

COMMENT ON “MAKING WORK PAY II”

Jack A. Meyer
Health Management Associates

The paper by Perry and Blumberg carefully, objectively, and concisely assesses the nature, magnitude, and causes of the problem of the uninsured in the United States. It also offers a very comprehensive yet practical plan for covering the uninsured. By building on the current system, at least initially, while addressing its key flaws, this plan has a very real chance of succeeding, and should be given serious consideration by political leaders with a wide range of views about how to cover the uninsured.

Perry and Blumberg have provided an important answer to the intense debate over whether health reform to cover the uninsured requires an individual mandate. Their essay strengthens my belief that this is not a question with a “yes or no” answer but rather a “when” answer. Achieving universal or near-universal coverage will at some point require everyone to obtain coverage. But an individual mandate is best left out of the *initial phase* of a reform plan.

The reason is not just pragmatic politics. Politics aside, it is unrealistic and unfair to require everyone to buy coverage before we have done both the architectural work and the full construction job of erecting and testing the new purchasing pools featured in their plan and the sliding scale subsidy arrangements needed to assure affordability.

Our knowledge of how to design and refine subsidies so they perfectly compensate people for both lack of income and higher health risks is not sophisticated enough to simply put an untested plan in place and require everyone to get insurance. Wherever subsidies phase out, some people just above that line would be required to get coverage but would struggle to afford it. This is turning out to be an important challenge in Massachusetts, which in April 2008 started imposing the “light” version of the penalty for remaining uninsured (the cost of a personal exemption from the state income tax, or \$219) and will next April begin imposing the “heavier” penalty (half the cost of the lowest-cost plan in the Connector).

New figures from Massachusetts illustrate this point. In the subsidized system, CommCare, enrollment grew quickly and now constitutes 176,000 people, exceeding projections. Similarly, large numbers of people are

newly enrolled in public programs as a result of the 2006 legislation. Yet, in CommChoice, the unsubsidized portion of the program, enrollment was only 17,000 in March 2008, and over 300,000 people in the state remain uninsured. Over time, more people will come into CommChoice, particularly as the penalty for noncompliance rises. But as it turns out, substantial numbers of people in Massachusetts in the middle-class range and above have not been convinced that health insurance is a good deal and are hanging back.

Against this backdrop, and similar challenges that hampered health reform proposals in California, I would like to suggest that the authors consider a different approach to assuring affordability for people with serious medical conditions. Perry and Blumberg call for creating a new set of insurance rules *within* the purchasing pools (e.g., guaranteed issue) while allowing current, and usually quite different, state risk rating and other rules to continue in force *outside* the pools. They acknowledge that this will lead to adverse risk selection against the purchasing pools but rely on the risk-adjustment of subsidies to compensate health plans for enrolling a disproportionate share of high-risk people.

The current state of knowledge about how to make risk-adjustment of premiums work is sufficiently weak to make this a risky strategy. Using such techniques as guaranteed issue or adjusted or full community rating of premiums within the pools, while allowing full medical underwriting outside the pools, is a prescription for massive risk selection. Neither strategy Perry and Blumberg employ—risk adjustment and allowing only lower-income people to get coverage through the pools initially—would be likely to avert, though they may mitigate, an upward spiral of premiums within the pools and cream-skimming in private markets.

A better approach would be to establish insurance market reforms to ensure that rules limiting the variance in premiums among different age, gender, and health risk groups be the same in private markets as they are within the pools.

Perry and Blumberg have no requirement in their reform plan for employers to offer coverage or contribute to the cost of subsidies through fees. While this might soften some political opposition from the business community, it gives non-offering firms a free ride and puts more pressure on public financing in an environment where federal deficits seem continuous. Employer coverage is likely to eventually wither away under the reform plan Perry and Blumberg propose, albeit at a somewhat slower pace than under various types of pay-or-play plans. But the authors have no way to capture employer dollars, while the pay-or-play plans do. Of course, all roads lead back to the consumers' wallet anyway, as employer contributions will likely be shifted back to workers to a large extent. But under a pay-or-play system, the business contribution, in one form or another, is locked in, which reduces the amount of new government spending required.

Perry and Blumberg should also consider the likelihood that it will be harder to move funds from the support of the safety net into coverage than many think, even with a fully phased-in reform plan. Hospitals, for example, worry about the serious distributional effects of trading DSH money for coverage. More important, even with comprehensive and near-universal coverage, there may be a need for some elements of Medicaid to remain and wrap around the new benefit package, particularly for minorities, immigrants, and others facing serious barriers to access.