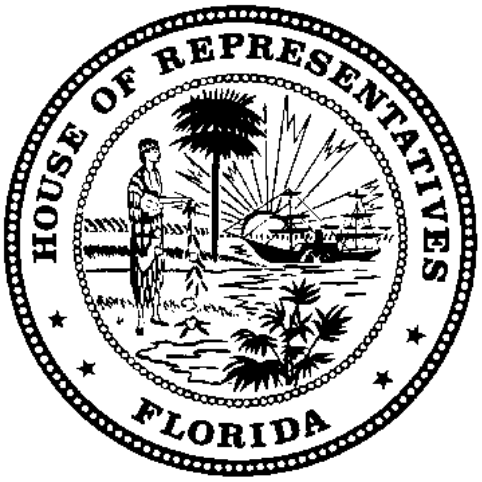

Marketplace for Affordable Health Insurance

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Executive Summary

This paper explores the potential for use of market based initiatives to address problems of access, cost and quality in health care. Using competitive market principles to improve health care is one of two approaches commonly recommended for health reform. The alternative path is government based and relies on expanding current programs, creating mandates and providing subsidies. Market-based initiatives increase choices, foster competition, expand information on price and quality, and empower consumers with buying power. The paper examines the issues and barriers to market-based reform and proposes a model for creating a new environment—a marketplace—for buying and selling health services and coverage.

The model proposed in this paper is a public private partnership—a marketplace—that creates a new environment for buying and selling health benefits. The target audience consists of small employers and sole proprietors who voluntarily choose to participate. Certain public employers, such as small cities and counties or school boards, may also want to join. When employers choose to participate, the marketplace administrators assist them to re-define their health benefits plans in accordance with Section 125 of the federal tax code. Under these regulations, employers can create cafeteria plans that offer multiple choices to employees including comprehensive insurance plans, limited benefit plans, flexible spending accounts, and other benefits.

Through the marketplace, resources for health benefits are placed in the hands of consumers who can choose the best uses of those resources to suit their needs. Insurance plans purchased in this way are individual and portable, allowing employees to maintain coverage even if they change jobs. Employees retain the ability to use pre-tax dollars for their health care purchases.

The marketplace provides administrative benefits to employers, allowing them to offer more choices and more affordable choices to their workers without having to maintain expensive human resource capabilities. Employers joining the marketplace shift to defined contribution plans that offer greater predictability and flexibility in the cost for offering health benefits.

Insurers and others selling health services through the marketplace will set their prices based on age, gender and location. The marketplace will use a variety of tools to assess the actuarial soundness of the prices in order to advise consumers of these findings. To avoid selection bias, the marketplace will apply a post enrollment risk adjustment to the paid premiums. Vendors choosing to sell products and services in the marketplace will commit to cover or provide services to any consumer who is qualified to buy. When sellers increase prices, consumers will be able to transfer to any other plan or product in the marketplace.

The goals of the marketplace are to encourage competition, offer more affordable choices to consumers, provide individual and portable coverage, and make price and quality information transparent to consumers who control the decisions about use of resources for health care.

Marketplace for Affordable Health Care
2007 Interim Report
Healthcare Council

What's the Problem?

Facts about Health Care Costs

- U.S. health care spending topped $2.1 trillion in 2006 or $7,026 per person.
- Currently health care constitutes 16% of Gross Domestic Product, but this share is expected to increase since growth in health spending outpaces the overall GDP growth.
- The average price of a family health insurance policy is nearly $12,000 per year—about 20 percent of the earning power for the median household.
- Public funding is the source of 46% of all spending for health services and supplies
- In Florida, health insurance costs mirror national trends with average annual premiums of $10,848 in small group plans.
- Medicaid spending in Florida is growing twice as fast as state general revenues, requiring at least 55 cents of every new dollar to sustain current services.

Facts about Health Care Access

- As many as 47 million Americans including 3.6 million Floridians are uninsured at any given time.
- More than half of uninsured Floridians have been without coverage for more than a year and about two-thirds of uninsured adults are employed.
- Federal law requires hospital emergency departments to provide timely and necessary medical treatment. Florida's hospitals provide more than $2 billion in uncompensated care each year.
- Limited payment rates for Medicare and Medicaid services create a disincentive for physician participation, resulting in less access to services, especially for specialty care.

Introduction

The problems with health care are well known. More than 25 years of study consistently focus attention on three broad concerns: access, cost and quality. Numerous analyses chart the persistent rise of the number of people who are uninsured[1]; document the relentless increases in cost for individuals, employers and government payers[2]; and bear witness to the inconsistent quality or, even worse, the preventable performance lapses[3]. The details of these failures become even more familiar as health care assumes a more visible place on the public agenda[4].

Health care is not just an academic subject; it is also an intensely personal and critically important component of each individual's life. Everyone has a health care story to tell—a story of needing or obtaining health care for themselves or a family member. Such stories cannot and should not replace a careful and systematic analysis, nevertheless, they comprise an important part of the public dialogue about social policy.

The following stories suggest some important insights into the changes that are needed in the health care system. They are illustrative because they demonstrate the kinds of frustrations that even trained health professionals and experienced system experts encounter when they seek services from the current health care system.

- David Gratzer, MD, a Canadian, reports an encounter with American medicine[5]:

  "In 2003, when my wife ruptured a disc in her spine, I set about to find her a neurosurgeon in western New York. Uninsured and uninformed, I resorted to cold-calling neurologists, asking for their opinions of reputable surgeons. Few were willing to speak to a stranger about a colleague's skills. Meanwhile, having a choice of two hospitals and no information on either, we selected one at random and then spent a nervous night before the operation at a Hampton Inn, which I had chosen after reviewing detailed reports at Hotels.com. I found myself musing darkly that for a mundane accommodation decision, we had a surplus of data, whereas for a critical medical decision, we had little or nothing to go on."

- Donald Berwick, MD, president of the Institute for Health Improvement, tells the story of his wife's serious illness and reports that despite the many compassionate and hard-working professionals, the health system is failing[6].

  "*The experience did not surprise me but it did shock me…I have read (about)…medical errors, but now I have seen them firsthand…The errors are not rare. They are the norm…We often heard a cacophony of meaningless and sometimes contradictory conclusions…Drugs tried and proven futile in one admission would be recommended in the next as if they were fresh ideas…There have been only two instances when someone actively sought our feedback on the care system itself…Continuity, when it occurred, was based on acts of near heroism…One after another, caregivers told us of their own distress. The occupational therapist apologized for cutting back Ann's treatment, explaining that 17 OTs had been laid off the week before. The doctors told us about insurance forms and fights for needed hospital days. The nurses complained that the transport service never came…And the bills were astounding."*

- Michael E. Porter and Elizabeth Olmsted Teisburg include reference to personal experience in the preface to their book, Redefining Health Care[7].

  "As is the case for so many Americans, we encountered the health care system in a personal way, in the course of addressing medical issues facing parents, relatives, and children. When Elizabeth's newborn son underwent complex—and remarkably successful—heart surgery to address a medical condition that would have been fatal or debilitating just a few years earlier, we experienced firsthand the very best of the U.S. system with all its innovation, medical skill, and human compassion. Yet even as the system was performing a miracle, getting the right doctors required circumventing the normal system. Even more troubling was the protracted struggle, which truly became a nightmare, to obtain reimbursement from the supposedly best health plan available."

Such stories illustrate the widespread frustration with the current system of care. While such shared understanding can provide a foundation for consensus on solutions, in health care, opinions on the course of change are sharply divided. *Public Agenda*[8] suggests that most debated strategies fall into one of three classifications: incremental changes to existing programs; creation of a national health care system; and use of competition and market based strategies.

The purpose of this paper is to explore the use of market strategies as a means of making quality health care more affordable and accessible in Florida. Although the underlying rationale

for use of market-based strategies is outlined below, this paper is not intended as a comprehensive comparative evaluation of free markets versus other alternatives. Varying assessments of that question have been offered by many scholars and policymakers. Rather than resolving the point, the debates continue "because the broad ideological battle over the role of markets remains a basic dividing line and dominant theme in American health policy".[9]

The focus of this paper is to offer an explanation of markets and market principles; to identify some practical considerations for applying these principles; and to outline some ideas for creating a market environment that can improve access, moderate increasing costs and enhance quality of health care in Florida.

What's the Problem?

Facts about Health Care Quality

- Rand researchers report that patients receive appropriate care, including preventive, chronic and acute care, only about one-half of the time—regardless of payer source or demographic characteristics.[10]
- The Institute of Medicine launched a concerted effort in 1996 to assess and improve health care. Their findings documented the serious and pervasive nature of the nation's overall quality problem, concluding that "the burden of harm conveyed by the collective impact of all of our health care quality problems is staggering".[11]
- More than 20 years of analyses by John Wennberg, MD and colleagues document the variability of medical care—high use areas fare no better than others indicating considerable uncertainty on the best course of treatment.
- Medicare spends twice as much on its Miami enrollees (approximately $50,000 per person more) as those in Minnesota and achieves worse outcomes.
- Delayed responses contributed to worse outcomes in nearly a third of cases of hospitalized patients with treatable heart abnormalities.

Economic Perspectives

What Does Market-based Mean?

- Markets are systems of exchange in which buyers and sellers make choices about producing, selling, and buying goods and services.
- Each choice is a trade-off—a decision to do one thing rather than another.
- Choices to buy and sell reflect the value individuals place on the items being traded.
- Prices are not the best measure of value; instead the cost of the foregone opportunity defines the value inherent in each transaction.
- Values are relative (or marginal) rather than absolute.
- Prices rise and fall based on scarcity.
- Scarcity stimulates substitutes and there are substitutes for everything.
- Choices have unintended effects—either beneficial or detrimental.

How Can Markets Meet Basic Needs?

Everyone <u>needs</u> medical care, but everyone also wants more care than they need. Markets are tools for sorting out wants and needs and determining the price it takes to satisfy them. This point is best illustrated by a story used in many introductory economics texts. The story looks at water and diamonds. Water is also a basic human need.

> *"Water is necessary to existence and of enormous value in use. Diamonds are frivolous and clearly not essential. The price, however, of diamonds, their value in exchange, is far higher than that of water…We would all rather do without diamonds than without water. But almost all of us would prefer to win a prize of a diamond than one of an additional bucket of water. To make this last choice, we ask ourselves not whether diamonds or water gives more satisfaction in total, but whether more of one gives greater additional satisfaction than more of the other…our answer will depend on how much of each we already have…Actual choices then reflect not just core values or preferences (water is more important than diamonds), but also relative scarcities. They reflect the weighing of marginal utility and marginal cost of the alternative opportunities before us."*[12]

Is Health Care Different?

This same insight is relevant to health policy and the consideration of need versus value. There is no question that acute illness or serious injury is a medical "need" that will drive most individuals to demand services regardless of price or difficulty—similar to the thirsty man in the desert and his need for water.

In most other circumstances, medical "need" is more subjective and debatable. Demand for medical care varies substantially, as in other markets. Consumer demand reflects choices based on individual evaluations of costs and benefits.

Providers recognize the uncertainty in much of medical science and their decisions are influenced by assessments of the trade-offs in each case. Providers considerations are not just clinical trade-offs, but economic ones as well—reimbursement amounts and opportunity costs influence provider choices.

Why Does An Economic Perspective Matter?

The following economic observations are relevant to health policy:

- Resources for health care are limited.
- Every health care system and every reform proposal allocates resources or rations supply in some way.
- Non-market reforms place responsibility for these choices into a bureaucratic, budget-driven process.
- Market-based reforms decentralize allocation decisions to consumers who weigh their own circumstances and personal values.
- Non-market systems of care must add on methods for assuring quality; quality information is not revealed through the purchasing transaction.
- Market systems force providers to compete based on price and quality and customer feedback is inherent in purchasing decisions.

Cumulatively, individual choices in a competitive market produce systematic and predictable results—prices drop when supply is abundant and increase when supplies are limited. Competition for customers drives continuous quality improvements as well as more efficient means of production. Substitutes are offered and tested for customer satisfaction. Products and services with the best results are rewarded with greater earnings and market share.

Financial Basis of Health Care

In 2006, 60 percent of all health care services and supplies were purchased with private funds and 40 percent were government sponsored.[13] Of the health expenditures made with private funds, 25 percent were made by businesses (largely employer contributions to health coverage) and 31 percent were made by households (including private insurance, Medicare payroll taxes and out-of-pocket spending).[14] The largest share of government spending occurs through Medicare and Medicaid.[15] State and local governments pay 17 percent of all health expenditures.[16]

Health care can be bought directly or through a third party such as an insurer or a managed care organization. Insurance is the way most people purchase health care. Third party coverage provides several benefits:

- Risk shifting: to prevent or limit financial loss due to unexpected events;
- Risk pooling: to decrease the variance of risk within a population;
- Pre-packaged bundles of services and established service networks: to compensate for differences in information between buyers and sellers;
- Bargaining: to enable access to price discounts;
- Pre-payment: to spread ordinary expenditures over time;
- Subsidy: to assist purchase of services for very high risk individuals.

Most Americans obtain health insurance through their employer. There are at least two important reasons for this: tax policy favors this method and employment groups provide a large and stable basis for pooling risk. Both of these factors make health insurance more affordable when acquired as an employment benefit.

As a result of the reliance on insurance, the costs even for routine medical encounters are invisible to most consumers. Individuals bear the cost of 31 percent of health expenditures, but more than half of this spending is through taxes or insurance premiums. Out-of-pocket spending for direct purchase of medical goods or services accounts for only 13 cents of every dollar devoted to health care.[17] Decisions to initiate care do not impart factual information to the consumer—demanding a dollar's worth of services seems like spending 13 cents. At this price, consumers make rational choices to use more care. Of course, not all costs are based on money. Consumers also spend time and effort to use resources and as these requirements increase, utilization may decline.

The insulation from ordinary expenses distorts the normal interaction of supply and demand that typically generate an efficient allocation of resources. As David Gratzer observes, "health care is so expensive because it is so cheap"[18]. But health care is not cheap. As of 2006, health care expenditures totaled over $2 trillion and accounted for 16 percent of the gross domestic product. Spending for health care amounts to an average of $7,026 per person per year, though the distribution of these resources is neither efficient nor equitable.

Florida Facts

Access

The number of Floridians with private health insurance is estimated to include 11.3 million residents.[19] More than half of these (58%[20]) are covered through self-insured plans with the remainder receiving coverage through carriers that are regulated or monitored by the Office of Insurance Regulation (OIR). In 2006, OIR reported activity for 140 carriers of major medical lines. Of these, 25 carriers earned premiums in the small group market; 80 carriers reported activity for individual plans.[21] Despite the number of participating carriers, market share is highly concentrated—just three companies account for nearly 70% of the small group market. The table below presents additional data from OIR regarding the overall size of the small and individual markets in Florida.

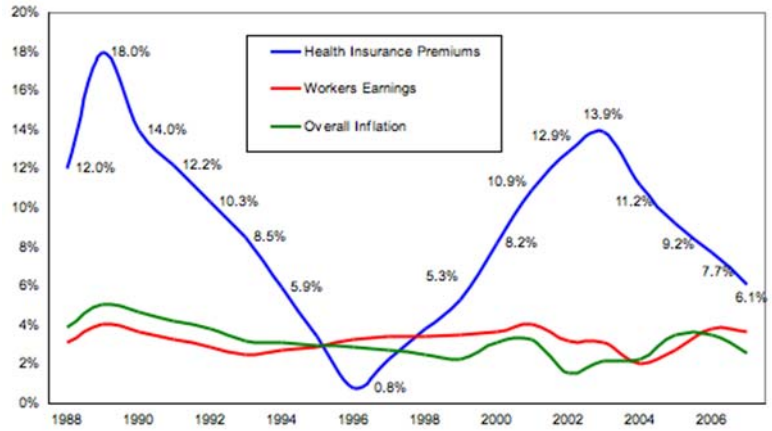
CY2006 Accident and Health Report: Summary by Major Medical Lines of Business[22]

Line of Business	Premiums New/Renewal	Losses Incurred	Employer Groups	Primary Insureds	Covered Lives
Instate Individual	$971,267,393	$627,135,429		318,586	479,550
Instate Self-Employed	$168,488,242	$144,585,527	18,830	18,830	32,330
Instate 2-5 Member Groups	$720,398,361	$537,063,636	43,065	122,891	200,253
Instate 6-50 Member Groups	$2,998,464,292	$2,173,105,057	72,733	550,501	892,326
Total	$4,858,618,288	$3,481,889,649	134,628	1,010,808	1,604,459

Over the years, Florida has launched numerous initiatives to try to increase access for groups and individual health insurance coverage. Examples include guarantee-issue, limits on individual underwriting practices, and protections for continued coverage. These efforts produce mixed results because while extending protections to certain individuals, they also can drive up costs and increasing cost is the primary reason that employers and individuals drop coverage.[23]

The Florida Health Insurance Study (FHIS) of 2004 found that about 19.2 percent of non-elderly Floridians are uninsured. The number of uninsured varies with the time period considered. Estimates of uninsured at a point in time, like FHIS, tend to be higher than counts of people uninsured year-round but lower than the number ever uninsured during the year.[24] About 75 percent of non-elderly Floridians were insured the entire year, while 14 percent were uninsured the entire year, and 11 percent were uninsured part of the year.[25] The primary reason employers do not offer health insurance or employees do not take health insurance when it is offered is cost.[26]

Annual Growth Rates for Health Insurance Premiums, Workers Earnings, and Overall Inflation, 1988-2007



Source: Kaiser Family Foundation/Health Research and Educational Trust.

Costs

Costs of insurance in Florida average $10,848 per year for a family in the small group market. This amount is somewhat higher than the national average of $9,768[27]. Florida's minimum wage (as of January, 2008) is $6.79 per hour. A full-time minimum wage employee would earn $14,123 annually. Average costs of family coverage constitute 77% of the minimum wage worker's annual earnings. Even with employer contributions to reduce the burden on the individual, health costs are likely to be too expensive for low-wage workers. For those employers who do offer health coverage and contribute to the premium, those benefits drain resources away from higher wages.

Mandated health benefits reflect an interest in guaranteeing access to certain types of health services. A mandated health benefit must be either provided or offered. Florida has one of the nation's most extensive set of coverage requirements. According to a report prepared by the House of Representatives staff for the Committee on Insurance in 2000[28], Florida has a total of 51 mandated health benefits applicable either to private insurers or HMO health plans. Additional mandates pertain to the regulatory requirements placed on insurers. Florida's mandates only apply to those insurers that are not exempt under federal law. Exempt insurers are those plans that are self-insured. The non-exempt insurers—those plans subject to state mandates and other regulation—account for about 42 percent of all Floridians with health insurance.

In 1993 the Legislature established Community Health Purchasing Alliances (CHPAs) as a tool for enabling small employers to shop for health care coverage with the pooling advantages of a larger group.[29] The intent was to use a model of managed competition as a way to make health insurance more affordable and consequently reduce the number of uninsured. Although as many as 45,000 previously uninsured people used CHPAs to purchase health coverage, the experiment was not successful and was repealed[30]. At least two of the reasons for this failure deserve mention. First, CHPAs never had authority to create a true pool and negotiate for

coverage and, second, CHPAs provided little remuneration to brokers who received better compensation for selling plans outside of the CHPA construct.

Health Flex plans were created as a pilot program by the Legislature in 2002.[31] The intent was to expand the availability of health options for low-income, uninsured Florida residents by encouraging health insurers, health maintenance organizations, provider sponsored organizations, local governments, and other community organizations to develop alternative approaches to traditional health insurance while emphasizing coverage for basic and preventive health care services. The 2003 Legislature expanded the program allowing the Health Flex plans to be sold to groups.[32] In 2004, the program was further modified allowing catastrophic coverage to be offered.[33] Currently, there are five state-approved plans in operation. Less than 2000 persons were covered by Health Flex plans in 2006. Among the barriers that limit the program's success are the following: limited support and community awareness, lack of incentives for provider participation, income limits and participation requirements that complicate employer recruitment, high turnover among workers of participating employers, and cost.

Subsequently, the Legislature enacted "The 2004 Affordable Health Care for Floridians Act"[34]. Among other provisions, the act created the Small Employers Access Program to allow the development of distinctive, innovative, and flexible benefit plans exclusively offered in defined geographical areas to small businesses up to 25 employees; any municipality, county, school district, or hospital located in a rural community; and any nursing home employer. The program was never fully implemented due to a lack of interest by insurers and limited response from employers.

Hospitals and other providers deliver a substantial amount of services without compensation to people who are uninsured or underinsured. For Florida's 289 hospitals, the cost of uncompensated care was estimated at $1.9 billion[35]. Hospitals are required by federal law to provide screening, treatment within their capabilities, or transfer if necessary to any patient presenting with an immediate medical need. Emergency department physicians are also affected by these federal requirements and in 2005, ED physicians provided at least $131 million worth of uncompensated care[36]. Estimates of amounts and costs of uncompensated care for community physicians are harder to come by, however, a study in the early 1990s estimated that at least 10 percent of all physician charges were unresolved with self-pay patients accounting for at least half of these amounts.[37]

Quality

The primary criticism about the quality of health care in the U.S. is not that the system cannot produce good outcomes, but rather that the results are inconsistent, unpredictable and undependable. Researchers including John Wennberg, the Institute of Medicine, the Institute for Health Improvement and many others have documented the variations in practice patterns and medical outcomes. The common observation among these studies is that the failure is systemic. Even skilled professionals can be stymied by inadequate information, fragmented care, and unreliable supports. Dr. John Wennberg was one of the first to suggest that more care is not always better care. For example, his research reveals that Medicare spends 2.5 time as much on its Miami enrollees as it does on those in Minneapolis. The outcomes in Miami are worse, despite the additional costs to Medicare of $50,000 per enrollee.[38]

Why Consider Markets?

The simplest answer to this question is because they work. In almost every other area of the economy, markets produce an efficient allocation of resources and a trajectory of product and service improvements that benefit consumers.

Why does competition fail in health care? Some observers assert these failures occur because of the nature of health care—it is too complex for consumers to understand; business interests only drain the resources necessary for care and services; shopping for care is inappropriate for people with immediate and serious medical problems. Advocates of market strategies point to the exceptions—the instances in which certain types of medical care are bought and sold under more normal market conditions with resulting improvements in price and quality. Lazik surgery is one such example.

Porter and Teisburg summarize the experience with market economies and note the exceptions to market performance that are typical for health care:

> *In a normal market, competition drives relentless improvements in quality and cost. Rapid innovation leads to rapid diffusion of new technologies and better ways of doing things. Excellent competitors prosper and grow, while weaker rivals are restructured or go out of business. Quality-adjusted prices fall, value improves, and the market expands to meet the needs of more consumers. This is the trajectory of all well-functioning industries—computers, mobile communications, consumer banking, and many others.*
>
> *Health care competition could not be more different. Costs are high and rising despite the fierce struggle to control them. Quality problems persist. The failure of competition is evident in the large and inexplicable differences in cost and quality for the same type of care across providers and across geographic areas. Competition does not reward the best providers, nor do weaker providers go out of business. Technological innovation diffuses slowly and does not drive value improvement the way it should; instead, it is seen by some as part of the problem. Taken together, these outcomes are inconceivable in a well-functioning market. They are intolerable in health care, with life and quality of life at stake. They are unsustainable in a sector that consumes a large and growing portion of the national budget*.[39]

The evidence for the applicability of economic insights to medical decision making is significant. On the consumer side, the Rand study documented sensitivity to price among health care consumers more than 25 years ago. The study was recently summarized and discussed by the principal investigator, Joseph Newhouse.

> *The RAND HIE randomized families to health insurance plans that varied their cost sharing from non ("free care") to a catastrophic plan that approximated a large family deductible with a stop-loss limit of $1,000 (in late-1970s dollars), which was scaled down for the low-income population. If one uses the rate of increase in per capita medical spending to convert late-1970s dollars into 2004 dollars, a $1,000 deductible then would be more than a $6,000 deductible is today. The HIE participants in the large-deductible (95 percent coinsurance) plan used 25-30 percent fewer services than those in the free-care plan; on average,*

> *they had just under two fewer face-to-face physician visits per person per year and were 23 percent less likely to be hospitalized in a year. Substantial reductions in use were found among all income groups…For most people enrolled in the RAND experiment, who were typical of Americans covered by employment-based insurance, the variation in use across the plans appeared to have minimal to no effects on health status. By contrast, for those who were both poor and sick—people who might be found among those covered by Medicaid or lacking insurance—the reduction in use was harmful, on average.*[40]

Newhouse goes on to observe that increased initial cost sharing became more common following publication of the study's results and that hospital admission rates fell, however, cost per hospital stay increased and premium costs continued to rise. The author points to several factors that may help to explain these trends including changes in Medicare payment policies that may have shifted more costs to private insurers. He also notes the later substitution of managed care for cost sharing as a means for moderating utilization and spending. The backlash against managed care that followed is generally attributed to consumers' and health professionals' distaste for the supply-side utilization controls necessary to manage costs. Newhouse concludes that cost-sharing and managed care may be complementary strategies, with the former reducing unnecessary care seeking behavior and the latter offering disease management to assure that beneficial care was provided.

There really are only two ways to pursue improvements in access, cost and quality: market-based reforms and non-market or government-based reforms. Within each of these two categories, the endless variations of strategy and technique produce more of a continuum of choices rather than a strict dichotomy. Because the purpose of this paper is to examine the potential for market-based changes, it is worthwhile to examine some reasons to consider this approach.

For at least 40 years, the largest experiment possible has been conducted on government based coverage in the form of Medicare—public insurance for the aged and disabled—and Medicaid—public insurance for low income people. The results of these programs provide reasons for caution in expanding to universal government-funded insurance. Costs have skyrocketed for both programs. Medicaid is largest single program in most states' budgets.[41] Medicare is also in serious financial difficulty according to the program's trustees:

> *Medicare's Hospital Insurance (HI) Trust Fund is already expected to pay out more in hospital benefits this year than it receives in taxes and other dedicated revenues. The growing annual deficits…are projected to exhaust HI reserves in 2019…The drawdown of Social Security and HI trust Fund reserves and the general revenue transfers into SMI will place mounting pressure on the Federal budget.*[42]

In response to these trends, government rations care—either directly or indirectly. Reimbursement rates are reduced and the number of participating practitioners dwindles. Facility payments are constrained and some facilities close. With service providers less available, utilization drops enabling the program to become more affordable. If these constraints are not sufficient, benefits can be reduced or eligibility restricted. Similar results can be found in other countries with government sponsored insurance. Waitlists for services are common. Access to specialty services is delayed.

The potential of market-based reforms is best evaluated in those areas of the health care system that are least distorted by third party payments. Lasik surgery and plastic surgery are two examples in which information on price is readily available, notably in the form of package pricing that consumers can understand. Prices have also come down as the technology for this procedure has developed. The express-care retail clinics offer another interesting test of market principles. These types of providers have proliferated and are achieving success based on transparent pricing and an emphasis on customer service. Pharmaceuticals experienced a similar benefit when Wal-Mart initiated the $4 prescription and several other retail pharmacy chains quickly followed suit. Publix took the idea one step farther by creating a free prescription drug program—offering seven generic antibiotics to their customers at no charge regardless of insurance status. All of these private initiatives help to make drugs more affordable and accessible.

Issues and Barriers

Recognizing the market failures during the last several decades, any new efforts to establish a market for affordable health care must address specific issues and develop ways to overcome expected barriers. This section identifies those considerations.

- Target audience

  Rising costs of insurance have the greatest impact on people in the individual and small group market. Recent national estimates indicate that as many as 246,000 people lose insurance for every one percent increase in health spending relative to personal income.[43] Rates of uninsurance are significantly higher for small employers compared to large employers. For example, only 40 percent of firms with 10 or less employees offer health insurance compared to 97 percent of firms with more than 100 employees[44]. In Florida, 58.2 percent of the uninsured work for employers with less than 25 workers.[45]

  Gaps in coverage also affect access to care. According to the Florida Health Insurance Study, 10.8 percent of Floridians under age 65 were uninsured for part of the year. Periods of uninsurance lasted six months or less for 60 percent of these adults and between seven to 12 months for 40 percent.[46]

- Failures of employment based health care

  According to the Committee for Economic Development ("CED"), "employer-based health insurance coverage is failing. Fewer Americans have coverages…fewer American firms are offering health insurance…the competitiveness of American firms is threatened by the cost of insurance. Public budgets at every level are eroded by the costs of health care, including costs that were previously paid by employers."[47] Among the causes of this failure, CED points to the following:

  - Lack of choice. To simplify administration and avoid adverse selection, the vast majority of employers offer only one plan.
  - Fee for service payment. Because employees value choice of physicians, employers tend to select plans that offer access to as many providers as possible.

- Lack of incentives. "Employees have no incentive to choose cost-effective , high quality plans, and health care insurers and providers have no inducement to provide the quality, affordable care that consumers want."[48]
- Increase in chronic diseases. The fee-for-service system is not well suited to early detection, prevention and management of chronic diseases. Costs increase with inefficiency and redundancies of service in these arrangements.
- Complexity: the administrative structures in the current health care system increase the opportunities for error or fraud.

- Individual Health Insurance

  Enabling the purchase of individual, portable health insurance is one way to overcome the failures of employment-based health. One of the significant challenges of this strategy is the potential for adverse selection and disruption of the risk pooling benefit of group insurance. This difficulty can manifest itself in two ways. First, a disproportionate number of small groups consisting of healthy workers may flee the current small group market affecting the risk profile and consequently increase the costs of insurance obtained in the usual manner. Second, the costs of individual insurance may be prohibitively high for people with serious or chronic health problems.

- Information

  Competitive markets require the availability of information for consumers to make rational choices based on consideration of price and quality as well as their personal values. Since 1963,[49] observers have noted that medical care is marked by an "asymmetry of information". In other words, physicians and other health care professionals have a depth of understanding about disease and the possible interventions that cannot be matched by the patients. Lay people cannot achieve the same level of understanding as trained professionals with years of experience.

  The question is whether consumers can acquire sufficient information to be more responsible purchasers of care. Designers of managed competition sought to create integrated delivery systems that would take the worry out of the consumers' hands and lead them to the right services at the right time from the right provider. This approach limits the "market" to a competition among corporate conglomerates with the consumer only a bit player in making the original selection of a delivery system. The backlash against managed care provides some evidence of the potential resistance to that approach.

  The newer version of market-based health reform assumes an ongoing active role for consumers who will weigh their decisions based on more transparency on price and quality. For this vision to be realized, better information must be available to consumers.

- Direct Purchase

  Increasing direct purchase of health services is an additional method for transforming health care into more of a competitive market environment. In a direct purchase transaction, the resources for health care are placed in consumers' control who then have the ability to choose between health care and other uses of money. The goal of these models is to reduce the demand-inflating effects of insurance. A variety of techniques have been proposed for achieving this goal including health savings accounts coupled with high

deductible catastrophic policies, and health reimbursement accounts that allow consumers to use pre-tax dollars for a variety of medical expenditures. Florida law encourages use of HSAs but less than 10 percent of the insured persons in the small employer market are covered by these types of plans.[50] Two other types of products are contemplated in Florida law. These are discount medical plans and pre-paid clinic services.

- Affordability

  Observers note that the critical market failure in the nongroup market is its inability to offer a reasonably priced product for low risk individuals.[51]. High administrative costs, notably costs associated with selling, as well as fear of adverse selection drive up the average price. Public policies requiring guaranteed issue and community rating also drive up prices. Nevertheless, Pauly and Nichols conclude that "about 80 percent of candidates for nongroup coverage could and would obtain that coverage at moderate premiums, relative to their expected benefits and ability to pay".[52]

  Costs that can be addressed in the development of a marketplace include the costs of mandates; the costs to insurers and employers for administering health benefits, insurers' costs for selling, and the consumers' costs associated with investigating and evaluating alternatives.

- Competition

  Although 25 companies are active in the individual and small group market in Florida, 70 percent of the insureds receive coverage through just three companies. Florida law requires that insurers offer standard and basic benefit packages but few employers select these plans and most choose a richer package of coverage. Factors limiting competition in the individual and small group market include higher administrative costs, the potential for adverse selection, and lower net profits due to the higher rate of claims per premium dollar.

  Normal markets stimulate the development of product alternatives, but this phenomenon has been very limited for health care. While insurance may be the exclusive way to protect financial assets from unexpected and substantial medical expenses, the potential exists for substitutes to develop for ordinary and predictable medical expenses. Minute clinics, concierge packages for physician services, and pre-paid service contracts provide some examples of how these products might function.

- Subsidies for sicker patients

  Strategies for making health insurance more affordable for sicker people can be based on either exclusionary or inclusionary mechanisms.[53] Exclusionary mechanisms separate high risk and low risk individuals and provide subsidies as needed. Inclusionary mechanisms transfer risk by redistributing a portion of the premiums in a way that is invisible to the enrollees.

- Lack of incentives to purchase coverage

  Past Florida experiments with a variety of initiatives from modifying pooling arrangements to creating more affordable and flexible policies have produced little effect on the number of uninsured. One of the major reasons is that the marginal change in price from these programs is insufficient to change many people's minds about buying coverage. In the case of HealthFlex plans, consumer surveys indicate that individuals are weighing the reduced

coverage and the price when making their decisions to participate. Implementing a market for affordable health care will require greater incentives to increase the value of a purchasing decision to the consumer.

- Regulations limit sellers and products

  In addition to these obstacles, insurers in the small group market face a significant regulatory burden including certification requirements, rate filings, and statutory mandates. Depending on how one counts, Florida has between 30 and 51 mandates. The Council for Affordable Health Insurance (CAHI) puts the count at 49 including 42 benefit mandates and 7 coverage mandates. This places Florida as a relatively mandate-rich state. CAHI assessed all 50 states and identified a total of 1961 mandates with a range of 15-64 in each state.[54] CAHI notes that the estimated costs of these mandates varies considerably—1 percent, 1-3 percent, 3-5 percent and 5-10 percent—depending on the nature of the mandate as well as the nature of the policy to which the mandate is added. Achieving a goal of affordable health insurance may require greater flexibility for insurers and consumers.

- Tax policies create subsidies for some but not others

  Another concern with expansion of individual portable health insurance policies is due to current federal tax policies. Health insurance purchase through an employer are made with pre-tax dollars. Individual policies are not typically eligible for this same tax benefit. Employers can compensate for this difficulty by creating cafeteria plans that enable each worker to use the available resources for health care in a way that they choose. Few small employers are likely to be aware of this option or to have the expertise in benefits management that would be necessary to steer through the IRS regulatory procedures.

- Organizational complexities

  Purchasing health care can be a complex and costly exercise. Small employers do not typically maintain the expertise to manage a benefit plan that includes many choices for their employees. Any initiative to stimulate a more competitive market and provide more affordable choices for individuals will need to provide administrative support for small employers.

Goals for Market Based Health Reform

Significant policy initiatives should establish clear goals that create a sound basis for action. In health care, setting the stage with such goals is especially important since the system is complex, the debate over strategies is often contentious, and implementation is likely to be affected by changing conditions. The following goals suggest a possible framework for development of a health care marketplace.

Goal	Strategy
Access:	Provide flexible ways to use pre-tax dollars for purchase services and coverage.
Affordability:	Encourage competition based on price and quality.
Portability:	Create a public-private partnership to serve as administrator for individual portable plans.
Choice:	Stimulate diversity in the service and coverage products available to Floridians.
Transparency:	Provide information to consumers about the quality and price of health care.
Consumerism:	Decentralize decision-making about health care—placing individual consumers in control over resources for their own health care.

Recommendations: Creating a Marketplace for Affordable Health Care

This proposal adapts concepts developed by the Heritage Foundation, the James Madison Institute and others. The centerpiece of the proposal is the creation of a public-private partnership that can function as a third-party administrator for employers and employees who participate in the marketplace. Similar to the Massachusetts Connector, this entity will process the purchasing transactions for consumers, serving as a single source of payment of premiums from multiple employers and multiple insurers. The Florida marketplace will also offer substitute products that create the opportunity for direct purchase of health services. The marketplace will be responsible for providing information on price and quality that consumers can use to select the products most suitable to them. More detailed recommendations are provided below.

Who Can Participate?

Participation is voluntary. Small employers (those with up to 50 employees) including self-employed individuals and sole proprietors may choose to join the marketplace. Participation is open to those who currently have insurance through the small group health insurance market as well as small employers who are not presently offering health insurance. Public employers may also participate. The marketplace will offer affordable health coverage and services to small public employer groups such as rural counties, cities and school boards that struggle with rising costs of employee benefits.

Employers initiate the entry to the marketplace and modify their current benefit structure into a defined contribution cafeteria plan qualified under Section 125 of the IRS code. Once this change has been made, the marketplace will serve employers like a centralized human resource department—managing the offering of multiple choices, payments of premiums, and other related functions.

Employers' responsibilities including setting their monthly contribution amount, maintaining an accurate record of their qualified employees, and forwarding monthly payments to the marketplace consisting of the employer's contribution and any employee contribution. Employer participation may be incentivized through tax credits on their business property insurance.

Once an employer joins the marketplace, their employees are eligible to participate. The individual employees are the real consumers, selecting the plan or products they wish to purchase. The plans or products are fully portable regardless of change in work status. The individuals participating in the marketplace can then continue to buy services and coverage as long as they choose. However, if they continue their participation while unemployed or after moving to a non-participating employer, the monthly payments—including the portion formerly paid by employer contribution—become the responsibility of the individual who owns the benefits.

What's a Cafeteria Plan?
Facts about Section 125

- Section 125 allows employers to offer employees a choice between cash salary and a variety of nontaxable (qualified) benefits.
- A qualified benefit is one that does not defer compensation and is excludable from an employee's gross income under a specific provision of the IRS Code, without being subject to the principles of constructive receipt.
- Qualified benefits include health care, vision and dental care, group-term life insurance, disability, adoption assistance and certain other benefits.
- There are three types of cafeteria plans: the Flexible Spending Account (FSA), the Premium Only Plan (POP) and the full cafeteria plan.
- An FSA allows employees to use pretax dollars to pay dependent care expenses and medical bills not covered by their insurance, while a POP allows employees to make their contributions to group health and group term life insurance with pretax dollars. [1]
- A full cafeteria plan usually includes POP and FSA features, and is popular at large companies.
- POP is the simplest type of cafeteria plan and most popular with smaller companies, as it requires low maintenance once it has been set up.
- Full cafeteria plans, which offer the most flexibility, are high maintenance and more costly, which is why they are more common at large companies.

Employee participation may also be encouraged with specific incentives. For example, individuals who make contributions to purchase coverage or services could receive a refundable tax credit.

Success of the marketplace is more likely if an initial group of participating consumers can be identified. This will help to attract vendors by assuring them of the availability and participation of a specific group of customers. Knowing who these customers are will help insurers and other vendors anticipate the coverages and services that customers may demand. Two groups that may be included in this initial wave are state employees who do not otherwise qualify for state employee health insurance and retired state workers who are under age 65. The first category consists of uninsured persons who can benefit from access to affordable health care. The marketplace offers a way for the state to offer a specific level of support to help uninsured state

workers. The second category may already be insured but are at risk of losing coverage because of the high costs of continuing to purchase through the state plan. The marketplace may offer these groups an affordable alternative.

Will People Participate?

The marketplace offers a new alternative for buying health insurance and health services. The design of the marketplace responds to many of the underlying causes of high costs, uncertain quality and limited access to health care. Nevertheless, the public's responsiveness to this new model is difficult to predict. Many initiatives have been launched to address these same problems and produced only modest impacts. For this reason it may be necessary to consider additional incentives to encourage participation and strengthen the possibilities for success.

What Choices Will Be Offered?

The marketplace will offer a broad range of insurance plans, HMOs, and pre-paid service products. Options will include comprehensive coverage, catastrophic plans, limited benefit plans, and flexible spending accounts. Consumers will be offered ways to spend their money to purchase services as well as ways to save their money for future needs. The competitive environment of the marketplace will encourage innovation so that vendors offer new arrangements and service agreements. Concierge medical services, information services, disease management, wellness programs, and obesity interventions are just a few examples of the types of services that may help consumers improve their health and obtain the services they need.

Vendors who can place products in the marketplace include insurers, managed care organizations, providers, and provider networks. To encourage participation by these vendors, incentives can be offered. Tax credits against premium taxes for insurers and HMOs and tax credits against the "sick tax" are two examples of incentives that may be offered.

Will the Choices Be Affordable?

Transparent pricing and a competitive environment will provide the foundation for achieving affordable products. Regulatory relief will serve as an additional tool for stimulating affordability as well as attracting the participation of vendors. Insurers, HMOs, and pre-paid clinic providers currently face extensive bureaucratic hurdles in order to do business in Florida. Additionally, Florida law requires insurers and HMOs to comply with as many as 51 separate mandates. The marketplace would serve as a mandate-free zone in which consumer demand would provide the impetus for including or excluding certain coverages.

In place of the extensive oversight on financial matters currently established through the Office of Insurance Regulation (OIR), marketplace vendors would be required to purchase a performance and payment bond as a simplified way to protect consumers in case of financial failure.

Some of the impetus for affordability will come from new products in the marketplace. Alternatives to traditional insurance may include pre-paid service contracts and other financing

arrangements for managing the costs of routine services while accessing discounts or specific pricing methods.

How Will Consumers Decide What to Buy?

Insurance agents who want to participate will be trained and certified to serve as "buyers' representatives" in the new marketplace. Traditionally, agents have worked for insurance companies and their commissions from these insurers may influence the advice provided to the purchasers. Such arrangements could continue within the marketplace, but must be disclosed to consumers before any information and advice is provided. Other agents may choose to work only as buyers' representatives in the context of the marketplace. Payment for agents' services will be provided by the marketplace from the administrative fees collected from participants.

The marketplace will develop a variety of tools for consumers to use in selecting their plans. A website that enables comparisons among available products and provides a mechanism for consumer feedback will facilitate online purchases.

How Will Consumers Be Protected?

While the marketplace will not control the prices of the products offered, several techniques can be used to assure that consumers are protected from predatory practices. Assessment tools can be used to test the actuarial soundness of the rates; mechanisms can be developed and implemented that help consumers evaluate whether the products they are considering are adequate to meet their medical needs.

Consumers will be assured that the vendors in the marketplace are reliable and capable of delivering the promised services through a variety of methods. Vendors that are certified by OIR will be qualified without any additional marketplace requirements. The marketplace will be able to establish qualifying standards and requirements for all other vendors, such as performance bonds, that will compensate in the event of future failures.

What Information Will Be Available?

The marketplace will collect information necessary for evaluating specific performance criteria. This information about quality of care and other service characteristics will be provided to the public along with prices for each product. Internet access to this information will enable consumers to identify and evaluate alternatives—web-based tools will make it easy to compare and contrast the choices that are offered by the marketplace.

To make it easier to compare prices, each vendor will set their prices based on age, gender, and location of each participant. This is similar to the process that is used by Massachusetts (http://www.mahealthconnector.org/portal/site/connector/) and eHealthInsurance.com. Through its website, the marketplace will also provide a profile of each participating vendor consisting of existing licensure and other regulatory data.

Customer comments will provide an additional and important source of information.

Why Will Employers Participate?

Employers will benefit from the marketplace in several ways. Administration of health benefits will be simplified at the same time that more choices are made available to employees. The marketplace will assist employers to secure IRS approval for cafeteria plans in accordance with Section 125. The marketplace will then be designated as the third party administrator for the employer's plan allowing it to assume all responsibilities for paying premiums to the plans selected by the employees, managing the flexible spending accounts, and other related duties. The employer will be left with the responsibility of accurately reporting participating employees and submitting one monthly payment to the marketplace consisting of the employer contributions for all workers and any employee contributions deducted from payroll.

The products purchased through the marketplace will belong to each individual employee who can continue to participate regardless of a change in work status—maintaining their current selections or changing to new products during a pre-determined enrollment period. This will assist workers who might otherwise experience a gap in coverage. When continuing coverage while unemployed or working for a non-participating employer, the monthly payments will be the responsibility of the individual. Coverage or services may be discontinued for failure to pay.

How Will the Marketplace Help Sicker People?

The marketplace will provide an environment in which niche products may develop that cater to particular conditions or illnesses. Disease management plans or comprehensive plans that specialize in selected patient groups will be among the innovative products available in the marketplace.

To prevent the possibility of adverse selection, the marketplace will apply a post-enrollment risk adjustment to redistribute a portion of the premiums paid to account for the distribution of risk among the vendors. This adjustment will be invisible to the consumer, but will have the effect of pooling risk among all participants even though the products they buy are individual and portable.

How Will the Marketplace Be Administered?

Several options can be considered to create and implement the marketplace including management by a designated state agency, an administrator selected through a competitive procurement, or a private corporation created in statute. This last model has been used successfully in Florida by the Florida Healthy Kids Corporation.

How Will the Marketplace Be Funded?

Start-up funding will be necessary to launch the marketplace. Costs will include staffing, marketing, IT services, and other expenses. Eventually, the marketplace should become self-sufficient, funded through fees paid by participants.

Summary of Issues, Problems and Proposed Solutions

Issue	Problem	Marketplace Solution
Target Audience	o 19% of Floridians are uninsured o Nearly 60% of the uninsured work for employers with less than 25 workers o 10% of Floridians are uninsured for part of the year	o More affordable plans and services will improve access to care and coverage. o Affordability is especially important for small employers
Employer Sponsored Insurance	o Numbers of people with employer sponsored insurance are declining o Most employers offer only one plan o Employers' selection of plans are not based on cost-effectiveness o Costs are not visible to employees o Gaps in coverage result from job change	o More choices will be available through the marketplace o Plans sold through the marketplace will be individual and portable. o Prices will be transparent allowing consumers clear choices about how to spend resources.
Individual Insurance	o Possibility of adverse selection o Disruption of risk pooling	o Post enrollment risk adjustment will ensure the pooling benefits of insurance are available for individual policies
Information	o Consumers are not used to evaluating and selecting plans o Information about price and quality has not been readily available	o Web-based comparative information tools will make evaluation easier for consumers o Both price and quality information will be available for all products o Brokers can play an important role as "buyers representatives" for the marketplace
Direct Purchase	o Direct purchase of services (instead of through insurance) has not been common o With few exceptions, providers have not tried to market services directly to consumers	o New competitive choices will be offered—not just insurance but ways to pre-pay for specific health services such as wellness programs, or disease management o The marketplace will make it easier for providers to sell innovative service arrangements
Affordability	o High administrative costs and fear of adverse selection have increased premiums for individual policies o Small employers may face higher premium costs due to state mandates and other regulation	o Competitive choices and transparency of prices will enhance affordability o Centralized purchasing through the marketplace will reduce overhead for small employers o The marketplace will function as a "mandate-free" zone
Competition	o 70 percent of the small group market in Florida is shared by just three companies o Administrative costs and lower net profits may discourage more competition	o Putting resources in the hands of individual consumers may create new market dynamics o Lower overhead for selling through the marketplace may stimulate involvement by more vendors
Sicker Patients	o Costs will always be higher for sicker patients o Group insurance spreads these costs o Individual plans risk selection bias	o Post enrollment risk adjustment spreads higher costs for sicker patients
Participation	o Health care is expensive but seems cheap at the point of service o Consequently, consumers expect comprehensive coverage at a minimal price o Participation in previous initiatives to expand coverage has been modest	o Offer a range of choices and transparent prices to help consumers find the plan or service package that suits their needs. o Provide incentives for coverage
Regulations	o Florida has 51 mandates o Costs of mandates vary considerably but generally range between 1 and 10 percent.	o Exemption from mandates for plans and services offered through the marketplace
Tax Policies	o Federal tax policies favor employment based insurance o Individual policies can be more expensive because they are purchased with after-tax resources	o Assist employers to qualify benefits plan under Section 125 of IRS code o Cafeteria plans provide favorable tax treatment to a broad range of services
Organizational Complexities	o Purchasing health benefits can be a complex and costly exercise. o Small employers often do not have the expertise to manage a benefit plan with multiple choices	o Centralize administrative activities and costs for greater efficiency. o Offer administrative services in order to serve as an "HR" department for many small employers.

Notes

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[21] Florida Office of Insurance Regulation, CY 2006 Gross Annual Premium and Enrollment; Accident and Health Markets, July 2007 *available at* www.fdhc.state.fl.us/SCHS/doc/2006-7-19/TAB_E2.doc.
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[30] *See* Chapter 97-45, Laws of Florida; Chapter 00-256, Laws of Florida at § 60; Chapter 00-296 Laws of Florida at § 11.
[31] *See* Chapter 02-389, Laws of Florida at § 1.
[32] *See* Chapter 03-405, Laws of Florida at § 5.
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