OPTIONS FOR IMPROVING & EXPANDING HEALTH INSURANCE

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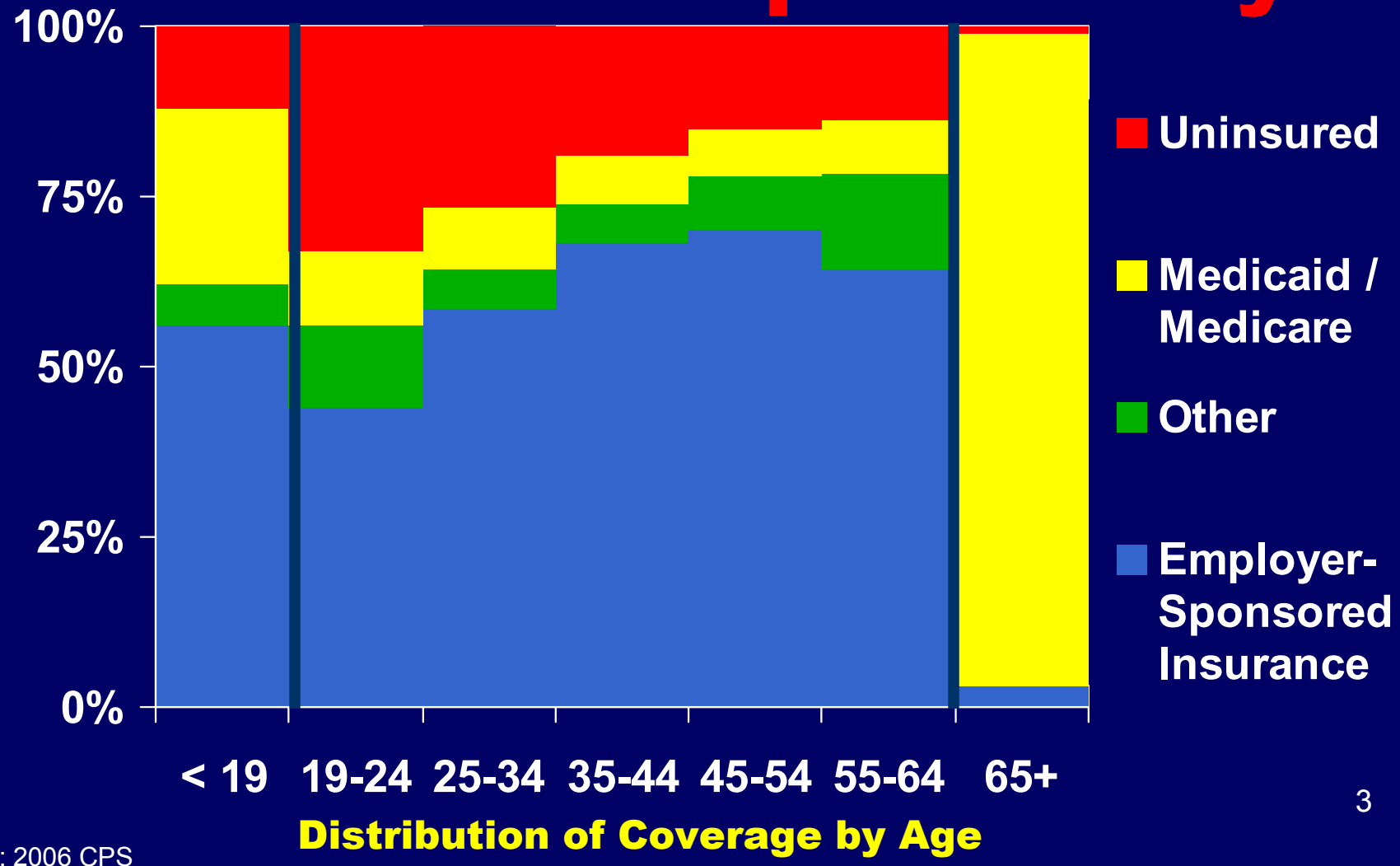
OUTLINE

- Review of the Problem
- Targeted Expansions
- Indirect Approaches
- Considerations
- Reasons for Optimism

REVIEW OF THE PROBLEM

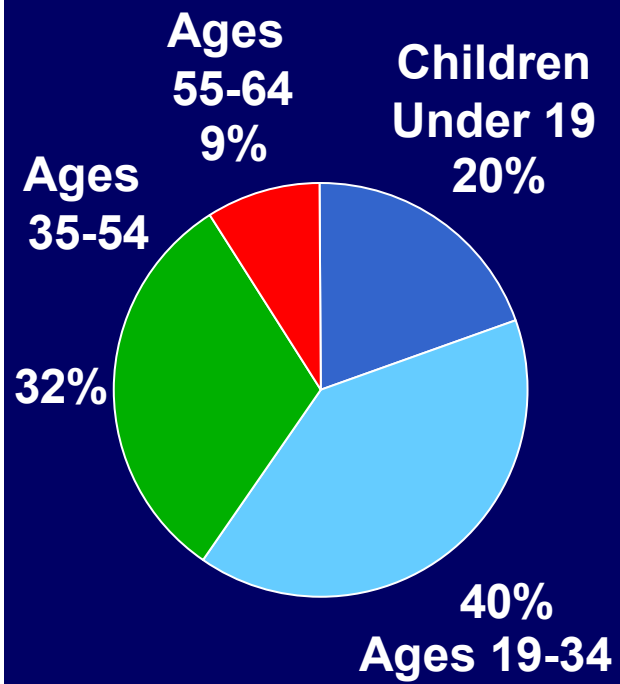
Baseline: Complex System Demands Complex Policy



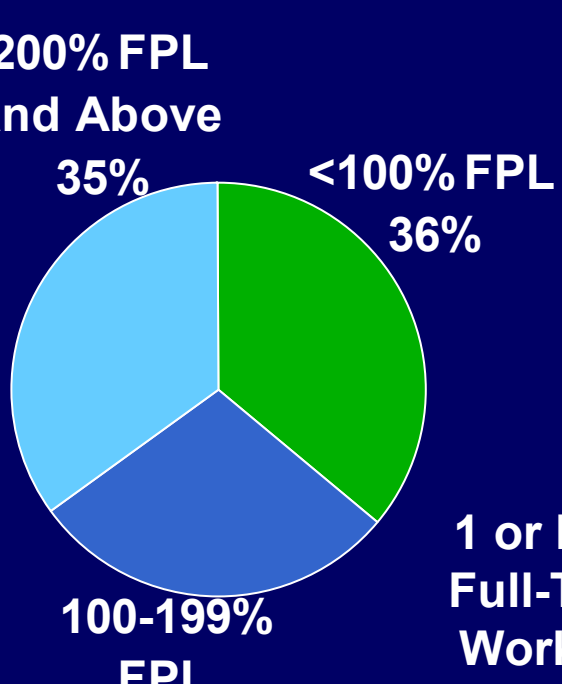
Source: 2006 CPS

Characteristics of the Uninsured, 2005

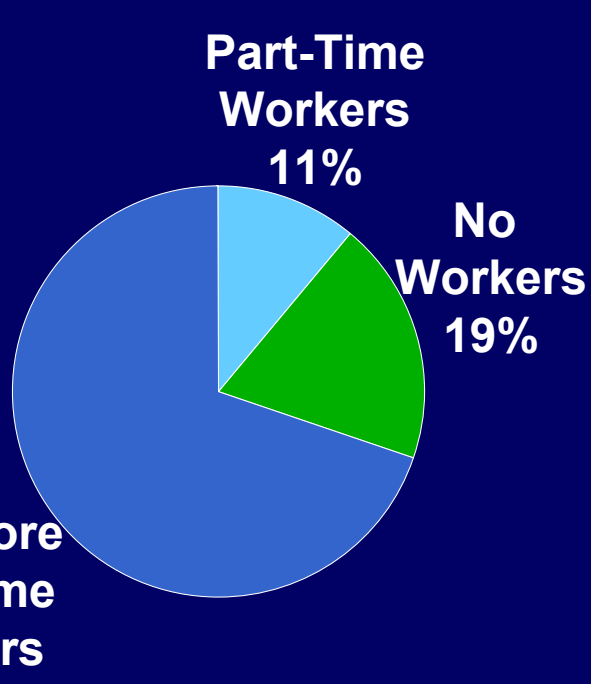
Age



Income



Work Status

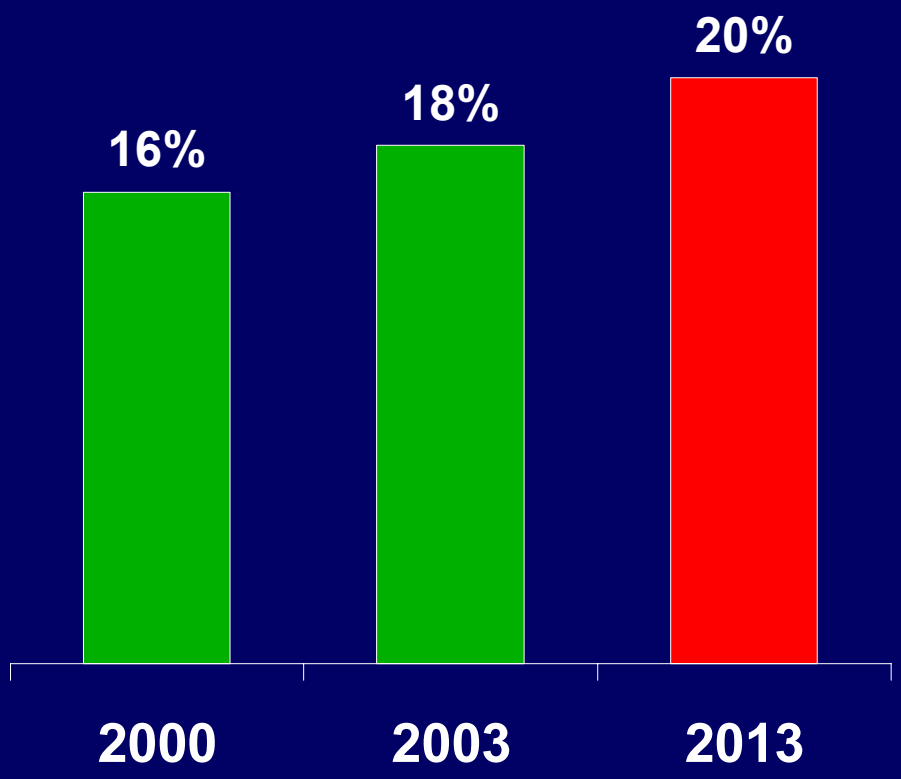


Total = 46.1 Million Uninsured

Note: The federal poverty level was $19,971 for a family of four in 2005.
SOURCE: KCMU and Urban Institute analysis of the March 2006 Current Population Survey.

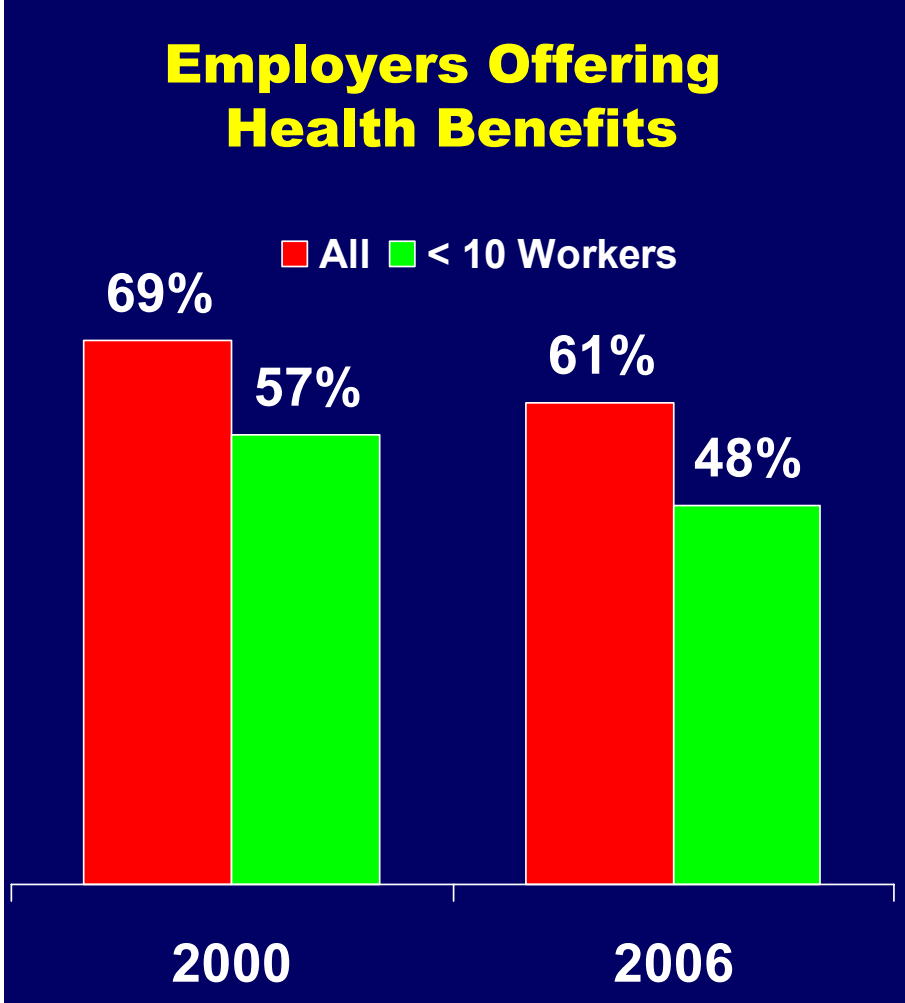
Uninsured Problem is Growing

- **Uninsured rose by 6 million between 2000-2005**
  - **All among non-elderly adults**
- **Would have been higher without public programs**
  - **States with low losses of ESI had larger reductions in uninsured children**
- **Problem expanding**
  - **Higher income, education**



Sources: Census Bureau. Projection for 2013 from Gilmer & Kronick,"It's the Premiums, Stupid: Projections of the Uninsured Through 2013," *Health Affairs* April 2005.

Eroding Employer Coverage

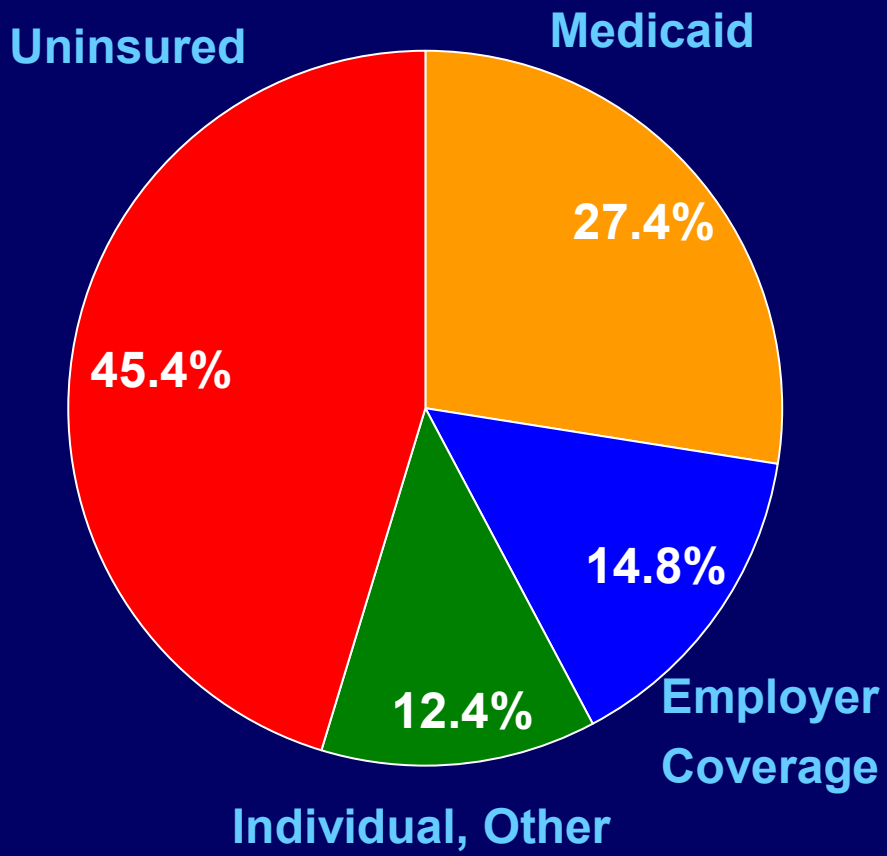


- **Employer-sponsored insurance remains the largest source of coverage**
  - Covers 61% of non-elderly
- **Trends show a decline**
  - Decline in job-based coverage responsible for rise in uninsured
- **Not just a small firm problem**
  - 75% of large firms are likely to increase employee payments

Source: Kaiser Family Foundation/HRET, 2006; DOL.

Gaps in Public Coverage

Insurance of Non-Elderly Adults in Poverty, 2005



28.2 Million Non-Elderly, Poor Adults

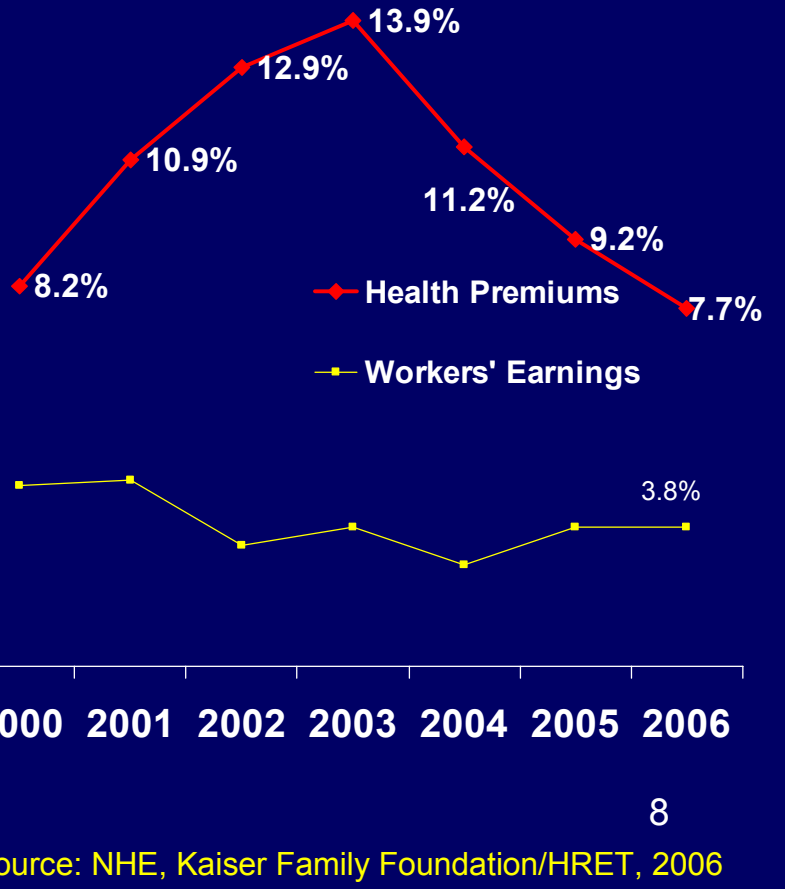
- **Medicaid / SCHIP have helped**
  - "Countercyclical" effect
  - Rate of low-income uninsured kids dropped by 1/3rd since '97
- **Options for adults are limited**
  - Average upper income limits are:
    - 74% of poverty for people with disabilities
    - 42% of poverty non-working parents
  - No option for adults without dependents
- **Gaps persist for children**
  - Over 6 million eligible, uninsured
  - 30-40% of uninsured children ineligible for Medicaid or SCHIP

Source: Data from Kaiser Family Foundation, *Uninsured: A Primer, 2006.*

Why Is The Happening? Health System Costs

- National health spending growth nearly than twice as high as general inflation
  - 5.9% per capita increase in national health spending in 2005
  - 3.4% increase in general inflation in 2004
- Employer health insurance premium growth four times higher than wages
  - Up 87% cumulatively since 2000
  - Compared to 20% cum. earnings growth
- Crippling businesses' competitiveness
- Affecting insured as well as uninsured
  - Medical bills accounted for nearly 50 percent of personal bankruptcy
  - 16 million (12%) of insured adults are under-insured

Growth In Employer-Sponsored Health Insurance Premiums and Workers' Earnings, 2000-06



Source: NHE, Kaiser Family Foundation/HRET, 2006

High Prices

- **U.S. spends the most**
  - Nearly 50% higher per capita than the 2nd most costly nation
  - $6,700 per person in 2005
  - Highest percent of economy (16.0%)
- **High prices makes us unique**
  - Higher pay for doctors hospitals
  - Intense services
  - Also, administrative costs

Source: NHE, OECD

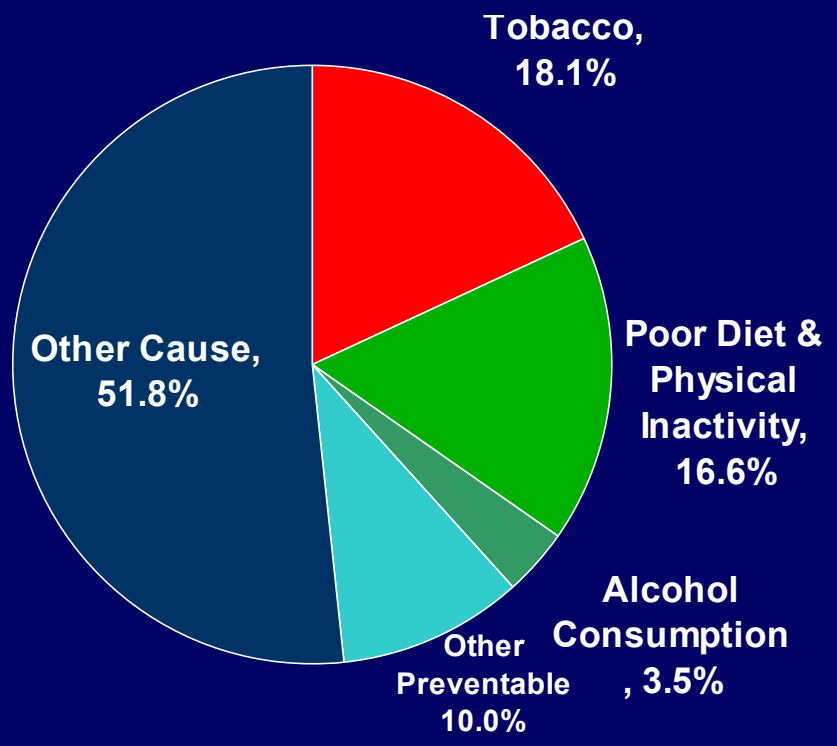
Poorly-Defined "Product"

- **Suppliers create demand**
  - More doctors and hospitals does not = lower prices
  - In the absence of evidence, more is better
- **Americans believe in scientific solutions**
  - Hope as well as fear drive demand
- **Insurance adds complexity and sometimes complicity**
  - Transitions, marketing, and bureaucracy add to costs with little added value
  - Consolidation of supply means little incentives to achieve discounts

Poor Performance & Targeting of Problems

- **Lower-than-expected quality for what we pay:**
  - Only 52% of recommended services provided when indicated
  - 34% of sick Americans report medical mistakes; 22% in England
  - 34th nation in life expectancy
  - 41st nation in infant morality rate
- **Little attention to new challenges:**
  - 50% of Americans projected to have a chronic disease by 2020
  - Emphasis on sickness not wellness

Causes of Disease, 2000



Source: McGlynn et al., 2003; Schoen et al., 2005; WHO; Mokdad et al. 2004; Wu and Green 2000.

TARGETED EXPANSIONS

By Demographic

- Children
- Young Adults
- Near Elderly

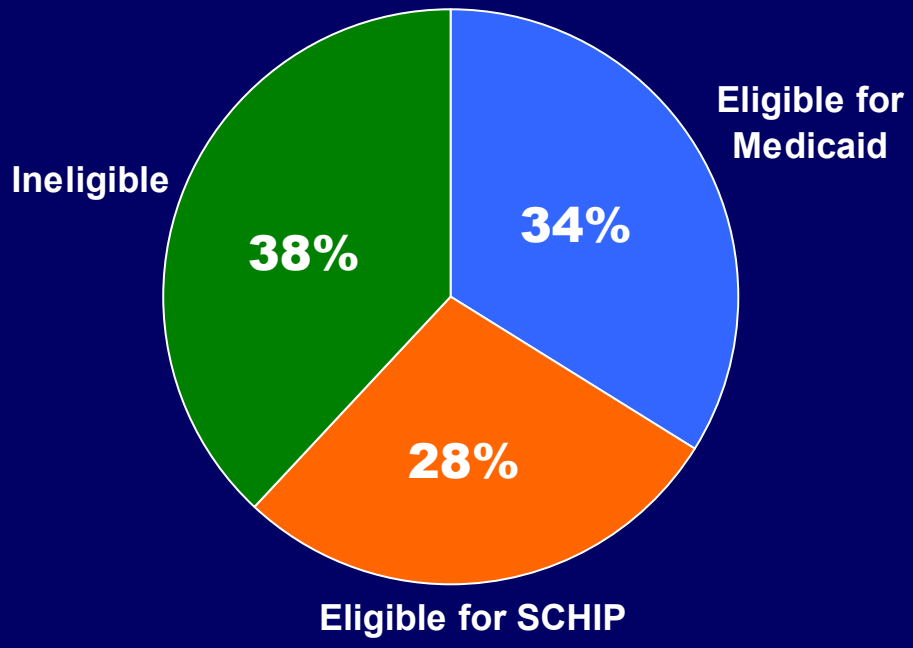
By Type of Coverage

- Employer Coverage
- Insurance Pools
- Public Programs
- Combinations

By Demographics: Children

- **Eligible but Uninsured**
  - Eligibility simplification
- **Ineligible groups**
  - Legal immigrants
  - State employee children
- **Parents of eligible kids**
  - Proven means of getting kids
- **Covering all kids**
  - SCHIP buy in
  - Mandates

Distribution of Uninsured Children by Eligibility, 2002

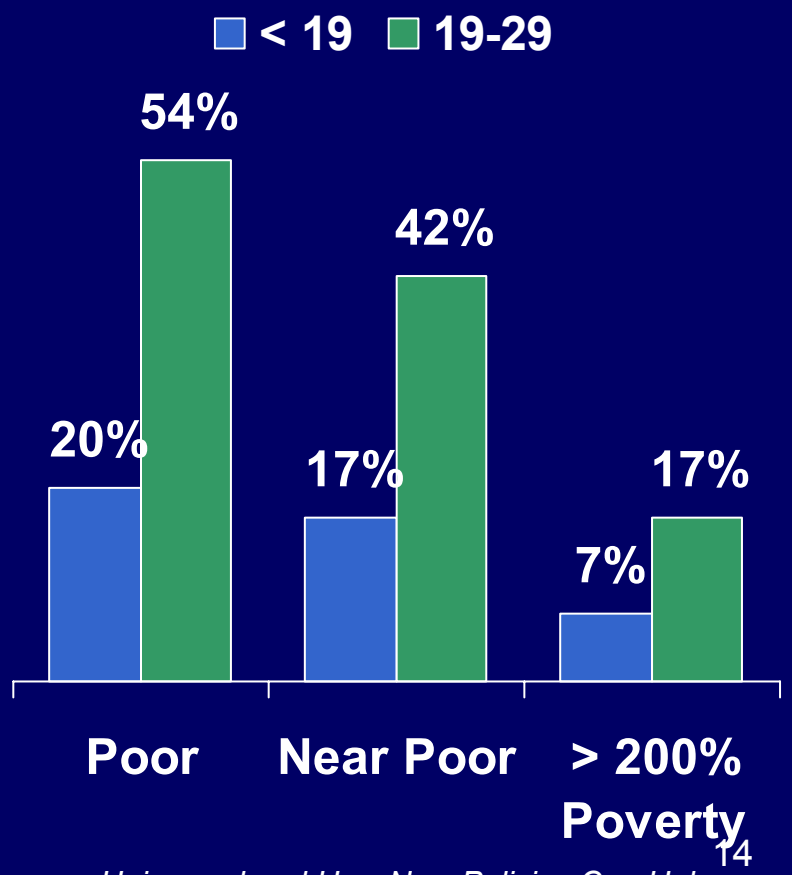


Source: Selden et al. (Sept/Oct 2004). "Tracking Changes in Eligibility and Coverage Among Children, 1996-2002," *Health Affairs* 24(5): 39-50.

Young Adults

- **Dependent coverage**
  - For part-time as well as full-time students
  - For any unmarried dependent
- **Stand-alone products**
  - For students
  - For young adults
- **Medicaid / SCHIP extensions**

Uninsured Rate by Age And Poverty Level, 2004

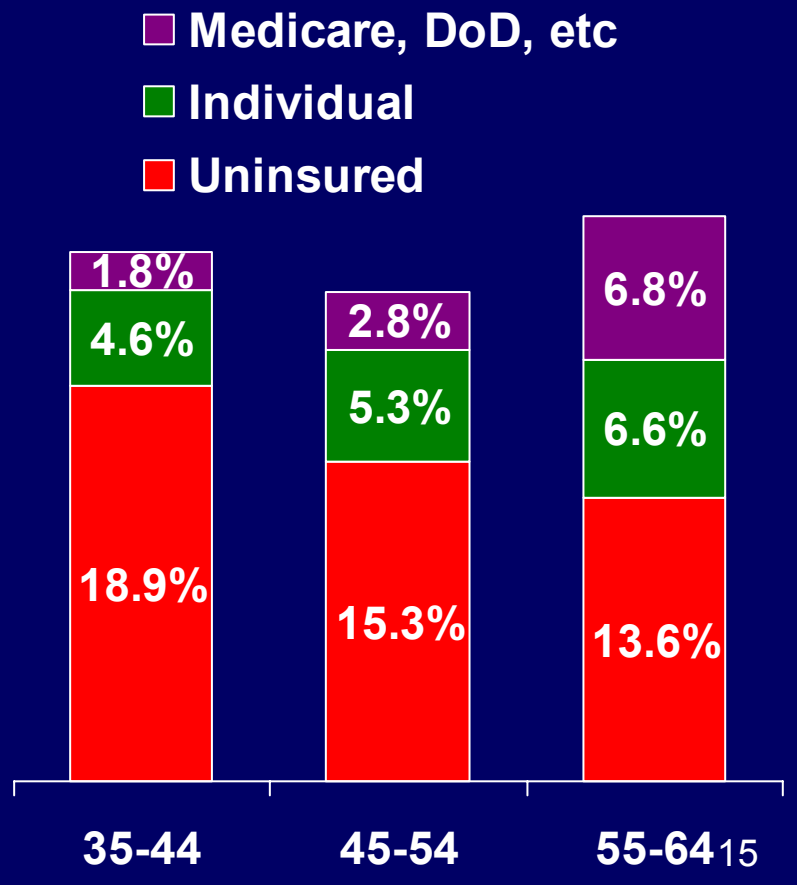


Source: Collins et al. (May 2006). *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help* New York: The Commonwealth Fund.

Near Elderly

- **Extend employer coverage**
  - COBRA
  - Tax credits for individuals and/or firms
- **Medicaid waiver**
- **Insurance regulation**
  - Rate bands and/or guaranteed access

Insurance Rate by Age And Poverty Level, 2004

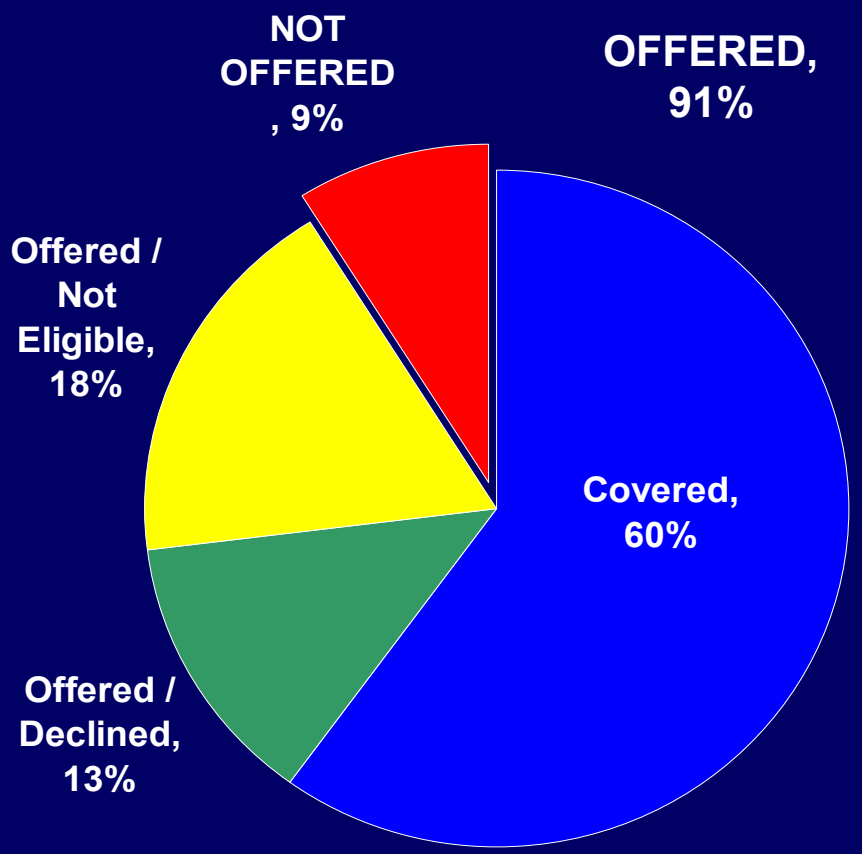


Source: Data from Kaiser Family Foundation, *Uninsured: A Primer, 2006.*

By Type of Coverage:
Build on Employer Coverage

- **Encouraging participation**
  - Tax credits, premium assistance
- **Encouraging eligibility**
  - Only 28% of part-time workers, 3% of temp. workers offered
  - Eliminating waiting periods
- **Encouraging offers**
  - Tax credits for small businesses
  - Pay or play

Distribution of Workers by Health Benefits, 2005



Sources: Kaiser / HRET 2005; Census 2005

Creating Purchasing Pools

Type of Pools

- Geography
  - City or state
- Type of firm
  - Size
  - Industries
- Affiliation or association

Rules Governing Pools

- Entry rules
  - All eligible firms
  - All individuals within firms
- Rating rules
- Consumer protections

Expanding Medicaid/SCHIP

Existing Options

- Children
- Parents
  - Pregnant women
  - Transitional Medicaid
- Targeted groups
  - Women with breast cancer
  - Workers with disabilities

Waivers

- Childless adults
- Subsets of groups
  - Sub-state, limited #
  - People with HIV
- Part of larger reform
  - Like MA, VT, CA

Combinations

- **Premium assistance**
  - Subsidize employer coverage through Medicaid/SCHIP
- **State-based purchasing pool**
  - Small businesses buy into Medicaid managed care plans
- **Three-share model**
  - Subsidize non-state purchasing pool

From Incremental to Universal

- **Same general questions:**
  - Where is coverage provided
  - What does "coverage" mean
  - Who receives what level of assistance
- **Questions that become central:**
  - Requirements:
    - Individuals
    - Businesses
  - Financing:
    - Two-thirds of the uninsured are low-income

INDIRECT APPROACHES
Getting at the Root Causes

- **Reducing prices, administrative costs**
  - Intra/inter-state purchasing pools for drugs, etc.
  - Anti-trust; review of non-profits' charity care
  - Insurance oversight
  - Information technology, greater purchaser access to prices
- **Promoting value-based benefit design**
  - Aligning coverage with outcomes
- **Addressing major drivers of cost**
  - Chronic disease
  - Preventive services and wellness

Creating Catalysts

- Creating study or blue-ribbon commissions
- Putting "teeth" into planning
  - Giving governor the authority to take certain actions is state legislators does not act
- Legislating "triggers"
  - Creating automatic mandates is voluntary actions fail after a certain period of time

Developing Financing

- **Redirected spending**
  - Uncompensated care, health funding
- **"Sin taxes"**
  - Tobacco
  - Soda, junk food
  - Alcohol
- **"Shared responsibility"**
  - Payroll or "pay or play"
  - Sales tax
  - Individual mandate

CONSIDERATIONS
Targeted Expansions

- **Efficiency**
  - Low public spending per newly insured
  - May get few uninsured
- **Effectiveness at reaching uninsured**
  - May get many uninsured but at a high cost
- **Equity**
  - Are individuals arbitrarily excluded to promote efficiency
- **Unintended consequences**
  - Erosion of existing coverage
  - Increased complexity
  - Lateral rather than forward movement toward goals

Implications of Indirect Options

- "Bank shot" at helping the uninsured
  - Little direct impact
  - Hard to recapture savings
- Public savings are someone else's profits
  - Pits providers groups against uninsured if linked
- But success could beget success
  - Helping insured as well as uninsured may strengthen support
  - Creates trust in policy process
  - Moves toward sustainable system

Implications of Catalysts

- No immediate results
- May result in delays or missed opportunity
- But catalyzing systemic change may be the most effective small step that can be taken

REASONS FOR OPTIMISM

- **Sense of crisis – and support for action – is spreading**
  - States
  - Business leaders
  - Newly elected officials
- **Brink of a presidential election that may focus on major health system change**
- **Congress may provide new options and financing**
  - Reauthorization of SCHIP as a opportunity
  - Interest in near elderly, Medicare
  - "Race to the top" due to State leadership