

Issues in Coverage Expansion Design

Decision Points and Trade-Offs in Developing Comprehensive Health Coverage Reforms

by Elliot K. Wicks, Ph. D.

Economic and Social Research Institute

1015 18th Street, N.W., Suite 210
Washington, D.C. 20036
(202) 833-8877
www.esresearch.org

February 2003
Number 1

Covering America

REAL REMEDIES
FOR THE UNINSURED

Approximately 41 million Americans have no form of health insurance. Proposals of many varieties have been put forward to extend health coverage to the uninsured. The differences among them reflect the decisions reformers make with respect to three kinds of judgments. First, the approaches differ because people assign different priorities to particular values. Second, system designers make different assessments about what is politically feasible and about what compromises they are willing to make to enhance their proposal's political acceptability. Third, proposals differ because reformers make different judgments about what mechanisms and structures will actually work best to accomplish the objective of extending coverage.

Of course, these three kinds of judgments are intimately related. It may be necessary, for example, to compromise some values to enhance political feasibility—for instance, accepting some inequities to hold down the budgetary cost. Or, a structure that might work well to achieve the

objective of covering everyone—for example, requiring all employers to offer coverage—may conflict with an important value, such as seeking to minimize the level of compulsion. In short, anyone seeking to solve the problems of the uninsured is forced to make many trade-offs. The judgments people bring to bear in making those trade-offs go far to explain the difference in the nature of their proposals.

It is useful to make explicit the decision points and the kinds of trade-offs reformers must make in designing policies to cover the uninsured. That is the purpose of this paper, which is the first in a series that will deal with issues that need to be addressed in designing comprehensive coverage expansion. Subsequent papers will address in greater depth some of the issues discussed briefly in this paper, as well as some additional issues.

Values

Because much of the political disagreement about an appropriate

The Coverage Expansion Design Series explores issues that policy makers designing comprehensive expansions of health coverage need to address. This series is a part of the *Covering America* project, which promotes serious consideration of a diverse range of comprehensive proposals to provide affordable health coverage for the millions of uninsured Americans. The project has published 13 proposals for major expansion of health coverage written by leading health analysts and researchers. The proposals are available from the Economic and Social Research Institute or on line at www.esresearch.org.

The *Covering America* project is coordinated by the Economic and Social Research Institute in Washington, D.C., and is made possible by a grant from The Robert Wood Johnson Foundation, Princeton, New Jersey. The Foundation does not endorse the findings of this or any other independent research or policy project.

ECONOMIC AND SOCIAL RESEARCH INSTITUTE

1015 18th Street, N. W., Suite 210
Washington D.C. 20036

(202) 833-8877
www.esresearch.org

approach to coverage expansion involves different judgments about which values should have priority, it is useful to identify the values that underlie various policy decisions. In general the problem is not that people disagree about the desirability of any particular value. Instead they disagree about how far to go in compromising some values to more fully achieve others. We identify the following values as being particularly relevant.

Degree of coverage expansion

Achieving a high level of insurance coverage is, strictly speaking, not a value but the objective of health coverage reform. However, system designers make different judgments about the compromises they are willing to make with respect to other values or to political feasibility in order to achieve this objective. For example, some reformers may be willing to compel every individual to have coverage as a way of ensuring universal coverage. Others who are more wary of compulsion may prefer instead to create strong financial incentives for people to buy coverage, even though fewer people would be covered.

Cost

Everyone is concerned about the cost of policy reforms, and everyone would agree that it is desirable to minimize cost, everything else being equal. Cost has a number of dimensions.

People tend to think first of the *budgetary cost* to government. There is strong consensus that any successful strategy for covering the uninsured will have a substantial budgetary impact because the cost of insurance is a major barrier that prevents many people from buying coverage. Therefore, it seems inevitable that government will have to make up much of the affordability gap. All else being equal, nearly everyone would prefer

an approach that minimized the budgetary cost to government and thus to taxpayers. Of course, minimizing the government budgetary cost normally requires that employers or consumers pay a larger share and will involve other trade-offs as well.

From a broader social perspective, a more important measure of cost than the budgetary amount is the total *resource cost* to society. This refers to the amount of additional real resources that are used up in providing medical care to people and are thus not available for other uses. To use an example, a policy that resulted in high rates of utilization of expensive medical resources while providing only minor improvements in the health of the population would be of questionable value, regardless of who paid the bill. The reason that it is important to distinguish between budgetary cost and resource cost is that some approaches that have a high budgetary cost may not have a high resource cost, and vice versa. For example, if a reform had the effect of inducing employers to drop coverage so that formerly covered employees now got coverage through a government-funded system (the “crowd out” effect), this would substantially increase the budgetary cost of the proposal but would likely have little effect on the real resource cost. Although different people would be paying the bill for medical services, the total utilization of medical services would probably not change appreciably, and so society would not be sacrificing any of its capacity to produce and consume other goods and services as a consequence of having people shift from private to public coverage. Of course, people whose values strongly incline them to prefer private over public coverage for the working population might still oppose this reform even though the total cost to society has not changed.

A third cost factor can be referred to as *target efficiency*. Essentially, this

refers to the amount of “bang for the budgetary buck.” In other words, how much of the money that government spends actually goes to cover people who lack insurance? To use a previous example, a reform that covered a given number of uninsured people without causing people to switch from private to public coverage would, with respect to this rating factor, be preferable to one that had the same impact on the uninsured but produced a major crowd-out effect. Achieving a high degree of target efficiency is often in conflict with achieving a high degree of equity. Programs that do well at subsidizing only people who lack coverage (good target efficiency) often do not give financial help to other people who are equally needy and otherwise similar but who have already made a substantial sacrifice to purchase coverage (poor equity).

A fourth relevant aspect of cost is an approach’s potential for *cost escalation*. People are justly concerned not only about the initial base cost but how that base is likely to increase over time. A program that seems likely to encourage rapid increases in costs is less desirable than one that is otherwise similar in its effects but includes acceptable provisions that seem likely to constrain cost increases.

Equity

Everyone agrees that it is desirable to design public policies that are as fair and equitable as possible given other constraints. With respect to policies to reform health care coverage, most of the equity issues revolve around the distribution of subsidies—who gets the subsidies—and the distribution of the financing burden—who finances subsidies. In each case, the equity issues are of two types—what economists refer to as *horizontal equity* and *vertical equity*.

Horizontal equity refers to equal treatment of people whose circum-

stances are essentially the same with respect to relevant characteristics, typically their ability to pay. A subsidy policy that scored high on this measure would not grant subsidies to a wage earner while denying subsidies to a self-employed person at the same income level or provide more generous benefits to someone living in Oklahoma than to an equally poor person in Tennessee. Likewise, with respect to the distribution of the burden of paying for a subsidy plan, a horizontally equitable plan would not collect more taxes from a self-employed person than from a wage earner, assuming both had the same real income.

Vertical equity refers to fair distribution of benefits or costs among people whose circumstances differ, usually in terms of their incomes. With respect to the distribution of subsidy benefits, most people would agree that it is not equitable to grant larger subsidies to higher-income people than to lower-income people. This inequity is a key problem with the current federal tax provision that excludes employer-paid health insurance premiums from employees’ taxable income. This policy especially benefits higher-income people, since they have higher marginal tax rates and often more comprehensive coverage, so that a given tax exclusion saves them more. At the same time, the policy provides no help to people whose employers do not offer health coverage or to the many low-wage workers who have no federal tax liability but still have difficulty affording health coverage. The vertical equity principle requires that more needy people get larger subsidies.

When it comes to deciding what constitutes vertical equity with respect to *paying for* income redistribution policies (which health coverage subsidies are), there is less agreement about what is fair. The general principle is that the payment burden should be related to ability to pay. Probably

no one would defend a policy that required lower-income people to pay more than higher-income people, but the controversy centers on how *much* more higher-income people should pay. A common rule of thumb is that the burden should not be *regressive* in its effects—which results when lower-income people pay a higher *proportion* of their income. This contrasts with a *progressive* policy, which has the tax burden rising as a proportion of income. The policy is said to be *proportional* when people at different income levels pay the same proportion of their income in taxes (note, though, that the *amount* paid by higher-income people will still be higher than for lower-income people).

Compulsion

Almost everyone would agree that if a choice can be made between a policy that compels people to alter their behavior in a way they would not freely choose and a policy that is equally effective but in no way interferes with individual choice, the second policy would be preferable. The problem is, of course, that virtually all public policies require some degree of regulation, which necessarily involves some constraints on someone’s behavior. But policies can clearly differ with respect to the amount of compulsion involved. For example, one approach to health reform would be to require every individual and family to purchase health coverage, a policy that involves a significant degree of compulsion. Of course, virtually no one would prefer a policy involving more compulsion except when the compulsion is seen as an acceptable trade-off for achieving some other desirable objective, such as, in this example, universal health coverage. But reasonable people will often disagree about the terms of the trade-off.

Choice

Other things being equal, people generally agree that choice is desirable. Choice becomes relevant for health coverage reform because approaches differ in the amount of latitude people have in choosing among health plans, between the public and private sectors, among providers, and among styles of treatment. Most people agree that having choice is especially important for something as personal as health care. People who have choices are also less likely to be discontented about being in a particular health plan. Different approaches to reform also give physicians, hospitals, and other health care providers and employers greater or lesser degrees of choice.

Stigma

For some people, there is a stigma associated with being covered by certain kinds of subsidized health care systems. For example, some people who are enrolled in Medicaid and many in the general public tend to think of this program as welfare, and that carries a degree of stigma with it. Of course, not all government-subsidized health coverage has a negative image. There is virtually no stigma associated with being enrolled in Medicare. Trying to devise a subsidy program that minimizes stigma is a legitimate end in itself, but there is also the practical concern that eligible people frequently decline to enroll in subsidized programs for fear of being stigmatized, thereby thwarting the goal of extending coverage. Reducing stigma is thus a desirable objective.

Administrative burden, bureaucracy, and complexity

Everyone would agree that ideally a reformed health coverage system would minimize the administrative burdens that all participants—consumers, providers, health plans, employers, and government—bear

and would require only a small administrative bureaucracy. Further, the system would be as simple as possible and therefore easy for everyone to understand and to conform to system requirements. The amount of regulation would be minimal. Of course, no system can achieve such an ideal, but depending upon what trade-offs one is willing to make, the system can be made more or less administratively burdensome and complex. For example, a system that goes very far in the direction of trying to ensure equity often proves to be quite complex and may require substantial regulatory authority. Systems that are relatively simple from the consumers' standpoint may require that health plans or providers absorb a larger administrative burden.

Fundamental Decision Points

There are certain fundamental issues that everyone who seeks to reform the system to move toward universal coverage has to address. The way they choose to address these issues has a major influence on the kind of reform structure that results. Because these issues represent major decision points for any health policy that seeks to extend insurance coverage to most Americans, it is useful to identify them and to show examples of the different ways reformers can choose to address them. The choices reflect different judgments about value priorities, political feasibility, and what is workable.

Budgetary cost

Virtually everyone who proposes to substantially expand health-care coverage recognizes that the objective cannot be achieved unless someone subsidizes the cost of health care for the large numbers of Americans who cannot afford (or believe they cannot afford) to pay for insurance from their own resources. Although government

is not the only possible source for subsidies, government will surely have to pay a substantial part of the bill. The size of that bill is of intense political concern. The need to constrain spending to a level that is politically acceptable is likely to strongly influence many of the decisions that reformers make about features of their reform proposals.

Which groups to subsidize and to what degree

Few people would disagree with a decision to begin a subsidy program by targeting those who are least able to afford coverage on their own. This suggests that it would be appropriate to base eligibility on income alone, rather than making eligibility conditional on family status, employment status, etc. People whose incomes put them below the poverty line are unlikely to get coverage unless subsidies are sufficient to pay virtually the full costs of a reasonably comprehensive medical plan.

But, of course, affordability is still a problem for people with incomes above the poverty level but well below the level that gives them substantial discretionary income. If coverage is to be extended to those above the poverty line, the question then becomes how far up the income scale to provide subsidies. Not only is this an equity issue; it is also related to the influence of the plan on work incentives: if people who are heavily subsidized lose all subsidies when their income rises above a cutoff level, the effect is to discourage people from working more or taking jobs that would put them into higher income brackets, which would have a negative effect on economic efficiency. Having a long phase-out is probably more equitable and produces better work incentives, but it adds to the budgetary cost.

Some reformers have offered proposals that extend subsidies to people with sufficiently high incomes that

they could afford to purchase adequate coverage without help. This decision normally reflects a political judgment that higher-income people are more likely to support a program that subsidizes low-income people if they too are the beneficiaries of subsidies (as is the case with Medicare). This policy approach is particularly relevant for those proposals that would do away with the current tax-exclusion policy, which exempts from personal income tax the amount that employers contribute to health insurance premiums for their workers. It may not be politically feasible to eliminate or substantially reduce the present form of tax subsidy without giving people who now enjoy that subsidy something in its place. Once again, the decision to extend subsidies to higher-income people raises the budgetary cost of the program.

A closely related decision point is where to establish the income cutoffs that divide people who receive various levels of subsidies. For example, some proposals would give full subsidies to people well above the poverty line to avoid having them get lower subsidies than they do now. Others would draw the line for full subsidy at the poverty level in an effort to keep costs down.

Benefit levels

Most proposals to subsidize the purchase of health coverage define some level of medical benefits and cost-sharing provisions that represent a standard plan that serves as a benchmark or a minimum benefits plan. A definition of some minimum or benchmark is generally considered to be necessary to ensure that the subsidies are applied to insurance coverage that provides some sensible minimum level of protection. Without such a definition, people might be enticed into using the subsidy for coverage that does not meet the social objective of ensuring access to appropriate medical services. Some propos-

als define the minimum as a “lean” benefit package, for example, one that is adequate to pay just for so-called catastrophic expenses. Others define the standard benefits to be quite comprehensive. The subsidy amounts are generally related to the benefit package, although the subsidy need not cover the full costs of the standard or minimum plan.

There is, of course, a strong interrelationship between these initial decision points. The budgetary cost is a product of the decisions about the income levels to which the subsidies will be extended, the package of benefits to be subsidized, and the proportion of the benefit package covered by the subsidy. And the decisions about these three characteristics of the system will determine how many people will have coverage and how adequate that coverage will be.

Financing

Decisions about financing have at least three dimensions. The first involves the *source of financing*. Given the history of health insurance in this country, there are four possible sources: the federal government, state governments, employers, and consumers. The present health care system relies on all of these sources, and it is likely that a future system will do so also, though not in the same proportion.

Given the high level of subsidies necessary to induce many of the uninsured to purchase coverage and the limited capacity of states to fund such subsidies, it seems certain that the federal government will need to be a primary payer of the additional costs of covering the uninsured. Because employers now pay for a large share of coverage, it seems likely that they will be expected to pay at least some portion of the cost of a reformed system. Consumers can pay in two ways: they can pay a portion of the health coverage premium, and they can pay a portion of the cost of services at the

time they consume them, through co-payments or deductibles. Most reforms are likely to require some levels of payments of both types.

Ultimately, of course, the *final* incidence of the burden of paying for health care rests on individuals, even when they do not pay out-of-pocket for services or for premiums. They may pay as taxpayers. Or, even if the employer is taxed, individuals ultimately pay—as employees in the form of lower wages, as consumers when they buy the products employers produce, or as stockholders if profits are reduced. The debate, therefore, is really not about who ultimately pays but rather who, in the first instances, writes the check and how the ultimate cost incidence is distributed among the citizenry.

A second dimension to the financing problem is *how to collect the revenue* that is needed to finance the government’s share. The question really is what kind of tax to rely on for the revenue. A strong case can be made on equity grounds for relying primarily on general federal tax revenues. Although general tax revenues come from a variety of sources, the most important of these is the individual income tax, which is moderately progressive in nature. An alternative way of collecting federal revenue is through a payroll tax. Typically, proposals using this approach would tax both employers and employees, although most economists would argue that employees ultimately bear the full burden of even the employer-paid portion, which makes the tax incidence substantially less progressive. Other sources could include a value-added tax, “sin taxes” on alcohol or tobacco, or other miscellaneous taxes.

A third dimension of financing is *how to provide the subsidy to eligible people*. Some current proposals rely on tax credits, which allow people to offset the costs of coverage by reducing their income tax liability. That is, in-

dividuals (or their employers) would pay for coverage but would have the burden of that payment reduced by being the beneficiaries of a tax credit. In a similar vein, some proposals provide vouchers to people eligible for subsidies, which can be applied to the cost of coverage. A contrasting approach involves providing subsidies by lowering the premium cost, so that eligible people pay less (sometimes nothing) than the actuarial value of the coverage. This is the approach used by Medicaid and the State Children's Health Insurance Program (S-CHIP). But some reformers approach the subsidy question in a very different way. They would make access to some minimum level of coverage a "right" for *everyone*. Individuals would not have to pay anything to be covered for the specified minimum level of benefits. Under this social insurance approach, similar to Medicare Part A (hospital coverage), everyone is automatically in the system and has access to the minimum benefit package without having to pay a premium of any kind or meet any test of eligibility other than citizenship. Of course, nothing is free; people still pay under these systems, but usually in the form of their share of general tax revenues or as workers paying payroll taxes on their earnings. These financing systems are common in many other industrialized countries.

The balance of authority between state and federal government

Under the present system for subsidizing health care, the federal and state governments share responsibilities, both for generating revenue and for administering elements of the program. The most obvious examples of this division of responsibility are Medicaid and S-CHIP. Whether a reformed system should have a similar mixture of responsibility for the federal and state governments is an im-

portant decision point, particularly in the present political context where many people are wary about enlarging the federal role.

The division of responsibility between the public and private sectors

The present health care system divides not only financing responsibility but also administrative responsibility between the public and private sectors. For example, employers currently are often responsible for selecting particular health care plans and for doing various aspects of administration on behalf of their employees. Many people believe that employers have an important positive influence both on the performance of the health care system and the extent to which workers have health care coverage. They have been a source for pressures to contain costs, and they have also been a driving force to improve the quality of care. Others suggest that employers fell accidentally into these roles and that the choices they make on behalf of employees are not always the choices employees would make for themselves. These critics think the system would work better if employers got out of the health coverage business and concentrated on their proper objective of producing goods and services. Given these contrasting perspectives, it is not surprising that some reformers would greatly reduce the employer's role, if not eliminate it entirely, whereas others would seek to build on the present employer involvement.

A similar issue involves a decision about the role of private health insurers. It is certainly possible to envision a system that would have a much more limited role for health insurers than is now the case. For example, under the conventional fee-for-service Medicare program, insurers do not offer health plans or determine benefit levels; they simply administer the claims process. Under Medicare, gov-

ernment has a much larger role than is true for most other parts of the health care financing system. Of course, a proposed reform that drastically altered the role of health plans and insurers would likely face stiff opposition.

Degree of movement away from the status quo

A critical decision in devising a reform is making a judgment about how much the new system should differ from the present system. There are many reasons to be concerned about this question.

An obvious advantage to building on the present system is that there is experience with that system. Policy makers can probably more accurately anticipate the kinds of problems that will arise, and the probability of experiencing severe unexpected consequences is probably less. The transition to the new system is also likely to be smoother if the new system builds on the foundations of the old. Implementation is also likely to be easier because there are fewer new problems to solve. A major political argument for building on the status quo is that this approach is likely to raise less acute political opposition. The stakeholders who are at least somewhat comfortable with the present system are likely to be more supportive of a reform that builds on that system rather than on one that abandons it and starts anew. This explains why many reform proposals rely on various elements of the current system.

The principal argument for jettisoning much of the status quo is that it constrains the options that are available. Some reformers wish to change the system in ways that are not compatible with substantial reliance on what is already in place. They presumably believe that some of the objectives they seek would be better met by designing a system that retains fewer of the present elements.

The present system is also administratively very complex, a source of inefficiency and inequities.

Risk segmentation, risk sharing, and pooling of risk

The fundamental purpose of insurance is to share risk. The essence of insurance is that people who incur large losses in a given period are subsidized by people who have no losses or only modest losses. In colloquial parlance, the healthy subsidize the sick. One of the most important issues in deciding how to accomplish this risk sharing is to decide how broadly the risk should be shared. For example, a social insurance approach, which is common in many countries and which resembles our Medicare system, involves sharing the risk across the entire population. The amount people pay for coverage in such a tax-financed system is completely unrelated to their risk. In contrast, systems which rely on private health insurance and allow insurers to base the premiums they charge on the risk of the people being insured spread the risk less broadly.

The basic problem is that healthy people would prefer not to be pooled together with less healthy people. If they were able to share risk only with other similarly healthy people, their insurance cost would be much lower. That approach, if carried to its extreme, would result in little spreading of risk and minimal subsidization of high-risk people by low-risk people. Insurance could be unaffordable or even unavailable for high-risk people. The critical decision, then, is to decide where to establish risk sharing between the extreme of complete social insurance and unfettered operation of the market.

There are, of course, a variety of ways to share risk. One way in a private insurance system is to put legal limits on the extent to which insurers can vary premiums based on the risk

potential of the people they insure and to require that insurers cover people regardless of their level of risk. The rules that the states and the federal government have established with respect to rate regulation, guaranteed issue, and coverage of prior medical conditions for the small-group market are of this character. This approach amounts to having people share risk by initially putting both the healthy and unhealthy in the same risk pool. Another way to accomplish risk sharing is to put the unhealthy—that is, those at high risk of incurring large medical expenses—in a separate “high-risk pool” and then subsidize the premiums that they have to pay. Of course, this approach does not escape the inevitability of the insurance principle: the healthy still have to subsidize the unhealthy. Thus, the funds to subsidize the premiums in the high-risk pool must somehow be collected from a population that is predominantly healthy.

A decision point that is inherently related to the issue of risk sharing involves risk adjustment. Risk adjustment is designed to deal with two problems. As long as insurers can with some degree of accuracy distinguish high-risk people from a low-risk people, they will have strong incentives to try to segment people into a variety of risk-rating categories. Because a quite small portion of the population accounts for a very high proportion of medical expenses in a particular period, insurers that can avoid these high-cost enrollees stand to substantially improve their bottom line. The evidence seems to indicate that at least some insurers will find ways to select favorable risks despite laws that are designed to limit this behavior. An effective system of risk adjustment can reduce the rewards for insurers to be successful at risk segmentation. Risk adjustment involves a transfer of funds from insur-

ers who have a disproportionate share of low-risk enrollees to insurers that have more than their share of high-risk enrollees. The second problem that risk adjustment addresses is that, even when they make no attempt to segment risk, some insurers will end up with a disproportionate share of expensive, high-risk enrollees, while others attract people who are less expensive to insure. Risk adjustment can make up for discrepancies that are due to the luck of the draw or to the fact that people with some kinds of expensive medical conditions are attracted to health plans with certain features.

Conclusion

Crafting a successful health insurance reform requires making difficult political and technical tradeoffs. No reform can optimize all objectives. People favor different proposals in part because they start with different priorities about which values are most important to promote, but also because they have different views about which approaches will work best from a technical standpoint and about what is politically feasible. This is part of the explanation for why the problem of the uninsured has proved so difficult for this country to solve. ■

The Covering America project promotes serious consideration of a diverse range of comprehensive proposals to provide affordable health coverage for millions of uninsured Americans. The project is coordinated by the Economic and Social Research Institute, a nonprofit, nonpartisan institute in Washington, D.C., and is made possible by a grant from the Robert Wood Johnson Foundation of Princeton, New Jersey. The Foundation does not endorse the findings of this or any independent research or policy project.