

COMMENT ON “MAKING WORK PAY II”

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The topic could not be more important to upcoming health policy debates. The paper is well-written and argued, and will make important contributions to that debate, and so I wholeheartedly applaud Perry and Blumberg at the outset. My comments are aimed at highlighting what I think are the most important contributions of the paper and at strengthening the core proposal elements against questions and critiques that might be leveled at the authors from less sympathetic readers.

First, the praise.

1. The paper describes the realities of low-income family access to affordable health insurance and health care very well. Even many policy wonks are unaware of what fraction of low-income individuals is ineligible for public insurance and yet lacks access to employer-sponsored insurance, even if individuals could afford the latter. It is helpful and good to emphasize and to spread awareness of these data.
2. The paper’s policy proposal itself is comprehensive and spans mechanisms for expanding coverage, integrating existing programs (e.g., Medicaid/SCHIP) into the new system, and articulating proper roles for individuals, employers, and governments at various levels. It also makes clear the need for systemic cost growth containment over time. The paper thus joins an elite but growing group of proposals that speak of “health reform” as far more than just financing shifts to cover the uninsured, though the best continue to include that bedrock goal.

The affordability rules/guidelines in tables 3 and 4 are a major contribution to the upcoming debate and will hopefully become widely used benchmarks for discussions in the future. I note they are based on Perry and Blumberg’s previously published objective analysis of what people spend today as well as their values-based judgment, which balances the impulse to help the low income while being realistic about the scale of subsidies our larger society might be willing to finance. To be blunt, these guidelines are extremely helpful and the authors’ articulation of them manifests great courage. Many are not acquainted with the facts about what people pay now for health insurance and care, and they therefore are sometimes unaware of policies that might be *both* extremely helpful to low-income families and politically feasible.

Now for things that can be strengthened.

1. The benefit package rules within the new pool may leave more room for debilitating risk selection than Perry and Blumberg intend. As I read the proposal, a comprehensive plan is *one* option, but by no means the only one for insurers to offer. Nor is there an actuarial value target (e.g., 90 percent of Blue Cross/Blue Shield standard within the Federal Employees Health Benefits Program) to anchor variable packages and make cross-plan risk adjustment far easier. If there is evidence of successful risk-adjustment across plans of widely varying actuarial values, then cite it and teach me and others. Not allowing subsidies outside the pool, and allowing employee choice to, in effect, bring their employer's dollar contribution to the pool, would help with de facto cross pool risk adjustment, I agree. But I worry that allowing plans to be sold with lower actuarial value than the benchmark plan would drive subsidy costs up. The "actuarially fair" premium for the comprehensive plan's enrollees—pre-risk adjustment—could be much higher than that of less generous plans, since the latter would naturally attract the healthiest enrollees. Any low-income person with a serious health condition would choose the generous plan, and with imperfect risk adjustment there might be melding of income subsidy and risk selection effects built into what seemed like a "fair" premium inside the pool for the comprehensive plan. The "excess risk" subsidies in Perry and Blumberg's plan then become something like icing on the comprehensive insurers' cake. I suggest considering an actuarial value target for benchmark plans within the pool, and then it will be easier to separate, I think, excess risk from income-based subsidies as the authors see fit.
2. Offering states the SCHIP matching rate for all subsidized individuals plus long-term care implies a lot of federal dollars replacing current state dollars, which I agree is a worthy, and probably politically savvy, goal. Still, even with this, I fear the net state budget hit of the program for states with lots of uninsured as a percentage of the population (California, Texas, New Mexico, and Florida come to mind) will be very large and make them reluctant to join the parade. Also, the provider payment rate increases implicit in moving from Medicaid to the new (private insurance provider rate schedule) purchasing pool would represent a major gain to providers while reducing the net new coverage bought per net new federal dollar injected into the subsidy stream. Maybe the authors have done more math here than the statement "microsimulation is beyond the scope of this paper" implies, but I would encourage the authors to think very hard about state heterogeneity in percent uninsured, the salience of long-term care, and provider payment rates before finalizing this part of the proposal. Maybe that is why and how Perry and Blumberg arrived at the SCHIP match offer in first place, but if so, I would encourage the authors to be a bit more explicit about that, just to reassure states that the net impact is indeed positive.
3. Leaving insurance rules as current law outside the pool with new and different rules inside the pool, as the authors well know, makes risk selection across the pools a big risk. I worry they may need more compulsion to make sure insurers sell inside the pool (if they want to sell outside, for example). By leaving the current federal tax preference for employer premium payments in place, I would guess large firms and high-wage small firms (e.g., law firms, etc) will stay out, at least initially, so the non-risk-bearing third-party administrator business may look better to many insurers than does competing for low-income and state employees in a guaranteed issue/community rating environment. Subsidizing the plans inside the pool that attracts higher-than-average risk will surely help, but I worry that the aggregate subsidy cost of this approach—income-based premium subsidies for people plus excess risk subsidies for unlucky plans within the pool—will cost a lot more than straight income-based subsidies in "normal" and simpler plans. One cannot avoid "giving" money away to plans/insurers/employers who remain outside the pool as they benefit from watching sicker people—with individual choice—gravitate inside the pool in search of subsidies of one kind or another. It would seem to me that the "excess risk" subsidy bill is likely to be proportional to the risk-based reduction in premiums outside the new pool. So in effect what is being proposed is to substitute explicit risk subsidies inside the pool for implicit risk spreading in the current group insurance market. Now since Perry and Blumberg would finance the excess risk subsidies with progressive taxation, their ideal proposal is potentially more fair than today's world, but (a) they might not win the battle about *how* to finance new subsidies of this magnitude and (b) they should be more explicit about what is being shifted here and why it is a good idea, *assuming* the authors get progressive

financing. At a minimum, in the tables on net cost of the program's elements, it would be instructive to include an estimate of how much the authors expect premiums outside the pool to fall (per person) and how much this does or does not offset the excess risk subsidy bill the new proposal would entail. At a minimum, this might help build the analytic case for some of the progressive tax increases that will be required to finance the program.

4. I strongly encourage Perry and Blumberg to include more citation, evidence, and discussion of potential cost growth–saving interventions. I think we know more than is commonly asserted. The Commonwealth Fund's recent paper on *Bending the Curve*, with estimates of a package of cost savings done by the Lewin Group; the Rand team's piece in *Health Affairs* on what a fully functioning electronic records system—with realigned payment incentives and better comparative effectiveness information—could save us over time; the ongoing work by the Dartmouth team on unscientific medical practice variation; the sustained promising results out of North Carolina's Medicaid Medical Home model; and Alan Garber's work at Stanford, Steve Pearson's at AHIP, and Sean Tunis' for the California HealthCare Foundation on comparative effectiveness all suggest that there is real—not just unknown—potential. Peter Orszag of CBO has recently sanctioned this view in his testimony and analysis of some comparative effectiveness proposals in Congress. It will not be easy to redirect and recapture savings, but lots of folks are now on the case, and some highly motivated big buyers (e.g., Wal-Mart, ERIC, CED, Pacific Business Group on Health, Intel, etc.) are clamoring at the gates. So there's more room for optimism, in my view, than the current impact estimates imply.
5. I encourage Perry and Blumberg to consider capping the current tax exclusion of employer premium payments, both to raise money and to facilitate the transition to their new system wherein all buy within the pools. A related point, I was bothered by the comparison of the cost of the proposal to the current cost of the tax exclusion, since the authors end up recommending to leave the current tax exclusion in place. Thus they are not saving the tax exclusion money to pay for their program, they are spending new money on top of the current tax exclusion. If Perry and Blumberg end up leaving the tax exclusion alone, then I think the proper “offset” to their new program costs is the IOM's estimate of the social cost of uninsurance, roughly \$60–120 billion in 2001, which my colleagues at New America recently updated to be between \$102 and \$204 billion in 2006 (http://www.newamerica.net/files/Cost_Of_Failure.pdf).
6. Finally, as the authors and others close to current health reform discussions know, the immigration issue is potentially a major stumbling block for those of us trying to expand coverage in 2009–10. Thus, I think we need to be a bit more nuanced about the implications of excluding immigrants and safety net providers' willingness to forgo DSH in exchange for proposals that would cover all Americans only. The paper's statements are surely true in high-illegal immigration states—California, Texas, Florida, and others—but perhaps not so much in many, maybe most states. The larger point is, the federal government will have to play a larger role in safety net support in states with high immigrant populations, if we are to get those states' agreements to embrace proposals like this one. I would recommend including explicit discussion of state heterogeneity on immigration in the paper. This issue highlights one more reason that state-specific tailored solutions—under federal guarantees and floors, of course—are essential in the real world with real politics.