A Private/Public Partnership for National Health Insurance

by Jonathan Gruber

Overview

The private/public partnership approach to health reform proposed in this paper builds on the popularity of a voluntary, private insurance system, while rationalizing public "wrap-around" support for this system. The plan's central features are discussed below.

Purchasing Pools. The central element of the proposal is a set of 51 voluntary purchasing pools established throughout the United States, one in each state and the District of Columbia. The federal government establishes each pool and documents its catchment area. Then it establishes a set of ground rules for any health insurance plan that wishes to be part of the local pool. Any insurance plan that meets those ground rules is eligible to be included in the pool,and plans in the pool offer insurance to potential enrollees at a community-rated price (by family type).

Individuals and Employers. Individuals or employers are eligible to purchase insurance from any plan in their local pool. This purchase is subsidized for lower-income families. All persons in families with incomes below 150 percent of the federal poverty line are enrolled automatically and free of charge in a plan near the pool's median-cost plan. All persons in families with incomes between 150 percent and 300 percent of the poverty line (roughly $25,000 to $50,000 for a family of four) receive a subsidy to help pay to purchase insurance from this pool. The subsidy caps the proportion of income that must be spent to purchase insurance from the median-cost plan in the pool;this cap rises from 0 at 150 percent of poverty-level income to 10 percent of income at 300 percent of poverty. These subsidies can apply to direct individual or employer purchase of insurance from the pool. Persons above 300 percent of federal poverty-level income receive no subsidy, but their insurance may cost them less because they can purchase it through this pool.

Employers are allowed to purchase insurance from the pool; they receive no direct subsidy if insurance is purchased through the pool, but low-income families can use their subsidies to help pay for employer-provided insurance from the pool. Employers and their employees are eligible for these subsidies only if they restrict the employees' insurance choices to plans offered through the pool. Continuation of coverage mandates (through the Consolidated Omnibus Budget Reconciliation Act [COBRA] and state regulation) also are removed for employers buying all their insurance through the pool, providing even greater incentive for employers to join the pool.

Plan Reimbursement. A key consideration with any pooling approach is adverse selection. Plans compete to attract the lowest-risk enrollees, which can raise prices significantly at the more generous plans that some truly sick enrollees may demand. Adverse selection in these pools is minimized through risk-adjusted redistribution across the plans in the pool. This risk adjustment is a mix of prospective (for example, based on demographic characteristics and long-term comorbidities) and retrospective (for example, actual cost outliers) factors.

Financing. This approach involves a significant federal expenditure, primarily through subsidies for the low-income insured. These costs are partly financed from two sources. The first is a cap on the exclusion from taxation of employer-provided health insurance premiums. Any currently tax-preferred spending by employers and employees on

insurance above the cost of the median plan in that state becomes taxable income to the employee.

After a transition period, the second financing source is the phase-out of current public programs that provide insurance to low-income families solely on the basis of income. Medicaid ultimately becomes a program only for the elderly and disabled, and the remaining Medicaid and State Children's Health Insurance Program (S-CHIP) populations move into this new subsidy program. The federal government then saves its share of spending on these programs and recaptures from states their spending on these programs.

Implications. This private/public partnership results in a very different situation for individuals, insurers, and employers. Insurance coverage rises significantly, as affordability, information, and stigma barriers to insurance for the lowest-income families are removed. Coverage is not universal, but almost all families in the United States should be able to buy insurance coverage for 10 percent of their income or less. Insurers offer their products in a competitive environment that provides strong incentives for cost control. Individuals pay the full costs for choosing more expensive insurance products, because the tax subsidy to purchase insurance is capped. This leads consumers to choose cost-effective plans, allowing for increased medical-sector cost control without public spending caps or other awkward interventions.

Background

The proposal developed in this report is designed to meet two key political constraints and to address the two key failings of our current system. The political constraints are that the U.S. Congress is unwilling to expand public insurance programs massively, or to legislate widespread new individual or employer mandates. The first failing is that employer-provided insurance results in incomplete access to pooling mechanisms for such groups as the unemployed,self-employed, and those in small businesses. The second failing is that public safety net programs cannot provide health care to everyone who is uninsured. These failings are discussed in more detail below.

Private Health Insurance

Several features of the current insurance environment call for the private/public partnership approach. The first is that the primary source of health insurance is employers. More than 90 percent of the privately insured, representing 65 percent of the total non-elderly population, are covered by employer-provided insurance. Employer provision has much to recommend it. Workplaces of sufficient size represent pooling mechanisms that are largely independent of underlying health status, providing the kind of predictable distribution of costs potential insurers want. They also provide a means of spreading the fixed costs of an insurance plan across a number of insured persons. In addition, human resource departments provide professionals generally dedicated to effective provision of benefits, leading to both high satisfaction and innovation in health insurance options.

On the other hand, employer-provided insurance as the primary mechanism of insurance has some failings.First,small employers provide neither the economies of scale nor the needed predictable distribution of expenditures that make them attractive sources of insurance. As a result, while insurance offering is nearly universal among medium-size and large employers, it is much less common among the smallest employers; even in our booming economy, only two-thirds of employers with fewer than 200 employees offer health insurance.

Second,the fact that insurance is linked to work, and is not available at all jobs,can lead to insurance-induced immobility across jobs, or "job lock." Workers who value insurance coverage may not leave their current positions for potentially more productive ones, for fear of losing their insurance coverage.Estimates suggest that job lock may reduce mobility by as much as 25 percent among those with employer-provided insurance. Job lock is mitigated by the availability of continuation coverage under state and federal mandates that allow individuals to continue to purchase insurance from their employer after leaving their jobs,at 102 percent of the employer's full cost of insurance. While research has shown these continuation mandates to be an effective means of increasing insurance coverage among job

changers, they are unpopular with employers because of their administrative costs and the (below average) health of employees who choose to continue their coverage (so that employers lose money, even though workers pay average insurance costs).

Finally, the residual nature of the non-group market has made it an inhospitable environment for those who leave the employer pool. The non-group market features high prices, typically at least 25 percent higher than group insurance costs for healthy employees, and much more for older and less healthy persons. Those with expensive medical conditions may be unable to obtain any coverage, and the coverage available in the non-group market generally is much worse than group coverage, with high deductibles and limited benefits.

A final issue related to employer-provided insurance is that its popularity can be traced, at least in part, to exclusion of employer-provided insurance payments (and roughly half of employee payments for such insurance, as well) from taxation. This tax subsidy has been criticized as regressive: Because it is equivalent to a tax deduction, those who pay the highest income taxes benefit the most. It is also cited as a source of medical cost inflation, because it subsidizes the price of health insurance and can lead individuals to purchase excessively generous insurance plans. Finally, this is a major expenditure for the government, more than $100 billion per year.

Public Health Insurance

In principle, public health insurance in the United States is designed to insure those unable to get coverage from the private insurance market. For the elderly, who are covered by Medicare, this is largely true (with some notable exceptions, such as the lack of coverage for prescription drugs). But some of the non-elderly still have difficulty getting coverage, which results in our high and rising level of uninsurance. In 1987, 14.8 percent of non-elderly Americans had no health insurance. Over the next decade, the non-elderly population without insurance coverage grew by nearly a quarter, to 18.3 percent, so that in 1998 44 million Americans were uninsured. This number declined to 42.5 million in 1999. Particularly troubling is the significant increase in the number of children in the United States who are uninsured; despite dramatic expansion of public health insurance since the mid-1980s,the share of children without health insurance has grown by more than 10 percent since 1987.

Medicaid is the primary source of public insurance. Most Medicaid spending is for insurance for the elderly and disabled, but most of the individuals covered are women and children. Traditionally, only those on cash welfare were eligible for public insurance, but this coverage has now been extended dramatically for two groups: pregnant women (for pregnancy-related expenses only) and children. Currently, pregnant women are automatically covered up to 133 percent of poverty-level income by federal mandate, and most states have extended this coverage to 185 percent of the poverty level or above. Children under age 6 are covered up to 133 percent of poverty level, as well, and most states cover all children to the poverty level or higher under their Medicaid programs. Moreover, the 1997 S-CHIP extended child coverage further by providing block grants to states, which many states have used to extend child coverage to 200 percent of the poverty level or even higher.

Despite these recent expansions, however, enormous holes in the public safety net remain. First, and most obvious, there is no source of public insurance (other than selected small state programs) for adults, aside from pregnant women. Second, even among eligible populations, the number of people taking advantage of this public insurance entitlement is low. Recent estimates suggest that as many as 7 million uninsured children may be eligible for Medicaid or S-CHIP, but are not taking advantage of this eligibility. This is likely due in part to the fact that entire families are not eligible, limiting the incentives for participation, and among middle-class families there is some stigma attached to using public programs. Despite the fact that Medicaid remains an entitlement for low-income families leaving welfare, recent declines in public coverage resulting from welfare reform highlight the difficulties facing the safety net.

Details of Implementation

An enormous number of details must be addressed when implementing a plan such as a private/public partnership. Important questions about such a plan and at least partial answers to them follow.

Eligibility and Subsidy Structure

Based on the income reporting described below, individuals are eligible for one of two kinds of subsidies. If income is below 150 percent of the federal poverty line for that person's family size ("poor" families), then the individual and his or her family members are automatically enrolled free of charge in an insurance plan. The plan is selected randomly from among the plans near the median-priced plan in the pool. The use of a default plan is critical to the success of this approach, because it will increase take-up of insurance by this low-income group significantly. But placing the whole group in one plan that happens to be at the median is potentially inequitable and problematic if the particular plan cannot handle this many enrollees. Therefore, this low-income group is assigned randomly to a small number of plans near the median;the exact number of plans depends on the size of the pool and the range of prices around that median.Of course,these individuals are free to choose a different plan from among those close to the median, and to switch among these plans once they are assigned. The pool administrator notifies plans of any enrollees in this group, and the plan bills the government directly, rather than the individuals, for the premiums.

A second subsidy for individuals in this income range is a cap on the copayments and deductibles for which they are responsible. Individuals enrolled in these plans are subject to maximum copayments of $10 for any visit or drug purchase. In addition, these copayments,and any deductible,are capped at 5 percent of income. Providers notify the plan, which, in turn, notifies the pool administrator, whenever a copayment is charged to someone in the poor group (who is identified by having a separate insurance card). When persons reach the 5 percent of income limit, they are sent a new card indicating that they are no longer to be charged copayments.

Individuals in this income range are also free to choose plans that cost more or less than the median. If they choose plans at above-median cost, they are billed by the plan for the difference between that plan's premiums and the premiums of the median plan. If they choose lower-cost plans, they do not receive the difference. If these cost savings were available,there would be significant opportunity for fraud; low-cost plans might be set up that do not actually provide insurance, but that just allow low-income individuals to turn their subsidies into cash. Because copayments and deductibles are capped for the low-income population, establishing such "cash cows" would be very easy.

The second subsidy group, those families between 150 percent and 300 percent of the poverty line (the "near poor"), receives a subsidy that is structured so that, if they sign up for the median-cost plan, they will never pay more than 10 percent of their family income on insurance premiums. The subsidy is phased in, so that there are no large reductions in subsidy as income grows (that is, to avoid large "implicit taxes" on income generation for families in this income range). In particular, at 150 percent of the poverty line, the cap is zero, with full subsidies; at 151 percent of the poverty line, the cap is 0.067 percent of income; at 200 percent of poverty, the cap is 3.3 percent of income; and by 300 percent of poverty, the cap is a full 10 percent of income.

For example, suppose that a family has four members and an income of $35,000 (roughly 200 percent of the poverty line), and that family coverage in the median-cost plan costs $5,000. That family receives a subsidy for $3,845, the difference between the cost of the median plan and 3.3 percent of the family's income. Individuals are then free to enroll in higher- or lower-cost plans as they wish, but the subsidy amount remains at $3,845, regardless of the plan chosen.

For this near-poor group, if individuals do enroll in a plan that costs less than the subsidy amount,the government will pay them 50 percent of the difference between the subsidy level (which is tied to the median plan) and the premiums in the plan they choose. This provides some incentive to choose low-cost plans, while potentially offsetting some costs of

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this subsidy program to the government.

For this near-poor population (and for any poor individuals who choose above-median-cost plans), the pool administrator would notify the plan of the enrollees' information and how much of a subsidy they are entitled to receive. The plan is then responsible for collecting the difference from the individual, and the subsidy is paid directly by the government to the plan. So, using the example above, the insurance plan bills the individual $1,155 per year, and the government, $3,845. If the individual chooses a cheaper plan—with a premium of $4,000 per year, for example—then the plan bills the individual only $155 per year and continues to bill the government $3,845. If the individual enrolls in a plan with premiums of $3,500 per year, then the plan bills the government $3,500, and the government pays the individual a subsidy of $172.50.

Income for these purposes is a modified version of adjusted gross income (AGI) that includes all income elements, but does not exclude from income deductions from AGI that are included in the current tax code (for example, the ability to deduct contributions to retirement savings accounts). So this corresponds to a gross income concept.

INCOME-RELATED SUBSIDY DETERMINATION

A technical, but absolutely critical, issue of subsidy design is how eligibility is determined. There are two models to choose from. The first is a refundable tax credit/voucher system, with reconciliation. Under this system, individuals apply for subsidies before the plan year, using either their previous year's income or a projection of their income for the coming year. They then receive those subsidies for that year. The following spring, there is a reconciliation process between the income they actually received during that year and the income they anticipated 15 months earlier for subsidy determination. As a refundable tax credit, this approach faces the additional problem of advancing money to individuals 15 months earlier so they can purchase the insurance. As a voucher scheme, however, the payments are advanceable by definition.

The second approach is more like welfare. Individuals apply for subsidies more frequently, and report their income when they apply. If they qualify, they become eligible for that period. There is no reconciliation, although some mechanism must be in place to catch significant dishonesty in reporting income.

The fundamental difference between these approaches is the reconciliation process. Reconciliation does provide a more natural means of correcting over- or underpayments than a backstop fraud mechanism does, but it may significantly deter participation by potential enrollees. For example, taxpayers can take advance payment of their Earned Income Tax Credit amounts, but only about 1 percent of potential recipients do so, partly out of fear that they will underestimate income and owe taxes the next April 15. As a result, a refundable credit/voucher approach could deter take-up significantly, for fear of reconciliation costs down the road.

For this reason, the private/public partnership approach adopts a more welfare-like approach. Every six months, at open enrollment in November and May, individuals are asked to verify their income. Supporting documents are required, such as pay stubs or W2 forms. If individuals qualify for one of the two subsidy programs, they are guaranteed those subsidies, subject to penalties for fraud, but no reconciliation. A significant enforcement program will be in place to ensure that individuals do not abuse this presumptive eligibility by systematically understating their incomes. But prospective enrollees can rest assured that honest mistakes and/or changes in income will not result in penalties.

Subsidies are also available on a shorter-run basis for those experiencing income fluctuations within a six-month period. If individuals can offer proof of income loss (such as unemployment), they can enter the subsidy pool at any point, and from then on, are on the regular six-month schedule.

THE ROLE OF EMPLOYERS

All employers are also allowed, but not required, to purchase their insurance through the local pool. Employers may provide their employees a menu of insurance options that includes some plans from the local pool, and some from outside the pool. There are two significant incentives for employers to limit their employees' choices to plans in the pool, however. First, only those employers that restrict employees' choices to plans available through the pool can access subsidies for their low-income employees. Second, employers that purchase all of their insurance through the pool are no longer required to provide continuation coverage, because individuals can now purchase insurance through the pool on their own. These incentives for employers to enroll all their employees in the pool are designed to minimize adverse selection into the pools (discussed further below).

Employers purchasing insurance through the pool effectively act as intermediaries for individual purchase. That is, employees enroll through their employers, perhaps using additional materials provided by employers to help them choose.Employers then withhold the premiums for the chosen plan from the worker's paycheck and remit that amount directly to the pool, which, in turn, reimburses the plans. Using the pool as a middleman between insurers and employers makes it easier for employers to take advantage of the pool, providing another incentive for employers to use it as their source of insurance.

Low-income employees who obtain their insurance through the workplace apply for subsidies through their employer. For the poor (incomes below 150 percent of the poverty line), the employer pays no premiums if the employee enrolls in the median-cost plan. If the employee enrolls in an above-median-cost plan, the employer has to pay the additional costs (of course, those costs may be passed on to employees, either directly, through premium sharing, or indirectly). For the near-poor (150 percent to 300 percent of poverty), the employer is billed for the cost (minus the subsidy) of the plan chosen by the employee.

Financing: The Employer Tax Subsidy and the Role of Public Insurance

This plan is financed from three sources. The first is general revenue financing, one hopes,from the projected federal budget surplus. But this program's cost to the general budget ultimately will be offset by the following two sources of savings.

LIMITING THE TAX PREFERENCE FOR HEALTH INSURANCE

Part of the financing for this plan will come from the limitation of the tax exclusion for employer-provided health insurance payments. This limitation will take two forms.First, for those low-income employees receiving subsidies, net employer payments for health insurance will be lower. Both economic theory and evidence suggest that the lower net employer payments will be passed on to workers in the form of higher wages, and, therefore, higher taxes. Thus, in essence, we will end the tax subsidy for employer-provided insurance payments to poor employees, and limit this subsidy for the near-poor.

Second, the government will limit the tax exclusion for employer-provided health insurance payments explicitly to the cost of the median-cost plan in the local pool. All employers will track the total payments they make and any pre-tax payments made by their employees for health insurance. The government tells each employer before the beginning of each year the cost of the local pool's median-cost plan. The employer is then responsible for reporting as part of an employee's wages and salaries the difference between the total pre-tax employer/employee expenditure on health insurance and the premiums for the median-cost plan. This difference becomes taxable income for the purposes of both the income tax and payroll tax system. This is true regardless of whether the employer purchases insurance through the pool.

reorganization of medicaid and the s-chip program

This program obviates the need for much of the existing Medicaid program by providing insurance for low-income populations, so the program can be reorganized. The portion of Medicaid that provides health insurance coverage for non-disabled and non-elderly families—acute-care Medicaid—can be abolished, because those families can be automatically enrolled in their local pool, or offered a significant subsidy toward enrollment. The remainder of Medicaid that provides health insurance coverage for the disabled and the elderly (the bulk of Medicaid costs) remains unchanged. The S-CHIP program also can end under this proposal, because insurance for low-income families is available through the subsidy mechanism described above.

This reorganization ultimately will result in considerable cost savings that can help to finance the new program. In addition to the federal government's savings from reducing its Medicaid and S-CHIP obligation, states can save considerable money by no longer paying the Medicaid and S-CHIP costs for their acute-care population, while the insurance coverage for this low-income population actually increases. To compensate for the loss of these payments, the federal government receives a transfer from each state equal to the amount the state was paying for the Medicaid and S-CHIP programs for the acute-care population in the year before the program was enacted. This payment rises over time with the cost of the median plan in each state. Once again, the majority of the program that applies to the disabled or elderly does not change, and no recapture applies to those funds.

There are two important concerns with removing the public insurance entitlement,however. First, the net insurance entitlement of some families could fall, since children now receive free coverage under Medicaid up to or above 200 percent of poverty in many states. But this should be more than offset by the subsidized or free coverage of adults in most families.

Second, and more important, there could be major disruption of insurance during the transition from the current public system to this new private system. Low-income individuals who are taking advantage of the public system may be confused or otherwise unable or unwilling to use this new private approach. An unfortunate byproduct of this attempt to increase insurance coverage might lead to displacement of the neediest who are currently publicly insured. Therefore, a transition period will be necessary during which both the existing Medicaid/S-CHIP programs and the subsidies for the public/private partnership are available. The length of this transition period can be based on evidence of understanding and willingness among lowest-income families to move to the new system. The phase-out of public programs will occur in a "top-down" fashion, with eligibility for the highest-income groups currently in the program phased out first (starting with S-CHIP).

A concerted outreach and public relations effort to establish an effective understanding of the new subsidy system will help this transition. This effort includes working through existing Medicaid offices, schools, day care centers, and other access points to reach low-income populations.

Administration and Regulation—Benefits and Risk Adjustment

Of key importance is how these pools that form the core of the private/public participation approach are established, administered, and regulated. In addition, a central feature of this proposal is risk adjustment among plans in the pool. This section addresses implementation issues in pool administration and regulation.

pool establishment and administrative costs

The federal government notifies all potential insurers of the option to offer insurance through the pool one year before the local pool is open for enrollment. The government bears the full cost of this initial solicitation, screening potential insurers in line with the conditions outlined above, and initially assigning applicants to plans within the pool. Continuing administrative costs of the pool are financed by the small fee assessed on premiums earned by plans in the pool.

The government administers the program out of

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a new agency, the Private/Public Partnership Health Insurance Agency (PPPHIA), that is responsible for establishing pools and overseeing existing pool administration, coordinating subsidy payments, and coordinating income reconciliation.

WHAT STANDARDS FOR PLANS?

There is a key trade-off in setting minimum standards for plans participating in local pools. On the one hand, the federal government is obligated to make sure that these are real insurance products. On the other, the government should encourage individuals to choose, or at least should offer the option to choose, efficient and low-cost health insurance plans.

These joint imperatives dictate a fairly minimal set of regulations that should guarantee that all the insurance products offered are real insurance, but then allows free choice. In particular, regulations should require only that each plan feature:

- guaranteed issue and guaranteed renewability;
- coverage of physician services, inpatient and outpatient hospital services (including emergency rooms), and prescription drugs; and
- no or nominal copayments for one well child visit per year, prenatal care, and immunizations.

These minimum standards should generate rough comparability across the benefit packages offered to plan enrollees. But variation in benefits, or in the value of insurance plans, will remain along four dimensions. The first is copayments and deductibles;there is no minimum standard for these patient charges, although, as noted above, they are subsidized for the poor. The second is variation in benefits around these minimum standards. For example, plans may or may not use a formulary to dispense prescription drugs; may vary and limit their outpatient and inpatient mental health coverage; may or may not cover home health care services, etc. These are not trivial differences, but, once again, it is critical to reflect diversity of consumer preferences across plans. The third is variation in provider networks offered among managed care plans, and the fourth is variation in the degree of management of managed care plans,in terms of utilization review and physician financial incentives, among others. As noted below, information about all of these variations is readily available to families during open enrollment periods.

In addition, the government must develop financial soundness criteria to ensure that the plans can provide their promised services. Subject to these criteria, any plan that wishes to offer its services through the pool may do so.

Each plan charges community-rated premiums for each of four distinct populations: single; single with children; married without children; and married with children. The use of community-rated premiums immediately raises concerns about adverse selection, which are addressed below.

OPEN ENROLLMENT

To mitigate adverse selection, individuals are allowed to choose a plan at only one time during the year. Open enrollment takes place during November for the next year, allowing pool administrators the month of December to process enrollment applications and assign enrollees to plans. Every family in each plan's local catchment area receives a mailing on November 1 detailing that family's insurance choices for the coming year. The mailing has two components. The first documents each plan's costs, reported after subsidy by income level, copayments and deductibles, and services covered. The second component provides more detail on the plans themselves. It includes information on provision of preventive care services and consumer satisfaction. In addition, it gives some details on provider financial incentives. There are also links to a web site where

individuals can learn more about each insuring entity and the plans themselves.

Assessing what information should be disclosed in the mailing, on the web site, or not at all is the subject of much debate, particularly surrounding financial incentives to providers. While detailed disclosure of provider incentives can improve the information available to very educated consumers significantly, these details may be more than most consumers need or want to know. Moreover, there are competitive concerns in mandating too much detail on such provider compensation arrangements, because part of how plans compete is over their provider incentive structures. As part of establishing these local pools, therefore, a commission of experts should meet to decide on the appropriate amount of disclosure.

Plan switching is allowed during the year. Individuals may switch during open enrollment period, but if they do not return their forms expressing their desire to change,they are automatically enrolled in the same plan for the following year. Individuals who join the pool during the year can choose their plan at that point. But to minimize churning, any individual who leaves the pool at any point during the year cannot reenter the pool until the next open enrollment period.

pool administration and billing

The pool administrator collects the open enrollment forms and informs each plan of the pool of enrollees for the coming year. Plans are responsible for billing enrollees and are entitled to terminate coverage of any enrollee who does not pay after three months (for example,if a bill is sent at the end of January, and is not paid by the end of April, the family can be disenrolled). Disenrolled families are barred from reentering the pool for three months. Plans also are entitled to charge interest on all premium payments not remitted within one month, at a rate set by the government to represent the borrowing costs of insurers.

After forms are collected, the administrator is responsible for notifying the government of all subsidy payments. The administrator also maintains a database of information on all enrollees,plan choices, and reported incomes, which is also shared with the government.

risk-adjusted plan redistribution

As noted earlier, risk adjustment is redistributed across the plans in the pool to minimize adverse selection. This risk adjustment represents a mix of prospective (for example, based on demographic characteristics and long-term comorbidities) and retrospective (for example, actual cost outliers) factors.

More specifically, when individuals enroll each November, they provide information about their age, sex, and incidence of a set of chronic or past major illnesses (for example,diabetes, hypertension, heart disease or stroke, etc.). This information is not given to plans, but is maintained by the government. Even if individuals enroll through their employer, they send this information directly to the government to maintain confidentiality. In addition, at the end of each year, each plan reports the costs for each enrollee to the government.

Based on these two sets of data, the government applies a formula to determine a set of cross-subsidy payments that flows across plans. This formula uses demographic and comorbidity information to form a predicted average health expenditure. It then takes a weighted average of that predicted health expenditure and the actual health expenditure per capita (the “cost index”). For each plan, the government tabulates its cost index and redistributes funds from the low-cost- to high-cost-index plans. Plans that leave the pool are still eligible to receive payments and are responsible for making payments for services incurred the previous year. The magnitude of the redistribution is determined by technical government analysis.

This technical analysis trades off two considerations: more redistribution means less adverse selection, but also lower incentives for cost control. The optimal redistribution scheme does not compensate plans fully for differences in expenditure patterns, but does compensate them enough to limit incentives for adverse selection. For example,the optimal plan could state that any expenditures that are more than one standard deviation from the mean for an age/gender category will be reimbursed through this

redistribution system. This sort of approach still offers incentives to keep costs down when close to the mean, while "insuring" firms that enroll cases with very high costs.

This risk adjustment does not address a different type of adverse selection risk: adverse selection into the pools themselves ("inside/outside adverse selection"). Since insurance is community rated, and plans that are less comprehensive are taxed by the risk-adjustment mechanism (higher premiums), there is a strong incentive for healthy individuals to remain outside this pool and in groups of healthy persons with very low insurance premiums. By the same logic, there is strong incentive for the sickest individuals to get into the pool, where insurance is subsidized for them more than it would be in the experience-rated and non-risk-adjusted private market. Enough adverse selection of this type could destroy this pooling mechanism; if only the sickest persons in society end up in the pools,the insurance in these pools will be so expensive that they will be unattractive to all but the most highly subsidized poor.

This approach is designed to minimize this type of inside/outside selection, however, because the nature of subsidies (and discontinuation of the coverage mandate) provides a strong incentive to be in the pool. In the long run, all of the poor and most of the near-poor should be in the pool. Moreover, any employer that has a sizable share of its workforce in the income range to which subsidies apply (which should be most employers) will forgo a significant financial subsidy to its employees by not joining the pool. Remember, employers have to be entirely in the pool for their workers to receive subsidies, so they cannot "dump" their sickest workers into the pool while keeping healthy workers outside it. Low-income employees ultimately should choose to leave employers that are unwilling to join the pool, thereby putting pressure on firms to enroll. And the removal of the deeply unpopular COBRA mandate provides an additional incentive to pool.

It is difficult to assess whether this impetus is powerful enough to get a critical mass of healthy persons into these pools. But it seems quite likely that it is, given the sheer size of the population to which subsidies apply. In short, the goal here is to use these subsidies to boost pool size to the minimum level necessary to lower costs and mitigate inside/outside selection significantly.

TRANSITION

The transition to the private/public partnership is fairly straightforward, since the pools are voluntary. For example, suppose implementing legislation is passed in October 2001 that establishes the PPHIA, which immediately begins drawing up local boundaries for the pools and gathering data from plans that want to participate for calendar year 2003. Then, in November 2002 the first enrollment period can open.

Beginning January 1, 2003, the government begins to phase out Medicaid coverage for the non-disabled and non-elderly. Also on that date, employers begin to include the "excess" (above-area-median) costs of their spending on health insurance as part of taxable wages.

Advertising to individuals about this new insurance system begins immediately with passage of the legislation in late 2001. Medicaid administrators are responsible for ensuring that all non-elderly/non-disabled enrollees are aware that their Medicaid entitlement is terminating, and for introducing this new alternative.

Implications of the Private/Public Partnership Approach

This approach represents a fairly radical departure from the current private and public systems of providing health insurance. While the impact of this new system on the scope and shape of the health care delivery system is difficult to predict, this section discusses some likely implications of this type of reform.

Politics

The primary implication is the political dynamic surrounding the type of major reform envisioned by this approach. Obviously, any intervention of this magnitude faces a daunting legislative process.

There are likely to be concerns from at least five stakeholders about this approach. First, firms and unions will be upset about the reduction in the tax subsidy to employer-provided health insurance. There will be a "camel's nose under the tent" concern about capping this deduction, even if the cap is relatively modest at first. Second, fiscal conservatives will object to the net price tag of this intervention, particularly given the tenuous nature of current surplus projections. Conservatives may also be upset about the attendant increase in government bureaucracy. Third, insurers that focus on the non-group market, but do not feel that they can compete effectively in this new pooled group market, will protest their loss of market share. Fourth, advocates of the traditional Medicaid program, rather than private market solutions to the uninsured, will raise concerns about the loss of Medicaid entitlement. Finally, tax administrators may oppose the expanded use of the tax system under this plan and, in particular, the introduction of area-specific adjustments to the tax subsidy to health insurance (which is capped at the median-cost plan in the area).

But important stakeholders will support this plan. Foremost will be reformers who see this as a means of reducing the number of uninsured significantly. In addition, this approach will be validated by market-minded advocates of competition as the best source of health care cost control. And advocates for the poor will recognize the important income redistribution of this approach. While upset about the limitation of the tax subsidy as a means of financing, employers (particularly small employers) ultimately may approve of this approach, because it allows them to shed their insurance provision obligations or buy into a more effective mechanism for purchasing insurance,and to discontinue an obligation they consider a significant burden. Group insurers should also approve of a system that expands the reach of their products, both locally and nationwide.

More relevant is that this approach has more politically attractive features than many other alternatives. The significant expansion in public spending programs necessary to cover an enormous share of the existing uninsured is not feasible in today's pro-private solution climate. And alternative private-sector solutions, such as expanded tax credits, face very high costs because of the limitations of the non-group market in which they would be spent.

Implications for Health Care Costs

The lull in health care cost inflation in the United States over the past few years has dictated a focus on uninsurance and a backlash against the stringency of managed care. But significant increases in health care costs over the past year once again have raised concerns about cost containment. At the same time, there is little taste among the public or policy makers for a public cost-containment strategy for the privately insured.

A key advantage of the public/private partnership is that it uses a competitive mechanism to assist in cost containment, while balancing the selection incentives inherent in competition through a mixed prospective/retrospective risk-selection adjustment. Unlike today's insurance marketplace, individuals will face the full marginal cost of moving from less to more generous insurance plans. This makes these individuals more cost-conscious shoppers, which,in turn,puts pressure on insurance plans to lower their costs to attract new enrollees.

Concern about competition as a source of cost control in the health care sector is twofold. First, there is some fear that competition will lead to inappropriate reductions in the quality of care. The best safeguard against this is providing complete information on plan characteristics, financial incentives, and consumer satisfaction, which will be done through the open enrollment mailing. Second,plans may compete, not to provide the most efficient care, but to select the best risks. This concern will be mitigated through the risk-adjustment mechanism described above.

The net impact of improved competition on health care cost growth is unknown. But competition, with full information, risk adjustment, and a level playing field across plans and consumers, remains the best politically feasible option for controlling costs.

Equity

This approach has significant implications for both "vertical" equity (redistribution) and "horizontal" equity (fairness). In terms of vertical equity, as described above, this program involves significant redistribution from average-income taxpayers to those below median income (and primarily below 150 percent of the poverty line). In terms of horizontal equity, this program removes many of the inequities that now haunt our private insurance system.Large employers,small employers,and individuals will be able to purchase insurance on the same basis, removing the existing enormous differences across these groups because of administrative loads and adverse selection premiums. Likewise, healthy and sick individuals have equal opportunities to purchase insurance from the same pool of providers. Sicker individuals may end up buying the more expensive plans in the pool, but this is by their own choice, not by the active selection efforts of insurers.

Implications for Income Generation

A concern with any program that includes income-related subsidies is the distortions toward income generation. The proposed system includes two such distortions. First, there is an additional implicit tax on income earned above the poverty line as the full subsidy available to those below poverty is phased out. The magnitude of this implicit tax is modest, however, amounting to only a 6.7 percent additional tax on income generation. For example, consider a family of four with an income at 150 percent of the poverty line (roughly $25,000) that faces group premiums of $5,000. That family's subsidy is the full group premium, or $5,000. If the family's income rose by 1 percent of the poverty line, to $25,170, their subsidy would fall by $11.40, or 6.7 percent of the income rise. This is a very modest additional tax and is likely to cause little distortion to income generation.

The second distortion is where the subsidy ends, at 300 percent of the poverty line. If, at this point, any families have premiums that exceed 10 percent of their income, then raising incomes above 300 percent of the poverty line could lower net resources significantly. If, for example, group premiums for the family of four were $6,000, then at 300 percent of poverty ($51,000), they would pay only $5,100 for their coverage, and receive a subsidy of $900. But, when the family earns the next dollar of income, that entire $900 subsidy disappears, which could present a significant disincentive to moving out of the subsidized range.

This concern raises a trade-off between limiting the subsidies and extending them further up the income range, which would mitigate this distortion but also would raise costs. I propose erring on the side of saving costs and limiting the subsidies for two reasons.First,at higher income levels,income is more dynamic (and less easily tracked, since higher shares are from non-wage sources),so that administering these subsidies is more difficult. Second, the magnitude of this distortion is likely to be relatively small. But the implementing legislation for this policy should include a mandate to study this issue and, in particular, keep track of the rise of health care costs relative to incomes and how this affects the magnitude of the "notch" at 300 percent of poverty.

Regional Variation

Another concern about income subsidies is that the federal poverty line is not tied to regional variations in cost of living. It seems highly unlikely that there would ever be regionally rated subsidies, given the enormous difficulties of assessing the correct regional adjuster. But the structure of the subsidies in this proposal provides implicit adjustment for regional cost variation, because the amount of the subsidy is tied to the cost of the median-cost plan, which reflects regional variations in the cost of living. That is, a much larger share of the population will be subsidized in Mississippi than in Massachusetts, but the subsidies for which they are eligible will be much smaller.

Conclusions

Radical change of the U.S. health care system involves a set of difficult trade-offs from both an economic and political perspective. The private/public partnership approach laid out in this propos-

al is designed to respect the demand for voluntary, private solutions to the problem of the uninsured in the United States in a way that could provide insurance to the vast majority of needy uninsured in this country.

But it is important to recognize that this proposal will not lead to universal health insurance coverage in the United States. Even with significant subsidies to the poor and near-poor, some still will choose to remain uninsured. In addition, a not inconsequential number of well-off people who can afford health insurance will continue to choose not to buy it. This raises a critical question of how far we are willing to go with health policy in the United States. This proposal guarantees that coverage is universally affordable, but not universally adopted. Is the role of the government to go beyond this to ensure universal coverage, or is universal access sufficient?

The reform has a number of additional virtues. It involves significant income redistribution and a leveling of the playing field on which individuals purchase insurance. And it uses the powers of competition effectively to address rising health care premiums. There are additional complications, as well, and these need to be addressed if the program is implemented. But the key political economy advantages of a voluntary system suggest that this type of approach has promise as a means of addressing the failings of the current health care system.

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Gruber Proposal

Key Elements

Jonathan Gruber has outlined a proposal to substantially reduce the nation's uninsured rate and allow nearly all households to obtain affordable health coverage under a voluntary initiative relying heavily on the private insurance market. The program includes the following elements:

VOLUNTARY STATE-BASED PURCHASING POOLS that would offer a menu of health plan choices to all individuals and employers.

FEDERAL SUBSIDIES THAT WOULD BE PROVIDED on a sliding-scale basis to individuals with incomes up to 300 percent of the federal poverty level buying insurance in the pool; most families with higher incomes could obtain coverage for 10 percent or less of their income.

PARTIAL FINANCING WOULD BE ACHIEVED by limiting the tax exclusion for employer-provided health insurance to the cost of a median-cost health plan and by phasing out the Medicaid program—and accompanying federal subsidies—for those families that qualify on the basis of income alone (while the program remains in place for the elderly and disabled).

HEALTH PLANS AND INSURERS WOULD BE PAID on both a prospective and retrospective, risk-adjusted basis that would spread health risk across entire purchasing pools so that higher-risk individuals could obtain affordable coverage.

About the Author

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