Building Blocks For Reform: Achieving Universal Coverage With Private And Public Group Health Insurance

A pragmatic approach to providing universal coverage with minimal disruption or increase in national health spending.

by Cathy Schoen, Karen Davis, and Sara R. Collins

ABSTRACT: This paper presents a framework for universal health insurance that builds on the current U.S. mixed private-public system by expanding group coverage through private markets and publicly sponsored insurance. This Building Blocks approach includes a new national insurance "connector" that offers small businesses and individuals a structured choice of a Medicare-like public option and private plans. Other features include an individual mandate, required employer contributions, Medicaid/State Children's Health Insurance Program (SCHIP) expansion, and tax credits to assure affordability. The paper estimates coverage and costs, and assesses the approach. Our findings indicate that the framework could reach near-universal coverage with little net increase in national health spending. [*Health Affairs* 27, no. 3 (2008): 646–657; 10.1377/hlthaff.27.3.646]

ACHIEVING HEALTH INSURANCE FOR ALL is again high on the public's agenda. Despite the leadership of Massachusetts and a handful of other states, the nation is losing ground on coverage, putting strain on families' health and economic security. To close the gaps and address the wide disparities across states, federal legislation is needed to provide a coherent framework for universal coverage and the requisite financing to make coverage affordable. Yet national policy discussions tend to break down regarding the choice between private insurance markets and public programs and how to finance expansion.

This paper presents a framework for expanding coverage that uses the building blocks of both private markets and publicly sponsored insurance with broad risk pooling. We outline an approach that offers small businesses and individuals a structured choice of private plans and a Medicare-sponsored plan, denoted as Medicare Extra, in a new national insurance "connector." Other features include an individual mandate to obtain coverage, a requirement that employers cover em-

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ployees or contribute to a pool, public program expansions, and tax credits to assure affordability. We include estimates of impact on coverage and costs.

What Mix Of Coverage? Issues And Design Choices

Much of the debate on how to move forward to achieve universal coverage centers on the relative roles of privately and publicly sponsored insurance. More than 60 percent of the under-sixty-five population now receives insurance through employer-sponsored health plans. When asked, a sizable majority rates this coverage highly, trusts employers to select high-quality plans, and would prefer to stay with their current coverage.[1] For those insured through the large-group employer market, employer coverage offers broad risk pooling and makes it easy to sign up, stay enrolled, and pay premiums. Employers currently contribute an estimated $420 billion per year for health benefits.[2]

At the same time, there is strong support for expanding Medicare. Two-thirds of adults ages 50–64 with employer coverage and 73 percent of all older adults express interest in early coverage under Medicare.[3] In the general population, support for public insurance is also strong—with 40–50 percent supporting a public approach.[4]

Broad-based risk pools with continuous coverage offer substantial administrative efficiency gains. Linking health insurance to jobs undermines continuity of coverage. A change in jobs or job status triggers a change or gap in insurance. Frequent churning drives up costs and undermines efforts to improve quality or efficiency. Volatility in private insurance markets with short-term enrollment also undermines long-term commitment and leverage to improve performance.

Insurance plans with different reporting, paperwork, and payment systems generate substantial transaction and overhead costs. In addition, insurance market competition often results in practices to avoid adverse risk selection, particularly in small-group and individual insurance markets.

As a result, the U.S. insurance industry is characterized by high overhead costs for marketing, underwriting, and administration, as well as often high profit margins that lower the share of premiums paid for medical care.[5] Individual and small-group overhead costs are particularly high, accounting for 40 percent of premiums in individual and 25–27 percent in small-group markets. In contrast, Medicare administrative overhead at 3 percent is low—and well below the 5–10 percent of premiums incurred by large companies' self-insured plans.[6]

Yet, with support for employer-sponsored insurance, its role in pooling risk, and its importance for financing, the United States is likely to continue a mixed private-public system of coverage unless or until viable alternatives are available. To do otherwise would entail substantial disruption in insurance distribution and financing.

In this context, the offer of public and private coverage has become a successful political formula for expanding coverage and benefits in the past decade. Medi-

care, Medicaid, and the State Children's Health Insurance Program (SCHIP) have expanded the role of private plans offered through these programs. With bipartisan support and Republican governors, Massachusetts has enacted and California proposed a combined approach that offers a choice of publicly sponsored and private plans.

At the national level, there is an opportunity to expand choices for those now covered under private insurance to include a high-quality public plan option, Medicare. Availability of a nationwide public option would enhance choice, competition, and continuity, permitting those with frequent job changes to select a stable form of coverage. Within a mixed private-public system, the major design questions are what reforms and mechanisms are needed to achieve broad risk pooling, without serious adverse risk selection, and how to ensure seamlessness and continuous coverage as the circumstances of households change.

Principles Of The "Building Blocks" Framework

The following set of core goals and design principles guided the specifications for reform: (1) provide access and affordability, with a national minimum standard of benefits, and financial protection relative to income; (2) offer choice of physicians and health plans; (3) lower administrative costs; (4) share responsibility for financing among government, business, households, and other stakeholders; and (5) pool health risk broadly, with market rules to limit competition based on health risk in private or public markets.

The Building Blocks framework, specified in detail below, would largely preserve current large-employer coverage and Medicaid/SCHIP, while offering new options for small firms and individuals who now experience the least access to attractive benefits and highest administrative overhead. This framework is an evolution of an earlier proposal advanced in 2003.[7]

The framework would innovate with a new "connector" to enable more-integrated insurance with continuity and to expand coverage choices. Through Medicare, the federal government is in the unique position to sponsor an insurance connector of national scope that would link public and private markets and pull together individuals and small groups. Using Medicare's administrative structure in a mixed private-public approach would enable offering both private plans and Medicare's nationwide provider networks and self-insured claims administration to the under-sixty-five population.

Elements Of The Building Blocks Framework

We present estimates of the Building Blocks framework from the Lewin Group, using its Health Benefits Simulation Model.[8] All estimates assume a fully implemented plan in 2008, using initial 2008 insurance and cost distribution estimates. The modeling used the following specifications.

- **Insurance connector: choice of Medicare and private plans.** A central ele-

ment of the framework is the establishment of a Medicare-like option for people under age sixty-five, along with a choice of private plans offered through a connector open to businesses with fewer than 100 workers, the self-employed, and everyone without large-employer insurance or Medicare. Plan offerings would include a Medicare Extra self-insured plan with improved Medicare benefits, Medicare Advantage (MA) health maintenance organizations (HMOs), and integrated health plans participating in the Federal Employees Health Benefits (FEHB) program. Medicare Extra would be the only fee-for-service (FFS) plan choice. Innovations in care coordination and disease management techniques, now being tested in Medicare demonstrations, could be incorporated if found to be successful.[9]

Benefits in the self-insured plan would be an enhanced Medicare Extra benefit package.[10] For modeling purposes, this was specified to include traditional Medicare benefits under Parts A and B with a $250 individual/$500 family annual deductible and 10 percent coinsurance for Part B services. Drugs would be covered as part of the integrated benefits, with 25 percent coinsurance and no deductible. There would be an out-of-pocket maximum of $5,000. Cost sharing would not apply to preventive care.

Provider payment in the Medicare Extra plan would be the same as under current Medicare. Premiums would be community rated for everyone under age sixty, estimated at $259 per month for single premiums and $702 per month for families in 2008. As necessary, the federal government would finance adverse risk selection to maintain community rates.

☐ **Employer play-or-pay.** All employers would be required to offer coverage or pay a payroll tax of 7 percent of earnings, up to $1.25 per hour. Exempt employers offering coverage must contribute at least 75 percent of the premium, and plans must meet general minimum standards with at least 80 percent of employees participating. Small employers would have the option of obtaining Medicare Extra coverage or a private plan through the new national connector or purchasing coverage directly. Dependent young adults up to age twenty-six would be covered under family policies. Employers would be required to finance Consolidated Omnibus Budget Reconciliation Amendment (COBRA) coverage for up to two months for employees losing jobs. Premium assistance would be available from the federal government for 70 percent of COBRA premiums for unemployed workers, replacing current Trade Assistance Act tax credits for displaced workers.

☐ **Medicare expansion.** Medicare would offer the Medicare Extra benefit package described above to current Medicare beneficiaries, with premiums set to finance the enhanced benefits. The two-year waiting period for coverage of the disabled under Medicare would be eliminated. Adults ages 60–64 would be eligible to buy in, as would dependents of Medicare beneficiaries. Premiums would be set to the expected community rate for all in this age group. The estimated premium is $532 per month, including Parts A, B, and D benefits with cost sharing as specified above.

☐ **Medicaid/SCHIP expansion.** All legal residents below 150 percent of poverty

(adults and children) would be eligible for SCHIP-type acute care services (excluding long-term care) with a $5 copay on all services. Premiums would be fully covered for those with incomes up to 150 percent of poverty. The expanded low-income protection would be available to wrap around Medicare for its beneficiaries.

Medicaid provider payment rates would be increased to Medicare levels to promote equity and strengthen Medicaid provider networks. To help states finance the expansion, federal matching rates would be increased to SCHIP levels for the existing Medicaid acute care program and those newly eligible. To offset costs of higher provider payment for the uninsured and equalizing payments for Medicaid/SCHIP patients, federal funds for disproportionate-share hospital (DSH) payments under Medicare and Medicaid would be redirected to cover low-income families, and there would be a new provider revenue assessment (4 percent for hospitals, 2 percent for physicians).

■ **Premium assistance.** All of those with health insurance coverage at tax filing time would be eligible for advanceable, refundable tax credits for premium expenses in excess of 10 percent of adjusted gross income (AGI), or 5 percent for those in the 15 percent or lower marginal income tax bracket. Premium assistance would be benchmarked to insurance connector rates. The assistance would be available to all, including Medicare beneficiaries.

■ **Mandatory participation and automatic enrollment.** All residents would be required to participate in insurance and provide evidence of coverage during annual tax filing. Tax filers would verify insurance coverage upon filing federal personal income taxes. Anyone without coverage and with incomes in excess of 150 percent of poverty would be automatically assigned coverage through the insurance connector, with Medicare Extra as the default option, if enrollees did not select a private plan or purchase private coverage directly. Uninsured tax-filing households with incomes below 150 percent of poverty would be enrolled in Medicaid/SCHIP, with the option to enroll in the insurance connector with premium assistance.

Enforcement would come from adding any premium liability to the household's income tax liability. Although this mechanism would miss nonfilers, a majority of them—that is, households with incomes under 150 percent of poverty— would be exempt from premium obligations.

■ **Insurance market rules.** To protect against adverse selection into the national pool and avoid competition based on risk segmentation, federal standards would require states to establish community or modified community rating and guaranteed issue for individual and small-group insurance markets for the connector to operate in the state and for new federal subsidies to apply. Rating rules would need to parallel those in the connector.

Impact On Insurance Coverage

In combination, the mixed private-public approach with mandatory participation described above would achieve near-universal coverage (99 percent of the

population). Based on the Lewin simulation, the numbers of uninsured people would drop from an estimated 48.3 million in 2008 to 3.6 million, largely non–tax filers, in the first year of implementation (Exhibit 1).

☐ **Sources of coverage.** An estimated 20 percent of the population, or sixty million people, would voluntarily obtain coverage through the new national insurance connector. About three-fourths of this enrollment would come from small businesses opting to purchase group coverage through the pool. Another fifteen million would come from individual enrollment, including fourteen million from among the previously uninsured and 1.2 million from among those insured in the individual market. The modeling estimates that about two-thirds of connector enrollment would be in the Medicare Extra FFS plan, and the rest would be in private plans. Counting small employers buying coverage for employees through the connector and employers contracting directly for insurance, an estimated 63 percent of the population would have employer-financed coverage. This includes 48 percent whose employers would continue to sponsor plans directly.

☐ **New options for the currently insured.** In addition to coverage for the uninsured, the framework provides new options for the insured, who may switch insurers to obtain better coverage or lower premiums, or both. These new options would also be offered to low-income working families currently on Medicaid who may now have employer-sponsored options as well as options through the connector. In total, an estimated forty-nine million currently insured people would change coverage, including thirty-eight million who would be insured through the new insurance connector.

☐ **Individual market.** The share of the population purchasing insurance in the individual market would drop by half. This would include a migration of older

EXHIBIT 1
Transitions In Coverage Under The Building Blocks Proposal, Millions Of People, By Coverage Source, 2008

Source of coverage	Distr. before reform	Insurance connector		Private coverage		Public coverage			Uninsured
		Empl.	Indiv.	Empl.	Indiv.	CHAMPUS	Medicare[a]	Medicaid/ SCHIP	
Employer	157.9	32.3	0.0	123.8	0.0	0.0	0.6	1.2	0.0
Individual	9.6	1.4	1.2	2.4	3.1	0.0	0.2	1.2	0.0
CHAMPUS	4.0	0.0	0.0	0.0	0.0	3.9	0.1	0.0	0.0
Medicare[a]	40.3	0.0	0.0	0.0	0.0	0.0	40.3	0.0	0.0
Medicaid/SCHIP	37.8	3.4	0.0	4.1	0.0	0.0	0.7	29.7	0.0
Uninsured	48.3	8.4	13.6	11.1	0.3	0.0	1.1	10.1	3.6
Total and new distribution	297.8	45.5	14.8	141.5	3.4	3.9	43.0	42.1	3.6

SOURCE: Lewin Group estimates using the Health Benefits Simulation Model, October 2007.

NOTES: The total starting population is 297.8 million. CHAMPUS is Civilian Health and Medical Coverage of the Uniformed Services, now known as TRICARE. SCHIP is State Children's Health Insurance Program.

[a] Includes dual eligibles (both Medicare and Medicaid).

adults into Medicare early, young adults into family coverage, and enrollment in the new connector.

■ **Medicare enrollment.** Enrollment in Medicare FFS coverage would increase markedly from about thirty-five million in 2008 to approximately seventy-five million in the first year of implementation. This substantial shift in source of coverage would result from voluntary choice. Small firms and individuals would have the option of contracting for private coverage directly or, within the national connector, the choice of a Medicare-like FFS option or private integrated plans.

The Medicare program itself would expand modestly by two million people from new provisions that eliminate the waiting period for the disabled and early buy-in for those ages 60–64. Medicaid/SCHIP net enrollment would increase from 13 percent of the population to 14 percent, as eligibility is extended to everyone under 150 percent of poverty and eligible tax filers are automatically enrolled. Partially offsetting new enrollment, some low-income working families are estimated to move to newly available employer-sponsored plans.

Impact On Health Spending

The estimated net effect on total national health spending is minor. On a base of an estimated of $2.4 trillion national spending in 2008, total health spending would increase by a net $15 billion, or less than 1 percent (Exhibit 2). Although use of services for the newly insured and those with improved coverage would increase spending by an estimated $51.5 billion, these expenditures would be offset

EXHIBIT 2
Changes In National Health Spending Under The Building Blocks Framework, Billions Of Dollars, 2008

Net change in national health spending	$ 15.3
Change in health services utilization spending (total)	51.5
Change in utilization for newly insured	49.0
Change in utilization due to improved coverage	2.5
Reimbursement effects (total)	-20.8
Medicare payment rates for Medicare Extra enrollees	-22.1
Improved payment for Medicaid and uninsured[a]	47.7
Provider assessment	-41.4
Increased cost shifting[b]	13.8
Elimination of DSH	-18.8
Change in administrative costs (total)	-15.4
Insurance administration[c]	-17.7
Administration of subsidies[d]	2.3

SOURCE: Lewin Group estimates using the Health Benefits Simulation Model, October 2007.

NOTE: DSH is disproportionate-share hospital.

[a] Equals payments for uncompensated care ($15.4 billion) and an increase in Medicaid rates to Medicare levels ($32.3 billion).

[b] Assumes that 40 percent of change in provider payment rates is passed on to health plans.

[c] Savings from connector self-insured Medicare option and Medicare Extra would reduce overhead.

[d] Assumes that the IRS budget increases by 25 percent to administer premium assistance.

in part by lower administrative costs ($15.4 billion) and a net reduction in provider reimbursement ($20.8 billion), including revenue assessments.

As specified, the Building Blocks framework would result in substantial savings for households and net savings for state and local governments (Exhibit 3). Federal spending would increase by $81.7 billion in 2008 to make insurance affordable for the under-sixty-five population and to improve financial protection for Medicare beneficiaries. Of the total net federal cost, about $43 billion would be for improved assistance for current Medicare beneficiaries (Exhibit 4). Although this is substantial, the design would include the same financial protection for Medicare beneficiaries as for those under age sixty-five, on equity grounds.

The federal budget cost, while significant, could be financed in large part by state maintenance-of-effort requirements under Medicaid/SCHIP ($12 billion), leveling the playing field between MA and Medicare FFS to finance improved benefits for all Medicare beneficiaries, and other initiatives to achieve health system savings.[11] Financing could also come from redirecting recent tax cuts for those with high incomes.

Discussion

☐ **Maximum coverage with minimal disruption.** The Building Blocks framework has many advantages—not least of which is that it provides a pathway to universal coverage with a minimal increase in total national spending and relatively modest net federal budget costs. It also provides expanded choices and improved continuity, and it focuses market competition on improved value. The framework takes a pragmatic approach and builds on current insurance sources. Medicare is a known quantity. Providers know how they will be paid, although there will be redistributions in revenue among providers, and the long-term consequences of administered prices and federal budget constraints on future payment rates are important unknowns. With a more connected insurance system in which businesses have a direct stake in Medicare's success, there would also be incentives for collaborative multipayer approaches.

EXHIBIT 3
Net Change In National Health Spending Under The Building Blocks Framework, Billions Of Dollars, 2008

Projected national health spending, 2008	$2,420
Net health system cost in 2008	15.3
Net federal government	81.7
Net state and local government	-11.5
Net households	-75.9
Net private employers (total)	21.0
Currently insuring employers	-24.1
Other employers	45.1

SOURCE: Lewin Group estimates using the Health Benefits Simulation Model, October 2007.

EXHIBIT 4
Net Estimated Change In Federal Government Spending Under The Building Blocks Framework, Billions Of Dollars, 2008

Net change in federal spending	$ 81.7
A. New federal expenditures for improved coverage (total)	162.5
Under-65 populations: insured and uninsured (subgroup total)	119.3
Premium assistance	34.0
Adverse selection into insurance connector	6.7
Medicaid/SCHIP expansion and improvement	64.5
Net cost to eliminate two-year wait for Medicare disabled and buy-in for age 60+	12.1
FEHB program (workers currently declining coverage take up coverage under mandate)	2.0
Current Medicare beneficiaries (subgroup total)	43.2
Adverse selection into Medicare Extra, duals plus private market	14.7
Premium assistance and low-income expansion	28.5
B. Funding offsets (total)	-80.8
Elimination of Medicaid and Medicare DSH payments	-18.8
Employer play-or-pay revenues	-19.1
Provider assessments	-41.4
Other	-1.5

SOURCE: Lewin Group estimates using the Health Benefits Simulation Model, October 2007.
NOTES: SCHIP is State Children's Health Insurance Program. FEHB is Federal Employees Health Benefits. DSH is disproportionate-share hospital.

Small businesses and individuals under age sixty-five would have more affordable options than now available through the small-group and individual market. If successful, the insurance connector could open to larger firms over time.

At the same time, the Building Blocks framework offers a pathway from the current fragmented insurance system to one that is more integrated and efficient. By preserving choice of coverage through private plans while offering the new option of Medicare Extra, the framework introduces a new market dynamic that would discourage private market competition based on risk segmentation. Medicare would have to keep up with initiatives in the private sector to remain competitive. Private insurers could not devote a high share of premiums to overhead without losing customers to Medicare Extra.

The framework represents less disruption of coverage than single-payer plans or totally private coverage, and decisions to change coverage sources would be voluntary. More than 200 million Americans would retain their current coverage. In addition, millions would voluntarily switch because a better plan or lower premium would be available, and nearly all of the uninsured would obtain coverage. Moreover, by equalizing Medicaid and Medicare provider payment rates, low-income beneficiaries enrolled through Medicaid would no longer have second-tier status in provider markets, and safety-net providers would have enhanced revenues to finance support services.

■ **A remedy for failures in individual insurance markets.** The Building Blocks approach would also address current market failures in individual insurance mar-

kets.[12] By offering a national connector that pools risk for the under-sixty-five population, and changing market rating rules, it would be possible to use tax credits to buy high-value coverage and keep coverage as circumstances change without fear that growing older or sicker would result in increased premiums or becoming "uninsurable."

☐ **Conceptual disadvantages.** With so many strong advantages, why hasn't the nation embraced such a framework in the past? Its major conceptual disadvantages are the potential for adverse risk selection, the need to change coverage as jobs or circumstances change, the need for federal financing, and the potential for rigidity or underfunding in a more heavily government-subsidized system. Private insurance markets would continue as they do today, alongside the option for Medicare Extra. Even with requirements for guaranteed issue and community rating, there remains the risk that insurers will market to healthier individuals or groups. The insurance connector could employ risk-adjustment techniques to limit the likelihood that plans would gain premium advantages through favorable selection. Yet, as Medicare's experience has demonstrated, risk adjustment is difficult and imperfect.

☐ **Political problems.** The more difficult political problems are the parties who are better off under the status quo. With universal coverage, providers gain revenue on average, but some that now serve primarily private patients and few Medicaid or uninsured patients could see their revenues decline or become more restricted over time. Although Minnesota successfully implemented a provider assessment to help finance coverage expansion, the debate in California indicates that achieving such shared financing is a challenge.

Similarly, private insurers would anticipate downward pressures on premiums. The estimates indicate that one-third of connector enrollment would be in private plans, leaving total private enrollment near current levels. Yet there would be new competition to innovate to compete with the self-insured Medicare Extra plan. This would occur in both the under- and over-sixty-five insurance markets.

☐ **Impact on employers and workers.** Employers that now provide coverage to workers come out ahead, saving an estimated $24 billion by sharing the cost of dependent coverage with other employers. Employers that do not now insure their employees would face increased costs up to 7 percent of payroll or $1.25 an hour, an estimated increase of $45 billion. Although many economists believe that ultimately this cost would be shifted back to workers in the form of lower wages, this is unlikely to happen instantaneously or for minimum-wage workers. Yet this financing feature is controversial: more modest employer contributions than proposed here have been strongly opposed by small firms.

☐ **Why not Medicare for All?** Compared to a Medicare-for-All approach, the Building Blocks framework would not achieve the simplicity, consolidated risk, administrative overhead, and provider payment net savings of covering nearly everyone through Medicare. Yet moving to Medicare for All in one step would require major disruptions in current coverage and financing. About 250 million people would

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need to change their current insurance—coverage that many value highly. It would also require a method to recapture employer contributions currently made on behalf of employees. In contrast, the Building Blocks framework offers a potential route to build on Medicare's strength with coverage of the population that is dynamic and subject to evolution over time.

☐ **A pragmatic approach.** The Building Blocks framework represents a pragmatic approach to a more connected insurance system with more continuity and competition than the system we have now. It builds on Medicare and large-group coverage, and if Medicare outperforms private plans in the future, it should experience growing enrollment over time. It would do so through competition with the private sector and voluntary choice. On the other hand, the best of private health insurance would also be able to prosper and grow, if insurers could provide employers and consumers with value-added health plans through innovation and flexibility.

Given projected increases in national expenditures, insurance expansion would need to be coupled with reforms targeted at moderating future cost trends and improving value. Federal premium assistance costs, in particular, would grow rapidly if health costs continue to grow much faster than incomes. Recent analysis suggests that combining a more integrated insurance system with reforms targeted on better information; payment reforms to align incentives with efficient, high-quality care, including care coordination; and public health initiatives could reduce total projected national expenditures and offset future federal costs to expand insurance.[13] A more integrated insurance system would provide leverage and opportunity for more consistent public- and private-sector policies.

Concluding Remarks

The combination of rising premiums and loss of coverage has put reform back on the national policy agenda. Although details and specifications differ, core concepts of a framework that builds on existing public and private group coverage and develops a structure for Medicare to be an option for employers are central to various national proposals.

Much is at stake if we fail to act with a coherent set of policies that focus on value. Health expenditures are projected to double and consume 20 percent of national income over the next decade, with increasing numbers of people losing their insurance.[14] To achieve savings with better access and health outcomes, insurance reforms will need to be combined with broader system reforms.[15] The Building Blocks framework described here would help forge a stronger, more cohesive insurance system and form the basis for other reforms to improve performance. For health reform to succeed, all stakeholders will need to be prepared to make con-

cessions to enable and finance a more efficient, effective health system. The Building Blocks framework offers a starting point for that discussion.

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