ADMINISTRATIVE SOLUTIONS IN HEALTH REFORM

Report of the Study Panel on

Administrative Issues in Expanding Access to Health Care

July 2009

NATIONAL ACADEMY OF SOCIAL INSURANCE

National Academy of Public Administration®

Robert Wood Johnson Foundation

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by the

National Academy of Public Administration

and the

National Academy of Social Insurance

July 2009

Study Panel on Administrative Issues in Expanding Access to Health Care

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Robert A. Berenson,+ *Co-Chair*
Urban Institute

William A. Morrill,* *Co-Chair*
Caliber Associates

Kenneth S. Apfel*+
University of Maryland

Beth C. Fuchs+
Health Policy Alternatives, Inc.

Thomas R. Hefty
Blue Cross Blue Shield United of Wisconsin (retired)

Feather O. Houstoun*
William Penn Foundation

Robert E. Hurley
Virginia Commonwealth University (emeritus)

Jack Lewin
American College of Cardiology

Catherine G. McLaughlin+
University of Michigan

Sallyanne Payton*
University of Michigan School of Law

Michael C. Rogers*
MedStar Health

Raymond C. Scheppach*
National Governors Association

Mark D. Smith+
California HealthCare Foundation

***** *Fellow, National Academy of Public Administration*
+ *Member, National Academy of Social Insurance*

Project Staff

Paul N. Van de Water, *Study Director*
National Academy of Social Insurance

Terry F. Buss, *Co-Director*
National Academy of Public Administration

Contractors

Jill Bernstein
Consultant

Lawrence D. Brown
Columbia University

Bryan Dowd
University of Minnesota

Timothy Stoltzfus Jost
Washington and Lee University

Mark Merlis
Consultant

Kieke G.H. Okma
New York University

C. Eugene Steuerle
Urban Institute

Elliot K. Wicks
Health Management Associates

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CONTENTS

FOREWORD

The U.S. health care system faces well-known challenges: 46 million people without health insurance coverage in 2007, rapidly rising costs that now consume over 16 percent of the Nation's economic output, and uneven and inequitable quality of care.

The National Academy of Public Administration and the National Academy of Social Insurance partnered with the Robert Wood Johnson Foundation to undertake a sweeping analysis of the management and administrative issues that arise in expanding health coverage. The two-year project identified and described core administrative functions that need to be performed regardless of the health system in place, and assessed how these functions might be performed under different health care alternatives. The study drew lessons from experience in the United States and abroad, and recommends administrative and management approaches designed to facilitate the improvement and expansion of health care coverage.

The NAPA-NASI report comes at a propitious time, as Congress and the Obama Administration consider health care coverage options for the American people. All health care delivery and financing structures raise management challenges. This report will help policymakers identify and consider critical management issues as changes to the healthcare system are designed and implemented.

NAPA and NASI would like to thank the 13 study panel participants, including NAPA Fellows, NASI members, and leading experts, for their outstanding work and keen insights into the issues. We also deeply appreciate the contributions of the health care experts who prepared a series of papers that informed this project report. Without the financial support, encouragement, and participation of the Robert Wood Johnson Foundation, this project would not have been possible.

Jennifer L. Dorn
President and CEO
National Academy of Public Administration

Janice M. Gregory
President
National Academy of Social Insurance

SUMMARY

Our Nation is once more engaged in a debate about expanding access to high quality and affordable health care. For the most part, the discussion centers around the preferred policies and programmatic provisions to expand coverage, improve quality, and slow the growth of costs. Much less attention is paid to issues of management—the structures, processes, and staffing necessary to implement a plan and establish an effective program.

If we were dealing with a simple, uncomplicated arrangement, this inattention to management would be understandable. But the American health care financing system is anything but simple and uncomplicated. Built piece by piece over a long period, lacking a comprehensive design, involving all levels of government, and accounting for almost one-sixth of the U.S. economy, it has a multitude of moving parts that must interact smoothly to achieve reasonable results.

These circumstances call for a comprehensive review of the administrative elements of health reform. The National Academy of Public Administration (NAPA) and the National Academy of Social Insurance (NASI), with the support of the Robert Wood Johnson Foundation, therefore convened a study panel to undertake such a review. This resulting report provides a compendium of the administrative activities that need to be fitted effectively into any new management structure.

The panel has identified seven administrative activities and functions that are central to a variety of health reform proposals: planning and coordinating implementation, subsidizing health insurance premiums and cost sharing, administering health insurance mandates, regulating health insurance, restructuring health insurance markets, designing administrative organizations, and simplifying administration and controlling costs. In each area, the report defines the choices, summarizes what is known about them, and draws appropriate conclusions. The summary table lists the panel's recommendations, and the report details the recommendations and their rationale.

The study panel has also commissioned noted experts to prepare research papers on the subjects of its inquiry. Edited versions of these papers have been published in a companion volume, *Expanding Access to Health Care: A Management Approach*, and they are also available on NASI's website (www.nasi.org) and on the NAPA website (www.napawash.org).

Before presenting its detailed recommendations, the panel calls attention to some overarching conclusions. As with other large, new government programs, health reform should build—to the extent feasible—on existing governmental capacities, arrangements, and institutions. In this instance, however, these capacities do not exist in a single entity but are spread across various agencies of federal and state governments.

To assure that all available administrative resources are brought to bear, the President should promptly designate an agency and a person to direct the implementation of health reform. The health reform administrator would draw attention to administrative issues while legislation is being drafted, begin planning to carry out the legislation even before it is enacted, and coordinate

the efforts of the various federal and state agencies that would be involved in administering the new programs. To the extent that state governments play a role, the administrator should be authorized to provide extensive technical assistance and prepare model legislation, regulations, and procedures that could be adopted by states to simplify and speed implementation.

Health reform legislation should also include a carefully constructed schedule for phasing in its many varied elements. Although the aim of reform is to extend health coverage as widely and quickly as possible, trying to start everything and cover everyone at one time could overwhelm the administrative apparatus. Gradual implementation would spread out the workload, allow processes to be improved based on early experience, and help assure a successful start.

The panel's most important conclusion is that the administrative challenges posed by expanding access to health care can be met. Experiences with similar programs in the U.S. and abroad, as well as extensive analyses of specific management issues, provide a wealth of guidance for those who are responsible for designing and implementing reforms. This report and its accompanying volume show how those experiences and analyses are relevant to the current debate.

The study panel makes no claims about the best policies and programmatic features to adopt in improving and reforming the Nation's health care system. Those features will be worked out in the weeks to come. The panel's objective instead is to set forth the management considerations that we believe are important in designing an effective program. We hope that this document will prove useful in developing and implementing a workable, comprehensive plan.

Summary Table
Recommendations of the NAPA-NASI Study Panel on
Administrative Issues in Expanding Access to Health Care

Planning and Coordinating Implementation

1.1 Administrative issues and their connections with each other should receive careful consideration when developing legislation.
1.2 The agency with primary responsibility for implementing health reform should have political stature and substantial operational flexibility.
1.3 Provide sufficient up-front administrative funds for a successful start.
1.4 Establish an implementation schedule that is ambitious, yet realistic.

Subsidizing Premiums and Cost-Sharing

2.1 Whether health insurance subsidies are administered through the tax system or a spending program, an emphasis should be placed on simplicity.
2.2 Eligibility criteria for subsidies should be easily enforceable and designed not to create incentives for abuse, thus raising either error rates or enforcement budgets.
2.3 Administration can be simplified if subsidies are provided through a health insurance exchange offering insurance plans with comprehensive, standardized benefits.
2.4 The subsidy system should be designed to assure eligibility before making payments and to avoid the need for end-of-year reconciliation or recovery of overpayments.

Administering Health Insurance Mandates

3.1 Emphasis should be placed on encouraging compliance with a mandate rather than penalizing noncompliance.
3.2 Penalties for noncompliance with a mandate should be moderate and collectable.

Regulating Health Insurance

4.1 The federal government should take advantage of the regulatory expertise and administrative mechanisms for protecting consumers that already exist in state governments. One approach would be to develop uniform national standards for health insurance enforced primarily at the state level.

Restructuring Health Insurance Market

5.1 A health insurance exchange could provide a structure for the health insurance market, guarantee individual access to health insurance, promote competition among health insurance plans on the basis of price and quality, and assure that health insurance plans play by the established rules.
5.2 If policymakers create a new public health insurance plan to compete with private plans in an exchange, the public plan should be administered by a separate organizational entity and not by the exchange itself.
5.3 Any restructuring of the health insurance market must account for the unique role of Medicaid in covering low-income and high-risk populations.

Designing Administrative Organizations

6.1 Organizations that use governmental powers and funds and make public policy must be accountable as well as effective.
6.2 Many administrative problems do not have solutions that require new organizational designs.
6.3 The Federal Reserve System does not provide an appropriate model for an entity to manage a national health insurance system.

Simplifying Administration and Controlling Costs

7.1 Efforts should continue to enhance the standardization of health care transactions to reduce administrative costs.
7.2 Investments in comparative effectiveness research and electronic medical records are compatible with a wide range of approaches to expanding health coverage and controlling costs.
7.3 The creation of a health insurance exchange is compatible with all of the major options for controlling health care costs.

CHAPTER 1: INTRODUCTION AND OVERVIEW

Health insurance is the primary way of obtaining access to health care in the U.S. today, but 46 million Americans are uninsured. The provision of health insurance involves extensive interactions between individuals, health insurers, and health care providers, between the public and private sectors, and across levels of government. Expanding health coverage without unduly adding to this complexity represents a major challenge to public administration. Yet it is a challenge that can and should be met.

Meeting the Administrative Challenge

Analyses of proposals to expand health coverage generally focus on their programmatic or policy impact. This emphasis is understandable, since many proposals provide only sketchy information about management, and administrative costs represent only a small portion of the total costs of a proposal. Nonetheless, failure to address matters of implementation can result in policies or programs that cost too much or fail to achieve their goals.

This report examines the management and administrative issues that are likely to arise as part of efforts to expand health coverage. It is the product of a study panel convened jointly by the National Academy of Public Administration (NAPA) and the National Academy of Social Insurance (NASI). Each of these organizations brings unique talents to the effort. Established in 1967, NAPA is an independent organization chartered by the Congress to improve governance at all levels. NASI, founded in 1986, promotes informed policy making on social insurance and related programs, including Medicare, Medicaid, and employer-sponsored health insurance. NAPA's fellows and NASI's members have been selected based on their sustained and outstanding contributions to the fields of public administration or social insurance.

The members of the study panel represent a wide variety of perspectives and include academics, researchers, consultants, and executives of health care companies, foundations, and associations. Several panel members have had hands-on experience in the administration of Medicare, Medicaid, or private health insurance programs or in the delivery of health care services. The panel has met three times, consulted with a range of experts, and commissioned ten research papers. Edited versions of these papers are being published in a companion volume (Buss and Van de Water 2009); they are available in full on NASI's website (www.nasi.org).

In conducting its work, the study panel has presumed a goal of expanding access to affordable, high-quality health care, with the ultimate aim of universal health coverage. But the panel does not endorse any particular plan for achieving that objective. Rather, the panel has selected for examination several administrative activities that are central to a variety of proposals:

- Planning and coordinating implementation,
- Subsidizing health insurance premiums and cost sharing,

- Administering health insurance mandates,
- Regulating health insurance,
- Restructuring health insurance markets,
- Designing administrative organizations for health reform, and
- Simplifying administration and controlling costs.

Within each of these areas, the panel has identified the major administrative functions that need to be performed, draws applicable lessons from experience in the U.S. and abroad, and makes recommendations to guide upcoming efforts to expand health coverage.

The panel has limited its scope by concentrating on options that go beyond incremental changes yet fall short of comprehensive reform. For example, this report does not consider expansions of existing programs such as reducing the age of eligibility for Medicare, covering older dependent children under private insurance, or raising the income or asset limits for Medicaid. For the most part, such incremental changes would not pose major new administrative challenges. Nor does this report look at comprehensive, tax-financed plans such as universal health care vouchers or Medicare-for-all. This emphasis does not represent a judgment on the merits of the competing approaches.

Access, cost, and quality are universally viewed as the three big issues facing the U.S. health care system. Increased access may rapidly become unaffordable without efforts to slow the growth of costs and increase the quality of care. And improvements in cost and quality are in turn likely to require changes in the way health care is delivered. Although this analysis centers on expanding financial access to health care, different financing models may have different implications for controlling costs and improving the performance and value of the health care delivery system. The report therefore concludes by examining the relationship between expanding health coverage and containing health costs.

Before delving into the administrative details, however, it is important to look at the big picture. The remainder of this introductory chapter therefore offers an overview of how two previous health reforms were implemented and what these experiences can teach us today.

Implementing Previous Health Reforms

Capable, committed public managers can make almost any program work on the ground, but policymakers can make the managers' task easier and the program more successful by paying attention to administrative issues when preparing proposals and drafting legislation. Some administrative issues are particular to certain plans, but others apply to implementing a wide range of new programs. The start of the Medicare program in 1965-1966 and the implementation of recent health care reforms in Massachusetts, as well as other U.S. and foreign experiences, offer some general lessons in planning for future expansions of health coverage.

Implementing Medicare

Medicare was signed into law by President Lyndon Johnson on July 31, 1965, and benefits for hospital and physician services began on July 1, 1966—less than a year later. The new program provided health care coverage to 19 million elderly Americans, only half of whom had previously had some form of hospital insurance. All elderly people who were eligible for Social Security—including those not yet receiving cash benefits—became eligible for Medicare's Hospital Insurance benefit. Supplementary Medical Insurance for doctor's bills was made available on a voluntary basis to those paying a premium.

The 1965 law also created Medicaid, a joint federal-state program of medical assistance for people with low incomes, and made some major changes to Social Security retirement and disability benefits. Robert Ball and Arthur Hess, respectively Commissioner of Social Security and Director of the Bureau of Health Insurance during that period, have recounted to an earlier study panel some of the features that facilitated carrying out such a large undertaking in such a limited time (Gluck and Reno 2002).

Planning to implement Medicare began well before the law was passed. Administration and Congressional leaders had discussed the Hospital Insurance portion of Medicare over several years during the early 1960s, and its provisions had been refined to facilitate administration. Commissioner Ball has provided several examples. The program was scheduled to start in mid-summer, when hospital occupancy was generally at its lowest. Coverage of nursing homes was scheduled to begin six months after hospital benefits, so that the two could proceed on separate tracks. And a proposal to offer beneficiaries a choice of benefit packages was dropped because of its administrative complexity.

Other aspects of the legislation also simplified implementation, although they were not adopted for that purpose. Notably, Medicare was a fully federal program that did not depend on the varying interests and administrative capacities of the states. Also, in Ball's words, "There was overwhelming political agreement that Medicare did not have a mission to reform delivery of, or payment for, medical care."

From the start of the discussions about Medicare, it was clear that the Social Security Administration would have responsibility for administering the new program, if and when it was enacted. The agency already had in place a network of field offices for dealing with its beneficiaries. The agency's leaders were strongly supportive of the new program and willing to take some chances by undertaking planning efforts for which there was no explicit appropriation and that would have been wasted if the law had not been passed. Upon enactment of the legislation, everyone in the federal government understood that Medicare was a top priority for President Johnson. Other agencies, such as the Civil Service Commission and General Services Administration, cooperated with Social Security in ways they had not in the past. To carry out its work, the agency received an additional 1966 appropriation of $125 million (about $900 million in today's dollars, and an increase of about one third), hired and trained 9,000 new staff (above the previous level of 35,000), and opened 100 new offices (for a total of 725 field offices). In contrast to Medicare, however, the Social Security Administration devoted only a tiny staff to running Medicaid and left its design and implementation largely to the states.

The Social Security Administration was delegated almost complete authority and responsibility for implementing Medicare, leaving many crucial issues in the hands of Ball, Hess, and their staff. In only one major instance did the White House get involved. Weeks before the program was to start, President Johnson became concerned that a flood of newly insured elderly people would suddenly overwhelm certain hospitals. A system to track hospital occupancy rates was therefore established, military and veterans hospitals were placed on standby, and plans were made to transport people to these facilities. In the event, however, hospital capacity proved more than adequate, and these contingency plans were never used.

Instead of relying on the formal federal rulemaking process, the Social Security Administration solicited input and developed consensus over policies through many informal working groups and task forces. After extensive staff work and consultation with interested parties, proposed policies were presented to the Health Insurance Benefits Advisory Council, a 16-member body established by law and reflecting a range of organizations and viewpoints. Although Social Security was not required to take the council's advice, according to Ball it usually did. For the most part, policies were incorporated in the conditions of participation for health care providers rather than in final regulations.

One of the conditions of participation was a requirement that hospitals desegregate. Though they met with some resistance, federal officials were steadfast in requiring hospitals to comply with the Civil Rights Act. As a result, more than 1,000 hospitals integrated their medical staffs, waiting rooms, and hospital floors in a period of less than four months (Smith 1999).

Ball suggested that the magnitude of the task and the tight time frame for implementing Medicare may, in some ways, have facilitated getting the job done. "The sense of urgency and excitement and so on was part of the success," he stated. "It is probably harder to implement a relatively small program without objection. If everybody understands that this is an emergency and that if you are going to make it work, you have to take extraordinary measures." Morale at the Social Security Administration was high. Local offices opened on evenings and weekends to enroll applicants, and staff throughout the agency willingly worked overtime. Advocacy groups, primarily aging organizations, were very supportive. Major stakeholders cooperated to make the program work well once it had been enacted, even if they had previously opposed the legislation. In today's environment, Hess remarked, more lead time may be required because one should "expect a lot more sand in the gears."

Implementing Health Reform in Massachusetts

Efforts to expand health insurance coverage in Massachusetts, which had unraveled in the 1990s, gathered renewed momentum in 2004. A local foundation began to lay out a "Roadmap to Coverage," including analysis of implementation issues (Weil 2005). Stakeholders came together for conversations, and the legislature overhauled its committee structure and added staff. Political leaders started to develop proposals and immerse themselves in both the theoretical and operational details of reform (Wielawski 2007). The legislation that was finally enacted in April 2006 showed clear signs of this attention to administrative issues.

The Massachusetts health reform imposes responsibilities on both individuals and employers. Every resident over age 18 must obtain health insurance as long as it is deemed affordable. Employers with 11 or more employees must make a "fair and reasonable" premium contribution toward health insurance or pay the state a Fair Share Contribution of up to $295 per employee; they must also offer a section 125 (cafeteria) plan that allows employees to pay for health insurance coverage on a pre-tax basis. To facilitate obtaining coverage, Massachusetts merged and restructured the individual and small-group markets for health insurance, created a purchasing exchange to offer affordable health insurance products, expanded eligibility for Medicaid, and provided subsidized health insurance coverage to families with incomes up to 300 percent of the poverty level (Kaiser 2007, 2008).

Implementing the Massachusetts reforms involves coordination among many existing state agencies, including the Office of Medicaid (MassHealth), the Department of Public Health, the Division of Health Care Finance and Policy, the Department of Revenue, and the Division of Unemployment Assistance. However, a new state agency—the Commonwealth Health Insurance Connector Authority—plays a central role. Rosemarie Day, deputy director and chief operating officer of the Connector, has described for the study panel the implementation process and drawn some lessons about its operations (Day 2008).

The Connector is an independent public authority overseen by a board of ten directors. Its primary role is to serve as a health insurance exchange offering standardized benefit plans and more affordable coverage options. It runs two major programs: Commonwealth Care, which offers a choice of subsidized health insurance plans to those with low incomes, and Commonwealth Choice, which provides individuals and small businesses with easy access to a range of unsubsidized products. The Connector is also assigned other critical policymaking and administrative responsibilities, such as defining minimum creditable coverage for purposes of the individual mandate to obtain insurance, determining when coverage is considered affordable, establishing regulations for employers' section 125 plans, and informing individuals and employers about their new options and responsibilities. (The Division of Health Care Finance and Policy determines which employers must pay an assessment.)

Although independent, the Connector is closely tied to the political process. Four members of the board are state officials who serve *ex officio*, three are appointed by the governor for three-year terms, and three are appointed by the attorney general. The appointed members come from outside government, are chosen from specified categories (actuaries, health economists, small business, consumer organizations, organized labor, and employee benefit specialists), and serve for three-year terms. The chair of the board, who is the governor's Secretary of Administration and Finance, selects the executive director, but the executive director views himself as being responsible to the entire board. Because health reform in Massachusetts was a bipartisan effort with broad support, the change from a Republican to a Democratic governor in January 2007 did not slow or change its course.

Like Medicare, the Massachusetts Health Connector had to ramp up operations rapidly. The executive director was hired in early June 2006 (less than two months after enactment of the legislation), and the first board meeting was held on June 7. The core staff was hired during the summer and fall of 2006. The legislation exempted the Connector from some constraints on

state agencies—notably from certain restrictions on hiring and procurement. According to Deputy Director Day, these flexibilities were essential in allowing the Connector to get off to a fast start. The Connector is not exempt from the state's rulemaking procedures or requirement for open meetings. Every meeting of the board, Day reports, attracts more than 100 attendees and is "like a press conference."

The Connector and its partner agencies succeeded in meeting the deadlines for making the Massachusetts health reforms operational. Enrollment in Commonwealth Care (the new subsidized insurance program) began in October 2006 for adults with incomes under 100 percent of poverty and in January 2007 for those between 100 percent and 300 percent of poverty. Enrollment in Commonwealth Choice (the unsubsidized program) started in May 2007. Employers were required to file Fair Share Contribution Reports with the Division of Unemployment Assistance by November 15 for the year ending September 30. Individuals subject to the mandate were required to obtain health insurance by the end of December in order to avoid a tax penalty.

Higher than expected enrollment in Commonwealth Care at times taxed the new systems. In the fall of 2007, as people attempted to beat the deadline for obtaining insurance, the *Boston Globe* reported "Uninsured face health plan delays" and "Health plan help line swamped with calls" (Dembner 2007a and 2007b). For the most part, however, the administrative processes have worked well, and the reforms continue to command broad support. The major remaining issue is not solely an administrative one, namely, the need to control rising health care costs.

Deputy Director Day has identified several factors that facilitated the Connector's implementation of the Massachusetts reforms:

- Tight deadlines, which limited the time for debate,
- Continued support from stakeholders, including providers, plans, and advocates,
- Flexibility granted by the law in determining programmatic details and administrative procedures, as well as in hiring and procurement,
- A board of directors that did not attempt to micro-manage,
- Partnerships with existing state agencies, and
- Sufficient start-up funds ($25 million provided to the Connector, plus a $10 million reserve fund allocated by the Executive Office for Administration and Finance).

Getting Commonwealth Care up and running further benefitted from:

- Using the existing infrastructure of MassHealth to determine eligibility,
- The ability to enroll individuals who had been receiving care through the state's Uncompensated Care Pool because they were already identified in MassHealth's eligibility system,
- Automatic assignment of fully subsidized participants (those with incomes below 100 percent of poverty) to a health plan if they did not choose one within 14 days,

- Using the Massachusetts Executive Office of Health and Human Services' virtual gateway—a single on-line access point to programs and services—to facilitate enrollment, and
- Outreach grants by MassHealth to nonprofit groups to provide education and enrollment assistance to those potentially eligible for MassHealth or Commonwealth Care.

The Connector has nevertheless faced a few operational challenges. First, billing premiums for Commonwealth Care has proved complicated, because changes in monthly income cause changes in monthly premiums. The Connector is implementing a new billing system and aiming to simplify the rules. Second, deducting premiums for Commonwealth Choice on a pre-tax basis is difficult for part-time employees if they do not have sufficient earnings in every pay period. Third, having to be fully transparent in its deliberations and operations can put the Connector at a competitive disadvantage, since its commercial business through Commonwealth Choice must compete with offerings in the individual and small-group market outside the Connector (including plans that are identical to those offered by the Connector).

Day draws several operational lessons from the first two years of the Connector. First, be a virtual organization. The Connector operates with a staff of only 42 full-time-equivalent employees and outsources most of its activities. MassHealth determines eligibility for Commonwealth Care, and private firms run the Connector's website, call centers, and enrollment and billing processes. Second, take incremental steps, and don't try to do everything at once. Third, be an organization that learns from its experiences to achieve better results. And fourth, do lots of outreach, advertising, and public education.

The Connector took the lead in educating the public about the health reforms, even though the legislation did not specify which state agency was to play this role. It ran a massive outreach effort that included paid advertising, partnerships with the business community (including, most notably, the Boston Red Sox), grassroots efforts with civic organizations, and postcards to taxpayers from the Department of Revenue. The public relations campaign aimed to inform individuals and employers about their new responsibilities and options, encourage compliance with the mandates, and build enrollment in the new insurance plans. In addition, by continuing to engage the stakeholders that had contributed to the reform's enactment, it kept them invested in the program and thereby contributed significantly to its success.

Findings and Recommendations

Thanks to Medicare, health coverage among the elderly is nearly universal. The reforms in Massachusetts have already succeeded in reducing the rate of uninsurance almost in half—from 10.4 percent in 2006 to 5.4 percent in 2007—and increasing the number of people with health insurance by more than 300,000 (U.S. Census Bureau 2008). Although separated by 40 years, the experiences of implementing these two programs offer some intriguing similarities and provide lessons for future national efforts to expand health coverage.

1.1. Administrative issues and their connections with each other should receive careful attention while developing legislation. Administrative convenience will never trump important political or policy objectives. Yet the easier it is for both participants and administrators to perform their assigned roles, the more likely a program is to achieve its objectives. In designing both Medicare and the Massachusetts reforms, policymakers considered how the programs would actually work in practice. Although not everything went perfectly, advance planning paid substantial benefits.

No bright line separates policy issues from administrative ones, and each administrative issue is intertwined with others. For example, requiring everyone to have health insurance coverage makes it possible to regulate the extent to which insurers may vary rates because of individual characteristics, such as age or health status. Yet mandating health insurance coverage requires that the premiums of low-income people be subsidized to make insurance affordable. Expanding health coverage will inevitably raise many such interrelationships, and policymakers must take care that the elements of any proposal work effectively together as well as separately.

1.2. The agency with primary responsibility for implementing health reform should have political stature and operational flexibility. The agencies implementing Medicare and the Massachusetts reforms carried clout and were able to move quickly because they had the strong support of the chief executive. They were also accorded flexibility in establishing both program policies and administrative procedures. Implementing health reform at the federal level will require the same high level of commitment and discretion.

1.3. Provide sufficient up-front administrative funds for a successful start. Administrative expenses typically represent a small portion of the total cost of a program, and they often get shortchanged in the budgetary process. In both cases examined here, however, the administrative funding was prompt and adequate.

1.4. Establish an implementation schedule that is ambitious, yet realistic. Lawmakers are eager to get a new program up and running as quickly as possible and may fail to allow sufficient time for smooth implementation. A relatively tight schedule, however, presents opportunities as well as challenges. In implementing both Medicare and the Massachusetts reforms, administrators found that a tight time frame created a sense of mission, speeded the decision-making process, and facilitated getting things done. Even the Medicare prescription drug benefit—a novel program, whose design and administration have been subject to some criticism—was put in place in a period of about two years after enactment. In the end, a well-reasoned timetable is needed to sequence implementation, and allowance must be made for adjustment and adaptation.

CHAPTER 2: SUBSIDIZING PREMIUMS AND COST-SHARING

Expanding health coverage requires some arrangement for subsidizing the premiums and cost-sharing that people would otherwise have to pay in public or private insurance plans. Such subsidies could be directed towards low-income individuals and families, or channeled through health insurance plans or small employers. If insurance underwriting practices and rates are not limited, arrangements will also be needed to help high-risk people obtain insurance. This chapter considers some of the administrative issues that arise in the provision of such subsidies. These issues are discussed in more detail in background papers commissioned for the study panel and in other recent sources (Bernstein 2009; Buss and Van de Water 2009a; Etheredge *et al.* 2009; Holtzblatt 2008; Steuerle and Van de Water 2009; Wicks 2009).

A universal, tax-financed health insurance program would not face many of the issues discussed here, although it would encounter its own set of administrative challenges. For example, Ezekiel Emanuel and Victor Fuchs (2007) have proposed that all U.S. residents receive a voucher that would provide access to a health plan that provides a set of comprehensive benefits with no deductibles and minimal copayments. Funding for the vouchers would come from a dedicated value-added tax, which would relate contributions to ability-to-pay. Since there would be no premiums and little cost-sharing in this arrangement, there would also be no need to establish a separate system of subsidies for low-income people, although a mechanism is still needed to assure use of the vouchers.

As Jill Bernstein explains in her background paper for the study panel, the terminology for different types of consumer spending on health care is not standardized. The focus here is on two broad categories. The first comprises premiums for health coverage, whether provided through private insurance or a public program. Premiums are due on a periodic basis irrespective of a person's use of health care services. The second is cost-sharing for specific health care services, generally through deductibles (an initial amount of spending per period not covered by insurance), copayments (a fixed dollar amount paid for a service), or coinsurance (calculated as a percentage of cost), and often with limits on total annual spending.

Beyond contributing revenues to finance health coverage, premiums and cost-sharing are typically advanced as ways of promoting appropriate and efficient use of health care. Premiums and cost-sharing can represent a major barrier to health care services for low-income people, however, and proposals to expand health coverage must offer a way to surmount this hurdle. "Subject to out-of-pocket limits, patient co-insurance can reduce medical utilization without adversely affecting health for the typical person," writes Gruber, summarizing the literature on cost-sharing. "However, some form of income-related limit on out-of-pocket expenses is necessary to protect those with few resources" (Gruber 2006).

Administrative Objectives, Tasks, and Agencies

Subsidies for health insurance can be provided to low-income individuals and families either through the tax system (a tax credit, deduction, or exclusion) or a spending program. In either case, designing a system of subsidies requires determining the objectives to be achieved, the tasks to be performed, and the agency or agencies to carry them out. The subsidy's structure may help determine the choice of an administrative agency and *vice versa* (Holtzblatt 2007a). As we will see in the next chapter, the administration of subsidies should also be coordinated with the administration of an individual mandate to purchase health insurance, if a proposal includes a mandate.

Several administrative objectives must be considered when structuring health insurance subsidies and weighing the choice of an administrative agency (Burman 2001; Holtzblatt 2007a). First, *compliance burdens*, the costs that individuals must incur to obtain benefits should be kept low. Second, the *administrative costs* of employers, insurers, and the administering government agency should also be held down. Third, *participation* of eligible individuals should be facilitated. And, fourth, *erroneous payments* (both accidental and deliberate) should be minimized.

These objectives clearly conflict, and achieving all of them simultaneously may be difficult. Simplifying compliance for individuals, for example, may well increase administrative costs or erroneous payments. The conflicts are also likely to be more acute for a new program of subsidized health insurance than for existing means-tested programs, since the value of the benefit to be gained is potentially much larger. For example, the maximum earned income credit for a taxpayer with three or more qualifying children is $5,657 in 2009, whereas the average cost of a family health insurance policy exceeds $12,000 a year.

The agency or agencies administering a system of subsidies must perform a number of tasks (Holtzblatt 2007a). It must determine an individual's initial and continued *eligibility* for the subsidy. Eligibility for a health-insurance subsidy has many dimensions. As with most tax preferences and benefit programs, eligibility is likely to depend on income, family circumstances, and other personal characteristics of the applicant. In addition, providing subsidies for private health insurance coverage raises several unique issues in determining eligibility. One challenge is determining whether the individual has health insurance coverage and, possibly, how much it costs. Another is confirming that the health insurance plan meets the standards that allow participants to be eligible for a subsidy. If a proposal allows multiple points of access to a subsidy (for example, both through a tax credit and through a public benefit program), steps may be required to prevent a person from receiving both subsidies. As Holtzblatt points out, "None of this information is currently available on a national large-scale basis. It will be a challenge for any agency to receive, process, and match such information in a timely enough fashion so that beneficiaries can receive subsidies to purchase health insurance in real time."

A second task is *verification* of the information provided by the taxpayer or applicant for subsidies. The tax system generally relies on self-assessment by the individual taxpayer, backed up by information reporting from third-parties and occasional audits and penalties. In contrast,

welfare programs typically require that applicants meet with a caseworker in person and provide up-front documentation of their eligibility for benefits. Self-reporting is generally more convenient for potential beneficiaries and cheaper for the administering agency, but the lack of up-front verification may lead to improper payments that are difficult to recapture later.

A third task involves *payment* of the subsidy. For low-income people who have few liquid resources, a subsidy will allow them to purchase insurance only if it is available at the time the premium must be paid. Cash benefits are usually paid monthly to the beneficiary by check, direct deposit in a bank account, or (as in the Food Stamp program) electronic debit card. In the case of a subsidy for health insurance, however, it would be preferable to pay the subsidy directly to the insurer. If the subsidy is provided through a tax credit, an advance payment mechanism must be established. Depending upon the accounting period for benefits, it may also be necessary to provide a procedure for reconciling differences between estimated and actual income after the income-reporting period is over and adjusting for changes in family status.

Tax credits and means-tested benefit payment have similarities and differences. The outcome is the same in both cases—helping low-income people pay their health insurance premiums and cost-sharing. From a budgetary perspective the two are virtually identical, since the refundable portion of a tax credit is treated as a budget outlay. Even their administrative process can be designed in a similar fashion.

If subsidies are provided through a public benefit program, the prime candidates for administering them are the Social Security Administration (as in the Medicare low-income drug subsidy), state Medicaid agencies (as with Commonwealth Care in Massachusetts), or a new health insurance exchange. If subsidies are provided through the tax system, the Internal Revenue Service would make the payments to insurers, but the exchange could determine individual eligibility and certify payment amounts to the IRS.

Administering Subsidies through the Tax System

Experience with subsidizing health insurance through the tax system provides several lessons about administering a new system of subsidies. The most significant way in which the tax system currently subsidizes health insurance is through the exclusion of employer-provided health insurance from an employee's income for purposes of income and payroll taxes. This tax expenditure conveys substantial benefits, and the current rules impose no significant administrative burdens on individuals, employers, health care providers, or the federal government. Employers do not need to determine the value of employer-provided coverage or the amount of benefits received, and neither employers nor employees must provide any information to the Internal Revenue Service (IRS) about the existence of a health plan, its benefits, or its coverage. The IRS devotes almost no attention to auditing employer health plans or enforcing non-discrimination rules (Hevener and Kirby 2008).

Tax credits for health insurance pose more complicated administrative issues than the current tax exclusion. Administration would be relatively straightforward if people claimed the credit only when filing their tax returns and adjusted their tax withholding during the course of the year. In that case, reconciliation would not be necessary because the taxpayer's exact income, family

status, and insurance coverage would be known when the credit was claimed. This approach would fail to reach much of its target population, however, because those most likely to be eligible for the credits would have little disposable income to pay premiums and might not be familiar with the mechanics of tax withholding or refundability (Fuchs, Merlis, and James 2002).

In 1990, the Congress provided a limited individual health insurance tax credit for children as an addition to the earned income tax credit (EITC). Advance payments of the health EITC proved error-prone, however, because recipients found it difficult to make a good forecast of earnings. Also, in response to the credit, some insurance companies marketed policies with very limited benefits to unsuspecting low-income families. The credit came to be viewed as unwieldy and subject to abuse and was repealed in 1993 (Burman 2001; Steuerle and Van de Water 2009).

When the Health Coverage Tax Credit (HCTC) for certain displaced workers was enacted in 2002, legislators and administrators aimed to avoid repeating the experience of the health EITC. The IRS determined that it was not equipped to determine eligibility or make monthly payments, so it turned to an outside contractor to handle those responsibilities. Because the HCTC does not vary with income or family status, taxpayers are less likely to receive excessive advance payments than was the case with the health EITC. Nonetheless, the process of applying for the HCTC is complicated and time-consuming. Applicants must deal with three or more public and private organizations to prove eligibility—as a dislocated worker, as meeting other requirements of the law, and as holding an appropriate health insurance policy. The procedures that have been put in place to provide advance funding, so that people can get the money they need to enroll in a health plan, have also proved to be very burdensome. Individuals are required to pay premiums in full before eligibility is determined and advance payment begins. Overall, the effort to avoid fraud and erroneous payments has resulted in a system with high compliance and administrative costs and low rates of participation (Bernstein 2009; Holtzblatt 2007a and 2008).

The earned income tax credit itself provides a variety of lessons for enforcement by tax authorities. Noncompliance with the EITC is fairly high, recently estimated to be between 27 and 32 percent. One major complication derives from determining in whose household or tax unit a child resides. There is also no reliable way of verifying a taxpayer's marital status. Although the EITC is available, at least in part, on an advance basis throughout the year, few employees take advantage of this option. One reason is that the amount of subsidy is generally unknown at the start of the year because the amount varies widely with moderate changes in income. Also, many families gain or lose members throughout the year due to marriage, divorce, and births; these changes also affect considerably the size of subsidy.

Both taxpayers and tax collectors benefit from modest amounts of over-withholding of income taxes during the year. Taxpayers prefer to avoid owing additional money when they file their annual returns. And the IRS has found that those who are over-withheld are more compliant than those who are under-withheld. Compliance is particularly low—often less than 50 percent—for taxes on income sources that are subject neither to tax withholding nor information reporting by third parties (Steuerle and Van de Water 2009).

An approach for administering subsidies that avoids end-of-year reconciliation is to condition eligibility for the subsidy, in most cases, on recent rather than current income. Switzerland, for

example, has had since 1996 a system of universal coverage that combines an individual mandate to obtain private health insurance with public subsidies for 30 percent of the population. Most eligible people receive their health insurance subsidy automatically, without need for an application, based on their taxable income in the year before last. The subsidies are paid directly to health insurers and are deducted from the premium owed by the individual (Steuerle and Van de Water 2009). Holtzblatt (2008) lists other tax provisions or proposals that have been based on prior-year characteristics, with taxpayer held harmless for changes in circumstances, but notes that this approach will add to costs.

Another major challenge of providing subsidies through the tax system is reaching people who would not otherwise file tax returns. For the most part, legitimate non-filers are low-income people with little or no attachment to the work force. Previous efforts to provide tax benefits to this group have proved less than fully successful. In 2007, the IRS created a special short form to allow non-filers to claim a rebate for telephone excise taxes, but the take-up rate was less than 2 percent (Holtzblatt 2008). In 2008, an estimated 20 million non-filers were eligible for an economic stimulus payment of $300 if they filed a simplified return, but 4.3 million of them had not yet filed as of early September, despite extensive outreach efforts (Center on Budget 2008).

Administering Subsidies through Spending Programs

The U.S. offers several examples of delivering health insurance subsidies through means-tested benefit programs. The largest is the complicated set of Medicare Savings Programs (MSP) that help low-income people pay for Medicare's premiums and cost-sharing for Parts A and B—the parts of Medicare that cover hospital and doctors' bills. Three separate programs provide varying degrees of assistance to people with income up to 135 percent of the federal poverty level and limited assets. Most Medicare beneficiaries also receive Social Security and have their Medicare premiums withheld from their monthly Social Security benefits. If they are found eligible for one of the Medicare Savings Programs, premiums are no longer withheld.

Some low-income people may apply for MSP benefits with the Social Security Administration (SSA), which also takes applications for Parts A and B of Medicare. Many others, however, must apply with their state Medicaid agencies. The asset test in the Medicare Savings programs has complicated the process. The burdensome application process has hampered outreach and contributed to low rates of participation. Recent legislation (Public Law 110-275, enacted on July 15, 2008) provides that, starting in 2010, anyone may apply for MSP benefits with SSA, which will transmit the data from the application to the state Medicaid agency. The asset test in the Medicare Savings Programs has also inhibited participation and complicated administration, since data on assets often are not readily available (Ebeler *et al.* 2006).

The low-income drug subsidy offers assistance with the premiums and cost sharing for Part D of Medicare—the prescription drug benefit—to people who have income up to 150 percent of poverty and meet the program's asset test. Its eligibility criteria and application process differ from those of the Medicare Savings Programs. The Social Security Administration does not take applications for Part D benefits, but it does handle applications and make eligibility determinations for the associated subsidy. SSA has designed an application process for the drug subsidy that is much less onerous than the one for the Medicare Savings Programs. Applications

may be submitted to SSA in person, by mail, or on line. Extensive documentation is not required. Income and resource amounts provided by beneficiaries are checked against SSA, IRS, and other governmental databases for accuracy; only if discrepancies arise must the applicant provide supporting documentation. SSA determines eligibility for the subsidy for the upcoming year using the most recent available data from the IRS. For example, in late 2009 SSA determines eligibility for the subsidy for 2010 using tax data for 2008. SSA generally reviews changes in income, resources, household composition, or other factors only once a year, thereby avoiding end-of-year reconciliation and overpayments. Thanks to these features, participation in the low-income drug subsidy is higher than in the Medicare savings programs—but still too low (Ebeler *et al.* 2006).

Simplified reporting requirements have also increased participation rates in the Food Stamp program. Eligibility for food stamps remains based on current circumstances, but program regulations now allow states to hold beneficiaries harmless for changes in income over six months. Previously, the burden of frequent reporting caused beneficiaries to drop out of the program (Holtzblatt 2007a). The reduction in reporting requirements has also contributed significantly to a reduction in Food Stamp error rates.

Other examples for administering subsidies are found among the growing number of state-based programs that help low-income people buy health insurance. The Massachusetts program is perhaps the most successful and instructive. The Commonwealth Care program, administered by the Commonwealth Connector, provides health insurance subsidies on a sliding scale to families with incomes up to 300 percent of poverty. The subsidies can be used only in conjunction with one of the health plans offered through Commonwealth Care. Enrollees have a choice of four private health insurance plans offered by the managed care organizations that participate in the Medicaid program. The subsidized plans all have low cost-sharing, and individuals with incomes less than 150 percent of poverty pay no premiums. By April 1, 2008, about l75,000 low-income adults had enrolled, exceeding estimates by more than 30,000 (Kaiser 2007 and 2008; Steuerle and Van de Water 2009).

Applicants for Commonwealth Care can apply on-line or by mail. The Connector contracts with MassHealth (the state Medicaid agency) to determine eligibility and with a private firm to handle enrollment and billing. One application is used for Commonwealth Care, MassHealth (Medicaid), and certain other health programs. Applicants must respond to all requests for verification from MassHealth. Those who are approved for enrollment in Commonwealth Care must choose a health plan and a primary care provider. Approved individuals with incomes up to 100 percent of poverty must choose a plan within 14 days; otherwise, the Connector will assign them to a health plan and primary care provider. For those who are required to pay premiums, enrollment does not start until they have paid their first month's premium. After that, premiums must be paid on a monthly basis. Someone who does not pay his or premium for two months is disenrolled from Commonwealth Care, but few members have been disenrolled for failure to pay premiums (Connector 2007; Day 2008).

Subsidizing High Risks or Small Businesses

The previous discussion has focused on arrangements for directly subsidizing the health insurance of low-income people, but other subsidy proposals raise other administrative issues. High-risk pools and public reinsurance are two means of increasing access to health insurance for people who, because of their poor health status, would otherwise be unable to obtain private insurance or would face very high premiums. Subsidies could also be directed to small employers.

Guaranteed issue (requiring insurers to offer coverage) and rate compression (limiting the extent to which premiums can vary based on the characteristics of an individual or group) provide a way of making coverage available and more affordable to people who are considered high-risk for health spending. Massachusetts, for example, provides for guaranteed issue in the merged individual and small-group health insurance market and allows insurers to vary rates based only on age, place of residence, and a few other specified factors. Massachusetts is able to impose these requirements on insurers because it mandates individuals to obtain health insurance and thereby prevents low-risk people from opting out of the insurance pool.

High-risk pools are a way of subsidizing those who are likely to incur above-average health-care costs in the absence of guaranteed issue and limits on rates. They offer people with high expected costs health insurance coverage through a separate risk pool composed only of high-risk people. The premium in the pool exceeds what the average person would pay for comparable coverage (typically 125 percent to 200 percent of the standard rate) but falls short of the full expected cost. The difference represents a subsidy that has to be funded from tax revenues or some other source (Wicks 2009). Thirty-three states have high-risk pools, but only three cover more than 1 percent of those with individual health insurance (Swartz 2006).

Implementing a high-risk pool raises several administrative issues. Some entity must determine who is eligible for the pool by verifying that the person has no other coverage available, has been denied coverage, or can only find coverage that excludes some health condition or is too expensive. The pool must carry out all of the functions that insurers normally perform, such as enrollment and disenrollment, collecting premiums, verifying and paying claims, and case management. If several insurers participate in the pool, people must be provided the means to make an informed choice among insurance plans and to transfer from one plan to another. Limits on coverage of preexisting conditions, if any, must be enforced. And mechanisms must be established to set premiums and assure adequate funding to subsidize the pool (Wicks 2009).

Another way of reducing health insurance premiums is to subsidize insurers through publicly funded reinsurance of high-cost cases. "The basic idea is simple," Wicks says, "if insurers were given a guarantee that claims costs in excess of some specified amount would be subsidized by government, they could be expected to lower premiums by approximately the amount of the subsidy." Public reinsurance has two goals: to make insurance less expensive for consumers, and to make insurers less reluctant to insure higher-risk individuals or groups. The cost of the reinsurance program could be reduced and its efficiency increased by limiting it to groups that face the greatest difficulty in obtaining coverage, such as participants in the individual or small-employer markets (Wicks 2009). Through retrospective sharing of risks, reinsurance can also

make up for limitations in systems of prospective risk adjustment and discourage efforts at risk selection by insurers (van de Ven 2008).

Perhaps the biggest administrative challenge facing a system of public reinsurance is determining that individuals' health costs are high because they are unusually sick and not because their insurance is particularly comprehensive. Reinsurance therefore works best if it applies to a single standardized benefit package, or a small number of standard packages. The reinsurance system must also be designed so that insurers continue to bear some of the risk of high-cost cases and thereby still have an incentive to contain the costs of expensive episodes of illness. The administrator of the program would need access to claims data in the relevant insurance market and authority to audit the cost of claims that exceed the threshold for reinsurance. These administrative activities could be carried out by a new or existing government agency or an experienced private vendor (Wicks 2009; Swartz 2006).

Subsidies for small businesses may be intended to compensate their employees for the lack of access to larger health insurance purchasing pools or to offset the higher administrative costs of insurance purchased in the small-group market. Typical proposals envision that these subsidies would be provided through the tax system. "The challenge," Holtzblatt says, "is defining small businesses in a manner that is consistent with both tax policy and health reform goals." There is no commonly accepted definition of small business in federal government programs, however, and the Internal Revenue Service does not currently have the information to target subsidies based on the size of a firm's workforce or its average wage. One alternative would be to base a subsidy for small businesses on a firm's gross receipts rather than its number of employees. A second would be to have an agency other than IRS administer the subsidy (Holtzblatt 2008). More important, employer subsidies are difficult to target effectively and do not eliminate the need for individual subsidies, since not all uninsured people have a connection to the labor force (Blumberg and Holahan 2008).

Findings and Recommendations

Proper design of a program to subsidize health coverage can facilitate smooth administration, which will in turn make the subsidy program more effective in reaching its target population. Regardless of whether subsidies are provided through the tax system or a spending program, many of the same issues arise. Providing health subsidies through the tax system faces challenges such as reaching current non-filers and distributing subsidies in a timely fashion, but other agencies would face other challenges, such as obtaining access to detailed income information about taxpayers.

2.1. Whether health insurance subsidies are administered through the tax system or a spending program, an emphasis should be placed on simplicity. Simplifying eligibility rules and program design will make it easier for eligible individuals to understand and claim benefits, reduce incentives for noncompliance, and facilitate the implementation of automatic enrollment programs. This principle has a number of corollaries listed below.

2.2. Eligibility criteria for subsidies should be easily enforceable and designed not to create incentives for abuse, thus raising either error rates or enforcement budgets. Subsidy systems should move toward determining eligibility based on information that is accessible to the administering agency, either directly or indirectly from another agency, rather than information provided by applicants. Data on assets are not readily available, for example, and asset tests have proved to be difficult to administer and to discourage program participation.

2.3. Administration can be simplified if subsidies are provided through a health insurance exchange offering insurance plans with comprehensive, standardized benefits. Limiting the number of plans eligible for a subsidy in this way would facilitate both verification of enrollment and payment of the subsidy or tax credit. The exchange would determine eligibility for the subsidy or tax credit, so that receipt of the subsidy would not require filing a tax return. The exchange would deliver the subsidy or credit directly to the insurer, and eligible individuals would pay their share of the premium, net of the credit.

2.4. The subsidy system should be designed to assure eligibility before making payments and to avoid the need for end-of-year reconciliation or recovery of overpayments. In both the tax and benefit systems, recovering overpayments is difficult for individuals and agencies alike. Thus, payment of a subsidy (including advance payment of a tax credit) ideally should not be made unless eligibility for the payment is guaranteed at the same time. This process requires up-front verification of income, family status, and the purchase of health insurance that is eligible for the subsidy. Recipients of the subsidy should be held harmless for changes in circumstances for a period of time and within specified limits.

CHAPTER 3: ADMINISTERING HEALTH INSURANCE MANDATES

Many proposals for expanding health insurance coverage contain mandates that would require individuals to buy health insurance. Other proposals would impose requirements on employers to provide or pay for coverage in addition to or instead of an individual mandate. Whether the mandate is imposed on the individual or on the employer, the economic incidence is much the same; the individual is likely to end up paying either way, at least in the long run. But individual and employer mandates differ significantly in the administrative issues they raise and how people may respond to alternative administrative structures.

Mandates to purchase health insurance have a firm grounding in social insurance principles of risk sharing and sound financing. They attempt to prevent people from being "free riders" who depend upon others to support the insurance, often implicit and insufficient, they receive from society. They also aim to assure that everyone who is in good health shares in helping those who face large health-care costs (Van de Water 2008).

Requiring everyone to have health insurance coverage makes it possible to restrict the ability of insurers to vary rates based on the characteristics of insured individuals or groups. Under a mandate, low-risk individuals cannot drop health insurance coverage, which creates adverse selection when the purchase of insurance is voluntary. Excluding pre-existing conditions or imposing waiting periods becomes unnecessary, since everyone has continuous coverage, and community rating becomes practical (Wicks 2009).

Although well grounded in principle, mandates confront important administrative challenges. Most important, an individual mandate to purchase health insurance requires that insurance be available and affordable. Mandates therefore must be combined with other provisions, such as the creation of health insurance purchasing pools, regulation of insurance policies and rates, and provision of premium subsidies. How well an individual mandate will work will ultimately depend on these other critical provisions. In particular, given the long history of less than full participation in means-tested benefit programs, administration of mandates and subsidies need to be carefully coordinated.

Any employer or individual mandate must specify the nature and size of the health insurance policy that must be purchased, either by listing specific benefits or establishing a required actuarial value. The more extensive the requirements, the greater will be the cost of the required insurance, and the greater the burden of the mandate. It is also necessary to develop procedures for enforcing the mandate, identify a responsible administrative agency, and establish penalties for noncompliance. Although a mandate does not have to be perfectly enforced, it needs to be enforced well enough that it appears to be fair and maintains the confidence of the public.

This chapter identifies ways to structure health insurance mandates, if adopted at the federal level, so that they are likely to be administered fairly and effectively. It draws on information about the administrative arrangements used for existing health insurance mandates in Hawaii, Massachusetts, the Netherlands, and Switzerland and for other types of mandates. The

background paper on mandates prepared for the study panel provides further details (Steuerle and Van de Water 2009).

Employer Mandates

Employer mandates can take one of two forms. In one, employers must provide most employees (and, possibly, their dependents) with health insurance meeting certain requirements and must make a prescribed contribution to that insurance. In another, often called play-or-pay, employers have the option of paying a tax instead of providing health insurance coverage. To enforce such a requirement, employers could be required to provide information about the size of its workforce, the kind of health coverage provided, the employees covered or not covered, and the payment required if coverage was not provided. Although these requirements could be administered by the Internal Revenue Service or another agency, the payment option would most likely have to be enforced by the IRS. The IRS would also need to take steps to prevent employers from misclassifying employees as leased workers or independent contractors (Hevener and Kirby 2008).

Employer mandates may, but need not, exempt small business. The extent of the required contribution may also vary by firm size or by a firm's average wage. Small business exceptions raise additional administrative issues because they create incentives to structure business activities to avoid or minimize the mandate. The fact that families often have more than one potential source of insurance coverage—through multiple wage-earners, multiple jobs, and access to public programs—may also complicate administration of an employer mandate. Various rough-and-ready approaches are available to deal with these complications, but at some cost in equity or efficiency.

Any plan that includes an employer mandate must make provision for noncompliance. Firms are already subject to a wide range of federal, state, and local requirements relating to wages and hours, unemployment compensation, workers' compensation, tax withholding, workplace health and safety, environmental protection, and more. Lack of compliance with a mandate to provide health insurance is likely to be concentrated among firms who fail to comply with existing requirements. For example, agricultural businesses have a poor record of compliance with the requirement to report an employee's taxable earnings using the correct Social Security number, and garment makers have a low rate of compliance with the minimum wage. Some of these same firms might also fail to provide required health insurance to their workers.

In the United States, only Hawaii and Massachusetts currently impose mandates on employers to provide or pay for health insurance, although employer mandates have been proposed in other states and at the federal level. The limited use of employer mandates is partly a consequence of the federal Employee Retirement Income Security Act (ERISA) of 1974, which frees self-insured employment-based health plans from state regulation. ERISA prevents states from requiring employers to provide health coverage or to spend any particular amount on health coverage (Jost 2009). Hawaii has a limited exemption from ERISA, but other states do not. Hawaii and Massachusetts illustrate the two types of employer mandates.

Since 1975, Hawaii's Prepaid Health Care Act has required nearly all employers to provide health insurance to employees who work 20 hours or more a week for four consecutive weeks. All plans must be approved by the state's Department of Labor and Industrial Relations (DLIR) as meeting prescribed minimum standards. Employers must pay at least half the premium, but the employee's contribution cannot exceed 1.5 percent of wages. Employees may claim an exemption if they have other health coverage, and an employee with two or more employers must designate a principal employer. The Disability Compensation Division of DLIR, which also administers workers' compensation, enforces the mandate by responding to complaints and conducting compliance visits with randomly selected employers. Although no data are available on the rate of compliance, the mandate appears to be effective in expanding health coverage. After the Prepaid Health Care Act became law, the rate of uninsurance in Hawaii dropped from 30 percent to perhaps as low as 5 percent. In 2007, according to the Census Bureau (2008), it was 7.5 percent—the second lowest rate in the Nation.

The employer mandates in Massachusetts are less far-reaching than in Hawaii, because Massachusetts does not have an exemption from ERISA. By the same token, Massachusetts relies more than Hawaii on other mechanisms, notably an individual mandate. Under the reforms that became effective in 2007, Massachusetts firms with 11 or more full-time equivalent (FTE) employees must make a "fair and reasonable" premium contribution toward health insurance for their employees or pay the state a Fair Share Contribution of up to $295 annually per employee. Starting in January 2009, an employer with more than 50 FTEs will be exempt from the Fair Share Contribution only if at least 25 percent of its full-time employees are enrolled in the employer's health insurance plan and the employer offers to pay at least 33 percent of the premium for individual coverage, or if at least 75 percent of its full-time employees are enrolled in the employer's plan. Firms must also offer a cafeteria plan meeting federal requirements (under section 125) that allows employees to pay for health insurance coverage on a pre-tax basis. Firms that do not comply are subject to a Free Rider Surcharge, effectively charging them for part of the care used by their employees or dependents that is financed by the state's Health Safety Net Fund.

Massachusetts employers with 11 or more FTEs (equivalent to 22,000 payroll hours) must submit a Fair Share Contribution Report on-line to the state's Division of Unemployment Assistance. This report also includes an employer Health Insurance Responsibility Disclosure report providing information about firms' section 125 plans. Starting in 2009, employers must file the disclosure form and pay any required assessment on a quarterly basis. Although the state currently does not collect information about the number of FTEs at each business, it reviews Unemployment Insurance data to identify employers who have a possibility of reaching the 11-FTE threshold. The latest data from the Census Bureau (2008) show an increase in the percentage of the population in Massachusetts with employer-sponsored health insurance.

Individual Mandates

Massachusetts illustrates a recent effort to administer an individual mandate in the context of comprehensive health financing reform. The Massachusetts mandate requires everyone age 18 and over to have "minimum creditable coverage," as defined by the Connector, as long as it is considered affordable under a schedule set by the Connector. The mandate is enforced by the

Massachusetts Department of Revenue through the process of collecting state personal income taxes. Individuals must provide information about their health insurance status on a schedule accompanying the personal income tax form. In 2007 individuals who did not obtain insurance, and who were not exempt, lost their state personal income tax exemption. Of 3.3 million taxpayers, 168,000 (5 percent) were uninsured, and 97,000 (3 percent) were deemed able to afford insurance. In 2008 and thereafter, uninsured adults must pay a monthly fine equal to half of the cost of the most affordable health plan available to them.

Various third parties are required to report information that helps enforce the individual mandate. Employers must collect an Employee Health Insurance Responsibility Disclosure Form from an employee who declines to use a section 125 plan or enroll in employer-sponsored health insurance. Insurance carriers and Medicaid must provide the state's Division of Insurance with a monthly list of residents for whom they provide creditable coverage. And hospitals must report the names and addresses of employers whose employees receive free care.

Additional guidance for administering individual mandates may be found in the experience of Switzerland and the Netherlands. Both countries have achieved coverage rates of 98 to 99 percent, but in both cases coverage was almost as high under the mixed public-private arrangement that existed before the imposition of an individual mandate. In addition, their political and cultural institutions differ from those of the U.S. in major respects.

In Switzerland, for example, every resident must register his or her presence with the local population control office shortly after taking up a new place of residence. The enforcement of the health insurance mandate by Swiss cantons (states) builds on this pre-existing registration requirement, which is absent in the U.S. If someone doesn't sign up for insurance or pay the premium, an employee of the canton or commune is likely to knock on his or her door to obtain compliance.

In the Netherlands, two features hold down the level of premiums and thereby facilitate compliance with the mandate. Half of the cost of insurance is paid for by an income-related tax, so that the premium covers—at most—the remaining half. Moreover, 40 percent of the population is eligible for a premium subsidy. Even so, an estimated 1.5 percent of the legal population is estimated to be uninsured, and a similar number of people are delinquent in the payment of premiums. Since the architects of the Dutch mandate did not envision any problem with noncompliance, the initial legislation created few effective sanctions if a person does not take out insurance or pay premiums, and the Dutch government had to take steps later to develop enforcement mechanisms.

Both opponents and proponents of an individual health insurance mandate cite the experience with automobile insurance to bolster their cause. Opponents argue that requiring motorists to purchase insurance coverage has been ineffective at reducing the number of uninsured motorists, which ranges from 4 to 6 percent in several New England states to 25 or 26 percent in Mississippi, Alabama, and California. Proponents contend that recent efforts in some states show how data matching and information technology can be used successfully to crack down on uninsured motorists—and, by extension, to enforce an individual health insurance mandate.

The government's experience in collecting debts also carries lessons for the enforcement of individual mandates. Despite the use of increasingly aggressive debt collection tools, for example, the amount of the Social Security Administration's delinquent debt has increased by more than half in the last four years. The agency finds it relatively easy to collect overpayments when the debtor is still eligible for monthly benefits; in such cases, the overpayment is gradually recovered through the reduction of subsequent monthly payments. When the debtor is no longer on the benefit rolls, however, debt recovery is more difficult.

Tax officials also rely, where possible, on receiving payments over the course of the year so that fewer liabilities are owed with year-end filing. The IRS estimates that when there is withholding on wages, there is almost 99 percent compliance with the tax laws. With information reporting from third parties (for example, banks reporting interest payments) but no withholding, compliance is on the order of 95 percent. Finally, where there is neither information reporting nor withholding, compliance is often less than 50 percent.

Automatic Enrollment

In recent years, behavioral economists have become increasingly aware of the power of inertia in individual behavior and have developed innovative approaches to harness that inertia in beneficial ways. They have found, for example, that more people contribute to retirement savings plans if they are enrolled automatically at work (but can opt out) than if they must take active steps to enroll.

This same approach—termed "automatic enrollment" or "default enrollment"—could be employed as a backstop, or as an alternative, to a mandate. In Switzerland, for example, cantons (states) automatically enroll in a private health plan everyone who fails to comply with the individual mandate. In this case, the insured person does not have a choice of an insurer; he or she is billed by the insurance plan and is liable for payment of the premium. In the U.S., enrollment in Medicare's Supplementary Medical Insurance (SMI) is voluntary, but nearly universal, because applicants for Hospital Insurance are enrolled automatically in SMI unless they opt out. At the start of Medicare Part D in January 2006, beneficiaries dually eligible for Medicare and Medicaid were automatically enrolled in a low-cost prescription drug plan, although they could still select a plan of their own choosing. In addition, many low-income people were automatically enrolled in the low-income prescription drug subsidy.

As part of a plan for expanding health coverage, those without insurance could be automatically enrolled either in a private plan available through an insurance exchange (as in Switzerland) or in an existing or new public program (as in SMI or as proposed by Jacob Hacker [2007]). Either way, enrolling people automatically in a health plan would encounter some of the same administrative issues as enforcing an individual mandate. Automatic enrollment might prove more successful in the end, however, if it were viewed as simpler and less punitive than an individual mandate.

Findings and Recommendations

Either an employer or individual mandate would necessitate the creation of new administrative mechanisms and the imposition of new reporting requirements on individuals, employers, and health insurers. Many proposals envision that the Internal Revenue Service would play a major role in enforcing a mandate, although the IRS has heretofore devoted little attention to monitoring requirements on health plans, and the agency's administrative resources are already stretched thin.

Mandates can be administered effectively if not too much is demanded of them—that is, if the cost of the required insurance is not too high in relation to income, and if the size of the related penalty is not so high that compliance and enforcement are threatened. Since compliance with a mandate will never be complete, plans that rely on mandates to expand coverage will continue to face issues of providing health care for those without insurance, albeit at a much reduced level.

3.1. Emphasis should be placed on encouraging compliance with a mandate rather than penalizing noncompliance. An individual mandate to purchase health insurance presumes that those affected can purchase insurance at an affordable price. The lower the insurance premium relative to income, the easier it will be to get people to comply with a mandate. Thus, achieving compliance with a mandate runs in parallel with efforts to make it easy for people to enroll for insurance and obtain available subsidies. Administration of a mandate must therefore be coordinated with premium subsidies and other public programs, including Medicaid and the Children's Health Insurance Program (CHIP). Regular information reporting from health insurers will also be required, as in Massachusetts, and the enforcing agency must make prompt use of the information to assure that people do not go for long periods without health coverage.

Government agencies encounter significant problems collecting debts from those with liabilities that are large relative to their income. Many households have little or no savings from which to draw. By the time a person has gone months without insurance, or has incurred uninsured medical bills, the prospect of recovering back premiums and charges, let alone penalties, is likely to be remote. Similarly, it seems infeasible to enforce a mandate by hitting uninsured people with large costs when they need care. Every effort should therefore be made to assure that required insurance payments are made on a regular basis. For many people, this will likely mean collecting payments through withholding by employers.

3.2. Penalties for noncompliance with a mandate should be moderate and collectable. Penalties are likely to be ineffective if they are set so high that few can pay. Fortunately, many people hate paying penalties, not matter how small, and the incentive effect of a mandate may exceed the size of the penalty imposed for not buying insurance. Thus, a mandate can be used as a tool for achieving more universal coverage, even though administrative considerations prevent assessing a large penalty for noncompliance. Among the more administrable types of arrangements are denying tax benefits or government transfer payments to individuals who do not buy insurance and a play-or-pay mandate that requires employers to pay a contribution or tax when they do not pay toward an employee's insurance.

CHAPTER 4: REGULATING HEALTH INSURANCE

Health insurance poses the same regulatory issues as other types of insurance, plus several additional ones as well. The insured individual depends on the insurance company to offer a contract that meets reasonable expectations about coverage, to explain the nature of the product being offered, and to pay claims promptly and fairly. Insurers carefully assess the risks they insure, denying coverage in some instances or charging higher rates in others. Disputes about payments are not uncommon, because it is extremely difficult to specify fully the coverage of a health insurance contract, and relying on litigation alone is unlikely to provide sufficient protection for insured. Moreover, as in other lines of business, some insurers or agents attempt outright fraud in marketing or claims processing. To protect consumers, state governments have long regulated the issuance of insurance products, including health insurance. In recent years, the federal government has also become steadily more involved in health care financing and insurance. (Unless otherwise indicated, most of the material in this chapter derives from the background paper on the regulation of health insurance prepared for the study panel by Timothy Stoltzfus Jost [2009].)

State Regulation of Health Insurance

By the time health insurance became common in the 1930s, the authority of the states to regulate insurance was well established. In 1945, in response to a Supreme Court decision that insurers were engaged in interstate commerce and thus subject to federal control, the Congress passed the McCarran-Ferguson Act, which allows the states to regulate the "business of insurance" except where federal law explicitly provides otherwise. Subsequent expansion of the federal role in regulating health insurance, notably through the Employee Retirement Income Security Act (ERISA) of 1974, is discussed below.

A division of insurance or similar agency in each state regulates the insurance industry. The National Association of Insurance Commissioners (NAIC) helps coordinate the regulation of multistate insurers. NAIC's model laws and regulations often serve as the basis for state policies and help bring some degree of uniformity to insurance regulation, although state adoption is voluntary and uneven. States also impose premium taxes on commercial insurers, which serve as a significant source of revenue.

The initial focus of health insurance regulation was assuring the financial responsibility of insurance companies to pay benefits. The federal bankruptcy code excludes insurance companies from its coverage and leaves the matter of assuring insurer solvency to the states. States have established procedures to manage insolvent insurers and cover their financial obligations. Other traditional regulatory concerns include prohibiting deceptive marketing and advertising, investigating consumer complaints, reviewing health insurance policies and (sometimes) rates, and coordinating coverage when more than one policy covers the same risk. Beginning in the 1950s, a number of states limited the ability of insurers to cancel or not renew health insurance policies. In the 1970s, state coverage mandates—requirements that health insurers cover specific persons, services (such as mammograms), or providers (such as chiropractors)—became much more common.

States differentiate in their health insurance regulation between large groups (usually more than 50 members), small groups (3 to 50 members), and the nongroup market (individuals and families). Small groups present insurers with a substantial threat of adverse selection, and problems are even greater in the individual market. Insurers therefore underwrite small groups and individuals carefully—denying, cancelling, or not renewing coverage for high-risk groups; imposing waiting periods; excluding preexisting conditions; increasing rates if a group's risk profile deteriorates; and adding a cushion to premiums to protect against higher-than-expected costs. These administrative activities, as well as marketing and other expenses, make the cost of small-group and individual health insurance policies higher than for large groups.

Starting around 1990, states began to enact reforms of the small-group health insurance market. Common reforms included guaranteed issue and guaranteed renewal of policies irrespective of a person's health status, limitations on exclusions of preexisting health conditions, and rate compression requirements aimed at limiting the variation in insurance premiums. To enforce limits on rates, state regulators must be able to review insurance policies and premium schedules to ensure that they are in compliance. Their administrative task is easiest if no variation at all is allowed in rates. Assuring compliance is most difficult if rating differences are allowed for a multiplicity of individual factors, such as health status, age, gender, geography, industry, or health-related behaviors. The administrative burden can be simplified through setting an overall limit on the amount by which premiums can vary based on all rating factors taken in combination (Wicks 2009).

Some states have attempted to broaden risk pooling in the small-group market through voluntary or mandatory risk pools, reinsurance programs for high-cost insureds, or purchasing cooperatives. Many states have also adopted reforms of the individual health insurance market, but these reforms are generally less extensive and demanding than in the small-group market. Two-thirds of the states have established subsidized high-risk pools for individuals who have been denied coverage in the regular market, but premiums in these pools are still quite high, and enrollment is generally low.

Managed care has been another new target of state legislative and regulatory activity. By the late 1990s many states had adopted comprehensive reforms that addressed many aspects of managed care plans. Virtually all states now require external review of managed care claims denials. Other common provisions include assuring direct access of members to certain specialists, limiting incentive arrangements for participating providers, and protecting the interests of providers in disputes with plans.

In the past few years, states have taken deregulatory actions to facilitate the spread of high-deductible health insurance plans. The Medicare Modernization Act of 2003 authorized tax subsidies for health savings accounts (HSAs) coupled with high-deductible health plans. The law did not preempt any state insurance regulation, but it did provide that the tax subsidies for HSAs would be available only in states that allowed high-deductible plans. "Most states rapidly fell into line," Jost (2009) reports, "repealing legislation inconsistent with the federal requirements." The full regulatory implications of high-deductible health plans and HSAs, however, are not yet clear.

Federal Regulation of Health Insurance

Although regulation of insurance is traditionally a responsibility of the states, the federal government's role has grown in recent years. Much of this federal regulation is carried out through the income tax system and the Medicare and Medicaid programs.

The Internal Revenue Code of 1954 confirmed earlier administrative rulings that employer contributions to employer-sponsored health insurance plans are taxable neither to the employer nor the employee. This tax subsidy has come to be conditioned on various legislated requirements, but the Internal Revenue Service provides little oversight and has generally been slow to develop implementing regulations or enforce tax penalties for violations. For example, nondiscrimination provisions of the tax code prohibit self-insured employers from offering better tax-favored health coverage to highly compensated employees. The IRS has never been known to have audited a company for discrimination in health benefits, however, and has done little to challenge the misclassification of employees as contract workers (Hevener and Kirby 2008). Federal income tax subsidies for nonprofit hospitals that provide public benefits have also operated with little IRS supervision.

Medicare and Medicaid now cover about a quarter of Americans and a third of health care costs. The rules governing coverage and payments for these programs constitute a major form of federal regulatory activity. Failing to comply with the program's rules or conditions generally results in denial of eligibility or payment, although submitting false claims can lead to civil or criminal penalties. Moreover, as the largest U.S. purchaser and regulator of health care, Medicare exerts a major influence on the rest of the health care system. Medicare's payment and coverage policies have been widely adopted by private insurers and other public programs. For example, many private insurers follow Medicare's lead in approving coverage of new medical technologies. Over the years, the private sector has also typically followed Medicare's lead in adopting new payment mechanisms — including the prospective payment system for hospitals and fee schedule for physicians. Medicare also influences the provision of care through its conditions of participation for hospitals and health plans, reporting requirements, claims review practices, and other administrative procedures.

Federal law generally preempts state laws that conflict with Medicare's requirements, notably state regulation of private health plans that participate in Medicare. States can license and regulate the insurance agents and brokers that sell these private plans, but they generally cannot regulate the companies that offer the plans. In contrast, federal requirements for Medicaid managed care organizations do not preempt more stringent state standards.

The Medicare Modernization Act of 2003 expanded the role of private health plans in Medicare while at the same time broadening the federal preemption of state regulation of these plans. In response to concerns about marketing and sales abuses in Medicare Advantage (MA) plans and Medicare prescription drug plans (PDPs), the Medicare Improvements for Patients and Providers Act of 2008 bans or limits certain sales and marketing activities under MA plans and PDPs and requires that insurance companies appoint agents and brokers in accordance with state law. State regulators continue to believe that the current federal regulatory structure for Medicare private

plans does not adequately protect consumers and have called for authority to enforce state laws on marketing practices of insurance companies that sponsor them (NAIC 2008).

In contrast to the regulation of private plans that participate in Medicare, both federal and state governments regulate Medicare supplemental insurance (Medigap) plans—the private insurance plans offered to Medicare beneficiaries that cover expenses not paid by Medicare. As provided by federal law, NAIC has worked with interested groups to establish a model regulation that includes standardized benefit designs and marketing and sales standards for all Medigap plans, and the Centers for Medicare & Medicaid Services (CMS) has incorporated the NAIC model in federal regulation. States that adopt the federal Medigap standards can then enforce them against the plans. States can also impose more stringent standards in certain cases (NAIC 2008).

Federal law governs responsibility for paying for medical services that are potentially covered both by Medicare and some other insurance. Since 1980, Congress has passed laws making payment by Medicare secondary to payment by employer-sponsored health insurance plans in a number of situations. The legislation imposes an excise tax for operating a plan that violates the rules. Although CMS has been vigorous in collecting insurance payments that are owed under the Medicare secondary-payer rules, the IRS has apparently not created any procedures for imposing the excise tax (Hevener and Kirby 2008).

The Employer Retirement Income Security Act of 1974 constitutes the federal government's most significant limitation on state regulation of health insurance. ERISA supersedes most state laws applicable to employment-based health plans subject to the federal statute (ERISA does not apply to church or governmental plans). ERISA's preemption of state regulation permits multi-state employers to offer health benefits on a national basis without having to adapt their plans to each state in which they operate. An employer can avoid any state regulation or taxation of its health plan if it assumes the plan's financial risk and does not purchase insurance to cover the funding of the benefits. In particular, it avoids state mandated benefits.

When ERISA was enacted in 1974, it dealt primarily with pension plans and imposed no requirements on employment-based health insurance. Since then, the Congress has added relatively few requirements. "Because ERISA preempts state law, but does not impose much in the way of substantive regulation," David Hyman concludes, "this framework means that self-funded employers have operated in a virtual regulatory vacuum" (Hyman 2008).

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 amended ERISA to allow for continuation in certain cases of employer-sponsored coverage that would otherwise be terminated. COBRA requires that employers with 20 or more employees that provide employer-sponsored insurance offer access to continuing health insurance temporarily to some who have left employment or who otherwise have lost coverage, if the beneficiaries pay 102 percent of the premium. Responsibility for administering COBRA is shared by three federal agencies—the Employee Benefits Security Administration in the Department of Labor (for notification rights for private-sector employees), the Centers for Medicare & Medicaid Services in the Department of Health and Human Services (for state and local government workers), and the Internal Revenue Service in the Department of the Treasury (for other enforcement). Most employer compliance with COBRA is prompted by the efforts of the Department of Labor and the risk of

lawsuits brought by participants under ERISA. The IRS is authorized to impose excise taxes on employers to enforce compliance, but it is not known to have done so (Hevener and Kirby 2008).

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 prohibits employment-based group health plans from discriminating in enrollment or premiums on the basis of health status, limits the exclusion of coverage for pre-existing health conditions, and requires special enrollment opportunities when certain events occur. HIPAA requires health insurance issuers to make health coverage available and renewable for small employers, although it does not limit the price that can be charged. It also requires insurers operating in the individual market to guarantee renewal of coverage except under limited circumstances. Administrative responsibility is dispersed. The Department of Labor enforces the requirements of HIPAA under ERISA for employer-sponsored group health plans. As with COBRA, the Department of the Treasury also has the authority to impose an excise tax to enforce compliance. States are generally responsible for enforcing the requirements imposed on health insurance issuers in the small-group and individual markets, although the federal government had to enforce HIPAA for a while in three states that did not enact implementing legislation in a timely fashion (Pollitz *et al.* 2009). States may impose stricter requirements on health insurance issuers in certain cases (U.S. Department of Labor 2008).

A few other federal laws also regulate health insurance. For example, the Congress has adopted coverage mandates relating to hospital stays for childbirth, breast reconstruction, and mental health services. Employers must generally offer the same health insurance coverage or coverage of the same value to all employees regardless of age, and employee benefit programs are required to cover pregnancy and childbirth related services. The Emergency Economic Stabilization Act (Public Law 110-343), enacted in October 2008, requires that the financial requirements and treatment limitations for mental health benefits be comparable to those for other medical services, although it does not require coverage of mental health conditions.

Findings and Recommendations

"However one judges the effectiveness of health insurance regulation to date," writes Jost (2009), "it is difficult to imagine a reformed health care system without health insurance regulation." Proposals to subsidize or mandate insurance must define the insurance coverage to be subsidized or mandated and establish procedures for assuring that plans comply with the requirements. A program based on subsidies for private health insurance will need regulation of risk underwriting and premium rating, risk adjustment of payments to insurers, and possibly some form of reinsurance. Insurer financial responsibility requirements and consumer protections against fraudulent marketing practices and denial of benefits will continue to be necessary as well.

Although the appropriate content of health insurance regulation is largely a policy question, the enforcement of whatever regulatory standards are established is an important administrative issue. As the foregoing discussion has shown, no significant administrative structure now exists at the federal level for regulating health insurance. In contrast, states have considerable regulatory experience and expertise. If health insurance reform is to take place at the federal level, several regulatory approaches are possible. The federal government could adopt its own

health insurance regulations and create an administrative apparatus to enforce them, or it could offer financial incentives to the states to take regulatory and enforcement actions, but it cannot constitutionally require states to enforce federal laws (Jost 2009).

4.1. The federal government should take advantage of the regulatory expertise and administrative mechanisms for protecting consumers that already exist in state governments. One approach would be to develop uniform national standards for health insurance enforced primarily at the state level. States could be given authority to enforce the national standards against all health plans in the state, including ERISA plans. States would not have to enforce the national standards, but only in states that did so would residents be eligible for federal tax benefits or other federal subsidies for health insurance, as is now the case for federal tax subsidies for health savings accounts. States could be permitted to establish standards that were more protective of their residents, as is allowed for Medigap plans.

The role of states in protecting health insurance consumers is likely to become more complex in a national system that expands access to health insurance coverage. Some proposals would shift this responsibility from state insurance departments to a health insurance purchasing exchange. Wherever regulatory arrangements are established, federal policymakers should recognize the variation in the resources and capabilities from state to state and should ensure that states have the necessary tools and resources to enforce new requirements on health insurers (GAO 1994).

CHAPTER 5: RESTRUCTURING HEALTH INSURANCE MARKETS

Many proposals would have the federal government create state, regional, or national bodies that would allow participants to select from a menu of competing health insurance plans (for example, Emanuel and Fuchs 2007; Gruber 2008; Hacker 2007; Lambrew, Podesta, and Shaw 2005; Nichols 2007; and Wyden and Bennett 2007). These entities go by various names—health insurance purchasing cooperatives, alliances, health marts, health help agencies, connectors, portals, gateways, or exchanges—and aim to increase the affordability, availability, and portability of insurance coverage.

A health insurance exchange is intended to provide a framework for the health insurance marketplace. Following guidance established in law, the exchange would specify the benefit packages to be offered to consumers, secure the participation of health insurance plans, collect premiums from participating individuals and employers, make risk-adjusted payments to insurers, and generally oversee the operation of the market. This chapter explores the administrative issues that would arise with a national health insurance purchasing exchange or a nation-wide system of state or regional exchanges.

In some proposals, participants in a health insurance exchange would be offered the opportunity to choose from a public-plan option as well as a range of private health insurance plans. The second section of this chapter examines the issues involved in designing a mixed system in which both public and private insurance plans compete on largely equal terms. The third section considers the relationship of Medicaid and the Children's Health Insurance Program to a new health insurance exchange.

Establishing a Health Insurance Exchange

The Commonwealth Connector in Massachusetts and the Federal Employees Health Benefits Program (FEHBP) provide two examples of how an insurance exchange can work, and Medicare offers some lessons as well. The Connector operates two distinct programs with separate insurance products: Commonwealth Care, which offers subsidized insurance to people with incomes up to 300 percent of poverty (as described in Chapter 2), and Commonwealth Choice, which offers individuals and small businesses a range of unsubsidized products.

Commonwealth Choice offers three tiers of plans (named gold, silver, and bronze), which differ with respect to their cost-sharing and restrictions on choice of provider. Benefits in the bronze tier are similar to the requirements for minimum creditable coverage under the state's individual mandate. In addition, a special young adult plan is available to people between the ages of 19 and 26 who do not have access to employer-sponsored insurance. Currently, six of the state's major insurers offer Commonwealth Choice plans.

Commonwealth Choice operates within Massachusetts' newly merged small-group and individual health insurance market, with its requirements for guaranteed issue and modified community rating, and is not a separate risk pool. With the exception of the young adult plan, the plans offered by Commonwealth Choice are also available directly from the plans or through

brokers at the same price. Commonwealth Choice, however, facilitates comparing plans and prices, provides a "seal of approval" for quality and value of plans, offers easy enrollment on-line or by phone, and combines payments from individuals and employers to health plans. Employers may allow their employees to access Commonwealth Choice coverage through their mandated section 125 plans. By April 1, 2008, nearly 18,000 people had enrolled in Commonwealth Choice plans (Day 2008; Kaiser 2008).

The Federal Employees Health Benefits Program offers a choice of private health insurance plans to more than 8 million active federal government employees, federal annuitants, and their dependents. The program is administered by the Office of Personnel Management (OPM), where about 160 employees approve and monitor plans and negotiate benefits and premium rates. Participants may enroll in a plan when they begin employment or during an annual open season. Active employees receive information about FEHBP and enroll at their workplace; employing agencies distribute the annual program guide, process enrollment forms, transmit enrollment information to plans, withhold premiums, and forward employee and agency contributions to OPM. OPM performs these functions for annuitants.

Participants in FEHBP can choose from several different types of plans: the government-wide Blue Cross Blue Shield plan, other national fee-for-service plans, local health maintenance organizations and point-of-service plans, and, since 2003, high-deductible plans combined with a tax-advantaged account. Each plan provides detailed information about its benefits in a brochure that uses a standardized format and is subject to OPM review. Private organizations also publish comparative information about the plans. There is no prescribed minimum benefit package, although OPM has moved since the 1980s to narrow differences among plans. Premiums are set to cover the prospective costs of each plan, and a system of reserve accounts holds the plans harmless if costs prove to be higher than expected. The government pays up to 75 percent of the premium for non-Postal employees and annuitants, but less for more expensive plans. Premiums do not vary by age, health status, or (for national plans) geographic location. Because payments to plans are also not adjusted for health risk or geography, the cost of plans may reflect differences in the people they serve, not just their benefits and efficiency (Merlis 2003).

Medicare also has some of the characteristics of an insurance exchange for its elderly and disabled beneficiaries. Beneficiaries have the option of receiving their hospital and supplementary medical insurance benefits through a choice of private insurance plans (called Medicare Advantage plans) instead of through the government-administered fee-for-service program. Benefits for outpatient pharmaceuticals are available only through stand-alone prescription drug plans or Medicare Advantage drug plans. Medicare adjusts payments to both Medicare Advantage plans and prescription drug plans to reflect the differential health risks of enrollees.

In a paper prepared for the study panel, Elliot Wicks (2009) identifies the key tasks that would arise in establishing a health insurance exchange at the national level or a nation-wide system of state or regional exchanges. The biggest challenge, according to Wicks, is to assure effective pooling of health risks and avoid having the exchange become a victim of severe adverse selection. Most likely, the exchange would be expected to provide coverage on a guaranteed-issue basis in the individual and small-group markets and to adopt community rating of premiums (perhaps allowing variation for age and geography, as in Massachusetts). Since many

states currently allow premiums to vary with the risk of the insured individual or group, higher risk individuals and firms from those states could flock to the exchange, thereby raising the cost of coverage well above the average. This problem could be avoided if the federal government required states to adopt uniform risk rating rules, and if the exchange used the same rules. Allowing large self-insured firms or individual employees of those firms to join the exchange on an optional basis, however, could create selection against the exchange.

Even if rating rules are the same inside and outside the exchange (or if almost everyone in a particular group is inside the exchange), so that the exchange as a whole is reasonably protected against adverse selection, individual insurers participating in the exchange may still attract enrollees with different levels of risk. Adjusting payments to insurance plans to reflect the anticipated costs of their enrollees is one way of offsetting the effects of enrolling a favorable or unfavorable mix of participants. Existing risk-adjustment methods are imperfect, however, and leave opportunities for insurers to profit through risk selection. Standardization of benefit packages would facilitate consumer choice based on price and quality and curtail the ability of plans to design benefits to attract those in good health (Lueck 2009; Wicks 2009). In addition, restrictions may be placed on activities that plans can use to attract favorable risks and discourage unfavorable ones. Retrospective sharing of risks among plans can further reduce the potential profits from risk selection (van de Ven 2008).

Other administrative tasks of an exchange include hiring a director and staff, designing a benefit package (if not specified in law or by another entity), securing the participation of health plans, educating consumers and employers about their options and responsibilities, enrolling individuals and groups, keeping enrollment information current, collecting premiums from individuals and firms, and distributing premiums to health plans. The exchange is also likely to play an important role in administering subsidies and mandates, as discussed in Chapters 2 and 3. Medicare, FEHBP, and state employees' health programs have experience with some of these tasks, but the administrative tasks would be larger and more extensive for an exchange that would potentially interact with much of the working-age population and most every employer (Wicks 2009). OPM is able to administer FEHBP with a very small staff because most of the work in enrolling active federal employees is carried out by their employing agency. Administration of FEHBP for federal annuitants piggy-backs on the federal retirement system, and Medicare relies heavily on the Social Security Administration, which serves the same population.

The administrative tasks facing a national health insurance exchange are sufficiently great that some decentralization may be appropriate (Wicks 2009). In one model, a single national entity would manage an integrated system of state or regional exchanges using common rules and procedures (Emanuel and Fuchs 2007). In another, the federal government would offer the states strong financial incentives to establish exchanges that operate according to rules detailed in federal law (Wyden and Bennett 2007). In a third, the federal government would allow the states substantial flexibility in designing exchanges, with the aim of encouraging experimentation and innovation (Butler 2008).

Offering a Public Plan in an Exchange

In some proposals, the menu of options available to consumers within a health insurance exchange would include a public, government-run insurance plan as well as several private insurance plans (for example, Hacker 2007). Advocates of this approach contend that a public plan would increase competition, have lower costs, be more transparent and accountable, and provide better access to care (Holahan and Blumberg 2008).

The Medicare program is the major U.S. example of a mixed system of public and private health plans and illustrates how such a system can work in practice. Although both fee-for-service Medicare and private Medicare plans have their own advantages, the public and private plans do not currently compete on a level playing field. The law constrains the public plan more in some respects and the private plans more in others. The design of the payment system for private health plans has been a particular and continuing source of controversy. At times some observers have charged that the Centers for Medicare & Medicaid Services has been hostile to private plans, but recently others have claimed that CMS is favoring private plans over traditional Medicare.

In a paper prepared for the study panel, Bryan Dowd (2009) argues "that public and private plans have inherent advantages and disadvantages, and neither type of plan needs to be favored with special subsidies or regulations." He concludes that, if policymakers decide to create a mixed system with public and private plans, both types of plans should be offered to consumers on the same terms. How to create a "level playing field" for public and private plans, however, is a contested issue. For example, Jacob Hacker (2009) provides an alternative perspective on addressing the administrative and implementation issues raised by a public plan option.

Benefit Package. Some analysts argue that a standardized benefit package, or a small number of options, makes it easier for consumers to compare health plans and reduces the opportunity for plans to design benefit packages to attract good risks. Others contend that, since consumers' preferences differ, limiting choice reduces well being. In either case, creating a level playing field requires that public and private plans abide by the same rules and have the same degree of flexibility in setting benefits.

Advertising and Consumer Information. A level playing field implies that both public and private plans should provide consumers with the same information. That information could take two forms: standardized information, such as is provided in FEHBP, and plan-generated advertising.

Risk Selection and Risk Adjustment. To promote informed choices and competition, premiums charged by competing health plans should reflect the relative efficiency with which care is delivered and differences in the value of the benefit package (if any) and not differences in the health status of enrollees in the plans. Achieving this goal requires that the exchange adjust payments to plans to reflect the risks of participants. Opinions differ whether the current technology of risk adjustment is sufficient to eliminate incentives for plans to profit from risk selection.

Default Enrollment. If purchase of insurance is mandated, it would be possible to enroll those who do not comply in a health plan by random or "intelligent" assignment. Some analysts argue that using a single plan (presumably the public plan) as a default is not consistent with a fully level playing field. Others suggest that default enrollment in the public plan could compensate for favorable risk selection by private plans.

Provider Payment Rates. How plans in the exchange should set payment rates for doctors, hospitals, and other health care providers raises thorny questions. In Medicare, provider payment rates in the public fee-for-service (FFS) plan are set according to procedures established in law; private plans are able to negotiate payment rates with providers, and providers may accept or reject plans' offers. This arrangement limits the flexibility of traditional FFS Medicare, but it may also place private plans at a competitive disadvantage if they cannot negotiate comparably low rates.

Managing the New System. Administering a mixed public-private system involves two distinct types of activities: (1) setting the policies and rules for the overall system and (2) managing the public plan. To assure that the public plan and private plans are treated equally, it may be desirable to assign these two sets of tasks to different entities. Under this model, the health insurance exchanges would provide the framework for competition among plans and manage the overall health insurance marketplace, but a separate organization would operate the public-plan option. The exchange would perform policymaking tasks that are inherently governmental in nature. In contrast, because the public insurance plan would perform a business-like function and would be potentially self-sustaining through revenues from premiums, it could be organized as a public corporation. Many of the administrative tasks of the public plan could be subcontracted to private firms.

The Role of Medicaid and CHIP

Another issue is whether to include beneficiaries of Medicaid and the Children's Health Insurance Program in a new insurance exchange or to maintain separate programs (Fowler and Jost 2008). Medicaid and CHIP are currently the major sources of health coverage for people with limited income and resources. Medicaid also plays a critical role in providing coverage to people with high health care needs, including the elderly and persons with a disability or chronic medical condition. Medicaid covered some 50 million full-year equivalent enrollees in 2008 at an estimated cost of $339 billion–$193 billion to the federal government and $146 billion to the states (CMS 2008). At some point during 2009, 68 million low-income people will be served by Medicaid and 6 million by CHIP, according to estimates by the Congressional Budget Office.

Medicaid is very flexible and, as a result, complex. The federal government sets the basic rules for the program, but states have broad discretion over eligibility policy. Some categories of beneficiaries and services are mandatory under federal law, but many others are optional. States also have flexibility in setting income and resource limits and may employ different ways of counting available income and resources. As a result, coverage varies widely from state to state by income level and category of beneficiary. For those who meet its eligibility criteria, Medicaid provides a legally enforceable guarantee of coverage to a wide range of services. The federal

government pays at least half of the cost of the program and pays a larger share for states with low income per capita.

Medicaid serves vital functions that go well beyond those of standard health insurance. It helps support major safety net providers, including federally qualified health centers, rural health clinics, and hospitals that treat a disproportionate share of uninsured and low-income patients. It finances medical and medical support services provided to Medicaid-eligible individuals through other state and local government programs, such as child welfare services, school health programs, special education, juvenile justice programs, home- and community-based services for the frail elderly and persons with disabilities, and mental health and developmental disabilities programs for children and adults. And it covers benefits and services not normally found in private insurance plans—for example, the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit for children, long-term care in nursing homes and the community, long-term case management, personal attendant care, special rehabilitation services, and supports needed to maintain severely disabled adults and children in their homes (Angeles 2009; Ferguson, Riley, and Rosenbaum 2002).

At the same time, aspects of Medicaid leave room for improvement. Eligibility varies greatly from state to state. Complex enrollment and renewal procedures inhibit participation. The program is vulnerable to state budget cuts during recessions, just when the demand for its services is greatest. Some beneficiaries may encounter limited access to key services, as well as many types of specialty care, because of low provider payment rates. Continuity of care can be interrupted when people move to a different state or another form of coverage. Federal and state governments often clash over program rules, requested waivers, and financing arrangements (Brown 2009; Hurley, Pham, and Claxton 2005; Mann and Lambrew 2005; Park 2008).

There are several ways of relating Medicaid to a system of health coverage that includes a health insurance exchange. One approach would retain and improve Medicaid and use it as a building block of the new system (for example, Baucus 2008; Lambrew, Podesta, and Shaw 2005; and Schoen, Davis, and Collins 2008). Its advocates point out that Medicaid has become the cornerstone of the nation's health care system for low-income Americans and those with serious disabilities. They contend that expanding and strengthening Medicaid offers a relatively quick, simple way to increase health coverage while minimizing disruption of current arrangements. Proposals of this sort typically require states to provide Medicaid coverage for acute care to everyone below a certain income level (usually between 100 percent and 150 percent of the federal poverty level) without regard to eligibility category or resources and to simplify and streamline the enrollment process. To make this approach succeed, however, additional steps would be needed to assure a stronger, more stable financing structure and adequate provider networks. These could include more federal funding, countercyclical assistance to states during economic downturns, and higher provider payment rates. Any plan that retains Medicaid must also develop administrative arrangements for coordinating the determination of eligibility for Medicaid and other subsidized coverage and for preventing loss of coverage when a person moves between Medicaid and other forms of coverage.

A second approach would eliminate or phase out Medicaid, except for long-term care, and include most of its beneficiaries in the private or public plans offered in a new insurance

exchange (for example, Emanuel and Fuchs 2007; Hacker 2007; and Wyden and Bennett 2007). Proposals of this sort aim to integrate Medicaid beneficiaries into the broader health care delivery system and to improve access and continuity of care. They would typically provide Medicaid beneficiaries with supplementary ("wrap-around") benefits for services that private health insurance generally does not cover, such as EPSDT for children and special services for persons with disabilities, and for reductions in cost sharing. Experience with Medicaid, CHIP, and Medicare, however, has shown the challenges of making such supplementary coverage work smoothly in practice. The challenges would be greatest if the insurance plans in the exchange varied widely in their benefits and cost sharing and would be significantly reduced if benefits and cost sharing were standardized across plans. If the wrap-around coverage did not work effectively, many low-income people or those with special health care needs could lose access to needed services or face higher costs. If Medicaid's role is reduced or eliminated, care must be taken to provide continued funding for various state programs that provide integrated health, social, and educational services to vulnerable populations and to assure that they continue to meet the needs of the people they serve in a coordinated manner (Park 2008).

The third approach would retain Medicaid coverage only for high-needs groups, generally the elderly and persons with disabilities (for example, Etheredge *et al.* 2009 and Nichols 2007). Other low-income families, who are more likely to have an attachment to the labor force, would be made eligible for subsidized coverage through the insurance exchange. This approach would still require providing wrap-around benefits for children and mothers, as well as maintaining federal funding streams for the state and local programs serving vulnerable populations, but both tasks would be easier with much of Medicaid still in place.

Determining the role of the Children's Health Insurance Program in a new system of health insurance coverage raises issues similar to those concerning Medicaid. Enacted in 1996, CHIP covers children whose families cannot afford private health insurance but earn too much to qualify for Medicaid. Like Medicaid, CHIP is administered by the states according to federal guidelines. States may create a separate CHIP program, expand Medicaid, or do a combination of both. In 2007, 71 percent of children enrolled in CHIP were in a separate program. Separate CHIP programs are modeled on private health insurance coverage and do not cover a number of Medicaid-covered services, including EPSDT (Rosenbaum 2007). Some analysts have suggested that establishing a system with tax credits or other subsidies for private insurance, guaranteed access to an insurance exchange, and an improved Medicaid program would "likely eliminate the need for a separate SCHIP program" (Mann and Lambrew 2005). Other proposals would require states to use CHIP to cover all children below a specified income level who are not eligible for Medicaid (Baucus 2008). Proposals of this latter sort would almost certainly require that current limits on federal funding be removed.

Findings and Recommendations

The Commonwealth Connector has played an important role in Massachusetts' efforts to expand health coverage, and health insurance exchanges are a significant component of many proposals to expand coverage nationally. Experience with exchanges at the state level strongly suggests, according to Wicks (2009), that "merely establishing such an entity is not by itself an effective strategy for bringing more people under the health insurance umbrella. . . . An exchange must be

viewed as part of a more comprehensive approach to coverage, which almost certainly must at a minimum include some form of subsidies to make coverage more affordable."

From an administrative standpoint, efforts to restructure health insurance markets and other steps to expand coverage must be considered as a whole. "The administrative and structural elements need to be coordinated and crafted with careful attention to their interactions," writes Wicks, "both to enhance the chances for success and to avoid unnecessary administrative burdens and duplication."

5.1. A health insurance exchange could provide a structure for the health insurance market, guarantee individual access to health insurance, promote competition among health insurance plans on the basis of price and quality, and assure that health insurance plans play by the established rules. Like the Connector in Massachusetts, a new national health insurance exchange (or system of exchanges) is likely to be assigned a wide range of tasks, including benefit design, education and outreach, enrollment, billing, making risk-adjusted payments to insurers, administering subsidies and mandates, and coordinating with the tax system and other public programs. Although certain federal and state agencies now perform many of these activities, the administrative tasks would be much larger and considerably different for a national exchange with the whole population as potential enrollees, and they would overwhelm any existing agency. Therefore, if a national health insurance exchange is to be established, a new federal government entity would be required.

5.2. If policymakers create a new public health insurance plan to compete with private plans in an exchange, the public plan should be administered by a separate organizational entity and not by the exchange itself. Asking the exchange to operate an insurance plan in addition to performing all its other activities would significantly complicate its work. In addition, making the exchange a participant in the marketplace could be viewed as compromising its role as referee.

5.3. Any restructuring of the health insurance market must account for the unique role of Medicaid in covering low-income and high-risk populations. Medicaid is an important source of financing for state health care programs serving vulnerable beneficiaries and provides high-needs beneficiaries with health care services not typically covered by private insurance. If such individuals were enrolled in insurance plans offered in a national insurance exchange, steps would need to be taken to assure that they had access to these programs and services.

CHAPTER 6: DESIGNING ADMINISTRATIVE ORGANIZATIONS

Previous chapters have described how expanding health coverage and containing the growth of health costs will create additional tasks for government. These tasks could be assigned to existing or new governmental entities. Prompted by concerns over political gridlock, the role of special interests, and inadequate or uncertain funding, several recent proposals would create new health-related entities or agencies with substantial independence from the usual political processes. Sometimes these proposed entities are described as a "Federal Reserve for health."

This chapter outlines some recent proposals to create new organizations as part of an expanded health coverage system. It considers the issues involved in choosing an appropriate organizational design, including the source and predictability of the entity's funding, its operational flexibilities, its degree of political independence and accountability, and the structure of its management. The background paper on administrative organizations commissioned by the study panel provides more details on these topics (Van de Water 2009a).

Proposals for New Health-Related Organizations

Major tasks that might be assigned to a new governmental or quasi-governmental organization include producing information on the comparative effectiveness of health care services, determining which benefits and services should be covered by public and private insurers, managing the marketplace for health insurance, or offering a public health insurance plan. Under some proposals, a single entity would perform more than one of these functions.

Producing Information on Comparative Effectiveness. Comparative effectiveness analysis is widely advocated as a way of slowing the growth of health costs without incurring adverse health outcomes. The Medicare Payment Advisory Commission, the Institute of Medicine, and other experts have recommended the creation of an independent entity to examine the comparative effectiveness of alternative ways of diagnosing and treating health conditions, including drugs, devices, surgical procedures, and medical services. Some of these proposals would give the new entity a high degree of organizational independence. For instance, the institute proposed by the Committee for Economic Development would, "like the Federal Reserve Board," be "free-standing and semi-autonomous." It would be independent of the annual appropriation process "to provide thorough insulation from short-term political pressures" (CED 2007).

The Children's Health and Medicare Protection (CHAMP) Act, which was passed by the House of Representatives in August 2007, took a somewhat different approach. This legislation would have established a Center for Comparative Effectiveness Research within the Agency for Healthcare Research and Quality (section 904 of H.R. 3162). It would also have established an independent Comparative Effectiveness Research Commission to oversee, evaluate, and set priorities for the center's work. The commission would be composed of two designated officials of the executive branch and 15 additional members appointed by the Comptroller General for 4-year terms. The center and the commission would be supported by a permanent appropriation

from a Comparative Effectiveness Research Trust Fund, which would be financed by fees on insured and self-insured health plans and transfers from Medicare.

The recent economic recovery legislation (the American Recovery and Reinvestment Act of 2009, Public Law 111-5) appropriates $1.1 billion for comparative effectiveness research, of which portions are to be administered by the Agency for Healthcare Research and Quality, the National Institutes of Health, and the Secretary of Health and Human Services. It establishes a Federal Coordinating Council for Comparative Effectiveness Research, which will be composed of up to 15 federal officials and chaired by the secretary. The council is charged with coordinating comparative effectiveness and related research conducted or sponsored by the federal government and advising the President and Congress on strategies for such research.

Determining Benefits and Coverage. Any government program to require or provide health insurance coverage requires determining the extent and nature of that coverage. In Massachusetts, the Commonwealth Connector is responsible for defining minimum creditable coverage for purposes of the individual mandate to obtain health insurance. Even if the law creating the program specifies the scope of coverage to some degree (for example, by category of service or actuarial value), the continual development of new medical services, drugs, and devices will always require an administrative agency to determine whether specific procedures or technologies should be covered. In the Medicare program, for example, coverage decisions are made by CMS and its contractors, not only for traditional Medicare but also for participating private (Medicare Advantage) plans.

Studies of coverage determinations typically find that proponents of expanding benefits are the most active participants in the process. To reduce the influence of health care providers, drug companies, device manufacturers, single-disease organizations, and other interested parties, some analysts have suggested that an independent entity should be created that would make decisions about which items and services would be covered by public and private health insurance and, in some cases, about payment rates for those service. Some proposals would have an independent board establish a mandated benefits package, as in Massachusetts, which would constitute the legally required minimum amount of health insurance coverage.

Managing the Marketplace for Health Insurance. Many proposals for expanding health coverage include a national system of health insurance exchanges (discussed in Chapter 4), which would serve as a central marketplace in which much or all health insurance would be bought and sold. Although these plans differ in their details, the proposed exchanges would perform such functions as establishing a basic benefits package (if not determined by a separate benefits board or commission), creating and managing a market for health insurance, assuring that health insurance plans meet standards of financial soundness and customer service, providing educational material to potential applicants, enrolling people in plans individually or as members of a group, maintaining enrollment information as individual circumstances change, collecting individual premiums and government subsidies, and distributing payments to plans on a risk-adjusted basis.

Some proposals model their administrative structure—a central board with a network of regional exchanges—on the Federal Reserve System. In these proposals, the governors of the central

board would be appointed for long, staggered terms, and the heads of the regional exchanges would be selected by the central board. The system would be funded by fees, such as a levy on health insurance premiums, and not subject to annual appropriations. According to the authors of one such proposal, this model is designed to "convey impartiality, expertise, freedom from narrow political interests, stability, and a long-term perspective" (CED 2007).

Offering a Public Insurance Plan. In addition to serving as a clearinghouse for private insurance plans, a new agency might also offer a competing public health insurance plan (see Chapter 5). In Jacob Hacker's (2007) proposal, for example, participants in a new health insurance exchange would have the option of choosing a public fee-for-service program or a range of private plans. In a recent paper, Hacker (2009) suggests that the administration of the public insurance plan should be separate from the administration of the health insurance exchange.

Types of Federal Agencies and Public-Private Entities

In choosing an appropriate organizational structure to carry out certain purposes, policy makers can choose from a wide range of models (Van de Water 2009a). For the most part, the federal government carries out its activities through agencies in the executive branch, of which the President is chief executive. Types of federal executive agencies include executive departments (State, Treasury, Defense, and so on), independent regulatory commissions (such as the Federal Communications Commission and Securities and Exchange Commission), government corporations (for example, Amtrak and the Postal Service), and various other independent agencies (like the Federal Retirement Thrift Investment Board and the Social Security Administration) that to not fit neatly into the previous categories.

The Federal Reserve System occupies a unique governmental niche. As the U.S. central bank, the Federal Reserve is responsible for conducting the nation's monetary policy in pursuit of stable prices and maximum employment. It is considered an independent central bank because its decisions do not need to be ratified by the President or anyone else in the executive branch. The Federal Reserve also plays a major role in regulating and supervising banks and in clearing paper checks and electronic payments. The system comprises a Board of Governors and 12 regional Federal Reserve Banks. The seven members of the Board of Governors are appointed by the President and confirmed by the Senate for 14-year terms.

Several agencies, boards, and commissions—for example, the Government Accountability Office (GAO, formerly the Government Accounting Office), the Congressional Budget Office, and the Medicare Payment Advisory Commission—are located in the legislative branch of the federal government. These organizations assist the Congress in undertaking its legislative functions and serve the Congress in a staff role or an advisory capacity. Any attempt to assign executive functions to a Congressional agency would most likely "violate the Constitution's command that Congress play no direct role in the execution of the laws," as affirmed in the Supreme Court's 1986 decision in *Bowsher v. Synar*.

Sometimes the federal government carries out public purposes through non-governmental organizations. Such entities are variously called public-private entities, quasi-governmental organizations, or private instrumentalities of government. Three types of public-private entities

have been suggested as possible producers of information on comparative effectiveness: federally funded research and development centers, agency-related nonprofit organizations, and Congressionally chartered nonprofit organizations. These entities have some legal connection to the federal government and may receive most or all of their funding from the federal government, but they are not federal government agencies.

Issues in Choosing an Appropriate Organizational Structure

The choice of an appropriate organizational structure to carry out a particular public function raises several issues. These range from relatively mundane questions of funding sources and managerial flexibility to the highest one—should the organization be located in the public or private sector.

Funding Authority. The degree of control by the President and the Congress over a government agency's funding—and the predictability of that funding—may vary, but it is not fully determined by an agency's organizational form. Most federal executive agencies are subject to the executive budget process and rely on annual Congressional appropriations to fund their personnel costs and other operating expenses. Even when the administrative expenses are paid out of dedicated taxes or premiums (as for the Medicare program) or user fees (as with the review of drugs and medical devices by the Food and Drug Administration), annual appropriations action is usually required.

A permanent appropriation—authority to spend money without annual Congressional action—can provide a substantial degree of stability in funding for an executive branch agency, although the Office of Management and Budget must still apportion the funds (make the funds available for obligation). Nevertheless, agencies with permanent appropriations remain responsible to the President and the Congress through their authorizing statute and periodic oversight. Entities that earn money from voluntary, business-type transactions with the public (such as the sale of power or postage) are subject more to market discipline than to the Congressional power of the purse, yet even in those cases political and regulatory oversight is never entirely lacking. No new agency can expect to obtain the financial independence of the Federal Reserve System, which can literally issue legal tender.

Operational Flexibilities. Government agencies are subject to various general laws affecting their operations, such as civil service and other personnel rules, contracting and other procurement requirements, and freedom of information or government-in-the-sunshine rules. These requirements were originally adopted to assure organizational accountability, to prevent use of public positions and funds for political patronage or personal profit, and for other laudable purposes, but they are now often viewed as impediments to governmental efficiency.

In recent years, various steps have been taken to provide additional flexibilities for government agencies. The Clinton Administration established a new organizational type, the performance-based organization, which provides flexibilities in personnel, contracting, and other areas in exchange for a commitment to achieving performance goals. Some federal agencies are exempted from certain personnel rules, including those for compensation, to facilitate the hiring of skilled personnel such as physicians and financial analysts.

Political Independence and Accountability. A public or public-private entity must steer a course between maintaining political accountability and avoiding undue political interference. There is no clear line, however, that separates accountability from interference, and two observers may view the same situation differently. Some contend that giving an agency more political independence will facilitate decisions that have long-term benefits but impose short-term costs. An agency that conducts comparative-effectiveness analyses or makes coverage decisions, for example, will affect the livelihood of health care providers and medical companies, the access of people to possibly life-saving treatments, and the cost of health insurance to those who pay the taxes or premiums. Others argue that balancing such conflicting objectives is an inherently political responsibility that should not be assigned to an entity that is far removed from the normal political processes.

Management Structure. "As a general rule," writes Thomas Stanton (2002), "a single administrator rather than a multi-member board best governs a federal agency." Boards may not be capable of timely decision-making, have little incentive to act collaboratively, and impede accountability, since no one person is fully responsible for decisions. On the other hand, multi-member boards may help insulate agencies from possible political interference. An advisory board can provide some of the advantages of a governing board without all the disadvantages. The CHAMP Act took such an approach by proposing a Comparative Effectiveness Research Commission to oversee the Center for Comparative Effectiveness Research.

Public or Private. The ultimate issue in designing an organization to carry out a public purpose is whether it should be governmental or private. As a rule, activities that are inherently governmental must be performed by a government agency and government personnel. Inherently governmental activities involve exercising substantial discretion in the use of governmental authority, including actions that significantly affect individual liberty or property and establishing policies for collecting or spending federal funds. Government entities must also accord extensive procedural and due process rights to individuals or businesses affected by their decisions.

Findings and Recommendations

The Standing Panel on Executive Organization Management of the National Academy of Public Administration has identified several principles to guide the structure and organization of the federal government. One principle is that "organizational design should be tailored to reflect the distinct requirements of different types of government programs so as to facilitate effective performance and maintain accountability." The panel observes, "One size does not fit all types of governmental programs. . . . The distinction between agencies responsible for formulating basic policies and those responsible for operations is especially important" (NAPA 1997).

6.1. Organizations that use governmental powers and funds and make public policy must be accountable as well as effective. A quasi-governmental entity might be suitable for producing advisory information on the comparative effectiveness of medical treatments and procedures, for example, or carrying out limited technical functions, but not for making coverage decisions or

managing the marketplace for health insurance—activities that clearly involve policy formulation.

6.2. Many administrative problems do not have solutions that require new organizational designs. As Stanton (2002) writes, "Freedom from unwise legal and regulatory constraints may be as important as organizational structure in the search for solutions to many problems that confront government agencies and programs." Experience shows that an agency will have as much or as little independence from rules governing personnel, contracting, budgeting, disclosure, and other management procedures as the Congress allows. If an agency would benefit from flexibility in a specific operational area, legislative relief can and should be targeted to the place where it is needed.

6.3. The Federal Reserve System does not provide an appropriate model for an entity to manage a national health insurance system. Proposals for a "Health Fed" raise serious issues of accountability. The autonomy of the Federal Reserve is acceptable because its primary task—the determination of monetary policy—is limited, involves no obvious coercion, and affects people only indirectly. In contrast, the decisions of a "Health Fed" regarding health care coverage and costs would directly affect millions of individual Americans. Such important, sensitive matters cannot and should not be taken out of politics. The Commonwealth Connector is Massachusetts exemplifies an agency that is assigned considerable discretion in important areas, yet remains subject to the political process.

CHAPTER 7: SIMPLIFYING ADMINISTRATION AND CONTROLLING COSTS

Efforts to expand financial access to health care must reckon with the rapidly rising growth in health care costs. Some people argue that nearly universal health coverage cannot be achieved without simultaneously taking steps to control health care costs. Others contend that it will not be possible to achieve significant progress toward controlling costs without first covering most everyone. In either case, the ways in which coverage is extended to the uninsured will have implications for the feasibility of different approaches for controlling costs.

The panel has not undertaken its own analysis of the reasons for high and rising health care costs or the efficacy of different approaches for slowing the growth in spending. Many others have done so. (See, for example, CBO 2008a and 2008b, Ginsburg 2008, and McKinsey 2007.) We presume that controlling costs will require trying and refining many different approaches over a long time. Our focus is on what sorts of coverage expansions facilitate or hinder particular approaches for controlling costs. This chapter looks first at possibilities for simplifying the administration of health insurance and then considers broader issues of restraining the growth of spending on medical services.

Simplifying the Administration of Health Insurance

The administrative costs of the U.S. health insurance system include both spending by insurers themselves and also costs incurred by consumers, providers, and employers in dealing with insurers. In the first of two papers prepared for the panel, Merlis (2009a) provides a taxonomy of those costs, reviews estimates of their size, discusses recent efforts to reduce administrative costs, and identifies options to simplify or expedite insurance transactions.

Both public and private health insurers engage in many of the same administrative activities; they provide information about their products, enroll and disenroll participants, collect premiums, keep track of covered dependents, process claims, coordinate benefits, issue benefit statements, make timely payments to individuals and providers, avoid improper payments, establish provider networks, manage utilization and quality of services, and handle complaints and appeals. In addition, private insurers market their products, underwrite individual and small-group coverage, negotiate contracts and prices with employers, and employ agents and brokers. Public programs also have some unique administrative tasks, notably the determination of eligibility for means-tested programs, such as Medicaid and CHIP.

Estimates of Administrative Costs

The national health expenditure accounts offer the most frequently cited estimates of the administrative costs of health insurance (CMS 2009). For public plans, the estimates include both costs incurred directly by public agencies and also those of participating private plans, such as Medicare Advantage plans, Medicare prescription drug plans, and Medicaid health maintenance organizations. For private insurers, the estimate represents total premiums less

benefit payments and thus includes taxes and profits as well as other administrative expenses. By this measure, administrative expenses in 2007 represented 5.0 percent of total spending for Medicare, 7.7 percent for Medicaid, and 12.2 percent for private health insurance.

Administrative costs vary further by type and size of plan. Within Medicare, administrative costs are roughly 2 percent for traditional Medicare and 11 percent for Medicare Advantage plans (CBO 2006). In the private sector, large employers who self-insure contract with insurance companies or other third-party administrators, who may charge 8 percent to 9 percent of total health benefits. By self insuring, these firms avoid premium taxes, risk reserves, and most marketing costs. Total administrative costs for Blue Cross plans and commercial insurers run about 12 percent of premiums. Administrative costs for small employer plans fall in the range of 20 to 30 percent of premiums. Costs in the individual, non-group market may be even higher, but there are no reliable data (Merlis 2009a).

Estimates of the administrative costs of private insurance vary for several reasons. First, there is no comprehensive source of data. Some studies rely on surveys of particular insurers, and others on reports that insurers file with state insurance departments. Second, there is no standard definition of administrative costs, and each study categorizes the data differently. Some classify profits as an administrative expense, for example, and others do not. Third, administrative costs vary from year to year and state to state because of fluctuations in profitability, differences in premium taxes, and other factors. The figures in the previous paragraph summarize the best available estimates.

Some writers contend that the usual estimates of administrative costs overstate the difference between traditional Medicare and private insurance, but these claims are largely without merit. Notably, Matthews (2006) and Zycher (2007) attribute to Medicare certain federal legislative, executive, and judicial costs in proportion to Medicare's share of total (or, in some cases, non-defense) federal outlays. Although federal agencies other than CMS undoubtedly incur some unreimbursed costs related to Medicare, this method of allocation vastly overstates these costs. Moreover, it ignores the fact that private insurance likewise imposes administrative costs on the Congress, state legislatures, insurance departments, the judicial system, and other agencies. Matthews and Zycher also assert that Medicare's administrative cost ratio is understated because the average claim paid in Medicare is larger than the average private claim. But, as Merlis (2009a) writes, "This is definitely not true of inpatient care—[Medicare] beneficiaries have more discharges at a lower cost per discharge—and probably not for other services."

Not all of the administrative costs of health insurance show up in the budgets of insurers. Health care providers incur costs for many insurance-related activities, such as obtaining information about health insurance coverage from patients, collecting copayments, submitting bills to insurers, contracting with insurers, and engaging in utilization management activities. These and other administrative costs of providers are incorporated in providers' charges for services and are not identified separately in the national health expenditure accounts. Estimates of the insurance-related costs of health care providers are surprisingly fragmentary. Studies have found a range of 10 to 15 percent of practice revenues for physicians' offices and 7 to 11 percent of patient revenues for hospitals. (For a recent study of physicians' offices, see Casalino and others [2009].)

Employers that sponsor health insurance also bear some administrative costs directly, in addition to the amounts they pay to an insurer or third-party administrator. Larger employers, in particular, often perform enrollment and premium collection functions that would otherwise be carried out by an insurer or administrative service organization. A study in 2000 found that firms with 200 or more workers spent $250 per covered worker to administer health benefits (Merlis 2009a). At today's earnings levels, that would amount to about $325 per covered worker, which is about 7 percent of the cost of health benefits for a single person and 3 percent of the cost of family coverage.

Simplifying Insurance-Related Transactions

Substantial progress has been made in standardizing the exchange of information between insurers, on the one hand, and providers and employers. The development of uniform claims forms was followed by the creation of health insurance clearinghouses to serve as intermediaries between providers and payers. Starting in the early 1990s New York, Utah, Minnesota, and other states took steps to encourage or impose standardization. Enactment of the federal Health Insurance Portability and Accountability Act (HIPAA) in 1996 built on these initiatives and spurred further developments.

HIPAA required the Secretary of Health and Human Services to develop standard forms and uniform data elements for electronic transmission of nine common health insurance transactions. The law required insurers and clearinghouses to accept electronic transactions in a standard format, but it did not require providers or employers to submit transactions electronically. To date, standards have been finalized for seven out of the nine specified transactions. HIPAA also required the Secretary to develop unique health identifiers for individuals, employers, health plans, and health care providers. Identifiers for plans and providers have been implemented, but concerns about privacy have stalled the development of individual identifiers.

The Administrative Simplification Compliance Act of 2001 required larger Medicare providers and suppliers to submit claims electronically and in compliance with HIPAA standards by October 2003. Although applying only to Medicare, the requirement may encourage providers to shift to electronic filing for other payers as well. However, the law exempts small providers, including an estimated 71 percent of physician offices and 69 percent of home health agencies.

Private entities and state governments are continuing their efforts to promote common health insurance transactions. The Council on Affordable Quality Healthcare (CAQH) has developed standards to verify eligibility and benefits in real time and certifies systems that meet the standards. Some insurers have created information systems that move towards real-time adjudication of claims. CAQH has also developed a nationwide database for the credentialing of health care providers. A Minnesota law requires electronic filing of all health insurance claims using standard state-developed specifications beginning in 2009.

Merlis identifies two key barriers to progress in simplifying health insurance transactions. First, the HIPAA standards do not establish absolute uniformity. The standards for a transaction specify the data fields, the format of the data, and the range of possible entries. In addition,

however, health plans typically issue "companion documents" or other supplemental instructions that require some fields be completed, forbid the use of others, and accept only certain values or codes in a field. Even Medicare contractors in different regions impose different requirements. As a result, health care providers still find it necessary to pay clearinghouses to format and transmit claims to different payers and receive notice of payments.

Second, some insurance transactions are inherently complicated and may not lend themselves to the use of standard forms and codes. To make coverage decisions, for example, insurers may require information about a patient's medical history, test results, and past treatment. Such information is typically included in attachments to health insurance claims—one of the two types of transactions for which HIPAA standards have not yet been finalized. By one estimate, 25 percent of health insurance claims require additional documentation, and no more than half of these requests for documentation might be satisfied by standardized formats for claims. Although the federal government could impose standard coding rules and forbid supplemental requirements (as under the new Minnesota law), such standardization could preclude certain payment policies, utilization review, or case management activities that insurers use to promote the efficient delivery of care.

Creating a national health insurance clearinghouse, similar to the statewide system pioneered in Utah, would be one way of further simplifying health insurance transactions. This step would fill some of the holes in the current piecemeal arrangement, since no existing clearinghouse, even Utah's, can match every provider with every payer. To be as effective as possible, however, a national clearinghouse would have to resolve some of the limitations of HIPAA, including the failure to issue standards for attachments to claims. At the same time, the Administrative Simplification Compliance Act could be broadened to require electronic filing of claims for all health insurance plans (not just Medicare) and all health care providers (not just the large ones). Minnesota's new universal electronic transaction law contains neither of these exemptions. Simplifying and expanding the electronic exchange of health insurance information is not the same as developing electronic medical records, although providers that adopt one of these new technologies may be more likely to adopt the other as well. Physicians have been found to be reluctant to adopt electronic patient records unless the medical records are tightly linked to billing, which is their source of income (Lohr 2009).

Finally, consolidation in health insurance markets itself simplifies administration. Concentration has increased greatly in recent years. In most states, a small number of insurers account for a large part of the business. By one recent estimate, the two largest insurers have at least half the enrollment in 40 states, and they hold at least three-quarters of the enrollment in 15 states. Many health care providers are thus likely to be sending most of their claims to just a few payers, including Medicare and Medicaid. As consolidation continues, providers and clearinghouses will have to deal with even fewer insurers (Merlis 2009a; Wicks 2009).

Cost Containment and Coverage Expansion

Simplifying the administration of health insurance offers a real but limited potential for containing health care costs. The largest savings will have to come from slowing spending for direct medical services—physician visits, hospital stays, tests and treatments, drugs and devices,

and so on. In a second paper commissioned by the panel, Merlis (2009b) identifies five categories of cost-control measures (see Table 1) and considers the extent to which they are compatible with different approaches toward expanding coverage. The list excludes cost containment options that are essentially regulatory and could be implemented under a variety of approaches for expanding health coverage. In this category Merlis places malpractice reform, stricter criteria for approval of new drugs and medical devices, restrictions on direct-to-consumer advertising of drugs, and stronger enforcement of antitrust laws.

Table 1
Cost Containment Options

Reducing the Need for Services

- Primary and secondary prevention
- Health promotion and education
- Health behavior-based premiums
- Patient safety and reduced medical errors

Modifying Consumer Demand

- Progressive cost sharing
- Tiered cost sharing
- Differential cost sharing by service or procedure
- Limiting the tax exclusion for employment-based health insurance
- High-deductible plans

Modifying Provider Behavior

- Pay-for-performance
- Bundled payment and capitation
- Coverage rules and preauthorization
- Improved care of patients with chronic conditions

Controlling Prices

- Uniform pricing
- All-payer systems

Instrumental Measures

- Electronic medical records and other information technology
- Comparative effectiveness research
- Price transparency

Source: Merlis 2009b, Mongan *et al.* 2008; CBO 2008a.

Many keen analysts of the U.S. health care system have reached the conclusion that no one of these options, or even a few, is likely to make much of dent in the growth of health care costs (Aaron 2008, Davis 2008, Mongan *et al.* 2008). "No single silver bullet will transform the U.S. health care system," writes Karen Davis (2008), "but a series of coordinated policy changes has the potential to substantially bend the curve of projected health care spending." Moreover, these steps will take time and will require continual adjustments. As Henry Aaron (2008) puts it, "Changing the U.S. health care system is the work of a generation, not of a single presidency."

Increasing numbers of experts have also concluded that improving the quality of health care and lowering its cost requires major changes in the way health care is organized and delivered. In this view, individual physicians and patients need the assistance of organized care management processes, supported by appropriate health information technology (for example, Casalino 2006). Taking this path will require modifying health care payment arrangements, so that the financial incentives of both providers and consumers promote quality and efficiency rather than a large volume of services. Many of the proposed measures, Merlis (2009b) notes, "point in the direction of integrated delivery systems that cross provider boundaries and that are able to bear bundled or capitated payment risk and to be held accountable for high performance." Some coverage approaches would be more likely than others to promote changes in the health care delivery system.

According to Merlis and other analysts, creation of a health insurance exchange is likely to facilitate, or at least be compatible with, all of the major options for controlling health care costs. In its basic form, the exchange would provide a mechanism for insurers to offer standardized benefit packages with guaranteed issue and renewability. By consolidating payers in a geographical area and serving as the vehicle for providing subsidies, an exchange could eventually develop into "a dominant financial entity, capable of effecting real systemic change" (Aaron 2008).

Although an exchange may provide a platform on which to build cost control measures, creation of an exchange does not by itself slow the growth in health costs. The initial legislation in Massachusetts, for example, included no significant cost controls, and the state's expenditures for subsidized coverage have grown more rapidly than expected. Slowing the long-term growth in costs is widely considered to be the major policy challenge facing Massachusetts health reform (Holahan and Blumberg 2009).

One category of cost containment options comprises instrumental measures, such as comparative effectiveness research and greater use of health information technology. These options do not contain costs by themselves but may support other approaches. "For example," observes Merlis (2009b), "knowing what medical practices are most effective is not the same as getting providers to adopt them, but may be essential for developing defensible coverage and payment rules. An electronic health record might alert a provider that a patient has already received a particular diagnostic test, but will not necessarily preclude a duplicate test if the provider will be rewarded for conducting it." Merlis finds that such instrumental measures are generally compatible or highly compatible with a wide range of models for expanding coverage.

The Recovery Act takes important steps with regard to two of these instrumental measures. It creates a new federal program to promote the use of health information technology and creates payment incentives in Medicare and Medicaid to encourage providers to adopt health information technology. It also establishes a Federal Coordinating Council for Comparative Effectiveness Research and appropriates $1.1 billion for such research.

Limiting the tax exclusion for employment-based health insurance is a key element of many proposals to expand health coverage and control costs (Van de Water 2009b). Payments by employers for the health insurance of their employees are generally excluded, without limit, from workers' taxable income. Eliminating or capping the exclusion could slow cost growth by encouraging employers and employees to choose more efficient and less expensive health plans. It would also provide an important source of additional tax revenues to help pay for an expansion of health coverage.

Any cap on the tax exclusion needs to be structured with careful attention to issues of administration and implementation. In a recent issue brief from the Employee Benefit Research Institute, Paul Fronstin (2009) draws lessons from previous unsuccessful efforts to assign a value to employer-sponsored health insurance. Fronstin finds that valuing health insurance would be easy for small, insured employers who pay a clearly identifiable premium to an insurer. Valuation would also be easy for large, self-insured employers if they could set the value equal to the employer's share of the premium charged for coverage under COBRA.

Findings and Recommendations

Coverage expansion will not be sustainable without cost control. Left unchecked, continued escalation of health costs will further undermine private insurance coverage and place steadily increasing pressure on public budgets. Efforts to expand health coverage must therefore be consistent with and reinforce measures to slow the growth of health care costs.

Simplifying the administration of health insurance can reduce costs to some extent, but it must be remembered that the appropriate goal is not to minimize but to optimize administrative costs. According to many observers, including a previous NASI study panel, the Medicare program spends too little on administration (King, Burke, and Docteur 2002). In the private sector, as Merlis (2009a) notes, administrative "complexity is not just a byproduct of the insurance system: it is what insurers are selling. The value-added of the managed care industry consists of the very features that make insurance complicated: different coverage rules and formularies, authorization requirements and careful scrutiny of claims, and so on. The variations are what differentiates one plan from another, and competition and uniformity may be conflicting goals." Thus, choosing among different approaches for expanding coverage "may require balancing their potential for medical spending restraint against their likely impact on administrative costs."

7.1. Efforts should continue to enhance the standardization of health care transactions to reduce administrative costs. Standardization of transactions is consistent with a wide range of options for expanding health insurance coverage. Care must be taken, however, to assure that standardization does not preclude activities that would allow health plans to promote and monitor the efficient delivery of care.

7.2. Investments in comparative effectiveness research and electronic medical records are compatible with a wide range of approaches to expanding health coverage and controlling costs. These instrumental measures will not contain costs by themselves, but they will facilitate the development of payment methods and evidence-based practices that will encourage quality and value and moderate the growth in costs. More and better information about the effectiveness of alternative tests and treatments could help guide and improve the health decisions of individuals, physicians, other providers, and health plans. Electronic medical records would provide an important source of data for conducting comparative effectiveness research and assessing system-wide outcomes, as well as for improving the care of individual patients.

7.3. The creation of a health insurance exchange is compatible with all of the major options for controlling health care costs. An exchange would enable people without access to employer-sponsored coverage to obtain a basic private insurance package with guaranteed issue and renewability. An exchange could also be designed to serve a wider population, administer health insurance subsidies, manage the health insurance marketplace, or offer a public insurance plan. Once established, an exchange would represent an administrative foundation on which could be built other elements of a reformed health coverage system. To slow the growth of costs, however, creation of an exchange must be accompanied by further measures.

REFERENCES

Aaron, Henry. 2008. *Remarks for 20th Anniversary of the Department of Health Care Policy, Harvard, Medical School.* http://www.hcp.med.harvard.edu/files/Aaron_Presentation.pdf. Accessed February 11, 2009.

Angeles, January. 2009. *Improving Medicaid As Part of Building on the Current System to Achieve Universal Coverage.* Washington: Center on Budget and Policy Priorities.

Baucus, Max. 2008. *Call to Action, Health Reform 2009.* Washington: Senate Finance Committee.

Bernstein, Jill. 2009. "Paying a Fair Share for Health Coverage and Care," in Buss and Van de Water, *Expanding Access*.

Blumberg, Linda J., and John Holahan. 2008. *Targeting Subsidies: Employers versus Individuals.* Washington: Urban Institute.

Brecher, Charles (ed.). 1992. *Implementation Issues and National Health Care Reform.* New York: Josiah Macy, Jr. Foundation.

Brown, Lawrence D. 2009. "Re-figuring Federalism: Nation and State in Health Reform's Next Round," in Buss and Van de Water, *Expanding Access.*

Burman, Leonard. 2001. "Tax-Based Approaches: Design Issues and Administrative Mechanisms." Presentation to a Congressional Budget Office seminar. March 29.

Buss, Terry F., and Paul N. Van de Water (eds.). 2009. *Expanding Access to Health Care: A Management Approach*. Armonk, NY: M.E. Sharpe.

Butler, Stuart M. 2008. "Insurance Exchange Is a Good Idea but Not at the National Level," *New York Times* Campaign Stops blog, http://campaignstops.blogs.nytimes.com/2008/10/07/insurance-exchange-is-a-good-idea-but-not-at-the-national-level/. Accessed October 17, 2008.

Casalino, Lawrence P. 2006. *Medicare, the National Quality Infrastructure, and Health Disparities.* Washington: National Academy of Social Insurance. Medicare Brief No. 14.

Casalino, Lawrence P., and others. 2009. "What Does It Cost Physician Practices to Interact With Health Insurance Plans?," *Health Affairs, Web Exclusive*, w533-43 (May 14).

Center on Budget and Policy Priorities. 2008. *4.3 Million in the United States Yet to Claim Economic Stimulus Payments*. September 7.

Centers for Medicare & Medicaid Services (CMS). 2008. *2008 Actuarial Report on the Financial Outlook for Medicaid*.

_____. 2009. *National Health Expenditure Web Tables.* http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf. Accessed February 6, 2009.

Committee for Economic Development (CED). 2007. *Quality, Affordable Health Care for All: Moving Beyond the Employer-Based Health Insurance System.* Washington.

Commonwealth Health Insurance Connector Authority. 2007. *Commonwealth Care: Frequently Asked Questions*. March 29.

Congressional Budget Office (CBO). 2006. *Designing a Premium Support System for Medicare.* Washington.

_____. 2008a. *Key Issues in Analyzing Major Health Insurance Proposals.*

_____. 2008b. *Budget Options, Volume I, Health Care.*

Davis, Karen. 2008. "Slowing the Growth of Health Care Costs—Learning from International Experience," *New England Journal of Medicine,* 359: 1751-55 (October 23).

Day, Rosemarie. 2008. "Massachusetts Health Care Reform: Early Lessons from the Health Connector." Presentation to the NAPA-NASI study panel, January 30.

Dembner, Alice. 2007a. "Uninsured face health plan delays: State deluged with applicants," *Boston Globe,* August 11.

_____. 2007b. "Health plan help line swamped with calls," *Boston Globe*, November 5.

DiIulio, John J., Jr., and Richard P. Nathan (eds.). 1994. *Making Health Reform Work: The View from the States.* Washington: Brookings Institution.

Dowd, Bryan. 2009. "Designing a Mixed Public and Private System for the Health Insurance Market," in Buss and Van de Water, *Expanding Access.*

Ebeler, Jack, Paul N. Van de Water, and Cyanne Demchak. 2006. *Improving the Medicare Savings Programs.* Washington: National Academy of Social Insurance.

Emanuel, Ezekiel, and Victor Fuchs. 2007. *A Comprehensive Cure: Universal Health Care Vouchers.* Washington: Brookings Institution. Hamilton Project Discussion Paper 2007-11.

Etheredge, Lynn, Judith Moore, Sonya Schwartz, and Alan Weil. 2009. "Administering a Medicaid-plus-Tax-Credits Initiative," in Buss and Van de Water, *Expanding Access.*
Ferguson, Christine, Patricia Riley, and Sara Rosenbaum. 2002. "Medicaid: What Any Serious Health Reform Proposal Needs to Consider," in Jack A. Meyer and Elliot K. Wicks (eds.), *Covering America: Real Remedies for the Uninsured, Volume 2*. Washington: Economic and Social Research Institute.

Fowler, Elizabeth J., and Timothy Stoltzfus Jost. 2008. "Why Public Programs Matter—and Will Continue to Matter—Even After Health Reform," *Journal of Law, Medicine, & Ethics*. 36(4): 670-76.

Fronstin, Paul. 2009. *Capping the Tax Exclusion for Employment-Based Health Insurance Coverage: Implications for Employers and Workers.* Washington: Employee Benefit Research Institute. EBRI Issue Brief No. 325.

Fuchs, Beth, Mark Merlis, and Julie James. 2002. *Expanding Health Coverage for the Uninsured: Fundamentals of the Tax Credit Option.* Washington: National Health Policy Forum.

Furman, Jason. 2007. *The Promise of Progressive Cost Consciousness in Health-care Reform.* Washington: Brookings Institution. Hamilton Project Discussion Paper 2007-05.

General Accounting Office (GAO). 2003. *Health Insurance: How Health Care Reform May Affect State Regulation*, Statement of Leslie G. Aronovitz, Testimony before the Subcommittee on Health, Committee on Ways and Means. GAO/T-HRD-94-55. Washington.

Ginsburg. Paul B. 2008. *High and Rising Health Care Costs: Demystifying U.S. Health Care Spending.* Princeton: Robert Wood Johnson Foundation. Research Synthesis Report No. 16.

Gluck, Michael G., and Virginia Reno. 2001. *Reflections on Implementing Medicare.* Washington: National Academy of Social Insurance.

Gruber, Jonathan. 2006. *The Role of Consumer Copayments for Health Care: Lessons from the RAND Health Insurance Experiment and Beyond*. Menlo Park, CA: Kaiser Family Foundation.

_____. 2008. *Taking Massachusetts National: An Incremental Approach to Universal Coverage.* Washington: Brookings Institution. Hamilton Project Discussion Paper 2008-04.

Hacker, Jacob. 2007. *Health Care for America*. Washington: Economic Policy Institute. EPI Briefing Paper No. 18.

_____. 2009. *Healthy Competition: How to Structure Public Health Insurance Plan Choice to Ensure Risk-Sharing, Cost Control, and Quality Improvement.* Washington: Institute for America's Future.

Hevener, Mary B.H., and Charles K. Kirby III. 2008. "Administrative Issues: Challenges of the Current System," in Henry J. Aaron and Leonard E. Burman (editors), *Using Taxes to Reform Health Insurance.* Washington: Brookings Institution Press.

Holahan, John, and Linda Blumberg. 2008. *Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reform?* Washington: Urban Institute.

_____. 2009. *Massachusetts Health Reform: Solving the Long-Run Cost Problem.* Washington: Urban Institute.

Holtzblatt, Janet. 2007a. "Comments on 'Paying One's Fair Share for Health Coverage and Care.'" Presentation to the NAPA-NASI study panel, November 14.

_____. 2007b. "Comments on 'Administering Health Insurance Mandates.'" Presentation to the NAPA-NASI study panel, November 14.

_____. 2008. "The Challenges of Implementing Health Reform through the Tax System," in Henry J. Aaron and Leonard E. Burman (editors), *Using Taxes to Reform Health Insurance.* Washington: Brookings Institution Press.

Hurley, Robert E., Hongmai H. Pham, and Gary Claxton. 2005. "A Widening Rift in Access and Quality: Growing Evidence of Economic Disparities," *Health Affairs, Web Exclusive,* w5: 566-76 (December 6).

Hyman, David A. 2008. *Health Insurance: Market Failure or Government Failure?* Urbana-Champaign: University of Illinois College of Law, Illinois Law and Economic Research Paper Series, Research Paper No. LE08-003.

Jost, Timothy Stoltzfus. 2007. *Legal and Regulatory Issues Presented by Health Care Reform.* Stanford: FRESH-Thinking. http://www.fresh-thinking.org/docs/workshop_071129/Paper_T_Jost.pdf.

_____. 2009. *The Regulation of Private Health Insurance.* Washington: National Academy of Social Insurance.

Kaiser Commission on Medicaid and the Uninsured. 2007. *Massachusetts Health Care Reform Plan: An Update*. Fact Sheet, June.

_____. 2008. *Massachusetts Health Care Reform: Two Years Later*. Fact Sheet, May.

King, Kathleen M., Sheila Burke, and Elizabeth Docteur. 2002. *Matching Problems with Solutions: Improving Medicare's Governance and Management.* Washington: National Academy of Social Insurance.

Lambrew, Jeanne M., John D. Podesta, and Teresa L. Shaw. 2005. "Change in Challenging Times: A Plan for Extending and Improving Health Coverage," *Health Affairs, Web Exclusive,* W5: 119-32 (March 23).

Lohr, Steve. 2009. "How to Make Electronic Medical Records a Reality," *New York Times,* March 1.

Lueck, Sarah. 2009. *Designing Benefit Standards for a Health Insurance Exchange.* Washington: Center on Budget and Policy Priorities.

Mann, Cindy, and Jeanne M. Lambrew. 2005. *The Role of Medicaid in the Context of a Restructured Health Care System.* Washington: New America Foundation.

Matthews, Merrill. 2006. *Medicare's Hidden Administrative Costs: A Comparison of Medicare and the Private Sector.* Alexandria, VA: Council for Affordable Health Insurance.

McKinsey Global Institute. 2007. *Accounting for the Cost of Health Care in the United States.*

Medicare Payment Advisory Commission (MedPAC). 2003. *Report to the Congress: Variation and Innovation in Medicare*. June.

_____. 2007. "Chapter 2: Producing Comparative Effectiveness Information," in *Promoting Greater Efficiency in Medicare.*

Merlis, Mark. 2003. *The Federal Employees Health Benefits Program: Program Design, Reent Performance, and Implications for Medicare Reform*. Menlo Park, CA: Henry J. Kaiser Family Foundation.

_____. 2009a. "Simplifying Administration of Health Insurance," in Buss and Van de Water. *Expanding Access.*

_____. 2009b. *Health Care Cost Containment and Coverage Expansion.* Washington: National Academy of Social Insurance.

Mongan, James J., Timothy G. Ferris, and Thomas H. Lee. 2008. "Options for Slowing the Growth of Health Care Costs," *New England Journal of Medicine*, 358: 1509-14 (April 3).

Monheit, Alan C., and Joel C. Cantor (eds.). 2004. *State Health Insurance Market Reform.* London and New York: Routledge.

National Academy of Public Administration (NAPA), Standing Panel on Executive Organization and Management. 1997. *Principles of Federal Organization*.

National Association of Insurance Commissioners. 2008. *White Paper on Regulation of Medicare Private Plans, Approved by the Health Insurance and Managed Care (B) Committee.* September 10.

Nichols, Len M. 2007. *A Sustainable Health System for All Americans.* Washington: New America Foundation.

Park, Edwin. 2008. *An Examination of the Wyden-Bennett Health Reform Plan.* Washington: Center on Budget and Policy Priorities.

Pollitz, Karen, Nicole Tapay, Elizabeth Hadley, and Jalena Specht. 2000. "Early Experience With 'New Federalism' In Health Insurance Regulation," *Health Affairs*, 19(4): 7-22.

Rosenbaum, Sara. 2007. "SCHIP Reconsidered," *Health Affairs, Web Exclusive*, 26: w608-17 (August 14).

Salamon, Lester M. (ed.). 2002. *The Tools of Government*. New York: Oxford University Press.

Schoen, Cathy, Karen Davis, and Sara R. Collins. 2008. "Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance," *Health Affairs*, 27(3): 646-57.

Smith, David Barton. 1999. *Health Care Divided: Race and Healing a Nation.* Ann Arbor: University of Michigan Press.

Stanton, Thomas H. 2002. *Moving Toward More Capable Government: A Guide to Organizational Design*. Arlington, VA: PricewaterhouseCoopers Endowment for the Business of Government.

Steuerle, C. Eugene, and Paul N. Van de Water. 2009. "Administering Health Insurance Mandates," in Buss and Van de Water, *Expanding Access*.

Swartz, Katherine. 2006. *Reinsuring Health: Why More Middle-Class People are Uninsured and What Government Can Do*. New York: Russell Sage Foundation.

U.S. Census Bureau. 2008. "Health Insurance Historical Tables, Table HIA-4, Health Insurance Coverage Status and Type of Coverage by State--All Persons: 1999 to 2007." http://www.census.gov/hhes/www/hlthins/historic/hihistt4.xls. Accessed September 24, 2008.

U.S. Department of Labor, Employee Benefits Security Administration. 2008. *Frequently Asked Questions about Portability of Health Coverage and HIPAA.* http://www.dol.gov/ebsa/FAQs/faq_compliance_hipaa.html. Accessed August 29, 2008.

van de Ven, Wynand P.M.M. 2008. "A Competitive Market for Social Health Insurance in Five Countries: Is There a Relation between Funding and Organizing Health Care?" in Colleen M. Flood, Mark Stabile, and Carolyn Hughes Tuohy (eds.). *Exploring Social Insurance: Can a Dose of Europe Cure Canadian Health Care Finance?* Kingston, Ontario: Queens University.

Van de Water, Paul N. 2008. *Achieving Universal Participation in Social Insurance Systems.* Washington: National Academy of Social Insurance. Health and Income Security Brief No. 11.

_____. 2009a. *Designing Administrative Organization for Health Reform.* Washington: National Academy of Social Insurance.

_____. 2009b. *Limiting the Tax Exclusion for Employer-Sponsored Insurance Can Help Pay for Health Reform.* Washington: Center on Budget and Policy Priorities.

Weil, Alan. 2005. *You Can Get There From Here: Implementing the Roadmap to Coverage.* Boston: Blue Cross Blue Shield Foundation of Massachusetts.

Wicks, Elliot. 2009. “Restructuring Health Insurance Markets,” in Buss and Van de Water, *Expanding Access*.

Wielawski, Irene M. 2007. *Forging Consensus: The Path to Health Reform in Massachusetts,* Boston: Blue Cross Blue Shield Foundation of Massachusetts.

Wyden, Ron, and Robert Bennett. 2007. *Healthy Americans Act, S. 334, 110th Congress.* Washington: United States Senate.

Zycher, Benjamin. 2007. *Comparing Public and Private Health Insurance: Would a Single-Payer System Save Enough to Cover the Uninsured.* New York: Manhattan Institute.

APPENDIX: PANEL MEMBERS

Robert A. Berenson,+ M.D., *Co-Chair* —Senior Fellow, Urban Institute; Adjunct Professor, Fuqua School of Business, Duke University; Clinical Professor, George Washington University School of Public Health. Former Deputy Administrator, U.S. Health Care Financing Administration; Founder and Medical Director, National Capital Preferred Provider Organization; Assistant Director, White House Domestic Policy Staff; Robert Wood Johnson Clinical Scholar.

William A. Morrill,* *Co-Chair* —Senior Fellow, Caliber Associates. Former Senior Fellow, Chair, and President, MATHTECH; Vice President, Mathematica Policy Research; Assistant Secretary for Planning and Evaluation, U.S. Department of Health, Education and Welfare; Assistant Director, U.S. Office of Management and Budget; Deputy County Executive, Fairfax County, Virginia.

Kenneth S. Apfel*+—Professor of the Practice and Director, Management, Finance and Leadership Program, University of Maryland. Former Sid Richardson Chair, Lyndon B. Johnson School of Public Affairs, University of Texas; Commissioner of Social Security, Social Security Administration; Associate Director for Human Resources, U.S. Office of Management and Budget; Assistant Secretary for Management and Budget, U.S. Department of Health and Human Services; Legislative Director, Office of Senator Bill Bradley; Staff Member, U.S. Senate Budget Committee.

Beth C. Fuchs+—Principal, Health Policy Alternatives. Former Specialist in Social Legislation, Congressional Research Service, U.S. Library of Congress; Professional Staff Member, U.S. Senate Special Committee on Aging.

Thomas R. Hefty—Retired Chairman and Chief Executive, Blue Cross Blue Shield United of Wisconsin. Former Counsel, Reinhart, Boerner, and Van Deuren; Interim County Executive, Waukesha County, Wisconsin, Adjunct Professor of Economics, Ripon College; President, Kern Family Foundation; Chair, Advisory Committee on Medicare Supplement Insurance, National Association of Insurance Commissioners; Chair, Wisconsin Council on Long-Term Care Insurance.

Feather O. Houstoun*—President, William Penn Foundation. Former Regional President, AmeriChoice, United Health Group; Visiting Senior Scholar, Fox Leadership Center, University of Pennsylvania; Secretary, Department of Public Welfare, State of Pennsylvania; Chief Financial Officer, Southeastern Pennsylvania Transportation Authority; Treasurer and Chief Financial Officer, State of New Jersey; Executive Director, New Jersey Housing and Mortgage Finance Agency; Deputy Assistant Secretary for Policy Development, U.S. Department of Housing and Urban Development.

Robert E. Hurley—Associate Professor Emeritus, Medical College of Virginia; Emeritus Faculty Member, Department of Health Administration, Virginia Commonwealth University.

Former Consultant, Research Triangle Institute, Urban Institute, Mathematica Policy Research, and Center for Studying Health System Change; Chair, National Review Committee, Robert Wood Johnson Foundation Medicaid Managed Care Program.

Jack Lewin, M.D.—Chief Executive Officer, American College of Cardiology. Former Chief Executive Officer, California Medical Association; Director, Hawaii Department of Health; Chief Executive Officer, Hawaii Community Hospital System; Founder and Director; Navajo Nation Department of Health; Commissioned Officer, U.S. Public Health Service Commissioned Corps.

Catherine G. McLaughlin+—Professor of Health Management and Policy, University of Michigan, School of Public Health; Director, Economic Research Initiative on the Uninsured; Senior Associate Editor, Health Services Research.

Sallyanne Payton*—William W. Cook Professor of Law, University of Michigan School of Law. Former Associate Professor, University of Michigan School of Law; Chief Counsel, Urban Mass Transportation Administration, U.S. Department of Transportation; Staff Assistant to the President of the United States, White House Domestic Policy Council; Attorney, Covington & Burling.

Michael C. Rogers*—Executive Vice President, Corporate Services, MedStar Health. Former Executive Director, Metropolitan Washington Council of Governments; City Administrator/Deputy Mayor for Operations, Government of the District of Columbia; Director, Minority Business Development Agency, U.S. Department of Commerce; Director, Mayor's Office of Contracts and City Chief Procurement Officer, City of New York; Vice President, Municipal Services, and Executive Director, Jacob Javits Convention Center; Deputy General Manager, Washington Convention Center; Staff Associate, Temporary Commission on Financial Oversight of the District of Columbia.

Raymond C. Scheppach*—Executive Director, National Governors Association. Former Deputy Director, Assistant Director for Natural Resources and Commerce, and Unit Chief for Energy and Transportation Cost Analysis, U.S. Congressional Budget Office; Vice President and Senior Consultant for Economic Studies, Jack Faucett Associates; Economist, Standard Oil Company.

Mark D. Smith, M.D.+—President and CEO, California HealthCare Foundation; Associate Clinical Professor, University of California–San Francisco School of Medicine; Attending Physician, San Francisco General Hospital. Former Executive Vice President, Henry J. Kaiser Family Foundation; Member, Committee on Performance Measurement, National Committee for Quality.

* *Fellow, National Academy of Public Administration*

\+ *Member, National Academy of Social Insurance*

NATIONAL ACADEMY OF SOCIAL INSURANCE
1776 Massachusetts Avenue, NW
Suite 615
Washington, DC 20036
Phone: (202) 452-8097
Fax: (202) 452-8111
Web: www.nasi.org

National Academy of Public Administration®
900 7th Street, NW
Suite 600
Washington, D.C. 20001
Phone: (202) 347-3190
Fax: (202) 393-0993
Web: www.napawash.org