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## AN EXAMINATION OF THE WYDEN-BENNETT HEALTH REFORM PLAN Key Issues in a New Approach to Universal Coverage

By Edwin Park

### Introduction and Executive Summary

The U.S. health care system suffers from a number of serious problems. According to the latest Census data, 45.7 million individuals were without health insurance in 2007, an increase of 5.9 million people since 2001. Employer-based coverage, the primary source of health insurance across the nation, continues to erode; the percentage of Americans with job-based insurance declined from 63.2 percent to 59.3 percent between 2001 and 2007. Moreover, those without insurance are disproportionately people with low or moderate incomes, and the principal government subsidy for health insurance — the exclusion from taxes for employer contributions to employees' coverage — is regressive. In addition, health care costs continue to rise relentlessly and are the primary factor responsible for the bleak long-term fiscal outlook the federal government faces. Finally, while the United States spends more on health care per resident than any other country, it falls short on a variety of quality of care measures compared to other western industrialized nations.

As a result, there is growing consensus that comprehensive reform of the U.S. health care system is essential, with the goals of such a reform effort being both to achieve universal coverage and to moderate health care cost growth while improving the quality of care.

There are several approaches that policymakers could take to achieve universal coverage. They could build on and expand employer-based health insurance and public programs like Medicaid and the State Children's Health Insurance Program (SCHIP), which provide health insurance to the vast majority of Americans. For example, researchers from the Commonwealth Fund have followed this approach in designing a comprehensive health reform plan intended to provide universal health insurance.<sup>1</sup>

Alternatively, one could take a more far-reaching approach by substituting another health insurance system for the current mix of employer-sponsored insurance and public programs. For example, the U.S. health care system could instead rely on a universal public health insurance system (a "single payer" system). Or it could rely on new private insurance pools, or on a revamped, tightly regulated individual market. To achieve universal coverage any of these types of approach would have to be supplemented with a mandate on individuals to have health insurance.

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<sup>1</sup> Cathy Schoen, Karen Davis and Sara Collins, "Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance," *Health Affairs*, May/June 2008.

The “Healthy Americans Act” (S. 334), introduced on a bipartisan basis by Senator Ron Wyden (D-OR) and Senator Robert Bennett (R-UT), is the most prominent example of a health reform plan that takes one of these latter types of approach. The plan has a significant number of Senate co-sponsors from each party, and the Congressional Budget Office and Joint Committee on Taxation have estimated that its budgetary effects would be neutral in 2014 (i.e., that it would not increase the deficit). For these reasons, it has garnered significant attention from federal policymakers and the media. Examination of the plan can provide insights into issues posed by an approach to universal coverage that blends new private insurance pools, reforms of the tax treatment of health insurance, and various other reforms, as the Wyden-Bennett plan does.

The Wyden-Bennett plan seeks to achieve universal coverage by creating a new private insurance system for the United States. It would establish state-based purchasing pools, with nearly all Americans (except those in Medicare and the military) required to enroll in a private insurance plan made available through their state’s pool. Employer-based coverage would likely be reduced substantially over time (few, if any, small employers likely would continue to offer coverage although a number of large employers probably would do so, at least initially), and Medicaid and SCHIP would be converted into supplemental insurance programs that “wrap around” the private insurance plans offered through the new pools. Premium subsidies would be provided on a sliding scale based on income to help make the coverage provided through the new purchasing pools affordable for low- and moderate-income families.

The Wyden-Bennett plan includes a number of positive features.

- According to the estimates of one independent analysis, it would succeed in providing health insurance to nearly 99 percent of Americans and thereby almost attain the goal of universal coverage.
- It would rely on *group* health insurance made available through new state-based purchasing pools, rather than the unregulated individual market, to pool risk so coverage is more accessible to people in poorer health as well as to those who are healthy.
- Premiums for the health insurance offered through the state-based purchasing pools would be “community-rated” — that is, sicker individuals would not be charged higher premiums than healthy people, as is the case in the individual health insurance market in many states today.
- It would set standards for the health insurance plans offered through the new pools, requiring plans to be actuarially equivalent initially to the current Blue Cross Blue Shield Standard Option available to federal employees.
- It would limit premiums and cost-sharing on the basis of income in an effort to ensure affordability for low- and moderate-income individuals. It also would prohibit any cost-sharing for preventive, chronic disease management and chronic pain management services.
- It would automatically enroll families in health insurance plans and enable families to retain the health insurance plan in which they are enrolled when a breadwinner switches jobs or becomes unemployed.
- It would make the financing of federal subsidies for health insurance, particularly those

provided through the tax code, more progressive than under the current system.

- It seeks to tackle the problem of rising health care costs by incorporating a number of financial incentives designed to encourage individuals to enroll in more cost-effective health insurance plans and to slow the rate of growth in health spending over time. It also includes a number of financing mechanisms. As noted, the Congressional Budget Office and the Joint Commission on Taxation together estimate that the plan would be roughly budget-neutral by 2014, assuming the plan was enacted in 2008.

The approach that the Wyden-Bennett plan takes also raises serious questions. These questions reflect a number of complex and difficult issues that arise as a result of a reform effort such as this, which largely replaces the current reliance on employer-based coverage and public programs like Medicaid and SCHIP with a new system of state-based purchasing pools through which individuals would enroll in private insurance plans.

This analysis examines the Wyden-Bennett plan in depth as a way to focus on some of the key questions that such an approach raises and that will have to be addressed successfully for such a plan to attain its laudable goals. Such questions include, but are not limited to, the following:

- Would the new system of state-based purchasing pools sufficiently reduce the risk of “adverse selection” — that is, the separation of healthier and less healthy people into different insurance plans — that otherwise could make coverage increasingly unaffordable over time for people in poorer health?
- Would access to needed health care for low-income Medicaid and SCHIP beneficiaries — particularly those with disabilities and special health care needs — be protected adequately if these public programs are converted into supplemental programs that “wrap around” the new private insurance plans?
- Would the subsidies provided under the plan be sufficient to make the private health insurance coverage provided through the new purchasing pools reasonably affordable for the many low- and moderate-income families who are currently uninsured?

The Wyden-Bennett plan does not provide all of the detail necessary to be able to answer these questions conclusively. It appears, however, that the plan would fall short in a number of these areas, thus highlighting the challenges that this approach to achieving universal coverage presents.

- Under the plan, there is a substantial risk that instead of the private health insurance plans in the state-based purchasing pools competing solely on the basis of cost and quality, they would compete in significant part on the basis of which plans could best attract healthy individuals and discourage enrollment by people in poor health. Some adverse selection likely would result, with healthy individuals choosing low-cost health insurance plans, like high-deductible plans attached to Health Savings Accounts, while people in poorer health opted for more comprehensive plans. If that occurred, sicker individuals would, over time, face increasingly unaffordable premiums for the coverage they need.
- Medicaid and SCHIP serve a unique role in the U.S. health care system, providing health insurance coverage to people excluded from the private insurance market and providing needed

services to low-income individuals with disabilities and special health care needs that are beyond the scope of private insurance. While converting Medicaid and SCHIP into effective supplemental wrap-around programs is possible in theory, it is quite difficult to do in practice. Experience with supplemental coverage has been mixed at best. Medicaid also serves a role well beyond directly providing health coverage, by helping to finance health-related services that states provide to very vulnerable low-income individuals — particularly children and adults with very serious disabilities — as part of an integrated package of social, educational, supportive and health services. This essential role would likely be at risk. There also is concern that some states could decide to scale back existing eligibility, benefits and cost-sharing protections in Medicaid and SCHIP if they are no longer primarily responsible for the health care needs of their low-income residents. Under the plan, millions of low- and moderate-income people who are now uninsured would gain insurance, but a substantial number of low-income people covered through Medicaid or SCHIP could be placed at risk and lose access to some needed care.

- The overwhelming majority of the uninsured population consists of people with low incomes. The Wyden-Bennett plan would provide relatively generous subsidies on a sliding scale based on income, up to 400 percent of the poverty line. It would provide additional subsidies through a new standard income tax deduction, while eliminating the current tax exclusion for employer-sponsored insurance. The subsidies made available under the plan would make coverage much more affordable for low-income individuals who now lack health insurance. At the same time, it is likely that a substantial number of low-income uninsured individuals would find the premiums and cost-sharing they would face difficult to afford. Because they would be required to enroll in the state-based health insurance plans irrespective of ability to pay, some low-income families and individuals — especially those who face high costs for other necessities — could find themselves with health insurance but without sufficient remaining income to pay for other essentials such as rent, child care, or adequately heating their homes.
- Finally, the Wyden-Bennett plan is designed in such a way that the health benefits the insurance plans would cover, as well as some of the subsidies to help people purchase health insurance, would erode each year, with the erosion likely to become substantial over time. These features of the plan lower its overall cost and constrain growth in health care spending. They help permit the plan to be roughly budget-neutral by 2014, according to CBO and the Joint Committee on Taxation. But they also would likely have some adverse side-effects. For low- and moderate-income people in particular, the steady erosion in the benefits packages and the subsidies could result over time in such individuals being enrolled in health insurance plans with significant and growing gaps in coverage that these individuals could not afford to fill.

These problems are not insurmountable. The Wyden-Bennett plan could be modified to try to address them. Doing so would entail substantial changes in various elements of the legislation, including the following:

- The plan could be modified to better minimize the risk of adverse selection. The plan could preclude the state-based purchasing pools from offering high-deductible plans attached to HSAs, since those plans would primarily attract people who are healthier than average. Equally essential to minimizing adverse selection would be greater standardization of the benefit packages the plans can offer; this is necessary to limit the otherwise relatively unconstrained ability of insurers to design benefits in such a way as to “cherry pick” — that is, to encourage

enrollment by the healthy and deter enrollment by those in poorer health. These steps would significantly improve the long-term ability of the new purchasing pools to pool risk effectively.

- The Wyden-Bennett plan could better ensure that Medicaid and SCHIP beneficiaries actually receive the supplemental benefits for which they would be eligible, both by placing additional requirements on private insurers participating in the new purchasing pools to improve access to care and by assigning vulnerable beneficiaries to plans that best meet their health care needs. The plan also could be modified to establish explicit new funding streams to support the integrated state services for vulnerable low-income populations that now receive funding through Medicaid, and it could provide financial incentives to states to encourage them to maintain adequate Medicaid and SCHIP eligibility and benefit levels over time, thereby preserving access for vulnerable low-income people to needed supplemental coverage.
- The plan could better ensure affordability by increasing the subsidies it provides to low- and moderate-income individuals. In addition, an overall limit on total out-of-pocket costs (premiums, deductibles and co-payments) as a percentage of family income could be established, at least up to certain income levels. The mechanism for adjusting the value of the benefit package each year also could be modified so that low- and moderate-income individuals do not increasingly become underinsured over time. These steps to ensure affordability would add to the legislation's costs and would likely require additional revenues beyond the existing financing sources the Wyden-Bennett plan now taps.

This analysis is not applicable only to the Wyden-Bennett plan. As the body of this analysis indicates, these suggested changes constitute essential features of any health reform plan that adopts a universal coverage approach similar to that of the Wyden-Bennett plan in substituting a new system of state-based purchasing pools offering a choice of private insurance plans for the current reliance on employer-based coverage and public programs like Medicaid and SCHIP. This analysis yields the following lessons regarding such an approach to universal coverage:

- Whatever the specific design of a new private insurance system, it should include standardized benefits packages and restrict the availability of plans that are very likely to provoke adverse selection such as high-deductible plans attached to HSAs.
- Replacing Medicaid and SCHIP and converting them into supplemental (or wrap-around) insurance may be appealing in theory but is much more difficult to accomplish successfully in practice without causing the loss of access to important health services by some of the nation's most vulnerable individuals. Very careful attention needs to be paid to how low-income beneficiaries — many of whom have disabilities, chronic illnesses and special health care needs — fare under such a system. Attention must also focus on the likely impact of a plan that largely replaces Medicaid with private insurance on the integrated state programs that serve very vulnerable populations, as well as on state finances and state health coverage decisions. Under certain reform plans, it may be more appropriate to exempt such populations — that is, to retain Medicaid coverage for them — than to shift them to the new system.
- Reform plans must both achieve affordability and constrain health care spending growth. Achieving one without the other will ultimately lead to serious problems. On the affordability side, a plan with an individual mandate must ensure that low- and moderate-income individuals are able to afford other necessities while complying with the mandate to purchase health

insurance, and that the insurance they obtain does not result either initially or over time in large gaps in coverage that they cannot afford to fill. To achieve these two essential goals without sacrificing one or the other, it very likely will be necessary to consider other revenue sources outside the existing health care system and to go beyond the financing sources that the Wyden-Bennett plan includes.

## **Description of the Wyden-Bennett Health Reform Plan**

The “Healthy Americans Act” (S. 334) introduced by Senators Wyden and Bennett proposes to restructure the U.S. health insurance system in an attempt to achieve universal coverage. It would establish new health insurance purchasing pools in each state administered by state “Health Help Agencies” (HHAs).<sup>2</sup> (States also could form multi-state purchasing pools.) Each state-based purchasing pool would offer a choice of private health insurance plans, known as “Healthy American Private Insurance” (HAPI) plans, with a minimum of at least two plans made available in each state.

Plans would have to provide a benefits package initially equivalent to the actuarial value of the Blue Cross Blue Shield Standard Option plan offered to federal employees. That actuarial value standard would then be increased annually by the rate of per capita growth in the economy. Plans would also have to cover certain benefits like wellness programs, disease prevention, disease management, and chronic condition management.<sup>3</sup>

Premiums for each health insurance plan would be “community rated” — premiums could vary only by geography and tobacco use, and could not vary by health status or other risk factors. (Plans could offer additional benefits beyond the required benefits standard; they would have to separately identify these benefits and their costs.)

Subsidies would be provided to help low- and moderate-income individuals pay the premium cost of the health insurance plan in which they enroll. Poor individuals would receive a full subsidy; individuals with incomes between 100 percent and 400 percent of the poverty line would receive subsidies on a sliding scale based on their income. The full subsidy would be equal to the average premium cost of the two lowest-cost plans in the state. (The subsidy would not be available for the cost of additional benefits.) Individuals below the poverty line would incur no cost-sharing charges.<sup>4</sup>

Except for people enrolled in Medicare and those serving in the military, all individuals would be required to have health insurance through the new state-based purchasing pools (or through their

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<sup>2</sup> This analysis is based on the revised version of S. 334 as described by the Congressional Budget Office and the Joint Committee on Taxation. Because the actual legislative language for the revised version of the Wyden-Bennett plan is not available, however, this analysis may not reflect all of the modifications to S. 334 as analyzed by CBO and JCT. See Congressional Budget Office and the Joint Committee on Taxation, Letter to the Honorable Ron Wyden and the Honorable Robert Bennett, May 1, 2008.

<sup>3</sup> The Wyden-Bennett plan also would establish an advisory panel to make recommendations to the Secretary of Health and Human Services and Congress on modifications to these benefit requirements.

<sup>4</sup> As discussed below, such individuals may also receive supplemental assistance to pay for premiums and cost-sharing through Medicaid and SCHIP (if they are eligible) and receive subsidies through the new standard income-tax deduction.

employer, as discussed below).<sup>5</sup> Their share of the premium would be deducted automatically from their paychecks.<sup>6</sup> Failure to choose a plan would result in automatic enrollment into the lowest-cost plan available in the state. Each year, individuals could switch health insurance plans during an open enrollment period.

Employers would be required to contribute to the costs of health insurance provided to their workers on a sliding scale based on firm size and the average amount of revenue per employee. In addition to this employer contribution requirement, employers could (but would not be required to) continue offering health insurance to their workers as long as the employer plans met the requirements for health insurance plans offered through their state purchasing pool. All employers that were providing health insurance before implementation of the Wyden-Bennett plan would be required to “cash out” their previous contributions to the health insurance costs of their workers by increasing workers’ wages.

Medicaid and SCHIP would be converted into supplemental wrap-around insurance programs. Low-income beneficiaries now on Medicaid and SCHIP would obtain their health insurance primarily through the new state-based private insurance purchasing pools.<sup>7</sup> Medicaid and SCHIP would continue to cover health services (like long-term care and related services under Medicaid) to the extent that such services are not covered by the private insurance plans available in the state but *are* covered by the state’s Medicaid (or SCHIP) program.<sup>8</sup>

Medicaid and SCHIP also would pick up beneficiaries’ premiums and/or cost-sharing to the extent that those charges exceeded the existing limits under these programs. For example, Medicaid generally does not charge premiums and permits only very modest co-payments, while SCHIP limits total premiums and cost-sharing to no more than five percent of a family’s income. In addition, states would be required to repay to the federal government the savings they accrued from the shift of primary responsibility for the health coverage of low-income beneficiaries from Medicaid and SCHIP to the private insurance plans offered through the new purchasing pools.

The Wyden-Bennett plan would be financed in part by the elimination of the current tax exclusion for employer-sponsored insurance and most other existing tax subsidies for health insurance and health care, except for the tax treatment of Health Savings Accounts, which would continue in

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<sup>5</sup> Both federal and state employees would be enrolled in the private insurance plans provided through the state-based purchasing pools. Enrollment, however, would be optional for individuals receiving care through the VA health system or the Indian Health Service and for retirees in employer-based coverage who retire before the Wyden-Bennett plan takes effect.

<sup>6</sup> Only the average premium cost of the two lowest cost plans in the state would be paid through tax withholding. Additional premium costs (as well as the full premium cost for the coverage of additional benefits, if any, offered beyond the required benefits standard) would be paid directly by the individual to the HHA that administered the state-based purchasing pool or the insurance plan. It appears that premiums would be collected from individuals who are paid in cash (of whom there are a large number) through the annual tax returns these individuals file. (Premiums apparently would not be collected from individuals with zero income tax liability who are not required to file a tax return.)

<sup>7</sup> States that enacted legislation (or a ballot measure) to provide health insurance to all of their residents that would be “at least as comprehensive as the coverage” required under the state-based purchasing pools apparently could opt out of the system. They also could apply for broad waivers of federal Medicaid and SCHIP rules and could potentially maintain Medicaid and SCHIP, in some form, as the primary form of health coverage for low-income beneficiaries.

<sup>8</sup> States presumably would use existing Medicaid and SCHIP reimbursement rates for providers furnishing such supplemental services.

modified form.<sup>9</sup> Other financing sources under the plan include the required employer contributions, premium payments, reduced federal Medicaid spending, the elimination of most Medicare and Medicaid Disproportionate Share Hospital (DSH) payments,<sup>10</sup> and the recouping of state Medicaid and SCHIP savings by the federal government.

In place of the tax exclusion, the plan would create a new standard income tax deduction initially set at \$6,025 for individuals and \$15,210 for joint filers with one child. (An additional \$1,000 deduction could be taken for each additional child.)<sup>11</sup> The value of the deduction would be unrelated to the premium cost of the health insurance plan chosen. The deduction would be available for individuals with incomes above 100 percent of the poverty line (those below that level would be eligible for a full premium subsidy), with the value of the deduction phasing in on a sliding scale based on income between 100 percent and 400 percent of the poverty line. The deduction would then begin to phase out at incomes of \$62,500 for individuals and \$125,000 for joint filers. Each year, the value of the deduction would be increased by the rate of overall inflation.

The Wyden-Bennett plan also includes several mechanisms to limit costs. As noted, the full premium subsidy would be limited to the average premium cost of the two lowest-cost plans in each state-based purchasing pool. In addition, the Wyden-Bennett plan would, as noted, adjust the value of its standard income-tax deduction annually to keep pace only with overall inflation; for decades, the overall inflation rate has been below the rate of growth in health care costs, a disparity that experts expect to continue. (The standard deduction would initially be set at levels above average premium costs nationally for employer-based coverage and then would rise at a slower rate than premiums for employer coverage have been increasing.<sup>12</sup>) These two elements of the plan would, over time, constrain the subsidies available to individuals for the purchase of health insurance and thereby reduce the legislation's cost and encourage enrollment in less costly health insurance plans.

In addition, the Wyden-Bennett plan would adjust the actuarial value standard for health insurance plans each year by the annual per capita growth rate in the economy. This rate, as well, is regularly outpaced by health care costs. This feature of the plan would be expected to result in a

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<sup>9</sup> The current exclusion from payroll taxes for employer-based health insurance would be eliminated after two years. Employers would also no longer be able to deduct as a business expense any additional contributions they make to the health insurance costs of their workers, except for contributions based on firm size and revenues per worker that the Wyden-Bennett plan would mandate and any contributions that employers chose to make for limited purposes such as wellness programs.

<sup>10</sup> *Medicare* DSH payments are supplemental payments made to hospitals that serve a disproportionate number of Medicare beneficiaries who are eligible for SSI and/or a disproportionate number of Medicaid beneficiaries. *Medicaid* DSH payments are supplemental payments made to hospitals that serve a disproportionate number of low-income and/or uninsured patients.

<sup>11</sup> Joint filers with no dependent children would be eligible for a deduction of \$12,050. An individual filer with one dependent child would be eligible for a deduction of \$8,610. An additional \$1,000 could be taken for each child.

<sup>12</sup> The value of the standard income tax deduction would be greater than the value of the current income tax exclusion for employer-sponsored insurance for individuals enrolled in an insurance plan in which the total premium cost per beneficiary is less than the amount of the standard deduction. In 2007, the average total premium cost of employer-based coverage nationally was \$4,479 for individuals and \$12,106 for family coverage; these average amounts are below the value of the standard deduction. Premium costs are rising more rapidly, however, than the standard deduction would be allowed to rise (since the deduction would be adjusted only for overall inflation), so this gap would dissipate over time. (See Kaiser Family Foundation and Health Research Educational Trust, "Employer Health Benefits: 2007 Annual Survey," September 2007.)

gradual scaling back over time of the scope of the coverage provided under the private insurance plans that are offered through the new purchasing pools, which would scale back the plan's cost and reduce growth in overall health care spending.

## **Wyden-Bennett Plan Includes Positive Aspects but Its Approach Also Raises Significant Questions**

The Wyden-Bennett plan includes a number of positive features in its design.

- It seeks to achieve universal health insurance coverage for all citizens and legal residents. According to the Lewin Group, which produced coverage and cost estimates of an earlier version of the plan, more than 99 percent of Americans would have health insurance under the plan.<sup>13</sup>
- Rather than relying on the flawed individual market to expand coverage, it creates new group health insurance purchasing pools in each state that are intended to make coverage affordable for both the healthy and the sick.
- It prohibits insurers from varying health insurance premiums based on individuals' health status, age and other risk factors. By requiring "community rating," individuals in poorer health who currently are unable to obtain health insurance in the largely unregulated non-group market may be able to finally obtain affordable coverage.
- It establishes standards for the health insurance that is provided, including a requirement that each benefit package initially be actuarially equivalent to the Blue Cross Blue Shield Standard Option currently offered to federal employees,<sup>14</sup> as well as requirements that wellness benefits be provided and that disease management, chronic condition management and disease prevention be covered without cost-sharing. It also requires that some minimum percentage of the money that plans collect in health insurance premiums be spent on health care, rather than on administration, marketing and profits. The legislation does not specify this percentage, leaving that to the discretion of the Secretary of Health and Human Services.
- The plan provides subsidies to help low- and moderate-income individuals pay for their health insurance premium costs, with poor individuals receiving a full premium subsidy and individuals with incomes between 100 percent and 400 percent of the poverty line paying premiums on a sliding scale. It also prohibits placing cost-sharing charges on individuals below the poverty line.
- It would automatically enroll individuals and families in health insurance plans, so that

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<sup>13</sup> John Sheils, Randall Haight and Evelyn Murphy, "Cost and Coverage Estimates for the 'Healthy Americans Act,'" The Lewin Group, December 12, 2006. The Wyden-Bennett plan also would authorize appropriations to provide financial assistance to states to cover children below 300 percent of the poverty line who are not otherwise eligible for coverage, including those ineligible because of immigration status. Congress would have to vote in appropriations bills to actually provide this money for these funds to materialize.

<sup>14</sup> In general, under current law, there are no requirements that employer-based health insurance plans meet a certain level of generosity (i.e. an actuarial value standard).

individuals who fail to elect a plan still have health coverage. Moreover, unlike the current system, which principally relies on employer-sponsored health insurance, it allows families to remain in the same health insurance plan when breadwinners change or lose their jobs.<sup>15</sup>

- It would make the financing of federal subsidies for health insurance, particularly those provided through the tax code, more progressive than under the current system.
- It attempts to address the problem of rising health care costs by including features (such as tying the full premium subsidy to the average cost of the two lowest-cost plans, increasing the value of the standard tax deduction only by general inflation, and increasing the actuarial value standard for the benefit packages only by the rate of growth in the economy) that are intended to encourage individuals to enroll in less costly health insurance plans and thus slow the rate of growth in health spending over time.

Nevertheless, the Wyden-Bennett plan, and more generally, the approach to universal coverage that it takes, raise a number of serious questions. These include:

- Would the new system of state-based health insurance purchasing pools that offer a choice of private insurance plans be designed in a way that sufficiently reduces the risk of “adverse selection,” which otherwise would make coverage increasingly unaffordable over time for those in poorer health?
- Would access to needed health care for low-income Medicaid and SCHIP beneficiaries — particularly those with disabilities and special health care needs — be adequately protected if these public programs are converted into supplemental programs that “wrap around” the new private insurance plans?
- Would the subsidies provided under the plan be adequate to make the health insurance coverage provided through the new purchasing pools reasonably affordable for low- and moderate-income families and individuals who currently are uninsured?

As the following analysis indicates, while many details remain unavailable, it is likely that the Wyden-Bennett plan as currently designed would not perform adequately in these areas and would need considerable revision to achieve its sponsors’ goals.

## **1. Are the New Private Insurance Purchasing Pools Designed in a Way that Addresses the Risk of “Adverse Selection”?**

The Wyden-Bennett plan would establish new state-based health insurance purchasing pools through which nearly all Americans would obtain health insurance. A key question is whether these

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<sup>15</sup> Under current law individuals can, through COBRA, generally remain enrolled for up to 18 months in the health insurance plan their former employer offers, so long as they pay 102 percent of the total premium cost (i.e., 102 percent of the combined employer contribution and employee share). COBRA coverage thus is very costly for laid-off workers. In addition, COBRA does not apply to firms with fewer than 20 workers and to workers whose former employers go out of business or no longer offer health insurance to their workers.

purchasing pools would function adequately or whether they would be vulnerable to significant “adverse selection” problems that could undermine the long-term viability of the new pools.

### A. Employer-Based Coverage and its Risk Pooling Function

The large majority of Americans obtain health insurance through their employers. Among the non-elderly, about 159 million individuals — more than 60 percent — had employer-based coverage in 2007.<sup>16</sup> This is a result of several factors:

- Employer contributions to the costs of health insurance are exempt from both income tax and payroll taxes for their employees. Through this exclusion, the federal government provided approximately \$200 billion in annual tax subsidies for employer-sponsored health insurance in 2007.<sup>17</sup> (As noted above, these exemptions would be eliminated under the Wyden-Bennett plan.)
- Employer-based coverage is also attractive because it benefits from economies of scale. The administrative costs of providing employer-sponsored health insurance — marketing, sales, billing, underwriting, and the like — are largely fixed, so when employers obtain coverage on behalf of their employees, those costs are spread over the employer’s workforce, and the portion of the health insurance premium devoted to administrative costs declines relative to what it would be if the same coverage were obtained on an individual basis.<sup>18</sup>
- Employer-sponsored insurance also can provide an effective form of “risk pooling.” As the American Academy of Actuaries states, “the pooling of risk is fundamental to all types of insurance...”<sup>19</sup> Well-functioning health insurance pools have a typical balance of healthy individuals and individuals in poorer health, where the majority who are healthy help subsidize the minority who are sick. Employer-based coverage, particularly among larger employers, provides a good mix of high-risk and low-risk individuals because the group — the workers in a firm — is formed for reasons independent of individuals’ health.<sup>20</sup> According to Census data, 65 percent of all workers with employer-sponsored insurance worked for firms with 100 or

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<sup>16</sup> CBPP analysis of 2007 Current Population Survey data.

<sup>17</sup> See Congressional Budget Office, “CBO’s Health Insurance Simulation Model: A Technical Description,” October 2007. See also Jason Furman, “Health Reform Through Tax Reform: A Primer,” *Health Affairs*, May/June 2008. (The Joint Committee on Taxation recently estimated the exclusion provides \$246 billion in tax subsidies, but this figure falls by about \$40 billion once one accounts for interactions with other existing tax provisions related to health care. The JCT estimate thus is generally consistent with the estimates cited in the text of approximately \$200 billion as well as with prior JCT estimates. See Joint Committee on Taxation, “Tax Expenditures for Health Care,” Testimony before the U.S. Senate Finance Committee, July 30, 2008.) Because state tax rules tend to follow federal rules, states provide additional subsidies for employer-sponsored insurance by exempting employer contributions for health insurance costs from state income taxes.

<sup>18</sup> Paul Ginsburg, “Employment-Based Health Benefits Under Universal Coverage,” *Health Affairs*, May/June 2008

<sup>19</sup> American Academy of Actuaries, “Wading through Medical Insurance Pools: A Primer,” September 2006.

<sup>20</sup> Jonathan Gruber, “Covering the Uninsured in the U.S.,” National Bureau of Economic Research, Working Paper 13758, January 2008. It should be noted that people enrolled in employer-based pools tend to be somewhat healthier on average than the population as a whole, because at least one individual in each insurance unit is able to work on a regular basis and thus to qualify for health insurance if his or her employer offers it.

more workers, where pooling is more effective.<sup>21</sup>

While serving as the primary source of health insurance coverage for Americans, employer-based coverage does suffer from several significant flaws. For example, compared to large employers, small firms — particularly those with the fewest employees — do not pool risk effectively. In many states, small firms can be charged substantially higher premiums if even a single member of the workforce becomes seriously ill.<sup>22</sup> They also typically face higher premiums for less comprehensive health insurance plans than large employers do, in large part because a greater share of the premium goes to administrative, marketing and other overhead costs.<sup>23</sup> Partly as a result, only 45 percent of firms with fewer than 10 workers offered health insurance in 2007,<sup>24</sup> and about 29 percent of workers employed by such firms were uninsured.<sup>25</sup> Smaller employers are also less likely to offer a choice of health insurance plans to their workers.<sup>26</sup>

In addition, while the income tax exclusion subsidizes employer-based coverage, it is highly regressive, with the largest subsidies going to high-income individuals.<sup>27</sup> This is another reason that small firms with a disproportionate number of low-income workers are less likely to offer health insurance coverage.<sup>28</sup> Moreover, as noted, reliance on employer-sponsored insurance can lead to disruptions in coverage, as people generally are not able to retain their health insurance plan when they switch or lose jobs.

Even with these weaknesses, because so many Americans obtain their health insurance through employer-sponsored health insurance, employer-based coverage effectively serves as the principal risk-pooling mechanism in the U.S. health care system.

## B. What is Adverse Selection?

Health insurance pools, including employer-sponsored insurance plans, can function inadequately in pooling risk (and even fail entirely) if they suffer from the phenomenon known as “adverse selection,” which occurs when healthy people and less-healthy people separate into different health insurance arrangements.

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<sup>21</sup> CBPP analysis of 2007 Current Population Survey data.

<sup>22</sup> Leonard Burman, “Tax Code and Health Insurance Coverage,” Testimony before the U.S. House Budget Committee, Tax Policy Center, October 18, 2007.

<sup>23</sup> See, for example, Karen Davis, “Public Programs: Critical Building Blocks in Health Reform,” Testimony before the U.S. Senate Finance Committee, The Commonwealth Fund, June 16, 2008. Small firms tend to offer health insurance plans that have a lower actuarial value (and thus less financial protection) than those provided by larger employers (including the Blue Cross Blue Shield Standard Option now provided to federal employees). See, for example, Jon Gabel, Roland McDevitt, Laura Gandolfo, Jeremy Pickreign, Samantha Hawkins and Cheryl Fahlman, “Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii Is Up, Wyoming Is Down,” *Health Affairs*, May/June 2006.

<sup>24</sup> Kaiser Family Foundation and Health Research Educational Trust, *op cit.*

<sup>25</sup> CBPP analysis of 2007 Current Population Survey data.

<sup>26</sup> Among firms with fewer than 200 workers, 89 percent of employers offered only one health insurance plan to their employees in 2007. Kaiser Family Foundation and Health Research Educational Trust, *op cit.*

<sup>27</sup> The value of the income tax exclusion for employer-sponsored insurance rises with one’s income and tax bracket. Burman, *op cit.*

<sup>28</sup> Furman, *op cit.*

- Adverse selection can result if healthy people decide not to participate in a particular health insurance pool, such as their employer’s health insurance plan, with the result that individuals in poorer health make up a disproportionate share of the pool and thus drive up the average cost of insurance provided through the pool.
- Adverse selection also can occur among health insurance plans, such as between different plans that an employer offers to its workers, if people in better health disproportionately enroll in one of the insurance plans being offered while those in poorer health enroll in another plan. If that occurs, the costs of the plan chosen by the sicker group will rise and that plan may become unaffordable over time.

Adverse selection is not merely a theoretical risk. Within the Federal Employees Health Benefits Plan (FEHBP) during the 1990s, premiums for the more generous Blue Cross and Blue Shield High Option plan increased much faster than premiums for the less generous Low Option plan because healthier federal workers increasingly chose the Low Option plan while sicker federal workers increasingly and disproportionately enrolled in the High Option. This occurred despite only a modest difference in benefits.<sup>29</sup> Eventually, the number of federal workers enrolling in the High Option declined substantially as the cost of the premiums mounted; the premium for the High Option plan ended up being \$2,800 higher than the Low Option premium.<sup>30</sup>

Similarly, Harvard University experienced adverse selection when it first offered its workers less generous HMO coverage alongside a more generous Preferred Provider Organization (PPO) plan. Healthier people disenrolled from the PPO in large numbers and chose the less generous HMO to take advantage of the lower premiums it required. Premiums for the PPO subsequently increased so much, relative to the premiums for the HMO, that within three years, Harvard no longer offered the PPO option because the premiums for it were viewed as prohibitive.<sup>31</sup>

### C. The Risk of Adverse Selection under the Wyden-Bennett Plan

While the Wyden-Bennett plan would give employers the option to continue offering health insurance to their workers as long as the employer plan otherwise met the requirements for health insurance plans offered through the new state-based purchasing pools, the Wyden-Bennett legislation is likely to lead to a substantial reduction in employer-based coverage over time and to the near-elimination of such coverage outside of some large firms (that may opt, at least initially, to continue coverage to avoid disruption and potential complications for their workers).

This is because many employers would likely decline the option to continue offering health insurance to their workers. As noted, the existing income and payroll tax exclusion for employer-sponsored insurance would be eliminated. Any direct employer contributions to the health

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<sup>29</sup> The difference in actuarial value between the two plans was only \$80 in 1994.

<sup>30</sup> Leonard Burman, “Medical Savings Accounts and Adverse Selection,” Urban Institute, 1997. See also W. Pete Welch, “Restructuring the Federal Employees Health Benefits Program: The Private Sector Option,” *Inquiry*, Fall 1989 (for a discussion of adverse selection within FEHBP during the 1980s).

<sup>31</sup> Burman, “Medical Savings Accounts and Adverse Selection,” *op cit* and David Cutler and Sarah Reber, “Paying for Health Insurance: The Tradeoff Between Competition and Adverse Selection,” *The Quarterly Journal of Economics*, May 1998. Notably, neither FEHBP nor Harvard University used risk adjustment, which is discussed in greater detail below, to address adverse selection.

insurance costs of a firm's workers (beyond the contributions based on firm size and revenues per worker that the Wyden-Bennett plan mandates and any contributions that employers elect to make for a few limited purposes such as wellness programs) would constitute taxable income to employees.<sup>32</sup> In addition, employers would no longer be able to deduct contributions for employees' insurance costs as an ordinary business expense, except for the mandated contributions and the limited exceptions such as for wellness programs. (Employers currently offering coverage would be able to deduct the "cash-out" payments that they would be required to make to their employees in the form of higher wages, and the employees could use these payments to purchase coverage either from the state-based pool or from their employer if the employer still offered a plan.)

Another factor is that employers electing to offer health insurance would continue to incur administrative costs in doing so — costs that otherwise would be shifted to the state HHAs that oversee the new health insurance purchasing pools.<sup>33</sup>

Finally, employers would likely derive far less advantage in recruiting and retaining workers by continuing to offer health insurance than they do today, because the plans available through the new state-based purchasing pools would be comparable to the employer plans — both would have to meet the same requirements, including the coverage standard — and because a firm's employees would have the option of obtaining health insurance directly through the purchasing pools.<sup>34</sup>

As a result, over time, many individuals who now have employer-based health insurance would likely be shifted from their current risk pools to the new state-based health insurance purchasing pools that the Wyden-Bennett plan would establish. The critical question thus is whether these new purchasing pools would effectively pool risk, as large employers (and some small employers) now do — and avoid the danger of adverse selection.

The design of the new state-based purchasing pools established by the Wyden-Bennett plan appears to be based on the theory of "managed competition" popularized by Alain Enthoven and others.<sup>35</sup> This theory posits that if health insurers within a pool compete on the basis of price and quality to attract enrollees, they can drive down health spending while improving the quality of care provided.

Plans also can decide to compete, however, at least in part on the basis of "selection": that is, on the basis of which plan can best attract healthier-than-average enrollees who have lower-than-average costs while discouraging enrollment by people in poor health who have very high costs. As Enthoven has written, the goal of managed competition "is to create powerful incentives for health

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<sup>32</sup> In contrast, Massachusetts' health reform plan (which is discussed further below) leaves intact the existing tax subsidies for employer-sponsored insurance, which helps explain why employer-based coverage increased after that plan was implemented. Employers continued to offer health insurance, and some individuals complied with the mandate to purchase health insurance (established as part of the state's reform plan) by opting for coverage offered through their employer.

<sup>33</sup> The Wyden-Bennett plan is silent on whether such administrative costs would continue to be deductible as business expenses.

<sup>34</sup> Because employees could obtain coverage through the purchasing pools directly, employers would have no assurance that many of their workers would participate in the employer's plan (or plans).

<sup>35</sup> See, for example, Alain Enthoven, "The History and Principles of Managed Competition," *Health Affairs*, Supplement 1993.

plans to succeed by improving quality and patient satisfaction, not by selecting good risks and avoiding bad ones.”<sup>36</sup> Unfortunately, it is likely that the Wyden-Bennett plan would (despite its sponsors’ intentions to the contrary) lead to harmful competition based on adverse selection, due to the following features of the plan.

*Insurers would have the flexibility to design benefit packages to disproportionately enroll the healthy and deter enrollment by those in poor health*

Any insurance pool that offers a choice of health insurance plans, as the Wyden-Bennett plan would do, can be vulnerable to adverse selection, depending on the nature of the pool and the plans it offers. That is because insurers have substantial experience in using a number of tools to encourage enrollment by healthier individuals and discourage enrollment by sicker ones.

For example, insurers can institute marketing campaigns that attract individuals in excellent health.<sup>37</sup> Insurers can establish provider networks that are highly restrictive and exclude certain specialty providers needed by people with certain high-cost diseases and illnesses. Insurers also can institute stringent utilization review procedures for certain services needed by people with chronic illnesses and adopt limited drug formularies that exclude various newer, high-cost drugs developed to treat particular medical conditions. In addition, insurers can design benefit packages in ways to disproportionately attract the healthy and discourage the sick from enrolling — for example, by featuring low premiums, high deductibles and substantial cost-sharing and by scaling back coverage of specialty services and other medical services used primarily by the very ill.<sup>38</sup>

The Wyden-Bennett plan does establish a standard for all private health insurance plans regarding the coverage they must offer. But this standard is unlikely to effectively limit the ability of insurers to use benefit design to attract healthier individuals. The standard would simply be that all plans must be actuarially equivalent to the benefits package currently provided under the Blue Cross Blue Shield Standard Option offered to federal employees through FEHBP. This would *not* mean that all plans would have to be identical — or even similar — to the Blue Cross Blue Shield Standard Option plan or have to cover specific benefits to the same extent, or even at all. Rather, this would simply mean that the dollar value of the overall coverage that each plan provides would initially have to match the dollar value of the Blue Cross Blue Shield Standard Option.<sup>39</sup>

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<sup>36</sup> Enthoven, *op cit.*

<sup>37</sup> Under the Wyden-Bennett plan, insurers would be somewhat limited on how much they could spend on marketing activities. The plan requires a “medical loss ratio,” under which some minimum percentage of the health insurance premiums that insurers collect would have to be spent on health care, rather than on administration, profits, and marketing. The effect of this provision is difficult to assess because the plan leaves it to the Secretary of Health and Human Services to decide where the minimum loss ratio should be set. In addition, during implementation, the Secretary (or the individual state-based HHAs) presumably could issue regulations further limiting the marketing practices used by insurers. The Wyden-Bennett plan neither requires nor precludes such regulatory action.

<sup>38</sup> See, for example, Harold Luft and Robert Miller, “Patient Selection in a Competitive Health Care System,” *Health Affairs*, Summer 1998; Joseph Newhouse, “Patients at Risk: Health Reform and Risk Adjustment,” *Health Affairs*, Spring 1994; Richard Kronick and Joy de Beyer, “Risk Adjustment Is Not Enough: Strategies to Limit Risk Selection in the Medicare Program,” The Commonwealth Fund, May 1997; and Congressional Budget Office, “Designing a Premium Support System for Medicare,” December 2006.

<sup>39</sup> Under an actuarial equivalence test, each plan would have to cover an overall dollar amount or percentage of a typical population’s medical costs, as under the actuarial value standard. For a more detailed explanation of how actuarial

A plan could meet this actuarial value standard by charging a substantially higher deductible and/or scaling back certain specialty benefits while increasing the generosity of benefits elsewhere. (Note: Insurers would be prohibited from charging any cost-sharing for preventive, disease management, or chronic pain management services.) This would be similar to the experience with the Medicare Advantage program, under which private plans not only have the flexibility to offer additional benefits but also the discretion to scale back existing Medicare benefits, so long as the actuarial value of the overall package they provide is not less than the value of the package under traditional Medicare. Some private plans have used this flexibility to scale back certain Medicare benefits used primarily by sicker individuals — for example, some plans have imposed substantially higher co-payment charges for days in the hospital and costly treatments like chemotherapy drugs than the changes levied under traditional Medicare<sup>40</sup> — while expanding certain benefits that may hold greater appeal for healthy individuals such as vision and dental care, preventive care, and even membership in gyms or health clubs.<sup>41</sup>

The legislation’s actuarial value standard thus is not actually a benefit plan standard but rather an overall financial generosity standard that allows for quite substantial variation in how insurers design their benefit packages and thus would leave significant opportunity for insurers to craft benefit packages in ways that encourage enrollment by the healthy. An infinite variety of plans could meet the actuarial value standard. As an analysis by the Commonwealth Fund notes, “diversity in benefit packages makes it difficult for beneficiaries to compare and choose among plans, and facilitates market segmentation and risk selection.”<sup>42</sup>

*Health Savings Accounts attached to high deductible health plans could be offered through the new purchasing pools and pose a particular risk of adverse selection*

The Wyden-Bennett plan permits high-deductible plans attached to Health Savings Accounts to be one of the plan options offered through the new state based-insurance pools. Numerous health policy experts and economists have expressed concern that HSA plans pose a significant risk of adverse selection, because such plans are likely to be disproportionately attractive to healthier and more affluent individuals who do not need much in the way of health care and who consequently

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equivalence is determined, see Actuarial Research Corporation, “Study of the Administrative Costs and Actuarial Values of Small Health Plans,” Small Business Administration Office of Advocacy, January 2003. See also John Bertko and Cori Uccello, “Comparing Health Plans: Demystifying ‘Actuarial Equivalence,’” American Academy of Actuaries, July 11, 2008 (which notes that actuarial value calculations do not take into account provider network differences).

<sup>40</sup> See Medicare Rights Center, “Too Good to Be True: The Fine Print in Medicare Private Health Plan Benefits,” April 2007; Brian Biles, Lauren Hersch Nicholas and Stuart Guterman, “Medicare Beneficiary Out-of-Pocket Costs: Are Medicare Advantage Plans a Better Deal?” The Commonwealth Fund, May 2006; Medicare Payment Advisory Commission, “Report to the Congress: Benefit Design and Cost Sharing in Medicare Advantage Plans,” December 2004; Patricia Neuman, “Medicare Advantage: Key Issues and Implications for Beneficiaries,” Testimony before the House Budget Committee, Kaiser Family Foundation, June 28, 2007; and Government Accountability Office, “Medicare Advantage: Increased Spending Relative to Medicare Fee-for-Service May Not Always Reduce Beneficiary Out-of-Pocket Costs,” February 2008.

<sup>41</sup> While plans would have flexibility to design benefit packages so as to attract healthier individuals and discourage enrollment by sicker individuals, the Wyden-Bennett plan would not permit plans to deny enrollment outright to those in poorer health.

<sup>42</sup> Kronick and de Beyer, *op cit*.

are less concerned about the higher out-of-pocket costs required under a high-deductible plan — and who also benefit most from the HSA tax breaks.<sup>43</sup>

Healthy people would be further enticed to enroll in HSA plans by deposits to HSAs made on their behalf by insurers. Under the Wyden-Bennett plan, insurers who offer high-deductible plans attached to HSAs must make tax-free contributions to enrollees' HSA accounts equal to the difference between the actuarial value of the high-deductible coverage itself and the actuarial value standard. For example, if the actuarial value of a high-deductible plan attached to a HSA was determined to be \$500 less than the value of the Blue Cross Blue Shield Standard Option plan, the insurer would be required to contribute \$500 to each of its enrollees' HSAs. For less generous HSA plans with very high deductibles whose actuarial value otherwise is significantly less than the actuarial value standard, the required HSA deposits could be substantial.<sup>44</sup>

The HSA deposits would grow tax free and could be withdrawn tax free if used for out-of-pocket medical costs. They also could be withdrawn on a taxable basis upon retirement, like traditional IRA and 401-k plans. (The Wyden-Bennett plan does sensibly restrict the current tax treatment of HSAs to make them less attractive to high income, healthy individuals. Individuals with HSAs would no longer be permitted to make their own tax-deductible contributions to HSAs and use HSAs primarily as tax shelters. The only contributions allowed would be the deposits made by insurers to comply with the actuarial value standard.<sup>45</sup> However, for a young healthy individual, the insurer contributions could mount over time, so the HSA accounts could still offer enticing tax shelter opportunities.)

In addition, healthy individuals enrolled in HSA plans who later become sick could always switch from HSA plans to other, more comprehensive plans during the next annual enrollment period, thus continuing to leave the pool of individuals enrolled in HSA plans healthier than average. Plan switching out of a plan by individuals becoming sick may be as large a contributor to adverse selection as initial enrollment choice.<sup>46</sup>

If healthier individuals enroll in HSA plans in large numbers over time while less healthy individuals — including very high-cost Medicaid beneficiaries with disabilities and special health care needs who have been transferred from Medicaid — remain in lower-deductible, more comprehensive plans such as plans that mirror the Blue Cross Blue Shield Standard Option, significant adverse selection would result over time and drive up premiums for the more comprehensive plans.

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<sup>43</sup> Edwin Park and Robert Greenstein, "Latest Enrollment Data Still Fail to Dispel Concerns about Health Savings Accounts," Center on Budget and Policy Priorities, Revised January 30, 2006. See also Burman, "Medical Savings Accounts and Adverse Selection," *op cit*; Len Nichols, Marilyn Moon and Susan Wallis, "Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers," Urban Institute, April 1996; American Academy of Actuaries, "Medical Savings Accounts: Cost Implications and Design Issues," May 1995; Daniel Zabiniski, Thomas Selden, John Moeller and Jessica Banthin, "Medical Savings Accounts: Microsimulation Results from a Model with Adverse Selection," *Journal of Health Economics*, April 1999; and Gail Shearer, "The Health Care Divide: Unfair Financial Burdens," Consumers Union, August 10, 2000 (relying on Lewin Group estimates).

<sup>44</sup> Insurer contributions apparently would still be subject to the existing annual contribution limits for Health Savings Accounts — \$2,900 for individual coverage and \$5,800 for family coverage in 2008.

<sup>45</sup> See Congressional Budget Office and the Joint Committee on Taxation, *op cit*.

<sup>46</sup> See, for example, Kronick and de Beyer, *op cit*.

*Default enrollment into the lowest cost plans could increase enrollment by the healthy into HSA plans*

People in poorer health tend to be more active in their health insurance choices than those who are healthy and do not require much in the way of health care. That is because sicker individuals, particularly those with chronic illnesses, need coverage of certain ongoing benefits and generally have established relationships with specific providers who may or may not be part of a particular plan's network.<sup>47</sup> Under the Wyden-Bennett plan, individuals who do *not* choose their own health insurance plan will be enrolled on a default basis into the lowest cost health insurance plan available through their state-based purchasing pool. This could mean further enrollment of younger, healthier-than-average individuals in HSA plans if those are the lowest cost plans in a state.<sup>48</sup>

*Tying the premium subsidies for low- and moderate-income individuals to the cost of the two lowest-cost plans would further encourage enrollment in HSA plans and other low-cost plans, thereby accelerating adverse selection*

The nature of the premium subsidies provided under the Wyden-Bennett plan would further exacerbate adverse selection risks. Subsidies would be based on the average of the premiums of the two lowest cost plans in each state-based purchasing pool. This means that a poor individual eligible for a full premium subsidy would receive a subsidy equal to 100 percent of the average premium cost of the two lowest-cost plans — even if the two lowest-cost plans were both high-deductible plans attached to HSAs and the individual preferred, or was already enrolled in, a somewhat more costly plan that provided comprehensive benefits.

As premiums for more comprehensive plans rose relative to the premiums for the lowest-cost plans due to adverse selection, the premium subsidy provided to low- and moderate-income individuals enrolled in the more comprehensive plans would fall as a percentage of the premiums that those plans charge, which would induce more low- and moderate-income enrollees who are *not* sick to shift out of the comprehensive coverage. Furthermore, as another feature intended to constrain costs, the value of the standard income tax deduction that the Wyden-Bennett plan would establish also would erode over time because the deduction would be adjusted annually only by general inflation rather than by the rate of increase in health care costs. This would increase the unsubsidized premium costs that people would bear over time and likely further induce individuals, particularly those who are healthier, to switch to lower-cost plans. That, in turn, would result in the individuals left in the more comprehensive plans being less healthy, on average, which would further push up premiums for those plans.

Eventually, an adverse selection “spiral” could result, with only the sickest individuals left in the more comprehensive plans and with these people facing very high premiums. Ultimately, such plans could cease to be a viable option for those who otherwise would prefer them. There is a risk that over time, HSA plans could end up being the principal, or even the only, type of choice available in many areas through the purchasing pools.

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<sup>47</sup> Joseph Newhouse, “Patients at Risk: Health Reform and Risk Adjustment,” *Health Affairs*, Spring 1994.

<sup>48</sup> If the lowest cost plan has insufficient capacity to accept every individual enrolled on a default basis, the next lowest cost plan would be designated as the plan for the remaining default enrollment (and so on).

## D. The Inadequacy of Risk Adjustment Alone

In theory, the risk of adverse selection described above could be addressed through a process known as “risk adjustment,” which tries to take into account differences in health status between people enrolled in different plans. According to CBO, “a well-designed risk adjuster could minimize or even eliminate adverse selection spirals.”<sup>49</sup>

Under the Wyden-Bennett plan, each Health Help Agency administering a state-based purchasing pool would take the premiums collected from individuals and the premium subsidies received on individuals’ behalf and “risk adjust” the payments per enrollee that the HHA would make to each insurance plan, in order to take account of the health status of each plan’s enrollees. If the enrollees in a plan were found to be in above-average health, the plan’s average premium payment per enrollee would be adjusted downward. If the enrollees in another plan were found to be in below-average health, the average premium payment per enrollee to that plan would be adjusted upward to reflect the poorer average health of the individuals in the plan.

In practice, however, risk adjustment — while essential — is unlikely to compensate for all or most of the adverse selection likely to result under the Wyden-Bennett plan.<sup>50</sup>

- As CBO has explained, “Current risk-adjustment systems tend to overpredict the costs of beneficiaries who end up with low health care spending and to underpredict the costs of those who end up with high spending. If those differences are systematic, they could cause premiums for enrollees in plans that attract higher-cost beneficiaries to rise substantially over time.”<sup>51</sup>
- Similarly, researchers from the Commonwealth Fund, citing Medicare’s experience with risk adjustment (Medicare’s risk adjustment methods are generally considered the state-of-the-art in this area), have concluded that “risk adjustment is difficult and imperfect.”<sup>52</sup>
- The ability of risk adjustment to help compensate for adverse selection would be further diminished if there were inaccurate measurement of the comparative health status of enrollees across the different plans in each state-based purchasing pool. This is a significant concern. There is growing evidence of distortion in the measurement of health status in the risk adjustment process used in the Medicare Advantage program; the patterns of diagnosis codes that are assigned to patients by their providers — and then used to measure health status for risk-adjustment purposes — have changed rapidly since Medicare implemented its current risk adjustment methods and have done so in a way that makes Medicare beneficiaries enrolled in private plans appear to be less healthy than they actually may be, relative to beneficiaries enrolled in traditional fee-for-service Medicare.<sup>53</sup> The less healthy a plan’s beneficiaries appear

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<sup>49</sup> Congressional Budget Office, *op cit.*

<sup>50</sup> While inadequate, risk adjustment, constitutes an essential element of any health reform effort that takes a similar approach to the Wyden-Bennett plan.

<sup>51</sup> Congressional Budget Office, *op cit.*

<sup>52</sup> See Schoen, Davis and Collins, *op cit.*

<sup>53</sup> See Edwin Park and Robert Greenstein, “Congress to Consider Repeal of Medicare Demonstration Project Designed to Promote Privatization, Rather than Yield Valid Results,” Center on Budget and Policy Priorities, July 23, 2007. See also Congressional Budget Office, *op cit.*

to be, the higher the risk-adjusted payments the plan receives.

For these reasons, it is likely that risk adjustment alone would fall well short of offsetting the significant adverse selection likely to occur among the health insurance plans provided through the state-based purchasing pools that the Wyden-Bennett plan would establish.

### E. Modifications Needed to Limit the Risk of Adverse Selection Under the Wyden-Bennett Plan

The American Academy of Actuaries has counseled that, “[p]ooling is essential for a healthy insurance program, but it does not by itself, guarantee viability.”<sup>54</sup> That is because any health insurance pool faces the risk of adverse selection.

A fundamental priority then is to minimize the risk of adverse selection to the fullest extent possible. The smaller the degree of risk selection that is present, the greater the ability of risk adjustment mechanisms to compensate for most of the risk that exists. The Wyden-Bennett plan would need the following types of modifications to significantly reduce the danger of extensive adverse selection under the bill.

- **Drop the Health Savings Accounts.** The Wyden-Bennett plan eliminates nearly all existing tax subsidies for health insurance and health care — except for those related to HSAs. (The bill would modify but not end the tax benefits that HSAs now enjoy.) Ending the remaining tax preferences for HSAs and not allowing them to be offered in conjunction with high-deductible health insurance plans within the state-based purchasing pools would eliminate the risk of adverse selection that HSA-related plans pose relative to more comprehensive plans.
- **Standardize the benefit packages.** The actuarial value standard required of the health insurance plans that would be offered through each state-based purchasing pool is loose and allows for benefit packages to be varied in numerous ways to attract healthier enrollees and deter enrollment by those in poorer health. The expansive flexibility that plans would have to design benefit packages in this fashion could be limited by much greater standardization of benefits. (This does not mean that only one type of health insurance plan could be offered; to the contrary, a number of benefit packages could still be permitted.)

Increased standardization is essential to reducing the risk of adverse selection and would be consistent with the theory of managed competition underlying the Wyden-Bennett plan, under which plans are supposed to compete based on price and quality rather than on risk selection. Alain Enthoven has explained that “standardization should deter product differentiation, facilitate price comparisons, and counter market segmentation.” Similarly, in discussing the Clinton health reform plan in the 1990s, Joseph Newhouse, a noted Harvard health economist, observed that “a standardized benefit package, for example, makes segmenting the market more difficult; differing covered services among plans will attract different risks.”<sup>55</sup> While some may argue that overly restricting benefit variation could risk stifling plan innovation that lowers cost and improves quality,<sup>56</sup> a middle ground could be found that significantly limits the benefit

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<sup>54</sup> American Academy of Actuaries, *op cit.*

<sup>55</sup> Newhouse, *op cit.*

<sup>56</sup> Congressional Budget Office, *op cit.*

variation in any given state — and thus restricts the ability of insurers to use variations in benefit packages in order to compete based on risk selection — but still preserves the choice of several benefit-package designs.

- **Change the default enrollment system.** As discussed above, individuals who do not choose a specific health insurance plan would be automatically enrolled in the lowest cost health insurance plan offered through their state’s purchasing pool. Default enrollment in the lowest cost plan could facilitate adverse selection if those who are enrolled on a default basis tend to be healthier than average and the lowest cost plans are already disproportionately attractive to the healthy. Default enrollment could instead be done on a random basis or by “intelligent assignment,” where enrollment is based to some extent on an individual’s existing providers and ongoing use of certain services to ensure continuity of care.
- **Modify the premium subsidy system.** In the absence of other changes that significantly limit the risk of adverse selection, tying the premium subsidies available under the Wyden-Bennett plan to the average of the two lowest-cost plans is likely to facilitate further adverse selection, because the lowest cost plans may be less costly primarily because they have disproportionately attracted healthier enrollees rather than because they are the most efficient plans. The premium subsidies could instead be tied to a fixed percentage of each insurance plan’s premiums, whatever those costs are. As noted, while tying the premium subsidies to the lowest-cost plans likely is intended to promote enrollment in cost-effective plans, and the modification proposed here could reward some inefficient plans with poorer quality of care and increase overall costs under the Wyden-Bennett plan, it also would effectively serve as a cross-subsidy of higher cost plans that may be disproportionately enrolling individuals in poorer health. It also would make more comprehensive plans affordable for low- and moderate-income individuals. Alternatively, the subsidies could be tied to a fixed percentage of premiums, but only up to an annual dollar limit equal to the average premium weighted by enrollment, as is done under FEHBP currently. Research has shown that this approach has somewhat reduced adverse selection.<sup>57</sup>

These modifications would not guarantee the elimination of adverse selection risks; no health reform plan of this type, no matter how well-designed, could reasonably remove all adverse selection risks. But these revisions could moderate to a substantial extent the selection risks that otherwise will be present under the Wyden-Bennett plan.

## **2. Does the Plan Adequately Protect Vulnerable Low-Income Beneficiaries Enrolled in Medicaid and SCHIP?**

Public programs like Medicaid and SCHIP are expected to provide health insurance coverage to an estimated 62.9 million low-income individuals during the course of fiscal year 2008,<sup>58</sup> many of whom have historically been excluded from the private insurance market. Medicaid and SCHIP

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<sup>57</sup> As noted, FEHBP does not use risk adjustment in its premium subsidies. Curtis Florence and Kenneth Thorpe, “How Does the Employer Contribution for the Federal Employees Health Benefits Program Influence Plan Selection,” *Health Affairs*, March/April 2003.

<sup>58</sup> Congressional Budget Office, “Fact Sheet for CBO’s March 2008 Baseline: Medicaid,” March 11, 2008. A smaller number of people is enrolled at any point in time. The 62.9 million figure is the number of people who are enrolled at some time during the year.

ensure access to needed care for beneficiaries. Among children, for example, they provide a usual source of care, furnish preventive care, treat unmet medical needs, and limit delays in seeking care because of cost — and do so at levels generally equivalent to those found for children covered under private insurance plans.<sup>59</sup>

As discussed below, Medicaid and SCHIP also cover various health care and related services that are needed by people with disabilities and special health care needs but are not typically covered by private insurance plans. In addition, Medicaid and SCHIP limit premiums and cost-sharing to levels well below those common under private insurance and serve a unique role in supporting integrated state programs that provide important services to vulnerable populations.

At the same time, the public programs are in need of improvement. Despite significant progress in simplifying eligibility and renewal procedures to make it easier for eligible individuals to participate and remain on the programs, millions of low-income uninsured children and adults are eligible for Medicaid and SCHIP but remain unenrolled.<sup>60</sup> The programs also are vulnerable to state budget cuts, particularly during economic downturns when more low-income families become eligible as breadwinners lose their jobs and health insurance and program costs rise.<sup>61</sup> In addition, particularly in Medicaid, some beneficiaries may lack access to needed providers because of low provider reimbursement rates.<sup>62</sup>

Nevertheless, converting Medicaid and SCHIP into supplemental health insurance programs, as the Wyden-Bennett plan would do, would raise serious questions and pose difficult challenges. It could have a large effect on Medicaid and SCHIP beneficiaries and their access to needed care.

### **A. Public Programs' Unique Coverage Role**

#### *Medicaid provides coverage not offered by private insurance*

Medicaid covers a number of low-income populations that have historically been excluded from the private insurance market. This includes people with disabilities and chronic illnesses, children with special health care needs, the frail elderly, and individuals needing long-term care. These individuals generally are unable to purchase coverage on their own in the individual market due to their health status. They also may lack access to employer-based coverage because they are not employed or because such coverage is not sufficient to meet their special health needs.

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<sup>59</sup> See, for example, Leighton Ku, Mark Lin and Matthew Broaddus, “Improving Children’s Health: A Chartbook about the Roles of Medicaid and SCHIP,” Center on Budget and Policy Priorities, January 2007 and Kaiser Commission on Medicaid and the Uninsured, “Impacts of Medicaid and SCHIP on Low-Income Children’s Health,” May 2007. See also Diane Rowland and Jim Tallon, “Medicaid: Lessons Drawn from a Decade,” *Health Affairs*, January/February 2003.

<sup>60</sup> Researchers from the Urban Institute estimated that in 2004, 25 percent of uninsured adults and children were eligible for Medicaid and SCHIP. See John Holahan, Allison Cook and Lisa Dubay, “Characteristics of the Uninsured: Who Is Eligible for Public Coverage and Who Needs Help Affording Coverage,” Kaiser Commission on Medicaid and the Uninsured, February 2007.

<sup>61</sup> See, for example, Stan Dorn, Bowen Garrett, John Holahan and Aimee Williams, “Medicaid, SCHIP and Economic Downturn: Policy Challenges and Policy Responses,” Kaiser Commission on Medicaid and the Uninsured,” April 2008.

<sup>62</sup> For example, as part of its comprehensive health reform plan, the Commonwealth Fund has proposed to increase Medicaid provider payment rates to “promote equity and strengthen Medicaid provider networks.” See Schoen, Davis and Collins, *op cit*.

To meet the needs of these high-risk low-income populations, Medicaid covers a number of services and supports that are beyond the scope of the benefits that private health insurance provides:<sup>63</sup>

- Medicaid provides a number of health services not offered by private insurance that are tailored to meet the specific needs of low-income people with disabilities, chronic illnesses and other special health care conditions. Such services are provided, for example, under Medicaid's rehabilitation option. That option includes coverage for an evidence-based treatment regimen that provides skills training and other supports to people with serious mental illness, as well as non-emergency medical transportation for individuals who need such assistance to see their health care providers and case management to coordinate medical, social and educational services for people with disabilities and special health care needs.
- Similarly, for low-income people with serious disabilities, Medicaid covers some complex services and supports intended to maintain functioning at the optimal level possible (even if improvement is unlikely) and to facilitate independent living. In contrast, private insurance tends either to cover services like speech and physical therapy only to the extent that they meet a narrow definition of medical necessity — when a condition can actually be ameliorated and normal functioning restored — or not to cover such services at all.<sup>64</sup>
- Medicaid also provides the Early Periodic Screening, Diagnostic and Treatment (EPSDT) benefit to low-income children. This benefit provides treatment that covers any service needed to treat any diagnosed health condition that a child has, even if the service is not otherwise covered by the state's Medicaid program. This benefit is much more comprehensive than comparable children's benefits under the Blue Cross Blue Shield Standard Option plan, since EPSDT is intended to broadly promote child development rather than just to provide acute care treatment.<sup>65</sup>
- In addition, Medicaid covers long-term care and services, including nursing home stays and home and community-based care, which are not covered by private insurance (or Medicare). Medicaid currently covers six of every 10 nursing-home residents and finances more than 40 percent of total long-term care spending in the United States.<sup>66</sup> While the majority of Medicaid beneficiaries who require long-term care are seniors, 45 percent of long-term-care beneficiaries are non-elderly people with disabilities, including both adults and children.<sup>67</sup>

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<sup>63</sup> Research has shown that even with these services and supports, Medicaid is more cost-effective than private insurance. The research finds that after taking into account differences in health status between individuals enrolled in Medicaid and those in private insurance, medical spending per person is lower under Medicaid than under private insurance. This appears largely to be due to Medicaid's lower provider reimbursement rates and administrative costs. See Leighton Ku and Matthew Broaddus, "Public and Private Insurance: Stacking Up the Costs," *Health Affairs* (Web Exclusive), June 24, 2008.

<sup>64</sup> See, for example, The Commonwealth Fund and George Washington University, "Comparing EPSDT and Commercial Insurance Benefits," September 2005.

<sup>65</sup> The Commonwealth Fund and George Washington University, *op cit.*

<sup>66</sup> Kaiser Commission on Medicaid and the Uninsured, "The Uninsured: A Primer," October 2007.

<sup>67</sup> Judith Kasper, Barbara Lyons and Molly O'Malley, "Long-Term Services and Supports: The Future Role and Challenges of Medicaid," Kaiser Commission on Medicaid and the Uninsured, September 2007.

As the Kaiser Commission on Medicaid and the Uninsured has noted, “Medicaid plays a critical role in providing health care services to people with disabilities — both filling in the gaps in Medicare and in private health insurance and going beyond the medical model to offer the broad array of services needed by people with severe disabling conditions.” The Kaiser Commission added that “Doctor visits and prescription drugs alone are insufficient to enable an individual with severe paralysis to get to his or her job — personal care assistance, transportation, and assistive services, all covered by Medicaid — are essential adjuncts to medical care.”<sup>68</sup>

In comparison, some SCHIP plans may mirror private insurance plans such as the Blue Cross Blue Shield Standard Option plan.<sup>69</sup> For example, SCHIP plans do not cover EPSDT unless a state has elected the option to use federal SCHIP funds to expand Medicaid. (For the 33 states that use SCHIP funds to help finance a Medicaid expansion for children rather than a separate state children’s health insurance program, or that use SCHIP funds for a combination of these two approaches,<sup>70</sup> the benefits provided under the SCHIP-funded Medicaid expansion programs are identical to those furnished under regular Medicaid, including benefits like EPSDT that are not offered under private insurance plans.)

*Both Medicaid and SCHIP substantially limit premiums and cost-sharing for low-income beneficiaries*

Because the populations they serve have low incomes, both Medicaid and SCHIP limit the premiums and cost-sharing charged to beneficiaries to levels well below those that private insurance plans charge. Medicaid generally does not charge premiums and requires only small co-payments of approximately \$3 per service.<sup>71</sup> SCHIP limits total premiums and cost-sharing to no more than five percent of a family’s annual income.

In contrast, workers’ average premium cost for their share of private employer-based family coverage was \$3,281 in 2007.<sup>72</sup> In addition, for people enrolled in employer-sponsored Preferred Provider Organization (PPO) plans that charge annual deductibles, the average deductibles were \$492 per family member in 2007. (Plans using aggregate family deductibles had average deductibles of \$1,040 per family.) Similarly, employer plans charge co-payments, on average, of between \$15 and \$25 per office visit to physicians within the plan network and co-insurance of up to 33 percent of the cost of out-of-network doctor visits.<sup>73</sup>

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<sup>68</sup> Diane Rowland, “Medicaid’s Role for People with Disabilities,” Testimony before the House Energy and Commerce Committee, Kaiser Commission on Medicaid and the Uninsured, January 16, 2008.

<sup>69</sup> Under SCHIP, states must provide one of three benefit benchmark plans — the Blue Cross Blue Shield Standard Option plan, the plan offered to state employees, or the HMO plan with the largest enrollment in the state — or a plan actuarially equivalent to one of these three benchmarks.

<sup>70</sup> Center for Medicare and Medicaid Services, “FY 2007 Annual Enrollment Report,” February 7, 2008.

<sup>71</sup> The Deficit Reduction Act of 2005 gave states greater flexibility in charging certain Medicaid populations higher premiums and cost-sharing as long as aggregate premiums and cost-sharing do not exceed five percent of a family’s annual income, as under SCHIP.

<sup>72</sup> The average premium cost for individual employer-sponsored health insurance was \$694 in 2007. Kaiser Family Foundation and Health Research Educational Trust, *op cit*.

<sup>73</sup> Kaiser Family Foundation and Health Research Educational Trust, *op cit*.

*Providing supplemental wrap-around coverage on benefits and cost-sharing would be difficult*

The Wyden-Bennett plan proposes to shift low-income Medicaid and SCHIP beneficiaries into the private insurance plans that would be offered through the new state-based purchasing pools. Medicaid and SCHIP beneficiaries would receive secondary coverage through Medicaid and SCHIP that supplements private insurance plans by covering those Medicaid and SCHIP benefits that private insurance does not cover (such as EPSDT for Medicaid-eligible children and various services for people with disabilities) and by picking up premiums, deductibles and cost-sharing charges to the extent that those charges exceed the Medicaid and SCHIP cost-sharing limits. (The current open-ended Medicaid financing structure and the individual Medicaid entitlement apparently would not be affected.)

This sounds reasonable in theory. In practice, however, providing seamless supplemental coverage is extremely difficult to do. Experience with Medicaid and SCHIP illustrates the hurdles that would have to be surmounted.

- Nearly all states contract with private managed care plans to provide Medicaid benefits to families and children. Certain services, such as EPSDT, are often carved out, with the state still directly responsible for the coverage of EPSDT as a wrap-around benefit. This has produced mixed results. Some families have not been aware they are eligible for supplemental coverage for additional benefits their children need.<sup>74</sup> In addition, because EPSDT services are well outside the scope of their usual benefit packages, managed care plans often have not fully appreciated the complexity of providing benefits to children with special health care needs or of establishing effective coordination with the state and various health care providers in providing the needed supplemental benefits.<sup>75</sup> Finally, the medical necessity standards that private managed care plans use may differ substantially from the necessity standards under EPSDT, with the result that some parents may fail to access certain services that their children need and are eligible for under EPSDT after having been denied coverage for those services by their managed care plan.<sup>76</sup>
- Few states have used what is known as “premium assistance” in their Medicaid and SCHIP programs, in part because of state concerns about the complexity of providing wrap-around coverage.<sup>77</sup> Under premium assistance, Medicaid or SCHIP-eligible children or families enroll in employer-based coverage, with the state generally providing wrap-around benefits for those

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<sup>74</sup> Sara Rosenbaum and Colleen Sonosky, “Federal EPSDT Coverage Policy: An Analysis of State Medicaid Plans and State Medicaid Managed Care Contracts,” Health Care Financing Administration, December 2000.

<sup>75</sup> Deborah Curtis, Neva Kaye and Trish Riley, “Transitioning to Medicaid Managed Care: Children with Special Health Care Needs,” National Academy of State Health Policy, October 1999.

<sup>76</sup> See Andy Schneider, “The Medicaid Resource Book,” Kaiser Commission on Medicaid and the Uninsured, July 2002.

<sup>77</sup> Because of concerns about administrative complexity, some states have, with the encouragement of the Bush Administration, obtained waiver approval from the Centers for Medicare and Medicaid Services to provide premium assistance *without* wrap-around coverage, an approach that generally reduces access to benefits otherwise covered under Medicaid and increases out-of-pocket medical costs for beneficiaries enrolled in premium assistance. Other factors contributing to limited state adoption of premium assistance programs include the inability of states to demonstrate cost effectiveness (to adopt premium assistance, a state must show that premium assistance will be no more costly than providing Medicaid and SCHIP directly) and lack of employer-based health insurance among most low-income workers and families eligible for Medicaid and SCHIP.

health services that Medicaid or SCHIP covers but the employer plan does not, as well as for cost-sharing charges that exceed Medicaid and SCHIP limits. Because of the large number of employers and the wide variation in benefits, premiums and cost-sharing among employer plans, some states have been discouraged from instituting “premium assistance” by the administrative complexity of coordinating benefits with many different plans, monitoring cost-sharing charges in numerous employer-sponsored plans to see if enrollees have exceeded the Medicaid and SCHIP cost-sharing limits and thus need a Medicaid or SCHIP subsidy, and establishing workable payment systems to pay providers for benefits that the employer-based plans do not cover.<sup>78</sup> There also is some limited evidence from the premium assistance experience in Medicaid which suggests that wrap-around coverage works least well in covering health care *services* not covered by employer plans, as distinguished from its performance in defraying excess *cost-sharing charges* that an employer plan may impose.<sup>79</sup>

- Similar difficulties have arisen among those low-income *Medicare* beneficiaries enrolled in private Medicare Advantage plans who are “Qualified Medicare Beneficiaries” (QMBs). These are poor Medicare beneficiaries for whom *Medicaid* pays their *Medicare* premiums and cost-sharing charges. Because of confusion on the part of private plans and poor coordination with states, many of the health care providers that Medicare Advantage plans use reportedly have imposed cost-sharing charges directly on these low-income beneficiaries, despite the fact that Medicaid should be paying those charges. Earlier this year, the Centers for Medicare and Medicaid Services had to clarify once again the requirement that private plans and their providers cannot charge cost-sharing to Qualified Medicare Beneficiaries and that state Medicaid programs are responsible for paying those charges.<sup>80</sup> (The overall lack of coordination between Medicare and state Medicaid programs for “dual eligibles” — i.e., for those Medicare beneficiaries who also are eligible for Medicaid — and the difficulty of developing integrated programs for these beneficiaries’ acute-care needs, which *Medicare* covers, and their long-term care needs, which *Medicaid* covers, has likely resulted in lower quality of care and higher costs.<sup>81</sup>)

The Wyden-Bennett plan provides little detail on how Medicaid and SCHIP programs would effectively implement wrap-around programs for their beneficiaries or how such an approach would produce better results than has been the historical experience with public programs and wrap-around coverage. If anything, the risk is of greater difficulties in this area under the Wyden-Bennett plan, because states would have to attempt to wrap around a number of different plans in each pool

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<sup>78</sup> See Joan Alker, “Serving Low-Income Families through Premium Assistance: A Look at Recent State Activity,” Kaiser Commission on Medicaid and the Uninsured, October 2003. See also Cynthia Shirk and Jennifer Ryan, “Premium Assistance in Medicaid and SCHIP: Ace in the Hole or House of Cards?,” National Health Policy Forum, July 17, 2006 and Richard Curtis and Edward Neuschler, “Premium Assistance,” in *The Future of Children*, “Health Insurance for Children,” Spring 2003.

<sup>79</sup> See Joan Alker, “Premium Assistance Programs: How Are They Financed and Do States Save Money?,” Kaiser Commission on Medicaid and the Uninsured, October 2005, which reports that 93 percent of the Medicaid costs for wrap-around coverage incurred by Rhode Island’s premium assistance program — a program often touted as a model — were for cost-sharing alone rather than for benefits.

<sup>80</sup> Letter from Gail Arden to All Associate Regional Administrators, Centers for Medicare and Medicaid Services, February 27, 2008. See also Center for Medicare Advocacy, “Medicare Cost-Sharing in Medicare Advantage Plans: Who Pays for Dual Eligibles?,” May 31, 2007.

<sup>81</sup> See Jeffrey Crowley, “Disability Community Perspective at the Medicaid Managed Care Roundtable,” Statement before the Senate Special Committee on Aging, Georgetown University Health Policy Institute, September 13, 2006.

that may provide widely varying benefits, premiums, and cost sharing.<sup>82</sup> (There also is significant risk that many low-income families and individuals who are eligible for Medicaid will not apply or will let their enrollment lapse when it comes up for renewal, because they perceive that they already “have insurance,” do not understand that enrollment in Medicaid brings important supplemental benefits, and thus see little reason to shoulder the paperwork and other burdens and devote the time that enrolling in Medicaid can entail.)

Unless the Medicaid and SCHIP supplemental coverage that would wrap around the private insurance plans offered through the new purchasing pools were provided in a much more effective manner than has been true of past efforts to provide wrap-around coverage, it is likely that a substantial number of low-income beneficiaries would lose access to some needed benefits or face higher premiums and/or cost-sharing charges than are now permitted.

Because of the nature of the vulnerable populations on Medicaid and SCHIP and their special health care needs — and the fact that cost-sharing disproportionately affects low-income people and reduces their access to care<sup>83</sup> — the Wyden-Bennett plan could have the unintended effect of placing a number of low-income individuals on Medicaid and SCHIP at significant risk of losing access to some needed care.

## **B. Medicaid’s Key Role in Supporting Other State Programs Serving Vulnerable Populations**

The health services and supports that Medicaid provides not only go beyond what private insurance ordinarily covers but also are often integrated into other state programs that coordinate and provide care for people with disabilities, children in foster care, individuals with developmental disabilities, and other vulnerable groups.

- As part of a comprehensive package of services that they offer to certain vulnerable low-income groups, state social service agencies and programs provide certain health and related support services that Medicaid covers. For example, many state child welfare systems, mental health and disability programs for children and adults, and special education and early intervention programs receive Medicaid reimbursement (through the Medicaid case-management benefit) for coordinating diverse health, social, supportive, and educational services for individuals they serve who are Medicaid beneficiaries. Research has shown that such integration of Medicaid-covered health services with other services can be cost-effective and improve the quality of services that vulnerable populations are provided.<sup>84</sup>
- These programs receive virtually no independent federal funding for the health-care services

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<sup>82</sup> To complicate matters further, under the Wyden-Bennett plan, each individual enrolled in a given plan could be charged a different premium, depending on his or her income and the size of the premium subsidy (if any) for which he or she qualified. Because the full premium subsidy would be limited to the average of the two lowest-cost plans, the proportion of an individual’s premium that would be defrayed by the premium subsidy would vary by health insurance plan, depending on whether the plan is a low-cost or higher-cost plan.

<sup>83</sup> Leighton Ku and Victoria Wachino, “The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings,” Center on Budget and Policy Priorities, Revised July 7, 2005.

<sup>84</sup> See, for example, Henry Ireys, Sheila Pires and Meredith Lee, “Public Financing of Home and Community Services for Children and Youth with Serious Emotional Disturbances: Selected State Strategies,” Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, June 2006.

and related supports they provide to Medicaid-eligible individuals, other than the funding that comes through Medicaid.<sup>85</sup> In 2005, Medicaid accounted for the majority of federal and state expenditures on developmental disability services. Similarly, in 2001, Medicaid provided 27 percent of national expenditures for mental health services, making it the largest single source of mental health financing.<sup>86</sup>

State child welfare, mental health, and developmental disability programs have responsibility for addressing the health care needs and the social and educational needs of vulnerable populations. Under the Wyden-Bennett plan, it likely would prove difficult for states to continue to effectively integrate health and social services provided by multiple state agencies with the private insurance plans that would replace Medicaid as the primary form of health insurance for these vulnerable populations. That, in turn, could reduce the coordination of care and access to needed services. These programs also could lose substantial funding they need to continue providing health-related services to these vulnerable populations.

The Wyden-Bennett plan does not address the question of how it would protect access to vital health services and supports that are now provided to a number of high-risk, vulnerable populations on an integrated basis through other state social service programs.

### **C. State Behavior Under the Wyden-Bennett Plan**

As primary responsibility for the health care costs of Medicaid and SCHIP beneficiaries is shifted from those programs to the private insurance plans offered through the state-based purchasing pools, state governments would achieve significant savings. The Wyden-Bennett plan would require states to make annual “maintenance-of-effort” payments to the federal government in amounts intended to equal those savings.<sup>87</sup> States would not receive a net financial benefit.

It is unclear what states would do once the Wyden-Bennett plan was implemented. Assuming the required maintenance-of-effort payments were calculated accurately, states would neither be better nor worse off financially than under current law. Nevertheless, as explained below, some states could decide to scale back their optional Medicaid and SCHIP coverage.

Federal Medicaid law requires states to cover certain “mandatory” populations, such as children below the poverty line and low-income seniors and people with disabilities who are enrolled in the Supplemental Security Income program. States have the option of covering additional populations, such as poor seniors with incomes too high to qualify for SSI and additional low-income children, but are not required to do so. According to the Kaiser Commission on Medicaid and the Uninsured, 29 percent of all Medicaid beneficiaries (and nearly half of elderly Medicaid beneficiaries) are from so-called “optional” populations.

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<sup>85</sup> Christine Ferguson, Patricia Riley and Sara Rosenbaum, “Medicaid: What Any Serious Health Reform Proposal Needs to Consider,” included in Economic and Social Research Institute, “Covering America: Real Remedies for the Uninsured, Volume II,” November 2002.

<sup>86</sup> Jeffrey Crowley and Molly O’Malley, “Profiles of Medicaid’s High-Cost Populations,” Kaiser Commission on Medicaid and the Uninsured, December 2006.

<sup>87</sup> Technically, the federal government would reduce premium subsidy payments to the HHAs administering the state-based purchasing pools by the amount that states owed under the maintenance-of-effort requirement.

Federal law also requires states to cover certain benefits like hospital and physician services and nursing home care, while other services — like prescription drugs and many of the services provided to people with disabilities, such as personal care, rehabilitation, and case management — are optional, although most or all states provide many of those services. The Kaiser Commission on Medicaid and the Uninsured reports that optional populations and/or optional benefits account for more than 60 percent of overall Medicaid spending.<sup>88</sup> (In other words, 40 percent of Medicaid expenditures goes to provide mandatory services to mandatory beneficiaries, while the other 60 percent goes either to provide optional services to mandatory beneficiaries or to cover optional beneficiaries.) In addition, the entire SCHIP program is optional to the states; federal law does not require a state to operate an SCHIP program, although all states do.

The Wyden-Bennett plan generally would not alter these requirements. The question is whether the transfer of primary responsibility for covering low-income people from Medicaid to the new private insurance plans would lead some states to scale back the optional populations they now cover and/or the optional benefits they now provide. States seeking budgetary savings could elect to do so, knowing that their beneficiaries would have at least some basic health coverage. One attraction to states would be that to the extent they did scale back, they could lessen or avoid the considerable administrative burdens of providing wrap-around coverage for these optional populations and benefits.<sup>89</sup>

In addition, since SCHIP has always permitted benefit packages similar to those that private insurance provides, some states could conclude there no longer is a need to continue their SCHIP programs. If that occurred, it would be a matter of serious concern: loss of SCHIP would eliminate SCHIP's ceiling on premium and cost-sharing charges, set at 5 percent of family income. Many low-income children could face considerably higher cost-sharing burdens if SCHIP programs faded away. Furthermore, if states with SCHIP-funded *Medicaid* expansions for children scaled back or eliminated those expansions, the children no longer enrolled in SCHIP-funded Medicaid programs might lose their access to Medicaid services like EPSDT that would not be covered through the private insurance plans.<sup>90</sup>

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<sup>88</sup> Kaiser Commission on Medicaid and the Uninsured, "Medicaid: An Overview of 'Mandatory' vs. 'Optional' Populations and Services," June 2005.

<sup>89</sup> To limit enrollment and thus reduce the cost and hassles of providing supplemental wrap-around coverage, some states also could elect to roll back in part or in whole some steps they have taken to simplify Medicaid and SCHIP application and renewal procedures and thereby to boost enrollment among eligible low-income families. During the economic slowdown in the early part of this decade when many states faced fiscal difficulties, a number of states acted to undo such steps in order to lower costs.

<sup>90</sup> Section 202 of the Wyden-Bennett legislation (S. 334) requires that a child continue to receive coverage through Medicaid for those health care items and services not available through the new private insurance plans "that the child would have received under the Medicaid program of the State in which the child resides if the Healthy Americans Act had not been enacted," including EPSDT services. This provision appears to at least require that children on Medicaid prior to implementation of the Wyden-Bennett plan continue receiving all Medicaid items and services they would have received in the absence of the Wyden-Bennett plan. The provision also would apparently underscore the fact that nothing in the Wyden-Bennett plan would affect the requirement in current law that states must ensure that children enrolling in Medicaid who fall into a "mandatory" coverage category be covered at least for all mandatory services. Senator Wyden's staff has indicated that this provision also is intended to prevent states from scaling back "optional" eligibility and benefits for children. But the current legislative language is highly imprecise, and it remains unclear to what extent — if any — this provision would place any actual requirements on states to provide coverage for children in

It is unclear how likely such scenarios would be. States that traditionally have maintained generous public health insurance programs might elect to continue these programs indefinitely, providing the same level of eligibility, benefits and cost-sharing limits as at present. A few states might even expand their programs. On the other hand, other states, particularly those that historically have operated less generous public programs, might scale back their programs significantly to obtain fiscal savings, unless the plan is modified to preclude that. (Senator Wyden's staff has said the plan is not intended to have this effect.<sup>91</sup>)

One other factor to consider is that, according to the Congressional Budget Office, the maintenance-of-effort payments that states would be required to make to the federal government would be modeled on the "clawback" payments established under the Medicare prescription drug law. (Under that law, states must make payments to the federal government each year to reimburse it for a large portion of the savings that states are securing from the shift of primary responsibility for prescription drug coverage from Medicaid to Medicare for those low-income Medicare beneficiaries who also are enrolled in Medicaid.) Particularly in their first year, these clawback payments turned out to be higher than expected. Many states maintain that the clawback payments are being calculated under a flawed formula that forces them to pay the federal government more than it would have cost them to continue providing drug coverage to these individuals through Medicaid.<sup>92</sup>

If states similarly come to believe they are paying more in maintenance-of-effort payments under the Wyden-Bennett plan than they would have paid to provide Medicaid and SCHIP coverage under current law, they would have an additional incentive to scale back optional coverage. States also may feel pressure to reduce optional coverage if they believe the required maintenance-of-effort payments are rising at a faster annual growth rate than their Medicaid and SCHIP spending would have increased under current law. (Under the Wyden-Bennett plan, the required maintenance-of-effort payments would be increased each year by the percentage that total national health spending has increased on a nominal basis.)

Yet another factor to consider is the effect of adverse selection on states' responsibility to provide supplemental wrap-around coverage for Medicaid and SCHIP beneficiaries. If widespread adverse selection occurred, premiums for more comprehensive health plans would rise significantly. To the extent that low-income Medicaid and SCHIP beneficiaries elected those plans — and low-income people with disabilities, special health care needs, or chronic illnesses would likely prefer those plans — states would apparently be required to pay these substantially higher premiums as part of the

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"optional" coverage categories who become eligible in the future or for "optional" health care services for children qualifying in the future. Clarification of the bill's language could address this matter.

<sup>91</sup> Senator Wyden's staff advises that the plan's intention is to freeze Medicaid eligibility and benefits in place in each state at the time of enactment for children (as well as for the elderly). Our analysis of the legislative language finds, however, that it does not produce this result for children (see footnote 90) and similarly, there is nothing in the plan instituting such a freeze for seniors. Senator Wyden's staff has indicated they are open to modifying the legislative language of the plan to institute such a freeze.

<sup>92</sup> See Andy Schneider, "The Clawback: State Financing of Medicare Drug Coverage," Kaiser Commission on Medicaid and the Uninsured, June 2004. See also Kaiser Commission on Medicaid and the Uninsured, "An Update on the Clawback: Revised Health Spending Data Change State Financial Obligations for the New Medicare Drug Benefit," March 2006.

supplemental coverage they would be required to provide.<sup>93</sup> At the same time, to the extent that some Medicaid and SCHIP beneficiaries — perhaps those in better health — chose lower-cost plans like HSA-eligible plans, states apparently would be responsible for picking up the high deductibles and cost-sharing that these plans charged beneficiaries.

Adverse selection could result in a greater percentage of the premium and cost-sharing charges for Medicaid and SCHIP beneficiaries being shifted to states over time. As noted, the maintenance-of-effort payments are based on the estimated savings that states would accrue in the *first year* of implementation of the Wyden-Bennett plan, increased each year thereafter by the rate of growth in national health spending. Actual state savings, however, could decline over time if state costs for supplemental coverage rose more rapidly because of adverse selection. If that occurred, it could produce a growing gap between what states owed in maintenance-of-effort payments and the savings they actually secured under the Wyden-Bennett plan.

Finally, there is some question about the adequacy of federal Medicaid financing for long-term care under the Wyden-Bennett plan. Long-term care and related services would *not* be covered by the private insurance plans offered through the new purchasing pools. States would be given a new long-term care option that would allow for individualized benefit packages, personal care management, and access to home- and community-based care, but in exchange states would have to accept an aggregate limit — or cap — on their Medicaid long-term care expenditures for five years. The cap would be based on both historical long-term care spending in the state’s Medicaid program and projected long-term care spending over the coming five years. (After five years, states could presumably elect not to continue the option and return to uncapped financing of long-term care services, as under current law.) Because the capped funding based on past and projected spending could turn out to be less than what the state would have received under current law, under which the federal government pays a fixed percentage of the state’s Medicaid costs, whatever those costs are, some states electing the option could end up with inadequate federal funding to finance needed long-term care services. A state that took the new option but subsequently found it had insufficient funding for long-term care during the five-year duration of the financing limit might opt to compensate by scaling back other parts of its Medicaid program.<sup>94</sup> (It is unclear whether a number of states would elect this option; greater flexibility on long-term care services would be attractive to some states, but the fiscal risks the financing cap would pose likely would act as a deterrent to states.)

Even if Medicaid and SCHIP were successfully converted into supplemental wrap-around programs that functioned well in filling various benefit and cost-sharing gaps in the private insurance plans, fewer low-income beneficiaries would have access to these protections if states scaled back Medicaid and SCHIP eligibility and benefits over time.

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<sup>93</sup> This assumes that states would be required to subsidize premiums for Medicaid and SCHIP beneficiaries irrespective of premium cost, even if the premium for a particular plan was substantially higher than those of other plans. The Wyden-Bennett plan does not address this issue.

<sup>94</sup> At best, assuming the federal funding cap is equal to what the state would have otherwise received under the current Medicaid financing structure, this state option would provide no additional federal funding to help states improve the provision of long-term care and services. Greater federal resources are likely to be necessary, however, if states are to make significant progress in promoting the use of home and community-based care in their Medicaid programs and in further shifting away from traditional institutional-care settings such as nursing homes.

## D. Modifications to Protect Low-Income Medicaid and SCHIP Beneficiaries

As the previous sections of this analysis indicate, converting Medicaid and SCHIP into insurance plans that supplement the private insurance offered through the new purchasing pools would be a complex and difficult task and would pose risks for low-income beneficiaries. It is unclear whether it is possible to restructure Medicaid and SCHIP in this fashion while maintaining Medicaid's unique functions in providing benefits needed by low-income people with disabilities and special health care needs and in helping finance various state programs that provide integrated health, social and educational services to vulnerable populations. These are uncharted waters.

One remedy would be to largely maintain Medicaid and SCHIP in their current form and exempt beneficiaries of those programs from enrollment in the private insurance plans provided through the new state purchasing pools. Alternatively, certain modifications to the Wyden-Bennett plan could be made that would better protect access by low-income Medicaid and SCHIP beneficiaries. It is unclear whether these modifications would fully address the problems in this area.<sup>95</sup> Such modifications include:

- **Establish strict requirements for private insurance plans serving public program beneficiaries.** The Wyden-Bennett plan could be modified to require private insurance plans to: 1) coordinate with state Medicaid and SCHIP programs regarding the provision of supplemental benefits and cost-sharing; 2) adopt Medicaid and SCHIP coverage and medical necessity rules for Medicaid- and SCHIP-covered benefits that private plans provide directly to low-income individuals enrolled in Medicaid or SCHIP; 3) develop special treatment plans that coordinate care for certain high-risk public program beneficiaries, such as people with disabilities, chronic illnesses and special health care needs; and 4) try to integrate care with other state programs that serve vulnerable beneficiaries. This could be attempted through a mechanism similar to the contract language that states have negotiated over the years with Medicaid managed care plans to protect access to care for the Medicaid beneficiaries enrolled in those plans. The experience with such contracts has been mixed, with the quality of the protections depending upon state enforcement, the specific contract language, and compliance by the plans. In addition, many current Medicaid managed care plans are modest-sized plans that specialize in these low-income populations, as distinguished from the larger commercial insurance plans that would likely become the major plans in the state-based purchasing pools. This heightens concern that even with efforts to apply such requirements to the private insurance plans through contract provisions, many low-income beneficiaries could fall through the cracks and lose access to some health care services.
- **Provide for “intelligent assignment” of Medicaid and SCHIP beneficiaries into private health insurance plans.** State HHAs could be provided the authority to enroll Medicaid and SCHIP beneficiaries into plans that are likely to include providers and to cover benefits and medications used by high-risk beneficiaries and to charge more modest co-payments for such

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<sup>95</sup> Note that these modifications do not include other improvements needed in Medicaid and SCHIP, both under current law and if Medicaid and SCHIP are converted to programs that perform a supplemental wrap-around role, in order to enable the programs to better meet beneficiaries' needs. Such improvements could include new tools and incentives to enroll more eligible but uninsured individuals and families, greater federal financial support for state Medicaid programs during economic downturns, improved provider reimbursement rates and greater provider availability, and additional federal resources to promote the use of home- and community-based care for people with long-term-care needs.

services.<sup>96</sup> (As noted, plans would already be prohibited from charging cost-sharing for preventive, disease management, and chronic pain treatment services.) That would facilitate better coordination and continuity of care for these vulnerable populations and ensure that overly burdensome cost-sharing does not deter their use of needed care. There is a conundrum here, however — such an approach could result in certain private plans disproportionately enrolling the highest-cost Medicaid and SCHIP beneficiaries, which could provoke adverse selection. A small percentage of Medicaid beneficiaries — 7.6 percent of them — account for nearly *two-thirds* of current Medicaid spending.<sup>97</sup> Intelligent assignment of these beneficiaries could be tied to special payments to plans, in addition to regular risk adjustment payments, as a way to subsidize these plans and moderate the likelihood of adverse selection.

- **Provide explicit funding for various state programs that provide integrated health, social and educational services to vulnerable populations.** The Wyden-Bennett plan could be revised to provide new funding to these state programs to help them coordinate with the new private insurance plans, as well as to offset the expected reductions in Medicaid funding that they currently receive. However, this would entail modifying numerous federal laws and programs (and in some cases, establishing new ones) and would be a large undertaking for Congress. It also is unclear whether increased funding alone would allow these state programs to continue meeting the myriad needs of the vulnerable populations they now serve in an effective, coordinated manner.
- **Reduce the maintenance-of-effort payments over time while encouraging states to maintain eligibility and benefits.** The Wyden-Bennett plan could be modified to somewhat reduce over time the size of the state maintenance-of-effort payments, so that states would eventually achieve some savings, and thereby to lessen fiscal pressures on states to scale back their Medicaid and SCHIP programs. The clawback payments that states are required to make under the Medicare drug benefit law phase down over time; a similar approach could be adopted for the Wyden-Bennett plan. Such a provision also could be designed so states that maintained Medicaid and SCHIP eligibility and benefit rules no more restrictive than their current rules could qualify for somewhat larger reductions in their maintenance-of-effort payments. Alternatively, the provision could be crafted so states would qualify for reductions in their maintenance-of-effort payments if they covered certain optional beneficiaries and/or optional services at some level of coverage above the existing federal mandatory requirements. Such a set of financial incentives could be designed to ensure that low-income beneficiaries, at least in principle, generally have access to the benefits and cost-sharing protections they now enjoy.

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<sup>96</sup> The Medicare Payment Advisory Commission is currently examining the merits of intelligent assignment in the Medicare Part D drug benefit. See, for example, Jack Hoadley, Elizabeth Hargrave, Katie Merrell and Laura Summer, “Beneficiary-Centered Assignment and Medicare Part D,” Presentation for the September 4-5 Public Meeting of the Medicare Payment Advisory Commission, September 4, 2008.

<sup>97</sup> Anna Sommers and Mindy Cohen, “Medicaid’s High-Cost Enrollees: How Much Do They Drive Program Spending?,” Kaiser Commission on Medicaid and the Uninsured, March 2006.

### 3. Would the Health Insurance Coverage be Sufficiently Affordable for the Currently Uninsured?

The large majority of Americans without health insurance consists of people with low or moderate incomes. The latest Census data from 2007 indicate that 54.5 percent of non-elderly individuals who were uninsured had incomes below 200 percent of the poverty line (\$35,200 for a family of three in 2008). Another 19.6 percent of the uninsured had incomes between 200 percent and 300 percent of the poverty line (\$52,800 for a family of three).<sup>98</sup>

Under the Wyden-Bennett proposal, nearly all individuals would be required to enroll in a health insurance plan provided through the state-based purchasing pools. Individuals would receive premium subsidies on a sliding scale based on income, as well as tax subsidies provided through the new standard income tax deduction. Their share of the premiums would be deducted automatically from their paychecks. Hence, previously uninsured individuals would now have health insurance. As noted, the Lewin Group estimates that 99 percent of Americans would have health coverage under the plan.

A key question, however, is whether the cost of that coverage would be reasonably affordable for people with low and moderate incomes who are now uninsured. As an analysis by health care experts at the Urban Institute and the Blue Cross Blue Shield of Massachusetts Foundation points out, affordability “is relevant to any insurance reform that mandates participation and requires contributions towards premiums or cost-sharing...”<sup>99</sup> If low-income people are mandated to pay more than they can afford for health coverage, some will not comply (and will remain uninsured), while some others will meet the requirement but will be unable to meet the cost of other necessities, such as paying rent, heating their homes adequately, paying for child care and the like.

#### A. Premium Subsidies Available under the Wyden-Bennett Plan

Under the Wyden-Bennett plan, individuals with incomes below 400 percent of the poverty line would receive subsidies to help them pay their health insurance premiums. People below the poverty line would receive a full subsidy; those with incomes between 100 percent and 400 percent of the poverty line would receive subsidies on a linear sliding scale based on income. People with incomes at 150 percent of the poverty line would receive a subsidy equal to 83.3 percent of the premium cost, while those with incomes at 200 percent of the poverty line receive a two-thirds subsidy. Those with incomes at 250 percent of the poverty line (half way between 100 percent and 400 percent of the poverty line) would receive a 50 percent subsidy. Those with incomes at 300 percent of the poverty line would receive a subsidy for one-third of the premium cost (see Table 1). Many low- and moderate-income uninsured individuals who currently lack access to employer-based

Income as a Percentage of the Federal Poverty Line	Premium Subsidy
100%	100.0%
150%	83.3%
200%	66.7%
250%	50.0%
300%	33.3%
350%	16.7%
400%	0.0%

<sup>98</sup> CBPP analysis of 2007 Current Population Survey data.

<sup>99</sup> Linda Blumberg, John Holahan, Jack Hadley and Katherine Nordahl, “Setting a Standard of Affordability for Health Insurance Coverage,” *Health Affairs* (Web Exclusive), June 4, 2007.

health insurance (or cannot afford it) and are not eligible for public programs like Medicaid and SCHIP thus would be eligible for significant subsidies for the purchase of health insurance.<sup>100</sup>

Individuals who earn enough to owe federal income tax also would qualify for a standard tax deduction. (The standard tax deduction would phase in on a sliding scale based on income between 100 percent and 400 percent of the poverty line. Those with incomes at 250 percent of the poverty line would thus qualify for 50 percent of the full value of the standard deduction. People with incomes of at least 400 percent of the poverty line would receive the full value of the standard tax deduction — initially set at \$6,025 for individuals and \$15,210 for joint filers with one child.) The actual subsidy that the deduction (whether full or partial) would provide — which would be the amount by which the deduction lowered someone’s tax bill — would rise with an individual’s tax bracket, up to the income levels at which the deduction would phase out. An individual with no income tax liability would receive no benefit from the deduction; an individual in the 15 percent tax bracket would receive at most a 15-cent subsidy for every dollar of the deduction. Thus, an individual in the 15 percent tax bracket eligible for the full value of the standard tax deduction (\$6,025 in 2009) would receive a subsidy of \$903.75 to help pay his or her health insurance premiums. Research has found that the overwhelming majority — 94 percent — of the uninsured either have no income tax liability or are in the 10 percent or 15 percent income tax brackets, where the value of the tax deduction would be modest.<sup>101</sup>

## B. Estimates of Premium Costs as a Percentage of Family Income

As noted, the Wyden-Bennett plan requires that the health policies initially be actuarially equivalent to the Blue Cross Blue Shield Standard Option plan currently offered to federal employees through FEHBP. The employee share of the premium under that plan currently is \$1,616 for individual coverage and \$3,774 for family coverage. The total premium — including the employer contribution — equals \$5,387 for individuals and \$12,335 for family coverage.

One can roughly estimate what the premium costs would be, as a percentage of family income, for individuals now without health insurance if the Wyden-Bennett plan took effect immediately and the average premium cost were equal to the total current premium cost of the federal Blue Cross and Blue Shield Standard Option.<sup>102</sup> These estimates indicate that some individuals and families who are

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<sup>100</sup> In 2006, nearly 83 percent of uninsured individuals were part of working families, but the family members who worked tended to be employed by firms that were less likely to offer health insurance coverage, such as small employers and firms in the service and agricultural industries. Only 15.2 percent of uninsured individuals were eligible for health insurance coverage offered by their employer in 2002. As a result, most of the uninsured lack access to the tax subsidy for health insurance currently provided through the existing income and payroll tax exclusion for employer-sponsored insurance. Paul Fronstin, “Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2007 Current Population Survey,” Employee Benefit Research Institute, October 2007.

<sup>101</sup> Sherry Glied and Dahlia Remler, “The Effect of Health Savings Accounts on Health Insurance Coverage,” The Commonwealth Fund, April 2005. See also Jonathan Gruber, “Tax Subsidies for Health Insurance: Evaluating the Costs and Benefits,” Kaiser Family Foundation, January 2000.

<sup>102</sup> This analysis differs in approach from a recent analysis issued by the Lewin Group that examined the estimated change in average health care spending among currently *insured* families under the Wyden-Bennett plan. The Lewin analysis projects that average health spending would decline for currently insured families with incomes below \$150,000. (This does not mean that all families with incomes below \$150,000 would incur less health care spending; some families would spend more and some families would spend less, with the average being a reduction in the health care costs that families incurred.) The Lewin analysis is problematic, however, in that it assumes that the value of the standard deduction for families with children rises by \$2,000 for each additional child beyond the first child, as under the original

now uninsured could face rather substantial premium costs even at relatively modest income levels, and even after taking into account the availability of the premium subsidy for people below 400 percent of the poverty line and the standard tax deduction.<sup>103</sup>

<b>TABLE 2</b>				
<b>Estimates of Illustrative Premium Costs for the Currently Uninsured as a Percentage of Family Income by Income Level After Application of Subsidy and Tax Deduction</b>				
	150 percent of the federal poverty line	200 percent of the federal poverty line	250 percent of the federal poverty line	300 percent of the federal poverty line
Individual	2.6%	5.9%	8.2%	9.7%
Individual + Child	4.3%	8.2%	11.3%	13.4%
Couple + Child	4.5%	8.4%	11.1%	13.1%
Couple + 2 Children	3.5%	6.4%	8.8%	10.4%

For example, if the premium costs mirrored those for the Blue Cross/Blue Shield Standard Option, an uninsured single mother with one child at 200 percent of the poverty line would face a premium equal to 8.2 percent of her income, an amount that could be unaffordable for someone in this income range.

The premium costs would vary significantly by family size, due to the difference in premium costs between individual and family coverage and also because the value of the tax deduction would increase by the number of children in the family. A currently uninsured individual with income at 200 percent of the poverty line would pay 5.9 percent of his or her income for health insurance premiums. A couple with one child and income at that level would pay 8.4 percent of income. (See Table 2.)

The premium costs would rise as a percentage of family income as income increased. At 300 percent of the poverty line, an uninsured single mother with one child would face premiums equal to 13.4 percent of income, while an individual at that income level would pay 9.7 percent of income. A couple with one child would pay 13.1 percent of income. A couple with two children would pay 10.4 percent of income (see Table 2).<sup>104</sup> These figures do not include the cost of deductibles and co-payments.

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version of the Wyden-Bennett plan (S. 334), whereas the current version of the Wyden-Bennett plan as analyzed by CBO and JCT includes an additional deduction of only \$1,000 for each additional child. Taking into account the lower value of the deduction would affect the Lewin estimates. See John Sheils, “The Healthy Americans Act (HAA) Makes Health Care More Affordable for Middle Class Americans,” The Lewin Group, September 16, 2008.

<sup>103</sup> The following estimates would not apply to individuals and families who now have employer-based health insurance. Under the Wyden-Bennett plan, employers no longer providing health insurance would be required to “cash out” their previous contributions to the health insurance costs of their workers by increasing workers’ wages. This would affect these workers’ income as a percentage of the poverty line, the level of the subsidies for which they would qualify, and their estimated premium cost as a percentage of family income.

<sup>104</sup> CBPP calculations are based on current premium costs for the Blue Cross Blue Shield Standard Option, the premium subsidy schedule under the Wyden-Bennett plan, the value of the standard deduction under the Wyden-Bennett plan, typical tax liabilities incurred by individuals and families by income, and the current poverty-line thresholds. (Note that

These figures also likely understate premium costs. If the current Blue Cross Blue Shield Standard Option plan for federal employees were offered through the new state-based purchasing pools, it is likely that the total premium cost would be somewhat higher than it is under FEHBP. The pool of federal employees tends to be of lower average health risk than the population as a whole due to federal workers' greater stability of employment, larger average income, and higher educational attainment. In addition, the administrative costs of providing such a plan through the state purchasing pools may be higher than administrative costs under FEHBP, which are quite low (lower in general than those for large employer plans) due both to the substantial experience of the Office of Personnel Management (OPM) in overseeing FEHBP and negotiating with individual plans and to the sharing of administrative costs with numerous federal agencies that have sophisticated enrollment and payroll systems.<sup>105</sup>

### C. What is Affordable?

There is no federal standard or other commonly-accepted definition for when health insurance premiums are sufficiently “affordable” — i.e., for whether low- and moderate-income individuals will still be able to pay for other necessary expenses such as housing, child care, the costs of commuting to work, and heating their homes.<sup>106</sup> Nevertheless, two benchmarks can be used to assess affordability for low-income and moderate-income families and individuals under the Wyden-Bennett plan and other proposals.

- Both Medicaid and SCHIP sharply limit premiums and cost-sharing for their enrollees, since these families have little in the way of disposable income and burdensome premium and cost-sharing charges can reduce access to needed care among people with low incomes. As noted earlier, SCHIP limits total premiums and cost-sharing to no more than five percent of a family's annual income.
- Researchers from the Urban Institute and the Blue Cross Blue Shield of Massachusetts Foundation have suggested a somewhat higher affordability standard based on what middle-income individuals and families pay for health insurance. The researchers suggest that premiums and other cost-sharing would not be affordable for low- and moderate-income people unless they are below — and for those with low incomes, *well below* — the amounts paid by a typical middle-income person (someone with income between 300 percent and 500 percent of the poverty line) who purchases coverage through his or her employer or the individual market. Their analysis finds that typical middle-income people now face premiums between 7.9

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the Blue Cross Blue Shield Standard Option currently charges separate premiums for individual coverage and family coverage but does not set a separate premium for coverage for an individual with children. The Wyden-Bennett plan, by contrast, would permit plans to charge four separate premiums — for individual coverage, coverage of a couple without children, coverage of an individual with children, and family coverage. For purposes of these calculations, the premium cost for Standard Option coverage for an individual without children was assumed to equal approximately 185 percent of the cost of individual coverage, based on a similar assumption used in the Lewin Group's estimates of the Wyden-Bennett plan.)

<sup>105</sup> For a discussion of why FEHBP has very low administrative costs, see, for example, Karen Davis, Barbara Cooper and Rose Capasso. “The Federal Employee Health Benefits Program: A Model for Workers, Not Medicare,” The Commonwealth Fund, November 2003.

<sup>106</sup> Blumberg et al., *op cit*.

percent and 15.2 percent of family income.<sup>107</sup>

The estimated premium costs under the Wyden-Bennett plan for low- and moderate-income individuals and families who are currently uninsured would exceed the first benchmark and approach the limits of affordability under the second benchmark. These costs also would exceed the affordability standards used by the state of Massachusetts in granting waivers from the state's mandate to purchase health insurance to individuals for whom doing so would constitute a financial hardship.<sup>108</sup> While the Wyden-Bennett plan would make health insurance substantially more affordable for many such families than is the case now, this finding raises concerns regarding whether the plan would provide adequate premium subsidies to ensure that health insurance is sufficiently affordable for many of these individuals and families.<sup>109</sup> Moreover, as noted above, the estimated premium costs as a percentage of income cited here for the Wyden-Bennett plan do not include the deductibles and other cost-sharing that individuals also would incur.

In addition, these figures do not take into account the fact that the actuarial value standard that the benefit packages would have to meet would erode over time. That value would initially be set at the value of the Blue Cross Blue Shield standard option (which may initially exceed the actuarial value of many existing employer-based plans, particularly among small employers), but as one of the Wyden-Bennett plan's features to constrain costs, this standard would then be increased annually only by the rate of per capita growth in the overall economy.<sup>110</sup> For more than 30 years, health care expenditures have been growing faster than the overall economy by an average of about 2 percentage points per year, a trend driven in substantial part by advances in medicine that improve health but raise costs. Per capita health care expenditures have risen at an average rate of 3.9 percent per year over the past three decades, after adjusting for inflation, while the economy has grown at an average annual per capita rate of 1.6 percent in inflation-adjusted terms. The benefit packages that the private plans would offer consequently would become somewhat less generous over time in terms of the health care coverage they would provide, since the value of the benefit packages would not keep pace with health care costs. As a result, under the Wyden-Bennett plan, out-of-pocket health care costs for individuals and families could eventually rise substantially over time. (This process could be similar to what has occurred in many employer-based plans where health care cost growth had led the employers to increase the out-of-pocket costs that workers bear by raising premiums, deductibles and/or other cost-sharing; or to scale back benefits.)

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<sup>107</sup> Economists believe that employees themselves generally pay the full cost of employer-sponsored insurance by forgoing wages in return for employer contributions to the cost of their health insurance. These amounts take that assumption into account. The state of Massachusetts used these estimates in establishing an "affordability" standard for health insurance premiums charged under its comprehensive health reform plan in determining whether individuals would be exempted from the mandate to purchase "affordable" health insurance due to financial hardship. In 2008, monthly premiums in Massachusetts are defined as affordable if they approximate no more than 2 percent of family income at 150 percent of the poverty line, rising to about 9 percent of income at 500 percent of the poverty line. These levels are lower than the estimated premium cost as a percentage of family income under the Wyden-Bennett plan. See John McDonough, Brian Rosman, Mehreen Butt, Lindsey Tucker and Lisa Kaplan Howe, "Massachusetts Health Reform Implementation: Major Progress and Future Challenges," *Health Affairs* (Web Exclusive), June 3, 2008 and Commonwealth Connector, "2008 Affordability Schedule and CommCare Enrollee Contributions," March 20, 2008.

<sup>108</sup> See footnote 107 for a discussion of the Massachusetts affordability standards. It may be noted that while Massachusetts uses an affordability standard more favorable to beneficiaries, its premium subsidies phase out at 300 percent of the poverty line, while those under the Wyden-Bennett plan extend to 400 percent of the poverty line.

<sup>109</sup> Blumberg et al., *op cit*.

<sup>110</sup> It is unclear whether this annual trend factor would be based on nominal, or real, annual per capita growth in GDP.

### **Lessons for Policymakers Designing Any Health Reform Plan that Substitutes A New Private Health Insurance System for Current Health Insurance Arrangements**

Analysis of the Wyden-Bennett health reform plan yields several important lessons for policymakers in designing health reform plans that follow a similar approach to achieving universal coverage by largely or wholly substituting a new private insurance system for the current reliance on employer-based coverage and public programs like Medicaid and SCHIP. Such lessons include:

- While the specific design of a new private insurance system taking the approach of the Wyden-Bennett plan may vary substantially, the new system should include standardized benefits packages to limit the ability of insurers to “cherry pick.” It also should restrict the availability of certain types of plans that are quite likely to provoke adverse selection, such as high-deductible plans attached to HSAs. Along with the use of risk adjustment, these steps would help minimize the risk of adverse selection, making it more likely that the new system would pool risk effectively over the long run, a critical requirement for any new system that would largely or entirely replace employer-based coverage, which currently serves as the principal risk-pooling mechanism in the United States.
- Converting Medicaid and SCHIP into supplemental insurance programs is fraught with complexity and difficulty. Very careful attention should be paid to how low-income beneficiaries — many of whom have disabilities, chronic illnesses and special health care needs — would fare under a new system that would replace most of Medicare and SCHIP with private coverage. Attention also must be paid to the likely impact of such an approach on integrated state programs that provide health and related services to vulnerable populations, as well as on the health reform plan’s effect on state finances and the incentives states face in the health care area. Under certain reform plans, it may be more appropriate to exempt such populations (i.e., to retain Medicaid and SCHIP coverage for them) than to shift them into the new system.
- It is critical to ensure that low- and moderate-income individuals who currently are uninsured be able to afford health insurance (as well as other necessities) if a health reform plan imposes a mandate on individuals to purchase health insurance in order to achieve universal coverage. Any such plan also should ensure that such individuals do not end up facing large gaps in coverage over time that they are not able to fill. At the same time, any reform plan must attempt to constrain its costs and to moderate overall health care spending growth. Achieving both of these priorities is critical, and doing so and striking an appropriate balance between them likely will necessitate considering additional revenue sources, outside the existing health care system.

Exacerbating this likely trend, the value of the subsidy provided by the standard tax deduction also would erode over time as a share of the costs of health care coverage, because the deduction levels would be adjusted by the general inflation rate rather than the rate of increase in health care costs. This feature would limit costs but place further pressure over time on benefit packages and out-of-pocket expenditures.

As noted, individuals with incomes below the poverty line would be exempt from cost-sharing. There would, however, be no overall cost-sharing limit to protect people with incomes slightly above the poverty line, unless they also were eligible for and enrolled in Medicaid or SCHIP (and able to access the supplemental wrap-around coverage).

This could present difficulties for low-income working parents in particular. While Medicaid and SCHIP generally cover *children* somewhat above the poverty line, these programs cover *parents* to a far more limited extent. The Medicaid income limit for parents in the typical (or median) state is set

at just 63 percent of the poverty line.<sup>111</sup> Moreover, most states do not cover poor non-elderly adults without children at all, unless they are disabled.

This suggests that under the Wyden-Bennett plan, many low- and moderate-income people likely would face overall out-of-pocket health care costs that would consume a substantial portion of their income, once deductibles and co-payments are taken into account. This likely would be the case even for families and individuals at 150 percent of the poverty line who are eligible for substantial premium subsidies. (See Tables 1 and 2.) Research shows that significant cost-sharing deters low-income people from using medically necessary care.<sup>112</sup>

New research also finds that individuals who are *underinsured* — defined as people whose out-of-pocket medical costs exceed 10 percent of family income (or five percent of income for people below 200 percent of the poverty line) — are significantly more likely to go without needed health care than people with adequate insurance. The Commonwealth Fund reported that 53 percent of individuals who were underinsured in 2007 failed to fill a prescription, skipped a test, treatment or follow-up care, had a medical problem but did not see a doctor, or did not get needed specialty care. In comparison, only 31 percent of those who were not underinsured reported similar access problems.<sup>113</sup>

#### D. Modifications to Better Assure Affordability

The Wyden-Bennett plan could be modified to ensure that low- and moderate-income beneficiaries do not face overly burdensome out-of-pocket costs. Such modifications could include the following measures:

- **Increase the premium subsidies.** The Wyden-Bennett plan phases out premium subsidies by income between 100 percent and 400 percent of the poverty line. The premium subsidies could be increased, particularly for the individuals and families in the lower parts of this range, to make coverage more affordable.
- **Convert the standard deduction to a refundable tax credit.** The value of a tax deduction rises with one's income and tax bracket. In contrast, a refundable tax credit provides the *same* level of subsidy irrespective of income. The standard deduction could be converted to a refundable tax credit, with the credit phasing down as income rises. This would further concentrate subsidies on those with low and moderate incomes.
- **Increase the annual adjustment for the tax subsidy and the actuarial value standard.** The value of the standard tax deduction (or a refundable tax credit to replace it) could be

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<sup>111</sup> Donna Cohen Ross, Aleya Horn and Caryn Marks, "Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles," Kaiser Commission on Medicaid and the Uninsured, January 2008. This is the Medicaid income eligibility level for parents in the typical state after taking into account the use of "income disregards" that subtract certain expenses like child care costs from countable income for purposes of determining eligibility.

<sup>112</sup> Ku and Wachino, *op cit.* See also Julie Hudman and Molly O'Malley, "Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations," Kaiser Commission on Medicaid and the Uninsured, April 2003.

<sup>113</sup> Cathy Schoen, Sara Collins, Jennifer Kriss and Michelle Doty, "How Many Are Uninsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* (Web Exclusive), June 10, 2008.

adjusted annually by a rate greater than the overall inflation rate (although not necessarily by a rate equal to the increase in health care costs) so that the value of the subsidy does not erode as much over time. A higher annual rate of increase also could be applied to the actuarial value standard required under the Wyden-Bennett plan to better ensure that the coverage the new private insurance plans provide does not become too restrictive over time. These modifications would reduce the impact of some of the cost-containment elements of the Wyden-Bennett plan, but the plan's current annual adjustments appear to be too modest and likely to result in steady reductions over time in low- and moderate-income individuals' access to care.<sup>114</sup> (There also is significant risk that the plan's current annual adjustment mechanisms, with their steady ratcheting down of benefits and subsidies relative to health care costs, would not be politically sustainable over time.)

- **Set an overall limit on premiums and cost-sharing as a percentage of family income.** The Commonwealth Fund reports that when families are underinsured and face out-of-pocket costs exceeding 5 percent or 10 percent of a family's income, this can lead to reduced access to health care services. The Wyden-Bennett plan could be modified to set an overall cap on premiums, deductibles and cost-sharing so families would not face out-of-pocket costs that exceed a specified percentage of income. This cap could be established on a sliding scale. No premiums or cost-sharing would be charged to those below the poverty line. The cap could be set at five percent of income for those with low incomes, as under the SCHIP program, and the cap could then increase (as a percentage of income) on a sliding scale as income rose, up to a maximum of something like 10 percent or 15 percent of income.

Such modifications would likely increase federal costs substantially under the Wyden-Bennett plan by expanding the size and scope of the subsidies provided to low- and moderate-income families and individuals. The plan currently relies on financing sources within the existing health care system, including revenues produced by eliminating the current tax exclusion on employer-sponsored insurance, to offset its overall cost. (As noted, other financing sources include the required employer contributions, premium payments, reduced federal Medicaid spending, the elimination of most Medicare and Medicaid disproportionate share hospital payments, and the recoupment of state Medicaid and SCHIP savings by the federal government.) This is how the plan can be roughly budget-neutral by 2014. Because the plan does not rely on other significant revenue sources outside the health care system, however, it is very financially constrained. It likely will not

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<sup>114</sup> For the purposes of constraining the costs of the bill (and overall health care spending growth), the Wyden-Bennett plan focuses primarily on reducing individuals' "demand" for health care by encouraging enrollment in lower cost plans and scaling back over time the benefit packages of the private insurance plans offered through the new state-based purchasing pools.

The Wyden-Bennett plan does not focus as heavily on other promising approaches that may "bend the curve" of health care spending over time, including greater adoption of health information technology, use of comparative effectiveness research, changes in the structure of provider payments to reward efficiency and quality of care, and health care delivery system reforms. The plan does include some provisions in this area, including a requirement that the private insurance plans provide wellness programs, a requirement that Medicare pay physicians a primary care management fee to establish a "medical home" for beneficiaries, a new chronic care disease management program within Medicare, and the placement of quality reporting requirements on hospitals. (The Congressional Budget Office and the Joint Committee on Taxation did not take these Medicare provisions into account in their analysis of the plan's fiscal impact.) The addition of promising approaches in other areas might produce long-term savings to help offset the greater cost (and higher health spending) that would result from applying a greater annual rate of increase to the actuarial value standard and the tax subsidy, although these measures are not likely to yield significant savings in the near term.

be possible to take the steps necessary to ensure sufficient affordability and to make certain other improvements recommended here unless some additional sources of financing are provided.

## **Conclusion**

The Wyden-Bennett plan is an ambitious health reform plan that seeks to achieve universal health insurance coverage by restructuring the U.S. health insurance system. It would replace much of employer-sponsored insurance over time and convert public programs like Medicaid and SCHIP into supplemental health insurance programs, while establishing new insurance purchasing pools through which nearly all Americans would obtain private coverage.

The plan has many merits. It also raises a number of critical questions, however, related to the long-term viability of the new purchasing pools, the effects on low-income beneficiaries who are now on Medicaid and SCHIP (and, in particular, on beneficiaries who have disabilities or other special health care needs), and whether the private health insurance plans offered through the new purchasing pools would be sufficiently affordable. These questions also would apply to other health care reform proposals that took a similar approach to the Wyden-Bennett plan.

While many details about the plan are lacking, the proposal clearly poses some significant risks in these areas. The state-based purchasing pools could be subject to substantial adverse selection, driving up health insurance costs for people in poorer health. Some vulnerable people who now rely on Medicaid or SCHIP could effectively lose access to some needed services, and some near-poor and moderate-income individuals could face out-of-pocket health care costs that exceed what they can afford without forgoing other necessities. As a result, the plan would need substantial modification in a number of areas to address these issues and meet its sponsors' worthy goals.

The emergence of the plan represents an important development in the long effort to achieve universal coverage. Examination of the plan thus is useful and yields important lessons regarding how to design similar types of health reform plans to better minimize adverse selection, protect access to care for low-income vulnerable populations now on Medicaid and SCHIP, and ensure affordability for low- and moderate-income individuals and families.