THE HAMILTON PROJECT

Advancing Opportunity, Prosperity and Growth

POLICY BRIEF NO. 2008-04 JULY 2008

Taking Massachusetts National: An Incremental Approach to Universal Health Insurance

HEALTH CARE RECONSIDERED

Options For Change

This proposal is one of four alternative approaches to achieving universal coverage that have been released by The Hamilton Project

UNTIL THE RECENT FOCUS ON HEALTH CARE in the presidential primaries, the debate over universal health insurance in the past decade had taken place largely at the state level. In the absence of national action, states considered acting themselves, and Massachusetts passed a plan to expand health insurance to all state residents. The Massachusetts approach allows private plans to function within a state-administered insurance pool and offers subsidies to help low-income residents purchase insurance. Massachusetts also mandates now that all residents have health insurance. Although the plan has been costly, the number of uninsured in Massachusetts has been cut by more than half.

Jonathan Gruber, an economist at the Massachusetts Institute of Technology (MIT) and one of the architects of the Massachusetts plan, proposes a nationwide health system modeled after the Massachusetts reforms. Under Gruber's plan, those happy with their current employer-sponsored health insurance plans could keep them, while those that want to change plans would have more choices than today. Like the Massachusetts model, the national system would include subsidies for low-income Americans, pooling mechanisms to keep premiums low, and a requirement that all residents purchase health insurance. Beyond the Massachusetts model, Gruber proposes larger subsidies to help middle-income families who do not have employer-based coverage, health care vouchers for those who cannot afford the insurance offered through their employers, and better mandate enforcement. Modeling a national plan after the Massachusetts reforms, argues Gruber, would expand coverage and provide affordability to all Americans.

THE BROOKINGS INSTITUTION 1775 Massachusetts Avenue NW, Washington, DC 20036

THE CHALLENGE

Despite increasing productivity and technological advances in health care, nearly 47 million Americans lack health insurance at any given time. Such point-in-time measures may actually underestimate the true number of uninsured, which could be as high as 70 million when including all people who are uninsured at some point over a year.

Two-thirds of uninsured Americans are in families with incomes below twice the poverty line (the poverty line is around $21,000 for a family of four). Since households below the poverty line are generally eligible for public insurance, most of the uninsured have an income that places them somewhat above the poverty classification. Uninsurance is not limited to households in which the adults are unemployed or working part time. Sixty-three percent of the uninsured are in families in which the head of the household is a full-time worker.

The most obvious consequence of uninsurance falls on the uninsured. Even though emergency rooms are not likely to turn the uninsured away, people without health insurance may not get preventive care. Studies show that the uninsured do have worse health outcomes; according to the Institute of Medicine, the uninsured have a 25 percent higher mortality risk than insured individuals, with eighteen thousand Americans dying each year due to a lack of insurance. Some of these studies merely document a correlation between a lack of health insurance and health outcomes; other studies that use more robust empirical methods have documented a causal effect of lack of health insurance on adverse health outcomes.

The effect of uninsurance also extends to society at large. Uninsurance among a significant portion of the population creates ripple effects across the health care system and economy. The most common economic argument for increasing insurance coverage is to reduce the external costs that the uninsured impose on the health care system. When uninsured individuals become sick and cannot pay their medical bills, costs for their care are passed on to others through higher taxes and higher health insurance premiums. This "uncompensated care" in the United States amounts to roughly $30 billion per year, or more than $250 per household. Another consequence to society is "job lock": workers are reluctant to change jobs or start a new business out of fear of becoming uninsured.

Perhaps the most important effect of the lack of health insurance coverage is the tendency toward what economists call adverse selection. Feeling invincible, the healthiest individuals may choose not to purchase health insurance, leaving only less-healthy individuals in the insurance market. Insurance companies may then offer less-comprehensive plans or raise costs to compensate for the higher average health risk of those who remain in the market. This increase in costs may force out even more relatively healthy individuals, creating increasingly smaller insurance pools of sicker people, which eventually can lead to the failure of the market. Given the risk of market failure, government intervention that seeks to bring more people into the insurance system can improve the market for insurance, leaving those in the system better off, on average.

The problems that uninsurance creates have been recognized by policymakers for almost two decades, but the political process has failed to produce a solution. Much of the debate has pitted opposing ideologies against one another. Gruber argues that reforming the health care system will require coming to a middle ground in the form of recognizing both the advantages of the private market in providing choice and efficiency and the need for a government role in ensuring that all Americans have health insurance they and their families can afford. Gruber argues that any attempt to address the problem of the uninsured must have three key features: affordable coverage, a pooling mechanism that combines the healthy and the sick, and a requirement that everyone has insurance.

A NEW APPROACH

The Massachusetts Model

In 2006 Massachusetts was uniquely placed to provide a model for health care

reform. The state needed to find a way to spend a large transfer from the Medicaid program or lose the money. The Centers for Medicare and Medicaid Services agreed to give the state some time to use the funds to increase insurance coverage. In addition, Massachusetts had more than $500 million reserved for uncompensated care, but would no longer need as much money for that purpose if it could use it to reduce the number of uninsured. With a source of funding and a deadline to meet, Massachusetts had the motivation and the resources to become the first state to establish a universal health insurance plan.

The Massachusetts model maintains the current system of employer-sponsored insurance and complements it with a regulated marketplace of private insurers that gives households without employer-provided insurance the opportunity to purchase insurance at lower cost than they can today. That new pool of insurers gives those without employer coverage the opportunity to purchase less-costly insurance. Additionally, the state subsidizes the purchase of insurance for low-income residents.

Subsidies for Low-Income Residents

All Massachusetts households with incomes below three times the poverty line, or about $63,000 for a family of four, can receive subsidies to purchase insurance through a new program called Commonwealth Care. Those with incomes below the poverty line receive a full subsidy, while households with income up to three times that amount receive partial subsidies to help pay premiums. These low-income households are responsible for some copayments but do not have a deductible.

State-Administered Insurance Market

In Massachusetts individuals and small businesses can buy insurance in a combined market. This market, known as the Health Connector, allows individuals to purchase private insurance if they are not eligible for insurance through their employers. Government is neither the provider nor the payer, as with Medicare.

> Sixty-three percent of the uninsured are in families in which the head of the household is a full-time worker.

Rather, the government's role is simply to pool people in a marketplace from which they can purchase insurance from private firms—just as the federal government does today in its role as a large employer through the Federal Employee Health Benefits Plan. The insurers in the Health Connector must offer insurance to all applicants. They must also adhere to community-rated pricing: insurers are not allowed to differentiate prices among applicants by any factor except age, and even for this factor the maximum differential is limited.

Mandates

Part of the impetus for providing substantial subsidies for purchasing health insurance was a desire to make sure that everyone was insured. Due to the increased affordability, more people should have been able to purchase insurance. The state realized, however, that not everyone would purchase insurance because people may not incorporate the social costs of their failure to have health insurance into their decision to purchase it. They may also have behavioral biases that cause them to underestimate their own health risks. Thus, Massachusetts required all residents to purchase health insurance by December 31, 2007. Individuals failing to comply with the mandate by the end of 2007 lost the tax exemption, valued at about $218; in 2008, the penalty rose to potentially half of the premiums they would have paid had they been insured. The Massachusetts plan also includes mandates for employers, requiring all employers with more than ten employees to either

Key Highlights

Massachusetts' Reform and Success

- **In 2006 Massachusetts became the first state** to implement health care reform that attempts to achieve universal coverage.
- **The health care reform plan in Massachusetts** reduced the uninsured by more than half; three hundred thousand of the four to six hundred thousand uninsured were covered as of the end of 2007.
- **The plans in the Health Connector** are affordable: options for young individuals cost less than $150 per month and options for middle-aged individuals are about $200 per month.

Taking Massachusetts National

- **Create a state-by-state health insurance market** for low-income individuals with subsides given to households with incomes up to 400 percent of the federal poverty line.
- **Allow individuals with incomes below 400 percent** of the poverty line who are not able to afford their employer's health insurance to use a voucher to buy health insurance in the low-income health insurance pool.
- **Create a health insurance pool called HealthMart for middle- and high-income individuals** in order to combine the risks of those not in an employer pool.
- **Mandate insurance coverage for all individuals,** and enforce it through the tax code

offer health insurance to employees or pay $295 per employee in fees. Employers with more than ten employees must also offer a Section 125 account, which is a company-administered savings plan that allows employees to purchase health insurance with pretax dollars.

Building on the Massachusetts Model

The Massachusetts plan has sharply reduced the number of uninsured. More than three hundred thousand of the four to six hundred thousand uninsured have been covered. Jonathan Gruber proposes that a system similar to that in Massachusetts be established nationwide and organized on a state level. His plan includes subsidies for purchasing health insurance, a new market for health insurance plans, and an individual mandate, as does the Massachusetts system. However, Gruber makes some important changes to the Massachusetts model, such as extending subsidies those with incomes up to 400 percent of the poverty line. He also attempts to reduce government costs by requiring more cost sharing from those with incomes above 200 percent of the poverty line.

Health Care for Low-Income Families

Under Gruber's plan, current public programs for low-income families, including Medicaid and the State Children's Health Insurance Program, would continue to provide coverage for parents and children who are below or near the poverty line. For households that are not eligible for either of these government programs or employer-sponsored insurance but have incomes less than four times the poverty line, state insurance pools would provide subsidized health care coverage. The amount households above the poverty line could be required to pay for insurance would be limited as a percent of their income. For example, households between 100 and 150 percent of the poverty line would pay at most 2 percent of their income, while households between 350 and 400 percent of the poverty line would pay at most 12 percent of their income. Gruber expands the subsidy up to

400 percent of the poverty line for the national plan, rather than keeping the 300 percent limit from the Massachusetts plan, in order to ensure affordability for all Americans at or below median income. (The median household income for all households is only $48, 201, but for households with a married couple, the median household income is $69,716).

> Low and middle-income households would receive subsidies to purchase health insurance through state insurance exchanges

Vouchers for Health Care

Although the plan's subsidies are focused on households without employer-sponsored insurance, many families that are eligible for employer-sponsored insurance still cannot afford it. To address this concern, Gruber proposes a health care voucher program, an idea that is part of the Massachusetts health care reform legislation but that has not yet been implemented. The voucher would allow individuals with incomes below 400 percent of the poverty line to purchase insurance in the low-income insurance pool by using the employer contributions that would have gone toward the employer-sponsored plan. The state would then help pay the difference between the employer contributions and the cost of the plan purchased in the insurance pool.

HealthMart

The low-income insurance pool and vouchers are designed to assist those with incomes below 400 percent of the poverty line, but Gruber recognizes that middle- and higher-income families also have a hard time affording health insurance outside the employer market. His plan would create a new pool called HealthMart, similar to the Health Connector in the Massachusetts Plan, which would be organized on a state-by-state basis like the low-income insurance pools.

HealthMart would offer three levels of benefits. The highest level of benefits would be a plan similar to a low-copayment HMO. The lowest level would have to provide a minimum set of benefits. The "minimum creditable coverage" in Massachusetts includes a deductible of $2,000 per individual and an out-of-pocket maximum of $5,000. The plan includes physician, hospital, and prescription drug coverage, but not dental or vision coverage.

Mandate

This proposal would enforce the individual mandate through the tax code. Under the new plan, all individuals would be issued forms stating their health insurance coverage. They would be required to attach these forms to tax documents when they file their taxes with the IRS. Any person without insurance would be fined an amount equal to the premiums that person would have paid if health insurance had been purchased. As noted above, low-income people receive significant assistance under Gruber's plan, so they would not be penalized for their inability to afford coverage. If affordability of health insurance continues to be a problem even for those with higher incomes, Gruber points to the possibility of providing subsidies for those with incomes above 400 percent of the poverty line that are spending an inordinate amount of their income, say 15 percent, on health care. Given these measures to ensure affordability, people would be required to take responsibility for entering the risk pool along with everyone else, helping to mitigate adverse selection problems. The fines would be combined into a fund to pay for any uncompensated care that remains within the health care system.

Evaluating the Effects of a National Health Insurance Plan

Gruber uses a microsimulation model to predict how many people would be insured under his proposal and what the costs of the plan would be. He

> Gruber offers an approach to health insurance that would preserve the choice and efficiency of the private market while achieving universal coverage through subsidies and mandates.

predicts that, with the mandate in place, nearly all Americans would have health insurance—46 million more people than today. As the plan is implemented, the number of Americans receiving subsidies to purchase health insurance would reach 59 million. Thus the plan would produce a 28 percent "crowd-out" rate: beyond the 46 million uninsured that would receive coverage, 13 million people who currently have private insurance would receive public subsidies to purchase insurance.

Gruber emphasizes the importance of the individual mandate in achieving universal coverage. Even with subsidies for health insurance, about 24 million individuals would choose to remain uninsured without a mandate, about half of those uninsured today. Therefore, Gruber concludes, universal access is not equivalent to universal coverage. The individual mandate is the final step needed to bring nearly everyone into the insurance market.

The total annual cost of the nationwide plan would be $131 billion. This plan could be funded through any tax increase or spending decrease, but Gruber proposes paying for the plan through the elimination of the current tax subsidy for employer-sponsored health insurance. Currently, the government allows individuals to exclude employer contributions to health insurance from their taxable income. This exclusion for health insurance is most beneficial to high-income individuals with high marginal tax rates, while low-income households receive little to no benefit from the exclusion. The elimination of the exclusion is a particularly suitable way to finance the plan because the amount the government saves each year would grow as health care costs rise.

In the first year, eliminating the exclusion would provide financing of $168 billion (net of the larger subsidies needed because more people move out of employer-sponsored insurance). On average, this shift would benefit families with incomes below twice the federal poverty line, with losses for families with incomes above three times the poverty line. This financing plan would produce a net federal surplus though so the government could give an extra boost to those with incomes between three and four times the poverty line. The surplus could finance a tax credit for those middle-income families equal to $380 per individual and $950 per family. Such a tax credit would make the combination of the health care proposal and the elimination of the health insurance exclusion cost neutral for those with incomes between three and four times the poverty line.

Implementation Questions and Concerns

Will mandate enforcement be successful?

Gruber's simulations show that even with subsidies for health insurance about 24 million people would choose to be uninsured without a mandate in the program. Some have argued that this mandate would be hard to enforce, but there is considerable evidence that mandates do work. The Netherlands and Switzerland both have compliance rates of 98 to 99 percent with their health insurance mandates. The compliance rate for auto insurance in states with high levels of information sharing is about 98 percent.

How would this plan address cost effectiveness?

Lack of health insurance coverage is only one of the problems in the health care system. Another is cost effectiveness, measured as the quality of care relative to the cost of care. In the long run we should develop policies to improve cost effectiveness, but in the short run,

Gruber argues, we should focus on expanding coverage rather than waiting until we can solve all problems associated with health care.

Why not have a public buy-in option?

Some proposals to expand health coverage include a public insurance buy-in option, in which families that do not qualify for free public insurance such as Medicaid can purchase public insurance as their primary source of health coverage or as a supplement to private coverage. However, a major problem with public buy-in is that public programs tend to pay physicians less than private plans do for the same service, causing physicians to stop accepting public insurance. Large public buy-in with low reimbursement rates may lead to few health care providers willing to accept public insurance, defeating the goal of expanded coverage and cost saving. The HealthMart proposed here would serve as a nationwide clearinghouse for all individuals to purchase private health insurance that is more likely to be accepted by health care providers. More broadly pooling risk, in combination with subsidies for low-income families, would be sufficient to provide affordable and functional health coverage to all households.

CONCLUSION

Although the Massachusetts health care reforms have been more costly than expected, the reforms have sharply increased insurance coverage. Jonathan Gruber argues the time is ripe to expand the Massachusetts system into a nationwide program. The Massachusetts program combined individual purchasers of health insurance into a larger market to promote cost savings and increase insurance coverage. The number of uninsured has fallen by more than half. With better enforcement the nationwide program has the potential to virtually eliminate the problem of uninsurance.

Gruber offers an approach to health insurance that would preserve the choice and efficiency of the private market while achieving universal coverage through subsidies and mandates. By aligning the goals of private provision and universal coverage, a national plan based on the Massachusetts model could minimize political divisiveness in the health care debate and garner bipartisan support.

Learn More About This Proposal

This policy brief is based on The Hamilton Project discussion paper, *Taking Massachusetts National: An Incremental Approach to Universal Health Insurance,* which was authored by:

DR. JONATHAN GRUBER
Economist, Massachusetts Institute of Technology (MIT)

Dr. Gruber's research focuses on the areas of public finance and health economics. He has published more than 100 research articles, has edited four research volumes, and is the author of *Public Finance and Public Policy*, a leading undergraduate text.

Alternative Approaches to Universal Coverage

This proposal is one of four alternative approaches to achieving universal coverage that have been released by The Hamilton Project

- **Gerard Anderson and Hugh Waters** propose extending Medicare to all firms and individuals wishing to buy into it. The reform, which includes individual and employer mandates and income based subsidies, is designed to expand affordable coverage to everyone.
- **Stuart Butler** proposes creating state-chartered health insurance exchanges as alternatives to employment-based pooling, using employers to facilitate (rather than fully sponsor) health coverage, and reforming the tax treatment of health care.
- **Ezekiel Emanuel and Victor Fuchs** propose giving vouchers to every American for comprehensive health insurance. They argue the vouchers, funded by a value-added tax, would provide portability and promote cost effectiveness.
- **Jonathan Gruber** examines the feasibility, costs, and benefits of extending nationwide the "Massachusetts model," which provides universal coverage through a combination of mandates, subsidies, and alternative insurance risk pools for purchasing insurance.

The Hamilton Project seeks to advance America's promise of opportunity, prosperity, and growth. The Project's economic strategy reflects a judgment that long-term prosperity is best achieved by making economic growth broad-based, by enhancing individual economic security, and by embracing a role for effective government in making needed public investments. Our strategy—strikingly different from the theories driving economic policy in recent years—calls for fiscal discipline and for increased public investment in key growth-enhancing areas. The Project will put forward innovative policy ideas from leading economic thinkers throughout the United States—ideas based on experience and evidence, not ideology and doctrine—to introduce new, sometimes controversial, policy options into the national debate with the goal of improving our country's economic policy.

The Hamilton Project Update

A periodic newsletter from The Hamilton Project is available for e-mail delivery.
Subscribe at www.hamiltonproject.org.

The Project is named after Alexander Hamilton, the nation's first treasury secretary, who laid the foundation for the modern American economy. Consistent with the guiding principles of the Project, Hamilton stood for sound fiscal policy, believed that broad-based opportunity for advancement would drive American economic growth, and recognized that "prudent aids and encouragements on the part of government" are necessary to enhance and guide market forces.

The Brookings Institution
1775 Massachusetts Avenue NW, Washington, DC 20036
info@hamiltonproject.org ■ 202.797.6279

THE HAMILTON PROJECT ADVISORY COUNCIL