Chapter IV

TEN STEPS TO INSURING THE UNINSURED

This chapter builds on the goals and implementation strategies of the previous two chapters in order to address the problem of uninsurance. We propose the 10 steps outlined below.

Step No. 1: Use Free Care Dollars to Subsidize Private Insurance.

As noted, the current system encourages people to be uninsured because it offers highly subsidized, or free, care to the uninsured and very little subsidy for the purchase of private insurance. As outlined above, states should correct this perverse incentive by offering the uninsured just as much subsidy for private insurance as people can expect in free care.

Step No. 2: Create a "Pay or Play" System and Use the Proceeds to Fund a Social Safety Net.

All but a handful of states have income taxes, and most of these piggyback on the federal system by duplicating what the federal government taxes, right down to inclusions and exclusions. As a consequence, people almost everywhere pay higher taxes to state governments if they fail to get insurance through an employer. These higher taxes become part of the state's general revenues. Instead, they should be dedicated to providing safety net care for uninsured patients who cannot pay their medical bills. In this way, the uninsured will pay a financial penalty for being uninsured and that financial penalty will help offset the costs of any charity care they may require.

Step No. 3: Enforce Maintenance of Effort Rules for Individuals and Employers.

The reforms to insure the uninsured will not have achieved their purpose if they encourage individuals to drop their coverage in order to get a subsidy, or if they encourage employers to lower their compensation costs by dropping group health insurance in order to dump their employees on the state subsidy system. Accordingly, the subsidies must be accompanied by maintenance of effort regulations.[1] Individuals who willingly drop their insurance coverage must face a required waiting period before they become eligible for a subsidy from the state. A similar principle would apply to employees of employers who discontinue their group health insurance.

It is important to recognize that maintenance of effort rules are a stopgap measure and not a permanent solution. Ultimately everyone needs to be brought under the same system of taxes and subsidies — and that almost certainly will have to be done at the federal level.

Step No. 4: Make the Form of Subsidy Premium Support Conditional on Health Status.

The subsidy from the state should be in the form of a fixed-dollar commitment. This implies two features. First, the form of the subsidy is defined contribution, not defined benefit. In other words, the insurance purchased must fit the subsidy (by reducing benefits and coverage limits if needed), not the other way around. Second, any additional premium (if needed) is paid by the beneficiary. This means that the cost of any additional insurance is fully borne by the person who expects to benefit from the added coverage.

The subsidy should be based on health status. A healthy uninsured person is not expected to use very many resources in the free care, safety net system. A person with chronic, recurring health problems, by contrast, is expected to cost much more. Ideally, each person should receive a risk-rated subsidy, dependent on health condition.

Step No. 5: Make the Availability of Free Health Care and the Subsidy for Private Insurance Vary by Family Income.

As noted, people should have just as much financial incentive to purchase private insurance as they have to rely on government provided free care. However, the higher an individual's income, the less help he or she should receive from the state, other things being equal. This means wealthier uninsured patients should pay more of their medical bills than lower-income patients. The same principle applies to the purchase of health insurance. Neutrality requires the private insurance subsidy and the free care subsidy to be the same. Equity requires the size of the subsidy to be reduced as income rises.

Step No. 6: Apply the Subsidy to any Currently Available Plan.

The subsidy should not be restricted to a particular kind of insurance. Rather it should apply to any currently available plan. This includes any plan that has been approved for the individual market, any approved group plan and any self-insured employer plan operating within the state. Individuals would enter group plans, of course, through their employers.

Step No. 7: Create New Health Insurance Opportunities.

Although the uninsured should be able to apply their subsidy to any plan approved for sale by the state, they should not be restricted to the currently available options. For example, insurers should be able to offer the uninsured any plan currently available to state employees as individual insurance. These plans typically are exempt from mandated benefits that legislatures impose on the private sector and, thus, should be less costly. The state should also consider limited benefit plans, such as the plan available for Utah Medicaid enrollees (discussed in Chapter III).

Special-needs delivery systems should also qualify as recipients of subsidy dollars. For example, a "center of excellence" for diabetes care should be able to offer subsidized care for diabetes so long as it covers entire episodes of diabetes-related care.[2] Care for at-risk pregnant mothers is another example. Parkland Memorial Hospital in Dallas (discussed above) should be a potential recipient of subsidies along with any private centers that want to compete with Parkland.[3]

Step No. 8: Create New Entry Points Into the Insurance Marketplace.

There are many ways in which state governments could make it easier for the uninsured to enroll in private insurance plans. For example, the vast majority of H&R Block's clientele consists of people who are filing

for earned income tax credit (EITC) refunds prior to April 15. Since the EITC "refund" is a grant of cash to people who might otherwise live from paycheck to paycheck, this is an ideal time of year to combine personal funds with a state subsidy and buy private insurance. Further, EITC families almost always have children, and children in general are inexpensive to insure. So allowing H&R Block and similar agencies to receive a commission for enrolling people in health plans would be a good idea.

There are also other vehicles. Hospitals and clinics could serve as entry points (as they do today for Medicaid); but unlike Medicaid, the insurance would not be retroactive. That is, newly acquired insurance would pay for future health costs, not costs that have already been incurred.

States could also facilitate entry into the health insurance system by setting up "entry offices" that would collect information about benefits and premiums and post them. The function of such offices would be informational, not regulatory, however.

Step No. 9: Allow the Issuance of Insurance to Follow Current State Rules.

No special rules (such as a guaranteed issue or community-rated pricing) are needed or desirable. If the uninsured are to be integrated into the same system as the privately insured, the same rules should apply. In most states, insurance in the individual market is medically underwritten. (People with health problems may face exclusions or higher premiums or be denied coverage altogether.) For those who are unable to obtain insurance at a reasonable price, most states now have subsidized risk pool insurance — which could also be a recipient of state subsidies for the uninsured. In all states, group insurance is guaranteed issue.

Step No. 10: Instead of Managed Competition, Encourage a Market for Sick People.

A number of state reforms currently underway — Massachusetts being the most notable example — envision creating a system in which people can switch health plans every 12 months at community-rated premiums. The model for these systems is the Federal Employee Health Benefits Plan.

The problem with these systems is that they create perverse incentives. By design, the premium any single individual pays has no relationship to his or her own expected health costs. Instead, the premium is an average of the expected costs for the group as a whole. As a result, health plans gain (make a profit) when healthy people enroll and lose (incur a loss) when high-cost people enroll. Perversely, this gives plans an incentive to seek the healthy and avoid the sick. Even worse, it leaves health plans with a perverse incentive to over-provide to the healthy and under-provide to the sick.[4]

Clearly these perverse incentives are not consistent with the desire to promote high-quality health care. The alternative to a system in which health plans have incentives to avoid the sick is a system in which the plans have incentives to compete for them the way producers and sellers compete for customers in other markets. In other words, what really is needed is a market for sick people**.** It might work something like the following description.

Imagine individuals who buy their own insurance (say, with a subsidy from the state). As is characteristic of the individual market, such insurance is guaranteed renewable. People tend to form long-term relationships with their insurer instead of rechoosing every 12 months. This in turn allows a long-term relationship with medical providers. Premium increases reflect the costs incurred by the group as a whole, and the increases from year to year are the same for all members of the insurance pool.

Not every health plan is equally efficient at providing all types of care, however. For example, some excel at cancer care while others excel at heart care. Specialization is a normal feature of other markets; why should health care be any different? A desirable system, therefore, allows people with a serious health problem to switch to the health plan that is most proficient at solving their problems.

A switch of health plans cannot be at community-rated prices, however. If it were, the plans would have no incentive to specialize, become efficient and attract sick people. So there must be a payment of money from the plan the patient leaves to his or her new plan, and the payment should be one that leaves all parties better off, including the patient.

Such a system would encourage health plans to specialize and produce efficient, high-quality care. Plans would seek to attract patients with serious health problems because they would profit from being the most efficient provider of care. Patients would gain because they would get more care and better care for the same premium. Yet this win-win solution is outwardly discouraged day in and day out by the current insurance regulatory structure.

Notes

1 Maintenance of effort requires that a new subsidy cannot offset or replace prior spending by either the individual or employer. If an employer drops pre-existing coverage so workers can take up a subsidy, there will be no maintenance of effort.

2 For instance, diabetic care integrates treatment of not just blood glucose levels, but also the associated complications common to diabetes. Diabetics must monitor kidney function, potential vision problems and extremities at risk of complications that might lead to amputations. Diabetics are also at much higher risk of cardiovascular problems.

3 These systems could operate as stand-alone insurance or they could be embedded in a wrap-around plan that covers not related (or unusual and unexpected) health care costs.

4 See the discussion of managed competition in John C. Goodman, Gerald L. Musgrave and Devon M. Herrick, *Lives at Risk: Single-Payer National Health Insurance around the World* (Lanham, Md.: Rowman & Littlefield, 2004), Chapter 22.