

Addressing Health Care Market Reform Through an Insurance Exchange: Essential Policy Components, the Public Plan Option, and Other Issues to Consider

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EXECUTIVE SUMMARY

HEALTH INSURANCE EXCHANGE: This *Issue Brief* examines issues related to managed competition and the use of a health insurance exchange for the purpose of addressing cost, quality, and access to health care services. It discusses issues that must be addressed when designing an exchange in order to reform the health insurance market and also examines state efforts at health reform that use an exchange.

RISK VS. PRICE COMPETITION: The basic component of managed competition is the creation of an organized marketplace that brings together health insurers and consumers (either as individuals or through their employers). The sponsor of the exchange would set "rules of engagement" for participating insurers and offer consumers a menu of choices among different plans. Ultimately, the goal of a health insurance exchange is to shift the market from competition based on risk to competition based on price and quality.

ADVERSE SELECTION AND AFFORDABILITY: Among the issues that need to be addressed if an exchange that uses managed competition has a realistic chance of reducing costs, improving quality, and expanding coverage: Everyone needs to be in the risk pool, with individuals required to purchase insurance or face significant financial consequences; effective risk adjustment is essential to eliminate risk selection as an insurance business model—forcing competition on costs and quality; the insurance benefit must be specific and clear—without standards governing cost sharing, covered services, and network coverage there is no way to assess whether a requirement to purchase or issue coverage has been met; and subsidies would be necessary for low-income individuals to purchase insurance.

THE PUBLIC PLAN OPTION: The public plan option is shaping up to be one of the most contentious issues in the health reform debate. Proponents also believe a public plan is necessary to drive private insurers toward true competition. Opponents view it as a step toward government-run health care and are wary of cost shifting from the public plan to private insurers.

FUTURE OF EMPLOYMENT-BASED COVERAGE: The availability of a health insurance exchange may have implications for the future of the employment-based health benefits system, and raises major questions for workers. Will employers provide a fixed contribution for the purchase of insurance through an exchange? Would that be large enough to purchase coverage? Would it be flat or vary by such factors as worker health status, age, and/or marital status or the presence of children? Would it be taxed? For both employers and workers, the implications are enormous.

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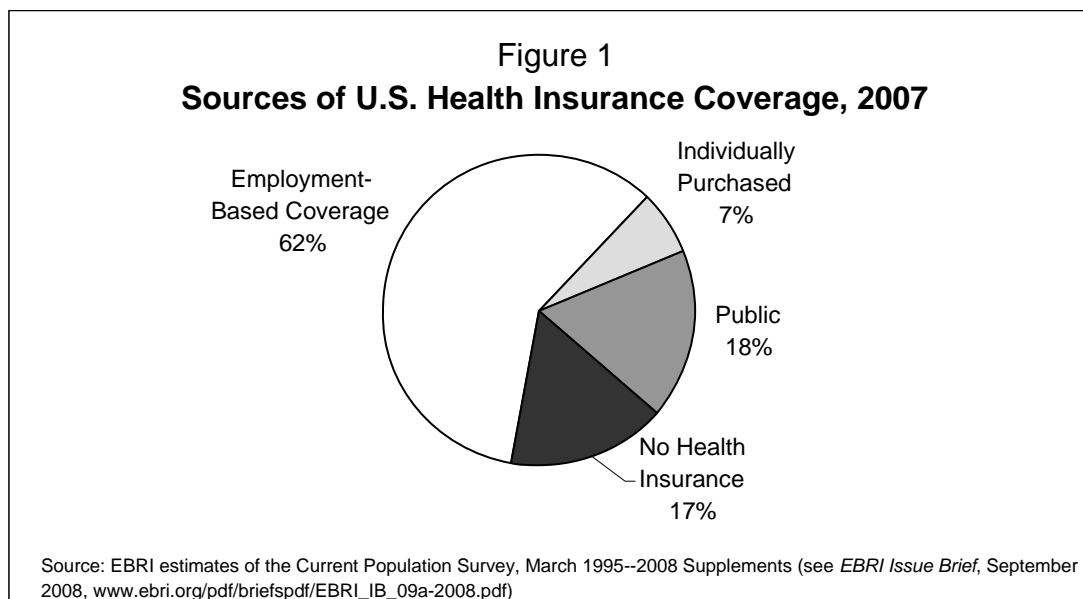
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Introduction

Among the 29 most economically developed nations in the world, only three—the United States, Mexico, and Turkey—do not provide universal (or nearly universal) health insurance or health care coverage to their citizens, according to the most recent data.¹ In the United States, voluntary employment-based benefits are the dominant source of health coverage among the population under age 65, while the federal Medicare program is the dominant source of coverage for the senior population.

In 2007, the large majority of Americans—162.5 million individuals, or 62 percent of the U.S. population under age 65 (including 71 percent of workers ages 18–64), were covered by an employment-based plan (Fronstin, 2008), while nearly all of the population age 65 and older (93 percent) was covered by Medicare (DeNavas-Walt, Proctor, Smith, 2008). Of the remaining nearly 100 million individuals without Medicare or employment-based coverage, 18 million purchased insurance directly from an insurance company, 36 million were covered by Medicaid, and 8 million were covered by Tricare or CHAMPVA, leaving 45 million without any health insurance coverage (Figure 1).²

Public health coverage programs, such as Medicare (the federal health care insurance program for the elderly and disabled) and Medicaid (the federal-state health care program for the poor), are designed to provide access to health care services for specific populations—the elderly, low-income families, and the medically needy—who are least



likely to have employment-based benefits. These programs generally do not attempt to cover uninsured workers, whether because their employers did not offer health benefits, they did not accept coverage when it was offered, or (by definition) they lacked sufficient resources to purchase coverage on their own. Thus, what more than 6 million employers individually, on a voluntarily basis, decide to do (or negotiate with employee representatives) in terms of offering, pricing, and designing health benefits, has a major impact on the number of Americans with and without health coverage.

Individuals who are without access to employment-based health coverage and are ineligible for public programs may attempt to purchase insurance directly from an insurer. While some people can obtain affordable coverage, many others often find that health insurance purchased in the individual (nongroup) market is significantly more expensive than employment-based coverage for older, sicker applicants and people with pre-existing conditions. In fact, these individuals may be denied coverage based on medical underwriting, as it is allowed in most states, and they frequently cannot purchase individual policies at any price.

About 37 million individuals—83 percent of the uninsured—are workers (and their dependents) who were not offered coverage by their employer, or who declined coverage that was offered to them and did not obtain it from another source. These individuals represent the *gap* between employment-based and public coverage that has existed for many years. In recent years, that gap has been growing.

The availability and affordability of employment-based health coverage is largely a function of the strength of the economy. When the economy is strong and unemployment is low, employment-based health coverage typically expands, as happened during the late 1990s. In contrast, when the economy is weak, fewer people have jobs and the number of people with access to health coverage falls. Furthermore, during a weak economy, fewer people can afford premiums for coverage under COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985), or coverage in the nongroup market.³ And, during periods of little or no economic growth, the number of uninsured typically increases because government programs do not automatically expand to cover everyone who may have lost employment-based health coverage. In fact, government agencies will be under greater financial pressure themselves during economic downturns.

Among the working uninsured, 21 percent had access to employment-based health benefits through their employer in 2005 but about three-quarters of them declined it because of cost (Fronstin, 2008). For many, health coverage is simply unaffordable. However, among the uninsured population with family incomes at or above 200 percent of the federal poverty level (45 percent in 2007), the decision not to purchase health insurance seems to stem more from the perceived value of coverage than from financial capacity alone (California HealthCare Foundation, 1999).

One reason for the persistence of the coverage gap is that, under current policy, employment-based health coverage and public programs are not coordinated and their fundamental differences make convergence virtually impossible.

Employment-based programs exist to support the success of employers in attracting and retaining qualified workers. As such, they are subject to numerous contingencies based on internal and external forces affecting the employers' enterprises. Employers exercise considerable discretion with regard to establishing, maintaining, and designing health coverage, especially in difficult economic times.

In contrast, public programs provide specified benefits to strictly defined populations and can be changed only by legislation or regulation. As with the current economic crisis, however, even public programs can be cut back during times of economic stress (unless the federal government provides additional funding),⁴ as most states are constitutionally required to balance their budgets.

To address expanding coverage to individuals who do not qualify for employment-based coverage or government programs, and to address the general affordability of coverage, policymakers and others have suggested reforming health insurance markets by creating a national health insurance exchange. The exchange concept builds on the idea of *managed competition*, originally developed by Stanford University Professor Alain Enthoven and others. Managed competition is a term that describes a wide variety of models for reforming the health insurance market. Those models have in common the creation of a sponsor that manages the competition among health insurers for the benefit of enrollees.

The purpose of this *Issue Brief* is to examine issues related to managed competition and the use of a health insurance exchange for the purpose of addressing cost, quality, and access to health care services. This analysis argues neither for nor against managed competition and the creation of an exchange as part of national health reform; rather, it lays out the various interdependent policy components that are essential for the success of such a program. This *Issue Brief* is neutral on whether an exchange should or should not be formed, and focuses instead on the logistics and implications of what would be involved in implementing an insurance exchange and the potential ramifications of such an action.

The next section describes the basics of managed competition. The following section presents issues that must be addressed when designing an exchange to reform the health insurance market. Some elements of reforming the health

insurance market are necessary to achieve a successful marketplace, while others are highly desirable yet challenging to implement. The report also examines state efforts at health reform that use a health insurance exchange and discusses implications for employment-based health benefits.

Managed Competition 101

Managed competition is not a new idea. Alain Enthoven, building on earlier efforts by a number of analysts, developed a concept known as managed competition in the late 1970s as an alternative to the markets for health insurance *and* health care services.⁵ A number of groups have adapted Enthoven's concept to fit their health care reform proposals.

The basic element of managed competition is the creation of sponsors that act as collective purchasing agents for groups of individuals. Enthoven's model of managed competition entailed sponsors acting on behalf of groups of individuals to negotiate with insurers and offer participants a menu of choices among different plans. Individuals could purchase health insurance through a new marketplace relying on information provided about each plan's quality of care and price. The exchange could also provide information on consumer satisfaction, provider networks, provider choice, benefits covered, specialized care programs, geographic coverage, coverage exclusions, and various other measures of quality.

A health insurance exchange can be organized at the national level, state level, or some combination of the two. Multiple exchanges within a state are also a possibility, each serving specific regions or market segments, although the possibility of competition among exchanges also exists. Ultimately, the goal of a health insurance exchange is to shift the market for health insurance from competition based on risk to competition based on price (Custer, 1994). Proponents hope that competitive insurance markets will drive price competition in the health care services markets as well.

Enthoven's original proposal was called the Consumer Choice Health Plan, which he described as "an agency that assures each eligible beneficiary financial coverage of health care expenses at a reasonable price." The sponsor's role is to act as a broker between the beneficiaries and the health plans, negotiating with health plans on the basis of price and quality and offering that range of choices to individual consumers.

Many recent descriptions of managed competition use the term health insurance *exchange* interchangeably with the term *sponsor*. However, the sponsor and exchange are distinct:

The sponsor is an entity (sometimes incorrectly described as a Health Fed) that has oversight of the creation and continued functioning of the health insurance exchange that would connect buyers of health insurance with sellers. The sponsor would become the knowledgeable negotiator with (or overseer of competitive bidding by) health insurance plans participating in the exchange.

The exchange would ensure that the rules of participation were known and adhered to by plans.⁶

Insurers offering coverage in a health insurance exchange would be required to accept any individuals who wanted to purchase health coverage. Such "guaranteed issue" would fundamentally change the insurance market, in that risk avoidance would no longer be a tool to control the costs of providing care. A health insurance exchange also fundamentally changes the nature of the insurance pool, away from the "natural pool" generated by the current employment-based health benefits system (in which people are drawn to the pool for reasons other than their health condition).

Individuals would be offered a menu of choices of health plans, along with information about each plan in the health insurance exchange. In addition to price, such information might include cost sharing, consumer satisfaction, provider networks, benefits, specialized programs, geographic coverage, and measures of quality. Theoretically, consumers would then choose the plan whose attributes most suited their preferences. To obtain the benefits of competition

requires that insurance policies be easily comparable to facilitate consumer choice, consumers be given a financial stake in their choice, and quality measures be developed that consumers can use to make informed decisions.

Managed competition has been proposed as a solution for health insurance reform in the past by others as well. In 1993, the Clinton administration proposal, known as the Health Security Act, would have set up a system of managed competition through regional and corporate alliances. States would have been responsible for setting up one or more regional alliances. While the plan incorporated many of the features of managed competition, it would have constrained the markets for health insurance and health care services by imposing premium caps and fee schedules. The plan would have required employers to pay a portion of employees' health premiums; it included an individual mandate, and established a standard benefits package.

Managed competition was also the underlying structure for "Medicare Premium Support," an approach to reform introduced by Aaron and Reischauer in 1995. It was further developed by the Bipartisan Commission on the Future of Medicare in 1998–1999,⁷ and proposed in legislation by Sens. John Breaux (D-LA) and Bill Frist (R-TN) in their bill titled "Medicare Preservation and Improvement Act of 2001." Under premium support, Medicare beneficiaries would have been provided a fixed-contribution to use in purchasing either traditional Medicare or a private health plan, such as a health maintenance organization (HMO) or preferred provider organization (PPO). Beneficiaries would have been responsible for paying the difference between the fixed contribution and the premium.

A number of current proposals for health reform incorporate managed competition, and some states have already adopted some form of a health insurance exchange. Current proposals differ in whether employers are mandated to offer health coverage to their employees, how the health insurance exchange is organized, and the standard benefits offered. State efforts and support for a national health insurance exchange are addressed below.

Issues to Consider

A number of issues regarding adverse selection and affordability of health insurance coverage need to be addressed if an exchange that uses managed competition has a realistic chance of reducing costs, improving quality, and expanding coverage.

Require Individuals to Have Health Coverage

For managed competition to realize its potential, everyone needs to be in the risk pool, with individuals required to obtain statutorily acceptable insurance coverage for themselves and their dependents or face significant financial consequences.

While this "individual mandate" has been criticized from the left and the right, the fact is that universal coverage cannot be achieved in its absence. Without a mandate—and given the requirement of guaranteed issue, discussed below—some people would find it advantageous to go without coverage until they developed a significant medical condition. Aside from the questionable fairness of allowing people to avoid contributing when healthy and imposing costs on others when sick, healthy people opting out of the market would raise the average premium for those who remain, in turn increasing the number of people for whom opting out was desirable. A so-called "death spiral"—in which healthy people withdraw from the insurance pool, leaving ever sicker and more costly people—would inevitably follow.

Also critically important is the fact that an ineffective (or unenforced) mandate is not a mandate. While there is considerable reluctance to criminalize being uninsured, having only token financial penalties would miss the point. Fortunately, policy options exist that could make mandates more palatable. For example, as noted below, subsidies would ease the impact for those most vulnerable. Further, premium surcharges could be collected (as is done now by Medicare) for people who do not enroll on time so that other consumers were held harmless. Finally, health insurance mandates hardly break new ground—since 1965, for example, American workers have been required to subsidize health insurance for Medicare beneficiaries.

Employer mandates have been proposed as an adjunct to and, occasionally, as a substitute for an individual mandate. The attraction of employer mandates is that they are perceived by some to “level the playing field” between employers that offer insurance and those that do not, and to use private rather than public resources to subsidize low-income workers. Building on the current employment-based system also reduces (although does not eliminate) the need for new mechanisms to pool risks.

By itself, an employer mandate would not ensure universal coverage, if for no other reason than not everyone is employed or in a family with an employed worker. And the strength of an employer mandate for expanding coverage would depend on how many exceptions were granted (small firms, low-wage firms, part-time workers, dependents, and so on, are often exempt from legal mandates for economic and operational reasons). Critics of employer mandates argue that the need to be competitive means most employers that can afford to offer health benefits do so, and that a mandate would have a negligible effect on expanding coverage and would impose new costs and reduce flexibility in ways that could lead to job losses. Economists believe that labor costs of any kind mandated on employers are ultimately paid for by employees; in other words, an *employer* mandate is, in the end, an *employee* mandate. Under some circumstances, however, employers may bear some of the costs of health benefits because they receive a benefit from offering health benefits that they would not realize by paying workers strictly in cash wages; in those cases, workers would not fully bear the cost of health benefits in either the short or long run (Garrett and Chernew, 2008, and O'Brien, 2003). Furthermore, the issue is even less clear cut among employers and others.⁸

Implement Effective Risk Adjustment

Today's health insurance markets punish plans that attract—strategically or not—sicker enrollees and reward those that attract healthier enrollees. Guaranteed issue and modified community rating (discussed in more detail below) both put a premium on attracting favorable risks; the former prohibits avoiding the bad risks and the latter prevents charging more for them. Effective risk adjustment is therefore essential to eliminate risk selection as an insurance business model—forcing competition on costs and quality—and would improve market stability by acting as a kind of reinsurance for small plans that might get a “bad draw.”

Risk adjustment would function in the background to move funds from plans that enrolled predictably low-cost enrollees to those that enrolled predictably high-cost people.⁹ It would also reduce incentives to avoid chronically ill and disabled enrollees and seek out healthy ones. However, risk adjustment is easy to say, and much harder to do. For example, it requires distinguishing between high costs attributable to *having sicker enrollees* and high costs attributable to *inefficient care provision*. Risk adjustment should not punish plans that achieve low costs through efficient management rather than selection.

No risk adjustment scheme will ever be sensitive enough to match the variation in health costs across individuals, meaning that there will always be a financial incentive to figure out what distinguishes the high-cost people in any group from the low-cost people. But risk adjustment need not be perfect; it need only make risk selection a less effective way to control costs than care management and other efficiencies.

Focus on Benefit Comparability

Just as it is necessary to limit variation in premiums that individuals can be charged to make guaranteed issue viable, so too it is necessary to specify what the insurance benefit covers. Without standards governing cost sharing, covered services, and network coverage, there is no way to assess whether requirements to purchase or issue coverage have been met.

This is a highly charged issue that, along with the individual mandate, confronts the “freedom of purchase” issue head on. However, the practical reality is that the status quo—with its relatively complete freedom to buy (or not) whatever insurance product the market can dream up—is not achieving a desirable outcome.

Economists generally argue in favor of consumer choice because having more choices increases social welfare when they are cheap to accommodate and decisions are not interdependent (that is, one person's choice of what to buy does

not impact what is available to others). A trivial example is product color; if some people like white shirts and others like blue shirts, all are better off if both colors are produced.

However, in health insurance markets, choices are highly interdependent. Tradeoffs exist between flexibility (allowing wide choice), workability (achieving policy goals), and fairness (not permitting underinsurance or high cost sharing to be financed by charity care). For example, the more benefit design is allowed to vary to meet consumer preferences—with high deductibles for some and comprehensive coverage for others, carve-outs, formularies, and so on—the more difficult it is to avoid and detect gaming and favorable selection.¹⁰

Variation that makes it hard for policymakers to assess policies would be acceptable if consumers benefited. But both research and practice suggest that confronting consumers with a large number of complicated benefit designs does not make them better off.¹¹ Without a standardized means of comparison, it may be very difficult (if not impossible) to judge the value of one complicated insurance policy against 20 others. Similarly, how can one judge whether a hospital is providing quality care if each hospital develops its own measure of quality?

Some amount of standardization is observed in markets for many goods and services, sometimes purely through voluntary action on the part of participants (beverage can size, computer keyboard layouts, and so on), and other times as a consequence of government regulation (Medigap policies, Part D benefits, bumper heights on automobiles, interest rate disclosures). It is fair to raise the issue of how much standardization (limitation of variation) of health plan design, documentation, and processes is appropriate; it is not fair to pretend such a policy would, by default, be an unprecedented attack on free markets.

Subsidize Insurance for Low-Income Individuals and Families

A mandate to purchase health insurance would only be feasible—and only be fair, many would argue—if it did not impose undue financial hardship. For low- and middle-income workers, premiums for even a modest package of benefits could easily consume an unreasonable share of income. For example, the average annual single premium for a commercially insured worker was \$4,700 in 2008 (or more than 30 percent of what a full-time minimum wage worker would have earned), and, at \$12,680, a family premium was virtually 100 percent. At higher income levels, what should be considered “burdensome” is a judgment call.

Subsidies are expensive, and previous reform proposals have contained a number of mechanisms to limit their size. But trying to limit subsidies is not easy:

- First, when health costs consume at least 15 percent of gross domestic product (GDP), the simple arithmetic is that the average premium will be at least 15 percent of income; the more generous the subsidy scheme, the greater the tax burden on those not eligible for subsidies.¹²
- Second, the temptation to reduce the cost of premium subsidies by allowing less generous benefit designs (with correspondingly lower premiums) is potentially self-defeating, as it would shift costs from subsidies to out-of-pocket payments by the sickest.¹³

Subsidies introduce a host of difficult technical and policy questions about how to pay them (refundable tax credits, payments directly to insurers and/or employers, and so on), at what level of income to phase them out (too slowly is expensive, too quickly discourages work through high implicit marginal tax rates), and whether they reinforce or counteract competitive forces (fixed-dollar subsidies maximize price sensitivity but leave individuals at risk for rising premiums if care costs go unchecked). An additional question is how to account for significant variation in health care costs across the country.¹⁴ A fixed national subsidy could be seen as short-changing high-cost regions, while fully variable subsidies would continue to reinforce unwarranted care variations.

Require Modified Community Rating

For better or worse, health coverage in the United States has evolved to incorporate two functions: insurance and income redistribution.¹⁵ The insurance function spreads risk across equally risky individuals and makes everyone in the pool better off. Income redistribution arises when insurance pools contain individuals with different levels of “baseline”

risk. Young people charged the same premium as older people subsidize the latter's higher predictable costs and would be better off financially in a risk pool of their peers. And in a voluntary market, this implicit subsidy leads to good risks underinsuring and poor risks overinsuring.

Taken alone, an individual mandate and guaranteed issue would reinforce the tendency of insurance markets to fragment along risk lines. Because costs vary widely by age and other factors, healthy people mandated to purchase insurance would have a potentially significant incentive to seek out "pools" of similarly healthy people. To stay in business, insurers would seek to accommodate this demand and at the same time be forced to raise premiums to cover the costs of the care for people remaining in sicker pools. Taken to the limit, this would set up a situation that a) entailed significant underwriting costs related to assessing individuals' risks and b) put the financial burden of illness on sick people (absent any subsidies for premiums).¹⁶

Modified community rating would allow premiums to vary somewhat across demographic groups (such as age and perhaps gender and health behaviors such as tobacco use) but not within them and not to the same extent that costs vary. It would thus embed some income transfers to sicker people through lower insurance premiums, rather than explicit subsidies. But it would also allow for larger risk pools and lower transactions costs (a real efficiency gain). How many groups and how much variation to permit are open policy questions.

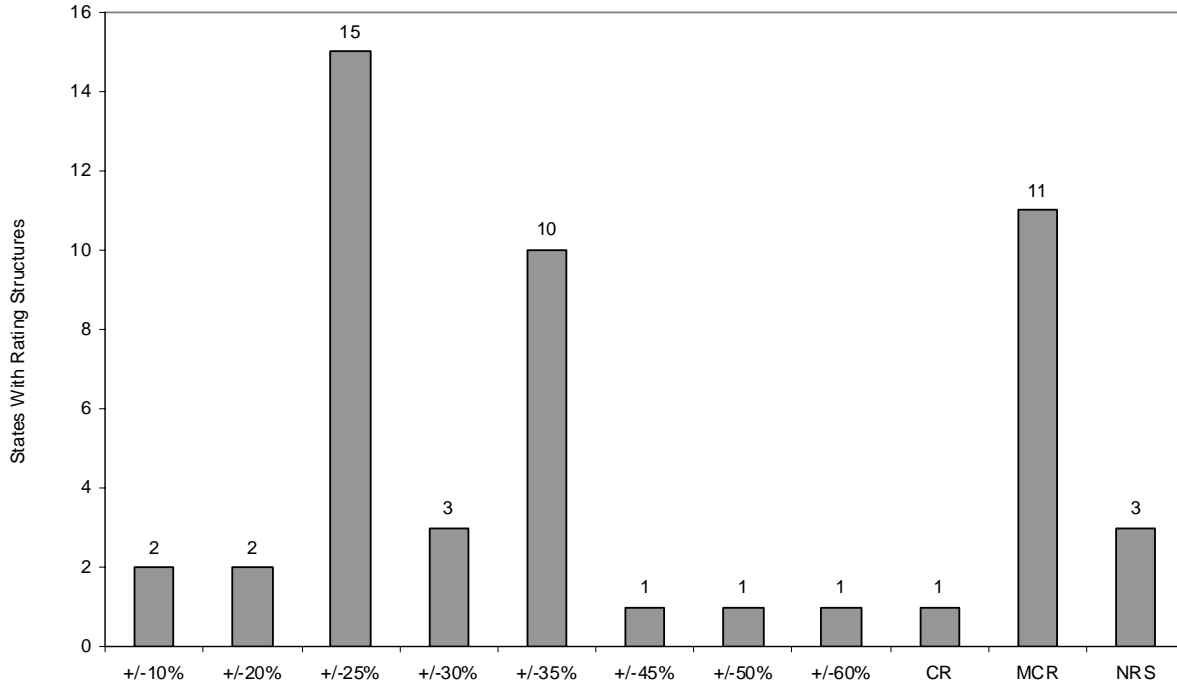
Modified community rating already exists at the state level to a degree. Figure 2 shows the variation in rating restrictions across the states, and Figure 3 contains a summary of those ratings. Eleven states already use modified

**Figure 2
Small-Group Market Rating Structures,
by State, October 2007**

| | | | |
|---------------|-----|----------------|-----|
| Alabama | 20% | Montana | 25% |
| Alaska | 35% | Nebraska | 25% |
| Arizona | 60% | Nevada | 25% |
| Arkansas | 25% | New Hampshire | MCR |
| California | 10% | New Jersey | MCR |
| Colorado | MCR | New Mexico | 25% |
| Connecticut | MCR | New York | CR |
| Delaware | 35% | North Carolina | 20% |
| Florida | MCR | North Dakota | 35% |
| Georgia | 25% | Ohio | 35% |
| Hawaii | NRS | Oklahoma | 25% |
| Idaho | 50% | Oregon | MCR |
| Illinois | 25% | Pennsylvania | NRS |
| Indiana | 35% | Rhode Island | 10% |
| Iowa | 25% | South Carolina | 25% |
| Kansas | 25% | South Dakota | 25% |
| Kentucky | 35% | Tennessee | 35% |
| Louisiana | 35% | Texas | 25% |
| Maine | MCR | Utah | 30% |
| Maryland | MCR | Vermont | MCR |
| Massachusetts | MCR | Virginia | NRS |
| Michigan | 45% | Washington | MCR |
| Minnesota | 25% | West Virginia | 30% |
| Mississippi | 25% | Wisconsin | 30% |
| Missouri | 35% | Wyoming | 35% |

Source: http://www.nahu.org/Legislative/market_reform/marketreformschartstate.pdf
MCR = Modified community rating
CR = community rating
NRS = no rating structure

Figure 3
Summary of Rating Structures in Small-Group Market, October 2007



Source: http://www.nahu.org/Legislative/market_reform/marketreformschartstate.pdf

community rating, while 19 states limit variation in premiums to no more than +/- 25 percent of the average. Hence, moving to more restrictive rating bands would affect people in some states but not in all of them.

The situation regarding rating is complicated by the presence of self-insured and association plans, both of which limit coverage to members of defined groups. A desire to build on the current system—or at least minimize disruption of currently insured people—suggests leaving these arrangements alone. But allowing healthier-than-average groups to opt out of the community pool would make it more difficult to maintain affordable competitive insurance markets than a situation in which insurers had to take all comers.

Guarantee Issue of Insurance

Given an individual mandate—and *only* in the presence of such a mandate—effective managed competition would require insurers in a geographic area to sell statutorily acceptable insurance coverage to any individual or family in that area seeking to purchase it. The simple rationale for this argument is that a requirement to buy is meaningless without a requirement to sell; otherwise, high-risk individuals would be excluded from the market.

But merely requiring insurers to guarantee issue in a geographic area would not ensure that any were there to do so. Some geographic areas may be too sparsely populated; in others, the income and health status of the population could make offering coverage unattractive. As discussed in the next section on fallback coverage, policymakers have several options.

Delivery system capacity should also be taken into account. Traditional HMOs that marry an integrated delivery system and a health plan may not have the physical capacity to expand enrollment. Network plans may be able to expand

capacity more easily, but possibly by having to contract with higher-cost or lower-quality providers they would otherwise reject.

Provide Fallback Coverage

An individual mandate requires that people who must purchase insurance have options for doing so. To protect residents of geographic areas that might lack private insurers, some mechanism would be needed to make coverage choices available. Such mechanisms might include deeming people to be residents of geographic areas with participating insurers, or offering a financial inducement for plans to participate in underserved areas. Fallback coverage could also entail a public or nonprofit plan that was very limited in scope and operated as an insurer of last resort that simply paid according to a fee schedule. This is a different role from that envisioned by supporters of a full-fledged public plan that would compete with private insurers, not operate only in their absence.

The possibility that no one might come to the party concerned the authors of Medicare Part D, who had been advised that offering a drug benefit through private insurers was likely to leave some areas without plans. The legislation included both the public fallback and financial inducement options, but, as it turned out, the financing mechanism was sufficiently generous that fallback plans were not needed.

The Role of the Sponsor and the Exchange

Ensuring effective competition would entail a set of governance functions undertaken by the sponsor and a set of operational functions handled by the exchange. Some of these exist today (although not necessarily in the needed location or at an appropriate level) and some would require new capacity. These functions include, but are not limited to:

Governance

- Enforcing the individual mandate.
- Specifying permissible benefit designs.
- Determining eligibility for subsidies.
- Providing for fallback coverage.
- Making risk adjustment work for insurers.

Operational

- Administering subsidies.
- Providing accurate and objective premium and benefit information to consumers.
- Enforcing guaranteed issue and ensuring rating compliance.
- Auditing or handling cash flows.

The success of the health insurance exchange is where the rubber meets the road. It is no small undertaking for a sponsor to produce what markets themselves have failed to do. This puts a high premium on introducing no more regulatory complexity than needed to achieve an objective; it also argues for being prepared to make adjustments on the fly on the grounds that it is difficult to specify everything in advance. The original Clinton proposal was widely criticized for being overly complex in its specification of the tasks listed above. That complexity resulted in part from trying to anticipate every contingency. Medicare Part D, by contrast, had many fewer moving parts and still stumbled out of the gate.¹⁷

Some observers fear the creation and success of a health insurance exchange will entail much more *management* than *competition*. Certainly, exchanges would require a high degree of sophistication in administration and management to execute a complex set of tasks. But that need not imply rigidity; delegation of authority and making allowances for real-world variation could alleviate some concerns. Just as speed limits can be written strictly and enforced loosely, so too can be the rules of the market.

Achieving Long-Term Cost Containment

Absent mechanisms to restrain growth in the underlying costs of care, the combination of universal coverage and subsidized premiums would produce even faster cost growth than the current system. After all, the point of expanding coverage is to pay for health care services that people are presumed not to be getting now. In the short run, policymakers may well judge the additional expenditures worth it to expand access to coverage. But in the long run, failure to address the underlying drivers of costs would make this expansion unsustainable.

An ever-lengthening list of tools has been proposed to constrain costs in health care: increased individual accountability through cost sharing, pay for performance, improving chronic condition management, sponsoring comparative clinical and cost-effectiveness research, fostering price transparency, spurring competition in provider markets, capping the tax exclusion for private health insurance, implementing electronic medical records, increasing prevention, and so on. Under the best circumstances, only some of these tools will lead to lower spending; some will produce better value at higher cost. And insurance market reform alone will not produce the best results without some way to also control costs.

What has been missing in many discussions is the need to align the payment for health care services by public and private insurers to the desired outcomes. When health care is purchased one service at a time, it is always in *providers'* financial interests to charge as much as possible and to furnish as many services as *patients* demand and insurers pay for. Arming them both with better knowledge and better tools will not be sufficient; payment systems need to encourage the use of knowledge and tools.

The larger problem is that payment systems have evolved around seeking the right price for the wrong unit of payment. Private insurers have explored a range of options to introduce sensitivity to costs in physicians' decisions only to be stymied by a legislative, media, and regulatory backlash. Medicare, over a 40-year period, has evolved from paying providers their costs to having fee schedules for virtually all of the services it buys. But paying "efficient" costs for an avoidable hospitalization or an unnecessary imaging service is not efficient. Ensuring that a stent was implanted safely begs the question whether the implant was necessary in the first place. Ultimately, cost containment will require payment reform that entails bigger bundles of services and moves away from fee-for-service.

The other half of the long-term cost containment equation relates to quality of health care services delivered. As the Institute of Medicine noted in its landmark report, *Crossing the Quality Chasm*, "The problems we face in U.S. health care are sufficiently profound that just trying harder will not work. We need to try differently." The problems we observe today stem from having a largely fragmented delivery system in which financial incentives are misaligned with broader objectives and clinical responsibility. Ultimately, insurance market reform will address the problem of access, but it will not by itself address costs and quality. For that, the nation needs to move from the current fragmented system of care to one that features a much higher degree of "systemness," meaning a far more comprehensive approach.

Notwithstanding nascent efforts to reward plans and providers for better care, the U.S. health care system is, for the most part, one that rewards providers and manufacturers for delivering more care at higher prices without regard to quality. Unless and until an information infrastructure is developed to support integration across providers, hold someone in the care delivery chain accountable for health outcomes and not just care processes, and change the payment system to support these objectives, we are doomed to continue on our current path. While a nation of large integrated delivery systems is neither necessary nor likely, the nation should be able to do far better than the fragmented system it has now.

Changing the delivery system entails a policy conundrum (Crosson, 2009). On the one hand, payment reforms that hold providers accountable for a larger bundle of services require providers with sufficient size and expertise to manage the greater financial risk. On the other hand, few such provider organizations have developed because payers have not developed the kinds of payment reforms that would reward them for doing so. Thus, health care delivery system reform will have to proceed largely contemporaneously with payment reform—and the process will be incremental, not revolutionary. But absent such changes, managed competition—and any other reform that does not address the fundamentals—will founder.

Public Plan Option in the Exchange

Both President Obama and Sen. Max Baucus (D-MT), chairman of the tax-writing Senate Finance Committee, have supported offering a public plan option within the health insurance exchange. A public plan option could be limited to a fallback provision for certain segments of the population or could be open to the entire population. While details regarding the public plan have not been released as of this writing, this option appears to be shaping up to be one of the most contentious issues in the health reform debate. An overall distrust of health insurers and the difficulty in regulating the insurance industry are two primary reasons for interest in a public plan (Nichols and Bertko, 2009). Proponents also believe that the availability of a public plan would be necessary to drive private insurers toward true competition. Opponents view the public plan option as a step toward government-run health care and are wary of cost shifting from public payers to private insurers.¹⁸

A public plan could have the means to lower costs in a number of ways, but setting provider payment levels at already-low Medicare levels is the most likely action in the short run. A public plan with premiums lower than private plans would either drive private plans to reduce costs to be competitive, or drive private plans out of business if they could not negotiate the same provider payment levels as the public plan. By contrast, a public plan designed in such a way as to prevent it from exploiting any unfair advantages or perverse incentives might not realize any premium savings as compared with private plans.

A public plan could exacerbate cost shifting from the public sector to private plans. It is well known that premiums for employment-based health benefits are higher than they would otherwise be because the federal government sets prices through Medicare. If this continued under a public plan option in a health insurance exchange for the under-age-65 population, private plans would see costs increase as health care providers increased rates to those plans. As long as premiums in the public plan were lower than those in private plans, individuals would flock toward the public plan, ultimately resulting in fewer private plans. Private plans would drop out of the market as they determined they were unable to compete with the public plan.

The Lewin Group found that if eligibility for the public plan was broad and the public plan paid providers using Medicare payment levels, premiums for the public plan would be 32 percent less than private plans and about 119 million individuals would shift from their current coverage to a public plan, were such an option available.¹⁹ If the public plan was on a level playing field with private plan options, the public plan would be able to offer coverage at 9 percent below private-plan options, and private coverage enrollment would decline by 13 million people.

Proposals for a Health Insurance Exchange

President Obama and Sen. Baucus both support establishing a health insurance exchange for individuals and small businesses that would not only include private health plans but a public plan option as well. The Baucus proposal, released as part of his larger vision for health reform, provides much more detail than President Obama's proposal, and is therefore the focus of this section.²⁰

Under the Baucus plan, subsidies would be available for those who could not afford coverage, and health plans would not be allowed to deny coverage due to pre-existing conditions. The exchange would provide an array of options, a

State Experience With a Health Insurance Exchange

Many states have passed legislation to expand health insurance coverage. Most have expanded the State Children's Health Insurance Program (S-CHIP) or Medicaid programs by permitting eligibility at higher income levels, and a number of states have established commissions to address access, cost, and quality. Massachusetts has enacted the most comprehensive health reform plan among the states and is seen as a model for other states and for national reform. It has received much attention because of the joint imposition of an individual and an employer mandate.

All Massachusetts residents were required to have health insurance as of July 1, 2007. Financial penalties were put in place for individuals who did not comply with the mandate, although hardship exemptions were allowed and some individuals are not subject to the mandate because it has been determined that insurance coverage was not affordable for them.

Employers with more than 10 employees are also required either to offer health coverage or pay a "fair share" contribution to the state. In addition, employers must offer a Sec. 125 plan in order to allow workers to pay their share of the premium on a pre-tax basis.

The state reformed the nongroup and small-group insurance markets by creating a health insurance exchange to provide a purchasing mechanism. The exchange (known as the Commonwealth Connector) has two parts:

- Commonwealth *Care* provides subsidized health coverage for individuals up to 300 percent of the federal poverty level who are not eligible for public coverage or employment-based coverage. It also covers individuals up to 100 percent of the federal poverty level who were previously covered by the state's high-risk pool.
- Commonwealth *Choice* is the unsubsidized part of the exchange. Individuals and employers with 50 or fewer workers are eligible to get their coverage through Commonwealth Choice. Six nonprofit insurers that represent about 90 percent of the commercial fully insured market currently offer health coverage. The insurers—Blue Cross Blue Shield of Massachusetts, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, Neighborhood Health Plan, and Tufts Health Plan—offer a range of health plan options with different premiums and cost-sharing levels, tiered by actuarial valuation standards.

Massachusetts health reform has been deemed a success in that, as of August 2008, 439,000 previously uninsured individuals had gained coverage since the start of the program. More than 176,000 individuals received coverage through Commonwealth Care, the subsidized side of the exchange, while Commonwealth Choice, the unsubsidized part of the exchange, covered about 18,000 individuals as of June 30, 2008. Another 167,000 individuals were newly insured through a private plan purchased directly from an insurer or through their employer.

The health insurance exchange is governed by a board that has the authority to establish policy on affordability and the benefits package. The board also negotiates premiums with the health plans.

Massachusetts health reform has also been deemed a failure because overall spending on health care is higher than the national average and has grown more rapidly. Higher spending cannot, however, be tied back to Commonwealth Choice, in which 18,000 individuals are enrolled. Health care spending is growing more rapidly for other reasons.²¹

A number of other states have also expanded coverage through private health plans. In 2006, Vermont created a number of low-cost and free health coverage programs. Premium assistance is available for persons with incomes under 300 percent of the federal poverty level for coverage in the nongroup market and to enable workers and their families to get coverage through an employment-based plan.

Maine also has a program, known as Dirigo Health, created in 2003. Small businesses, the self-employed, and people without access to employment-based health benefits are eligible for the program. People with incomes under 300 percent of the federal poverty level are eligible for subsidies on a sliding scale that varies with income, and are also eligible for reductions in deductibles and other out-of-pocket cost sharing.

standard enrollment application, and individuals could compare plans based on a number of different factors, such as premiums and quality of care provided by the plan.

Employers offering coverage through the health insurance exchange would have to enroll all of their employees. Insurers offering health plans both inside and outside of the exchange would be required to offer the same products at the same premiums. The proposal is silent on whether health plans would continue to be regulated at the state level, as they currently are.

Health plans would be reimbursed by the exchange for any enrollment related to a disproportionate number of sicker-than-expected enrollees. However, the proposal would also impose new rating rules in the exchange and in the nonexchange private market, preventing plans from denying coverage to persons with pre-existing conditions, and make other changes governing rating practices.

Employers, except the smallest ones (not yet defined), would be required to offer a Sec. 125 plan so that workers could pay their share of premiums with pretax dollars. Employers not offering coverage would be required to pay a percentage of payroll, that varied by firm size and annual revenues, into a fund to be used to provide coverage to uninsured workers.

The Baucus plan also envisions the creation of an Independent Health Coverage Council. The Council would provide guidance on what is considered affordable coverage in the exchange. It would determine income-related out-of-pocket cost limits. It would also set standards for chronic care management and quality reporting within the exchange.

Industry Groups—A number of corporate groups have endorsed the idea of a health insurance exchange as a central component of health reform. In May 2007, the ERISA Industry Committee (ERIC) released *A New Benefit Platform for Life Security*.²² ERIC believes that competing sponsors or benefit administrators (BAs) are in a much better position than individual employers to oversee what they view as community-based health systems. Each BA would offer three to five standard health plans that would be designed either by the federal government, the National Association of Insurance Commissioners, or some other entity. There would be an individual mandate, and subsidies would be available for lower-income persons. Employers would continue to finance coverage for their employees, but instead of offering coverage they would choose one or more BAs to sponsor coverage for their employees and could make a direct payment to the BA chosen by each employee. ERIC sees employers as making a fixed contribution similar to the Enthoven proposal, and workers would then be free to pick a plan whose premiums were at or below the fixed contribution (if one were available) or they would be free to pick a higher-cost plan by paying the difference between the fixed contribution and the premium for it.

ERIC also proposes that health plans be required to be offered on a modified community-rated basis. Age-rating would be allowed for individual plans but not employment-based group plans. Premium adjustments would be allowed for lifestyle risks such as smoking and alcohol consumption. Health plans would be allowed to adjust premiums based on administrative practices, and any savings realized from health promotion, disease management, and other innovations designed to lower costs and improve quality.

ERIC also believes that there should be definitions and standards for quality care that cover both process and outcome measures applied to doctors, hospitals, and delivery systems. Health plans would also be subject to transparency and accountability standards. Furthermore, information gleaned from transparency initiatives would be used to implement payment methodologies that reward high-quality, lower-cost care.

Like ERIC, the Committee on Economic Development (CED) has also endorsed the concept of managed competition, in its report *Quality, Affordable Health Care for All: Moving Beyond the Employer-Based Health-Insurance System*, released in October 2007.²³ The CED proposes that individuals be able to choose from “health-care delivery systems.” However, the proposal in large part limits the presentation to a discussion about individuals choosing health plans and being provided by a fixed contribution from the federal government, funded through a broad-based tax on workers and employers. Furthermore, in the CED proposal, employment-based health benefits would cease to exist. An individual

mandate would not be enforced but would be *implied* in the sense that all individuals would be paying for coverage through the broad-based tax.²⁴

Health Plans—George Halvorson, CEO of Kaiser Permanente, and author of *Health Reform Now! A Prescription for Change* (2007), takes the notion of competition one step further than the health exchange. In addition to creating a marketplace for health insurance plans, Halvorson's infrastructure vendors (IVs) proposal would also create a marketplace for health care services. Halvorson's plan goes into great detail describing the optimal marketplace for health care services—and how it would provide consumers with the means to make informed choices about both caregivers and health care.

The BlueCross BlueShield Association (BCBSA) has also endorsed the creation of a health insurance exchange.²⁵ It proposes health insurance exchanges based at the state level and argues against creating a new federal agency.

America's Health Insurance Plans (AHIP) does not officially support or oppose any type of health insurance exchange, but does support guaranteed issue of health insurance as long as there is an individual mandate.²⁶ Individuals with pre-existing conditions would be able to purchase health insurance coverage as long as all individuals are required to purchase coverage. Subsidies would be available for those with low income.

Implications for Employment-Based Health Benefits

The availability of a health insurance exchange could have implications for the future of the existing employment-based health benefits system.

On the one hand, a health insurance exchange is envisioned to be part of an equation that not only improves competition among health insurers but also brings efficiencies in the delivery of health care to the market. Both are expected to reduce health care costs, which would benefit both workers and employers.

On the other hand, it is logical to ask whether employers would respond to the availability of a health insurance exchange by dropping health benefits.

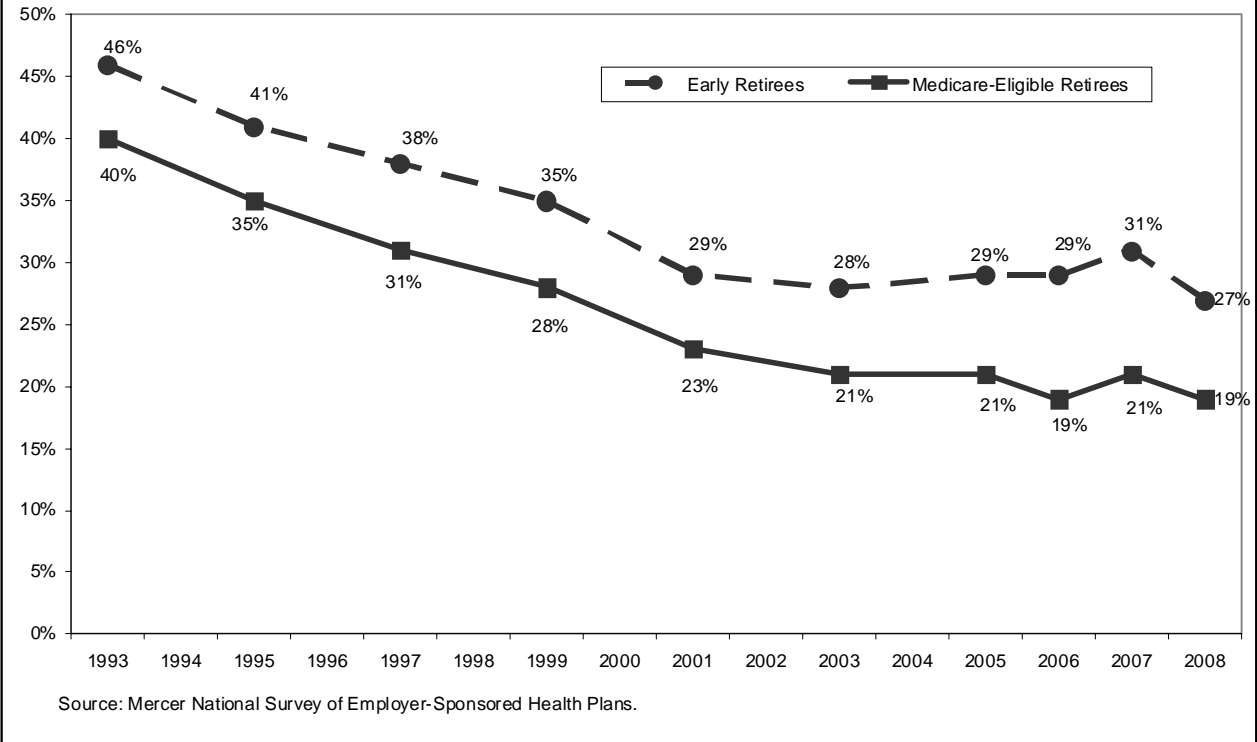
Employers offer health benefits for several reasons: to recruit and retain workers, to improve worker health status and thus productivity, and to provide a viable alternative for purchasing health care coverage (Fronstin and Helman, 2003; and Fronstin, 2007). If these reasons for offering health benefits to workers become less important, absent an employer mandate, employers might drop health benefits.

If employers do not think they need to offer health benefits to be competitive in the labor market, they might drop coverage. The weak economy—with a national unemployment rate of 9.4 percent in May 2009, the highest level seen since the 1982–1983 recession—means employers are less inclined to argue that they need to provide health benefits to be competitive in the labor market. Furthermore, the availability of an exchange would provide the functional health insurance market that many employers think must exist before they would stop offering health benefits.²⁷

Dropping health benefits would not only reduce the costs associated with coverage but would also reduce the costs associated with benefits enrollment and administration, time spent negotiating with health plans, and quality monitoring. Furthermore, the costs associated with COBRA would be eliminated, although with the availability of a health insurance exchange, questions would arise as to the need for the availability of COBRA coverage. The degree to which employers would save money would depend on whether and how much of the cost savings was passed along to workers.

The availability of a health insurance exchange could also give employers offering health benefits to retirees not yet eligible for Medicare a means to drop those benefits. While it can be argued that employers have already been dropping health benefits for early retirees, the availability of an exchange could accelerate the trend (Figure 4). Retirees under age 65 are the most costly age cohort to insure outside of the Medicare program. If retirees were guaranteed access to health insurance that covered pre-existing conditions and could be purchased on a modified

Figure 4
**Percentage of Employers With 500 or More Employees
 Offering Health Insurance to Retirees, 1993–2008**



community rating—and at the same time were offered a greater choice of health plans than what could be offered by an employer—they would likely find the exchange a very attractive option at the same time that employers were seeking to drop the benefit. Sen. Baucus’ proposal includes a provision allowing pre-65 retirees to buy into the Medicare program, until the health insurance exchange is fully phased in.

Experience in Massachusetts

In predicting whether employers would drop coverage once a health insurance exchange is available, prognosticators will examine the experience in Massachusetts. There is no evidence to suggest that employers there have dropped coverage because of the availability of the health insurance exchange for workers. However, it may not be possible to generalize the experience in Massachusetts to the national level.

First, it may be too soon to see the effects of the availability of a health insurance exchange on employer behavior. The law took effect in July 2007, and decisions for 2008 were made in late 2007 when the economy was still strong, making it difficult for employers to drop health benefits. Any cutbacks that might have occurred in late 2008 or early 2009 could reflect the availability of the health insurance exchange or a weaker economy; distinguishing causes is difficult. It may also be too soon because employers tend to take a wait-and-see approach, and any transition away from health benefits in the work place would not occur overnight.

Health reform in Massachusetts included an employer mandate. Employers are required to offer a group health plan and to make a “fair and reasonable premium contribution.” Employers that do not offer health benefits are required to contribute \$295 per employee to the Commonwealth Care Trust Fund. While the \$295 may not seem like a large penalty for not providing coverage, employers with more than 10 employees and not offering health benefits also may be subject to a “free-rider” surcharge when their employees receive uncompensated care.

If national health reform includes an employer mandate along the lines of this “play or pay” provision, employers already offering health benefits may find it advantageous to continue offering them. As long as employers are required to pay a portion of the costs of health benefits, they may want some control over the way that money is spent. Employers have invested heavily in health promotion and disease prevention programs to control health spending and to maintain a healthier, more productive labor force. If employers think that they can do a better job than the plans in the health insurance exchange in providing these programs, then they may continue to provide them. Alternatively, employers might drop traditional health benefits, but continue to offer supplemental programs, such as the health promotion and disease prevention programs that they consider valuable. If national health reform does not include an employer mandate, then the experience in Massachusetts cannot be used to predict employer behavior.

Another reason why the experience in Massachusetts should not be used to predict employer behavior is that employers may respond differently to a nationally available exchange than to an exchange in one state. Large employers typically take the lead in designing and experimenting with benefit program changes. Large employers in Massachusetts may not have changed or terminated benefits to workers in that state as a result of the availability of the exchange if one of their goals was to provide a uniform benefits package across states. The availability of a national health insurance exchange could allow large employers operating in multiple states to provide a fixed-contribution to workers in all states, even if health insurance exchanges were provided on a state basis, despite any disparities in the types or cost of coverage available.

Employer Role

Employers play a crucial role that goes above and beyond simply offering health benefits to their workers. In some sense, employers act as a watchdog. Employers often act as an advocate for workers during coverage disputes between the insured and the insurer. For example, an employer experiencing widespread dissatisfaction with a specific health plan will either find a new health plan or threaten to find a new health plan if the insurer does not respond to the issues brought up by members of the plan. Insurers are more likely to respond to an employer than to an individual because of the risk of losing a large group contract when that group is not adversely selected.

Employers also frequently become involved in matters of quality assessment of care and influencing health care matters in the policy development arena. With the rise of health care costs in the 1970s and 1980s, large employers began to pay closer attention to health care quality. One aspect of this increased attention was the formation of coalitions of employers to facilitate the sharing of information about health care quality and health care providers in order to contract with the best insurers and providers. Many believe that employers are better able than individuals to perform the role of monitoring quality of health care.

However, proponents of a health insurance exchange do not envision individuals as filling the watchdog role that employers play. In a health insurance exchange, individuals will have options and if they are dissatisfied with their health plan they can change plans at open enrollment. Furthermore, health plans would not have an incentive to avoid bad risks if effective risk adjustments are employed. In terms of driving quality and innovation in health care financing and the delivery of health care, supporters of a health insurance exchange point out that it will be overseen by a governor, who will effectively take over many of the roles employers now have.

Workers and Retirees

The potential for a health insurance exchange to trigger a movement away from traditional employment-based health benefits raises questions for workers as well. Will employers provide a fixed contribution for the purchase of health insurance through an exchange? Will the fixed contribution be large enough to purchase coverage? Will the fixed contribution be flat, or will it vary by such factors as worker health status, age, geographic region and/or marital status or the presence of children? Will the fixed contribution increase as health insurance premiums increase? Will the fixed contribution be treated as taxable income?

The answers to these questions can only be known definitively as more detail about health reform is known, but it is possible to speculate as to the winners and losers under a scenario in which employers no longer provide health benefits.

For instance, it is certain that workers would be winners if the *only* issue examined is job lock. In 2008, 25 percent of adults reported that they or an immediate family member had either passed up another job opportunity, stayed at a job they would have quit otherwise, or did not retire only because of the need to keep health insurance.²⁸

But the picture is murkier when other issues are considered. For example, there will be winners and losers depending on if and how employers distribute the money that they spent on workers' health benefits. If workers were all given an equal sum of money regardless of age, and health insurance was available on a modified community-rated basis, as has been proposed and would allow insurers to set rates based on age, then young workers would get more money than necessary to purchase health insurance while older workers would not get enough. Under this scenario, employers would have to age-rate the distribution of money that was previously spent on health benefits in order to make workers whole. Questions would also arise as to whether married workers would receive more money than single workers, and how the presence of children might affect any payouts.

Similarly, questions will arise as to whether retirees would be better off under employment-based retiree health benefits or under a health insurance exchange. Retirees whose former employer pools them with active workers in determining premiums (and who were provided that blended rate upon termination of the benefit) would have higher costs in an exchange if premiums were age-rated. In contrast, retirees for whom premiums are set based on a pool that does not include active workers should see premiums in the exchange that were close to what they now pay. This of course assumes that the benefits package is comparable.

The bottom line is that, while the availability of a health insurance exchange and the termination of employment-based health benefits would benefit workers (and employers) by reducing job-lock, and would increase health plan choices for both workers and retirees, terminating health benefits is not as simple as giving all workers the same amount of money when premiums in the exchange are determined on a modified community-rated basis. Inevitably, complexities would be introduced into the transition that would create winners and losers.

Conclusion

Comprehensive health reform would affect every American. President Obama has said that such reform is intended to improve access to health insurance coverage and therefore health care services. It is also intended to lower the rate of health care cost increases and possibly even reduce the cost of health care.

Managed competition and a health insurance exchange appear to be the primary proposed vehicles for expanding Americans' access to health insurance coverage. For managed competition to work, most analysts agree that a number of components will need to be included: individual mandates, risk adjustment, streamlined comparability of benefit design, subsidies for the low-income population, some form of community rating, and guaranteed issue. Most also agree that, absent mechanisms to restrain the growth of the underlying costs of care, the combination of universal coverage and subsidized premiums will produce even faster cost growth than the current system.

Comprehensive reform will affect important sectors of the economy and the labor market as well. Available analysis finds that a public plan option could reduce the overall cost of health care by reducing payments to providers, but possibly at the cost of impairing access to care. The trade-off would be price setting similar to Medicare and movement away from private health insurance coverage. The availability of a national health exchange, whether or not it includes a public plan option, may cause some employers to move away from employment-based health benefits. Employers might start to question the necessity of offering health benefits when workers are not only required to have coverage through an individual mandate, but have the guarantee of getting coverage without fear of pre-existing conditions either being excluded or driving up the premium.

Ultimately, health reform will redistribute resources and income and create winners and losers. Determining the winners and losers will be difficult, given the complexity surrounding health reform and the uncertainty surrounding the behavioral response of patients, providers, employers, insurers, taxpayers, policymakers, and others.

The complexity of comprehensive health reform, combined with the assumed but unknown ultimate effect of reforms, make it impossible to know whether President Obama can keep one of his central health reform promises to the American public: those who like the coverage they now have will be able to keep it. In the end, that simple measure may be what determines the reaction of the general public to whatever is done.

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Endnotes

¹ See www.oecd.org/document/38/0,3343,en_2649_201185_40320102_1_1_1_1,00.html

² The estimates for sources of health insurance and the uninsured will not sum to 100 percent because persons can have insurance from more than one source at the same time or during the course of a year. For example, nearly all of the population age 65 and older is covered by Medicare, while one-third also have (mostly supplemental) coverage through an employer, and another 28 percent purchase supplemental insurance directly from an insurance company. In addition, the nonelderly population may also be covered by more than one source of health insurance coverage during the course of a year. In some instances, a person will have employment-based health benefits for part of the year and Medicaid for a different part of the year.

³ The continuation-of-coverage provision of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers with 20 or more employees to make available continued health care coverage for a specified period to employees (and/or their qualified dependents) who terminate employment for reasons other than gross misconduct.

⁴ As part of the 2009 American Recovery and Reinvestment Act, \$87 billion was provided to the states to shore up their Medicaid programs, and another \$25 billion was provided to individuals to subsidize premiums for COBRA coverage.

⁵ See Enthoven (1978a, 1978b, 1988) and Enthoven and Kronick (1989a, 1989b).

⁶ Professional sports offer an analogy. Team owners typically operate as governors, setting conditions of participation for teams and often the rules of the sport itself. Referees ensure that the rules are obeyed during a game. Teams, having met the conditions of participation, are permitted to play according to the rules.

⁷ See <http://thomas.loc.gov/medicare/>

⁸ A case in point: Recent reactions to the weak economy by employer cuts in matches to workers' 401(k)s have not increased worker wages in the short run.

⁹ Predictability is the issue, not just low or high costs. Insurance is intended to spread the costs of random events; risk adjustment would address gains from enrolling a disproportionate number of (say) young enrollees or losses from enrolling a disproportionate number of (say) people with chronically conditions.

¹⁰ "Actuarial equivalency"—where policies are priced out for average lives does not solve the problem because there are too many dimensions on which to assess equivalence.

¹¹ See DiCenzo and Fronstin (2008), Hibbard et al. (2006), and Schwartz (2004).

¹² Persons age 55–64 spent \$7,787 on health care in 2004, while their per capita income was \$50,400. In contrast, among the population ages 65 and older, median income was \$17,146 in 2004, while per person health spending was nearly \$15,000. See Hartman, et al. (2007), McDonnell (2009), and www.census.gov/prod/2005pubs/p60-229.pdf

¹³ To the extent these out-of-pocket charges go unpaid, the result would be similar to the current situation of uncompensated care and cross-subsidies.

¹⁴ See www.dartmouthatlas.org/ for more detail on how use of health care services varies by geographic region.

¹⁵ Robinson (2005) also notes wellness promotion and wholesale pricing.

¹⁶ The “taken to the limit” scenario occurs in many insurance markets today, except that some people forgo insurance if their pool is too expensive.

¹⁷ One valuable lesson learned was not to introduce a new entitlement program on a Sunday.

¹⁸ One study found that a public plan that pays providers based on Medicare rates would result in a \$43 billion annual cost shift to private payers. See www.hrpolicy.org/downloads/2009/09-48%20Final%202009-3%20AES%20Cost%20Shift%20for%20Public%20Plan%20Policy%20Memo.pdf

¹⁹ See www.lewin.com/content/publications/OpeningBuyInPublicPlanRev.pdf for more information.

²¹ See <http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf>

²⁰ See www.urban.org/UploadedPDF/411820_mass_health_reform.pdf

²² See www.eric.org/forms/uploadFiles/ccea00000007.filename.ERIC_New_Benefit_Platform_FL0614.pdf

²³ See www.ced.org/images/library/reports/health_care/report_healthcare07.pdf

²⁴ Other employer groups support the idea of a health insurance exchange as well. See, for example, www.nfib.com/Portals/0/PDF/healthcare/healthcare-danner-20090505.pdf

²⁵ See www.blueadvocacy.org/uploads/SIMs_One_Pager_010809.pdf

²⁶ See www.ahip.org/content/pressrelease.aspx?docid=25126

²⁷ In 1999, Xerox publically discussed a system in which it envisioned giving each employee, regardless of marital status, a fixed sum of money that could be used to purchase any health plan of the employee's choosing. And, as mentioned in the text, the CED supports ending employment-based benefits, as it believes it is “dragging down the entire health-care delivery system.” See www.unmarriedamerica.org/members/news/1999/usnarch/usnewsarchive-12011999-12051999.html and Rubin (1999).

²⁸ See question 8 in the findings from the 2008 Health Confidence Survey, www.ebri.org/pdf/surveys/hcs/2008/questionnaire.pdf

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