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Restructuring Health Insurance Markets



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RESTRUCTURING HEALTH INSURANCE MARKETS

Many states—and some federal legislators—are considering major policy changes to make health insurance more affordable and to increase the number of people who have health coverage. Often these policies involve changes in the structure of health insurance markets, such as establishing risk pools or insurance exchanges for certain populations and altering the rules for selling coverage in the individual and small-group markets. This paper examines six specific structural changes that might be made to expand coverage, with special focus on the administrative issues that must be addressed. The six are: changes in rating rules, high risk pools, standard benefit plans, reinsurance, Section 125 plans, and insurance exchanges. We examine what benefits these changes might produce, how they can be most effectively structured, and how they can be implemented.

THE PURPOSE OF HEALTH INSURANCE

It is useful to begin by recalling the fundamental purpose of health insurance. People buy health insurance to ensure that the cost of paying for medical services will not be a barrier to receiving necessary care and to protect themselves against the financial catastrophe of incurring a very large medical bill that they could not afford to pay from their own resources. When they buy health insurance, people choose to incur a small, certain loss—the insurance premium—to protect themselves against the possibility of incurring a very large, unpredictable loss—the cost of paying for very expensive medical care. In other words, people pool their risk. But this form of protection is sustainable only under very specific conditions: *Insurance works only so long as most people who are in the pool incur expenses that are far below the amount they pay in premiums so that there will be enough money in the insurance pool to cover the few people who incur large losses.*

The role of health insurers is to design and sell health insurance policies that provide this kind of financial protection. But the market does not always perform as intended, especially for people whose risk of needing health services is relatively high. If every person bought health insurance and had identical coverage—the same covered services, the same limits, and the same cost sharing structure—the role of insurers would be very different and most of the problems related to the functioning of insurance markets would

disappear. Such a system would be essentially a system of social insurance, like Medicare, where everyone is automatically covered, the benefits are essentially identical, and everyone pays the same premium rate. But, of course, this is not a description of the current private health insurance system. Under competitive pressures in a voluntary market, where people may or may not buy coverage, insurers face strong incentives to develop many different benefit structures and coverage options to try to attract the most profitable business. They find it profitable to segment the market by risk: if other insurers are pooling high-risk and low-risk people together and charging them one rate, a competitor can gain business by pooling only low-risk people together and offering them a lower rate. For similar reasons, insurers have incentives to structure their benefit plans to be especially attractive to lower-risk people and to avoid the highest-risk individuals.

Of course, once one insurer adopts these tactics, others must follow to remain competitive. If unchecked by legal constraints, the result is extensive segmentation of the market by risk, with the result that coverage becomes unaffordable for many higher-risk people. And, of course, the proliferation of coverage options and the mechanisms insurers must employ to differentiate people on the basis of risk add to insurers' administrative costs and create burdens for the people who buy coverage. Legislators and other who seek to restructure the insurance market hope to ameliorate some of the problems while still retaining the private insurance system.

CHARACTERISTICS OF A WELL-FUNCTIONING MARKET

Before turning to the issue of how to restructure insurance markets, it is important to lay out the characteristics of a well functioning market and then compare that picture with markets as they exist today.

Efficiency. One desirable characteristic of an insurance market is that it would operate efficiently—that is, administrative costs, including transactions costs for consumers and providers, would be minimized. Costs associated with reviewing the characteristics of people applying for coverage, determining who is eligible for coverage, and setting different prices for categories of applicants—what is referred to as medical underwriting—would be minimized, since the resources used for medical underwriting have essentially no benefits for consumers. Marketing costs would be a small portion of the total premium.

Reasonable choice. A well-functioning market would offer people a useful range of choice of different insurance benefits packages and delivery systems—for example, health maintenance organizations (HMOs), preferred provider organizations (PPOs), indemnity plans, etc. The number of benefit options would be sufficient to allow people to choose a plan that suited their preferences but not so many as to make choice confusing and difficult. Consumers would have objective information in a form that would make it easy for them to make intelligent choices as they compare the value of different coverage options and health plans.

Useful competition. A well-structured market would promote useful competition among insurers so that they are motivated to minimize the cost of coverage and provide timely, efficient, and effective customer service. Competition would induce insurers to compete by trying to reduce not only administrative costs but also the underlying costs

of medical expenses. No insurers would be so dominant that they could have significant control over the market. Insurers would receive a return on investment sufficient to induce them to continue in business, but profits would not be excessive.

Pooling risk. Market rules would ensure that risks would be pooled in a way that spreads the risk broadly and fairly and does not result in high-risk people facing premiums that are unaffordable. In other words, no one who could afford to pay for average-priced insurance would be priced out of the market because of their higher-than-average risk. To the extent that market segmentation exists, it would not be so extensive as to threaten the basic insurance principal of having low-risk people subsidize the medical expenses of high-risk people.

COMPARING THE REALITY TO THE IDEAL

Comparing present insurance markets to the ideal shows that performance often falls short. Administrative costs are a relatively high proportion of premium costs, especially in the individual market but also in the small-group market. Marketing costs also tend to be high in these markets because each sale adds only a few enrollees. The number and variety of insurance benefit plan options are far more than necessary to meet consumer needs and, along with the complexity of benefit structures, make informed choice difficult. Few people can go to a single source to see and compare all the options. Consumers bear the burdens of trying to keep track of bills and submit claims, worrying about coordination of benefits, and generally trying to ensure that they are getting the financial benefits to which they are entitled. If people's family or job status changes, they risk falling between the cracks in insurance coverage or even being denied coverage entirely. In states that allow risk rating in the small-group and individual markets, competitive pressures force insurers to devote resources to identifying the relative risk posed by different applicants. In such circumstances, the rewards for being effective at-risk segmentation may be as great or greater than those associated with controlling underlying medical costs. As a result, higher-risk people, especially in the individual market, may be priced out of the market; so the basic risk-pooling function of insurance is impaired.

In most states, a very small number of insurers account for a very high proportion of the business in the individual and small-group markets—not the picture of a classic competitive market. Market domination by only a few insurers has been common in many states for a number of years, but recently the degree of market concentration has increased greatly, reflecting, in part, a wave of mergers.¹ For employment-based and individually purchased health insurance, WellPoint and UnitedHealth Group each hold 14 percent shares of the national market, and Blue Cross plans control 32 percent of the overall market.² Concentration is much higher in many state and regional markets. According to

¹ James C. Robinson, "The Commercial Health Insurance Industry In An Era Of Eroding Employer Coverage," *Health Affairs*, Vol. 25, No. 6, 2006; James C. Robinson, *Consolidation And The Transformation Of Competition In Health Insurance*, *Health Affairs*, Vol. 23, No. 6, 2004; Deborah Chollet, Fabrice Smieliauskas, Madeleine Konig, "Mapping State Health Insurance Markets, 2001: Structure and Change," *AcademyHealth*, September 2003; GAO letter, October 13, 2005, GAO-06-155R, *State Small Group Insurance Markets, Subject: Private Health Insurance: Number and Market Share of Carriers in the Small Group Health Insurance Market in 2004*; American Medical Association, "Competition in health insurance: A comprehensive study of U.S. markets, 2007 update."

² Robinson 2006.

one recent study, the two largest insurers have at least half the enrollment in 40 states (out of 44 for which data were available), and they hold at least three-quarters of the enrollment in 15 states.³

These deficiencies and others not described have prompted some critics to call for wholesale reform, often arguing that only something like a single payer system can fully address such deficiencies. But the opposition to such massive change is fierce, and such a system brings its own set of problems. It seems likely that in the near future we will continue to have a system composed of multiple insurers offering competing plans. If that is so, the policy question is what are the options for streamlining the administrative structure of the present system and bringing its performance closer to the ideal.

THE MAJOR OPTIONS FOR STRUCTURAL CHANGE

In this paper we will look at six options: rate compression, high-risk pools, standardized benefit plans, public reinsurance, Section 125 plans, and insurance exchange/purchasing pools. Although we will discuss the policy justification for each approach, our emphasis will be on the administrative issues that are involved in trying to implement the approach.

Rate Compression

As noted earlier, in the absence of legal constraints, insurers will segment people by risk, creating large premium differences between high-risk and low-risk people. Most states have placed some limits on risk rating in the small-group market—although the limits vary widely from state to state—and a few have done so in the individual market. Some states have gone all the way to “pure” community rating in one or both of these markets, so that everyone pays the same rate for similar coverage regardless of health status or any other personal characteristics. In states with the least restrictive rate rules, the rate variation ratio can be as much as 10:1 in the small-group market, and the highest-risk people in the individual market may be denied coverage entirely. The purpose of rate compression, of course, is to broaden the sharing of risk to make coverage more affordable for higher-risk groups and individuals. The problem with this solution is that rate compression, while making coverage less expensive for higher-risk people, makes it more expensive for lower-risk people. In the absence of a mandate—that is, a requirement that everyone have coverage—the higher premiums may cause some lower-risk individuals or groups to drop coverage and discourage others from acquiring it in the first place. If the exodus is too great, there will be too few people in the risk pool whose medical expenses are substantially less than their premiums. The average cost of medical claims will rise, forcing the insurer to raise the premium, which causes other people with below-average risk to leave the risk pool. The result is a spiral of adverse selection and a continually deteriorating risk pool.

Experience suggests that this phenomenon of adverse selection against the market as a whole is less of a problem in the small-group market than in the individual market. The reason is that it is much easier for an individual than a group to assess when he or she is

³ American Medical Association, 2007.

most likely to need expensive medical care and to buy coverage only when that need is imminent and to go without coverage at other times.

The policy challenge, then, is how far to go in compressing rates. States have chosen different paths, and their experience can be a useful guide for those considering whether to move toward greater rate compression. In general, rate compression has seemed to work reasonably well in the small-group market in helping to make coverage more affordable for high-risk groups, but it has not increased the overall rate of coverage.⁴ In the individual market, the problems have been greater because of adverse selection against the market as a whole, created when low-risk people drop out.

From a purely administrative standpoint, rate compression does not pose significant new challenges for most states since they already have an administrative structure in place to enforce their current rating rules. The federal government does not now impose rating restrictions in either the small-group or the individual markets, but even if this policy were to be changed, it is likely that the responsibility for enforcing the law would fall on the states. To enforce rate limits, states must be able to review individual insurers' procedures and policies and to collect and analyze premium data to ensure that they are complying with the rating restrictions.

If a state adopts pure community rating, allowing no variation based on any rating factors, the administrative task is much simpler than when insurers are permitted to use a variety of rating factors. For example, it is not unusual for states to allow rate differences based on some combination of health status, age, gender, geography, industry, health-related behaviors, and class of business, typically with different limits attached to each factor. When there are multiple rating factors and different limits on the extent to which insurers can vary rates based on each factor, both compliance with and enforcement of the law becomes very complicated and therefore more expensive.

One way to greatly simplify the administrative burden and to make the rating restrictions more comprehensible, while still allowing any degree of variation in premium thought to be advisable, is to set an *overall limit* on the amount by which the rate can vary based on *all factors in combination*. For example, if a state decided that no high-risk group should have to pay more than four times the rate paid by the lowest-risk group, the state would simply stipulate that whatever rating factors were used, the maximum rate variation for all factors in combination could not exceed a ratio of 4:1. Besides being simpler, this approach makes less important the choice about which particular rating factors insurers are permitted to use. Under this approach state regulators would find it much easier to determine whether an insurer is complying with this requirement than one that allows insurers to vary rates based on multiple factors each with its own limit. Under the latter circumstance, it is sometimes difficult to determine even what total rate variation is the theoretical maximum.

Taking this approach also allows states to move gradually to greater rate compression—for example, starting with a ratio of 5:1 and moving to 3:1 by reducing the ratio by 0.5 each year for four years—which will help to reduce the “sticker shock” for low-risk people and may make them less likely to forego insurance.

⁴ Mark A. Hall, *Health Insurance Market Reform Study*,
http://www.phs.wfubmc.edu/web/public/pub_insurance/pub_insur_summary.cfm

High-Risk Pools

Rate compression is a way to make coverage more affordable for high-risk people, but it is a tool most commonly used in the small-group market, since, if employed in the individual market, it is more likely to produce adverse selection against the market as a whole. The tool more frequently used in the individual market is a high-risk pool. Like rate compression, it is a way of subsidizing high-risk people. The idea is simple: Some mechanism is used to identify people whose risk profile is so high that they could almost surely not afford to pay a premium that would fully cover their risk.⁵ These people are then offered coverage with a specified benefit package through a special risk pool composed of just high-risk people. They pay a premium that is higher than what “normal-risk” people would pay for such coverage but still not sufficient to cover their full expected medical claims. The shortfall represents a subsidy that has to be funded from some source, typically some kind of surcharge on insurers but sometimes, and preferably, from broader-based revenue sources.

Implementing a high-risk pool raises a number of policy and administrative issues.

Eligibility. The obvious first question is how to determine who will be eligible, or, to put it another way, how will high-risk people be identified? Most states have given insurers great discretion in deciding who will be denied individual coverage, essentially allowing them to deny coverage to anyone they judge to be especially high risk. In California, an approach is being considered that would leave insurers no discretion: the state would develop a questionnaire that all insurers would administer to applicants, and insurers would be permitted to deny coverage only to those people who “failed” the test. Everyone who “passed” would have coverage available on guaranteed-issue basis. This approach has the advantage of predictably limiting the number of people who will fall into the high-risk category, as well as providing uniform treatment for applicants regardless of the insurer to which they apply.

Some states require the individual to show that he or she has been turned down for coverage by more than one insurer. Denial of coverage does not by itself make one eligible in most states. States frequently also require that the person not have available any source of group coverage, including COBRA. In some instances a denial is defined to include having available only individual coverage that excludes some major medical conditions. Some states also allow a person to be eligible if the cost of the only coverage that is available exceeds some high dollar amount.

This approach involves many administrative issues, mostly related to verifying eligibility. Someone has to verify that the person has no other coverage available, has been denied coverage, or can only find coverage that excludes some condition or is too expensive. For some of the information, the only reasonable verification may be the applicant’s self-report, subject to penalty for false statements, though some states require written proof of having been denied coverage in the form of a letter from the insurer. If written proof is not required, some agency will need to audit some applications to ensure that there is at least a credible threat of a penalty for providing false information.

⁵ For example, in California the premiums paid by people in the high-risk pool cover only slightly more than half of the cost of the program. *California Major Risk Medical Insurance Program 2006 F/ACT BOOK*, The California Managed Risk Medical Insurance Board, 2006, http://www.chcf.org/documents/insurance/MRMIPFBV3_23_06.pdf

As explained below, virtually all states have a limited funding pool on which to draw to provide the subsidies that are inherent in this approach. The questions then arises what to do when the fund is nearing depletion. States may establish waiting lists in that instance, which obviously involves some administrative issues related to notifying people initially that they are on a waiting list and then notifying them again if the funding allows more people to be covered, presumably with a re-check of eligibility. Some states have chosen to make the eligibility requirements more restrictive when funding limits are being reached, which requires a procedure for making this change. Presumably, most high-risk pools will be governed by a board that has the authority to make limited policy changes within legislatively set constraints.

Role of insurers. A high-risk insurance pool involves all of the normal functions that insurers perform: enrollment, determining eligibility and maintaining eligibility rolls, disenrolling those who do not pay premiums, collecting premiums, and verifying and paying claims. A different sort of function, which may be especially important to control costs of this high-risk population, is case management.

In most instances, it would not be cost effective for states themselves to perform all of these functions. It would normally be wiser to contract out these tasks to insurers, who already have in place the necessary administrative apparatus, and to pay them an administrative fee. If the state is at risk for medical claims that exceed the expected amount for the risk pool—that is, the state *is* the insurer (as in Maryland)—then the state would presumably contract with a single insurer to perform the administrative functions. However, if insurers are at risk, either in whole or in part, then the insurer or insurers would presumably perform these functions for their own enrollees and recover the cost from the premium paid by their enrollees plus the state-supplied subsidy. From a state’s standpoint, it would obviously be safer to have the insurers bear the risk of expenditure overruns because the fund that finances the subsidies is normally a fixed amount and thus cannot be easily or quickly increased if there are cost overruns. But, of course, insurers would charge a higher premium for assuming the risk. In addition if there are multiple insurers participating, there has to be a mechanism in place to permit people to make an informed choice among participating plans and to transfer from one to another from year to year. Presumably, the state would need to fill this role.

Pre-existing conditions. The purpose of a high-risk pool is to provide coverage on a guaranteed-issue basis to people who could not otherwise get affordable coverage because of their poor health status. People often find themselves in this position because of some pre-existing medical condition. The problem is, however, that if the high-risk pool accepts people without any pre-existing condition limits, it encourages people to postpone buying coverage when they are healthy, knowing that they can always go to the high-risk pool if they develop some serious condition. The result could be even greater-than-expected adverse selection against the pool, which could threaten its financial viability. Some state have chosen to address this issue by including pre-existing condition restrictions but making them shorter than what insurers typically impose—for example, three or six months rather than a year or two.

If there are pre-existing condition limits, someone has to have responsibility for collecting and verifying the information that applicants supply regarding these conditions. Commonly, applicants are asked to self-report such data.

Setting premiums. Four factors are inextricably linked: the number of people who are eligible for the risk pool, the scope of benefits, the amount of funds set aside for the risk pool, and the size of the premium. If more people are eligible for the pool, more funding will be required for subsidies, and the fund will have to be larger, other things being equal. If coverage is more comprehensive, the subsidy cost will be higher, other things being equal. If the premium is lower (making coverage more affordable), the premium subsidy is greater and more funding will be required, other things being equal. Varying any one of the four factors will have implications for the other three. Policymakers will need to keep this fact in mind when setting premiums.

Typically, states have determined that a person in the high-risk pool should pay no more than 125 percent to 200 percent of the “standard rate,” which is essentially the rate a person of “normal” risk would pay. The question is what rating factors should be used in establishing the standard rate. Based on age alone, medical expenses can vary by a ratio of at least 3:1 between young adults age 20 to 24 and adults just under age 65. So it would make little sense to charge people in the high-risk pool a premium that is, say, 125 percent of the average rate for the normal *population as a whole*. That could result in a 62 year old in the high-risk pool paying less than someone of the same age buying coverage in the normal individual market. It would seem more sensible to make the rate equal to 125 percent of the rate for a person of average risk *in the same age cohort*. A case might also be made for also using geography as a rating factor in determining the standard rate if geography is used as a rating factor for the non high-risk population.

From an administrative standpoint, the task is to determine what the standard rate is, using real-world data, and then to make sure that the premiums in the high-risk pool actually are the agreed-upon multiple of the standard rate.

Funding the pool. The purpose of having a high-risk pool is to spread risk more broadly to make coverage more affordable for high-risk people. The ideal source of funding for providing such subsidies would be one that is as broad as possible and generates revenues from the population on the basis of ability to pay. General revenues are probably the source that best meets this test. But most states have looked to sources other than general fund revenues to finance the high-risk pool subsidies, presumably because it is politically difficult to raise the taxes that produce general revenues.

Frequently, states assess insurers to provide the funding. From the standpoint of fairness and equity, if this is the course states choose, the ideal approach would be to assess all insurers based on their *total* share of the market, not just their share of the individual market. If the assessment is just on individual-market business, the cost is passed back just to people buying in the individual market, where costs are already higher for comparable coverage than in other markets. That would defeat the purpose of having the high-risk pool, which is to avoid having lower-risk people absorb the costs of claims generated by high-risk insured people. In other words, the approach is not consistent with broad risk sharing or making individual coverage more affordable. Even assessing all health insurers fails to spread the risk over all who have coverage, since those who are covered by self-insured plans would not contribute. Some policy makers have contemplated assessing the third-party administrators who administer health plans for self-insured companies based on the number of covered lives under the plans. Though desirable from the standpoint of equity, this approach would likely be challenged as being in-

consistent with ERISA requirements, which limit states' ability to regulate employer health benefit plans.

From an administrative standpoint, if states look to insurers to fund the high-risk pool, the state will have to collect and audit information about insurers' revenues, perhaps for different markets separately, depending on how broadly the assessment is spread. Most states already collect and analyze such information, so little additional administration would be required. The more challenging task will be to monitor outflows from the pool fund to ensure that funding will be adequate and, if shortfalls seem likely, to decide how to remedy the problem—whether to change eligibility requirements, modify the benefit package, establish waiting lists, try to increase the size of the fund, etc.

Standard Benefit Plans

A number of states have adopted, or at least considered, the policy of limiting the number of benefit plans that could be sold in the individual or small-group market. Instead of allowing each insurer to offer dozens of different plans, some state entity would define a few standardized benefit plans that all insurers and health plans would offer (with some additional differences to reflect the different nature of HMOs, PPOs, and indemnity plans). New Jersey, for example, limited the number of benefit plans in the small-group market to six options, and California is now considering legislation that would require all individual market insurers to offer just five standardized plans. Such a policy is designed to make it easier for consumers to compare options and make an informed choice about which offers the best value. Research shows that when people are faced with too many options, probably more than six or seven, they have difficulty making the “best” choice.⁶ They resort to simplifying procedures or choice-limiting tactics that are not consistent with economists' notions of “rational decision-making.” Thus it could be argued that consumers would be better off—in the sense of being able to making a choice that best meets their tastes and preferences—if they had fewer choices. At a time when there is increasing agreement about the kinds of health insurance protection that people need, it is hard to believe that meeting people's needs and preferences requires the degree of choice that is the rule in the individual and small-group markets. The difficulties involved in having too many choices are presumably the reason that Medicare limits the number of benefit plans that supplemental insurers may offer to Medicare enrollees.

If limiting the number of choices enhances consumers' ability to make well-informed choices, it follows that it is also an effective way of promoting beneficial competition among insurers. When consumers can make valid judgments about the relative value of the plans offered by each insurer, insurers have much stronger incentives to compete on the basis of price, quality, and service. That, in turn, gives them incentives to encourage participating providers to be more efficient and to improve quality.

A final reason for moving to a limited number of standard plans is that implementing such a policy reduces the potential for risk segmentation. People tend to choose different

⁶ For an example of such research, see Sheena S. Iyengar and Mark R. Lepper, “When Choice is Demotivating: Can One Desire Too Much of a Good Thing?” <http://www.columbia.edu/~ss957/whenchoice.html>

kinds of plans depending on their health status. For example, those with poorer health status tend to choose coverage that is more comprehensive, has lower cost sharing, and gives greater choice of providers. Insurers know how to tailor benefit plans to attract lower-risk populations, and if there is no constraint on the degree to which they can vary the benefit structure, they can be very creative in devising plans that achieve their desired enrollee mix.

From an administrative standpoint, the challenge is less in enforcing a requirement to offer standard plans than it is in defining what benefits should be in the standard plans. All benefit plans have two elements: the medical services that are covered and the amount of consumer cost-sharing (including coverage limits). The cost of the coverage is directly related to these two elements: the more medical services are covered, the greater the protection for insured people but the higher the premium; and the greater the amount of consumer cost-sharing, the lower the premium but the greater the financial risk to the insured person. Of course, deciding on the optimum trade-off is the reason that defining standard benefit packages is difficult.

At least in general terms, there seems to be increasing agreement about the kinds of medical services that should be covered to provide good protection, although there are still many areas of controversy “around the edges.” Few would argue that coverage that does not include hospital care, physician services, radiology and laboratory services, prescription drugs, and substance abuse and mental health services is adequate. There is still much disagreement about what limits there should be on some services, especially outpatient mental health services. And there is a great deal of disagreement about how much consumers should be expected to pay out of pocket. This is especially true now that the idea of “consumer-driven” health plans has become popular. Advocates argue that benefit plans that include large deductibles and co-payments are desirable as a way of giving consumers financial incentives to be cost-conscious when consuming medical services.

So almost certainly the standard plans will need to include different levels of cost sharing in recognition of the fact that some people will not be able to afford the most generous plans, whereas other will prefer plans that offer the maximum financial protection. In fact, it may be desirable to have all plans offer the same covered medical services but to have them vary only with respect to cost sharing.

There is the additional problem that different kinds of delivery systems are inherently structured to use different kinds of cost sharing. HMOs are essentially closed-panel plans, so that services from non-panel providers are not covered at all (except in emergency situations); patients using out-of-plan providers pay 100 percent of the cost. Moreover, HMOs have typically been designed around the idea that physicians, not patients, should have primary responsibility for ensuring that the care provided is cost-effective, and so they may have no deductibles and only relatively small co-payments at the point of service. PPOs have varying cost-sharing requirements depending on whether patients seek care from participating or non-participating providers. Indemnity plans have no panel of providers, and so the cost-sharing requirements are the same regardless of which providers patients choose. The upshot is that standardized plans will probably have to have different cost-sharing provisions for each of these delivery types, even when the covered medical services are the same.

Defining standard plans is a challenge because changes in medical technology may make it desirable to change the covered benefits. However, most of the technological advances occur *within* a category of covered services. For example, new imaging technologies may be developed that have not previously been covered, but these fall within the larger category of radiological services. The decision about whether or under what circumstances a new technology, or even an existing expensive technology, will be covered has generally been left up to insurers to decide, though their decisions have sometimes led to disputes that have produced court challenges. Letting insurers make separate and different decisions about such new technologies, however, introduces a degree of complexity in the benefits they offer that makes it more difficult for consumers to compare plans to determine which offers the best value. On the other hand, having the regulators make such decisions would require a procedure for gathering expert opinion and a decision-making process that would have to be able to withstand scrutiny of critics.

A final issue is whether insurers will be required to offer plans that are completely identical to the standard plans or whether instead some flexibility will be permitted by allowing them to offer actuarially equivalent plans. (Two benefit plans are actuarially equivalent if they have the same value in terms of the claims the insurer expects to have to pay.) There are several problems with this approach. First, the state regulators must have some method for verifying that the plans meet the test of being actuarially equivalent. This is often done by accepting the certification of the insurer's actuary. Second, allowing this kind of flexibility opens the door for plans to tailor their benefit packages to attract lower-risk enrollees, unless the degree of flexibility is strictly constrained. But if it is so constrained, what is really gained by allowing any deviation from the standard plan? Certainly, allowing greater flexibility adds to administrative complexity: what level of deviation from the standard plan would be considered acceptable, and who would make that decision?

States have typically assigned the responsibility for defining standard benefit plans to a specific board, requiring them to seek expert advice and public opinion before making their decisions. The most ambitious of such efforts was the process that the state of Oregon followed back in the late 1980s in trying to establish a ranking of possible covered services based on a combination of cost-benefit assessment by experts and public input. Elements of the outcome of that process, the Oregon Plan, are still in used today for the Medicaid program. Most other states have employed less comprehensive approaches to defining standard benefit plans.

Once the standard plans are defined, the ongoing administrative task should be relatively minor, since it is relatively easy for regulators to determine whether health plans are conforming to the requirements simply by reviewing their benefit plans.

Public Reinsurance

A high proportion of people who lack health insurance cite cost as the reason for being uninsured. Lowering insurance premiums would obviously cause more people to acquire coverage, although the research shows that only a relatively large price reduction would produce a significant influx of new people to insurance markets. In essence, the only way to produce large premium reductions is by providing subsidies. Typically, proposals for subsidies target lower-income people or perhaps small, low-wage employers. Another

option is to subsidize insurers—an approach inherent in the notion of publicly funded reinsurance. The basic idea is simple: if insurers were given a guarantee that claims costs in excess of some specified amount would be subsidized by government, they could be expected to lower premiums by approximately the amount of the subsidy.

Although public and private reinsurance are similar in some ways, they have different effects. Both provide an extra layer of protection against unexpectedly high claims costs. But since the insurers are paying for private reinsurance from their own resources, for the system as a whole, the insurers' costs are not reduced, and so no significant premium reduction would be expected, with perhaps one exception: when they buy reinsurance, insurers do not need to set aside so much in reserves to protect themselves against the possibility of having to pay for an extremely costly case, so then can offer somewhat lower premiums because capital is freed up. But publicly funded reinsurance has a different effect: the claims costs paid by the public program are not costs to the insurers, and so they can lower premiums in the aggregate by the amount of the subsidy. The larger the subsidy, the larger the likely premium reduction.

In essence, public reinsurance involves “socializing” risk—that is, shifting a portion of the risk and the cost from the private sector to the public sector. Such a policy has advantages besides the obvious one of making insurance generally less expensive for buyers. Reinsurance of this type also protects insurers from some of the worst consequences of adverse selection.⁷ Even if they end up with a disproportionate number of high-risk people who then incur high costs, they do not have to bear much of that cost. Being relieved of this risk should make insurers somewhat less reluctant to take on higher-risk individuals or groups (although they still might avoid them because they are more likely to incur costs below the point where the reinsurance takes effect). Moreover, since insurers do not have to set aside as much to cope with the possibility of realizing adverse selection, they can be expected to reduce their premiums by an amount approximately equal to the expected subsidy.

It is not entirely clear what approach insurers would use in lowering premiums in this instance. The reinsurance should make them more willing to take on high-risk enrollees because they are no longer high risk for the insurer. Insurers could decide to pass on the cost reduction in the form of lower premiums for just higher-risk applicants. But because higher-risk enrollees are probably more likely to incur costs in general, including costs below the threshold for reinsurance, it is more likely that insurers would reduce premiums more or less across the board, making coverage somewhat more affordable for everyone.⁸

Such subsidized reinsurance would also reduce year-to-year premium variations because insurers would be less concerned about the fact that some change in an insured group's characteristics would increase the probability that the group will incur high medical claims.

The advantage of this government-financed reinsurance approach is that it spreads risk very broadly, across the whole tax-paying population, and it does not compel insurers, enrollees, employers, or anybody else to do anything. The market is left to work. The

⁷ Randall R. Bovbjerg and Elliot K. Wicks, “Implementation of Reinsurance as Part of the Massachusetts Roadmap to Coverage,” Report for the Blue Cross Blue Shield of Massachusetts Foundation, the Urban Institute, August 2005.

⁸ Bovbjerg and Wicks, 2005.

disadvantage is that it is not efficient in the sense of having a given allocation of government monies produce the largest possible expansion in the number of insured people. The dollars would not be spent in a “target efficient” way because much of subsidy would go to people who are already buying coverage with their own money. Premiums can be expected to decline across the board, for everybody purchasing insurance. Most of the people who benefit from the lower premium are people who are already buying insurance and who thus are paying for the high-cost cases with their own money when they pay premiums. Government dollars would thus mostly substitute for private dollars. This result is undesirable if the overriding objective is to produce the greatest reduction in the number of uninsured with the fewest dollars. It may be desirable if the objective is to spread risk in the broadest possible way and to move toward a social insurance model like Medicare.

The size of the reinsurance subsidy can be kept lower and the target efficiency greatly improved by limiting the reinsurance program only to groups that generally cannot afford current coverage and among whom a high proportion is uninsured. For example, the reinsurance might be available only for coverage provided to small firms that employ predominantly low-wage workers. These firms often do not buy coverage because of the cost, and thus many employees of such firms lack coverage. Reinsurance subsidies available only to this group would not produce much substitution of public dollars for private dollars already being spent. Reinsurance limited to certain groups would, of course, affect the rates for only those groups, not the market as a whole.

Public reinsurance can take several forms. One option is for the reinsurance to cover some or all of an insurer’s *aggregate* claims for a defined population that are in excess of some specified amount. Another approach allows insurers to identify, within a short time after initial enrollment, certain small groups or individuals within a group that they wish to reinsure. In essence, this approach amounts to a high-risk pool for high-risk small groups. This differs from traditional reinsurance because the insurer has to identify the high-risk enrollees or groups *before the fact*, that is, before the costs are incurred.

But the approach most commonly considered is for the reinsurance to cover a portion of the costs of the really high-cost cases. The reinsurance would pay all or a large portion of the costs incurred by any insured individual during a year that are beyond some threshold (technically, the “attachment point”). For example, the insurer might be responsible to pay all the costs up to \$50,000, and then the government would pay a large proportion of the costs thereafter—for example, 90 percent. Such a policy would provide substantial subsidies for insurers. Less than 1 percent of the U. S. population incurs medical costs above \$50,000 per year, but these few account for approximately 28 percent of total expenditures.⁹

Another option would be for government to pay a portion of costs for the highest 1 percent or 2 percent of cases. Such an approach has the advantage of having an inherent inflation-adjustor.¹⁰

Instead of having all expenditures above a certain level reinsured, there could be a “corridor” of costs for which government is responsible—above some amount government

⁹ Katherine Swartz, “Reinsurance: Host States Can Make Health Coverage More Affordable for Employers and Workers,” The Commonwealth Fund, publication no. 280, July 2005.

¹⁰ Swartz.

pays, but above another higher amount the insurer resumes full responsibility. This is the approach taken by Healthy New York. The argument for this approach is weak if the prime objective is to protect insurers against high risk. But it does help to limit government's exposure and creates stronger incentives for insurers to manage the extremely high-cost cases.¹¹ Typically, whether there is a corridor or not, the insurer would still be responsible for a portion of the costs even when the reinsurance threshold is reached, so that the insurer would have an incentive to contain costs of the expensive episodes of illness. The incentive to manage costs is obviously greater the larger the insurer's share of the cost.

This government subsidy would allow insurers to offer reduced premiums, since they would not pay for much of the high-cost care their enrollees need. The lower the threshold point where the reinsurance takes effect, the lower the premium that insurers will charge but, of course, the larger the cost to government. For example, the Healthy New York reinsurance system covers 90 percent of costs between \$5,000 and \$75,000, and that represents more than one-quarter of the insurers' total medical spending.

From an administrative standpoint, reinsurance may be heavily resource-consuming in the stage of setting up the program, but once underway, the burdens should be fewer.

Reinsurance can probably work smoothly only if the reinsurance applies to a standardized benefit package, including identical cost sharing, offered by all the insurers. Otherwise, it would be very hard to determine whether insured individuals passed the reinsurance threshold because their illness was especially severe and therefore costly or because their coverage was especially comprehensive. Another problem is that an episode of care can be expensive because an insurer does not do a good job of managing the care of a very sick patient. Reinsurance could reward such an insurer. In any case, the reinsuring agency would have to have a system in place to verify insurers' expenses.¹²

A significant task will be to determine what kind of threshold level and risk-sharing arrangement will yield costs to the state consistent with the budget for the program. This requires, among other things, predicting how many uninsured people will be induced to buy coverage because of the subsidized premium and how many people whose health care has been directly or indirectly financed publicly might take up private coverage because of the reduced cost, thus reducing costs to the state. The cost can obviously be manipulated by altering the threshold, the corridor of risk sharing, the level of risk sharing, and the number of people who are eligible.¹³ Some agency probably needs to be assigned the responsibility for monitoring and overseeing the reinsurance program and to have some flexibility in changing the threshold and cost sharing parameters to ensure that the program is achieving the desired objectives.¹⁴ The need for such flexibility became apparent in the case of Healthy New York when the initial parameters proved to be more restrictive than necessary. Fewer-than-expected enrollees were higher risk, and so the state decided to lower the reinsurance threshold to lower premiums by a greater amount to attract more enrollees.

¹¹ Bovbjerg, Randall R., A. Bowen Garrett, Lisa Clemens-Cope, and Paul Masi, *Reinsurance in State Health Reform*, Washington: AcademyHealth, May 2008.

¹² Swartz.

¹³ Swartz.

¹⁴ Bovbjerg and Wicks.

In many ways, the administrative tasks of operating a reinsurance system are like those insurers generally perform, apart from the enrollment functions. The state would obviously need to be able to verify insurers' reports of claims costs that exceed the threshold. The state may also want to ask insurers for early warnings of cases that are expected to pass the threshold as a way of ensuring that the health plan is take adequate steps to manage the care to keep costs under control. A system for paying insurers would be needed. All of these functions can be performed efficiently only with adequate data collection and computing capabilities. States may find it more cost effective to select an experienced private vendor to perform these functions.

Section 125 Plans

Under federal tax law, employers are allowed to establish so-called Section 125 plans, often referred to as cafeteria plans or salary reduction plans. Employees agree to reduce their salary by a specified amount and to have their employer put that amount into an account from which employees can draw to pay for certain expenses, in this case medically related expenses, including insurance premiums. The practical effect of this sleight of hand is that the money in the account is considered to be an employer contribution rather than employee income and is therefore not taxable, so that employees can pay for the benefits covered by the account with pre-tax dollars, thereby reducing the net cost to them. The savings from not paying federal or state income taxes or FICA taxes can be as much as 40 percent, depending on the employee's tax bracket. So, for example, a family policy that might cost an employee \$10,000 a year if the employee had to pay with after-tax dollars might cost a net of only \$6,000 after the tax savings. The employer benefits as well because there is no employer FICA tax due on the amount the employee puts in the account. The savings to the employee is realized even if the employer contributes nothing to the health insurance premium, although employer-paid premiums are also not subject to tax.

Several states are considering legislation that would require employers to establish Section 125 plans, and Massachusetts already has such a law in force. Requiring employers to offer Section 125 plans is an especially attractive policy because it provides a way for a state to reduce the cost of coverage for employed people who have to buy insurance as individuals because their employer offers no coverage, but without mandating employers to contribute to coverage or having the state come up with any new money. The "cost" of the employee savings is borne by the federal government in the form of foregone tax revenues.

Apart from the modest administrative cost of establishing and operating such a plan, the burden on the employer is minimal. The employer would have to withhold the amount employees designate and then transfer the appropriate amount from the employee's account for the premium payment. Of course, such a policy is likely to be more effective in reducing the number of uninsured if it is combined with subsidies for lower-income employees and/or a purchasing pool or insurance exchange to provide a cost-effective source of coverage for people who have such accounts and use them to purchase individual coverage.

Although a requirement to establish Section 125 plans is not technically a restructuring of insurance markets, it certainly is designed to make insurance more affordable, and it works best when combined with some of the insurance market reforms previously discussed.

From an administrative standpoint, mandating Section 125 plans is not an especially burdensome task. Obviously, employers have to be informed of the requirement; they have to report that they have complied; and someone at the state must verify that there is a plan in place that meets state requirements. This would require cross-checking with the state agency that has records of all businesses in the state, presumably the agency that administers business taxes. The federal requirements for establishing Section 125 plans are modest; employers do not even have to file their plans with the IRS.¹⁵ If the state decides to exclude certain employers, as Massachusetts does for employers with 10 or fewer employees, or to allow employers to not include certain employees in their plans, such as part-time or temporary employees, the state would need to issue regulations to spell out the exceptions. Massachusetts has developed a website that contains the information that employers need to know to comply with the requirement. The website includes documents that spell out all the regulations related to Section 125 plans.¹⁶ According to legal experts, a requirement to establish Section 125 plans should not run afoul of ERISA limitations on states' authority to regulate employer health plans because the U.S. Department of Labor does not consider Section 125 plans to be ERISA plans.¹⁷

Insurance Exchange

The idea of having small employers and/or individuals join together to purchase health insurance is not new, but the concept has been reinvigorated recently as a result of its inclusion as a key element in the widely publicized Massachusetts comprehensive health reform policy. The basic principle of collective purchasing underlies not only the Massachusetts "Connector" but a host of similar past efforts: health insurance purchasing cooperatives (HIPCs), insurance exchanges, alliances, and purchasing pools. The idea of having small purchasers come together to purchase as a group seems attractive because it is clear that large employers generally fare better than small employers or individuals when they purchase health coverage. Because they represent a large number of potential enrollees, large employers have purchasing "clout" and thus can negotiate for better prices and improved quality and service. Their large size allows insurers to realize administrative economies of scale, which translates to lower premiums. The thinking is that if many small employers and/or individuals could join together to form an entity to represent them in purchasing coverage from insurers, they could realize savings comparable to what large employers enjoy.

Such a purchasing entity (hereafter referred to as an exchange) offers several other potential advantages. Because the exchange contracts with several insurers, *individual employ-*

¹⁵ Massachusetts Commonwealth Connector, "Helping Your Employees Connect to Good Health: Section 125 Plan Handbook for Employers," July 1, 2007.

<http://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/FindInsurance/>

¹⁶<http://mahealthconnector.org/portal/site/connector/menuitem.5de15e4af5dc94de505da95c0ce08041/?fiShown=default>

¹⁷ Patricia A. Butler, *ERISA Implications for State Health Care Access Initiatives: Impact of the Maryland "Fair Share Act" Court Decision*, Washington: AcademyHealth and the National Academy for State Health Policy, November 2006.

ees within a firm can choose to enroll in any participating health plan rather than all being forced to accept the insurer their employer would have chosen if the employer had conventional coverage. If the exchange accounts for a large share of the small-employer market, coverage portability is increased because employees may not need to switch health plans when they change jobs. And the fact that employees individually select plans every year and can readily switch from one to another means that insurers are in direct head-to-head competition at every open enrollment, which creates stronger incentives for insurers to compete to offer high-value coverage. The environment for this kind of “managed competition” is strengthened by the fact that the exchange can provide objective information in a format that makes it easier for enrollees to compare the relative value of competing plans, especially if the benefit structures are standardized.

The real-world experience with stand-alone exchanges strongly suggests that merely establishing such an entity is not by itself an effective strategy for bringing more people under the health insurance umbrella. Even if an exchange could realize its full potential for reducing the costs of coverage, the reduction would not be enough to cause large numbers of the uninsured to newly acquire coverage. Thus an exchange should be viewed as a part of a more comprehensive approach to coverage expansion, which almost certainly must at minimum include some form of subsidies to make coverage more affordable for low-income and lower-middle-income people.

The past experience with exchanges for small employers has not been especially encouraging. In the early 1990s a number of states passed legislation that resulted in the formation of exchange-like entities. Although some experienced modest success for a time, ultimately almost all failed, including the ones in North Carolina, Florida, Texas, Colorado, and California. They had trouble recruiting sufficient numbers of enrollees. Insurers were sometimes reluctant to participate and, even when they did, often abandoned ship when they realized how few employers sought coverage through the exchange. Exchanges often experienced adverse selection, primarily because they were a magnet for tiny, relatively high-risk employers. Ultimately, few exchanges were able to offer coverage at a price any lower than what employers could find outside the exchange. So the primary benefit was that individual employees within a firm could choose different health plans from those participating in the exchange rather than being forced into the plan selected by their employer.

Some private exchanges started before the wave of the early 1990s and without benefit of state legislation continue to operate successfully, most notably CBIA in Connecticut and COSE in Cleveland. Some others have been started since—for example, HealthPass in New York City—but most account for a tiny portion of the potential small-group market. Some other exchange-like organizations that operate as part of a subsidy program of one kind or another exist; nearly all have very limited enrollment.

The past experience makes clear that it is important to structure an exchange in a way that will make it effective. We turn now to those structural issues.

Size

Perhaps the most important lesson from past experience is that exchanges have to be large to realize their potential advantages. Large exchanges can more readily attract and retain health plans because there is enough business to make it worth insurers’ while to

participate. They have enough visibility and market presence to make them an attractive option for small employers. They can realize economies of scale. And with significant market share, they can negotiate more effectively with insurers, if they choose to take that approach.

The size problem is something of a dilemma. Unless they are large, exchanges have difficulty offering an attractive price because they do not represent enough business to negotiate favorable prices and they cannot realize economies of scale to reduce costs. But unless they can offer a lower price than the outside market, exchanges will have difficulty attracting sufficient numbers of enrollees to become large. Probably the most successful examples of large exchange-like entities are government employee plans. Government exchanges have a unique advantage in reaching critical mass size: because they have a “captive audience”—the government employees—they do not have to attract customers. And for all practical purposes, their low-risk enrollees do not have the option of going outside the exchange to get lower prices because they would lose the employer contribution. So government employee plans are much less likely to suffer adverse selection. Prime examples are the Federal Employees Health Benefit Plan (FEHBP) and CalPERS, the public employees plan in California, which serves not only state employees but municipalities as well. Because of their size, these exchanges have no trouble recruiting health plans, and they use their market power to influence the levels of service, the kinds of products insurers offer, the prices at which they offer those products, and even the nature of the delivery of medical care.

One way to ensure that an exchange achieves sufficient size is for government to make it the only option for certain populations. For example, a state that provides subsidies to lower-income people could require that they use the exchange as their source of coverage. If as a result of its large size, the exchange achieves administrative cost reductions, the benefit of requiring use of the exchange is that more of the subsidy dollars are spent for the delivery of medical care rather than for administrative costs. Another option is for the state to require that all who purchase as individuals or all employers below a particular size—perhaps those with 25 or fewer employees—use the exchange. This approach seems particularly sensible for people purchasing in the individual and small-group markets because the premiums they pay in conventional markets include disproportionately high administrative and marketing costs, costs which might be reduced if purchases were made through the exchange. They are also in the poorest position to get information that allows them to make valid price-value comparisons among health plans, a problem that the exchange can ameliorate by being a source of objective information provided in a format that makes plan-to-plan comparisons relatively easy. While policy makers may be reluctant to adopt a plan that involves this level of coercion, the approach does not limit consumer choice in any significant way, since a number of health plans would be available to choose from, and health plans still have an opportunity for compete for the same total market.

Price Taker or Negotiator?

In designing the exchange, policymakers must decide whether the exchange will simply be a “price taker” or instead will assume the role of active buyer and negotiate with health plans. From an administrative standpoint, the simplest approach would be for the exchange to solicit bids, accept whatever price is offered by any insurer choosing to par-

ticipate, and let competition for enrollees be the disciplining force to ensure that prices are reasonable. The other approach is for the exchange to actively negotiate with health plans, aggressively seeking to attain more favorable offerings, which is the approach that most large employers use. Being a negotiator is a more complicated role, requiring the exchange to be active rather than passive and to be able to command the information and develop the skills to be effective at negotiation. And to have real bargaining power, the exchange must have the authority to decide not to contract with a health plan that does not offer a reasonable price. Of course, it will always be difficult for an exchange to exclude a health plan that accounts for a large share of the people currently enrolled.

Public or Private?

One of the key issues to be addressed is whether the exchange will be a private or a public agency.

A Private Exchange

The case for having an exchange be private is that it could be more flexible, more entrepreneurial, and quicker to react to changing circumstances. For example, private agencies generally have greater latitude in terms of hiring and terminating personnel and changing policies without undue delay. In addition, small employers in particular tend to be wary of government and may be more hesitant to acquire coverage from a public agency than a private entity. A private entity is also likely to face less skepticism and wariness from agents and brokers. Public organizations may also have a harder time justifying expenditures for marketing, including payment of sales commissions.

A private exchange could be either a for-profit or a non-profit organization, although the potential for realizing substantial profits may not be large, and given the general view of an exchange as serving the public interest, there might be some skepticism about assigning the role to a for-profit firm.

If the exchange is to be a private entity, state government could still retain considerable control. It could issue a request for proposals (RFP) to select a contractor, or it could certify an entity to serve as the exchange. In either case, the state could require that the exchange have a governing board that would ensure accountability to the people the exchange is designed to serve. This would give the state some of the advantages of both a private and a public entity.

If the exchange is to be a private entity initiated through legislation, then someone within either the governor's office or an executive branch agency would need to be responsible for starting the process of establishing the exchange. Whichever choice is made, it is important that the people responsible have considerable flexibility and not be unduly hampered by bureaucratic restrictions. Criteria would need to be developed as a basis for choosing the organization to be the exchange. Then it might be necessary to prepare and issue an RFP to elicit responses from parties willing to serve the function.

One of the issues to be concerned about with this approach is that there may not be any existing entity that is appropriate or willing to perform the functions of the exchange, either because none is prepared to take on the task or because qualified entities (like insurers or brokers) have a conflict of interest. (It is important to make the distinction between the exchange being a private entity and having the exchange contract with a pri-

vate entity for certain non-policy functions, such as administration of premium collection and distribution, maintaining eligibility files, etc. This issue is discussed below.)

A Public Exchange

The case for having the purchasing exchange be a public entity is related to issues of coordination and control, confidentiality, accountability, and the capacity to serve the public interest. If the exchange is established as part of a larger reform, the functions assigned to the exchange would likely be interwoven with other processes and policies that are under state control—for example, determining who is eligible for subsidies, which involves gathering confidential information about income, family size, work status, etc. Especially if the exchange is not a public entity but is responsible for administering the subsidies, safeguards should be in place to ensure that confidentiality is protected and that the exchange is acting responsibly, efficiently, and effectively in handling large sums of government money. Ensuring that the exchange’s activities are consistent with and further the total system reform goals would probably be easier if the exchange were a government entity or at least an entity that is clearly accountable to serving the public interest and is subject to government oversight.

If policymakers assign the exchange responsibilities to government, they must then decide whether to locate the exchange in an existing agency or to create it as an independent entity. The advantage of assigning responsibility to an existing agency is that there would already be people on board who could begin work immediately, and not all procedures would need to be invented anew. On the other hand, a new entity might be less constrained by existing procedures and cultures and more ready to experiment and be innovative. An independent government entity governed by a board representing the interests of the people the exchange serves—perhaps something like the Federal Reserve at the national level—would help to give the exchange an identity separate from existing institutions and provide a more flexible structure for moving quickly and being able to adapt to changing circumstances. This is the approach Massachusetts chose in assigning the exchange role to the Connector. The exchange should probably have wide latitude and as much flexibility as possible with respect to the way it carries out everyday procedures, free of some civil service and procurement procedures usually required of government agencies, though always subject to the approval of its governing board.

The composition of the governing board of the exchange is important. While the initial impulse might be to include all the stakeholders on the board to help ensure that they “buy into” the process, the counter argument is that the exchange should mainly represent the *buyers* of health care, namely employers, employees, and non-employed individuals. If the exchange is assigned the task of bargaining with insurers to get the best value, putting sellers on the board—that is, insurers, agents, and providers—creates a clear conflict of interest. The governing board should probably include representatives of employers, employees, and individual health insurance purchasers, as well as health policy experts, perhaps including state officials, who are knowledgeable about and sympathetic to the overall objectives of the exchange. However, a strong argument could be made for also having an advisory panel that includes insurers and providers, both because their input would be valuable and because it would be counterproductive to have them feel shut out of the process. The board should probably also be somewhat removed from short-term political influence, which suggests the need for relatively long terms that are staggered so as to maintain policy continuity through changes in political control.

Start-up Issues

Once operations are fully underway, it would be possible to finance operations of the exchange through an administrative fee added to the premiums. But initially, funding will have to come from elsewhere. Experience with other purchasing pools suggests that several millions will be necessary to fund the start up. Assuming funding has been solidified, the first task will be to identify the entity that is to be the exchange if this is not specified in the legislation. If this is to be a private entity, criteria will need to be developed to choose an organization, and someone will have to be assigned responsibility to research possible candidates and to make the selection. This is likely to be a several-month process.

A closely related step is to appoint a governing board, the composition of which will presumably be specified in the enabling legislation if that is the impetus for the establishment of the exchange.

The third step is to develop a job description for an executive director, do an executive search, and then hire the person. This responsibility would most logically be lodged in the governing board, though if the exchange is a public entity, the task might be assigned to an existing government or to the governor's office. Supporting staff will need to be hired or transferred as well, although the executive director would be expected to take primary responsibility for this task.

Once the initial staff is in place, a first order of business will be to prepare a work plan and spending plan for the first year and ideally a tentative budget plan for the second and third years.

The exchange will also probably need to seek legal advice about a number of issues, including indemnification of staff and board members and making sure the exchange activities are consistent with federal law, especially ERISA.

Major Tasks

What follows is a discussion of the major tasks the exchange must perform before it can begin enrolling people. A number of the tasks will have to be performed simultaneously, and some of them will need to be repeated periodically during the operation of the exchange in future years.

The general experience of those who have been through the task of beginning a exchange is that once the exchange is formed, if all goes very smoothly, it generally takes at least a year of intense work to complete the tasks that have to be completed before the exchange can start enrolling people.

Choosing a Plan Administrator and Defining Its Tasks

Plan administration refers to specific tasks that the exchange must perform—specifically those that involve enrolling people in health plans, collecting premiums from employers and individuals (along with subsidies from government if they are part of the reform), transmitting payments to appropriate health plans, providing customer service to employers and individual enrollees, and coordinating functions with insurers. The plan administrator is not a policy-making entity but instead does the routine but very important

tasks just enumerated. The administrator's role is similar in many ways to the role that third-party administrators (TPAs) play in administering self-insured employer health plans.

Most of these functions are now performed by insurers themselves, with the help of agents and brokers, but they would become the primary responsibility of the exchange or its contractor. The process is more complicated if individual employees, not their employers, can separately choose from any of the participating health plans. A firm employing five people might have employees enrolled with five different carriers. This complicates the premium determination process for each employer as well as the process of maintaining eligibility files and distributing premiums to health plans.

Past exchanges have typically chosen to contract for administrative services with firms that specialize in this kind of administration, evidently deciding that it was not practical or cost-effective to try to develop the required expertise in-house, especially today, given the need for sophisticated computer technology and web-based access for enrollees, employers, insurers, and the exchange itself. Developing such systems is expensive, and there are substantial economies of scale. Having an experienced administrator that is used to working with insurers to implement the individual-choice system is also important, since insurers may have little experience with this model, especially in the context of the small-group market. Smaller employers seldom offer multiple health options.

People with experience in administering exchanges emphasize that it is important that the plan administrator have a cooperative relationship with health plans and that the administrator be able to listen to the problems raised by health plans and work to accommodate them whenever possible. Retaining the good will of health plans is important to the success of the total effort, since they tend to be wary of dealing with exchanges. The insurers need to view the administrator as a partner rather than an adversary, according to people involved in past exchange start-ups.

Given the fact that insurers already perform most of the administrative functions that the exchange must undertake, it might seem obvious to hire a health plan as the administrator. However, the exchange should approach this solution cautiously. The unsuccessful Texas exchange tried this approach and discovered that other insurers were concerned that the administering insurer would gain a competitive advantage by obtaining access to competitors' information, and they did not trust the administrator to be fair in making decisions that have financial repercussions. At the very least, such an approach creates the perception of a conflict of interest.

If the exchange is established as a result of legislative mandate, the state employees' health plan might be seen as a likely candidate to serve as the exchange's administrator. Although state employees' health plans perform many similar functions, the exchange has some unique responsibilities. The administrative process involves collecting premiums from many employers, each of whom may have employees enrolled in several health plans. Maintaining eligibility rolls for such a system is obviously more difficult than for the present state employee system. These functions require mechanisms, processes, and computer technologies that the state probably does not have, and developing them and interfacing that system with insurers' systems would likely be expensive and time-consuming and could be difficult to do in a timely way.

On the other hand, an advantage of using the state employees' plan as the administrator is that the state develops expertise and retains the institutional memory and thus does not become a captive to an outside vendor. If a vendor proves unsatisfactory, it is not a trivial or easy task to switch to a new vendor.

We are not aware of any state that uses the state employees' plan as an exchange for small employers or individuals, although a number of states offer coverage to municipalities and school boards as well as state employees.

Past experience shows that it is important to have the plan administrator on board before trying to recruit health plans. The administrator can help to sell the idea to insurers. Health plans have generally not been eager to participate in exchanges, and one element they are concerned about is the administrative aspects of the new program. They have to be convinced that they can trust the plan administrator to properly maintain eligibility files and properly allocate premium revenues. They have to trust that they are getting paid what they are due and that they are not paying claims that are not valid. Insurers are more likely to participate if they are confident of the administrator's expertise and integrity. Thus the decision about who is to administer these functions needs to be made before approaching health plans to seek their participation.

Getting Participation of Health Plans

Recruiting and maintaining participation of health plans has proved to be a challenge for previous exchanges. Insurers are not always eager to enter into an arrangement that gives their customers greater bargaining power. They are also worried about being victims of adverse selection, especially when the exchange allows individual employee choice: insurers feel better protected against adverse selection when they can be assured of getting whole groups rather than just some individuals within the group, since there is some spreading of risk even within small groups. One way to relieve insurers' concern is to establish arrangements that protect them against adverse selection. Examples include reinsurance, which transfers at least part of the risk of high-cost cases to someone other than the insurer, and risk adjustment, which transfers monies from insurers that enroll a disproportionate share of low-risk enrollees to insurers that end up with more than their fair share of higher-risk enrollees.

The best way to ensure that health plans will participate is to structure the exchange so that a large portion of insurers' potential pool of business goes through the exchange. Under such circumstances, insurers cannot afford to exclude themselves.

Experience with other exchanges indicates that it is highly desirable to consult with health plans early in the process. They will have concerns about the new system and how it meshes with their normal way of doing business—for example, what changes in their administrative processes will be required and what that will cost. They are especially likely to be worried about adverse selection, as noted above. They may have reservations about having to offer a new benefit package, especially since that normally requires a filing with the regulatory authorities. In short, health plans need to be reassured that they can profitably participate in the new system.

As noted earlier, exchanges can take one of two approaches in contracting with health plans, either accepting all comers or choosing only those that offer high-value bids. If the decision is to selectively contract, the exchange will have to decide how many plans

should be included in the exchange and what characteristics they should have. Past experience suggests that getting desirable, prestigious plans in the exchange may be more of a problem than keeping unwanted plans out. But if the number of plans wanting to participate is large, how many should be selected? The number should be large enough to ensure real choice, especially if some of the health plans do not have broadly overlapping provider networks. People understandably do not like to be forced to change providers, so it is desirable to offer enough choices that few people are forced to change providers in order to purchase through the exchange. In addition, the number should be large enough to engender vigorous price competition. In making plan choices, consumers give substantial weight to price differences; thus, plans have strong incentives to compete on the basis of price.

A case could be made for limiting the number of plans, however, to reduce the complexity of choice for consumers and the administrative costs for the exchange. Moreover, if the number of plans is relatively small, each plan has the potential to enroll many people, creating a situation where they have strong incentives to offer an attractive price to gain business.

Even if the exchange chooses to limit the number of participating health plans, it should always keep open the option of allowing other plans in. In fact, this should be the expectation, and whenever rebidding is done, non-participating plans should be encouraged to bid. The exchange should avoid the situation of becoming the captive of the health plans that currently participate.

Designing Benefit Packages

Plan design has two elements: the medical services to be covered and the extent of consumer cost-sharing. Although there is a growing consensus about most of the medical services that should be included in a comprehensive benefit package, there is still disagreement about services that may be considered more marginal. Every provider group wants their services included as part of the minimal package. How to structure cost-sharing is also controversial. Advocates of “consumer-driven plans” favor high deductibles and copayments to encourage consumer cost consciousness. Others view such plans as providing inadequate protection and as leaving consumers excessively exposed to financial hardships. And of course, if the exchange is part of a reform that includes subsidies, the more generous than minimum benefit package, the greater the cost to the state of financing the subsidies.

Whatever the decision regarding the comprehensiveness of the benefit structure, the advice from exchange officials who have been through this process is to involve the health plans in the early stages. They will have ideas about the specifics of plan design. It will be important to know the directions the market as a whole is going with respect to benefits even if the exchange decides to set its own course, and the health plans will be able to provide that context. The insurers will also need time to adapt to the exchange’s requirements; doing so may involve some administrative burdens for the insurers, and they will probably need to file their plans with insurance regulators.

Another policy decision involves how many different benefit packages the exchange should offer. On one hand, if the exchange offers only a few standardized plans, consumers will have an easier time comparing the relative values of the plans offered by different insurers, which creates a favorable environment for vigorous competition. Each

year each individual can compare all of the plan offerings and choose the one that offers the best value. So insurers have strong incentives to compete on price, service levels, and quality. But this works well only if individuals assessing the options can easily and meaningfully compare the various offerings. If the benefit packages are not standardized or even if there are an excessive number of standardized plans, the task of comparing the value of the different plans is much more difficult; there are just too many variables to keep in mind. The evidence shows that when people are faced with too many options, they resort to choice-limiting techniques that are not consistent with economists' view of rational decision-making.

On the other hand, people do value some degree of choice, and some variation in benefits may be desirable. One way to achieve elements of both objectives is to have every insurer offer the standard set(s) of benefits, but then allow them to offer add-ons—for example, dental or vision coverage—that are priced separately from the main benefit plan. It is important that such “riders” be separately priced so that potential enrollees are still able to compare a standardized benefits base without the riders.

Recruiting Agents and Brokers

Experience with previous exchanges shows that agents and brokers play a crucial role in attracting business to the exchange. Because small employers do not have specialized personnel to negotiate and administer a health insurance plan, they depend heavily on the advice and expertise of their insurance agents and brokers. If agents and brokers do not bring the exchange to an employer's attention, the employer is unlikely to buy coverage from the exchange. And if agents and brokers are not part of the exchange's marketing plan, they are likely to be hostile, which will hurt the exchange's ability to attract small employers. Disgruntled agents and brokers may also steer higher-risk people to the exchange, which would exacerbate any adverse selection that the exchange might experience. The exchange offers some features that can help agents and brokers sell coverage, particularly the individual choice feature. Both employers and employees like the fact that if the employer chooses to buy coverage from the exchange, the employer does not have to force employees into any particular plan. This feature of exchange coverage also makes it easier for employers to contribute to employee health premiums on a defined-contribution basis, thereby making it somewhat easier for employers to limit their cost exposure as premiums rise. Partly for these reasons, employers are less likely to switch to a new carrier at the end of a plan year, which means that the agent enjoys higher retention rates and lower servicing costs.

Once again, experience shows that it is important to involve brokers and agents early in the process—to sell them on the idea and to educate them about the product and the potential markets. The exchange will need to make software available to the agents so that they can easily and quickly provide price quotations to employers.

Marketing and Education of Employers, Employees, and Other Consumers

Past experience shows that even though the exchange is offering coverage with important advantages for employers and employees, this is no guarantee that large numbers of employers will take up the offer. Of course, the situation is different if there is an individual mandate in force, requiring people to buy coverage, especially if subsidies are available only to people who purchase through the exchange. If the mandate is not part

of the reform package, the exchange will need to have a marketing strategy to bring in as many employers as possible if it is to be assured of being large enough to realize administrative economies of scale and to have bargaining power with health plans.

Past exchanges have tried a variety of marketing approaches, and there is no clear evidence that one particular approach is most effective. Some of the more successful exchanges have had relationships with organizations already known and trusted by business, such as Chambers of Commerce. The exchange will probably need to hire a marketing firm to develop a strategy that suits the particular environment. The general conclusion of other exchanges is that they need more money than they have had to carry out a really effective marketing campaign.

Rating Practices

An important issue for the exchange will be the degree to which it restricts insurers' ability to vary premium rates based on past history or characteristics of insured individuals and groups. Advocates of exchanges sometimes see the exchange as a mechanism for offering more affordable coverage for higher-risk individuals and groups. They support the exchange as a vehicle for pooling risk—bringing together higher-risk and lower-risk people and spreading the costs evenly among them through some form of community rating. Unfortunately, the reality is that the exchange cannot be more lenient in its risk-rating practices than the rest of the market. Essentially, the exchange must adopt the same rules for determining the conditions under which people will be allowed into the risk pool and the prices they will pay based on their risk. If the insurers outside the exchange rate on the basis of age, location, and prior claims experience, for example, the exchange insurers must do the same. If the exchange adopts more lenient rules—for example, using community rating while the rest of the market rates on the basis of individual or group risk—the exchange insurers will end up with a disproportionate share of high-risk enrollees. High-risk people would get a better deal by buying exchange-based coverage because they will not be penalized for being higher risk, while lower-risk people can get a more favorable price by going outside the exchange where the price they pay is based on their lower risk. Under these conditions, the exchange would become a victim of adverse selection: its claims costs and thus its premiums would rise, the lower-risk people would leave to get a better deal outside the exchange, and the exchange could become financially unviable.

Similarly, if those buying coverage outside the exchange are subject to exclusions and waiting periods for prior conditions, the exchange should follow the same practices. The rules change *in a system in which everyone is mandated to have coverage*, as is the case in Massachusetts. There is no need to have pre-existing condition exclusions or waiting periods inside *or* outside the exchange. These are in place at present to prevent people from waiting until they become ill or know they need expensive services to enroll in a health plan. Under a mandate, people cannot delay getting coverage in this way; they will normally have continuous coverage. Likewise, community rating becomes practical for the market as a whole. Even though rates would rise for lower-risk people as they are coming down for higher-risk people, the lower risk people do not have the option of dropping out of the market, which is what creates adverse selection against the market in a voluntary environment.

As noted earlier, one way to avoid adverse selection against the exchange is for the exchange to enroll a population that does not have the option of going elsewhere for coverage. If an exchange is established as part of a more far-reaching reform that includes subsidies, and subsidies are available only to people who use the exchange as their source of coverage, the exchange could adopt more lenient rating rules for those eligible for subsidies. If the subsidies are relatively large and available only through the exchange, people who are eligible for those subsidies, even low-risk individuals, will always get a better deal by staying with the exchange.

Although exchanges are typically thought of as sources of coverage for small employers and perhaps individuals, some analysts have advocated allowing larger employers to opt for exchange-based coverage. The advantage from the exchanges' standpoint would be that the inclusion of these firms would enhance its bargaining power with insurers. But if the participation of larger firms is permitted, the question arises about how they should be rated. The danger is that if the exchange-based coverage is favorably priced relative to the market as a whole, the exchange would be most attractive to larger firms with a disproportionately high-risk population. Including them in the risk pool on the same basis as other employers could cause an increase in the average premium. Thus, it may be desirable for the exchange to permit such larger firms to participate but to require that they pay a premium that reflects the risk of their unique population rather than pooling them with the entire exchange population.

Risk Adjustment

If the exchange adopts the same rating rules as those that apply outside the exchange, the exchange as a whole will be reasonably protected against adverse selection. But this does not mean that individual insurers participating in the exchange will not attract enrollees of different levels of risk. Adverse selection for some insurers can be the result of chance, a reputation for being very good at treating particular serious illnesses, differences in marketing practices, and so forth. Of course, if some participating insurers enroll a disproportionate share of less healthy people, their costs will be high and they will not be able to compete over the long run unless this disadvantage is somehow offset.

Risk adjustment is an approach to offsetting the effects of enrolling a favorable or unfavorable mix of enrollees. In effect, money is transferred from insurers that enroll a disproportionate share of lower-risk enrollees to those that enroll a disproportionate share of higher-risk enrollees. A perfect risk-adjustment mechanism would completely eliminate any economic disadvantage to enrolling higher-risk people or any advantage to enrolling lower-risk people. It would thus eliminate any incentive for insurers to seek out low-risk enrollees and avoid higher-risk enrollees. Of course, there is nothing approaching a perfect risk-adjustment mechanism because no system can predict exactly the level of medical expenditures that a particular population will incur. But even a "good" approach can give insurers greater confidence that they will not be put at a severe economic disadvantage if they attract older, sicker enrollees.

A detailed discussion of the administrative issues involved in developing and putting in place a risk-adjustment mechanism is far beyond the scope of this paper. To a considerable extent, the degree of difficulty will depend on the intricacy and sophistication of the mechanism for measuring risk differences. There is a trade-off between administrative simplicity and accuracy in predicting medical expense. The simplest approach might be

to adjust for age only, which would be easy to administer but would not be a very accurate predictor of expenditure differences. Much more sophisticated approaches have been developed that explain a larger proportion of expenditure variance, but they require major data collection and analysis efforts and involve much more administrative detail.¹⁸

A National Insurance Exchange

To this point, the discussion of exchanges has generally assumed that they would be established at the state level. However, many analysts and policymakers who have proposed programs for national health reform have also included exchanges as a critical element of their plan. In fact, the generally acknowledged success of the Federal Employees Health Benefits Program has led some presidential candidates to suggest that this “national exchange” be opened up as a source of coverage for people besides federal employees.

Although some of the administrative and policy issues that arise in establishing state-based exchanges apply to national exchanges, the order of magnitude is so different that many of the issues, problems, and solutions have to be rethought. A thorough discussion of how to address all the issues is beyond the scope of this paper. But it would perhaps be useful at least to identify the key issues and to show the nature of the problems related to establishing an exchange at the national level.

The first thing to note is that the problems will differ depending upon whether or not national reform includes an individual mandate requiring everyone to have some form of coverage. Under a mandate, the number of people getting coverage would be much larger, which obviously would add to the administrative challenge. But there are other differences as well, which we will try to identify as we discuss particular issues.

Risk Rating Challenges

From a policy perspective, perhaps the biggest challenge is to avoid having the exchange become a victim of severe adverse selection. If the exchange is open to any employer or any individual, people will choose the exchange if the cost for comparable coverage is cheaper than what they can get elsewhere. From the standpoint of political acceptance, it is difficult to envision how the federal exchange could charge substantially higher premiums to higher-risk people than to lower-risk people. The exchange would almost certainly have to provide coverage on a guaranteed-issue basis and adopt some form of community rating that did not result in higher-risk or older people paying substantially more than those who posed a lower level of risk. Otherwise it would fail to correct some of the major deficiencies of the current insurance system, which is presumably the point of undertaking the reform. But many states have rating rules that allow substantial variance in premiums depending on the risk of the individual or group seeking insurance. Under those circumstances, higher-risk individuals and groups would almost certainly find the federal exchange to be less costly and would gravitate to it, leaving it with a very disproportionate share of high-risk people and raising the cost of providing coverage

¹⁸ As one example, Medicare uses a very sophisticated risk adjustment approach in paying capitated health plans. For an explanation of this approach, see Gregory C. Pope, *et al.*, “Risk Adjustment of Medicare Capitation Payments Using the CMS-HCC Model,” *Health Care Financing Review*, Summer 2004, Volume 25, Number 4.

well above that of the average for the nation as a whole. Unless the federal government were willing to subsidize this adverse selection, coverage through the exchange could become unaffordable for many people, and the purpose of having the exchange would be thwarted.

The danger of attracting high-risk individuals would be particularly acute if any employee could opt out of employer coverage and take his or her employer's contribution to the federal exchange. Employers would have strong incentives to encourage or even offer financial incentives to high-risk employees to do that to improve the risk profile of the employee group and thereby lower the employer's health insurance bill.

Even if the federal exchange were to adopt rating rules that allowed some variation based on the risk of the applicant, the rating rules in some states would almost certainly allow more variation, again making the federal exchange a more desirable source of coverage for high-risk people from those states. This problem would likely arise whether or not an individual mandate were in force unless federal policymakers were willing to require all states to adopt uniform risk rating laws for health insurance. Then, as long as the federal exchange used the same risk rating standards, it would not be likely to become the victim of severe adverse selection. Without a mandate, however, the rating laws would almost certainly have to permit some rate variation based age, at minimum; otherwise, low-risk individuals would likely often not buy coverage because of the high cost relative to their expected expenditures for medical services. Of course, if a mandate were in force, they would not have this option, so it would be possible to impose community rating on the entire national market. But such a policy could cause severe "sticker shock" for lower-risk individuals and groups and for those in geographic areas with relatively low medical costs.

From an administrative standpoint, if the exchange employed any kind of risk rating, that would add to the administrative burden. However, if age and geographic location were the only rating factors, the task would not be especially difficult.

Eligibility for the Exchange

Another major policy issue with important implications for administrative complexity would be who is permitted to use the national exchange as a source of coverage. If it is open to anyone, the size of the administrative task is obviously greater than if only a portion of the population can use the exchange. One option would be to make it the source—perhaps the sole source—of coverage for individuals (perhaps only those without access to employer coverage) and small firms (perhaps those with 25 or fewer employees). If it were so limited, the exchange would have to employ some mechanism to ensure that the applicants met the eligibility criteria. Another option would be to make the exchange the source of coverage for all those who receive subsidies designed to make private insurance more affordable. As noted earlier in the paper, this policy would make it less likely that the exchange would experience adverse selection.

The administrative tasks of an exchange include the following:

- Education: Provide potential applicants with information about the insurance policy and health plans options along with information to compare cost and quality of competing health plans and their provider networks.

- Enrollment: Enrolling individuals and/or groups and maintaining enrollment rolls.
- Premium administration: Collecting premiums and distributing proper amounts to health plans based on their enrollment.

The federal government has some experience with these tasks because of its administration of two programs: Medicare and the Federal Employees Health Benefits Program. But the administrative tasks would be larger and somewhat different for a national exchange with the whole population as potential enrollees.

Just getting the information about options out to the entire population when there is no national database containing contact information for everyone would be a major challenge. How could everyone be contacted? It would presumably be possible to have the Post Office deliver information to every mailbox.

Maintaining enrollment information as people move, change names, die, move from employer to employer, drop out of the labor force, etc. would be a massive undertaking, perhaps not different in character from what large insurers do but certainly on a much larger scale. And insurers are usually dealing with employer groups with a defined membership, where the employer has accurate information on who is in the group along with their contact information.

How would premiums be collected? When employers use the exchange as a source of coverage, presumably the employer would send in both the employer and employee share. A different approach would be needed for people who enroll as individuals. What would the exchange do if a premium is simply not paid? How would the exchange know if the employer went out of business or just failed to pay, and how would the rights of the individual employee be protected in either case? This is only a sample of many issues related to premium collection that would require carefully constructed administrative procedures.

Perhaps none of these potential problems is qualitatively different from those that a state-based exchange would have to face, but the magnitude of the task makes the administrative challenge more difficult. Some decentralization of administration might be a good way to address this challenge.

An Individual Mandate

If the federal exchange is coupled with a requirement that all citizens acquire coverage—the so-called individual mandate—the tasks are even more complicated.¹⁹ The most obvious additional challenge would be how to ensure that everyone has coverage. One approach to enforcement would be to use the income tax system. Everyone could be required to file proof of coverage, supplied by insurers, along with their income tax return; and those without proof of coverage would incur a tax liability for every month they and their dependants were not insured. Even those without any net tax liability would be required to file a return. Most who failed to do so would probably be eligible for insurance subsidies, which would certainly be necessary to make coverage affordable. If they failed to file, they would not get the subsidy. But anyone who showed up for medical care

¹⁹ For a detailed discussion of issues related to an individual mandate, see C. Eugene Steuerle and Paul N. Van de Water, “Administering Health Insurance Mandates,” draft paper prepared for the National Academy of Social Insurance and National Academy of Public Administration, November 2007.

without an insurance card would be reported to the administrator and automatically enrolled in a public plan if eligible, and, if not, in a private plan if they failed to choose one on their own. They would be billed for insurance premiums not paid in the past when they were not enrolled.²⁰ Obviously, such a process would require much in the way of new administrative structures, both within the IRS and elsewhere, but it seems one reasonable way to address the problem.

CONCLUSION

Policymakers and analysts tend to agree that the small-group and individual insurance markets often do not perform particularly well. Along with all insured people, people in these markets bear the burden of paying the high premiums that reflect ever-increasing medical care cost. But for people in these market coverage is even pricier than for those buying in the large-group market. And high-risk people are especially vulnerable to being priced out of the market.

The general problem of controlling health care costs requires solutions that go well beyond structural reforms of insurance markets. Even if insurance markets worked much better, it is likely that the underlying costs of medical care would continue to be too high to make insurance affordable for many people. For such people, only substantial subsidies of some form or other will make the purchase of coverage feasible. But some structural changes in the insurance markets may help to alleviate the cost problem for people who are in the higher-risk categories and make the markets function more smoothly and efficiently, with some prospect for improved cost control. We have examined six such strategies. While all show some promise of dealing with parts of the problem, it is evident that they will be much more effective in adding to the number of people with coverage if they are combined in creative ways. From an administrative standpoint, it is critical that any such combination be considered as a whole, because the administrative and structural elements need to be coordinated and crafted with careful attention to their interactions, both to enhance the chances for success and to avoid unnecessary administrative burdens and duplication.

²⁰ Elliot K. Wicks, Jack A. Meyer, and Sharon Silow-Carroll, "A Plan for Achieving Universal Coverage: Combining the New with the Best of the Past," in Elliot K. Wicks and Jack A. Meyer, eds., *Covering America: Real Remedies for the Uninsured*, Vol. I, Economic and Social Research Institute, June 2001.