Approaches to Expanding Health Coverage in Michigan

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Health Insurance Propositions

- Purpose of insurance is to spread risk: Healthy (temporarily) must subsidize unhealthy
  - Reduce rate variation (toward community rating)
  - Direct subsidies to cover high-risk cases/persons
    - From private source, often insurers
    - From government
- Anyone accepting enrollees on less restrictive basis than others will get "adverse selection" and won't survive without subsidies.

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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.

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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.

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High-Risk Pool-Individual Market

- Special, subsidized insurance for very high-risk people—often those denied normal coverage.
- Rates capped (typically around 150% of normal rates); subsidy pays shortfall—from all insurers or general state funds

Pros:
- May be only viable solution in voluntary market

Cons:
- Often not adequately funded
- Rates may still be too high to be affordable
- Won't increase coverage rates substantially

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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

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State-Authorized Reinsurance No Subsidy

- Insurers identify *specific* high-risk groups or individuals they wish to reinsure; put into a pool that covers much of their cost, for which they pay a premium.

Pros:
- Lowers the risk of high loss, so reinsuring insurer should lower premiums somewhat to high-risk groups (though still reflected in market-wide premiums).
- Less need for medical underwriting.

Cons:
- Large insurers don't want to participate; they reinsure themselves. Difficult to sustain without them. So sometimes assess all insurers to cover pool losses.
- Insurers can't always identify the high-risk.
- Doesn't lower overall cost very much, so won't cause many people to be newly insured.

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MEWAs, METs, AHPs

- Pools formed of multiple employers/individuals (related somehow) to purchase collectively
- Claimed and sometimes got exemption from state regulation and mandates (as ERISA-exempt) to lower cost

Pros:
- Same as other pools + operate across state lines, possible benefit to multi-state employers

Cons:
- When not adequately regulated, many failures, leaving beneficiaries/providers with unpaid claims and no coverage (often fraud)
- Critics: Get lower costs by forming pools of low-risk employers, leaving everybody else paying more
- May not cover many newly insured

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Insurance Reform: Rate Compression

- Move toward community rating to lower rates for high-risk small groups/individuals

Pros:
- Makes coverage affordable to some (most in need) who could not otherwise afford.
- May be perceived as more fair: people not penalized for being high risk

Cons:
- Won't increase number insured by much
- Lower-risk people pay slightly more; some will drop coverage
- Probably won't work in (voluntary) individual market

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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 - uses existing system.
- Enrollment can be managed by modifying income threshold to match available funds.
- Parents and kids in same health plan.

Cons:
- Some "welfare" stigma.
- Political opposition to expanding Medicaid.
- Creates SOME financial entitlement and a corresponding budgetary burden for the state.

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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 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
- Requires state matching funds

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Cover Parents, Childless Couples and Single Adults –HIFA Waiver

Use unspent Medicaid DSH or SCHIP allocations, or savings from other Medicaid groups to extend coverage to additional low-income adults.

Pros:
- If SCHIP, 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
- Michigan has no unused federal SCHIP or DSH funds.

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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.

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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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"Bare Bones" Insurance – Primary Care

- Allow sale of insurance covering only primary and preventive care and limited prescription drugs.

Pros:
- Some people would buy because of low cost, knowing they will get some use out of it.
- Opportunities to maintain health and improve health behaviors/lifestyle.

Cons:
- Would require dispensation from mandated benefits.
- Continues reliance on hospitals to fund the cost of acute and emergency care for the uninsured.
- Adverse selection: young and healthy may not buy.
- Prepayment not insurance; may not be cheaper than paying out of pocket.

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"Bare Bones" Insurance – Catastrophic, High-Deductible Coverage

- Perhaps exclude first $5,000 for family, $2,500 for individual.

Pros:
- Premium cost would be lower and thus more affordable.
- Protects against financially devastating medical event.
- Might be attractive to young, healthy, often-uninsured people, who don't use much primary care.

Cons:
- Experience suggests few people want such coverage.
- Cost might still deter many people from buying.
- Likely opposed by those who think preventive services should be promoted.

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HSAs, MSA, "Consumer Driven"

- Employee &/or employer puts money in a tax-favored "pot" for employee to pay medical expenses. Usually combined with high-deductible insurance.

Claims:
- Consumer initially spending "own" money, so incentive to be cost-conscious—keeps costs down, premiums are lower, more people can afford

Critics:
- Young, healthy, and rich will buy; those left will pay more for their insurance
- May discourage use of preventive services
- May not be adequate protection for lower-income people
- Cost reduction not sufficient to induce many to newly insure

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Individuals in Transition

- Avoid having people who have coverage lose it: going off Medicaid, new workers previously on family coverage, unemployed
  - Subsidize COBRA coverage for those getting unemployment compensation
  - Temporary tax credits
  - Buy in to state employees' plan with subsidies

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Extending Coverage for Young Adults:

- Extend Medicaid beyond age 19
- Cover dependent adult children on family policies

Pros:
- Make up high percent of uninsured
- Low cost because generally healthy

Cons:
- If automatic on private coverage, adds to everybody's premiums; some might drop dependent coverage entirely.
- If option on private coverage, adverse selection likely, and premium cost would be higher because not spread widely.

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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.

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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

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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

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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.

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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.

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Other Questions/Comments from 8-3

- Has anyone ever tried an experience-rated mechanism, similar to unemployment for health insurance? (Employer free to buy in)
- Can we explore a model where people who pay too high a share of their income toward premiums can get a subsidized plan?
- Items missing from EMET:
  - Levels of care offered/does model encourage prevention?
  - To what extent will the expansion model decrease inappropriate use of the ER, uncompensated care and cost shifting to employers?

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