

Market Initiatives to Improve Access to Health Insurance

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Mr. Chairman and members of the Committee, it is a pleasure to appear before you today. I am Joseph Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute, a Washington-based think tank. My testimony will address the opportunities we have to improve the functioning of the health insurance market and make health coverage more affordable for millions of Americans.

The states, most notably Massachusetts, have launched bold experiments that could improve access to private insurance and promote more efficient health care delivery. The federal government has opened the door to new types of health insurance, including high-deductible plans coupled with Health Savings Accounts (HSAs). Congress has an opportunity this year to build on these initiatives and make additional progress on the problems of the uninsured.

Insurance Costs Remain High Despite Recent Slowdown

A recently-released study from the Centers for Medicare and Medicaid Services (CMS) reports that runaway increases in the cost of health care appear to have eased, at least temporarily. According to the study, U.S. health spending in 2005 increased 6.9 percent to almost \$2.0 trillion.¹ This is the third year in a row when national health spending grew at a slower rate than the previous year. National health spending grew 7.2 percent in 2004.

Although this is good news, it is tempered by the fact that health costs continue to grow more rapidly than the economy. Over the past 35 years, health spending has grown at an average annual rate of 9.8% while GDP has grown at about 7.4%, both measured in nominal terms. In 2005, the disparity in growth rates narrowed, but health spending still outpaced the economy. A sharp slowdown in prescription drug spending is the main factor driving the recent trend. Notably, there has been no comparable slowdown in spending for hospital care, which has grown at nearly an 8.0% growth rate for the last few years.

Private health insurance premiums have also risen more slowly, but those premiums remain expensive. According to CMS, premiums grew 6.6 percent in 2005, down from the 7.9 percent increase in 2004. A recent survey of employer health benefits shows that the cost of family coverage in employer-sponsored plans averaged \$11,480 in 2006, up 7.7 percent from 2005.² Small firms have faced more rapid cost escalation than larger firms; the average premium for firms with fewer than 200 workers grew 8.8% in 2006 compared with 7.0% for larger firms.

Nearly all large firms offer health benefits, but only about 60 percent of small firms (with fewer than 200 employees) offered coverage in 2006.³ Only two-thirds of

¹ Aaron Catlin and others, "National Health Spending in 2005: The Slowdown Continues," *Health Affairs*, January/February 2007: 142-153.

² Kaiser Family Foundation (KFF) and Health Research and Educational Trust (HRET), *Employer Health Benefits: 2006 Annual Survey*, <http://www.kff.org/insurance/7527/index.cfm>.

³ KFF and HRET, 2006.

workers in firms offering a health plan are covered by that plan. Some of the workers who are not enrolled may have coverage from some other source (such as a spouse), but some are not eligible for coverage and others reject coverage even though they are eligible.

High cost is a major reason why an employer, and particularly a small employer, might not offer health coverage to its workers. People who do not have access to a health plan from an employer must purchase coverage on the individual market, which typically means higher premiums, more narrow benefits, or both. Moreover, those who buy health insurance on the individual market generally cannot take advantage of a major tax break: premiums paid for employer-sponsored health insurance are excluded from taxable income.⁴ Without the benefits of group purchasing or the tax preference, many people go without insurance rather than pay unaffordable premiums.

Recent Initiatives Are Promising

The high cost of health care is driving efforts in both the private and public sectors to improve the performance of the health system. Employers have taken steps to promote high-value health care and information that can inform the purchase and use of health care. The Leapfrog Group is a well-known example of such private sector activity. Numerous initiatives also are underway in federal and state health programs to improve health care delivery and make limited funds go further. Employers, insurers, and government programs are all involved in testing and developing pay for performance, disease management, improved consumer information, and a host of other new ideas.

The most important recent federal initiatives to promote more efficient and effective use of our health dollars are the enactment of HSAs and the expanded flexibility given to states to reform their Medicaid programs. The HSA provision in the Medicare Modernization Act of 2003 is a milestone in the evolution of the insurance market. Consumer-directed health plans, which combine high-deductible insurance with health savings accounts, promote greater awareness of the cost of care on the part of both consumers and providers. The HSA provision extends a tax break for contributions to the accounts that partly levels the field between insured health expenses and expenses that are paid out of pocket.

According to a recent survey, 3.2 million people are covered by HSA-compatible health plans as of January 2006.⁵ Although that represents a small percentage of the entire insurance market, employers and insurers appear interested in exploring the potential of such insurance products to lower costs. Importantly, the introduction of HSA-compatible insurance has focused attention on the fact that consumers cannot become smarter purchasers without information about their treatment alternatives, the

⁴ The self-employed receive a partial tax break. They may exclude their premium payments from income subject to the personal income tax, but not from the payroll tax. Others who purchase coverage on the non-group market do not receive any tax benefits.

⁵ America's Health Insurance Plans (AHIP), *January 2006 Census Shows 3.2 Million People Covered By HSA Plans*, <http://www.ahipresearch.org/pdfs/HSAHDHPReportJanuary2006.pdf>.

quality of care offered by different providers, and the price of care. Such data are needed by all patients, not only those with consumer-directed health plans.

State Medicaid programs also have been given greater flexibility to innovate through the expanded use of federal waivers. CMS introduced the Health Insurance Flexibility and Accountability (HIFA) initiative in 2001. HIFA allows states to restructure their Medicaid and State Children's Health Insurance Programs, including modifying enrollment, changing benefits, increasing beneficiary cost sharing, and providing financial assistance for the purchase of private health insurance.⁶ The 2005 Deficit Reduction Act gave states even more flexibility to redesign their Medicaid programs, including the ability to customize benefits for different groups of beneficiaries.

A number of states are introducing a stronger consumer focus to their Medicaid programs through waivers and state plan amendments.⁷ For example, Florida is moving to a system of risk-adjusted subsidies for individuals that can be used to enroll in a Medicaid managed care plan or buy into an employer plan or purchase individual coverage. Beneficiaries would also have healthy care accounts through which they could earn additional contributions by adopting a healthy lifestyle. Vermont has also adopted capitated payments for its Medicaid program. Other states, including West Virginia and Kentucky, have created benefit tiers, with more coverage for people with greater health needs.

Innovative Massachusetts Plan Faces Challenges

The Massachusetts health reform signed into law by Governor Mitt Romney in April 2006 has attracted national attention.⁸ The plan's goal is health insurance for virtually all Massachusetts citizens, to be achieved by a mandate on individuals to buy coverage and a subsidy for low-income persons who otherwise could not afford it. The plan also creates an insurance "Connector" which facilitates insurance pooling and purchasing by individuals outside the workplace.

Agreement on the Massachusetts plan was reached because of a unique set of circumstances. The state was faced with the loss of \$385 million in federal funds for its uncompensated care pool unless a new approach was developed to reduce the number of people without insurance.⁹ The state's economy was in good shape, and the percentage of people without coverage was low in comparison to other states—10.7 percent

⁶ Teresa A. Coughlin and others, "An Early Look at Ten State HIFA Medicaid Waivers," *Health Affairs* web exclusive, April 25, 2006: W204–W216, <http://content.healthaffairs.org/cgi/content/full/25/3/w204>.

⁷ Cindy Mann and Samantha Artiga, *New Developments in Medicaid Coverage: Who Bears Financial Risk and Responsibility?*, Kaiser Commission on Medicaid and the Uninsured, Issue Paper #7507, June 2006, <http://www.kff.org/medicaid/upload/7507.pdf>.

⁸ John E. McDonough and others, "The Third Wave of Massachusetts Health Care Access Reform," *Health Affairs* web exclusive, September 14, 2006: W420–W431, <http://content.healthaffairs.org/cgi/reprint/25/6/w420>.

⁹ Edmund F. Haislmaier and Nina Owcharenko, "The Massachusetts Approach: A New Way to Restructure State Health Insurance Markets and Public Programs," *Health Affairs* November/December 2006: 1580–1590.

compared with 15.7 percent nationwide over the period 2003 to 2005.¹⁰ The state has a history of supporting insurance mandates, and consensus emerged across political lines.

There are a variety of attractive features of Massachusetts' plan. Instead of paying hospitals for their uncompensated care, those funds will be used to provide individual subsidies for the purchase of insurance. Families with incomes up to the poverty level will receive full subsidies, paying no premiums and responsible for modest copayments. Higher-income families up to 300 percent of poverty will receive a sliding-scale subsidy. This "money follows the individual" principle is an important element in assuring accountability in the health system.

The Connector could simplify the purchase of health insurance for individuals, providing a choice of health plans and offering tax benefits for workers who do not have access to an employer-sponsored health plan. Employers must offer insurance to their workers, but small employers who do not offer coverage themselves can designate the Connector as the source of insurance. Those employers must establish Section 125 cafeteria plans, allowing workers to pay premiums with pretax dollars but otherwise not requiring an employer premium contribution.

The Massachusetts reform plan is complex and faces many challenges as it unfolds over the next few years. A critical factor in the success of the plan is the ability to deliver affordable health insurance coverage, as determined by the Connector. The high cost of health insurance in the state, exacerbated by state mandates and market conditions, makes achieving that goal a difficult challenge.

Massachusetts has some of the most costly mandated benefits in the nation, including coverage for infertility treatments and generous mental health coverage.¹¹ The health reform law did not remove those mandates. The one exception is new insurance products designed exclusively for 19 to 26 year olds with no employer-sponsored coverage. Considering the difficulty of marketing to this small group of low-income young people who typically have little interest in health insurance, the narrow exemption on mandates is not likely to do much to increase the purchase of insurance or make it affordable.

In addition, concentration in the Massachusetts health market keeps health care costs high.¹² The reform plan assumes that those costs will be squeezed down by the use of "value-driven" networks of providers and other changes, including additional cost-sharing by beneficiaries. "Any willing provider" restrictions on health plans are dropped, which could lead some insurers to direct their patients to less expensive providers. However, the state may have been optimistic in the savings possible through such

¹⁰ Carmen DeNavas-Walt and others, *Income, Poverty, and Health Insurance Coverage in the United States: 2005*, U.S. Census Bureau, Current Population Report P60-231, August 2006.

¹¹ Jon Camire and Dianna Welch, "Turning Debate Into Action: Universal Health Care in Massachusetts," *Contingencies*, September/October 2006: 32-39.

¹² Tom Miller, "Massachusetts: More Mirage Than Miracle," *Health Affairs* web exclusive, September 14, 2006: W450-W452, <http://content.healthaffairs.org/cgi/reprint/25/6/w450>.

mechanisms. According to early estimates, the state expects monthly premiums in the small group market to drop by as much as 55 percent, from \$350 to \$154.¹³ While not impossible, such an improvement seems highly unlikely.

Even if premiums could fall by such a large amount, it is not clear that the average person in Massachusetts would regard health insurance as affordable. There are some early signs that interest in obtaining health insurance may not be high, particularly among low-income workers. Many of them have relied on walk-in clinics and free emergency room care, and they may not want to pay for care they previously received at no cost.¹⁴ Even with subsidized monthly premiums ranging from \$18 to \$58, the new coverage might look like a bad buy to people in the lowest income range.

The mandates on individuals and employers are unlikely to push up enrollment in the face of high insurance premiums. The initial penalty for individuals who do not have coverage is the loss of the personal exemption under Massachusetts income tax, worth roughly \$200 to \$400.¹⁵ The initial penalty for firms that do not offer health insurance is an annual assessment of up to \$295 per worker. Neither penalty is likely to have much impact on insurance take-up. Although steeper penalties are part of the Massachusetts plan, it remains to be seen whether the legislature will allow them to stand if there is much public opposition.

The Massachusetts plan is a bold initiative that intends to improve the functioning of the private insurance market rather than replacing it with government programs. The Connector gives residents one-stop shopping for insurance and promotes more effective competition among insurers and health plans, but it is only a first step. The recent legislation can be criticized for failing to more aggressively address the cost of health care in the state. Fiscal pressures in the coming years are likely to cause Massachusetts to take another hard look at its health reform and seek new ways to promote high-value, effective, and appropriate health care.

New Initiatives Should Be Advanced

Although there are many reasons why someone might not have health insurance, the high cost of coverage is the paramount factor. As the latest national health spending data discussed earlier demonstrate, the rising cost of health care is a system-wide problem and there are no simple solutions. We need better information on what really works in health care, delivery systems that operate efficiently, and improved decision-making by patients, providers, and health plans.

¹³ "Massachusetts Health Care Reform," slide presentation by Timothy R. Murphy, Massachusetts Secretary of Health and Human Services, May 15, 2006.

¹⁴ Jeffrey Krasner, "Sign-Up Push is on the Health Coverage," *Boston Globe*, December 29, 2006.

¹⁵ For 2006, the personal exemption is \$3,850 for an individual return and \$7,700 for a couple filing jointly. The income tax rate is 5.3%. See <http://www.mass.gov/?pageID=dorhomepage&L=1&L0=Home&sid=Ador>.

Some policymakers advocate expanding Medicare eligibility as a way of increasing access to insurance, but such a proposal would do nothing to address the more fundamental issue of cost growth. Indeed, Medicare spending has rarely deviated from the cost trends seen in the rest of the health sector, once differences in benefits are taken into account.¹⁶ That is hardly surprising: Medicare and private insurance operate in the same health system and are affected similarly by advances in health care, changes in consumer expectations, and other forces affecting spending growth.

No one has the complete answer to the health care cost problem, but federal, state, and private entities are busy developing policy options that could help ameliorate the spending crisis.¹⁷ Congress should promote further efforts by the states to shape their health programs to meet the needs of their populations. The Massachusetts reform is not for every state, but every state has the potential to develop its own approach to improving the effectiveness of its Medicaid program.

The reauthorization of the State Children's Health Insurance Program (SCHIP) can be an opportunity to enhance the flexibility states have to make their SCHIP dollars go further. The health information technology bill, which stalled in Congress last year, can promote the adoption of a nationwide interoperable information system that could help improve the quality of care and avoid unnecessary spending. The challenges faced by small businesses in offering health benefits to their workers should be addressed. Promising ideas include small business health plans and widening access to insurance by reducing disparities in state insurance regulation. Congress could encourage states to form regional compacts that would reduce regulatory barriers and promote competition in the insurance market.

Policymakers have an opportunity this year to help the uninsured. In a tight budget climate, that does not mean a massive expansion of federal programs. Congress should look to prudent legislation to reduce unnecessary spending, promote efficiency, and build on the innovative ideas for real reform found at all levels in the health system.

¹⁶ However, such adjustments are difficult to make; see Joseph R. Antos, "The Role of Market Competition in Strengthening Medicare," testimony before the Senate Select Committee on Aging, May 6, 2003, http://www.aei.org/publications/filter.all.pubID.17131/pub_detail.asp; Michael J. O'Grady, "Health Insurance Spending Growth: How Does Medicare Compare?," Joint Economic Committee, June 10, 2003.

¹⁷ Many of those efforts are discussed in Alice M. Rivlin and Joseph R. Antos (eds.), *Restoring Fiscal Sanity 2007: The Health Spending Challenge*, (Brookings Institution Press, forthcoming 2007).