Approaches to Expanding Health Coverage in Michigan

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Categories of Uninsured

1. Low-income people eligible for public programs but not enrolled.
2. Low- and moderate-income people who can’t afford “market price” for insurance.
3. Middle- and high-income people who can’t afford coverage because they are high risk.
4. Higher-income people who can afford but don’t buy coverage.

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Increase Enrollment Rates of Those Eligible for Public Programs

- Vigorous outreach, simplified enrollment, new enrollment locations, enroll with other public programs for the needy.

Pros:

- Potentially very needy people
- No new programs needed
- Feds pay more than half the cost

Cons:

- Still substantial state cost
- Not very easy to do

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Middle Categories Need to Have Lower Net Price — Possibilities

- Make coverage less costly or more efficient
  - E.g., Lower administrative cost, reduce waste & unnecessary care, bargain for better prices
- Reduce risk-related cost variation
  - E.g., community rating, reinsurance, high-risk pools
- Subsidies — *NEW ADDITIONAL MONEY*
  - Government: e.g., tax credits, public program expansion, reinsurance
  - Employer: e.g., employer mandate

Tax Credits for Individuals

Pros:

- "Mainstream" coverage; no separate program.
- Uses existing administrative procedures of tax system.
- More acceptable to those wary of government (tax cut).

Cons:

- Incomes of many uninsured are so low that tax credit must be "refundable."
- Credit available only at tax filing wouldn't help pay monthly premiums - must be "advanceable." May be administratively difficult and costly.
- Large credits required to create significant take-up effect, with higher budgetary cost.
- Crowd out: some might drop coverage
- Trade-off: Cover those already having coverage? Choice between horizontal equity, or high budgetary cost.

Tax Credits for Employers

Pros:

- Depends on market forces and “mainstream” coverage.
- Uses existing administrative procedures of tax system.
- More acceptable to those wary of government.

Cons:

- Many potential firms are small and not very profitable; little income against which to apply credit — refundable.
- Firms (and employees) might still find it difficult to afford coverage.
- To be effective, credits would need to be large, with high budgetary cost.
- “Crowd out” potential: firms already offering coverage might seek tax credits, with no net reduction in the uninsured.
- May be less “target efficient” than individual credits.

Purchasing Pools for Small Employers

Pros:

- Administrative savings, bargain for good prices (theory)
- Cost to state is small—perhaps start-up money.
- Politically acceptable generally, though often not to insurers and agents.
- Allows small employers to give individual employees choice of health plans.

Cons:

- Most past pools have not captured large market share; so couldn't offer lower prices.
- Any savings will be insufficient to make coverage affordable for large numbers of uninsured people.
- Pools have had trouble getting health plans to participate.
- If permissive in accepting high risk groups, will not be able to compete with regular market.

Subsidized Buy-in to State Employees Plan

- Open to certain small, low-wage employers and low-wage individuals at same rates the state negotiates for state employees.

Pros:

- No new administrative structure; existing economies.
- Enhanced bargaining power.
- State has ability to use cost-control tools, since it controls the plan.
- Fair way to spread subsidy costs - general revenues

Cons:

- Major “crowd out” potential: employers as well as employees might drop existing plan, knowing employees can join the state plan.
- Need to cope with adverse selection (accept and pay, or protect against to some degree). Potentially costly.
- State employees might oppose - need separate risk pool.

Government-Subsidized Reinsurance

- Costs of episodes of care above a threshold (e.g., $100,000) are largely paid by government (e.g., 75%) [Healthy New York for small employers]

Pros:

- Increased affordability, especially for higher-risk groups.
- "Socializes" high-cost cases, broadly spreading risk

Cons:

- Relatively poor "bang for buck"
  - Won't lower cost much
  - Subsidizes costs that are currently being paid privately
  - Not well targeted to individuals needing help (although could limit to low-wage employers)
- Reduces insurers' incentive to control costs

Employer “Play or Pay” Mandate

- Employers not offering coverage pay a fee to cover cost of coverage for standard plan. Fee is waived for employers who offer coverage and pay specified percent of premium (California).

Pros:

- Low budget cost, but borne by employers and employees.
- Builds on existing employer system.

Cons:

- Aids only people with jobs.
- High degree of compulsion.
- May cause loss of some jobs for minimum-wage workers.
- Difficult for low-profit employers (may need subsidies).
- Regressive tax burden.

Extend Medicaid to Parents Below Poverty Income

Pros:

- Group is arguably the most in need.
- Federal government would pay ~ 57% of cost.
- Administrative burden low because using existing system.
- Parents and kids in same health plan.

Cons:

- Some “welfare” stigma.
- Political opposition to expanding Medicaid.
- Creates a financial entitlement and a corresponding budgetary burden for the state.

Parent Coverage (up to 200% of Poverty) Through SCHIP

- Option is not available in Michigan at present since Michigan's unspent SCHIP allocation has been dedicated to the Adult Benefits Waiver for the Adult Medical Program.

Pros:

- Federal government pays nearly 70% of cost.
- Enrollment can be capped to control state cost.
- Existing administrative system.
- Employer Buy-In is an option.

Cons:

- "Crowd-out" Issues
- "Welfare" stigma

One-Third Share Plan

- Employees of low-wage business receive subsidized “first dollar” coverage for a benefit package that includes primary and preventive care, but has caps on total cost or days of care. Several models exist in Michigan.

Pros:

- Affordable health care for low-wage workers.
- Causes new contribution of new employer dollars.
- Model already developed: has support from the Governor.

Cons:

- Source of subsidy must be identified.
- Requires intensive marketing.
- Uneven availability if subsidy is locally funded.

Limited Benefit Plan ("Plan B")

- Low-income individuals (for example up to 150% of poverty) who are not insured or eligible for Medicaid receive primary and preventive care, including pharmacy. No premiums; limited copayments.

Pros:

- Provides basic health care to a large number of individuals at a low cost.
- Opportunities to maintain health and improve health behaviors/lifestyle.

Cons:

- Continues reliance on hospitals to fund the cost of acute and emergency care for the uninsured.
- Creates disincentive to join employer-sponsored insurance or third-share plan for low-income workers.

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Individual Mandate for High-Income People

- People with incomes above some level (e.g.,400% of poverty) either get coverage or pay penalty (e.g., surcharge on income tax)

Pros:

- High-income people account for significant share of uninsured.
- Eliminates “free rider” problem when catastrophic costs incurred.

Cons:

- High degree of compulsion.
- Could create hardships if family is high risk.

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Single Payer and Variations

- Everyone automatically enrolled as a “right”—like Medicare for all.

Pros:

- Universal coverage guaranteed
- Complete portability within state
- Greatly reduced administrative burden and costs
- Increased equity: everyone, regardless of risk or income, has equal access; and system financed through taxes

Cons:

- Very high budgetary cost (in large degree offset by reduced private costs)
- Major change from status quo - providers, insurers
- High degree of compulsion
- Possible influx of sick people from other states

Multiple Payer Variation

- Everyone enrolled in a single statewide purchasing pool but with multiple insurers offering coverage
- People pay premiums based on income

- Less disruption of status quo, but still universal coverage substantial administrative savings