

Expanding Health Insurance Coverage

by Patrick M. Barkey

This is shaping up to be a year for significant changes to the American health care system. Congress has already enacted into law the reauthorization and expansion of the State Children's Health Insurance Program (SCHIP), funded largely through a 62 cent a pack increase in the federal tax on cigarettes. Extensions to Medicaid and funding for health information technology were passed in the recently enacted stimulus bill. And the Montana Legislature, at this writing, continues to debate the funding of the Healthy Montana Kids initiative approved by the voters last November.

Given the rhetoric of last year's presidential campaign, when both candidates promised more comprehensive changes, expectations are running high. But finding the consensus – and the money – that is needed to make

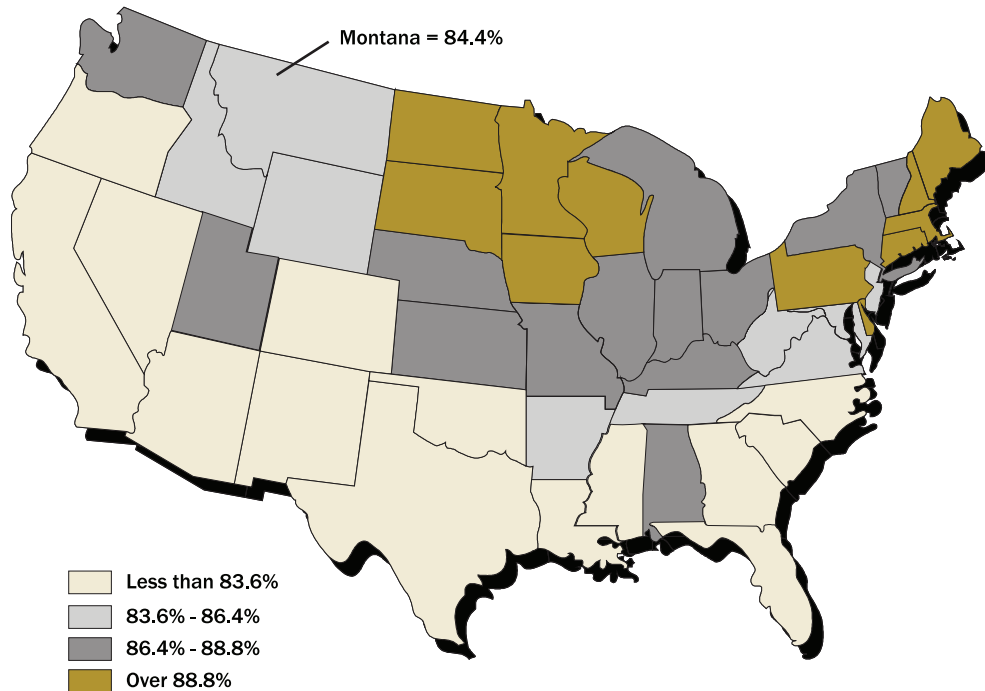
significant changes to the structure of health care delivery and finance remains, as always, an obstacle to change.

Where We Are Today

The health care system in the United States has evolved in a way that is distinctly different from that of other industrialized countries. The majority of the U.S. population (62 percent) has group health insurance from private companies that is offered – and substantially paid for – through arrangements with their employers.

This peculiar system – an artifact of tax law changes made during the wage and price control era of World War II – has endured for more than 60 years, largely for one simple reason: It has proven to be a very effective way of pooling risk. Since

Figure 1
Health Insurance Rates, by State, 2007



Source: U.S. Current Population Survey, March 2008 Supplement.

a large fraction of insurance premiums for most employer-sponsored group insurance plans are paid for by the employer, most employees usually enroll. This puts plenty of healthy, younger people in the risk pool, and helps make the inevitable cash transfers from the healthy to the sick sustainable.

But the problems with that system have been apparent for years as well. Since insurance is connected with employment, those without jobs are shut out. So are those whose employers cannot or do not offer insurance as a benefit.

And the falloff from employer-offered group insurance is steep. Individual insurance plans are usually uncompetitive, with high premiums and stingy benefits. Lower income households can't afford them and healthy, younger people don't buy them, producing a pool that is sicker and costlier than the general population, feeding a cycle that pushes up costs.

The Status of Health Insurance Coverage

The basic problem of the U.S. health care system, as many see it, is that many households have no insurance coverage. About 15 percent of the population, or 46 million people, are not covered by public or private health insurance. And substantial differences in insurance coverage exist between states and regions as well.

In 2007, 15.6 percent of Montana's population – over 147,000 people – lacked health insurance, according to the U.S. Current Population Survey. As shown in Figure 1, that puts us squarely in the middle of states on this score, between the more highly insured populations of the upper Great Plains states and New England, and the more sparsely insured south and southwest states.

But in Montana insurance coverage is much less likely to be the comparatively more generous employer-based plans than the nation as a whole, as shown in Table 1. Only 52.1 percent of Montanans were covered by such plans, compared to 62.7 percent nationally. The typical insured Montanan is more likely to have individual health plan coverage, or be covered by Medicare or a military-based health care plan, than his or her national counterpart.

Addressing the Situation

The plan put forth by President Obama during the presidential campaign contains a number of elements designed specifically to address gaps in insurance coverage, depicted in Table 2. Examining this plan highlights the issues involved in crafting policy to increase insurance coverage.

The National Health Insurance Exchange (NHIE) envisions a marketplace of regulated private insurance plans that would offer individual insurance policies that met criteria

Table 1
Health Insurance Coverage
Montana and U.S., 2007

| | Montana | U.S. |
|--------------------------------|-----------|------|
| | (percent) | |
| Covered by health insurance | 84.4 | 84.7 |
| Private health insurance | 67.6 | 71.9 |
| Employer-based group insurance | 52.1 | 62.7 |
| Public health insurance | | |
| Medicaid | 13.5 | 13.2 |
| Medicare | 16.1 | 13.8 |
| Military | 5.4 | 3.3 |
| Uninsured | 15.6 | 15.3 |

Source: U.S. Current Population Survey, March 2008 Supplement.

Table 2
The Obama Health Care Plan

| The Obama Health Care Plan |
|--|
| » National health insurance exchange |
| » Tax credits for low-income individuals |
| » Small business tax credit |
| » Pay-or-play for larger employers |
| » Mandates |

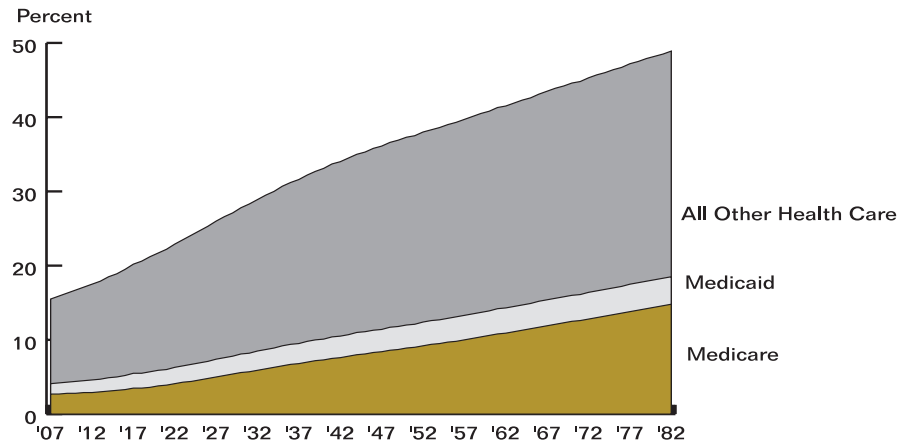
established by the federal government. Individuals could purchase plans from the NHIE with some confidence that regulators had looked over the details and declared them sound. One of the plans in the exchange would be a national health plan, offering benefits similar to those enjoyed by federal government employees.

Can private insurance companies with responsibilities to stockholders really compete with a federal health plan with access the public purse? That remains to be seen.

But making insurance available isn't enough. Low income households would need subsidies to afford it. In fact, the Obama plan calls for some level of subsidy for the NHIE for families and individuals with incomes up to 400 percent of the poverty line, or about 61 percent of the American population.

Part of the plan is to allow those who currently enjoy employer-sponsored group coverage the option of changing nothing. But that, in turn, depends on policymakers crafting penalties and incentives to maintain a careful balance. Since part of the plan is to impose a pay-or-play mandate on employers, who must either offer group coverage or pay a tax, regulators face a dilemma. If they make the penalty – the tax – too low, then employers will drop their expensive plans and pay the tax. If the penalty is too high, companies may reduce hiring or go out of business.

Figure 2
Projected Spending on Health Care
as a Percentage of GDP, 2007-2082



Source: Congressional Budget Office.

There are plenty of other provisions deserving of full treatment here, including small business tax credits, mandates for child health insurance, and pushes for electronic medical records.

Paying for It All

Even if the passage of some legislation that will expand insurance coverage looks certain, the cost of those reforms remains up in the air. Most plans either duck the issue entirely, or make unrealistic assumptions about the private sector's reaction to reform. Perhaps even more importantly, proposals to expand insurance coverage and help families pay their medical bills will almost certainly pour fuel on the fire of health care spending growth in general, which is clearly on an unsustainable trajectory.

Cost growth in health care is perhaps the single biggest issue impacting the long-run sustainability of entitlement programs and – ultimately – the federal government's long term debt. Since 1965, health care spending has grown from a 6 percent share of national output to more than 16 percent today. The Congressional Budget Office projects that by 2035 the health care share of the economy will be more than 30 percent, with public programs accounting for roughly half of the spending total.

Proposals to limit the growth in health care spending to date have mirrored the nature of the health care economy

itself. While the ideas themselves are varied – capping or reducing reimbursement payments to doctors and hospitals, allowing the reimportation of prescription drugs that sell for less in other countries, or ramping up the adoption of health information technologies – they all share one characteristic in common. They all top down, administrative solutions designed to restrict or redirect health care spending to cut waste and increase efficiency.

There are certainly plenty of examples of both to be found in health care. Yet previous efforts to do the same have not meaningfully impacted the trajectory of cost growth. One can only conclude that we have not yet discovered how to bring this trajectory down to earth.

Decision Time for Health Care Reform

Expectations of significant reform to health care are higher today than at any time since the first Clinton administration. But if curing the ills of our health care system were easy, it would be done by now. Let's hope that the reforms to come in the next year make the situation better instead of worse. □

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