

## **Incremental Universalism for the United States: The States Move First?**

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**A** standard health policy joke goes like this: Health policy expert X dies and goes to heaven. God himself greets X, and the Lord says that the health expert can ask one question before entering heaven. The health expert asks: “Will we ever have universal health insurance coverage in the United States?” God answers: “Yes, but not in my lifetime.”

This joke summarizes the prospects that policy experts have typically seen for universal health insurance coverage in the United States. For senior policymakers, this perspective reflects past battle scars, most recently with the Clinton administration’s proposed Health Security Act in 1994. There has been no serious national attempt at universal coverage since that time. In the run-up to the November 2008 election, the tone of the discussion shifted. Politicians running for office at the national level talked freely about spending tens of billions of dollars on expanding health insurance coverage. But perhaps the most intriguing practical developments occurred at the state level. Most notable has been the health reform plan enacted by Massachusetts in April 2006. This sweeping bill altered insurance markets, subsidized insurance coverage for a large swath of the population, introduced a new health insurance purchasing mechanism (the “Connector”), and mandated insurance coverage for almost all citizens. The Massachusetts experience has led to similar proposals in a number of states, including a major (but ultimately failed) effort in California.

This new wave of health care proposals and laws is marked by what I call

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“incremental universalism”—that is, getting to universal health insurance coverage by filling the gaps in the existing system, rather than ripping up the system and starting over. In this paper, I provide an overview of this type of approach, the issues it raises, and how these issues are being addressed at the state level.

## **Universal Coverage: What Are the Issues?**

### **Who are the Uninsured?**

The nearly 48 million uninsured in the United States are a diverse group that are not easily targeted by a single policy intervention. According to the most common source of data on the uninsured, the Current Population Survey (CPS), the uninsured have lower-than-average incomes; nearly two-thirds of the uninsured are in families with incomes below twice the poverty line. However, not all the uninsured are poor: 20 percent of the uninsured are in families with incomes above \$50,000 per year. Seventy percent of the uninsured are in families where the family head is a full-time, full-year worker, but is either not offered health insurance or doesn't take it up. Thus, the modal uninsured person is a member of what might be called the “working-poor class”: below median income, but not among the poorest in the nation (all facts from EBRI, 2007). Roughly 30 percent of the uninsured are eligible for free or highly subsidized insurance already, either through public insurance programs or offers from their employers (Gruber, 2007).

This point-in-time estimate misses some important dynamics within the uninsured population. A problem with the Current Population Survey estimate is that it is a strange hybrid of a point-in-time estimate and a backwards look at the previous year. Other surveys which are less widely cited provide different perspectives on the uninsured. The Congressional Budget Office (2003) finds that other surveys that ask about lack of health insurance at a particular point in the year provide estimates very similar to the Current Population Survey. But the other surveys also find that estimates of those who lack health insurance over an *entire* calendar year are only about one-half to two-thirds as large as point-in-time estimates; correspondingly, estimates of the number of individuals uninsured *at any point* in the last year are on the order of 40–50 percent higher than point-in-time estimates. These findings highlight the dynamic nature of lacking health insurance.

### **Three Critical Issues: Pooling, Affordability, Mandates**

Any approach to universal insurance coverage in the United States must address three critical issues: pooling, affordability, and mandates.

Insurance is meant to share risk across pools of individuals. If these pools are too small, or if they are created in a way that seems likely to attract people with a high risk of needing costly care, then insurers will be reluctant to offer insurance, or will do so only at very high prices, for fear of adverse selection and high cost exposure. The majority of Americans have access to insurance through such pools, either through their place of employment or through publicly-provided insurance

like Medicare and Medicaid. But most of the uninsured lack access to any such pooling mechanism—for example, most of those without health insurance do not work for an employer that offers such insurance. Solving the problem of the uninsured requires developing some new pooling mechanism, either through government insurance, or through private insurance purchasing arrangements such as the Federal Employees Health Benefits Plan (FEHBP) discussed by Feldman, Thorpe, and Gray (2002). The success of attempts to create a new pool will depend on its scale; existing state-level attempts to create pools for small businesses have generally failed because they did not attract a sufficient number of enrollees to deal with concerns about adverse selection and to spread administrative costs.

Health insurance is expensive. The average cost of family health insurance offered through large firms in Massachusetts is about \$12,000; for those attempting to obtain insurance without a large pool, like small firms or the nongroup market, the price is even higher. For a family of four at 200 percent of the federal poverty line—that is, with an income level of \$42,400—family coverage would cost more than one-quarter of before-tax family income—a huge share of income to devote to health care. These high costs highlight the fact that even if those who are uninsured and have low incomes had access to a large pooling arrangement, they would still need large subsidies to help cover the cost of their health insurance.

However, even large subsidies to health insurance coverage will not be sufficient to end the problem of lacking health insurance. As noted above, many of the uninsured are eligible for either free public insurance or highly subsidized employer-provided insurance and still do not take it up. To come close to full insurance in a U.S.-type health finance system will require an individual mandate—that is, a requirement on individuals to obtain some type of insurance coverage. The most important justification for such a mandate is that more effective risk pooling that would be accomplished, essentially, by the transfer from those who are currently healthy to those who are currently sick implicit in a mandate. Without such a mandate, the uninsured are responsible for the majority of the \$30 billion in uncompensated care delivered by hospitals each year, costs which are presumed to be shifted to insured patients. Many of the uninsured may not appreciate the health risks they face over time, through accidents, communicable disease, or genetic misfortune. Others may rationally decide, given their attitude toward risk, that the costs they would pay for health insurance aren't worth the likely benefits at this point in their lives. Either way, a mandate would prevent people from opting out of health insurance, similar to the way that individuals in most states are required to buy auto insurance if they want to drive a car.

### **Expanding Public or Private Insurance?**

Universal health insurance could in principle be accomplished either through expansion of public or private coverage. Eighteen percent of the nonelderly population and all of the elderly population are already covered by public insurance through the Medicaid and Medicare programs (Employee Benefits Research Institute, 2007). Public insurance has the advantage that it is already targeted to the

low-income groups most likely to lack insurance coverage, and thus an incremental expansion of these programs—without fundamental redesign—can reach most of the uninsured (Gruber, 2005). Public insurance also has a clear advantage through savings in administrative costs. Administrative costs in U.S.-based private insurance average about 12 percent of premiums, while administrative costs in the Canadian National Health Insurance program are 1.3 percent. Of course, it would be unwise to compare administrative costs too casually across countries with cultural and legal differences in their practice of medicine. Moreover, some of the administrative cost differential represents money spent on care management in the private sector, some of which may be cost effective. Still, public programs by their nature avoid certain marketing costs that U.S. private insurers incur.

A public insurance program could in principle be run at the national level or at some regional or state level. A nationally-determined set of health benefits may have disadvantages, since localities vary considerably in income and the prevalence of common medical practices. A single mandated benefits package—identical from New York City to Little Rock, Arkansas, to Juneau, Alaska—may result in a package that is wrong for most Americans. Moreover, a national set of rules could result in missed opportunities for learning which approaches are best for benefits coverage, provider reimbursement, and cost control. Thus, there is an argument for a program that might be based on minimum national standards, but with some flexibility at the regional or state or local level.

A completely government-run program of health insurance seems like an extraordinarily unlikely outcome for the United States. The majority of Americans, particularly those working for large firms with choice of plans, are quite content with their private health insurance. Telling them that they have to give up that insurance, and perhaps accept a lesser degree of nationally-determined coverage, will be a very difficult political sell. The private health insurance industry in the United States is enormous, with more than \$500 billion in claims paid annually. It is impossible to imagine that a half-trillion-dollar industry will be legislated out of business. It seems unlikely in our lifetime, or even in God's lifetime, to have a health insurance reform in the United States that does not incorporate private health insurance.

Indeed, some have proposed expanding health insurance coverage primarily through the private insurance system. For example, the Bush administration budget proposals every year since 2001 have included a provision that individuals could be given tax credits to purchase health insurance from private vendors. Such an approach does address directly the affordability concern. But this approach explicitly does not address either of the other two issues that must be addressed to move to universal coverage—pooling or mandates. Individuals who lack access to either large employer pools or public insurance face an insurance market that features high and variable premiums, often for seriously incomplete insurance coverage. Providing individuals with more resources but not giving them a place to take those resources to buy insurance at a price based on risk-sharing across a large pool is a costly and uncertain way to expand health insurance coverage. When coupled with

a lack of mandates, a private-sector approach cannot provide anywhere near universal coverage. As I show in Gruber (forthcoming), even very generous policies to subsidize the purchase of private insurance are unlikely to cover more than half of the uninsured on a voluntary basis.

## **Massachusetts: Cleaving the Middle**

The Commonwealth of Massachusetts is not typically regarded as a bastion of centrist thinking. The state does have a strongly partisan Democratic legislature, but at the time of reform, it had been led by a Republican governor for 15 years. Moreover, the particular Republican who was governor in 2006, Mitt Romney, had identified health insurance reform as one of the major goals for his administration.

### **Some Factors Favoring Reform**

Massachusetts in 2006 had three advantages that made universal health insurance coverage more than just a wishful thought. First, the state has a relatively low uninsured rate of about 9 percent of the nonelderly population, compared to 18 percent nationally. This lower uninsured rate partly reflects the much higher rate of people with access to employer-offered insurance in Massachusetts relative to the rest of the nation. Thus, Massachusetts needed relatively fewer subsidies than in some other states to move to universal coverage.

Second, a large federal transfer to the state was at stake. In 1997, Massachusetts had received a Section 1115 waiver, which is a provision that allows states to experiment with different types of coverage than would be allowed under Medicaid or the State Children's Health Insurance Program (SCHIP) program and to receive federal matching funds for doing so. Massachusetts had been receiving a large intergovernmental transfer through matching federal funds for state payments to "safety net" hospitals, largely as a result of the political influence of the state's Congressional delegation. In 2004–2005, the Center for Medicare and Medicaid Services was working to crack down on such intergovernmental transfers as a means of reducing federal spending, and the Bush administration threatened to remove the Massachusetts transfer of almost \$400 million as well. In response, Massachusetts government Mitt Romney suggested that if the money continued to flow, instead of being used for payments to safety net providers, it would be used for subsidies to individuals to buy insurance. The Center for Medicare and Medicaid Services agreed to consider this alternative, placing a deadline on the state of early 2006 to come up with a plan to use the funds to increase insurance coverage—or lose the funds altogether. This deadline importantly affected state deliberations.

Finally, Massachusetts already had a ready-made source in place to supply some of the funding for a universal health insurance plan: the state "uncompensated care pool." As part of an earlier attempt at health care reform in the late 1980s, the state set up a mechanism through which hospitals could bill the state for the costs of treating low-income patients (in fact, hospitals are forbidden from billing anyone

who is eligible for this program), rather than having the hospital absorb those costs and passing them on to other payers. The cost of this pool had risen to over \$500 million by 2005. Since universal coverage would lower the ranks of the uninsured, some of these funds could be rededicated to paying for a universal coverage system.

### **Key Features of the Massachusetts Health Insurance Reform**

The reform ultimately crafted and passed in Massachusetts had several key features. Perhaps most notable is what the reform *did not* do. The existing sources of insurance coverage for most state residents were not changed. The state's Medicaid program ("MassHealth") was slightly expanded to cover children up to 300 percent of the poverty line. There were only very modest reforms to employer-sponsored insurance detailed below.

Instead, the reform focused on filling the cracks in the existing system. For adults below three times the poverty line, a new program was established called "Commonwealth Care" that provides health insurance coverage at subsidized rates. The legislation specified that health insurance be free of charge for those below the poverty line, with minimal copayments, and that it be subsidized for those with income between 100 and 300 percent of the poverty line, with some premiums and no deductibles. The legislation did not specify either the exact subsidy levels or the package of benefits (other than mandating that all insurance continue to include previously state-mandated benefits); these were decided later by the Connector Board (and are described below). Individuals were to choose from one of (up to) four Medicaid managed care organizations, the largest two of which were maintained by the large safety net hospitals; coverage of these Medicaid managed care organizations varies throughout the state, but for most residents there is a choice of all four plans.

For those with income above 300 percent of the poverty line, there were major changes to existing insurance markets. First, the nongroup and small group markets were effectively merged through regulation of insurance companies; there is now one market for all individuals either buying insurance on their own or through firms of fewer than 50 employees, with common prices for any individual regardless of how that individual comes to the market. Insurers face a "guaranteed issue" rule that they must sell to all applicants in this market, and they face a "community rating" rule that insurers could not differentiate their prices across applicants by any factor other than age—and even then the ratio of prices for the oldest to youngest can only be 2 to 1. Second, the "Connector" was established as a clearinghouse for individuals to purchase private health insurance. The Connector has no monopoly power, and plans sold inside the Connector must be sold outside for the same price. But it does operate as something of a market maker, specifying benefits packages that are likely to be emulated elsewhere.

Finally, the law specified that all adults in the state must be covered by health insurance—but only to the extent that such insurance was deemed "affordable" by the board of the Connector. Individuals who did not have coverage by December

31, 2007, would face the loss of their individual state-level tax exemption (worth \$218), and those who did not have coverage in 2008 could be liable for a penalty of half of the premiums they would pay if insured. The law also mandated a charge of \$295 per employee on all employers with more than 10 employees who did not offer some health insurance plan to their employees; in addition, it mandated that all employers with more than 10 employees offer a “Section 125” account, which under the federal tax code allows employees to pay health insurance contributions with pre-tax dollars.

Within the context of this basic framework, the Connector board has been filling in a number of details around how the plan would work in Massachusetts. For example, what premiums should be charged for low-income residents in Commonwealth Care? What is the minimum level of coverage that should qualify for an individual fulfilling the mandate to have health insurance. Is insurance “affordable” under the mandate, and, if not, who should be exempted from the mandate? The answers to these questions will be explored further in the next section.

### **Early Results on the Massachusetts Reform**

I am far from an objective observer in discussing the Massachusetts law. I was one of the architects of the law and since 2006 have been a member of the board overseeing its implementation. Despite this bias and the fact that the state is still relatively early in the implementation of this ambitious plan, I can say that some early results do point to major successes with reform.

First, there has been a huge reduction in the number of uninsured. By early 2008, the number of individuals with insurance either through Commonwealth Care, employer-sponsored insurance, or nongroup insurance policies increased by 350,000. This represents more than half of the number of previously uninsured, although there is significant uncertainty about that number (with estimates ranging from 400,000 to 600,000). This number is an overall estimate of the uninsured, so it does not simply reflect churning across forms of insurance. Indeed, a survey in the fall of 2007 (even before insurance was mandated) found that the uninsured rate in the state had been cut in half (Long, 2008). Interestingly, the uninsured rate fell in half *both* for the low-income population that was subsidized by Commonwealth Care and for the higher-income population that was not subsidized (albeit off a much smaller base in the latter case).

This new system seems to be functioning well. The administrative budget for the Connector, which both administers Commonwealth Care and oversees the rest of reform, is roughly \$25 million (on a FY 2009 expenditure of \$1 billion). All decisions so far have been made by complete consensus of the Connector board, a group of ten citizens with three appointed by the (then, Republican) governor (an actuary, a business representative, and a health economist); three appointed by the (then, Democrat) Attorney General (a consumer representative, a labor representative, and a benefits expert); and four ex-officio members of the governor’s administration (the current governor is a Democrat). Perhaps as a result of this cross-party consensus, advocacy groups of all stripes have continued to be support-

ive of the evolving plan. Indeed, public support for the plan grew from mid-2006 to mid-2007 (Long, 2008).

Early tax return data from 2008 show very high compliance with the new requirement to include a “Form 1099-HC” reporting health insurance coverage with tax returns. Of 3.4 million tax returns required to have a Form 1099-HC, only 41,000 tax returns did not file the form. Of those who filed the form, only 168,000 were uninsured, or 5 percent. Roughly 58 percent of that group were required to have insurance and are subject to the \$219 tax penalty for 2007. The other 42 percent were individuals not subject to the mandate, either on affordability grounds (discussed below) or due to religious exemptions (Massachusetts Department of Revenue, 2008).

Market reform for those above 300 percent of the poverty line has also been successful. A typical policy in the nongroup market costs half of its previous level, and is more comprehensive. Overall premiums in the set of plans offered through the Connector rose by only 5 percent for 2008, which is considerably lower than the national rise in health insurance premiums.

The major concern that has emerged with the program is its public sector costs. Originally projected to cost \$750 million by FY 2009, the program is now budgeted at \$1 billion. This run-over is due exclusively to a higher-than-projected enrollment in the highly subsidized portion of the Commonwealth Care program. The survey data on which enrollment was projected appears to have both undercounted the uninsured and overcounted their income, leading to a much higher number of the lowest-income uninsured who are fully subsidized by the state.

## **Incremental Universalism: The Issues**

As the Massachusetts model takes form, it is useful to review the major issues facing policymakers interested in pursuing this approach.

### **The Iron Triangle of Affordability**

A mandate is not politically viable unless insurance is “affordable” for the individuals who are required to pay. The government has three possible tools at its disposal for dealing with this problem, leading to an “iron triangle” of affordability. First, it can subsidize insurance sufficiently so that it seems affordable to all. Second, the government can mandate insurance which is low cost, so that individuals have to spend a smaller share of their income to meet that mandate. Finally, the government can exempt some share of the population on affordability grounds.

The state of Massachusetts has used all three of these tools. Insurance is heavily subsidized for those with incomes up to three times the poverty line: specifically, it is free for those with incomes below 150 percent of the poverty line, and has monthly premiums ranging from \$35 to \$105 for those with incomes at 150 to 300 percent of the poverty line. Individuals with incomes above that level are mandated only to buy a relatively lean insurance package: a plan with a \$2,000 deductible and

\$5,000 out-of-pocket maximum, but which covers preventive care without a deductible; this policy costs about \$200/month for the typical uninsured person. Finally, the mandate applied fully only to those eligible for subsidized insurance or above state median income; for those with income levels between three times the poverty line and median income (about five times the poverty line), the mandate was only partial (more on this below). Ultimately, about 15 percent of the uninsured were exempted from the mandate on affordability grounds; this matches closely the number who actually applied for exemptions in the first year of tax reporting.

Each of these policy tools presents tradeoffs. Subsidies are expensive, and even when limited to those below three times the poverty line, remain a major new expenditure for Massachusetts. Indeed, as noted earlier, the biggest challenge facing the program is the high and growing expenditure on subsidies. Moreover, there was considerable debate over whether even these subsidized levels were affordable for low-income populations (see the arguments in Greater Boston Interfaith Organization, 2007, versus those in Gruber, 2007).

Setting a lean insurance package for mandated benefits is also highly controversial because many hold a strong belief that everyone should have comprehensive health insurance. Here, however, economists have strong evidence that health insurance can be more limited than the generous coverage many receive today *without* sacrificing health. This strong evidence comes from the RAND Health Insurance Experiment of the 1970s, as described in detail in Manning, Newhouse, Duan, Keeler, and Leibowitz (1987) and reviewed more recently by me (Gruber, 2006). The evidence from this study, and from subsequent research in health economics, shows that for the typical consumer, having to pay moderately more at the point of service for health care does reduce the amount of care received but does not have adverse effects on health. For the subset of consumers who are chronically ill, it may be cost-ineffective to have large financial barriers to crucial maintenance care. But the evidence suggests that a cost-effective insurance policy has high consumer cost-sharing, protection against large out-of-pocket risks (and bankruptcy), and only limited out-of-pocket costs for maintenance care of the chronically ill. The Massachusetts minimum policy follows this general pattern. Of course, a limitation of such an approach to affordability is that the lowest-income populations cannot feasibly bear the risk of a \$5,000 out-of-pocket expenditure in a year. As a result, the plans for those on Commonwealth Care are more generous, with income-related copayments of \$5–\$20 for physician visits and no deductible.

Finally, mandate exemptions are problematic because they undercut the goal of universal coverage. But not all exemptions to mandates are created equally. For example, in Massachusetts, where premiums above three times poverty are adjusted by age, insurance is mostly deemed to be affordable for younger individuals, but not always for older persons and for large families between 300 percent of the poverty line and median income, so that the latter group is exempted from the mandate. Given that the goal of the mandate is to ensure that young and healthy individuals with sufficient income to pay will participate in insurance markets, this problem is not necessarily a major one; the individuals who will be exempt from the

mandate are the not the ones who the mandate was primarily targeting in the first place.

### **Integration with Employer-Sponsored Insurance**

A more technical yet quite important issue is the integration of new low-income subsidy programs with existing coverage of low-income individuals through employer-sponsored insurance. This issue has not yet been resolved in Massachusetts. The law specified that Commonwealth Care not be available to those with offers of employer-sponsored insurance. A problem arises, then, concerning that group of low-income individuals who are charged high contributions for their employer-sponsored insurance and cannot afford their employer's plan, but aren't eligible for Commonwealth Care. In the short run, the board addressed this problem by exempting from the mandate anyone who is offered employer-sponsored insurance but would have to pay more for that plan than the Commonwealth Care premium levels.

The underlying problem here is that making subsidies available to those with employer-sponsored insurance could be very expensive. To understand why, it is useful to contrast the three options available for treating employer-sponsored insurance with a Massachusetts-style plan. The first approach is to have an employer-sponsored insurance "firewall," under which those with offers of employer-sponsored insurance in their workplace can't receive any subsidy under the state-run plan. The second approach is premium assistance, whereby the state subsidizes employer-sponsored insurance by paying the difference between (a) the contribution required of the employee by the employer-sponsored insurance plan and (b) the contribution required under the state subsidized plan. The third approach is to use a "voucher"-style system whereby individuals with employer-sponsored insurance can come to the exchange, but only if they bring with them their employer contribution towards health insurance to offset state costs. The Connector board has the option to use this approach in Massachusetts.

All three of these approaches have pros and cons. The "firewall" approach will save money by limiting the eligible population, but tends to lead employers toward reducing their contributions. It also raises equity concerns about low-income workers with offers of employer-sponsored insurance who can't afford that insurance. The other approaches, however, can be quite expensive because the subsidies cannot realistically be restricted only to those who would otherwise be uninsured. For example, in Massachusetts, there are roughly 700,000 workers offered insurance with incomes below three times the poverty line, only 30,000 of which are both uninsured and have employee contributions above the Commonwealth Care premium level. Thus, by offering subsidies to any worker below 300 percent of the poverty line, the state could spend an enormous amount to ensure only a very small number of persons. This effect could be magnified if employers respond to such a subsidy program by lowering their spending on insurance (and raising employee contributions), so that more employees qualify for these state subsidies.

Thus, a state using a Massachusetts-style plan faces a tradeoff: leave some

individuals—those who are offered insurance by their employers but for whatever reason do not take up that insurance—out of the subsidy system; or spend state dollars to subsidize not only those individuals, but also other low-income individuals who now are buying employer-sponsored insurance on their own.

### **The Broader Role of Employer Insurance**

The past 20 years has seen a steady erosion of employer-sponsored insurance, matched with a growth in the number of uninsured; over the past eight years alone, employer-sponsored insurance coverage has fallen by about 1 percent of the population per year (Employee Benefits Research Institute, 2007). Plans to reform health care can treat this trend in three ways: they can accommodate it, they can fight it, or they can facilitate it. The Massachusetts plan accommodates the trend by providing an alternative pooling mechanism to employer-provided insurance, without much addressing those employers who don't offer insurance. This approach will likely lead to a faster erosion of employer-sponsored insurance, although the individual mandate will offset this to some extent by increasing enrollment in employer-sponsored insurance among workers now eligible but not enrolling.

An alternative is to fight the trend towards declining employer-sponsored insurance by pairing an incremental universalism plan with a “pay or play” component that penalizes firms that do not offer insurance. For example, the original proposal from the California legislature would have levied an assessment of 7.5 percent of payroll on firms that did not offer employer-sponsored insurance (or did not spend at least that amount on the employer-sponsored insurance). Such a component will continue to prop up the employer-sponsored insurance system but at the cost of lower wages for employees working at such firms and potentially with distortions to business formation.

Finally, proposals in a spirit of incremental universalism can facilitate the demise of employer-sponsored insurance, by pairing non-employer-sponsored insurance coverage options with reduced subsidies to employer-sponsored insurance itself. In Gruber (forthcoming), I advocate a national version of the Massachusetts plan which would cost roughly \$125 billion/year in new federal expenditure. To finance this initiative, I propose ending the tax subsidy to employer-sponsored insurance, so that employer-paid health insurance premiums would be taxed like regular income. This large subsidy to employer-sponsored insurance is regressive, since it is worth the most to the higher-income individuals with the highest tax rates. It also induces inefficient insurance purchase, since individuals can buy excessively generous insurance with pre-tax dollars. Moreover, this subsidy costs the federal government over \$200 billion/year in foregone tax revenues (both income and payroll tax), making it the nation's third-largest health care program after Medicare and Medicaid.

In my ongoing work, I find that the United States could finance a national version of the Massachusetts plan through ending the tax exclusion to employer-sponsored insurance *and* have about \$50 billion/year in excess revenues. The reason that there are only \$50 billion in excess revenues, and not the \$200–\$125 = \$75 billion one might expect, is that this approach will lead to an erosion in

employer-sponsored insurance: I estimate that under this plan, employer-sponsored insurance would fall by about 24 million persons, which is about 15 percent of the existing employer-sponsored insurance base. These individuals then move into the subsidized pool, increasing the costs of the program. Thus, this approach facilitates the erosion of employer-sponsored insurance.

### **What about Cost Control?**

Two crises are facing the U.S. system of health care finance: high and rising uninsurance, and high and rising health care costs. This essay, the Massachusetts plan, and most current proposals all focus on the first and pay only lip service to the second. Providing additional benefits is both politically and practically easier than finding ways to reduce spending. This round of reforms thus involves a decision not to hold the attainable goal of universal coverage hostage to the (currently) unattainable goal of fundamental health care cost control.

The effects of measures currently being discussed under the guise of cost control are likely to be quite modest. Initiatives such as electronic medical records, increased preventive and maintenance care, and reduced medical errors will at best reduce health care costs by only a few percentage points, and are just as likely to raise costs (while also increasing quality); see, for example, the recent Congressional Budget Office (2008) discussion of the illusory costs savings from health information technology. With health care costs rising at 7–10 percent per year, such steps don't amount to much. To control health care costs our society will need to be willing to deny care that does little for health but consumers nevertheless want. The reduction in care of low marginal value could be accomplished through government technology policy that limits the use (or future development) of new technologies, through medical standards that limit the use of high-cost, low-benefit care, or through global provider budgets that limit what is spent and force providers to set priorities within that total.

However, considerable controversy swirls over the appropriate level of such government interventions to reduce the rise in health care spending—or whether such steps are necessary at all. Some argue that past health care spending advances are justified by improvements in population health (Cutler, 2004). Others point out that there are huge variations in health care practices across the United States with no tangible difference in outcomes (for example, Skinner, Staiger, and Fisher, 2006), which suggests that some medical care is producing little benefit to health. The earlier discussion of optimal insurance pointed out that high cost-sharing (higher costs for consumers) results in a lower quantity of care being received but no diminution of health status, which again suggests that some care is producing little benefit. These views are not necessarily inconsistent: it is possible that the average value of additional medical care over time has been worth the cost, but the marginal value of additional health care is low. But economists and public policy analysts have not yet resolved these different facts into an agreed-upon method for designing a system that will separate health care spending which is justified from

that which is not. Until then, politicians are clearly unprepared to take on the American public on health care cost control.

## **Other States?**

While this essay has focused on developments in Massachusetts, other states have been moving towards health insurance reform as well, some more boldly than others. The health care proposals enacted in Massachusetts in 2006 and debated in California throughout 2007 shared one feature not used by other states: the use of individual mandates to have health insurance. Absent individual mandates to bring young adults into the system, no state can hope to approach universal coverage. A variety of sources describe efforts undertaken by the states as they expand insurance coverage. Perhaps the best summary is provided on the website for the Robert Wood Johnson Foundation's "State Coverage Initiatives" (<http://www.statecoverage.net>). Virtually every state has undertaken some effort to raise the insurance coverage levels in its states. We begin here with a discussion of the California proposals, and then review several policy tools commonly used in state efforts at incremental universalism.

### **California**

Throughout 2007 and into early 2008, California was seriously debating what would have been the second most-ambitious health insurance reform plan in the nation, after the Massachusetts plan. The debate in California in many ways reflected the tension between the incremental universalism approach and the previously dominant employer mandate model that remains favored by many labor unions. Governor Arnold Schwarzenegger proposed a plan very similar to that in Massachusetts, albeit with the additional funding sources in the form of a 4 percent assessment on employers of more than ten employees who do not offer health insurance and a tax on hospitals and physicians (essentially to replicate the existing provider tax fund that existed already in Massachusetts). The legislature promoted a version of a plan that it had passed the previous year, which relied much more intensively on employers as both a source of insurance and a source of program financing. In early 2008, the reform proposals were shelved after analyses were published suggesting they would be more costly than expected (California Legislative Affairs Office, 2008).

In retrospect, it is unsurprising that California's proposed reforms ran into cost difficulties, because California does not have the financial advantages of Massachusetts. The rate of those uninsured in California is roughly twice as high as in Massachusetts; in fact, roughly one-tenth of all the nation's uninsured live in California. The state currently devotes little money to the uninsured, so there was little funding that could be shifted to a new program. Major county funds in California are devoted to caring for the uninsured, but these funds (a) are very difficult for the state government to recapture and (b) may be required for those

that remain uninsured. Finally, roughly one-quarter of the uninsured in California are undocumented immigrants. The federal government will not pay matching dollars to the state to cover this group, and there is much state-level opposition to covering them as well. At least in 2008, these hurdles proved too difficult for a health insurance reform effort to cross.

### **Insurance Market Reform**

One general approach taken by states is to reform their health insurance markets to provide better access to coverage for less healthy individuals who cannot find coverage in today's nongroup market. States have pursued one or more of three approaches to addressing this problem.

A first approach is to minimize how much insurance companies can vary prices according to health status, especially in the small group market. For example, some states have mandated "guaranteed issue," where insurance companies are required to sell to all comers; or guaranteed renewability of insurance; or regulated the factors that can be used in insurance pricing and the range that is acceptable for those factors. These reforms have been successful in making coverage available for older and sicker individuals, but have, if anything, lowered insurance coverage on net by leading to higher prices for insurance that drive even more healthy and young individuals out of the market (Simon, 2005).

Second, an alternative to regulating insurance markets so that less healthy individuals can be pooled with more healthy individuals is to set up separate high-risk pools for the least healthy risks. These pools typically offer insurance to enrollees at 125–150 percent of the average market price, with the state subsidizing the remaining differential. The pools in most states are very small, with the largest pools enrolling 30,000–50,000 individuals.

A third alternative, which can be used separately or in concert with the others, is to provide reinsurance to some segments of the insurance market to absorb excess risk and ensure more uniform pricing.

No available evidence suggests that these approaches have made a major dent in the rate of uninsurance. Moreover, each of these approaches results in either implicit or explicit taxation. Insurance market reforms implicitly tax the healthy; that is why, on net, they probably lower insurance coverage (although they may raise the value of insurance to society by covering more sick individuals). High-risk pools and reinsurance likely raise insurance coverage, but only at a revenue cost to the state.

An important issue is whether these revenues would be more appropriately spent elsewhere. High-risk pools and reinsurance do help the sick, but most of the individuals helped by these programs probably already had insurance. Incremental programs to increase insurance coverage are most effective when they are targeted at the lowest-income groups who are most likely uninsured (Gruber, 2005). Thus, states could likely have more "bang for the buck" in terms of increased insurance coverage by targeting these dollars to insurance expansions for those with low incomes. Insurance market subsidies such as high-risk pools or reinsurance may

provide more horizontal equity for the ill, but likely do little to increase insurance coverage.

### **Voluntary Insurance Pools**

Another approach taken by many states is the use of voluntary pools to try to solve the problems of pooling in the small and nongroup markets. Unfortunately, for the most part, such voluntary pools have either stayed quite small (with only 2,900 enrollees in the plan in Arkansas, for example) or failed altogether (such as PacAdvantage in California); the only notable exception is the CBIA “Health Connections” small business pool in Connecticut, which has 88,000 members. The failures that have occurred are largely due to adverse selection. When the pools were unable to attract a broad base of subscribers, insurance companies charged high premiums to cover both adverse selection risk and high administrative costs. For an overview of such state efforts, see California Health Care Foundation (2005).

### **Expansions of Public Insurance**

An approach followed by most states over the past decade is to increase entitlements to public insurance, particularly for children. With extensive federal financing through S-CHIP (the State Children’s Health Insurance Program) and federal flexibility for state innovation through the Medicaid Section 1115 waiver program, a number of states have moved to cover children up to and beyond 200 percent of the poverty line and to cover other groups as well (mostly parents of eligible children). By most estimates, this approach has significantly lowered the uninsurance rate of children relative to the growing adult baseline. At the same time, this program has induced significant “crowd-out”; estimates suggest that as much as half of the increase in the rolls of public insurance is offset by declining private insurance coverage (LoSasso and Buchmueller, 2004; Gruber and Simon, forthcoming).

### **Subsidies to Employer-Sponsored Insurance**

A recent approach pursued by a number of states, most notably the state of Maine through its “Dirigo” program, is either to subsidize employers to provide insurance or to subsidize their employees to enroll in that product. Subsidies to small businesses are likely to be successful in increasing insurance coverage, because small businesses (many of which do not now offer insurance coverage) are fairly price sensitive in their insurance decisions (Gruber and Lettau, 2004). But as the universe broadens to include larger firms, the targeting of such subsidies becomes much less efficient. The vast majority of firms with more than 25 employees and virtually every firm with more than 100 employees already offers health insurance.

To target low-income individuals, many states have also turned to subsidies to low-income individuals to enroll in the insurance offered by their employer. This approach faces two problems, however. First, these subsidies are very poorly targeted, because even at low income levels, the overwhelming majority of those who

are offered health insurance by an employer have taken up that insurance. Among those with incomes below the poverty line who are offered employer-sponsored insurance, 75 percent are insured; among those with incomes between 100 and 200 percent of the poverty line who are offered employer-sponsored insurance, 87 percent are insured; and among those with incomes between 200 and 300 percent of the poverty line who are offered employer-sponsored insurance, 93 percent are insured (Gruber, 2007). As a result, subsidies targeted to those low-income individuals who are already offered employer-sponsored insurance will mostly “buy out the base” of those already insured rather than expanding insurance coverage.

The second problem with subsidizing low-income employees to buy pre-existing employer-sponsored health insurance is that a large body of evidence, which I reviewed in Gruber (2005), shows that the small share of employees who are offered employer-sponsored insurance but who turn it down are very price inelastic. This finding should perhaps not be surprising; after all, they are already turning down, on average, large employer subsidies to take health insurance coverage. As a result, additional subsidies will be unlikely to increase their insurance enrollment and instead will just accrue to those already insured. For example, when the federal government allowed its employees to pay their premiums before-tax, it substantially reduced federal tax revenues with little noticeable effect on enrollment; on net this policy cost between \$30,000 and \$80,000 per newly insured person (Gruber and Washington, 2005).

### **Is Health Insurance Reform a State Issue?**

Most states have shown a limited ability to implement plans that bring them even close to full insurance coverage. This result naturally raises the question of whether universal coverage is indeed a state issue, rather than federal one. The usual arguments for and against decentralization apply here.

On one hand, decentralization allows states to match the unique landscapes of their health economies and tastes of state consumers. For example, states where most citizens are already covered by stable employer-sponsored insurance may find the type of approach pursued in Massachusetts attractive. Other states with higher levels of uninsured citizens and lower levels of employer-sponsored health insurance may want to take more radical steps, such as setting up a monopoly “connector” in the insurance market to enforce a new pooling mechanism. States may vary in the level of minimum standards for insurance coverage which are viewed as acceptable by their citizens. Multiple state approaches could foster innovation and perhaps even competition and continued improvement across states. For example, the Massachusetts approach was the basis for the proposal in California and has attracted interest from other states.

On the other hand, following a state-based approach raises important questions. On the equity front, states left to their own devices would probably evolve with very different “affordability” standards across states, leading individuals in

neighboring states to pay dramatically different amounts to meet the target of universal coverage. If the ultimate goal is universal coverage with meaningful health insurance for all Americans, then some body will have to monitor state reforms to ensure that this standard, however it is defined, is met.

What is clear is that states cannot meaningfully innovate in this area without a massive injection of federal funds. Of the state initiatives discussed in the previous section, the only one that has been broadly successful in lowering the number of uninsured Americans is expansion of public insurance, mostly through the State Children's Health Insurance Program, for which the federal government pays at least 65 cents of each dollar. If the United States wants to pursue a policy of expanded health insurance through state-level actions, the federal government will need to put the money behind such an effort.

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