Near-Universal Coverage Through Health Plan Competition

An Insurance Exchange Approach

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Overview

We propose to expand access to private health insurance among the non-elderly population ineligible for Medicare. Our plan will accomplish this goal by making private plans more affordable for low- and middle-income households and by promoting competition to increase the value of insurance offerings. The proposed approach will promote the collection and dissemination of information on the quality of health plans and their providers. The plan promotes higher-value health insurance coverage by exposing consumers to price differences and better information about plan quality. Although the plan can accommodate Medicare beneficiaries with little structural modification, we do not propose to replace Medicare during the plan's initial implementation. Beneficiaries currently enrolled in Medicaid, State Children's Health Insurance Programs (S-CHIPs), or other government programs could remain in these programs, but could choose instead to enroll in private plans. The plan also provides new funding and incentives for states to improve access to basic health services for the uninsured,and to improve insurance coverage rates. The plan does not impose new mandates on employers to pay for coverage.

The proposed plan has these key elements:

• *Insurance exchanges* are public or private entities, including certified employers, that serve as the vehicle through which most individuals acquire health insurance. They offer individual choice of a minimum of two different health plans on a guaranteed-issue and community-rated basis, with incentives to choose high-value plans. At least one insurance exchange generally is available in each geographic region. Exchanges help make coverage affordable by being large enough to achieve economies of scale in brokering plans and in providing information to enable people to make choices among plans. The principal incentives to support establishment of insurance exchanges are (1) new tax credits for low- and middle-income households that could be used only for coverage purchased through a qualified insurance exchange, (2) preemption from state insurance mandates (that is, Employee Retirement Income Security Act of 1974 [ERISA] protection), and (3) protection from the effects of adverse selection for exchanges and participating health plans.

• *U.S. Insurance Exchange (USIX), a national program parallel to the Federal Employees Health Benefits Program (FEHBP),* will serve as an insurance exchange for individuals and firms with fewer than 50 employees, in areas in which no private health insurance exchange has emerged.

• *Subsidies in the form of refundable tax credits for health insurance* will be available for low- and middle-income Americans who purchase qualifying health insurance plans. In contrast to families in higher tax brackets, such households today have limited financial incentives to purchase private health insurance plans.

• *New financing for "default plans" and basic health care services* will be provided for low-income individuals who are eligible for the refundable tax credit, but who do not choose to enroll in a health plan. Each state will receive new grants to provide a default plan in each geographic area within its jurisdiction; people who do not choose their own health

plan will be enrolled automatically in the default plan. Many states will provide new financing for public hospitals, clinics, and other providers that meet open-access standards, as part of their default plan.Each state would receive a payment equal to 50 percent of the new tax credits for individuals who are eligible for such credits but who remain uninsured.States will receive incentive bonuses or reductions based on the extent to which they improve performance of a set of preventive care measures (for example, childhood vaccinations, first-trimester pregnancy visits, hypertension control) and reduce the percentage of the population that remains uninsured. The goal is to ensure that every eligible individual is enrolled in a health plan.

• *There would be a phased-in cap on the currently unlimited health insurance exclusion* from taxable income for health insurance benefits paid by employers or individuals. Individuals eligible for both the exclusion and the subsidy could choose which of the two tax benefits to use.The dollar value of the cap would be set high enough to represent a substantial subsidy, yet low enough to provide substantial new financing for expanding health insurance coverage and other uses.

• A new, independent *Insurance Exchange Commission* (IEC) with narrow, specific powers would be created to accredit insurance exchanges, conduct risk adjustment across insurance exchanges, and serve as a clearinghouse for public information on the quality of health plans. This agency would have an appointment procedure and organizational structure similar to that of the Securities and Exchange Commission (SEC), and would have a similar function—to encourage smooth information flow and functioning of insurance exchange markets.

No single component of this proposal is likely to achieve near-universal health insurance by itself. Effective cost containment is essential to the expansion of health insurance in the long term, which otherwise would require prohibitively costly subsidies. Moreover, tax credits will be ineffective if beneficiaries cannot use the credits to obtain coverage. Thus they need access to competitive,high-value health insurance plans with guaranteed issue (that is, the requirement to offer health insurance, regardless of the applicant's medical history). For these reasons, we propose to implement a coordinated policy of targeted subsidies, consumer choice, and incentives to offer and choose high-value health care coverage.

A summary of the proposed subsidies and associated requirements follows (see next page).

Coverage/Eligibility: Establishing Insurance Exchanges to Expand Plan Choice

Central to the proposal is individual choice of subsidized plans through insurance exchanges. Ideally, almost everyone would be covered through insurance exchanges large enough to achieve economies of scale in brokering plans and capable of providing information about plans to individuals and businesses. Like the FEHBP, the California Public Employees Retirement System (CalPERS), and a number of recently formed private purchasing groups that serve employers, the insurance exchanges would offer a choice among multiple plans, with incentives for individuals to choose high-value ones.

Advantages of such insurance exchanges include:

• The exchanges would provide reasonably priced coverage for the self-employed, non-poor unemployed, people between jobs, and employees who currently lack access to affordable,high-quality health insurance.

• Insurance exchanges would facilitate continuity of plan coverage. Exchanges are likely to offer many of the health plans operating in an area, so that most people could keep their health plan membership when they change jobs.

• The exchanges would serve as an entry point for low-income, uninsured individuals, who would become eligible for substantial new subsidies to purchase coverage.

• The exchanges would mitigate many of the market imperfections that plague the small-group market (for example,through risk pooling, community rating, guaranteed issue, and competition), making it easier for small employers to offer a choice of plans.

SUMMARY OF PROPOSED SUBSIDIES AND REQUIREMENTS

Eligibility Category	Proposed Subsidy	Requirements
Medicare beneficiaries	Medicare	No alternative proposed
Medicaid and S-CHIP eligibles	Medicaid and S-CHIP, respectively, or full refundable tax credit	If refundable tax credit is chosen, forgo Medicaid and S-CHIP benefits and must purchase through an insurance exchange
Low-income individuals up to $31,000 and families up to $51,000	Full refundable tax credit equal to 70 percent of median-cost plan	Must choose between the tax credit and the capped exclusion; if tax credit is chosen, must purchase through an insurance exchange
Low-income individuals up to $31,000 and families up to $51,000 who do not enroll	50 percent of the full refundable tax credit, paid to state	Automatic enrollment in default plan
Middle-income individuals up to $41,000 and families up to $61,000	Partial refundable tax credit, phased out to $0	Must choose between the partial tax credit and the capped exclusion; if tax credit is chosen, must purchase through an insurance exchange
Individuals not eligible for the refundable tax credit	Capped exclusion	NA

Federal, state, and private group-purchasing arrangements operate in many markets today, with varying success. Insurance exchanges will share some features with these organizations, but will improve on existing arrangements in several important ways. The most important problems associated with existing group-purchasing arrangements include the inability to gain market share and achieve administrative savings; adverse selection, either as a natural feature of plan competition or as a result of regulatory and legal constraints; and resistance to or opposition from health plans and insurance brokers.[1]

From the individual's perspective,the exchanges offer far more choice than typically would be available today. In contrast to the current system, when individuals enroll in an HMO through an exchange, it would be because they chose to enroll voluntarily, rather than because they lacked an alternative insurance option. Furthermore, choices would be determined by value as perceived by the consumer, since the consumer who chooses a plan with a higher premium than the low-priced plan will pay for the added cost of the choice.Good information, such as our proposal would generate, is critical to the operation of the exchanges; people are more likely to be satisfied with their choices if they know what they are getting.

A key challenge will be the formation and growth of the exchanges. Our proposal includes substantial incentives to promote private insurance exchanges.

• People are eligible for the substantial new refundable tax credits for low-income individuals only if they purchase health insurance through certified insurance exchanges.

• Health plans offered through an insurance exchange are exempt from state small-group market

[1] Elliot Wicks, Mark Hall, and Jack Meyer. "Barriers to Small-Group Purchasing Cooperatives." Washington: Economic and Social Research Institute, March 2000.

reforms and laws mandating health plan benefits for enrollees (that is, ERISA preemptions). These preemptions are necessary to allow insurance exchanges to form and operate across state lines, to enable insurance exchanges to become a competitive option for employers who now self-insure, and to give employees of small firms and the self-employed access to flexible insurance plans that are currently available to employees of many large firms.

• Exchanges and health plans participating in insurance exchanges are protected from adverse selection (see "Insurance, Risk Selection, and Risk Adjustment" below).

Insurance exchanges could be private or public, for-profit or non-profit organizations, electronic or traditional. Large and mid-size employers also could be designated as insurance exchanges serving employees of the firm. The IEC will certify that insurance exchanges meet minimum standards for eligibility for tax credits and ERISA preemption. Exchanges would be certified through annual filings with the IEC, which would be empowered to deny or withdraw certification for exchanges that failed to meet these requirements. Certified insurance exchanges will be required to meet the following basic requirements:

• Non-employer exchanges must accept all individuals not eligible for Medicare and groups in their service area (guaranteed issue) at a flat premium rate (community rating), with adjustments only for covering additional people, such as a spouse or dependents. Beyond these requirements, non-employer exchanges would have flexibility in formulating eligibility rules (that is, employer size maximum) and underwriting policies (for example,waiting periods and open enrollment practices for individuals). Employers can also qualify as exchanges if they accept all employees, except part-time workers, at a flat premium rate.

• Exchanges must offer a "meaningful choice" of plans, defined as the offer of a minimum of two products from a minimum of two independent companies,[2] though considerably more choices would be desirable, including point-of-service (POS) or preferred provider organization (PPO) products as well as closed-panel health maintenance organizations (HMOs) and newer alternatives such as defined-contribution "care groups." Such offers must include at least one product that provides some coverage for treatment by most providers in a region (for example, a POS-type plan), and a low-priced alternative (perhaps with more restrictive choices or catastrophic coverage).

• Exchanges must require participating plans to offer some standardized basic benefits to facilitate plan comparison and discourage plans from segmenting markets by health risk. However, plans would be allowed to offer enhancements to the basic features.

• Exchanges must perform at least minimal risk adjustment (initial risk adjustment would be based on age) and/or rely on other mechanisms to limit the financial rewards to plans for engaging in practices that encourage risk selection, to preserve choice among plan types and create incentives for plans to enroll and care for high-cost patients. Exchanges also must participate in risk adjustment between insurance exchanges in a region or state.

• Exchanges must require participating plans and providers to meet minimum standards for measuring quality.

• Exchanges must make available comparative information on plan benefits, pricing, quality measurement, quality improvement initiatives,and other aspects of plan performance in an effort to help members make informed, high-value choices.

Employers that would prefer not to fulfill these minimum requirements can choose not to become an insurance exchange. If they chose this option, they would continue to be regulated by ERISA, and they could not participate in the tax credit program. States would continue to regulate the non-insurance exchange market; most states have guaranteed issue and some rating requirements in the small-group market.

[2] For purposes of defining "companies" and "products," exchanges that contract directly with provider groups would be counted as contracting with multiple companies, as long as a sufficiently large number of different risk-bearing provider groups in an area could be chosen. For example, Buyers Health Care Action Group's (BHCAG's) "care groups" would meet this definition.

Group-purchasing arrangements and many employers that provide health insurance today meet most of these requirements. Most offer a choice of plans and products and provide guaranteed issue to all participating employees. Many independent insurance brokers and/or consortiums of brokers could meet this requirement, as well. PacAdvantage, a small group-purchasing organization in California, performs risk adjustment, using demographic and administrative health data, to protect products and plans that attract high-risk individuals. Benefits Alliance, a group-purchasing organization for mid-size employers in California, helps to ensure that health risks are spread evenly among participating plans by requiring that each plan offer both an HMO and an open-network product. Many such groups offer comparative information that is becoming more sophisticated as it migrates toward electronic forms. For example, California Consumer HealthScope, a web site by Pacific Business Group on Health, provides consumers with comparative quality information and the ability to search for information about physicians and the health plans through which they are accessible. HealthScope also provides comparative information about drugs available through health plan formularies.

Our proposal includes incentives to encourage the growth of electronic insurance exchanges. Today, such exchanges offer electronic procurement, enrollment, administration (for example, eligibility verification and bill payment), and information about health insurance options. For instance, Ehealthinsurance. com claims to offer products from about 40 carriers and sells insurance to individuals and small employers in 45 states.[3] EbenX and Sageo, two additional electronic insurance exchange companies, facilitate transactions for employees on behalf of employers and health plans. According to industry analysts, online individual and small-group sales currently represent approximately 2 percent of total policy sales.[4] Additional e-commerce companies, such as TriZetto and HealthAxis, provide traditional insurers,insurance exchanges, brokers,and employers with electronic capabilities to purchase health insurance. Six of the nation's largest insurers have formed MedUnite to develop online enrollment, physician selection, claims approval and processing, and prescription services. Individual insurers are developing similar capabilities.

Even in the absence of new subsidies to help them increase enrollment and, thus, spread fixed costs, electronic insurance exchanges and e-commerce companies may be able to achieve the administrative savings that many group-purchasing arrangements have failed to achieve thus far. Projected long-term administrative savings from electronic insurance exchanges range from 20 percent to 30 percent of administrative costs.[5] In a survey of large employers, 91 percent of respondents indicated interest in using the Internet to help employees enroll in a health plan or choose a physician group.[6] According to industry research, many consumers also strongly prefer to purchase health insurance online.[7]

The advantages to enrollees of joining insurance exchanges (that is, subsidies, choice, and lower-cost coverage) likely will drive demand for such services; this demand, in turn, will encourage entrepreneurs and employers to seek certification as insurance exchanges. Brokers, who have traditionally served the small and mid-size market, but who have often been denied the ability to form purchasing groups, may find this a particularly attractive opportunity. We would not prohibit insurers from sponsoring an insurance exchange, nor would we prohibit exchanges from becoming insurers themselves. However, the IEC would monitor exchange sponsorship and report concern about abuses to the

[3] Frank Cerne. "Reaching Out on the Web." *Insurance Networking* (April 2000).

[4] Ibid.

[5] Tara Ashish et al. "Opportunity for Health Care Savings through Internet Technology." Stanford, CA: Graduate School of Business. Independent student research, May 24, 2000; Jason Gertzen. "Blue Cross Steps into Internet Territory to Sell Health Insurance." *Milwaukee Journal Sentinel* (October 4, 2000).

[6] "Despite Costs, Employers Stick with Health Benefits." *Reuters Health* (October 13, 2000).

[7] Cybercitizen Health. "Internet Users Want to Manage Health Insurance Benefits Online." Press release, New York: CyberDialogue, www.cyberdialogue.com/resource/press/releases/1999/08-25-cch-insurance.html, August 25, 1999.

The benefits of purchasing through the exchanges likely will make them the predominant mode of health insurance purchase, especially for employees of small and mid-size firms and for individuals.

Department of Justice and the Federal Trade Commission, and could establish firewalls against anti-competitive practices if necessary. Given the high degree of flexibility in sponsorship and benefit design, we expect that many individuals and employees will use an insurance exchange to enroll in a health plan.

Our proposal requires that at least one insurance exchange serve every geographic region in the United States. With new subsidies and flexibility in sponsorship and benefit offerings, we expect existing private purchasing group arrangements to expand to meet this requirement. The benefits of purchasing through the exchanges likely will make them the predominant mode of health insurance purchase, especially for employees of small and mid-size firms and for individuals. Most employees of large employers will purchase through exchanges, as well, because their employers are likely to seek qualification as exchanges to make it possible for low- and middle-income employees to obtain subsidies (in the form of refundable tax credits). If, despite these advantages, insurance exchanges do not materialize in parts or all of a state within several years, that state can work with the IEC to develop alternatives. The IEC can waive the insurance exchange requirement and authorize one or more alternatives. For example, exchanges may develop more slowly in rural areas. To serve residents in these areas, the IEC could work with states to promote expansion of insurance exchanges specializing in plans for rural areas to cover multiple states.

Alternatively, if no private insurance exchanges are available in particular regions of a state by three years after enactment of the proposal, a state can request authorization from the IEC to implement a national program parallel to the FEHBP, called the U.S. Insurance Exchange (USIX), in these areas. Individuals and employers with up to 50 employees would be eligible to participate in USIX; at the discretion of the states (and with authorization from the IEC), the maximum size of participating employers could be increased. Much like FEHBP, USIX would be required to offer all plans in the region that meet specified, reasonable standards (negotiated with USIX), and each plan would set its own price. Start-up administrative costs in each state for USIX would be financed primarily by each state, but states also could receive some limited federal funding. After a start-up period of,at most,several years, administrative costs would be incorporated into the premiums charged by USIX in the state.

Coverage/Eligibility: Coverage of Unaffiliated Individuals through Default Plans

Low-income individuals who are eligible for full subsidies (see below), but who are ineligible to purchase through an insurance exchange, or who are eligible but fail to purchase a health insurance plan during a defined enrollment period, would be enrolled automatically in a "default plan" developed by the state.[8] Individuals who are eligible for both the subsidies and Medicaid or S-CHIP, and who fail to enroll in any program or plan, also would be enrolled in the default plan. States would identify the default plan providers and distribute payments to them. We expect that default providers in most states will be public hospitals, community clinics, and other "safety net" providers. Because states would have considerable flexibility in targeting default plan payments to providers, they might

[8] B. Madrian and D. Shea. "The Power of Suggestion: Inertia in 401(k) Participation and Savings Behavior." NBER Working Paper 7682, May 2000. This research found that an automatic enrollment approach raised pension participation rates from 37 percent to 86 percent. For lower-wage ($20,000-$29,000) and younger (age 20–29) workers, participation increased from 25 percent to 83 percent.

make other choices, such as low-cost private plans.

Default plans would be expected to meet certain minimum standards in order to receive federal payments. For example, default plans would be required to conduct outreach to default plan members, encourage and provide primary and preventive services, and encourage eligible individuals and families to enroll in private plans offered through insurance exchanges or employers. Our plan provides for considerable state flexibility and financial incentives to achieve these goals.

New federal payments to states for the default plan would be set equal to 50 percent of the value of the refundable tax credit (see below) multiplied by the number of individuals presumed eligible for the full tax credit who do not actively enroll in a health insurance plan. A 50 percent subsidy for these individuals is generous compared with current payment levels for the uninsured and their expected use of services. A 50 percent subsidy also preserves incentives for individuals to join conventional health insurance plans.States that increase this group's rate of active enrollment in insurance plans would retain a portion of the affected default plan payments (for example,the payments would be reduced by 40 percent multiplied by the improvement in coverage, rather than 50 percent).

The default payments to states also would include incentive components related to a state's performance in providing clearly effective health care to its population, particularly higher-risk population groups (for example, low-income children and adults). States that improved performance (after accounting for trends in income and state economic performance) would receive additional incremental payments; states with worsening performance would face incremental payment reductions. Initially, measures could be selected from health measures already being collected to track Healthy People 2010 performance goals, which are likely to be particularly sensitive to uninsurance rates and/or the quality of public outreach programs. Such measures include rates of pre-natal care (collected from birth records), vaccination rates (obtained from state public health records), and avoidable hospitalization rates (collected from hospital discharge data). Additional measures might be added from the National Health Care Quality Report Card, which probably will be published annually beginning in several years. As a condition for receiving default plan payments, states also might be required to collect some measures of the services they are providing to uninsured patients.

Changes in Tax Incentives to Improve Equity and Affordability in Health Insurance Purchasing

Current federal tax law does not count employer-paid health premiums as taxable income for employees. This unlimited tax exclusion has helped to promote the purchase and availability of health insurance, particularly employment-based insurance, but it also weakens incentives to control health plan costs, because the added costs are in pre-tax dollars. Over time, our proposal would transform the unlimited exclusion into a capped exclusion. Individuals could take either the capped exclusion or, if they are eligible, the new refundable tax credit (described below).

In year one, the exclusion would be capped at double the price of the median-cost plan premium in the previous year. (Depending on data availability, the median-cost plan premium of a representative sample of plans analyzed by actuaries working with the IEC, or the median-cost plan of FEHBP premiums, would be used for this calculation.) For the next eight years, the exclusion would be capped at whichever is lower: the level of the cap in the previous year or 190 percent, 180 percent, 170 percent, etc., of the price of the median-cost plan premium in the previous year (adjusted for any demographic changes). In the 10th and subsequent years, the cap would be equal to the median-cost plan premium in the previous year, plus 5 percent.

Implementation will require employers to impute employer premium payments (which would be subject to Internal Revenue Service [IRS] and Department of Labor [DOL] audits) and to report employer-paid premiums that they have excluded from taxable business income (up to the cap) on the employee's W-2. Employees then could exclude any

SCHEDULE FOR THE HEALTH INSURANCE EXCLUSION CAP PHASE-IN

Year	Percent of median plan premium in the previous year
1	200 percent
2	Lesser of 190 percent, or level of cap in Year 1
3	Lesser of 180 percent, or level of cap in Year 2
4	Lesser of 170 percent, or level of cap in Year 3
5	Lesser of 160 percent, or level of cap in Year 4
6	Lesser of 150 percent, or level of cap in Year 5
7	Lesser of 140 percent, or level of cap in Year 6
8	Lesser of 130 percent, or level of cap in Year 7
9	Lesser of 120 percent, or level of cap in Year 8
10 and following	105 percent

additional premium payment, up to the cap on the exclusion.

We would expect the IEC, with the technical assistance and advice of accountants, to develop standards for imputation of employer health care expenses to employees. A question of regional cost variations would arise.Generally, the tax laws do not provide for regional variations, but they could. As is the case for other things (for example, sales taxes, when they were deductible, or business meals), the Treasury could publish tables with applicable caps by ZIP code. There are arguments on both sides of this issue. We would favor allowing regional variations based on factor prices, analogous to those used in the Medicare Prospective Payment System.

The cap on the exclusion will be adjusted geographically, using a formula determined by Congress and administered by the IEC. A formula based on insurance premium variations by metropolitan statistical area (MSA) and non-MSA regions is a potential starting point. These geographic adjustments could be based on actual premium costs in the area (for example, demographically adjusted FEHBP premiums) or on geographic cost adjusters, such as those used in the Health Care Financing Administration (HCFA) Prospective Payment System (PPS). If the adjustment is to be based only or primarily on geographic cost differences, and not on health plan cost differences across areas after accounting for differences in input costs, then a long transition period would be required.

The transformation of the unlimited employer exclusion into a capped exclusion is attractive for several reasons. First, the capped exclusion discourages employer contribution policies that inhibit cost consciousness. Second, since the value of the tax exclusion rises with the marginal tax rate, capping the exclusion makes it less regressive. Third, the cap provides a significant source of financing for the proposed health insurance tax credits, which also will contribute to greater equity in government subsidies for private health insurance purchases. Without this provision, our proposal still could be enacted. However, the new budget costs of the proposal would be significantly higher, and/or the new tax credits would be significantly smaller or restricted to a lower income range.

Subsidies

Low- and Middle-Income Individuals and Families

Our proposal would create a new refundable tax credit for low- and middle-income individuals and families. The base credit amount would be equal to 70 percent of the median-cost plan premium for single coverage (adjusted to the demographic charac-

teristics of the eligible population) in the previous year. Tax credits could be taken on a single, dual, or family basis. We envision a credit equal to twice the single credit for dual coverage,and 2.6 times the single credit for family coverage (that is, equivalent to the relative single, dual, and family premiums of many large employers). Subsidies would vary by region, and they would be adjusted geographically in the same manner as the tax exclusion cap described above. Tax credits would not vary by age (see following discussion of risk adjustment of premiums).

Individuals eligible for Medicare would not be eligible for the new tax credit. Individuals eligible for Medicaid or S-CHIP could take the credit and enroll in a certified exchange plan or an employer-covered plan, though this would require that they relinquish their Medicaid or S-CHIP benefits. Thus,individuals or families currently eligible for Medicaid or S-CHIP could continue to participate in these programs if they chose, and they would have an incentive to continue, because the average subsidy is considerably greater. However, financial disincentives to enroll in a private plan provided by an exchange or employer would be reduced substantially. If many Medicaid- or S-CHIP-eligible individuals and families chose to enroll in such a private plan, the state and federal government likely would realize significant net cost reductions. Given the difference in the level of subsidy between the average Medicaid and S-CHIP benefit and the proposed tax credit, this would be true even if relatively healthy individuals switched out,as is likely to be the case. States would be required to maintain support for Medicaid and S-CHIP beneficiaries who enroll in a private plan, contributing 30 percent of the median-cost plan.Eligible individuals in employer-provided plans could choose either the tax credit or the capped exclusion.

The tax credits would begin to be phased out at incomes of $31,000 (single) and $51,000 (couples and families). They would be phased out fully at income levels of $41,000 (single) and $61,000 (couples and families). These amounts would be indexed in the same way as tax brackets. The phase-out is structured to begin at income levels above the phase-out of earned income tax credits and most other means-tested benefits, so that the implicit marginal tax rate applied to an increased income does not rise steeply.

Setting the subsidy equal to 70 percent of the median-cost plan premium, rather than an alternative, such as the full price of the low-priced plan, maintains an incentive to limit the prices of low-priced plans. In many markets today, several health insurance plans are available at 70 percent of the median-cost plan. We assume that health plans will offer products priced to meet the needs of this new, large population of potential enrollees, even if this means adjusting benefits or changing cost-sharing provisions to reduce premiums. Insurance exchanges and USIX could encourage insurers to offer such plans. Because we propose only limited standardization of health plan benefits, setting the tax credit as a percentage of the median-cost plan provides some assurance that the reference benefits package provides a reasonable level of coverage.

Employed individuals would claim the credit through an additional few lines of paperwork for their current W-4 filing, which determines their tax withholding. Individuals who do not receive the credit through their employer (that is, individuals who purchase through an insurance exchange that they choose individually and, thus, to which they pay premiums directly) would attach proof of coverage through a certified exchange to a W-4 to claim the credit. States would be allowed to use some of their uninsured funds to develop capacity to assist unemployed individuals with the credit. And, along with Consolidated Omnibus Budget Reconciliation Act (COBRA) notification, those terminated from a job would be notified of potential eligibility for this assistance. All individuals also would be required to provide similar documentation of coverage on their tax return. In the absence of a presumption of eligibility, insufficient income tax withholding due to improper credit claims would be subject to the usual IRS interest and penalties.

To increase take-up rates,simple prospective criteria would be used to create a presumption of eligibility, based on wages and hours worked (for example, full-time workers earning less than $15 an hour who purchase a family policy would be presumed eligible), and based on last year's family tax

returns (for example, workers eligible in the previous year who have not indicated new employment or earnings on their current W-4 form—which they would need to fill out to claim the credit in advance—also would be presumed eligible). Individuals who meet the eligibility presumption, but who turn out to be ineligible in their end-of-year tax filings, would not be subject to penalties; they simply would be required to repay the amount credited on a reasonable repayment schedule. Precedent for this policy comes from the IRS, which forgives tax penalties for insufficient withholding for those whose tax liabilities are much higher than they were the year before. Some state health insurance programs for lower-income families, for example, Wisconsin, also have implemented steps similar in spirit to this presumption.

For employed individuals, credits would be transferred directly to employers. The credit would be made available to employers in advance for individuals with insufficient tax liability. Making these payments to firms rather than individuals (as in Earned Income Tax Credit [EITC] payments) would improve accuracy and simplify administration for the IRS. Also, relatively few employers would owe negative taxes as a result of any incorrect payments.

Certified insurance exchanges also could collect credit-based payments monthly or quarterly on behalf of the individuals enrolled through their exchanges via the IEC. We expect this option to be used most often by individuals (along with their families) who do not receive coverage through their employers. The IEC would receive an annual appropriation from Congress for this purpose. In this case,the certified insurance exchange would submit proof of coverage on behalf of the eligible individual. Thus, these individuals would have to pay only the portion of their premium not covered by the credit. Such individuals would not be allowed to receive the credit through their employer also. The IEC would forward the tax identification numbers of all individuals receiving subsidies through insurance exchanges to the IRS for audit purposes, and would assist the IRS in detecting other types of fraud. The IEC and the IRS would have the authority to impose sanctions on exchanges that use tax credits fraudulently.

Although recent studies have suggested a significant fraud rate with the EITC, it seems unlikely that fraud will occur at a similar rate here. First, to be eligible, an individual must document coverage in a certified exchange. The number of certified exchanges is likely to be small compared with the number of individuals and businesses filing tax documents related to the EITC, thus creating simpler oversight. Second, sanctions against exchanges—including losing certification and criminal penalties—presumably would deter their participation in fraud. Third, in contrast to dollars, individuals are not likely to want more than one health insurance plan.

Administration of the tax credits will require employers to collect some additional information from their employees. However, the process represents a relatively minor addition to the information on wages and other benefits employers currently provide to the federal government, so this should create a relatively minimal burden. No other private entity is as well situated to provide this needed information about employees, and any additional preparation costs could be deducted as a business expense.

Payments to Default Plans

Payments to states for individuals enrolled in their default plan will be administered by the IEC. The default plan payment will be equal to 50 percent of the value of the tax credit for eligible individuals in the state who do not actively enroll in an insurance plan. These payments, and the associated incentive payments, were described earlier.

Insurance, Risk Selection, and Risk Adjustment

Our proposal attempts to strike a balance between protecting health plans and insurance exchanges from adverse risk selection and stifling innovation, variation, and flexibility.

Because we have attempted to minimize complexity by maintaining tax credits that do not vary with risk status, and by fixing premiums that indi-

Critical to this proposal is an ongoing quality measurement and public reporting program, including risk-adjusted outcome studies and comparison of actual care patterns with recommended guidelines.

viduals pay when they purchase insurance through an exchange, there is substantial potential for adverse selection. Some aspects of our proposal, such as the large subsidies available up to relatively high-income levels, will mitigate adverse selection by attracting large numbers of average and low-risk enrollees. However, additional efforts are likely to be necessary. Consequently, the IEC will develop minimum standards for risk adjustment of plan premiums *within* insurance exchanges, and the IEC will provide risk adjustment *among* insurance exchanges in a particular region or state.

Among Plans within Insurance Exchanges

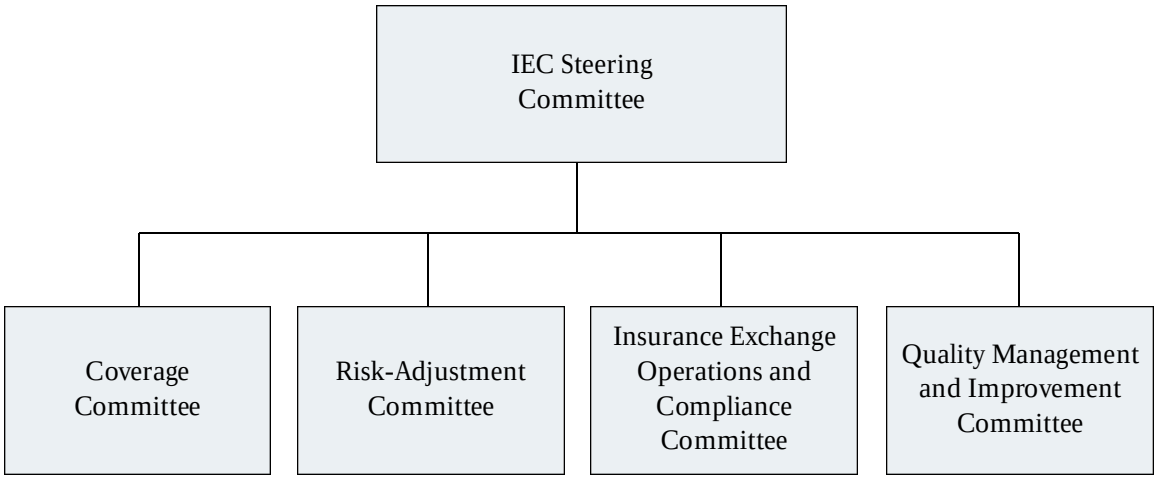
A key challenge is to ensure that plans do not face financial penalties for attracting enrollees who are likely to have above-average health expenditures, or, conversely, are not rewarded for attracting low-cost enrollees. An ideal risk-adjustment procedure would remove the disincentives to attract high-cost enrollees without rewarding health plans whose costs are high because they are inefficient or unable to limit use 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. Insurance exchanges 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 IEC 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 alone. As risk-adjustment technology improves, and as experience with other methods accumulates, the IEC may implement alternative standards. Note that within-exchange risk adjustment will redistribute payments within the exchange from lower-risk to higher-risk plans; it does not include any cross-exchange subsidies.

Among Insurance Exchanges in a Region or State

The IEC would oversee risk adjustment across insurance exchanges in each region or state. The IEC would develop methods for measuring selection effects,based on data provided by health plans and exchanges. If necessary, the IEC would conduct demographic risk adjustment and, possibly, more sophisticated risk adjustment, to redistribute premiums among insurance exchanges. In effect, plans with higher-risk demographics would be subsidized by lower-risk plans in the same region. The IEC 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. Exchanges also could attract high-risk enrollees, who are more likely to be sick, simply because they are open to individuals. Consequently, the IEC would monitor adverse selection between insurance exchanges 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.

STRUCTURE OF THE INSURANCE EXCHANGE COMMISSION



Oversight of Insurance Exchanges: The Insurance Exchange Commission

The federal Insurance Exchange Commission (IEC) will be created to oversee the proposed new subsidies and the insurance exchanges eligible to benefit from them. Its 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. The IEC would be an independent agency structured like the Securities and 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.

A Steering Committee, made up of individuals with experience and expertise in health care financing and organization, would direct the IEC's activities. In addition, the IEC would operate four standing committees: (1) Coverage, (2) Risk-Adjustment, (3) Insurance Exchange Operations and Compliance, and (4) Quality Measurement and Improvement. Committee membership would include individuals from the payer and provider communities, industry (including pharmaceutical and device manufacturers), consumers,and health care experts. Some of the IEC's responsibilities could be contracted out to other agencies, such as the Agency for Healthcare Research and Quality (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.

Among the main functions of the IEC would be distributing tax credit payments toward premiums to insurance exchanges and distributing default plan payments to states. By assigning these responsibilities to the IEC,our proposal minimizes new burdens for the IRS.

The four standing committees of the IEC, shown in the chart above, would have the following responsibilities.

The *Coverage Committee* would issue recommendations and set minimum standards for benefits covered by health plans offered through certified insurance exchanges. The minimum standards will 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 ones, 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 that 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 as eligible to receive subsidies. Based on proposals from affected states, it also 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 make sure that residents of regions that failed to establish exchanges within three years would be able to enroll in health care plans through USIX.

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 IEC 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 *Quality Measurement 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 IEC. Insurance exchanges also might be required to report some measures of quality, for example, disenrollment, complaint,and satisfaction rates. The IEC 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 IEC would include the IEC 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. The operating budget,as shown below, is approximately $60 million annually.

Financing the Proposal

Costs of the proposal include the new tax credits for low- and middle-income Americans, additional payments to the IRS to administer the tax aspects of the plan (with assistance from the IEC), limited

ANNUAL BUDGET* OF THE INSURANCE EXCHANGE COMMISSION

Staffing	**(000s)**
Steering Committee	
Director and 7 members	
Salary + full benefits	$1,800
Senior (professional) staff (10)	$1,800
Standing Committees	
Average 0.5 FTE per committee member	
Director and 7 members of each committee	$4,500
Senior (professional) staff (5 for each committee)	$4,500
Administrative staff (300 total)	$30,000
Office expenses	$1,000
Travel	$1,000
Risk-adjustment development	$1,500
Quality measurement and improvement	$2,000
Exchange Incentives Fund*	$10,000
TOTAL	$58,100

*Initial-year budget; will be reduced in subsequent years.

start-up costs for USIX,and an operating budget for the IEC. These costs will be financed by:

• capping the current unlimited exclusion of employer-paid health insurance;

• savings over time through behavioral effects among consumers and health plans because of increased cost-consciousness and improved value-based competition among health plans; and

• general revenues.

Fit within Existing System and Transition from Present to Future

This proposed plan for near-universal health insurance relies primarily on existing institutions, and preserves the best features of the existing health insurance system while closing gaps in coverage.Our proposal retains the employer-based system and the option for all those eligible for low-income state and federal health care programs to continue in them if they so desire. Our proposed default plan would improve support for "safety net" providers and provide new incentives for preventive services that might help lower their costs. This proposal also builds on what we know works best today and is most acceptable to the American public, that is, large-scale group-purchasing arrangements such as FEHBP and CalPERS, and independent agencies with limited authority to help competition work well in complex industries, such as the SEC. Competition among private health plans and among private insurance exchanges with minimal federal oversight fits American values best.Economic theory also suggests that this is the most effective way to expand choice,lower prices, and improve quality of care and service. Where such arrangements fail to develop, our proposal offers USIX as a backup program that also would create competition and choice.

Where we recommend a significant departure from the current system, we propose a gradual transition. In particular, we recommend a 10-year transition period to adjust the tax exclusion of health insurance premiums fully. We also recommend a minimum of three years for development of private insurance exchanges before introducing USIX in a market.

Political Feasibility

Opposition to such a plan is likely to emerge from these major features:

1. The cost of the plan is substantial; the bulk of its costs come from the tax credits used to subsidize insurance coverage. Furthermore, some opponents would claim that a tax credit mechanism like the one proposed here is "inefficient" because it provides new subsidies for many low- and middle-income families that are currently purchasing private health insurance. The claim of inefficiency is easily misunderstood, and applies only in the narrow sense of government expenditures for health insurance. The system of tax credits proposed here gives tax credits to low- and middle-income individuals, regardless of whether they already have insurance individually or through their employer, as long as the employer is certified as an insurance exchange. Even non-eligible

employers may encourage low- and middle-income individuals to seek coverage outside the firm to avail themselves of the tax credit. The purpose of giving tax credits to all low- and middle-income individuals is to compensate those low- and middle-income individuals and families who purchase insurance (or obtain it through an employer), giving up either premium payments or wages to do so. Offering the subsidy only to those who lack insurance is,in our view, short-sighted and inappropriate policy, since it strongly encourages employers to drop coverage, thus "crowding out" private insurance and distorting incentives. Moreover, it is unfair to the many families that continue to struggle to make their monthly health insurance premiums. Funds spent on low- and middle-income individuals under this plan are transfer payments, and they provide social benefits even if the low-income individuals would have purchased insurance in the absence of the subsidy. The cost per additional insured individual may be higher than under plans that crowd out private insurance, but the added costs represent socially desirable transfer payments (like the EITC) rather than waste. This tax reduction also would achieve a second goal—improving health insurance coverage while reducing incentives to switch to even more heavily subsidized government plans. Educating the public and policy makers about the reasons for the costs and the advantages of the plan will be challenging.

2. The plan limits the tax exclusion for health insurance expenditures. The current tax exclusion is popular, and particularly benefits high-income individuals and families who purchase high-cost plans. Such people will not favor the cap on the exclusion, which reduces the overall cost of the plan. We believe that the gradual phase-in of the cap, and pegging the cap to the cost of a reasonably representative and generous private health plan, will help to overcome objections to it.

3. The plan creates an independent federal agency to oversee health insurance. Some critics will object to creation of the IEC, claiming that it will be another federal bureaucracy that imposes undue burdens on employers,health plans,and health care providers and provides poor service to the public. Some also may object to what they perceive to be the IEC's complexity. However, the IEC's authority is limited to a small set of specifically designated powers, and its main functions are to assist in implementing the tax credits and developing better data on risk adjustment and health plan quality. In setting minimum standards for use of the tax credits, the IEC will play a relatively hands-off role, setting standards more like those used by the FEHBP, rather than, for example, the very detailed recommendations of President Clinton's 1993 health care task force. At the same time, by extending the ERISA preemption to insurance exchanges and plans that will serve many small employers and individuals, we remove an inequitable set of regulatory burdens that currently face small employers and individuals seeking coverage.

4. The plan will not provide coverage for every single American. Although our goal is universal health insurance coverage, this plan does not contain a mandate to cover every American. Thus,those who seek immediate universal coverage will object that this plan falls short. We believe that plans that propose 100 percent coverage typically do not achieve access for all individuals, and that attempts to do so require some combination of high costs, restrictions on choice of plans or providers, limited coverage, and a constrained role for the private sector. We also believe that our proposal to offer new funding to states to provide "basic" and preventive care to individuals who do not choose to enroll in a subsidized plan (and so may be less likely to use health care until they really need it) will improve their access to care, as well. We believe that the political objections to a plan that would come closer to immediate universal coverage would be far greater than to our plan.

5. Groups that favor either a single-payer system or another form of comprehensive government intervention in health care will oppose the heavy reliance on existing private institutions. Some of them will argue that administrative costs will be lower with a government-run plan, and that equity in access to health care will be put at risk by a plan that promotes choice among private health insurers. We believe that many of those groups, however, will see the appeal of our plan, which achieves much

broader health insurance coverage, despite their objections to specific features,and that this proposal will enjoy far broader political support than the alternatives they favor.

6. The plan will change the mechanism through which safety net providers receive payment. Under this proposal,safety net providers would receive payments for care for the uninsured by participating in default plans. In addition, to receive payments,states will be required to meet minimum requirements and will have financial incentives to conduct outreach to facilitate enrollment of unaffiliated individuals in private plans. The payments outlined are more generous than safety net providers receive today, and they promote high-quality care and expanded coverage. However, many safety net providers like the current system and may resist change.

Overall, the plan represents little threat to existing interests and little change in familiar institutions and structures. Its key features—preservation of private health insurance, expansion of choices and flexibility, use of targeted tax credits, improvement of markets for individual insurance, and protection of safety net providers like public hospitals—are also features of plans that already have demonstrated bipartisan support. Like those plans, it does not attempt to solve every problem in the current health insurance system. Because our proposal represents a fine balance between the achievable and the ideal, it has the potential to attract broad political support.

Quality, Cost, and Efficiency

Critical to this proposal is an ongoing quality measurement and public reporting program, including risk-adjusted outcome studies and comparison of actual care patterns with recommended guidelines. Much of this effort would be conducted or promoted by the IEC, which would set standards for information collection and dissemination. It would build on existing best practices in quality measurement, whether public- (for example, Medicare) or private-sector (for example, the Consumer Assessments of Health Plans Study [CAHPS] and the Foundation for Accountability [FACCT]), and would sponsor development of new measures. It also would encourage standardization of data collection across exchanges and other public or private purchasers. These efforts would help plans and providers to develop improved measures of processes and outcomes of care by plans and providers. Finally, the IEC would develop and enforce standards for data security and confidentiality.

Also critical to this proposal is effective cost containment, requiring conditions in which all Americans have a personal reason to care about health care costs, support serious cost-containment efforts, and economize. This is partly a matter of cultural attitudes, but it is also a function of the economic structure of health plan choice. Our strategy for containing costs and increasing value rests on competition among health care organizations to serve price-sensitive consumers.

Recognizing wide variations in quality and economy of health care delivery systems, the proposed economic structure of health plan choice would encourage greater cost consciousness, and the proposed quality measurement program would increase consumers' confidence in their choices. We anticipate that informed and cost-conscious consumers will migrate, gradually and voluntarily, to models that offer the greatest value, as they have done in exchange models such as FEHBP and CalPERS.

Equity

Use of the tax credit to subsidize low-income individuals and families promotes equity by direct income transfer. Qualification for the tax credit is broad,and it is available to low- and middle-income individuals who are not enrolled in Medicare, Medicaid, or S-CHIP. Individuals with qualifying income who are now adequately insured,along with those who are uninsured or underinsured, would qualify for the tax credits. In addition, the middle-income individuals who would purchase insurance if they could do so at costs similar to those available to groups would now be able to obtain insurance at more favorable rates via the insurance exchange. Making the tax exclusion for health insurance universal will lower the after-tax cost to those lower-income individuals who currently must pay health

insurance premiums with after-tax dollars. The cap on the tax exclusion will affect primarily high-income individuals who purchase very generous health insurance policies.

An additional protection for at-risk populations, most of which are lower-income,is explicit designation of the default plan. We believe that most default plans will provide access to county and other public hospitals, which will then have a reliable source of revenue that can be used to subsidize the costs of uncompensated care. Such institutions routinely provide care to individuals who are uninsured and unable to pay for medical services,and undoubtedly have mitigated the adverse consequences of lack of insurance. The continued viability of such institutions is critical unless and until it is possible to ensure that all Americans can receive care at other institutions.

An additional source of equity concerns is the treatment of persons with chronic illnesses and others who are expected to have disproportionately high health expenses. Many such individuals now face exceedingly high health insurance premiums or may not be able to purchase insurance at all. The proposed system emphasizes development of risk-adjustment mechanisms for health insurance premiums that would make community rating feasible and thus enable such high-risk individuals to purchase insurance at the same rates as other people. Overall,the proposed plan provides substantial protections to those who are unable to obtain insurance at reasonable rates, either because their incomes are too low or their expected medical costs are too high.

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Singer, Garber, and Enthoven Proposal

Key Elements

Sara J. Singer, Alan M. Garber, and **Alain C. Enthoven** have designed a comprehensive, new approach for expanding access to health insurance. The proposal is built on the following key elements:

THE PLAN WOULD PROVIDE near-universal coverage by making private plans more affordable and helping low- and middle-income people buy coverage. This would be accomplished though tax credits and by creating "insurance exchanges" that would provide health insurance choices and promote competition among health plans.

INSURANCE EXCHANGES WOULD BE OPERATED by public or private entities or employers (for their own employees). Exchanges would offer individuals a choice of at least two health plans in every geographic region at community-rated premiums. The "U.S. Insurance Exchange" would be established to serve individuals and companies with fewer than 50 employees in areas where private exchanges do not emerge. Coverage purchased through exchanges would be exempt from state small-group reform laws and insurance mandates.

LOW- AND MIDDLE-INCOME AMERICANS who purchase insurance through an exchange would receive refundable tax credits valued at 70 percent of the median-cost plan. The credits would apply only for coverage purchased through the exchanges. Eligible low-income individuals who did not enroll in a health plan would be automatically enrolled in a federally funded default plan organized by the state. Other individuals would continue to exclude from taxable income their individual or employer-paid health insurance contributions, but a phased-in cap would limit this exclusion.

A NEW "INSURANCE EXCHANGE COMMISSION" would be created. It would be similar to the Securities and Exchange Commission—having authority to distribute tax credits and default payments, accredit insurance exchanges, risk-adjust premiums across insurance exchanges, and serve as an information clearinghouse for consumers.

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