
**Covering
America**

REAL REMEDIES
FOR THE UNINSURED

Lessons from

Cost and Coverage Analysis of Ten Proposals to Expand Health Insurance Coverage

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Summary

Lessons of the Cost and Coverage Analysis

The Lewin Group's analysis sheds light on important questions facing the country as it grapples with the continuing problem of more than 40 million Americans without health insurance. Following are key lessons of this analysis, which estimates the cost and coverage results of ten comprehensive reform proposals commissioned by the Economic and Social Research Institute.

- 1) **Significant progress in covering the uninsured is possible.** These proposals would reduce the number of uninsured by 12 million to 40 million (out of an estimated 41.9 million who were without coverage in 2002).
- 2) **Covering the uninsured would cause a relatively small increase in total national health care spending.** Financing this new spending may cause significant shifts in the distribution of health costs and savings among households, employers, and government. Most approaches require substantially increased federal spending.
 - a) These reform proposals would increase total national health care spending by 1.5 percent to 3.7 percent—that is, \$23 billion to \$57 billion more than the \$1.5 trillion we spent in 2002. In important ways, the net increase in national health spending is the best measure of reform's total cost, since it reflects the amount of new real resources that would be diverted to produce medical services and would therefore not be available for other uses.
 - b) Regardless of how reforms are structured, households ultimately pay all increased health costs, whether in direct payments for health care, increased taxes, lower wages, or higher prices for other goods and services. Nevertheless, the proposals allot the initial costs of purchasing coverage quite differently, because they make different trade-offs among competing goals. Under the proposals, direct household premium payments and other costs decline between \$3 billion and \$187 billion a year. The impact on employer spending ranges from a \$69 billion annual increase to a \$77 billion annual savings. State and local spending varies between a decrease of \$28 billion and an increase of \$6 billion. And federal health spending is projected to increase between \$34 billion and \$552 billion a year.
- 3) **Health reform involves difficult trade-offs among important goals.** There is no ideal solution to the problem of the uninsured. Most proposals combine coverage expansion with other objectives, such as fairness to the currently insured, limiting growth in total national health care spending, limiting the amount of new federal spending, targeting new federal spending to just the previously uninsured, and increased consumer choice. Such goals cannot all be achieved simultaneously. Decision-makers must balance these objectives and make trade-offs among them.
- 4) **Proposals that reach universal coverage (or come close) involve either a mandate or some form of legally guaranteed coverage.** The proposals that cover nearly all of the uninsured (37 to 40 million) either guarantee coverage to every citizen or require employers or individuals to purchase coverage. The other proposals avoid these features, thereby sidestepping the philosophical and practical concerns that some have expressed about mandates and guarantees of coverage. However, they cover a smaller, though still significant, number of uninsured (12 million to 27 million). This tension between preserving a voluntary and non-guaranteed system of health insurance, on the one hand, and maximizing increased coverage, on the other, is one of the central trade-offs facing policymakers.

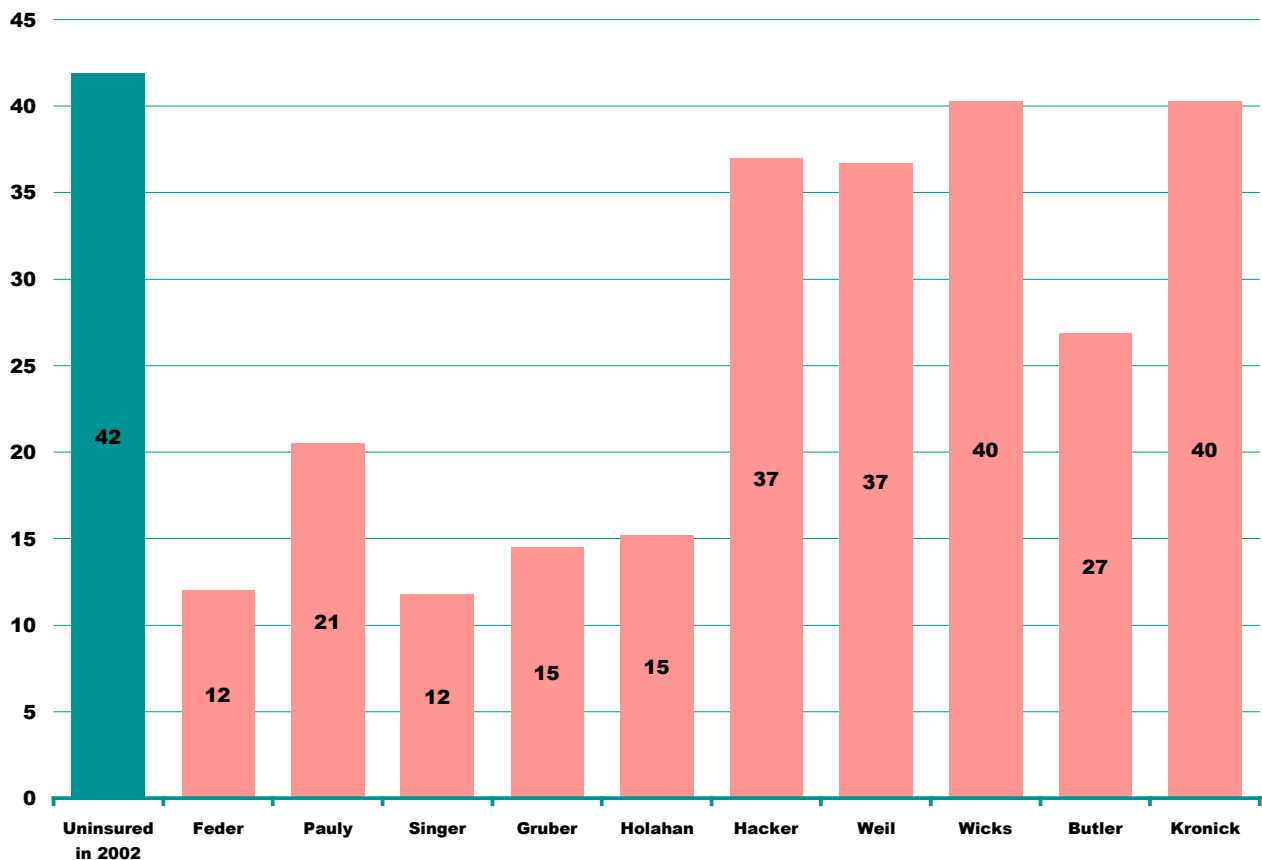
LESSONS OF THE LEWIN COST AND COVERAGE ANALYSIS

In 2000, the Economic and Social Research Institute commissioned 10 proposals to substantially reduce the number of people without health insurance. John Sheils and Randall Haught of the Lewin Group analyzed these proposals to determine how many people they would cover and how much they would cost. (Subsequently, seven more proposals were commissioned, but they are not included in the cost and coverage analysis. All 17 proposals can be found at www.esresearch.org.) Four key lessons of this analysis follow.

Significant progress in covering the uninsured is possible

The ten proposals embody diverse philosophies and approaches, ranging from individual health insurance tax credits to legally guaranteed and federally financed coverage for all. According to the Lewin estimates, all the proposals would substantially reduce the number of uninsured. The number of newly covered Americans would range from 12 million to more than 40 million (of an estimated 41.9 million uninsured in 2002). Clearly, there are many ways to achieve significant progress in covering the uninsured. (Here and in all subsequent graphs, the proposals are identified by the name of the lead author.)

Figure 1: Number of Uninsured Who Would Be Newly Covered, 2002 (millions)



Covering the uninsured would cause a relatively small increase in total national health care spending

Financing this new spending may cause significant shifts in the distribution of health costs and savings among households, employers, and government

Most approaches require substantially increased federal spending

Increased Net Health Spending

There are a variety of ways to look at the increased cost of coverage expansion proposals. One of the most important cost measures is the change in total national health spending. This represents the additional spending going to the health sector of the economy. Total health spending could change for at least four reasons:

1. previously uninsured people use more medical services;
2. previously insured people whose coverage is now more or less comprehensive change the amount of health care they consume;
3. health care services are provided more or less efficiently—for example, if an expansion proposal includes cost containment provisions that produce real resource savings;
4. provider reimbursement levels change—for example, if an expansion proposal shifts people from low-paying Medicaid into higher-paying private insurance coverage, or because increased demand for provider services drives up fees.

The first three contributors to new health spending are in many ways the most important. They represent the real resource cost of coverage expansion—the manpower, capital equipment, and other resources that are used to produce health services and are thus not available to produce other goods and services that people value. These costs represent other opportunities foregone because of the decision to expand the health sector.

The estimates indicate that the net effect of the interaction of these factors is an increase in overall health spending. However, compared to the total amount we already spend for health care, the cost of coverage expansion is relatively small. In 2002, the nation spent an estimated \$1.5 trillion for health care. If fully implemented in 2002, the expansion proposals would have added from \$23 billion to \$57 billion to the \$1.5 trillion base, which, though large in absolute terms, represents an increase of only 1.5 percent to 3.7 percent. From 1997 to 2002, the average annual increase in health spending was 7.2 percent. Thus the additional increases estimated for the expansion proposals are equivalent to about one-half or less of the normal increase in health spending that occurs each year for other reasons. (See Figures 2 and 3 below.)

Changed Distribution of Health Financing

Another important way to look at costs is to examine who pays the health care bill. Households ultimately bear all costs of financing health care—in the form of direct payments for health services, as part of the price of non-health goods and services, as reduced wages or other compensation, or as taxes. Nevertheless, it is also important to analyze how the initial financing of the health care bill is shared among the various payers. Even though many coverage expansion proposals produce only a relatively small increase in total health expenditures, they may cause large shifts in the distribution of health care financing among households, employers, and government. These shifts occur for several reasons:

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- To make coverage more affordable for those who are currently uninsured, all the proposals provide subsidies to lower-income people, high-risk individuals, or small or low-wage employers. The result is that the cost borne by the federal government—and, in a few instances, state governments—increases.
 - Most proposals provide government subsidies to some people who already purchase health coverage without subsidies. These are people who are covered by their employers or purchase coverage in the individual market but switch to the new public program or become eligible for subsidies. To some extent, this shifting from the private sector to the public sector may be unintentional but unavoidable; it is often impossible to design a structure that keeps all currently insured people from taking advantage of the new subsidies. In other cases, the shifting may be intentional. Some authors give priority to achieving greater horizontal equity by providing subsidies to needy people who already have coverage (sometimes bought at considerable financial sacrifice). Others maintain some subsidies for higher-income people in order to gain their political support. Still other authors conclude that access to health care coverage should be a right of all citizens without any income test. In each case, the result is an increase in federal expenditure levels. Of course, this increase is offset by a reduction in the share of expenditures borne by either households or businesses.

The proposals assign initial costs quite differently to households, employers, and government, based on the trade-offs authors are willing to make and the objectives they seek to promote in addition to expanding coverage.

- Household payments of health premiums and out-of-pocket health costs decline between \$3 billion and \$187 billion a year.
- For employers, the impact on health spending ranges between a \$69 billion increase and a \$77 billion annual savings.
- State and local health care spending would fall under most proposals, by as much as \$28 billion, and rise under a few, by as much as \$6 billion per year.
- Federal costs would grow between \$34 billion and \$552 billion annually.

It is useful to look at a few more specific examples of why proposals distribute costs so differently. For instance, both the Wicks and Butler proposals substantially reduce premiums and out-of-pocket payments for households, but households' take-home pay would decline because the proposals end the tax exemption for employer-paid insurance premiums. The Kronick and Hacker proposals increase employer payroll taxes while making substantial offsetting reductions in firms' health premium payments. Similarly, although the Gruber proposal would increase federal spending substantially, that federal spending would reduce premium payments by both households and employers, provide new premium subsidies for employers, and lower out-of-pocket costs for households.

Charts 4 through 7 show how health spending would change under each of the proposals for households, employers, and government. It is important to note that the shares cannot be summed in a direct way for each proposal, because some health-related expenditures appear as costs for more than one sector. For example, payroll taxes that finance some of the plans appear as costs for the households and employers who pay those taxes (Figures 4 and 5), but they also show up as federal expenditures for health insurance (Figure 6 and 7).

Figure 2: Annual National Health Spending: Current Total vs. New Costs Under Reform Plans, 2002 (billions)

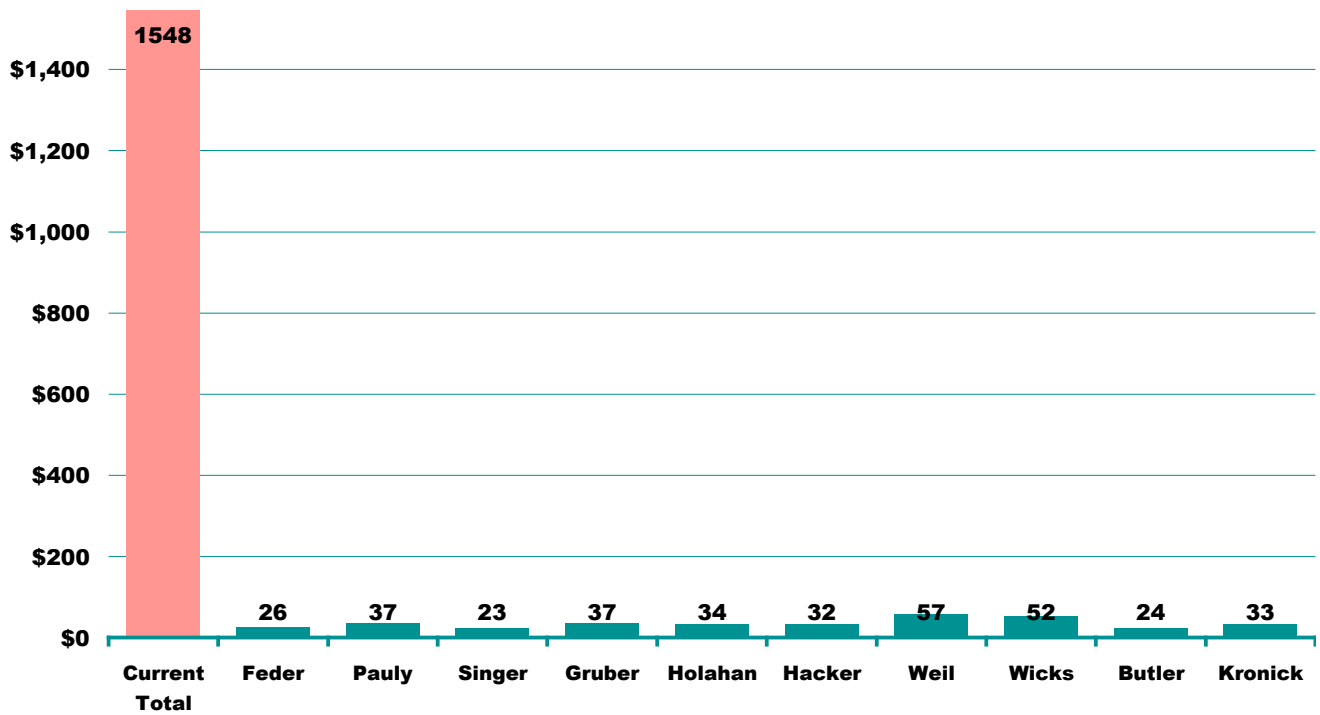


Figure 3: Average Annual Rate of Growth in Total Health Spending, 1997-2002, vs. Percentage Increase in 2002 Health Spending Under Reform Plans

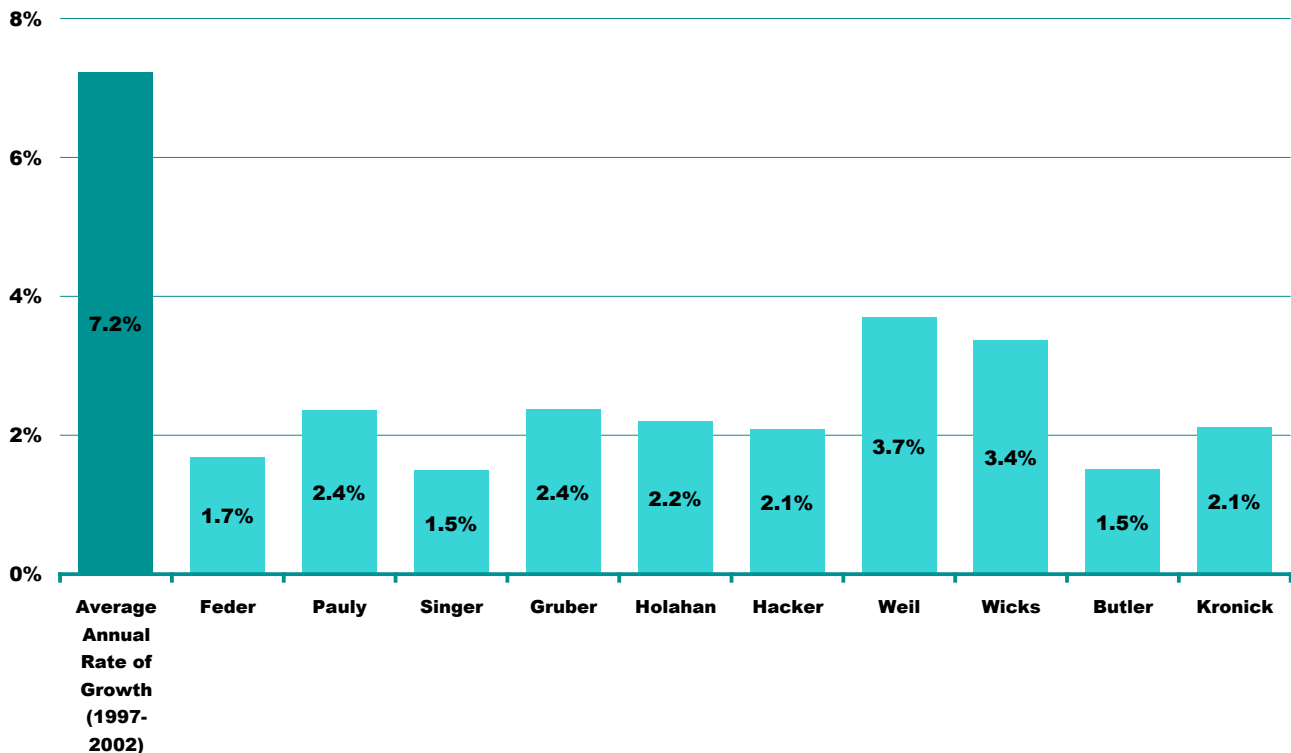
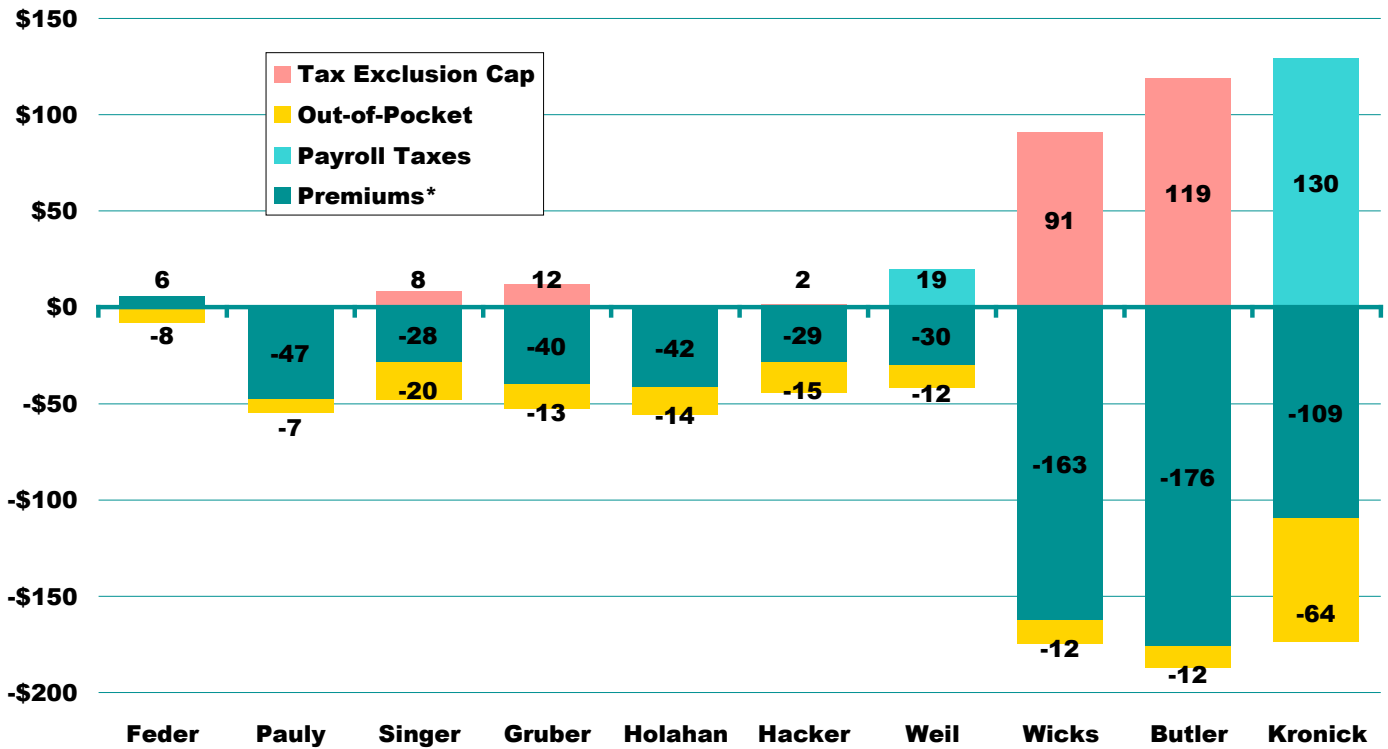


Figure 4: Change in 2022 Household Spending (billions)



*Before wage effects and increase in income taxes/general revenues.

Figure 5: Change in 2022 Employer Spending (billions)

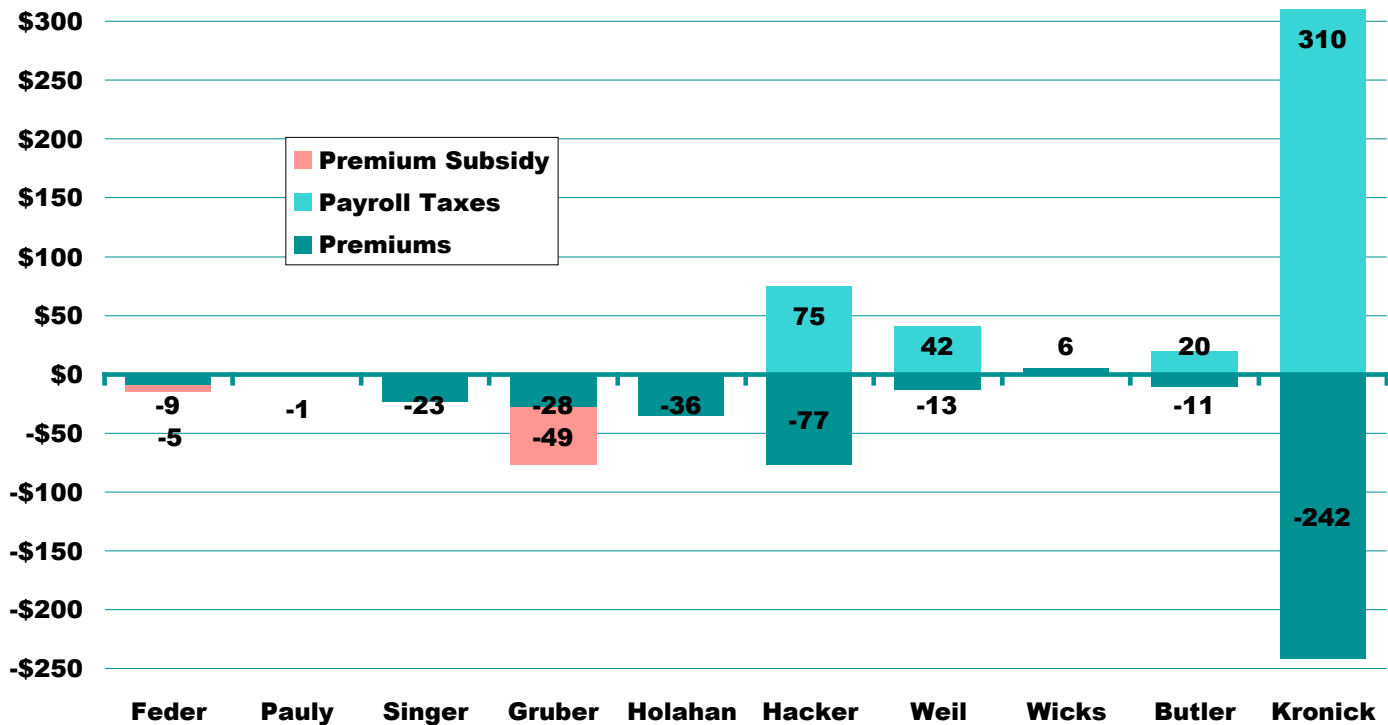


Figure 6: Net Annual Change in Federal and State-Local Spending, 2002 (billions)

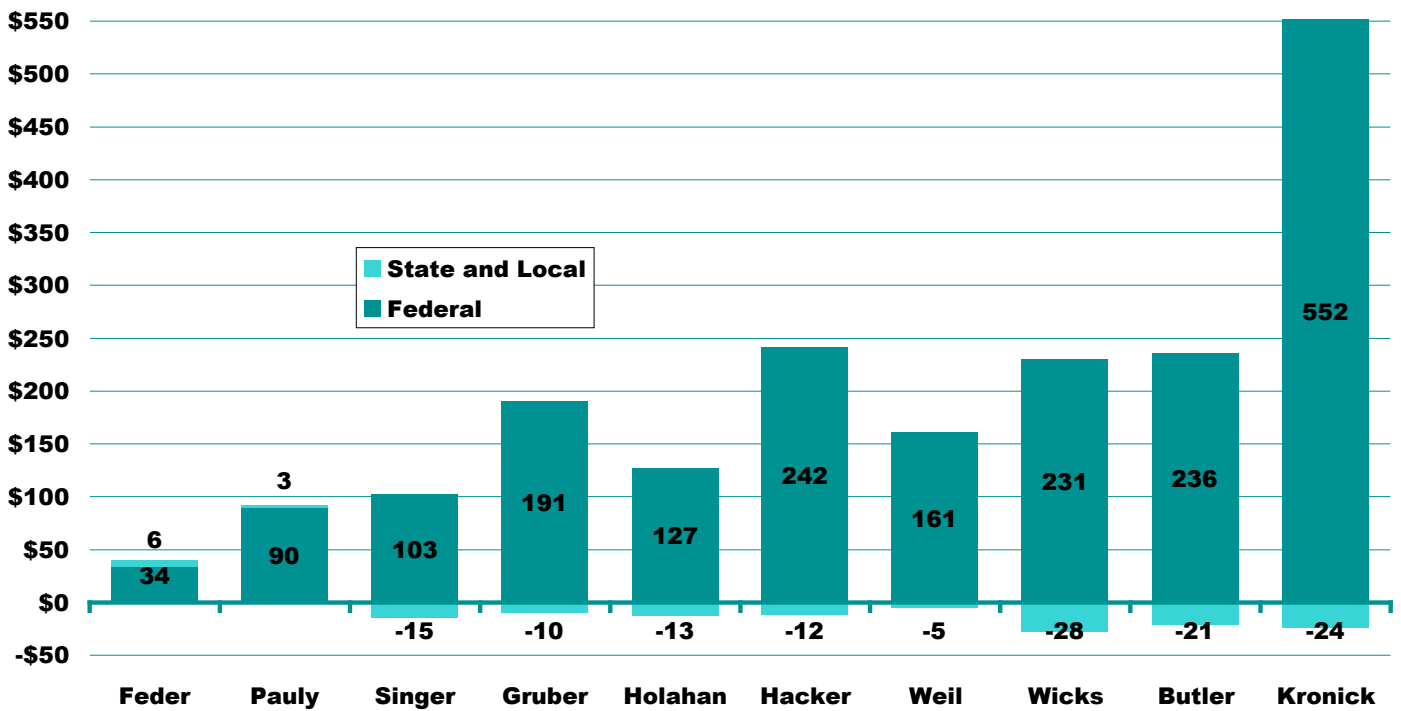
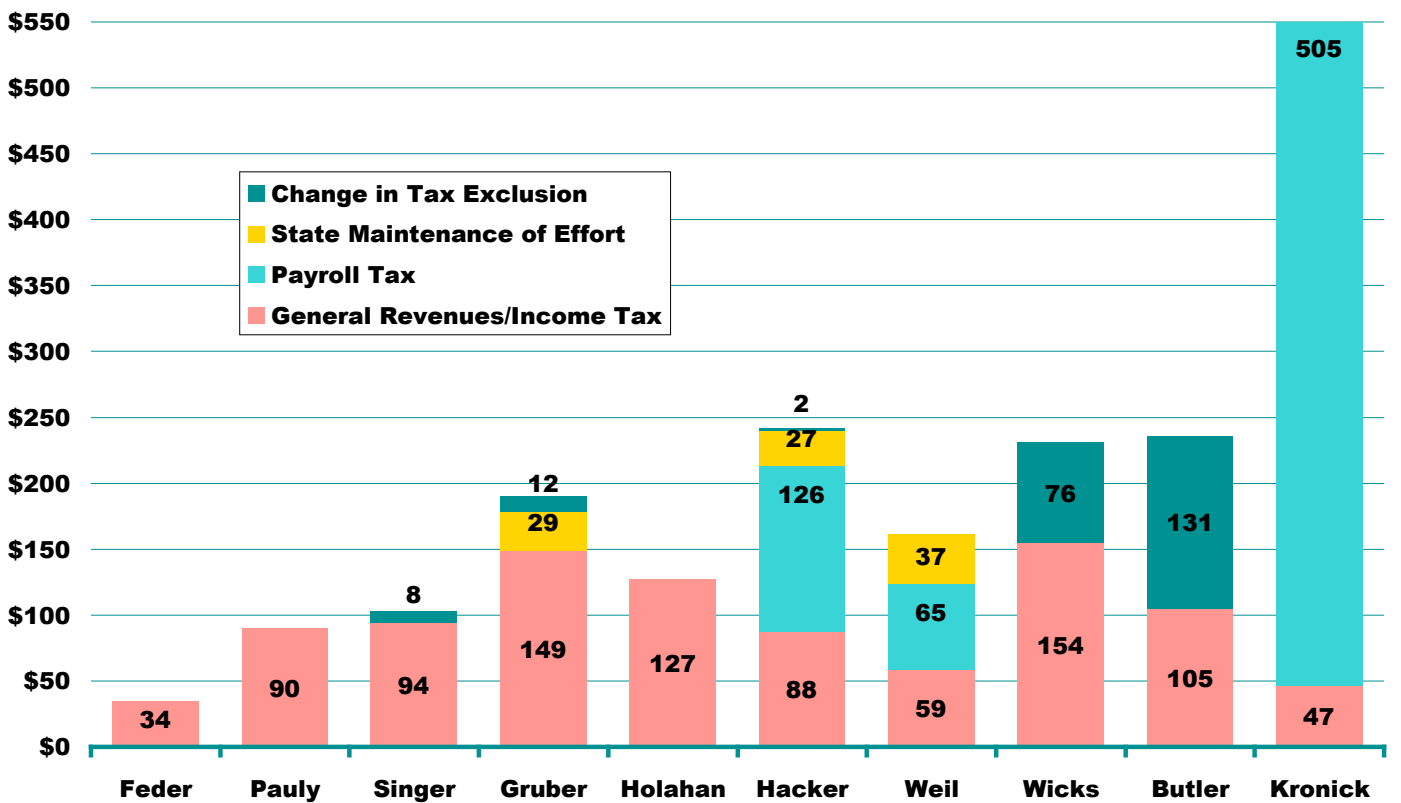


Figure 7: Sources of Federal Financing, 2002 (billions)



The proposals make difficult trade-offs among competing goals

In deciding how to structure major reforms, policymakers must balance a number of goals, which may include the following:

- covering a large number of people who otherwise would be uninsured;
- avoiding unfair treatment of currently insured individuals;
- limiting the extent of new federal spending;
- limiting growth in total national health spending;
- increasing consumer choices among health plans and health care providers;
- improving quality of care; and
- limiting the amount of new federal spending that goes to people who already have coverage.

Frequently, pursuing one goal requires trading-off another. For example, a number of proposals deliberately incur additional federal costs to accomplish goals other than expanded coverage:

- Some tax credit proposals shift hundreds of billions of dollars in annual premium costs from currently insured, lower-income households to the federal government. This serves “horizontal equity” by providing the same level of tax subsidy to all similarly situated, low-income individuals, including both the uninsured and those who previously purchased coverage on their own (sometimes at considerable financial sacrifice).
- Some proposals seek to limit future growth in national health care spending and to increase consumer choice through insurance pools that offer multiple health plan options, with federal premium subsidies, on terms that give consumers incentives to select less expensive coverage. However, because such pools are not limited to the newly insured but also serve numerous workers who previously received employer-sponsored coverage, some of these proposals, depending on how they are structured, may shift billions of dollars in annual health premium costs from employers to government.

In contrast, other proposals prioritize the competing policy goal of limiting new government spending to just the uninsured, whenever possible. By reducing the shift of current private-sector costs to the public sector, such proposals spend fewer government dollars per newly insured person. This does not mean that the proposals with a higher ratio of new federal spending to coverage gains are accidentally inefficient. Rather, proponents of these higher-ratio proposals intentionally prioritize other objectives (such as consumer choice, equally subsidizing individuals with similar incomes but different prior insurance status, and slowing the growth of national health care spending) over target efficiency.

In sum, there is no problem-free solution to the problem of the uninsured. Policymakers must inevitably resolve trade-offs among competing, desirable objectives.

Proposals that reach universal coverage (or come close) involve either a mandate or some form of legally guaranteed coverage

The proposals that cover nearly all of the uninsured (37 to 40 million) either require employers or individuals to pay for health insurance (proposals by Weil, Hacker, and Wicks) or guarantee coverage to every citizen (the Kronick proposal). The proposal without these features that comes the closest to this level of coverage (by Butler) automatically enrolls eligible individuals by default unless they opt out of coverage. Under the latter approach, 27 million currently uninsured Americans receive health insurance.

Some of these policy elements—particularly mandates—have been controversial, with many policymakers and stakeholders expressing strong opposition. The other proposals do not include mandates, guarantees of coverage, or default auto-enrollment mechanisms and so avoid such controversies. But they cover significantly fewer uninsured (albeit still a large number—12 million to 21 million).

This analysis suggests that policymakers may face a basic tradeoff between preserving a voluntary and non-guaranteed system of health insurance and maximizing the increased coverage that results from reform. Automatic enrollment mechanisms appear to increase the coverage gains from voluntary and non-guaranteed systems, but even policymakers incorporating auto-enrollment strategies must decide whether to seek the additional increment of coverage that would result from mandates or legal guarantees of health coverage.