, stifle competition to mitigate adverse

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[28] 71% of Arabs, but 33% of Jews perceived improvements since the law. 44.4% of the periphery population, but 35% of city center residents report improvement.

[29] David Chinitz emphasizes government oversight, in tandem with these stringent regulations, as responsible for stifling efforts to select healthy citizens or deter unhealthy ones.

selection. Finally, the Germans, who seem to capture best the free market ethos of managed competition in the U.S., fail to adequately control risk-selection despite the use of sophisticated risk-adjustment methods and ex-post sharing of outliers. Unimpeded employer pressure to save costs may have fueled a race to the bottom.

Of course, one cannot reject alternative explanations for the different outcomes in each of these nation-states. Other factors that distinguish the rules of competition, such as different bargaining instruments available to insurers (Germany and Israel, for example, are polar opposites), information dissemination processes, duration of open-enrollment periods, or health worker unions. All these institutional features could contribute to the relative successes and failures of these systems. However, these seem to be secondary factors, compared to the primary factors discussed above.

V. A Proposal for Plan Choice in the United States

Building on these principles and observations, we propose a system of competition among health plans in the United States that closely follows the model proposed by Singer, Garber, and Enthoven (2001). The proposed reforms are designed to encourage competition on price (when measured on a quality-adjusted basis), quality of care, and features that respond to the needs of insured individuals and families. In addition, they are designed to mitigate wasteful competition for healthy patients.

To some advocates of health reform, competition among private health plans would merely perpetuate a broken system that should be dismantled. The problems that fuel their skepticism are real. As job turnover has increased and public subsidies to the largest employers (such as AT&T, which at one point employed 1% of the civilian workforce) have disappeared, the rationale for continuing to provide coverage in this

manner has steadily eroded. And as the critics of private insurance note, employment-based insurance is a historical accident—a consequence of wage controls instituted during the Second World War. Yet employers serve two very useful functions in the current system. First, benefit managers serve as information brokers, screening health plans for quality and price in a way that would be too costly for each employee to do on his or her own. Second, they bring people together for a reason other than health, and thus mitigate the selection effects that would occur among groups formed solely to purchase health insurance.

Our plan competition proposal is designed to build on these successful models, and it has four salient features:

- The creation of large, diversified health insurance purchasing pools, called *Qualified Insurance Exchanges* (QIX);
- Community-rated premiums with (flexible) risk adjustment across health plans and QIX;
- Tax-free *health investment accounts* to pay health insurance premiums and other health care expenses; and
- An independent federal authority to oversee plan competition, data collection, and dissemination of information on premiums and plan performance.

Our plan choice approach is designed to complement other features of health reform. Therefore, in this document we do not describe the other features, such as financing, that are crucial to such efforts. It is important to note that although there are many benefits to creating the structures we propose here, coordinated health reform

efforts would provide much of the incentive to create and maintain QIX and the other features we describe. This infrastructure is particularly well suited for systems of tax credits for health insurance, vouchers, and so-called premium support (a type of defined contribution approach that was favored by a majority of The Bipartisan Medicare Reform Commission during the Clinton administration). Insurance Exchanges

Under our proposal, the locus of health plan choice takes place in diversified risk pools (called Health Insurance Exchanges by Singer, Garber, and Enthoven). Qualified Insurance Exchanges are public or private entities, including large employers, that serve as clearinghouses for the purchase of health insurance. They build upon features of the most successful employer programs for providing health insurance, including those offered by the Federal Employees Health Benefit Program, the California Public Employees Retirement System, and many large employers. By doing so, our reforms will not be disruptive for a large majority of the employed population who are satisfied with their current choices. In addition, exchanges will serve as natural laboratories to try various risk adjustment approaches.

Some aspects of QIX would vary by region, but to become qualified all would need to meet ten requirements:

1. **Declared as open or closed**. At the time of their initial designation, exchanges declare whether they were open to the general public or restricted in eligibility. Closed exchanges could limit membership to employees of a company or group of companies, union, or group of unions. Open exchanges would be available for anyone to join during an annual open enrollment period. Every region must have at least one open exchange.

An exchange wishing to convert from open to closed (or, less commonly, from closed to open,) would need to apply for approval to convert status.

2. **Choice of plans**. Exchanges must offer at least two health insurance products from at least three independent insurance companies. Qualified plans need to meet certain specifications determined by a federal oversight body described below.

3. **Open enrollment.** Initially, insurance purchases would occur during an annual open enrollment period such as is now used by private employers, the federal government, and many state agencies. Eventually, however, insurance plans would be offered for terms longer than one year as well. This approach, analogous to life insurance policies that range from annual renewable term policies to extended term and whole life policies, would offer individuals a broader array of choices, reduce administrative costs, and diminish the impact of adverse selection. Such plans could include features such as no-penalty early termination of the policy for job changes and relocations.

4. **Guaranteed issue and renewability.** Each health insurance product must be made available to all exchange members without exception.

5. **Community-rated premiums.** Exchanges must charge premiums for each health insurance product that differed only by age, gender, region**,** and number of dependents.

6. **Comparative data**. Exchanges must make available—through easily accessible media and presentation formats—data on plan quality, benefits, premiums, quality improvement initiatives, and other salient coverage information.

7. **Data collection**. Exchanges must collect, at a minimum, standardized data on its membership for risk adjustment and other purposes; including, but not limited to, demographic data, disability status[30], and presence of chronic conditions.

8. **Reporting standards**. Exchanges must set minimum standards for the reporting of plan and provider data on quality, patient satisfaction, and other relevant health outcomes.

9. **Risk adjustment within the exchange**. Exchanges must risk-adjust premium contributions to health insurance plans to mitigate efforts by plans to select only good health risks. Exchanges would be encouraged to experiment with various risk adjustment or risk-sharing models and to collect and share data on their performance.

10. **Risk adjustment across exchanges.** Exchanges would be required to participate in cross-exchange risk adjustment managed by the federal oversight body and based on a minimal set of risk adjustment criteria.

These features will ensure a robust marketplace within which exchange members can make informed choices across multiple health insurance options. They resemble employer plans, but in this case beneficiaries would pay premiums using money that will come, as we shall explain, from their health investment accounts or from their own pockets. We expect that the most popular QIX will offer a variety of plan choices, ranging from preferred provider organizations to closed-panel health maintenance

[30]Measurement of functional status may be performed via survey of a random sample of plan membership, stratified by plan enrollment and other factors such as age, gender, and presence of disease. Plans would be required to achieve a reasonable response rate determined by an independent authority.

organizations, and able to satisfy a range of consumer preferences. Insurance purchasers will be able to compare plans across the salient dimensions of benefit generosity, quality (and perhaps satisfaction), physician choice, and price. They will pay the same community-rated premiums regardless of health risk, with the sole exception that there may be age rating with defined age bands. This will facilitate comparison shopping and encourage robust price competition. Successful, open QIX may even choose to advertise themselves as a thriving marketplace for health insurance choice, thereby drawing in more members and improving consumers' options. Some closed exchanges with the most successful company benefit managers may see an opportunity to market their services beyond their employees and would open their exchanges to the public. In this way, valuable benefit management services—previously restricted to a specific company—would be made available on a much larger scale.

A. Oversight by an Independent Authority

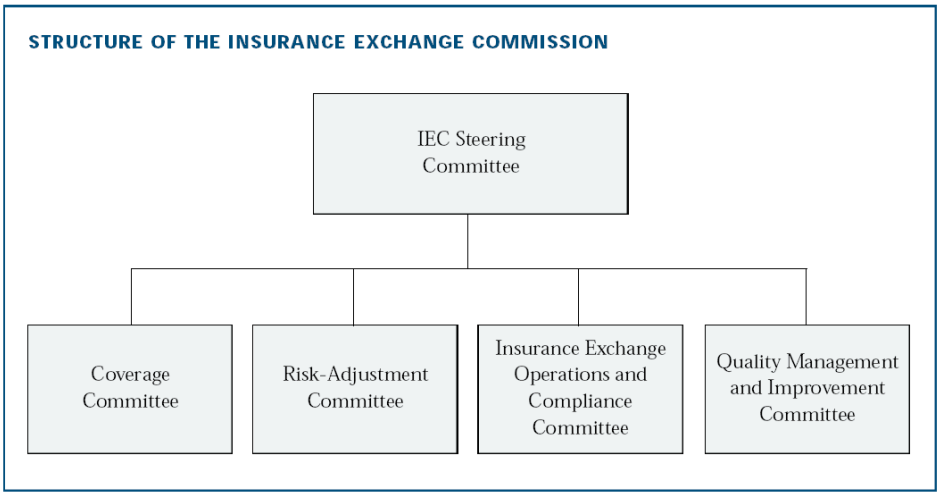
An independent authority would certify and oversee QIX at the national level, with its primary mission to ensure that marketplace is open to all and that healthy but vigorous competition exists across plans and exchanges. Specific responsibilities include:

1. Assuring that at least one QIX is available to every American;
2. Monitoring exchanges for evidence of deleterious adverse selection and non-compliance with statutory requirements;
3. Developing and managing the risk adjustment system across exchanges;
4. Defining the basic benefits package, including coverage for primary and preventive services, generic drugs; and

5. Defining the default, safety-net option for those who do not purchase other insurance.

The authority's broad mission is to help the market provide access to high-quality health care. However, its powers for achieving this goal would be relatively narrow and tailored to ensuring that insurance exchanges and the competition they foster function effectively and with minimal intervention. Singer, Garber, and Enthoven (2001) describe a prototype Federal agency structured like the Securities and Exchange Commission, called the Insurance Exchange Commission. An appointed board of directors, whose members would be selected for their professional qualifications, would serve for fixed, staggered five-year terms. Board members would be appointed by the President, with the advice and consent of the Senate.

The structure of the Commission is shown in Figure 1 (reproduced from Singer, Garber, and Enthoven). Four separate committees address key areas of responsibility for the IEC: (1) Coverage, (2) Risk-Adjustment, (3) Insurance Exchange Operations and Compliance, and (4) Quality Measurement, Reporting, and Improvement. An advisory board or steering committee would direct these activities, with membership drawn from the payer and provider communities, industry (including pharmaceutical and device manufacturers), consumers, and health care experts. Some of the independent authority's responsibilities could be contracted out to other agencies, such as the Agency for Healthcare Quality and Research (AHRQ), or private-sector organizations, such as the National Committee for Quality Assurance (NCQA). Committee members would meet usual conflict-of-interest standards for senior government officials.



The Coverage Committee would issue recommendations and set minimum standards for benefits covered by health plans offered through QIX. The minimum standards would be designed to ensure that participating plans cover medical goods and services that are known to be effective and that are provided at reasonable cost, but they also will be sufficiently general and flexible to allow plans to create a wide range of coverage options.

The Risk-Adjustment Committee would be responsible for developing and implementing new approaches to risk adjustment. They would be expected to draw on a wide range of expertise and consult broadly in developing and testing new methods. Although risk adjustment will be limited to simple age adjustment initially, the Risk-Adjustment Committee will review existing and developing risk-adjustment methods on an ongoing basis, test such methods, and implement the best methods, based on their feasibility and their ability to overcome adverse selection within and among insurance exchanges.

The Insurance Exchange Operations and Compliance Committee would encourage development of insurance exchanges, and would develop and administer

incentives to create and continue the exchanges. It also would establish and enforce minimum standards for the formation and operation of insurance exchanges to ensure they serve the interests of members. The new federal minimum standards would replace state laws for plans offered by insurance exchanges. This committee would certify private insurance exchanges and would be responsible for ensuring the development of at least one insurance exchange to cover every geographic region in the country. In addition, it would be able to establish exchanges in regions where no other public or private entities blossomed.

The committee also would be responsible for monitoring market concentration and detecting abuses of either monopoly or monopsony power that an insurance exchange might develop. The committee also would have the ability to obtain price information from the exchanges to detect evidence of abuse of monopsony power, such as contract prices with plans that fall well below the prices paid to plans in other markets. The committee would monitor exchanges for abuses by sponsors who also offer insurance through their exchange. It would provide information on such questionable competitive conditions to the Department of Justice and the Federal Trade Commission. To date, group-purchasing arrangements and similar entities have not accounted for a large share of insured lives in any geographic area, so concern about market power is based on the potential growth of the exchanges, rather than on current problems.

We would not prohibit insurers from sponsoring an insurance exchange, nor would we prohibit exchanges from becoming insurers themselves. However, the independent authority would monitor exchange sponsorship and report concern about abuses to the Department of Justice and the Federal Trade Commission, and could

establish firewalls against anti-competitive practices if necessary. The obvious conflicts that could occur with among dual insurer-exchanges make it unlikely, in our view, that many would be formed.

The Quality Measurement, Reporting, and Improvement Committee would establish minimum quality measurement and reporting standards for health plans participating in insurance exchanges and for those acting as default plans. Health plans would report quality data directly to the independent authority. QIX would be required to gather and report specified measures of quality, for example, disenrollment, complaint, and satisfaction rates. The independent authority would ensure that such data could not be used to compromise individual patient confidentiality and would provide these data for use by government agencies, consumer groups, consultants, benefit managers, and others in evaluating the quality of insurance products and exchanges.

The committees' operating budget would be determined and appropriated by Congress. Staffing for the independent authority would include its director and seven members of the steering committee, full-time chairs for the four standing committees, and full-time staff supporting the steering committee and each of the standing committees. The budget also would include funds for operations, an annual budget for development activities, and incentive funds for exchanges.

B. Adjusting and Sharing Risk

A successful risk adjustment strategy will strike a balance between protecting health plans and insurance exchanges from adverse risk selection and the need to avoid discouraging innovation, variation, and flexibility. Because we have attempted to minimize complexity by fixing premiums that individuals pay when they purchase

insurance through an exchange, other methods must be used to avoid adverse selection. Thus, each QIX is allowed to develop its own method for risk adjustment to apply to participating health plans.

Our proposal addresses plan competition and can be a component of various approaches to health insurance expansions, including proposals for universal coverage. It is particularly suitable for linkage to Medicare, sharing some features (but important differences) with Medicare Advantage. It is likely that this model would be combined with reforms that offer individual subsidies (or mandates) to encourage insurance purchase. Such reforms could mitigate adverse selection by attracting large numbers of average and low-risk enrollees. However, additional efforts are likely to be necessary. Consequently, the independent authority will develop minimum standards for risk adjustment of plan premiums within insurance exchanges, and it will conduct risk adjustment among insurance exchanges in a particular region or state.

Among Plans Within an Exchange. A key challenge is to ensure that plans do not face financial penalties for attracting enrollees who are likely to have above-average health expenditures, or conversely, are not rewarded for attracting low-cost enrollees. An ideal risk-adjustment procedure would remove the disincentives to attract high-cost enrollees without rewarding health plans whose costs are high because they are inefficient or unable to manage utilization appropriately. Obviously, such an ideal system does not exist, thus considerable flexibility in dealing with risk selection problems within exchanges is desirable.

Because of variation in plan features, such as the groups of participating providers, services reimbursed, and breadth of choice of prescription drugs, different

plans within an exchange are likely to attract enrollees who would be expected to generate different levels of expenditures. QIX would be required to meet minimum standards for risk adjustment of payments to their participating plans, based on differences in the expected use of populations of enrollees that they attract. The independent authority would specify minimum standards. Individual exchanges and states would be free to use additional methods, such as partial reinsurance. Initially, the risk adjustment is likely to be based on age and disability status. As risk-adjustment technology improves, and as experience with other methods accumulates, the authority may implement alternative standards. It is important to note that the within-exchange risk adjustment will redistribute payments within the exchange from lower-risk to higher-risk plans; it does not include any subsidies from one QIX to another.

Cross-QIX Risk Adjustment in a Region or State. The independent authority would oversee risk adjustment across exchanges in each region or state. It would develop methods for measuring selection effects, based on data provided by health plans and QIX. If necessary, the independent authority would conduct demographic and geographic risk adjustment and, possibly, more sophisticated risk adjustment, to redistribute premiums among insurance exchanges. In effect, exchanges with higher-risk demographics would be subsidized by lower-risk plans in the same region. The independent authority also would have some authority to work with states to adapt high-risk pools and other state initiatives to the insurance exchange program. Adverse selection could affect exchanges, despite these measures if, for example, non-exchange employers encouraged sicker employees to seek coverage through exchanges as individuals. QIX also could attract high-risk enrollees, who are more likely to be sick, simply because they are open to

individuals. Consequently, the independent authority would monitor adverse selection between insurance QIX and the non-exchange market and, if necessary, would recommend the inclusion of the non-exchange market in the risk-adjustment calculations. An alternative solution could be to provide stop-loss protection for employers functioning as exchanges that had very high-cost employees. Note that for these purposes, all employers that qualify as insurance exchanges would be included in the risk adjustment calculations and premium redistribution.

In the Singer, Garber, and Enthoven plan, employers would have incentives to become designated exchanges since otherwise they and their low-income employees would not qualify for tax subsidies. The same would be true for any voucher or premium support plan – failure to become a QIX would mean forgoing tax subsidies. At least initially, however, we would not propose that employer-based health insurance could only continue to be provided on a tax-free basis if the employer qualified as a QIX. However, consideration should be given to a requirement that employers who wish to continue to receive a tax exclusion for health insurance should participate in the cross-QIX risk adjustments and subsidies and must offer health plans that meet the or exceed QIX standards for a basic plan.

QIX will be required to provide (standardized) membership data to the independent authority. These data include demographic detail, disability status, and presence of chronic conditions and detailed description of its risk adjustment methods. These data would be supplemented by information on premiums, plan quality, network size and availability, and provider quality. In that way, the oversight authority would be able to identify and perhaps improve upon the most successful risk adjustment methods.

C. Health Investment Accounts

Most plan competition proposals emphasize only care provided via health insurance, largely ignoring out-of-pocket expenditures. Most versions of consumer-directed health plans, health savings accounts, and medical savings accounts envision that such accounts would be used only to pay deductibles and co-payments for a catastrophic health insurance plan. Typical tax-advantaged flexible savings accounts provide mechanisms to use pre-tax dollars to pay for such health expenses, but because the funds must be contributed in advance and expire at the end of a calendar (or up to the following April), they can induce unnecessary expenditures. Furthermore, even today health insurance purchases for some individuals are not eligible for the tax exclusion. This patchwork approach creates numerous distortions in the prices patients pay for health services, and contribute to inefficient use of resources. We propose an alternative that provides health savings that can be used for a wide array of services and products, including health insurance. Such accounts would offer a convenient mechanism for limiting the tax exclusion for health insurance, and also equalizes the tax effects of purchasing a health service through insurance and outside of insurance.

We propose that every adult American would have the opportunity to create a *health investment account*. Money from this account could be used to pay health insurance premiums for an individual or family or to pay for out-of-pocket expenses for health care expenses qualifying under the Internal Revenue Service definition. Any unused funds would accrue tax-free and could be withdrawn upon reaching Medicare eligibility as retirement income subject to the usual income taxes.

Contributions to health investment accounts could come from several sources. Employers could make tax-free contributions up to a pre-specified cap. The unlimited exemption of employer contributions to health care from payroll and income taxes is often cited as one of the most distortionary features of the tax code, and according to many economists is the fundamental cause of excess health spending. Limiting these contributions would raise billions of dollars that could be used to pay for subsidies, while also removing incentives to over-insure. Additional contributions could be made by the employer or employee. However, these contributions would come from taxable income once the contribution limit was reached; the tax treatment is the same as for IRAs, 401k plans, and other retirement accounts. Federal and state authorities could also make contributions to these accounts to subsidize the purchase of health insurance by lower income residents, with the subsidies electronically withdrawn if the beneficiary does not enroll in a plan during an open enrollment period. Employers could also choose to have the funds returned by the account administrators if the employee did not enroll in a plan.

By contributing to health investment accounts of their employees, employers would not only have a convenient vehicle for providing health benefits, but they could also contribute to health insurance purchased through a spouse's employer. It also allows employees to economize on health insurance choices and still get a tax break—similar to health savings accounts. In addition, by allowing funds to accrue and be withdrawn upon retirement it creates additional incentives to avoid over-spending on health insurance.

D. Default Plan

Particularly if plan choice is tied to universal coverage, it is essential to determine how people who fail to enroll in a health plan will obtain care. This issue is most important

for low-income individuals, who may lack the resources to pay for care they need if they are not enrolled in a health plan. Another risk of plan competition approaches is that they could threaten safety net institutions, such as county hospitals, as their low-income clients with commercial health insurance shift to other providers. Furthermore, the safety net features of these providers might be needed if unanticipated problems arise during (or after) the transition period of a health care reform effort. For example, in the beginning of 2006 when Medicare Part D was implemented, some Medicare beneficiaries who also received Medicaid experienced an interruption in their drug coverage. Although this problem was resolved quickly, it demonstrates that a more ambitious health reform effort could face more disruptive problems.

For any subsidy mechanism like a voucher-based reform plan or a tax-subsidy, one way to address default choices is to direct the state to designate default plans for individuals who qualify for subsidies but do not make an active choice. For the most part, we would expect the default plans to be organized around public hospitals and clinic. If the default plans experienced adverse risk selection, they would be eligible for the same subsidies as any other plan within a QIX.

E. Medicare-Specific Provisions

Medicare Part A already offers universal coverage for Americans 65 years of age and older, and for individuals who qualify on the basis of disability or end-stage renal disease. A plan competition approach that applies to the Medicare population would need to ensure that Medicare beneficiaries would continue to receive universal coverage and would receive satisfactory benefits, without interruption. Appropriate integration of Medicare into a plan competition approach would, however, enable people to retain the

same health care providers and health plans that they had before becoming eligible for Medicare.

Medicare Advantage plans already represent a form of plan competition within Medicare. Medicare Advantage plans are offered in a manner similar to a national exchange with regional options. The current program has Medicare make a payment to health plans, and beneficiaries can then choose among plans that may or may not charge a co-premium beyond the Medicare payment. These payments are risk adjusted by Medicare. These plans have been criticized for a number of reasons, most prominently that payments to some Medicare Advantage plans are well in excess of expected payments for comparable individuals in traditional Medicare. Criticisms also include claims that many plans are distinguished solely by benefits that are designed to attract low-risk enrollees, and that they fail to promote genuine innovations in health care.

In our model, Medicare would make payments into the health investment accounts for all beneficiaries. This money could then be used to purchase a fee-for-service option (traditional Medicare), a fee-for-service option with more generous coverage (traditional Medicare plus a Medigap supplementary plan) and a higher premium, or a Medicare Advantage product. The exchange could require a similar set of benefit restrictions just as Medicare does, and could publish benefit characteristics as it does now. The real difference though is that it might offer an insurance product with less generous coverage than traditional Medicare, such as a managed care plan with a restrictive network or a catastrophic plan that met the default options. This option would essentially allow patients to 'cash-out' some of their Medicare benefits, while at the same time reducing overall health care spending by Medicare beneficiaries.

F. Conclusions

A plan competition approach requires new infrastructure, but designed in a way that will promote choice, efficiency, and high quality care. Furthermore, it can be adapted to many different approaches to financing health coverage and reforming the health system. It will allow individuals to maintain continuous coverage with a health plan without a tie to employment. The flexibility of the approach offers the best opportunity to promote innovation in plan design and health care delivery.

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