



PRIVATE PURCHASING POOLS TO HARNESS
INDIVIDUAL TAX CREDITS FOR CONSUMERS

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EXECUTIVE SUMMARY

A health insurance tax credit could help many people who cannot afford to purchase coverage. However, even with these subsidies, many of the uninsured would probably still find non-group private insurance too expensive. Many would also find the complexities of the individual market and its myriad insurance products bewildering. Private purchasing pools for tax-credit recipients could address these problems by providing individual purchasers with many of the advantages of a group market, such as relatively low administrative costs, no health rating and professional purchasing expertise. Insurance purchased through pools should cost 5 percent to 10 percent less than private, non-group insurance. Unlike many employer plans, however, purchasing pools will allow individuals to choose among several health plans.

All tax-credit recipients would be required to purchase coverage through private purchasing pools. This requirement is necessary to ensure that the pools become large enough to operate efficiently and offer their members the advantages of group purchasing. Individual purchasers who were not eligible for tax credits, and firms with 50 or fewer employees could also join the pools. Income-eligible workers in small firms with a majority of low-wage workers would be eligible for the full amount of the tax credit for coverage purchased through a pool, whether or not their employer paid any part of their premium.

In the recent past, many small state-run purchasing pools have failed, largely because of hostility from insurers and agents. Agents fear loss of commissions, and health plans prefer to deal with employer groups directly through exclusive contracts. However, the pools proposed here should be more attractive to insurers. Because pools would be the only vehicle for using the health insurance tax credit, they would be much larger and have greater cohesion and stability than any other pools to date. In addition, since people will join pools for reasons not related to their health status, risk selection should be much less frequent than in the individual insurance market.

In turn, pools should be attractive to low-income purchasers of health insurance, because they would provide a more consumer-friendly source of coverage than the existing individual health insurance market. Like large employers, pools would act as “sponsors,” using their size and professional purchasing expertise to obtain good value for their members. Individual consumers would be assured that the plans offered through the pool were those that best met the informed standards of their sponsor, the pool.

Premiums for full tax-credit recipients would not vary based on individual health status. They would be permitted to vary only by age, and only to the extent permitted in

the state's regular insurance market. Premiums for non-tax-credit recipients could be health rated, and health rating could be phased in for recipients of partial credits. More generally, these pools would provide a stable source of coverage for people whose circumstances change, allowing them to keep their insurance provider and their physicians.

The federal government would provide the enabling legislation and start-up funds for health insurance purchasing pools, so that at least one competing pool would be available in every region of the United States. Federal funds would cover 80 percent of the cost of establishing a pool, up to \$2 million per pool. Thereafter, administrative costs would be paid for with a small (3%–4%) surcharge on premiums. State responsibilities would include regulating pools, preventing “redlining,” limiting the number of pools so they reach sufficient size, and arranging an alternative purchasing mechanism for tax-credit recipients if no private organization came forward to sponsor a pool in the state. Where necessary, state benefit mandates would be waived, so that plans costing no more than the value of the tax credit could be offered through pools. However, a federal minimum benefit package would be established. Pools would be permitted to contract selectively with health plans.

In each region of the United States, several competing pools would be preferable to just one, for several reasons. First of all, people prefer to have a choice of plans, and presumably a choice of pools. More importantly, a single purchasing pool, especially one seen to be an agent of government, might not have the same freedom to contract selectively with the health plans it considers the best value.

Starting up a pool would be considered a “charitable purpose,” so that pools could more easily obtain foundation grants to pay for start-up and administrative costs. Their boards of directors would represent employers and consumers, not insurance vendors or health care providers. Pools would negotiate with health plans, and would provide easy ways to enroll. The pools would receive tax credits and pay premiums, and would serve as an ombudsman for participants. Pools would be required to offer at least three different health plans and at least one coverage option that cost no more than the maximum tax credit, and pools could refuse to contract with plans that are deemed too expensive or that offer poor benefits. Pools must be open to all tax-credit recipients.

The tax credits would be payable in advance, based on an individual's tax return from the previous year or expected income for the current year. Overpayments and underpayments would be adjusted through a reconciliation process at the end of the year. Employers would use payroll deductions to obtain the employee's share of the premiums, when required, and send them to the pools.

PRIVATE PURCHASING POOLS TO HARNESS INDIVIDUAL TAX CREDITS FOR CONSUMERS

OVERVIEW

Context and Concept

In order to “fill the coverage gap” between Medicaid and employer-sponsored health insurance, other papers in this series propose that low-income workers be eligible for federal income tax credits to enable them to purchase private health insurance. Larry Zelenak¹ proposes a refundable tax credit of \$2,000 for individual coverage and \$4,000 for family coverage for uninsured workers earning less than twice the federal poverty level. (Above that income level, the credit would phase out gradually.) Workers not currently covered by an employer plan (even if eligible for one) or by a public program could use the credit to buy private non-group (individual) health insurance.

This paper deals with the issue of how to make health insurance available to individual tax-credit recipients in a cost-effective manner, incorporating constructive market forces. The paper has two premises: first, that there is a need to provide a more efficient and consumer-friendly source of coverage for individuals with tax credits (and their low-wage small employers) than the existing individual health insurance market; and, second, that many policy makers and most working Americans would prefer private-market-based approaches over government programs.

To address these issues, we propose that private purchasing pools, meeting specified criteria, should be established as the only venue through which individual tax credits could be used to purchase health insurance. This paper lays out the rationale for our recommendation and discusses how the proposed system would work.

Introduction and Rationale

Individual health insurance markets are generally dysfunctional. They are characterized by high turnover and high average medical costs, risk segmentation, aggressive underwriting, and competition among carriers based on risk selection. These interrelated problems lead to high overhead costs and large variations in premiums based on health status, and therefore make it highly unlikely that using tax credits to purchase coverage through those markets would be a cost-effective means of covering uninsured workers and their dependents.

But the attributes of individual choice of health plans through private markets have broad appeal. People want to be able to choose their own physicians and do not want to

be forced to change physicians just because they have changed jobs. Even if provider selection were not an issue, people care about how they are treated and resent being forced to stay with an employer-selected plan that has treated them poorly. They want to be able to “vote with their feet.” These attributes are generally associated with private markets and not government programs.

Furthermore, many policy makers oppose expanding government-run programs to cover working populations; and many working families seem more likely to participate in privately sponsored coverage, due in part to the potential “welfare stigma” that, as Alan Weil notes, can be associated with state government programs. Moreover, providers and other interested groups fear that Medicaid-like price limits would ultimately follow.

Americans also like getting their health coverage through their work. The Commonwealth Fund’s 1999 National Survey of Worker’s Health Insurance found that adults who have coverage through their employer greatly preferred that approach over buying insurance directly from insurance companies (56% v. 20%). Even the currently uninsured preferred employer coverage to direct individual purchase (35% v. 27%).²

Why do people prefer employer coverage? Obviously, obtaining coverage through work is more convenient and cheaper than buying coverage on one’s own. But workers may also see their employer as a sponsor who has the resources to discern and select a good health plan, and the leverage or market clout to obtain good value and to intervene on the worker’s behalf when a problem arises. Whatever considerations are at work, they must be powerful to generate such strong support for employer coverage, given that plan choice has been found to be a powerful determinant of consumer satisfaction with health plans and that most workers with employer coverage are not offered a choice of plans.

If individuals received tax credits to purchase coverage on their own rather than through their employer, private purchasing pools would be a sensible alternative market vehicle. These pools would allow tax-credit recipients and taxpayers to benefit from economies of scale, risk pooling, choice of health plans and group sponsorship by an organization with purchasing expertise and market clout—much like an employer.

We propose that the private purchasing pools serve individuals and small-employer groups regardless of their subsidy status. In this way, pools can provide a stable source of coverage for a population—low- and modest-income working families—whose employment status and eligibility for tax credits and other subsidies, such as State Children’s Health Insurance Programs, may vary substantially over short periods of time. Thus, a

family could remain enrolled in the same health plan, even while the source(s) of payment for that coverage varies.

Consider, for example, a typical family at 225 percent of the federal poverty level. The children are eligible for coverage through the State Children's Health Insurance Program for a full year; one parent works seasonally at low wages and is eligible for a modest employer contribution for 6 months out of the year and for a tax credit during the other half of the year; and the other parent is a full-year low-wage worker but has no employer coverage and is therefore eligible for a tax credit throughout the year. Without some new sponsor who can manage multiple funding sources, the proposed tax credits would simply exacerbate the fragmentation of funding sources for family members' health insurance.

The potpourri of legislative proposals to encourage creation of such organizations indicates that the general concept has broad bipartisan appeal. We have decided to use the simple and, hopefully, neutral term "purchasing pools."

Some will argue that a private-pool strategy already has been shown to be a failure. They observe that voluntary small-employer purchasing cooperatives have not reduced the count of uninsured small firms and workers and have generally not obtained the large market share some policy makers said they would. Several state-run or state-established purchasing pools have simply failed. We discuss briefly below some key reasons why voluntary small-employer health purchasing cooperatives have not attained the market share supporters envisioned for them, except in a few states, such as Connecticut.

While there are relevant lessons from this experience, it is important to emphasize that the construct being proposed here is fundamentally different. Most obviously, the subsidies (tax credits) involved have great potential for reaching a large pool of otherwise uninsured workers; no federal subsidies have been available before for coverage through such pools. Making the subsidies available *only* through pools will guarantee pools the significant volume they need to realize their potential.

Some proponents of individual tax credits as a free-market mechanism to cover the uninsured also expect that a variety of voluntary pools will emerge; suggested sponsors include civic groups, churches, and so on. Individuals would presumably be free to join and benefit from these pools. But such pools would almost certainly be doomed, and would never work as well as employer groups, simply because they do not constitute a "natural group" with cohesion and stability. That is, individuals could join or leave to purchase individual coverage, and would be likely to do so when they could obtain a better price on the outside market. With large-employer-based coverage, stability and

cohesion result from the fact that a significant contribution is generally not available unless a worker participates in that employer's plan. Thus, leaving the plan would mean foregoing a significant benefit.

Furthermore, large-employer groups usually represent a reasonably broad spectrum of health risks—members join the group for reasons other than their health risks. Conversely, individual health insurance markets are inherently fragmented with respect to risk. To succeed in such markets, underwriters and carriers have become adroit at attracting individuals who are low risk and shunning those who are high risk. Thus, if individuals can apply their tax credits wherever they wish—through a purchasing pool or to any individual market product they choose—the better risks will be drawn to underwritten individual products and the pools will be left with a high-risk, high-cost population.

But the proposed tax credits are large, as high as most employer contributions and greater than some. Thus, just as employer groups remain stable because the employer's contribution cannot be used elsewhere, purchasing pools will gain cohesion and stability if tax credits can only be used towards coverage purchased through a pool.

This cohesion and stability will in turn attract more participation from health plans, something existing purchasing groups have had problems doing. Health plans may prefer contracting directly with individual small employers, rather than with small-employer purchasing cooperatives; but if there is a large population that can only be reached through the pools, plans will be motivated to contract with them.

This is the real lesson from the Federal Employees Health Benefits Program experience, which some observers like to cite as proof that voluntary individual pools offering a broad choice of competing health plans and benefit designs would be viable. In fact, many health plans are very concerned about the risk selection problems experienced in FEHBP and similarly structured programs. But federal employees represent a huge source of enrollment and premium revenue that plans cannot reach through any other means; if they want access to that population, they must participate in FEHBP—so they do.³ Similarly, our proposal is structured so that health plans would view the proposed purchasing pools as the sponsors of a significant “natural group”—tax-credit recipients.

A Brief Overview of the Proposal

Our proposal includes the following major components:

- To qualify for arranging of coverage for tax-credit recipients, private purchasing pools would be certified by states as meeting federal criteria (specified later in this proposal).
- To ensure qualified pools are available everywhere, federal “seed money” grants would be available, on a competitive basis, to cover start-up costs for private purchasing pools. Preference in the awarding of federal funds would be given to entities that can obtain 20 percent of the necessary funds from non-federal sources, such as states, private charitable foundations and non-profit business organizations. The number of federal start-up grants per state would be limited, based on the size of the target population. Nothing would preclude states or other organizations from providing additional start-up funds if they wished.
- Pools would be permitted to serve all individuals except those who have access to coverage through a large employer (more than 50 workers). Multiple competing pools would be allowed. Allowing multiple pools, rather than one exclusive pool, is more likely to make it politically acceptable to permit pools to contract selectively with health plans. Selective contracting, in turn, is how pools ensure that the plans they offer represent good value. However, to assure that each pool can attain sufficient size to operate efficiently, states would be authorized (and given incentives) to limit the number of pools serving a geographic region.
- Federal tax credits for the purchase of health insurance could be applied *only* to coverage purchased through a certified pool, except in states with qualified alternative-market structures that meet efficiency and risk-pooling objectives.
- Each qualified purchasing pool would offer its individual members a choice among competing health plans and alternative benefit packages, with different covered services and cost-sharing levels. To do this, pools would negotiate and contract with at least 3 unaffiliated health plans, except in (primarily rural) areas where the state deemed competing plans to be not achievable or desirable. Pools would not themselves accept any insurance risk.
- Pools would provide a choice of health plans, and offer at least one option (benefit package) that costs no more than the maximum tax credit for the lowest income groups (e.g., \$2,000 per worker). Pools would be allowed to offer benefit packages that do not meet state benefit mandates, which are extensive in some cases, to help ensure that affordable coverage is available to those who cannot pay more than the

maximum credit amount. However, coverage eligible for federal tax credits must provide real protection for major medical needs. Therefore a national minimum floor for benefit packages offered through pools would be established through a negotiated process run by a recognized national organization with significant state participation and relevant expertise, such as the National Association of Insurance Commissioners or the National Academy for State Health Policy.⁴

- For fully subsidized populations, health plans could not charge more or less based on the health status of an individual. (Partially subsidized populations present a difficult conundrum that will be discussed below.) To encourage young workers eligible for partial credits to obtain coverage, and to minimize selection concerns among participating health plans, premiums would be allowed to vary by age to the same extent that states permit age rating in the non-subsidized market. (Age rating is more standardized and much simpler to accomplish than health rating. Still, to make this approach work, the tax credits themselves must also vary by age, as the recently enacted deductions for long-term care insurance do.)⁵
- Low-wage small firms (i.e., those with a majority of low-wage workers) could arrange coverage for their workers through the pools. These workers could combine credits with any contribution their employers chose to make. This aspect of our proposal differs from the basic Zelenak proposal, which would deny credits to workers participating in employer-sponsored coverage. In our view, however, allowing these workers to use credits along with employer contributions would not cause significant “crowd-out” problems because (1) most low-wage small firms do not sponsor coverage in any event; (2) those that do sponsor coverage are very likely to drop coverage as premium rates or their circumstances change; and (3) we have little doubt that in such firms the worker is directly and immediately paying for any employer contribution through a reduction in wages. These firms would not have any of the legal responsibilities of a plan “sponsor” (other than a fiduciary responsibility not to misappropriate funds).
- Purchasing pools could also be a venue for applying other public subsidies available to family members, such as State Children’s Health Insurance Program subsidies for coverage of children. We prefer this approach, even though it is also at variance with the basic Zelenak tax-credit construct,⁶ because it would enable parents and children to stay together in the same health plan. This would mean easier “one-stop-shopping” enrollment and service use and, hopefully, a stable source of coverage for entire working families. It would also be good for children

because they are more likely to get needed care if they are enrolled in the same health plan as their mothers.⁷

BACKGROUND: LESSONS FROM THE EXPERIENCE OF SMALL-EMPLOYER PURCHASING POOLS

Many lessons can be drawn from the experience to date with small-employer purchasing pools that offer individual choice of health plan. However, many of those lessons are not directly relevant to the current proposal because making significant tax credits available exclusively for pool coverage would so greatly change the context in which such groups operate.

The primary reason existing purchasing pools do not have a larger share of the small-group market is resistance from health plans and agents. Health plan participation is crucial because, without it, pools have no product to offer. Support from agents is also critical because they are small employers' primary source of information on insurance matters.

Why Have Many Health Plans Resisted Participating in Purchasing Pools So Far?

Supporters and analysts are often bewildered by health plans' resistance to the growth of voluntary purchasing pools. It would seem that health plans might welcome the opportunity to help create a more efficient and consumer-friendly venue for small-firm coverage. After all, choice of health plans leads to higher consumer satisfaction and very few small-firms offer such choice. Further, high-volume purchasing pools would allow for administrative economies of scale.

Instead, most health plans have tended to see pools as a less desirable way to reach workers in small firms that they could reach in other ways, i.e., through direct exclusive contracts (with whole employer groups). If pools were merely one option tax-credit recipients could use to obtain health insurance, and the traditional individual market were another, we believe pools would be stymied for the same reasons. These reasons include the following:

First, health plans were generally concerned that state-run or state-created small-employer purchasing cooperatives could, if allowed to grow too big, replace private-market purchasers and become price regulators. This apprehension grew because these organizations often came into being at the same time that health reform proposals were being put forward to develop just such regulatory roles for pools.

More generally, most health plans understandably have had little interest in helping to create larger purchasers with more bargaining clout out of smaller groups. In general, they can better control their own enrollment and are in a better position to realize higher profits by dealing directly with small employers.

Plans have also expressed apprehension that agents, and others the plans could neither directly monitor nor control, would send only higher-risk groups to purchasing pools. Plans no doubt would continue to have such concerns if pools were an optional, rather than mandatory, venue for tax-credit recipients. The fear that pools would become “dumping grounds” for poor risks greatly exacerbated plans’ general concern that allowing individual choice of plan increases their exposure to adverse risk selection. If a plan enrolls an entire employer group, even a small one, the risk of adverse selection is reduced.

Furthermore, many plans do not want to cede to pools, or to anyone else, administrative functions such as premium collection and enrollment. They are concerned about accuracy and losing control where they are potentially liable. But they are also concerned about losing revenues and functions that are a key component of their resource base and their value-added role in a business sense. It is now generally understood that health plans have evolved toward broad network models rather than more tightly integrated systems of care. What is often overlooked is that this results in greater health plan resistance to giving up traditional insurance functions. These traditional insurer functions are a more important share of contemporary health plans’ retained role and net budget than the managed-competition model originally assumed.

In a Voluntary Market, Support from Agents Is Critical for Purchasing Pools’ Success

Agents are small employers’ and individuals’ primary source of information on insurance matters and are therefore crucial to the success of purchasing pools in a voluntary market. Existing small-employer pools succeed or fail based in large part on whether or not agents choose to mention them as an option when discussing health insurance with their clients.

Agents have resisted growth of purchasing pools when they perceived that eliminating or greatly reducing the role of agents, and the commissions they are paid, was one of the purchasing pool’s goals. In fact, reducing costs by eliminating agents’ commissions was widely discussed during health care reform debates. We expect, however, that agent resistance should not be a significant problem if tax credits are relatively generous, pools are the only venue through which people can use them, and policy makers refrain from inveighing against the role of agents or how much they are

paid. In any event, their role will ultimately be determined by the preferences of consumers and the rapidly evolving role of Internet commerce.⁸

TARGET POPULATION

Although this paper discusses purchasing pools primarily in the context of tax credits aimed at helping low-income people obtain health insurance, pools could benefit any worker, and her dependents, who does not have access to health coverage through her employer.

But pools should also have relationships with the small employers for which tax-credit-eligible individuals work, both because payroll deduction is the easiest way to pay premiums for those receiving only a partial credit, and because the workplace is the convenient and accepted entry point to health insurance for working people in America and in a number of other countries as well.

There are both policy and personal reasons to encourage people to obtain health coverage through the workplace. State and federal policy makers very much want to encourage continuing employment and career development for low-income populations; arranging health and other benefits through the workplace contributes to this goal. Moreover, many modest-income people take pride in their work and want the same job-based, mainstream coverage for their families as their co-workers have.

Pools can also benefit workers whose (small) employers do contribute toward health benefits by providing an efficient means of giving these workers a choice among different health plans—something small employers usually cannot do on their own.

Therefore, the population eligible to use pools would include both individuals and firms with fewer than 50 workers (i.e., firms that meet the current official definition of “small employer” under the federal Health Insurance Portability and Accountability Act). But only employees of low-wage firms⁹ with fewer than 25 employees that arrange health insurance through a pool could apply tax credits to pay for their coverage. This limitation is intended to minimize “crowd-out” of current employer contributions.

As noted elsewhere, in some states, insurance carriers may be permitted greater flexibility in varying the premiums they charge to non-subsidized individuals (or small groups) who buy coverage in the regular insurance market (based on such factors as health risk) than they will be permitted to use in setting premiums for tax-credit eligibles. In

these states, to protect pools from adverse selection, pools would have the option not to enroll unsubsidized individuals (see *Regulatory Issues*, below).

ADMINISTRATIVE STRUCTURE—MACRO

Federal legislation would establish tax credits or vouchers for eligible individuals (as described elsewhere), and would establish the framework necessary to make pools available to credit recipients nationwide. Also, federal funds to cover start-up costs would be made available to ensure that at least one pool is, in fact, available to all tax-credit recipients. Changes in federal law would also make it easier for charitable foundations to give start-up grants to pools. The IRS would establish ongoing working relationships with pools to verify that credit recipients have enrolled and to handle “advance payment” of credits.

States would continue to have primary responsibility for regulating insurance markets. They would assess whether pools and the plans they offer meet federal criteria (unless they opt not to play this role) and would have ongoing purview over pools’ market behavior. In order to assure that each pool can attain sufficient enrollment to operate efficiently, states would have authority to limit the number of qualified pools as needed. They could also choose to provide start-up funds to encourage pool development. States would work with pools to coordinate state subsidies for individual families (such as State Children’s Health Insurance Programs) with federal tax credits, as necessary and appropriate.

State benefit mandates would be preempted for coverage offered through pools, but states acting collectively would play a key role in determining a nationwide minimum benefit package that all pools must offer to ensure that coverage supported by federal tax credits provides adequate protection. Federal legislation would direct that the minimum benefit package be established through a negotiated process run by a prestigious national organization, with significant state participation, such as the National Association of Insurance Commissioners or the National Academy for State Health Policy. Pools would be free to offer other benefit packages that met state requirements.

To help achieve a pluralistic approach, changes in federal tax law would clarify that establishment and operation of purchasing pools that serve tax-credit recipients is a “charitable purpose.” Doing so will make it easier for private foundations to grant funds for this purpose, if they wish to do so.

Finally, private purchasing pools would organize the system on behalf of individual consumers (tax-credit recipients and others). They would negotiate and selectively

contract with health plans to ensure that individuals and families had several affordable health coverage options to choose from. They would provide easy job-based ways to enroll and access tax credits. They would also collect any necessary additional premiums, and would serve as an ombudsman to help members resolve any problems with their health plans.

Next, we explain the roles of each of these parties in greater detail.

ADMINISTRATIVE STRUCTURE—MICRO

Principal Federal Roles

Federal enabling legislation would establish the basic criteria and standards for qualifications of purchasing pools and the regulatory structure under which they would operate. (Recommended criteria are described later.) Federal legislation would also preempt any existing state rules that would interfere with the operation of pools in the manner intended. These could include:

- State “fictitious group” laws that might preclude pools from operating at all.
- State benefit mandates. However, a national minimum benefit package would ensure that coverage could be purchased for the amount of the federal tax credit, and that such coverage provided adequate protection.
- The national minimum package, which would be established through a negotiated process run by a prestigious national organization, with significant state participation, such as the National Association of Insurance Commissioners or the National Academy for State Health Policy.
- State rating rules, to the extent they limit or interfere with pools’ ability to negotiate lower prices from health plans than are available to direct purchasers.

Federal “seed money” grants are intended to ensure that at least one pool is actually available to tax-credit recipients, regardless of where they live. A pluralistic and community-based approach to selecting pool sponsors is desired. To this end, the federal selection process would give preference to applicants who can obtain 20 percent of their projected start-up costs from non-federal sources, such as the applicant organization itself (or its parent), the state or private charitable foundations.¹⁰ The federal grants themselves could not exceed \$2 million per grantee. Grants from charitable foundations or other sources would be permitted and encouraged. Federal tax law would be changed to clarify

that development and start-up of a purchasing pool qualifies as a “charitable purpose,” even if the recipient is not a charitable organization.¹¹ “Charitable purposes” could also include ongoing outreach to the uninsured, consumer assistance, and possibly other activities of pools.

More generally, successful applicants for federal start-up grants would be required to have the organizational capacity to function as a purchaser of private health insurance, and to reach and serve the target population. The number of federal grantees would be limited to one in most states. In states with more than 1,500,000 projected tax-credit-eligible people, there could be one additional grantee per 1,000,000 projected tax-credit-eligible people in the state (or major fraction thereof), unless the state requested a lower number.¹² No federal grants would be made in any state (or sub-state area) if a non-subsidized purchasing pool already operating in that state (or area) can show that it meets federal requirements and has the capacity to serve all the projected tax-credit eligibles in the state (or area). This limitation is necessary to avoid unfair subsidized competition for a pool that has had to absorb its own start-up costs.

Pools would have to register with the IRS and meet certain basic requirements, because they would be receiving federal tax-credit funds on behalf of eligible individuals and transmitting those funds to participating health plans to pay premiums.

Subsidies, in the form of vouchers or tax credits, must be available on a current basis, when premiums are due, if they are to help low-income people buy health insurance. After-the-fact reimbursement or once-per-year tax refunds will not be effective. Therefore, the Zelenak proposal makes provision for “advance payment” of tax credits, and pools could play a key role in that process.¹³ Similarly, pools would have all the information necessary to provide verification to the IRS that individual tax-credit recipients are in fact enrolled. Tax credits would be subject to adjustment at the close of the tax year on the worker’s individual income tax return.

State (and Residual Federal) Roles

States could, if they wished, provide funds to develop and establish purchasing pools in addition to federal “seed money” grants. By choosing to provide the suggested 20 percent non-federal contribution, a state could largely preselect what organization(s) would receive the federal start-up grant(s) in that state.

States would retain principal responsibility for overseeing market conduct of pools, health plans, and agents. Consequently, unless a state refused to do so, it would review every

application for designation as a qualified purchasing pool, presumably through its insurance department. Federal criteria would be used, but the state would make the determination and issue (or withhold) certification. In any event, certified pools would still need to register with, and obtain approval from, the IRS with respect to handling federal funds.

- In the event a state refused to perform the purchasing-pool-certification function, a federal agency would do so.
- Also, in certain circumstances, a federal entity might provide a limited mechanism for appeals, in cases when a state decided to withhold certification, to discourage arbitrary and capricious state decisions.

States would also have purview over the geographic areas served by each pool (to preclude risk-selection by redlining) and would have authority to limit the number of certified pools in the state. Such a limitation may be necessary to ensure that each pool could attain sufficient volume to operate and achieve efficient use of federal tax credits. In a larger state it might be necessary to permit adequate state oversight and monitoring. After an appropriate start-up period, if the average enrollment per pool in a state with three or more pools fell below 150,000 covered lives, the state would be required to provide funding to offset the extra administrative costs that tax-credit recipients would otherwise face. Exceptions would be allowed for sparsely populated states and for states with only one or two pools.

If no qualified pool emerges in the state, or no pool is able to obtain participation by at least three health plans (except as may be permitted by the state), some alternative or “fail-safe” mechanism is needed to ensure that tax-credit recipients will have access to a choice of health plans. The primary purpose of prospectively establishing such “fail-safe” mechanisms is to help motivate private creation of pools and voluntary health plan participation in pools. Possible alternatives include:

- Where pools exist, but were unable to obtain competitive bids from an adequate number of health plans, the state could require health plans serving state employees or other state programs to make a good faith bid when requested by a private pool.
- If no qualified pool applied for certification for some or all service areas, the state could hire an administrative vendor to offer tax-credit eligibles enrollment in any of the health plans serving state employees. Such plans would be required to participate.

- ✓ If the state failed to act, the federal government would retain an administrative vendor to manage a “pool” and require health plans serving federal employees to participate.
- For each of these alternatives, plans that did not comply would be excluded from serving public employees or public programs.
- The “good faith” of a health plan’s bid, or the appropriateness of the premium it proposed to charge, could be assessed by comparing the bid to the plan’s prevailing commercial or public employee rates. Deviations would have to be actuarially justified based on differences in benefits and expected demographic (but not health risks) composition between the two populations. This assessment would be made by the state insurance commissioner or, if federal, by the appropriate federal agency.

Coverage available through such “fail-safe” mechanisms would be available *only* to tax-credit eligibles, *not* to non-subsidized consumers.

In a few states with highly structured health insurance markets, private purchasing pools (as described in the next section) may not be needed to create a market that will work effectively for tax-credit eligibles. If the state requires all carriers to offer a limited number of state-defined standard benefit packages (only), allows premium rates to vary only by age (or be community-rated), and requires carriers to guarantee issue to all applicants, then the “purchasing” component of a private pool may not be necessary.

In this case, the state could apply to the appropriate federal agency to operate an alternative system for tax-credit eligibles. The state would modify its rules to allow carriers to establish a separate set of rates for tax-credit eligibles (using the existing standard benefit plans and age categories) and would hire a vendor(s) to carry out the administrative functions necessary to support employee choice of health plans for participating (low-wage) small-employer groups. Separate rates would be needed because current individual market premiums are high, due to self-selection by non-subsidized consumers; with subsidies, average medical costs for enrollees should be much lower. On the other hand, carriers would probably want to charge more than current small-group rates, which are based on the carrier enrolling the entire group. New Jersey is the most obvious example of a state that might wish to take this approach.

Private Foundations and the Need for Pluralism

It will be important that private purchasing pools be seen as serving primarily the needs of their communities and their members, rather than as simply responding to government directives. Therefore, a variety of community organizations should be encouraged to undertake the development of purchasing pools.

Private charitable foundations can play an important role in achieving this kind of pluralistic, community-based approach. As noted above, federal tax law would be changed to clarify that development, and start-up of a purchasing pool qualifies as a “charitable purpose,” even if the recipient is not a charitable organization.

Start-up funding could come from other private-sector organizations as well, such as business groups. As noted above, pluralistic support would be encouraged by granting preference, in the selection process for federal start-up grants, to applicants who can obtain 20 percent of their start-up funds from non-federal sources.¹⁴

Private Purchasing Pool Roles

The basic purposes of a purchasing pool are:

- to offer its (individual) members a choice among competing health plans and alternative benefit packages (covered services and cost-sharing levels) more efficiently and effectively than alternative approaches,
- to provide the administrative systems necessary to enroll members in their chosen health plan and to collect and transmit premium contributions made by or on behalf of members to their chosen health plans as simply and efficiently as possible,
- to assure its members that participating health plans offer good value and to serve as an ombudsman when a member requests assistance in resolving a problem with a plan, and
- to offer small employers a single, simple mechanism for giving their workers access to a choice of health plans through payroll deduction. (The pool provides employers with a single point of contact for health insurance matters, including a single consolidated bill and single enrollment form covering all participating health plans.)

Pool Functions and Powers

To achieve these purposes, purchasing pools must carry out a number of key functions and would be granted certain powers with respect to those functions:

- a. Pools would design benefit packages and negotiate contracts with health plans on behalf of consumers, seeking to maximize value for their members, i.e., to offer the benefits most desired by the members at the lowest possible premium. In this way, pools would play the role of a “sponsor,” aggregating the purchasing power of their members and using it to obtain the best deals possible from health plans.
 - ✓ Pools may change coverage options (benefit packages and carriers) offered over time as conditions warrant.
 - ✓ Pools would be permitted to offer different benefit levels as well as different carriers. Although doing so can lead to internal risk selection between benefit levels, the necessity of negotiating participation from health plans will preclude unworkable relationships.
- b. Purchasing pools would *not* bear insurance risk themselves. They would contract only with insurance carriers and health plans licensed by the state.
- c. To negotiate effectively and to assure members that the health plans offered are of good quality, pools must have the authority to contract selectively, i.e., to refuse to contract with any particular health plan and to cancel or terminate health plan contracts. To allow such negotiations, health plans must also have the legal authority to offer different rates to pools than they charge in the regular insurance market.
 - ✓ The ability to contract selectively defines a purchasing pool. If pools were required to offer any willing health plan at whatever premiums that plan chose to charge, pools would become little more than administrative vendors or another marketing vehicle for health plans.
 - ✓ The federal authorizing legislation would preempt state rules that might otherwise preclude health plans from offering lower premiums to pools than are available in the regular market. (But limits on how premiums can vary within pools would apply. See below.)

- ✓ To maintain true competition, pools would be required to solicit new bids and contracts from health plans/carriers every 3 to 5 years.
- d. Certified pools would be required to offer their members a choice of at least three unaffiliated health plans for at least one coverage option (benefit package) that costs no more than the maximum tax credit for the lowest income groups.
- ✓ Certified pools would be authorized to develop a benefit package(s) that does not include all state-mandated benefits, as long as each package meets the national minimum requirements established to ensure that coverage supported by federal tax credits provides adequate protection.¹⁵
 - ✓ States would be authorized to waive the 3-competing-plans requirement in areas where the state found that offering multiple plans was either not possible or not desirable (due to the need for sufficient volume). It is expected that such waivers would be granted primarily in rural areas and may require additional oversight of rates charged.
- e. For tax-credit recipients at least, health plan premiums through pools would be permitted to vary only by age and only to the extent permitted in that state's regular insurance market.¹⁶
- ✓ Age rating is more standardized and much simpler to accomplish than health rating.
 - ✓ Pools will establish common-age bands that all participating health plans must use.
 - ✓ If health rating is permitted in the state's regular insurance market, pools will be permitted to establish underwriting standards and use health rating only for non-subsidized pool members. Since experience shows that pools offering consumer choice usually cannot compete effectively in underwritten markets, pools in these states would have the authority not to accept any non-subsidized members.¹⁷ (However, if a pool chose this option, participating plans would be required to provide continuing coverage to individuals who previously received tax credits and were covered through the pool.)
 - ✓ In states that allow health rating, a difficult issue arises as to whether or not pools should be allowed to use health rating for the population eligible only for partial tax credits. See *Regulatory Issues*, below.

- f. Pools, and the health plans that serve them, must abide by basic non-discrimination, access, renewability, and market-conduct rules that apply to all insurance products under state and federal law, adapted as appropriate to the pool context. Additional protections would apply for tax-credit eligibles.
- ✓ Tax-credit eligibles may not be denied enrollment for any reason, unless they do not work or reside within a network plan's service area. For non-subsidized applicants, state individual or small-group market rules apply.
 - ✓ Pursuant to and as defined by applicable state and federal law, pools and health plans must credit members' prior coverage (if any) toward any time limit for coverage of preexisting conditions.
 - ✓ Pools must guarantee renewal of coverage for all members except for reasons currently permitted under state and federal law applicable to health plans (e.g., fraud, non-payment of premium). But, as long as the pool continues to exist, this duty of renewal is the responsibility of the pool, not of the health plans. (i.e., A health plan that no longer contracts with a pool may terminate and not renew enrollment of pool members when its pool contract ends. The renewal guarantee is met by offering members coverage through a choice of all contracting health plans.)
- g. Pools would collect and make available information to assist members in choosing among participating health plans.
- ✓ This could include comparative information on health plan performance and quality, and development and implementation of consumer satisfaction surveys.
- h. All purchasing pools would routinely provide (or, more likely, contract for) the administrative capacity necessary to:
- ✓ *Allow members to select* which coverage option and health plan they wish to enroll in.
 - ✓ *Process enrollment* applications and transmit clean information to the selected health plan. Also process and transmit to the appropriate health plans additions to and deletions from family groups and coverage terminations as they occur.

- ✓ When applicable, *notify the member's employer* of the amount (if any) of the member's premium liability (to be deducted from the worker's pay). (Workers receiving less than a full credit or choosing a higher priced plan would be required to pay the additional premium.)
 - ✓ *Bill* employers periodically for premium contributions payable by the employer (if any) and the member. Bill members directly for any premium liability when the employer is not involved. (Members eligible for advance payment of the full tax-credit amount who choose a "no-extra-cost plan" will have no premium liability, i.e., the pool will collect the tax credit directly from the government and forward it to the health plan.)
 - ✓ *Collect premium payments* from all sources and transmit payments to the appropriate health plans. Reconcile payments and resolve errors. Collect delinquent payments.
 - ✓ *Provide customer service*: Develop and distribute consumer information materials (brochures, benefit plan summaries, health plan comparative pieces, etc.); answer general information calls; handle member inquiries about applications, eligibility, billing, or payment; assist members with complaints about health plans; establish procedures for resolving grievances, etc.
- i. For purposes of administering tax credits, pools would also have to provide (or, more likely, contract for) the administrative capacity necessary to:
- ✓ Determine whether applicants (members) appear to be eligible for full or partial tax credits and the amount thereof.
 - ✓ Notify members and the IRS (or other designated federal agency) of the amount of tax credit they appear to be eligible for.
 - ✓ Periodically (presumably, monthly) collect the total amount of tax credits due to pool members from the federal government and distribute the funds as premium payments to the health plans the members have enrolled in.
 - ✓ Notify the IRS when tax-credit recipients terminate health plan enrollment (of themselves or any family member), and provide periodic verification of current enrollment of all tax-credit recipients as requested by the IRS.

- ✓ For tax-filing purposes, provide each member with an end-of-year statement showing months enrolled in a health plan and total tax credit received.¹⁸
- j. Where administrative functions are contracted to vendors (as is usually the case), pool staff will develop the necessary specifications, solicit and evaluate proposals, negotiate the contract, and monitor the vendor's performance on an ongoing basis.
 - ✓ Vendors that handle funds must be bonded and insured.
- k. To encourage participation by health plans that fear adverse selection (as most do), and to permit individual members to choose levels of coverage (which invites significant selection problems), pools would be empowered to develop and implement risk-adjustment programs.
 - ✓ Risk adjustment raises or lowers the amount health plans actually receive in premium payments from the pool, based on the extent to which the risk profile of the members that health plan actually enrolls differs from the average risk profile of the entire pool.
 - ✓ Even simple risk-adjustment methods can help to protect health plans from adverse selection, but gaining the cooperation needed to implement them is typically difficult because they are sometimes viewed by health plans as increasing rather than decreasing uncertainty—plans do not know what their net payments will be.
 - ✓ Where multiple pools compete, the state could decide that it is necessary to risk-adjust payments across pools in order to counter biased selection. If the state establishes such a system, pools would be required to participate.
- l. Pools could also provide an efficient means of channeling/combining tax credits with other public subsidies available to family members to provide a single, stable source of ongoing coverage for entire working families. One obvious example is State Children's Health Insurance Program (SCHIP) subsidies for coverage of children.
 - ✓ Pools could design and offer benefit packages that meet SCHIP and other applicable requirements.

- ✓ Pools (vendors) already have the capacity to collect revenues from multiple sources and to make payments to the family's choice of health plan.
- ✓ By using the pool, the family would retain its coverage, choice of health plan, and physicians even as earnings, subsidies, and other contribution sources vary.

Organizational Requirements for Certified Pools

In addition to the specific operational requirements listed above, organizations desiring to be certified as private purchasing pools for tax-credit administration purposes would be required to be non-profit although not necessarily charitable. The Boards of Directors of these organizations must represent consumers and purchasers of health care and health insurance, rather than vendors and providers. Specifically, no Board member could be affiliated with, or receive any compensation from, any health care provider or any entity that contracts with the pool or otherwise provides services to the pool, such as health plans/carriers and administrative vendors. Insurance agents would be thus excluded from Board membership because they typically receive their compensation from health plans. The primary purpose of these conflict-of-interest exclusions is to preserve the integrity of the pool's purchasing role.

Pools would also be expected to employ professional staff for certain critical functions, including initial contracting with health plans and vendors and ongoing oversight and monitoring. Administrative vendors that handle funds would be required to be bonded and insured.

Pools would be required to file certain information annually with the federal government and the state Insurance Department. This information would include enrollment, number of health plans contracted, types of benefit plans, etc. These reports would contain information similar to what employer-sponsored plans currently must file.

Expected Pool Costs

Based on experience to date with small-employer purchasing pools that offer individual choice of health plan, we estimate that total pool administrative costs, for all the functions they perform except any agent commissions and major media advertising, are in the range of 3 to 4 percent of premium once enrollment reaches about 30,000 subscribers and should fall even lower at higher enrollment levels.¹⁹ If, as we propose, the pool is the only vehicle through which individuals can use tax credits to purchase health insurance, enrollment should exceed this level in many states. We should also note that, in the existing small-employer pools on which this estimate is based, there is little or no health

underwriting, and most have low turnover among participants. High turnover, which is common in the individual market, increases administrative costs. We have assumed that the proposed tax credits are generous enough to discourage individuals from dropping out of the pool when they don't need insurance immediately, and that turnover will therefore be similar to the current experience. If this proves not to be the case, administrative costs will be higher than estimated.

Some pool administrative functions replace, to a greater or lesser extent, tasks that health plans or agents would otherwise perform. However, functions aimed at ensuring a good selection of health plans and facilitating member choice among them are new roles not generally performed on behalf of individuals or small employers at present, although many large employers routinely perform them. These functions, which include designing benefit packages, negotiating and contracting with health plans and vendors, monitoring and overseeing contractors, developing consumer information such as surveys and report cards, etc., add value but do require resources. Fortunately, the administrative costs of these "purchasing" functions are essentially fixed. Therefore, while they will represent a significant proportion of premiums during start-up when enrollment is low, they will fall dramatically as pool enrollment grows, down to less than 1 percent of premiums once enrollment exceeds 100,000 members.

Pools' administrative functions related to enrollment, premium collection, and plan payment have the potential to largely replace or substitute for tasks currently performed by health plans. These costs are not fixed but do benefit from economies of scale. But, to avoid duplication of functions and realize savings, health plans need to reconfigure their systems to take advantage of efficiencies offered by the pool, such as electronic transmission of enrollment and payment information. Experience has shown that health plans are often loath to do this, until a pool becomes a significant portion of a particular health plan's business, and has demonstrated that its administrative capacity is reliable. Once that threshold is reached, however, health plans should be able to reduce their internal administrative costs, and pools should be able to negotiate lower premiums that account for the lower plan overhead the pool has made possible.

Because pools must accept all tax-credit eligibles and vary their premiums only by age, they will incur no underwriting expenses (for this population). In states that allow health rating in the regular insurance market, health plans will also save substantially on underwriting and associated "churning" costs for this population, compared to their regular (non-pool) business. However, administrative costs will remain higher for underwritten individuals.

Finally, we anticipate that pools' outreach costs, however they may carry it out, will be substantially lower than marketing costs in the traditional insurance market, particularly if pools are the sole means through which low-income individuals can qualify for the tax credit.

During start-up, pool administrative costs—primarily those related to the purchasing function—would be paid for, at least in part, by grant funds (federal and private). Once the pool was operational, ongoing costs would be funded by an operational fee built into the premium. This fee would include any charges from outside administrative vendors, which would be expected to capitalize any necessary start-up costs of their own (such as systems development) and recover them over a several-year period.

For coverage of equivalent benefits, insurance purchased through pools is conservatively estimated to cost at least 5 to 10 percent less than a comparable individual health insurance plan now costs. This estimate is based on the observation that currently operating pools are at least no more expensive administratively than traditional small-employer health insurance, which has lower overhead than the individual market.²⁰ Additional administrative savings should accrue from the absence of underwriting. Also, as pools' market share grows and greater efficiencies are achieved, administrative savings can be expected to grow.

Using an administratively more efficient distribution mechanism has a clear net benefit, both for the government as the provider of subsidies and for the consumer. Either the basic subsidy amount can be reduced, leading to lower subsidy costs for the government, or more benefits can be purchased for the same amount, leading to better coverage for the consumer.²¹

REGULATORY ISSUES

Key regulatory issues include access and rating rules for tax-credit eligibles. Most of these have already been discussed in preceding sections but are reiterated here with elaboration in some cases. They include:

- Tax-credit eligibles may not be denied enrollment for any reason, unless they do not work or reside within a network plan's service area. More generally, pools and the health plans that serve them must abide by basic nondiscrimination, access, renewability, and market-conduct rules that apply to all insured products under

state and federal law, adapted as appropriate to the pool context. These were specified in the previous (“purchasing pool”) section.

- ✓ On the other hand, some counterbalance is needed to offset the known tendency of individuals to buy health insurance only when they know they will use it and to drop coverage after the immediate need has been met. This “demand side” selection effect, which pervades the voluntary individual market, as well as existing small-employer pools that admit “groups of one,” significantly raises costs.
- ✓ To encourage continuous enrollment and counter “demand side” selection, especially for workers eligible only for partial credits or only for part of a year, we recommend that credits be proportionally reduced if the worker is not enrolled for an entire tax year.
- No health rating would be allowed for subsidized populations. In our view, attempting to adjust tax-credit amounts for the health status of recipients would be wholly unworkable. Without such an adjustment, tax credits would be insufficient to purchase coverage for low-income workers (or dependents) in poor health unless they had no upper dollar limit.
- ✓ In a non-subsidized individual market, charging the healthy the same amount as the sick means that, proportionately, more of the sick and fewer of the healthy choose to buy coverage. As a result, premiums reflect higher medical costs than the average for the entire population, and an adverse selection “death spiral” may occur.
- ✓ The proposed tax credit is designed to cover the full premium for low-income workers, and could only be used to purchase coverage through a certified pool. For these reasons, it is unlikely that this sort of adverse selection will occur. Sick and healthy tax-credit eligibles should join pools at similar rates, even if rating based on health status is not allowed.
- ✓ For example, Washington State’s Basic Health Plan experienced little adverse selection early on, when most enrollees received significant subsidies. Later, a large number of non-subsidized people chose to enroll, because many carriers withdrew from the state’s regular individual market. This later, non-subsidized population was noticeably more expensive.

- ✓ Issues do arise for those who receive only partial subsidies (discussed further below).
- Age rating would be allowed to the extent permitted in the state's regular individual insurance market, and tax credits/subsidies would be age rated to the same extent.²²
 - ✓ We do not assume flat community rating (i.e., elimination of age rating) in the unsubsidized, voluntary individual market because it is not politically achievable or workable without mandatory participation.
 - ✓ If age rating were allowed in the outside market but not for tax-credit recipients, many modest-wage young workers eligible for only partial tax credits could face higher net prices inside the pool than those available to them outside, even without subsidies. As a result, they would likely either remain uninsured or leave the pool to obtain coverage. In either event, their absence would increase average premiums inside the pools by removing lower-cost participants. As premiums rose, even more young workers with partial credits would find age-rated non-subsidized coverage a better deal; as they left, premiums would rise still further. This dynamic could precipitate a classic "age/rate spiral" for the pools.
- In the few states that do not permit health rating in their regular individual insurance markets, there is no further issue. However, most states allow health plans to vary premiums for individuals based on an assessment of their personal health status, and we have proposed that in these states pools would be permitted to establish underwriting standards and use health rating for any non-subsidized pool members. However, in this case a difficult conundrum arises for recipients of partial tax credits.
 - ✓ If no health rating were allowed for *any* tax-credit recipients, then there are two undesirable results for partial credit recipients. First, a "cliff" effect is created under which workers (or dependents) in poor health would face a large increase in health insurance premiums if an increase in earnings made them ineligible for any tax credit. Second, at the upper end of the credit-eligibility range, those in good health might in fact be able to purchase non-subsidized coverage at a lower net cost than the (partially) subsidized coverage available through the pool. This result seems inequitable and could also encourage lower

risks to leave the pool, thus raising average pool premiums (as discussed above for age rating).

- ✓ Alternatively, pools that use health rating for non-subsidized populations could be permitted to “phase in” health rating once a worker’s credit fell below some percentage of the total premium cost—perhaps 50 percent. Doing so would avoid the “cliff” effect and the worst selection effects against the subsidized pool, but could be difficult administratively and would raise premiums, perhaps steeply, for unhealthy tax-credit eligibles at the upper end of the credit-eligibility range.
- ✓ Due to the inherent conflict between the socialization of risk inside the publicly subsidized pool and the lack of such socialization in most states’ voluntary individual insurance markets, we see no elegant solution to this conundrum.
- Because government-certified multiple private pools, each offering competing plans, would be available, there do not seem to be any antitrust issues.

AMOUNT AND STRUCTURE OF SUBSIDY

For purposes of this discussion, we have assumed the tax-credit structure in Larry Zelenak’s paper, “A Health Insurance Tax Credit for Uninsured Workers.” Zelenak proposes a refundable tax credit of \$2,000 for individual coverage and \$4,000 for family coverage for uninsured workers earning less than twice the federal poverty level. Above that income level, the credit would phase out gradually. Workers not currently covered by an employer plan, even if they were eligible for one, or by a public program could use the credit to buy private non-group health insurance. We suggest the following additions and changes:

- As noted throughout this paper, we propose that credits could be used only for coverage through a certified pool. This would allow pools to offer credit recipients the same prices regardless of health status.²³ It would also enable pools to grow big enough to achieve economies of scale and successfully obtain health plan participation and favorable rates.
- Since certified pools could age-rate premiums, in states that permit it in the outside market, tax credits would also be adjusted for age to the same extent. The rationale for age rating was explained under “Regulatory Issues,” above. This does mean

that maximum credit amounts by age will differ across states. In the few states that do not allow age rating, such as New York, credit amounts would not vary by age.

- In addition, we propose that, where lesser credits are available for the employee share of employer-sponsored coverage, as suggested by Mark Merlis,²⁴ employees of small firms should be eligible for such credits only when their coverage is purchased through purchasing pools. The pools would implement special requirements for these populations. For example, the employer's contributions must be equal for all eligible employees, and eligibility must not relate to wage or tax-credit status.

MAJOR ISSUES/INTERACTION WITH OTHER PROGRAMS

One Pool or Competing Pools?

This paper proposes that multiple purchasing pools be permitted to serve the same geographic area, subject to optional state-imposed limits to ensure each pool reaches an efficient scale. Some would argue that it is inefficient and wasteful to have more than one purchasing pool per state, or per region in the larger states, especially given the quasi-governmental role the pools will play with respect to tax credits.

While exceptions should be made in states too small to reasonably support more than one pool, we believe it is sensible to permit competing pools, for several reasons:

- Even though the proposed individual tax credits are targeted to workers who do not have employer-sponsored insurance, the cooperation of employers is critical to the success of this initiative. Payroll deduction is the easiest and most reliable way for workers to pay their share of insurance premiums.²⁵ Direct billing of individuals (and collecting delinquent payments) is expensive and administratively burdensome. Therefore, pools will want employers to "participate" by allowing workers to complete and submit enrollment forms through work and by deducting employee contribution amounts and forwarding them to the pool. Employers are more likely to cooperate with a competitive, business-oriented private-sector organization than with a single, quasi-governmental entity.
- Pools will reach an economically efficient operating scale sooner and will be better able to negotiate with health plans on behalf of workers and employers if they are able to serve all small firms and their workers, not just those who are eligible for tax credits. Small employers should view pools not as government agencies, but as business-oriented private groups that represent their interests as health insurance

purchasers, if pools are to be an attractive market alternative to a traditional direct contract with a health plan. With one exception, state-initiated small-employer purchasing pools have failed outright or failed to gain significant enrollment; and the single exception—in California—has now been transferred to a private business purchasing organization, as envisioned in the original authorizing legislation. Several employer-initiated pools are flourishing.

- To act effectively as purchasers and advocates on behalf of their members, and to negotiate favorable premium rates, pools must have the authority to contract selectively, i.e., to refuse to contract with any particular health plan and to cancel or terminate health plan contracts. A government-anointed purchasing pool that was the single venue through which tax credits could be accessed would come under extreme political pressure to contract with “any willing (licensed) health plan.” If pools were required to offer any willing health plan at whatever premium, pools would become little more than administrative vendors or another marketing vehicle for health plans.²⁶ If multiple pools are allowed to compete, it is harder to argue that they should be required to contract with all health plans.

Is a National Minimum Benefit Floor Needed?

Some states have enacted extensive benefit mandates that raise the price of health insurance and may make it difficult for plans to offer coverage for the amount of the federal tax credit. Therefore, this paper proposes that purchasing pools be allowed to offer benefit packages that do not meet state benefit mandates. On the other hand, the federal government has a reasonable interest in assuring that coverage purchased with federal funds, such as tax credits, provides adequate protection, particularly for major medical needs. Therefore, this paper also proposes that a national minimum floor for benefit packages offered through pools be established. The content of the minimum package would be determined through a process of negotiation in which all major interested parties would be represented. The process would be run by a recognized national organization with significant state participation and relevant expertise, such as the National Association of Insurance Commissioners or the National Academy for State Health Policy.

The process of establishing a national minimum floor would be subject to the same pressures that are brought to bear on state legislatures to mandate inclusion of specific benefits. There is, therefore, some risk that the benefit package will be a “minimum” (affordable) floor in name only. The process we propose, however, would differ from typical legislative consideration of new mandate proposals in two significant ways: First, the participants in the decision process would not be legislative officials. Second, we

assume there will be an overt federal responsibility to ensure that the lowest-income workers can buy coverage for no more than the amount of their tax credit. Therefore, the federal government would be required to pay the cost of any additional benefits that were included in the minimum package. The requirement to pay provides a strong counterbalance to the natural political desire to provide more benefits to constituents. State-legislated benefits paid through private insurance premiums have not generally been subject to such fiscal discipline. This state-level experience contrasts with, for example, that of Medicare, where the need to pay for any additional benefits has been relatively effective over the years in limiting the addition of new benefits.

In the event that even the national minimum package is too expensive in a particular state or geographic region, a “special exception” process would allow purchasing pools in that state or region to seek approval for a lesser benefit package, if they demonstrated the need for it and the reasonableness of their proposed package to an appropriate authority.

Interaction with State Children’s Health Insurance Programs

Pools could efficiently channel/combine tax credits with other public subsidies available to family members to provide a single, stable source of ongoing coverage (“one-stop shopping”) for entire working families. If whole families were covered under one plan, enrollment and service use would be easier, and children would be more likely to get needed care, because they would be enrolled in the same health plans as their mothers.²⁷ One obvious example is SCHIP subsidies for coverage of children. We have proposed that pools design and offer benefit packages that meet SCHIP and other applicable requirements. Pools (vendors) already have the capacity to collect revenues from multiple sources and make payments to the family’s choice of health plan. By using the pool, the family would retain their coverage, choice of health plan, and physicians even as earnings, subsidies, and other contribution sources vary.

Take-Up

We have no information on which to base an estimate of likely take-up rates for tax credits if there were purchasing pools. Experience with the Washington State Basic Health Plan and similar state efforts might shed some light on the question, but these programs differed from the one proposed here.

Purchasing pools could be responsible for carrying out general information campaigns about the availability of credits and purchasing pools, and funding could be provided for this. We are not outreach experts, but it seems such campaigns could include

public service announcements linked to informational websites and a variety of other mechanisms aimed at both small firms and individuals.

In addition, it is likely that pools will “market” their coverage in more traditional ways, such as through insurance agents. Experience with small-employer purchasing pools has demonstrated that their (general) insurance agent is the first place small employers turn to when they are seeking information about health insurance. Agents working on commission will be highly motivated to refer previously uninsured clients to pools where subsidized coverage is available.

Crowd-Out

Because the proposed tax credits are income-based, crowd-out concerns focus primarily on firms with a large percentage of potentially eligible workers. For firms with more income-heterogeneous workforces, non-discrimination and health-plan-participation requirements should be sufficient to discourage employers from reducing their contributions.

Merlis proposes that workers eligible for an employer contribution toward health insurance (of at least 70 percent for worker-only coverage and 50 percent for family coverage) should *not* be eligible for the (non-group) individual tax credit. Instead, they would be eligible (at the same income levels) for a smaller credit keyed to the employee share of coverage. This seems sensible to us and should improve take-up rates for employer-sponsored coverage without creating a significant crowd-out problem, if properly designed.

In this case, we propose that employees of small firms (whether their employers contribute to health insurance or not) would be eligible for such credits *only* for coverage purchased through certified pools, except in states with qualified alternative market structures that meet efficiency and risk-pooling objectives.

- We propose that full tax credits should be made available to all workers in firms with fewer than 25 employees and a majority low-wage work force, regardless of how much the employer contributes towards employee health insurance. For these firms, we believe crowd-out concerns should *not* apply, for the following reasons: According to the 1997 Medical Expenditure Panel Survey (MEPS), only about 16 percent of such firms, with only 26 percent of all workers in such firms, provide health insurance to any of their workers.

- Data from the 1997 Robert Wood Johnson Foundation Survey of Employer-Sponsored Health Benefits also show that such firms add and drop health coverage much more frequently than other firms.
- It seems extremely likely that these firms would stop offering coverage at all if their employees were eligible for a tax credit. The ability to participate in a pool and parlay individual tax credits could encourage more small firms employing low-income workers to contribute something, and just as importantly, to provide the efficiencies and reliability of work-based payroll withholding for employees who make contributions.

Adverse Selection

As discussed earlier, for those receiving the full amount of the tax credit, or a high percentage of the full amount, selection will not be a concern. For those receiving partial credits, and for the unsubsidized population, selection will indeed be a concern. To mitigate selection effects, we have recommended that pools age-rate premiums and that tax credits be age-adjusted as well. The conundrum of health rating for partially subsidized populations has already been discussed.

Where multiple pools compete, risk selection between pools is another possible problem, likely related to the sponsorship of the competing pools. Pools organized by existing membership organizations or affinity groups, although they would be required to be open to all tax-credit eligibles, would likely attract members primarily from their own group, whose health characteristics might differ from the general population. In these cases, the state would decide whether it is necessary to risk-adjust payments across pools in order to counter biased selection. If the state elected to establish such a system, pools would be required to participate. Pools would have the authority to implement risk adjustment among their participating health plans.

Politics

The key issue will be whether tax credits should be limited to coverage purchased through pools.

Entities that benefit from the current structure of the individual insurance market will clearly oppose limiting credits to coverage purchased through pools. These entities include health insurance agents and the subset of insurance carriers that currently specialize in individual insurance. Conservative organizations in general can also be expected to

oppose the perceived limitation on complete individual freedom to choose whatever health insurance product people prefer at the best price they can get for themselves.

Most other elements in the debate should be supportive or, at least, neutral. Consumer advocates should find this kind of structured plan more consumer friendly. Provider organizations primarily are concerned about enhancing individual choices of health plans and should be supportive, as long as the requirement to offer a choice of plans is strong. They may also respond well to the notion that allowing pools to negotiate will reduce health plan overhead and profit.

Business organizations that perceive an opportunity to be a pool organizer, particularly those with many self-employed members, may also be supportive. Health plans that do not now specialize in individual products may perceive a business opportunity to reach new enrollees they cannot realistically reach now.

HOW WILL THE MODEL WORK?

This has already been discussed in considerable detail.

SUCCESS MEASURES

- Number, demographic characteristics, and wage structure of people covered
- Prior insurance status/history of people entering pools
- Consumer satisfaction on a variety of dimensions (separately for previously insured and previously uninsured)
- Stability of coverage for families: plan turnover/retention rates/average length of enrollment in a particular plan

WEAKNESSES

Some will view this proposal as too narrow and rigid. They will argue that people should take tax credits wherever the merits, salesmanship, and their whims might take them, and that administrative costs and selection problems in the individual market are small prices to pay for individual freedom and the creativity and innovation the market will bring. There is merit to the concern that large, not-for-profit pools will not be as innovative as free-market entrepreneurs in a robust individual market. We think the scale economies, accountability, and risk-pooling advantages outweigh these concerns.

Others will see the proposal as too unstructured, with too few restrictions, too much inequality, and too many opportunities for mischief. This is a judgment call. We tried to balance these concerns against the desire for choice, pluralism, and market innovation.

Still others will complain that pools are a costly and unnecessary additional layer. We think most Americans want larger sponsors representing them because of the complexities and perils of health insurance.

NOTES

¹ "A Health Insurance Tax Credit for Uninsured Workers."

² Smaller percentages of each group would prefer a government program. Lisa Duchon, Cathy Schoen, Elizabeth Simantov, Karen Davis, and Christina An, *Listening to Workers: Findings from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance*, Table 1.

³ FEHBP also gives plans some control over risk selection by allowing them to design their own benefit packages.

⁴ The need for a national minimum benefit package is discussed further under "Major Issues," below.

⁵ In the alternative, plans could be required to have flat rates for all tax-credit recipients while pools could be required to risk-adjust payments to participating plans. But low-risk partial-credit eligibles would have incentives to leave the pool, and plans might be less willing to participate due to the uncertainties they perceive in risk-adjustment schemes.

⁶ The basic Zelenak proposal would deny tax credits to anyone covered by SCHIP. But presumably an uninsured worker would not be considered "covered" by SCHIP if her children were covered, so she would still be eligible for a tax credit for herself, which could lead to her and her children being enrolled in separate health plans. Also, the family coverage credit proposed by Zelenak is sufficient to cover two working spouses or a single working parent with children but not to cover two parents and their children. (Full family coverage tends to cost at least 3 times as much as single coverage.) Therefore, there seems to be no reason to deny low-income workers access to SCHIP subsidies for their children in addition to the tax credit.

⁷ Common sense suggests that parents will know better how to get care for their children if they are familiar with how the health plan works because they use it themselves. Available research documents that children are more likely to use care if their parents use care. See Karla Hanson, "Is Insurance for Children Enough? The Link Between Parents' and Children's Health Care Revisited." *Inquiry* 35 (Fall 1998): 294–302.

⁸ Existing purchasing pools have learned that agents perform a real and useful function. Most employers and workers strongly prefer that someone sit down and explain the options available and assist them in choosing among the plans offered by the purchasing pool. If there is no agent to do so, the purchasing pool would have to employ staff for this task. Of course, the Internet has already revolutionized the sale of a wide variety of other goods and services, and it is easy to imagine that increasing use of the Internet may soon replace, or at least supplement, face-to-face contact with an insurance agent.

⁹ In a "low-wage" firm, the majority of workers earn less than a specified wage level.

¹⁰ Applicants would not qualify for this preference if any of their start-up funds were obtained from health care providers, health plans or carriers, health insurance agents, or potential administrative vendors to the pool. (Administrative vendors themselves will not be eligible for federal start-up funds. Costs they incur during start-up will be considered capital investments.)

¹¹ In its last two Budget submissions (for fiscal 2000 and fiscal 2001), the Clinton Administration has proposed just such a clarification with respect to start-up costs of "qualified purchasing coalitions" serving small employers.

¹² i.e., A state with 1,500,001 project tax-credit eligibles could have two federal grantees.

¹³ To avoid collection problems, the Zelenak proposal allows only 60% of the tax credit to be payable in advance. Not advancing the full amount will clearly lead to a lower take-up rate among the target population than would otherwise be the case, but that discussion is not germane to the purpose of the present paper.

¹⁴ See earlier note for a limitation on what sources of support would qualify for this preference.

¹⁵ In the event that even the national minimum package is too expensive in a particular state or geographic region, consideration might be given to a "special exception" process that would allow

purchasing pools in that state to seek approval for a lesser benefit package if they can demonstrate the need for it and the reasonableness of their proposed package to an appropriate authority.

¹⁶ In the alternative, plans could be required to have flat rates for all tax-credit recipients, while pools could be required to risk-adjust payments to participating plans. But low-risk partial-credit eligibles would have incentives to leave the pool, and plans might be less willing to participate due to the uncertainties they perceive in risk-adjustment schemes.

¹⁷ To survive in heavily underwritten individual and small-group markets, a pool would have to aggressively underwrite which (a) multiple-plan pools are not well situated to do and cannot do as well as individual carriers, and (b) could well create an organizational “identity crisis.”

¹⁸ We assume that subsidies phrased as “advance payment of tax credits” would be required to be reported in the worker’s annual income tax filing and would be recouped to the extent the worker’s total annual income exceeded the eligibility threshold.

¹⁹ We excluded agent commissions from the estimate because they are already included in premiums when health insurance is purchased in the traditional way, directly from a carrier. Pools’ administrative costs do vary significantly based on how and to what extent the pool chooses to undertake functions such as use of actuaries, marketing, consumer surveys and information, audits of health plan performance data, etc.

²⁰ It is well known that administrative costs are considerably larger for individual health insurance than for employer-sponsored health coverage. Estimates that are both well-documented and recent are hard to find; but Mark Pauly, a well-known health economist who is in general favorably disposed toward individual insurance (because of the wide range of choice it potentially offers individuals), suggests 30 percent of premium as a rough current average for administrative costs of stand-alone individual health insurance policies. Pauly further suggests that the equivalent figure for small-group health insurance (groups with fewer than 25 members) is 20 to 25 percent. See Mark Pauly, Alison Percy, and Bradley Herring, “Individual Versus Job-Based Health Insurance: Weighing the Pros and Health Affairs 18 (November/December 1999): 34. It is not clear whether these estimates include any allowance for profit in addition to administrative costs.

²¹ Consider an example based on the proposed basic subsidy amount for single coverage of \$2,000 per year. In the traditional individual market (i.e., assuming administrative costs consume 30% of premium), this amount will purchase benefits worth (actuarially) \$1,400. If administrative costs can be reduced to 20% of premium by using a pool, the same subsidy amount will purchase benefits worth \$1,600. If the named services covered were the same in both policies, this would translate into a \$200 reduction in (actuarially) expected out-of-pocket costs under the policy (through some combination of a lower deductible and lower coinsurance or copayments).

Even at twice the poverty level for a single individual (the proposed maximum income that would qualify for the full subsidy amount), this \$200 difference in benefits equals 1.2 percent of total income. For a single individual at the poverty level, it equals 2.4 percent of income. Deductibles or copayments of this magnitude are likely to constitute significant barriers to seeking care.

²² There is precedent for age rating in the tax code. The Health Insurance Portability and Accountability Act of 1996 clarified that the tax code allows premiums for long-term care insurance to be deducted on the same basis as other medical expenses, but limits the amount that can be deducted based on the age of the policy holder.

²³ If tax credits could be used in the regular, underwritten individual market, lower risks would leave the non-underwritten pool to obtain less expensive coverage in the outside market. The absence of lower-risk members would raise medical costs, and therefore premiums, within the pool. To protect itself, the pool would have to vary its rates by health status also, which would severely disadvantage high-risk pool members unless tax credits were also adjusted for health status—a task we believe is not feasible.

²⁴ “Public Subsidies for Required Employee Contributions toward Employee-Sponsored

²⁵ Under the Zelenak proposal, only 60% of the tax credit amount would be payable in advance (to reduce collection problems if the recipient’s annual income turns out to be higher than projected).

Also, some people will be eligible only for partial credits, and others may choose coverage that costs more than the credit available to them.

²⁶ Using this type of structure (which was legislatively mandated) was one major reason why Florida's Community Health Purchasing Alliances failed. They were not, in fact, allowed to be purchasers in any reasonable sense of the word.

²⁷ Common sense suggests that parents will know better how to get care for their children if they are familiar with how the health plan works because they use it themselves. Available research documents that children are more likely to use care if their parents use care. See Karla Hanson, "Is Insurance for Children Enough? The Link Between Parents' and Children's Health Care Revisited." *Inquiry* 35 (Fall 1998): 294–302.

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#419 Allowing Small Businesses and the Self-Employed to Buy Health Care Coverage Through Public Programs (December 2000). Sara Rosenbaum, Phyllis C. Borzi, and Vernon Smith. Public programs such as CHIP and Medicaid offer the possibility of economies of scale for group coverage for small employers as well as individuals. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, proposes allowing the self-employed and those in small businesses to buy coverage through these public plans, and providing premium assistance to make it easier for them to do so.

#418 A Federal Tax Credit to Encourage Employers to Offer Health Coverage (December 2000). Jack A. Meyer and Elliot K. Wicks, Economic and Social Research Institute. Employers who do not currently offer health benefits to their employees cite costs as the primary concern. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, examines the potential of offering tax credits (or other financial incentives) to employers of low-wage workers to induce them to offer coverage.

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#416 Transitional Subsidies for Health Insurance Coverage (December 2000). Jonathan Gruber, Massachusetts Institute of Technology and The National Bureau of Economic Research, Inc. The unemployed and those switching jobs often lose coverage due to an inability to pay premiums. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, suggests ways that the existing COBRA program could be enhanced to help avoid these uninsured spells.

#414 Increasing Health Insurance Coverage Through an Extended Federal Employees Health Benefits Program (December 2000). Beth C. Fuchs, Health Policy Alternatives, Inc. The FEHBP has often been proposed as a possible base to build on for group coverage. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, proposes an extension of FEHBP (E-FEHBP) that would operate in parallel with the existing program. The proposal would require anyone qualifying for a tax credit to obtain it through E-FEHBP and would also permit employees of small firms (<10 workers) to purchase health insurance through the program. The proposal would also provide public reinsurance for E-FEHBP, further lowering the premium costs faced by those eligible for the program.

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#411 *ERISA and State Health Care Access Initiatives: Opportunities and Obstacles* (October 2000). Patricia A. Butler. This study examines the potential of states to expand health coverage incrementally should the federal government decide to reform the Employee Retirement Income Security Act (ERISA) of 1974, which regulates employee benefit programs such as job-based health plans and contains a broad preemption clause that supercedes state laws that relate to private-sector, employer-sponsored plans.

#392 *Disparities in Health Insurance and Access to Care for Residents Across U.S. Cities* (August 2000). E. Richard Brown, Roberta Wyn, and Stephanie Teleki. A new study of health insurance coverage in 85 U.S. metropolitan areas reveals that uninsured rates vary widely, from a low of 7 percent in Akron, Ohio, and Harrisburg, Pennsylvania, to a high of 37 percent in El Paso, Texas. High proportions of immigrants and low rates of employer-based health coverage correlate strongly with high uninsured rates in urban populations.

#405 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. This summary report, based on *The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70*, reveals that those nearing the age of Medicare eligibility and those who recently enrolled in the program place high value on Medicare. At the same time, many people in this age group are struggling to pay for prescription drugs, which Medicare doesn't cover.

#391 *On Their Own: Young Adults Living Without Health Insurance* (May 2000). Kevin Quinn, Cathy Schoen, and Louisa Buatti. Based on The Commonwealth Fund 1999 National Survey of Workers' Health Insurance and Task Force analysis of the March 1999 Current Population Survey, this report shows that young adults ages 19–29 are twice as likely to be uninsured as children or older adults.

#370 *Working Without Benefits: The Health Insurance Crisis Confronting Hispanic Americans* (March 2000). Kevin Quinn, Abt Associates, Inc. Using data from the March 1999 Current Population Survey and The Commonwealth Fund 1999 National Survey of Workers' Health Insurance, this report examines reasons why nine of the country's 11 million uninsured Hispanics are in working families, and the effect that lack has on the Hispanic community.

#364 *Risks for Midlife Americans: Getting Sick, Becoming Disabled, or Losing a Job and Health Coverage* (January 2000). John Budetti, Cathy Schoen, Elisabeth Simantov, and Janet Shikles. This short report derived from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance highlights the vulnerability of millions of midlife Americans to losing their job-based coverage in the face of heightened risk for chronic disease, disability, or loss of employment.

#363 *A Vote of Confidence: Attitudes Toward Employer-Sponsored Health Insurance* (January 2000). Cathy Schoen, Erin Strumpf, and Karen Davis. This issue brief based on findings from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance reports that most Americans believe employers are the best source of health coverage and that they should continue to serve as the primary source in the future. Almost all of those surveyed also favored the government providing assistance to low-income workers and their families to help them pay for insurance.

#362 *Listening to Workers: Findings from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. This full-length analysis of the Fund's survey of more than 5,000 working-age Americans finds that half of all respondents would like employers to continue serving as the main source of coverage for the working population. However, sharp disparities exist in the availability

of employer-based coverage: one-third of middle- and low-income adults who work full time are uninsured.

#361 Listening to Workers: Challenges for Employer-Sponsored Coverage in the 21st Century (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. Based on The Commonwealth Fund 1999 National Survey of Workers' Health Insurance, this short report shows that although most working Americans with employer-sponsored health insurance are satisfied with their plans, too many middle- and low-income workers cannot afford health coverage or are not offered it.

#262 Working Families at Risk: Coverage, Access, Costs, and Worries—The Kaiser/Commonwealth 1997 National Survey of Health Insurance (April 1998). This survey of more than 4,000 adults age 18 and older, conducted by Louis Harris and Associates, Inc., found that affordability was the most frequent reason given for not having health insurance, and that lack of insurance undermined access to health care and exposed families to financial burdens.