

EXPANDING HEALTH INSURANCE COVERAGE
TO THE UNINSURED:
RATIONALE, RECENT PROPOSALS, AND
KEY CONSIDERATIONS

Statement of

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Education and Labor Committee
Subcommittee on Health, Employment, Labor, and Pensions (HELP)
United States House of Representatives

March 15, 2007

Mr. Chairman, Mr. Kline, and distinguished Members of the Subcommittee,

Thank you for the opportunity to talk with you today about the problems faced by those without health insurance, and to share my thoughts on strategies for expanding coverage to them. I appreciate the fact that this Committee is considering this important issue. While I am an employee of the Urban Institute, this testimony reflects my views alone, and does not necessarily reflect those of the Urban Institute, its funders, or its Board of Trustees.

The problems associated with being uninsured are now widely known. There is a substantial body of literature showing that the uninsured have reduced access to medical care, with many researchers concluding that the uninsured often have inferior medical outcomes when an injury or illness occurs. Urban Institute researcher Jack Hadley reviewed 25 years of research and found strong evidence that the uninsured receive fewer preventive and diagnostic services, tend to be more severely ill when diagnosed, and receive less therapeutic care.¹ Studies found that mortality rates for the uninsured within given time periods were from 4 to 25 percent higher than would have been the case had the individuals been insured. Other research also indicated that improving health status from “fair” or “poor” to “very good” or “excellent” would increase an individual’s work effort and annual earnings by as much as 20 percent.

But while the negative ramifications of being without health insurance are clear, the number of uninsured continues to grow. According to an analysis by my colleagues John Holahan and Allison Cook, the number of nonelderly people without health insurance climbed by 1.3 million between 2004 and 2005, bringing the rate of

uninsurance to just under 18 percent of this population.² The vast majority of this increase, 85 percent, was among those with incomes below 200 percent of the federal poverty level. About 77 percent of the increase in the uninsured was attributable to adults. In recent years, the share of the population with employer-sponsored insurance has fallen, while the share of those with public insurance coverage has risen, but by smaller amounts. This pattern has persisted since 2000.

Why is the rate of employer-sponsored insurance falling, causing the number of uninsured to climb in recent years? First and foremost is increasing premium costs that have outstripped wage and income growth.³ But additionally, overall employment has been shifting away from firms with traditionally high rates of employer-based insurance coverage, moving workers into the types of firms that are significantly less likely to offer coverage to their workers.⁴ For example, employment in medium size and large firms has fallen, and growth has occurred among the self-employed and small firms. Employment has shifted from manufacturing, finance, and government to services, construction, and agriculture. There also has been a population shift toward the South and the West, regions with lower rates of employer-based coverage and higher uninsurance.

The good news is that policymakers at both the federal and state levels are talking about the need to expand health insurance coverage again, and some states are already

¹ J. Hadley. 2003. "Sicker and Poorer—The Consequences of Being Uninsured: A Review of the Research on the Relationship between Health Insurance, Medical Care Use, Health, Work, and Income," *Medical Care Research and Review* 60(2): 3S–75S.

² J. Holahan and A. Cook. 2006. "Why Did the Number of Uninsured Continue to Increase in 2005?" Kaiser Commission on Medicaid and the Uninsured Issue Paper. <http://www.kff.org>.

³ M. Chernew, D. Cutler, and P. Kennan. 2005. "Increasing Health Insurance Costs and the Decline in Insurance Coverage," *Health Services Research* 40(4): 1021–39; T. Gilmer and R. Kronick. 2005. "It's the Premiums, Stupid: Projections of the Uninsured through 2013," *Health Affairs Web Exclusive* (April 5): w5-143–w5-151; J. Hadley. 2006. "The Effects of Recent Employment Changes and Premium Increases on Adults' Insurance Coverage," *Medical Care Research and Review* 63(4): 447–76.

taking action. While proposals are being developed in a number of states and at the federal level as well, I will focus my attention here on two of the most notable state designs, that of Massachusetts and California. I chose both states as they delineate potential avenues for bipartisan compromise on this issue. In addition, Massachusetts is the only state that has already passed legislation, enacting far-reaching health care reform, and California is, of course, the largest state, and hence what it can accomplish has significant implications for the country as a whole. I treat these two approaches as case studies in policy design and use them to highlight the types of features required to achieve significant coverage expansions as well as the policy challenges faced by such an undertaking.

Massachusetts

There are four main components to the landmark health care reform legislation enacted in Massachusetts in April 2006:⁵

- A mandate that all adults in the state have health insurance if affordable coverage is available (an individual mandate);
- A small assessment on employers that do not provide coverage to their workers;
- A purchasing arrangement—the Commonwealth Health Insurance Connector (the Connector)—designed to make affordable insurance available to individuals and small businesses and to provide subsidized insurance coverage to qualifying individuals/families; and
- Premium subsidies to make coverage affordable.

⁴ J. Holahan and A. Cook. 2006. “Why Did the Number of Uninsured Continue to Increase in 2005?” Kaiser Commission on Medicaid and the Uninsured Issue Paper. <http://www.kff.org>.

⁵ J. Holahan and L. Blumberg. 2006. “Massachusetts Health Care Reform: A Look at the Issues,” *Health Affairs Web Exclusive*, September 14: w432–43.

Theoretically, these components of reform could move the state to near-universal coverage; however, many practical issues remain to be resolved.

For example, the individual mandate to purchase health insurance will not be enforced unless affordable products are available. The definition of “affordability” and how it will vary with family economic circumstance was not provided in the legislation, and is left up to the board of the Connector. This definitional issue is clearly critical to the success of the Massachusetts reform and any other policy approach to expanding health insurance coverage. Ideally, each family would be subsidized to an extent that would allow them to purchase coverage within the standard set. Setting the affordability standard at a high level (for example, individuals being expected to spend up to 15 percent of income on medical care) would mean that the individual mandate would have a broad reach and thus increase coverage a great deal. This would be true because individuals and families would be expected to pay a considerable amount toward their insurance coverage, more insurance policies would be considered “affordable” by this standard, and thus the individual mandate would apply to more people. But setting the standard at such a level would also place a heavy financial burden on some families and might be considered unreasonable. Setting a low affordability standard (for example, expecting individuals to spend only up to 6 percent of their income on health care) would ease the financial burden of the mandate on families, but would increase the per capita government subsidy required to ensure that individuals could meet such a standard. To the extent the revenues dedicated to the program were not sufficient as a consequence, either further revenue sources would be required or enrollment in the subsidized plans

would have to be capped, and some would have to be excluded from the requirement to purchase coverage.

Under the Massachusetts plan compromise, each employer of more than 10 workers that does not make a “fair and reasonable” contribution to their workers’ insurance coverage (with “fair and reasonable” yet to be defined) will be required to pay a per worker, per year assessment not to exceed \$295 (this amount would be prorated for part-time and seasonal workers). This very modest employer payment requirement was the product of a compromise between those concerned about a potential decline in employer involvement in the financing of health care and strong resistance from the business community (especially small businesses) to potentially burdensome employer payroll tax assessments. The assessment decided upon had widespread support in the business community and was acceptable to consumer advocates as well. This broad-based support was critical for passage of the legislation and continues to prove pivotal in garnering continued support through various implementation challenges.

All employers are also required to set up Section 125 plans for their workers, so that workers can pay their health insurance premiums with pretax dollars, even if their employers do not contribute toward their coverage. Those employers who do not establish Section 125 plans may be required to pay a portion of the care their employees receive through the state’s Uncompensated Care Pool, which provides hospital care to low-income uninsured persons.

Ideally, the reform would not cause significant disruption to existing insurance arrangements between employers and their workers. As currently designed, most employers, particularly large employers already offering group coverage, likely will

continue to offer coverage. The benefits of risk pooling, control over benefit design, and lower administrative costs associated with purchasing through a large employer will not change under this reform. The situation for small employers is likely to be somewhat different, however.

By allowing workers to purchase coverage on a pre-tax basis through Section 125 plans, the Massachusetts reform reduces the incentive for small employers to offer coverage to their workers independently. The current law tax exemption for employer-sponsored insurance is an important motivator for small employers to offer insurance coverage today, and the Connector combined with Section 125 plans would level the tax playing field between employer provision and individual purchase. This is a more important issue for small firms than for large firms because small firms face significantly higher administrative costs, do not receive the risk pooling benefits of large firms, and are more frequently on the cusp between offering and not offering coverage. Decisions small firms make under the reform will, however, be quite dependent upon the particular plan offerings in the Connector, how attractive they are, and whether negotiating power in the Connector will be sufficient to generate true premium savings.

The attractiveness of the benefits offered in the Connector, and its size as a consequence, will have important implications for its negotiating power—the higher the enrollment, the greater the Connector’s ability to be a tough price negotiator and to create savings in the system. This economic reality of purchasing pools may be somewhat at odds with those who would like to see organized public purchasers playing a small role in relation to private insurance providers. Thus, there is a tension for those that would like to have plans that are offered in such a purchasing pool be low cost/high cost

sharing/limited provider network plans, as such plans have not proved popular with most purchasers. Therefore, if a purchasing pool limits its offerings to such plans, it may be unable to reach a critical mass for negotiating purposes.

At this time, the Connector will require each insurer to offer four different benefit packages of defined levels of actuarial value. In another context, offering such variety in benefit generosity could lead to adverse selection, with the healthy attracted to the high cost sharing/limited benefit plans and premiums in the comprehensive plans spiraling upwards. However, in order to protect the viability of more comprehensive plans and thus to better meet the needs of those with serious medical care needs, the Connector board has instituted a policy designed to counteract such a harmful dynamic. Premiums for each benefit plan will be set as if the enrollees in *all* of the insurer's plan options were enrolled in that plan. In this way, the premium for a particular plan is not a function of the actual health care risks of those people who voluntarily enroll in it. This is clearly an important first step to ensuring broader sharing of high health care risks. It may also be necessary for further risk adjustment across insurers, but that remains to be seen, and modifications within the Connector can be made if appropriate.

In addition to selling unsubsidized health insurance to individual and small employer purchasers, the Connector will also operate the Commonwealth Care Health Insurance Plan (CCHIP), which will provide subsidized coverage for those with household incomes up to 300 percent of the federal poverty level (FPL). CCHIP has no deductibles, has cost-sharing requirements that increase with income, and does not charge premiums for those individuals with incomes below 100 percent of FPL. Premiums on a sliding scale are charged for those between 100 and 300 percent of FPL.

It is widely accepted that those with incomes below 100 percent of FPL have virtually no ability to finance their own health care needs, and that those of modest incomes require significant assistance as well. Deductibles and substantial cost-sharing responsibilities are likely to prevent the low-income population from accessing medical care when necessary; hence, the benefit package offered through CCHIP is considerably more comprehensive than that typically offered in the private insurance market. These policies are available only to those who have not had access to employer-based insurance in the past six months, with the hope of reducing the displacement of private employer spending by public spending.

California

The health care reform proposal Governor Schwarzenegger developed is an ambitious one. Many of its general components are similar to those implemented in Massachusetts, but the details are quite different and illustrate the types of choices that policymakers can make, and the very significant implications that these details can have.

The components of the California proposal are the following:

- an individual mandate that all Californians have at least a minimum level of health insurance coverage;
- a “pay or play” employer mandate requiring that all firms with 10 or more workers pay a 4 percent payroll tax, a liability which can be offset by employers’ contributions to health insurance for their workers and their dependents;
- a purchasing arrangement that would provide a guaranteed source of insurance coverage for individuals to purchase the minimum level of benefits required to

satisfy the mandate and that also would provide subsidized insurance to eligible individuals;

- income-related subsidies to make premiums affordable for those with incomes up to 250 percent of FPL.

The minimum health insurance coverage required to satisfy the individual mandate under the California proposal is a \$5,000 deductible plan with a maximum out-of-pocket limit of \$7,500 per person and \$10,000 per family. This is a package that would require substantially more cost sharing than is typical of private insurance today, and thus can be expected to be made available at premium levels significantly below typical employer-sponsored insurance premiums.

This minimum plan would be made available on a guaranteed issue basis through a new purchasing pool that the Managed Risk Medical Insurance Board (MRMIB) would run. MRMIB is a government agency and currently runs the Healthy Family's Program (California's SCHIP program) and the state's high-risk pool. In the past, the agency also ran a small employer health insurance purchasing pool. It is an agency experienced in health insurance purchasing, contracting, enrollment, and eligibility determination and has a structure for all the administrative tasks necessary for these roles; thus, it is an excellent choice for basing a new purchasing pool under a broad reform.

However, the policy that would be offered is likely to be unattractive to workers with modest incomes, in particular to those over 250 percent of FPL who would be ineligible for subsidized coverage and often could not afford to pay such a high deductible. Such a family would still be severely limited in their financial access to medical services, even with the guaranteed issue policy. Those that do not buy policies in the new pool, do not

have employer insurance offers, and are not eligible for subsidized coverage would be required to purchase a policy in the existing private non-group market, and would face all the shortcomings inherent in that market. This would be a particularly difficult option for older workers and workers with significant health care needs, many of whom may not be able to obtain a policy at all in that market. Even those lucky enough to be offered a policy would likely be unable to obtain an affordable policy with more comprehensive benefits and effective access to needed medical care.

The “pay or play” mechanism is a tool for financing the new low-income subsidies proposed under the plan. This 4 percent payroll tax liability creates a significantly higher employer financial responsibility than does Massachusetts’s employer assessment. Employers with fewer than 10 workers are exempt from the tax. Consequently, the reform should not impact the smallest employers at all but will provide new subsidies and a source for buying coverage for their low-income workers.⁶ And because the vast majority of large firms already provide health insurance coverage to their workers (98 percent of firms with 100 or more workers offered health insurance nationally, as of 2004⁷), the biggest impact of this reform would be on the employers and workers in firms of 10 to 100 workers.

The proposal provides some competing incentives that make it uncertain whether workers in currently non-offering small firms (of 10 or more workers) would prefer to have their employers begin to offer coverage or would prefer to purchase coverage on their own and have their employers pay the payroll tax. First, small firms do not tend to

⁶ It should be noted that this “carve-out” of employers with fewer than 10 workers may provide incentives for the smallest employers to stay small and may also create incentives for somewhat larger employers to break up into smaller pieces.

be efficient purchasers of health insurance. The administrative loads associated with small group insurance can be quite high and might be significantly higher than those in the new purchasing pool. This imbalance, combined with the inability of small groups to spread their health care risks broadly, implies a significant incentive for workers to prefer enrolling in pool-based coverage. This incentive would be particularly strong for lower-wage workers in small firms, who could enroll in a subsidized comprehensive health insurance product through the purchasing pool.

However, the payroll tax assessment works in the reverse direction of these incentives. Economists believe that the burden of employer-paid payroll taxes made on behalf of workers are effectively passed back to workers through lower wages paid over time. In the case of the California proposal, this would mean that workers whose employers opt to pay the tax would experience declines in their incomes relative to what their incomes would have been without the reform, and would then be required to purchase health insurance directly. In essence, they would be paying twice—once for the payroll tax and once for the insurance policy; they would get no credit toward the purchase of health insurance to account for the fact that their employers (and indirectly the employees themselves) were paying the payroll tax.

While workers eligible for generous subsidies on a comprehensive health insurance package might still be better off this way than having their employer offer insurance, the same is unlikely to be true for unsubsidized workers. The only unsubsidized product available in the new purchasing pool would be the very high deductible policies. As noted, these policies may be very unattractive to modest-income

⁷ Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey—Insurance Component 2004, calculations based on published tables, tables available at <http://www.meps.ahrq.gov/>.

workers with incomes over 250 percent of FPL, who would be ineligible for subsidized coverage. Given also the substantial shortcomings of the current nongroup market, these issues taken together might create significant incentives for workers to ask their employers to begin offering health insurance in exchange for wage reductions commensurate with their employers' contributions.

The proposal also would make all children (including undocumented residents) in families with incomes up to 300 percent of FPL eligible for state subsidized health insurance, all legal adult residents with incomes up to 100 percent of FPL eligible for Medicaid at no cost, and those between 100 and 250 percent of FPL eligible for subsidized coverage through the new state purchasing pool. These expansions would cover quite comprehensive health insurance plans and would, on their own, lead to significant expansions of coverage in the state. These policies also would have important implications for employees of small firms in California, since over half of California's uninsured workers are employed by firms with fewer than 25 workers, and approximately two-thirds of the uninsured workers employed in these small firms have incomes that would make them eligible for subsidized insurance.⁸ The lower-income workers in these small firms therefore account for over a third of all uninsured workers in California.

Conclusions

A number of states are already developing comprehensive health insurance reform plans. However, many more states will not be able to accomplish significant reforms on their own due to financial and political constraints. Indeed, it is not feasible for any state to finance any of the plans and proposals currently on the table without accessing at least some federal matching funds. As a consequence, federal legislators are now engaged in

discussions and policy development of their own. Federal involvement will be necessary to spread further the early successes some states are seeing.

Therefore, I would like to take this opportunity to delineate what I consider to be the most critical components for the effective development of universal or near universal health insurance coverage within a private insurance-based system.

The first component is a comprehensive, subsidized set of insurance benefits for the low- and modest-income population. Subsidies should be directed to individuals (as opposed to employers), should increase with increasing need, and should be sufficient to ensure that adequate benefits are made available to meet health care needs at an affordable price. While a high deductible plan may be perfectly adequate coverage for a high-income person, it will not be adequate to meet the needs of someone with more modest means, and meaningful reform must take that into account.

The second component is a guaranteed source of insurance coverage for all potential purchasers. The current nongroup insurance markets are simply inadequate to do the job. The guaranteed source of coverage will most likely need to take the form of an organized purchasing entity, such as newly established health insurance purchasing pools, or it may also be developed using existing organized purchasers, such as government employee benefits plans, state high risk pools, or State Children's Health Insurance Programs.

The third component is a mechanism for broadly spreading the costs associated with those who have the greatest need for health care services. Importantly, the health care risks of those that enroll in a guaranteed accessible insurance plan should not determine the premiums charged to individuals in that plan. Instead, the premiums should

⁸ Author's estimates from the 2004/2005 March Current Population Survey.

be based on what the premiums would be if a broader population enrolled. In this way, choice of varied benefit packages can be maintained, and the needs of the most vulnerable Americans can be met.

The fourth component is either an individual mandate or an individual mandate combined with a “light” employer mandate. Absent automatic enrollment in a fully government-funded insurance system, an individual mandate is necessary to achieve universal coverage. Many advocate combining an employer mandate of some type with an individual mandate to ensure continued employer responsibility in health care. Such employer mandates raise a number of difficult political, distributional, and legal issues. But Massachusetts, for example, was able to enact a non-burdensome employer mandate that should be considered a model of political compromise.

Designing such a reform, complex as it may sound at first, is actually the easy part. The most difficult truth is that financial resources are necessary for ensuring accessible, affordable, and adequate insurance for all Americans. If the political and public will strengthens sufficiently in this regard, there are many options for identifying the necessary funding. If asked for my personal favorite, I would suggest we turn to a redistribution of the existing tax exemption for employer-sponsored insurance, providing those with the greatest needs the greatest assistance, as opposed to the opposite, which is true today. The current level of this tax expenditure is sufficient to finance comprehensive health care reform and is already dedicated to subsidizing health care insurance. The current spending is not particularly effective in expanding coverage, however, since it subsidizes most those who are most likely to purchase coverage even in the absence of any subsidy. And while the notion of restructure the current tax subsidy

has been somewhat politically taboo in the past, the president himself has recently opened the political conversation regarding how best to spend that that money.

Thank you very much for the opportunity to share my thoughts on these important issues.