

Making Work Pay II

Comprehensive Health Insurance for Low-Income Working Families

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New Safety Net Paper 2

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MAKING WORK PAY II

Comprehensive Health Insurance for Low-Income Working Families

While employment has never been a guarantee of health insurance, the link between employment and health insurance has weakened, particularly for low-income families. Between 2000 and 2005, the number of uninsured Americans grew by 6 million. Most of this growth was among low-income working families (Clemans-Cope, Garrett, and Hoffman 2006). Limited access to public insurance for these families, especially for adults, combined with the limitations of private, individually purchased insurance leave many modest-income workers and their family members without access to affordable, adequate health insurance.

Strategies for addressing low-income working families' health care needs must take account of the weaknesses of private markets as currently structured, the gaps in the public insurance system, and the pressures of health care costs rising far faster than incomes. Below we outline such a strategy—a systematic approach for expanding health insurance coverage and ensuring consistent coverage for all income and employment groups and for all life-cycle transitions.

Impacts of Being Uninsured

Health insurance provides an important financial support to families struggling to cover daily living expenses. This support is particularly important for low-income families, which are more likely to have members in fair or poor health than are higher-income families, as shown in table 1 (Bloom, Dey, and Freeman 2006; Pleis and Lethbridge-Çejku 2006).

Table 1. Prevalence of Uninsurance and Fair or Poor Health by Family Income

<i>Family income as a percent of the federal poverty level</i>	<i>Percent of working families with at least one member uninsured</i>	<i>Percent of working families with at least one member in fair or poor health</i>	<i>Percent of working families with at least one member uninsured AND at least one member in fair or poor health</i>
< 150%	52.84	20.70	11.07
151–200%	41.59	18.32	7.27
201–250%	33.11	19.58	6.63
251–300%	25.51	17.16	4.69
301–401%	17.92	16.34	2.72

Source: Medical Expenditure Panel Survey, 2003–05.

Low-income families are also less likely than better-off families to have assets to use to buffer unexpected health care costs; thus, low-income families are more likely to forgo care or to get hit with medical bills that they cannot pay (McKernan and Radcliffe 2008). Also, insured people have access to better or more timely health care, whether for acute illnesses such as heart attacks or chronic conditions such as hypertension or diabetes. Access can affect outcomes, leaving the uninsured at higher risk of mortality for any given condition (Hadley 2003). This risk is of particular concern for low-income families as they have a higher-than-average incidence of many health problems.

Finally, health insurance coverage is an important support for low-income families because poor health reduces annual earnings, an effect that can operate both through reduced labor force participation or through a reduced hourly wage. Reviewing studies of poor health’s effect on earnings, Hadley concludes that “‘fair or poor health,’ due to either a disability, a serious chronic condition, or general self-assessment, is associated with a 15 percent to 20 percent reduction in annual earnings. Most of the reduction appears to come from lower labor force participation and work effort” (2003, 60S).

While access to health insurance might particularly benefit low-income working families, systemic reforms that help only this group discourage such families from increasing their earnings if doing so jeopardizes guaranteed access to affordable health insurance. Gaps in access to coverage in today’s private markets—particularly for those with above-average health care needs—can produce tremendous discontinuities in insurance access if family income is too high to qualify for public insurance. In addition, it is not politically feasible to redirect current funding for uncompensated care toward financing a new, more efficient system of coverage unless everyone is brought into the system. Without universal coverage, safety net providers will insist that current streams of funding for uncompensated care continue flowing.

Accordingly, the reforms we describe to aid low-income families are part of a comprehensive reform aimed at continued access to affordable health insurance coverage as families’ and individuals’ income grows. If politics dictate that comprehensive reform be phased in, it would be best to implement the components for low-income people first.

The Magnitude of the Uninsurance and Access Problem

The share of nonelderly adults in low-income working households who lacked health insurance increased from 39 percent to 43 percent during the 2000 to 2005 period; for children, nearly 15 percent remained uninsured at the end of this period, though their rate of uninsurance declined relative to the beginning of the decade (table 2). Behind these statistics lie falling rates of employer-sponsored insurance (ESI) coverage, public programs’ emphasis on children instead of on all who need help, and limitations of the private nongroup insurance market.

Table 2. Insurance Status of Low-Income Children and Adults in Working Families, 2000–05

	Children (0–17)			Adults (18–64)		
	2000	2005	Percent change	2000	2005	Percent change
Uninsured	21.3	14.8	-6.5**	38.6	42.8	4.2**
Nongroup	1.3	0.4	-0.9*	2.2	1.4	-0.8*
Public	35.0	53.1	18.1**	11.1	13.0	1.9*
ESI	38.3	28.2	-10.1**	43.5	37.2	-6.3**
Other	4.1	3.4	-0.7	4.6	5.5	0.9
Unweighted sample size	4,712	7,700		5,928	9,480	

Source: Medical Expenditure Panel Survey. Data for 2000 are drawn from a sample of data from 1999 and 2000; data for 2005 are drawn from a sample of data from 2004 and 2005.

Note: Low-income working families have incomes below 200% of FPL and have at least one adult in the health insurance unit working at an establishment.

* Difference is statistically significant at the $p < .05$ level.

** Difference is statistically significant at the $p < .01$ level.

Low-Wage Workers Are Less Likely to Have Access to Employer-Sponsored Insurance

About half of children living in low-income families had no access to employer-sponsored insurance in 2005 (Clemans-Cope et al. 2007). Public insurance covers many children whose parents do not have ESI, but many parents remain uninsured. In fact, in low-income working families without an ESI option, children are twice as likely—and parents are nearly three times as likely—to be uninsured as their counterparts in families offered this insurance.

Among employers with more than 50 percent of workers in low-wage jobs, only 41.5 percent offered health insurance to at least some of their workers in 2005, compared with 63 percent in establishments with less than 50 percent of workers in low-wage positions.¹ Even if a low-income worker’s employer sponsors ESI for some employees, low-income workers are less likely to be eligible to enroll because of short job tenure, part-time status, job classification, and so on. Fifty-five percent of employees with family incomes below the federal poverty level (FPL) have no access to ESI; among those with incomes between 100 and 200 percent of FPL, 35 percent lack access. Employees higher up the income distribution fare much better: only 13 percent of families with incomes between 200 and 400 percent of FPL and 4 percent of those above 400 percent of FPL have no access to ESI (Clemans-Cope et al. 2006).

Low-Wage Workers Are Less Likely to Take ESI When Their Employers Offer It

Even low-income workers with access to ESI may find the required premium contributions unaffordable. Among ESI-offering firms whose workforces are more than half low-wage, the average employee contribution to a single policy in 2005 was \$840. For family coverage, this figure was \$3,049.²

High prices depress take-up rates among eligible low-income families offered ESI. In 2005, only 64 percent of such workers with family incomes below the federal poverty level took up the offer, compared with 84 percent of workers with incomes above 400 percent of FPL (Clemans-Cope et al. 2006). The relationship between the share of the premium that workers must contribute and the rate of take-up is direct and negative (Kaiser Family Foundation 2007b). Also, low-income (below 200 percent of FPL) families’ decisions to take up ESI offers are more than twice as sensitive to the out-of-pocket premium price as those of average-income families (Blumberg, Nichols, and Banthin 2001). Thus, a given increase in the worker’s share of the premium lowers take-up of health insurance coverage most among low-income families.

Public Insurance and Private Nongroup Insurance Only Partially Fill the Gap Left by Declining ESI

ESI coverage for low-income adults fell from 44 percent in 2000 to 37 percent in 2005 (see table 2). For children in these families, it fell from 38 percent to 28 percent during the same period. Meanwhile, ESI for those with family incomes above 400 percent of FPL remained high and essentially unchanged.

Especially for children, public insurance has filled some of the gaps as ESI for low-income families has declined. While public insurance eligibility rates for children have been constant from 2001 to 2005, take-up of public insurance for children has been growing during the same period (Hudson and Selden 2007). The share of low-income children in working families enrolled in public insurance increased by 18 percentage points during this period, more than offsetting the 10 percentage point decline in ESI (see table 2).

Public program eligibility is much more limited for low-income working adults, however. According to Davidoff, Yemane, and Adams (2005), just 29 percent of low-income uninsured adults qualified for public coverage in 2002. Public coverage for adults rose by just 2 percentage points, far short of offsetting the 6 percentage point decline in ESI (see table 2).

Private nongroup insurance decreased modestly over the five years studied, so it did not compensate for the ESI declines. Given the inherent weaknesses of the current private nongroup insurance market, it is unrealistic to expect it to be a greater part of the solution. The high administrative costs of individually purchased plans make the price of given benefits significantly higher than under an ESI policy. Beyond that, because adverse selection is most severe in this market, nongroup insurers work hard to protect themselves from the risks that come with attracting high-cost enrollees. Most states allow private insurers in these markets to deny coverage outright based on current or past health status, to refuse to cover specific conditions or body parts, to charge higher premiums to enrollees with current or past health problems, and/or to limit some applicants' choice of plans. The private nongroup markets are thus very small and generally do not provide guaranteed sources of insurance coverage, let alone affordable guaranteed sources, especially for people with above-average health care needs, a group disproportionately represented among low-income families.

Out-of-Pocket Financial Burdens Can Be Extremely Large, Even for the Insured

Health insurance premiums are only part of the financial burden of health care. Out-of-pocket spending—including deductibles, coinsurance, copayments, and care that insurance companies do not reimburse—can also weigh heavily on low-income families, particularly if they are also paying premiums. Typically, different sources of coverage (e.g., public versus private, employer versus nongroup) have different out-of-pocket spending liabilities, and those with significant health care needs may face much higher burdens than healthier counterparts with the same type of coverage. Thus, out-of-pocket financial liabilities may limit low-income families' access to necessary medical care, even for those with insurance.

Public insurance and ESI can provide very different protection against high health care costs for low-income families. According to Zuckerman and Perry (2007), families with incomes below 150 percent of FPL spend 13 percent of their income on health care (including premiums and other out-of-pocket spending) if their children are privately insured³ but less than 5 percent if their children are publicly insured. Even for families in the next-highest income group (between 150 and 250 percent of FPL), the burden is still significantly higher for private insurance (8 percent of income) than for public insurance (4 percent).

Annual out-of-pocket financial burdens vary due to differences in health status, medical need, and benefit packages, even for workers with continuous ESI. For example, median out-of-pocket costs for families with full-year ESI total roughly 3 percent of income for those between 100 and 200 percent of FPL (Blumberg et al. 2007). However, at the 95th percentile of the distribution for that group, out-of-pocket medical costs consume 27 percent of family income, not counting direct premium contributions. For those with full-year private nongroup insurance, median out-of-pocket medical spending accounted for 11 percent of income for

families between 100 and 200 percent of FPL; the burden at the 95th percentile was 41 percent of income. Clearly, policymakers and analysts trying to define affordability need to consider these extraordinary burdens, not just out-of-pocket burdens at the mean or median of the distribution.

In sum, uninsurance among low-income families is a large and growing problem. Its implications for low-income families' economic well-being, health, and productivity are huge and could include inadequate care for those who need it most, financial hardship, and even bankruptcy. The current patchwork of employer-based insurance, private nongroup insurance, and public programs simply is not enough to meet these families' needs.

Setting Goals

To best serve the health insurance needs of low-income working families, a system affording access to adequate, affordable health insurance to all Americans is essential. Targeting narrower groups—whether by income strata or family type—will engender inequities and discontinuities in coverage as income, employment, and family situations fluctuate. Such targeting could also discourage work.

Phased health care reform could begin with coverage for low-income people, but that emphasis ignores the breadth of the uninsurance problem and the reach of difficulties caused or exacerbated by medical care's high costs. More than a third of uninsured Americans live in families with incomes above 200 percent of FPL. Ignoring their coverage problems would leave at least 16 million people uninsured now—and more later—absent government intervention. A system limited strictly to the low income could also stymie efforts to move individuals and families out of poverty or near-poverty if economic advancement is at the expense of adequate affordable health insurance. As already-high health care costs grow, the middle class too faces heavier financial burdens on, and constricted access to, care. And in all income classes, Americans with expensive-to-treat health conditions may find getting private insurance coverage increasingly hard.

Without a fully government-financed system that automatically covers everyone, the only path to universal health insurance coverage is through an individual mandate—a requirement that all individuals obtain at least an established minimum level of coverage. Besides resulting in health insurance for all, this approach also allows policymakers to better deal with the complexities of adverse selection and to redirect current spending on the uninsured to help finance reforms.⁴ From an equity perspective, an individual mandate could not be imposed on low-income people alone. But such a requirement also cannot be imposed universally without guaranteed access to affordable insurance coverage; only broad-based reform can make that a reality.

Given these practical and political constraints, we propose a comprehensive reform of today's health care system, one that would address low-income families' needs along with those of low-income individuals without children, middle-income individuals and families, and individuals of all incomes with high health care needs. If politics requires phasing in such a comprehensive system gradually, step one would be structuring a guaranteed source for purchasing health insurance coverage and making subsidized coverage available to all low-income individuals and families voluntarily. Once those systems and structures are in place and low-income people are enrolled, the purchasing pools can be opened up to higher-income individuals and employers, and an individual mandate can be added.

In constructing a comprehensive reform package, we aim to maintain the structure of the existing system—particularly the availability of employer-sponsored insurance plans as a primary source of insurance coverage. We make maintaining the involvement and primacy of private plans a priority as we believe it is the most politically feasible approach to reform at present.

A key policy decision is what level of health care expenditures will be considered affordable for families and how that threshold should vary with family income. We define affordability in terms of total health care

spending (including premiums paid by the worker plus co-payments, deductibles, and coinsurance). The lower individual/family contribution requirements are, the greater the perception that reform is affordable, and the greater the likelihood of voluntary participation in the program. The trade-offs are higher government costs and greater income redistribution to finance them.

Suggested Reform Option

Our approach—based on a policy option developed by Holahan, Nichols, and Blumberg (2001)—focuses on the insurance needs of the nonelderly. (Medicare would continue to be maintained as a separate program.) The approach has five central features:

1. Create state-based purchasing pools to provide guaranteed issue health insurance to any individuals and employers that choose it. These pools would incorporate current nonelderly Medicaid beneficiaries, SCHIP enrollees, and state employees.
2. Use income-related subsidies for premiums and out-of-pocket costs to make comprehensive health insurance coverage *offered within the purchasing pools* affordable to all.⁵
3. Pay premium subsidies to plans in the purchasing pools to offset the excess risk they face with any adverse selection of enrollees. These subsidies would be structured to offset total actual spending by the enrollees that exceeds the total expected costs under the same plan if all nonelderly individuals in the state were enrolled.
4. Once the previously described components of the plan are in place, implement an individual mandate. Alternatively, the system can be phased in by first developing the purchasing pools, opening the pools up to the low-income population (those with incomes at or below a defined threshold—say, 200 percent of FPL), and providing income-related subsidies. Some risk-related subsidies are likely to be needed at this initial stage as well. Later, the purchasing pools would be opened to the higher-income population, the additional risk-related subsidies added, and the individual mandate implemented.
5. Phase in cost-containment strategies as the system is implemented and moves toward universal coverage.

Implementing this comprehensive reform will require policymakers to make a host of administrative decisions. Examples include which methods to use to verify income for determining eligibility for subsidies, how income will be defined to determine program eligibility, how and how often to reverify eligibility; how to structure purchasing pools and their administration, and how to enforce the mandate. Detailed discussion of these choices is beyond the scope of this paper, but such treatments are available elsewhere on an array of reform topics.⁶

State-Based Purchasing Pools: A Guaranteed Source for Purchasing Coverage

The current U.S. health care system offers no guarantee that individuals will be able to find a vendor to sell them a health insurance policy, even if they can afford one. Individuals who are ineligible for public coverage and do not work for a firm that offers ESI may find themselves stranded if the nongroup insurers in their state will not insure an individual with their particular health profile—age, disease history, and so on. While many states operate high-risk pools that sell coverage to individuals denied insurance in private plans due to health status, these pools have their limitations too. Pools vary by state in size, eligibility rules, benefits provided, premium pricing, waiting periods, and exclusions for preexisting conditions. But all have very limited funding to support assistance for the high-cost population they serve. As a result, only about 180,000 people were covered by high-risk pools in 2005, and more than half of that enrollment was in just four states—Minnesota, Texas, Wisconsin, and Illinois (Abbe 2005). Our plan would guarantee insurance access for all through government-run purchasing pools that include current nonelderly Medicaid beneficiaries, children and others enrolled in SCHIP, and state employees.

Each state would design a purchasing pool to afford all individuals access to insurance coverage. States would be free to design the purchasing pool and its benefit packages, within broad federal guidelines. States could contract with private plans to cover those in the purchasing pool, could develop their own self-funded plan, or both. At least one option in the pool would have to be comprehensive coverage, and the low-income subsidies (detailed below) would be set to make that coverage affordable for low- and moderate-income people.

While no individual would be required to purchase coverage in the purchasing pool, coverage purchased elsewhere would not be subsidized. Families that qualify for subsidies and have ESI offers would use their employer’s contribution to offset the subsidy’s cost to government—an extension of current nondiscrimination laws. Insurance market regulations outside the purchasing pool would be unaffected, and employers and individuals could continue purchasing coverage outside the pools if they so choose.

State participation in the new program would be voluntary, but the financial incentives for participating would be very strong. Presumably, just as all states eventually opted in to the Medicaid and SCHIP programs, all would opt in to this reform program. Participating states would receive the higher SCHIP federal match for all purchasing pool enrollees eligible for public subsidies and for all residual Medicaid expenditures, including long-term care. Since SCHIP’s federal matching contribution is roughly 30 percent higher than Medicaid’s, a major coverage expansion would cost the state relatively little.

The larger the state’s purchasing pool, the greater bargaining power the pool would have when negotiating with insurance plans or providers. Cost-containment strategies (discussed below) could also be most effectively implemented in larger pools. With a few standardized benefit packages in the pool, consumers would find comparison shopping much easier than it is now.⁷

Outside the purchasing pools, the insurance business would remain virtually unchanged. Its regulatory environment would not tighten unless an insurer chose to participate in the purchasing pools, where products offered, rating rules, data requirements, and marketing guidelines are determined by federal and state policymakers and pool administrators.

Government Subsidies: Making Coverage Affordable for the Modest-Income Population

To significantly expand coverage or require low-income individuals to obtain it requires significant government subsidies. The high cost of medical care and the limited reach of current private markets make unsubsidized insurance unaffordable to substantial segments of the low-income population and those with high health care needs. Either individuals or their employers could be subsidized, but subsidizing employers is far less efficient at reaching the right people and much less likely to engender new insurance policies (Blumberg and Holahan 2007). Thus, our preferred approach is to subsidize individuals directly.

Using the affordability analysis done by Blumberg and colleagues (2007) as a guide, we have developed the following guidelines for health care spending relative to income (table 3):

Table 3. Income-Based Subsidy Schedule

<i>Family income as a percent of the federal poverty level</i>	<i>Total individual/family payment cap (premiums plus out-of-pocket spending)</i>
0–150%	0% of family income
151–200%	6% of family income
201–250%	8% of family income
251–300%	10% of family income
301–400%	12% of family income

Under these guidelines, states would have some flexibility in setting subsidy schedules; however, required family contributions relative to income could not exceed the federal ceilings outlined in table 3.

Table 4 shows the maximum financial burdens (in dollars) for two typical families choosing to purchase insurance coverage through the subsidized insurance pool. Once families had spent more than this amount on health care in a given year, they would make no further payments that year.

Table 4. Financial Burdens under Reform

<i>Family income as a percent of the federal poverty level</i>	<i>Maximum dollar burden for family of three</i>	<i>Maximum dollar burden for family of four</i>
0–150%	0	0
151–200%	2,060	2,478
201–250%	3,434	4,130
251–300%	5,151	6,195
301–401%	8,282	9,912

Source: 2007 HHS Poverty Guidelines, *Federal Register*, Vol. 72, No. 15 (January 24, 2007), pp. 3147–48, available at <http://aspe.hhs.gov/poverty/07poverty.shtml>.

Note: The 2007 federal poverty level for a family of three living in the 48 contiguous United States is \$17,170; for a family of four, it is \$20,650.

Government Premium Subsidies: Addressing the Complexities of Adverse Selection

Because coverage inside the purchasing pool would be comprehensive⁸ and guaranteed, the pool plans could attract enrollees with higher-than-average health care costs. This adverse selection would be offset partly by attracting into the pool low- and moderate-income individuals eager to take advantage of the income-related subsidies. In other words, subsidies would attract the healthy along with the unhealthy and change the ratio of low-cost to high-cost enrollees. Even so, to spread the costs of admitting high-cost enrollees as broadly as possible, plans would be fully compensated for excess costs related to adverse selection.

Premiums charged to enrollees in the purchasing pool plans would be set at a statewide community rate—set by figuring out what premiums would cost if all the nonelderly in the state were enrolled.⁹ The difference between actual costs and this community rate would be the risk subsidy, paid by government and financed through a broad-based progressive tax. In this way, all taxpayers would share the cost of financing medical care for those with the greatest health care needs according to the ability of each to pay, not according to whether a taxpayer happened to obtain health insurance from a particular source or at a particular time. If high-cost people join the purchasing pool, as expected, the costs of private insurance premiums in plans outside the purchasing pool should fall since the average person insured this way would be healthier than is the case today.

Individual Mandate

Once the system of purchasing pools and subsidies is up and running, states and the federal government could set up mechanisms for implementing and enforcing an individual mandate. Because the voluntary system is subsidized, it will attract both low-income and high-cost populations, so the marginal cost to government of imposing the individual mandate would be relatively small. Without a mandate, some individuals will remain free-riders who will not obtain coverage until they anticipate a medical need. The political pressure for government to reimburse providers who care for the uninsured under the current system would remain powerful unless universal coverage for the target populations was guaranteed. Indeed, without an individual mandate, redirecting current public spending on care for the uninsured to help finance new subsidies would be extremely difficult.

Cost-Containment Strategies: Maintaining the Long-Term Viability of Reform

Together, rapid annual growth in health care spending and pressures from all sides on state and federal government budgets make the long-term viability of comprehensive health care reform dependent on effective cost containment. Generally, that means reducing payments to providers or reducing health care use by those who need it most. Reducing use among those at the low end of the spending distribution will not appreciably curb overall spending; 70 percent of the total is for the highest 10 percent of recipients, while only 3 percent goes to the lowest 50 percent (Berk and Monheit 2001). Meanwhile, effective cost-containment mechanisms that do not degrade care are hard to identify and design.

Possible cost-cutting reforms include promoting managed care through purchasing pools, managing high-cost cases to promote cost-effective care, investing in cost-effectiveness analysis for both existing and emerging technologies and treatment regimes, expanding and synchronizing electronic record-keeping systems, purchasing pharmaceuticals and medical devices collectively to negotiate lower prices, and reforming the structure and level of provider payments. Each approach has both advocates and detractors with political support, and reliable evidence on these strategies' potential impacts is very limited. That said, we propose making certain promising cost-containment strategies part of implementing comprehensive reform. We suggest formal and ongoing evaluation of cost-containment strategies to determine best practices and ascertain whether modifications to these strategies are appropriate.

Possible Funding Sources

Current federal and state spending for health care and health insurance can be reallocated to help implement our proposal or any other major reform package. If individuals are to be required to purchase health insurance, payments to hospitals who serve disproportionate shares of uninsured and Medicaid-insured residents (Disproportionate Support Hospital, or DSH, payments) can be converted to subsidies for insurance for low-income people or used to increase payments to Medicaid providers. Similarly, some states have funding pools for offsetting losses by health care providers and hospitals that care for the uninsured. These so-called uncompensated care pools can be redistributed as more of a state's population becomes insured. Until the individual mandate is in place, however, providers that benefit now will naturally oppose any reallocation of these dollars.

The remaining cost of comprehensive reform can be funded through increased taxes, but the distributional burden on low-income families would have to be taken into account. Provider taxes are one option, though providers could charge all purchasers of health care services more to offset the tax. Sales taxes tend to be regressive since low-income individuals spend more of their income than do higher-income families. Income taxes can be targeted to fall more heavily on any particular segment of the income distribution or levied proportionately across all income levels to reflect political or equity considerations, or both. Alternatively, a value-added tax, or VAT, could be created as a dedicated health care financing source. However, VATs too tend to be regressive. Currently, tax subsidies for ESI reduce income and payroll tax receipts—by as much as \$200 billion in fiscal year 2007 (Burman 2007). Eliminating this subsidy and redirecting the savings could finance broad-based health care reform but would also decrease employers' incentive to continue providing health insurance to their workers directly. While the purchasing pools and subsidies proposed here would make a substantial decline in employer-provided coverage more practical, strong political opposition from organized labor and others probably makes it infeasible in the near term.

The appropriateness of the financing burdens for all these approaches should be considered in conjunction with the distribution of the benefits and the distribution of the impacts of any other changes to the tax code. Here we presume that health care for the targeted groups would be financed largely by a progressive income tax and, once an individual mandate is in force, by the redirection of current public spending.

Coverage and Cost Impact Estimates

The most effective way to estimate the coverage and cost implications of comprehensive insurance reforms is to use a microsimulation model. A model that allows for the various agents acting in insurance markets (employees, self-employed, nonworkers, employers, insurers) to respond to new coverage options and incentives based on their own preferences and objectives can best capture the interactive effects of such complex changes to the insurance landscape. While such a simulation exercise is beyond the scope of this paper, we use results from earlier microsimulations (Holahan et al. 2003 and Blumberg et al. 2006) to roughly estimate the cost and coverage implications of our proposed approach.

Table 5. Rough Estimates of Net Changes in Government Costs and the Number of Uninsured under Reform, with and without Mandate (2008 dollars)

		<i>Full reform</i>	<i>Incremental reform</i>
Net change in the uninsured ^a		-46,700,000	-18,180,000
Net new government costs (state plus federal)	Income subsidies	\$148 billion	\$48 billion
	High-risk subsidies	\$54 billion	\$1 billion

^a Baseline number of uninsured is based on counts of the uninsured for 2006 (Kaiser Family Foundation 2007a).

Drawing on related microsimulation modeling, documented growth in per capita health care spending, and data on the target populations, we estimate the net cost of implementing the proposed comprehensive reform in table 5. The bottom line shows state and federal funds required to finance the reform less most of the spending on Medicaid and SCHIP acute care for the nonelderly under the current system (since these programs would largely be subsumed under the new approach). All estimates are based on a reform fully phased in in 2008 and reflect the cost of making a comprehensive benefit package that includes mental health and dental benefits available through the purchasing pool. Although for political reasons many reform proposals exclude noncitizens from access to new sources of subsidized insurance coverage, our estimates include them to both avoid the political hurdle of trying to redirect money currently used for uncompensated care and lessen persistent citizenship-related inequities in the health care system.

Our estimates suggest that the comprehensive reform with an individual mandate would cost \$202 billion in new government spending, with approximately 73 percent of that total (\$148 billion) attributable to income-related subsidies and the remaining \$54 billion to subsidies to cover the additional costs associated with those with high medical expenses.

Our estimates also suggest that the purchasing pools would be attractive for small employers currently offering health insurance to their workers because administrative costs would be lower and risk sharing higher than in today's private markets. Conversely, large employers would be more likely to continue to offer coverage to their workers outside the purchasing pools since large self-insured plans have lower administrative costs than purchasing pools do and since large firms already have enough enrollees over which to spread the high costs of the relatively small number of workers with above-average health care needs.

If it is politically expedient to implement our approach incrementally, we suggest first structuring the state-based purchasing pools and making coverage and subsidies within those pools available to a narrow income group—say, those at or below 200 percent of the federal poverty level¹⁰—and initially excluding those with higher incomes, even without subsidies. We would also suggest admitting the nonelderly Medicaid in acute care and the SCHIP populations into the pools at this time. This approach avoids potentially significant adverse selection problems in the pool and saves government the costs of risk-related subsidies to the higher-income population.

As further public financing becomes available, the pools and the income-related and risk-related subsidies could be opened up to higher-income populations.

Following the more incremental approach and limiting eligibility to those with incomes at or below 200 percent of FPL would, we estimate, reduce the number of uninsured by slightly more than 18 million people, or 60 percent of the uninsured in that income group. The estimated net government cost is approximately \$49 billion a year.

Conclusion

Low-income working families have experienced significant declines in employer-sponsored insurance coverage in recent years, and no evidence suggests that the trend will reverse. Coverage is declining both because smaller shares of employers are offering insurance and because smaller shares of workers are taking up available offers—reflections of increasing health care costs and decreased affordability. Since eligibility for public programs is limited, particularly for the adults in these families, and since most states have no guaranteed source of individually purchased private insurance (let alone a guaranteed source of affordable and adequate insurance), these declines in employer coverage have driven up the number of uninsured.

Low-income working families without insurance coverage are at increased risk for tremendous financial burdens and lack of access to necessary medical care. And while the largest increases in the numbers of uninsured have been among the low-income population, higher-income people are also facing coverage declines, especially if they have health conditions that are costly to treat or manage. Today's coverage and affordability gaps cannot be addressed without comprehensive reform, including subsidies for low-income people and, ideally, those in poor health. A system focused only on accessibility and affordability for low-income families could create a perverse incentive, forcing them to pass up opportunities to earn more out of fear that they would lose affordable health insurance if they did. Thus the system recommended here addresses the needs of modest-income families, remains accessible and affordable to low-income families moving up the economic ladder, and does not discriminate against those with greater medical care needs.

Reforms that meet all these criteria are costly, as the rough estimates of our proposed reforms suggest. But, for perspective, consider that the current income tax exemption for employer-sponsored insurance cost roughly \$200 billion in 2007. This badly targeted health care subsidy costs the government roughly the amount needed to effect comprehensive reform.

NOTES

¹ From Medical Expenditure Panel Survey, Insurance Component (MEPS-IC), 2005 National Level Summary Tables, table A.1.2. Available at http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables.jsp.

² MEPS-IC, 2005, tables I.C.2 and I.D.2.

³ Insurance status in this paper is defined based on full-year insurance coverage of the children in the family. Mixed insurance coverage among children is defined as a separate group.

⁴ For a full discussion of these issues, see Blumberg and Holahan (2008).

⁵ Some wraparound benefits for certain Medicaid beneficiaries will probably be necessary.

⁶ For example, see Blumberg and Holahan (2008) and Blumberg, Bovbjerg, and Holahan (2005) on individual and employer mandates; Berenson (2005) on cost containment; Wicks (2005) on purchasing pools; and Weil (2005) on tax credits to subsidize the cost of coverage.

⁷ See Wicks (2005) for a discussion of purchasing pool implementation issues under reform.

⁸ In the event that coverage inside the pool represented a benefit cut for Medicaid beneficiaries, wraparound coverage could be provided.

⁹ Some states might choose to use statewide modified community rates as opposed to pure community rates. The federal government could require that premium variation be limited to no more than a specified range.

¹⁰ Cost estimates assume that individuals already eligible for Medicaid would be brought into the new system with those newly eligible under this incremental reform.

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