Affordable Health Insurance for All

Karen Davis and Christine Haran[*]

Over the last year, lawmakers of both parties have embraced the importance of improving access to health care. Not only is health insurance emerging as a major issue in the 2008 presidential campaign, but state governors and legislatures are also pointing the way toward reform with innovative programs for their residents. In addition, business, labor, and consumer coalitions have endorsed moving forward on coverage for the uninsured.[1] Together, these developments suggest the time is ripe for the discussion of practical approaches to providing high-quality, affordable health care coverage to all Americans.

A Growing Problem

The renewed attention to health coverage reflects the growing urgency of the situation. There are currently nearly forty-seven million uninsured Americans—an increase of seven million since 2000.[2] An estimated sixteen million more adults are considered "underinsured" because they have high out-of-pocket health care costs relative to their income.[3] Where someone lives, as well as their income, is very likely to affect his or her insurance status. For example, the rates of uninsured non-elderly adults vary from eleven percent in Minnesota to thirty percent in Texas; two-thirds of all low-income adults ages nineteen to sixty-four lack insurance or are underinsured.[4]

Yet, the inability to afford health insurance affects both lower-income and middle-income households. Both groups have been affected by marked declines in employer coverage. For example, the percentage of non-elderly adults at 400% of the federal poverty level that spend at least ten percent of their disposable income on family out-of-pocket medical costs and premiums rose from seven percent in 1996 to ten percent in 2003.[5]

Health care experts, industry leaders, and the public agree that covering the insured should be the top health policy priority for Congress and the president.[6] The severe consequences of being uninsured or underinsured include: an estimated 18,000 lost lives annually; underuse of essential health care services; and poorly coordinated care that leads to duplicate tests, missing medical records, overuse of emergency care, and other inefficiencies.[7] Providing coverage clearly makes economic sense. The Institute of Medicine calculates the annual cost of coverage at $34 to $69 billion—less than the loss in economic productivity from gaps in coverage ($65 to $130 billion annually).[8]

Fortunately, the United States already has the building blocks needed to extend affordable health insurance to all and to improve coverage for the uninsured. Now it is a matter of bridging our political divides and putting these building blocks to good use.

Shared Responsibility

The foundation for affordable and high-quality coverage for all is the concept of "shared responsibility," which means that individuals, employers, and the government all bear the responsibility for health insurance. This approach includes an individual mandate that makes it

[*] Karen Davis is president of The Commonwealth Fund, a national philanthropy engaged in independent research on health and social policy issues. Christine Haran is the Web Editor at The Commonwealth Fund.

every individual's responsibility to have coverage and to be able to pay for care when they need it. The individual mandate is an integral part of the coverage plan under way in Massachusetts, Governor Schwarzenegger's proposal for California, and presidential candidate John Edwards's health plan. To make the individual mandate realistic, these plans will have to follow through on proposals to provide premium assistance for low-income residents and expand public programs.

Likewise, it is critical that employers—still the backbone of our health insurance system—continue to play a major role. Employers agree. A recent survey revealed that employers say that they should share in the cost of health insurance for employees, either by covering their own workers or by contributing to a fund to cover the uninsured.[9] When employers do not provide health insurance to their own employees, those workers' medical costs are met by other sources—mostly other employers.[10] In 2004, employers that cover their workers spent an estimated $31 billion for working spouses through dependent coverage. The cost of health care for workers that are not covered through their employers is also borne by public programs ($8 billion) and shifted to the insured through uncompensated care ($13 billion).[11]

The third component of shared responsibility is the government. The government will need to extend its largely successful public programs, such as Medicare and the State Children's Health Insurance Program (SCHIP), to cover uninsured older adults and low-income families and provide sliding-scale premium assistance to working families.

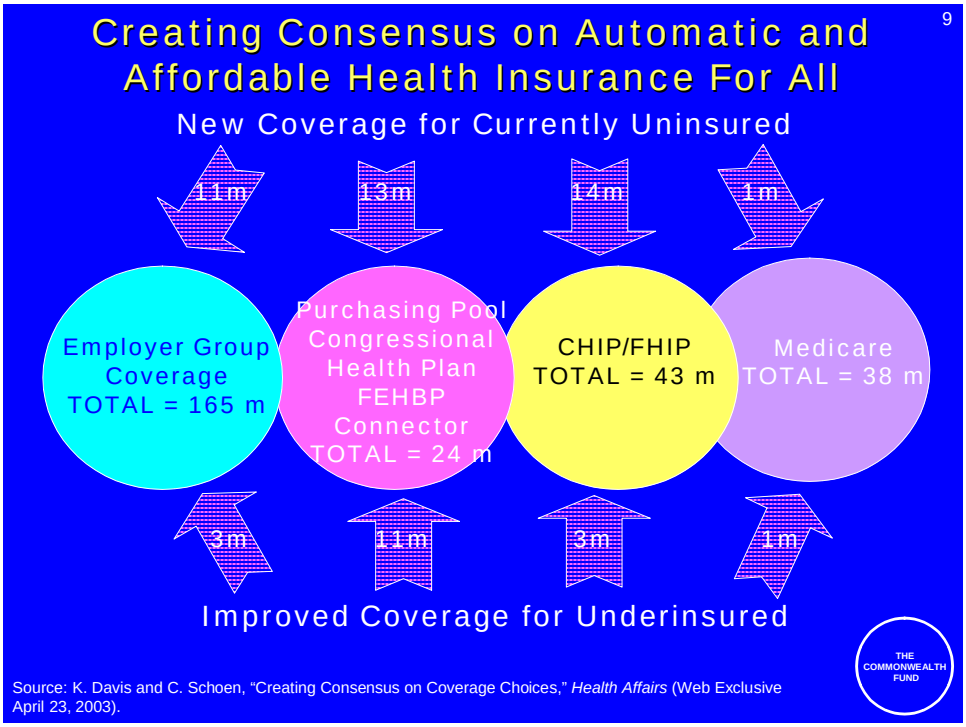
Most proposals under discussion build on a "Creating Consensus" framework that incorporates public and private approaches to affordable, high-quality coverage and supports the shared responsibility concept.[12] The framework involves: (1) automatic enrollment in health insurance, with premium assistance available on a sliding scale based on family income; (2) employer group coverage expansion; (3) a new purchasing pool for individuals and small businesses; and (4) public program expansion.

Requiring individuals to have coverage ensures take-up by healthy individuals, especially young adults, who might otherwise go without coverage and gamble that they will not incur a serious illness or injury. An alternative is to automatically enroll everyone who does not verify coverage when filing income tax returns but with an opt-out for those who can afford to remain uncovered. Sliding-scale premium assistance through refundable tax credits, for example, would be available to subsidize premiums that exceed five percent of income (or ten percent of income for those in higher tax brackets).[13]

Employer coverage would remain the mainstay of the group health insurance system. However, incremental changes could improve coverage. Such changes could include: covering young adults under their parents' policies up to age twenty-three or twenty-five, whether or not they are full-time college students; limiting waiting periods for new employees; and continuing coverage for employees for two months after termination of employment. Employers that do not provide health insurance could be required to contribute up to $1 per hour worked, or five percent of payroll earnings toward a new group insurance option.

This new option would make the health plans offered to members of Congress (an idea sometimes called the Congressional Health Plan) available to individuals or create a state purchasing pool of private insurance plans meeting certain requirements, such as covering the sick as well as the healthy and charging the same premium to all. The self-employed, employees of businesses with fewer than fifty workers, and the uninsured would be eligible to purchase coverage through the federal or state purchasing pool, with premiums effectively capped as a percent of income through provisions in the income tax code.

Finally, public programs would be expanded. A Medicare "Part E" could extend the program to dependents of current Medicare beneficiaries, older adults under age sixty-five, and the disabled that are in the two-year waiting period for Medicare. Likewise, SCHIP, perhaps renamed the Family Health Insurance Plan, could be expanded to cover all individuals and families with income below 150% of the poverty level.



Many new health plans, including the Massachusetts and California plans, Senator Ron Wyden's "Healthy Americans Act," Representative Pete Stark's "Medicare for All" plan, and John Edwards's plan, incorporate some or all features of the "Creating Consensus" framework. The pooling option for individuals, for example, is called the Commonwealth Connector in Massachusetts and the Insurance Exchange in the proposed California plan. Representative Stark would use the Medicare program as the purchasing pool, while John Edwards would use state or regional markets but with a Medicare-like plan offered as one option. Similarly, these plans call for contributions from employers that do not provide coverage, and the Massachusetts and California plans expand their Medicaid programs.

Evaluating Benefits and Costs

The combined strategies proposed in "Creating Consensus" not only would improve coverage of the uninsured and underinsured, but also would lead to greater stability of coverage and care. Savings would come from reducing the high administrative costs associated with turnover and gaps in coverage and from replacing private coverage with public coverage that has lower overhead. Stronger group coverage, in turn, could help reduce prescription drug costs and provider payment costs due to drug price negotiation and improved purchasing power.

The coverage extensions will therefore lighten the financial burden on the uninsured and underinsured, reduce uncompensated care costs to safety net providers offering charity care,

ease the burden on states that are already covering the uninsured, and provide an estimated $20 billion in savings to those businesses that are providing insurance.

Still, there are upfront costs associated with establishing high-quality affordable coverage. Revenue will be needed to expand coverage to the uninsured and underinsured and to increase financial assistance to those with high out-of-pocket expenses or premiums. In short, there is a need for an increase of about $70 to $100 billion per year in federal financing to provide fiscal relief to states that have already expanded coverage to their uninsured residents and to cover administrative costs for the new insurance options.[14] A new revenue stream will be required, such as new taxes or a rollback of the recent tax cuts for the wealthy.

Not everyone will come out a "winner" in the short-run in this national undertaking to streamline and improve our health insurance system. Among those affected would be employers that do not currently cover their workers; industries affected by cost-containment provisions, such as insurers, pharmaceuticals, and health care providers that do not serve the uninsured; and perhaps higher-income taxpayers who could fund subsidies for the low-income insured.

Investing Savings Derived from Increased Efficiency

Some savings could come from efforts to improve efficiency. Savings could include the establishment of quality standards to control costs for the chronically ill—high users of health services who account for a significant share of health care spending overall. Likewise, investment in patient-centered primary care to improve chronic care, reduce hospital admissions, and improve preventive care would lead to savings. Similarly, investment in better health information technology and state-based health care information exchange programs could reduce inefficiency though the sharing of online medical records and more.[15]

Reforming payment of providers to reward efficiency as well as clinical quality and patient-centered care is another strategy, which is known as pay-for-performance (P4P). Under the current system, providers are rewarded for providing more and more expensive care, rather than evidence-based care given over an entire episode of care, such as surgery for a hip replacement and subsequent therapy and recovery. A P4P demonstration program led by Premier Inc., an alliance of nonprofit hospitals, and the Centers for Medicare and Medicaid Service has shown that the processes of care that the program has established and rewarded may have improved outcomes and cut costs.[16] Other P4P demonstrations in Medicare are currently under way, and many private health plans are also experimenting with P4P.[17]

Another key component in the drive to increase efficiency is increased transparency in health care. Today, consumers, insurers, and even other providers rarely have access to information on a provider’s clinical quality or their provision of patient-centered care and records on efficiency. With such information publicly available, all parties could make better health care decisions.

States Paving the Way for Federal Action

While support for affordable health care coverage for all is building, the prospect of a federal initiative still seems remote because of the budget deficit, dramatic tax cuts, party divisions in Congress, and the Administration's approach to health care. Rather than wait for the right political moment nationally, several states, including Maine, Massachusetts, and Vermont, have already extended health care to all. Other states, including California, have proposed plans to cover their residents.[18]

All of the initiatives under way, however, are in states with relatively small uninsured populations. And, they all draw on federal matching funds, which are critical to any state program's success. In recognition of the need for federal financing and leadership, bipartisan bills have emerged in Congress that would provide federal funding for state expansion efforts. For the United States to achieve a high-performing health system that provides affordable access to high-quality care to all, both state and federal commitments are absolutely necessary. Until that time, uninsured and underinsured Americans will continue to struggle to pay for often-inadequate care, while insured Americans will foot the bill by taking on ever-higher health care costs.

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