

Big Choices

The Future of Health Insurance for America's Families

Edited by
Kenneth S. Apfel
and
Betty Sue Flowers



Center for Health and Social Policy
Lyndon B. Johnson School of Public Affairs
The University of Texas at Austin

Lyndon Baines Johnson Library

**Big Choices:
The Future of Health Insurance
for America's Families**

Proceedings of a Conference Held on April 25, 2003

Edited by Kenneth S. Apfel and Betty Sue Flowers

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Acronym List

AGI	Adjusted Gross Income
CBO	Congressional Budget Office
CHP	Congressional Health Plan
COBRA	Consolidated Omnibus Reconciliation Act
ERISA	Employee Retirement Income Security Act
FEHBP	Federal Employees Health Benefits Program
FHIP	Family Health Insurance Program
FPL	Federal Poverty Level
FSA	Flexible Spending Accounts
HIAA	Health Insurance Association of America
HIFA	Health Insurance Flexibility Accounts
HIPAA	Health Insurance Portability and Accountability Act
HRA	Health Reimbursement Arrangement
MOE	Maintenance of Effort
MSA	Medical Savings Account
OECD	Organization for Economic Cooperation and Development
RTC	Refundable Tax Credit
SCHIP	State Children's Health Insurance Program
SSI	Supplemental Security Income

Foreword

The Lyndon B. Johnson School of Public Affairs created the Center for Health and Social Policy (CHASP) in 2002 to conduct research, educate students and practitioners to become future leaders, and provide a forum for today's foremost policymakers and scholars to debate pressing policy issues in the realm of health and social policy.

In April 2003, CHASP and the LBJ Library launched a five-year policy symposia series called *Big Choices: The Future of Social Policy in America* to provide a forum for policymakers and scholars to debate the enormous challenges in health and social policy that our nation will face over the several years. The ultimate goal of the series is to allow for an exchange of ideas that will contribute toward the development of sound policy solutions for the next generation and beyond.

The first symposium in the series was held on April 25, 2003, at the LBJ Library and Museum at The University of Texas at Austin, and was titled *Big Choices: The Future of Health Insurance for America's Families*. A number of state and national policymakers and scholars were invited to share their thoughts on improving the health insurance system in the U.S. The symposium was important because it was a collaboration between a presidential library and a school of public affairs, and this relationship enabled us to do something special for our students, which is to stretch their time horizons and help them understand that significant policy issues haven't been developed only during the present or immediately previous administrations, but have been evolving over a long period of time, as have many of the proposed solutions.

The topic of health insurance is a very significant policy concern. Although there is a growing consensus that our health care system is deeply flawed and needs to be remedied, there is no consensus on how to implement or pay for the solutions. By devolving costs and responsibilities from the federal to state and local levels of government, we are producing a situation in which the poorest people are being forced to seek care in the most expensive component of our health care system: emergency rooms. There is something not just inefficient but deeply perverse about that.

Big Choices: The Future of Health Insurance for America's Families succeeded in bringing together a number of national leaders to engage in meaningful discussions about the problems and potential solutions to the health insurance crisis. We hope this collection of symposium proceedings and background articles will help to further the dialogue on this important topic.

Finally, it should be noted that neither the LBJ School nor The University of Texas at Austin necessarily endorses the views or findings of this report.

Edwin Dorn
Dean, LBJ School of Public Affairs
The University of Texas at Austin

Preface

This book offers proposals for approaching one of the most significant choices now facing Americans—health insurance for America’s families.

Our objective in sponsoring this book and the symposium on which it is based is to create a clear picture of the policy choices on all sides of the issue in order to help Americans create informed opinions about issues that deeply affect their lives. To accomplish this objective, we’ve organized the book in a way that we hope will offer the reader as much—or as little—as he or she might want to know about a particular approach. We begin with an overview (Part I) of the most common general approaches that think tanks and policymakers offer as solutions to our looming crisis in health insurance. This overview is followed by the presentations that experts in the field offered to a general audience in a symposium cosponsored by the LBJ School and the LBJ Library (Part II). Finally, in the last section of the book (Part III), detailed descriptions and analyses are offered for those who want to learn more about the particular approaches.

This architecture reflects our conviction that the best public policy is created when grassroots engagement meets informed expertise. For this meeting to be possible, a common language must be available so that an informed public can express its opinion in a nation-wide “conversation.” Such expressions can offer a counterweight to the capture of public policy decisions by private interests.

The LBJ School is committed to fostering the *professional* expertise necessary to create effective public policy. The LBJ Library is committed to fostering the necessary level of *public* expertise—by sponsoring symposia, lectures, public issues forums, and books like this one—to help ensure that public policy is not only effective but also in the public interest. We hope that this partnership between a public policy school and a presidential library will illuminate the “Big Choices” that Americans face.

Betty Sue Flowers

Director, Lyndon Baines Johnson Library and Museum

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A number of people dedicated a great deal of time and effort to ensure the success of this endeavor. First and foremost, we want to thank Kristine Niemeyer, Program Coordinator for the Center for Health and Social Policy at the LBJ School of Public Affairs, for her patience, perseverance, and professionalism which helped to move this project to fruition.

We also want to thank three LBJ School graduate students who worked as research assistants on this project. Jennifer Eldridge, April Grady, and Sarah Stout all helped to write, research, and provide logistics for the conference as well as this book.

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Lastly, we want to thank the Foundation for Insurance Regulatory Studies in Texas, the Commonwealth Fund, the Sid Richardson Chair at the LBJ School, and the LBJ Library and Museum for providing vital financial assistance. Without all of their support, we could not have been successful.

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Part I

Overview

Chapter 1

The Uninsured: A Growing Challenge

by April Grady, Kenneth Apfel, and Sarah Stout

Americans can be proud of the many accomplishments of our health care system. The United States is the world leader in basic medical research and new technology. Life expectancies continue to increase, in part due to medical advances. Most Americans have access to some of the most sophisticated medical care available in the world, and almost all Americans have access to some form of health care. For most Americans, a major illness no longer translates into a catastrophic financial setback for the family.

While the United States has much to be proud of in the health care area, it also faces real challenges. The U.S. spends more on health care than any other nation, and costs continue to grow. Demographic changes place growing demands on our systems of care, including long-term care. The U.S. still faces significant public health challenges such as obesity, HIV/AIDS, and tobacco use and our public health infrastructure is inadequate to meeting the tasks at hand.

While all of these issues are serious and need attention, perhaps the most daunting challenge that the U.S. faces is the growing number of persons with little or no health insurance. Without access to insurance, individuals face major financial risks and limited access to care.

In 2001, 41 million Americans under age 65 (16.5 percent of all people in this age group) went without health insurance for the entire year, and millions more were underinsured or had lengthy gaps in coverage. While a majority of American families have been adequately and often generously covered by their employers, and most elderly and very low-income people have been covered by Medicare and Medicaid, the remaining uninsured individuals have, for the most part, been able to get by on their relatively good health and the availability of charity care at critical times.¹ Despite this, it is still the case that many of the uninsured are at significant financial and health risk, and the growth in the uninsured places growing pressures on our methods of financing health care.

It is not clear that our current system of health insurance can—or should—be

sustained in its current form, and there is growing interest among many policymakers to take major steps to address this issue. But no option is free, and none are without significant trade-offs. As a result, policymakers face a difficult set of choices regarding the future of health insurance in America.

This book contains description, analysis, and debate on a number of federal policy options for increasing access to health insurance in the United States. It is based in part on a conference held in April 2003 in Austin, Texas, at the LBJ Library and the Center for Health and Social Policy at the LBJ School of Public Affairs entitled *Big Choices: The Future of Health Insurance for America's Families*.

To provide context for the policy options, this chapter describes the historical development of the American system of health insurance and provides background on the growth in health care costs in the U.S. The chapter also includes a description of who is covered and why some people remain uninsured, as well as the challenges to increasing access to health insurance.

Historical Development of Health Insurance in the United States

Early 20th Century Advances

In the early part of the 20th century, few Americans had any form of health insurance. In the early 1900s, the primary objective of insurance-like initiatives was to protect against the loss of income due to illness or injury, not to provide reimbursement for medical expenses. This lack of emphasis on medical expenses was due in part to the fact that truly effective services were limited, with hospitals serving mainly as sick houses for the poor and those infected with contagious diseases.²

Fraternal orders and benefit societies at the time were extensively involved in providing life insurance and aiding the sick and disabled. By 1914, there were 179 fraternal associations nationally with nearly eight million members affecting 25 to 30 percent of American families. However, only about one percent of the \$97 million they paid out in benefits that year went for medical care.³

Employer-sponsored health benefits for American workers were quite limited well into the early 20th century. The railroad, mining, and lumber industries were exceptions, with geographical isolation and legal liability issues being the principal reasons for extensive company involvement in medical care. Other employers generally avoided taking on any significant responsibility in this area.⁴

Over time, advances in science, technology, and hygiene (including the use of trained nurses, antiseptic techniques, and surgical anesthesia) created more effective means of medical intervention, allowing hospitals to evolve into physician “workshops” for all types and classes of patients. As medical care became more complex and physicians became increasingly dependent on special equipment and consultation with other medical specialists, the number of U.S. hospitals increased from 178 to more than 4,300 over the period 1870 to 1910.⁵ Still, while hospital costs were on the

verge of becoming an important cost concern, protection against lost income due to illness and injury rather than protection against excessive medical expenses remained the significant objective in the pre-World War I era.⁶

In the late 1920s, mounting concerns about the cost and distribution of medical care prompted the formation of the Committee on the Costs of Medical Care (CCMC), a commission funded by six major foundations. With the cooperation of organizations that ranged from insurance companies to the American Medical Association, the CCMC issued nearly 30 field studies and reports between 1928 and 1932. A majority of committee members endorsed the concept of voluntary insurance, arguing that compulsory coverage would be too costly for taxpayers and employers.⁷

Around the time of the CCMC's tenure, payments for medical expenses amounted to only about 10 percent of benefits paid under health insurance for the few who had it. However, the concept of group coverage for hospitalization and physician expenses was beginning to gain popularity. The first Blue Cross plan began in Dallas in 1929, when the Baylor University Hospital agreed to provide 1,500 school teachers with up to 21 days of hospital care a year for \$6 per person. In 1934, commercial insurers followed suit and began offering coverage for hospital care on a group basis.⁸ The first Blue Shield plan designed for coverage of physician services began in 1939, with commercial insurers and groups of physicians offering their own versions of coverage as well.⁹

During and after World War II, the growth of employer-based health insurance was fueled by a number of factors, including federal actions. For instance, a 1943 ruling by the War Labor Board, which had one year earlier introduced wage and price controls, ruled that contributions to insurance and pension funds did not count as wages, a move that prompted employers to use these benefits as a means to attract scarce workers. The right of unions to bargain collectively over health insurance benefits was affirmed by the Supreme Court in 1949, and in 1954, the Internal Revenue Code made it clear that contributions for health insurance were tax deductible as a business expense for employers and were to be excluded from employees' taxable income.¹⁰ As a result, while 12 million people were covered by private health insurance in 1940 (less than 10 percent of the population), that figure rose to 32 million by 1945. Seventy-seven million were covered by 1950.¹¹

Public Program Expansions

While the idea of voluntary private insurance was gaining ground, numerous initiatives to introduce compulsory or public health insurance were largely unsuccessful. Legislation to study and plan for national employment, old age, and sickness insurance was introduced but not passed by Congress in 1916 and 1917, and efforts to establish compulsory health insurance plans failed in 16 states from 1915 to 1920. The Social Security Act passed in 1935 with no provisions for health insurance, in part due to strong opposition by the medical profession and the hospital industry. Although President Truman was in favor of national health insurance, Congress

never brought a bill out of committee during his administration. The Eisenhower administration's efforts to subsidize private insurance coverage for poor, elderly, and high-risk individuals were also unsuccessful.¹²

By the late 1950s and early 1960s, a number of factors led to the passage of limited government-sponsored health insurance, including the growth of medical schools, hospitals, and other institutions with an interest in adding dollars to the health care financing pool, labor's continued support for compulsory health insurance, and pressure from older Americans who gathered for hearings held around the country by a new Senate subcommittee on aging. The Kerr-Mills Act extended federal support for state programs to benefit the aged poor in 1960, but dramatic changes did not take place until 1965 with the passage of Medicare and Medicaid, an integral part of President Johnson's Great Society and the War on Poverty.¹³

As noted by longtime advisor Wilbur Cohen, President Johnson saw lack of education and ill health as two of the greatest elements in producing poverty and disadvantage in the United States.¹⁴ Fortunately, the economic and political situation of the country in the mid-1960s provided "one of those rare moments when a government ha[d] real freedom to compose a national agenda, with some assurance that it would be able to do most of the things it chose to do," and Johnson knew this.¹⁵ Medicare and Medicaid were just two of the policy initiatives undertaken during his administration that would contribute to improvements in the health and well-being of the population, as well as to a dramatic decline in poverty over the next two decades.

The Medicaid program provided health insurance for some of the poor, although coverage was fairly limited in most states. Medicare provided coverage for the elderly, who particularly benefited from expansions in public health insurance coverage. In the early 1960s, only 54 percent of Americans age 65 and older had private hospital insurance.¹⁶ By 1976, 87 percent of the elderly population had coverage through the Medicare program, and only 2 percent were uninsured.¹⁷ Today, the Johnson legacy lives on in part because 96 percent of the elderly population is covered by Medicare, and less than 1 percent is uninsured.¹⁸

While both Medicare and Medicaid are important sources of coverage for those who would otherwise go without, Medicare was designed as universal social insurance program with uniform national standards for eligibility. In contrast, Medicaid was left as an open-ended federal-state funded means-tested program to be administered by the states within broad federal guidelines.¹⁹ As a result, while nearly all elderly individuals had Medicare coverage in 2001, Medicaid coverage has been very uneven among the states, and less than half of people under age 65 who lack other health insurance are covered by the Medicaid program.^{20, 21}

Both Medicare and Medicaid have seen very important incremental expansions over time, but Congress would not enact another major public health insurance program for more than 30 years. Numerous national health insurance and universal coverage proposals were rejected in the 1970s, and again in the 1990s. One such proposal was President Clinton's Health Security plan, which called for universal health

coverage through employer and individual mandates. In 1993, millions listened as he gave a speech to the nation calling for “America to fix a health care system that is badly broken” and advocated providing every American “health care that’s always there, health care that can never be taken away.” Although the plan—described as “courageous” by one commentator—was initially well-received, it ultimately collapsed under the weight of heavy opposition.²²

It was not until 1997 that Congress would enact a significant new public health insurance initiative, the State Children’s Health Insurance Program (SCHIP). SCHIP was created to provide coverage for children whose family incomes are too high to qualify them for Medicaid, but too low for them to easily afford private coverage. Rather than establishing a social insurance mechanism such as Medicare or an open-ended federal-state entitlement such as Medicaid, SCHIP used a block grant model that capped federal contributions and therefore the number of individuals who would be served by the program. In the early years of SCHIP, to reach as many children as quickly as possible, many states made a concerted effort to streamline their SCHIP eligibility and enrollment processes. Recently, some of these efforts have been cut back as state budget pressures mount and federal spending caps are reached. In 2001, total program enrollment was nearly 5,000,000.²³

Government Regulatory Role in Private Insurance

While state and federal roles in the operation of public programs such as Medicare, Medicaid, and SCHIP are fairly unambiguous, government regulation of private health insurance has traditionally been far more complex. In 1945, Congress enacted the McCarran-Ferguson Act to clarify that states have the primary role in regulating the business of insurance. States license insurers and establish laws that govern insurers’ legal structure, finances, and obligations to insured individuals.²⁴ However, a number of federal laws also regulate private health insurance. Enacted in 1974, the Employee Retirement Income Security Act (ERISA) was passed to protect workers from the loss of benefits provided through the workplace. It also had the effect of allowing many employers—specifically, those that finance their employees’ medical care expenses internally, rather than through an outside insurer—to escape regulation under state insurance laws (including those governing payment of taxes on premiums, benefit mandates, limits on contracting arrangements, funding requirements, and claims settlement procedures).²⁵

While not a mandate on insurers, the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 required employers with 20 or more employees to offer continued coverage for workers who leave their job or who risk losing coverage. Employers may charge COBRA enrollees no more than 102 percent of their average premium cost, and they must provide coverage to individuals and their dependents for up to 18 months in most circumstances. Today it is estimated that at least three out of four insured workers are eligible for COBRA coverage, but only about one in five eligible employees elect to participate.²⁶

What Is Health Insurance?

Health insurance is a mechanism for protecting against financial loss.¹ Although many health care needs are fairly routine and predictable (e.g., vaccinations, annual checkups, occasional doctor visits for minor illnesses that require prescription medications), insurance helps to shield individuals from the high cost of medical care in case of an accident or a severe illness. Under most insurance policies, individuals pay only a portion of their health care costs for covered services, and the insurer picks up the remainder.

Private insurers are able to provide this kind of financial protection by “pooling” the risk of high health care costs across a large number of people. In any given year, some of an insurer’s customers will experience high costs, while others will not. Based on past experience and a number of other factors, insurers charge a policy premium that reflects their anticipated costs for a particular group of customers. In the end, healthy customers with low health care costs end up subsidizing sick customers with high costs. Presumably, healthy customers agree to this arrangement because they too could become sick as the result of an unexpected accident or illness.

Although public health insurance (including Medicare, Medicaid, and SCHIP) may also protect against financial loss, these programs are different than private health insurance in that participants may or may not be responsible for paying premiums or costs related to covered care, and public dollars provide the main source of program funding.

In addition to protecting against financial loss, another function of health insurance may be to facilitate timely access to care.² Health care providers know that they are likely to receive reimbursement when they treat an individual with insurance, and as a result, they may be more likely to take on insured individuals as patients. However, for a number of reasons, some providers may not be eligible for reimbursement from certain insurers. Providers may also refuse to take on patients whose insurers offer low reimbursement rates (this is an issue for public insurance programs in particular).

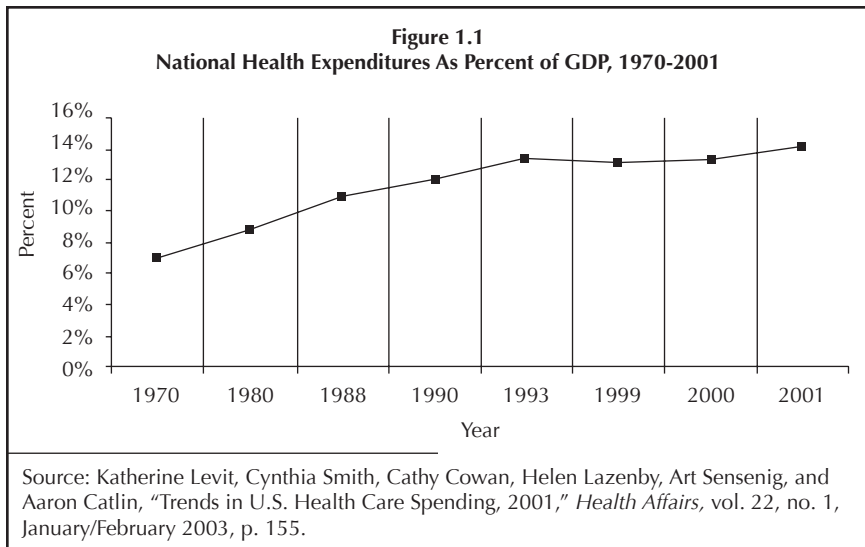
1. Gary Claxton, *How Private Insurance Works: A Primer* (Washington, D.C.: Kaiser Family Foundation, April 2002), p. 7.

2. *Ibid.*

Passed by Congress in 1996, the Health Insurance Portability and Accountability Act (HIPAA) was considered at the time to be perhaps the most significant federal health care reform in a generation. It created the first national standards for the availability and portability of group and individual health insurance coverage, provided tax incentives to purchase long-term care insurance, increased the tax deductibility of health insurance premiums paid by self-employed persons, permitted terminally and chronically ill persons to receive life insurance benefits tax-free, and strengthened federal authority to regulate health care fraud and abuse.²⁷ One study of the early years of HIPAA implementation found that while it has somewhat improved protections for group health insurance coverage, it has not significantly improved access to individual coverage. In addition, although HIPAA provides the basis for federal-state partnerships to strengthen insurance regulation, many analysts have concluded that greater resources for enforcement, oversight, and public education may be needed for the reforms to create more significant change.²⁸

Cost of Health Care

Despite the large population of persons without health insurance, the system of health care that has evolved over time in the United States is the most expensive in the world. Overall spending in this area continues to increase, and health care is one of the fastest growing segments of the U.S. economy. Since 1970, national health expenditures have increased dramatically, from \$73.1 billion to \$1.4 trillion in 2001.²⁹ Adjusting for inflation, national health expenditures grew five-fold during this time period.³⁰ As a percentage of gross domestic product (GDP), national health expenditures increased from 7 percent to 14 percent between 1970 and 2001 (see Figure 1.1).³¹



Over the past few years, the annual rate of growth in health care spending has also increased. In 2001, inflation-adjusted health care spending grew by 6.2 percent, which is the fastest rate of growth in a decade. There is widespread consensus that spending growth will continue in the future.

Though some policymakers consider health care's increasing share of the economy as a sign that the health system is out of control, others argue that the increase in health spending is a reflection of the increased value of health care purchased. Some point to advances in medical technology, which have contributed to the increased costs of health care, but which may also contribute to improved health outcomes and life expectancy.³² Whatever one's point of view on this debate, almost all analysts agree that the increasing cost of health care is a key reason why more persons are uninsured. In addition, cost increases make it increasingly difficult to expand health insurance coverage to the uninsured.

A Comparative Snapshot of Health Expenditures

Since 1990, health care expenditures in Organization for Economic Cooperation and Development (OECD) countries have risen significantly across the board, although the United States, Switzerland, and Germany stand out as the highest spenders per GDP. These same three countries have experienced the greatest increases as well over the past decade, rising 2 or more percentage points (see Table 1.1). Total health expenditures in all OECD countries are at an historical high, averaging 8.4 percent of GDP in 2001. In fact, health care spending has grown 1 percent faster than their economies over the past decade.

Table 1.1
Total Expenditures on Health (Percent GDP)

	1960	1980	1990	2000
Australia	4.1%	7%	7.8%	8.9%
Canada	5.4	7.1	9	9.2
France	—	—	8.6	9.3
Germany	—	8.7	8.5	10.6
Italy	—	—	8	8.2
Japan	3	6.4	5.9	7.6
Mexico	—	—	4.5	5.6
Spain	1.5	5.4	6.7	7.5
Sweden	—	8.8	8.2	8.4
Switzerland	4.9	7.6	8.5	10.7
United Kingdom	3.9	5.6	6	7.3
United States	5	8.7	11.9	13.1

Source: Organization for Economic Co-operation and Development, "OECD Health Data 2003, 2nd ed.," database on CD-ROM, 2003.

Note: Data not available for all countries in all years.

The U.S. not only tops the list as the highest per capita spender (an average of \$4,900, more than double the OECD average), but the U.S. also spends the most as a percentage of GDP, at 13.9 percent, up from 13.1 percent in 2000. While more than half of the U.S. health care expenditures are private, public spending is still relatively significant, at 5.8 percent of GDP in 2001. However, public spending in the U.S. as a percentage of total health expenditures is the lowest of all OECD countries (44 percent, compared with an average of 72 percent, with Nordic countries' government spending accounting for over 80 percent of their totals). The proportionally low public spending in the U.S. relates to the fact that a much smaller share of the population in the U.S. is insured through public programs compared to other OECD countries.³³

When U.S. government estimates of spending are adjusted to account for the fact that (1) public employee benefit costs are actually a government expense (although part of the premiums are paid with public funds, these amounts are not counted as such because a private insurer ultimately pays the claims), and (2) the government "spends" money (in the form of forgone revenue) by exempting the cost of employer-paid health insurance from income and payroll taxes, the current government-financed share of U.S. health spending may actually be closer to 60 percent. Incorporating these adjustments, government per capita health expenditures in the United States exceeded total public and private per capita health expenditures in every other nation except Switzerland. As a result, Americans paid higher taxes per capita for financing health care than did any other nation's citizens. Despite this fact, the U.S. has not been able to provide the nearly universal coverage available in most other OECD countries.³⁴

Factors Contributing to U.S. Health Care Spending Growth

A number of factors have contributed to the increase in health care spending over time, including greater consumer demand for health services, increased prevalence of chronic disease, the aging of the population, the introduction of new and expensive technologies, increased spending on prescription drugs, wage increases in the health care labor market and changes in the insurance marketplace.³⁵ Many of these factors are interrelated and the extent to which they drive health care spending varies with changes in the health care marketplace and the population. A discussion of these factors and how they affect health care costs follows.

Advances in Medical Technology

Though relatively little is known about how the introduction of new technologies affects health care costs,³⁶ it is considered by many economists to be one of the most consistent and significant drivers of health spending growth over the past several decades.^{37, 38, 39} A Project Hope review of the various studies that assessed the impact of technology on health spending found that the percentage of health spending attributable to technology ranges between 5 percent to 60 percent, depending on the

methodology of the study and the time period examined.⁴⁰ Given the current state of medical science, it seems likely that medical technology will continue to advance rapidly and that these advances will continue to contribute to overall spending growth.

Prescription Drugs

In the past ten years, prescription drug spending has grown at almost twice the pace of all other health services. In 1990, prescription drugs accounted for 6 percent of total national health expenditures and by 2001, that figure had nearly doubled to 10 percent.⁴¹ This is partly attributed to the introduction of “blockbuster” drugs in the late 1990s. Over the past three years, growth in prescription drug spending has slowed from 19.7 percent in 1999 to 15.7 percent in 2001. This is due in part to the introduction of fewer new drugs and the implementation of several cost control methods, including generic incentive programs, prior authorization, higher co-payments, and drug utilization review.⁴² The U.S. Centers for Medicare and Medicaid Services projects that in 2010, prescription drugs will account for 14.2 percent of national health expenditures.⁴³

Chronic Illness

In 2000, 125 million Americans were living with a chronic condition, representing 45.4 percent of the population.⁴⁴ Projections by the RAND Corporation indicate that this number will increase to 171 million people by 2030, representing 49.2 percent of the population.⁴⁵ As health care spending for persons with chronic conditions is twice as high as that for persons without chronic conditions, this trend has significant implications for health costs.⁴⁶ People suffering from chronic illness account for 76 percent of all hospital admissions, 88 percent of all prescriptions, 72 percent of all physician visits, and 78 percent of all health care spending in the U.S.⁴⁷

Aging Population

The aging of the U.S. population has been a significant contributor to rising health care costs, and in the next few decades it is projected to become a more significant factor. Older Americans have more medical needs than people under age 65, and they have higher per capita health care costs. According to the Centers for Disease Control and Prevention (CDC), health care expenditures for individuals over the age of 65 are four times higher on average than those of persons aged 40.⁴⁸

The high cost of treating the elderly will become a more significant factor in health care spending growth as the percentage of the elderly population increases over the next 30 years. The percentage of the population that is over 65 is projected to grow by 102 percent between 2000 and 2030.⁴⁹ In 2000, there were 35 million Americans over the age of 65, and as baby boomers age, that number is projected to grow to 53.7 million by 2020 and to 70 million by 2030.

The CDC estimates that by 2030, the aging of the population alone will contribute to a 25 percent increase in health care spending, even when controlling for infla-

tion and new technologies.⁵⁰ This trend is particularly significant for Medicare, the primary insurer of Americans over the age of 65. It is also a cost consideration for the Medicaid program, which now covers a large portion of nursing home and long-term care costs for the elderly.

Third-Party Reimbursement

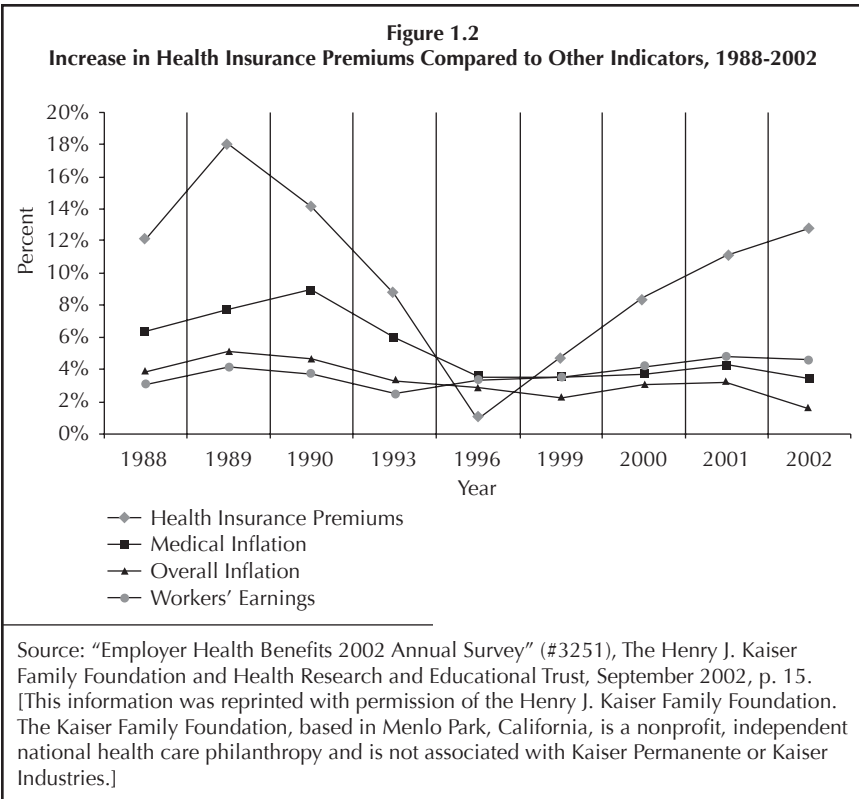
Another factor that has contributed to growth in health care spending is the use of insurance to pay for health care. The purpose of health insurance is to pool risks and premiums in order to provide reimbursements for health expenses when they are incurred. Insurance tends to shield people from the full costs of health expenses, and therefore provides an incentive to use more health services. Without aggressive regulatory or market controls, people may “consume” more health care than is necessary or desirable. A number of complex regulatory and public sector control mechanisms have been put in place over the years to reduce the incentive by consumers and providers of care to lower the consumption of health services. But these mechanisms have been less than satisfactory in controlling utilization of health care. The trend towards the use of managed care may have slowed these growth trends, but while managed care is still one of the primary forms of insurance, the public has resisted many of its strictest cost containment strategies.

One of the effects of the recent movement away from a tightly controlled system of managed care is believed to be an increase in hospital inpatient and outpatient spending. Hospital care is the largest area of health expenditures accounting for 31 percent of total national health expenditures in 2001.⁵¹ Managed care is credited with decreasing the growth in utilization of inpatient services during the 1990s, though the cost savings were partially offset by an increase in outpatient services. Since 2000 spending on inpatient hospital care began to increase again while outpatient spending growth also accelerated.

In the past two years, the increasing cost of hospital care has been the most significant factor contributing to overall health care spending. Between 2000 and 2001, hospital spending increased by 8.3 percent—this is the fastest increase in a decade and accounted for 30 percent of total increases in national health expenditures.⁵² Of the two factors that have contributed directly to an increase in hospital spending—higher utilization and higher prices—higher utilization is a more significant factor.^{53, 54} The higher prices for hospital services is due in part to increased wages resulting from labor shortages and the greater negotiating power of providers.⁵⁵

Rising Cost of Insurance Premiums

The Kaiser Family Foundation and the Health Research Educational Trust produce an annual report on trends in employer health benefits. According to their 2002 report, the rate of growth in the cost of health insurance premiums has outpaced inflation, medical inflation, and workers’ earnings since 1996 (see Figure 1.2).⁵⁶ In 2001, the annual percentage increase in the price of job-based health insurance premiums



reached the double digits for the first time in a decade. Between 2001 and 2002, the cost to employers of providing health insurance to families increased by 12.7 percent and the cost of providing health insurance to individuals increased by 15.4 percent.⁵⁷ In 2002, the average job-based annual premium (including employee and employee share) for a family of four was \$7,954 (up from \$7,053 in 2001), and the average annual premium for an individual was \$3,060 (up from \$2,650 in 2001).

The cost of all types of health plans increased in the double digits in 2002. Health maintenance organization premiums grew by 13.3 percent, indemnity insurance and preferred provider organization premiums rose by 12.7 percent, and point of service premiums rose by 11.9 percent.⁵⁸ Premiums for self-funded plans and insured plans grew at approximately the same rate, indicating that increased expenditures, not an adjustment in the medical underwriting cycle, may have driven the premium increases in 2002.⁵⁹

Overview of Recent Trends in Health Insurance Coverage

Among the 248 million nonelderly individuals in the United States in 2001, 65 percent obtained health insurance through an employer, 14 percent were covered by Medicaid or another public program, and 5 percent purchased private insurance on their own. The remaining 16.5 percent (41 million individuals) were uninsured. Although fewer children than adults were covered by private insurance, Medicaid and other public programs more than offset this difference. As a result, while 19 percent of adults went without coverage in 2001, only 12 percent of children were uninsured (see Figure 1.3).^{60, 61}

In recent decades, the percentages of people with and without health coverage have fluctuated for different reasons at different points in time (see Figure 1.4). For example, between 1987 and 1993, growth in the number of uninsured individuals can be attributed to the erosion of employer-based health benefits. Although public

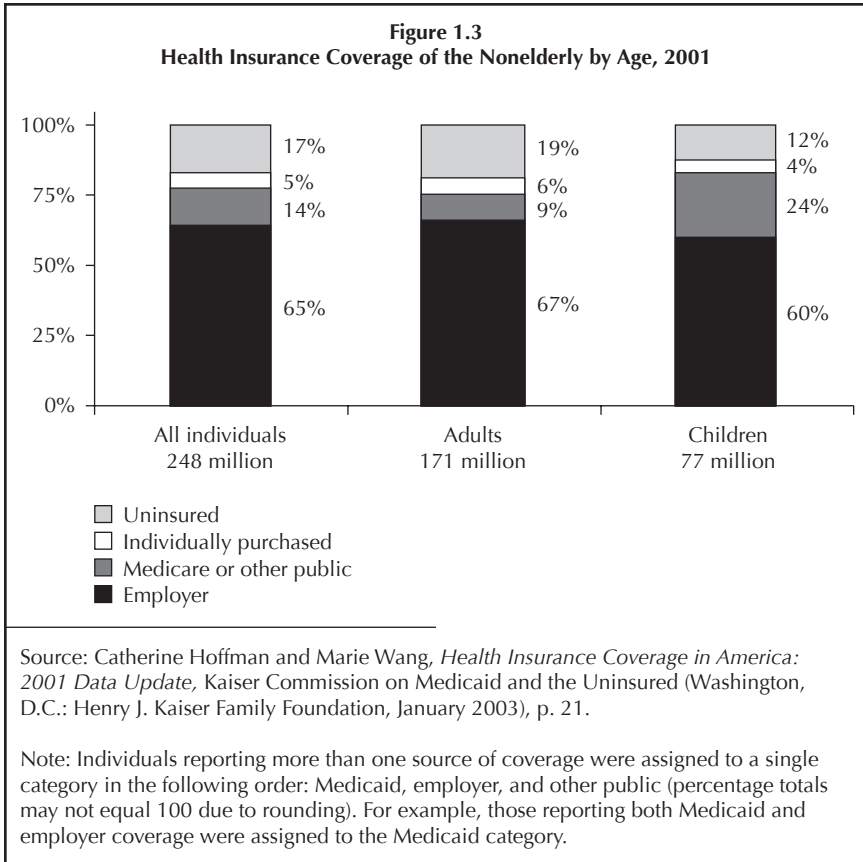
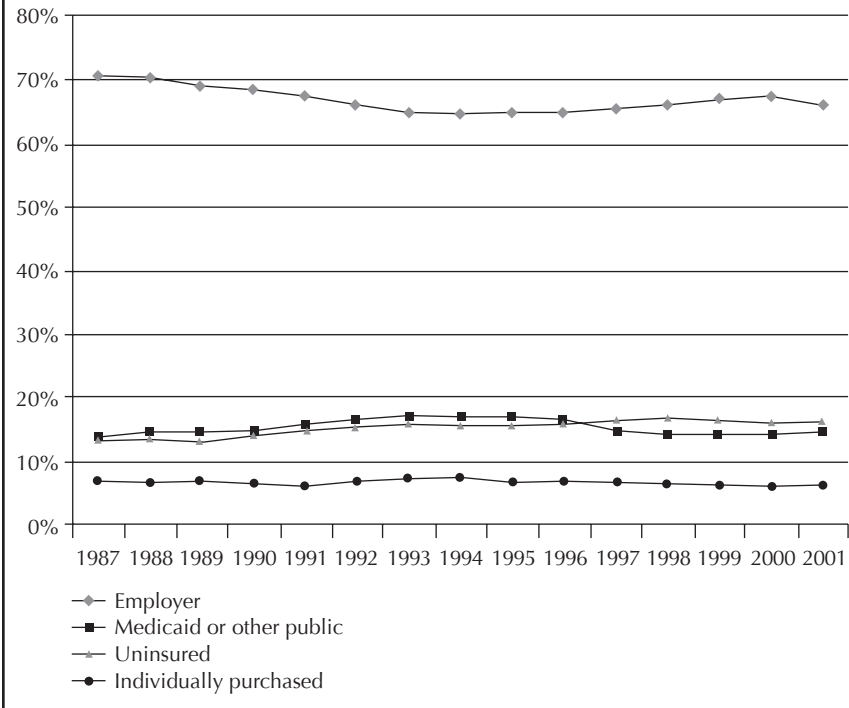


Figure 1.4
Sources of Health Insurance among the Nonelderly, 1987-2001



Source: Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2002 Current Population Survey*, Issue Brief no. 252 (Washington, D.C.: Employee Benefit Research Institute, December 2002), p. 4.

Notes: Individuals may report more than one type of coverage, so percentage totals in each year may be greater than 100. Due to a CPS questionnaire change that resulted in fewer persons counted as uninsured in 1999 and years following, percentages for 1987-1998 have been adjusted to provide roughly comparable estimates over time.

programs were covering an increasing percentage of Americans during this period, their growth was not enough to offset declines in employer coverage. In contrast, from 1994 to 1998, while the percentage of Americans with employer-based health insurance increased, so did the percentage of uninsured individuals. During this period, declines in public and individually purchased coverage were large enough to offset gains in employer-sponsored insurance.⁶²

From 1998 to 2000, while employer-sponsored coverage continued to grow, rates of public and individually purchased coverage stabilized. As a result, the

percentage of uninsured individuals decreased slightly. In 2001, this brief trend was reversed, and the percentage of Americans without health insurance increased from 16.1 percent to 16.5 percent. Public coverage increased from 14.1 percent to 15.3 percent but this growth was not enough to offset the decline seen in employer-sponsored insurance.⁶³

Employer-Based Coverage

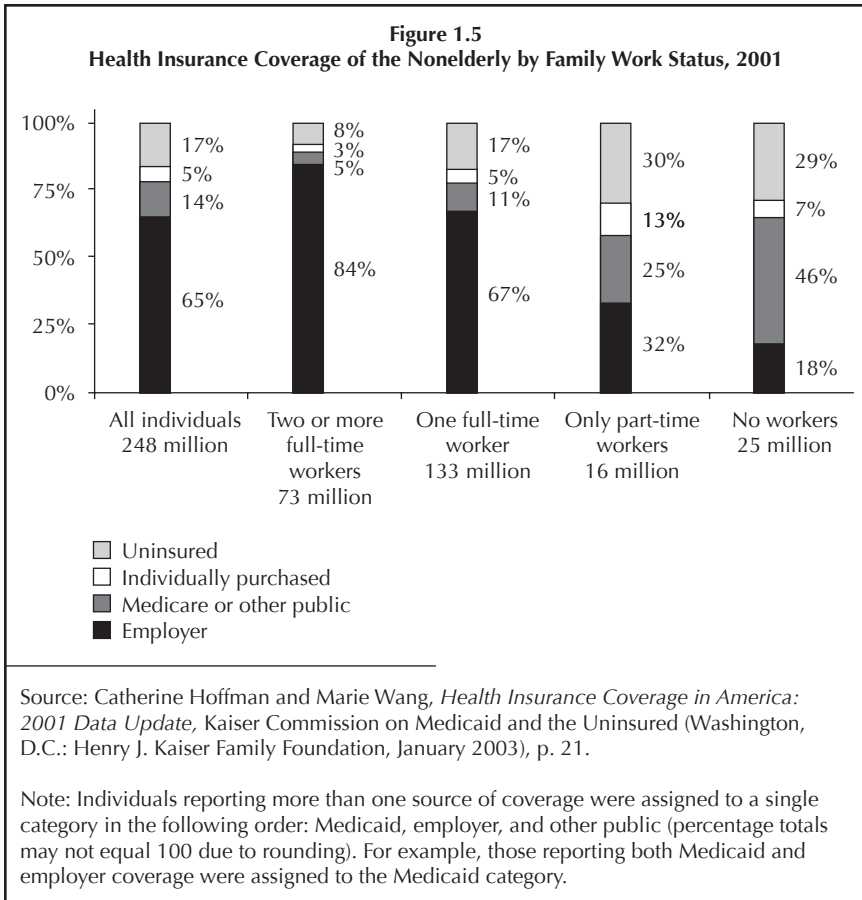
Most Americans under the age of 65 obtain health insurance through their employers or a family member with employer-based insurance. However, work does not guarantee access to this type of coverage. Among people in families with two full-time workers and a total income of less than 200 percent FPL, less than half (45 percent) had job-based coverage in 2001 and more than a quarter were uninsured. In contrast, among individuals in higher income (i.e., 200 percent FPL or more) families with two full-time workers, almost 90 percent had job-based coverage and only 6 percent were uninsured (see Figure 1.5).⁶⁴

While the percentage of individuals insured through their own employer has remained steady in recent years, the percentage with dependent coverage has declined. For example, in 1987, 34.3 percent of nonelderly individuals obtained health insurance through their own employer and 35.9 percent were covered as the dependent of a family member with employer-based insurance. In 2001, a similar 34 percent obtained health insurance through their own employer, but only 31.6 percent were covered as dependents.⁶⁵

Who Is Offered Coverage and Who Enrolls?

To date, the rising cost of health insurance has not led a large number of employers to drop health insurance as an employee benefit, but the percentage of smaller firms offering health insurance benefits has declined. Between 1996 and 2002, the percentage of large firms (those with more than 200 employees) offering health insurance remained stable at about 99 percent. For firms with between three and 199 employees, the percentage of firms offering health benefits increased from 59 percent to 67 percent between 1996 and 2000 and then declined to 61 percent in 2002. Sixty-eight percent of small employers that do not offer health benefits report that the high cost of premiums is a very important reason that they do not do so.⁶⁶

According to data from the Medical Expenditure Panel Survey conducted by the Agency for Healthcare Research and Quality, while the percentage of private-sector employees who worked in establishments that offered health insurance increased from 86.5 percent in 1996 to 89.1 percent in 1999, the percentage of workers who were actually eligible for coverage in those establishments fell from 81.3 percent to 78.5 percent. As a result, the overall proportion of U.S. private-sector workers eligible for health insurance remained steady at about 70 percent over this period (see Figure 1.6). Among those who were eligible, the percentage of workers who actually enrolled in their employer's plan fell from 85.5 percent in 1996 to 82.3 percent in 1999.



Overall, the percentage of private-sector workers enrolled in health coverage through their employer fell from 60.1 percent to 57.5 percent over this period.⁶⁷

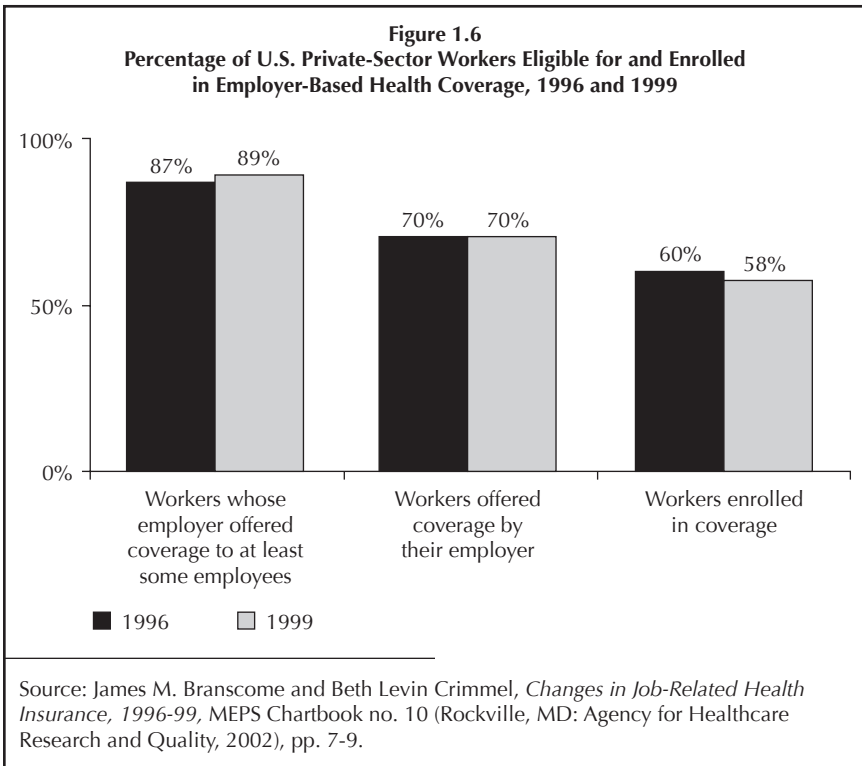
It is important to note that these figures can vary substantially by job characteristics and worker demographics. In general, workers employed in small firms are less likely to be offered coverage than those in large firms. Health insurance also varies by industry of employment. While about 88 percent of public sector and manufacturing employees were offered coverage in 1997, only 65.8 percent of wholesale and retail trade workers and 55.3 percent of agriculture, forestry, fishing, mining, and construction workers received offers. Union employees and full-time workers are much more likely to be offered health insurance than their non-union and part-time counterparts, and older workers are more likely to be offered coverage than those under age 25. Women are somewhat less likely than men to be offered health insurance by their employer, and Hispanics are less likely to be offered coverage than workers of other races.⁶⁸

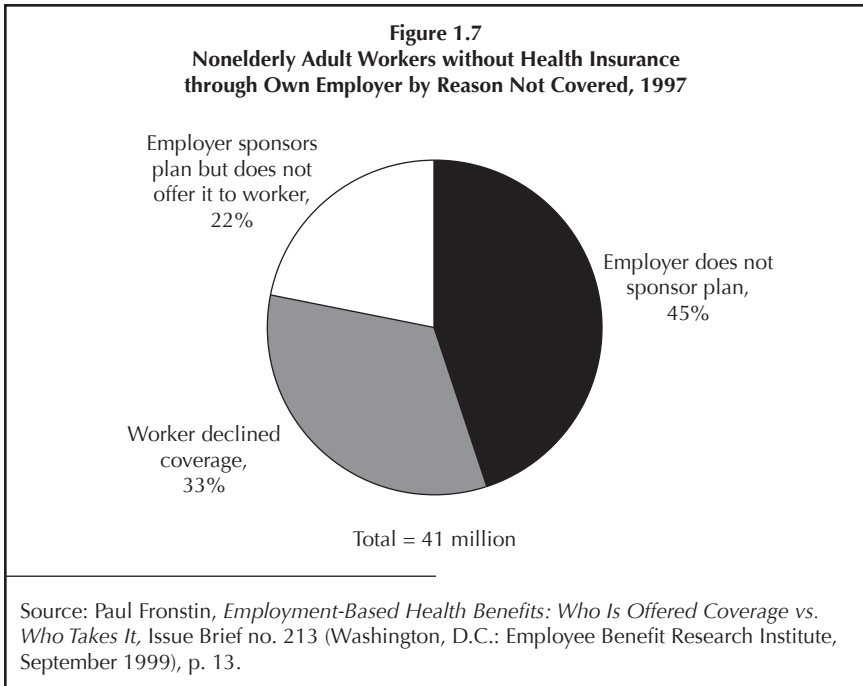
Among those who are offered health insurance by their employers, take-up rates vary as well. In general, workers who are more likely to be offered coverage are more likely to accept it, and vice versa. For example, while 85.5 percent of workers in large firms (100 employees or more) were offered coverage in 1997 and 86 percent of those workers enrolled, 56.6 percent of workers in small firms were offered coverage and only 75 percent enrolled.⁶⁹

Why Are Some Workers Not Covered?

Overall, nearly 40 percent of America's 108 million workers (excluding the self-employed) did not have health insurance through their own job in 1997. Among these individuals, 45 percent were employed at a firm that did not provide health insurance to any of its workers, 33 percent were offered coverage but declined it, and 22 percent were employed at a firm that sponsored a health plan but did not offer it to the worker (see Figure 1.7).

Among the one-third of workers who declined coverage, 61 percent did so because they were covered by another plan. Another 20 percent said the coverage was too expensive, and only 2 percent reported that they did not need or want health insurance.

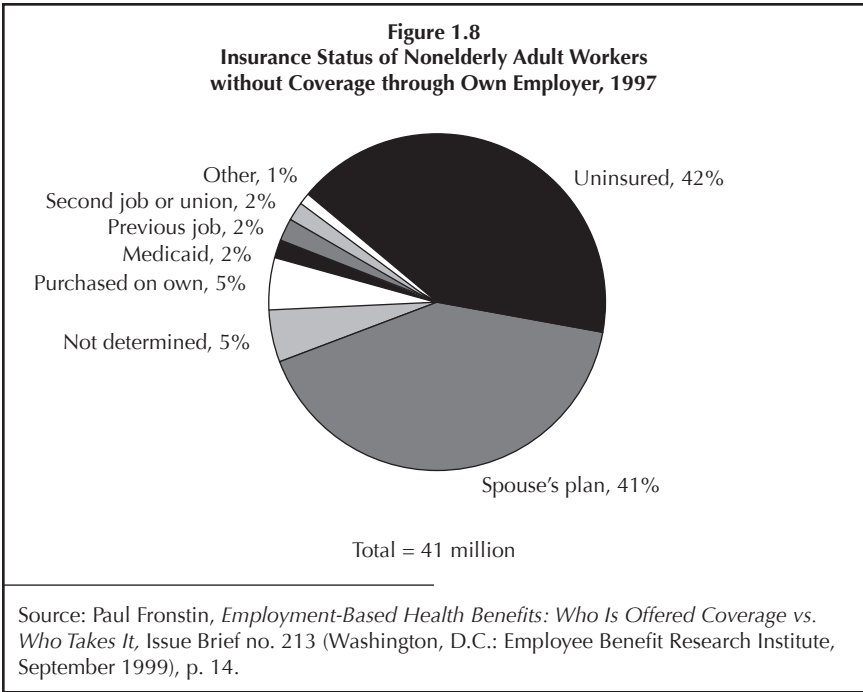




Among those whose employer sponsored a health plan but were not offered coverage, 53 percent reported that they did not work enough hours per week or weeks per year to qualify. Another 22 percent had not completed the waiting period required by their employer for eligibility, and only 1 percent reported that they were not eligible due to a pre-existing condition.⁷⁰

Among all workers without health insurance through their own job, 41 percent were covered by their spouse's plan, 12 percent obtained coverage from some other source, and 42 percent remained uninsured (see Figure 1.8).⁷¹ Most workers who remain uninsured (80 percent) are either employed by a firm that does not offer coverage or not eligible for the coverage their employer provides. Only 20 percent of uninsured workers go without coverage as the result of declining an offer from their employer.⁷²

Among the more than two-thirds of nonelderly individuals with access to employer-sponsored insurance (i.e., workers offered coverage and their dependents), data from a 1996-1997 household survey conducted by the Center for Studying Health System Change found that 86 percent were enrolled. An additional 9 percent had some other type of coverage (individually purchased insurance, Medicaid, etc.), and the remaining 5 percent (7.3 million individuals) were uninsured. When asked why they did not enroll in an employer-sponsored plan when it was offered, two-thirds of all uninsured workers and three-fourths of low-income uninsured workers



cited cost as the main reason for declining coverage. In fact, cost may be a barrier to enrollment for low-income workers not only because health insurance premiums consume a larger percentage of their income (relative to higher-income workers), but also because their required out-of-pocket contribution may be higher. As shown in Table 1.2, employee contributions (even for the least expensive plan offered) tend to be higher in firms that primarily employ low-wage workers.⁷³

Premium Increases and Employers

In 2002, small firms experienced a higher average increase in premiums (13.2 percent) than larger firms (12.5 percent). Many firms, both large and small, experienced significant premium increases of greater than 15 percent, but as Figure 1.9 reflects, small firms were more likely to experience increases of that level.⁷⁴

To cope with the increased cost of health insurance premiums, employers may pass on more of the costs to their employees, offer less expensive plans with less generous benefit packages, or drop coverage for some or all of their employees. As health insurance is a highly valued benefit among workers, employers are less likely to use these strategies in tight labor markets in which they must compete for employees. In fact, in comparison with 2001, more employers in 2002 reported that they can attract good employees without offering health insurance.⁷⁵

Table 1.2
Employee Cost of Health Insurance and Take-Up Rate
by Typical Wage in Firm, 1996-1997

Typical wage in firm (per hour)	Percent of all workers	Average monthly contribution for lowest cost option		Average take-up rate among those offered coverage (percent)
		Self only	Family option	
Less than \$7	16	\$27	\$130	78
\$7 to \$10	19	\$20	\$112	86
\$11 to \$15	27	\$20	\$120	89
More than \$15	39	\$17	\$ 84	89
All firms	100	\$20	\$106	87

Source: Peter J. Cunningham, Elizabeth Schaefer, and Christopher Hogan, *Who Declines Employer-Sponsored Insurance and Is Uninsured?* Issue Brief no. 22 (Washington, D.C.: Center for Studying Health System Change, October 1999), p. 2.

Though the rising cost of health insurance premiums has not resulted in a collapse of employer-based health insurance, there are signals of some erosion in this area, particularly with small employers.

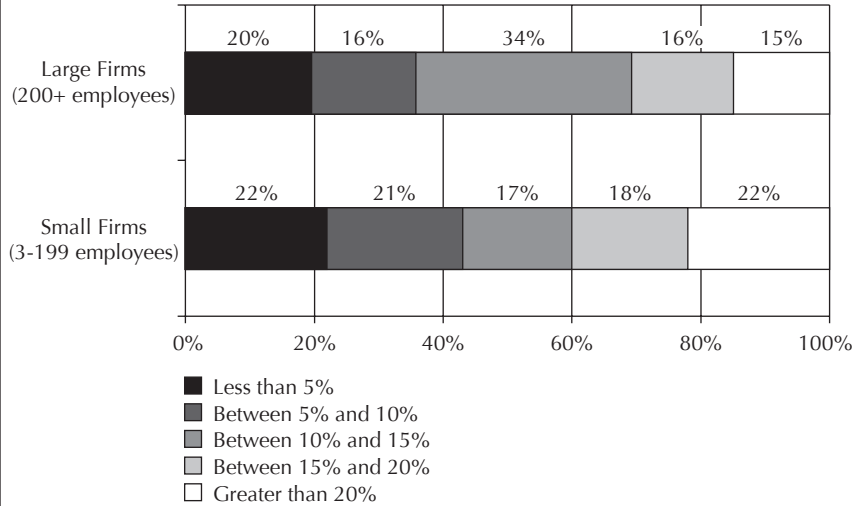
Trends in Changes to Benefits Packages

One concern about the increase in the cost of health insurance is that in order to afford higher premiums, employers will reduce benefits packages. Over the last 20 years, job-based health insurance benefits packages have expanded, a trend that is attributed largely to managed care, which emphasizes a wide range of preventive services. Today, most health plans offer a standard package of benefits, which includes annual physicals, visits with the obstetrician/gynecologist, inpatient and outpatient services, prenatal care, prescription drugs, and mental health services. In the last three years, however, more firms are reporting that they have reduced their health benefits packages. Though most workers experienced no change in their employee benefits in 2002, 17 percent reported a reduction in their benefits and 7 percent of workers experienced an increase in their health benefits.⁷⁶

Trends in Employee Contributions and Cost Sharing

As the cost of health insurance rises, employers are passing on more of the cost of that insurance to their employees. They do this in two ways: 1) by increasing the share of the monthly or annual premium that employees contribute, and 2) by offering plans that require employees to pay higher out-of-pocket expenses for health care services. Total employee contributions to insurance premiums have increased significantly over the past 15 years from \$41.3 billion in 1987 to \$126.4 billion in 2002. However, over that time the percentage of total premiums paid by employees has not changed significantly. In 1988,

Figure 1.9
Distribution of Premium Increases by Firm Size, 2002

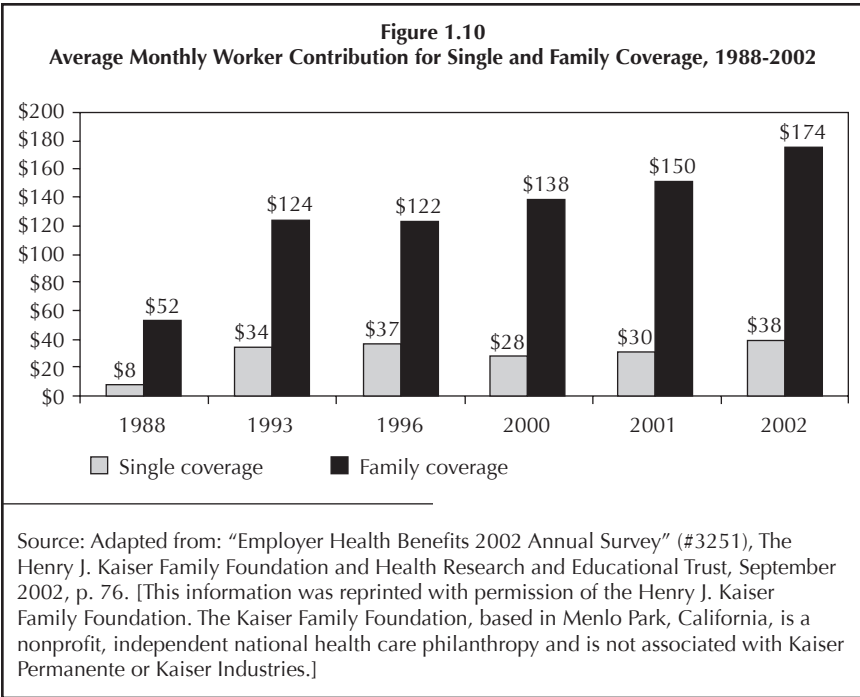


Source: Adapted from “Employer Health Benefits 2002 Annual Survey” (#3251), The Henry J. Kaiser Family Foundation and Health Research and Educational Trust, September 2002, p. 17. [This information was reprinted with permission of the Henry J. Kaiser Family Foundation. The Kaiser Family Foundation, based in Menlo Park, California, is a nonprofit, independent national health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries.]

employees contributed 11 percent of the cost of single premiums and 29 percent of the cost of family premiums. In 2002, employee contributions accounted for 16 percent of single premiums and 27 percent of family premiums.

In 2002, employers passed on a larger share of premiums to their employees. Between 2001 and 2002, the average monthly employee contributions to single health insurance increased from \$30 to \$38 and the average monthly employee contributions to family health insurance increased from \$150 to \$174 (see Figure 1.10).

The recent increase in employee contributions for health insurance premiums may be a reflection of employers’ willingness to pass on higher costs for health insurance to employees in a less competitive labor market. Employer-sponsored coverage generally shields individuals from out-of-pocket payments more than other types of coverage, but employees are now paying higher out-of-pocket payments for health services in the form of higher deductibles, co-payments, or co-insurance rates.⁷⁷ In the 2002 annual employer survey on health benefits conducted by the Kaiser Family Foundation and the Health Research and Educational Trust, 29 percent of employers



indicated that they had increased the amount that employees pay for health insurance, 28 percent had increased the amount employees pay for prescription drugs, 22 percent had increased the amount that employees pay for deductibles, and 20 percent had increase the amount of employee co-pays and co-insurance.⁷⁸ In general, large firms were more likely than small firms to have made these changes in their policies. According to another study, only 12 percent of small firms increased workers' co-payments or deductibles.⁷⁹ Many employers anticipated increases in the amount employees pay for health benefits in 2003, particularly for health insurance premiums.

Impact of Cost-Sharing on Families

The financial impact of cost-sharing is most significant for people with lower incomes. A recent analysis of 1996 MEPS data found that nearly one-third of non-elderly families spend at least 5 percent of their household spending on health care when their contributions to health insurance premiums and out-of-pocket expenses are taken into account. Health care accounts for a substantial portion (more than 10 percent) of household spending for 11 percent of families, many of whom tend to have lower incomes and higher health care needs.⁸⁰ As depicted in Figure 1.11, families below 100 percent of the poverty level are more likely to spend a greater portion of their income on out-of-pocket expenses than those with higher incomes.

Of families spending more than 10 percent of their income on direct health care expenses, 17 percent report that they forego needed care and 20 percent report difficulty in obtaining services for financial reasons.⁸¹

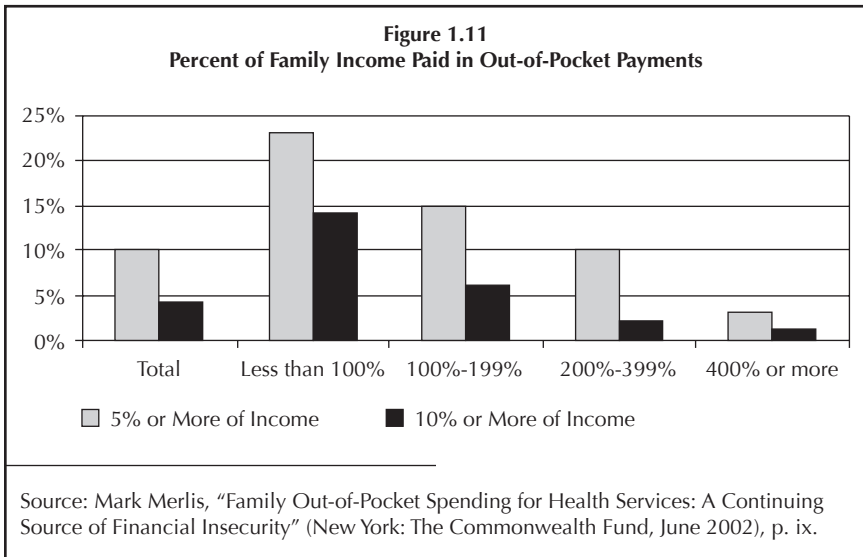
The Individual Market

While most nonelderly Americans obtain health insurance through their employer, in 2001, 6.6 percent (16.4 million) were covered by a policy they or a family member purchased on their own.⁸² Unlike coverage in the group market (e.g., insurance obtained through employers, trade associations, and unions), the availability, comprehensiveness, and cost of insurance in the individual market depends largely on a person's health status, age, place of residence, coverage history, and other factors.⁸³ While 30 to 40 percent of those with individual coverage are enrolled for less than a year to fill gaps created by a change in economic or other life circumstances, more than half of those who purchase individual policies do so as a more permanent source of coverage.⁸⁴

Who Enrolls?

Individuals commonly seeking this type of coverage include the self-employed (this may include people who, while technically self-employed, are working under contract for an employer), those who retire before becoming eligible for Medicare, part-time or contingent workers, those who lose coverage through a spouse, young adults who grow too old to be covered by a parent's health plan, and those who do not otherwise have access to an employer-sponsored or public coverage.⁸⁵

While 18.9 percent of self-employed workers were covered by an individual policy



in 2001, only 4.5 percent of those employed by a firm had individual coverage. Only 5.3 percent of people in families headed by a full-time, full-year worker had individual coverage in 2001, compared with 11.3 percent of those in families headed by a part-time or part-year worker. While 12.5 percent of young adults ages 18-20 and 11.5 percent of those ages 21-24 were covered by an individually purchased plan in 2001, 7.5 percent of children, 4.2 percent of those ages 25-34, and 8 percent of adults ages 55-64 had individual coverage.⁸⁶

How Is Coverage Obtained?

Applying for individual health insurance can take anywhere from two to six weeks, and consumers are typically asked to provide a deposit with their application to help cover the first month's premium. An underwriting process (i.e., review of an individual's health status, history, and other considerations) determines how much a policy will cost, what will be covered, or whether coverage will be offered at all. In addition to the information provided on an application form, insurers may request copies of medical records or other information from an applicant's physician, a physical exam, or lab tests. They may also consult a database maintained by the insurance industry to obtain information on an individual's history with other insurers.⁸⁷

How Much Does Coverage Cost?

A recent study released by the Kaiser Family Foundation tested access to coverage in the individual health insurance market by constructing seven hypothetical applicants (of varying ages and health statuses) and asking insurers in eight markets across the country to consider them as if they were real consumers seeking a policy with a \$500 deductible and \$20 co-payment per physician office visit. The seven hypothetical consumers made a total of 420 applications (60 each), and 154 (37 percent) were rejected (an HIV-positive applicant accounted for 60 of the rejections). Fifty-three percent of accepted applications included benefit restrictions, premium surcharges, or both. Among the five single applicants who received any offer of coverage, the average premium quoted was \$333 per month (\$3,996 per year). If the five applicants had been in perfect health, the average standard rate available to them would have been \$249 per month (\$2,988 per year).⁸⁸

However, averages mask the high degree of variability in the individual insurance market. Health status, age, gender, and other personal characteristics may play an important role in determining the cost and terms of coverage. Place of residence is also an important factor, since states vary in their degree of individual health market regulation. Some states prohibit insurers from placing exclusions on policies, and others require insurers to sell standardized policies at standardized rates within certain guidelines. States have also created "high risk pools" for those who cannot obtain adequate insurance elsewhere, but relatively few people are enrolled in such programs and their costs and covered benefits vary.⁸⁹

Medicaid, Medicare, and Other Public Programs

While nearly all Americans are eligible for health coverage through the Medicare program when they reach age 65, most nonelderly individuals qualify for public coverage on the basis of income, disability, or military service. In 2001, 96.6 percent of people age 65 and older obtained coverage from Medicare or another government program, and less than 1 percent were uninsured.⁹⁰ In contrast, only 15.3 percent of the non-elderly population had public coverage (mostly through Medicaid and SCHIP) at some point during the year, and 16.5 percent were uninsured for the entire year.⁹¹

Medicaid and SCHIP

Two joint federal-state programs, Medicaid and the State Children's Health Insurance Program (SCHIP), are the main sources of public coverage among those under age 65, serving more than 28.3 million nonelderly people (mostly disabled individuals and people in families with children) in 2001.⁹² Because they are both means-tested programs, an applicant's income and resources (e.g., the value of a car) must fall below certain minimum levels in order to qualify.

Under federal law, states are required to provide Medicaid coverage for all children under age 6 with incomes below 133 percent of the federal poverty line (FPL), and all children under age 19 with incomes below 100 percent FPL. Beyond these minimums, income eligibility varies by state and age group, with standards for younger children tending to be more generous. For those with family incomes too high to qualify for Medicaid, all but 11 states currently cover children to at least 200 percent FPL under SCHIP.⁹³

As of June 2001, income thresholds for a parent with two children applying for Medicaid ranged from 22 percent of the federal poverty line (\$259 per month for a family of three) in Arkansas and Louisiana to 200 percent FPL (\$2,358 per month) in the District of Columbia. Overall, 14 states required monthly earnings below 50 percent of the federal poverty line, 25 allowed earnings from 50 to 100 percent FPL, and 11 states and the District of Columbia allowed earnings of 100 percent FPL or greater.⁹⁴

Rates of private insurance coverage among the nonelderly vary considerably from state to state, ranging from a low of 59.2 percent in New Mexico to a high of 81.4 percent Wisconsin during 1996-1998. This coverage variability directly affects the size of the population at risk of being uninsured, or what some call the "insurance gap." For those who fall into this category, Medicaid is by far the largest source of coverage in every state. However, the proportion of at-risk individuals (i.e., low-income individuals without private insurance) covered by Medicaid also varies substantially, ranging from 26.8 percent in Nevada to 74.7 percent in Vermont during 1996-1998.⁹⁵

Medicaid Enrollment and Spending Issues

Over the past few years, a significant challenge to increasing access to care in the United States has been the sensitivity of the health insurance system to the state of

the economy. The United States has been in a period of economic slow-down during the early part of this decade. With rising rates of unemployment, fewer people have employment-based health coverage. Some may be able to continue their employer-based coverage under COBRA, but most find that an unaffordable option. Others may purchase individual or family plans in the individual health insurance market to temporarily fill the gap in coverage. Others will either qualify for public programs or join the ranks of the uninsured.

During the recent economic decline, enrollment in Medicaid has grown substantially. As enrollment in Medicaid and other public programs grows, the amount of money that governments at the federal, state, and local levels spend to support the programs also increases. At the same time, governments' tax revenues decline because of the decline in the economy. Facing a fiscal squeeze, many states have implemented restrictions on Medicaid eligibility in order to stop or slow the growth in enrollment and to contain costs. As a result, more low-income Americans lose their health insurance. The growing number of uninsured is an increased burden on public safety net providers. Consequently, during periods of economic decline, at the same time that people are losing employer-sponsored coverage, governments at the federal, state, and local levels are struggling to maintain coverage under public programs and may not have the resources to expand coverage to health care for the uninsured.

The recent economic decline has contributed to a substantial growth in the number of people enrolled in Medicaid. Between December 2000 and December 2001, enrollment in the program grew by 9.8 percent, from 33.3 million individuals to 36.6 million individuals.⁹⁶ By 2003, the number of people on Medicaid reached 42 million.⁹⁷ Other factors contributing to the growth in Medicaid enrollment over this time period were loosening of eligibility requirements and administrative simplifications.⁹⁸

The growing number of individuals enrolled in Medicaid has contributed to an increase in the cost of operating the program. In fiscal year 2002, the average annual rate of growth in Medicaid spending was 12.8 percent. This was the highest annual growth rate in a decade and it followed a 9 percent growth rate in the previous fiscal year.⁹⁹ In addition to enrollment growth, these changes have also been attributed in part to increasing expenditures on prescription drugs.¹⁰⁰

The combination of increasing Medicaid expenditures and declining tax revenues has contributed to a substantial fiscal squeeze in most states. In order to balance their budgets in fiscal year 2003, 37 states were forced to cut spending in the middle of the year by a combined \$14.5 billion.¹⁰¹ According to the National Governors Association and the National Association of State Budget Officers, this is the largest spending cut in the 27 years that the survey has conducted. It is projected that in fiscal year 2004, states will again face budget deficits, which will increase pressure on Medicaid coverage. The extent to which Medicaid has contributed to states' fiscal problems depends on the percentage of the state's budget accounted for by Medicaid spending. As a percentage of their budgets, the amount that states spend on Medicaid varies

significantly from 8.7 percent to 30 percent. On average, states spend approximately 20 percent of their budgets on Medicaid.¹⁰²

The federal government acted to provide some relief to states on Medicaid spending in 2003 and 2004. The Jobs and Growth Tax Relief and Reconciliation Act of 2003, which was enacted earlier this year, temporarily raises the federal matching rate for Medicaid funds, thus decreasing state's share of Medicaid spending.¹⁰³ The legislation also included grants to the states for additional fiscal relief.

Despite this, many states have responded to the federal squeeze by cutting spending in their Medicaid programs. In the past two years, at least a dozen states have enacted legislation or obtained permission from the federal government to drop Medicaid coverage for hundreds of thousands of optional beneficiaries (individuals who are eligible under the states' Medicaid plans, but who the federal government does not require states to cover).¹⁰⁴ For example, Tennessee dropped 200,000 beneficiaries, Michigan eliminated 38,000 beneficiaries, and Massachusetts cut 36,000 childless adult beneficiaries.¹⁰⁵

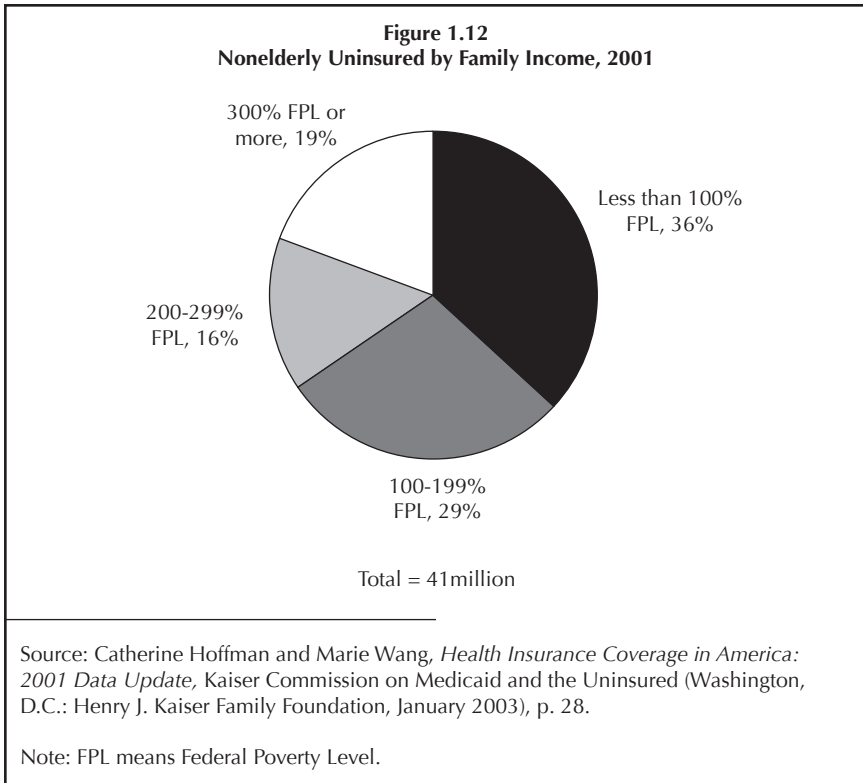
Medicare and Military Coverage

While Medicaid supplies the vast majority of public health insurance coverage for people under age 65, a relatively small number of nonelderly individuals obtained Medicare (5.6 million) or military coverage (6.6 million) in 2001. The proportion of nonelderly individuals with Medicare coverage has increased slightly over the past 15 years, from 1.5 percent in 1987 to 2.3 percent in 2001. However, the proportion with military coverage declined from 4 percent to 2.7 percent over the same period, in large part due to downsizing in the armed forces.¹⁰⁶

The Uninsured

In general, the likelihood of being uninsured or being covered by various sources of health insurance depends on a number of factors. These include income, job and employer characteristics, education, health status, age, gender, race and ethnicity, citizenship status, and geography. In 2001, 41 million Americans under age 65 (16.5 percent) went without health insurance for the entire year. While low-income individuals (i.e., those with incomes below 200 percent FPL) represented only one-third of the total nonelderly population, they accounted for almost two-thirds of those who were uninsured in 2001 (see Figure 1.12). Adults are also overrepresented in the uninsured population, in part due to the fact that they are less likely than children to qualify for public coverage. While they accounted for 69 percent of all nonelderly individuals, adults represented 77 percent of the uninsured in 2001.¹⁰⁷

As discussed earlier, the availability of employer-based health insurance varies by firm size, industry of employment, and other job characteristics. For example, within three industry groups that account for 60 percent of all jobs in America, health insurance coverage is quite different for those in service/labor versus professional/technical positions. While 33 percent of wholesale, retail, and trade workers in service/labor



jobs were uninsured in 2001, only 18 percent of the professional/technical workers in that industry were uninsured. The breakdown for the professional services industry was 20 percent versus 8 percent, and 15 percent versus 6 percent in the mining and manufacturing industry.¹⁰⁸ In 2001, more than two-thirds of the nonelderly uninsured lived in families that had at least one full-time worker (see Figure 1.13). Only 18 percent of uninsured individuals lived in a family with no workers.¹⁰⁹

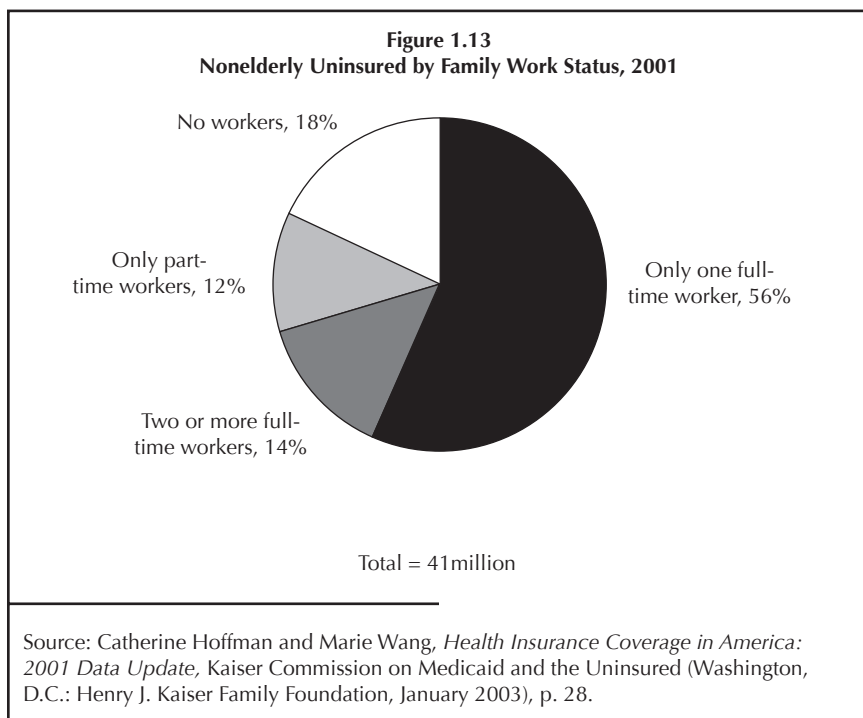
Among young adults (many of whom have “aged off” a parent’s insurance plan and do not have jobs that offer coverage), the probability of being uninsured is particularly high. In 2001, 29.9 percent of adults ages 19-24 were uninsured. In contrast, only 16.2 percent of those ages 35-44 were uninsured. Hispanics are another group with a high proportion of uninsured individuals. While 11.6 percent of whites and 20.1 percent of blacks went without coverage in 2001, 34.8 percent of Hispanics were uninsured.¹¹⁰

Without using more sophisticated statistical methods, it is difficult to say how much of the difference between the uninsured rates of various groups can be attributed solely to particular social or economic characteristics or to differences in

immigrant status or race and ethnicity. While most published analyses examine each factor separately (such as percentage of uninsured individuals by income, by employment status, etc.) to provide a general picture of how coverage varies among different groups, it should be noted that these types of comparisons do not allow us to evaluate the relative importance of each factor in determining an individual's insurance status. For example, while both young adults and never married individuals have higher-than-average probabilities of being uninsured, it is difficult to isolate the effect of being young from that of being never married without using more sophisticated (multivariate) statistical methods.¹¹¹

One recent analysis that attempts to examine many of these factors together found that, for example, about two-thirds of the difference in uninsured rates between non-Hispanic whites and Hispanics can be accounted for by measured differences in each group's socioeconomic and demographic (including nativity) characteristics. In other words, much of the difference in uninsured rates between these two groups is due to the fact that they are also different with respect to other characteristics (besides race/ethnicity) that affect the probability of being uninsured.¹¹²

Finally, although lack of health insurance is a major problem throughout the nation, differences in employment patterns, population characteristics, and public program eligibility standards mean that some states have larger numbers of uninsured individuals



than others. In 2001, nonelderly uninsured rates ranged from 8.6 percent in Wisconsin to 25.7 percent in Texas. In general, western and southern states have higher proportions of uninsured residents than states in other parts of the country.¹¹³

How Long Do People Stay Uninsured?

While figures on the uninsured cited in this chapter have thus far referred only to those who were without health insurance for an entire calendar year according to the Census Bureau's Current Population Survey (which does not ask respondents for insurance start and end dates), it should be noted that the lengths of spells without coverage do vary.¹¹⁴ Using data from the Census Bureau's Survey of Income and Program Participation for the period October 1994 to September 1995, one study found that two-thirds of spells without health insurance lasted for less than one year, and approximately one-third lasted the entire year.¹¹⁵

Using data from the 1996 Medical Expenditures Panel Survey, another study showed that one-third of nonelderly individuals were uninsured at least once during a two year follow-up period. Among those who had an uninsured spell, 25 percent were chronically uninsured, going without coverage for the entire two years. Individuals with higher socioeconomic status have shorter periods without coverage; and while young adults are more likely to be uninsured than other age groups, they have shorter uninsured spells. Non-workers, Hispanics, and high school dropouts have longer uninsured spells, and there is evidence to suggest that the likelihood of regaining coverage declines as people remain uninsured for longer and longer periods of time.¹¹⁶

Consequences of Being Uninsured

Research showing that health insurance positively affects the use of health services is widely accepted, and it is clear that accessing medical care is a bigger problem for people without health coverage. For example, according to data from a household survey conducted by the Center for Studying Health System Change, 15 percent of uninsured people reported an unmet need for medical care in 2001, while only 4.4 percent of insured people reported this problem. Similarly, uninsured people were almost twice as likely to delay needed medical care as insured people (15.7 percent versus 8.6 percent). Among those who had an unmet need or delayed care, cost was the most frequently cited reason. In addition, while 52.3 percent of those with insurance worried about the cost of care, 93.1 percent of those without insurance reported cost as a concern.¹¹⁷

Although the link between insurance and access to care is well-established, the relationship between health insurance and individuals' health outcomes is more ambiguous. As noted in a recent study from the Joint Center for Poverty Research that reviewed the research literature in this area, establishing a causal relationship between insurance status and health is difficult for two main reasons. First, while people who have health insurance and people who do not are different from each other in ways that can be measured (e.g., age, race, educational attainment), they may also be dif-

ferent in ways that cannot be measured easily or at all (e.g., environment, attitudes, preferences). As a result, statistical analyses may be problematic. Second, the relationship between health insurance and health can be interrelated. For example, health insurance may lead to better health through increased access to care, but at the same time, access to health insurance may be affected by one's health status (e.g., an individual who cannot obtain coverage due to a pre-existing condition or someone who "spends down" their income on medical expenses to qualify for public coverage). As a result, it may be difficult to determine the "real" cause of health outcomes.¹¹⁸

To avoid these potential difficulties, the authors' literature review focused on quasi-experimental and experimental studies whose research designs provided a basis for establishing a causal relationship between health and health insurance in specific situations. Overall, the conclusion was that policies to expand insurance can also promote health. However, the authors noted that based on the available evidence, they were unable to say exactly which interventions related to health insurance would be most effective for improving health in the future.¹¹⁹ As discussed in this chapter and those that follow, this uncertainty is a key reason why so much disagreement exists about the best way to ensure access to quality health care for all Americans.

Another recent review of the research literature from the Kaiser Commission on Medicaid and the Uninsured also concludes that health insurance positively affects health outcomes, including mortality rates. Since extra years of life and more healthy years of life could add to individuals' and families' earnings, as well as to our national wealth, the authors argue that the next step for research should be to estimate the size of these and other potential benefits. Ultimately, such estimates could be used to inform the policy debate over expanding health insurance coverage.¹²⁰

Where Do the Uninsured Go for Care, and Who Pays?

In what is often referred to as the health care "safety net," individuals without insurance must navigate a fragmented, patchwork system of providers and services. Hospitals, health clinics, and physicians all provide care for the uninsured, but the delivery and financing of safety-net care varies substantially across communities. For example, in some areas, a sole public hospital is the core of the local safety net. In others, a network of community health centers serves as the main source of care. The mix of financial resources used to support safety-net care varies as well. While some states rely more heavily on direct state and local funding for the uninsured (in addition to federal dollars), others largely depend on the ability of providers to pass costs along to third-party payers.¹²¹

In the aggregate, a recent study published in *Health Affairs* estimated that uninsured individuals received \$35 billion in uncompensated care (defined as the difference between the cost of care provided and the amount actually paid by the uninsured) in 2001, or about 2.8 percent of total personal health care spending in the United States. Most of this uncompensated care (\$30.6 billion) was financed by governments through a variety of mechanisms including grants, direct provision pro-

grams, tax appropriations, and Medicare and Medicaid payment add-ons. The federal government financed the largest share of these costs, and most of the money went to hospitals (which deliver about two-thirds of uncompensated care).¹²²

Future Projections of the Uninsured

Absent any major changes in policy, the number of Americans without health insurance is likely to grow in the future. However, attempts to predict future patterns of health insurance coverage are complicated by a number of factors.

To the extent that we wish to determine how changes in the U.S. population (e.g., an increase in the percentage of near-elderly coupled with an increase in the percentage of part-time workers) might affect the number of individuals with various types of insurance, predictions are complicated by the fact that future economic conditions that will also affect health coverage (including health care cost inflation, wage growth, and the rate of unemployment) are highly uncertain. For instance, states faced with a budget shortfall might react to rapid health care cost inflation by tightening the eligibility criteria for public insurance programs. Similarly, some employers might pass on the cost of rising premiums to their employees (possibly leading to decreased participation), while others might stop offering health insurance altogether. At the same time, rising unemployment could lead to growth in the uninsured population if those who lose their jobs do not qualify for or cannot afford COBRA or some other type of coverage.¹²³

As a result of these uncertainties, researchers must make assumptions based on trends and past experience when projecting the number of individuals with health insurance into the future. Inevitably, different assumptions will lead to different projections. For example, a 2001 study published in *Health Affairs* found that the nonelderly uninsured population could decrease slightly by 2009 under “extremely optimistic” assumptions, increase to about 44 million under moderate assumptions, or increase to about 52 million under pessimistic assumptions.¹²⁴ Using various scenarios of economic growth and health care cost inflation, a 2000 study commissioned by the Health Insurance Association of America estimated that the number of nonelderly uninsured could range from 48 million to 61 million in 2009.¹²⁵ Similarly, a 1999 study by the National Coalition on Health Care estimated that the nonelderly uninsured population could constitute between 52.2 million and 61.4 million individuals in 2009.¹²⁶

Policy Alternatives and Key Questions to Consider

It is fair to conclude that the number of persons in the U.S. without health insurance will likely increase unless current policies are substantially revised. As interest has grown in addressing this problem, so have the policy solutions. There is a very wide range of proposals to provide access to health insurance to the millions of Americans who are uninsured. Though the proposals share a common goal of increasing access to health insurance, they vary in the approach to achieving that

goal, which segment of the uninsured population they would target, and how many Americans they would affect.

The wide range of proposals to increase access to health insurance can be grouped into four broad categories: 1) proposals to assist individuals to purchase insurance, 2) proposals to expand the public programs, 3) proposals to strengthen the employer-based system of health insurance, and 4) proposals to replace most of the current health insurance system with a single-payer national health insurance system. The remainder of this book provides examples of proposals in each of these categories as well as analysis and discussion of the various approaches.

1) Individual Tax Incentives

One approach to increasing access to insurance is to expand options for obtaining insurance through the individual market. As noted earlier in this chapter, approximately 6.6 percent (16.4 million) of Americans purchase health coverage on their own.¹²⁷ The affordability and availability of coverage in the individual market depends greatly on the person's age, health status, place of residence, and other factors.¹²⁸ For young and healthy individuals, purchasing health insurance in the individual market can be a viable option for obtaining temporary or long-term coverage. However, for older and sicker individuals, the cost of such coverage may be prohibitive.

In Chapter 2, Mark Pauly and Ruben King-Shaw discuss options for expanding health insurance coverage through refundable tax credits. In Chapter 8, Mark Pauly's and Bradley Herring's paper entitled "Expanding Coverage via Tax Credits: Trade-Offs and Outcomes" examines how tax credits of different designs would reduce the number of uninsured. They conclude that small credits (25 percent or less of the cost of a premium) would not draw substantial numbers of the uninsured into the individual insurance market. Credits covering approximately half the cost of an individual health insurance premium might make it possible for a significant number of uninsured Americans to buy insurance in the individual market.

In 2002, President Bush proposed a tax credit of up to \$1,000 for individuals purchasing their own insurance, and up to \$3,000 for families, targeted to individuals and families with incomes below about 300 percent of the poverty level.¹²⁹ According to the Bush Administration, the credit would cost about \$10 billion a year and would provide coverage to 6 million of the uninsured—about 15 percent of the uninsured population.¹³⁰ Other participation estimates of the Bush proposal are considerably smaller. The U.S. Joint Tax Committee assumes costs and participation rates about 30 percent lower,¹³¹ and a recent estimate provided in congressional testimony assumed participation rates of about 65 percent lower than administration estimates, thereby leading to a reduction of about 2 million uninsured persons—a 4 percent reduction in the total number on the uninsured. While the numbers of individuals affected are modest relative to the options discussed below, it is important to point out that larger individual tax credits would certainly benefit more people.

There is serious debate over the long-term impact of such a change. Proponents

argue that the individual tax credit approach helps individuals to purchase individual insurance and thus will make up for some of the continued erosion of employer-based and public health insurance. In addition, tax credits may promote individual choice and help to control health care costs by empowering people to make cost-conscious decisions about their own health care. Opponents argue that the credits would not be large enough for most low- and moderate-income individuals to purchase health insurance and that insurance policies would provide only very limited benefits to low and moderate income people. In addition, opponents argue that individual tax credits would further weaken the employer-based insurance system, because younger and healthier workers would opt out of employer coverage, leaving older and less healthy workers in employer plans, thereby driving up costs and encouraging more employers to drop health insurance coverage.¹³²

2) Public Program Expansion

A second category of proposals to increase access to insurance is public program expansion. The most common sources of health insurance coverage for the nonelderly are the Medicaid and SCHIP programs, which together insured more than 28.3 million nonelderly individuals (mostly women, children, and disabled adults) in 2001.¹³³

The Medicaid program was expanded significantly in the 1980s and 1990s. Legislation was enacted extending eligibility to certain population groups (pregnant women and children up to the age of six with incomes below 133 percent of FPL and children ages 6 to 18 with incomes below poverty) and federal Section 1115 waivers were established to expand the scope of coverage under Medicaid.¹³⁴ Many states have also attempted to increase enrollment in the program by simplifying the eligibility determination and enrollment processes.

A number of presidential candidates have proposed expansions in public programs to reduce the number of uninsured. For example, former Governor Howard Dean has proposed to extend health coverage to everyone with incomes below 185 percent of the poverty level through expansions in Medicaid and SCHIP, which would expand coverage to roughly 12 million of the uninsured. Senator Joe Lieberman has proposed a similar plan, but with more expansive Medicaid changes to cover more families. Senator John Kerry proposed that nearly all uninsured children be covered by SCHIP and that parents up to 200 percent of the poverty level be covered by Medicaid.

In Chapter 3, Judith Feder discusses public program expansion. In the corresponding paper in Chapter 9, "Covering the Low-Income Uninsured: The Case for Expanding Public Programs," Judith Feder, Larry Levitt, Ellen O'Brien, and Diane Rowland discuss the potential for increasing access to the uninsured through an expansion of the Medicaid program. They propose raising income eligibility requirements and allowing all individuals who are income-eligible to enroll in the program.

The strongest argument for expanding public programs is the capacity to target limited additional resources to persons most in financial need. About 64 percent of uninsured nonelderly Americans (27.7 million) are in families with incomes below

200 of the poverty line, and 36 percent (15.6 million) live below the poverty level.¹³⁵ Public programs such as Medicaid and SCHIP can effectively target support to these families and individuals. Opponents counter that dramatic expansions of public programs would be prohibitively expensive and that the employer-based system will be further eroded if public programs are expanded to take in more working families.

3) Expanding Employer-Based Coverage

Employer-based health insurance is currently the foundation of insurance coverage for nonelderly Americans. While some point to signals of decline in employer-based coverage as a sign of the eventual erosion of job-based health insurance, others believe that the best way to expand access to insurance is by strengthening and expanding this form of insurance. A number of health policy reform proposals are designed to increase access to the employer-based system of coverage. Proposals in this category include employer mandates (requiring employers to offer health insurance to their employees), which may be combined with employer tax subsidies, purchasing pools for small employers, and/or health savings accounts. The most notable proposal in this area in recent years was the Clinton health care proposal, which coupled employer mandates with new employer subsidies.

Recently, Representative Dick Gephardt unveiled a proposal that provides a 60 percent refundable tax credit to employers, coupled with an additional 25 percent credit to lower-wage workers to pay for insurance. The proposal, which more than doubles the relative value of current law tax incentives for the purchase of employer-provided insurance, would likely ensure coverage for the vast majority of the working uninsured. The costs of such an approach are considerable; according to one analysis, the annual costs after full implementation would be about \$100 billion a year.¹³⁶

In Chapter 4, Cathy Schoen discusses the employer-based approach. In the corresponding paper in Chapter 10, "Creating Consensus on Coverage Choices," Karen Davis and Cathy Schoen propose a major expansion in employer-based coverage as part of a multi-tiered approach to expanding access to care, which includes strategies for the employer system, the public sector, and the individual insurance market. Among the employer-based strategies contained in their proposal are a continuation of coverage for two months after an employee leaves a job, subsidies for COBRA coverage for the uninsured who are between jobs for extended periods of time, and extending private insurance coverage of dependent youth up to the age of 23 regardless of whether they are in school. To reduce the inequities between firms that provide health insurance and those that do not, employers that do not provide health insurance would be required to contribute funds to a public health insurance program. In addition, to give small firms the economic advantage of a large purchasing pool, small firms would be allowed to join a large publicly-funded health insurance program.

Moving toward universal coverage by requiring or greatly expanding employer-based health insurance is also very contentious. Some proponents argue that the provision of health insurance should be part of the social contract for employers,

with health insurance as a legally mandated employee benefit, similar to Social Security or unemployment insurance. Opponents argue that significant expansions in this area would lead to cuts in wages, non-health benefits and overall employment levels, particularly for low-wage workers. Supporters counter that expanded tax incentives would ameliorate these concerns, but opponents argue that major new tax subsidies would be very expensive and lead to significantly higher levels of health care inflation.

4) National Health Insurance

The most ambitious proposal to address the uninsured would be to create a national health insurance program. Under most national health insurance plans, health care would be financed by taxpayers and administered by government at the federal, regional, or state levels. All Americans would be eligible for the program—insurance would no longer be tied to jobs—and private insurance would be eliminated or significantly scaled back. Risk would be held by the taxpayers through the government, which would have primary responsibility for overseeing care and controlling costs.

Former Senator Carol Mosley Braun and Representative Dennis Kucinich have both proposed variants of the single-payer national health insurance plan. For example the Kucinich plan calls for “Medicare for All,” a single-payer system that over time would remove private insurance companies from the system, to be financed by a 7.7 percent employer tax.

In Chapter 5, James A. Morone discusses universal health care. Chapter 11 contains his corresponding paper entitled “Medicare for All,” as well as a paper entitled “A National Health Program for the United States: A Physicians’ Proposal.” In this paper, Steffie Woolhandler and David Himmelstein present a proposal for replacing the current health care system with a national health insurance system. The key advantage of a national health insurance system is that it would guarantee health insurance to all Americans. It could potentially reduce the overall costs of the American health insurance system because it would reduce system complexity. But national health insurance is strongly opposed by many due to the magnitude of the disruption to the current system and whether such a drastic change would be acceptable to many Americans. Most Americans support few if any limits on the use of health services or choice of providers. There are serious questions regarding quality of care as well as the form, nature and effect of regulatory cost containment mechanisms.

Issues, Choices, and Actions

While the options described above all deal with the same issue, the approaches are profoundly different, and raise a number of enormously important and complex issues. One key issue relates to the relationship of the reform to the existing system. Any major reform to substantially reduce the number of uninsured will have implications for how the overall system is structured. Strengthening one part of the system—individual insurance, employer coverage or public programs—could poten-

tially reduce the role now played by the other parts of our insurance system. What part of our current system do we wish to build on in the future?

A second key issue is that different options likely lead to very different outcomes for the uninsured population. For example, should policies provide comprehensive health insurance benefits and/or minimum cost-sharing or should they have limited benefits and/or require substantial contributions from the individual? Public programs historically have provided the most comprehensive set of benefits, while individually purchased policies have been the least comprehensive in nature. These differences have implications for who would most likely benefit under different reforms. A move toward less comprehensive insurance plans or plans that have substantial cost-sharing may benefit people who are young and healthy because their need for health services is relatively low, but they may not be as beneficial to heavier users of the system. On the other hand, less comprehensive coverage might make the public more prudent in their daily health care decisions, thereby potentially lowering health care inflation.

A final key issue that is perhaps most important relates to the values and principles underlying the various reform proposals and where they would lead us as a society in the future. The core values question underlying this overall issue seems clear: who ultimately should have primary responsibility for Americans' access to health insurance—the public, employers, or individuals? What do we want our society to provide to its citizens in this area, and what are the values inherent in those choices?

It is clear that the United States faces major choices in this area—choices that will lead to very different outcomes. Will we see action soon?

Over the course of its history, the United States has taken several dramatic steps to address important social policy issues. Two such examples in the 20th century were the creation of Social Security and the enactment of sweeping civil rights protections. What were the conditions that existed at the time that enabled the nation to tackle those longstanding issues? And to what extent do these conditions exist today?

At a very basic level, two key elements had been present in the 1930s and the 1960s that provided sufficient alignment for major reforms to be adopted. First, there was a deep and growing public concern that something major had to be done, even if it necessitated real sacrifice. And second, assertive presidential leadership was present, coupled with a strong governing coalition that was in general agreement with the direction of reform proposed by the president.

Do These Conditions Exist Now?

It is clear that public pressures continue to mount on the issue of health insurance for the uninsured. The number of persons without health insurance continues to grow. Many middle class families are without coverage or are concerned about insurance coverage cutbacks. Health care providers have growing concerns about their capacity to provide quality care. Health care costs continue to grow unabated, and employers and states are increasingly reluctant to maintain current levels of insurance coverage.

But real questions remain. Are the uninsured in a position to place sufficient political pressure on the system to force action? For the average voter, are there other concerns that have higher priority? And in an area as complex as health care, is there anything approaching a public consensus on the public versus private role in the provision of health insurance? To some extent, it is not surprising that there are profoundly different approaches to address this issue, because today's public is not united on how to proceed.

And what about the role of presidential leadership? The role of presidents is not simply to ride an emerging public consensus; presidents lead efforts to bring about public consensus as well as consensus in Congress. Given the absence of national consensus, the polarization of the electorate and a deeply divided Congress, presidents face real challenges making substantial progress on this issue.

In April 2003 the LBJ Library and the Center for Health and Social Policy at the LBJ School of Public Affairs held a conference with national policy experts to discuss policy alternatives and grapple with these questions. As this book makes clear, there is no consensus on the best approach. This book attempts to frame these choices to help the reader come to a greater understanding of the choices we face and the implications of the alternatives for change.

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Part II

Policy Alternatives

Chapter 2

Health Insurance Tax Credits

One approach for expanding coverage to the uninsured is to subsidize the purchase of health insurance using the income tax system. Although there are many possible ways of doing this, including tax deductions and credits for businesses, the most commonly proposed method is tax credits for individuals. This approach would entail the federal government offering individuals a tax credit—a reduction in their federal tax liability—to use toward the purchase of health insurance coverage.

Although various tax credit proposals have been debated since the early 1970s, the United States has only limited experience with these programs. A tax credit aimed at subsidizing the cost of health insurance premiums for children in low-income families was in effect from 1991 to 1993. A small-scale tax credit is currently in effect as a result of the Trade Act of 2002. This legislation includes a provision that allows displaced workers eligible for trade adjustment assistance to qualify for a 65 percent refundable, advanceable health insurance tax credit. The credit is also available to workers between the ages of 55 and 64 if their pension plans are being administered by the Pension Benefit Guaranty Corporation. The U.S. Department of the Treasury is currently working to implement this program. Aside from these limited measures, however, Congress has enacted no major legislation to use credits for tackling the problem of the uninsured. Tax credits are currently a topic of heated debate among policymakers, scholars, analysts, and advocates who are considering different approaches for expanding health insurance coverage.

This chapter includes two perspectives on the tax credit issue: one from health care economist Mark Pauly and the other from Ruben King-Shaw, a senior adviser for health initiatives at the U.S. Treasury. Mark Pauly is the Bendheim Professor and chair of the Department of Health Care Systems at the University of Pennsylvania's Wharton School. Dr. Pauly is a health care economist and a longtime proponent of health insurance tax credits. Mr. King-Shaw has an extensive background in health care management, and he previously served as the Deputy Administrator/COO for the Centers for Medicare and Medicaid Services. For further information on tax credits, see the three papers in Chapter 8.

Presentation

by Mark V. Pauly

Professor

University of Pennsylvania

I'm delighted to be here, but actually, I'm willing to go almost anywhere at any time to talk about the problem of the uninsured. The way we deal with the uninsured is both inefficient and immoral. We have a sizable fraction of the American population, around 14 percent, who are uninsured and get almost no help from the government at any level to help them afford medical care. And, on the other hand, we have a sizable fraction of upper-middle income people—you're looking at one of them—who get substantial assistance from the government as tax-free compensation in the form of health insurance. If you have a cafeteria plan, your nominal employee payments are also shielded from income taxation. My glasses here were paid out of my flexible spending account—so 50 percent was paid by the U.S. Treasury. Something needs to be done about a situation in which we provide substantial subsidies to people who don't need them while neglecting to provide subsidies to people who do.

I hope to try to convince you that a possible non-disruptive strategy to reduce the number of uninsured and gradually move toward universal coverage is the use of refundable tax credits (RTCs).

There is a kind of paradox here. Because the uninsured are a very heterogeneous group, we can't use uniform policies to get universal coverage. We're probably going to need a mix of policies—different strokes for different folks, depending on their circumstances—in order to most efficiently and effectively provide appropriate levels of insurance coverage.

The beauty of refundable tax credits is that they are supremely flexible. If you find something bothersome, you can always fix it. Of course, fixing a problem may make the tax laws more complicated, but it's at least possible to do it. It's worth saying, just in case anybody wonders, that in the 2004 budget, constrained as it is, there's still \$40-plus billion for tax credits. For some set of the population up to 200 percent of the poverty line for individuals, the administration is proposing a credit equal to 90 percent of the insurance premium, up to \$1,000.

The target population for refundable tax credits—the population for which they're most suitable, although they can be used for others—are the “tweeners,” the people between the poverty line and the median income. These people are a plurality of the uninsured. They are more likely to be privately insured at any point in time than uninsured or publicly insured, and almost certain to have been privately insured in the past or will be in the future. So, one of the arguments for refundable tax credits is that it is a graceful way to help people stay in a private insurance system, the system they're most likely already to be in, from time to time. It's less disruptive than moving them back and forth from one system to another.

Here are some data, which may differ slightly from the data offered previously, depending on how poverty is defined (see Table 2.1).

Even though this data goes back to 1999, the qualitative message is the same: roughly speaking, about a third of the uninsured are poor. But surprisingly, about a quarter of the uninsured aren't poor at all. Who are these people, the Evel Knievels of health insurance? It's important to know they exist. The population that I've focused my thinking on is the tweeners, who by this calculation were 40 percent of the uninsured, those between 125 percent of the poverty line and 300 percent of the poverty line, which is approximately the median income.

Most of the uninsured are neither poor nor rich. This is some evidence that they are not totally incapable of affording health insurance. As you can see, for all income brackets above 125 percent of the poverty line, most people somehow get private health insurance (see Table 2.2). You may say that's because their employers give it to them. But economists, at least, believe that employers don't give employees anything—employers pay employees in the form of health insurance premiums rather than cash because there are tax advantages for doing so. In effect, employees are paying for their own health insurance.

In the real world, there's not enough taxpayer willingness to finance generous coverage for all, so compromises and limits of some type are needed. So I'm going to assume, at least for the moment, that mandates—either individual mandates, which I actually proposed more than 10 years ago, or employer mandates—are off the table. And I'm also going to assume—although this assumption is more

Table 2.1
Percentage of Those without any Health Insurance by Family Poverty Level
Age 0-64 without Medicare coverage (N=115,474)

Family Income Level (Percent of poverty level)	Percent of the Uninsured	
Under 100%	25.1%	} 32.6%
100 to 124%	7.5%	
125 to 149%	8.1%	} 39.9%
150 to 174%	7.5%	
175 to 199%	6.0%	
200 to 249%	10.4%	
250 to 299%	7.9%	
300 to 399%	10.0%	} 27.6%
400 to 499%	6.5%	
500% and over	11.1%	
Total	100.0%	

Note: Using post-1996 CPS health insurance variables and appropriate CPS March Supplement weights to reflect national population. Data set is CPS March Supplement for 2000, reflecting coverage in 1999.

Table 2.2
Any Private or Employment-Based Health Insurance by Family Poverty Level, 1999
 Age 0-64 without Medicare coverage (N=115,474)
 Percent of those in poverty category

Family Income Level (Percent of poverty level)	Percent with Some Private or Employment-Based Health Insurance
Under 100%	26.3%
100 to 124%	45.7%
125 to 149%	51.8%
150 to 174%	58.0%
175 to 199%	66.2%
200 to 249%	73.2%
250 to 299%	80.1%
300 to 399%	85.8%
400 to 499%	89.1%
500% and over	92.4%
Total	74.2%

Note: Using post-1996 CPS health insurance variables and appropriate CPS March Supplement weights to reflect national population. Data set is CPS March Supplement for 2000, reflecting coverage in 1999. Any private or employment-based insurance is defined as employment-based or individually purchased coverage, as a policyholder or a dependent, and includes CHAMPUS, CHAMPVA, VA, and military health care.

debatable—that price controls, including controls on insurance premiums, are also off the table.

What about refundable tax credits? If “voucher” weren’t a dirty word because of the political debate about education vouchers, we would call these credits “vouchers” because that’s what they are. My vision is that every eligible person would get a coupon in the mail that would say, “This coupon good for \$1,500 off your next health insurance policy,” and then maybe add a free Coca-Cola, just to provide you with incentives to come in to redeem it. That’s the form they would take.

These vouchers are also advanceable; that way, you don’t have to front your share of the money. If you were a worker, you could turn your voucher over to your employer, effectively offsetting what otherwise would have been withholding tax. Thus, your take-home pay would rise by enough for you to get the money for your share.

These vouchers are also checkable. One of the useful insights of the Bush Administration’s plan is that it says, in effect, let’s not sweat the small stuff here. If we want to offer these vouchers not to all Americans, because we can’t afford that, but to a target set, let’s base their eligibility on their last year’s taxable income, which we know for sure, and if they hit the lottery this year, we’re not going to take their vouchers away; we’ll get them later. That’s what I mean by checkable and advanceable.

What credits do is to make insurance more affordable. These tweeners can afford

to pay something for insurance; we know that because they do. But they can't always pay enough to cover the full cost of policies that might be made available to them. To use the rope metaphor, we're going to throw them some rope down in the hole, and they've got some rope down there already, and we have to tie the two pieces together, and then we can pull them all up.

In addition to the problem of affordability, which is part of the reason why the uninsured are not insured, a fair number of people are uninsured not because they can't afford insurance, but because insurance looks like a bad deal to them. That's especially true of young people. But if you have a tax credit that is meaningful, like a 90 percent credit or a 50 percent credit, insurance would look like a better deal. My 24-year-old son, for example, might be willing to pay for it out of his starting income. That's what I mean: the almost-immortals could actually be induced to buy insurance.

One of the problems with the market that most of these credits would have to be used in—the fairly yucky individual insurance market—is adverse selection. Because individual insurance is costly and relatively unattractive, insurers worry that buyers know something that sellers don't—such as “This is the year we're going to have a baby,” or “This is the year I'm planning to get my knee fixed.” If you armed 41 million people with \$1,500 vouchers, insurers would be much more likely to believe that the people who were showing up looking for insurance are reasonably healthy people, rather than people who know something the insurer doesn't. It should greatly reduce the problem with adverse selection and the behavior known as medical underwriting. There's no point to costly medical underwriting if you have mostly healthy people coming.

Tax credits raise a number of design issues. For example, you must decide, within a constrained budget, what will be covered and what you'll have to wait for. One of the trade-offs in design is that you can design a tax credit plan that would get the maximum number of heads covered (maybe not perfectly), or you can design a tax credit that will cover fewer people but in some ways more generously. That decision will be up to the representatives of the public to make.

If you wanted to get the maximum number of people covered, one way to do it for a given budget, assuming you've decided already how much is going to be spent on this, is to make the credit a fixed dollar amount—like \$1,000. (My proposal actually would be more like \$1,500 for an individual policy.) That would mean that the credit is virtually equal to the premium for young people for an individual insurance policy that's not too shabby—maybe \$1,000 deductible. In some states \$1500 is equal to the full premium. We can actually make free insurance available to the MTV generation for that kind of money. And since this group is the most likely of any age group to be uninsured, we could get a lot of people covered.

Another way to make it more likely that people will use their credit to get covered is to put relatively few restrictions on the kinds of policies that are eligible. The holder of the credit may load up the policies with things that sound reasonable—mental health coverage, substance abuse coverage, podiatric services—but eventually will likely decide it's not worth the extra money.

While I don't favor medical savings accounts for myself, a lot of people may like them. So they, too, should be eligible for the use of this credit. Then we can let the different forms of insurance duke it out.

Finally, it's important that the credit could be used for either private or public insurance. So a state Medicaid program or the program for state employees could make an offering to the people who use the credits and allow people to choose whether they'd rather have their insurance produced by the public sector or the private sector. Some people trust the government, and some people trust the market. We don't really have to fight that ideological war if we let the credit be used either way. Those who want to go with the post office of health insurance can, and those who prefer FedEx can do that as well.

You can, of course, make some trade-offs. For a given budget you can cover fewer people but feel better about those you do cover if you require the benefits to be more generous. Fewer people will take them up, but they will pay for more things—that's a trade-off. The further up the income distribution you extend the subsidy, the fewer low-income people you will cover. And this is the headache topic of tax credits and of health insurance: what about people who are at higher levels of risk? It is possible to design a credit that's more generous for higher-risk-level people to cover them, but of course that will use up more of the budget than if you covered lower-risk people. Those are your trade-offs.

The punch line here is this: the tax credit is a supremely flexible instrument. Let me suggest what might be a reasonable policy. Think of a policy that has four income steps. For people below 125 percent of the poverty line, let the credit be 90 percent of the cost of coverage up to \$2,500. That should allow most people to buy a pretty generous policy, at least for now.

For the low tweeners, by which I mean 125 percent to 200 percent of the poverty line, the target could be a \$1,500 credit. That would be about 75 percent of the cost of a not-too-shabby policy, by which I mean one with somewhere between a \$500 and \$1,000 deductible. The high tweeners ought to get a credit of around \$1,000 or a little less. And then, just so everybody gets something out of this deal, I'd make a credit available to everybody else of about \$500 to \$750. That's about equal to the value of the exclusion of a person at 300 percent of the poverty line.

Another important feature of the design as I would favor it is that you could use the credit for group coverage as well as individual coverage. If you used it for group coverage, effectively you wouldn't be eligible for the current tax exclusion. You'd have to pay taxes on your benefits, but you would have the credit to offset that—and \$750 is about equal to the amount of the tax exclusion. I would imagine most higher-income people would stick with the tax exclusion, but at least the self-employed among them or the non-employed, the people who get income from capital, would have the credit available to them. That would be fairer and more efficient than biasing subsidies to favor either group insurance or individual insurance.

What about dealing with risk variation? The complicated but ideal way to do it

would be to vary the credit with risk. Insurers have to figure out who's the high risk, so that information is generated in part of the underwriting process. If I have evidence that insurers want to charge me 150 percent of average because I have a chronic condition, the dispenser of the credit could give me a higher credit, or, as an approximation, because it already exists, high-risk pools may be able to deal with that.

You can also vary the credit with geography because without a doubt \$1,000 goes a lot further in Idaho than it does in New York City. To deal with income variation, you would vary the credit with income. Again, that makes it more complicated than just a flat credit for every American, which has some merit. You could inflate the credit with medical costs so it keeps up with cost. And then—and here I'm thinking more of the marketing side of it—you could create a kind of GEICO or subsidized health insurance. People may know what the acronym stands for—it was Government Employees Insurance Company—and the original idea was to target a set of people who were relatively low-risk, relatively stable people with good reason to want to buy auto insurance. The same story would be true for the individuals armed with tax credits.

If we can have 41 million people armed with \$1,500 tax credits, I believe that insurers will find them. This stuff could sell itself to a large fraction of the target population, instead of the scandal that we had with Medicaid, where up to a third of the people eligible for Medicaid don't even want to go through the bureaucratic hassle of applying for it, and of course the even worse scandal that about a third or more of the people below the poverty line are not categorically eligible for Medicaid.

Some final thoughts on this subject. The president's heart is in the right place on this, I think, but the amount of spending proposed is certainly well below the kind of credit that would be needed. That credit is going to cost a lot more than \$41 billion spread over seven years. But there's a way to think about that, and we'll try this out on the Treasury. Instead of viewing tax credits as expenditures, view them as tax cuts. They are tax cuts. They reduce a person's taxes, and they are in effect saying, "You lower-middle income people, we're going to give all of you tax cuts as long as you're responsible in your behavior"—meaning you get health insurance for yourself and your families. If you don't bother to get health insurance, you're not entitled to the tax credit, but if you are willing to get health insurance, we'll give you the tax cut. Since I tend to favor lower-middle income tax cuts, this seems to be a way to get three for the price of one: stimulate the economy, change the equity of the tax system, and reduce the number of uninsured.

As I think everybody knows, a couple of weeks ago we had Cover the Uninsured Week. I was upset about that because it tended to portray the uninsured as miserable people, and that's why we ought to help them. I personally believe that, but my impression is that that hasn't had much resonance with the American public. My thought—and it's certainly true when you look at the tweeners—is that most of the uninsured are not actually miserable, because most of them didn't get sick and so they saved paying for that exorbitantly expensive individual health insurance. They're

preoccupied with the other things in life, so they need help to draw their attention to the importance of insurance. They need help to deal with the fact that for some of them, especially the young ones, insurance is actually overpriced relative to what they can expect to get.

Finally, when we design these things at the beginning, we can't require perfection. My strategy is to get some kind of tax credit plan out there. It can always be adjusted later on. If the credits are too low, we can raise them. If they're too generous, we can cut them. If risk selection turns out to be a more serious problem, we can deal with it. But let's get something going!

Presentation

by Ruben King-Shaw

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It's important that you hear where we begin philosophically, and it's probably not where you would think. As a Republican administration we often get tagged as people who don't care about the little guy, which is the farthest thing from the truth. We really do focus on the nexus between the uninsured, the individual, and the larger economy in some ways that perhaps you're not used to hearing us say. It's not just a clinical issue. People in the clinical world often will say that the important thing about health insurance is that it provides the financing for health care. I would submit to you that it's much more than that.

People who are not connected to the health care finance and delivery system tend to have negative clinical outcomes—that's a fact. These are people who are typically not benefiting from continuity of care, and they're not benefiting from screening, prevention, wellness, and health education. They're not getting early intervention in health care services, so that by the time they do present in a health care setting—typically the emergency room—their acuity levels are much higher.

If you look at the clinical outcomes of test scores, by almost any standard, the health problems of those people without insurance who experience illness tend to be more severe and acute because they lack the relationship with the health care system and with a provider that would more easily, more reasonably, and more effectively allow their illnesses to be addressed. So there are some very real, clinical reasons why a relationship between an individual and a family and the health care finance and delivery system is important.

But the health care issue goes beyond an individual's health. Look at the effect of the uninsured population on the economics of the individual, the industry, and the employer. People tend to gloss over the fact that many people, because they lack health insurance, are exposed to financial catastrophe within their own household. A major reason for bankruptcy, homelessness, and a number of other things, is the lack of a health insurance benefit to guard against the financial distress that comes from a sudden, unexpected, unfinanced experience of significant illness. We don't talk enough about that, but it's a fact.

At the same time, if we're trying to stimulate growth in investment on the part of individual households, and if these households feel the need to reserve for medical expenses because they don't have adequate health insurance, the need for health care works against the very behavior that we're trying to promote: savings, spending, and investment. It becomes a drag on personal income. We don't talk about that enough, either.

If you look at the industry itself, one of the major factors going on right now is that the cost of health care is crowding out profit margins in small, medium, and large corporations. Increasingly, firms are deciding not to provide health care coverage because it's a competing expense toward investment and savings and growth and employment and higher wages—all the things that our economic package is trying to do, and all the things that we want to strengthen in the American economy. If you're competing in international trade and commerce, you're put at a distinct disadvantage when you're competing against goods and services from overseas, where the cost of health care services is not a cost of goods sold.

In increasing numbers, employers who used to provide health insurance coverage are no longer providing it. The conventional wisdom is that they will come back as the economy rebounds, but we're skeptical that as many will come back as used to in the past. Therefore, what we have is not a cyclical problem but a structural problem in the relationship between the individual health insurance market and the employers.

A good example of this can be seen in the consequences of the consolidation of big steel across the country. Steel industry retirees represent an enormous health care expense to the large steel manufacturers around the country. One of the big barriers of that consolidation to strengthen the steel industry was the question of who would carry the cost of retiree health care benefits. One of the reasons why the health coverage tax credit was attached to the Trade Adjustment Act is our understanding, perhaps for the first time, of the link between international trade, consolidation and competitive forces in the economy, and health care expenses for the individual. Also, there is absolutely no question that the productivity of the individual has a great deal to do with the health of the individual.

Every uninsured person not only creates a burden for themselves, their families, and the larger economy, but often represents an uncompensated care issue for the desperately challenged health care finance and delivery system itself. If you ask medical professionals and the people who run hospitals, they will tell you that the single largest threat to a viable, robust, strengthened health care finance and delivery system is the growing uninsured population in America.

Typically, the number of uninsured is given as 41.2 million. But if you ask the question, "how many folks have been uninsured over some period of time over the past two years," then the Urban Institute would give you a number of about 76 million people. There are approximately 40 million Medicare beneficiaries. We talk a lot about their needs. There are as many if not more people who are uninsured, and we talk a lot less about their needs. Hence these initiatives that we've launched in Washington to address those issues.

If you look at the landscape of the uninsured—and we'll just talk about the 41 million, not the 76 million—they are everywhere, but particularly in the South and in the West. If you look at who they are, a third are Hispanic-Americans; nearly 20 percent are African-Americans; and Asian-Americans are right behind them. If you ask the question, "who in America is most concerned about the threat of being un-

insured,” it is women of all demographics and all geographies. I ask you, how do you win an election without the South, the Midwest, Hispanics, African-Americans, and women? For this reason, at election time, you’ll hear more about the uninsured than you usually hear.

There are so many reasons for changing the system. But since these are all reasons you would expect, I will highlight just a couple of them for you. We talk a lot about the interaction between the uninsured and Medicaid and SCHIP. We have a couple of facts here. One, states are near bankrupt—the ability for Medicaid and SCHIP to expand, to embrace, to continue to be the first-tier response to the needs of the uninsured is increasingly difficult as states simply don’t have the money. Even with the existing Medicaid populations, most states struggle to provide comprehensive benefits and adequate provider reimbursement rates. When you then ask them to expand that responsibility to include greater numbers of uninsured, the situation gets even more difficult.

We do have HIFA Medicaid waivers (the Health Insurance Flexibility Accounts) that states can enter into, and we’ve done some wonderful things between the Department of Health and Human Services and the states to use primarily Medicaid and SCHIP as a way of covering more of the uninsured. States are in different places in their ability to do that, and increasingly, fewer and fewer states, if any, will be able to do that. States are currently looking to contract their Medicaid programs to deal with the populations that they have. When you throw in the obligation to reimburse physicians and other practitioners for the cost of Medicare/Medicaid patients, the possibility of meeting the need becomes even more dubious.

That’s why we believe that the recently passed legislation authorizing advanced monthly federal tax credits as premium assistance is a viable part of any suite of solutions for the uninsured.

I would point out is that clearly we understand that the advanceable option is a major part of the new legislation. We believe that incentives are a part of the answer and that the tax credit incentive—because we can provide it on time and make it advanceable and nonreconcilable—is a major part of the new program’s success.

Let me give you a brief description of our maiden voyage, if you will, in providing health care tax credits. I’m talking about the 65 percent tax credit health care which was tied to the Trade Adjustment Act. There’s a flat 65 percent tax credit (not 60), and there is no ceiling and no floor. This flat rate is one of the ways we addressed the regional differences in this first voyage—so it’s 65 percent of the rate in New York, Texas, San Diego, Paducah, Kentucky, wherever you might be. While this voyage is slightly different from where we will go in the future, it has many of the things that we already talked about—the advanced payments, for example—and it’s nonreconcilable.

This tax credit is available not just to people who are displaced because of trade legislation. When benefit programs are taken over by the federal Pension Benefit Guarantee Corporation, for example, there will be approximately 500,000 individuals who become immediately eligible. And they live in places you might expect—they

live in Pennsylvania, New York, and the state of Maryland because of Bethlehem Steel. If you haven't followed the Bethlehem Steel story, I'd like to point out that it illustrates what happens to people when big industrial complexes have to consolidate.

This situation can also be found in Maine, where people are suffering from international competition to Hathaway Shirts and paper. It's a big issue in Florida, because in Florida they have a number of Pension Benefit Guarantee retiree folks that are a major part of their economy. So you see the populations that we've started with and why they are important. They have a number of characteristics that we think are very telling: you have elders, you have workers, you have pre-retirement populations, you have rural and urban, and you have industrial fallout.

One of the important things to keep in mind is that this new program offers wide variety in the options that qualify for the tax credit. The tax credit is not specifically targeted toward the individual market because in most states, that market isn't robust. But with the number of individuals in that market and the product offerings you will build a more cost-effective, more appropriate individual market. That is one of the options. It is not necessarily the objective. States can deliver a number of options that would qualify for the tax credit, which would include some standard ones that the statute said automatically applies for the credit.

Any other arrangement that the state enters into with an insurer would also count if it has four patient protections listed—the guaranteed issue, the preexisting condition issue, the nondiscrimination of premium, and the same benefits—which means that self-directed care models, as long as they fit those criteria, qualify. Group plans qualify. State purchasing plans qualify. High-risk pools qualify. Any arrangement between the state and an insurer qualifies as long as it observes those four criteria.

The conceptual model behind this program requires working with state agencies and the federal government to identify the individuals and the groups who qualify for this benefit and building an infrastructure that enables us to deliver to the insurer, once the state picks one, 100 percent of the premium. The way it works is that we deliver 65 percent of the tax credit to an intermediary while the individual sends a check or a bank draft for 35 percent to that intermediary. Then the intermediary directs 100 percent of the premium to the insurer. It's not as easy as it sounds, but that's the basic concept that we're working on here.

Our next proposal is an \$89 billion initiative to take the next phase of health care tax credits forward. This initiative calls for the options of paying a monthly advanceable option where individuals can get their tax credits every month in advance, with the matching directed to the insurer. Or they can pay 100 percent of the premium and at the end of the year, file for the tax credit. Individuals have both those options under the current health coverage tax credit program with the Trade Adjustment Act, and we'll have these same options going forward should Congress agree with our proposals.

Our proposal for the next phase includes an option for states to elect to include/buy-in/attach the public/Medicaid/SCHIP sector as a viable option for the tax credit. In the end, we don't have to have a philosophical debate about public versus private

mechanisms. States can choose to do either or both, and our resources and commitment remain the same.

But in the meantime, the voucher we're proposing would provide up to a 90 percent subsidy, indexed toward income, so it phases out at up to \$60,000 for a family of four. For example, at the modified adjusted gross income of \$15,000, you have a maximum credit of \$1,000. Some people ask, "What does that buy you in New York versus what that buys you in Peoria?" That is an issue—and there's a lot of academic discussion back and forth about how many individuals you can add to the system with \$1,000 incentive. The elasticity of demand—the price sensitivity of health insurance to influence behavior—is something that we'll test because there are differences of opinion on how much of an incentive you need for someone who would otherwise not buy insurance to buy insurance.

The uninsured issue is not only a social issue, it's also an economic and political issue, and, increasingly, a cultural issue. It's also an issue of credibility and character. When we talk about fueling the economy, when we talk about liberty and justice for all, and we do not talk about access to health care services, we are not living up to our promise. If we're going to talk about the ability of our nation to mobilize its resources in creative ways to harness private markets as well as to support public initiatives, then I think we need to get serious about insuring the uninsured.

Chapter 3

Public Program Expansions

Another approach for covering the uninsured involves expanding eligibility for existing public health insurance programs to allow more people to qualify for coverage. Medicaid and the State Children’s Health Insurance Program (SCHIP) currently provide an insurance safety net for disabled individuals and low-income children and their families, and Medicare covers nearly all elderly Americans. But adults without children—no matter how poor—generally are not eligible for coverage under these programs.

In their simplest form, public program expansions would extend existing program benefits to a larger population. The income eligibility cutoff for newly expanded programs could vary depending on budgetary constraints or other considerations, as could the comprehensiveness of benefits, required premium amounts, and required level of cost-sharing. While proponents argue that public expansions would efficiently target the low-income uninsured and minimize administrative costs by utilizing existing program infrastructure, opponents have a number of concerns. These include the overall cost to federal and state governments and the possibility of “crowd-out,” which occurs when people who have access to health insurance from a private source (such as their employers or family members’ employers) instead choose to obtain public coverage when offered, because it is cheaper or offers a better package of benefits.

This chapter includes a perspective on this issue from Judy Feder, Dean of the Public Policy School at Georgetown University. Dr. Feder is a nationally respected figure in health care policy, and her expertise on the uninsured, Medicare, Medicaid, and long-term care is regularly drawn upon by members of Congress, executive branch officials, and the national media. For further information on public program expansion, see the three papers in Chapter 9.

Presentation

by Judy Feder

Dean of Policy Studies

Georgetown University

When you look at insurance expansion proposals, the questions you have to ask are: (1) Will these proposals or proposed actions reach the uninsured? If so, who among the uninsured will they reach? (2) Will the proposed action provide them meaningful insurance, that is, benefits that actually assure access to care, that being the purpose of insurance? (3) Will the proposed action strengthen or weaken the insurance that we currently have in the system?

Unless we're proposing to change the entire system, we have to look at two kinds of impacts on coverage. The first is the impact on coverage that most of us under age 65 (the working-age population) rely on, coverage that comes through the employer-based system. Despite its significant inequities—it reaches the better-off better than it reaches the less-well-off—it does provide a mechanism for bringing people together, regardless of health status, and, to some extent, regardless of income, in the same insurance pool. As a result, it reduces selection problems, where the healthy get insurance and the sick don't. So we have to watch what a proposal does to that mechanism. The second impact on coverage we have to watch is the impact on existing public coverage, mostly Medicaid, which is also quite successful in providing meaningful coverage for a substantial portion of our low-income population.

When you ask these questions, you have to take into consideration a political environment with constraints, in which the dollars for social programs are not as plentiful as some believe they ought to be, and in which the most widely advocated policy initiatives tend to undermine rather than secure our current insurance safety net. In that environment, I focus on targeting any new dollars to extend the existing insurance safety net to the population whom I believe is the most deserving of support—that being not the “tweeners” but the lowest income population, who are least able to obtain health insurance with their own resources.

Let me describe what I'd change in order to achieve that objective and then contrast it to the tax credit alternative in terms of whom it reaches among the uninsured, the effectiveness of the insurance that it provides in ensuring access to care, and its success in avoiding harm to the bulk of the system.

Before I focus on what I'd change, let me remind you of what Medicaid is and how successful it's been—a story that's not sufficiently often told. Medicaid provides a full subsidy for the full cost of a full range of care to the population whom it makes eligible. Now, I don't want to tell you that I think Medicaid is perfect, or that it's not buying health care on the cheap. But I do want to tell you about the evidence of its success. The evidence tells us, first of all, that a full subsidy for the full cost of care

for low-income people is necessary to enable those people to take advantage of what subsidies are offered. If they have to add dollars by paying premiums, the evidence tells us that their participation rate falls off. If they have to buy it and they have very limited incomes, they tend not to buy it. Medicaid, by providing a full subsidy, enhances participation.

Experience also tells us that when we administer Medicaid programs in a way that facilitates rather than erects barriers to participation, that we are extremely successful in getting people to take advantage of subsidies. What we find is that when we administer the program in ways that make people want to come in and make it easy to apply, as we've been doing in particular in the administration of the State Children's Health Insurance Program in recent years, we get tremendous participation. When we look back to the late 1980s and early 1990s when we made major expansions of Medicaid for mothers and kids, in a period of three years we went from 19 million people on Medicaid to 27 million people, immediately generating concerns that we had too much, not too little, participation. We can achieve participation if indeed we want it.

Another thing that we've learned from the Medicaid experience is the value of covering the full cost of the full range of services that people need. For example, we have a public program that provides examinations regarding breast cancer, but no treatment. One might say, you're still better off knowing than not knowing—but not well enough off, from my perspective. If you're going to guarantee meaningful insurance for people, it need to provide appropriate health care when they need it, whether it's in the early stages of diagnosis and prevention or the later stages of treatment.

We know from experience with Medicaid, whatever its difficulties, that if we look at the use of services by people with Medicaid relative to the uninsured, in most cases they are using services more like the insured population than like the uninsured population. We know Medicaid in general is achieving access. We also know the way federal dollars flow with Medicaid—they flow with the need for care. The dollars follow the people.

We have tremendous concern right now about states' ability to meet the demands on the Medicaid program, given the recession's increase in the number of people whose incomes have declined and who need help from public programs. Although the states are having trouble coming up with their share, the federal dollars in Medicaid, or the federal guarantee, is to match what states spend. The federal guarantee gives states the ability to spend more money to deal with a larger eligible population. The dollars flow with the people, so that we have a steady stream of funds to match needs.

Could Medicaid do better? Sure it could. We could pay providers better, we could make access more uniform across states, and we could assure more federal dollars to alleviate the pressures that the states are facing. Is it a mechanism that works for low-income people? Absolutely. It's designed to meet their needs, and we know from experience that it can work.

What's the limitation on Medicaid that I most want to fix? Medicaid is available under federal law to only some of the low-income population. We do best by our kids, which is a good thing. With Medicaid, with the addition of the money from the State Children's Health Insurance Program, now, in most states, we are reaching children with incomes up twice the poverty level and higher with health insurance. But we do much less well by the parents who are eligible under Medicaid (except for pregnant women, where we do pretty well). The eligibility standards in most states—the incomes you have to have—are so low that people earning the minimum wage are too rich to be eligible for Medicaid. So we don't do very well by the parents, and we don't do well at all by adults who are not parents of dependent children, and who constitute the bulk of the low-income uninsured. Federal law does not make those people eligible for federal matching dollars under Medicaid. This situation is a vestige of our welfare system, which focused on what might be called "the deserving poor." Working-age adults, no matter how low their incomes, are not considered in our policies to be "deserving poor."

That's what I'd fix. My priority would be to change those rules in Medicaid, get rid of what are called "categories" of eligible people, and make all low-income people eligible for a Medicaid system. In doing that, I would rely very heavily on federal dollars because as long as we rely on states' willingness and ability to match, we are going to have variations across states in the level of coverage. I believe we ought to have a national safety net—below a certain level of income, the federal government ought to pick up the tab. I would not only apply that rule to expand the safety net, but I would also put in more federal money for the safety net we already have so that we're not at risk of losing it, as we are today.

Let me contrast this approach to the tax credit approach. First, it's important to remember that a tax credit, like Medicaid, is a subsidy. But unlike Medicaid, the way in which this subsidy is being provided doesn't jibe very well with the circumstances of low-income people. In fact, tax credits as proposed by the Bush administration are aiming higher up the income scale.

Tax credits tend to be advocated as a government hands-off policy—putting the subsidy out there for individuals to take advantage of so they can shop for and find insurance themselves. It is appealing that people don't have to go to a government agency to be found eligible, and are enabled to make their own choices. No bureaucracy and lots of choice are very appealing to a lot of people. The problem is that, in order for this system of tax credits to work, we would have to modify both the tax system and the insurance system in significant ways that really challenge the hypothesis that you can do this hands-off.

First, on the tax side, what we hear described is what I call a refundable, advanceable, unreconcilable tax credit. It's not enough just to offer the money; you've got to give the money to people in advance so that they can go buy health insurance, you've got to give it as a refund to people who don't have tax liabilities (we do that in other areas, but it's a departure from the bulk of our tax system), and you have to accept

that if income changes, you're not going to take the tax credit back because otherwise people will be afraid that they'll lose it, as indeed some of them are under the Earned Income Tax Credit. To make the tax credit system work, you'd have to transform the tax system into something it's not. That's not impossible to do—but it would require a lot of changes.

The second issue has to do with how you get insurance. Where do you shop with this tax credit? As has been pointed out, we've got a "yucky" market for people shopping for non-group health insurance. We know that the benefits are lousy, that people who are older or have health conditions can't get it, or have to pay more, or have to get insurance that doesn't cover the very health conditions for which they are most likely to need coverage. So we have high cost-sharing (low-income individuals don't use services when they have high cost-sharing), lousy benefits, and some people who can't get it at all.

How much coverage, what kind of coverage, and who can buy coverage with this \$1,000 or \$1,500 tax credit that the administration is proposing? Is this coverage for the full cost of services? Is it a full subsidy? No, it's not. It may be enough for the youngest, healthiest individuals to buy health insurance, and I think that's great. I think everybody should have health insurance. But don't you think it ought to be enough for people for whom insurance is going to be more expensive because they need health care? Those people who are now likely to need health care (myself among them) would not be able to buy it without adding substantial dollars that low- and even modest-income people don't have.

Could we fix that by adding more money to the system? We could, but here there's another concern: watch what it does to the system we already have. Tax credits run the risk of disrupting both existing employer coverage and existing public coverage. The availability of tax benefits outside of employment is likely to lead some employers who want out of this market to stop offering coverage and essentially say that their employees can get coverage somewhere else. So we've actually uninsured some people in that process, not all of whom are likely to take advantage of the tax credit. In addition, it runs the risk of undermining our existing public program. States, who are struggling with Medicaid, will look at the availability of new federal dollars and say, "Ah-ha! Another way to get healthcare, so we can just pull back our public coverage." But the coverage is very different, and the people who get it will be very different. So tax credits pose real risks to the existing system.

I would take the tax credit subsidy and design it so it would be refundable, and advanceable, would not be reconciled over the year, and would guarantee you the full cost and range of benefits. But, if you claim you're going to do this hands-off and don't put your hands on, you're going to have a mess. And if you've got to put your hands on anyway, then for heaven's sake, we already have an advanceable, full cost, full range of benefits system. That is the Medicaid program. Let's put our money there and let it work for all low-income Americans.

Chapter 4

Employer-Based Approach

Employer-based health insurance is currently the foundation of insurance coverage for nonelderly Americans. Whether to expand employer-based coverage to uninsured employed individuals is a heavily debated topic. While some point to signals of decline in employer-based coverage as a sign of the eventual erosion of job-based health insurance, others believe that the best way to expand access to insurance is by strengthening and expanding this form of insurance. Strategies for expanding employer-based insurance include employer mandates (requiring employers to offer health insurance to their employees), which may be combined with tax incentives, purchasing pools for small employers, and/or health savings accounts.

This chapter includes a perspective on this issue from Cathy Schoen, Vice President of Health Policy Research and Evaluation, with the Commonwealth Fund. The proposal she refers to in her presentation is explained more fully in the article in Chapter 10 entitled “Creating Consensus on Coverage Choices” by Karen Davis and Cathy Schoen. The approach outlined in this paper proposes a *consensus framework* that aims to expand both the public and private sectors of the current system. The authors offer concrete suggestions for integrating expanded public programs with stimuli for expanding employer-based schemes in the form of tax credits for private insurance carriers.

In line with much of their work in the area of health care delivery policy, Schoen and Davis introduce significant mechanisms to expand employer-based coverage, not just for the uninsured, but also for the “insecurely insured.” On the one hand, previous employers would offer extended coverage for two additional months to employees transitioning between jobs, and on the other, proposed subsidies to the COBRA program would increase the number of participants in that program. Employers would also extend coverage to dependent young adults regardless of their educational status, and finally, employers who do not currently help finance coverage for their workers would be required to contribute 5 percent of payroll to the Congressional Health Plan in a “play or pay” system. A key component of their recommendations is the creation of this Congressional Health Plan (CHP), modeled after the Federal

Employees Health Benefits Program (FEHBP), which would extend affordable coverage to small businesses, the self-employed, and those who have been uninsured for over six months and are without group coverage.

Significant expansion of existing public programs, including Medicare and the State Children's Health Insurance Program (SCHIP), is an important part of the plan. Adding a proposed new Medicare "Part E" would reduce adverse risk selection in the CHP by extending coverage to dependents of key vulnerable groups, including dependents of current beneficiaries, as well as the disabled and adults aged 60 or over without access to group coverage. Expanding the current state-administered SCHIP to low-income families under a program called FHIP (Family Health Insurance Program) would make coverage both affordable and automatic for families who file tax returns and meet eligibility requirements.

Presentation

by Cathy Schoen

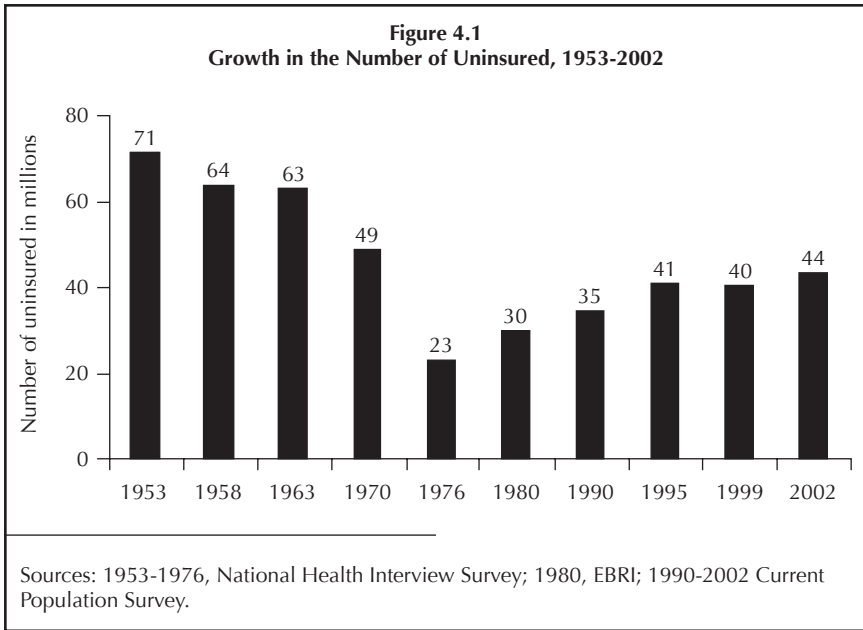
*Vice President for Health Research and Evaluation
The Commonwealth Fund*

As we enter the first decade of the 21st century, the security and future of health insurance for the under-65 population is in question. The number uninsured jumped up by 4 million from 2000 to 2002 reaching 44 million uninsured in one year, with over 80 million uninsured at some time over a two-year period.¹ Among those with insurance, millions more face difficulties or worry about their future as changes at the workplace leave them paying a higher share of premiums or medical bills or worrying about what will happen if they become sick or lose or change jobs with any time unemployed.

My remarks today focus on the erosion of coverage and policy options that could build a more secure foundation in the future. To underscore the need to reach consensus to move forward, I want to talk not just about the uninsured, but also the under-insured, insecurely (or unstably) insured, and the worried insured, including small businesses and most of us in the current recession. Will coverage be there for us? How do we hold onto it? With 44 million uninsured at the latest count and double that number losing coverage due to insurance churning, with often repeated times uninsured, our insurance systems clearly aren't working well for many people.² At today's forum, we have an opportunity to talk about solutions that could work for the long run, especially if we think of building blocks that could get us there. Even if we approach expansions incrementally, it's important to have a vision of where we are going.

In considering ways to improve insurance coverage, it is important to remind ourselves that in the U.S., as in countries world-wide, the formation of stable groups has provided the essential foundation for health insurance. Although a limited market existed for individual health insurance starting in the 1950s and continues today, we only achieved more widespread coverage with the onset of group coverage in the late 1950s and 1960s, through enactment of Medicare and spread of employer-based group coverage (see Figure 4.1).

The big drop in the number of people and proportion of the population uninsured occurred with Medicare and the rollout of employer group coverage. Despite numerous efforts by states and the federal government over decades to try to improve markets for individual health insurance, the dynamics of health insurance works poorly when sold on a single-person basis with each person tailoring the package to what they want or their expected health care risks and insurance plans trying to avoid taking risks that would exceed risk allowances built into premiums. For the under-65 working population, the advent of employer coverage with groups formed on a basis



other than health to pool risks for coverage, plus near-automatic enrollment, enabled widespread coverage by providing a viable foundation for health insurance group sales. The simplicity of signing up and near-automatic enrollment feature has been particularly key to job-based coverage survival and popularity. When you think about your own employer coverage, you don't have to do much to get it if you get it at your job. You sign up for a job, you get your coverage, and it just continues year after year, so it's there as a secure safety net and benefit. That's what group coverage has been.³

In contrast, the incremental public expansion steps we've been taking since then to fill in the holes left by job-based coverage have failed to get us to the point of easy access to insurance, much less automatic coverage of everyone. The percent uninsured varies a lot by states and state incremental efforts have made a difference. Yet there remains almost a direct correlation between states with a lower employer-based coverage and states with higher uninsured rates. Moreover, even in states with extensive efforts to expand public programs incrementally, too often narrow eligibility criteria and efforts to target coverage narrowly increase administrative costs and complexity and end up failing to reach those eligible to participate.⁴ Programs rules often fuel instability: even minor changes in circumstances—an increase in wages or hours worked, getting pregnant or giving birth, growing a year older—can result in loss of eligibility with no link to a new source of coverage.

Higher uninsured rates and insurance churning result in a range of negative consequences for personal health and financial security, the health care system and the

economy. One consequence that we don't talk enough about is what high uninsured rates do to the workforce, especially the low-wage workforce, not only because the uninsured are vulnerable to having their savings wiped out but also because lack of access to timely health care lowers productivity and increases stress. Inadequate health insurance coverage is the sixth leading cause of death, according to the Institute of Medicine. There are real health consequences of being even sporadically uninsured.⁵

We also tend to undercount the uninsured because they constitute a dynamic population—people move in and out of coverage. Based on recent federal surveys that track coverage over time, the number of people during the course of any one year who are uninsured for at least some time reached 62 million in 2000; over two years, the national estimate of people uninsured was 75 million from 2001-2002, a time of generally tight labor markets and economic growth. This rose to 81 million uninsured during 2002-2003 as the economy weakened and health premiums started once again to rise at double-digit rates.⁶ Those with unstable coverage as well as the long-term uninsured are at risk for barriers to medical care when needed and the financial stress brought on by medical bills without the protection of health insurance.⁷

Unstable coverage and insurance churning has consequences beyond the personal risk to the uninsured. One of the effects of all this churning is to raise insurance costs in the United States. We have by far the most expensive health insurance in the world. If you look underneath these costs, you'll find high and rising costs for the administrative overhead of running a very complicated system with persistent entry and exit.⁸ You sign people up, you lose them, there's a set of paperwork, everybody has a different set of paperwork, employers change plans—and these are just the costs to the insurer. Public programs similarly incur entry and exit costs as well as overhead costs of enforcing complex eligibility rules. These costs proliferate in physician and hospitals as providers seek to track insurance and bill for patient care. Although the broader effects of churning and the complexity of insurance system are often not counted as insurance costs, a visit to the billing departments of doctors or hospitals offers visible testimony to the consequences.

As we examine policy options for the future, it is important to focus on the characteristics of the uninsured and unstably insured. Both populations are predominately low-income adults—adults with incomes below poverty and near poverty, in the up to 200 percent poverty range. In this income range, affordability of premiums and of the benefit package is a key concern. We know a fair amount about trying to reach and insure this population—what has worked and what hasn't worked. One of the things we know that hasn't worked is designing programs that fail to reach low wage workers by setting income standards too low, excluding adults without children, or ending with even modest fluctuations of income or circumstances. In most states, for poor and near-poor adults it is very hard to qualify or to stay on current public programs even if working part-time at minimum wage. With a few exceptions, childless adults, no matter how poor, are not covered and working adults with children would typically have incomes too high to qualify.

We've done better with poor and near-poor children thanks to SCHIP. But even here, we spend substantial resources getting people in, yet continue administrative hurdles to staying on and even small changes in income and circumstances can push you off. As an illustration of the challenge of keeping low income families people covered, Leighton Ku of the Center on Budget and Policy Priorities did a study for the Commonwealth Fund on what would happen if we took low-income adults or children who were insured at the beginning of the year and kept them insured all year. What you get is a 40 percent reduction in the rate of uninsured for the lowest-income children and 28 percent for adults—just by keeping them covered throughout the year. As yet, however, we don't have good mechanisms to keep people connected.

By definition, those with incomes at or near poverty have little or discretionary income and must stretch to pay even basic living costs, before any allowance for advance payments for insurance in the event of illness. States have experimented with trying to expand to the “tweener” group—the group with income right above poverty level—by charging zero or minimal premiums for those with very low-income and then moving premium shares up for the near-poor. At such low incomes, take-up of coverage is very sensitive to even relatively small increases in monthly rates. A study based on experiences in several states estimated that if the premium gets to be much more than 5 percent of income, participation rates plummet.⁹ Similarly, U.S. Medicaid and Canadian efforts to charge low income patients even very modest co-payments for drugs find that patients with very low incomes often postpone or go without needed and recommended care if confronted with out-of-pocket expenses for co-payments or deductibles.

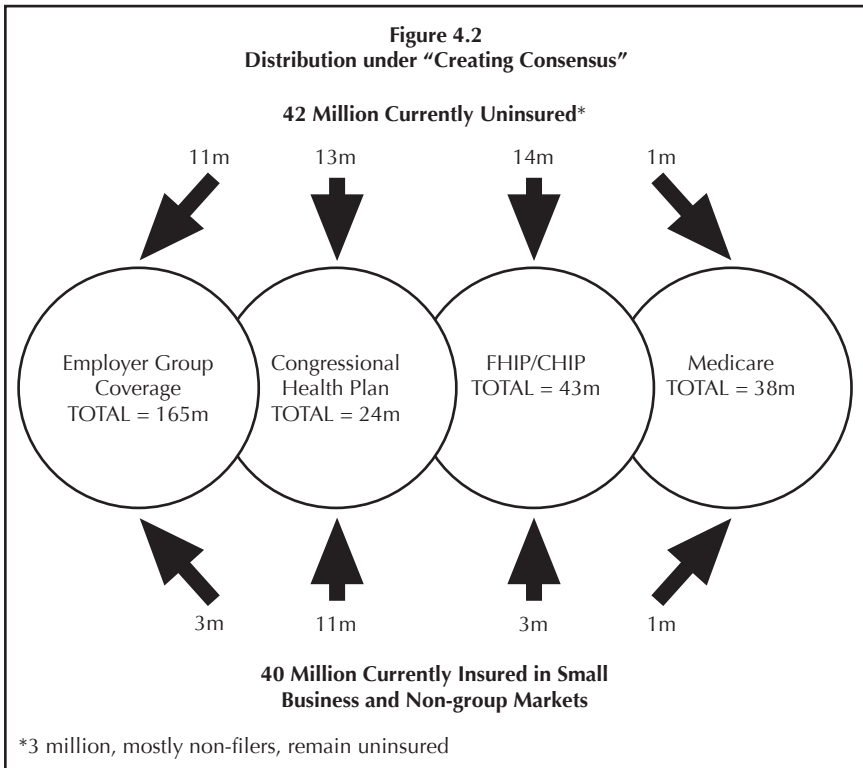
The private sector experience of high take up rates and relatively low administrative costs due to near-automatic, job-based, group coverage and public programs experiences indicate that successful efforts to expand and provide a more secure insurance foundation for the future will need to adopt three basic design principles. First, policy options will need to keep entry premiums and cost-sharing low and affordable to attract poor and near-poor families. With family budgets already stretched to cover necessities, insurance will need to be quite comprehensive with premiums low relative to incomes to attract and protect those with incomes at or below 200 percent of poverty.¹⁰ Second, we need to develop new mechanisms that will make coverage more automatic, with smoother transitions between public and private sources of coverage. And third, we need to build on group coverage and avoid the individual health risk screening and negative market dynamics associated with selling coverage one person at a time that have long plagued the market for individual health insurance.

In a recent *Health Affairs* article, Karen Davis and I outlined a framework that follows these design principles. The framework would use automatic enrollment and build on existing public and private group insurance coverage to reach near-universal coverage.¹¹ Distributed as part of the conference materials and reproduced in Chapter 10 of these proceedings, this framework builds on the strengths of existing employer-based and public group coverage through a combination of tax credits coupled with

automatic enrollment, a new public option known as the Congressional Health Plan, and expansion and simplification of existing public insurance programs. The paper also illustrates how such an approach could be phased over time to build towards near-universal coverage.

Expanded Group Insurance: With the goal of providing everyone, regardless of income, with at least one affordable *group* insurance option, the framework would establish a new group plan available at the national level to the uninsured and small businesses and, at the same time, would expand existing public programs (see Figure 4.2)

The Congressional Health Plan could be modeled and linked to the federal employees’ plan that serves members of Congress. This option would be available throughout the country for those without access to the large-group, employer-based market. To ensure benefit package options that could meet low income families’ needs for comprehensive benefits with low or no patient cost-sharing, current Medicaid/SCHIP programs would be expanded to cover all those with incomes below 150 percent of poverty. This expansion would use income to determine eligibility, eliminating other current categorical restrictions and rules that exclude low income adults. Medicare would be expanded by offering coverage to those nearing the age of



Medicare and by eliminating the current two-year waiting period for disabled adults who otherwise qualify for benefits.

Each of these group options would provide a “default” source of coverage for the targeted population. Nationally everyone would have at least one group option for coverage. The framework would retain employer coverage as the mainstay for the group insurance system. Small employers (less than 50) would have the option of participating in the Congressional Health Plan or buying directly from the small group market. All employers would be required to offer insurance that met minimum standards or contribute to national pool towards the premium costs for the Congressional Health Plan.

Tax Credits and Automatic Enrollment

New tax credits, tied to income, would provide funds to help make coverage affordable. The tax system would also provide a vehicle for enrolling people automatically. Tax credits would be available on a sliding scale based on income and based on premiums costs pegged to a default option within the new Congressional Health Plan. By design, this link would assure that tax credits come with a guaranteed insurance source of coverage willing to provide coverage to the uninsured without regarding to age, sex, or health risks. The uninsured with very low incomes (below 150 percent poverty) would automatically be enrolled in expanded public programs with the option of moving to the new Congressional Health Plan. Similarly, those nearing the age of Medicare would be enrolled by default to Medicare with credits helping to pay premiums and the option of opting out to select the Congressional Health Plan.

By using tax credits not just to give people money but also to enroll people automatically into various affordable, default options—with the choice to move—the framework would avoid the cost of outreach and would increase participation levels. By design, the variety of expanded public options would also take on costs and uncertainty insuring higher-health risk individuals. This would provide more secure and affordable coverage for individuals at risk and would help stabilize private health insurance markets.

Surveys have repeatedly found that those who currently have employer-based group coverage like it, value the job employers do selecting plans, and generally prefer this source of coverage to the individual, private market.¹² The design of tax credits and qualifications rules would leave the large group employer-market foundation basically intact with new options for smaller employers.

As illustrated by Figure 4.2, this comprehensive approach would provide four basic building blocks to insure the population. This framework could be enacted with participation either voluntary or mandatory basis. If mandatory, estimates indicate the expansions would cover 39 of the 42 million uninsured in the estimate year; if voluntary (with and opt-out option), 33 million.

Where would the uninsured go? Some would go into employer group coverage; some would go into the new, national group option because they don't have an em-

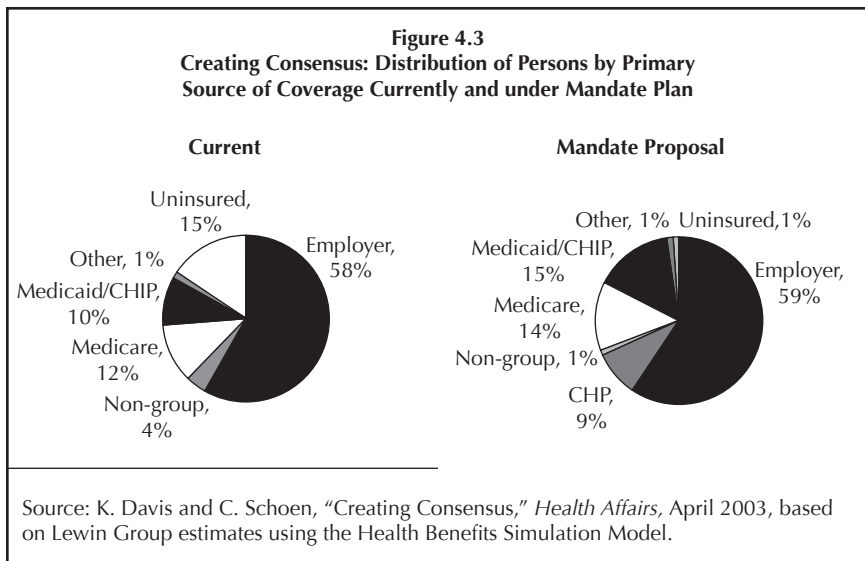
ployer or they're self-employed or they work for small firms; some would go into low-income; and some would go into Medicare (see Figures 4.2 and 4.3).

This combined approach could also address small business and individual concerns by giving them a group option. As it is now, small businesses get less for their money—pay higher or similar premiums for fewer benefits than large employers, and face much less stable premiums.¹³ The new national group insurance option could address these concerns, reduce plan administrative costs, and provide enhanced choice of health plans.

Such a combined approach would minimize disruption of current sources of coverage where these are currently working well. A model simulating likely coverage patterns with all expansions in place estimates that the combination of tax credits, automatic enrollment, and these four sources of coverage could get to near-universal coverage with minimal movement for most of the insured population—see Figure 4.3.

One of the benefits of this type of approach to coverage expansion is that it can be phased in with a vision and road map of how the incremental steps could combine in each phase. Phasing would allow different aspects of the approach to move forward, budgeted year by year in a series of scheduled phases, building the new insurance foundation over time. Alternatively, states, with federal financing, could be used as demonstrations sites for different features, as suggested by a recent report by the Institute of Medicine.¹⁴

Too often the debate on health coverage reform falls short on the question of how to finance reforms and federal budget constraints, without considering revenues lost to past tax decisions or potential longer term health system savings or the benefits to society of improved coverage. Estimates of the net federal costs to finance the



framework in *Creating Consensus* indicate that more than half of the net federal cost of the plan could be offset by repealing the one percentage point reduction in income scheduled for January 2004.

Often in economic expansions, when insurance and job trends are more positive, the pressures for health care reform ease just as resources become more readily available. As public pressures build for national attention to erosion and insecurity of health insurance, a broad spectrum of the public is once again looking for leadership. Opportunities exist to use the momentum for change to move towards a vision of a future insurance system to could build bases that to provide more secure, high-quality, and affordable coverage for the future for the worried insured as well as the uninsured.

Notes

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Chapter 5

Single-Payer System

Proposals for implementing universal health care in the United States have gotten more attention as awareness of the severity of the health care crisis has grown. This chapter contains a commentary by James A. Morone, Professor of Political Science at Brown University and nationally recognized author, entitled “Thinking Big: How to Fix American Health Care.” In it he references his paper “Medicare for All,” which is reprinted in Chapter 11. Morone proposes a single-payer system that would provide automatic coverage for all legal residents of the United States, breaking the increasingly eroding link between insurance coverage and employment. The current Medicare program serves as the delivery model for his proposal, which is popular and successful but needs some changes, with expanded benefits and no cost-sharing. Under his “Medicare for All” proposal, states could opt out by creating their own health plans for residents under age 65. Employers could offer additional benefits. All funding for the program would come from a new federal value-added tax (VAT). Morone states that incremental changes are no longer enough to solve our health care problems, and we must think big and continue pushing for a large-scale meaningful solution.

Physicians for a National Health Program (PNHP) is also an avid promoter of universalist reforms. PNHP is a non-profit organization of physicians, medical students, and health professionals founded in 1986 by Drs. David Himmelstein and Steffie Woolhandler of Harvard Medical School in an effort to build public awareness of the possibilities for a single-payer national health insurance system that would provide equal access to health care for all citizens. See Chapter 11 for their paper entitled “A National Health Program for the United States: A Physicians’ Proposal,” published in 1989. The authors borrow from the Canadian health care system, adapting the model to the unique features of the United States system.

Written Presentation

by James A. Morone
Professor of Political Science
Brown University

If we Americans are going to address our health care troubles the first step requires tossing aside the conventional wisdom. Everyone knows the conventional wisdom: Big, ambitious health care proposals are doomed to failure. A half-century of lost reforms—stretching from the Truman (1945-1953) to the Clinton Administrations—have left public health advocates timidly seeking “plausible,” “incremental,” small-scale solutions to our health care dilemmas.

The problem with incremental programs, however, is that they are not likely to take us very far. The cost of health care continues to escalate—somewhere between two and three times the rate of general inflation; that, in turn, puts pressures on business, governments, and individuals. Some 42 million people have no health insurance, roughly 30 million more do have not enough. The uninsured get less care, they get it later in their illnesses, and they are roughly three times more likely to have an adverse health outcome. The Institute of Medicine recently blamed insurance gaps for 17,000 preventable deaths a year. And even getting care can ruin people's lives—health care episodes (mainly ruinous hospital bills) are involved in half of all American personal bankruptcies.

A look at America's health data reveals the gloomy consequences. American girls are born with a life expectancy that ranks 19th in the world (another ranking pegs them at 24th). Male babies rank 31st—in a dead tie with Belize and Dar es Salaam. Among the 13 wealthiest countries, the United States ranks last or nearly so in almost every way we measure health: infant mortality, low birth weight, life expectancy at birth, life expectancy for infants, and mortality rates for young adults.

And don't blame all this on poor people or bad behavior. Yes, people die younger in Harlem than in Bangladesh. Why? It is not what most people think—homicide, drug abuse, and AIDS are far down the list. Rather, as the *New England Journal of Medicine* reports, the leading causes of death in poor black neighborhoods are “unrelenting stress,” “cardiovascular disease,” “cancer,” and “untreated medical conditions.”¹

Thinking Big

No society can address a problem this size—again, one out of eight Americans does not have health insurance—by tinkering at the edges of the system. Covering this many people will be extremely expensive. It will require a major national commitment. And all that is going to add up to a major new program with significant tax increases. Moreover, this is America's largest industry. Any reform will face hostile interests, defensive stakeholders, critical politicians, and a fusillade of negative arguments.

None of this is anything new. Back before it passed, even Medicare faced 15 years of shrill (and effective) attacks. Today, most people remember the Harry and Louise advertisements attacking President Bill Clinton's health plan; they seem positively mild compared to the following (quite typical) speech urging Americans to write Congress and oppose Medicare:

Write those letters now; call your friends and tell them to write them. If you don't this program, I promise you, will pass just as surely as the sun will come up tomorrow. And behind it will come other federal programs that will invade every area of freedom as we have known it in this country. Until one day . . . we will awake to find that we have socialism. And if you don't do this and I don't do it, one of these days you and I are going to spend our sunset years telling our children and our children's children what it was like in American when men were free."²

The speaker was Ronald Reagan, fighting Medicare and big government back in 1962. Yet Medicare passed and—never mind socialism—became one of the nation's most popular programs. As president, Reagan criticized plenty of government programs. But not Medicare.

How do we overcome all the many barriers and enact national health insurance? American history offers clear lessons. After all, both liberals and conservatives have won ambitious reforms that seemed chimerical when they were first proposed.³ The key to successful change lies in at least two factors: first, advocates have to develop a concrete plan, publicize it, and push, push, push against all odds. Second, the reformers have to ignite a movement—a following that mobilizes and demands the change. Solving the American health care puzzle will take precisely that combination. Really fixing American health care will require one of the great reform efforts in American history. And that is not likely to happen without a great popular outcry.

A big universal plan makes no sense measured simply by contemporary Beltway politics. But we're not going to cover 40 million people (much less rein in health care costs) with elaborate (and, to the layperson, incomprehensible) Beltway compromises, complications, and concessions. Health reform proposals will not work if they do not generate a populist uprising. A powerful movement—as Newt Gingrich showed in 1994—can turn Washington's wisdom upside down. Health reform will only get through Congress via the grassroots.

The entire issue of feasibility can usefully be put in the larger context of policy change over time. Political historians often describe American political development as a process of punctuated equilibrium. Under normal conditions, the fragmented political system—with checks and balances everywhere—seems designed for stalemate. Only relatively small, incremental changes successfully negotiate the political process. Most of the time, American politics is the politics of tinkering on the margins. Most reform proposals sensibly reflect that reality. But over time, demands for

larger change build up. Those underlying demands eventually are met in recurring moments of vast, tectonic change—like the New Deal or the Great Society. Fixing America's health care dilemma will take a comparable change.

Reformers who agree with that assessment ought to set their sights on the longer term. Leave others to work for incremental improvements and, instead, begin rallying support for a plan that is likely to address our health problems in a systematic and popular way. Medicare's supporters pushed for more than a decade (without much to show for it) before their opportunity came.

Medicare for All

What kind of reform might do the trick? Extending Medicare to the entire population. In another paper I explain precisely how this might be done (see Chapter 11, "Medicare for All"). The essential logic is simple: Medicare is one of America's most successful and popular programs. The perversities of our health care system finally lift when people become eligible for the program. The cross-national data that look so terrible for our young people reverse themselves for our elders; in fact, we're number one in life expectancy for 80-year-olds. And by every measure the program is extremely popular.

"Medicare for All" takes a popular program for elders and extends it across the entire population. To be sure, the program itself needs to be simplified, modernized, and reformed (we will have to cover prescription drugs, enhance community medicine, and completely rethink the bureaucracy). We will have to figure out how to finance the expansion (I suggest a VAT tax). We'd have to think of ways to keep the program from growing sclerotic (there are multiple ways to foster innovation). But Medicare's essential logic would remain unchanged.

"Medicare for All" builds on past policy success. It is simple to understand. It puts opponents in the relatively awkward situation of pledging allegiance to the old Medicare while arguing against its expansion. And if any health reform is likely to generate broad, deep, grassroots support, Medicare is a good bet.

Breaking with the Current System

"Medicare for All" introduces two sharp changes with current practice. It breaks the link between coverage and employment—a great American innovation rendered increasingly obsolete in the new global economy. And it limits the long, futile American effort to run a system with competing health care payers.

First, consider the link between employment and health insurance. The idea developed during World War II when health care benefits sidestepped wartime wage limits. It got a further boost from post-war policy, especially the seminal Taft-Hartley Act. The approach was well geared to an industrial sector marked by stable (often lifetime) employment, relatively predictable domestic markets, and regular labor-management relations. By 1979, more than four out of five full-time employees got their health care from their employers. The numbers have declined ever since (with a brief

uptick in the 1990s).⁴ Rising health care premiums take a steady toll on the employment-based systems, and the apparent return of relentlessly rising costs (employer health insurance premiums increased by three times the rate of general inflation in 2001) have eroded an old saw that corporate America would have the will and skill to rein in its health care costs.⁵

More important, the old industrial economy is sinking into history. People shift jobs frequently—lifetime employment with a single firm has become unusual. Global trade and fierce equity markets put enormous pressures on firms (and on their employee benefits). Contingent and part-time workers, consultants, and other flexible arrangements all undermine the kind of long-term commitment to employees that nourished the old system of health benefits. Of course, the pressures on companies vary by sector and firm—most large companies still offer health benefits; most small firms no longer do. However, the numbers are declining in every category. Efforts to reform the system by shoring up employer health care confront the new realities of an emerging global economy. As the quicksilver economy of the 21st century gathers velocity, the mid-20th century employment-based health system will be increasingly difficult to defend—or revive. It offers patchy coverage, it offers few footholds for expanding coverage to the uninsured (or the underinsured), and it places a heavy burden on many companies. Put bluntly, its days are numbered. As that becomes clear, “Medicare for All” may stand out as an appealing reform alternative.

Second, “Medicare for All” rejects one of the great health care reform standards: consumer choice of health plans. In theory, American health care offers two different kinds of consumer choice: the choice of provider is one of the great—and unassailable—values in American health care. That is not the same as choice of insurers. The idea of competing insurance packages has been a kind of holy grail for health reformers; the idea is intuitively appealing, because it more or less fits with traditional economic models. Consumers chose among competing plans, selecting the mix of price and services they most value.

However, the reality has rarely met expectations. In the real world, the choice of insurance packages is a source of confusion and frustration. People have no idea how to cut through the complexities. They do not understand what exactly they are buying or what trade-offs they are making. A full range of options is rarely available to them in any case (nine out of ten small employers offered just one plan in 2001).⁶

Worse, the two kinds of choice often conflict: choice among competing health plans leads to limits on the choices that really matter to most people, a choice among health care providers. That, in turn, has led to the political backlash against managed care. “Medicare for All” challenges the conventional wisdom: competition among insurance plans is an idea that has never worked except in special circumstances. Medicare’s current beneficiaries do not miss it. Nor will the rest of the population when Medicare is extended to them.

The Single Most Important Thing

Of course, there are many approaches to insuring health care—Democratic and Republican, private-sector plans and large government programs. It would be silly to suggest that there is only one scheme that can succeed. The key for any approach is framing a transparent, unambiguous commitment to the central reform: insuring all Americans. And the lessons from great reforms in the American past—from Social Security to civil rights—are unambiguous: Think big. Define the core principles. Negotiate the details. And never stop pushing no matter how long the odds.

Notes

1. For the data in the previous four paragraphs, see Lawrence Jacobs and James Morone, *Healthy, Wealthy and Fair: Health Care and the Good Society* (New York: Oxford University Press, 2004), Introduction and Conclusion; and Jacobs and Morone, “Inequality and Health, *The American Prospect*, June 2004, p. A20-1.
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4. See Marie Gotshalk, *The Shadow Welfare State* (Ithaca: Cornell University Press, 2000), for a fine description of Taft-Hartley and, more generally, the rise of the employment health care state. See also Michael Graetz and Jerry Mashaw, *True Security: Rethinking American Social Insurance* (New Haven: Yale University Press, 1999), chapter 7.
5. *Employer Health Benefits: 2001*, The Henry J. Kaiser Family Foundation and HRET, pp. 3, 13, 14; Lawrence Brown, “Dogmatic Slumbers: Business and Health Care Policy,” in James Morone and Gary Belkin (eds.), *The Politics of Health Care Reform* (Durham, NC: Duke University Press, 1994).
6. *Employer Health Benefits: 2001*, p. 7.

Chapter 6

Response Panel Discussion

Response

by Paul Fronstin

Senior Research Associate

The Employee Benefit Research Institute

In our lifetimes we have seen Medicare, Medicaid, ERISA, HIPAA, the SCHIP program, and, of course, the Medicare drug bill in 1988. It is important that researchers strive for the best possible analysis of proposals so that policymakers have the best information available to make sound public policy. The papers, which I highly recommend you read, have done a good job of doing that.

I have a couple of comments about the papers. First, Cathy Schoen and Karen Davis's paper: I think risk selection is going to be a major problem and a destabilizing factor in the Congressional Health Plan. Whether it is real or made up by the insurers, policymakers are going to play politics with risk adjusters, so we should not be surprised if health plans drop out of this Congressional Health Plan and/or the federal employees' health plan, as they will need to be in both in order to provide coverage. If insurers offer coverage in the federal program, they also must participate in the Congressional program. I would not be surprised if insurers dropped out, just like they have been dropping out of the Medicare Plus Choice program. I think once risk adjustment mechanisms become political, insurers are going to do what they have to do to make sure that the subsidies are high enough for them to make a healthy profit.

Concerning the two-month COBRA extension and the subsidy thereafter—I do not see employers supporting it. Employers dislike COBRA coverage—it costs them real money. Even if COBRA subsidies would save employers money by reducing adverse selection, they would be skeptical, and would prefer to avoid setting a COBRA expansion precedent. They will not know where the precedent may go. Employees

can already get COBRA coverage for free for more than 60 days. The rules are such that employers have up to 44 days to notify employees or former employees of their COBRA rights. Employees then have another 60 days to notify the employer if they are going to accept COBRA.

A former employee can notify his or her employer that he or she is going to accept COBRA and then never pay the premium. After a former employee notifies, he or she has another 45 days to pay the first premium. It adds up, for various reasons, to 144 days of COBRA coverage before an employee has to pay anything. So who would even elect COBRA during this period, or who would pay for it? Most people would elect it if they were in a situation where they got sick or had an accident and needed care; then it makes sense that if the cost of the care is more than the cost of the insurance, you pay the insurance, and you get coverage retroactively.

The employer mandate will only affect small firms, because just about all large firms already offer coverage. It can only be harmful to small firms since those that are not offering coverage are probably not in a position to offer it. My colleagues and I at EBRI have done research on this, and we have found that small businesses that do not offer coverage do not see a negative impact on their businesses from not offering coverage.

We have heard that the rising cost of health benefits affects various aspects of a business. My colleagues and I at EBRI have also done research in this area, and we have found that only 19 percent of small employers report that they changed health plans because of rising health benefit costs. That surprised us, but we dug a little deeper and found that 42 percent reported that rising health benefit costs affected some other aspect of their business that had nothing to do with the health benefit plan. Employers reported that it affected wage growth, bonuses, hiring practices, and capital purchases. These are real costs to businesses. So any mandate requiring a small employer to provide health benefits is going to have other impacts on the business that we need to be aware of.

Interestingly, I think that large firms—at least large firms that compete against small firms—may actually support a mandate, if they think about it. In the 1980s, the CEO of American Airlines testified in front of Congress in favor of an employer mandate because he thought a mandate would hurt Continental. He was supporting it for competitive reasons. Employers that do offer the benefit may lobby for a mandate because they already offer it, so it will not cost them anything more, and it may improve their situation competitively. But, I also think that they might be concerned about setting that kind of precedent.

In response to Judy Feder's paper, I would note that her proposal to expand Medicaid was developed in 2000. At that time the economy was strong—unemployment was at 3.9 percent, and the public sector was looking at budget surpluses. Today we are near 6 percent unemployment, and the public sector is looking at budget deficits—states are cutting programs, and the number of people in need is growing. I think it will be even more costly to do anything to expand public coverage, and the money is just not there.

I share Feder's concern about tax credits eroding employment-based coverage. Employers are desperate to find a solution to rising health benefit costs. Right now, some are experimenting with consumer-driven health benefits, and they hope that it will reduce their costs. But some say that if it does not, they are going to get out of the business of providing health benefits. Tax credits may give them the excuse they need to do just that.

A couple of comments on Mark Pauly's paper. He presented results from various modeling exercises in which he found that tax credit proposals would reduce the uninsured. He gave a number of ranges—I will remind you about four ranges that were straight from his paper. Between 17 and 73 percent reduction in the uninsured; between 36 and 66 percent; between 21 and 85 percent; and between 3 and 85 percent. I think the strength of this exercise was to show that we cannot find a point estimate on what the impact is going to be. I'll just quote from the paper: "predictions are fraught with uncertainty." We just do not know what the impact would be.

I will leave you with a few thoughts. Tax credit studies are already old because they use 2001 data on premiums. Premiums for group coverage have increased about 25 percent in the last two years. Premiums for individual coverage have probably increased about the same. Tax credit proposals such as the one by the Bush Administration are still using a \$1,000 subsidy for single coverage. This means that the net premiums would be higher and the take-up rates would be lower. I think one of the reasons why Pauly was proposing a \$1,500 tax credit was to address just this. Studies have generally ignored the way the tax credit would work for families. It is easy to generalize these things for a married couple with no children because we could assume they may buy two individual policies, but when it comes to a family, you cannot generalize these results. Family premiums are easily two to three times that of individual premiums.

The proposals typically cap the tax credit at \$2,000, though the Bush Administration goes up to \$3,000. Targeting the uninsured is like trying to hit a moving target. About 50 percent of the uninsured will get coverage within six months of losing coverage. We need to think about whether tax credits should be prorated for people who need them for less than a year, and how that would work. We need to think about the impact on these estimates of coverage expansion that does not take into account HIPAA portability rules and how they may affect premiums. I'll give you one example: in Washington, D.C., an underwritten policy for a person age 55 this year is about \$4,600. It is actually a little bit lower than an employment-based policy on average. The HIPAA-eligible policy—for the same person, the same policy, somebody who will get coverage for their preexisting conditions—is more than \$12,000.

We tend to talk about solutions on a national level, and we tend to ignore the role that employment-based coverage can play in coverage expansion. There's been a slight decline in the percentage of people covered by employment-based coverage, but we should still keep in mind that this is the most common source of coverage for people in the U.S., covering about two-thirds of the population under age 65. We talk about

reform at the national level, but we need to recognize that health care is delivered at the local level. At the local level, a number of communities have come together with proposals and have implemented some to expand coverage in their communities, and these have been very successful in a number of areas in the country. We need to look at these models as we talk about big solutions and see what role they will play.

Response

by *Randall Johnson*
Vice Chairman
The ERISA Industry Committee

I received a call about a year and a half ago from Mary Ann, a friend of mine. She had just retired, as had her husband Joe—he was 61 and she was 59. She asked, “Randy, do you know where I can get health care coverage? I’m paying \$850 per month, and Joe is paying \$650 per month, and I don’t know where to get coverage that’s less expensive.” The reality is that the cost for retirees is twice what it is for active employees. The subject that we’re talking about today is a significant issue for employers.

Why should we care? Retiree medical coverage is going down. The number of companies offering it is going down, and the subsidy—that is, the costs that are being born by companies—is going down even faster. The problem will get worse. The aging boomer workforce is just about to enter retirement. Medicare and Social Security are not well-funded, the number of pension plans has been declining, benefits are declining, and 401(k) balances are not as high as they’ve been in the past.

Why should we care? Fifty-four percent of the costs exceed out-of-pocket limits, which means that patients have no incentive under most plans today to be cost-conscious when purchasing their health care. The market is failing to incentivize excellence. We have an opportunity to improve quality of care by improving the system. You’ll find my remarks today are going to respond somewhat to the tax credits, but we need to do more than tax credits.

Most people who currently are covered by health plans do not understand or care about their health insurance costs because their perception is that “someone’s going to take care of it for me.” They don’t want to hear that their employers’ health care costs are out of control. They expect the employers to take care of that. Only a strong minority have an understanding of what’s happening in health care today.

As employers, we do agree that we need to fix the system. We’re very concerned. The question regarding our discussion today is, is our focus correct? Is it principally a tax credit that will help us meet the needs? Another question is, who should have the primary responsibility for citizens’ health? Should it be the individuals themselves? Should it be the government? Should it be employers? I think the data is showing that if the government or employers handle it for our citizens, we’re doing them a disservice. Why not have an individual mandate? Why have we given that away as a potential idea?

What is really our objective? To first cover those in lower income ranges just because they’re in lower income ranges? Is that an assumption we’re going to accept without testing it? Is our objective to provide health care coverage that is meaningful? Or is it just to say we have covered everybody in the United States? Is our objective to

ensure that our workers at most, if not all, income levels are healthy and productive? If we have healthy workers, will we have a more productive economy?

Here's an idea that not too many are talking about, but that we're ready to support with great vigor. Would mandatory health and financial education at the high school and college levels be helpful in meeting our objectives, especially when we consider the status of Medicare and Social Security and retiree incomes? Probably so.

Meaningful and helpful coverage will cost more than \$1,000 to \$2,000 a year. That amount won't do very much to help people afford health care. Will those who purchase a \$1,000 plan be able to afford the related coinsurance and deductibles? Here's a thought that might be totally at odds with some of our thinking today—would it be fairer and more helpful to initially provide preferential tax treatment to workers (all of those who buy their own health care coverage) rather than to people in the lowest pay ranges? This is just a question to consider.

Legislative mandates, including broad and corporate coverage, add costs to employers' plans. Paul hit the nail on the head when he said that we are concerned about extending corporate coverage because those who take it most often are people whose costs far exceed the costs that they pay. That means that the employer is going to absorb the cost of its former employees. What is the result of additional mandates? Costs have been passed on to employees. Health plans are being discontinued. Jobs are being shifted overseas. Is it possible that the reason we have the best health plan delivery system in the world is because employers have used their leverage to try to improve the quality of care?

We didn't hear anything about it this morning, but what's the possibility that we'd actually get more mileage out of a tax credit giving X dollars to an *employer* to incentivize them to provide the kind of health care programs that will more effectively meet the needs of the employees? Maybe it would only be for employees who are earning less than Y dollars, but maybe we'd get some mileage out of that. Someone mentioned "do no harm" to those who have coverage now. This is very important because of the potential for costs to spiral.

Then what can we do to bring excellent thinkers, such as you who have been on the panel and others who are in the room, together to dialogue with employers on these really important subjects? We need to find ways to do that.

Here's our focus for the future. First, we're going to have to move in larger rather than incremental steps toward consumerism. Two, we have to increase transparency and disclosure of outcomes. If we do steps one and two, the health care system will be reengineered. Count on it. If, in fact, Dr. Smith's outcomes are projected on a *Consumer Reports* style of report for a patient, she's going to try to identify the best doctors and the best hospitals available. Those that are not listed among the best are going to either have to improve or they're not going to be in business for very long. Three, we'd like to suggest a tax deduction for all who purchase their own coverage, potentially with a tax credit for some who are in the lower pay ranges. But, we would start with the tax deduction and build on that with a tax credit for those in lower

pay ranges after we have demonstrated affordability. Changes in the tax code to fund retiree medical coverage would be huge. We need to reform Medicare, and we need to identify new quality cost-effective delivery systems, where people like Joe and Mary Ann will have access.

We're working with the Consumer Purchaser Disclosure Group, and here's our goal. "By January 1, 2007, you and I will be able to select hospitals, physicians, physician groups, delivery systems, and treatments based on public reporting of nationally standardized measures of quality, consumer experience, equity, and efficiency." In other words, when you're thinking of your providers and hospitals, you'll be able to look at a report on how they rate in terms of clinical quality of care, patient satisfaction, and efficiency. If Dr. A is charging \$12,000 for a procedure and Dr. B is charging \$15,000, it looks like A is a better, more efficient provider. But is it possible (and this often happens) that Dr. A brings his patients back for three more treatments at \$2,000 per treatment, and therefore he is not the most efficient provider? He just happened to have the deepest discount for that particular service at that particular time. So we're going to have to look at efficiency and equity.

A variety of organizations are working with us on this—not only purchasers but consumer groups as well. We are driving this very, very hard, working with some colleagues in CMS, working with some of the consumer organizations, and working with the American Hospital Association to move this initiative forward. Here are the reasons for having national standards: 1) comparability across markets, 2) credibility, 3) reporting burden, 4) economies of scale, 5) understandability, and 6) propensity for improved quality. These may not be consistent with what some of you who are involved with state purchasing would like to see, but we have to have national standards.

Then, we need to give a plan design to consumers so they will benefit from selecting wisely. If they choose three- or four-star providers, they will get reimbursed at a higher level and they will have the lowest out-of-pocket limit. If you want to go to any doctor you wish, regardless of outcomes, you can do that; however, lower efficiency and quality doctors will be reimbursed at a lower level and without out-of-pocket limits.

In summary, here are some of our thoughts again about where we need to go in the future:

- Dramatic increase in consumerism.
- Dramatic increase in transparency and disclosure.
- Re-engineering of the health care delivery system.
- Tax deduction for all who purchase their own coverage, with potentially a tax credit for some.

- Changes in the tax code to encourage workers to fund for their retiree medical coverage.
- Medicare reform, including a comprehensive drug program for all Medicare beneficiaries.
- Identification of new high-quality, cost-effective delivery systems.

We encourage continued dialogue between people such as you and us as employers. If we move forward, we can improve the health care delivery system so as to provide broader coverage and insure healthier people.

Response

by Amanda McCloskey
Director, Health Policy Analysis
Families USA

I'd like to look at the presentations through the lens of the consumers and the individuals that we're actually trying to help—the 41 million people who lack insurance. I want to give you a little bit of context, though, about Families USA and our work on this issue. Families USA has been active in the health care reform debate and in efforts to achieve universal coverage for a long time, most notably in working for the passage of the Clinton health reform plan during 1994.

In spite of that proposal's failure, we learned two really valuable lessons from that effort. The first is that in health care reform, whether it's the Clinton reform proposal or Nixon's reform proposal, the first choice for everyone is too divisive. The players are too big, there's too much money at stake, and a major overhaul of the system becomes too divisive. What happens is that we get everyone's second choice, and the second choice of everyone is the status quo, and the status quo doesn't work. We continue to have 41 million uninsured—and that number continues to grow—and this is clearly unacceptable. I think every panelist agreed that this is unacceptable and that we need to begin to address this problem.

With regard to the presentations, I can't agree enough with the comments made by Judy Feder about public programs being the highest priority needs. Medicaid and SCHIP are essential to low-income individuals. I think there's a question of how you define low-income: is it 125 percent, is it 150 percent, or is it 200 percent of poverty? I would argue it's probably somewhere between 150 and 200 percent of poverty, not as low as 125 percent, as Mark Pauly claimed.

Private insurance at any subsidy is unlikely to work for low-income individuals. The cost-sharing inherent in many of the private insurance plans is just too significant for people who are living on \$9,000 per year. If you're being asked to absorb a \$250, \$500, or \$1,000 deductible before you can even begin to get a dollar of coverage, this just doesn't work. On top of that, you have to add the co-pays and all the services that may or may not be covered by these plans.

Clearly, we need to do more to expand public programs for low-income individuals, and the federal government needs to do more to help states, particularly in times like this, where states are having such a difficult time. The Medicaid program by its very nature is counter-cyclical, so when the economy's down, more people are unemployed, and more people need help, and yet states are taking in less revenue. We need to begin to address this counter-cyclical nature.

That said, I want to move on and talk about the individual tax credit. Mark introduced the concept of the 10-foot rope and the 20-foot hole. We think of it as a

40-foot hole, particularly when you're talking about low-income individuals and the tax credit. Karen Pollitz penned this metaphor of a 10-foot rope for a 40-foot hole, but it's one that we at Families USA latched onto and think it's a fairly clear description of the problem.

We think the administration's proposal of a \$1,000 tax credit just isn't enough for low-income individuals. Individual coverage isn't guaranteed when you're in the individual market, and the individual market isn't affordable for low-income folks and for people who are sick. If you are not in perfect health, the individual market just doesn't work.

At Families USA, we did a report looking at what happens if you're a consumer, you're uninsured, and you're being offered a \$1,000 tax credit. How do you find out what you can get and what's available to you? If you go to a Web site called ehealthinsurance.com, you can, in fact, shop for health insurance policies by state. We looked at what was available in the 50 states for women age 25 who are nonsmokers and 55-year-old women who are nonsmokers. We found that for the value of \$1,000, even for 25-year-olds, there was not a policy available in 19 states. Individuals would have to pay significantly more out of pocket to get a policy that was about the value of the tax credit. For 55-year-olds, it was even more dramatic. Policies were not available in 48 states and the District of Columbia. Even where policies were available, the deductibles associated with those policies were enormous in many cases. When you're talking about people who are living with low income and modest means, these figures represent a significant chunk of their income.

Add on top of that some of the issues about underwriting. Karen Pollitz did an interesting study that was released in June 2001. That study profiles seven individuals who had applications submitted for them to 60 different insurers and HMOs, and then asked those insurers, with their cooperation, knowing that these were profiles of individuals, to give them a response that they would give someone who fit this profile. The seven individuals ranged from a healthy 24-year-old waitress to someone with HIV/AIDS.

There were very dramatic results from this study, but I want to focus on one that I think was particularly interesting, and that's the 24-year-old waitress. She was the healthiest of the bunch—her only health condition was hay fever. Of the 60 possible offers, she was denied by five. Of the offers she received, the majority of them had some sort of restriction on the policy, all related to her hay fever. A number actually included complete exclusion of her respiratory system from coverage. That's not coverage. That doesn't work for people. Whether or not she could afford the policy didn't really matter because in fact the one thing that she really needed coverage for wasn't covered. The individual market just doesn't work.

That's not to say that Families USA opposes all tax credits. In fact, after the 1996 health care reform effort, Families USA worked very closely with the Health Insurance Association of America, which worked very hard against the Clinton health care reform proposal, but worked with Families USA to find some common ground and to come together on some ideas. Out of that agreement came a clear recognition that

you *do* need to expand public programs for low-income individuals. We just can't do enough in terms of a tax subsidy for a private insurance policy to make a private policy affordable. Even HIAA and others support this point of view. There was general agreement that we need to focus on expanding public programs for those folks below 150 percent of poverty and potentially for those folks below 200 percent of poverty.

The other important piece of that proposal was a tax credit, but it was a tax credit that went to employers and built on the employer-based system, rather than eroding the employer-based system. We've heard from several of the presenters this morning, as well as from Paul and Randall, expressed concerns about eroding that system. We would rather see that system bolstered than to erode it.

I want to take just another minute and talk briefly about the Trade Adjustment Assistance Act that was mentioned earlier today. This was a piece of legislation that passed the last Congress. It is a very small but significant expansion in health care coverage. It is a tax credit, and it's worth noting and watching what happens with this tax credit, because I think there are some lessons to be learned here. The law makes available a tax credit to workers who lost their jobs for trade-related reasons. It's a very small number of people, but Texas happens to be one of 11 states where there are more than 10,000 people in the state who are potentially eligible for this tax credit.

It has several key provisions which I think make it very different from the \$1,000, 90 percent subsidy tax credit in the individual market that the administration has talked about in the past. This is a subsidy for 65 percent of the cost of coverage. It can be used for purchasing COBRA or for other group-like coverage. I think that's a very important distinction. Keeping people in a group market is very important. Again, if you do not have perfect health, you are going to have a tremendously difficult time in the individual market affording any policies that are offered to you if, in fact, something is offered to you at all, so that provision is particularly important.

There are just three other pieces I want to mention. It has guaranteed issue, so if you are eligible for that tax credit, you have to be treated like you're in the group market. You have to be given a policy; you can't be flat-out denied. There are no exclusions for preexisting conditions, they can't discriminate on premiums, and there's non-discrimination in benefits. While it's only available to a limited number of people, we haven't really seen how this is going to work yet. It's only in the early stages. It is worth watching because it takes what has been a concept we've heard a lot about and moves it from an individual concept to a group market concept that may actually make this work better for the people at whom it's aimed.

In the end, it still doesn't help the lowest-income folks, and, in fact, there are a number of people in Congress talking about taking what was done with the Trade Assistance tax credit and using that to build on in this Congress in terms of another expansion. There's actually \$50 billion in the current budget resolution to expand access to care. While that could be a really good thing, it will still not help the poorest individuals. It's important that we do what we need to do to help those low-income folks get the coverage they need at the same time that we look at these other options.

Response

by Nina Owcharenko

Senior Policy Analyst

Heritage Foundation Center for Health Policy Studies

We all want to give Americans better access to affordable care. I think if fundamentally we come from there, we can build on consensus. There are a lot of sides, and maybe we'll disagree on some of the details, but if we can come together with consensus, I think ideas can percolate up, and maybe we can make movements toward the right direction.

Having said that, I do come from a conservative mindset, so when I look at proposals and ideas, I have an automatic feeling of where I set my benchmarks and how proposals reach those benchmarks. I'm going to go through a couple of them that I fundamentally believe, philosophically.

One is strengthening individual control. Health insurance is mine—it's what I want to choose. It's the providers I want and the health care I want. Those are value decisions, and the individual who has the personal incentive to figure them out is the best one to be in control. Unfortunately, we have systems where the employer makes decisions for us or the government makes decisions for us on what benefits we have, what our co-pay should be, and what access we'll have to the care that we value as the best. However, while I believe that there is a role for government and employers to play, we need to figure out a way to utilize the benefits that they can provide, whether it's a financial benefit or a structural benefit, while allowing individuals to choose their own health insurance.

The second benchmark I look for is whether we are increasing coverage options. I think everyone has agreed that what's out there isn't obviously doing everything that it should be doing. We have gaps in coverage, so we need to look beyond the status quo and see if there are ways to create more options—for example, we could look for group options that aren't based on employer options, but on long-term, consistent relationships.

One of my colleagues at the Heritage Foundation, Stuart Butler, has long been discussing the idea of having churches involved in sponsoring coverage, where you know that if you're part of one church, you are in essence going to stay with that type of organization throughout your life. Or perhaps the March of Dimes or other organizations that you participate in could help unify your coverage over your lifetime.

We want to look at how we can promote continuity in care, establishing relationships between doctors and patients, and between individuals and their families. Right now we have a lot of discontinuity. We want to get families covered. We don't want to put one child in one program and another child in another and then have a parent that doesn't have coverage. We can see why there are lapses and problems there. How

can we best build a system where individuals are able to make decisions on behalf of those that they care about?

Finally, I want to look at the coverage options. As Mark Pauly pointed out, MSAs are an option. I personally would not choose to participate in an MSA, but a lot of my friends may. Those who are young and healthy may choose that as an alternative. But there are lots of coverage alternatives that we can envision, whether through MSAs, the individual market, states, or federal opportunities. Tax credits are a financing mechanism that will create incentive and demand for new opportunities to come out. Right now, with such a small population in the individual market, there is no need to react to them. They're not a large enough factor to result in changes in the system.

There is a role for existing programs. You will never be able to provide a private coverage option that will meet the truly indigent concerns. You're going to have those people who cannot provide any sort of a co-pay. We do need to take care of those people. That's what the idea of the public program at its inception was: a safety net for those who cannot afford to be in the mainstream of society, getting coverage like the rest of us get our health care coverage. But with budgetary problems, we know that just expanding that system is going to result in some concerns. Maybe what we should do is look at how we improve the existing public programs to be more receptive to the needs of those who truly need to be on that program. How can we make those programs better?

On the other hand, we have tax credits aimed at the uninsured, people who aren't fitting into the existing system. We have to do something for them, expanding one way or the other. As we've heard, there are budgetary problems for the federal government and the states if we expand Medicaid, and expanding an employer mandate may cause heartburn with the employers, so what can we do for this targeted group of people? I really believe that financing and dollars is the best incentive for people. It gives them the money that they need. Low-income individuals don't necessarily need an extravagant, comprehensive package handed to them. We're talking about people who want to buy coverage either through their employers or on the individual market. They just need financial assistance to help them integrate into the mainstream of society.

The administration proposal and the Commonwealth Fund proposal have really done a good job of focusing on both sides and trying to bring them together. The Commonwealth Fund proposal contains some great ideas, especially the FEHPB model; that's something that has worked and has shown little risk selection hazard within it, if it's designed properly with the right subsidy.

We can also look at the right, at what the administration's talking about, which really wasn't highlighted—incentives for states to do something to provide coverage for those within their states, thus leveraging federal tax credits to create purchasing options for individuals. That's an important component, especially when you look at the discrepancies between states. The problems in Texas are completely different from

the problems in Minnesota, so states should be able to use the federal dollars as best they can to fix their markets.

Building consensus—where is the vision and where can we really look to go toward? My vision would be to incorporate financing mechanisms for individuals through tax credits, to improve public programs by allowing additional assistance to be added to the tax credit through the states, and to recreate some of the public programs so that they're better able to respond to individual choices.

One of the examples that we've seen some success with in Florida, Arkansas, and New Jersey is the idea of cash and counseling. Certain Medicaid participants are able to get an account with a fixed dollar amount to pick and choose the services they want to use. There is some counseling and some education that goes along with this, but they're able to pick and choose what services they want. Do they want a nurse to visit them three times a day, or do they want someone to come twice a day and use their extra dollars to have increased physical therapy treatments? Those are the decisions that, as consumers, they're being empowered to make. Interestingly, these programs result in very high satisfaction rates. I think looking at ways of maybe transforming even some of our public programs into more consumer-directed ones may be a way to go.

In the end, I agree with Mark—let's start with a little bit, go somewhere, and then make adjustments along the way. There may be those waitresses that may not fit into the system, but let's try to get as many people as we can with one product, see how it works, and then adjust along the way. Maybe it does require an expansion of Medicaid for those at the lower levels, but maybe those at the higher levels with different individual needs can use a tax credit.

One of the things that I liked about the Commonwealth proposal is the idea of allowing the individuals to choose. Do they want to go into the Medicaid program, do they want to buy into Medicare, or do they want to stay with the private sector and try to get coverage that way? That would be a great way of bringing together the two ideas and seeing which one pans out in the end.

Response

by Edwin Park

Senior Health Policy Analyst

Center on Budget and Policy Priorities

I'd like to talk about the costs associated with the tax credit, primarily for use in the individual market. We've heard a lot of concerns already, but I want to provide a little more explanation about the "do no harm" principle and about how tax credits could undermine both employer-based coverage (where the vast majority of Americans get their health care) and public coverage like Medicaid and SCHIP.

The availability of the tax credit, under the administration's proposal, for example, could induce employers to voluntarily drop coverage, as we've heard from Paul Fronstin and others. With health insurance premiums rising in double digits, that could be a very attractive option for an employer that's on the margin in terms of being able to keep its coverage. But what hasn't been mentioned yet is what happens when employees who are currently participating in their employer-based coverage voluntarily opt out, take the tax credit, and go into the individual market. As we've heard Amanda and others discuss regarding the individual market, it's primarily associated with healthy and young individuals because of the barriers to it. Those young and healthy individuals want bare-bones coverage, less generous benefits, less comprehensive benefits, because, in general, they're healthier.

Would this lead to an adverse selection problem, where the healthiest and youngest employees, who are the lowest risk, opt out and go into the individual market, changing the risk pool that's currently in the employer-based health insurance system so that older, sicker workers are left behind? The size of the administration's credit is relatively small. According to the Joint Committee on Taxation, it's about \$64 billion over 10 years. But certainly, a larger credit would just intensify these effects. If employer premiums go up, there may be more employers who drop coverage in the overall context of rising health insurance premiums for employers generally.

Professor Jon Gruber from MIT, who's done some modeling, did an analysis of the administration's proposal from last year, which is nearly identical to this year's budget proposal. He found that 2.4 million people would lose their employer-based coverage as a result of the tax credit. One million would go into the individual market and 1.4 million (over 50 percent) would become uninsured because of the unavailability of the individual market to them. Primarily these are workers who are older and sicker and are not able to afford or even access coverage because in the individual market, high-risk individuals can be excluded entirely.

In addition, he assumed that 1.5 million would voluntarily leave their current employer-based coverage for the individual market. The administration's estimates that the Treasury did showed that 2.5 million (at least from last year) previously had

employer-based coverage. They didn't specify whether that was voluntarily transferring from employer-based coverage, or employers dropping it. Clearly, this effect could happen. Adverse selection could arise, and employer-based premiums could increase, and cause further dropping. That's a broader understanding of the potential effects that a tax credit primarily for use in the individual market could have on employer-based coverage.

Second, I will talk about the tax credit's effect on Medicaid and SCHIP. Medicaid currently covers 47 million people. It's the largest public program providing health insurance; if you add SCHIP, it's another 4 million kids and some low-income parents. It provides coverage; it does not, as we've heard from Judy and others, cover everyone below 100 percent of poverty. But states are looking to cut Medicaid and SCHIP. States are facing deficits of \$25.7 billion from the current fiscal year, and an additional \$70-85 billion for the upcoming fiscal year that most states have to close by July 1, when the fiscal year starts. That's on top of the \$50 billion in deficits that have already been closed either by tax increases or spending cuts. Medicaid, since it's the second-largest budget item in state budgets, has been a prime target.

Under an analysis we did earlier this year, looking at just 22 states, 1.7 million people who are currently in Medicaid and/or SCHIP could lose their coverage. Those are both cuts already implemented and cuts that have been proposed. A lot of those cuts are to populations that the tax credit for the individual market would cover. As Judy mentioned, 40 states prior to 2002 covered kids up to 200 percent of poverty (including the District of Columbia) and 20 states had gone up to poverty on parents. Looking at the Medicaid cuts that have been implemented so far, there have been major parent expansions reduced to welfare levels, from 100 percent of poverty and even higher, down to 40 or 50 percent of poverty in Missouri, Connecticut, and New Jersey. California's talking about that; their cuts would encompass nearly half a million parents.

With that in mind, the tax credit is 100 percent federally funded. Granted, some people might not be able to get coverage. But the credit could be very attractive to states. Medicaid and SCHIP require a state match; the tax credit doesn't require any state match. States may decide to drop coverage as a result and even when budgets recover, when revenues go back up and the economy's strong again, may decide not to (1) restore the cuts that they've already implemented as a result of this downturn, and (2) expand coverage as they were previously doing prior to 2001 when the downturn started.

One additional point that really hasn't come up is that no one is talking about taking away Medicaid. Granted, there may be some states that decide to drop coverage as a result of the tax credit. But the administration also has a proposal to cap Medicaid funding. Right now it's an entitlement stream of funding. For every dollar of total Medicaid spending, the federal government on average pays about 57 percent. In Texas, it's 60 percent. If, because of the recession, for example, there are more Medicaid costs, and costs rise because there are more enrollees, the federal government will pick up a portion of that increase in cost.

The administration's Medicaid reform proposal is a block grant, basically capping the vast majority of that entitlement stream so that it's a fixed amount, calculated through some formula from some base each year. If a state has spending requirements where under the current entitlement structure it would get more dollars than this cap, the state will have no choice but to cut. Medicaid's coverage in the long run is thus at risk. The cap applies at least to so-called optional spending, and that's really where rising Medicaid costs are—that's the elderly, that's the disabled, that's nursing home costs, and that's for all optional spending (about two-thirds of spending overall). It's 83 percent of the spending on the disabled, 85 percent of the spending on nursing home residents, and 90 percent of the spending on long-term care services. As one would expect, those are the big drivers. Kids and parents don't cost that much relatively, but the elderly and disabled do.

When we have the baby boomers starting to retire in 2011, this kind of cap would only add more pressure. The tax credit would be an inadequate substitute, not only by inducing some states to drop coverage or not restore coverage, but also in tandem with this block grant, by reducing coverage. Those are the two cautionary notes I wanted to raise with the tax credit.

One last thing that hasn't been brought up is targeting. Looking at analyses of previous tax credits by the administration, Jon Gruber, the Kaiser Family Foundation, and others, we find that under a tax credit primarily for the individual market, at least two-thirds and up to three-quarters of expected participants would previously have had coverage, whether it's in the individual market or through employer-based coverage. It's a question of targeting. Most studies of public program expansions found that about 20 to 25 percent of people may have had coverage previously, so it's a question of both what you're buying and also where those resources are going.

Response

by Alan Weil

Director, Assessing The New Federalism Project

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I am going to make five completely unrelated points. First of all, as Edwin alluded to, it is impossible to talk about the effects of tax credit proposals on the uninsured without taking into serious consideration the fact that this administration has proposed converting the Medicaid program into a block grant to states. With two-thirds of the spending in that program on the elderly and people with disabilities, putting the program on a fixed path of spending and then expecting states to maneuver within that grant to deal with the varying needs of the low-income uninsured is going to have a tremendous effect, much more than one could talk about even if I spent all my time on that. But these issues are completely intertwined, so we can't talk about tax credits without also talking about public programs. There is a very radical proposal out there to fundamentally change the Medicaid program, which does form the basis of coverage for low-income families.

Second of all, Nina raised the issue of state variation. I think this is a critical issue, one that my project at the Urban Institute has studied for the last seven years. It is certainly the case that there is a tremendous amount of state variation. It is not the case that state variation immediately implies that there should be massive degrees of state flexibility. State flexibility can be beneficial, and it can be harmful. If you look at the track record of flexibility among states in insurance coverage, I would conclude that flexibility in administration has led to tremendous levels of creativity, tailoring managed care to local markets.

But flexibility in coverage, eligibility, and spending has yielded a nation with massive inequities. Some of those inequities may be just fine with some of you; they aren't fine with me, and I don't think they're fine in a system where the federal government is paying more than 50 percent of the cost. Flexibility sounds good, but there are different kinds of flexibility, and I don't think we should convert the notion of state variation immediately into the notion that all flexibility is positive.

State variation also has implications for what we might want to think about in terms of federal policy. Certainly, a uniform tax credit is going to mean something very different to people living in different states. As a political matter, a \$1,000 tax credit doesn't hold a great deal of interest, for example, to the senators from New York, who know that \$1,000 won't get their citizens much of anything—but it might be of interest to other senators. In addition, as Ruben's data show, the uninsured population in the United States is overwhelmingly concentrated in the South and the West. If we are going to take a lot of federal dollars and send them to places where most of the uninsured people live, we are going to do a massive transfer of income

from the Northeast, particularly, and the north middle West to the South and the West. That may be good policy, but it's complex politics.

Third, from my perspective, we should learn from the State Children's Health Insurance Program, not a perfect model but one that retains the matching financing structure so states and the federal government are both on the hook and states have more flexibility and a better match rate. I think that's a promising model. The argument that we should not build on Medicaid and SCHIP because of state fiscal problems is an argument that annoys me to no end. First of all, I challenge you to find anyone who makes that argument today who two years ago, when states had a lot of money, were saying, "States have a lot of money; they should expand Medicaid and SCHIP." Two years ago, when states had money, those folks were arguing that we should cut taxes, not that we should invest that money in Medicaid and SCHIP. Those who oppose expanding SCHIP are masking their opposition as concern for states, which is disingenuous.

In addition, they're willing to invest \$80 billion in the individual insurance market, which works poorly to put it well. If, however, we took that same \$80 billion and invested it in the structure that already exists in Medicaid and SCHIP, simplified administrative systems, made it easier for people to gain access to services, and gave states some fiscal relief, we would have tremendous benefits. It's kind of like the child who kills his parents and says, "Take pity on me, I'm an orphan." If the federal government is unwilling to help states when they are in difficult fiscal times and then says, "You're having bad times, we shouldn't build on that program that you run, but we're willing to put \$80 billion over here in a system that really doesn't work very well," that's an argument that I don't buy.

Fourth, I would like to offer two immodest proposals for rhetorical purposes. First of all, I would challenge those who have put a tremendous amount of effort and creativity into designing tax credits to make them user-friendly (we're going to make them advanceable, we're not going to reconcile them at year-end, we're just going to send you a little voucher) to put that creativity into the Medicaid program, where, when you filed your tax return, the IRS looked and said, "You have low income, so we're going to send you your Medicaid card. We're not going to tell you to come into an office that's only open from 10:00 am to 4:00 pm during work hours when you're supposed to be out there moving off of welfare into work. We're not going to make you bring pay stubs for the last three months, and we're not going to give you an assets test to figure out whether you're deserving. We're just going to send you a card because you're poor." That's what's being proposed for tax credits. If we use that same ingenuity in the Medicaid program, a lot of the complaints that people have about Medicaid and the low take-up rate would disappear. I would challenge those who want to make tax credits work to put some of that energy into Medicaid.

A second immodest proposal is that rather than block-granting Medicaid, which is for the neediest people, and then creating this massive new federal entitlement to a tax credit for the higher-income people, why don't we switch the two? Let's make coverage for the

poorest Americans a federal responsibility, or at least some federal standards for eligibility, and let's give states a block grant for the "tweeners." Mark Pauly appropriately says there's a lot we don't know about how tax credits are going to work.

What's the best way to learn? State flexibility—let states, with a block grant, decide if they want to do a tax credit or if they want to expand their Medicaid or SCHIP programs. Some will go one way; some will go another way. We'll learn a lot. But if you take Medicaid, which is serving the neediest population, and put them at risk by capping the federal appropriation, and then create a single uniform federal program for the population that's most variable from state to state, you've got it exactly backwards. If we're serious about state flexibility and learning, and, if we think tax credits are a good idea, give states a block grant for the 100-200 percent of poverty population and let them figure out the best way to do it.

Finally, I really appreciated Randall bringing us back to principles. I'd like to close with a challenge that we think about principles. What are the goals of the health care financing system? I think the goals of the system ought to be (and the Institute of Medicine said this better than I did, I'm only paraphrasing) to reduce the burden of acute and chronic illnesses on individuals, families, and society. I would also add to share the cost of that system in an equitable manner. Equity is a term that we all might have different definitions for, and I'm not going to try to say there's one definition of equity.

But if we're trying to reduce the burden, I would just close with two thoughts. First of all, the vision of a consumer-driven, quality-focused system is a beautiful vision, but I've done some work on quality, and I think it's fair to say that on a scale of 1 to 100, where we have the information and data and systems to allow and encourage individuals to choose health care providers and systems on the basis of quality, if 100 is 100 percent, today we might be at 10. I'm not even sure we're there. I believe there are tremendous gains from an individual and consumer-driven system, but we don't have the infrastructure to do it. I would argue that all of the impetus to get us to the 10 we have has come from group purchasers, employers, and government systems. It has not come from individuals out there on their own promoting quality in the health care system. If we can get to 90 percent (or 80 or 70 maybe), individual choice can maybe get us the rest of the way. But if we start now, it's all going to be on the basis of cost and none of it on the basis of quality.

And finally, we have chosen, I think, to adopt insurance as the preferred vehicle for ensuring that people have access to services. Insurance is about pooling. If I had my choice, I would like to be in a pool with a lot of 20-year-old healthy guys. If you give everyone choice, you are undermining the principles of insurance. Insurance and choice are in tension. They are not impossible to reconcile, but they are in tension because my choice affects the products that are available to you and the cost of those products to you. It's very important that, although we should have choice as a value and we should promote it as a value, so long as we rely on the insurance system, there will have to be constraints on choice or else the principles of insurance won't work.

Chapter 7

Summary of Roundtable Discussions

by April Grady and Sarah Stout

During the conference, presenters and response panelists, state policymakers, scholars, and business and consumer group representatives participated in roundtable discussions that focused on national policy options as well as on issues relevant to Texas. This chapter contains a thematic summary of these discussions. (The participants in these discussions are listed under “Roundtable Participants” at the end of the Contributors section.)

What Are Some of the Stresses on the Current System?

Throughout the course of the roundtable sessions, participants discussed some of the stresses on our health care system that contribute to and affect our ability to address the problem of the uninsured. Among the stresses identified were demographic shifts in the population, chronic disease, the growth of pharmaceutical and medical technology, and the need for public health preparedness in light of potential domestic terrorism. Each of these add a layer to the cost of providing health care, and as a result, we see insurance premiums growing, public programs shrinking, employers backing off from covering their employees, and providers receiving inadequate reimbursement for their Medicaid patients.

As noted by one participant, demographic changes (especially in our large urban centers) continue to create underserved populations at particular risk for poor health outcomes and costly diseases. While providing affordable and accessible health insurance packages and opportunities will work for some, we should recognize that it may not be enough for members of highly disadvantaged populations. The safety nets that we rely upon in many of these communities are fragile, and they have been weakened by the changes taking place in our medical care system. Growth in the demand for services continues to outstrip growth in funding, and today there are additional requirements to be met in terms of emergency preparedness and public health infrastructure. For example, on top of their other duties, hospital care systems are faced

with developing decontamination and quarantine capacities, providing additional staff training and vaccination against diseases like smallpox, and implementing many other protective measures.

The topic of health coverage for immigrants was also discussed, with one participant noting that this issue tends to be ignored in Washington. Under federal law, most non-citizens do not qualify for Medicaid coverage. As a result, states with large immigrant populations (including Texas) must finance their care with local dollars. Budgets are being stretched to their limits, and the participant suggested that the impacts of federal decisions (e.g., non-coverage of immigrants) should be paid for with federal dollars.

Other comments highlighted difficulties facing the private, employer-based insurance system that currently covers more than two-thirds of all nonelderly Americans. For example, one participant reported findings from a recent survey showing that over half of small employers in the state of Texas report being able to pay no more than \$50 a month per employee for health insurance, and over 75 percent report being able to pay no more than \$100. Since many of their employees are low-wage workers for whom a large out-of-pocket contribution would be a hardship, these amounts—\$ 50, \$100—are probably not enough to purchase a policy with meaningful coverage.

With regard to employer-based coverage, one participant stated that the system may be disintegrating. He commented that in many ways, employers are not a natural grouping of people for insurance purposes. The arrangement did not develop because it made clinical or social sense; it developed because it made economic sense as a means for attracting and retaining employees. If the benefit is no longer viewed as crucial to staying competitive, and firms can no longer justify the cost, he believes we will see a continuing decline in the employer-based insurance model. Coverage contractions in the small and medium group markets have been significant, and cost-sharing is up. Firms are backing off from prescription drug and comprehensive coverage for retirees, and he stated that it may only be a matter of time before this trend works its way into the everyday employee population.

A member of the audience spoke up to echo this sentiment, noting that she has seen big changes (primarily in the small group market) during her 15 years in the insurance business. At the start of her career, zero-deductible policies with dependent coverage were common, and many employers paid premiums in full for their employees. Today, the majority of her employers pay only 50 percent of premium costs for policies with larger deductibles, and dependent participation is down. She commented that during many of the benefit meetings she attends, employers encourage employees to explore alternative options for coverage under public programs, including Medicaid and SCHIP.

In response, one roundtable participant stated that he thought “disintegrating” was too strong a word to describe what is happening with the employer-based system, because changes in the data are cyclical and so small that they are probably insignifi-

cant. There were improvements in coverage during the economic boom of the 1990s, even if the improvements were not as great as some would have hoped for. There is a trend in the opposite direction right now, but considering the dismal state of the economy, a true disintegration would be producing numbers much worse. The participant stated that employers are going to be in the game as long as they see a reason for doing so, and as long as they get something out of it. Among larger firms that have consistently offered coverage, no one wants to be the first to walk away. However, due to the shortcomings of available data, we know less about the dynamics of small business offerings.

Despite the fact that nearly half of the population was uninsured, a physician in the audience noted that in the 1950s, there was not much discussion to be had about the “problem” of health insurance coverage. Fifty years ago, medical care was not nearly as expensive or complex. Individuals with catastrophic illnesses could foot a relatively small bill, simply because there wasn’t very much that could be done to help them. Today, we talk about insurance (or lack thereof) being a problem because costs are so much higher. Pharmaceuticals and advances in medical technology are a contributing factor, as is the administrative burden associated with private insurance. Noting that the cost of running Medicare is about five percent, he believed that the equivalent figure for a private company might be 30 to 40 percent (with CEOs making up to 100 times as much as health care providers).

In response to the discussion of rising costs, one roundtable participant called attention to the complexity of the issue, commenting that “if we decided we were going to get dissuaded and talk about costs, we may be another decade before we get back to talking about this [current discussion topic of access to health care versus access to insurance].” While admitting that we do need to do something about the problem, she believed that the cost issue would lead the discussion down a difficult path.

What Role Does the Individual Play?

Another recurring topic of roundtable discussion was the role of the individual when it comes to taking responsibility for his/her own health and for his/her own health insurance decisions. Since lifestyle choices can contribute to the development of chronic illnesses (cardiovascular disease, diabetes, smoking-related conditions, etc.), many participants viewed prevention as an integral part of any health care or health insurance initiative. Others were concerned that most people find health insurance choices to be complex and confusing; additional consumer education may be needed if we wish to empower individuals to make informed decisions about coverage.

With regard to prevention and patient education, one participant pointed out the growing number of children with adult-onset diabetes seen in Texas clinics. While noting that she did not want to “victimize the victim,” she believed that we should be doing a better job of helping individuals to help themselves. While treatment is important, more emphasis should be placed on low-tech prevention efforts that reduce the need for high-tech interventions down the road. Smoking and obesity

were mentioned as two specific areas for improvement. Following these comments, another participant noted that it may be particularly helpful to custom-tailor preventive efforts at the community level.

A physician from the audience suggested that teaching individuals how to stay healthy is both a moral and economic imperative for the country. Reiterating the point that prevention education should begin at an early age, he described a bill in the Texas Legislature that requires every elementary school in the state to have a comprehensive program for promoting healthy lifestyle behaviors in place by 2007. Other participants worried, however, that even when armed with information, individuals may still make poor decisions. For example, while it is impossible today to avoid warning messages and information about the harmful effects of cigarette smoking, many people continue to smoke. Some agreed with the statement that “people who make the dumb decisions ought to pay for [the cost of] making the dumb decisions,” but others expressed concern about deeming individuals deserving or undeserving of care.

Another issue that arose was the responsible use of health care. One individual suggested that first-dollar insurance coverage (which could actually be referred to as prepaid health care, rather than insurance in the traditional sense) is one of the reasons why premium costs are rising today. Most people realize that their \$10 copay doesn't cover the full cost of a doctor visit, but neither they nor their health care providers have an incentive to limit the use of services (above and beyond what is medically necessary) when required out-of-pocket payments are low and reimbursements are flowing.

More transparency with regard to actual costs, charges, and payments for medical care was mentioned as a possible solution, as was moving towards a system with better incentives for both healthy behavior and cost-effective service utilization. While some agreed that not everyone should have free or subsidized access to every medical test or procedure available, others were concerned about how and where to draw that line.

As the discussion continued, one participant made a point of distinguishing between making decisions about health care and making decisions about health insurance. While some of the morning panelists favored more freedom for individuals to choose the type of insurance plan that suits their needs best, she suggested that based on findings from a survey conducted in Texas, small employers and individuals were “begging for someone else to take this decision away from them.” They reported finding the insurance business complex and confusing, and many favored limited over unlimited choice when came to policy decisions.

Health insurance education is notably absent in school curricula, and this may be part of the reason why consumers find these choices so difficult. A comment was made that if we plan to head down a road that requires more individual responsibility and choice in the insurance market, we also have a responsibility to provide information that will make those decisions easier.

How Should We Allocate Resources for Health Care?

Another recurring theme of the roundtable discussions was allocation of resources within the health system. Specifically, the panels discussed how resources should be allocated within the health system, whether there are enough resources already in the system to address the problem of the uninsured, and whether reducing the uninsured is the highest priority when balancing that need against many other health system issues.

One of the themes of the roundtable discussions was whether limited resources should be used to increase access to health insurance for some segment of the population of uninsured (and if so, which segment should be the priority), or if resources should be used to strengthen the network of safety net providers that serve uninsured Americans. There was agreement that community health clinics and safety net providers play a critical role in ensuring that all Americans have access to some level of care and that they provide quality care, and that this service should be maintained.

Some panelists argued, however, that given a choice between strengthening this network and increasing access to insurance, the priority should be to increase access to insurance because people with health insurance have access to a broader array of services than safety net providers can typically afford to offer, and because health insurance allows individuals to choose their providers and better coordinate their care. It was also observed that studies have found that people who have access to health insurance have better health outcomes. Furthermore, it was noted that increasing access to health insurance benefits not only the individual who gains insurance, but also the health system as a whole. However, citing a recent survey conducted by the Texas Department of Insurance that found that there is a segment of the uninsured population that will probably never acquire health insurance (either because they do not want or it or they cannot afford it), one panelist argued that exploring alternatives for increasing access to care for the uninsured should be a high priority.

Of course, dealing with the problem of the uninsured must be balanced with other priorities in the health system. While most panelists agreed that reducing the uninsured should be a top priority, one panelist suggested that it would be sensible for states and communities to scan the horizon to see if there are other areas they could invest in that would do more to improve health outcomes (such as pediatric immunizations or cancer screenings) with the same or fewer resources. Another panelist observed that increasing access to insurance, particularly if it is through the Medicaid program, may not be effective if the low rates of Medicaid reimbursement are not improved. He suggested that low Medicaid rates in Texas have already discouraged many providers from participating in the program or have forced them to limit their participation in the program, and that if the Medicaid program expands, Medicaid consumers will find it difficult to find a provider who will see them.

Some panelists commented that they believe that there are enough resources in the health system to reduce the number of uninsured, but that they are not being

used efficiently. One participant observed that the state of Texas, in particular, could do more to maximize the resources it devotes to health care. He noted that the state has not been able to successfully secure federal matching funds for the money that hospital districts pay to care for people without health insurance.

Part III

Policy Alternatives: Additional Resources

Chapter 8

Tax Credits

Expanding Coverage Via Tax Credits: Trade-Offs and Outcomes

by Mark Pauly and Bradley Herring

ABSTRACT: In this paper we discuss various options for using refundable tax credits to reduce the number of uninsured persons. The effect of tax credits on the number of uninsured depends on the form of the credit scheme adopted. Moreover, since large subsidies for private insurance directed to low-income persons have never been implemented, there is considerable uncertainty about the effect of various tax credit proposals. We find that small credits will do little to reduce the number of uninsured but that credits covering about half of the premium for a benchmark policy might have a significant effect, especially if they take a fixed-dollar form and can be used for policies with few restrictions. Finally, we discuss the normative issues surrounding the “costs” of these credits schemes, and the policy issues raised by the uncertainty of the effects.

The 16 percent of the U.S. population that lacks health insurance defies simple characterization. It covers the spectrum of family structures, ages, work involvement, ethnicities, and tastes. However, there are two causes of the lack of insurance that all analysts accept: Many people’s incomes are too low to allow them to afford insurance, and the premium they would have to pay is too high to make insurance purchasing attractive. The “refundable tax credits” (hereafter, just “credits”) approach to increasing the extent of insurance coverage targets the uninsured in these groups. (Using

refundable credits in some fashion to help people afford insurance is a recurring proposal on the part of presidential candidates and members of Congress.) Credits do something exceedingly simple: They reduce the net premium a person would have to pay for at least some insurance policy. Refundable credits are used to offset other taxes or are paid to the household if there is no tax liability; they differ from tax deductions because they are not used to change taxable income and do not depend on the household's income tax rate. Thus, credits simultaneously increase the affordability and the value of coverage (compared to its absence). This key observation points to both the strengths and the weaknesses of the credits approach.

One of the strengths is simplicity itself. While their actual administration can be complex, tax credits are a simple, straightforward tool. They do not require changing the health care regulatory structure, negotiating with providers, reorganizing the delivery system, or altering the philosophy of medical treatment. However, for those who think that the problems of the uninsured go far beyond their need for insurance, or who think that the problems of the U.S. health care system go far beyond the problem of the uninsured, this sharp but narrow focus will be viewed as a weakness. Credits will not necessarily reduce waste, lower administrative costs, improve doctor/patient relationships, or cure dread diseases. Credits are intended to increase access to the current system, not to redesign the system. Still, the influx of millions of formerly uninsured persons now armed with health insurance probably would change the system—but that would be an indirect (although probably desired) effect, not a goal.

For some, further restructuring of the insurance markets in which credits can be used is also an objective. In both the individual and small-group markets, it would be desirable to lower administrative costs and protect insured persons against risk-related jumps in premiums, if ways can be found to achieve these goals that do more good than harm.¹ In this paper, however, we do not focus directly on such restructuring, but we highlight links between credits programs and reforms and discuss some aspects of reform.

What Do We Want; What Do We Want to Know?

Credit plans can take on many forms for a given population and can be targeted at a wide variety of subpopulations. Within the overall objective of reducing the number of uninsured persons, a range of impacts are possible. Especially if resources are limited, there are trade-offs and valuations that must be considered. For example, are “we” indifferent among strategies that reduce the head count of the uninsured, regardless of which type of uninsured population gains coverage? Are some uninsured persons more of concern than others: the poor versus the nonpoor, high risks versus low risks, people who reject opportunities to obtain coverage cheaply versus those with few good chances, rational consumers who plan ahead versus those who assume that they are immortal?

Two equally important effects of credit programs should be of interest to policymakers: (1) the change in the number and mix of the uninsured (compared with

no program); and (2) the effect on “disposable income” of those who use the credit (compared with no credit). The first measure describes potential impacts on the health care system; the second, potential impacts on the fiscal system and (eventually) on overall macroeconomic activity. The first impact occurs because the credit provides a targeted subsidy; the second, because the credit provides a targeted tax cut.

Because credit programs can have so many design variants, attempts to estimate the two effects necessarily cover a wide range. The proper answer to the question of the impact of credits is that it all depends on the size and form of the credit. In addition, because many plans direct subsidies to populations that have never before received the kinds or magnitudes of subsidies for purchasing the qualified private insurance plan of their choice, attempts to estimate what credits would do must necessarily cover a wide range. However, it is the range of likely values, not a point estimate of a particular researcher’s best guess, that ought to be relevant for policy.

Policy design in the face of uncertainty. Virtually any program to reduce the number of uninsured persons or relieve the financial burden of paying for medical insurance will have uncertain impacts as long as people participate in them voluntarily and resources are not so lavish that any alternative to participating in the plan is economically irrational. Our view of proper policy evaluation is that this uncertainty should be front and center, not ignored or disguised to avoid “confusing” policymakers. The reason is that what seems the best policy if only we knew everything with certainty will be an inferior policy if our guesses turn out wrong; another policy may not be the unique best in any given setting but may offer a good outcome over a wide range of eventualities.

This kind of flexibility and adaptability are inherent benefits of tax credit schemes. They can be designed to fit a wide variety of equity definitions. Moreover, they do not require enormous investment in fixed administrative structures, which are difficult to change later in the face of experience, and their financial design parameters can be modified easily and quickly.

Analyzing the Design and Impacts of Credits: A New Approach

The great bulk of analyses of tax credit approaches to health insurance have taken one of two forms: either a specific credit plan is proposed, costed out, and defended (or perhaps attacked); or general observations on the desirability of credits are provided with little detail.² A few quantitative analyses have made comparisons within an eclectic set of proposals, usually chosen to span some spectrum of whatever is politically germane at the moment.³ In this paper we adopt a different method, first specifying a set of “universal” design parameters for credit plans and then illustrating the trade-offs among those design parameters by estimating the effects of a variety of plans with specified parameters. Our primary goal is to illustrate these trade-offs, and we comment briefly on the confidence in estimates of impacts, including our own.

Design parameters. Besides eligibility, any credit scheme has three important

design parameters: (1) the dollar or proportional subsidy the credit provides; (2) whether the credit is a set dollar amount or a set proportion of the premium; and (3) the premium for the lowest-cost insurance plan eligible for the credit. For instance, a credit might pay \$1,000 toward a set of plans, the least costly of which carries a premium of \$1,200 but whose premium could be as high as \$2,500; the potentially insured person would then face a net premium ranging from \$200 to \$1,500. Or the credit might pay 50 percent of the premium; the person would then have to pay \$600 for the least costly plan but \$1,250 for the most costly.

To illustrate the differences among plan design features, we have estimated the reduction in the numbers of uninsured in working families and their distribution across people of different types for plans taking on a range of values for each of these three parameters.⁴ Much of our discussion, though, highlights results that are subject to approximately the same “cost” of \$1,000 in terms of tax reductions—either a flat-dollar credit equal to that amount or a proportional credit covering about 50 percent of average premiums.⁵

Using data from the 1996 Medical Expenditure Panel Survey (MEPS), we employ two different methods to estimate these effects. We do so because current knowledge is sufficiently imprecise that it is desirable to look for overlap among different approaches to estimation rather than basing conclusions on a single calculation or even a single method applied to a variety of data sets.

Problems of imprecise measurement. The reason current estimates are imprecise is instructive and relevant to our own choice of methods. Current counts of the number of uninsured in working families presumably reflect people’s responses to the current set of incentives to buy insurance. (According to the MEPS data, more than 80 percent of the uninsured have an employed family member.) The primary incentive is the current tax treatment of employer coverage. This tax law provision allows those who receive part of their total compensation in the form of a group insurance premium to exclude the amount the employer paid from taxable income for all federal and state taxes. The implicit subsidy is therefore equal to the worker’s marginal tax rate, and could be as high as 50 percent for high-wage workers facing high state income taxes.

We do know the proportion of high-wage workers who obtain insurance when they are subsidized at such a high rate—virtually all of them. We also know that many—but by no means all—low-wage workers obtain insurance when the subsidy rate is low; the current subsidy rate would range from 8 percent to 23 percent for the low-wage workers with either zero or 15 percent marginal federal income tax rates. However, most tax credit proposals involve high subsidies—up to 50 percent or more—directed at low-income persons. So while we know what happens with high-wage workers and high subsidies, and with low-wage workers and low subsidies, we have no observations on actual behavior of low-wage workers with high subsidies, with the subsidy applying primarily to individual insurance.

We take specific account of the existence of current subsidies in both how we

estimate behavior and how we calculate the effect of behavior on the proportion uninsured. Specifically, since many uninsured workers could have obtained tax-subsidized job-related insurance (especially in today's tight labor market) but chose not to do so, any new subsidy will have to be at least as large as the rejected subsidy. Small subsidies, on the order of 25 percent of premiums, will therefore generally only affect those who are self-employed—a minority of today's uninsured workers. To generate more relevant estimates, however, we can use the observations on the insurance purchase rates of low-wage employees who obtain both a tax subsidy and low administrative loading provided by large-group insurance. This comes closest to what might be achieved with moderately large subsidies for the purchase of individual insurance.

We therefore estimate an econometric model to predict the likelihood that workers and their dependents obtain insurance, where the “price” of insurance incorporates the administrative loading appropriate to their industry and the tax subsidy (applied to the average employer-paid portion of the premium) appropriate to their income level. This is intended to be a model of long-run behavior, so we assume, as empirical evidence and theory strongly suggest, that the incidence of both credits and employer premium payments is on workers' wages.⁶ The loading and the subsidy are initially assumed to be proportional to the premiums in the group and individual markets.

As might be expected, the administrative loading for individual insurance as well as the size of the proportional credit will determine the proportion of the population induced by the credit to obtain insurance. In the results presented below, we assume that such loading equals 30 percent of premiums. This appears to be what more efficient nongroup insurers can achieve.⁷

Impact of credits for a benchmark plan. Exhibit 1 shows the change in the proportion of uninsured for different proportional tax credits applied to a comprehensive benchmark plan. While the estimates we present assume that persons at all income levels are eligible for credits, results also are shown for persons either below or above 300 percent of the poverty level (\$48,108 for a family of four in 1996). A small (25 percent credit) is claimed largely by the self-employed and causes only a small reduction in the number of uninsured persons. A moderate (50 percent) credit, in contrast, cuts the proportion uninsured in half, and a large (75 percent) credit converts more than four-fifths of the uninsured to insured. The empirical fact driving these results is that, even among low wage persons, only a tiny proportion of persons working in industries or occupations characterized by very large firms remains uninsured. A key issue is whether the behavior of low-wage employees in that setting can be extended to other workers with similar net premiums but in different types of insurance markets.

“Reservation price.” Because of concern that extrapolating from the group insurance setting, although reasonable, may be overly optimistic, we implemented a second technique. This other simulation approach is based on expected-utility maximization for a population facing a given distribution of medical expenses. The idea is that we can observe both the mean and the variance of the total out-of-pocket costs faced by a certain proportion of the population; here, too, we use the large-sample

Exhibit 1
Impact of Proportional Tax Credits: Extrapolating Group Insurance Purchase

Income Level	Percent Insured	Percent Reduction in Uninsured
<i>All income levels*</i>		
Currently	80.0%	—
25% credit	82.6	13.0%
33% credit	84.0	20.2
50% credit	90.3	51.7
66% credit	95.1	75.5
75% credit	96.6	83.2
<i>Below 300% of poverty</i>		
Currently	69.3	—
25% credit	72.7	11.1
33% credit	75.5	20.0
50% credit	85.2	51.8
66% credit	92.1	74.2
75% credit	94.4	81.9
<i>Above 300% of poverty</i>		
Currently	89.7	—
25% credit	91.5	18.0
33% credit	91.8	20.8
50% credit	95.0	51.5
66% credit	97.8	79.1
75% credit	98.6	86.9

Source: Authors' calculations using 1996 Medical Expenditure Panel Survey data.

Notes: The federal poverty level was \$16,034 for a family of four in 1996. A proportional tax credit of x percent reimburses an amount equal to x percent of the insurance premium to the insurance purchaser through decreasing one's tax liability—perhaps via a refund. The reduction in the uninsured results from a proportional tax credit equal to the specified amount applicable to individual insurance with 30 percent administrative loading. Individual-market premiums are assumed to be risk-rated by whatever mechanism exists in the employment-based market.

*Sample includes full-time workers and their dependents only.

1996 MEPS data. Given an assumption about the level of risk aversion, we can estimate the maximum premium or “reservation price” such people would be willing to pay for a given insurance policy. If the reservation price exceeds the premium, net of the credit they will face, we then assume that they will choose to become insured. Presumably even a person who is not at all risk-averse will prefer insurance if the net premium is less than the expected value of out-of-pocket expenses.

The strength of risk aversion turns out to be a relatively minor determinant of what proportion of people buy insurance. What is much more important is the expected amount of out-of-pocket expense; this value is reduced considerably by access

to free care by the uninsured. Indeed, the MEPS data indicate that the uninsured typically pay only about 30 percent of the actual cost of their care.⁸

Specifically, we used the MEPS data to estimate the expected cost of out-of-pocket expenses for adults, adding to that an estimate of risk aversion and the value of the additional care that insurance will induce them to consume. This then is the price they would be prepared to pay for insurance. The expected cost of out-of-pocket expense is assumed to include two components: the actual out-of-pocket payments the person makes, and a “disutility” cost associated with any free or bad-debt care (because of lower quality, less personal attention, or longer waits).

A lower bound for this reservation price results from assuming that currently uninsured persons will continue to use relatively low amounts of medical care if insured (even after adjusting for moral hazard); an upper bound results from assuming that the currently uninsured will use amounts equal to those used by currently insured persons with similar observable characteristics (such as age, sex, and health status). For our “central tendency” estimates we assume that the quantity is the average of these two levels, but we also show the range about this average. People are assumed to be willing to buy insurance if their reservation price exceeded the premium for individual insurance, with 30 percent loading and adjustments for age and sex, as reduced by a tax credit.

In Exhibit 2 we assume that the great majority of persons who receive care whose cost is covered by charity or bad-debt forgiveness cannot pay the full cost for the care they need, but that they do attach disutility to this outcome. An important determinant of the effectiveness of credits is how large this disutility is. If we assume that one dollar of the bill for bad-debt or charity care carries disutility equivalent to thirty cents of out-of-pocket payment, the estimated reduction in the percentage uninsured for a 50 percent proportional credit is estimated to be 58 percent (range, 30-85 percent), as shown on line 3 of Exhibit 2. If instead we assume that this disutility equals fifteen cents on the dollar, the central estimate is 27 percent (range, 6-49 percent). Only if we were to assume that the uninsured attach no disutility at all to bad debt and charity care do credits have negligible effects.

A key determinant of the effectiveness of a proportional credit program, therefore, is how much access to free care the uninsured have and how they feel about it. It is obvious but painfully true that if uninsured persons have easy access to free care, that policy (even if unattractive) may for some be preferable to having to pay even half of the premium under a credit program.

Fixed dollar or proportion? The reduction in the number of uninsured persons also depends importantly on the form of the credit. Suppose that the same tax credit amount is used to provide a fixed-dollar rather than a proportional credit toward a benchmark plan. This means that persons who would have paid a low total premium will now have more of that premium covered by the credit, while those who would have paid a high premium will receive less. As shown in the bottom panel of Exhibit 2, the effect of substituting a fixed-dollar credit for a proportional credit of equal total

Exhibit 2
Impact of Tax Credits: Estimating Utility-Derived Reservation Prices

	Percent reduction in uninsured	
	Estimate	Range*
<i>Proportional credits</i>		
Higher cost of "free" care		
25% credit	38.9%	(12.0-65.9)
33% credit	44.7	(17.9-72.5)
50% credit	57.5	(30.3-84.7)
66% credit	73.1	(51.9-94.3)
75% credit	82.6	(68.4-96.9)
Lower cost of "free" care		
25% credit	13.3	(01.8-24.8)
33% credit	17.1	(02.6-31.6)
50% credit	27.4	(06.0-48.8)
66% credit	46.2	(19.5-72.9)
75% credit	58.6	(31.2-86.0)
<i>Fixed-dollar credits</i>		
Higher cost of "free" care		
25% credit	46.9	(27.6-66.3)
33% credit	53.5	(36.2-70.6)
50% credit	65.5	(53.0-78.0)
66% credit	71.9	(59.0-84.9)
75% credit	74.3	(60.9-87.8)
Lower cost of "free" care		
25% credit	26.0	(11.6-40.5)
33% credit	35.8	(22.9-48.8)
50% credit	48.1	(38.1-58.1)
66% credit	58.9	(54.7-63.1)
75% credit	61.2	(55.5-66.9)

Source: Authors' calculations using 1996 Medical Expenditure Panel Survey data.

Notes: Reservation prices were determined for a comprehensive insurance plan with a \$200 deductible, 20 percent coinsurance, and a \$1,500 out-of-pocket maximum. Premiums vary proportionately with respect to age- and sex-related expected expenses, and administrative loading is assumed to equal 30 percent of premiums.

*The lower bound of each estimate assumes that the currently uninsured continue to consume relatively low levels of medical care given their age, sex, and health status when insured—even after controlling for increased consumption due to moral hazard. The upper bound assumes that the currently uninsured consume the same amounts of medical care that the currently insured consume, given the same age, sex, and health status.

"cost" is generally to increase the "effectiveness" of the credit in reducing the number of uninsured. The reason is simple: A fixed-dollar credit equal to about half of the total premium for a typical individual is equal or very close to the total premium for younger persons, especially males. In effect, the fixed-dollar credit can cover more

persons than the proportional credit can because it covers younger, lower-risk persons (who also skimp on care to a large extent when they are uninsured). While one might well prefer that high-risk people (who will benefit more in terms of access to care—and possibly final health levels—and financial protection) become insured, the choice of credit type is not so obvious when the trade-off is between covering a few more high risks and many low risks.

Altering the level of benefits. The third policy design feature that can alter the effect of a credit is to change the cost of the plan for which the credit must be used. If the cost of the required plan is cut from \$2,000 for an individual to \$1,000, fixed-dollar credits bring in many more people. However, \$1,000 obviously buys a less comprehensive policy than \$2,000 does. In the limit, if the person eligible for a \$1,000 credit could use it on any policy that costs at least \$1,000, there should be virtually universal take-up of the credit, as long as insurance is worth anything and people know about the credit. Coverage could become near-universal in the sense that almost everyone would have some coverage, but it would not be comprehensive.

Evaluation obviously depends on estimating what the coverage a smaller credit would buy would look like. If it was catastrophic coverage, the deductible would have to be high; there would not be much additional financial protection. Much of the benefit then would go to just replace free care, which is disproportionately provided to persons who incur high expenses. If the premium were used to buy a first-dollar policy, the upper limit would have to be set at less than \$2,000, exposing the person to financial risk even in the case of moderate illness and covering many small claims with high administrative costs. However, most people will prefer neither pure catastrophic nor pure fixed-dollar coverage. Lower-income persons will want coverage with a modest deductible and a decent upper limit.

Effects of partial coverage. We use our second simulation technique to estimate what \$1,000 policy people would choose to maximize their expected utility. If free care is available for large expenses, but the person prefers to avoid free care, we estimate that the policy the person would most prefer with a \$1,000 premium for an average-risk individual will have a \$525 deductible but an upper limit of \$4,072. Compared with no insurance, the person will be protected against those moderate expenses he or she might have expected to have to pay. (Of course, if providers begin to charge for some of the catastrophic care formerly provided free, the financial protection—but not the utility gain from less charity care—is eroded.) An upper limit on benefits is chosen (against traditional economic intuition), since we have observed that the proportion of free care to total expenses increases dramatically as total expenses rise.⁹

The key policy issue obviously is how beneficial the improved access associated with this partial-coverage policy would be. The trade-off is then between having a population in which everyone has some but incomplete coverage and having one in which some have much better coverage than before but others still remain totally uninsured. If we are not prepared to spend the money to cover everyone, this type of painful trade-off is unavoidable.

Real Costs versus Budgetary Accounting

Considerable effort has been made to estimate the effect of various tax credit proposals on the number of uninsured persons. The next step usually is to calculate the budgetary impact of the credit and then divide the reduction in the number of the uninsured by the net budgetary impact to calculate a so-called cost per newly insured person. However, this amount does not represent a cost in terms of real resources used, even if one assumes that insurance premiums are exactly equal on average to the cost of resources consumed by persons with insurance. Usually the measured “cost” exceeds the premium because some of the credit is claimed by persons who would have been insured in the absence of the credit, in either the group or individual market. In the case of persons who would have received subsidized group insurance, the actual net “cost” is relatively small, since it is only the difference between the credit and the current tax subsidy. In contrast, most of those who buy individual insurance are not subsidized at all, and thus their entire credit is incorrectly counted as a “cost” to the tax system.

Our key point is that credits claimed by the formerly insured in excess of their current subsidies do not represent real resource costs. If the insurance is equivalent, the real resources used for their medical benefits are the same with or without a credit. The payment from the Treasury to such persons is just a transfer or, more accurately, is a tax reduction relative to their tax obligation before a credit program was introduced. What taxpayers as a group “lose” when the credit is offered they gain in the form of lower taxes. This is a hard message for policymakers to accept, not just because some feel that tax collections “belong” in some sense to the government, but also because discussions of the federal budget tend to treat credits as identical to government outlays for real resources (such as buying a tank), even though no resources are consumed by transfers.

The transfer represents substitution of a targeted tax cut for responsible behavior for some alternative tax cut. How can we make the distinction between real costs and transfers sharp enough to offset this accounting distortion? One way is to consider an example in which some people are eligible for credits to help them buy health insurance while others who are identical with regard to income, health status, and everything else but the value they place on insurance are declared ineligible. Specifically, the rule is that if your value of health insurance was higher than its cost, so that you had already obtained insurance (which you paid for by sacrificing money wages), you are ineligible. Would this be fair?

We think that the answer is clearly negative: No principle of equity of which we are aware which would make this distinction. In fact, no one has proposed to deny credits to those who have already bought individual insurance, although many propose to deny credits to persons who obtained the insurance they value highly by taking a less attractive job just because it comes with insurance. (Perhaps this is because such persons are under the mistaken impression that the employer is “giving away” insurance to them rather than taking the cost out of their wages.)

The other way to make the distinction is to think of credits explicitly as tax cuts. Suppose we proposed to reduce every worker's income and payroll taxes by \$1,000 across the board but refused the tax reduction to those who failed to obtain health insurance. Especially if the credit or reduction is large enough that most people at every income level would claim it, this arrangement could hardly be labeled unfair.

How to Navigate through the Uncertainty?

A number of studies have estimated the impact of tax credit schemes on the number of uninsured persons; results range widely. Why do analysts disagree? Our own estimates have already shown how different and equally plausible assumptions about parameters still unknown (for example, such as how people feel about charity and bad-debt expense) can lead to a wide range of estimates of outcomes. Since no one has observed relatively large subsidies for the lower-income populations who are the bulk of the uninsured, analysts are forced to extrapolate from behavior in slightly similar but by no means identical settings.

One such setting is the behavior of the self-employed in response to changes over time in the tax deductibility of their insurance premiums.¹⁰ The problem here is generalizability: The self-employed for whom deductibility matters tend to have different incomes from all uninsured and to be less attracted by the fringe benefits that come from wage employment.

The other approach, used in the larger-scale simulations, is to estimate the rate of purchase of health insurance by assuming that a program of tax credits for all is equivalent to the reduction in premiums some employees face when they select jobs in which the employer pays part of the premium. Both cross-section and time-series variations have been studied.¹¹ The question therefore, is: If x percent of the workers at ABC Corporation are uninsured when the firm asks them to pay some proportion of the premium, would x percent of a random sample of workers also choose to be uninsured if a credit covered the same proportion of their premium? The answer would be affirmative only if workers were randomly distributed across jobs, independent of the values they attach to health insurance, which is surely not the case. But since employers provide insurance to attract those workers who value health insurance, it seems quite unrealistic to assume that even after controlling for workers' observable characteristics, each firm's workforce represents a random slice of the working population.

To be more specific, there are at least two differences between the choice setting under a credit and what is observed in the employment-based setting with nonzero employee premiums. The first difference is that employees usually have only a few if any choices, whereas persons with credits could choose the plan they like best from a wide range of plans. If I am asked if I want to pay half of the premium for the oppressive managed care plan my employer has selected, the fact that I turn it down hardly proves that there is no insurance plan I would select if I received a credit toward the plan I choose. Second, persons who value health insurance at less than they would

have to pay for it under group provision presumably would most prefer to work for firms that pay higher cash wages and offer no employer-paid health insurance at all or who pay only a small fraction of its premium if they do pay something. Thus, the observed percentage of uninsured in firms with high employee premium shares is likely to overstate what the percentage would be among a random or average sample of all workers.

Other researchers have tried to estimate uninsurance rates based on experience in Medicaid programs, on the impact of variation in state income tax rates, and on the behavior of small employers who received subsidies.¹² It should be no surprise that the range of estimates is large, which appropriately reflects great uncertainty.

Other Design Features

As suggested by this discussion, there is more to the purchase of insurance than just the size of a credit. People will be more likely to use a credit of a given size if they can use it easily for a very wide range of insurance policies. The difficult experience of Medicaid and the State Children's Health Insurance Program (SCHIP) in some states in getting people to enroll in free coverage for which they are eligible is often and appropriately cited as evidence that a credit program may not reach all of the uninsured. Today's individual insurance market (as we have discussed elsewhere) is sorely in need of improvement, especially in terms of cost, ease of enrollment, and continuation of coverage.¹³ While guaranteed renewability, which protects people against the onset of high-risk conditions, is now required for individual insurance, that type of insurance remains costly to administer. The economies associated with group choice of plan and group billing available in the group setting are not easily extended to a market in which persons choose individually whether to be insured, what plan to take, whether to pay their premiums, and whether they should complain.

Simplified eligibility procedures. Some features that are intrinsic to tax credit plans may help with some of these problems. How easy it is to establish eligibility depends on how complex the eligibility rules are. Suppose that every worker at a given (low) family income level is declared to be eligible for a credit. Then there is no need to "apply." Once the government knows the person's income (which it must know in order to establish that there is little or no income tax liability), it could simply mail out or distribute credit certificates to all such persons, which they could then redeem against the premium for a previously qualified insurance plan or against their taxes. Millions of potential customers armed with large discount coupons might be enough to induce individual insurers to offer attractive and easy-to-buy policies. Such a program could greatly reduce selling costs and stimulate the individual health insurance market to transform itself (possibly with the help of electronic means) into a more efficient mass market for coverage.

Links to employment-based coverage. One of the most common sources of confusion about the use of credits is the belief that they will destroy the employment-based groups in which the great bulk of Americans now buy insurance. The goal for

a credits scheme is clear: People should buy insurance in the most efficient setting for them. For those who work for large firms where the advantages of group insurance are strong, the availability of a tax credit need not change their choices, as long as the credit can be voluntarily substituted for the tax exclusion and can be used to pay for group as well as individual insurance. If the program denies the use of credits to persons who want to arrange their insurance purchases at the workplace, there will be an inappropriate negative effect.

There may be an appropriate negative effect at small firms with heterogeneous workforces, which were settling for the single policy that pleased few of them only because the tax exclusion made it a good deal. If the administrative cost savings over individual insurance are small, and the value of the wider range of choices potentially available in that market is large, it is desirable to terminate small-group purchasing in favor of individual insurance. Since group insurance does not pool risk much more effectively than does individual insurance with guaranteed renewability, not even older workers or those who become higher risks will stand to lose from such a transition.¹⁴ If the credit is neutral with regard to the way in which coverage is obtained, people will not use it for alternatives to group insurance if those alternatives are more costly.

The workplace is the place at which all workers are required by law to specify the amount of federal tax they expect to have to pay and to begin to pay it in installments through the use of withholding. The withholding mechanism provides a tailor-made vehicle for financing health insurance: The person who expects to be eligible for a large credit can declare this fact and receive a reduction in withholding, which can then be used immediately to pay for part of the monthly insurance premium. Some employers may be willing to act as collection agents for insurers (through the use of defined contribution plans) to reduce transactions costs, which could be incorporated into Web-based billing and administration systems.

Concluding Comments

Since we are virtually certain that part of the reason why some people are uninsured is because they feel they cannot afford insurance, we can be virtually certain that any well-designed tax credit program that cuts net premiums will reduce the numbers of uninsured persons somewhat. However, because the great bulk of the uninsured could have taken advantage of a least a moderate tax subsidy for employer coverage but did not, we can also be virtually certain that a small (say, 25 percent or less) tax credit will not have much effect. It will reduce the taxes of the self-employed who were already purchasing or close to purchasing insurance, but they are a small proportion of all workers. A small credit makes more sense as tax policy (to achieve equity and efficiency on the choice between employment and self-employment) than as health policy.

Beyond these conclusions, predicting the effect of credits that are large enough to matter is fraught with uncertainty, both because there are many possible designs and

because the behavioral responses are properly subject to a wide range of conjecture. The form of the credit matters: If it takes the form of a proportional credit for a comprehensive policy at less than 50 percent of the premium, the effect on both coverage and equity could be limited to a few higher risks. In contrast, a fixed-dollar credit for any policy that costs as least as much as the credit would be widely used. In between these two extremes, a fixed-dollar credit targeted toward a more comprehensive plan could cut the proportion of uninsured by a third to two-thirds—although those who switch would be healthier.

Targeting the poor. Another design issue concerns eligibility: Since affordability is a greater problem for those with low incomes (but not just for those with incomes close to the poverty line), it would seem sensible to target a limited credit to such households. A policy that provided a generous credit to the poor (enough to cover the full premium of a decent insurance policy) and then reduced the size of the credit as income rose would direct subsidies to where they are needed but would have some negative effects on work effort. The rate of reduction in the credit can be made smaller only by extending the credit to higher income levels. The question of how to design and administer a credit that varies inversely with income is one we have discussed at length elsewhere.¹⁵

Limiting the credit. Still another design issue is whether everyone at a given income level is eligible for the credit (as a substitute for the tax exclusion if they are already covered by group insurance), or whether it is limited to those who have not taken or are not eligible for such group insurance. In the latter case, there would still be an increase in the number of insured persons, but limiting the credit would exchange one kind of inefficiency for another. We now inefficiently subsidize people to get group insurance of their employer's choosing; if a generous credit could only be used in the individual insurance market, we would be subsidizing people to use an insurance with a wide range of choices but with higher administrative cost. (We do not think that there would be an appreciable impact on risk pooling, for reasons we discuss in our previous work.)¹⁶ Generalizing the credit to all low-income persons would raise the level of additional "cost" per newly insured person, but that cost would only be a transfer to people who deserve it and whose employment and health insurance choices become less distorted. Transfer or not, however, it would still show up in the public sector's budget and take on a life of its own.

Value of an incremental approach. Given the uncertainties of estimation and the range of trade-offs that have barely been considered and that themselves lack crucial data (such as whether coverage improves health more per dollar for high risks or low risks), suggesting policy is a dangerous mission. If we were to accept this assignment, we would propose to begin in an incremental fashion and use observation of effects as real-time feedback. One sensible place to begin might be with a relatively moderate (but not modest) fixed-dollar credit to families with incomes no higher than the median (and possibly lower). The credit should be enough to cover most of the cost of a basic preferred provider-type policy for the poor and would decline in value as

taxable income rises. The policies eligible for the subsidy would be subject to only mild limitations, and people would be permitted to use the credit for the “moderate-deductible/moderate-limit” form we think many would prefer. Such a strategy would not initially lead to ideal insurance for all, but it should get some insurance to almost everyone who is now uninsured. If the credits are about \$800-\$1,000 per individual, the annual gross value of this tax cut would be on the order of \$79 billion, to be offset in part by higher income and payroll taxes on higher taxable incomes.¹⁷

This first step would not achieve perfection in the view of many (even though it would be costly), since the coverage is less than comprehensive and makes painfully apparent the ambiguous role played by charity and bad-debt care. (Some states have been paying for stop-loss coverage for insurance for low-income persons.) But it could hardly be worse than staying where we are and probably seeing more growth in the ranks of the uninsured when the economy slows. We should perhaps not make the perfect we as taxpayers will not finance the enemy of the good we would cover. By seeing where credits stimulated coverage and where they were relatively ineffective, policymakers would be in a much better position to modify and fine-tune, to achieve adequate coverage for all Americans at a fair price.

Notes

1. For more discussion, see M. Pauly et al., *Responsible National Health Insurance* (Washington: AEI Press, 1992); and M. Pauly and B. Herring, *Pooling Health Insurance Risks* (Washington: AEI Press, 1999).
2. For examples of the former, see D. Cox and C. Topoleski, “Individual Choice Initiatives: Analysis of a Hypothetical Model Act,” EBRI-ERF Policy Forum (5 May 1999); G. Wozniak and D. Emmons, “Tax Credit Simulation Project Technical Report,” American Medical Association Discussion Paper no. 00-1 (June 2000); and K. Thorpe, “New Estimates of the Federal Costs and Numbers of Newly Insured in Senator Bradley’s Health Insurance Proposal” (Unpublished paper, Emory University, 8 November 1999). For examples of the latter, see S. Butler, “A Tax Reform Strategy to Deal with the Uninsured,” *Journal of the American Medical Association* (15 May 1991): 2541-2544; M. Pauly and J. Goodman, “Tax Credits for Health Insurance and Medical Savings Accounts,” *Health Affairs* (Spring 1995): 125-139; and L. Blumberg, “Expanding Health Insurance Coverage: Are Tax Credits the Right Tack to Take?” (Unpublished paper, Urban Institute, 12 August 1999).
3. These include J. Sheils, P. Hogan, and R. Haught, “Health Insurance and Taxes: The Impact of Proposed Changes in Current Federal Policy” (Paper prepared for the National Coalition on Health Care, 18 October 1999); and J. Gruber and L. Levitt, “Tax Subsidies for Health Insurance: Costs and Benefits,” *Health Affairs* (Jan/Feb 2000): 72-85.
4. The explicit methodology used to obtain these estimates can be found in M. Pauly and B. Herring, “Cutting Taxes for Insuring: Options and Effects of Tax Credits for Health Insurance” (Paper to be published in the AEI Seminar Series in Tax Policy, presented 2 June 2000).
5. Data from the 1996-1997 Community Tracking Study’s Household Survey indicate that the average single premium for individual insurance policies is approximately \$1,500, with premiums actually paid varying around this value, primarily because of age and sex differences. However, individual insurance is generally thought to be less comprehensive than group insurance, so a credited “benchmark” generous plan obtained in the individual market may perhaps be more costly than these currently held policies. Jonathan Gruber’s simulation model assumes that considerable adverse selection

exists in this market with individual insurance premiums set to average \$2,214, so that a \$1,000 fixed-dollar credit covers 43 percent of a single premium for a typical uninsured person. For details, see J. Gruber, "Tax Subsidies for Health Insurance: Evaluation of the Costs and Benefits" (Prepared for the Kaiser Family Foundation, January 2000). Empirical evidence that such systematic adverse selection is not observed in this market can be found in Pauly and Herring, *Pooling Health Insurance Risks*. In short, a \$1,000 credit toward the purchase of individual coverage will cover, on average, 40-67 percent of the premium.

6. For more discussion, see M. Pauly, *Health Benefits at Work: An Economic and Political Analysis of Employment-Based Health Insurance* (Ann Arbor: University of Michigan Press, 1997).
7. M. Pauly, A. Percy, and B. Herring, "Individual versus Job-Based Health Insurance: Weighing the Pros and Cons," *Health Affairs* (Nov/Dec 1999): 28-44.
8. More detail regarding the amount, type, and sources of free care the uninsured receive can be found in B. Herring, "Access to Free Care for the Uninsured and Its Effect on Private Health Insurance Coverage" (Doctoral Dissertation, University of Pennsylvania, 2000).
9. *Ibid.*, for the relationship between free care and the magnitude of total charges.
10. J. Gruber and J. Poterba, "Tax Incentives and the Decision to Purchase Health Insurance," *Quarterly Journal of Economics* (August 1994): 701-733.
11. For analysis extrapolating upon variation in employee-paid premiums across different firms, see M. Chernew, K. Frick, and C. McLaughlin, "The Demand for Health Insurance Coverage by Low-Income Workers: Can Reduced Premiums Achieve Full Coverage?" *Health Services Research* (October 1997): 453-470. For analysis extrapolating upon the growth in employee-paid premiums over time, see Sheils et al., "Health Insurance and Taxes."
12. Gruber assumes low responsiveness of the uninsured with very low incomes to tax credits based in part upon the less-than-universal take-up rates of free Medicaid. For more details, see J. Gruber, "Tax Subsidies for Health Insurance"; A. Royalty, "Tax Preferences for Fringe Benefits and Workers' Eligibility for Employer Health Insurance" (Unpublished paper, Stanford University, May 1999); and K. Thorpe et al., "Reducing the Number of Uninsured by Subsidizing Employment-Based Health Insurance: Results from a Pilot Study," *Journal of the American Medical Association* (19 February 1992): 945-948.
13. Pauly et al., "Individual versus Job-Based Health Insurance."
14. Pauly and Herring, "Pooling Health Insurance Risks."
15. See Pauly et al., "Responsible National Health Insurance."
16. See Pauly and Herring, "Pooling Health Insurance Risks."
17. Consider a \$900 credit. There are four cost components we calculate. The first is a cost of \$28.5 billion in credits going to 31.6 million currently uninsured persons with incomes below 300 percent of poverty; we assume a 95 percent take-up rate of at least a partial coverage policy equal to the credit. The second is a cost of \$3.6 billion in credits to the 4.0 million low-income persons who are currently insured in the individual market. The third is a cost of \$47.2 billion in credits to the 52.4 million low-income persons who are currently insured in the group market. These three costs comprise a "gross" value of \$79.3 billion. The fourth "cost" is a gain of \$7.3 billion in taxes collected from these group-insured persons who no longer receive the current subsidy equal to their marginal tax rate; thus, the "net" value of this tax credit would be approximately \$72.0 billion. More detail of the above calculation is available from the authors upon request; e-mail Bradley Herring, <bradley.herring@yale.edu>.

Press Release

Testimony by Mark McClellan and Mark Weinberger

Mr. Chairman, Congressman Rangel, and distinguished Members of the Committee, we appreciate the opportunity to discuss with you today the President's proposals for tax credits for the purchase of health insurance.

Mr. Chairman, the Administration looks forward to working with Congress, in a bipartisan manner, to address the pressing need to expand access to health insurance for uninsured Americans. Almost 40 million Americans are reported to go without health insurance coverage for an entire year, and as many as 20 million more are without health insurance coverage during some part of the year. In addition, millions more Americans are struggling to afford rising health insurance premiums, with little help from the government. The scope and persistence of this issue highlights the importance of our making progress this year.

The President's proposals to introduce health credits for the purchase of health insurance will enable millions of Americans to purchase private health insurance, improving the functioning of private markets, empowering patients to make informed decisions, and increasing utilization of high quality health care. This proposal is part of a broader vision for promoting health care quality and access by developing flexible, market-based approaches to providing patient-centered health care coverage for all Americans.

Health insurance credits use the infrastructure of the tax system to expand access to health insurance. They are a common element of proposals from both Republicans and Democrats. Many of the distinguished Members of this Committee have supported such proposals and sponsored such legislation in prior sessions of Congress. We must seek to bridge partisan divides to come to agreement on this key issue which enjoys such wide bipartisan support.

To help do so, the President has proposed health insurance credits that build on the best features of previous proposals, and that include new innovations to address past criticisms of tax credit proposals. And the President's budget backs up his agenda for using health insurance credits to improve access to good coverage with over \$100 billion in funding. We hope that these steps forward will provide a foundation for decisive action in Congress this year to address the serious problem of health care affordability and the uninsured.

Joint Testimony of Mark McClellan, Member, Council of Economic Advisers and Mark Weinberger, Assistant Secretary of the Treasury (Tax Policy), United States Department of the Treasury before the House Ways and Means Committee on Health Insurance Tax Credits

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The Problem of the Uninsured

In 2000, 14 percent of Americans reported that they were uninsured for the entire year. They may go without effective health care, or may rely on inefficient episodic care at hospital emergency rooms. As a result, our health system spends more than it should on complications of diseases that could have been prevented and on inefficient ways of delivering health care. Even worse, the absence of insurance makes it harder for Americans to work with health care professionals to stay healthy.

The uninsured population does not consist only of the poor or the unemployed. In 1999, 81 percent of the uninsured population were in families with at least one full-time worker. Furthermore, while 36 percent of the uninsured had incomes below the poverty line, a large fraction, 29 percent, had incomes between 100 and 200 percent of poverty. Nearly three-quarters of the uninsured below 200 percent of poverty are adults, many of whom do not live in households with children.

Insurance coverage differs significantly by race and ethnicity. In 2000, 32 percent of Hispanics were uninsured, compared to 20 percent of blacks and 19 percent of Asians. In contrast, just 10 percent of whites were uninsured.

The benefits of increasing participation in health insurance markets extend beyond the ability to have more control over their health care and health realized by the individuals themselves. First, although some people without insurance could receive subsidized basic health care through emergency rooms, it is a very expensive way to provide care, and it is either paid at governmental expense or is uncompensated care that imposes higher costs on others. Second, improved public health through expanded health insurance coverage is important to control the spread of disease. Third, as discussed below, greater participation in insurance markets allows better pooling of health risks—the insurance markets themselves work better.

Problems in Health Insurance Markets

The major goal of health insurance is to allow individuals to join together to reduce their risk of high medical expenses by sharing that risk. Individuals trade the uncertainty of very unpredictable health care costs for the greater certainty of a known premium and protection from very high medical expenses. An important element of insurance is thus the “pooling” of risk—people sign up for insurance before they know how much they will spend on health care, and then the premiums of those who have low expenses help subsidize spending on those with high expenses.

Another important goal of health insurance is to make sure that Americans have access to the most innovative, high-value health care available. The American health care system leads the world in Nobel prizes and in the development of new drugs, devices, and other treatments to prevent and cure illnesses. To make sure these impressive medical breakthroughs translate into good care, health care coverage must be innovative as well. One need look no further than the lack of prescription drug coverage in Medicare to understand the consequences of out-of-date health care coverage. In the years ahead, far more breakthroughs are possible—such as customized treat-

ments based on a clear understanding of an individual's genetic makeup, and specialized "disease management" programs that rely on the Internet and other modern telecommunications technologies that allow patients with chronic illnesses not only to stay out of the hospital, but also out of the doctors office. Innovative health care coverage is essential for creating an environment for medical practice that encourages innovation, value, and continuous improvement in health care.

Several problems can interfere with the ability of insurance markets to achieve these goals. A key problem is lack of choice and competition. As the President has said, our health care system works best when it is centered on helping patients work with health care professionals to decide the best possible treatments. To give control to patients, Americans need the opportunity to choose the health care coverage that is best for them. Without good choices, patients do not have the power to make sure that they are getting the best value from the health care system for their own needs. Instead, government or health plan bureaucrats effectively make decisions for them about what is covered, how their care is reimbursed, and how treatments are provided. In other countries, this has led to queues for treatments, poor quality, and lagging availability of innovative care. Our country has chosen another path: private sector health care based on trust in patients and their physicians. This path rewards innovation in delivering the best possible health care. But the tremendous potential of our health care system is threatened when patients do not have choices about how to get health care coverage. For this reason, the President strongly believes that we must take action to improve the health care coverage options available to Americans.

A second problem is adverse selection. If only individuals whose health insurance expenditures are likely to be high sign up for insurance, then the pooling of risk that is the key to insurance is undermined. Just as individuals with higher expenses want more insurance, insurance companies want customers with lower expenses, and may design their plans to appeal to those with low risk.

Health insurance credits can help solve these problems in health insurance markets by making more coverage options affordable, increasing participation, and reducing adverse selection. Greater affordability and participation will encourage competition to provide coverage that delivers high-value, innovative care. Thus, well-designed health insurance credits reinforce the best features of our private, highly innovative health care system.

In the remainder of our testimony, we discuss the critical design issues in more detail. Design issues include the mechanics of how people actually use the credits to get assistance with health insurance purchases. To work effectively, especially for families with modest means, credits must be refundable, advanceable, and nonreconcilable.

Refundability means that the value of the credit does not depend on taxes owed; even persons who owe no taxes can still receive its full value.

Advanceability means that those eligible for the credit have the option of using it when they are actually purchasing insurance, to reduce their monthly premium payments, rather than having to wait until they file their tax return at the end of the year.

Nonreconcilability means that eligible persons do not have to wait until they know their actual income at the end of the year before they know exactly how much assistance they are eligible to receive. Rather, they can be confident that—as long as they are not committing fraud—they are entitled to the full value of an advanceable credit.

Health insurance credits are not the only promising direction for a health care policy that helps patients get high-quality, innovative care. There is no single approach that can work with the best features of all of our health care institutions to help ensure that our health care system remains the best in the world. Given the need for a broad approach to this problem, the President supports both an immediate temporary health insurance tax credit for displaced workers, as contained in the economic security package, and a permanent new health insurance tax credit to expand health insurance coverage for others that is not dependent on employment status. The President's Budget also contains a number of other initiatives designed to expand health insurance coverage. These include: (i) an above-the-line deduction for the purchase of long-term care insurance; (ii) expanded flexibility of health flexible spending arrangements; (iii) reform and permanent extension of Archer Medical Savings Accounts, to permit Americans to set up health accounts to help them meet the out-of-pocket payments required in many health plans that do not restrict choices of doctors and treatments; and (iv) an additional personal exemption for home caretakers of family members.

These proposals are designed to target a diverse group of people while improving the functioning of insurance markets. In addition, as the President outlined in an address on his health care agenda on Monday, the President's budget includes many other proposals to give all Americans access to high-quality, affordable options for health care coverage. Together, these proposals will provide health security and additional health insurance coverage for millions of Americans, while preserving the best features of our highly innovative health care system.

Permanent Health Insurance Credit for Americans Who Do Not Have Employer-Provided Coverage

Current law provides a number of tax incentives for individuals to obtain health insurance coverage. Employer-provided health insurance and reimbursements for medical care are generally excluded from gross income for income tax purposes and from wages for employment tax purposes. Active employees participating in a cafeteria plan may pay their employee share of premiums and other medical care expenses on the same pre-tax basis. In addition, for self-employed individuals who are not eligible for subsidized employer coverage, 70 percent of health insurance premiums are deductible for 2002, and 100 percent are deductible for 2003 and thereafter.

Proposal

However, as noted above, millions of Americans still are without health insurance coverage. The refundable health insurance credit proposed in the President's Budget

is designed to provide these incentives to assist uninsured individuals in purchasing health insurance.

The credit is refundable, so even those without income tax liability can receive the benefit of the credit. In addition, the largest subsidies will be targeted to low-income families, and only individuals who are not covered by public or employer-based health insurance will be eligible for the credit. Therefore, the credit will be of most help to individuals who are most likely to be uninsured—childless adults who are generally not eligible for public insurance and persons in families with incomes too high to participate in public insurance programs and too low to find affordable coverage options in the private market. The credit will help families who prefer the innovation and flexibility of private insurance options to public insurance, and will enable families to obtain coverage for the entire family from the same providers. The credit is also designed to be available at the time the individual purchases health insurance. That is, people eligible for the credit can receive it in advance, before filing their tax returns, to reduce their monthly checks for insurance premium payments. Finally, because the credit is based on income from the previous year, it is nonreconcilable—earning more income in the current year does not reduce the value of the credit. We believe that the availability and certainty of the advance credit will increase the credit's attractiveness, making it more effective in expanding health insurance coverage.

The proposal would create a refundable, advanceable income tax credit for the cost of health insurance purchased by individuals under age 65. Individuals participating in public or employer-provided health plans would generally not be eligible for the tax credit. In addition, individuals would not be allowed to claim the credit and make a contribution to an Archer MSA for the same taxable year. Eligible health insurance plans would be required to meet minimum coverage standards, including coverage for high medical expenses.

The credit would provide a subsidy of up to 90 percent of a capped amount of health insurance premiums. The maximum credit would be \$1,000 per adult and \$500 per child for up to two children. The maximum subsidy percentage of 90 percent would apply for low-income taxpayers and would be phased down at higher incomes. While the subsidy percentage would be phased down with income, the maximum premium that could be taken into consideration in calculating the credit amount would be fixed at \$1,111 for an adult and \$556 for a child. These dollar amounts would be indexed by the Consumer Price Index for all-urban consumers.

Individuals with no dependents who file a single return and have modified Adjusted Gross Income (AGI) up to \$15,000 would be eligible for the maximum subsidy rate of 90 percent and a maximum credit of \$1,000. The subsidy percentage for these individuals would be phased down ratably from 90 percent to 50 percent between \$15,000 and \$20,000 of modified AGI, and then phased out completely at \$30,000 of modified AGI. For example, the maximum credit for these individuals would be \$556 at \$20,000 of modified AGI.

All other filers (including single filers with dependents, heads of households, and

joint filers) with modified AGI up to \$25,000 would be eligible for the maximum subsidy rate of 90 percent, and the maximum credit of \$1,000 per adult and \$500 per child for up to two children. The subsidy percentage would be phased out ratably between \$25,000 and \$40,000 of modified AGI in the case of a policy covering only one individual, and between \$25,000 and \$60,000 of modified AGI in the case of a policy or policies covering more than one person.

The maximum credit for these other filers would vary by income and the number of adults and children covered by a policy. For example, the maximum tax credit would be \$3,000 for a low-income family with modified AGI up to \$25,000 who obtained a policy covering two adults and two or more children. The maximum credit would be phased down to \$1,714 as the family's modified AGI rose to \$40,000. For a policy covering only two adults, the maximum credit would be \$2,000 for families with modified AGI up to \$25,000 and \$1,143 for families with \$40,000 of modified AGI.

Individuals could claim the tax credit for health insurance premiums paid as part of the normal tax-filing process. Alternatively, the tax credit would be available in advance at the time the insurance is purchased.

Individuals would reduce their premium payment by the amount of the credit and the health insurer would be reimbursed by the Department of Treasury for the amount of the advance credit. Eligibility for the advance credit would be based on the individual's prior year's tax return.

The credit would be used for qualifying health insurance purchased in the non-group market. In addition, qualifying health insurance could also be purchased through private purchasing groups, state-sponsored insurance purchasing pools and state high-risk pools. At state option, effective after December 31, 2003, the tax credit would be allowed for certain individuals not otherwise eligible for public health

Examples of the Maximum Credit			
1. Individuals with No Dependents Filing a Single Return			
Modified AGI	\$15,000	\$20,000	\$30,000
Maximum Credit	\$1,000	\$556	\$0
2. Other Filers Obtaining a Policy Covering Only One Adult			
Modified AGI	\$25,000	\$30,000	\$40,000
Maximum Credit	\$1,000	\$667	\$0
3. Other Filers Obtaining a Policy Covering Two Adults			
Modified AGI	\$25,000	\$40,000	\$60,000
Maximum Credit	\$2,000	\$1,143	\$0
4. Other Filers Obtaining a Policy Covering Two Adults and One Child			
Modified AGI	\$25,000	\$40,000	\$60,000
Maximum Credit	\$2,500	\$1,429	\$0
5. Other Filers Obtaining a Policy Covering Two Adults and Two or More Children			
Modified AGI	\$25,000	\$40,000	\$60,000
Maximum Credit	\$3,000	\$1,714	\$0

insurance programs to purchase insurance from private plans that already participate in State sponsored purchasing groups, such as Medicaid, SCHIP, or state government employee programs.

States could, under limited circumstances, provide an additional contribution to individuals who claim the credit in connection with purchases of private insurance through Medicaid or SCHIP purchasing groups. The maximum state contribution would be \$2,000 per adult for up to two adults for individuals with incomes up to 133 percent of poverty. The maximum state contribution would phase down ratably reaching \$500 per adult at 200 percent of poverty. Individuals with income above 200 percent of poverty would not be eligible for a state contribution. States would not be allowed to provide any other explicit or implicit cross subsidies.

The health insurance tax credit would be effective for taxable years beginning after December 31, 2002.

Discussion

This proposal contains a number of important and innovative features. First, the credit amount varies with family size and composition, reflecting the impact of these factors in the non-group market. For example, two adults face higher premiums, and will receive a larger credit, than a single adult. Likewise, families with children face higher premiums, and will receive a larger credit, than families without children. Second, the credit is “advanceable,” and eligibility for the advance credit is based on the individual’s prior year’s tax return. This design guarantees certainty of the amount of the credit and makes it available at the time individuals purchase health insurance; they do not have to wait until they file their tax returns after the year is over. Third, the proposal allows the credit to be used toward private insurance purchased through private purchasing groups, state-sponsored insurance purchasing pools and state high-risk pools. This provision will increase coverage options, achieve economies of scale, and encourage risk pooling in the non-employer market.

In designing a policy to expand health insurance coverage to the uninsured, one concern is that the policy does not inadvertently decrease health insurance options to those presently insured. Some have suggested that if the purchase of health insurance outside of the employer market became sufficiently attractive, employers might stop providing health insurance coverage to their workers, potentially resulting in a net decrease in health insurance coverage among the population.

Based on these concerns, the Administration’s proposal has been carefully designed to avoid “crowdout” of subsidized employer coverage, and thus will expand coverage substantially. Several elements of the credit design contribute to this desirable result. Most importantly, low-income individuals and families, who are least likely to have employer-based health insurance, will receive the largest incentives under this proposal. In addition, the health credit subsidy rate decreases with income, requiring larger individual contributions for any given policy and making it a less attractive alternative to the employer-provided insurance at higher income levels. The health

credit is further limited by a cap on the amount of premium eligible for subsidy. Although this capped premium amount is adequate for many individuals to purchase health insurance, it is typically less generous than most employer plans.

The credit is also designed to be targeted to the individuals who are most likely to be uninsured during at least some part of the year. Approximately six million such individuals are expected to gain coverage as a result of the credit. Most of these individuals are neither offered employer-based insurance nor eligible for public programs over the course of their uninsured spells. The credit will provide a strong new incentive for these persons to find coverage in the individual market. It will also allow many families that are already purchasing coverage in the individual insurance market, and receiving very little government assistance in doing so, to obtain better coverage at a lower out-of-pocket cost.

The credit will significantly increase participation and quality of coverage in non-group health insurance markets. These improvements will not come at the expense of employer group markets. Those low-income Americans who are eligible for the largest credit are less likely to have employer-sponsored health insurance. Around 80 percent of uninsured workers are not offered health insurance by their employers. Only 36 percent of people under age 65 with income below 200 percent of the federal poverty line have employer-sponsored health insurance, while 77 percent of those above do. Furthermore, the generosity of employer-sponsored insurance is determined by the tax benefits for the group of employees, not the attractiveness for low-income employees only. Tax benefits for employer coverage will remain large for the middle- and higher-income workers that make up most of the employees of most firms that offer generous employer-sponsored plans. Those workers' incomes are too high for them to get more attractive benefits from the proposed health credit. Thus, employer-provided coverage will remain more attractive for firms that offer generous coverage today. That is, the phase-out and cap on the credit ensure that employers will continue to offer insurance and that employees will continue to enroll. The proposed credit will simply eliminate an inequity in the current system that disadvantages workers without employer coverage, helping them to purchase the coverage that meets their needs.

Recent research also suggests that the credit would provide good, affordable health insurance options for the vast majority of individuals who are eligible for the credit. This is the subject of a detailed analysis by the Council of Economic Advisers. The minority of less healthy persons who lack any insurance options and find insurance unaffordable or unavailable for their health status in the individual market could use the credit to buy into the state high-risk pool for which the premium is usually subsidized. The proposal also permits certain low-income individuals to purchase private insurance through other state-sponsored health insurance purchasing groups.

Coupled with the Administration's other proposals for strengthening employer coverage and for providing more assistance to individuals with the greatest health care needs, the health credit is a critical part of our approach for ensuring that all Americans have good, affordable private health care coverage options.

This proposal is part of a broader Administration goal of achieving more patient-centered health care by encouraging innovations in the financing and delivery of health care services. Market-based approaches such as this will encourage high-quality, high-value coverage by giving patients the ability to choose the coverage that best meets their needs. In turn, innovative coverage will permit Americans to benefit from the tremendous potential of our health care system in the 21st century.

Health Insurance Credit for Displaced Workers

Because the permanent health insurance credit would not be effective until next year, the President continues to support the immediate health insurance credit for displaced workers, which was one component of the economic security bill supported by a bipartisan group of centrist Senators and passed by the House last December.

The health credit for displaced workers is a refundable, advanceable tax credit that could be claimed by unemployed workers for a period of up to 12 months. The credit can be used to offset 60 percent of the cost of health insurance premiums for unemployed workers and their families.

The credit can be applied to the purchase of COBRA or “super-COBRA” continuation coverage, and other types of qualified private non-employer health insurance. Eligible unemployed workers include those receiving unemployment insurance benefits and those who would be eligible for benefits except that their rights to benefits were exhausted or the period during which their benefits were payable ended.

The design of the health credit for displaced worker reflects the President’s goals of providing targeted, quick assistance to Americans who have lost their jobs in the recession. Because the proposal builds on the existing infrastructure of programs to assist displaced workers, and because it strengthens all of the coverage options available to displaced workers now, it can be fully implemented in a matter of a few months. In particular, state workforce agencies will certify eligibility for the health insurance credit when they certify that a displaced worker is eligible for unemployment insurance benefits. Almost all unemployed workers who lose their job involuntarily are eligible for unemployment insurance, at least initially. The Administration also supports emergency grants to states to enable them to quickly provide additional health insurance assistance, without the need for state legislative action. Displaced workers can claim an advance credit at the time of purchasing health insurance coverage by providing their insurer their certification along with the remainder of the premium. The insurer will be reimbursed by the U.S. Treasury for the amount of advance credits it provides.

We believe the displaced worker credit offers a number of advantages over competing proposals that limit tax credits or subsidies to COBRA-only policies. Medicaid expansion is also not an ideal way to provide quick and efficient replacement insurance to the affected individuals.

A COBRA-only credit would provide no benefit to 40 to 50 percent of displaced workers with health insurance, because they work for small firms not covered by

COBRA or they purchase non-employer policies. The alternative of forcing workers not covered by COBRA into a State Medicaid plan would require these workers to drop their current insurance coverage and possibly change health care providers if they do not participate in Medicaid. Extending Medicaid to cover these displaced workers would require State legislation, and would necessitate delays before State legislatures were even in session to address this issue. Many States have made clear that, because of tight budgets, they cannot afford such unprecedented expansions beyond their core target populations anyway. Moreover, such expansions would take away resources from their ability to fund better coverage for their priority populations: low-income children, families, and seniors.

In addition, a COBRA-credit would impose a costly new mandate that employers would be required to implement immediately. The mandates are most burdensome on smaller firms and those that have had significant layoffs—precisely the firms that need the most help now to prevent further job losses. Further, a COBRA-credit is poorly targeted to workers who lose their jobs because of the economic downturn. At least 60 percent of those eligible for the COBRA-credit are workers who voluntarily leave their job, not displaced workers. According to independent estimates, twice as many workers who have lost their jobs in the recession would be helped by the health credit for displaced workers than by a COBRA credit or subsidy.

As a result, for a similar budgetary cost (and at no budgetary cost to States), the health insurance credit for displaced workers would be available for a longer period of time, would be more efficiently targeted, would offer workers a greater choice among health insurance plans, and would not weaken employer incentives to continue to provide health insurance to their workers. The credit would also reduce adverse selection in both the employer market (because more healthy workers would choose to remain in COBRA coverage) and in the individual market (because many people who otherwise would have gone without health insurance will purchase coverage).

Conclusion

The absence of health insurance coverage for some 40 million Americans is a problem calling for immediate solutions. The President's Budget sets forth a package of solutions, including most importantly a proposal for the use of tax credits to offset the cost of obtaining health insurance that has received broad bipartisan support. If enacted, this proposal can lead to a significant reduction in the uninsured population and at the same time lead to improvements in the market for individually purchased health insurance, greater choice and flexibility for individuals in determining the coverage that best fits their needs, and improvements in the quality and price of health care provided to all Americans. This Administration desires to work closely with Congress, in a bipartisan manner, to make this vision a reality.

Chapter 9

Public Program Expansion

Covering the Low-Income Uninsured: The Case for Expanding Public Programs

by Judith Feder, Larry Levitt, Ellen O'Brien, and Diane Rowland

ABSTRACT: In a new administration and Congress, any health insurance coverage initiative will focus on some, rather than all, Americans. Because lack of affordability is the main reason people lack coverage, most observers acknowledge that government-financed subsidies are needed to expand coverage. But there is considerable disagreement about how these subsidies should be provided. Here we argue that priority in expanding coverage should go to the uninsured population that is least able to afford coverage and most likely to have difficulties getting appropriate and timely care. Despite flaws in existing public programs, which can and should be remedied, strengthening these programs establishes a foundation for truly effective health insurance coverage for all low-income Americans.

Any initiative to extend health insurance coverage to the forty-three million Americans without it is likely to take an incremental rather than a universal or comprehensive approach. An incremental strategy inevitably requires decisions about whom to provide the financial wherewithal to obtain coverage, as well as how to effectively provide it.

In this paper we argue that an incremental initiative should give priority to the uninsured who are least able to afford coverage, and that the most effective way to do

this is by expanding publicly provided insurance. Today more than thirty-five million low-income Americans receive their health coverage through Medicaid, and as many as three million additional children get assistance from the State Children's Health Insurance Program (SCHIP). Strengthening and building on these programs to help the twenty-five million low-income uninsured persons is the most effective approach for targeting coverage to this group.

Gaps in coverage. More than half (56 percent) of the uninsured nonelderly Americans are in families with incomes below 200 percent of the federal poverty level (\$32,900 for a family of four in 1998). Among the low-income uninsured, twelve million are from poor families with incomes below poverty.¹ With insurance coverage for a family policy costing in excess of \$6,000, purchasing such coverage without an employer contribution is clearly out of reach for most families earning less than \$35,000 per year.²

These are the families who fall through the cracks in employer-based health insurance, which has never reached everyone. Low-wage and less-educated workers have always been much less likely to be offered and covered by employer plans than workers who are better-paid and -educated. Erosion of employer coverage rates from the late 1970s through the early 1990s greatly widened these gaps.

Although the slide in employer coverage stopped in 1993, employer coverage for nonelderly Americans in 1999 (65.8 percent) was still below its level in 1989 (68.6 percent)—the last business cycle peak—and far below its 1979 level.³ The recent prosperity has resulted in gains in coverage for workers across the wage distribution, but it has narrowed the gap between high and low wage earners only slightly. Although those in the second and third quintiles of the wage distribution gained coverage between 1995 and 1998 (with coverage rates rising by 5.1 and 5.4 percentage points, respectively), those at the very bottom of the wage distribution experienced much smaller gains (their coverage rates increased by just 1.9 percentage points). Just 29.6 percent of workers in the bottom fifth of the wage distribution had employer coverage in 1998, compared with 82.3 percent of those at the top.⁴ Although the past few years have brought an increase in employer coverage offerings, especially among small firms, that increase has not occurred among low-wage firms.⁵ Even more so than a decade ago, most uninsured workers (70 percent in 1996) lack access to employer coverage, whether through their own job or that of a family member.⁶

Public programs provide a safety net for some low-income persons, but practice and policy have limited these programs' ability to fill the cracks in employer coverage for the low-income uninsured. Medicaid has for thirty-five years effectively provided health insurance protection to families receiving welfare assistance and to children and pregnant women who meet its income guidelines. In 1997 enactment of SCHIP supplemented Medicaid coverage by providing extra federal funds to states for extending coverage to children in families with incomes up to 200 percent of poverty.

But both Medicaid and SCHIP have a limited reach. Part of the problem is participation. Cumbersome Medicaid eligibility requirements have long left many eli-

gible children uninsured. More recently, welfare reform has created new participation problems by disrupting traditional patterns of enrollment and failing to effectively replace them. And since most people leaving welfare find themselves in low-paying jobs without coverage, loss of public coverage leaves them without coverage altogether.⁷ Although SCHIP has expanded coverage to an estimated three million children, this increase, together with recent increases in Medicaid enrollment, is only beginning to offset the decline in coverage associated with welfare reform.

Some states are now addressing these problems by applying streamlined enrollment procedures and outreach strategies developed under SCHIP to their Medicaid programs as well.⁸ But Medicaid's inability to reach uninsured adults reflects restrictions on eligibility that are far less tractable. Although states have the option to include parents in Medicaid, in thirty-two states uninsured working parents are ineligible for Medicaid if they work full time at the minimum wage (\$5.15 per hour).⁹ Equally important, low-income childless adults, no matter how poor, are ineligible for coverage under federal law unless they qualify as disabled.¹⁰ Without changes in federal law, Medicaid is unlikely to reach the bulk of uninsured adults—the vast majority of the low-income uninsured.

Extending Public Programs to Cover Adults

Changes in law and practice to make programs now available to low-income children available to low-income adults offer a straightforward approach to coverage for the low-income uninsured population. The attractiveness of this approach rests on two factors. First and foremost is the extension of a subsidy for the full cost of comprehensive insurance to persons with limited incomes. Research shows that those with low and modest incomes are unlikely to take advantage of subsidies that fall short of the costs of insurance and are unlikely to use care if they face large out-of-pocket costs.¹¹ Medicaid and SCHIP are designed to address these problems. Second is the existence of an administrative apparatus in every state to determine eligibility for subsidies in advance and facilitate enrollment in health insurance plans. Medicaid and SCHIP programs—which now serve nearly forty million Americans—have contracts in place with providers and managed care plans and have established mechanisms for collecting and matching funds from the federal government. Although recent attention has focused on barriers to participation, a decade ago attention focused on the speed of Medicaid expansions in response to changes in federal law. Enrollment increased from 19.2 million in 1989 to 26.7 million in 1992—with nearly half of the increase among women and children not eligible for welfare.¹²

Simply stated, a public program expansion aimed at the low-income uninsured would extend protections that are now available to some low-income persons to all such persons. But enacting and implementing such an expansion requires decisions on exactly how to expand subsidies and how to make the new subsidies most effective. The following outlines a possible approach to these decisions, highlighting some of the choices necessary to efficiently and effectively ensure coverage for all low-income Americans.

Redefining eligibility and benefits. Extending coverage through public programs such as Medicaid and SCHIP means replacing the current eligibility standard, based on a variety of demographic or “categorical” requirements, with an eligibility standard based solely on income. Because they have little if any discretionary income, people with incomes below a minimum eligibility standard should be provided with comprehensive benefits, without premiums or cost sharing. For persons above that minimum, it may be appropriate to provide less comprehensive benefits and require some premium and cost sharing.

Evidence indicates that even modest premiums deter participation and even modest cost sharing deters use of necessary care among poor and low-income persons.¹³ At the same time, as incomes rise, people are more likely to gain job-based insurance, so subsidies provided to those at higher income levels may substitute for private insurance instead of inducing the purchase of new coverage by uninsured persons. The choice of an eligibility level is therefore largely a political one, governed by views on the appropriate balance between affordability and substitution as well as by the amount of tax dollars the nation is willing to spend.

One reasonable strategy would be to extend to low-income adults the political choice made for establishing eligibility levels for children in Medicaid and SCHIP. Medicaid offers full and comprehensive coverage for the lowest-income children, while SCHIP offers somewhat less generous benefits with modest premiums and cost sharing. Drawing on this model, persons with incomes below 150 percent of poverty would be guaranteed full access to comprehensive benefits without cost sharing or premium contributions. Clearly, at an income of 150 percent of poverty—about \$12,500 for an individual in 1998—it is difficult to afford premiums and cost sharing. The rate of private coverage is modest among persons at this income level, so the potential for substitution or crowding out is not a major policy impediment. Below this level private coverage is relatively rare—just 30 percent of the nonelderly have it.¹⁴

However, even those earning just above \$12,500 clearly cannot afford to purchase comprehensive private health insurance coverage on their own. To reach these workers and their families requires extensive (if not full) subsidies. Following eligibility levels modeled after SCHIP coverage, almost-full subsidies for almost-full benefits could be provided to those with incomes between 150 and 200 percent of poverty (\$12,500-\$16,700 for an individual in 1998). In this group, 60 percent of the nonelderly have existing private insurance (raising issues about the extent of possible substitution), but more than a quarter (28 percent) are uninsured, suggesting the need for substantial subsidies.

The need for subsidies does not stop at twice the poverty level, where a premium of \$2,000 represents about 12 percent of a person's income—an expenditure burden that historically has been considered “catastrophic.” But the higher up the income scale subsidies go, the more difficult it becomes to target the new subsidy dollars to the uninsured rather than to insured persons. For example, in the income range of 200-250 percent of poverty, 71 percent of the nonelderly already have private

coverage. That proportion rises to 80 percent at 250-300 percent of poverty and 89 percent above 300 percent of poverty.¹⁵ A reasonable balance might be achieved by retaining a subsidy for persons with incomes above 200 percent of poverty but reducing it gradually as income rises until the subsidy disappears at 300 percent of poverty (\$25,100)—at which point the vast majority of people (although still not all) have employer coverage.

According to unpublished estimates from the Urban Institute, 25.4 million uninsured poor and low-income Americans (with incomes below 300 percent of the poverty level) would be made newly eligible for publicly subsidized coverage under the proposed expansion. More than a third of those potentially eligible (9.5 million) are poor—mostly adults who are not eligible for Medicaid or SCHIP—and an additional five million are near-poor, with incomes between 100 and 150 percent of the poverty level. An additional 10.9 million uninsured low-income persons (150-300 percent of poverty) would be eligible for a partial subsidy.¹⁶

Assuring program participation. Achieving the potential of expanded eligibility for public programs depends in large part on the ability to get people enrolled. The likelihood of achieving that objective is not as limited as critics might suggest, given evidence from previous experience. Establishing eligibility for a means-tested benefit has historically been complex and often difficult, because of specific state policies that create barriers in the enrollment process (for example, lengthy applications, extensive documentation requirements to certify income, requirements for frequent redetermination of income, and inclusion of complex asset tests). The evidence also suggests that the culture and training of enrollment workers can have a significant effect on enrollment, and a commitment to simplify the process can broaden participation.¹⁷ The enrollment experience under SCHIP, and under Medicaid when streamlined enrollment processes have been adopted, suggests that such efforts can make a difference and are critical to the success of a strategy to expand publicly sponsored health insurance.

Assuring access to care. Although administrative barriers are the main stumbling block, other aspects of Medicaid can deter both participation and access to care. Specifically, Medicaid's low payment rates to providers or health plans—relative to rates paid by Medicare or private insurers—may limit beneficiaries' choice of providers and make the program less attractive to potential enrollees. The significance of these limitations should not, however, be exaggerated. Evidence on the difference Medicaid makes to access to services—when the experience of its beneficiaries is contrasted with that of the uninsured at comparable income levels—indicates that despite low provider payment rates, the program provides effective insurance protection and has largely closed the utilization gap between low-income persons with Medicaid and those with private insurance.¹⁸ Nevertheless, if the goal is to assure access to “mainstream” care, it may be necessary to reduce payment disparities by raising Medicaid payment rates.

The issue of payment disparities, and the need for a remedy, may become more compelling if Medicaid is expanded beyond the very poor. Near-poor persons are

more likely to have had private insurance in the past, as well as established relationships with providers who may not now participate in Medicaid. Higher payment rates may be important in encouraging this group to participate. However, increasing rates means spending much more—not just for new enrollees, but also for those already covered. Whether policymakers will consider the benefit gained worth its costs will depend on how much they are willing to spend overall on a program expansion.

Addressing the crowding out of private dollars and coverage. In a world of unlimited resources, few would argue that the substitution of public spending for private spending on health insurance by or on behalf of low-income persons—commonly characterized as “crowd-out”—is undesirable. Indeed, substitution does help to achieve equity by providing persons in similar economic circumstances with similar benefits, regardless of their insurance status. One analysis estimated savings of about \$1,000 per family to previously insured low-income families made eligible for hypothetical Medicaid-like subsidies—a substantial financial benefit for low or modest-income people.¹⁹

Having limited public dollars, however, means that there must be trade-offs. If the policy goal is increased coverage, it seems reasonable—from both a policy and a political perspective—to maximize the use of new dollars for the uninsured rather than for the already insured. As discussed above, some degree of substitution is unavoidable at any eligibility level. But other policy choices will influence success in targeting new benefits to the uninsured and have implications for equity and the scope of coverage. For example, improving the operations of a public program may affect the degree of crowding out. Making a public program more accessible and attractive to beneficiaries (for example, by making it easier to enroll or by raising provider payment rates) is essential to success. However, these policies will also tend to increase crowding out by making those who have private coverage more willing to drop that coverage in exchange for “good” public insurance.

At the other extreme, some measures aimed at preventing substitution may backfire or pose new problems. For example, previous analysis has concluded that charging modest premiums (at the level allowed in SCHIP) would deter participation by the uninsured, without greatly reducing the financial advantages of participation to those already spending a lot to participate in employer coverage.²⁰ As a result, a larger share of new public dollars would go to the already insured than would have done so in the absence of premiums.²¹

Another approach to preventing crowding out is to establish “firewalls” that limit eligibility to those who have been uninsured for some period of time. Not only is that strategy difficult to enforce, but it also creates a new inequity by requiring people who have lost employer-sponsored insurance to go without protection for a period of time before they can get help.

Some crowding out is inevitable under any approach to expanding coverage, and its outcome—that is, financial relief for low-income insured persons—has value. However, so long as public dollars are limited, policymakers will have to make trade-

offs among the often conflicting goals of equity, affordability, and the desire to limit public spending.

State/federal relationship. In concept, an expansion of existing public programs to cover the uninsured is relatively straightforward. In practice, with the existing complex web of state and federal roles and financial relationships, the mechanics and politics of designing such a program become more complicated. Extending Medicaid or SCHIP assumes that an expansion would be implemented by the states, subject to federal requirements. This strategy raises questions regarding the distribution of costs between the federal and state governments, the balance between federal requirements and state flexibility, and the acceptability of variation across states in the scope of coverage.

The federal government now matches state spending under Medicaid and provides matching funds under SCHIP at a higher rate (although federal funding under SCHIP is capped). This type of arrangement encourages states to spend more than they would otherwise on health coverage; it provides more federal money (higher matching rates) to offset the greater needs and diminished financial capacity of poorer states; and it compensates for economic downturns with higher federal payments.

State participation in Medicaid and SCHIP is voluntary; states do not have to take advantage of available federal funds. SCHIP offers states “enhanced” federal matching rates, to promote state participation. Any expansion in public programs would likely require federal financing at least as great as under SCHIP, particularly since states have yet to maximize eligibility under existing Medicaid or SCHIP rules. But the differential between Medicaid and SCHIP has created tension between the two programs, with some states showing greater willingness to improve and promote SCHIP than to expand and support Medicaid. An extension of differential matching rates could further complicate the system and provide states with additional perverse incentives to enroll some groups over others.

Flexibility and variation. Further complicating the state/ federal relationship is the question of how much flexibility to allow states in using federal money. Medicaid has always provided states considerable flexibility in setting eligibility, benefits, and provider payment levels. But in recent years states have successfully advocated expanded flexibility in Medicaid (with respect to use of managed care) and SCHIP (with respect to benefits and cost sharing). The question would be where on the Medicaid/SCHIP spectrum to place a new expansion, especially since the new eligibles would range from very low income childless adults who are not now eligible for Medicaid to more modest income families and adults who are similar in many respects to current SCHIP enrollees.

This choice inevitably merges into another: how much variation to tolerate across states. As long as states decide whether and how much to take advantage of federal funds, eligibility levels and generosity of coverage are likely to continue to vary. If the goal of an expansion is to achieve a uniform level of coverage, experience tells us that federally established floors are critical. However, the political or fiscal acceptability of

federal mandates for insurance coverage for the low-income population, or federalization of all costs, is questionable. Without these actions, variation—and, in some states, inadequacy of protection—remains inevitable.

Entitlement or block grant? The most fundamental design question for a public program may be whether it will be a federal entitlement to individuals or a block grant to states. Medicaid provides the former, which means that everyone who satisfies eligibility requirements is guaranteed coverage and that federal and state funding follows the individual and cannot be capped. Although states can affect how easy or difficult it is for people to participate and how generous or restricted are their benefits and access to care, states cannot deny coverage to an eligible individual. By contrast, SCHIP provides capped federal funds to states and allows them to choose whether to create an individual entitlement. States can choose to use the new federal funds to expand Medicaid, thereby creating Medicaid-like obligations to individuals (and assuring access to federal funds at the regular Medicaid matching rates if the cap is exceeded). But, if they prefer—as many have—states can create separate programs in which they can cap enrollment and receive a capped federal allotment to help pay for services.

This aspect of SCHIP's design was a critical element of the political compromise believed necessary both to enact the SCHIP legislation and to ensure that states would participate. So far, the capped nature of SCHIP has not proved to be a major issue in practice—the economy is good and enrollment is modest, in part because the program is so new. But an economic downturn could lead states to limit enrollment as federal funds are exhausted. (Although Medicaid allows states to control eligibility for some groups, its uncapped federal funds mitigate pressure on states to cut eligibility, and its entitlement prohibits waiting lists.)

The choice of which model to follow is a matter of fundamental philosophy and pragmatic politics. Philosophically, the question is whether coverage is the paramount goal—in which case, the guarantee of meaningful coverage to all those who qualify is essential—or whether coverage is subordinate to other goals, such as federal fiscal constraint or a preference for state over federal authority. Politically, the question is which goal will prevail.

Alternatives to Public Programs

Public programs have historically been the preferred mechanism to provide health insurance to low-income persons, but they are not the only possible approach. Recently, enthusiasm for an alternative mechanism has emerged: use of tax policy, rather than a public program, to provide subsidies. The appeal of this approach appears to be its potential to expand coverage with minimal government involvement. People would apply by filing tax returns and would choose a health plan on their own, rather than relying on the plan options selected by the government. Overall, a tax approach appears to be “hands-off.”

However, this tax model does not mesh well with the circumstances of low-in-

come people. If they are the target population for a coverage expansion, the most prominent tax proposals pose a number of problems.²² First, about half of those without coverage have such low incomes that they do not pay taxes.²³ Tax credits that only apply against taxes owed—the most common form of credit in the tax code—clearly cannot help them. Hence, most proposals to use tax credits would make them “refundable” or available without regard to tax liability, like the Earned Income Tax Credit (EITC), which has so successfully enhanced income for the working poor.²⁴

However, it is more challenging to support the purchase of health insurance than to boost income. Tax credits, including the EITC, are typically refunds—money the taxpayer gets back at the end of the year. To buy health insurance, people with limited incomes need the cash in advance. Further, they must know they can keep the money, even if their incomes change. (Under the EITC, fewer than 1 percent of eligible persons use advance payment, behavior analysts interpret as reflecting a fear of owing money to the government).²⁵ Both adjustments would be administratively cumbersome and represent departures from a tax system whose hallmark is to look backward in order to ensure precise and accurate income determination.

Second, the most prominent tax credit proposals involve credits in the neighborhood of \$1,000 for individuals and \$2,000 for families. Yet insurance premiums average about \$2,000 for individuals and \$6,000 for families (even more for persons in poor health). Experience suggests that those with low incomes are unlikely to be willing or able to fill that gap.²⁶ Instead, the primary beneficiaries of such a credit will be persons with higher incomes who already have health insurance. One estimate indicates that three of every four dollars spent on such a credit would go to the already insured, while the bulk of the uninsured would remain unprotected.²⁷

Third, the most prominent tax credit proposals anticipate that recipients will use the credits to shop in the nongroup insurance market. But that market is riddled with problems. Except in a few states with comprehensive regulation, private insurers can reject applicants, limit benefits to exclude not only important services but also body parts or body systems, or charge rates well above the average. As a result, low- and modest-income persons with health conditions will face out-of-pocket costs (for insurance or services) that are well beyond their means.²⁸

It is, of course, possible to adopt policies to remedy these limits to tax policy: determine eligibility and provide cash up front, cover the full cost of insurance, and guarantee the availability of benefits that are adequate to assure affordable access to needed care. However, these measures would require the very government involvement that tax credit advocates aim to avoid. In other words, to be effective, a hands-off tax mechanism would need to become a hands-on public program; even then, its impact would be uncertain. Although there may be differences of opinion as to the income level at which to draw the line, even some advocates of a tax approach recognize that a public program is needed to provide coverage to the low-income uninsured.²⁹ It is unclear when and if a new debate on health care coverage will begin in earnest. If not directed at all Americans, any proposals to extend coverage must

be clear about which Americans they aim to reach. A variety of strategies—including use of the tax system—may be appropriate to assuring coverage for uninsured persons who are better off. But for low-income Americans, who are least able to obtain coverage on their own, reliance on public programs is essential.

Historically, public programs—most especially Medicaid—have been enormously effective in securing health insurance for poor children and their very poor mothers. Now, through SCHIP, they are extending coverage to children in better-off families. Disrupting these programs would put coverage at risk for the millions of persons who now depend upon them. By contrast, strengthening these programs establishes a foundation for truly effective health insurance coverage for all low-income Americans.

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Block Grants Are the Wrong Prescription for Medicaid

by John Holahan and Alan Weil¹

The Bush administration has proposed major modifications to the Medicaid program.² Under its proposal, each state would have the option to obtain more flexibility in program design if it accepts a predetermined allotment of funds in lieu of the open-ended matching funds of the current program. Medicaid, which covered 47 million people at some point during FY 2002 at a total (state and federal) cost of \$256 billion, is now as large as Medicare. Payments for Medicaid account for 43 percent of all grant funds transferred from the federal government to the states. Changes to this program have major implications for the health care system, the people covered, and the relationship between the states and the federal government.

Transforming a program that has operated as an individual entitlement with an open-ended funding commitment from the federal government into a block grant has substantial and complex implications that represent fundamental ideological choices.³ While accepting the offer of a block grant is up to each state, having this option available is likely to change the federal government's approach to administering Medicaid. States that opt for the block grant will presumably be barred from returning to the traditional Medicaid design in order to prevent gaming, thereby constraining the options available to future state lawmakers. All told, converting Medicaid into a block grant changes the states' and the federal government's incentives and options, which will yield changes in the program, some predictable and some unknown. This paper examines these changes and discusses their consequences.⁴

The Bush Administration Proposal

The administration's proposal—details of which are not yet available—would be voluntary for states, unlike the Medigiant proposal passed by Congress but vetoed by President Clinton in 1995. States choosing the block grant approach would get two allotments—one for acute and one for long-term care. States choosing to take the fixed allotments would be required to continue providing basic services to a core population, presumably the benefits and eligibility groups states are currently required to cover. Mandatory benefits include hospital, physician, laboratory, x-ray, and nursing home services. Mandatory eligibility groups include poor children, children under age 6 and pregnant women with incomes below 133 percent of the federal poverty level, adults who would have met 1996 eligibility standards for welfare, and SSI recipients.

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Payments to states: States choosing the block grant would receive allotments that grow by about 8.5 percent per year, the same rate the Congressional Budget Office (CBO) estimates for program growth under current law.⁵ The growth rate is a major difference between this block grant proposal and the earlier one, which had lower rates of growth and raised immediate concerns about states' ability to continue to fund services for their populations. States choosing the block grant would also be given extra money—about 2 percent more in 2004 and 1 percent more between 2004 and 2010—but all extra payments are taken back after 2010, making the proposal budget-neutral to the federal government over a ten-year period.

MOE requirement: States would have a maintenance of effort (MOE) requirement but this would be less than they are now projected to spend. The MOE would be set at the 2002 base level spending and increase at the rate of the medical care consumer price index. This would allow states to spend less than they are projected to do under current law and still receive the full federal allotment. It is not yet clear how MOE requirements would be defined or enforced, but experience suggests they will be controversial and subject to some manipulation by states.

Objectives of the Proposal

Why has the Bush administration made this proposal?

Achieve fiscal savings: The first reason seems to be fiscal. Medicaid expenditures are projected to grow at 8.5 percent per year for the next decade. Since the proposal retains this growth rate, at first glance it does not appear that saving money in the federal budget is a motivation. But the 8.5 percent figure under current law is just an estimate and the administration may prefer the certainty of a fixed amount, or perhaps it is assuming it could ratchet down the growth rate in the future if federal budgetary pressures make that necessary.

Reduce Medicaid maximization: Second, there is considerable frustration with the variety of Medicaid maximization schemes—disproportionate share hospital (DSH) payments and upper payment limit (UPL) arrangements—states have developed. These arrangements can be structured in many different ways and are estimated to have resulted in \$16 to \$18 billion in federal expenditures with little or no state matching funds. Recent federal changes in 2001 and 2002 have curtailed these efforts to some degree, but federal officials remain nervous that states' creativity could yield new approaches that will result in another spike in Medicaid spending, as occurred in the early 1990s. Current dire state fiscal conditions give states particularly strong incentives to rely upon accounting tricks to generate federal matching funds. With fixed allotments, the federal budget would no longer be subject to state manipulation.

Encourage efficiency: Third, the administration hopes to unleash a great deal of creativity at the state level to make Medicaid more efficient. Critics point to Medicaid's complex eligibility rules, the failure of many eligible people to enroll, the rich benefit package, and the cumbersome waiver process as sources of inefficiency that could be eliminated if states were free to modify the program.

Shift policymaking to the states: Finally, the argument for block grants rests on the view that health policy should be made at the state level. Without federal restrictions states could do a better job reflecting the needs and priorities of their own citizens.

Can Efficiency Reduce Program Costs?

The ideal outcome from converting Medicaid into a block grant would be the generation of programmatic efficiencies that come at no cost to the program's beneficiaries. Ideally, states freed from federal rules and at greater risk for program costs would have the appropriate motivation and tools to redesign the program. Projected annual growth rates averaging 8.5 percent seem high, and suggest that efficiency savings might be attainable.

Reasons for high-cost growth: Recent cost increases and those projected for the near future are high for several reasons. The first is enrollment. Declining employer coverage for low-income populations, outreach designed to attract enrollment in the SCHIP program, and demographic and medical trends yielding larger numbers of people with disabilities all factor into Medicaid's enrollment growth. The second is health care inflation. Along with private payers, Medicaid has been hard hit by the growing cost of prescription drugs, recent increases in hospital prices, and the consolidation of providers to counter the negotiating power of managed care plans. The new flexibility provided by this proposal does nothing to address these factors.

While growth in the Medicaid budget is significant, and costs are high per enrollee, Medicaid is not expensive on a risk-adjusted basis.⁶ When one adjusts for the relatively poor health status and high prevalence of disabilities, expenditures on Medicaid beneficiaries are lower than for those with private insurance coverage. These lower costs are due primarily to low provider payment rates, which can impede patient access to services. Obtaining the same services for the same populations at a lower cost is likely to prove quite difficult.

The most likely prospect for efficiencies in Medicaid will come from more substantial reorganization of the health care delivery system. Efforts to reduce medical errors, increase coordination of service providers, and assure appropriate care for those enrolled in the program may yield cost savings, particularly in the longer term. However, there is little indication that these efforts are impeded by the current Medicaid structure and little reason to believe their adoption would be accelerated by converting the program into a block grant.

Can Restructuring Medicaid Coverage Significantly Reduce Program Costs?

If substantial savings from increased efficiency are unlikely, will restructuring benefits and eligibility save states money?

Richness of benefit package: Many policymakers believe that the Medicaid benefit package is too rich, particularly as states have expanded Medicaid eligibility to people with incomes above the poverty level. This sense of richness comes from three aspects:

the benefit package covers some services, such as dental and vision care, not included in all commercial insurance; copayments are generally quite low, and may not be imposed on children, pregnant women, and people living in institutions; and states cannot charge premiums to enroll in the program.

States currently determine eligibility and benefits within federal guidelines. About one-third of the Medicaid population and about two-thirds of expenditures are for optional populations and services.⁷ States do not have to cover children above the poverty level, adults above 1996 welfare standards, the disabled above SSI levels, or most of the elderly in nursing homes. They do not have to cover drugs, mental hospitals, homes for the mentally retarded, or most community-based long term care services.

If states feel that Medicaid imposes too large a fiscal burden, why don't they cut these optional enrollees and services? The most obvious reason is that citizens value these services. Services for many of the chronically mentally ill, developmentally disabled, and frail elderly are optional in Medicaid lingo, but states feel they have no choice but to provide them—indeed many of these services were paid for with state funds before Medicaid existed. Once the state chooses to provide these services, including them in the Medicaid program often provides savings to the state, since the burden is shared with the federal government.

Certain optional benefits substitute for more expensive hospital, nursing home, or physician services that are mandatory or reduce demand for social services that states pay for outside of the Medicaid program. The primary example is prescription drugs, but the same can be said for dental care, vision care, prosthetic devices, personal care, case management, physical therapy, and other optional services.

Finally, the strength of provider groups and the economic benefits associated with pulling federal dollars into the state encourage inclusion of optional services and beneficiaries in the Medicaid program.

The new flexibility offered by the proposal: States have at their disposal many mechanisms to cut Medicaid costs. A block grant would provide three new kinds of flexibility: tailoring benefit packages to different groups, expanding the use of cost sharing, and imposing enrollment caps. What would these changes achieve?

Reducing Benefits

One type of flexibility states would obtain under the administration's block grant proposal is to cover different sets of optional benefits for different populations. Under current law, an optional benefit provided to one categorically eligible group of Medicaid enrollees must be provided to all.⁸ The proposal would allow, for example, a state to cover eyeglasses and dental services for children age 6 through 18 in families with income below the poverty level, but not for children in families with income above the poverty level (the latter being an optional eligibility group that the state could choose to not cover at all).

In the abstract, with more than 40 million Americans lacking health insurance, the option of reducing benefits to cover more people is appealing. However, the po-

tential benefits associated with this choice are likely to prove quite limited because the new flexibility will add little to the policy options already available and thus provide little additional saving.

An examination of optional benefits under Medicaid reveals relatively few realistic opportunities for saving money. Prescription drugs are optional, and account for about 9 percent of Medicaid spending,⁹ but it is unlikely that reducing this benefit in ways that are not already allowed under current law would yield any savings—in fact it might increase spending as sick patients turn to more expensive services. About 40 percent of Medicaid spending is on long-term care services for optional populations, such as the elderly and disabled with incomes too high to qualify for SSI. Despite needing nursing home-level care, these people cannot afford it on their own, and it is difficult to imagine eliminating these benefits.

Ultimately, the likely major target for reductions in optional services are acute care services such as prosthetic devices, vision, hearing and dental services, chiropractors and podiatrist services, and medical equipment. Spending on these services for all groups amounted to \$14.1 billion in 1998 or about 7.0 percent of Medicaid spending. But states could eliminate these services for all groups (except children) now and choose not to. No doubt it is politically difficult to cut these services for the disabled and elderly. In the end the ultimate target is likely to be spending on these services by non-disabled adults; this amounted to about \$2.3 billion in 1998 or about 1.5 percent of Medicaid spending on medical services.¹⁰ This is a substantial amount of money, but not enough to help much with state fiscal problems or to allow states to go very far in expanding insurance coverage to new populations.

Increasing Cost Sharing

A second possible source of savings for states operating under a block grant is to make greater use of beneficiary cost sharing. Cost sharing is quite limited in the existing Medicaid program. Premiums may not be charged, deductibles may not be imposed, and copayments may be no more than nominal, and may not be charged to certain eligible groups, including children, pregnant women, and people in institutions. Through waivers some states have begun charging premiums to some enrollees with incomes above the mandatory eligibility levels, but cost-sharing rules cannot be waived.

Cost sharing for higher income beneficiaries might bring Medicaid in line with the insurance policies Americans obtain through their jobs. But it is not without its problems as a policy tool. Medicaid beneficiaries have quite low incomes (median annual family income for enrolled children was \$16,980 and for nonelderly adults was \$15,363 in 2001).¹¹ Cost sharing can deter use of unnecessary services but can also deter necessary care, defeating the purpose of coverage. Copayments, a common feature of private insurance, impose a very different burden on the typical family with, say, five office visits and three prescriptions filled each year than on a person with a chronic illness requiring regular care. Finally, many providers object to the

hassle of collecting small copayments from poor families and view them as equivalent to reimbursement rate cuts, which states can make under current law.

Capping Enrollment

Under a block grant, states may cap enrollment to limit their costs. This stands in contrast to the current Medicaid program in which all who are eligible must be permitted to enroll. Enrollment caps are employed in other programs, such as Section 8 housing assistance and many states' childcare subsidy systems.

Caps are arbitrary and affect potential beneficiaries regardless of income or health status. They tend to benefit long-term recipients, such as the elderly and disabled, over people whose health status or income fluctuates, which can terminate eligibility and force a person to start again at the end of a waiting list. Enrollment caps for health insurance can create unpredictable inequities. For example, a person who suffers an acute illness may be denied enrollment while a healthy individual with identical income who happened to enroll first retains coverage. Waiting lists do not add much to states' toolkits for cost savings, since under current law states can reduce eligibility, and have shown a willingness to do so during their recent fiscal difficulties.

Shifting Financial Risk to the States

A block grant shifts financial risk from the federal government to the states. This shift makes sense if it will improve efficiency but such a shift is likely to present states with difficult problems. In the current Medicaid program, if costs rise for any reason—including increased enrollment, medical inflation, or new medical technologies—these costs are shared between the states and the federal government. Under a fixed grant program, higher costs are borne entirely by the states, while lower costs create a windfall that states keep in its entirety.

If the next ten years of Medicaid precisely match budget projections, the shift in financial risk would be unimportant. However, history shows that Medicaid spending is quite volatile, just as private sector health insurance premiums are. Annual Medicaid cost growth for health services has ranged from 2.3 to 20.7 percent since 1990. Thus, the shift in risk is likely to be meaningful.

There are two reasons to be concerned about shifting financial risk to states. First, Medicaid enrollment grows during periods of economic weakness, when state revenue collections also are low. Given their balanced budget requirements, states are in a weaker position than the federal government to meet the increased needs of Medicaid at these times. In fact, the current fiscal structure makes Medicaid a countercyclical program, with the federal government spending more when the economy is weak. This structure increases the flow of federal funds to states during downturns, helping both beneficiaries and state economies. A block grant design would likely shift the program to being somewhat procyclical. When the economy weakens federal funds will not increase and states, facing fiscal pressures, are likely to cut spending. (State actions will depend in part on whether they are spending at or above their

MOE—see below.) Second, states, with their narrower tax bases and less heterogeneous economies, are subject to greater volatility in revenue collections. Shifting risk to states is placing the risk at the level of government less able to absorb it.

Implications of Changing State Incentives

The move to a block grant changes the incentives states face when considering policies in the Medicaid program. Under a block grant, the marginal benefit to a state from reducing coverage or spending (down to the floor imposed by the MOE) would increase dramatically—from between 23 and 50 cents on the dollar (depending upon the state) to a full dollar-for-dollar; the marginal cost to a state for expanding coverage would increase similarly. In other words, states would get to keep all the savings associated with reducing program coverage or benefits and need not share them with the federal government, but they bear the full cost of eligibility expansions.

Recent evidence shows that states are reluctant to cut Medicaid, even though state budgets are very tight. Some of this reluctance would disappear if states saved a full dollar for every dollar they cut. Similarly, when states bear the full cost of expansions they are less likely to make them. In general, a matching formula program encourages expansion—an appropriate policy when more than 40 million Americans are without health insurance. A block grant will likely discourage expansions except in exceptionally good economic times.

Block Grants and Equity

A block grant would lock in current differences in federal payments across states. In the current Medicaid program, the amount of federal dollars that states receive depends on how they structure their programs, i.e., their policy choices regarding coverage, benefits, and provider payments. The more expansive their programs, the more federal dollars. Federal payments also depend on the federal matching formula, which varies inversely with state per capita incomes. In general, the first factor has a greater effect than the second. Although there are several exceptions, high-income states tend to get more federal dollars per low-income person than low-income states.

The block grant proposal would use FY 2002 federal spending levels in each state and apply a growth factor to determine each state's yearly allocation. To look at how federal allocations for acute and long-term care would vary across states, we began with 2002 expenditures for acute and long-term care services for each state. We applied the current federal matching rate and divided by the number of people below 200 percent of poverty.¹² Table 1 shows considerable variation in federal payments per low-income person across states.

New York and California, who are often compared with each other, would fare quite differently. In the acute care allocation New York would receive \$1,818 per low-income person while California would receive \$876; the long-term care allocation would be \$1,354 in New York and \$362 in California. In general high-income states such as New York, Vermont, Rhode Island, and Massachusetts would receive

Table 1
Federal Medicaid Acute and Long Term Care
Expenditures Per Low Income Person, FFY 2002

Acute Care		Long Term Care	
District of Columbia	2,849	New York	1,354
Alaska	1,872	Connecticut	1,299
New York	1,818	Iowa	1,299
Rhode Island	1,811	Minnesota	1,257
Vermont	1,627	District of Columbia	1,125
Maine	1,563	Wisconsin	1,121
Massachusetts	1,537	North Dakota	1,022
Missouri	1,477	Pennsylvania	1,004
Kentucky	1,452	Rhode Island	983
Tennessee	1,388	New Hampshire	969
Mississippi	1,385	Maine	948
South Carolina	1,378	New Jersey	921
New Mexico	1,250	Nebraska	915
Louisiana	1,201	Ohio	909
Delaware	1,188	Missouri	888
Michigan	1,146	Massachusetts	886
New Hampshire	1,142	Vermont	843
Connecticut	1,129	South Dakota	821
Georgia	1,127	Alaska	820
Maryland	1,119	Kansas	805
Minnesota	1,119	Louisiana	741
North Carolina	1,116	Delaware	677
Pennsylvania	1,115	West Virginia	672
New Jersey	1,096	Indiana	650
West Virginia	1,069	Maryland	619
Ohio	1,044	Wyoming	584
Indiana	1,033	Virginia	581
Washington	1,008	Kentucky	577
Oregon	970	Montana	576
Arkansas	963	South Carolina	564
Nebraska	962	North Carolina	558
Illinois	944	Michigan	551
Wisconsin	937	Oklahoma	549
Arizona*	935	Arkansas	549
Alabama	924	Washington	541
Iowa	917	Oregon	524
South Dakota	910	Tennessee	522
Hawaii	881	Mississippi	520
California	876	Idaho	502
Utah	805	New Mexico	501
Idaho	801	Alabama	489
Oklahoma	787	Illinois	442
Texas	732	Hawaii	431
Florida	730	Colorado	395

continued—

Table 1 continued—

Montana	728	California	362
Kansas	715	Arizona*	354
Colorado	664	Georgia	345
Virginia	632	Texas	344
North Dakota	618	Florida	337
Wyoming	594	Utah	331
Nevada	511	Nevada	189

Sources: Urban Institute estimates based on data from CMS (Form 64). Population counts from the March Current Population Surveys, 2001, 2002.

Notes: Includes total civilian population. Low-income is defined as having family income below 200% FPL. Does not include administrative costs, accounting adjustments, or the U.S. Territories. Acute care services include inpatient, physician, lab, X-ray, outpatient, clinic, prescription drugs, EPSDT, family planning, dental, vision, other practitioners' care, payments to managed care organizations (MCOs), disproportionate share payments and payments to Medicare. Long-term care services include nursing facilities, intermediate care facilities for the mentally retarded, mental health, home health services, and personal care support services.

*Of the \$2.9 billion in prepaid/managed care expenditures reported by Arizona, 68% was assumed to pay for acute care and 32% was assumed to pay for long-term care. These proportions are based on data included in the "2002 AHCCCS Overview" report produced by the state.

the highest allocations. There are exceptions; such low-income states as Tennessee and Mississippi would get relatively high allocations as well.

But more typically, lower-income states such as Florida and Texas would receive considerably less. If low-spending states wanted to expand coverage to levels similar to those of higher-income states they would not receive any federal help. The scale of today's interstate federal Medicaid spending differences is difficult to defend; locking them in is even less so.

Allotments that grow at equal rates among all states also are potentially inequitable. The composition of enrollees and benefits varies among states, as do labor markets, which affect provider costs. State populations also grow at different rates. All have implications for expenditure growth.

How Would States Respond to a Block Grant Program?

One goal of the administration's proposal is to encourage state innovation. While a few states might take bold approaches under a Medicaid block grant—just as a few states have applied for and received Section 1115 waivers to fundamentally transform the program—we anticipate that states innovations will by and large be quite modest. In our assessment, block grants will most likely have the ironic effect of *reducing* innovation for two reasons.

First, block grants lock states in to where they are at the outset and take away the primary tool they need to make changes: money. States are constantly recalibrating their programs, changing payment rates for providers, and considering coverage for new medical technologies, and they periodically add new eligibility groups. Without federal matching funds to cover a portion of the cost, many of these changes will come to a halt.

Second, as described above, block grants shift a large financial risk to states. The natural response to this shift is to seek to reduce other sources of risk. Major policy changes are precisely the sort of risk states are likely to avoid to provide themselves with some stability in an increasingly uncertain fiscal position.

Ultimately, how states respond to block grants will depend primarily upon whether the underlying costs of the program increase at a rate faster or slower than the statutory 8.5 percent, or whatever growth rate is ultimately agreed upon.

The best-case scenario is that block grants are enacted and medical inflation is low, the economy is strong, and no major health care system shocks occur for a sustained period. Experience tells us that in this scenario, the existing Medicaid program might have grown at a rate of 4 or 5 percent. States would receive a federal grant that grows at a much higher rate, and with the maintenance of effort requirement, actually must spend more on health care than they need to cover the “old” program’s cost. These extra dollars create room to fund other priorities: expansions of benefits, coverage for new populations, and greater investment in community-based services.

A more pessimistic scenario is that block grants are enacted and followed by a period of high medical inflation, a weak economy, and one or more shocks to the health care system. The combination of the federal block grant and the state’s maintenance of effort is insufficient to cover the costs of the eligible population. Some states would dig deeper into their own pockets to cover the costs, while others would cut provider payment rates, optional benefits, and optional eligibility groups.

Over time, states will have good and bad years, with results that depend upon whether the state is spending more than is required for maintenance of effort. In good economic times, states with more limited programs may find that maintenance of effort requirements and growing federal block grant funds will force them to expand coverage more than they otherwise would just to spend the required funds. In bad times, those states will scale back coverage to keep their spending close to the required minimum. For states that are willing to spend more than the minimum required, in good economic times they will expand their programs because they have the resources, but expansions will be less ambitious than they are today because the state will bear the full cost. In bad times these states will cut back more quickly than they do now because they will keep all the savings—no longer sharing them with the federal government.

The net result is that for states with more limited programs the block grant design is more stable from a budget perspective—with fairly predictable and controllable rates of growth each year as the federal grant and the state effort both rise by formula.

In order to achieve this stability, states will need to (and will have more tools that enable them to) adjust eligibility, benefits, and payment rates, and perhaps establish waiting lists, each year. For states that want to go beyond the minimum the incentives in the block grant design are likely to reduce the pace of expansion and accelerate the pace of contraction.

This increase in budget stability will come at the expense of lower overall rates of insurance coverage.

The Bottom Line

Ultimately, the problem with the block grant approach is that it is not real Medicaid reform. The new flexibility states would gain—tailoring benefits, altering eligibility criteria, imposing more extensive cost sharing, establishing waiting lists—add only modestly to the tools states have. The basic dynamics of the Medicaid program would remain unchanged: When health care costs are under control the program will expand to meet new needs, and when costs spiral higher the program will be cut. Block grants mean the details of the expansions and cuts will be different, but the cycles remain.

Real Medicaid reform must confront two problems facing the Medicaid program.

First, the cost of meeting the acute and long-term care needs of the poor, elderly, and disabled is growing faster than current state tax revenues. This problem will remain even after economic growth resumes. Second, variation across states in how well Medicaid meets the needs of the low-income population and how many financial games have been played makes the federal government reluctant to build upon Medicaid's strengths. Real reforms would promote a more cost-effective health care delivery system and a more rational allocation of financial and programmatic responsibility among employers, families, states, localities, and the federal government.

States are less able than the federal government to bear financial risk and engage in policies that redistribute income. When faced with the full cost of any policy changes, rather than the sharing arrangement in the current Medicaid program, states are less likely to expand coverage and more likely to make large cuts in difficult times. Predetermined budget allocations lock states in to the policies and priorities chosen in the past. If meeting the health care needs of the poor and the sick is a national priority, the federal government's role must remain larger than writing checks to states. Converting Medicaid into a block grant moves health policy in the wrong direction.

The views are those of the authors and do not necessarily reflect those of the Urban Institute, its board of trustees, or its sponsors.

Notes

1. John Holahan is director of the Health Policy Center at the Urban Institute. Alan Weil is director of the *Assessing the New Federalism Project* at the Urban Institute.
2. Information on the administration's Medicaid plan can be found at "HHS Secretary Tommy G. Thompson Announces Medicaid Reform Plan" (http://www.kaisernetwork.org/health_cast/hcast_

index.cfm?display=detail&hc=766), January 31, 2003, and U.S. Department of Health and Human Services, "FY2004 Budget in Brief," February 2003.

3. The Bush administration does not refer to its proposal as a block grant. The administration's budget proposes to give states "significant flexibility" to spend what it calls "lump-sum allotments," which are determined in advance by formula.
4. Other reviews of the implications of a Medicaid block grant can be include Cindy Mann, "The Bush Administration's Medicaid and State Children's Health Insurance Program Proposal" (Washington, D.C.: Georgetown University Institute for Health Care Research and Policy, February 10, 2003); Cindy Mann, Melanie Nathanson, and Edwin Park, "Administration's Medicaid Proposal Would Shift Fiscal Risks to States" (Washington, D.C.: Center on Budget and Policy Priorities, April 1, 2003); and J. Guyer, "Bush Administration Medicaid/SCHIP Proposal" (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, May 12, 2003).
5. Details on methods for determining the growth factor have not been made public, but setting the trend factor at a rate equal to current program growth has been mentioned in public presentations and in the budget.
6. Jack Hadley and John Holahan, "Is Health Care Spending Higher Under Medicaid or Private Insurance?" Report prepared for Kaiser Commission on Medicaid and the Uninsured, forthcoming.
7. Kaiser Commission on Medicaid and the Uninsured, "Medicaid 'Mandatory' and 'Optional' Eligibility and Benefits," July 2001.
8. Medically needy eligible populations may be offered different benefits. The distinction between categorical needy and medically needy is technical and is not explored here. It is important to note that this distinction is not the same as the distinction between optional and mandatory populations.
9. Authors' calculations from CMS Form 64 for 2002.
10. Kaiser Commission on Medicaid and the Uninsured, "Medicaid 'Mandatory' and 'Optional' Eligibility and Benefits," July 2001.
11. Authors' calculations from the March 2002 Current Population Survey.
12. Acute and long-term care spending is from fiscal year 2002 (CMS Form 64). Population counts are from the March Current Population Surveys for 2001 and 2002. Other population-based denominators may be appropriate. When we used the population below 100 percent of the FPL, there was little change in the results.

Covering the Uninsured: How States Can Expand and Improve Health Coverage

by Robert E. Moffit and Nina Owcharenko

Innovative governors and legislators in every state of the Union can take specific steps to increase health insurance coverage and improve the range of choice and quality of that coverage for individuals and families.

State officials' range of action is constrained severely by federal law because America's health insurance markets are shaped—and distorted—by the federal tax treatment of health insurance. But while state officials obviously cannot change the federal tax code, they can still take major steps to create more expansive and efficient consumer-based health insurance markets.

Working with Washington

State officials can work directly with the Bush Administration and Congress to increase access to health care coverage for millions of Americans, including those who have difficulty obtaining coverage because they cannot get it at their places of work, are low-income working people, or have lost their health coverage with their employment. Moreover, states can do it right by creating new structural arrangements that would give millions of Americans more choice and control over their health care decisions.

Specifically, the states can:

Cooperate with the Bush Administration in expanding private health insurance coverage and improving public programs. This means making changes in state law and regulation to accommodate proposed federal changes in the tax treatment of health insurance and medical care. These include new health care tax credits, tax-free rollover of funds in existing flexible spending accounts, and the expansion of tax-free medical savings accounts.

State officials can also take advantage of U.S. Department of Health and Human Services (HHS) waivers, particularly the new Health Insurance Flexibility and Accountability (HIFA) demonstration waivers.¹ These federal waivers encourage state officials to develop innovative coverage options using existing federal funds and incorporating private coverage options. Seven states have already sought and obtained expedited waiver authority from HHS. The Administration is proposing to build on this model by giving states even greater flexibility in improving the function of their Medicaid and State Children's Health Insurance (SCHIP) programs.²

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Create a state-based information system of health plans available in the state. Individuals and families who do not get health insurance at the place of work or do not have Internet access to health plans often do not know how or where to secure affordable coverage. State officials should break the “awareness barrier” and make that information, including consumer information on quality care, available in an easy and accessible way through agencies that routinely contact working families, such as the motor vehicle administration, the revenue department, or even local hospitals.

Allow displaced workers who are eligible for new federal assistance for health coverage to enroll in private plans offered to state employees. Under the Trade Adjustment Reform Act of 2002, an estimated 260,000 American workers displaced by international trade can now qualify for a 65 percent federal tax credit for the purchase of health insurance. While such displaced workers are found in all states, they are particularly numerous in Florida, North Carolina, Ohio, Pennsylvania, Texas, and Washington. State officials can make available a variety of congressionally authorized options for these workers, but they could secure quick coverage for these workers by allowing them to enroll in the private health plans routinely offered to state government employees.

Allow state and municipal employees to use the new health reimbursement arrangements (HRAs) to secure the doctors and medical services of their choice. In 2002, the U.S. Department of the Treasury issued a major tax policy ruling allowing employers to deposit funds in tax-free health care accounts for employees and roll over the unused funds year after year in these accounts. Combining a wellness program with this new account, the Louisiana State University Healthcare Network (LSUHN), for example, experienced a 9.6 percent increase in physician office visits and a 28 percent decrease in total health costs.³ Under the Treasury Department’s ruling, employers can also make the accumulated funds in these accounts available to employees when they retire to help them offset retirement health care expenses. State officials can now make the HRA option available to their employees, just as it is available to federal employees and their families.

Create preventive care accounts for Medicaid beneficiaries. While Medicaid, the huge federal-state program for the poor and indigent, is in desperate need of reform, state officials should seek waivers to improve the program for the 44 million people enrolled in it. To improve access to physicians, states could establish state-based cash accounts for Medicaid recipients with a PIN number and debit card. Payments for routine medical and preventive care services such as doctors’ visits and checkups could be paid directly out of the preventive care account. Not only would doctors get quick, hassle-free reimbursement for their services, but Medicaid beneficiaries could avoid emergency rooms and roll over the unused funds in the Medicaid account each year. When Medicaid beneficiaries leave welfare or get a job in the private sector, the unused funds in their account could be transferred to pay for private insurance or put into a medical savings account. Using a federal waiver, Florida officials have already created a consumer-driven option for disabled Medicaid beneficiaries.⁴

Make health care coverage more affordable for individuals and families through state regulatory reforms. Benefits are mandated nationwide. A 1999 study of state-mandated benefits, conducted by the Health Insurance Association of America, found that as many as one out of four Americans who are uninsured lack coverage because of the costs of state-mandated benefits.⁵ State officials should review the continuing and accumulating costs of state-mandated benefits and health insurance regulations, and scale back or repeal those that exceed their regulatory benefits.

Enact serious medical malpractice reform. In several states, including Texas, Pennsylvania, and Nevada, soaring medical malpractice costs have made the practice of medicine increasingly difficult for doctors and other medical professionals. Beyond encouraging doctors to practice roughly \$50 billion worth of defensive medicine annually to avoid litigation,⁶ flawed medical malpractice laws are also causing doctors to leave their states or even quit medicine altogether. This is creating serious access problems for patients in several states. At the very least, state officials should give malpractice relief to all doctors who treat Medicaid patients or dispense charity care to the poor.

Create a statewide voluntary purchasing cooperative. Unlike other forms of insurance, health insurance is routinely insulated from consumer choice. According to Alain Enthoven, a professor at the Graduate School of Business at Stanford University, 77 percent of all employees with employer-based coverage do not have a choice of health insurance carrier.⁷ State officials can reverse these dynamics by creating a structure that gives individuals and families easy access to health plans and allows private health plans to compete directly with each other for consumers' dollars. This is, in effect, what the federal government does today for federal employees and their families in the popular and successful Federal Employees Health Benefits Program (FEHBP). The components would include a state "clearinghouse" for comparative information, the enforcement of minimum benefit requirements and consumer protection rules, a service center for enrollment and the collection of premiums, a reinsurance pool for companies to cope with adverse selection, and a system of premium subsidies or state-based tax credits for insurance coverage. The best way to establish an infrastructure for consumer choice and competition would be to fold state employee health plans into the new system.

Study the cost of the uninsured and create a system of state-based tax credits or premium subsidies for private health insurance. Faced with tight budgets, many state officials are understandably reluctant to create a new system of health care tax credits or premium subsidies for low-income persons to purchase private health plans. But the cost of expanding coverage must be balanced against the cost of not expanding coverage. According to Jack Hadley and John Holohan of the Urban Institute, a prominent Washington public policy institution, Americans today pay \$34.5 billion, mostly through government spending, in uncompensated care costs on behalf of the uninsured.⁸ State officials should emulate the Texas Comptroller's Office and undertake a similar analysis of the total cost of the uninsured to state taxpayers.

The Texas Comptroller estimated that in 2002, Texans paid roughly \$1,000 for each uninsured Texan, or the same amount that President Bush has proposed for his \$89 billion program of health care tax credits for eligible uninsured adults.⁹

The Next Steps: Creative Federalism

Policy analysts at the Institute of Medicine, reflecting a growing consensus among health policy analysts, have suggested that the states, in cooperation with the federal government, undertake innovative demonstrations to find out what works best in expanding coverage for the uninsured.¹⁰ As one example of “creative federalism,” Congress could specify a “menu” of changes available for federal funding, including various consumer choice alternatives, a set of “performance goals” for the states to meet as a condition for federal funding, and a bonus program to reward states that meet the agreed-upon goals of expanding patient choice, insurance coverage, quality improvements, and patient satisfaction.¹¹

In the 1990s, innovative state welfare initiatives helped to drive the overhaul of national policy to fix the crumbling welfare system. Governors and other state officials can pattern their health care reform efforts after the success in welfare reform. To assist states, Congress has already created a new source of federal funding to create pooling arrangements to cover the uninsured under the Trade Adjustment Assistance Reform Act of 2002.

How States Can Expand Health Care Coverage, Improve Quality, and Control Costs

Securing health insurance coverage for millions of Americans is both a federal and a state problem. State officials should engage in a continuing dialogue with officials at HHS and take advantage of new opportunities to expand choice, control cost, and reduce the number of the uninsured.

To advance this agenda, state officials can take a variety of steps:

STEP 1: Cooperate with the President in reducing the number of uninsured.

Over the past two years, the Bush Administration has outlined an ambitious and fairly comprehensive health care reform agenda.¹² It includes an \$89 billion program of refundable tax credits for the uninsured, an annual rollover of up to \$500 of unused funds in employer-based flexible spending accounts (FSAs), and a lifting of existing statutory restrictions on medical savings accounts (MSAs).¹³

In concert with congressional action on these items, or even in anticipation of such changes, state officials could start changing state law and regulations to accommodate these federal initiatives in order to facilitate increases in patient choice, control, and coverage. For example, the Bush tax credits would be available not only for private health insurance on the individual market, but also for individuals and families who purchased health plans through “private purchasing groups, state-sponsored insurance purchasing pools and state high risk pools.”¹⁴

After December 31, 2004, under the Bush proposal, the states could permit eligible individuals and families to buy into state employee purchasing groups using the new federal health care tax credits.¹⁵ Moreover, states could supplement federal health care tax credits for individuals and families with incomes at or below 200 percent of poverty with additional state contributions ranging from \$500 to \$2,000 per adult, depending on their income levels.¹⁶ State officials should start planning for such changes.

STEP 2: Take a statewide inventory of private plans and design a consumer-friendly information clearinghouse for individuals and businesses on available health plans.

Most Americans easily access the health insurance system through the place of work; but for those who do not get health insurance through their places of work, the task of securing affordable coverage can be formidable. The 41.2 million uninsured Americans are a dynamic population, uninsured largely because of a change in employment. According to a special report on the uninsured produced by researchers at the University of Michigan, “Half of the uninsured go without coverage for six months or less, while more than 40 percent are uninsured for at least 18 months.”¹⁷

While expanding Internet access has helped make better information available to consumers, states could do more to make that information more readily available for those without Internet access or those who just do not know where to secure health care coverage. According to a 1999 study by the California Health Care Foundation, 53 percent of the “non-poor” uninsured said that they would be more likely to buy insurance coverage once they knew the true cost of available plans.¹⁸

Breaking down barriers to awareness becomes increasingly important if Congress or the state legislatures start providing individual tax relief or creating a system of premium supports for individuals and families to purchase health insurance. If Congress or state legislators enact a health care tax credit, the mere existence of that assistance is of little help if the persons who would benefit most from it are unaware of the health plans available to them. State officials could establish information centers or clearinghouses for individuals and families seeking health insurance and make comparative information available at state offices, including the revenue department and the motor vehicle administration.

There is precedent for the provision of consumer information in a consumer-driven health care system at the federal level. The U.S. Office of Personnel Management (OPM) and the personnel offices of all federal agencies provide comparative plan information for federal employees and retirees enrolled in the consumer-driven FEHBP. These enrollees can choose from many private health plans and receive useful comparative information on the available health plans, including premium costs, co-payments, the levels of benefits, and solid comparative information on health plan performance.

STEP 3: Make sure that health plans available to the uninsured are affordable.

A key advantage of group health insurance is that group coverage makes premiums affordable, but individual health care policies can also be affordable for millions of Americans without coverage. A national on-line source of health insurance policies, eHealthInsurance.com, has reported that the average premium for an individual policy purchased through their Internet service was less than \$1,500, with a typical deductible of \$500 or less.¹⁹

Studies conducted by the National Health Underwriters and the Health Insurance Association of America (HIAA) report similar findings. HIAA, for example, found that of its members who sell individual policies, the average premium was \$2,070 for single coverage and \$4,000 for family coverage.²⁰

Policy costs vary from state to state, reflecting differing economic conditions, demographics, and patterns of medical practice. However, health plan costs also reflect the cost of state rules and regulations governing individual policies.

For example, states impose benefit mandates on individuals and families that purchase health insurance, regardless of whether they want or need such benefits. In a recent analysis of the factors driving health care costs, PricewaterhouseCoopers estimated that, nationwide, government mandates and regulations contributed 15 percent of the total increase in health care premiums for 2001-2002.²¹ In 2001, Maryland led the nation with 54 such mandated benefits, including legislative requirements to cover politically favored medical specialties, treatments, and procedures.

For various political reasons, state officials might hesitate to reduce or eliminate all such benefit mandates, but they could at least reduce or eliminate such mandates for those who are uninsured or have endured a spell of uninsurance for a specified period of time. Such a policy could make health plans more affordable for those young families who desperately need coverage.²² A young family with two children needs a health plan that gives them access to physicians and hospitalization services; they should not be forced to buy a health plan that incorporates dozens of benefits they do not want or need, some of which—like alcohol and substance abuse treatments or coverage for in vitro fertilization—are very expensive.

Mandated benefits are often popular with provider groups and medical specialty societies, which battle ferociously to make sure that state legislators include their treatments or procedures in all state-regulated health plans. Research shows that health mandates increase health costs, pricing many individuals and families out of the private market. According to a 1999 HIAA study, as many as one in four of the uninsured are without coverage because of state health benefit mandates.²³

Some states have begun to change their benefit mandate policies. North Carolina, for example, has imposed a moratorium on any new benefit mandates.²⁴ Hawaii, Texas, Louisiana, and Vermont require a cost assessment before imposing new benefit mandates.²⁵ Some states have considered “mandate-lite” plans, and others are taking similar steps.²⁶

State officials should also order an independent econometric review of state health insurance regulations, including a cost-benefit assessment and an assessment of their impact on the affordability and accessibility of private health plans. This type of analysis should be performed by a top-ranked, private econometrics firm, not by a state agency or any other political institution that has a vested interest in maintaining the regulatory status quo.

In many states, the health insurance market is heavily regulated, and this raises the cost of insurance and prices many lower- and middle-income families out of coverage. In a state-by-state price comparison of insurance policies, analysts for eHealth-Insurance.com found significant price differences between states that have differing levels of insurance regulation. Two of the most significant insurance rules include community rating, in which all enrollees pay the same premium regardless of risk or health status, and guaranteed issue, in which insurers are required to offer policies to all, regardless of risk or health status. For example, in Texas, a state with no community rating or guaranteed issue, the average single monthly premium was \$181, while in New York, a state with both community rating and guaranteed issue, the average monthly premium was nearly \$300.²⁷

State legislators may strongly believe that there are very good policy reasons to impose such rules as community rating and guaranteed issue of insurance; but there are trade-offs, and these trade-offs should be made visible. State officials should realize that while community rating and guaranteed issue are often enacted to assure increased access of individuals and families to health insurance, they often accomplish exactly the opposite result.

STEP 4: Conduct a study of the true cost of the uninsured and use that study to justify state credits or premium subsidies for the uninsured.

As noted, a recent analysis by Urban Institute scholars indicates that Americans pay an estimated \$34.5 billion in uncompensated care for the uninsured.²⁸ State officials should likewise get a clear idea of what they are already paying for the uninsured.

The Texas Comptroller's Office, for example, found in a major study that the total cost of health care spending in 1998 for uninsured Texans was \$4.7 billion, including the costs to local governments, doctors, hospitals, and state agencies. In effect, Texas citizens paid about \$1,000 for health care for each uninsured Texan.²⁹

State officials can use this kind of analysis if they wish to expand coverage further and piggyback on any federal health care tax credits or premium subsidies. Additional state assistance, especially targeted at low-income or harder-to-insure individuals and families, would bring the cost of coverage within closer reach of these low-income working families. As noted, the Bush Administration encourages such assistance. State officials should follow through, especially if they believe that the President's proposed federal health care tax credit would not be generous enough for certain populations.

Moreover, for the unemployed, state-based assistance could be administered quickly and easily through state unemployment compensation offices. A person who

is eligible for unemployment compensation could automatically be eligible for the credit or the subsidy and for private health insurance. This process of “one-stop shopping” for displaced workers and their families could be done with both a federal and a state credit or premium subsidy approach.

STEP 5: Secure HHS waivers to use existing federal funds to expand private health care coverage.

Officials at the U.S. Department of Health and Human Services have created the Health Insurance Flexibility and Accountability demonstration initiative, along with an expedited approval process, “to encourage new comprehensive state approaches that will increase the number of individuals with health insurance coverage within current-level Medicaid and SCHIP [State Children’s Health Insurance Program] resources.”³⁰

HHS officials emphasize the value of “approaches that maximize private health insurance coverage options” and target populations below 200 percent of the federal poverty level.³¹ Nationally, a substantial majority of uninsured Americans are below 200 percent of the poverty line. State officials can take advantage of this new demonstration authority and use it to secure innovative private-sector coverage options for low-income, uninsured populations.

Under HIFA, HHS Secretary Tommy Thompson has approved several waivers. New Mexico and Oregon, for example, take advantage of Medicaid and SCHIP funds and combine them with private-sector health plans to expand coverage to the uninsured. In New Mexico, state officials can use unexpended SCHIP funds to subsidize private health insurance for 40,000 low-income residents. Under the New Mexico waiver, employers can also contribute to private health plans. With a combination of government subsidies from existing government programs and employer contributions, HHS estimates that these low-income employees will be paying about \$25 to \$35 per month in insurance premiums.³²

Based on its waiver, Oregon officials will expand the state’s premium support program, the Family Health Insurance Assistance Program, to cover as many as 25,000 beneficiaries. Under the Oregon waiver, Oregon residents earning up to 185 percent of the federal poverty level would be eligible to receive “for the first time” federal premium assistance for employer-sponsored coverage or individual health insurance.³³

Finally, the President’s budget proposal would provide states with increased flexibility under Medicaid and SCHIP. Under this proposal, states would be able to implement program changes and improvements without having to go through the waiver process.³⁴

STEP 6: Improve care for Medicaid enrollees by creating a Medicaid preventive care account.

The best Medicaid policy gets low-income persons and their families out of the traditional Medicaid program and mainstreams them into the private health insurance market.³⁵ Meanwhile, states can adopt initiatives that give Medicaid patients more

control over their health care spending and decisions while ensuring that they get the care they need when they need it.

State Medicaid programs often have a rich benefits package. While Medicaid coverage looks good on paper, however, the program has a well-deserved reputation for perverse economic incentives, disruptions in the continuity of care, and poor-quality care. If Medicaid beneficiaries experience a change in income or assets, their eligibility will change, regardless of health status, possibly resulting in a loss of coverage. As a Baltimore Sun report on the plight of Medicaid patients in Maryland summarizes the problem, “They are poor, but not poor enough. They have medical bills that are high, but often not high enough. They are insured some months, but uninsured others.”³⁶ Getting clarity with respect to Medicaid eligibility can be a problem for doctors, patients, and state officials.

Faced with exploding Medicaid spending, states are cutting back on benefits, thereby causing a further deterioration in the quality of care.³⁷ As a recent Kaiser Commission survey of Medicaid directors shows, states are planning cost-cutting measures such as limiting access to prescription drugs and reducing or freezing payments to doctors, hospitals, and other medical professionals.³⁸

Most doctors treat Medicaid patients, but they also find that Medicaid reimbursement levels are too low and loathe wrestling with Medicaid paperwork and regulations. In 2001, roughly 20 percent of physicians were not accepting new Medicaid patients, and the overall proportion of physicians serving Medicaid patients declined slightly.³⁹ The danger, of course, is that Medicaid patients will start to experience difficulty in getting access to doctors and, like the uninsured, will end up either in hospital emergency rooms for routine medical services or, worse, being treated for deteriorating medical conditions that could and should have been treated more effectively if treated much earlier in a doctor’s office.

A partial solution to this problem would be to create a Medicaid preventive care account for each Medicaid recipient with a specified amount accessed using a PIN number and a debit card. Payments for routine medical services—doctors’ visits, regular checkups, and preventive care—could be paid directly out of the Medicaid account. For Medicaid enrollees, states could roll the unused funds over each year in an interest-bearing account. When enrollees leave welfare or get a job in the private sector, the unused funds could be used to pay for private health insurance or transferred into a medical savings account or health reimbursement account.

The creation of such a Medicaid account is thus compatible with welfare reform, helping low-income persons make the transition not only into productive jobs, but also into the private insurance market. Such an account would combine the best features of the private-sector-style health reimbursement arrangement with the public-sector-style administration of the food stamp program.

HHS has already established a precedent for this approach with its “Independence Plus” initiative. This initiative both improves the existing “cash and counseling” program and provides states with an expedited process to offer families with disabled

individuals the opportunity to have greater control of “the design and delivery of their own health care services.”⁴⁰ State officials should examine the success of such programs in New Jersey, Arkansas, and Florida, where Medicaid recipients decide how best to spend their allocated health care dollars instead of having government officials decide for them.

STEP 7: Establish a statewide voluntary purchasing cooperative for the uninsured.⁴¹

To give residents more coverage options, states should consider designing voluntary purchasing cooperatives that would function much like the Federal Employees Health Benefits Program, which covers members of Congress, federal workers and retirees, and their families—roughly 9 million Americans.⁴² Nationally, hundreds of private health plans compete directly for consumers' dollars. Unlike other government health care programs, the FEHBP functions with comparatively little bureaucracy and regulation. It also enjoys a solid historical record of cost control, competitive benefits, programmatic stability, and a high degree of patient satisfaction.⁴³

Because of its historical record of solid performance, the FEHBP is a leading model for Medicare and health care reform.⁴⁴ In 2001, the Maine legislature voted overwhelmingly, on a bipartisan basis, to create a voluntary purchasing pool called “an insurance exchange,” and Maine officials are in the first stages of implementing it.⁴⁵ This policy initiative has precedents in other states.⁴⁶

To give individuals and families greater access to affordable coverage, a voluntary purchasing cooperative could incorporate several features:

The state employees' health benefit program. All uninsured employees in the state could have access to existing health plans in the state employees' system, which is usually a system of multiple health plans, plus any additional health plans that meet basic benefit and fiscal solvency requirements.⁴⁷ These plans, as well as the plans that serve state employees, could be made available to every uninsured person in the state.

Initially, it might be prudent to separate the state employee pool from the private, non-state-employee pool and allow the competing private plans to risk and rate these populations separately. Since most of the uninsured are young and healthy, it is likely that state employee organizations will soon realize that the combination of the pools would directly benefit state employees with lower premiums. In the meantime, it would be politically attractive for the governor and the state legislators to open up their own health insurance system to the states' uninsured citizens.

Automatic sign-up for uninsured workers at their place of employment. More than four out of five uninsured workers are in full-time working families. Lynn Etheredge, a prominent health care policy analyst at George Washington University, argues vigorously that the most efficient way to target workers is therefore through their place of work.⁴⁸ While employers would not pay for health insurance, there is no reason why they could not serve as the place for employees and their families to sign up for available health plans. Of course, employers could also contribute, if they wished,

to their employees' premium and reap the same tax breaks as corporate employers do in the conventional payment of health insurance premiums.

Automatic payroll deduction for premium collection at the place of work. Employers are legally required to use the payroll deduction system for Social Security, Medicare, federal income tax, state taxes, and unemployment compensation. While employers do not sponsor the tax code, they do enforce it. With a state voluntary purchasing cooperative, employers could deduct the premium, over and above any tax credit assistance or state assistance (through SCHIP or Medicaid waivers) that would be available, and send it to the plan of the employee's choice. National Federation of Independent Business surveys show strong interest on the part of small employers in helping to administer a system of individual tax relief for insurance for their employees.⁴⁹

In order to stimulate maximum take-up, Etheredge and others have suggested that policymakers create a system of automatic enrollment for employees, with the proviso that they can refuse in writing both the available health insurance and any state tax relief or premium assistance.⁵⁰ An employee's rejection of health insurance coverage and any refusal to accept help to pay for health insurance would require the employee to make a conscious trade-off, making the direct costs transparent to the employee and the employee's family.

A light regulatory regime. A system based on the principles of consumer choice and market competition cannot work without a system of light and intelligent regulation. This means that the state agency administering such a system should act as a referee—and not play favorites—in the competition among different types of health plans: traditional indemnity insurance, managed care, preferred provider plans, high deductible plans, health reimbursement accounts, and medical savings accounts. An efficient market requires free entry and exit of suppliers and the freedom of consumers to make the decisions in accordance with their personal wants and needs.

A statewide reinsurance pool to cope with adverse selection. In the adoption of a voluntary choice cooperative for the uninsured, or any similar consumer choice system that allows individuals and families to pick the kinds of plans and benefits they want, state policymakers should establish a mechanism to cope with risk segmentation or adverse selection—a process whereby higher-risk or higher-cost individuals congregate in one or more plans, contributing to spiraling costs and encouraging younger, healthier, and lower-income enrollees to leave the higher-cost plan(s) or drop out of health care coverage altogether.

There are many ways to cope with the possible issues of adverse selection. One might be for state officials to charter a nonprofit, self-governing corporation that would be administered and financed by the health insurers themselves and that would create a pool to finance high-cost individuals without disrupting the individual's continuity in coverage. In creating such a system, state officials could require that all plans selling state-regulated health insurance, including plans writing policies for state employees or Medicaid, participate and contribute to the pool. While every

health plan that ceded a risk to the pool would pay a premium to the pool for each risk ceded, there would be no taxpayer subsidies to the pool.

Such a mechanism could protect both carriers and enrollees from the effects of adverse selection. Plans would be encouraged to cover the broadest possible pool of individuals and families and also would be able to recover a portion of the costs incurred as a result of the enrollment of high-risk individuals.

STEP 8: Enact meaningful medical malpractice reform legislation.

The Bush Administration has put the medical malpractice problem front and center in the national policy agenda. This alone is sparking a major debate. But the medical malpractice issue is essentially a matter of state tort law.

There is a medical malpractice crisis in several states. Median jury awards have increased dramatically. Malpractice premiums are soaring, “defensive” medical procedures are common, and patient access to care is being compromised.

State legislators can take remedial action. While a sound malpractice reform measure would provide for unlimited economic damages, state legislators can reduce the growing pressures on physicians through several amendments to state tort law. Such changes could include an up-front disclosure of attorneys’ fees; limiting non-economic damages (such as pain and suffering) to \$250,000; limiting punitive damages to \$250,000 or twice the amount of economic damages (such as medical expenses or the cost of domestic services); and limiting attorneys’ fees to ensure that a maximum amount of recovery for damages would go to patients. Moreover, if state legislators are unable to secure comprehensive medical malpractice reform, at the very least they could provide legal relief for doctors who accept Medicaid patients and give doctors immunity from malpractice suits when they provide charity care to the poor.

Several states have made significant progress in reforming medical malpractice laws: Alaska, California, Colorado, Maine, Michigan, and Utah. A sound model for medical malpractice reform would be the Medical Injury Compensation Reform Act of 1975, enacted by the California legislature.

STEP 9: Take advantage of the new federal health care tax credits to cover workers displaced by international trade.

In the Trade Adjustment Assistance Reform Act of 2002, Congress enacted a provision to give a 65 percent health care tax credit to the roughly 260,000 workers nationwide who have lost employment and their health care coverage in part because of expanded international trade.⁵¹ The purpose of this first-of-its-kind health care tax credit is to help these workers secure health care coverage.

While the legislation contains artificial and complicated restrictions on personal choice, it does offer states broad authority to determine new purchasing options available to these workers.⁵² Indeed, state officials can build such an infrastructure with a view to facilitating the coverage of other classes of uninsured Americans, particularly if Congress enacts significant health care tax credit legislation. As noted, the

trade legislation also provides states with additional federal assistance to help them administer newly created purchasing options.

STEP 10: Take advantage of the new health reimbursement arrangements for state and municipal employees.

In June 2002, the U.S. Department of the Treasury ruled that America's employers could set aside funds for their employees under a new health reimbursement arrangement (HRA), a special tax-free account for the payment of health bills. Employers could roll over unused funds in the employee's account from year to year and allow employees to use accumulated funds for their health care needs in retirement.

For 2003, the Office of Personnel Management (OPM), the federal agency that runs the FEHBP, allowed the American Postal Workers Union (APWU) health plan to offer an HRA to federal employees and retirees. Under the APWU plan, federal employees can get an up-front credit of \$1,000 per person or \$2,000 per family in their account to pay for traditional medical expenses as well as dental, vision, and other expenses that may not be covered by insurance. The funds are available before enrollees pay deductibles, or out-of-pocket costs, and traditional insurance covers their health costs.⁵³

State officials may also consider employing the new health accounts as a means of promoting innovative employee wellness programs. For example, the LSU Health Care Network, which covers Louisiana State University health care employees, has recently initiated such a plan, and its preventive care program ranges from routine checkups and tests to prostate exams, mammograms, and children's vaccinations. As noted, the initial comparative data showed an increase in physician visits but an overall reduction in costs.⁵⁴ State officials should allow state employee to choose similar arrangements. Likewise, municipal employees should also be able to take advantage of the new HRAs.

STEP 11: Engage faith-based organizations in preventive care and wellness programs.

State and local officials manage or oversee public health clinics and health centers. These organizations help low-income and uninsured families secure health care services.⁵⁵

An enormous resource exists among faith-based and religious organizations. These organizations can play a vigorous role in promoting and sponsoring wellness and preventive care programs. State officials should make every effort to tap the power of faith-based and religious organizations in their health care outreach into various communities, particularly inner-city and ethnic communities.⁵⁶ They should also find ways of integrating these faith-based wellness initiatives into their public assistance programs.

Where conventional government efforts may not inspire trust or confidence, religious and faith-based organizations can often succeed. That success could result in many more poor Americans getting the checkups and routine preventive care they need.

Conclusion

Innovative and imaginative governors and state legislators can make significant headway in reducing the number of America's uninsured, improving access to quality health care, and expanding choice and competition in the state health insurance markets.

They can achieve this by taking several key steps, including:

Cooperating with the President and the Administration in expanding health coverage,

Promoting solid information on available health plan options,

Reducing barriers to coverage by reviewing the costs of mandates and eliminating excessive regulation,

Accepting new HHS flexibility to expand private insurance coverage for individuals and families,

Taking an inventory of the costs of the uninsured in their states and offsetting those costs with state health care tax credits or premium subsidies,

Creating preventive care accounts for Medicaid beneficiaries,

Cooperating with the Administration in securing coverage for displaced workers under the Trade Adjustment Reform Act of 2002,

Enacting serious medical malpractice reform, and

Engaging faith-based and religious organizations in public health efforts to secure preventive care services among poor and low-income people.

The problems of the uninsured are problems for both federal and state officials. While the central weakness of the health insurance market is the inefficient, inequitable, and restrictive federal tax treatment of health insurance, state officials can nonetheless take direct action without waiting for Congress to enact major changes in the federal tax code.

States can work energetically with the Administration and also implement innovative solutions on their own. Millions of Americans desperately need that federal-state cooperation.

Notes

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Administration's Medicaid Proposal Would Shift Fiscal Risks to States

by Cindy Mann, Melanie Nathanson, and Edwin Park¹

The Bush Administration's fiscal year 2004 budget proposal appears to provide a modest amount of funding to help states meet Medicaid costs during this time of state fiscal crisis. This offer, however, comes with a major catch. States that opt for this fiscal relief would receive lower federal Medicaid payments than they otherwise would get, starting in fiscal year 2011. In addition, states would have to accept a significant risk that the capped federal payments they would receive even in the years *before* 2011 would not keep pace with increases in costs they incur and thus would fall short of what they would have received under current law.

- From 2004 to 2010, states would, as a form of short-term fiscal relief, receive capped payments that would exceed by \$12.7 billion the federal Medicaid and SCHIP payments they currently are *projected* to receive under current law. Then, in fiscal years 2011-2013, states would be required to repay these additional funds through reductions in the capped federal payments they receive in those years. The President's budget shows that states would receive \$150 million less in federal funding in 2011 than they are projected to receive under current law, \$4.4 billion less in 2012, and \$8.3 billion less in 2013.
- In exchange for this "loan" against future payments, states would have to give up open-ended federal Medicaid financing and transform their Medicaid and State Children's Health Insurance Programs (SCHIP) into a capped, consolidated block grant. Federal payments to states would no longer be tied to the actual costs that states incurred in operating their Medicaid programs.
- If the actual costs that states incurred over the next ten years turned out to be higher than had been anticipated, the capped federal block-grant payments would fall short of actual costs, and states would receive less in federal funding even before 2011 than they would have received under current law. Actual state costs in Medicaid are affected by a number of factors that cannot be predicted accurately in advance, including changes in the economy, changes in the size and demographics of a state's population, developments in medical technology (including the emergence of new and improved but costly treatments), and other difficult-

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to-predict factors that can affect health care costs in both the public and private sectors, such as the outbreak of an epidemic or the onset of new diseases. States opting for the block grant would bear the risk that actual costs would exceed the predictions the federal government used when setting the block-grant allotments. If that occurred, states would either have to pay the additional costs entirely from state funds or to scale back the coverage available to state residents.

Under the proposal, states would receive an annual allotment from the federal government to fund two programs—one for acute care (e.g., physician, pharmacy and hospital services) and one for long-term care (e.g., nursing home and community-based long-term-care services).² States could use up to 15 percent of their allotment for program administration and direct payments to safety net providers.

A state's allotments would be based on the amount of federal Medicaid funds (including Disproportionate Share Hospital payments) and certain SCHIP funds the state had received in fiscal year 2002. The amount of the capped payments that would be provided to states would be adjusted upward each year, with the annual adjustments based on a pre-determined formula that would be established in legislation or through negotiated state adjustment rates, rather than on changes in the actual number of people served and the actual cost of services. If program costs exceeded the capped amount, a state opting for the block grant would not receive additional federal funding.

This approach holds risk for states.

- The federal government and the states currently have a financial partnership, under which they share the risks and the burdens of greater-than-anticipated increases in Medicaid enrollment and health care costs, which are notoriously difficult to forecast accurately. The block grant would terminate this partnership. It would cap the federal government's financial commitment and absolve the federal government of any risk or responsibility related to greater-than-expected increases in costs.
- This change would come at a time when health care costs are rising rapidly and the retirement of the baby-boom generation, which will bring with it large increases in health care costs whose magnitude cannot be predicted precisely, is only a few years off.
- No information has been provided on how the annual adjustments in block-grant allocations to states would be determined. If the block-grant funding levels were adjusted each year by the same percentage amount for all states, the impact would be quite varied among the states, since the factors that cause state health-care expenditures to rise over time do not have uniform effects across the states. A one-size-fits-all percentage adjustment would not serve states well.

- State-specific block-grant adjustment rates would not fully address these problems either. Under such an approach, the total amount of federal block-grant funding for a fiscal year would presumably be fixed. The amount that each state would receive would then be determined either through negotiated adjustment rates (with different rates established for each state) or through a formula that would be used to compute state-specific adjustment rates each year, based on a set of predetermined factors. If payments to states were based on negotiated adjustment rates, states would essentially compete with each other over how much of the increase (and in later years, the decrease) in federal funding each state would get. States would have difficulty estimating and defending the proper adjustment rate for their state, given the difficulties involved in projecting the percentage amounts by which Medicaid costs will rise each year. The process would likely be somewhat arbitrary and could be subject to political influence, in part because of the lack of objective standards for setting state-based adjustment rates.
- If instead of state negotiated adjustment rates, a formula for distributing funds to states was developed that resulted in the computation of annual payment adjustments for each state based on a pre-determined set of factors, the formula would only be as good as the factors included in it and the data used to make the adjustments. It would be virtually impossible to take into account in such a formula all of the myriad factors that contribute to changes in state Medicaid costs. In addition, the state-based data that would be needed to effectuate such adjustments often are not unavailable, are not reliable (or at a minimum, are subject to varying reliability across states), or are available only after a significant time lag.
- Even if a formula did a tolerable job of anticipating cost increases in a particular state, this would be of limited help if the *overall* adjustment factor used to determine the increase in the total amount of federal block-grant funding available nationally fell short of fully reflecting the increases in costs that states incurred. If that occurred, most or all states electing the block grant could be adversely affected.
- At bottom, setting capped allotments for states entails, by its very nature, making projections in advance of how much health care costs will rise. Over the years, the most sophisticated projections often have fallen well short of costs. For example, the projection the Congressional Budget Office made in 1998 for federal Medicaid spending five years hence (i.e., in 2002) turned out to be 12 percent—or \$17 billion—below actual 2002 expenditures.
- Finally, the reduced federal payment levels that states would receive in 2011-2013 could form the basis for reduced payments to states in years *after* 2013, when the block grant would be reauthorized. Given the budgetary difficulties that the

federal government is expected to be facing at that time, it is likely that the level of block grant payments that states would receive in 2013—when the payments would be \$8.3 billion below what states are projected to receive under current law—would serve as the starting point for deliberations over federal block-grant funding levels for years after 2013.

For such reasons, New Mexico governor Bill Richardson recently observed, “Capping the federal portion of Medicaid spending leaves states with all the risk.”³

Once in the block-grant structure, a state would be required to juggle a plethora of needs and demands within a fixed pot of funds. Capped funding essentially creates a “zero sum” game for states.

- Although some question remains about whether certain segments of the Medicaid population (the so-called “mandatory” beneficiaries) would be served with block-grant funds or whether states would continue to receive open-ended federal matching funds for these people, some of the most costly and fastest growing parts of state Medicaid budgets—including most costs for elderly and disabled beneficiaries—clearly *would* come under the capped payment structure. While states would have increased flexibility to change the rules for many beneficiaries and services, it appears unlikely that this flexibility could lead to large savings unless a state took steps to reduce coverage or services significantly.
- In addition, once the economy turns around and states are again in a position to consider making improvements in their Medicaid programs to cover more of the uninsured (and thereby to lower costs for uncompensated care), they would be foreclosed from receiving any additional federal Medicaid payments to help finance such improvements. The federal funds they would receive would be limited to their capped allotments. Any new resources for expansions or other improvements would have to be financed entirely by state funds (or by reducing coverage or services for people whom the state already is covering or cutting provider payments). As a consequence, states would have less ability under the block grant to address unmet health care needs and reduce the ranks of the uninsured than they possess under the current financing arrangements.

In short, while the proposal would increase state flexibility in some areas, it would eliminate what is perhaps the most important element of flexibility for states that is built into Medicaid—the flexible, open-ended federal funding arrangement that lies at the heart of the program and under which states can count on the federal government to bear its share of any unanticipated costs that occur and any eligible expenditures that states determine they need to incur on behalf of their residents. States would no longer be assured of additional federal

Medicaid funds in the case of an outbreak of a potentially lethal disease, such as

Severe Acute Respiratory Syndrome, or if a new treatment for AIDS or cancer became available or a plant closed and hundreds of families and retirees in a state suddenly qualified for public coverage. The current flexible financing mechanism would be replaced by an inflexible, capped federal funding allocation. That could put states in something of a fiscal straitjacket.

While many details of the Administration's plan are not yet known, the proposal would, by its very nature, end the longstanding federal-state partnership under which the federal government shares with states the risks of rising health care costs. It would cap the federal government's fiscal liability and thereby make states more vulnerable to growing health costs at the very time the baby-boom generation is approaching old age. This is not an appropriate prescription for what ails states and their Medicaid programs. If Medicaid is to remain a viable and stable source of insurance for those whom the private market will not cover, the federal government needs to remain a full funding partner.

Today, states face their worst budget shortfalls since World War II. Many states currently find themselves driven to make cuts in their Medicaid programs. States' legitimate need for fiscal relief ought to be met by measures that can help them contain costs in effective and responsible ways while assuring that adequate resources are available to help them maintain health care coverage for their residents.

State problems will worsen if the federal government ceases to be a full partner in funding for acute-care and long-term care services. The block-grant proposal takes states in the opposite direction from what many of them have been seeking. Many states have been calling for the federal government to assume a greater share of the cost for long-term care services. Instead, this proposal would cap federal funding for long-term care. By capping and ultimately reducing federal contributions to states in the years in which the baby-boom generation will begin to retire, the proposal diminishes rather than enhances the federal role in helping to shoulder the burgeoning costs that states will face as their populations age and their numbers of low-income elderly and disabled residents grow.

Immediate fiscal relief is surely needed to help states address rising Medicaid costs amidst the current fiscal crisis. More flexibility in certain areas also may be useful in order to provide states with some new tools to manage costs. But neither short-term fiscal relief nor enhanced state flexibility should come at the price of losing open-ended federal financing and shifting all fiscal risk to the states, or of requiring cuts in federal funding for states starting in 2011.

Several bills introduced in the Senate and the House of Representatives with strong bipartisan support would provide states with temporary fiscal relief without these harmful "strings." None of those proposals require repayments or force states to accept damaging changes in the financing structure of their Medicaid programs.

Furthermore, on March 21, the Senate voted 80-19 in favor of a "Sense of the Senate" resolution declaring that the "economic growth" package that Congress is scheduled to pass this spring should include at least \$30 billion in immediate fiscal

relief to states, with half of that amount being provided to states through a temporary increase in the federal Medicaid matching rate. This resolution does *not* include repayment or block-grant conditions. A combination of short-term fiscal relief of this nature and longer-term financing changes under which the federal government assumes a larger share of the health care costs of low-income elderly and disabled people receiving both Medicaid and Medicare—which could be achieved in part through Medicare prescription drug legislation—would represent a sounder and safer approach for states and beneficiaries than the proposed block grant.

The more closely the Administration's proposal is examined, the more troublesome it appears. It would provide states with a modest upfront loan and some additional programmatic flexibility. But it would require states to pay the money back subsequently and to assume all of the risk if health care expenditures rise faster than the federal government has projected. It also would foreclose states from receiving any additional federal funds to help them extend coverage to more of their uninsured residents.

Notes

1. Cindy Mann is a Research Professor at the Georgetown University Institute for Health Care Research and Policy. She is the former Director of the Family and Children's Health Program Group at the Health Care Financing Administration (now the Centers for Medicaid and Medicare Services). Melanie Nathanson and Edwin Park are Senior Health Policy Analysts at the Center on Budget and Policy Priorities.
2. Initially, the Administration proposed two distinct allotments but this part of the proposal has reportedly been dropped.
3. Testimony of Governor Bill Richardson before the House Committee on Energy and Commerce, March 12, 2003.

Chapter 10

Employer-Based Approaches

Creating Consensus on Coverage Choices

by Karen Davis and Cathy Schoen

ABSTRACT: The framework for reaching near-universal coverage outlined in this paper combines tax credits for private insurance and public program expansions. It illustrates how a series of incremental steps could be phased in to achieve near-universal coverage. Hallmarks include creation of a Congressional Health Plan; use of the income tax system to provide tax credits and enroll uninsured people; creation of a state Family Health Insurance Program open to everyone below 150 percent of poverty; and creation of a Medicare Part E, open to the disabled and uninsured older adults. The paper provides coverage and cost estimates and identifies potential sources of revenue to finance coverage.

Despite the stalemate on universal health insurance coverage, there are important areas of consensus in the policy debate. Most importantly, there is consensus that the current health care system does not work well, and broad public support exists for covering the uninsured.¹ The characteristics of the uninsured are well defined.² The scientific literature provides convincing documentation that the uninsured do not get needed care, especially preventive services and proper management of chronic conditions.³ Important health and economic benefits accrue to the uninsured from coverage.⁴

The major disagreement is over the role of private insurance in covering the uninsured, whether public programs should be expanded to additional groups, and the

commitment of adequate budgetary resources required to assist those who are unable to afford the full cost of health coverage.⁵ There is also the question of whether to focus simply on expanding coverage or to reform the delivery of health care services at the same time, and whether to focus expansion efforts on the uninsured or to replace existing coverage with a new system of insurance for all.⁶ Attempts at radical reform of the health care system or proposals that threatened insured people's current coverage have failed.⁷

This paper outlines a framework that could help bridge differences between those who would expand coverage using private insurance and those who prefer public insurance, as well as differences between those supporting an incremental approach and those seeking more fundamental changes. It incorporates features from an individual mandate with tax credits as well as expansion of public programs, and it illustrates how these might work in tandem to improve coverage and enhance choices for both the insured and uninsured. As a framework, it should not be viewed as a "single best plan" but rather as a guide for possible action in the near term and a roadmap for moving toward universal coverage. It constitutes a beginning point for discussions around which parties with differing views could begin to identify areas of common agreement and feasible near-term steps.

The framework also illustrates how incremental steps, if structured as part of a longer-term strategic plan, could move toward more universal coverage. This addresses concerns that moving in increments might otherwise result in more fragmented coverage or that erosion of private coverage might offset reform initiatives with little forward progress.

The framework discussed here focuses primarily on making insurance accessible and affordable. However, it could also contain features that would promote a quality agenda: policies to improve quality of care, promote modern information technology, encourage science-based appropriate services, and involve patients more actively in their care.⁸

In brief, the most serious health insurance problems facing the nation are as follows. Forty-one million people were uninsured in 2001.⁹ One-fourth of people under age sixty-five are uninsured at some point during the year, and one-third of Americans change insurance plans over any given three-year period.¹⁰ Two-fifths of insured people with incomes below \$35,000 still have difficulty obtaining needed care or paying medical bills, despite having coverage.¹¹ Participation in current programs is low: More than half of the nation's eight million uninsured children are eligible for Medicaid or the State Children's Health Insurance Program (SCHIP).¹² Only about 20 percent of those eligible for continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) participate.¹³ About one-third of adults seeking coverage in the individual insurance market find it difficult or impossible to find a plan that meets their needs.¹⁴ Small firms with older employees or a few sicker employees are also at risk for paying much higher premiums if they lack an option that pools health risks.

Study Methods

To illustrate the coverage potential and associated costs of a mixed public-private approach, we present estimates provided by the Lewin Group using estimates from Lewin's Health Benefits Simulation Model. All estimates assume 2002 population initial insurance and cost distributions.¹⁵

A consensus framework. Several general principles shape the consensus framework: choice of coverage, including retention of current coverage choices; affordability; automatic coverage; and protection from adverse risk selection. We describe below how each of these could be achieved and the potential of a combined approach for improving coverage and insurance stability, quality, and affordability.

Congressional Health Plan. A central element of the framework is the establishment of a new Congressional Health Plan (CHP), which would make available a choice of any insurance plan participating in the Federal Employees Health Benefits Program (FEHBP). The CHP would be distinct from the FEHBP, although plans participating in one would be required to participate in the other. Members of Congress would switch their own coverage to the CHP to symbolize their commitment to ensuring high-quality coverage and choices. Benefit packages would be the same in the CHP and FEHBP markets and, as they are now, subject to FEHBP approval. Any new carrier would be required to meet the same standards.

Enrollment in the new plan would be open to self-employed people and small businesses with fewer than fifty employees, as well as any person who has been uninsured for six months and lacks access to group coverage. New electronic enrollment processes over the Internet would help to ease administration, making it easy for individuals and small businesses to initiate, change, or terminate coverage and make premium payments.

This new option would set premiums at expected community rates and offer coverage irrespective of the individual's or small firm's anticipated health risks. Expecting that initially this community rate would attract those with higher-than-average health risks, federal funds would finance these risks through reinsurance or other risk-pooling arrangements. The resulting "average" premium rates would likely be particularly attractive to those now insured in the individual or small-group market who have higher-than-average health risks. Furthermore, because the federal government would compensate participating plans for adverse risk selection, the community-rated premium would be less than that now available to many small businesses and individuals purchasing coverage in the individual market. Based on the Blue Cross Blue Shield Standard Plan, the estimated premium in 2002 would be \$2,880 for an individual, \$5,772 for a couple, \$8,328 for a two-parent family, and \$4,716 for a single-parent family.

Insurance verification and tax credits. One of the framework's important new features is a mechanism to assess health insurance coverage annually, automatically enroll uninsured people in coverage, and provide tax credits for premiums in excess of a certain percentage of income. All individual tax filers would need to show evidence of health insurance when they file their personal income taxes.

Any individual or family without coverage would receive tax credits for premiums in excess of 5 percent of adjusted gross income for those with lower incomes and in the lower tax brackets (15 percent or lower, or below \$27,950 for individuals and \$46,700 for families) and 10 percent of adjusted gross income for those with higher incomes. The tax credits would apply to standard-plan premiums for insurance coverage in the CHP effective July 1 following filing of the annual tax return. Enrollment of uninsured people would be automatic. Such coverage could be required, or people could have the choice of declining participation.

Once insurance verification systems were in place, the federal government could also establish an insurance verification electronic clearinghouse.¹⁶ Any health care provider could query this database to check the source of a patient's insurance coverage. Uninsured people could be informed about insurance options available to them. This would help minimize the numbers of uninsured people surfacing during the income tax filing process and would promote earlier enrollment.

Public program expansions. *Medicare.* To further reduce adverse risk selection in the CHP and to promote insurance continuity and integrity within families, a new Part E would be added to Medicare (Part D is reserved for a drug program). Three groups would be offered coverage through Medicare: dependents of current Medicare beneficiaries, adults age sixty and older without access to group coverage, and the disabled in the two-year waiting period for Medicare coverage. The disabled would pay the Part B annual premium, while Medicare family members and adults age sixty and older would pay a community-rated annual premium, estimated to be \$4,344.

In costing out this option, it is assumed that all of Medicare includes a prescription drug benefit with a \$250 deductible and \$4,000 out-of-pocket limit enacted through separate legislative action. This new Medicare Part E would be the default option at tax filing time for uninsured adults ages 60-64. Enrollment for this group and tax credits for premiums in excess of 5-10 percent of income would be automatic through tax filing, as above.

Low-income families and individuals. The CHP options are unlikely to work well for families and adults with very low incomes who cannot afford out-of-pocket costs for excluded benefits, cost sharing, or premiums. Their situations are also more unstable than those of other Americans—with fluctuations in income, employment, and residence—and they are more likely to have serious health problems requiring special services. States with experience in administering health care programs for low-income people are probably better able to deal with these circumstances than is a tax system oriented toward annual reporting of income.

To provide an option that is more suitable for low-income people, eligibility under public programs would be expanded to include Americans living below 150 percent of poverty. Any low-income person or family preferring to obtain coverage through the CHP and meeting its eligibility requirements could still do so; in fact, some may well prefer its greater choice of private plans and providers.

This proposal would expand SCHIP to include all families and single people with

incomes below 150 percent of poverty (approximately \$13,800 for an individual and \$21,400 for a three-person family in 2001). This program would be renamed FHIP. It would have the same benefits that SCHIP has, and states would administer it as they now administer SCHIP. States would have the option of buying eligible families into employer coverage, or potentially into the CHP. States also would have the option of extending coverage above 150 percent of poverty through use of federal matching funds and premiums charged on a sliding scale. FHIP would be the default coverage for all uninsured people filing tax returns with incomes below 150 percent of poverty.

Federal matching rates for all families and nonelderly adults for acute care services (excluding long-term care) in Medicaid as well as for the expansion group would be at the enhanced SCHIP rate. This enhanced matching rate for those currently covered would offset the state share of costs for new FHIP enrollment.

Employer group coverage. Employer-sponsored health insurance is the coverage of choice for most working Americans.¹⁷ It has many advantages: health risk pooling, lower administrative costs and premiums, automatic enrollment and payroll withholding for the employee share of premiums, and experienced health benefit managers who select plans and resolve administrative problems. Importantly, employers now cover 160 million workers and family members and contribute about \$335 billion toward health insurance coverage.¹⁸ Keeping employer coverage as a mainstay of the current health insurance system in a transition to more universal coverage is essential, to minimize disruptions in coverage and the incremental budgetary cost of covering the uninsured. To strengthen the stability of employer benefits for working families, several reforms would modestly expand employer health coverage and help workers and their families retain their insurance.

For workers who are between jobs, a continuation of previous employer coverage for two months would provide a bridge to subsequent coverage in the next job and would eliminate the administrative hassle of signing up for COBRA coverage. For those who are uninsured over a longer term, provision of a subsidy covering 70 percent of COBRA premiums could be expected to increase the number of people participating in the program. A recent study suggests that a subsidy of this magnitude could more than double participation rates.¹⁹

Changing insurance practices to cover dependent young adults up to age twenty-three under their parents' health insurance would further reduce uninsurance rates for this population during a time of transition. Employer plans typically cover full-time college students, but not young adults in similar circumstances who do not attend college or attend part time.²⁰ This practice discriminates against lower-income working families whose children are unable to pursue college studies full time.

There is also a fundamental inequity between employers that help finance coverage for their workers and those that do not. A contribution from all firms would be needed to help generate the revenue to finance coverage, to create a disincentive for firms to drop coverage, and to reduce inequities across firms and in labor markets. Companies not of-

fering coverage to employees would contribute 5 percent of payroll, up to \$1 per hour worked, through the payroll tax system. These funds would be pooled to provide coverage in the CHP. Those offering coverage would be exempt from this “play or pay” contribution. To be exempt, however, they would have to meet general prevailing minimum standards on coverage and achieve 80 percent participation.

Small firms would be able to join the CHP, under which they realize the administrative economies of community-rated coverage of a larger group and have more insurance plan choices for employees. However, some firms may prefer making the financial contribution and leaving their employees to enroll directly in the CHP or through the personal income tax default mechanism.

Impact on Insurance Coverage: All Features Combined

The features described above could be combined and linked through the tax system to identify and enroll the uninsured automatically. This expansion could either require everyone to participate (individual mandate) or allow opting out.

The numbers of uninsured people would drop under either alternative. Among the forty-one million people who are now uninsured, an estimated thirty-three million would be insured under the opt-out version and thirty-nine million under the individual mandate (some nonfilers or undocumented immigrants are likely to remain uninsured) (Exhibit 1). The individual mandate would be particularly effective in lowering uninsurance rates among those at higher income levels who might not participate under a purely voluntary scheme.

The uninsured would be covered by a balance of private and public coverage (Exhibit 2). About 59 percent of the population would be covered in private plans in the individual-mandate version. Public programs would enroll slightly less than a third of the population under either version.

Exhibit 1
Numbers of Uninsured People Under Current Law and
Distribution of Coverage Under Individual Mandate, by Income Level

	<i>Total</i>	Percent of Poverty			
		<i>Below 100</i>	<i>100-149</i>	<i>150-159</i>	<i>200 or more</i>
Total uninsured under current law (millions)	41.9	11.8	6.9	6.0	17.3
Coverage under individual mandate					
Employer	26%	15%	25%	35%	30%
Congressional Health Plan	30	5	3	33	56
Medicaid/Family Health Insurance Program	35	63	61	23	9
Medicare	3	4	4	3	3
Uninsured	7	14	7	5	2

Source: Lewin Group estimates using the Health Benefits Simulation Model.

The mix of private and public coverage for people who are now uninsured would vary by income (Exhibit 1). In the individual-mandate version, the majority of the poor would be covered through public insurance unless they chose private alternatives (63 percent Medicaid/SCHIP/FHIP, 4 percent Medicare compared with 20 percent CHP and employer plans) and those with incomes at more than twice the poverty level would be predominantly in either CHP or employer plans (86 percent CHP or employer plans).

The framework is designed to minimize involuntary disruptions in current sources of coverage. Most insured people with coverage from employers, Medicare, or Medicaid/SCHIP would keep that coverage. As a result, the current mix of private and public coverage for the entire population would remain relatively unchanged (Exhibit 2).

Some insured small businesses and individuals in the nongroup market, however, might choose to change coverage. An estimated twenty million people would have improved or lower-cost coverage available to them. About ten million people who now have coverage through a small business would move to the CHP as employers sought out its lower-cost premiums. This amounts to lower premium rates for an estimated one-third of all small-firm employees now receiving health benefits.²¹ An estimated eight million people would switch from nongroup coverage to private or public group coverage as this group also made gains from lower premium costs and improved benefits. About two million people now covered by Medicaid would switch to employer coverage.

Expansion costs. This gain in coverage is expected to increase the use of health care services by an estimated \$50 billion. This represents about a 3 percent increase in the \$1.5 trillion in national health spending expected in the absence of change. The improved coverage would help correct the underuse of preventive and chronic

Exhibit 2
Distribution of People by Primary Source of Coverage
Under Current Law, Automatic Enrollment With Opt-Out, and Mandate

	<i>Current law</i>	<i>Automatic enrollment with opt-out</i>	<i>Individual mandate</i>
Employer	58%	58%	59%
Congressional Health Plan	n/a	8	9
Nongroup coverage	4	1	1
CHAMPUS/others	1	1	1
Medicare	12	14	14
Medicaid/SCHIP	10	15	15
Uninsured	15	3	1

Source: Lewin Group estimates using the Health Benefits Simulation Model.

Note: CHAMPUS is Civilian Health and Medical Services, now known as Tricare. SCHIP is State Children's Health Insurance Programs.

disease services by the under- and uninsured. Out-of-pocket costs for the under- and uninsured would fall by \$20 billion, reducing the financial burdens and risk of medical bankruptcy that are all too common today.

Efficiency gains. A number of efficiency gains are possible from this proposal. Most importantly, the economies of group coverage are substituted for those of individual coverage. The new CHP is estimated to have total administrative costs of 19 percent—compared with 30-50 percent in individual plans. The number of people covered through the individual market would drop by eight million. Through this shift to group coverage, people would receive better coverage and greater choice at lower premiums and much lower administrative overhead.

Emphasis on electronic administration would also yield savings. Establishment of an electronic clearinghouse to verify insurance enrollment would reduce providers' administrative costs. Families would tend to be covered under the same plan, rather than under multiple plans for different family members.²² The proposal would also reduce insurance turnover and the administrative costs associated with this turnover, as more people would be able to find a stable source of coverage that did not change over time even as their income or job changes. The reduced turnover would foster greater continuity in physician-patient relationships, which some evidence shows can reduce health care spending.²³

Basing tax credits on standard-plan premiums would give everyone enrolled in the CHP an incentive to seek out plans that offer good benefits and lower premiums. Some people may be willing to join more restricted networks, gaining the advantage of both lower premiums and more comprehensive benefits, or other plans that appeared to offer high value for comparable premiums.

The reinsurance trust fund, meanwhile, could be structured to retain some incentive for insurers to control costs (for example, the government could pick up 90 percent of costs above a given threshold, such as \$30,000 per year). However, it would also be important to incorporate a mechanism for identifying high-cost individuals who could benefit from modern methods of chronic disease management and science-based quality standards. Since 10 percent of the population accounts for 70 percent of all health care outlays, focusing quality improvement efforts on chronic disease treatment should be particularly effective in reducing unnecessary duplication of procedures and other waste.²⁴

Phasing In: Incremental Steps Within a Longer-Term Strategy

The proposal lends itself to being phased in over time and to having elements modified based on experience. Ideally, the CHP component would be established first, perhaps opening coverage to small businesses and uninsured people on a voluntary basis. Insurance verification through the income tax system would require time to be put in place and should be implemented early on. It could start with automatic enrollment with opt-out, perhaps followed by the individual mandate in later phases.

Medicaid/FHIP expansions could occur in steps, as could the Medicare coverage expansion for the disabled and for older adults.

One illustrative incremental phasing strategy that uses income to guide each step is shown in Exhibit 3. In the first phase, tax credits and FHIP expansion of coverage would be targeted to people living below 100 percent of poverty. In the second phase, the target population would increase to 150 percent of poverty. In the third phase, tax credits would be available to those with incomes up to 200 percent of poverty. The opt-out version for all would be adopted in the fourth phase, and the individual mandate, in the final fifth phase.

As shown in Exhibit 3, the number of uninsured Americans would decline by nine million in the first phase, six million in the second phase, five million in the third phase, fourteen million in the fourth phase, and six million in the fifth phase.

Enrollment in the CHP is likely to build gradually to a total of twenty-four million by the final phase. Eventually, if this plan is successful in providing a choice of high-quality, stable coverage at competitive premiums, it could be opened up to larger employers or added as a choice for those covered under public programs.

Costs and revenues. The plan is designed on balance to impose no net additional cost on employers or state and local governments. Employers that now offer health coverage, however, would save an estimated \$22 billion, while employers that do not would incur additional costs of \$20 billion. This amount would be split about equally between firms purchasing coverage through CHP and those contributing to a pool to fund coverage for uninsured workers.

The enhanced match for current Medicaid non-long term care services plus the

Exhibit 3
Illustrate Incremental Phasing-In toward Universal Coverage,
Number of Uninsured People Remaining after Implementation
of Each Phase (Millions), by Age Group

	<i>Total</i>	<i>Under 19</i>	<i>19-24</i>	<i>25-44</i>	<i>45-59</i>	<i>Disabled and 60-64</i>
Baseline uninsured	41.8	9.0	7.4	17.1	6.9	1.4
Phasing—remaining uninsured						
Phase 1: under 100% of poverty	32.5	7.2	5.7	13.5	5.1	1.0
Phase 2: up to 150% of poverty	26.9	6.1	4.7	11.3	4.0	0.8
Phase 3: up to 200% of poverty	22.3	5.2	3.9	9.5	3.1	0.6
Phase 4: all features with opt-out	8.8	2.6	1.4	4.2	0.5	0.1
Phase 5: mandate	2.9	0.6	0.6	1.3	0.4	0.0

Source: Lewin Group estimates using the Health Benefits Simulation Model.

Notes: See text for description of phases. Table illustrates rough estimates of people covered in each phase, based on poverty and age grouping. Actual coverage would depend on specific features implemented and financed in each phase.

expansion groups would offset new costs for public programs. State and local governments would see modest net savings as a result of reduced costs of charity care in public hospitals and reduced costs of public employees' health benefits.

There are five major sources of federal budget costs: CHP reinsurance costs; tax credits for CHP premium assistance; tax credits for Medicare buy-in premiums and COBRA coverage; coverage of disabled and older adults under Medicare Part E; and expansion of Medicaid/SCHIP/FHIP. Offsets to these costs could include contributions from employers not offering coverage and from reduction of \$30 billion in current federal subsidies for uncompensated care.²⁵

Given current economic and budgetary conditions, implementation would most likely be achieved in phases. Actual costs would depend on the specific phase-in scenarios as well as health care spending trends. Possible sources of financing include tax savings from repeal of the current income tax deduction for health care expenses; assessment of a one-percentage-point income tax in January 2004 or January 2007, when reductions of one percentage point are now scheduled for all tax brackets; or other budgetary trade-offs.²⁶

The fully implemented federal budgetary costs (based on 2002 health expenditures) would be an estimated \$70 billion (Exhibit 4). Revenues from repeal of the one-percentage-point reduction in the income tax scheduled for January 2004 would yield \$39 billion, and repeal of the current tax deduction for health expenses would

Exhibit 4
Changes in Federal Spending under the
Congressional Health Plan (CHP) Proposal, Billions of Dollars

	Opt-out	Mandate
<i>Costs</i>		
CHP Reinsurance Trust	\$17	\$12
Tax Credits	35	39
Net new Medicare	12	11
Net new Medicaid/SCHIP/FHIP	36	37
Uncompensated care offsets	-30	-30
<i>Total Costs</i>	71	69
<i>Revenue</i>		
Income tax assessment	39	39
Elimination of tax deduction for health expenses over 7.5% of adjusted gross income	4	4
Other revenues and budgetary trade-offs	28	26
<i>Total revenues/offsets</i>	71	69

Source: Lewin Group estimates using the Health Benefits Simulation Model.

Notes: SCHIP is State Children's Health Insurance Program. FHIP is Family Health Insurance Program.

yield \$4 billion, leaving a balance of \$27 billion to be financed through other budgetary trade-offs.

Concerns. Maintaining the existing system of health insurance coverage while adding features to provide affordable choices to the under- and uninsured has its drawbacks. It is admittedly more complex than eliminating the current system and creating one new system for all.

One of the greatest potential weaknesses is that healthier and sicker people will choose different forms of coverage. This risk selection could prove destabilizing. While design features attempt to address this flaw through reinsurance and making public coverage the preferred source of coverage for the poor, elderly, and disabled, private plans might withdraw from participation if they are not adequately protected from adverse risk selection.

Financing is always the most controversial issue. Employers are likely to resist bearing additional costs, whether covering workers who are now uninsured or paying the additional cost of COBRA coverage. Diverting funds that now go for uncompensated care of the uninsured will also meet with resistance from safety-net providers. Substantial new federal revenues would be required, forcing societal trade-offs of tax relief versus improved insurance coverage. But universal coverage is unlikely to be feasible unless all parties—the uninsured, the insured, employers, providers, and government—are willing to share in the cost.

Finally, the ultimate cost of covering the uninsured will depend upon the strength of the economy, trends in health costs, and other health and economic factors. The costs are only an estimate and could be higher or lower. The virtue of a phased-in strategy is that assessments of experience with the plan and economic and budgetary conditions can be weighed as each additional step is taken.

Concluding Comments

The proposed framework introduces the feature of automatic coverage to the health insurance system, addressing the nation's current failure to enroll many people who are technically eligible for public programs or employer coverage. By doing so, it achieves near-universal health coverage, employing a balance of private and public insurance and preserving current sources of coverage where they are working well. It makes coverage affordable for the uninsured and spreads the cost of coverage over multiple parties. It removes the risk of adverse selection from private coverage through reinsurance and stop-loss mechanisms. It builds on the advantages of group coverage where possible and preserves employer contributions to health benefits—without adding, on balance, to employers' costs. It builds on existing administrative structures such as the FEHBP, Medicaid/SCHIP, and Medicare. Finally, it introduces new electronic clearinghouse and health insurance enrollment mechanisms that simplify and increase the efficiency of our current fragmented system.

The framework also provides people with choices as to their source of health coverage. The plan makes good coverage both easily available and affordable. It also pre-

serves the diversity of benefits and insurance plans in our current system: Over time, people could choose the source of coverage and specific plan that best meets their individual or family circumstances. Many of those employed by small businesses would join the new Congressional Health Plan, where their coverage would remain stable even if they moved from job to job.

Most importantly, it ensures that all Americans have access to health care services and removes the fear of burdensome medical bills or bankruptcy from catastrophic medical expenses. It enables the health care system to provide care to all without concern that the financial health of the institution would be put at risk by serving those unable to pay.

We propose a flexible framework that provides a long-term vision within which to make incremental changes. It lends itself to phasing in. Any given element of the plan—such as methods for covering low-income or high-risk people—can be replaced with a better alternative that gains widespread support. It is hoped, however, that setting forth this framework will provide a mechanism for building consensus for change. It is offered not with the view that it is the best plan, or even the authors' preferred approach, but with the hope that it will stimulate public interest and debate and a better appreciation of the choices, benefits, costs, consequences, and trade-offs involved.

Continuing gridlock on health system reform is unacceptable. The uninsured and underinsured are growing in number and exacting an economic and health toll that the nation can ill afford. Inaction is undermining the financial vitality of the health care system at the very time it needs to be prepared in the event of an attack or natural disaster. The framework described here would help forge a stronger, more cohesive society; a more productive economy; and a nation better prepared to withstand any challenge. It is an investment worthy of the United States in the twenty-first century.

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Building a Consensus for Expanding Health Coverage

by *Charles N. Kahn III and Ronald F. Pollack*

A first-step proposal from some “strange bedfellows” that transcends ideological, partisan, and interest-group boundaries.

ABSTRACT: Despite a flourishing economy and recent growth in employment-based health coverage, forty-three million Americans remain uninsured. Extending coverage to the uninsured is not an intractable public policy problem but could be addressed if the various health care stakeholders could only find common ground. We argue that to win broad-based support from across the ideological and political spectra, a meaningful proposal should achieve a balance between public- and private-sector approaches, focus attention on those who are most in need of assistance (low-income workers), and build on systems that work today. With the aim of pulling together a political coalition, we present a proposal specific enough to attract support but whose details will arise later, in the context of the legislative process.

Almost forty-three million Americans (approximately one of every six) are without health insurance today. This number has remained high despite a thriving economy—with unemployment and inflation down and individual and business incomes up. Once an inevitable slowdown occurs in the longest peacetime economic expansion in U.S. history, today’s unacceptably high levels of uninsurance will undoubtedly get worse. Our nation’s uninsurance epidemic deserves to be at the top of the policy-making agenda.

Efforts to broaden access to health coverage in the twentieth century have repeatedly ended in failure. In addition to Bill Clinton’s unsuccessful attempt in 1993-1994, other presidents—including Franklin D. Roosevelt, Harry Truman, John F. Kennedy, Richard Nixon, and Jimmy Carter—have sought and failed to achieve meaningful coverage expansions.¹ (The lone exception is Lyndon Johnson, who, after an electoral landslide that was accompanied by overwhelming Democratic majorities in both chambers of Congress, succeeded in enacting Medicare and Medicaid in 1965.)²

A combination of factors led to these failures. In each of those efforts, one or more of the large health interest groups strongly opposed the legislation and spent significant amounts of political and financial capital to rouse the public and mobilize

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members of Congress. Similarly, the pro-reform groups often overreached and were unwilling to compromise, which also contributed to defeat.

In effect, all of the players in health care reform—from the ideological right to the left, from the special interests to the reformers—came to the political process with strong convictions in support of their first-choice proposal. For each of these groups, their second-favorite choice was the status quo.³ And, indeed, the ultimate result of these efforts was the status quo, with more and more Americans losing health coverage.

If there is a lesson to be drawn from this history, it is that proposed changes to health care financing can easily alarm stakeholders, who may then erect roadblocks. Moreover, while the public's support for health coverage expansions is encouragingly broad, it is discouragingly thin and, as a result, is susceptible to a well-financed opposition campaign.⁴ Meaningful health coverage expansions, therefore, require broad-based support, transcending ideological, partisan, and interest-group boundaries.

The political landscape in our nation's capital today underscores this conclusion. In contrast to 1965, when Medicare and Medicaid were enacted, today neither the Democrats nor the Republicans truly control Congress, no matter which is in the majority. Without strong champions from both sides of the aisle, in both the House and the Senate, it will be virtually impossible to achieve significant coverage expansions. Indeed, considerably less ambitious proposals, such as the State Children's Health Insurance Program (SCHIP) in 1997 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996, succeeded only because they had substantial bipartisan support.⁵

It is critical, therefore, that common ground be sought for a proposal that can attract the key stakeholders in health care policy making. Further, we believe that providing health coverage for everyone will occur neither through tiny increments nor through one comprehensive package. Rather, progress will be made step by step. We are convinced that the first of these steps must achieve significant expansion of coverage.

We propose to accomplish that, and have begun by initiating a process designed to involve key stakeholders, many of them "strange bedfellows." We believe that the proposal and process we are pursuing are substantively sound and politically achievable.

Guidelines for Developing a Viable Proposal

To develop this proposal to expand health care coverage, we have followed four guidelines that we believe to be fundamental to success. We address each of these in turn.

Maintain current coverage levels. The proposal cannot take away, or appear to take away, health coverage from people who have it today. Any proposal that appears to threaten existing health coverage for people who are insured is a political non-starter. Simply stated, if asked to make a change that affects their own health coverage, many of those who are insured will not support reform efforts. This means that any proposal that changes the form of people's health coverage, appears to diminish the scope or quality of that coverage, or threatens to result in increased costs for that coverage is likely to provoke unbeatable opposition.

Build on existing structures. The proposal should build on the health coverage structures that currently work. There are fundamental reasons, both technical and political, for building on what works. Using existing structures, whether public or private, will allow for quicker and more effective implementation and avoid the creation of new bureaucracies and further fragmentation of the health care system. Additionally, building on what currently works has a much better chance of gaining support from the public, policymakers, and interest groups.

Employment-based coverage. In the private sector this means building on employment-based health coverage. Today, 91 percent of privately insured Americans receive health coverage at the workplace.⁶ Even if one questions whether it made sense to build America's health coverage system on an employment-based model, it is the model with which most people feel comfortable. Replacing it will not only result in political turmoil, it also may do considerably more harm than good. Undermining the employment-based health coverage system could result in lost cost efficiencies realized today through group purchasing and would require greater government regulation to ensure that sick and frail persons retain affordable access to coverage. Moreover, it would engender enormous political opposition from workers, who might fear that employers' diminished health coverage contributions would not be offset by wage increases or other benefits.

Medicaid and SCHIP. In the public sector the proposal should build on Medicaid and SCHIP. Today, Medicaid covers forty-one million low-income persons, and the newly implemented SCHIP has already enrolled 2.5 million children.⁷ These two programs constitute the bulwark of health coverage for America's most vulnerable populations, the groups least likely to afford health coverage through the private sector. Moreover, as a recent Henry J. Kaiser Family Foundation survey indicates, the overwhelming majority (94 percent) of parents of children enrolled in Medicaid view it as a good program.⁸ Thus, by building on employment-based coverage as well as Medicaid and SCHIP, the first-step proposal would be based on what works today and would not need to create new bureaucracies or coverage structures.

Maximize public funds. The proposal should use public resources in a way that maximizes new health coverage. Providing coverage for the uninsured is not inexpensive. And since there are many competing demands for government resources—including those of other health care matters such as Medicare and prescription drugs—it is unlikely that sufficient funds would be made available in the near term to cover all of the uninsured. Therefore, a first-step proposal should make the best use of available resources to maximize coverage of the uninsured.

For all aspects of the proposal, the substitution of taxpayer funds for coverage already provided through private spending (“crowding out”) must be minimized. Since crowding out occurs more frequently among higher-income populations, it is best to first focus expansion efforts on those with incomes below 200 percent of the federal poverty level. This is consistent with our next guideline.

Focus on those with greatest need first. The proposal should focus on low-wage

workers, their families, and other low-income populations that are least capable of obtaining health coverage on their own. Low-wage workers are less likely to be offered coverage through the workplace than are higher-paid workers: 93 percent of U.S. workers who earn more than \$15 an hour are offered health insurance by their employer, whereas only 43 percent of those earning \$7 an hour or less are offered such coverage.⁹ Even when coverage is offered, it is often too expensive for low-wage workers to purchase. In fact, such benefits are often more expensive for low-wage workers than they are for higher-paid workers. The average monthly contribution required for the lowest-cost family coverage plan is \$130 in firms where the typical wage is less than \$7 an hour but only \$84 in firms where the typical wage is more than \$15 an hour.¹⁰ As a result, almost a quarter of workers with incomes below 200 percent of poverty turn down coverage when offered.¹¹

In effect, low-wage workers experience a “triple whammy”: They are less likely to be offered coverage by their employers, they have to pay considerably more for coverage when employers do offer it, and they have the least discretionary income available to pay for it.

Public-sector programs such as Medicaid and SCHIP also leave a large number of low-income persons without health coverage. In effect, these programs divide low-income populations into three groups—children, parents of children, and childless adults—and treat each group very differently. This categorization and differential treatment is an unfortunate vestige of the sixteenth-century Elizabethan Poor Laws that formed the basis of our nation's welfare system and, starting in 1965, the Medicaid program as well.¹²

Children, who in recent years have aroused the greatest political sympathy, are accorded better coverage than the two adult groups. Most states now consider children eligible for public-sector coverage if they live in families with incomes below 200 percent of the federal poverty level (\$28,300 for a family of three in 2000).

While low-income parents are viewed with some sympathy, they receive considerably less coverage protection than their children do. In thirty-two states a parent working at the minimum wage (\$5.15 per hour) has “too much income” to qualify for Medicaid if he or she works full time.¹³ In Louisiana, for example, a parent is ineligible for Medicaid if his or her income exceeds 22 percent of poverty. In Texas, it is 33 percent; in Michigan, 47 percent; and in Illinois, 51 percent. As a result, when parents leave welfare for work, they often lose their Medicaid coverage even though they are likely to wind up in entry-level jobs that provide no health benefits.

Single adults or childless couples, no matter how poor, are excluded from Medicaid coverage in the vast majority of states, unless they are severely disabled. As a result, many millions of low-wage working people and families who have no access to employment-based health coverage or cannot afford such coverage remain ineligible for Medicaid.

Thus, placing a priority on expanded health coverage for low-wage workers and others with low incomes makes good sense. This group is in greatest financial need

and will have the most difficulty securing health coverage without public intervention and support. Moreover, although this group has little or no political clout, we believe that it will be much easier to achieve a consensus on its behalf than is true for other segments of the uninsured population.

A Proposal for Common Action

Our proposal was designed as a policy framework, not a set of legislative specifications. We chose this approach for two reasons. First, we wanted to articulate a clear vision for action. Second, we deemed it important as part of the initial consensus-building process to start out with a framework that would later involve additional stakeholders in the development of legislation.

Our policy framework focuses on the low-wage working population with incomes below 200 percent of the federal poverty level. The proposal has three parts.

Medicaid expansion. First, the proposal would require an expansion of Medicaid to cover all persons with annual incomes below 133 percent of the federal poverty level (approximately \$18,820 for a family of three in 2000). Eligibility for such coverage would be based exclusively on income, no longer on membership in one of several prescribed categories that are, in fact, the absurd vestiges of long-obsolete laws. To ensure that states have the financial resources necessary to implement this expansion (and continue to support it even during economic downturns), federal matching funds would be provided well in excess of the current Medicaid funding formula. To the extent that funds are limited, this part of our proposal would be phased in first.

Expansions for higher-income persons. Second, we propose that states be given the option of establishing Medicaid or SCHIP-type coverage for adults with incomes between 133 and 200 percent of the federal poverty level. For states that choose this option, coverage would be based on income, not parental status. Similar to the Medicaid proposal for lower-income persons, more federal matching funds would be made available.

The public program expansions will be developed to ensure optimal enrollment of those newly eligible for coverage. As we develop legislative specifications, several mechanisms will be considered to achieve this, including the implementation of “presumptive eligibility” mechanisms that enable social service agencies to temporarily enroll eligible persons; fiscal “carrots and sticks” to state agencies so that they meet enrollment targets; elimination of resource standards of eligibility; mail-in application processes; putting state certification officials in the field; and the establishment of one-year (or longer) certification periods.

Tax credits. Third, we propose a nonrefundable tax credit for businesses to encourage them to make coverage affordable for their low-income workers. This tax credit should be established in tandem with the implementation of public program expansions for persons with incomes between 133 and 200 percent of poverty. The credit would be available to those employers that pay a larger share of the premium (than what is offered to other workers in the company) for workers with family in-

comes between 133 and 200 percent of poverty. For example, if a business currently pays 70 percent of the premiums for all workers and decides to pay all or part of the remaining premium for low-income workers, that business would receive a tax credit for that additional amount.

The employer tax credit would be available only to companies that make contributions to their health plans commensurate with the contribution levels of other similarly situated employers. To ensure that this facet of our proposal strengthens existing coverage, the legislation would seek to secure, not weaken, current employer coverage and contributions that workers receive through their jobs.

Although the tax credit constitutes a new approach to expanding coverage, it is a familiar element to the business community. It is comparable in structure to the Work Opportunity Tax Credit designed to encourage companies to hire persons from low-income communities. It can work to help extend coverage precisely because employers are familiar with it, and it will enable businesses to extend help to their low-wage workers at no cost to them.

A Good Second Choice

This proposal is neither Families USA's nor the Health Insurance Association of America's (HIAA's) ideal plan. For Families USA, health coverage expansion proposals based on tax incentives have never been a favored option. Indeed, Families USA would not have agreed to even the tax credit approach in this plan without its linkage to the Medicaid and SCHIP expansions. Similarly, HIAA's original "InsureUSA" plan envisaged a larger private-sector approach and a much more modest Medicaid and SCHIP expansion.

We expect that this proposal will not be considered ideal by other major health care organizations as well. However, from the perspective of forty-three million uninsured persons, any so-called ideal plan that cannot get enacted is an illusory ideal. It is no solution at all.

The proposal outlined above presents a good second choice to our two organizations, and to others as well. It has the potential for increasing health coverage for a very large portion of persons who are uninsured today. It achieves a reasonable balance between public-sector and private-sector approaches. It focuses priority attention to those most in need of assistance. It builds on systems that work today and, therefore, does not create new bureaucracies or cause further fragmentation of our health care system. It eliminates the cumbersome and unfair poverty categorizations in a way that is consistent with experimentation undertaken by a number of states. It is designed to eliminate work disincentives by providing new health coverage opportunities to support low-income workers and people moving from welfare to jobs.

It also does not trespass on the interests of key stakeholders in the health care system. Indeed, based on our preliminary discussions with numerous major stakeholder organizations, it can gain broad support and, hence, is politically achievable. It can

be enacted, and it can provide prompt coverage for many uninsured Americans, individuals and families alike.

To be sure, this proposal, like any other that would result in a major increase in health coverage for lower-income Americans, will require a significant public investment. Although no reliable cost estimate can be made until detailed legislation is developed, it is obvious that this proposal will be expensive. But there has never been a better time to take on such an investment. The federal budget has a large projected surplus, and most state budgets are in good shape as well. Our economy continues to grow, while inflation remains moderate. There is a palpable thirst among many health interest groups to find common ground on a significant health coverage expansion. Thus, as a new president and Congress begin their work, this balanced proposal is well suited for inclusion as part of a blueprint for our nation's immediate future.

We believe that this proposal, and the broad coalition-building effort to which we are committed, constitute our best—perhaps our only—near-term chance to expand health coverage for many millions of uninsured Americans. Certainly if our two organizations can find common ground for this noteworthy objective, it augurs well for many other groups to do likewise. Through a common effort, we have a real chance to proceed down the road toward health coverage for all Americans.

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Chapter 11

Single-Payer System

Medicare for All

by James A. Morone

Overview

Medicare for All proposes a sharp break with both the current health care system and with conventional wisdom.¹ The proposal begins with the assumption that the problems of American health care—most notably the problem of the uninsured—will not be fixed by tinkering at the margins. Nor will they be fixed without popular agitation, without a movement.

This is not a proposal geared to the current Congress, but it does build on and improve one of the nation's most popular public policies. It is easy to understand. It is a proposal that citizens could rally around. And, given the trends in the American economy and health care system, it might eventually prove to be more politically feasible—and effective—than programs lodged more securely in conventional wisdom.

The proposed program would improve the Medicare program and extend it to all legal residents. *Medicare for All* would cover a broad range of health care services: acute care, prescription drugs, mental health services, maternal and child health, and other services detailed below.

The proposed program addresses our health care delivery systems by placing strong emphasis on primary care. *Medicare for All* would fund primary health care in non-traditional settings. For example, it would foster community health centers and school-based health centers. More important, it would rethink and vastly expand the delivery of home

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health services, especially to the elderly and disabled. A generation ago, the medical profession resisted these kinds of innovations in care settings; today, the managed care revolution has prepared the way for such alternative practice settings.

Medicare for All would break with current financing arrangements. Medicare payroll taxes would be abolished. Medicare would not draw from general revenues. There would be no cost sharing. The current benefit limits (which force some elderly to spend down their life savings) would be eliminated. Providers could not bill their patients for covered services.

The system would be financed by a value-added tax (VAT) specifically earmarked for the new program. Today, the VAT is championed by a range of political bedfellows. In the United States, many fiscal conservatives seek to replace the income tax with a VAT; some tax specialists would combine the VAT with an income tax paid only by relatively wealthy people. And the VAT is the major tax used (in fact, required) by the European Union. In short, this is a familiar tax with a substantial track record. Turning to the VAT cuts through the Gordian knot of health care finance. The VAT's potentially regressive effects could be offset by graduated income tax reductions for low- and moderate-income taxpayers.

Employers could continue to offer health benefits by providing wraparound coverage that fills in the gaps in *Medicare for All* (such as dental insurance, expanded mental health benefits, or amenities such as private hospital rooms). These would be equivalent to contemporary Medigap policies. The tax advantages that accrue to employer-sponsored health benefits would remain in place.

Medicare for All would permit states to experiment—essentially mirroring Medicaid waivers. Any state could opt out of the Medicare program for residents under age 65. States that chose to opt out would design their own alternatives—under simple federal guidelines. State plans would be required to guarantee universal coverage, they would have to offer health options with no cost sharing, and they would be required to organize their plans in a simple and transparent way. While Medicare would be fully funded from the VAT, state plans would get 75 percent of costs, matched by funds raised at the state or local level.

Medicare for All puts special emphasis on organizing an efficient bureaucracy. It would establish a new cabinet-level Department of Health, which would be charged with creating a simple, transparent, user-friendly health care system. By putting an end to multiple payment sources and extensive patient cost sharing, the proposed system would end some of the major sources of complexity in the American health care system. The new program would operate with electronic billing and payment. Major organizational initiatives would include a benefits board that would review, evaluate, and update the benefits package and a division for community health.

The existing Medicare program would be streamlined—for example, we would eliminate the arbitrary division between Part A (hospital) and Part B (physician services). Medicaid would become a smaller program focused largely on long-term care benefits.

Breaking with the Old Logic

Medicare for All introduces two sharp changes from current practice. It breaks the link between coverage and employment—a great American innovation rendered increasingly obsolete in the new global economy. And it limits the long, futile American effort to run a system with competing health care payers.

First, consider the link between employment and health insurance. The idea developed during World War II when health care benefits sidestepped wartime wage limits. It got a further boost from post-war policy, especially the seminal Taft-Hartley Act. The approach was well geared to an industrial sector marked by stable (often lifetime) employment, relatively predictable domestic markets, and regular labor-management relations. By 1979, more than four out of five full-time employees got their health care from their employers. The numbers have declined ever since (with a brief uptick in the 1990s).² Rising health care premiums take a steady toll on the employment-based systems, and the apparent return of relentlessly rising costs (employer health insurance premiums increased by three times the rate of general inflation in 2001) have eroded an old saw that corporate America would have the will and skill to rein in its health care costs.³

More important, the old industrial economy is sinking into history. People shift jobs frequently—lifetime employment with a single firm has become unusual. Global trade and fierce equity markets put enormous pressures on firms (and on their employee benefits). Contingent and part-time workers, consultants, and other flexible arrangements all undermine the kind of long-term commitment to employees that nourished the old system of health benefits. Of course, the pressures on companies vary by sector and firm—most large companies still offer health benefits; most small firms no longer do. However, the numbers are declining in every category. Efforts to reform the system by shoring up employer health care confront the new realities of an emerging global economy. As the quicksilver economy of the 21st century gathers velocity, the mid-20th century employment-based health system will be increasingly difficult to defend—or revive. It offers patchy coverage, it offers few footholds for expanding coverage to the uninsured (or the underinsured), and it places a heavy burden on many companies. Put bluntly, its days are numbered. As that becomes clear, *Medicare for All* may stand out as an appealing reform alternative.

Second, this plan largely rejects one of the great health care reform standards: consumer choice of health plans. (States that opt for their own health plans may keep the idea alive, however.) In theory, American health care offers two different kinds of consumer choice: the choice of provider is one of the great—and unassailable—values in American health care. That is not the same as choice of insurers. The idea of competing insurance packages has been a kind of holy grail for health reformers; the idea is intuitively appealing, because it more or less fits with traditional economic models. Consumers chose among competing plans, selecting the mix of price and services they most value.

However, the reality has rarely met expectations. In the real world, the choice of

insurance packages is a source of confusion and frustration. People have no idea how to cut through the complexities. They do not understand what exactly they are buying or what trade-offs they are making. A full range of options is rarely available to them in any case (nine out of 10 small employers offered just one plan in 2001).⁴

Worse, the two kinds of choice often conflict: choice among competing health plans leads to limits on the choices that really matter to most people, a choice among health care providers. That, in turn, has led to the political backlash against managed care. *Medicare for All* challenges the conventional wisdom: competition among insurance plans is an idea that has never worked except in special circumstances. Medicare's current beneficiaries do not miss it, nor will the rest of the population when Medicare is extended to them.

Benefits and Coverage

Fixing Medicare

The first step for the proposed program involves fixing Medicare itself. The program's organization and benefits package (introduced in 1966) makes little sense today. Medicare is divided into two parts: Part A covers hospital costs and is financed by a payroll tax; this was the package that Medicare's proponents originally proposed. Part B (Supplementary Medical Insurance) was originally a voluntary program covering physician services and out-of-hospital expenses; it was proposed as a Republican answer to Medicare and dramatically added onto the package in the House Ways and Means committee. Part B is funded 25 percent by beneficiary premiums and 75 percent from general revenues. Today, almost all Medicare beneficiaries participate in both parts of the program.

Medicare for All would abolish Parts A and B. A general benefits package would be available to all Americans. The financing mechanisms for both A and B would be abolished.

The benefits package would begin with current Medicare services: inpatient hospital services, physician services, short-term nursing care, home health services, hospice care, and post-hospital skilled nursing care and rehabilitation services.

Medicare operates with some gaping benefit holes that would be closed under the proposed plan. For example, outpatient prescription drugs and durable medical equipment would be covered. More generally, a careful review of the benefits package would be undertaken (and updated every two years, as described below). In part, Medicare services would have to be tailored to the entire population. Such benefits as maternal and child health care costs would be covered by the program.

Today, reformers often criticize Medicare for not protecting beneficiaries from catastrophic costs. People over 65 who do not have good supplemental insurance run a real risk of being impoverished by their medical expenses. That eventuality would be solved by abolishing patient cost-sharing altogether.

Community Medicine

Medicare, like most of the American health care system, emphasizes highly technical sickness insurance. The closer a patient gets to the operating theater, the more sophisticated—dazzling is not too strong a word—American medicine generally gets. *Medicare for All* would make a strong commitment to the other end of the health care spectrum. The program would emphasize full access to primary care and early intervention.

Medicare for All would create a special Office for Community Medicine, which would oversee a new initiative in community-based programs. In some cases, this would mean returning to old efforts such as community health centers; in others, it would involve major new initiatives. Take four important examples: community health centers, school-based health centers, home health services, and drug treatment facilities.

In the mid 1960s, the Office of Economic Opportunity launched a national network of community health centers (CHCs). The centers were meant to overcome the shortage of services in poor neighborhoods. They were originally conceived as a companion to Medicaid—Medicaid would overcome financial barriers to health care, and the CHCs would address other barriers by rethinking service delivery systems. Reformers expected the two programs to grow at roughly the same rate and predicted 1,000 centers serving some 25 million poor people by 1973. Of course, Medicaid grew, while the CHCs, which proved to be too sharp a departure from the existing models of medical care delivery, faded. The medical profession resisted the idea of working in health clinics that were not organized on a fee-for-service basis. Ironically, the managed care revolution has largely broken down professional resistance to what was once a radical service delivery innovation. Physicians routinely work in clinics and are often salaried. *Medicare for All* would return American medicine to the clinic model, funding a network of community health centers through state departments of health.

The program would also offer funds (on a per capita basis) for any school district that established a school-based health center. This is a popular intervention, and over 1,000 such centers have sprung up in the past decade. The idea is to get primary care to children and youths by going to where the kids are. The school-based clinics seem especially effective at getting care to teenagers—a population that is difficult to reach, especially in poor and immigrant neighborhoods. The centers offer annual physicals, mental health services, and reproductive health services, among others.⁵

Finally, one of the great, silent innovations in American medicine lies in the many home health workers who have begun to care for the elderly, disabled, and very sick. Three-quarters of a million dedicated, low-wage workers are offering care and compassion in American communities. The Office of Community Medicine would place home health services in an entirely new framework. Currently, Medicare's home health services operate as an alternative to skilled nursing facilities. Eligibility is tied to hospital discharge and acute symptoms. However, a rapidly aging society is going to require far more extensive, but less intensive—less medical—home health care.

Old people need a vast range of help in the simple activities of daily living. Some of these activities are not medical: getting dressed or getting in and out of bed, for example. Other services involve very minor medical interventions: changing bandages, administering eyedrops, giving drugs, monitoring blood pressure, caring for skin wounds.

Today spouses and children provide much of this care. However, by all accounts, it is exhausting; aging spouses, in particular, often require help to care for their partners. Recent studies document the extraordinary contortions home health workers go through to qualify elderly clients for Medicare (looking for skin sores, for example). Under current rules, Medicare calls that fraud. Scholars like Deborah Stone counter that it looks to them a lot more like simple decency. In any case, an aging society is going to require enhanced home health care—and simple care that helps elders get through their daily activities while assisting with routine medical tasks fits the emphasis on community care that characterizes *Medicare for All*.⁶

Another important benefit is drug addiction treatment. The United States has, in the words of former Clinton drug czar Gen. Barry McCaffrey, “some five million people chronically addicted to drugs [who] are a total mess.” Since the mid-1980s, the policy response has emphasized police action—incarcerating addicts at extraordinary rates. Drug policies have fueled an expensive (and extensive) penal regime; one in 33 Americans is now in jail or prison, on parole or under probation, about a third of them for drug offenses. *Medicare for All* would offer states treatment funds for first- and second-time drug users. The goal would be to shunt addicts from incarceration to treatment, a strategy now being undertaken in New York and California.⁷

The Benefits Commission

The benefits package would be overseen and updated by a commission. The Medicare experience offers a warning—echoed by the experience of national health insurance in some other nations. Political systems often freeze a benefits package into place; they rarely keep up with new health care technologies as efficiently as market systems do. The result of this program would be growing inequity: people with good wrap-around policies would enjoy a more flexible and up-to-date benefits package. This problem tends to grow more acute in the generations after the program has been put in place—Medicare’s failure to cover prescription drugs is a good example.

To begin to address the problem, *Medicare for All* would empower an independent national commission that would include representatives of provider groups, consumer groups, public officials, and local representatives. The commission would issue a bi-annual report on health care benefits proposing adjustments to keep up with medical technology.

The commission would report to the Secretary of Health, who, after review, would submit a proposal to Congress under fast-track authority. Congress would then vote the benefit changes up or down without amendment.

Cost Sharing

The proposed program would operate without any cost sharing, a perennial issue among health specialists. On the one side, analysts argue that cost sharing brings the discipline of economic calculation to bear on people's health care choices. On the other side, critics contend that cost sharing leads people to put off needed care; it discriminates against poor people, leads to worse health at lower income levels, and gets gamed by medical providers who often influence the use of services. There is good evidence for both sides of the argument—indeed, the two views are not incompatible.

However, the entire cost-sharing debate is not central to the current proposal. A single-payer, tax-based, health care system such as the one proposed here does not require cost sharing to control costs; it has a more formidable cost-control mechanism (tax resistance, discussed below). Almost all industrial democracies operate with few (if any) cost-sharing mechanisms.⁸

Without cost sharing, another trouble with contemporary Medicare could be addressed: its maddening complexity. Forms and statements could be kept brief and simple. Likewise, providers ought to be freed from the tyranny of billing that plagues every medical practice. An advisory committee of consumer and provider representatives, selected for three-year terms, would offer an annual report on program transparency.

Option Two: State Plans

The proposed system would offer states the option of forming a health care alternative for citizens under 65. States would apply for waivers and, following federal guidelines, organize and operate their own health care financing systems.

The guidelines could be kept relatively simple and would include the following:

- States would be required to guarantee universal coverage to all legal residents.
- States would be required to at least offer all residents a benefit package equivalent to *Medicare for All*
- States would offer at least one plan without any cost sharing (again, equivalent to *Medicare for All*). Of course, states might choose to organize systems that also offered other choices—for example, front-end rebates with higher cost sharing for people who fell ill.
- All plans offered in a state must safeguard against catastrophic costs.
- The states would guarantee portability by reimbursing the federal Medicare program for care delivered to residents traveling in other states.

The state plans would be vetted for simplicity and transparency, and they would be monitored and rated for costs, quality, and access to care. Plans that experienced

significantly higher inflation rates or substantially lower access to care would not be renewed after five years.

Federal funds would provide 75 percent of the cost of the state program; states would find other sources for the remaining 25 percent. If state health care taxes were levied for the remaining 25 percent, individuals would receive limited exemptions on their income taxes, though the rebates would not cover the full tax burden.

For proponents of *Medicare for All*, this will seem an odd twist to the system. After all, to its partisans, the proposed plan's biggest difficulty will be overcoming the political hurdles to its realization. Once those victories are finally won, why raise all the complications of state alternatives? After all, there has been no popular outcry for waivers from the current Medicare program—despite all the problems the program has had over the years.

The answer lies in the politics of innovation. State-level experiments would try out fresh ideas and innovations. Those that prove to be successful could be imported to the national programs. Many (perhaps most) successful social programs have their origins in innovative state efforts. A handful of state-level experiments, overseen and largely funded by the federal government, would foster innovation and creativity in the national program.

If the federal program began to falter over the years (by not keeping up with innovations in medicine, for example), ambitious politicians in innovative states might find it appealing to try and organize their own alternatives. The prospect would pressure federal policy makers to remain responsive, especially after the program has been running for some time.

Still, state programs would prove difficult to sustain over time. Successful programs would require skillful oversight and administration; the most successful state officials often move up to better positions in the federal government or the private sector. Moreover, states cannot engage in deficit spending, so economic downturns are likely to pressure states to participate in the national program. Finally, *Medicare for All* is likely to prove extremely popular with the public—like Medicare and Social Security. National administrators may very well need to tinker with the incentives to state policy makers if they are to keep a handful (say three to five) of states experimenting with health plans. Failing that, of course, the state option would simply fall into disuse.⁹

Skeptics of *Medicare for All* will have far more positive predictions about the success of the state plans. It might be politically useful to let the states try to do better than *Medicare for All*.

Financing

Medicare for All introduces a sharp break with current health care financing. Today, Medicare (Part A) is financed by a payroll tax currently pegged at 2.9 percent and split between employers and employees. Part B is funded largely (75 percent) out of general revenues, with the rest coming from monthly premiums paid by enrollees.

For middle-class Americans, tax-subsidized employment plans are the most important source of insurance. More than 80 percent of households earning \$50,000 or more are offered coverage by employers; in contrast, only a third of households earning between \$15,000 and \$20,000 are offered insurance coverage by employers.¹⁰

Medicare for All puts an end to this patchwork arrangement. Medicare payroll taxes are abolished as are Medicare premiums. General revenue funds are freed for other uses. Employers can offer supplemental and wraparound policies, but workers are not reliant on them for basic medical care coverage.

Instead, the proposed program would be funded by a value-added tax (VAT), mentioned earlier. The value-added tax is a kind of national sales tax. However, rather than simply apply the tax to retail sales, the VAT is paid every time a product is sold. For example, a VAT is added when a manufacturer sells a product to a wholesaler, when the wholesaler sells a retailer, and when the retailer sells to a consumer. Put differently, the difference between a business's purchases and its sales is its value added. A portion of the tax is applied to every stage in the production process.¹¹

The VAT is the official tax of the European Union. All but two nations in the Organization for Economic Cooperation and Development (OECD) rely on it. (The European single market has not gotten its member countries to agree on the VAT rate, however, which varies from nation to nation.) The other source of VAT proposals fiscal conservatives in the United States, who would replace the entire income tax with a VAT. Rep. Sam Gibbons (R-FL) and Sen. Ernest Hollings (D-SC) have proposed the most recent shift to a national VAT.

Why a VAT? Because health care comprises the largest sector of the American economy. Nationalizing the funding has many advantages—as most other nations have discovered (and as I discuss in the last section, below). There is no question, however, that it would be extremely expensive. We are not likely to fund the American health care system by squeezing a bit more out of businesses, juggling payroll taxes, or turning to general revenues. Instead of the usual pastiche, a VAT offers a clear, transparent, familiar way to cut through the conundrum of health care financing. This is not a theoretical idea but a practical source of revenue that can be studied in action across the industrial world before being put into place to fund American health care.

In short, consumer spending—the motor of the American economy—would provide the funds that finally solve the seemingly endless crisis in American health care.¹²

Two criticisms of the VAT are worth noting:

First, VATs are usually criticized for being sharply regressive. People earning \$15,000 a year typically spend all their income on consumption items. Those earning \$150,000 typically spend less on consumption, so they pay a smaller percentage of their income in taxes. There are many ways to relieve VATs of this regressive quality, however. *Medicare for All* would not tax food, medicine, or shelter. Moreover, the tax would be linked to an expansion of the earned income tax credit. That is, income tax relief could render the tax burden neutral for people earning less than \$30,000

a year, and the tax credit would gradually phase out for individuals earning between \$30,000 and \$45,000 a year.

Second, critics caution that a federal VAT might compete with state revenues. The states have traditionally relied on the sales tax, while the federal government has used the income tax (at least since the 1920s). But things have been changing in the states. By 1997, less than half of total state revenue (48 percent) came from sales taxes. In fact, the states themselves increasingly rely on incomes taxes (now up to 39 percent of total state revenues). Moreover, *Medicare for All* solves the problem of health care finance—in many ways, the largest challenge facing state budget directors. On balance, the *Medicare for All* is a good deal for the states.¹³

Of course any new tax system will take time to implement. The Internal revenue Service (IRS) studied the implementation burden of converting the whole tax system to a VAT (in 1982) and estimated that the tax would apply to 20 million firms and would take some 18 months to put in place. Implementation of *Medicare for All* would require enough time (and attention) to get the tax changes right.¹⁴

Existing Programs

Employers

Medicare for All would end the longtime practice of relying on employers as the primary provider of health care insurance. As noted above, those practices developed in a very different social and economic context. If health premiums continue to rise faster than the general rate of inflation, employer-based health care will erode at a faster pace. But if the United States turned to this proposal, many companies would still want to offer some health benefits to employees. Some, for example, would find those benefits a good way to recruit and maintain valued workers.

The proposed program would encourage employers to continue offering health benefits. Employers might offer coverage that wraps around the *Medicare* benefit package. Such coverage might include dental benefits, enhanced mental health benefits, or hospital amenities such as private rooms. Even in the early years of Canadian Medicare (as they call their national health insurance), private insurers thrived by filling the gaps in what was back then a very generous package of benefits.

To encourage employer health benefit packages, the tax subsidies for employer health insurance would remain in place. This issue raises another difficult choice for supporters of a *Medicare for All* system: just how egalitarian a system should we be aiming for? Looking cross-nationally, even single-payer systems vary enormously on this dimension.

The argument against subsidizing employer benefits is simple: it fosters a multi-tier and non-egalitarian system from the start. As cost constraints begin to clamp down on the public system (discussed below), these differences will tend to grow. Over time, individuals with good wraparound coverage will have access to better facilities, new forms of treatment, and so forth. Encouraging supplemental policies

will only hasten the development of inequalities. From this perspective, basic equality of opportunity—simple justice—requires treating people in equal circumstances in equal ways.

Although these are powerful arguments, there are compelling reasons to encourage employer supplementary policies. The United States is a markedly non-egalitarian society. *Medicare for All* addresses health inequities in dramatic ways. However, people who are better off financially will always seek better care and more amenities, and private insurers will find and offer services that Medicare does not cover. In this context, encouraging companies to offer supplemental health benefits has numerous advantages: it increases the number of people with access to enhanced benefits, it accommodates the relentless American quest for “business class” upgrades, and it creates a market for innovation and luxury that is often missing in nationally funded health care systems.

The great trade-off lies in creating a first-rate health care system for all Americans on the one hand, and accommodating demands for different tiers of care and service on the other hand. To make the balance work, *Medicare for All* would not permit providers to extra-bill patients for covered services; it would cover full payment for covered benefits. On the other side, private insurance markets would pick up and develop benefits not covered by *Medicare for All*. Making this balance work will take careful oversight.

The Medicare Benefits Commission would be required to report to Congress on the state of the benefits package every two years. One of the commission’s important tasks would be to scan the private insurance markets to ensure that important health care services were not migrating from public to private systems. This would be a significant danger as decades pass: medical progress introduces new therapies, program cost constraints grow, and private insurance markets stand ready to take up the slack. A well-run system would keep a close eye on private-sector innovations to keep Medicare up to date.

Medicaid

Medicare for All would replace a significant part of Medicaid. The new program would cover acute care benefits for every age group. Most of the services covered by the State Children’s Health Insurance Program (S-CHIP), for example, would be turned over to the new program. Medicaid would also be relieved of paying Medicare premiums and copayments for low-income elders (since *Medicare for All* would operate without cost sharing). The new program’s community health benefits and home health benefits would offer additional health coverage for low-income and older people. Taken together, these changes would offer enormous budget relief in many states.

Some important features of the Medicaid program would remain. Most significant, Medicaid is currently the single largest expenditure source for nursing homes (covering just under 40 percent of total costs for the elderly). Though it is beyond the scope of this chapter, reduction of Medicaid’s responsibilities (along

with budget relief to most states) would offer an opportunity to rationalize funding for long-term care.

Administration

Health would be removed from the Department of Health and Human Services (HHS), carefully reorganized, and elevated to a cabinet-level department. Organizational details do not attract much media scrutiny, but, at the end of the day, a plan such as this one can really thrive only with a sensibly organized, reasonably financed, and well-motivated bureaucracy.

Classic bureaucratic theory suggests that organizations with a bold new mission and adequate resources tend to attract more motivated workers. There is supposed to be a life cycle to bureaucratic agencies—the peak comes early on when the agency faces large challenges and forges new routines. Looking back on Medicare's implementation, for example, Lyndon Johnson described it as the greatest organizational mission the nation had undertaken since the invasion of Normandy. But effective organizations do not spring up spontaneously; they have to be put together with care.¹⁵

In the high drama of winning health reform, the shape of the bureaucracy is overlooked—a detail, an afterthought. Ignoring the details early on will produce chaos during implementation.¹⁶

Planning for the new organization should begin very early in the political life of the proposed program. (That should be true for every proposal in this collection, incidentally.) Before *Medicare for All* is even introduced, a small bipartisan panel of former health officials (to include the last eight Health Care Financing Administration [HCFA] administrators) would develop an organizational plan for the new Department of Health, the administrative agency responsible for the proposed program. Those details may actually matter more for the health of this (or any) reform, than far more visible questions such as the details of the benefits package.

The committees already noted in this proposal signal some of the most important organizational elements of the proposed program. They include:

- an Office of Community Health;
- a Benefits Board to oversee the benefits package and keep it up to date over time; and
- a paperwork and simplification board, made up of both consumers and providers. As Medicare developed, it became extraordinarily complicated for both beneficiaries and providers. The new program should make a commitment to simplicity and transparency—and vest that commitment in a visible part of the agency.¹⁷

Simplicity is an especially important issue for the American health care system. A half-century of health care inflation, all the programs designed to deal with that inflation, a vibrant market for health insurance products, and a host of other factors have

produced an extraordinarily complicated and inefficient system. Enormous resources are squandered in determining eligibility or negotiating reimbursements from multiple sources. A single payer system with no out-of-pocket costs can bring a welcome simplicity—but only if policy makers are committed to achieving it.

A single-payer regime could be organized around a simple, national, centralized, electronic method of paying claims. A swift, efficient, and simple reimbursement regime would be the greatest spur to medical system productivity in recent history—it would release medical providers from their paperwork, and it would yield enormous cost savings; estimates range as high as 25 percent of health care costs.¹⁸

Practical Considerations

Political Feasibility

By the standards of contemporary politics, this is not a practical proposal. It would not be taken seriously, for example, in the current Congress.

However, American political history is full of far-reaching changes—both liberal and conservative—that seemed chimerical when first proposed.¹⁹ The key to successful change lies in at least two factors: first, advocates have to develop a plan, publicize it, and push, push, push. Second, they have to find a following—a movement—that mobilizes and demands the change. Solving the American health care puzzle (with 40 million uninsured people *and* runaway costs) will take precisely that combination. Really fixing American health care will require one of the great reform efforts in American history. And that is not likely to happen without a great popular outcry.

Medicare for All does not make much sense if measured simply by contemporary Beltway politics. But few other proposals are as well geared for generating a populist uprising. In that sense, it may ultimately prove more feasible than proposals that try to cover 40 million people with elaborate (and, to the layperson, incomprehensible) compromises, complications, and concessions.

Political History

The issue of feasibility can usefully be put in the larger context of policy change over time. Political historians often describe American political development as a process of punctuated equilibrium. Under normal conditions, the fragmented political system—with checks and balances everywhere—seems designed for stalemate. Only relatively small, incremental changes successfully negotiate the political process. Most of the time, American politics is the politics of tinkering on the margins. Most reform proposals sensibly reflect that reality. But over time, demands for larger change build up. Those underlying demands eventually are met in recurring moments of vast, tectonic change—like the New Deal or the Great Society. *Medicare for All* is based on the premise that fixing America's health care dilemma will take a comparable change.

Reformers who agree with that assessment ought to set their sights on the longer term. Leave others to work for incremental improvements and, instead, begin rally-

ing support for a plan that is likely to address our health problems in a systematic and popular way. Medicare's supporters pushed for more than a decade (without much to show for it) before their opportunity came.

Cost Control

Though many Americans will find it hard to believe, the cross-national experience is unambiguous: single-payer systems (featuring monopsony buyers) are the most effective modes of health care cost control. Indeed, over time they tend to create the opposite problem, they control costs too tightly. Why? Because public funding means that every rise in health care costs is very visible—it translates more or less directly into a rise in taxes. And there is no greater spur to cost control.

In 2002, many private corporations experienced double-digit health care premium increases. Some universities, for example, faced a 50 percent rise in premiums. Such increases pose serious problems for employers and workers, of course. But spread over thousands of institutions, the problems are local and dispersed. In contrast, a large premium increase in a single-payer system creates a crisis, because meeting the higher costs requires raising taxes. That dispersed problem becomes highly concentrated. Of course, employees are going to pay the premium increases, either directly or indirectly. In a nationalized system, however, those increases immediately become political. There's nothing like the prospect of a big rise in taxes to focus the public mind on effective cost-control measures. The chronic American health care problem—rising costs—would suddenly become politically unacceptable.

Is there anything comparable to a single-payer health system in American politics? Arguably, defense spending. Here is another highly technical industry performing services simultaneously vital and baffling to the layman. Health care providers are asked to square the circle among quality, access, and costs; likewise, defense contractors are asked for timeliness, high performance objectives, and low cost. There are other similarities and one great difference. Defense is funded—as *Medicare for All* would be—by the government. And in contrast to health care, defense spending remained under tight control throughout the entire Cold War. It never rose more than five years in a row as percentage of gross domestic product (GDP). And, after the 1950s, it consumed a steadily diminishing portion of the American economy despite occasional rises (1965-67 and 1974-5). The Reagan administration defense spending perfectly illustrates the syndrome of government-controlled expenditures: a popular politician articulates a new demand for spending; Congress allocates a large increase in funds; spending rises relative to other national priorities. However, the growth soon runs up against competing national goals, other programs, tax resistance, and alarm over the deficit. After the early and mid-1980s, defense spending flattened out and, once again, began to decline again as percentage of GDP.²⁰

In short, for a nation that especially hates tax increases, the problem with a plan like this one is likely to be *too much* cost control.

Access to Care

The proposed plan would solve the problems of access to care. All legal residents would have health insurance, and they would pay no costs at the point of service. Providers would not be permitted to extra-bill their patients; Medicare would pay the costs in full. Moreover, the plan also addresses other barriers to access: community health centers, school clinics, home health benefits. Each feature of the plan would help ensure broad—and unprecedented—access to health care.

Innovation

Broad access and lower costs come at a price. *Medicare for All* would very likely dampen the fast pace of innovation in American health care. National systems are slower to adopt new organizational forms and new technologies. Today, the American system is marked by nothing so much as the proliferation of new insurance products, new medical technologies, and new organizational models (that fly rapidly in and out of favor—remember managed care?). This feature of the American system would diminish rapidly even as we solved cost and access problems.

One reason to continue encouraging employer-sponsored health insurance is to maintain a market (albeit a smaller one) for innovative services and technologies not covered by the new national program. On balance, I have argued, the risk of injecting inequality back into the health system is worth taking for the innovations the private market is apt to stimulate. The key, again, is to organize *Medicare for All* to monitor and adopt the best innovations of the private insurance sector.

Quality of Care

Nothing will improve the quality of care for more Americans than extending health insurance to the 40 million people who do not have it (or the 30 million more who do not have enough). That said, the proposed plan marks a shift in American health care priorities. This plan emphasizes primary care and low-technology interventions—home health workers are a good example.

On the other side, the grip of cost control will loosen the irresistible march of high technology. This plan is likely to force hard choices about heroic measures undertaken on the very sick and the very old. Americans will be much slower to perform heroic measures that prolong life for a matter of weeks. Does that diminish quality of care? In some ways it does. And yet, anyone who has recently watched a dying loved one run the gauntlet of high technology is likely to think not.

Notes

1. This article originally appeared in Jack Meyer and Elliot Wicks, eds., *Covering America: Real Remedies for the Uninsured*, Vol. 2 (Washington, D.C.: Economic and Social Research Institute, 2002). I am grateful to Jack Meyer, Elliot Wicks, the staff members of ESRI, and the advisory board they assembled for their innovative project on covering the uninsured.
2. See Marie Gotshalk. *The Shadow Welfare State*. Ithaca: Cornell University Press, 2000, for a fine de-

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- scription of Taft-Hartley and, more generally, the rise of the employment health care state. See also Michael Graetz and Jerry Mashaw. *True Security: Rethinking American Social Insurance*. New Haven: Yale University Press, 1999, chapter 7.
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 4. *Employer Health Benefits, 2001*, p. 7.
 5. See James Morone, Elizabeth Kilbreth, and Kathryn Langwell. "Back to School: A Health Care Strategy for Youth." *Health Affairs* (January/February 2001): 122-36.
 6. See Deborah Stone. *Reframing Home Health-Care Policy*. Cambridge, MA: Radcliffe Public Policy Center, 2000.
 7. James A. Morone. *Hellfire Nation*. New Haven: Yale University Press, 2003, chap. 15.
 8. My discussion of cost sharing follows Richard Kronick and Thomas Rice. "A State-Based Proposal for Achieving Universal Coverage" In Jack Meyer and Elliot Wicks (eds.). *Covering America: Real Remedies for the Uninsured*. Washington: Economic and Social Research 123-4; See also the essays in *Journal of Health Politics, Policy and Law*, October 2000 and Fall 1995.
 9. See Harvey Sapolsky, Jamie Aisenberg, and James A. Morone. "The Call to Rome: Obstacles to State Level Innovation." *Public Administration Review* 47 (2) (April 1987).
 10. Graetz and Mashaw, p. 139.
 11. See Michael Graetz. *The Decline (and Fall?) of the Income Tax*. New York: Norton, 1996.
 12. Though it is beyond the scope of this discussion, I would propose using the VAT to fund the two great American social problems: health care and education. A per capita grant to states for education funding (tied to per capita income) would also offer a way to solve the education funding dilemma and promote a basic and equitable floor for all students. Covering both health care and education would reflect American values by offering all Americans a real opportunity. I develop this plan elsewhere.
 13. Data computed from U.S. Census Bureau, *Statistical Abstract of the United States* (119th ed.). Washington: pp. 325-7.
 14. Graetz, p. 2000.
 15. For an excellent summary of the literature on bureaucracy, see Anthony Downs, *Inside Bureaucracy*, Boston: Little Brown, 1967; Lyndon Johnson. *The Vantage Point*. New York: Holt, Rinehart and Winston, 1971, p. 220. See also Judith Feder. *Medicare: The Politics of Federal Hospital Insurance*. Lexington, MA: Lexington Books, 1977.
 16. This, incidentally, was one of the most serious flaws with the Clinton health proposal, though it never got much press. See James A. Morone. "Organizing Reform." *The American Prospect* (Spring 1994): 11-12.
 17. On Medicare's growing complexity, see T. R. Marmor. *The Politics of Medicare*. New York: Aldine, 2000, p. 107, and John Oberlander. *Medicare and the American State*. Ph.D. Dissertation, Yale University, 1995.
 18. See Elliot Wicks, Jack Meyer, and Sharon Silow-Carroll. "A Plan for Achieving Universal Coverage." In *Covering America*, p. 196.
 19. For examples—from the abolition of slavery to the prohibition of liquor, from racial desegregation

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to welfare reform, from social security to gender equality—see Morone, *Hellfire Nation*; Morone, *The Democratic Wish*.

20. For the defense spending analogy, see James A. Morone. “Beyond the N Word: The Politics of Health Care Reform.” *Bulletin of the New York Academy of Medicine* 66 (4) (July-August 1990): 344-65.

A National Health Program for the United States: A Physicians' Proposal

by *David Himmelstein and Steffie Woolhandler*

Our health care system is failing. It denies access to many in need and is expensive, inefficient, and increasingly bureaucratic. The pressures of cost control, competition, and profit threaten the traditional tenets of medical practice. For patients, the misfortune of illness is often amplified by the fear of financial ruin. For physicians, the gratifications of healing often give way to anger and alienation. Patchwork reforms succeed only in exchanging old problems for new ones. It is time to change fundamentally the trajectory of American medicine—to develop a comprehensive national health program for the United States.

We are physicians active in the full range of medical endeavors. We are primary care doctors and surgeons, psychiatrists and public health specialists, pathologists and administrators. We work in hospitals, clinics, private practices, health maintenance organizations (HMOs), universities, corporations, and public agencies. Some of us are young, still in training; others are greatly experienced, and some have held senior positions in American medicine.

As physicians, we constantly confront the irrationality of the present health care system. In private practice, we waste countless hours on billing and bureaucracy. For uninsured patients, we avoid procedures, consultations, and costly medications. Diagnosis-related groups (DRGs) have placed us between administrators demanding early discharge and elderly patients with no one to help at home—all the while glancing over our shoulders at the peer-review organization. In HMOs we walk a tightrope between thrift and penuriousness, too often under the pressure of surveillance by bureaucrats more concerned with the bottom line than with other measures of achievement. In public health work we are frustrated in the face of plenty; the world's richest health care system is unable to ensure such basic services as prenatal care and immunizations.

Despite our disparate perspectives, we are united by dismay at the current state of medicine and by the conviction that an alternative must be developed. We hope to spark debate, to transform disaffection with what exists into a vision of what might be. To this end, we submit for public review, comment, and revision a working plan for a rational and humane health care system—a national health program.

We envisage a program that would be federally mandated and ultimately funded by the federal government but administered largely at the state and local level. The

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proposed system would eliminate financial barriers to care; minimize economic incentives for both excessive and insufficient care, discourage administrative interference and expense, improve the distribution of health facilities, and control costs by curtailing bureaucracy and fostering health planning. Our plan borrows many features from the Canadian national health program and adapts them to the unique circumstances of the United States. We suggest that, as in Canada's provinces, the national health program be tested initially in statewide demonstration projects. Thus, our proposal addresses both the structure of the national health program and the transition process necessary to implement the program in a single state. In each section below, we present a key feature of the proposal, followed by the rationale for our approach. Areas such as long-term care; public, occupational, environmental, and mental health; and medical education need much more development and will be addressed in detail in future proposals.

Coverage

Everyone would be included in a single public plan covering all medically necessary services, including acute, rehabilitative, long-term, and home care; mental health services; dental services; occupational health care; prescription drugs and medical supplies; and preventive and public health measures. Boards of experts and community representatives would determine which services were unnecessary or ineffective, and these would be excluded from coverage. As in Canada, alternative insurance coverage for services included under the national health program would be eliminated, as would patient copayments and deductibles.

Universal coverage would solve the gravest problem in health care by eliminating financial barriers to care. A single comprehensive program is necessary both to ensure equal access to care and to minimize the complexity and expense of billing and administration. The public administration of insurance funds would save tens of billions of dollars each year. The more than 1500 private health insurers in the United States now consume about 8 percent of revenues for overhead, whereas both the Medicare program and the Canadian national health program have overhead costs of only 2 to 3 percent. The complexity of our current insurance system, with its multiplicity of payers, forces U.S. hospitals to spend more than twice as much as Canadian hospitals on billing and administration and requires U.S. physicians to spend about 10 percent of their gross incomes on excess billing costs.¹ Eliminating insurance programs that duplicated the national health program coverage, though politically thorny, would clearly be within the prerogative of the Congress.² Failure to do so would require the continuation of the costly bureaucracy necessary to administer and deal with such programs.

Copayments and deductibles endanger the health of poor people who are sick,³ decrease the use of vital inpatient medical services as much as they discourage the use of unnecessary ones,⁴ discourage preventive care,⁵ and are unwieldy and expensive to administer. Canada has few such charges, yet health costs are lower than in the

United States and have risen slowly.^{6,7} In the United States, in contrast, increasing copayments and deductibles have failed to slow the escalation of costs.

Instead of the confused and often unjust dictates of insurance companies, a greatly expanded program of technology assessment and cost-effectiveness evaluation would guide decisions about covered services, as well as about the allocation of funds for capital spending, drug formularies, and other issues.

Payment for Hospital Services

Each hospital would receive an annual lump-sum payment to cover all operating expenses—a “global” budget. The amount of this payment would be negotiated with the state national health program payment board and would be based on past expenditures, previous financial and clinical performance, projected changes in levels of services, wages and other costs, and proposed new and innovative programs. Hospitals would not bill for services covered by the national health program. No part of the operating budget could be used for hospital expansion, profit, marketing, or major capital purchases or leases. These expenditures would also come from the national health program fund, but monies for them would be appropriated separately.

Global prospective budgeting would simplify hospital administration and virtually eliminate billing, thus freeing up substantial resources for increased clinical care. Before the nationwide implementation of the national health program, hospitals in the states with demonstration programs could bill out-of-state patients on a simple per diem basis. Prohibiting the use of operating funds for capital purchases or profit would eliminate the main financial incentive for both excessive intervention (under fee-for-service payment) and skimping on care (under DRG-type prospective-payment systems), since neither inflating revenues nor limiting care could result in gain for the institution. The separate appropriation of funds explicitly designated for capital expenditures would facilitate rational health planning. In Canada, this method of hospital payment has been successful in containing costs, minimizing bureaucracy, improving the distribution of health resources, and maintaining the quality of care.⁶⁻⁹ It shifts the focus of hospital administration away from the bottom line and toward the provision of optimal clinical services.

Payment for Physicians' Services, Ambulatory Care, and Medical Home Care

To minimize the disruption of existing patterns of care, the national health program would include three payment options for physicians and other practitioners: fee-for-service payment, salaried positions in institutions receiving global budgets, and salaried positions within group practices or HMOs receiving per capita (capitation) payments.

Fee-for-Service Payment

The state national health program payment board and a representative of the fee-for-service practitioners (perhaps the state medical society) would negotiate a simplified,

binding fee schedule. Physicians would submit bills to the national health program on a simple form or by computer and would receive extra payment for any bill not paid within 30 days. Payments to physicians would cover only the services provided by physicians and their support staff and would exclude reimbursement for costly capital purchases of equipment for the office, such as CT scanners. Physicians who accepted payment from the national health program could bill patients directly only for uncovered services (as is done for cosmetic surgery in Canada).

Global Budgets

Institutions such as hospitals, health centers, group practices, clinics serving migrant workers, and medical home care agencies could elect to receive a global budget for the delivery of outpatient, home care, and physicians' services, as well as for preventive health care and patient-education programs. The negotiation process and the regulations covering capital expenditures and profits would be similar to those for inpatient hospital services. Physicians employed in such institutions would be salaried.

Capitation

HMOs, group practices, and other institutions could elect to be paid fees on a per capita basis to cover all outpatient care, physicians' services, and medical home care. The regulations covering the use of such payments for capital expenditures and for profits would be similar to those that would apply to hospitals. The capitation fee would not cover inpatient services (except care provided by a physician), which would be included in hospitals' global budgets. Selective enrollment policies would be prohibited, and patients would be permitted to leave an HMO or other health plan with appropriate notice. Physicians working in HMOs would be salaried, and financial incentives to physicians based on the HMO's financial performance would be prohibited.

The diversity of existing practice arrangements, each with strong proponents, necessitates a pluralistic approach. Under all three proposed options, capital purchases and profits would be uncoupled from payments to physicians and other operating costs—a feature that is essential for minimizing entrepreneurial incentives, containing costs, and facilitating health planning.

Under the fee-for-service option, physicians' office overhead would be reduced by the simplification of billing.¹ The improved coverage would encourage preventive care.¹⁰ In Canada, fee-for-service practice with negotiated fee schedules and mandatory assignment (acceptance of the assigned fee as total payment) has proved to be compatible with cost containment, adequate incomes for physicians, and a high level of access to and satisfaction with care on the part of patients.^{6,7} The Canadian provinces have responded to the inflationary potential of fee-for-service payment in various ways: by limiting the number of physicians, by monitoring physicians for outlandish practice patterns, by setting overall limits on a province's spending for physicians' services (thus relying on the profession to police itself), and even by

capping the total reimbursement of individual physicians. These regulatory options have been made possible (and have not required an extensive bureaucracy) because all payment comes from a single source. Similar measures might be needed in the United States, although our penchant for bureaucratic hypertrophy might require a concomitant cap on spending for the regulatory apparatus. For example, spending for program administration and reimbursement bureaucracy might be restricted to 3 percent of total costs.

Global budgets for institutional providers would eliminate billing, while providing a predictable and stable source of income. Such funding could also encourage the development of preventive health programs in the community, such as education programs on the acquired immunodeficiency syndrome (AIDS), whose costs are difficult to attribute and bill to individual patients.

Continuity of care would no longer be disrupted when patients' insurance coverage changed as a result of retirement or a job change. Incentives for providers receiving capitation payments to skimp on care would be minimized, since unused operating funds could not be devoted to expansion or profit.

Payment for Long-Term Care

A separate proposal for long-term care is under development, guided by three principles. First, access to care should be based on need rather than on age or ability to pay. Second, social and community-based services should be expanded and integrated with institutional care. Third, bureaucracy and entrepreneurial incentives should be minimized through global budgeting with separate funding for capital expenses.

Allocation of Capital Funds, Health Planning, and Return on Equity

Funds for the construction or renovation of health facilities and for purchases of major equipment would be appropriated from the national health program budget. The funds would be distributed by state and regional health-planning boards composed of both experts and community representatives. Capital projects funded by private donations would require approval by the health-planning board if they entailed an increase in future operating expenses.

The national health program would pay owners of for-profit hospitals, nursing homes, and clinics a reasonable fixed rate of return on existing equity. Since virtually all new capital investment would be funded by the national health program, it would not be included in calculating the return on equity.

Current capital spending greatly affects future operating costs, as well as the distribution of resources. Effective health planning requires that funds go to high-quality, efficient programs in the areas of greatest need. Under the existing reimbursement system, which combines operating and capital payments, prosperous hospitals can expand and modernize, whereas impoverished ones cannot, regardless of the health needs of the population they serve or the quality of services they provide. The na-

tional health program would replace this implicit mechanism for distributing capital with an explicit one, which would facilitate (though not guarantee) allocation on the basis of need and quality. Insulating these crucial decisions from distortion by narrow interests would require the rigorous evaluation of the technology and assessment of needs, as well as the active involvement of providers and patients.

For-profit providers would be compensated for existing investments. Since new for-profit investment would be barred, the proprietary sector would gradually shrink.

Public, Environmental and Occupational Health Services

Existing arrangements for public, occupational, and environmental health services would be retained in the short term. Funding for preventive health care would be expanded. Additional proposals dealing with these issues are planned.

Prescription Drugs and Supplies

An expert panel would establish and regularly update a list of all necessary and useful drugs and outpatient equipment. Suppliers would bill the national health program directly for the wholesale cost, plus a reasonable dispensing fee, of any item in the list that was prescribed by a licensed practitioner. The substitution of generic for proprietary drugs would be encouraged.

Funding

The national health program would disburse virtually all payments for health services. The total expenditure would be set at the same proportion of the gross national product as health costs represented in the year preceding the establishment of the national health program. Funds for the national health program could be raised through a variety of mechanisms. In the long run, funding based on an income tax or other progressive tax might be the fairest and most efficient solution, since tax-based funding is the least cumbersome and least expensive mechanism for collecting money. During the transition period in states with demonstration programs, the following structure would mimic existing funding patterns and minimize economic disruption.

Medicare and Medicaid

All current federal funds allocated to Medicare and Medicaid would be paid to the national health program. The contribution of each program would be based on the previous year's expenditures, adjusted for inflation. Using Medicare and Medicaid funds in this manner would require a federal waiver.

State and Local Funds

All current state and local funds for health care expenditures, adjusted for inflation, would be paid to the national health program.

Employer Contributions

A tax earmarked for the national health program would be levied on all employers. The tax rate would be set so that total collections equaled the previous year's statewide total of employers' expenditures for health benefits, adjusted for inflation. Employers obligated by preexisting contracts to provide health benefits could credit the cost of those benefits toward their national health program tax liability.

Private Insurance Revenues

Private health insurance plans duplicating the coverage of the national health program would be phased out over three years. During this transition period, all revenues from such plans would be turned over to the national health program, after the deduction of a reasonable fee to cover the costs of collecting premiums.

General Tax Revenues

Additional taxes, equivalent to the amount now spent by individual citizens for insurance premiums and out-of-pocket health costs, would be levied.

It would be critical for all funds for health care to flow through the national health program. Such single-source payment (monopsony) has been the cornerstone of cost containment and health planning in Canada. The mechanism of raising funds for the national health program would be a matter of tax policy, largely separate from the organization of the health care system itself. As in Canada, federal funding could attenuate inequalities among the states in financial and medical resources.

The transitional proposal for demonstration programs in selected states illustrates how monopsony payment could be established with limited disruption of existing patterns of health care funding. The employers' contribution would represent a decrease in costs for most firms that now provide health insurance and an increase for those that do not currently pay for benefits. Some provision might be needed to cushion the impact of the change on financially strapped small businesses. Decreased individual spending for health care would offset the additional tax burden on individual citizens. Private health insurance, with its attendant inefficiency and waste, would be largely eliminated. A program of job placement and retraining for insurance and hospital-billing employees would be an important component of the program during the transition period.

Discussion

The Patient's View

The national health program would establish a right to comprehensive health care. As in Canada, each person would receive a national health program card entitling him or her to all necessary medical care without copayments or deductibles. The card could be used with any fee-for-service practitioner and at any institution receiving a global budget. HMO members could receive nonemergency care only through their HMO, although they could readily transfer to the non-HMO option.

Thus, patients would have a free choice of providers, and the financial threat of illness would be eliminated. Taxes would increase by an amount equivalent to the current total of medical expenditures by individuals. Conversely, individuals' aggregate payments for medical care would decrease by the same amount.

The Practitioner's View

Physicians would have a free choice of practice settings. Treatment would no longer be constrained by the patient's insurance status or by bureaucratic dicta. On the basis of the Canadian experience, we anticipate that the average physician's income would change little, although differences among specialties might be attenuated.

Fee-for-service practitioners would be paid for the care of anyone not enrolled in an HMO. The entrepreneurial aspects of medicine—with the attendant problems as well as the possibilities—would be limited. Physicians could concentrate on medicine; every patient would be fully insured, but physicians could increase their incomes only by providing more care. Billing would involve imprinting the patient's national health program card on a charge slip, checking a box to indicate the complexity of the procedure or service, and sending the slip (or a computer record) to the physician-payment board. This simplification of billing would save thousands of dollars per practitioner in annual office expenses.¹

Bureaucratic interference in clinical decision making would sharply diminish. Costs would be contained by controlling overall spending and by limiting entrepreneurial incentives, thus obviating the need for the kind of detailed administrative oversight that is characteristic of the DRG program and similar schemes. Indeed, there is much less administrative intrusion in day-to-day clinical practice in Canada (and most other countries with national health programs) than in the United States.^{11,12}

Salaried practitioners would be insulated from the financial consequences of clinical decisions. Because savings on patient care could no longer be used for institutional expansion or profits, the pressure to skimp on care would be minimized.

The Effect on Other Health Workers

Nurses and other health care personnel would enjoy a more humane and efficient clinical milieu. The burdens of paperwork associated with billing would be lightened. The jobs of many administrative and insurance employees would be eliminated, necessitating a major effort at job placement and retraining. We advocate that many of these displaced workers be deployed in expanded programs of public health, health promotion and education, and home care and as support personnel to free nurses for clinical tasks.

The Effect on Hospitals

Hospitals' revenues would become stable and predictable. More than half the current hospital bureaucracy would be eliminated,¹ and the remaining administrators could focus on facilitating clinical care and planning for future health needs.

The capital budget requests of hospitals would be weighed against other priorities for health care investment. Hospitals would neither grow because they were profitable nor fail because of unpaid bills—although regional health planning would undoubtedly mandate that some expand and others close or be put to other uses. Responsiveness to community needs, the quality of care, efficiency, and innovation would replace financial performance as the bottom line. The elimination of new for-profit investment would lead to a gradual conversion of proprietary hospitals to not-for-profit status.

The Effect on the Insurance Industry

The insurance industry would feel the greatest impact of this proposal. Private insurance firms would have no role in health care financing, since the public administration of insurance is more efficient^{1,13} and single-source payment is the key to both equal access and cost control. Indeed, most of the extra funds needed to finance the expansion of care would come from eliminating the overhead and profits of insurance companies and abolishing the billing apparatus necessary to apportion costs among the various plans.

The Effect on Corporate America

Firms that now provide generous employee health benefits would realize savings, because their contribution to the national health program would be less than their current health insurance costs. For example, health care expenditures by Chrysler, currently \$5,300 annually per employee,¹⁴ would fall to about \$1,600, a figure calculated by dividing the total current U.S. spending on health by private employers by the total number of full-time-equivalent, nongovernment employees. Since most firms that compete in international markets would save money, the competitiveness of U.S. products would be enhanced. However, costs would increase for companies that do not now provide health benefits. The average health care costs for employers would be unchanged in the short run. In the long run, overall health costs would rise less steeply because of improved health planning and greater efficiency. The funding mechanism ultimately adopted would determine the corporate share of those costs.

Health Benefits and Financial Costs

There is ample evidence that removing financial barriers to health care encourages timely care and improves health. After Canada instituted a national health program, visits to physicians increased among patients with serious symptoms.¹⁵ Mortality rates, which were higher than U.S. rates through the 1950s and early 1960s, fell below those in the United States.¹⁶ In the Rand Health Insurance Experiment, free care reduced the annual risk of dying by 10 percent among the 25 percent of U.S. adults at highest risk.³ Conversely, cuts in California's Medicaid program led to worsening health.¹⁷ Strong circumstantial evidence links the poor U.S. record on infant mortality with inadequate access to prenatal care.¹⁸

We expect that the national health program would cause little change in the total costs of ambulatory and hospital care; savings on administration and billing (about 10 percent of current health spending)¹ would approximately offset the costs of expanded services.^{19,20} Indeed, current low hospital-occupancy rates suggest that the additional care could be provided at low cost. Similarly, many physicians with empty appointment slots could take on more patients without added office, secretarial, or other overhead costs. However, the expansion of long-term care (under any system) would increase costs. The experience in Canada suggests that the increased demand for acute care would be modest after an initial surge^{21,22} and that improvements in health planning⁸ and cost containment made possible by single-source payment⁹ would slow the escalation of health care costs. Vigilance would be needed to stem the regrowth of costly and intrusive bureaucracy.

Unsolved Problems

Our brief proposal leaves many vexing problems unsolved. Much detailed planning would be needed to ease dislocations during the implementation of the program. Neither the encouragement of preventive health care and healthful life styles nor improvements in occupational and environmental health would automatically follow from the institution of a national health program. Similarly, racial, linguistic, geographic, and other nonfinancial barriers to access would persist. The need for quality assurance and continuing medical education would be no less pressing. High medical school tuitions that skew specialty choices and discourage low-income applicants, the underrepresentation of minorities, the role of foreign medical graduates, and other issues in medical education would remain. Some patients would still seek inappropriate emergency care, and some physicians might still succumb to the temptation to increase their incomes by encouraging unneeded services. The malpractice crisis would be only partially ameliorated. The 25 percent of judgments now awarded for future medical costs would be eliminated, but our society would remain litigious, and legal and insurance fees would still consume about two thirds of all malpractice premiums.²³ Establishing research priorities and directing funds to high-quality investigations would be no easier. Much further work in the area of long-term care would be required. Regional health planning and capital allocation would make possible, but not ensure, the fair and efficient allocation of resources. Finally, although insurance coverage for patients with AIDS would be ensured, the need for expanded prevention and research and for new models of care would continue. Although all these problems would not be solved, a national health program would establish a framework for addressing them.

Political Prospects

Our proposal will undoubtedly encounter powerful opponents in the health insurance industry, firms that do not now provide health benefits to employees, and medical entrepreneurs. However, we also have allies. Most physicians (56 percent)

support some form of national health program, although 74 percent are convinced that most other doctors oppose it.²⁴ Many of the largest corporations would enjoy substantial savings if our proposal were adopted. Most significant, the great majority of Americans support a universal, comprehensive, publicly administered national health program, as shown by virtually every opinion poll in the past 30 years.^{25,26} Indeed, a 1986 referendum question in Massachusetts calling for a national health program was approved two to one, carrying all 39 cities and 307 of the 312 towns in the commonwealth.²⁷ If mobilized, such public conviction could override even the most strenuous private opposition.

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This proposal was drafted by a 30-member Writing Committee, then reviewed and endorsed by 412 other physicians representing virtually every state and medical specialty. A full list of the endorsers is available on request. The members of the Writing Committee were as follows: David U. Himmelstein, M.D., Cambridge, Mass. (cochair); Steffie Woolhandler, M.D., M.P.H., Cambridge, Mass. (cochair); Thomas S. Bodenheimer, M.D., San Francisco; David H. Bor, M.D., Cambridge, Mass.; Christine K. Cassel, M.D., Chicago; Mardge Cohen, M.D., Chicago; David A. Danielson, M.P.H., Newton, Mass.; Alan Drabkin, M.D., Cambridge, Mass.; Paul Epstein, M.D., Brookline, Mass.; Kenneth Frisof, M.D., Cleveland; Howard Frumkin, M.D., M.P.H., Philadelphia; Martha S. Gerrity, M.D., Chapel Hill, N.C.; Jerome D. Gorman, M.D., Richmond, Va.; Michelle D. Holmes, M.D., Cambridge, Mass.; Henry S. Kahn, M.D., Atlanta; Robert S. Lawrence, M.D., Cambridge, Mass.; Joanne Lukomnik, M.D., Bronx, N.Y.; Arthur Mazer, M.P.H., Cambridge, Mass.; Alan Meyers, M.D., Boston; Pauick Murray, M.D., Cleveland; Vicente Navarro, M.D., Dr.P.H., Baltimore; Peter Orris, M.D., Chicago; David C. Parish, M.D., M.P.H., Macon, Ga.; Richard J. Pels, M.D., Boston; Leonard S. Rodberg, Ph.D., New York City; Jeffrey Scavron, M.D., Springfield, Mass.; Gordon Schiff, M.D., Chicago; Isaac M. Taylor, M.D., Boston; Howard Waitzkin, M.D., Ph.D., Anaheim, Calif.; Paul H. Wise, M.D., M.P.H., Boston; and William Zinn, M.D., Cambridge, Mass.

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Kenneth S. Apfel joined the faculty of the LBJ School of Public Affairs at the University of Texas at Austin in January 2001. His major teaching and research interests are in the areas of social policy and public leadership and management, with a particular focus on aging, health care and retirement issues.

Prior to his academic appointment, Apfel served as Commissioner of the Social Security Administration (SSA) from 1997 until his term ended in January 2001. He was the first Senate-confirmed Commissioner of Social Security after SSA became an independent agency and the Cabinet-level position was authorized by Congress.

During his tenure as Commissioner, Apfel was deeply involved in efforts to strengthen the long term solvency of Social Security. He significantly strengthened the policy, planning and public education activities at the Social Security Administration. He also played a leadership role in efforts to strengthen childhood disability programs, to expand retirement planning activities and to enable persons with disabilities to return to work. In addition, he served from 1997 to 1999 as a member of the President's Management Council.

Before becoming Social Security Commissioner, Apfel worked in the Office of Management and Budget (OMB) in the Executive Office of the President, where he served from 1995 to 1997 as the Associate Director for Human Resource Programs. Prior to that appointment he served from 1993 to 1995 as Assistant Secretary for Management and Budget at the U.S. Department of Health and Human Services.

From 1983 to 1993, Apfel worked for Senator Bill Bradley, as Bradley's Legislative Director and his chief staff person for federal social and budget policy, with a particular focus on the Social Security, Medicare, Medicaid, and welfare programs under the jurisdiction of the Senate Finance Committee. Between 1980 and 1982, Apfel was committee staff for human resource programs for the U.S. Senate Budget Committee. From 1978 to 1980, he held a Presidential Management Internship at the U.S. Department of Labor. He was a college administrator from 1973 to 1976 at Newbury College in Massachusetts.

Apfel received his bachelor's degree from the University of Massachusetts, Amherst, in 1970; a Master's degree in rehabilitation counseling from Northeastern University in 1973; and a Master's degree in public affairs from the LBJ School of Public Affairs in 1978. He is a Principal of the Council for Excellence in Government and an elected Fellow of the National Academy of Public Administration and the National Academy of Social Insurance.

Judy Feder, Ph.D.

*Dean of Policy Studies, Georgetown University
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Judy Feder is Professor and Dean of Public Policy at Georgetown University. Under her leadership, Georgetown's Public Policy Institute (GPPI) draws on the University's academic excellence and the extraordinary resources of the nation's capital to train highly skilled and committed policy professionals (about 85 graduates each year) for leadership positions in private firms; federal, state, and local government (including the District of Columbia); and nonprofit organizations. Feder is also a senior scholar at Georgetown's Institute of Health Care Research and Policy, where she continues the health policy research that has made her a national expert.

Feder is one of the nation's leaders in health policy—most particularly, in efforts to understand and improve the nation's health insurance system. A widely published scholar, her three decades of policy research began at the Brookings Institution, continued at the Urban Institute, and, since 1984, has flourished at Georgetown University. Her expertise on the uninsured, Medicare, Medicaid, and long-term care is regularly drawn upon by members of Congress, Executive officials, and the national media.

Feder has also held leadership policy positions, both in the Congress and in the Executive Branch. As staff director of the congressional Pepper Commission (chaired by Senator John D. Rockefeller IV), Feder is widely credited with setting the stage for the health reform debate of the 1990s. She became a key actor in that debate, as a senior official in the Clinton Administration. In her three years as Principal Deputy Assistant Secretary at Health and Human Services, Feder helped shape the Administration's health care policy, working intensively with members of Congress and with the national media to promote the expansion of health care coverage.

Feder today pursues her policy leadership as senior advisor to the Kaiser Family Foundation's Commission on Medicaid and the Uninsured; co-director (with Sheila Burke) of Kaiser's Incremental Health Reform Project and of Robert Wood Johnson's Long-Term Care project; member of the board of the Academy of Health Services Research and Health Policy and the editorial boards of health policy journals; and member of the National Academy of Public Administration and the National Academy of Social Insurance. Feder is a political scientist, with a B.A. from Brandeis University (1968) and a Master's (1970) and Ph.D. (1977) from Harvard University.

Betty Sue Flowers, Ph.D.

Director, Lyndon Baines Johnson Library and Museum

Betty Sue Flowers, Ph.D., has degrees from the University of Texas and the University of London. She was appointed Director of the Lyndon Baines Johnson Presidential Library and Museum in 2002, and was Kelleher Professor of English and a member of the Distinguished Teachers Academy at the University of Texas at Austin before that. She is also a poet, editor, and business consultant, with publications ranging from poetry therapy to the economic myth, including four television tie-in books

in collaboration with Bill Moyers, among them, *Joseph Campbell and the Power of Myth*. She hosted “Conversations with Betty Sue Flowers” on the Austin PBS-affiliate, KLRU, and has served as a moderator for executive seminars at the Aspen Institute for Humanistic Studies, consultant for NASA, member of the Envisioning Network for General Motors, Visiting Advisor to the Secretary of the Navy, and editor of Global Scenarios for Shell International in London and the World Business Council in Geneva (on global sustainable development and, most recently, on the future of biotechnology).

Paul Fronstin, Ph.D.

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Paul Fronstin is a senior research associate with the Employee Benefit Research Institute (EBRI), a private, nonprofit, nonpartisan organization committed to original public policy research and education on economic security and employee benefits. He is also Director of the Institute’s Health Security and Quality Research Program. He has been with EBRI since 1993. Dr. Fronstin’s research interests include trends in employment-based health benefits, consumer-driven health benefits, the uninsured, retiree health benefits, employee benefits and taxation, and public opinion about health care. He currently serves on the steering committee for the Mellon College Retirement Project, the board of advisors for CareGain, and on the Maryland State Planning Grant Health Care Coverage Workgroup. Dr. Fronstin earned his Bachelor of Science degree in economics from SUNY Binghamton and his Ph.D. in economics from the University of Miami.

Randall L. Johnson

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Director of Human Resources Strategic Initiatives, Motorola

Randy Johnson assumed the role of Director of Human Resources Strategic Initiatives at Motorola in 2001 with responsibility for representing Motorola regarding human resources legislation and regulations in both Washington, D.C., and state governments. In this role, he serves as the spokesperson for Motorola on human resources matters such as health care, education, Social Security and Medicare reform, retirement plans, compensation and stock programs, flexible workforce, and immigration.

Prior to 2001, he served as Director of North America Rewards, with responsibility for retirement, health care and insurance benefits planning, development, and marketing of Motorola benefits programs covering 70,000 employees in the United States and Canada. He has been a leader in the installation of Motorola’s Health Advantage Program, the “stigma-free” Mental Health/Chemical Dependency Program, Centers of Distinction, and Healthy Quality of Life Programs—customer-designed programs and networks designed based on input from Motorola’s employee and provider community.

He has also been a leader in the development and implementation of Horizons 2000, Motorola's approach to retirement and investment programs, which includes the 401(k)/Profit Sharing Plan, the Motorola Portable Pension Plan, MOTshare (a discounted stock purchase program), and "Take Charge of Your Financial Future," a customized financial planning program.

He is Vice Chairman of the ERISA Industry Committee (ERIC) Board of Directors, and serves on the ERIC Retirement Committee and Health Policy Committee, of which he is the Chairperson; and is a member of the American Benefits Council (ABC) Board of Directors, Retirement Policy Committee, of which he is the Chairperson, and the Health Care Policy Committee. He also served eight years on the Profit Sharing Council of America Board of Directors. He has testified before the Employer-Employee Relations Subcommittee of the House Economic and Educational Opportunities Committee, the Department of Labor, and the Internal Revenue Service on both health care and retirement plan proposal legislation and regulations.

He has served on the WorldatWork Board of Directors. He served on its Benefits Committee in 1992 when the WorldatWork (then the American Compensation Association) established its Certified Benefits Professional Program. He currently serves as an instructor in WorldatWork health care and retirement seminars.

He also recently served as Board of Directors' Chairperson of New Moms, a Chicago-based organization providing services to homeless and teenage new mothers and their families. He also served on the Board of Michigan HMO Plan in the mid-1970s. Previously, he was with Northwest Industries, Inc. and Manufacturers Bank in Detroit. He is a graduate of the University of Wisconsin.

Ruben Jose King-Shaw, Jr.

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Ruben Jose King-Shaw, Jr., is currently Senior Advisor to the Secretary for Health Initiatives at the Department of the Treasury. He previously served as the Deputy Administrator/COO for the Centers for Medicare and Medicaid Services, formerly known as the Health Care Financing Administration. In this capacity, he was responsible for the day-to-day direction of Medicare, Medicaid, Child Health Insurance Programs, Survey and Certification of health care facilities, and other health care initiatives.

Prior to his position at the Centers for Medicare and Medicaid Services, Mr. King-Shaw was the Secretary of the Florida Agency for Health Care Administration. He has an extensive background in health care management, having served as Chief Operating Officer of the Neighborhood Health Partnership; Senior Vice President of the New Ventures division of John Alden Health, Inc.; and Director of the JMH Health Plan. Mr. King-Shaw also has been active in international health issues. He led a delegation of state health officials to Panama in 1999 at the request of Panama's President Moscoso and consulted with the government of South Africa's Western Cape Province and with governmental representatives from Jamaica and Haiti.

Mr. King-Shaw received a Master's of Health Services Administration from Florida International University; Master's of International Business from the Center for International Studies in Madrid, Spain; and Bachelor of Science degree in Industrial and Labor Relations from Cornell University. He resides in Potomac, Maryland, with his wife and two daughters.

Amanda McCloskey

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Amanda McCloskey is the Director of Health Policy for Families USA, a nonprofit, nonpartisan consumer advocacy organization. In her work with Families USA, Amanda conducts research and policy analysis on the Medicare program, prescription drug prices and coverage, and other issues of importance to American's most vulnerable populations. Prior to joining the staff at Families USA, Amanda spent seven years at AARP in the Office of Legislative Counsel and with the AARP Public Policy Institute. While at AARP she was involved in policy development and advocacy on a broad range of health and long-term care issues, including Medicare, Medicaid, and nursing home quality. Amanda has also worked for the National Governors' Association and the Kaiser Commission on the Future of Medicaid where she conducted research on state and federal issues related to improving health insurance coverage of low-income and uninsured populations. Amanda holds a Master's of Health Science degree in Health Policy from Johns Hopkins University.

James A. Morone, Ph.D.

Professor of Political Science, Brown University

James Morone is Professor of Political Science at Brown University. Morone's first book, *The Democratic Wish*, won the Political Science Association's Kammerer Award for the best book on the United States and was named a "notable book of 1991" by the *New York Times*. His most recent book, *Hellfire Nation: the Politics of Sin in American History* (published by Yale University Press) was nominated for a Pulitzer prize. Morone has written over 100 articles about American politics, history, and health care policy. He has testified before Congress many times and has won multiple grants including two Investigators' Awards from The Robert Wood Johnson Foundation. He was a secretary and member of Governor Cuomo's task force on *Universal Health Care for All New Yorkers* and has served in leadership positions in numerous national associations. Morone recently co-edited *Healthy, Wealthy and Fair: Health Care for a Good Society* (published by Oxford University Press) and is on the editorial board of several scholarly journals. He is a founding member of the health section of the National Academy of Social Insurance. Morone received a B.A. from Middlebury College and a Ph.D. from The University of Chicago.

Nina Owcharenko

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Nina Owcharenko is a Policy Analyst for health care at The Heritage Foundation. In this position, Owcharenko researches and writes on all aspects of health care policy, from the debate over the “Patients’ Bill of Rights” to Medicare reform. Before coming to Heritage, Owcharenko served as the legislative director for Rep. Jim DeMint, R-SC, and Rep. Sue Myrick, R-NC. She also worked for Sen. Jesse Helms, R-NC.

Owcharenko received her bachelor’s degree in political science from the University of North Carolina-Chapel Hill in 1994. Originally from Charlotte, North Carolina, Owcharenko now lives in Alexandria, Virginia.

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Edwin Park is a Senior Health Policy Analyst at the Center for Budget and Policy Priorities, focusing on Medicaid, the State Children’s Health Insurance Program, and expanded coverage for the uninsured. He also conducts analysis on tax policies related to health care, low-income Medicare beneficiaries, and prescription drugs. Prior to coming to the Center, he served as a health policy advisor for the National Economic Council in the Clinton Administration. He also has worked as a Medicaid professional staff member for the Senate Finance Committee minority staff of Senator Daniel Patrick Moynihan and as an attorney in private practice focusing on health law. He has a law degree from Harvard Law School and an A.B. from Princeton University’s Woodrow Wilson School of Public and International Affairs.

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Mark V. Pauly currently holds the positions of Bendheim Professor and Chair of the Department of Health Care Systems. He received a Ph.D. in economics from the University of Virginia. He is Professor of Health Care Systems, Insurance and Risk Management and Business and Public Policy, at the Wharton School, and Professor of Economics in the School of Arts and Sciences at the University of Pennsylvania. Dr. Pauly is a former commissioner on the Physician Payment Review Commission and an active member of the Institute of Medicine.

One of the nation’s leading health economists, Dr. Pauly has made significant contributions to the fields of medical economics and health insurance. His classic study on the economics of moral hazard was the first to point out how health insurance coverage may affect patients’ use of medical services. Subsequent work, both theoretical and empirical, has explored the impact of conventional insurance coverage on preventive care, on outpatient care, and on prescription drug use in managed care. He is currently studying the effect of poor health on worker productivity. In addition, he has explored the influences that determine whether insurance coverage

is available and, through several cost-effectiveness studies, the influence of medical care and health practices on health outcomes and cost. His interests in health policy deal with ways to reduce the number of uninsured through tax credits for public and private insurance, and appropriate design for Medicare in a budget-constrained environment. Dr. Pauly is a co-editor-in-chief of the *International Journal of Health Care Finance and Economics* and an associate editor of the *Journal of Risk and Uncertainty*. He has served on Institute of Medicine panels on public accountability for health insurers under Medicare and on improving the supply of vaccines.

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Cathy Schoen is vice president for health policy, research, and evaluation and has oversight responsibilities for the Commonwealth Fund's survey work and programs on health care coverage and access. She also serves as the executive director of the Fund's Task Force on the Future of Health Insurance. Previously, Ms. Schoen was director of special projects at the University of Massachusetts Labor Relations and Research Center and on the research faculty of the UMASS School of Public Health. During the 1980s, she directed the Service Employees International Union's Research and Policy Department in Washington, D.C. Earlier, she served as a member of the staff of President Carter's national health insurance task force and as a senior health advisor during the 1988 presidential campaign. Prior to federal service, she was a research fellow at the Brookings Institution. She holds an undergraduate degree in economics from Smith College and an M.A. in economics from Boston College. She is the author and coauthor of many publications on health care coverage and quality issues.

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Professor Warner has served as a consultant to a number of organizations in the health sector, and for six years was a member of the Board of Directors of Austin's Brackenridge Municipal Hospital. In addition, he was Chairman of the Texas Diabetes Council from January 1985 to December 1989. He has also served on several editorial and advisory boards and been appointed to other state level advisory committees.

At the LBJ School, Professor Warner has directed policy research projects on a variety of health and mental health topics. Among his publications are *Toward New Human Rights*, more than forty articles and book chapters, and sixteen books, monographs, and policy research project reports. He is currently working

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Alan Weil directs the Assessing the New Federalism project at the Urban Institute. This project, the largest in the Institute's 34-year history, monitors, describes, and assesses the effects of changes in federal and state health, welfare, and social services programs. Mr. Weil was formerly executive director of the Colorado Department of Health Care Policy and Financing—the cabinet position responsible for Colorado's Medicaid and Medically Indigent programs, health data collection and analysis functions, health policy development, and health care reform. He was also health policy adviser to Colorado Governor Roy Romer, program director of the Colorado Children's Campaign, and legal counsel to the Massachusetts Department of Medical Security. He holds a bachelor's degree in economics and political science from the University of California at Berkeley, a Master's of public policy degree from the John F. Kennedy School of Government at Harvard, and a J.D. from Harvard Law School.

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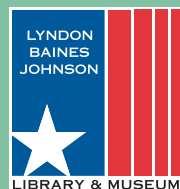
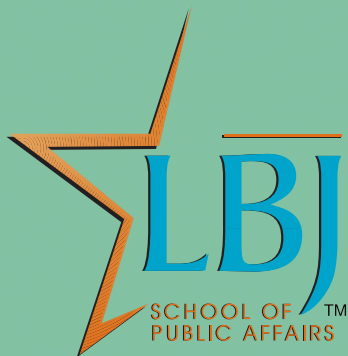
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