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Doing It Right: The District of Columbia Health Insurance Market Reform

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LAWRENCE H. MIREL: Before joining the Washington, D.C., law firm of Wiley Rein & Fielding in October of 2005, I served for more than six years as the Commissioner of Insurance, Securities and Banking for the District of Columbia. As Commissioner, I became involved in health insurance issues, and I spent a considerable amount of time and effort trying to find better ways to make sure that the citizens of the District of Columbia had access to reasonable and affordable health insurance.

That is no easy task. Advances in medical science and technology assure that health care costs continue to rise as people receive more expensive care and live longer as a result.

In addition, the District's unlimited tort recovery system means that premiums for medical malpractice insurance go up every year, adding further costs to the system. Medical providers—doctors, hospitals, and clinics—are increasingly being squeezed between rising costs for medical malpractice insurance and flat or even declining reimbursement by health insurance companies that are trying to hold down the cost of health insurance. For some, and especially those physicians and clinics that serve the poor, the squeeze is threatening their survival.

Comprehensive solutions are hard to come by. I did undertake two separate initiatives, however, as Commissioner that were aimed at ameliorating some of the more egregious problems with the current system. Both of these initiatives are still in the works, so their value has yet to be proven, but I believe that they hold

Talking Points

- Under the proposed D.C. Equal Access to Health Insurance Act, small employers could provide defined health benefit payments for their employees, who could then sign up for one of the policies offered under a new District-wide program.
- A D.C. Health Benefits Program would be a central clearinghouse through which anyone who lives, works, or attends an institution of higher education in the District of Columbia, and their dependents, could obtain health insurance coverage.
- A separate Health Insurance Risk Transfer Pool would allow participating carriers to transfer claims for high-cost enrollees to the pool and evenly spread those expenses across all insured individuals.
- A professionally managed insurance company involved in providing liability coverage for clinics would ensure that the best risk management practices are required, providing maximum safety to patients and to the District government.

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out real promise for improving our health delivery system in the District of Columbia.

Large vs. Small Groups: An Artificial Distinction

The first is aimed at what I consider to be unfair discrimination between persons who are employed by large employers—private or government—and have reasonable health insurance options, regardless of their medical history, and persons who are employed by small employers, are self-employed, or are not employed at all. People in this latter group have a much tougher time finding decent insurance coverage, usually pay more for the coverage they do get, and, if they have a history of medical problems, may not be able to get insurance at all.

There is no good reason for this discriminatory treatment. Insurance is subject to the "law of large numbers," which simply means that the larger the number of people in a group of insured, the easier it is to cover them all, even those who have or will have medical problems. That is because most people are healthy, meaning that the premiums they pay for health insurance can cover the costs for the much smaller number in the group who become ill. For those in small groups, however, or those who are self-employed, there is no large body of healthy people to share costs with. They pay according to their individual health status.

This distinction between large and small groups is entirely artificial. If we lump enough small groups together, we end up with a large group. That is the basic idea behind a bill that was drafted in the D.C. Insurance Department, known as the Equal Access to Health Insurance Act. Under that bill, which was introduced in the Council of the District of Columbia but has not been enacted, *all persons who live, work, or go to school in the District of Columbia* would be treated as a single group for purposes of health insurance rating. Members of this large group would be able to choose from among a wide array of private health plans—health maintenance organizations (HMOs), preferred provider organizations (PPOs), high-deductible plans, etc.—the particular policy that best suits their needs. But they would pay *group rates* for those policies and would not be individually underwritten.

Looked at another way, the legislation would require that the District of Columbia Employees Health Benefits Plan, which provides a menu of options at standard rates to all District government workers, be opened up to all persons who live, work, or go to school here. No longer would someone who works for a restaurant or small retail business have fewer choices and pay higher prices for health insurance than people who work for the District of Columbia government. No longer would someone who is self-employed be individually underwritten while someone with exactly the same medical history but who works for the District government pays standard rates regardless of that medical history.

The Equal Access bill is designed to create a structured market for providing personal, portable health insurance in the District. Under the Equal Access bill, small employers would no longer have to negotiate health plans for their employees each year, deciding whether it would be better to include dental coverage or maternity benefits and whether they can afford either. Instead, small employers could provide defined health benefit payments for their employees, and those employees could then sign up for one of the policies offered under the District-wide program that would be set up under the Act.

Not only employers, but also churches, civic organizations, and social service agencies could help their members and constituents purchase insurance through this program. We think just the ease of being able to access the health insurance system without having to find, design, and negotiate individual plans on a yearly basis will increase the number of people who are insured.

D.C. Health Benefits Program

The legislation would create a District of Columbia Health Benefits Program, which would be a central clearinghouse through which anyone who lives, works, or attends an institution of higher education in the District of Columbia, and their dependents, could obtain health insurance coverage. Any District employer could designate the program as its "employer-group" health insurance plan for its workers and their dependents—both those who live in D.C. and those who live elsewhere. Dis-

trict residents could also enroll in the program directly.

Once enrolled, individuals would be able to select coverage from a menu of health insurance plans offered through the program and could elect to change coverage during an annual open season.

All of the insurance plans offered through the program would be private plans offered by health insurers licensed to do business in the District. They would be regulated by the D.C. Department of Insurance, Securities and Banking (DISB) and would have to comply with all applicable D.C. health insurance laws, just like any other licensed health insurance plans. The program itself would operate much as the federal Office of Personnel Management does in making available private health insurance plans to federal employees; that is, it would administer the offering of a menu of private insurance options.

Although the D.C. Health Benefits Program would be similar in some ways to health insurance purchasing or pooling arrangements established by some states, it also differs in that it is designed to be considered "employer-group" insurance for purposes of federal tax and employee benefit law. In extensive discussions with the federal Departments of Labor, Treasury, and Health and Human Services, we worked out a novel approach as follows:

- Any employer could contract with the D.C. Health Benefits Program to make the Program its "employer-group" health insurance "plan." For purposes of federal law, that employer's "plan" would consist of the menu of insurance product choices offered through the program and the premium subsidy provided to its workers by the employer.
- This means that any contribution made by the employer to the premium for a policy purchased through the program would be tax-free to the worker. It also means that employees and dependants covered through the program would receive all of the protections afforded by federal law to workers covered by "employer-group" health insurance. However, because the policies offered through the program are personal, portable, D.C.-regulated insurance products, workers would be able to keep their coverage when they switch employers.

The program would also operate a payroll withholding system to facilitate collection of premium contributions by workers and/or their employers. Employers could choose to augment the coverage offered through the program with their own separate, supplemental plans providing additional benefits such as vision care, dental care, long-term care, and health care flexible spending accounts.

As the legislation is currently drafted, the program would offer a choice of 10 to 15 health plans selected so as to offer a choice of plan types (indemnity, HMOs, PPOs, consumer-directed, etc.). All plans offered through the program would have to provide major medical coverage (defined as hospital benefits, surgical benefits, in-hospital medical benefits, ambulatory patient benefits, and prescription drug benefits) and meet D.C. mandates, but within these broad parameters, insurers would be free to design specific benefit packages in response to consumer preferences.

Policies sold through the program would charge standard, age-adjusted rates, without underwriting, to all enrollees who had at least 18 months of previous coverage or who enrolled in the program as part of a participating employer-sponsored group. Each participating plan would be free to set its own table of standard, age-adjusted rates, subject to review by the DISB, to ensure that the rates reasonably reflected the anticipated costs of the offered benefits.

Persons who joined the program as part of a participating employer-group would be able to obtain coverage at standard rates and without underwriting, regardless of previous coverage. Persons who enroll in the program directly as individuals would be able to buy coverage at standard rates without underwriting if they have at least 18 months prior creditable coverage. Individual enrollees with less than 18 months prior creditable coverage could be charged premiums of up to 150 percent of standard rates for up to two years and could be subject to pre-existing condition exclusions of up to 12 months, reduced by the number of months of creditable coverage.

The program would be a self-governing, separate legal entity, sponsored by the D.C. government and

subject to regulatory oversight by the DISB. The administrative costs of the program would be financed out of assessments on participating carriers, apportioned according to the share of enrollees electing coverage offered by each carrier through the program.

Any enrollee who ceased to be eligible to participate in the program by reason of a qualifying event (employment termination, divorce, loss of dependent status, etc.) would be permitted to continue participating in the program for up to 36 months on the same terms as other enrollees, regardless of the loss of eligibility.

Insurance agents who brought individuals or groups to the program would be paid a 5 percent commission by the plans selected by those individuals. Associations and private social service organizations that enrolled groups or individuals in the program would be similarly compensated.

The legislation specifies that the D.C. government would put its employees into the program. Thus, the program would start with a core group of about 30,000 (about 19,000 D.C. workers and their dependents). The presence of this large, stable, initial core group in the program would be a strong inducement to insurers to participate in the program and to offer attractive rates and benefit packages. Then, as private businesses and individuals join the program, its growing size would make it even more attractive to insurers and encourage even more vigorous competition for enrollees.

Health Insurance Risk Transfer Pool

Finally, the Equal Access legislation would also establish a separate Health Insurance Risk Transfer Pool. The pool would be a "back-end reinsurance pool" structured as an industry-run, mandatory association. It would allow participating carriers to transfer claims for high-cost enrollees to the pool and then evenly spread those expenses across all insured individuals. That way, no single carrier would bear a disproportionate share of the costs associated with high-risk individuals. This would also permit high-risk individuals to have the same health plan choices as everyone else.

The pool would be self-governing and financed by assessments on all health insurance carriers selling health insurance in the D.C. market, both in and outside of the D.C. Health Benefits Program, as well as any self-funded employer plans that also elected to participate in the pool.

Clinics and Medical Malpractice Insurance

The other initiative is designed to help the economic viability of the network of clinics that serves the District's population, and especially its less affluent members. Because of the District's unlimited liability tort system, the cost for medical malpractice insurance continues to rise astronomically. Obstetricians, for example, now pay more than $150,000 a year for medical malpractice insurance while health insurers hold down the amount paid for deliveries, making the practice of obstetrics in the District of Columbia financially unviable.

Particularly at risk in this financial squeeze are the dozen or so independent clinics that provide much of the city's primary care for its poorer citizens. Especially since the demise of the old D.C. General Hospital, these clinics have become the major source of primary health care for a large portion of the city's most vulnerable citizens. If they were to fold, the people they serve would have no choice but to take their medical problems directly to hospital emergency rooms—a most dangerous and uneconomical way to provide the care they need.

Medical malpractice insurance premiums have become a huge burden to these clinics. I know of one clinic—the Family Health and Birth Center in Northeast Washington, which provides essential prenatal, birthing, post-partum and pediatric care to hundreds of District residents—that recently saw the cost of its medical malpractice insurance go from $90,000 to $175,000 in one year. The total budget of this clinic is only $1 million a year. These clinics must have malpractice insurance, if for no other reason than that the District cannot contract with them to provide their health services unless they do. And much of their business is done under contract with the District government.

In my former position as D.C. Insurance Commissioner, I proposed that the District set up its own

medical malpractice insurance company—a "captive" insurer—to cover all medical malpractice risks to which the District government is exposed, either directly because of health services it provides to its citizens or indirectly because of health services provided by clinics under contract with the government.

Individual clinics have little or no leverage with malpractice insurers. They are generally so small that there are few insurers willing to even make them an offer of insurance. They are victims of the same inflexible insurance "law of large numbers." But the District government is a large player, and it can negotiate among insurers for good rates. By sweeping the private clinics into the District's own insurance mechanism, we can ensure that the clinics enjoy the better rates that the District can command, and the District can subsidize those costs when necessary.

Moreover, the captive insurance company will be able to provide important risk management services to those clinics. At present, the District may be liable for malpractice committed at those clinics, but because they are independent organizations, the District government cannot help them to properly mitigate their risks.

Currently, the District government is self-insured for tort claims, including medical malpractice. Since there is no sovereign immunity for the District government, and since there are no legal limits in District law on tort claims, the government has open-ended exposure for claims of medical malpractice committed by District employees or contractors. What it pays out in judgments and settlements each year comes from a "settlements and judgments fund" in the District's annual congressional appropriation. There is little ability for the government to control or account for the amount of money paid out each year, or to engage in the kinds of rigorous risk management that could reduce those claims. By setting up a wholly owned captive insurance company that would be professionally managed, the District will be able to budget better and better manage its liability risks.

By allowing clinics to buy insurance from the captive insurance company, the District will enable these private entities to realize the market stability and savings that will come from the pooling of risks with the government.

Moreover, the District will have the ability to subsidize the insurance costs for those clinics that cannot afford to pay them without jeopardizing their ability to provide patient care. Those subsidies will be a bargain for the District government because they will ensure that the private clinics will be able to continue their mission to serve the District's poorest population without the need for more expensive and cumbersome programs that the government would have to establish if they did not exist.

Finally, having a professionally managed insurance company involved in providing liability coverage for these clinics will ensure that the best risk management practices are required, thus providing maximum safety to the patients of the clinics as well as to the District government.

These are modest but important initiatives that I believe can help the District provide better medical care for its citizens on a more rational and cost-effective basis. Because they are innovative ideas, they naturally meet with some resistance from persons who do not understand what they are trying to do or who are genuinely concerned that matters not be made worse. But innovation is what is needed, and these are ideas that will work.

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EDMUND F. HAISLMAIER: There exists a substantial body of data and analytical research on health insurance coverage, including analyses of the demographics of the insured and uninsured populations according to various demographic factors such as income, age, race, sex, geography and employment. However, the vast majority of that analysis and research can be summarized by saying that in the case of any given uninsured person, his or her lack of coverage is attributable to one or more of the following three basic factors: the

affordability, the availability, and the perceived value of health insurance.

Affordability

Some of the uninsured simply do not have sufficient incomes to pay for coverage. Furthermore, even if coverage could be made less expensive than it currently is, many of those individuals would still be unable to afford health insurance absent additional assistance in the form of some kind of public subsidy.

The biggest public policy issue in this regard is the current binary, or "all or nothing," structure of publicly funded health coverage programs. Those who qualify get full coverage, while those who do not qualify get nothing. In the case of the District of Columbia, this applies to Medicaid, D.C. Healthy Families (the District's S-CHIP program), and the Alliance. It should be noted in passing that the federal Medicare program works the same way.

For income-related programs, the reality is that some individuals with incomes just under a program's eligibility thresholds could probably afford to contribute something toward their coverage, while many of those just above the eligibility thresholds will certainly need some subsidy to afford health insurance. In recognition of this reality, some states have expanded their public programs by permitting income-related "buy-in" arrangements. For example, Maryland permits families with incomes between 200 percent and 300 percent of poverty to "buy into" S-CHIP coverage for their children by paying a partial premium. Less common is the alternative approach of providing qualified individuals with income-related contributions to subsidize private coverage.

Availability

For other uninsured individuals, the issue is one of availability as much as (or more than) it is one of affordability. In general, these are persons who lack access to employer-provided insurance. For many of them, the availability problem quickly translates into an affordability issue. That is because the current system of federal tax subsidies for employer-sponsored coverage, combined with state insurance laws that divide the market into small-group, large-group, and non-group segments, each with different regulations, makes employer-group insurance significantly less expensive than the alternative of non-group insurance.

However, it is important to keep in mind that non-group insurance does offer the advantage of coverage portability, while employer-group insurance is never truly portable. Thus, were governments to equalize the costs of employer-group insurance versus non-group insurance through public policy changes, the purchase of non-group insurance would likely become the preferred solution for many individuals, particularly those who change jobs more frequently.

Value

Finally, the principal issue for some of the uninsured is one of perceived value. These are individuals who have access to coverage and can afford to pay for it but still decline to purchase health insurance (either group or non-group) because they perceive it to have low value for the price charged (premium). This perception of health insurance as a "poor value for money" can result from several factors, including:

- Community rating practices that make coverage more expensive for younger and better-risk individuals;
- Regulations that prevent the offering of less comprehensive, and thus less expensive, plans;
- A system of public subsidies for uncompensated care that perversely encourages the healthy uninsured to go without coverage, knowing that someone else will pay for their treatment should they in fact happen to need care; and
- A general market structure that results in the offering of plans that focus on near-term protection at the expense of long-term protection, such as by applying underwriting in the non-group market equally to those who are with and without continuous prior coverage.

Given the interaction of these three basic factors, it is not possible to simply subdivide the uninsured into three groups. Rather, the reality for any given uninsured individual is that one of these three factors is the dominant reason for a lack of coverage

while one or both of the remaining factors also influence the coverage decision.

Three Sets of Reforms

However, this analysis is useful in suggesting a three-pronged approach that policymakers can take to measurably expand health insurance coverage. The most promising strategy is to systematically address the three basic factors that produce uninsurance with three complementary sets of reforms.

Set One: Undertake reforms designed to moderate the cost of coverage in general and to permit health insurance markets to better align premiums with perceived value.

Set Two: Institute reforms in the ways that health insurance is bought and sold to make coverage more accessible and available, particularly for those whose employment patterns do not match the premise of long-term employment at a large firm offering employer-group coverage that underlies the current market structure.

Set Three: Reform public programs to provide subsidies to more individuals, but scale them according to income and need. Also, convert existing subsidies for uncompensated care, currently directed to medical providers, into coverage subsidies directed to individuals.

The data indicate that many of the uninsured are part-time or contingent workers, including significant numbers employed by federal, state, and local governments and large private employers. Another significant share consists of those working for small businesses, particularly "micro" businesses with 10 or fewer employees, and the self-employed. Finally, almost all of the remaining uninsured individuals are the dependents of workers in the first two categories.

National research also shows that the long-term uninsured comprise only a small portion of the total uninsured population. A recent study that looked at the total population experiencing one or more spells of uninsurance over a four-year period found that only 12 percent were consistently uninsured. In contrast, fully one-third cycled repeatedly in and out of insurance coverage, and another 29 percent experienced coverage gaps during the four-year period. These results led the authors to conclude that continuity of coverage should be an explicit and principal policy goal for health reform.[1]

The simple reality is that employment-based health insurance works well only for those who are long-term employees of large firms, and Medicaid is reliable coverage only for the very poor. Neither system, alone or in combination, is doing an acceptable job of ensuring health care coverage for the people who don't fit either of those categories.

Enhancing Availability and Continuity of Coverage

The D.C. Equal Access to Health Insurance legislation is designed to make health insurance coverage more readily available to District residents and promote greater continuity of coverage. It would create a single "clearinghouse," in the form of a new D.C. Health Benefits Program, through which those who live and work in the District could obtain the health insurance plan of their choice. In the case of individuals whose employers elected to make the D.C. Health Benefits Program their "group-health insurance plan," they would be able to buy coverage through the program using tax-free contributions made by their employer.

The effect would be that, as those individuals changed employers, they could keep their chosen health insurance policy and take it with them from job to job—just as they now do with their auto, home, or life insurance. Thus, as they changed jobs, the only thing that would differ from one employer to the next is the arrangement for paying for coverage with tax-free dollars. Instead of stan-

1. Pamela Farley Short and Deborah R. Graefe, "Battery-Powered Health Insurance? Stability in Coverage of the Uninsured," *Health Affairs*, November/December 2003. See also Pamela Farley Short, Deborah R. Graefe, and Cathy Schoen, "Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem," Commonwealth Fund *Issue Brief* No. 688, November 2003, and Kathryn Klein, Sherry Glied, and Danielle Ferry, "Entrances and Exits: Health Insurance Churning, 1998–2000," Commonwealth Fund *Issue Brief* No. 855, September 2005.

dardizing the insurance benefit package, as Maryland and some other states have done in their small-group markets, the D.C. Equal Access bill would standardize and centralize the administrative functions involved in offering a menu of plan choices, managing an annual open season, handling enrollment, and transmitting premium payments to the chosen insurers.

In short, the D.C. Health Benefits Program would provide for all District residents and participating employers the same kinds of administrative services that the Federal Employee Health Benefits Program now provides for workers throughout the federal government.

As noted, studies of the data on health insurance coverage over time have led researchers to conclude that, "To the extent that job turnover undermines coverage stability, designing ways for employers to contribute to the cost of coverage, without directly administering health insurance, could enhance continuity."[2] The D.C. Equal Access bill is designed to implement precisely the solution called for by these researchers.

The researchers also point out how such an approach can provide benefits beyond simply reducing the number of uninsured. They note that reducing coverage gaps will also aid efforts to improve continuity of care, which can in turn result in better health outcomes, improvements in health status, and potentially lower system costs. Specifically, they conclude that:

> Efforts to reduce churning in public and private plans or to assure more seamless transitions from one source of coverage to another would also enhance the efforts of physicians and other clinicians to provide effective care. The possibility of changing networks of care, frequent transitions from one insurance program to another, and losing coverage entirely are likely to undermine the continuity, timeliness, and appropriateness of care.

Thus, another (and very important) benefit of the proposed D.C. Health Benefits Program is that it would facilitate and reinforce delivery system initiatives designed to improve the effectiveness of care, specifically the "medical homes" initiative of the District's primary care clinics.

Other Advantages of Reform

The design of the Equal Access legislation and the D.C. Health Benefits Program would offer a number of other advantages as well.

For example, the D.C. Health Benefits Program would administer "premium aggregating" mechanisms, including a uniform payroll withholding system, to facilitate the collection of premium payments. Those mechanisms would be able to combine contributions from multiple sources.

Thus, a two-earner couple would no longer have to choose coverage from one spouse's employer and forgo the coverage contribution offered by the other spouse's employer. Instead, they could combine the contributions from the two employers and use the total amount to buy the coverage they really want for their family through the exchange. Similarly, an individual with two part-time jobs could ask for a prorated contribution from each employer and then combine them to buy coverage through the program.

With these features in place, small employers would no longer face the risks and administrative burdens associated with trying to obtain group coverage for their handful of employees. Rather, a business could designate the program as its "group" health insurance plan and give its employees whatever tax-free contribution the business can afford to help them buy coverage.

Under the Equal Access legislation, insurance brokers would continue to receive commissions for bringing employer groups and individuals to the program. They would earn their commissions by providing workers with benefits counseling on picking the best plan for their personal situations and by assisting employers in setting up arrangements, currently permitted under federal and state tax law, that make the share of the premium paid by their workers also tax-free to the workers. Today,

2. Short, Graefe, and Schoen, "Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem."

while such arrangements are common among large firms, small firms rarely offer them.

Furthermore, the Equal Access bill is designed to open up additional avenues for providing coverage to hard-to-reach subpopulations. One provision would allow private social service entities, such as clinics or church groups, to subcontract with the program to handle enrollment for populations that they serve. Another provision stipulates that if membership groups bring their members into the program, those groups would be paid the same commission as insurance brokers. In other words, business and professional associations as well as civic, religious, or social service organizations would be rewarded for ensuring that those they serve get health insurance coverage. That could greatly augment outreach and enrollment efforts.

The Equal Access bill would also require the District government to take the lead by providing health insurance to its own employees through the program. This provision would have several positive effects.

First, D.C. government workers would gain a wider choice of coverage options.

Second, it would facilitate getting coverage to those government employees, particularly contractual and contingent workers, who are currently uninsured.

Third, the presence of such a large number of workers plus their dependents (about 30,000 in total) would be a catalyst for ensuring the program's success. Insurers would have a huge market incentive to offer attractive benefit packages at attractive premiums through the program, while small businesses and their employees would be eager to join.

Finally, the costs of coverage for D.C. government workers might actually decline somewhat under such an arrangement. This is because the average age of workers with employment-based insurance tends to be significantly higher that the average age of the uninsured. Thus, expanding coverage to uninsured workers who are generally younger and healthier should have a favorable impact on premiums for all covered individuals.

Improving the Equal Access Bill

The D.C. Equal Access to Health Insurance Act of 2004 was the first legislative proposal in the country to embody this new approach to restructuring state health insurance markets. As is true with pioneering efforts in any field, subsequent models that replicate and modify the original design often reveal aspects of the original design that could be further improved.

A number of states have produced, or are in the process of developing, their own versions of the D.C. Equal Access legislation, most notably the recently enacted reforms in Massachusetts and the Consumer Health Open Insurance Coverage Act of 2006, introduced during the 2006 session of the Maryland General Assembly.[3] These subsequent versions have identified several areas for further improvement in the original D.C. Equal Access legislation, most notably:

- **Carrier and plan participation.** The Equal Access bill as introduced in the D.C. Council limited to between 10 and 15 the number of insurance plans that could be offered through the new D.C. Health Benefits Program and further provided that no more than three to four of those plans could be of any one type of product: specifically, indemnity, HMO, PPO, or consumer-directed plans. The intention behind those limits was to spur carriers to compete aggressively for the available "plan slots" while also ensuring that a diversity of plan types is made available to participants.

  In contrast, the Massachusetts and Maryland reforms take what could be called an "any willing plan" approach, meaning that their state health insurance exchanges would have to offer any plan that gained normal pre-market approval from the state's insurance regulator.

3. The Consumer Health Open Insurance Coverage Act of 2006, Senate Bill 530 and House Bill 1416, Maryland General Assembly, 2006 session.

The latter approach is probably the better one, as it provides for broader competition while simplifying participation in the program for insurance carriers.

- **Elimination of parallel markets.** The original Equal Access legislation permits the District's current non-group and small-group health insurance markets to continue operating in parallel with the new D.C. Health Benefits Program. In contrast, the Massachusetts legislation will fold that state's non-group market into the new Massachusetts Health Insurance Connector and creates a commission to study the feasibility of also folding the state's small-group market into the Connector as well at some later date.

  The Maryland legislation goes even further and proposes simply to make the new Maryland Health Insurance Exchange the only place in the state where individuals and small groups could buy insurance. Under the Maryland bill, separate group plans could be sold only to employers with more than 50 employees.

  The case for combining those submarkets is that such a move would not only reinforce and accelerate the creation of a "single market" for health insurance in a state, but, more important, would also serve to eliminate potential residual selection effects. That is a very important consideration with respect to the non-group market, but it is also a relevant issue in the small-group market, particularly for so-called micro employer groups of 10 or fewer where the observed selection behavior is very similar to that in the non-group market.

- **Use of Section 125 plans.** A particularly noteworthy innovation included in the Massachusetts legislation is the addition of a provision requiring employers seeking to cover their employees through the Connector to agree also to establish a Section 125 "cafeteria plan" for their workers. Under Section 125 of the federal tax code, employers may offer their workers a menu of benefits, and the workers may make "voluntary salary reduction" elections to pay for those benefits on a pre-tax basis, including paying their share of the premiums for employer-sponsored health insurance. Thus, by adding the Section 125 plan feature to the exchange, 100 percent of the premiums paid for, or by, anyone participating in the exchange as part of an employer group becomes completely tax-free. The obvious advantage to the state is that it is indirectly tapping another source of federal subsidy for more of its residents.

  At the same time, such a requirement essentially makes moot any debate over how much of a premium contribution participating employers should be required to make as a condition of participating in the exchange. Since employer group health insurance premiums are simply a subset of total compensation, as long as both employer and employee payments receive the same tax treatment, it is irrelevant to the state how various employers and their workers decide to divide those payments for accounting purposes. The state's interest in encouraging individuals to purchase coverage is satisfied by the fact that workers declining the offered coverage would lose a very substantial tax benefit.

  The Equal Access bill as introduced in the D.C. Council was silent on the question of Section 125 plans, though the authors did recognize that it would be to the advantage of both employers and workers to create such plans voluntarily as a "wrap around" product for any employer group electing to participate in the D.C. Health Benefits program. Revising the Equal Access legislation to make sponsorship of a Section 125 plan one of the conditions for employer-group participation in the D.C. Health Benefits Program would be an improvement on the original legislation.

Helping the Low-Income Uninsured

The remaining missing piece of the puzzle is how to address the needs of the low-income uninsured, for whom affordability of coverage is a major barrier. The good news is that the District took the first step in the right direction when it transferred the subsidies it was paying D.C. General Hospital for uncompensated care to the new D.C. Health-

care Alliance. The next step would be to convert the D.C. Healthcare Alliance funding into premium support payments to assist the target population in obtaining personal, portable health insurance through the D.C. Health Benefits Program.

That is precisely the strategy embodied in the comprehensive health reform package given final approval by the Massachusetts legislature just the other day. The Massachusetts legislation includes a health insurance exchange that is taken, with some modifications, directly from the D.C. Equal Access bill, which we shared with them. But the Massachusetts bill also takes the next step of converting that state's present system of provider subsidies, currently paid out of a hospital uncompensated care fund, into income-related premium support payments.

The final, still missing piece would be to assist the District's primary care clinics in creating the necessary infrastructure to accept insurance reimbursement.

When all of these elements are put together, the vision emerges of a D.C. in which all residents can easily obtain and keep personal, portable health insurance; those with low-incomes have the cost of their insurance subsidized through the redirection of existing public funding; and individuals use their insurance to obtain necessary medical care provided or coordinated by the doctor or clinic that is their "medical home."

It is a vision in which all of the incentives in the system are aligned to put the needs of the patient first, in which health insurers compete for customers by offering the best value for money, and in which providers compete for patients by offering the best quality of care at the best price. It is a vision in which patients, providers, and insurers all have incentives to collaborate in managing the patient's care to achieve optimum long-term benefits at the lowest long-term cost. It is a vision worthy of the nation's capital.

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