

Healthcare Reform

**Health expert X dies and goes to heaven. God greets X and the Lord says that the health expert can ask one question before entering heaven. The health expert asks: “Will we ever have universal health coverage in the US?” God answers: “Yes, but not in my lifetime.”**

The following material is mostly from the following two papers:

[Jonathan Gruber. “Covering the Uninsured in the United States.” \*Journal of Economic Literature\*. Vol. 46, No. 3 2008, 571–606.](#)

[Jonathan Gruber. “Incremental Universalism for the United States: The States Move First?” \*Journal of Economic Perspectives\*. Vol. 22, No. 4 Fall 2008 \(pp: 51- 68\).](#)

Two Big Issues

1. Access
  - a. 47 million or about 18 percent of the population do not have health insurance
  - b. What do we do with this diverse group of individuals without access to medical care?
2. Cost
  - a. Too much insurance? The wrong type of insurance
  - b. Technology -- who has access, how do we adopt?
  - c. Who gets to have it? What are we willing to pay for? When is it not worth it? Cost effectiveness.

Most proposals to deal with “Health Reform” deal with issue 1, and give only cursory coverage to issue 2. I will focus on the access issue first, and then we can talk about costs. Both are very difficult issues and they are most likely mutually exclusive.

## I. Access

TABLE 1  
NONELDERLY AMERICANS' SOURCE OF HEALTH INSURANCE COVERAGE

	People (Millions)	Percentage of Population
Total Population	260.0	100.0%
Private	179.4	69.0%
Employment-based	161.7	62.2%
Individually purchased	17.7	6.8%
Public	45.5	17.5%
Medicare	6.5	2.5%
Medicaid	34.9	13.4%
TRICARE/CHAMPVA	7.1	2.7%
Uninsured	46.5	17.9%

70 Percent of the nonelderly population has insurance through private coverage – 62% through their employer (risk pooling, taxes) and 7% individual purchased. Almost 18% are uninsured.

### 1. 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

### 2. Why are they uninsured?

- a. Too expensive – individuals may be unwilling to purchase insurance if it is not available at an actuarially fair price.
  - i. Administrative costs
  - ii. Irregularities in insurance market – small families subsidize large families
  - iii. Adverse selection
    - some of the administrative costs of private insurance are the costs devoted to screening potential applicants



- b. Labor market inefficiency – job lock
  - c. Paternalism – the concern that individuals may be harming themselves by not buying insurance. Those without insurance have a 25% higher mortality risk – 180,000 die each year because of a lack of insurance (IOM, 2005). Note these are correlations but not necessarily causations. Other studies have made the causal link though. A study looking at Canada’s staggered introduction of national health insurance across the nation’s provinces found it was associated with a 4 percent decline in infant mortality, and an 8.9 percent decrease in the incidence of low birth weight among single mothers. A study looking at the removal of eligibility for public insurance in California (due to a fiscal crisis) found that blood pressure rose among hypertensive patients, leading to a 40 percent increased risk of death. Etc.
  - d. Redistribution – the uninsured are disproportionately low income and insurance is expensive relative to their incomes. Thus we may want to redistribute health care resources – again paternalism, or failure of intrahousehold utility maximization whereby providing health insurance to poor children offsets the failures of their parents to sufficiently provide for their care.
4. Two types of solutions;
- a. Sweeping Universalism
  - b. Incremental Universalism

**See New Yorker: Getting There from Here**

- c. 3 Critical issues with incremental universalism
  - i. Pooling
    - a. 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
  - ii. 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.

iii. Mandates

- Even 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.

d. Should the uninsured be covered through public or private insurance?

- i. 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
- ii. Administrative savings of public insurance – in US 12% of premium vs 1.3 in Canada
- iii. 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
- iv. But complete public program seems highly unlikely
- Majority of Americans have private insurance, giving that up would be difficult.
- v. Some argue for expansion primarily through private
- vi. 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.

5. Background issues

a. Political considerations

- i. Private insurance industry -- \$500 billion in claims paid annual. It is hard to imagine this will be legislated out of business – *Not in God's Lifetime*
- ii. Fiscal situation of the US government

b. Bang for the buck – given the above, it is important to pay attention to efficiency of any policy reform. Note that a key concept will be the extent to which new public spending is directed to those who would otherwise be

uninsured – as opposed to buying out the base of (or crowding out) existing insured individuals. This is a notion referred to as *targeting*.

Gruber uses an analogy. Think about the uninsured as tuna and those who already have insurance as dolphins. The goal of environmentally conscious fishermen is to catch as many tuna as possible in their nets, while minimizing the number of dolphins. If the uninsured tunas were swimming in a separate ocean from the insured dolphins, the problem would be easy. And if the uninsured tunas greatly outnumbered the insured dolphins then we'd be ok too. But there are 47 million tunas swimming with 190 million dolphins!

TABLE 2  
NONELDERLY POPULATION WITH SELECTED SOURCES OF HEALTH INSURANCE, BY FAMILY INCOME

Family Income	Total	Employment- Based Coverage	Individually Purchased	Public	Uninsured
Population (Millions)					
Total	260	161.7	17.7	45.5	46.5
Under \$10,000	20.5	2.2	2.1	9.5	7.3
\$10,000–\$19,999	22.8	4.9	2.1	9.1	7.8
\$20,000–\$29,999	25.0	9.8	2.0	6.8	7.6
\$30,000–\$39,999	25.6	13.4	1.9	5.5	6.1
\$40,000–\$49,999	23.4	15.0	1.6	3.6	4.5
\$50,000–\$74,999	48.9	36.6	3.0	5.2	6.4
\$75,000 and over	93.8	79.9	5.0	5.7	6.7

The above table is from the March 2006 Current Population Survey. Note that the uninsured cover a broad range of income groups.

- One third of them have incomes below 20k per year and make up over one third of the total population.
- Another 40 percent of the uninsured have incomes between 20k and 50k per year and make up about a quarter of the population in this income range.
- One seventh of the uninsured have incomes between 50 and 75k, and make up less than one seventh of the total population in that group.
- Finally another one seventh of the uninsured have incomes above 75k and make up only 7 percent of the population.

So the conclusion here is that the uninsured are in parts of the population where they make up less than one-quarter of the population making targeting a real challenge.

Any policy that sets a simple income cut off for eligibility will catch a lot more dolphins than tunas!

It is even more complicated – most insurance is provided through firms, and take-up of employer provided insurance is only partial. Roughly one-quarter of the uninsured work in firms that offer insurance. But these are costly tuna to collect, because those uninsured who are offered insurance represent only about 7 percent of the total pool that is offered. So targeting this 7 percent of uninsured within firms without providing government subsidies to the other 93 percent already insured will be very difficult.

## 6. Massachusetts

### a. Background – things making reform easier

- i. Low uninsurance rate – 9% of nonelderly pop. Requires fewer subsidies
- ii. 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
- iii. 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

- i. 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.
- ii. For adults below 3x the poverty line, a new program was established: Commonwealth Care, that provides coverage at subsidized rates.
  - 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.
  - Legislation did not specify either the exact subsidy levels or the package of benefits, decided later by Connector Board.
  - Individuals were to choose from one of four Medicaid managed care organizations.
- iii. Those with income above 300% of poverty line:
  - 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 and then no greater than 2 to 1.
2. The Connector was established as a clearinghouse for individuals to purchase private insurance.
- iv. 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 than 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
    - i. Successes
      - Reduction in number of uninsured – 350,000 – more than half of the number of previously uninsured.
      - Administrative budget of connector is \$25 million (for a \$1 billion expenditure). Politicians playing nice.
      - High compliance
      - 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 of plans offered through connector rose by 5% in 2008 – lower than national rise.
    - ii. 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.

See NY Times: **Massachusetts Faces Costs of Big Health Care Plan**

7. Major Issues of Incremental Universalism
  - a. 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:

- i. It can subsidize insurance sufficiently so that it seems affordable to all.
  - ii. The government can mandate insurance which is low cost, so individuals have to spend a smaller share of their income to meet the mandate.
  - iii. The government can exempt some share of the population on affordability grounds.
  
- b. Mass uses all three of these tools.
  - i. 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)
  - ii. 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.
  - iii. 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:
  - i. Subsidies are expensive, define affordability.
  - ii. Lean polices is also controversial some believe all should have comprehensive.
    - RAND health insurance experiment suggests insurance can be more limited and not sacrifice health.
    - 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.
    - 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.
  - iii. 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:
  - i. Employer-sponsored “firewall” -- those with offers of employer-sponsored insurance in their workplace receive no subsidy under the state plan.
    - 1. Save money by limiting the eligible population, but tends to lead employers toward reducing contributions.

2. Raises equity concerns about low income workers with offers of employer-sponsored insurance who can't afford that insurance.
  - ii. 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.
  - iii. 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.
    - 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.
  - iv. 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. Broader issue of the role of employer sponsored insurance
  - i. There has been an erosion of employer-sponsored insurance. Reforming health care can either accommodate this trend, fight it, or facilitate it.
  - ii. Mass accommodates it by providing alternative pooling mechanisms. Lead to faster erosion of employer sponsored insurance – though the individual mandate will work against this.
  - iii. 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.
  - iv. 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.

See NYTimes: **Administration Is Open to Taxing Health Benefits**

8. Is reform a state issue?
- a. Pros
    - i. Decentralization allows states to match the unique landscapes of their health economies and tastes of state consumers.
    - ii. 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.
    - iii. States may vary in the level of minimum standards for insurance coverage
    - iv. Multiple state approaches could foster innovation and perhaps even competition and continued improvement across states
  - b. Cons
    - i. 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.

## II. COSTS

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!

- i. Controls such as electronic medical records, increased preventative care, reduced medical errors, will reduce costs by at best a few percentage points.
- ii. To control costs society will need to be willing to deny care that does little for health but consumers nevertheless want.
- iii. 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.
- iv. This is a can of worms!

See series of blogs by Uwe Reinhardt

**February 27, 2009 “The Mounting Price of Health Care’s Status Quo”**

<http://economix.blogs.nytimes.com/2009/02/27/health-cares-status-quo/>

**March 6, 2009: “How Appropriate is Your Medical Care?”**

<http://economix.blogs.nytimes.com/2009/03/06/how-appropriate-is-your-medical-care/>

*March 13, 2009 “‘Cost-Effectiveness Analysis’ and U.S. Health Care”*  
<http://economix.blogs.nytimes.com/2009/03/13/cost-effectiveness-analysis-and-us-health-care/>

*March 20, 2009 “Pricing Human Life (-Years)”*  
<http://economix.blogs.nytimes.com/2009/03/20/pricing-human-life-years/>