

Gruber –
Incremental Universalism

I. Purpose

Two ways to get to universal coverage:

Sweeping universalism vs incremental universalism, focus of the paper is on the later,
With a focus on how the state level approach to this

II. Issues of Universal Coverage

a. Who are the uninsured?

- 48 million uninsured – diverse group
- Lower than average income 2/3 income below twice the poverty line
- 20% in families with incomes above 50k
- 70% in families where the head is a full-time, full year worker but is not offered HI or doesn't take it up.
- Modal uninsured is “working-poor” below median income but not among the poorest
- Roughly 30 percent of the uninsured are eligible for free or highly subsidized insurance
- Dynamics: those who lack insurance over an entire calendar year are only about one-half to two-thirds as large as point-in-time estimates
- Estimates of the number of individuals uninsured at any point in the last year are on the order of 40-50% higher than point-in-time estimates

b. 3 Critical issues

- Pooling
 - if pools are too small, or attract high risk, insurers will be reluctant to offer insurance – fear of adverse selection or high cost exposure.
 - Medicare/Medicaid Employers – but most w/out insurance do not work for an employer that offers insurance.
 - Solving the problem of the uninsured requires developing some new pooling mechanism – government, private insurance purchasing arrangements

- Affordability
 - Health insurance is expensive! Average cost of family in MASS is 12k – for those without a large pool it is even higher
 - For a family of four at 200% of the poverty line (income = 42,400) family coverage more than ¼ of before tax family income.
 - Even if those w/out insurance with low incomes had access to large pooling arrangement, they would still need subsidies.

- Mandates
 - Even with large subsidies will not be sufficient. – many of the uninsured are eligible for free public insurance or highly subsidized employer-provided, and still do not take it up.
 - Full insurance requires a mandate
 - More effective risk pooling – the transfer from those who are currently healthy to those who are currently sick.
 - Note there is an implicit subsidy already – the uninsured generate 30 billion in uncompensated care delivered by hospitals each year – these costs are shifted to insured patients.
 - Some uninsured may be making rational decisions, others may not fully understand the risks – either way a mandate would prevent people from opting out of hi and would provide a more efficient subsidization.

c. Public vs private insurance?

- Public insurance already targeted to low income groups most likely to lack insurance – 18 percent of nonelderly and all the elderly covered by public insurance
- Administrative savings of public insurance – in US 12% of premium vs 1.3 in Canada
- National vs regional level of public coverage?
- Nationally determined set of benefits may have disadvantages due to differences in incomes, medical practices, etc. Would end up w/a package that is “wrong” for most Americans.
- Minimum national standards with flexibility at local level
- But complete public program seems highly unlikely
- Majority of Americans have private insurance, giving that up would be difficult.
- Private insurance industry is enormous -- \$500 billion in claims paid annually.

- Hard to imagine this will be legislated out of business.
- Not in God's lifetime
- Some argue for expansion primarily through private
- Tax credits to purchase HI from private vendors. – addresses affordability but not pooling or mandate issues. This would be a costly and uncertain way to expand coverage. Next paper deals with this issue in a bit more detail.

III. Massachusetts

a. Background – things making reform easier

- Low uninsurance rate – 9% of nonelderly pop. Requires fewer subsidies
- Large federal transfer to the state was at stake – large federal payment to state for payments to safety net hospitals – move money away from providers and to individuals to buy insurance
- Already had a state uncompensated care pool – earlier attempt to reform: hospitals could bill the state for the costs of treating low-income patients. Cost \$500 million in 2005 – these funds could be rededicated

b. Key features of the plan

- Existing sources of insurance coverage for most state residents were not changed. Medicaid was expanded to cover children up to 300 % of poverty line. Modest changes to employer sponsored insurance.
- For adults below 3x the poverty line, a new program was established: Commonwealth Care, that provides coverage at subsidized rates.
 - i. Free of charge for those below the poverty line, with minimal co-payments, subsidized for those with income between 100 and 300 percent of poverty line, some premiums and no deductibles.
 - ii. Legislation did not specify either the exact subsidy levels or the package of benefits, decided later by Connector board.
 - iii. Individuals were to choose from one of four Medicaid managed care organizations.

- Those with income above 300% of poverty line:
 - i. Nongroup and small group markets were merged through regulation of insurance companies – one market for all individuals either buying insurance on their own or through firms of fewer than 50 employees,
 1. common prices for any individual regardless of how that individual comes to the market. Insurers face a “guaranteed issue” rule that they could not differential their price by any factor other than age. No greater than 2 to 1.
 2. The Connector was established as a clearinghouse for individuals to purchase private insurance.
- All adults in the state must be covered by health insurance – but only to the extent that such insurance was deemed “affordable” by the board of the connector. Individuals without coverage would face the loss of their individual state-level tax exemption, then penalty increases to half the premium they would pay if insured. Also a charge of \$295 per employee on all employers with more that 10 employees who did not offer some health insurance. Also required them to offer “section 125” accounts – pretax dollars.

c. Early results of the reform

- Successes
 - i. Reduction in number of uninsured – 350,000 – more than half of the number of previously uninsured.
 - ii. Administrative budget of connector is \$25 million (for a \$1 billion expenditure). Politicians playing nice.
 - iii. High compliance
 - iv. Market for those above 300% seems to be good. A typical policy in the nongroup market costs half its previous level and is more comprehensive. Overall premiums in the set o plans offered through connector rose by 5% in 2008 – lower than national rise.
- COSTS – originally projected to cost \$750 million by FY 2009, now budgeted at 1 billion – due exclusively to a higher than projected enrollment in the highly subsidized portion of the Commonwealth Care program. Initial projections appear to have both undercounted the uninsured and over counted their incomes. Leading to a higher than expected of fully subsidized individuals.

IV. Major Issues of Incremental Universalism

- a. Iron Triangle of Affordability – mandate is not politically viable unless insurance is affordable for the individuals who are required to pay. Three possible tools to deal with this problem:
 - It can subsidize insurance sufficiently so that it seems affordable to all.
 - The government can mandate insurance which is low cost, so individuals have to spend a smaller share of their income to meet the mandate.
 - The government can exempt some share of the population on affordability grounds.
- b. Mass uses all three of these tools.
 - Insurance is heavily subsidized for those with income below 3 times the poverty line (free to those below 150, monthly premiums from 35 to 105 for those with 150 to 300)
 - Individuals with incomes above 300x are mandated only to buy a relatively lean policy – 2k deductible and 5k out of pocket max, but covers preventative care w/out a deductible. Costs about 200/month.
 - Mandate applies fully only to those eligible for subsidized insurance or above state median income (5x poverty line). For those with incomes between 3x poverty line and median, the mandate was only partial (see below). About 15% were exempted on affordability grounds.
- c. These options present tradeoffs:
 - Subsidies are expensive, define affordability.
 - Lean policies is also controversial some believe all should have comprehensive.
 - i. RAND health insurance experiment suggests insurance can be more limited and not sacrifice health.
 - ii. For the typical consumer, having to pay moderately more at the point of service for care does reduce the amount of care received but does not have adverse effects on health.
 - iii. Cost-effective insurance has high consumer cost-sharing, protection against large out of pocket risks, and only limited out of pocket costs for maintenance care of the chronically ill.
 - Exemptions are problematic b/c they undercut the goal of universal coverage.
- d. Integration with Employer-Sponsored Insurance. What to do with those low income workers being offered insurance from their employer? Basically three choices:
 - Employer-sponsored “firewall” -- those with offers of employer-sponsored insurance in their workplace receive no subsidy under the state plan.

- i. Save money by limiting the eligible population, but tends to lead employers toward reducing contributions.
- ii. Raises equity concerns about low income workers with offers of employer-sponsored insurance who can't afford that insurance.
- Premium assistance – the state subsidizes employer-provided insurance by paying the difference between a) the contribution required of the employee by the employer-sponsored insurance plan and b) the contribution required under the state plan.
- Voucher-style system whereby individuals with employer sponsored contribution towards hi can come to the exchange, but only if they bring with them their employer contribution towards HI to offset costs.
- i. These last two are expensive since the subsidies cannot realistically be restricted only to those who would otherwise be uninsured: in MASS 700,000 workers offered insurance with incomes below 3x poverty line, only 30k of which are both uninsured and have employee contributions above the Commonwealth care premium level. Thus, by offering subsidies to any worker below 300percent the state could spend an enormous amount to ensure only a small number of persons.
- So there is a tradeoff: leave some individuals – those who are offered insurance by their employers but for whatever reason do not take up that insurance – out of the subsidy system; or spend state dollars to subsidize not only those individuals, but also other low income individuals who now are buying employer-sponsored insurance on their own.
- e. The role of Employer sponsored insurance
 - There has been an erosion of employer-sponsored insurance. Reforming health care can either accommodate this trend, fight it, or facilitate it.
 - Mass accommodates it by providing alternative pooling mechanisms. Lead to faster erosion of employer sponsored insurance – though the individual mandate will work against this.
 - Could fight the trend – with “pay or play” component that penalizes firms that do not offer insurance – California tried this – 7.5% of payroll on firms that did not offer employer sponsored insurance. Cost is lower wages to employees and other distortions.
 - Could facilitate it – pairing non-employer-sponsored insurance coverage options with reduced subsidies to employer sponsored insurance. Tax subsidy on employer sponsored insurance is around 200 billion annually. Use this money.

- f. Cost Control? Keep in mind there are two competing objectives with reform – the uninsured, and costs. Most reform deals with uninsured. Cost controls are likely to be modest – this stuff is expensive!
- Controls such as electronic medical records, increased preventative care, reduced medical errors, will reduce costs by at best a few percentage points.
 - To control costs society will need to be willing to deny care that does little for health but consumers nevertheless want.
 - Government could implement policy that limits the use of new technologies, medical standards that limit the use of high cost, low benefit care, global provider budgets that limit what is spent and force providers to set priorities within that total.
 - This is a can of worms!

V. Other states

a. California?

- Similar plan as MA
- Additional funding source in the form of a 4 percent assessment on employers of more than 10 employees who do not offer HI and a tax on hospitals and physicians.
- In early 2008 reform failed.
- Not too surprising given differences between MA and CA:
 - i. Financial disadvantages
 - ii. Rate of uninsured is about twice in CA relative to MA
 - iii. No existing funding that could be shifted.

b. Insurance market reforms other states have tried:

- Minimize how much insurance companies can vary prices according to health status: guaranteed issue – insurance companies are required to sell to all customers. Guaranteed renewability, etc.
- These have been successful at making care more affordable to sick, but lead to lower overall insurance coverage due to higher prices.
- Separate high-risk pools for the least health risks. These tend to be small. Offer insurance at 125-150 % of average mkt price.
- Most of these programs have very small effects at pretty high costs.

c. Voluntary insurance pools. State level pools individuals can participate in. these tend to be small.

- d. Expansion of public insurance: S-CHIP. This has significantly lowered the uninsurance rate of children relative to the adult baseline, but has also introduced significant “crowd-out”.
- e. Subsidies to employer-sponsored insurance. Subsidies to employers to provide insurance to their workers -- or subsidies to low income individuals to enroll in the insurance offered by their employer. Two problems with this:
 - Poorly targeted – even at low income levels the overwhelming majority of those who are offered health insurance by an employer have taken up that insurance. Among those with incomes below the poverty line who are offered employer-sponsored insurance 75 % are insured; among those with incomes between 100 and 200 % who are offered employer-sponsored insurance 87% are insured; those with 200 and 300% it is 93%. Thus most of the subsidy will go to those already with insurance
 - The small share of employees who are offered employer insurance but who turn it down are very price inelastic. Note they are already turning down a large employer subsidy. Thus, additional subsidies will be unlikely to increase their enrollment. When the federal govt allowed its employees to pay their premiums before-tax, it substantially reduced federal tax revenues with little noticeable effect on enrollment.

VI. Conclusion – is reform a state issue?

- a. Pros
 - Decentralization allows states to match the unique landscapes of their health economies and tastes of state consumers.
 - States with high insured rates may find a MA type approach attractive, while in other states with higher uninsured populations, they may want to take more radical steps such as setting up a monopoly connector to enforce new pooling mechanisms.
 - States may vary in the level of minimum standards for insurance coverage
 - Multiple state approaches could foster innovation and perhaps even competition and continued improvement across states
- b. Cons
 - States left to their own devices may well evolve with very different “affordability” standards across states leading individuals to pay different rates to meet the targets. So some body will have to monitor state reforms to ensure the standard of universal coverage is met.
- c. Either way it is not possible without a massive injection of federal funds.