SMALL BUT SIGNIFICANT STEPS TO HELP THE UNINSURED

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OUTLINE
• Review of the Problem
• Targeting Expansions
• Getting at Root Causes
• Creating Catalysts

REVIEW OF THE PROBLEM
Baseline: Complex System Demands Complex Policy

Source: 2006 CPS
Characteristics of the Uninsured, 2005

<table>
<thead>
<tr>
<th>Age</th>
<th>Income</th>
<th>Work Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages 35-54</td>
<td>Ages 55-64</td>
<td>Ages Under 19</td>
</tr>
<tr>
<td>32%</td>
<td>9%</td>
<td>20%</td>
</tr>
<tr>
<td>Ages 19-34</td>
<td>20%</td>
<td>100% FPL</td>
</tr>
<tr>
<td>40%</td>
<td>29%</td>
<td>36%</td>
</tr>
<tr>
<td>200% FPL</td>
<td>30%</td>
<td>Part-Time</td>
</tr>
<tr>
<td>1 or More</td>
<td>1 or More</td>
<td>No Full-Time Workers</td>
</tr>
<tr>
<td>Workers</td>
<td>Workers</td>
<td>19%</td>
</tr>
<tr>
<td>69%</td>
<td>69%</td>
<td>11%</td>
</tr>
<tr>
<td>&lt;100% FPL</td>
<td>&lt;100% FPL</td>
<td>100% FPL</td>
</tr>
<tr>
<td>36%</td>
<td>36%</td>
<td>36%</td>
</tr>
<tr>
<td>100-199% FPL</td>
<td>100-199% FPL</td>
<td>100-199% FPL</td>
</tr>
<tr>
<td>29%</td>
<td>29%</td>
<td>29%</td>
</tr>
<tr>
<td>9%</td>
<td>9%</td>
<td>9%</td>
</tr>
</tbody>
</table>

Total = 46.1 Million Uninsured

Note: The federal poverty level was $19,971 for a family of four in 2005.

Uninsured Problem is Growing

- Uninsured rose by 6 million between 2000-2005
  - All among non-elderly adults
- Would have been higher without public programs
  - States with low losses of ESI had larger reductions in uninsured children
- Problem expanding
  - Higher income, education

Percent of Non-Elderly Americans who are Uninsured

<table>
<thead>
<tr>
<th>Year</th>
<th>2000</th>
<th>2003</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>16%</td>
<td>18%</td>
<td>20%</td>
<td></td>
</tr>
</tbody>
</table>


Why Is The Happening? Health System Costs

- National health spending growth more than twice as high as general inflation
  - 6.6% per capita increase in national health spending per capita in 2003
  - 2.3% increase in general inflation in 2003
- Employer health insurance premium growth four times higher than wages
  - Up 87% cumulatively since 2000
  - Compared to 20% cum. earnings growth
- Crippling businesses’ competitiveness
- Affecting insured as well as uninsured
  - Medical bills accounted for nearly 50 percent of personal bankruptcy
  - 16 million (12%) of insured adults are under-insured

Growth In Employer-Sponsored Health Insurance Premiums and Workers’ Earnings, 2000-06

<table>
<thead>
<tr>
<th>Year</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.6%</td>
<td>18.4%</td>
<td>15.9%</td>
<td>12.8%</td>
<td>11.2%</td>
<td>9.7%</td>
<td>8.7%</td>
<td>7.1%</td>
</tr>
</tbody>
</table>

Source: HWE, Kaiser Family Foundation/HRET, 2006
Eroding Employer Coverage

- Employer-sponsored insurance remains the largest source of coverage
  - 60.8% of non-elderly are insured through their job-based insurance
- Trends show a decline
  - Research points to this as the reason for the spike in the uninsured
- Note just a small firm problem
  - 75% of large firms are likely to increase employee payments

Source: Kaiser Family Foundation/HRET, 2006; DOL.

Gaps in Public Coverage

- Few poor adults are eligible:
  - 74% of poverty for people with disabilities
  - 42% of poverty non-working parents
  - No option for adults without dependents
- 30-40 percent of uninsured children ineligible for Medicaid or SCHIP
- Medicaid is de-facto high-risk pool
  - Insures one-fourth of most expensive Americans – many more than high-risk pools
  - Yet access is uneven

Source: Data from Kaiser Family Foundation, Uninsured: A Primer, 2006.

High Prices

- U.S. spends the most
  - Nearly 50% higher per capita than the 2nd most costly nation
  - $6,280 per person in 2004
  - Highest percent of economy (16%)
- Higher prices is the main reason
  - Lower supply of doctors, hospital beds, use of certain services

Source: NHE, OECD
**Poorly-Defined Product**

- Supply-induced demand
  - Evidence on what works not emphasized
  - More doctors and hospitals doesn’t = lower prices

- American belief in scientific solutions
  - Hope as well as fear drive demand

- Insurance complexity and – sometimes – complicity
  - Transitions, marketing, and bureaucracy add to costs with little added value
  - Consolidation of supply means little incentives to achieve discounts

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**Lower-than-Expected Quality and Outcomes**

- On Quality:
  - Fewer seniors with flu vaccine than Australia
  - Higher asthma mortality than in Australia and Canada
  - Lower odds of surviving colorectal cancer than Canadians; cervical cancer than Australians, and kidney transplants than Brits

- On Outcomes:
  - Lower life expectancy than 34 other nations
  - Higher infant mortality rate than 41 other nations

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**Medical Mistake Experience Among Sicker Adults, 2005**

- United States: 34%
- Canada: 30%
- Germany: 23%
- United Kingdom: 22%

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**TARGETING EXPANSIONS**

**By Demographic**
- Children
- Young Adults
- Near Elderly

**By Type of Coverage**
- Employer Coverage
- Insurance Pools
- Public Programs
- Combinations
By Demographics: Children

- Eligible but Uninsured
  - Eligibility simplification
- Ineligible groups
  - Legal immigrants
  - State employee children
- Parents of eligible kids
  - Proven means of getting kids
- Covering all kids
  - SCHIP buy in
  - Mandates

Distribution of Uninsured Children by Eligibility, 2002


Young Adults

- Dependent coverage
  - For part-time as well as full-time students
  - For any unmarried dependent
- Stand-alone products
  - For students
  - For young adults
- Medicaid / SCHIP extensions

Uninsured Rate by Age And Poverty Level, 2004


Near Elderly

- Extend employer coverage
  - COBRA
  - Tax credits for individuals and/or firms
- Medicaid waiver
- Insurance regulation
  - Rate bands and/or guaranteed access

Insurance Rate by Age And Poverty Level, 2004

Source: Data from Kaiser Family Foundation, Uninsured: A Primer, 2006.
**By Type of Coverage:**

Build on Employer Coverage

- Encouraging participation
  - Tax credits, premium assistance

- Encouraging eligibility
  - Only 28% of part-time workers, 3% of temp. workers offered
  - Eliminating waiting periods

- Encouraging offers
  - Tax credits for small businesses
  - Pay or play

*Distribution of Workers by Health Benefits, 2005*

![Chart showing distribution of workers by coverage status](chart.png)

*Sources: Kaiser/HRET 2005, Census 2005*

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**Creating Purchasing Pools**

<table>
<thead>
<tr>
<th>Type of Pools</th>
<th>Rules Governing Pools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geography</td>
<td>Entry rules</td>
</tr>
<tr>
<td>- City or state</td>
<td>- All eligible firms</td>
</tr>
<tr>
<td>Type of firm</td>
<td>- Rating rules</td>
</tr>
<tr>
<td>- Size</td>
<td>- All individuals within firms</td>
</tr>
<tr>
<td>- Industries</td>
<td>Consumer protections</td>
</tr>
<tr>
<td>Affiliation or association</td>
<td></td>
</tr>
</tbody>
</table>

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**Expanding Medicaid/SCHIP**

**Existing Options**

- Children
- Parents
  - Pregnant women
  - Transitional Medicaid
- Targeted groups
  - Women with breast cancer
  - Workers with disabilities

**Waivers**

- Childless adults
- Subsets of groups
  - Sub-state, limited #
  - People with HIV
- Part of larger reform
  - Like MA, VT, TN
Combinations

- Premium assistance
  - Subsidize employer coverage through Medicaid/SCHIP

- State-based purchasing pool
  - Small businesses buy into Medicaid managed care plans

- Three-share model
  - Subsidize non-state purchasing pool

Considerations

Key Questions

- Efficiency
  - Low public spending per newly insured
  - May get few uninsured

- Effectiveness at reaching uninsured
  - May get many uninsured but at a high cost

- Equity
  - Are individuals arbitrarily excluded to promote efficiency

- Unintended consequences
  - Erosion of existing coverage
  - Increased complexity
  - Lateral rather than forward movement toward goals

GETTING AT ROOT CAUSES

- Reducing prices
  - Intra/inter-state purchasing pools for drugs, etc.
  - Anti-trust and review of non-profits’ charity care
  - Insurance oversight

- Promoting value-based benefit design
  - Aligning coverage with outcomes

- Addressing major drivers of cost
  - Chronic disease
  - Preventive services and wellness
Implications for Covering the Uninsured

- “Bank shot” at helping the uninsured
  - Little direct impact
  - Hard to recapture savings

- Public savings are someone else’s profits
  - Pits providers groups against uninsured if linked

- But success could beget success
  - Helping insured as well as uninsured may strengthen support
  - Creates trust in policy process
  - Moves toward sustainable system

Creating Catalysts

- Creating study or blue-ribbon commissions

- Putting “teeth” into planning
  - Giving governor the authority to take certain actions if state legislators do not act

- Legislating “triggers”
  - Creating automatic mandates is voluntary; actions fail after a certain period of time

Implications for Covering the Uninsured

- No immediate results

- May backfire
  - Create delay rather than forcing action

- But catalyzing systemic change may be the most effective small step