

DEALING WITH KANSAS' UNINSURED

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EXECUTIVE SUMMARY

Kansas, like many states, faces a significant problem in the lack of health insurance among some of its citizens. The problem is sizeable and persistent and threatens to grow in the future.

Nationally, estimates as to the number of uninsured range from 20 to 80 million. More consistent estimates show a much narrower range between 41.1 million and 46 million for 2003. In Kansas, a recent estimate indicates that over 10 percent of the population lacks coverage. The majority of these Kansans, as in the U.S., are adults.

There is some reason to question these totals. Many of the national numbers of over 45 million that are thrown out exaggerate the number of uninsured for a host of reasons, including the fact that many are uninsured for just a few days in a two year period, many are eligible for Medicaid and the State Children's Health Plan but do not enroll, and many have substantial incomes but choose not to purchase insurance. Nonetheless, these factors merely mitigate what remains a real problem.

In this report we seek to examine what causes citizens to be uninsured. We then examine well meaning proposals that will, unfortunately, make the problem worse. Finally, we will develop a comprehensive proposal that will significantly reduce the number of uninsured in the state. This will involve reversing bad government policies that contribute to the problem, assisting the private marketplace in providing low cost health insurance products, and providing subsidies to encourage the uninsured to enroll in health plans.



BACKGROUND ON HEALTH INSURANCE IN THE U.S.

The Creation of Medicaid and Medicare

The enactment of Medicaid and Medicare in 1965 fundamentally altered the U.S. health care system. These programs essentially adopted cost-based reimbursement with no or extremely limited cost sharing. The results were entirely predictable with health care demand soaring and the cost and quantity of medical services provided increasing dramatically. Many private plans also marketed limited cost sharing to private firms which further contributed to rising health costs. The practice of community rating produced incentives for firms with healthier employees to drop out of the insurance pool and "self-insure." This trend accelerated with the passage of the Employee Retirement Income Security Act (ERISA) in 1974.¹

The increase in health care spending was dramatic. In the 1970s the U.S. economy grew at annualized rate of 10.6 percent vs. 12.8 percent for health care. In the 1980s real health expenditure growth accelerated to 3 percent. This declined to 1.3 percent in the 1990s. Unfortunately, the difference has expanded again since the turn of the century. The growth of GDP has been 5.0 percent in this period while medical expenditures have increased at a rate of 8.1 percent. Over this 35 year period the economy grew at an annual rate of 7.5 percent with health costs rising by 9.8 percent per annum. To put this in perspective, if health insurance premiums in real dollars were \$5,000 for a family in 1970 they would have increased to almost \$10,500 real dollars in 2005.²

The Impact on Private Insurance

The private health insurance market during this time became two-tiered. The large group market of over 50 employees developed

along side a small group and individual market. In many instances, particularly for firms with larger numbers of employees, guaranteed issue is not a problem. The law of large numbers gives some predictability to the actuarial risk that the carrier takes by enrolling bigger groups. For smaller firms, especially below 50 employees, virtually all applications are underwritten with high risk individuals excluded in one way or another. This may involve extraordinarily high premiums, exclusion of coverage for preexisting conditions or outright denial for the employee in question. This is particularly true for individual coverage. As more large firms dropped out of the carrier pool and began to self-insure the problem of obtaining insurance in the small group market grew worse. **Any reform regarding reduction of the number of uninsured needs to focus primarily on the small/individual market.**

The Increased Cost of Health Insurance

The relentless increase in the cost of health insurance over time contributes to the number of uninsured. Academic evidence suggests that those covered in the small group and individual market are sensitive to the cost of insurance. That is, they have a negative "price elasticity of demand." Some estimates indicate that a 10 percent decrease in the cost of health insurance leads to around a 5-6 percent decrease in the number who purchase insurance (either on their own or through their small group employer). Any solution to reducing the number of uninsured needs to recognize this economic finding.³

The Increased Demand for Health Care

Mechanically, health costs (like any price) rise because of the interaction of demand and supply. In the case of rising prices demand must be increasing faster than supply. Explanations for rapidly increasing demand are fairly obvious. From above, the



development of front loaded, low deductible public and private health insurance made the consumer extremely insensitive to medical costs. In the Rand Health Insurance Study, those with free care used 30 percent more than those with high deductible plans. Further, in the non-poor part of those studied, there was virtually no difference in health outcomes. The inescapable conclusion is that third party payment dramatically drives up medical demand.⁴

Another factor increasing demand is that health care may be "income elastic." This means that as real incomes rise over time we would expect the population to spend a higher proportion of it on medicine.

In addition, the dramatic increase in the quality and availability of health services and products serves to drive up demand. The rapid development of expensive new drugs, services and products contributes significantly to the health usage.

The ability to easily litigate also drives up the demand for health care. In order to reduce the possibility of lawsuits providers often order unneeded tests and procedures that are simply not cost effective. Fear of litigation eliminates most reasonable efforts to limit care and many providers have simply returned to fee for service coverage. The persistence of fee for service without significant cost sharing drives the current system towards treatment of acute problems rather than focusing on preventative care and management of chronic conditions. The system is woefully inefficient in terms of wide variations in treatment methodologies with significant over and underuse of treatments and services, depending on the medical condition. Lack of significant competition exists between providers which boosts costs and reduces innovation in developing new cost effective delivery methods.⁵

One crucial element of reducing the number of uninsured is promoting effective competition between providers.

Employer Plans

Around 80 percent of those covered by employer plans have no choice in their carrier.⁶ In effect, by buying at the company store they get what the company wants for them. This produces further inefficiency and reduction in supply by producing a "one size fits all" package that cannot possibly meet the diverse health issues faced by the population. Further, of those who do have a choice the employer often does not distinguish between the costs of the competing plans so beneficiaries have no incentive to economize. It is far easier to force competition by allowing each employee to choose between plans than by individual employers doing so. This would allow choice to those people who would select less expensive care if they could benefit financially from the lower costs.

Summary

From above, we can see how the U.S. healthcare system evolved to its current state. Wage controls and, later, tax laws caused most health care to be purchased through employers. Health plans reimbursed on a cost basis in a fee for service framework. They practiced community rating which gave low risk participants an incentive to self-insure or drop out coverage. The enactment of Medicare and Medicaid as front loaded, low deductible fee for service plans dramatically increased the demand for health care. Private sector plans copied this framework, further increasing demand. Employers offering little choice in coverage dramatically limited real competition among providers. They set HMOs up to fail by giving little or no choice to beneficiaries and the reduced costs they had achieved were quickly lost. Finally, they have been extremely slow in offering products such as



Health Savings Account (has) plans that would sensitize consumers to the real cost of health care.

The result is a health system that, while producing miracle outcomes, is extraordinarily inefficient and riddled with inflation.⁷ Fundamentally, it does not work right because there is no real marketplace in either the private or public sector. Any industry without a real marketplace will suffer from rising costs, lack of innovation and low quality. Health care suffers from all of these issues.⁸ The problem of the uninsured relates directly to the lack of an effective market. **Solving this and other problems related to health care will involve the creation of a real marketplace.**

REDUCING THE NUMBER OF UNINSURED IN KANSAS

Designing a plan to reduce Kansas' (and the nation's) uninsured requires that we know who the uninsured are and why they are uninsured. Who they are is fairly straightforward. Over two thirds live at or below 200 percent of the federal poverty level (FPL). Of this amount around 55 percent are actually below the poverty level with the others earning between 100 percent and 200 percent of FPL. So, low income is obviously a major factor in the lack of insurance. Two thirds of the under 65 population in Kansas has employer based insurance with 13 percent covered by Medicaid (or other public coverage) and around 12 percent uninsured. The remaining 8 percent have individual policies. Finally, over 97 percent of employees of firms in the large group market (50 or more workers) have coverage as opposed to around 41 percent in the small group market.⁹ **These facts logically dictate that reducing the uninsured requires reforms in the small group (and individual) insurance market, providing subsidies to buy coverage, and finding ways to enroll the Medicaid eligible.**

PROPOSAL #1: CREATE A SGI EXCHANGE

The starting place for reducing the number of uninsured is for the State of Kansas to create a Small Group and Individual Health Insurance Exchange (SGIX). This is nothing more than a state sponsored "mart" where small employers and individuals can go to purchase health insurance. After initial state funding, it would exist via a small levy on premiums. This system will have significant advantages over the current small group marketplace. One of the factors that make insurance so expensive in this market is higher loading costs relative to large, self-insured firms. These may range from 5 percent to over 30 percent.¹⁰ This has a significant impact on premiums (or employer costs for the self-insured). A plan with average employee expenses of \$5,000 would have a premium (cost) of \$5,263 vs. \$7,143 with overhead rates of 5 percent and 30 percent, respectively.

Reduction of Loading Costs

By putting all potential small group buyers in one mart the loading cost could be significantly reduced. They should be able to operate the system with no more than the overhead of major corporations (5 percent). This reform alone would significantly lower premiums. From above, increasing affordability is crucial in reducing the number of uninsured. Thus, the ability of the SGIX to contribute to lower premiums amounts to the health insurance equivalent of picking low hanging fruit by achieving significant economies of scale. In addition, by expanding the size of the insured pool, it would reduce the unsystematic risk that exists when writing policies for the small group market. This would further reduce premiums.



Accessibility of Choices and Information

The SGIX would serve other functions as well. It would be a central shopping place for health insurance for this group. It would be accessible online or via toll free telephone for convenience shopping. It would present the available products in an easy to understand format. The format would also allow for easy comparison among product costs and coverage items. It would act like an HR department for this group of buyers but would have significant economies of scale.

It is important to understand that SGIX is a "market maker," not a regulatory agency. It should not set prices and/or benefits packages (with the exception of requiring providers to offer a certain minimum amount of coverage). It would have the power to not allow carriers to sell if they fail to meet minimum capitalization, benefit and quality criteria. But it would not allow for any special consideration for any particular carrier marketing their product to potential customers.

No Guaranteed Issue

A crucial part of the SGIX is setting up a system that can actually work for this group. **First, there would be no guaranteed issue for potential enrollees.** A provision for that would seriously hamper the workings of the SGIX by allowing individuals and small firms to enroll after someone becomes very sick. This would cause premiums to soar and drive healthy members out of the risk pool. Every state with regulations along these lines has significant problems of high premiums and greater numbers of uninsured related to those regulations.

Risk Adjustment

Another issue that the SGIX would deal with is the pricing of risk. From above, one of the reasons for the problems that the small

group/individual market faces is related to "community rating" where everyone in a specific geographic area pays the same for health insurance. This would destroy the market for auto, life and home insurance and was a major culprit in the dysfunctionality of health insurance. **Therefore, the SGIX would not allow carriers to set premiums on a community basis.**

The exchange would assist small firms in assessing the risks of their employees. For example, suppose a small firm with ten employees wishes to buy insurance at the SGIX. Nine of the employees are young with good health histories while the remaining person is older with some medical issues. A carrier examining this group will either overcharge the younger individuals or outright exclude the sicker employee through actuarial underwriting. An alternative would be for the carrier to offer the total premium amount to these ten employees with SGIX assisting the firm in risk-adjusting the beneficiary support amounts. This would have the effect of significantly reducing the difficulty that older and/or sicker applicants would be excluded from coverage.

In the past risk adjustment was not widely practiced and not particularly effective. Indeed, the difficulty in doing it was one of the reasons for actuarially unsound community rating. But now the advent of high speed computers and software has made risk-adjustment much more effective and economical to implement. A perfect example of this is Medicare Advantage which is the new Medicare Part C managed care plan. Medicare Part C was very ineffective primarily because the payment schedules were based entirely on demographics such as age, sex, employment status, Medicaid and disability eligibility and institutional status. Medicare is in the process of implementing a new risk adjustment system called the Centers for Medicare & Medicaid Services Hierarchical Condition Category (CMSHCC).



Switching Medicare reimbursement of private plans to CMSHCC has had very desirable effects. Indeed, private firms under Medicare Advantage are able to market directly to those with chronic illnesses under what are called Special Needs Plans (SNPs).¹¹ So instead of attempting to cherry pick healthy enrollees the market is now functioning to provide care to the chronically ill since they receive a significantly higher payment from Medicare. This accomplishes two things. First, it makes the sick desirable customers. Second, it will accelerate medical innovation in dealing with higher cost patients. Why? Because the plans are prepaid and finding ways to keep enrollees healthier will flow to the provider's bottom line.

So an important task of the SGIX will be to assist both providers and potential purchasers in risk-adjustment. In addition, the SGIX functions as a large pool so carriers offering health plans can get the 5,000 or so individuals they needed to get predictability (relative to the entire population) in health expenses. From above, this will also reduce insurance overhead and save on marketing and other costs through economies of scale. In addition, SGIX could assist employers in adjusting their premium contribution by income level as well as risk characteristics. On average a 25 year old male employee should pay less than a 55 year old male employee. Suppose the 25 year old earns \$25,000 per year while the 55 year old earns \$50,000. An additional employer adjustment might be to (on their own or with the assistance of SGIX) provide a greater amount of premium support for lower income employees. This might be difficult for the firm to do on without actuarial help given that most firms budget for fringe benefits on a percentage of payroll basis. **The SGIX is one of the important reforms needed to reduce the number of Kansas' uninsured.**

SGIX Boundaries

From above, it is important that the duties of the SGIX be clearly defined and limited by state legislation. The SGIX will exist to spread out risk, achieve economies of scale, assist in risk-adjustment and allow for vigorous competition among providers. The SGIX would essentially become the HR Department for the small group and individual health insurance market. It would allow for easy comparison among provider costs and benefit plans. It would be a market maker, not a government regulatory agency.

There is precedent for attempted misuse of this type of operation. The exchanges that were envisioned under the proposed Clinton Plan in 1993 (called "Health Alliances") were an inappropriate misuse of the insurance exchange concept. First, the Alliances were allowed to exclude providers from offering plans if the premium was an arbitrary percentage above the average offered at the alliance. Whether a plan's cost is appropriate should be determined by consumers spending their money, not by government bureaucrats.

The Clinton Alliances also would have also had so many incentives for employers with as much or more than 5,000 workers to join the government pool that most would have enrolled in them. The SGIX needs to be specifically limited to the biggest problem area in health insurance, the small group and individual market. In addition, the Clinton plan set a requirement that the Alliances would reduce the real rate of medical inflation by two thirds. If the competition that they were supposed to produce did not have this unrealistic effect the plan's fallback approach was to implement price controls. **Under no circumstances should the SGIX have the power to set plan costs either initially or over time.**



PROPOSAL #2: PLAN CHOICE AT THE SGIX

From above, the existence of tax free status of employer provided health insurance has resulted in most employees receiving their insurance from their boss. Further, as mentioned previously, most employers offer only one health plan. The employee gets what the employer wants, not necessarily what the employee and his or her family needs. This occurrence has the undesirable impact of significantly limiting competition among health plans and providers. It is far easier for an individual/family to switch to a plan of their choice than for the employer to do so for all their workers.

Increasing Individuals' Choices

The SGIX can solve this problem. Competing carriers and provider plans will be listed at the mart with individual employees able to choose among these plans. Instead of one size fits all with choices made for them, the individual will select among different benefit packages at different prices. At the company level, they will use risk-adjusted employer funding (actually, their pay distributed as a benefit instead of wages) to buy the plan of their choice. More expensive coverage will require greater contributions on their part with the effect of producing incentives to economize on costly plan provisions.

In addition, the allowance of plan choice will allow the employee (rather than the firm) to select the plan that best fits their needs. This should increase the quality of care in three ways. First, the SGIX will allow for easy comparison of plan benefits so that the "customer" (the employee) can enroll in a package that gives them the coverage with the best match to various health issues they face. This cannot be overstated. Not only will the SGIX allow for complete transparency in benefit packages, it will also employ counselors to help enrollees select the best

plan for their needs. Second, if they feel they are not being treated properly they can easily enroll in a competing plan. This significant increase in competition will induce providers to offer better care or face the loss of customers (isn't that how other industries work?).

Incentives

Finally, in order to keep existing enrollees and increase their profits, the competing plans will have powerful bottom line incentives to innovate. This acceleration in the rate of innovation will initially be reflected in higher plan profits. Ultimately, competition among the providers will be reflected as a slowing of the rate of medical inflation. It is this productivity gain that, as in other industries, will make health care finance sustainable within individual and employer budgets over time. These efficiencies will occur slowly over time but the compounding effects will be enormous after a few decades.

"Braiding" Services

Another role the SGIX could play involves helping health plans to "braid" services to enrollees. This concept is being used on a limited basis in some Medicaid Plans such as New Mexico. The idea is that some health issues and problems have multiple sources of treatments and/or funding. SGIX could assist private plans in working with these private/public entities that deal with a host of medical problems. To the extent that additional resources are available to beneficiaries that, on the margin, are free and/or low cost, the total premium for coverage could be lowered.¹²

The actual mechanics of consumer choice would involve the following: If an employer (or individual seeking insurance) selects the SGIX as its "insurer" all of its employees may purchase care from any of the competing plans. **Note that it is not required to offer**



coverage nor are individuals mandated to enroll in health care. The plan will use a carrot, as opposed to a stick, incentive system. From above, the SGIX will assist employers in risk-adjusting its employee contributions and will provide the same service for carriers and providers who request it. While most insurance companies and HMOs have the capability to price risk, newly formed groups may need assistance with this calculation.

The SGIX would assist employers in setting up section 125 plans to allow employee contributions to the cost of their insurance to be paid with pre-tax dollars. Indeed, 125 providers could sell their products through the SGIX. Federal law limits the deduction for individual purchases but the SGIX could assist those enrollees with taking advantage of the deduction that does exist. A crucial advantage of this framework, from above, is that the employee (not the employer) selects the coverage they want. While there would be no guaranteed issue upon initial application there would be guaranteed issue if the employee decided to switch coverage during the open enrollment period. In the situation where a high risk individual covered at the SGIX decides to switch plans it may be advisable for the mart to require some type of actuarial payment from the initial plan to the new one.

Portability

The ability to switch coverage after initial acceptance by one of the SGIX plans would allow for a solution to one of the current problems in employer based health insurance, namely, the lack of portability. An individual could retain the same coverage if they moved to a new job. They would simply use the employer premium provision from the new boss to pay for their existing coverage. This would significantly reduce the "job lock" that exists - especially for those who are covered but in poor health. As with the

Massachusetts "Connector" (a less desirable form of the SGIX) a husband and wife could combine their separate employer's insurance contribution to purchase a desired plan at the SGIX.

After an employer selects the SGIX as its "carrier" the mart would examine enrollee characteristics to make sure none of them are eligible for Medicaid and Kansas SCHIP. Certainly employers have an incentive to cooperate in this since it would reduce their medical premium. Those employees and/or families that are eligible will be automatically enrolled in Medicaid. Presuming that Kansas' path breaking Medicaid reforms are expanded to the entire state, these enrollees will also have numerous choices in their health plans. This will automatically reduce the official number of uninsured by explicitly recognizing the current Medicaid eligible who are not enrolled.

Increasing Competition

The use of actuarially fair premiums may be expected to draw numerous competing health plans at the SGIX. It should also be expected to reduce the number of applicants who are rejected on the basis of preexisting conditions. There will, however, be a small number of individuals who cannot qualify for insurance even with risk based premiums. From above, the SGIX will attempt to enroll as many as these individuals in Medicaid as are eligible. The SGIX also would try to expand private coverage by "braiding" the plans with other existing sources of care. Both of these measures would be useful but there would still be a small number of uninsurables.

A High Risk Pool

To deal with this group SGIX would operate a "high risk pool." This would be an expanded version of the current Kansas Health Insurance Association. Once it is determined



that coverage is unavailable through the above mechanisms this group would be enrolled in selectively contracted prepaid plans. Each enrollee would have a gate keeper physician with significant control over health services usage (essentially a closed panel HMO). The enrollments would be for a specific period, say one month, each year to reduce attempts at gaming the system. Premiums would be established as a percentage discount from the average pool cost. There would be several sources of funding. These include existing premium taxes on private sector health plans, subsidies to enrollees (discussed below), and sliding scale beneficiary contributions based on income levels.

PROPOSAL # 3: ELIMINATE STATE MANDATES ON SGIX PLANS

A significant factor in many people being uninsured is the high cost of health plans. From above, there are many reasons for medical care being expensive. One of those is the existence of state mandates on health providers. There are several aspects to mandates. These include access, cost and quality mandates. Access mandates involve required benefits in plans as well as required coverage by certain providers such as podiatrist and chiropractors. It also involves required coverage of specific groups. Cost mandates involve things like state premium taxes and conforming with rules related to ERISA and the Health Insurance Portability and Accountability Act (HIPAA). Quality mandates relate to items such as patient "bill of rights" laws, any willing provider laws and external review requirements. Mandates should be eliminated for both SGIX plans and other small group plans not sold at the SGIX.

Estimates of the gross cost of these mandates nationwide range from a low of \$68 billion to a high of \$172 billion. In some areas the mandates add as much as 45 percent to the cost of health insurance.¹³ This has the

disproportionate impact of driving the healthy out of the insurance pool which further increases costs. It does not include other regulations such as facilities and professional requirements that drive up costs. Nor does it include the cost of the medical tort system. This will be examined a section below with proposed remedies.

Minimum Basic Benefits Packages

The best way to deal with the cost of mandates is to allow the SGIX to set a minimum package of basic benefits that each plan must provide to enrollees. SGIX could establish this based on the lowest coverage plan offered by the state less non-physician services such as dental and eyeglass coverage. It is important that the ability to offer a no-frills plan be readily transparent to the purchaser. Thus, providing easy to compare benefit lists for competing plans is an important responsibility of the SGIX. Remember, this is an absolute minimum amount of coverage and many of the plans will offer benefits beyond it. Consumers will make the final cost-conscious decision on how much coverage they want to buy.

Florida's Model

A model for this is the State of Florida's Health Flex Plan Pilot Program (Health Flex) passed by their legislature in 2002. This program exempts health plans from the 51 mandated health care benefits in Florida. SGIX would be empowered legislatively like Health Flex to establish a minimum benefits package that all providers would offer. It would also be allowed to review and offer alternative "special plans" that would deal with chronic medical conditions. These plans would be similar to Medicare Special Needs Plans and Florida Medicaid's "specialty" plans currently being developed under that state's reform demonstration.¹⁴



SGIX will not regulate the types of coverage available to purchasers. Providers may offer HMOs, provider networks, point of service plans and other delivery systems. They may offer comprehensive coverage, extensive co-pays, and health savings account plans. As with the level of risk discussed above, the plans would price the nature of the product. For example, sicker individuals may be less likely to enroll in HSA plans so the employer contribution for HSA products would probably be lower. Again, consumer choice will drive the product offerings. **However, in order to encourage “best practices” in terms of identifying and treating particular health problems all plans would be required to assign enrollees a primary care physician.**

PROPOSAL #4: PROVIDE SUBSIDIES TO BUY HEALTH INSURANCE

Any plan to reduce the uninsured in Kansas must recognize that the cost of health insurance needs to be significantly lower to induce many of the current uninsured to obtain coverage. A subsidy plan should take into account two factors: the risk of enrolling a particular individual and the income of the person/family in question. And, obviously, there need to be sources of funding. Finally, given the voluntary nature of enrollment at the SGIX, subsidies will be provided on a “use it or lose it” basis. Benefits will be provided as a credit usable at the SGIX.

Payments to Hospitals

One obvious source of financing for these credits is the payments made to hospitals to compensate them for performing unreimbursed care. For example, in 2005 Kansas spent \$64 million on Disproportionate Share Payments to providers.¹⁵ It is far preferable to provide subsidies to the uninsured to purchase coverage for several reasons. First, from above, it allows them to obtain the type of coverage that best serves their needs. Second, by purchasing from

insurers the payments to providers are negotiated, giving doctors and hospitals an incentive to deliver care more efficiently. Third, it will produce more competition among providers who will wish to enroll new plan members, increasing quality and producing even more innovation. From above, these subsidies should be adjusted for the health status of SGIX enrollees.

Additional Public Funding

Providing meaningful subsidies will also involve additional public funding. Two possible sources of funding include alcohol and cigarette taxes. Kansas current levies on these products are below the national average and an increase in them to fund health coverage makes sense.¹⁶ This is a “double positive” in that it provides funding for expanding health coverage and simultaneously reduces smoking. While the demand for cigarettes, in particular, has generally been found to be “inelastic”, that is, a one percent increase in the price reduces consumption by less than one percent, it clearly is negative.

Federal Credits

Another source of funding may be forthcoming in Washington. From the history of health insurance above, the development of employer based insurance was largely related to the tax free status of this benefit. For someone in a marginal tax bracket of 25 percent a \$10,000 employer paid plan saves them \$2,500 in taxes relative to receiving this benefit in the form of wages/salary. Nationwide, this exclusion may have a value of \$200 billion. In its current form it is highly regressive. Per dollar of employer paid health care, top bracket earners (more than \$336K) receive a 35 cent tax benefit while the lowest bracket (less than \$15) are subsidized by 10 cents.



President Bush recently suggested giving tax deductions of \$7,500 for individuals and \$15,000 for families for health premiums and then making employer paid premiums taxable. A better proposal is to take this pool of funds, equalize the subsidy and make it a refundable "use it or lose it" credit to all non-Medicare individuals. This includes those purchasing individual insurance who are heavily discriminated against under current law. Those receiving employer paid insurance would have that portion of their compensation become taxable income and then would use their credit to offset all or part of the tax due. Benefits would remain tax free at the state level unless the state offered a similar credit arrangement. The credit would also be available to those on Medicaid as a carrot to enroll in private plans.¹⁷

Removing Medicare beneficiaries indicates a per person value of the benefit of around \$750. Thus, a family of four would receive \$3,000 to purchase health insurance. If they had family coverage from their employer worth \$10,000 and were in the low tax bracket their lost subsidy would be \$1,000. Thus, they would have a net gain of \$2,000. A family of four in the top bracket would lose \$500 in tax subsidies under the new plan. The biggest gainers would be low income families with children while those losing the most would be single high income individuals with no children. An additional benefit would be that employees would now have an incentive to shop around for better coverage because they would not lose the tax subsidy by walking away from their company's plan.

THE MASSACHUSETTS PLAN – A FRAMEWORK FOR KANSAS?

The State of Massachusetts is undertaking a bold experiment to make sure all of its citizens have health insurance. Essentially, all Massachusetts residents must buy health insurance or receive it through their employer. Firms with more than ten

employees must pay a per worker contribution to the state. While there aspects of the plan that make sense other parts of it represent a dangerous precedent.

On the positive side the legislation is the creation of an "insurance exchange" where individuals and small group (less than 50 workers) can buy health insurance from competing providers. This exchange (called the "Connector") is a mart where employees will be able to choose the type of health plan that they want. It is Massachusetts' version of the Flint Hills Center's proposed SGIX. The "Connector" will allow many competing plans to sell to firms who designate it as their carrier. Once a firm has registered at this mart each individual employee may select the plan that they deem best for their needs. This has two positive impacts. It moves the health insurance choice from the employer to the worker and, second, it allows providers to the freedom to develop plan designs for the diverse needs of this group. This, on its own, will lead to competition and innovation by providers that should produce lower medical inflation and higher quality care in the long run.

Another positive part of the plan is that a two income couple may use the combined contribution of their differing employers to buy the coverage they need. This is also true for a worker with two part time jobs. Individuals will also be able to buy their coverage at this exchange. While Federal law does not allow them the complete tax break available to workers with employer coverage they will be able to switch coverage during the annual enrollment period without fear of underwriting. An important positive step for employees is the ability to change employers and retain their existing coverage, thus, the plans are portable.

While the above reforms are good there is much to be concerned about with this proposal. First, the legislation does little to



reduce extensive mandated benefits that increase the cost of insurance. Second, the penalty for a firm not making payments to the "Connector" for their employees is \$295 per worker. This is in a state where average health expenses per capita are around \$6,000. The plan provides for a subsidy from the state's uncompensated care plan to instead flow to the "Connector." Hospitals and providers currently receiving payments from this fund have to enroll those individuals in health plans at the mart. While this good (since providers will now negotiate prices with carriers), the Achilles heel of the proposal is that the subsidy is not high enough to cover the mandated coverage.

If Massachusetts signs up 700,000 uninsured with average health costs of just \$3,000 (far below the current state average) the cost will be over \$2 billion. Back of the envelope calculations show the state is \$700 million short of this amount. This presumably will be made up by employer contributions to the "Connector." This averages around \$1,000 per worker. It doesn't take a genius to figure that many firms will forgo signing up at the state mart and simply pay the \$295 penalty per employee. Of course, if the average cost of the uninsured is closer to the state average of \$6,000 the incentive for businesses not to join will be much higher. Politicians can't compel businesses to do unprofitable things any more than they can cause the tide in Boston harbor not to rise.

As of March 1st, the Massachusetts plan is in serious trouble. Premiums for plans have come in at \$380 vs. the \$200 per month that the program designers predicted. This is the cost of a plan with a \$2,000 deductible and total potential out of pocket expenses of \$5,000. In addition, the cost of subsidies to the State are 80 percent higher than originally anticipated for the reasons stated above. An individual with an income of \$30,000 would thus have over 30 percent of their gross income exposed to health premiums,

deductibles and co-pays. At the same time those running the "Connector" are in the process of making high deductible plans illegal.¹⁸

This mandate problem is in addition to other self-imposed problems in Massachusetts. The state has community rating and the "Connector" will offer limited risk bands which means the healthy will continue to be overcharged and have a strong incentive not to purchase insurance. The plan also retains guaranteed issue which makes health costs much higher than they need be and drives the healthy out of the insurance pool. **It is crucial that the SGIX avoid these mistakes. It must be a) voluntary b) allow underwriting by carriers and c) properly adjust subsidies for enrollee health status.**

HOW MANY UNINSURED WILL OBTAIN COVERAGE?

Estimating the impact of the above proposals on reducing the number of uninsured in Kansas is challenging. Since there is very little history of a major effort like the Flint Hills Center Proposal for increasing health coverage our estimates on take up are rough calculations. Nonetheless, we believe they show that the program we are advocating can significantly reduce the number of uninsured. As sensitivities to our proposals increase we believe there will be even greater reduction in the ranks of the uninsured in years to come.

The introduction of the SGIX will be accompanied by an active marketing campaign to encourage enrollment. From above, one of the rolls of the SGIX is identifying individuals/families that are eligible for Medicaid and other public health plans and support. Nationwide, it has been estimated that over 30 percent of the uninsured are actually eligible for these programs. Why they don't enroll is not certain. They may be unaware of their eligibility and/or in good health and



unconcerned about coverage. There may be a stigma to enrolling in a government plan. Or the qualification process may be daunting. A central goal of the SGIX is finding and enrolling these individuals. **Based on this we estimate a 30 percent reduction in the uninsured population over a short period of time.**

Another 30 percent or so of the uninsured are clearly middle class with incomes of more than \$50,000 per year. Of this group, around one half earn in excess of \$75,000. These are individuals who are very insurable and can afford health coverage. They might not sign up based on current good health and/or believe that healthy insurance premiums are too high to be a good deal for them. The reduction in premiums that we anticipate from the efficiency gains of the SGIX as well as actuarially fair premiums it requires are likely to significantly reduce the cost of enrollment for much of this group.

In addition, the availability of HSA products are likely to be very popular with this portion of the uninsured. HSA Plans will allow these people to buy high deductible catastrophic coverage with premiums 30-40 percent below the already reduced SGIX rates. These savings can be deposited into tax-free HSAs to be used for paying low dollar medical bills with pre-tax funds. Evidence on long-run medical claims suggests that the vast majority of HSA users will build up significant balances over time. These may be used for Medigap coverage after age 64 and/or withdrawn as taxable retirement income. In effect, the HSA coverage becomes a combination health and retirement plan for the cost of health insurance alone. As with the other uninsured going to the SGIX these individuals/families will receive "use it or lose it" subsidies to buy coverage. Obviously, given their health status these credits will be lower than average.

The remaining 40 percent or so of the uninsured earning less than \$50,000 are not eligible for public coverage. Over half of this group earns less than \$20,000 per year. Around half of the group are employed by small firms (less than 50 workers). Some studies indicate that around 75 percent of the uninsured are so because of high cost. It makes sense that this is an even more important reason for those earning under \$50,000. Reducing premiums is crucial for enrolling these individuals. We believe that our "use it or lose it" subsidy proposal based on health status and income level will be a powerful motivator for health plan enrollment.

How many of the 70 percent of the uninsured ineligible for public coverage will actually sign up under the Flint Hills Plan? Research on the demand for health insurance indicates a price elasticity in the range of $-.5$. That is, a 10 percent reduction in real premiums will increase enrollment by 5 percent. This figure is even higher for those below the poverty level with elasticities in the $-.8$ to $-.9$ range. We believe that the "full court press" of the SGIX in encouraging insurance enrollment will increase the sensitivity to price. It could be in the range of -1 . Thus, a 10 percent decrease in premiums might increase coverage by around 10 percent. Given the premium reductions from SGIX efficiency and the state subsidy we are advocating, the increase in insurance coverage could rise by 30 percent. **The combination of enrolling those eligible for public coverage along with non-eligibles suggests that a short-term reduction in the number of uninsured of 50 percent is possible.**

CONCLUSION

Kansas has an uninsured problem that is likely to grow in the future if it is not addressed. Fortunately, there is a way to curtail this problem. Creating a real marketplace in health care will put Kansas on the path to solving this uninsured problem. It



will give individuals and small groups greater choices, increased quality, and portability in their health care and will lead to a greater number of insured Kansans.

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¹ For an excellent summary of how the U.S. health care developed see John Goodman and Gerald Musgrave's *Patient Power: Solving America's Health Care Crisis*, (Washington, DC: The Cato Institute, January 1994).

² Data from Bureau of Economic Analysis, author's calculations. See <http://www.bea.gov/>.

³ See, for example, "The Price Sensitivity of Demand for Nongroup Health Insurance," Congressional Budget Office, Background Paper, August 2005. Available at: <http://www.cbo.gov/ftpdocs/66xx/doc6620/08-24-HealthInsurance.pdf>.

⁴ See Joseph Newhouse, "Free For All? Lessons From The Rand Health Insurance Experiment," Harvard University Press, 1996, 339-340.

⁵ See Enthoven.

⁶ *Ibid.*

⁷ Enthoven "Market Forces and Efficient Health care Systems," *Health Affairs*, 23, no. 2, 2004, 25-27.

⁸ Jack E. Triplett and Barry P. Bosworth. "Productivity in Service Industries: Trends and Measurement Issues," Brookings Institution, November 2003. Available at: http://www.brookings.edu/es/research/projects/productivity/workshops/20031121_chapter4.pdf.

⁹ See Statehealthfacts.org from the Kaiser Family Foundation.

¹⁰ Uwe E. Reinhardt, "Breaking American Health Policy Gridlock," *Health Affairs*, Summer 1991, 100.

¹¹ Jim M. Verdier, "Medicare Advantage Rate Setting and Risk Adjustment," Mathematica Policy Research, October 2006. Available at: http://www.chcs.org/publications3960/publications_show.htm?doc_id=412536.

¹² See www.valueoptions.com/news/releases/rel;ease09292006.htm.

¹³ See, for example, "Health Insurance Mandates in the States," Council for Affordable Health Insurance, March 2006. Available at: http://www.cahi.org/cahi_contents/resources/pdf/MandatePub2006.pdf.

¹⁴ See Verdier.



¹⁵ See www.kff.org/mfs/medicaid.jsp?r1=KS&r2=US.

¹⁶ Data from the Tax Foundation, www.taxfoundation.org.

¹⁷ M.V. Pauly and J.C. Goodman, "Tax Credits for Health Insurance and Medical Savings Accounts," *Health Affairs*, Spring 1995;14:125-139.

¹⁸ See Sally Pipes, "Intensive Care for RomneyCare," *Wall Street Journal*, February 26, 2007, 19.

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