



Health Policy Reports

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EXPANDING INSURANCE COVERAGE: ARE THE OPTIONS REALLY OPTIONS?

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The previous article in this series (1) examined the fundamental complexities of expanding health insurance coverage to the almost 40 million Americans who are uninsured. In this follow-up piece, we will discuss – in general terms – several of the options that have been proposed.

WHAT IS A SUCCESSFUL OPTION?

An initial issue is to determine the criteria by which a proposal to expand coverage should be assessed. Feder (2) proposes three questions to establish the success of an option to expand coverage. First, “will the resources allocated to the new program be targeted to people who lack insurance?” This, as discussed in the previous paper(1), emphasizes *efficiency* (that is, the proportion of people who receive assistance from the new program that are uninsured), rather than *effectiveness* (that is, the number of people without insurance who will gain insurance with the new program).

The second question is, “will the new program be sufficient to assure adequate health care?” This assesses, for example, whether or not an insurance program’s payment rates are adequate for clinicians to care for covered patients; a new program may purport to offer services but provide insufficient reimbursement so that no providers participate. In addition, as discussed later in this article, financial subsidies intended to facilitate the purchase of insurance may not be large enough to make policies, in reality, affordable.

And the third question asks, “will the new program disrupt coverage for those who are already covered?” For example, a new program may make it more difficult for employers who already offer coverage to their employees to continue to do so. A new program may thus expand coverage to some but take it away from others.

WHAT ARE THE CHOICES?

Many programs have been put forward for expanding insurance coverage. They may be categorized into five groups (3,4). All are based upon existing models and structures of insurance coverage and reflect incremental changes (5) in these already functioning programs.

Programs may *expand incentives for individuals* to purchase health insurance. These seek to overcome the current financial and administrative obstacles that individuals without access to employer-based or public insurance face. Options include, as examples, providing tax deductions or tax credits to individuals who purchase health insurance to reduce the net cost of coverage; establishing private purchasing pools to spread risk over a larger population and to, thereby, reduce costs; and changing insurance regulations to limit or eliminate risk selection to make individual coverage more accessible.

Other reforms rely upon *expansion of public programs*. These options seek to cover the uninsured by opening existing, and generally effective, public programs to new groups of the uninsured. These include offering the Federal Employee Health Benefit [FEHB] program to non-government employees, thereby providing numerous options for coverage at relatively low cost; expanding Medicaid and State Children's Health Insurance Program (SCHIP) to include new groups of uninsured; and permitting people not normally eligible for public programs to "buy-in" to these programs by paying actuarially established premiums.

A third group of programs increase *incentives for employers* to offer coverage to their employees. Currently, only 55.5% of employers in Tennessee offer health insurance to their employees. Options designed to increase this percentage may be based on providing federal tax credits to employers who participate; offering public subsidies to employers for their contributions; allowing employers to buy-in to public programs at lower costs; or mandating employer offerings through "pay or play" rules, that is, employers would be required to either offer adequate coverage for their employees or pay into a pool to provide public coverage for them.

Fourth, programs may be designed to *impact specific groups*. These programs generally represent politically-sensitive populations. Groups that may be targeted include the pre-Medicare population; parents of children already covered by SCHIP; and those moving from job to job or in and out of the workforce.

Finally, new efforts may focus on *enrolling the many uninsured who are eligible* for current programs. It is estimated that three-fourths of the children and one-third of adults in New York state are uninsured and eligible for coverage (6). Reasons why they are not enrolled will be considered in a subsequent article in this series.

WILL THEY WORK?

These options may be evaluated based on the criteria proposed by Feder (2). Two proposals will be considered as examples. Consider, first, approaches based on tax policy changes that would provide tax deductions to individuals without access to employer-sponsored or public coverage who purchase individual insurance policies. These options build on current policies that provide over \$75 billion in tax benefits to employed and self-employed workers who purchase coverage but that provide nothing for the unemployed who wish to do so. These approaches would thus promote coverage by expanding equity within the present tax system.

This conceptually appealing and logical concept scores poorly on the evaluation criteria. The number of uninsured who would be impacted is limited because 80% of the uninsured are already employed and 40% do not pay income taxes because of their low income levels. Those who do not pay taxes would not receive benefits (unless tax credits were made refundable).

The amount of the benefit would also be unlikely to make private insurance affordable and accessible. The lower a person's income, the less able he or she is to make up the difference between cost of insurance and the subsidy. And most of the uninsured are poor or "near poor." This is, as described by Feder et al (2), like "extending a 10 foot rope to people trapped in a 40 foot hole." Tax incentives would favor those with higher income, more of whom already have coverage, lowering program efficiency.

Finally, tax-based subsidies to individuals may encourage employers to reduce their contribution to health insurance. This would substitute public dollars for private ones (a form of "crowd-out" to be considered in a later paper). Subsidies may also encourage young and healthy employees to shift from employer coverage to the non-group market, leaving behind a sicker group in the employer-sponsored plans – raising the costs of coverage to employers and remaining employees. These higher costs would then reduce coverage of the employed.

A quantitative analysis (7) of these issues has demonstrated the limited impact tax-based programs would have on the uninsured. Consider, as an example, a nonrefundable tax credit of \$1000 to individuals (or \$2000 for a family) with full subsidies going to individuals with incomes under \$15,000 (or under \$30,000 for families) and decreasing in amounts until individual incomes reach \$30,000. This would provide benefits to 10.1 million people. However, only 30% (3.0 million) were previously uninsured (a low efficiency), representing only 8% of the 38.3 million uninsured (a low effectiveness). In addition, 1.4 million people would lose their current insurance as employers shift coverage to individual or public sources. Thus, only 1.6 million people would gain health insurance.

Even this estimate may be optimistic. Many would be unable to get insurance in the private market (8) and a \$1,000 subsidy may be insufficient to make individual coverage affordable. Data suggests that, for a 55 year man in good health, only half can purchase a policy for under \$2184 (9). If they could get, it would cover only 42% of expected health care costs. Thus, many who may become insured will remain significantly "underinsured."

Proposals to expand employer-sponsored insurance encounter similar obstacles. These options would be useful to the 80% of uninsured who are members of working families, especially those with steady jobs and in families with multiple employers. This program is based on evidence that most employers who do not offer health insurance consider it too expensive (10). Here, too, the Feder criteria (2) predict problems. Almost 60% of people who would be eligible for employer-subsidy programs are already insured, reducing efficiency. Large subsidies would be needed to produce even modest increases in coverage. In a simulation by Reschovsky and Hadley (11), a 30% reduction in premium cost to employers with fewer than 50 employees would be needed to increase the percent of employers offering insurance from 40% to 46%. The number of uninsured workers in these firms who actually gain coverage would be only 500,000.

WHERE DO WE GO FROM HERE?

This brief discussion suggests two contradictory conclusions. First, options for expanding insurance coverage are numerous and are rooted in the existing health care finance system. Second, the complex and highly variable nature of the uninsured population and the complex structure of the U.S. healthcare system makes these options relatively ineffective and inefficient in addressing the core issue.

This seeming paradox is a direct result of the highly fragmented nature of the U.S. healthcare finance system. Numerous independent options exist for specific subsets of the population, resulting in overlapping coverage for some and no coverage for many others. Manipulating one program without compensatory changes in others, as suggested by the options described here, leads to little overall improvement.

Rather, the answer seems to be only in a comprehensive reform of the health finance system, including (but not limited to) the insurance coverage options and a commitment in this redesign of assuring adequate

and appropriate coverage to all. This outcome would reduce, if not eliminate, the conflicts between overlapping and competing programs described here.

Of course, such an outcome is not likely, even after decades of trying. We are destined to continue in our path of incremental change. Given this apparent inevitability, it is important to not let “best become the enemy of better.” That is, while it is important to recognize the shortfalls among the options for expanding coverage, it is equally important to recognize the benefit that even small increments in coverage provide to those in need. Doing better is better than doing nothing at all!

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