DataWatch

The Public Cost Of Expanding Coverage

by John F. Sheils, Raymond J. Baxter, and Randall A. Haught

Abstract: The 103d Congress considered several health care reform bills that would encourage voluntary expansions of coverage through insurance market reforms, new tax deductions for premiums, and direct premium subsidies for low-income persons. We found that insurance reforms alone will do little to expand coverage. We also found that most of the proposed tax deductions would go to persons who already have insurance and would have little impact on coverage. Premium subsidies for low-income persons would greatly increase coverage. However, coverage would change little for those who would have to pay all or part of the premium.

If we learned anything from the health care reform debate of 1993-1994, it is that there is no free lunch. Although there surely is waste in the system, no collection of delivery system reforms will get the price of health insurance down to the point at which a single parent with three children earning $8,000 per year will be able to afford a comprehensive family insurance policy that in today's market costs $4,500 or more per year. If we want families like these to have insurance coverage, we must help them pay for it-to the tune of $40-$60 billion per year. We can pretend that we are paying for these subsidies by reducing provider payments under Medicare and Medicaid, but this only shifts provider costs to private payers, which in the end is nothing more than a tax on privately insured persons.

At the close of the 1994 legislative session, Congress was considering several health care reform bills, most of which would encourage people to obtain coverage voluntarily through insurance market reforms, tax deductions for premium payments, and direct premium subsidies for low-income persons. Our analysis indicates that insurance market reforms alone will do little to expand coverage. We also found that providing additional tax deductions for insurance purchases would have little impact on coverage because the families benefiting most from these deductions would be in upper-income groups made up of mostly insured persons. However, we found that direct premium subsidies for low-income persons would induce a significant number of the nation's thirty-nine million uninsured persons to

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obtain coverage.

Most of these bills include small employers in a community-rated insurance pool together with nonworkers who purchase private coverage. This tends to increase small employers' premiums because, on average, nonworking persons use about twice as much health care as workers use. Including nonworkers in the community-rated pool would effectively raise small employers' premiums by 25 percent or more while reducing premiums for the nonworking population by as much as 50 percent. It also would tend to reduce the federal cost of subsidizing premium purchases for nonworkers, most of whom would qualify for subsidies under these bills. This DataWatch summarizes the estimates of coverage and costs under these bills that we developed using the Lewin-VHI Health Benefits Simulation Model.[1]

Alternative Health Care Reform Bills

At the end of the 103d Congress, there were several bills under consideration that are likely to serve as starting points for health care reform efforts in the 104th Congress and beyond. These include Rep. Richard A. Gephardt's (D-MO) universal coverage bill and four bills emphasizing voluntary expansions of coverage, including the bills proposed by Sen. George J. Mitchell (D-ME); Rep. J. Roy Rowland (D-GA); Senators Robert Dole (R-KS) and Bob Packwood (R-OR); and the so-called Mainstream Coalition in the Senate.

Representative Gephardt's bill is designed to achieve universal coverage by the end of the century by requiring employers to cover their workers and by requiring all persons to have coverage. Senator Mitchell's bill also would rely upon mandates but only if the insurance reforms and premium subsidies proposed in the bill fail to expand coverage to 95 percent of the population by the turn of the century. The bills proposed by Representative Rowland, Senators Dole and Packwood, and the Mainstream Coalition also would expand coverage through insurance reform and premium subsidies but would not resort to mandates even if coverage goals are not met.

All of these bills include insurance market reforms that are designed to assure that coverage is available to all, regardless of health status. These proposals also would fully subsidize premiums for persons below poverty and would provide premium subsidies on a sliding scale with family income through 200 percent of poverty (150 percent of poverty under Dole/Packwood). Additional subsidies are provided to children and pregnant women through 300 percent of poverty under the Mitchell bill and 240 percent of poverty under the Rowland and Mainstream bills. Persons now covered by Medicaid would obtain subsidized private insurance under the same rules that apply to the general population in all of these bills except

the Mainstream bill, which retains the Medicaid program.

Premiums Under Alternative Reform Bills

A unique feature of the Gephardt bill is that it would create a Medicare Part C program to provide coverage for nonworkers, firms with fewer than 100 workers, and many persons who are eligible for Medicaid. The Medicare Part C premium would be about $190 per person per month in 1998, which is about 8 percent higher than the per capita monthly premium for private firms excluded from Part C ($177). This reflects the fact that Part C would include many nonworking adults, who use up to twice as much health care as workers use (Exhibit 1).[2]

Premiums would vary widely under the four voluntary enrollment bills, primarily because of differences in the health status and health care utilization patterns of persons included in the community-rated pools under these bills. Under all of the voluntary enrollment bills, the premium in the community-rated pool would be higher than for employer groups that are excluded from the pool. For example, the monthly premium for employers outside of the community-rated pool would be about $162 per person, compared with premiums in the community-rated pool as high as $202 under the Rowland bill (Exhibit 1). This reflects the fact that the community-rated pool under these bills includes higher-cost nonworking adults as

Exhibit 1
Monthly Premiums In Community-Rated Pools Created Under Alternative Health Reform Bills In 1998

	Gephardt bill		Community-rated groups				Groups not in community rate
	In Medicare Part C	Out of Medicare Part C	Mitchell	Mainstream	Rowland	Dole/ Packwood	
Family type							
Individual	$268.25	$211.83	$227.79	$212.62	$245.24	$245.24	$196.80
Couple	536.50	423.66	552.70	509.34	550.84	474.92	456.98
Two parents	533.00	542.92	579.75	472.67	608.37	553.41	489.05
One parent	460.91	359.08	538.26	304.57	614.77	649.40	300.82
Child-only coverage							
One child	-	-	94.48	80.43	101.07	-	-
Two or more children	-	-	255.32	217.28	273.02	-	-
Per capita cost	190.01	177.12	191.70	177.05	202.21	200.29	162.48

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).
Notes: Assumes that eligibility for subsidies is fully phased in in 1998 under all bills. All but the Gephardt bill assume voluntary enrollment. The standard benefit package under the Gephardt bill is the Medicare package expanded to include prescription drugs and preventive care. Assumes Medicare payment rates in Part C. The standard benefit package under all of the voluntary enrollment bills is the Blue Cross/Blue Shield standard option for federal employees, expanded to include preventive care.

well as many pregnant women and persons with chronic conditions who are now covered by Medicaid.

The Mitchell bill pools firms with fewer than 500 workers together with persons purchasing individual, nongroup insurance and many of those now covered by Medicaid. The community-rated premium in the pool would be $192 per person per month in 1998, an amount based upon the overall average cost of the various groups in the pool. The average monthly per capita cost for employer groups in the pool would be $154, compared with $189 for individuals and $288 for Medicaid recipients included in the pool. Thus, the impact of community rating under the Mitchell bill would be to increase the premiums for firms with fewer than 500 workers by 25 percent while reducing premiums for other groups in the pool.

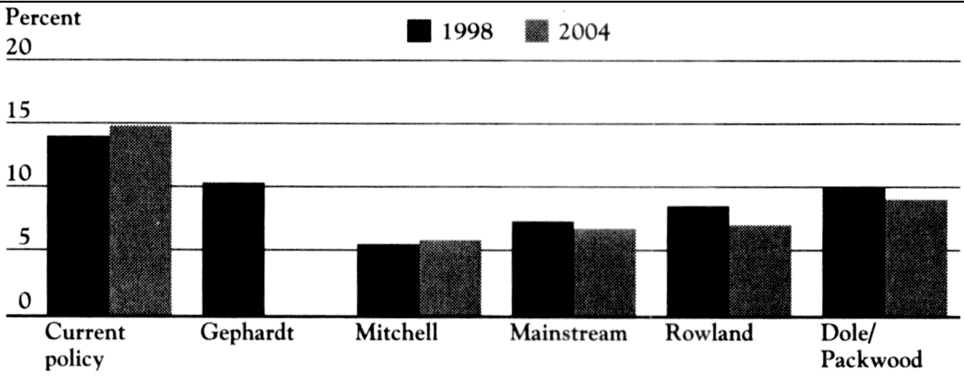
While community rating under the Mitchell and Rowland bills would increase costs for small employers, it would reduce federal spending for those who are now covered by Medicaid. This is because the government could purchase insurance for these persons at the community rate of $192 per month, which is less than the cost of covering them under the current Medicaid program ($217 per month in 1998). Thus, the government's cost of insuring persons now covered by Medicaid is reduced by shifting a portion of these costs to small employers through the community rate.[3]

Insurance Coverage

All of these bills would result in at least 90 percent coverage by 2004. Even under the Dole/Packwood bill, which provides subsidies only through 150 percent of poverty, the percentage remaining uninsured in 2004 would be reduced from 14.9 percent under current policy to about 9.1 percent (Exhibit 2). In 2004, 7.1 percent would remain uninsured under the Rowland bill; 6.8 percent under the Mainstream bill; and 5.9 percent under the Mitchell bill. In theory, the Gephardt bill would achieve universal coverage in 1999, when the mandates on employers and individuals are fully implemented. However, even with mandates, many persons may continue to be uninsured because of noncompliance and other factors. For example, a recent study of the employer mandate in Hawaii indicates that up, to 10 percent of all workers who are required to be covered by their employer do not receive employer-based coverage.[4]

Under all of the bills considered here, families below the poverty level are required to pay nothing toward their premium. Based upon Medicaid program experience, we estimate that about 73 percent of such persons would enroll. Under most of these bills, a family at 125 percent of the poverty level would receive a 75 percent premium subsidy, leaving the family to pay 25 percent of the premium ($1,739), which would equal about

Exhibit 2
Average Monthly Percentage Of Population Remaining Uninsured Under Alternative Policies, 1998 And 2004



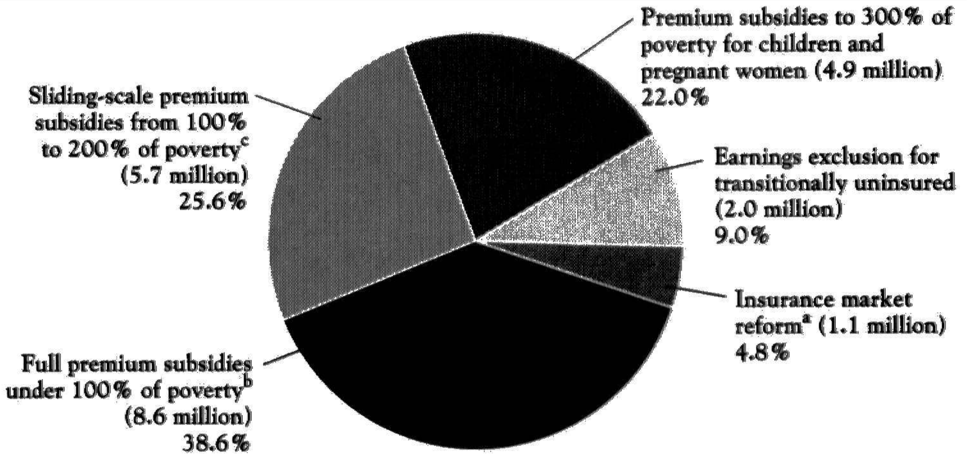
Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

11 percent of income for families at this income level. Based upon an analysis of private insurance coverage data, we estimate that the percentage of persons electing coverage at this contribution level drops to about 33 percent. The percentage of persons obtaining coverage under the Mitchell bill drops to 21 percent for families at 175 percent of poverty (where families must pay 75 percent of the premium).

We estimate that under the Mitchell bill, about 22.3 million uninsured persons would become covered (Exhibit 3). Of these, 39 percent (8.6 million) would be persons below poverty who qualify for full premium subsidies. Only about 25 percent (5.7 million) of those who become insured would be persons between poverty and 200 percent of poverty, where partial subsidies are provided. About 22 percent (4.9 million) would be covered under the extended premium subsidy program for children, many of whom qualify for full premium subsidies. About 9 percent (2.0 million) would be transitionally uninsured persons who qualify for a special income exclusion under the bill. Only about 5 percent would be persons who are now excluded from coverage because of health status.

With the exception of the Mitchell bill, all of the voluntary enrollment bills provide a tax deduction for premium payments by persons who do not have employer-sponsored insurance. We estimate that this would reduce the number of uninsured persons by only about 600,000 persons. This is because these tax deductions would have their greatest impact on upper-income families in higher tax brackets where relatively few persons now lack coverage. Despite having a small impact on coverage, this tax deduction would cost the federal Treasury about $8.0 billion per year, because most of those qualifying for the deduction would be persons who are already purchasing insurance under current policy.

Exhibit 3
Number Of Uninsured Persons Who Become Covered Under The Mitchell Bill, Bv Policy Provision



Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).
a Insurance market reform includes limitations on preexisting condition clauses and guaranteed issue and renewability of insurance policies.
b Premiums are subsidized in full for families with incomes below the poverty level.
c Premiums are subsidized on a sliding scale for families with incomes between 100 and 200 percent of poverty. For families with children and/or pregnant women, the portion of the premium attributed to children and pregnant women is subsidized in full for families with incomes below 185 percent of poverty and on a sliding scale through 300 percent of poverty.

Program Costs

We estimated the federal cost of the various subsidies and tax deductions provided under these five health care reform plans using the eligibility and phase-in schedules the bills specified. These estimates include administrative costs and reflect offsets to new federal spending, including state maintenance-of-effort payments and savings resulting from shifting the Medicaid population to private insurance (Exhibit 4). Our estimates do not include the various Medicare spending cuts and revenue provisions that would be used to fund subsidies under these bills because these provisions are unrelated to the proposed programs themselves and are essentially interchangeable across bills.

All of these programs would be fully implemented by 2004. Federal subsidy costs under the Mitchell bill would be about $60.3 billion in 2004 net of federal Medicaid savings and maintenance-of-effort payments. Net federal costs under the Rowland bill would be about $21.9 billion higher than under the Mitchell bill, largely because the Rowland bill provides tax deductions that are not provided under the Mitchell bill. Net federal subsidy costs in 2004 would be $56.0 billion under the Gephardt bill.

Exhibit 4
Federal Cost Of Subsidies Under Alternative Health Reform Bills, Billions Of Dollars, 1997-2004

	Gephardt	Mitchell	Mainstream	Rowland	Dole/Packwood
1997	-	$36.4	$44.8	-	$16.6
1998	-	38.9	49.8	$26.5	15.7
1999	$46.4	41.9	55.6	31.1	14.7
2000	46.2	45.2	61.0	40.0	22.3
2001	52.1	48.4	67.1	52.9	23.9
2002	50.3	52.1	73.9	60.7	25.4
2003	58.9	56.2	81.7	69.6	26.9
2004	56.0	60.3	90.1	82.2	28.7
Total	$309.9	$379.4	$524.0	$363.0	$174.2

Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).
Notes: Estimates do not reflect funding provisions under the various bills. Includes the cost of premium subsidies, cost-sharing subsidies, and tax deductions under the bills and administration (assumed to be split with states) less savings to Medicaid and state maintenance-of-effort payments.

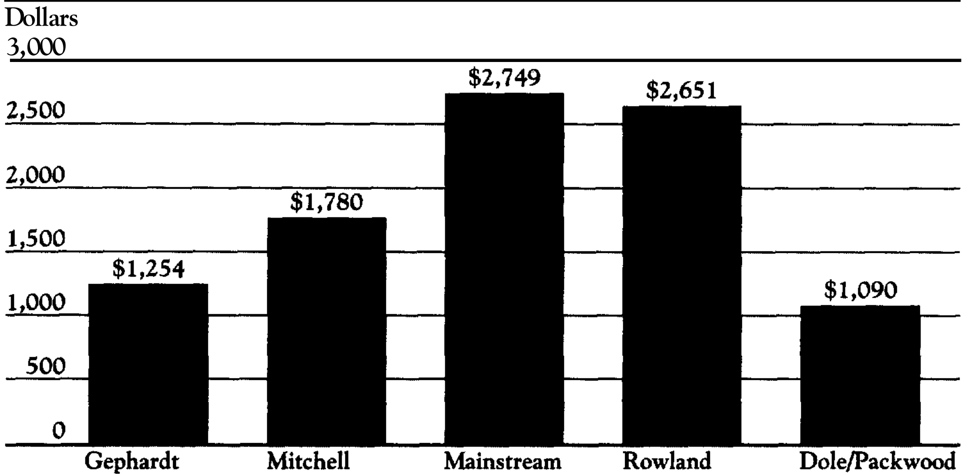
The net federal cost of the Mainstream bill in 2004 would be higher than under the Rowland bill even though income eligibility levels for subsidies are identical in that year under both bills. This is because the Rowland bill reduces federal costs by pooling the Medicaid population with lower-cost small-employer populations while the Mainstream bill does not. However, the Mainstream bill does not produce the 25 percent increase in small-employer premiums that would occur under bills that shift the Medicaid population to the community-rated pool.

The net federal cost of subsidies per newly insured person in 1998 would be $1,254 under the Gephardt bill, compared with $1,780 under the Mitchell bill (Exhibit 5). Costs per newly insured person are lower under the Gephardt bill because many of those who obtain coverage under a mandate are in higher-income groups that do not qualify for subsidies. The Rowland and Mainstream bills would cost more than $2,600 per newly insured person, which reflects the fact that the tax deductions provided under these bills would benefit primarily persons who now have insurance without having much impact on coverage. Net federal costs per newly insured person would be only about $1,090 per person under the Dole/Packwood proposal because the bill limits premium subsidies and is the only bill that does not provide subsidies for patient cost sharing.

Conclusion

The estimates presented in this DataWatch should be considered illustrative of the likely impacts of reform rather than precise point estimates of program outcomes. Several of the various health care reform bills were

Exhibit 5
Average Annual Net Federal Subsidy Cost Per Newly Insured Person Under Various Health Reform Proposals, 1998



Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).
Notes: Assumes bills are fully phased in in 1998. Reflects premium subsidies, tax deductions, and administrative costs.

continually being revised while we conducted this study. Where the bills are unclear, we have made certain assumptions about the structure of these programs, which are likely to change as the legislation is refined. Moreover, it is quite difficult to predict how individual insurance purchasing decisions will be affected by the various premium subsidies and market reforms proposed in these bills. Nonetheless, these estimates provide a useful basis on which to compare these various reform proposals, as the great health care reform debate continues.

NOTES

1. See Lewin-VHI, "The Health Benefits Simulation Model: Technical Documentation" (Report to the Office of Research, Health Care Financing Administration, Washing ton, D.C., 13 April 1990).
2. This is true even for the disabled portion of the Medicaid population that does not receive Supplemental Security Income (SSI). Estimates reflect the use of Medicare payment rates in Part C. J. Sheils et al., "Health Insurance Coverage under Alternative Health Reform Proposals" (Report to The Henry J. Kaiser Family Foundation, Lewin-VHI, 4 November 1994).
3, See Lewine-VHI, "Permitting Voluntary Enrollment in Regional Alliances under the Health Security Act: The Impact on Spending for Employers and the Federal government" (Report to The Henry J. Kaiser Family Foundation, 21 April 1994).
4. A.W. Dick, "Will Employer Mandates Really Work? Another Look at Hawaii," Health Affairs (Spring I 1994): 343-349.