

Striving for Universal Coverage:  
An Analysis of the 2010 U.S Health Care Legislation  
Reforms

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## **ABSTRACT**

The United States is the only OECD country without universal health insurance coverage, yet spends more than any other nation on medical care. As a potential solution to this problem, this Thesis will explain and analyze the various aspects the U.S. Federal Government's recent health care reform effort, specifically the provisions that aim to expand insurance coverage. Each of the mechanisms for expanding coverage, such as the individual and employer mandates, open enrollment, premium subsidies and community rating, is rooted in health economics theory, which is presented here. Since the entirety of these reforms will not be implemented for several years, it is difficult to predict their success or their financial feasibility. My findings suggest, however, that while the reforms will be able to significantly expand health insurance coverage, both by improving access and affordability, they will not come near achieving universal coverage. Furthermore, the costs of these reforms will likely be higher than the U.S. government suggests.

## **1 INTRODUCTION**

This Thesis will explain and analyze various aspects of the U.S. Federal Government's recent health care reform effort. Specifically it will examine the legislative provisions that aim to expand health insurance coverage in the United States. It will describe how the two plans originally put forward by the U.S. Senate and the U.S. House of Representatives in 2009 intend to implement a variety of mechanisms for increasing coverage both administratively and financially. By looking at the reforms from a theoretical perspective, this Thesis will analyze the feasibility of the various mechanisms and assess how far they will go toward actually reducing the number of un(der) insured Americans. Although many countries that have universal coverage, such as the Netherlands, often actually have one or two percent of the population still uninsured, the United States may struggle to reach even that level of coverage.

The rising cost of health care and the growing number of uninsured Americans have long been concerns for the U.S. government and people. The recent passage House Resolution 3590, the "Patient Protection and Affordable Care Act," has the potential to greatly improve financial access to health care. A thorough analysis of the legislation, as follows in this Thesis, is thus relevant to the current U.S. health care environment and necessary for successful reform.

## **2 BACKGROUND**

The United States stands out from its peers in the OECD with its lack of universal health insurance coverage. Recent estimates state that fifty million Americans or fifteen percent of the population are uninsured (CBO March 20, 2010, 21). U.S. President Barack Obama's Council of Economic Advisors estimates that this figure will rise to twenty-two percent over the next thirty years (Executive Office 2009, 8). Still millions others are currently underinsured, meaning some essential benefits are not covered or coverage is inconsistent throughout the year (OECD 2008, 122). Together, these statistics indicate that, presently, almost a quarter of Americans have inadequate health insurance coverage. With the ever-rising costs of medical care, a lack of health insurance almost always implies an inability to access sufficient care. Even those who do have some form of coverage often cannot access the care they need because of their plans' limited benefits.

Without a call for mandatory health insurance from the federal government, universal coverage would be difficult, if not impossible to achieve. Attaining universal coverage

would not only benefit those who are currently uninsured, but would also improve the overall efficiency of the health care system. Currently, many Americans lack the incentive and/or funding to purchase health insurance. The uninsured do consume health care, however, but often wait until their illnesses or injuries have progressed quite far. This untimely consumption of health care is inefficient and expensive (Reinhardt 2001, 2). With mandatory coverage, these “free riders” would not be able to abuse the system. Instead, they would pay a premium and hopefully utilize care at the appropriate time. Furthermore, by bringing currently uninsured healthy individuals into the insured population, the average premium would drop. This is because the new, broader risk pool would contain a greater number of people whose premium payments exceed their medical costs. In addition, universal coverage would improve the distribution of cross-subsidies by both increasing the number of insured individuals and the variety of risk levels.

Health care reform has been a priority for several U.S. presidents over the past seventy years. President Franklin Roosevelt first proposed a national, compulsory insurance plan in 1934 (Blumenthal and Morone 2009, 15). This plan, like attempts made by fellow Democrats over the next thirty years, was defeated by Americans’ aversion to the public provision of social welfare benefits. The “American Way,” as it was referred to in 1950s insurance debates, is to use private institutions, like employers and health insurance companies, to provide these benefits (Blumenthal and Morone 2009, 17). More recently, Presidents Carter and Clinton proposed expanding health insurance coverage but maintaining more private involvement than their predecessors had suggested. In the 1990s, President Clinton’s commitment to universal health care seemed promising. Unfortunately, he lacked the support of Congress and repeatedly pushed aside health care reform to focus on other issues (Blumenthal and Morone 2009, 373-377). Although none of these administrations achieved universal coverage, or even got close, there have been some successes, such as the creation and subsequent expansions of Medicare, Medicaid and SCHIP, the government sponsored health care programs for the elderly, low-income families and children, respectively (Blumenthal and Morone 2009, 15-17).

Since his presidential campaign began, President Obama has advocated health care reform. Although his ideas have morphed somewhat over the past two years, increasing and enhancing insurance coverage has always been a priority. Now, with the passage of the “Patient Protection and Affordable Care Act,” it seems that President Obama will actually follow through with his promises and substantially reform the American health care system. There are several reasons why President Obama may have had more success than Presidents

in the past. First, President Obama possesses some of the Congressional support that President Clinton lacked, which is evidenced by both houses of the U.S. Congress drafting and passing health care reform plans in late 2009 and reconciling them in early 2010. Second, the recent recession has greatly increased the uninsured population, as three million workers lost their employer-sponsored health insurance (Iglehart 2010, e39 (3)). Furthermore, spending in the U.S. health care system has reached an unsustainable level and is expected to continue to grow. In 2010, total health care expenditures are expected to reach \$2.6 trillion, which is almost twenty percent of the U.S. Gross Domestic Product (GDP) (U.S. Census Bureau 2010a). The United States spends more on health care, both in gross amount and as a percentage of GDP than any other nation, without much to show by way of quality or coverage. In 2000, the United States came in thirty-seventh in the World Health Organization's ranking of overall health system performance, falling behind several Asian and Latin American countries as well as most of Europe (World Health Organization 2000, 152-155).

### **3 RESEARCH QUESTIONS**

This Thesis will assess how far the U.S. government's health care reforms will go towards increasing health insurance coverage and how feasible these reforms are. Section 4 will present the relevant theoretical framework. Section 5 will provide an overview of the mechanisms in the Senate legislation that aim to expand and enhance insurance coverage. This section will also present additions and changes to the plan made in the Reconciliation Act as well as a brief overview of the proposed funding mechanisms. Section 6 describes a recent, similar reform in Massachusetts. Section 7 will then discuss whether these proposals are likely to be successful at increasing insurance coverage as well as their financial practicability and impact on employment. This section will also touch on the potential cultural obstacles the reforms will face. Lastly, Section 8 will offer some general conclusions.

### **4 THEORETICAL FRAMEWORK**

#### **4.1 The Health Care Market and the Need for Government Intervention**

From an economic perspective, the market for health care is far from perfect (Folland, Goodman and Stano 2007, 389-391). Risk and uncertainty play a huge role. While an individual knows about how much he or she will spend on groceries each month for the next

five years, there is really no way to know what his or her health care costs will be. Accidents and illnesses happen unexpectedly. Health care also differs from traditional markets because of the presence of asymmetrical information. Physicians largely determine individual demand. Most people cannot diagnosis an illness and determine the best treatment plan on their own. In addition, most individuals are not able to assess quality in health care. This market is also plagued by monopoly power, held by large hospital conglomerates and pharmaceutical companies, and externalities, such as benefits from universal vaccination. These market failures reduce the efficiency of the health care market and also create inequity because the sick and poor tend to suffer the most, both physically and financially (Baicker and Dow 2009, 215).

With all of these imperfections, government intervention is necessary to ensure that the health care market functions as efficiently and equitably as possible. While the United States has historically opposed “big government” and resisted intervention into citizens’ personal lives, there has been some degree of government involvement in health care for decades. Indeed the federal and state governments now pay for almost half of the United States’ exorbitant health care costs (OECD 2008). Examples of government involvement include licensing and accreditation regulations to ensure that physicians and hospitals maintain adequate levels of care. The government also runs the Medicare and Medicaid programs, which provide health care to the nation’s elderly and low-income populations, respectively (Folland, Goodman and Stano 2007, 465-474). Beyond these and a few other examples, the United States is less enthusiastic about increased government intervention than most other developed nations. In Western Europe, for example, universal coverage is standard (Cutler 2002, 883). While countries differ on the degree of public versus private provision and payment, there is generally a well-organized system that ensures that all residents can access and afford sufficient health care. Although the new legislation may seem obviously acceptable to those living in countries with government run health care systems, for the citizens of the United States, increasing government involvement in health care will be a significant change.

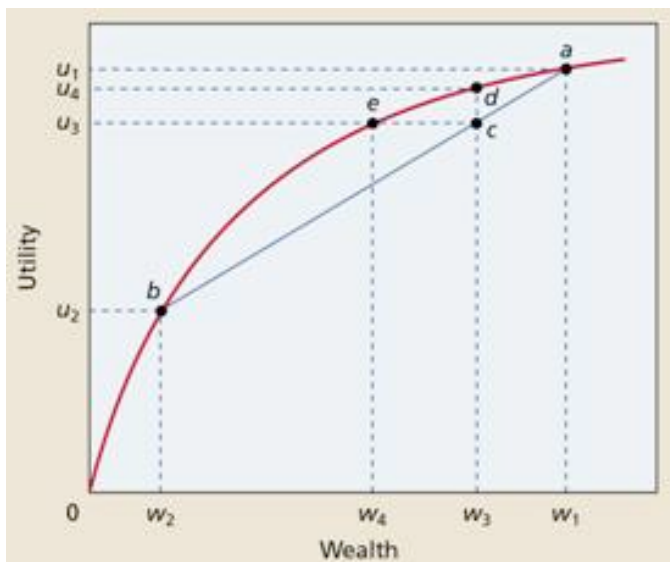
#### **4.2 The Insurance Market**

The inherent uncertainty of demand for health care coupled with the high costs of medical care impel most individuals to purchase health insurance. People tend to be risk averse and would generally rather sacrifice a determined portion of their income for the assurance that they will not need to pay tens of thousands of dollars for health care in the



event of an illness or accident. For most people, purchasing health insurance represents a utility gain. In the following graph, a healthy individual without insurance would be at point a, with wealth  $w_1$  and utility  $u_1$ . In the event of a major illness, however, he would move along the straight line to point b and face a substantial drop in wealth and utility, to  $w_2$  and  $u_2$  respectively. The curve shows the individual's risk aversion. By purchasing health insurance at an actuarially fair premium, however, the individual moves along the curve from point a to point d, with an income reduction to  $w_3$  but a utility drop only to  $u_4$ . This is preferable to position c, which has a lower utility at  $u_3$  and represents the expected loss in the absence of insurance. Because of the certainty inherent in this new position d, it is preferable to risk averse people. This situation suggests that the premium is equal to  $w_1 - w_3$ , or the expected loss. Of course, if the insurance company charges a higher premium, the utility loss will be more substantial. This situation is shown by point e. Here, the insurance company is also charging a loading fee, which is equal to  $w_3 - w_4$ . Even with this higher premium, the individual would still elect to purchase insurance because of his risk aversion. As long as the total premium is less than  $w_1 - w_4$ , the individual will purchase insurance.

FIGURE 1 HEALTH INSURANCE UTILITY CURVE



An individual will only purchase health insurance up to the point where the marginal benefit of the insurance equals the marginal cost, which is point e in Figure 1 (Van de Ven, September 2009). For some, this point may be full insurance while for others it may be a barebones insurance plan or even no insurance at all. An individual's marginal costs and benefits of insurance depend on the person's risk aversion, wealth and loss probability

(notably risk factors for illness or accident) as well as the expected medical costs and the insurance loading fee (Van de Ven, September 2009). The shape of the curve in Figure 1 suggests that people with lower initial levels of wealth will be less likely to purchase insurance because it will result in a more substantial utility drop. For these individuals, the increase in marginal benefits may not outweigh the costs

High-risk individuals or those with pre-existing conditions often face much higher premiums than their healthier peers. Similarly, those who are not offered health insurance through their employers may miss out on the lower group rates. For these individuals, the marginal costs of purchasing insurance will be substantially greater. Conversely, many young, healthy, generally low-risk individuals elect to forgo purchasing insurance because the expected marginal benefits are much lower than the marginal costs. These two groups make up a significant portion of the uninsured population in the United States.

This situation is further complicated by the various strategies that insurance companies use to pursue profits. In the United States, insurance companies face few regulations. They are generally free to risk select, differentiate their products, discontinue coverage, erect entry barriers, deny coverage of preexisting conditions or deny coverage completely. While these tactics certainly increase profits for insurers, they also render an equitable and efficient health care system impossible.

### **4.3 Managed Competition**

Some countries have chosen to cope with these market failures by establishing a mandatory single-payer system. In this type of system, like in Canada's Medicare, the government serves as the sole purchaser of health care (Folland, Goodman and Stano 2007, 503). Providers, however, may still be private. The advantage of such a system is that there is no incentive for risk selection or risk rating because the single-payer is not in competition. Additionally, the single payer may be able to take advantage of economics of scale and standardize coverage. One major drawback, however, is the limited incentive for efficiency and innovation. Without competition, the insurer does not need to improve quality or curb costs. As a result, countries with single-payer systems often face substantial waiting lists for hospital services (Folland, Goodman and Stano 2007, 508). This idea has never really taken hold in the United States because of the population's general aversion to big government. An alternative, managed competition may be a more viable alternative.

First proposed by Alain Enthoven in the late 1970s, managed competition (or regulated competition as it is often referred to in Europe) refers to the use of tools to structure

“cost-conscious consumer choice” among competing health plans to “reconcile equity and efficiency” (Enthoven 1988, 307-308). Instead of a market left to just consumers and health insurers, managed competition involves “sponsors” as well (Enthoven 1988, 307). The sponsor is the body that uses the managed competition tools to structure and adjust the market to guarantee affordable and sufficient coverage. Traditionally in the United States, when managed competition does take place, large employers who contract with health insurance companies assume the role of the sponsor. Governments generally serve as the sponsors in European countries. Government sponsorship may be preferable because it will also include non-working individuals.

The preceding section listed some of the causes of market failure in health care, which will be further discussed here. To ensure a profit, health insurers have an incentive to avoid enrolling high-risk individuals who are likely to incur substantial medical costs, a practice often referred to as “cream skimming” (Pauly 2010, 671). To do this, insurers may offer poor quality service to high-risk enrollees or exclude top specialists from their provider networks (Baicker and Dow 2009, 219). Insurers may prohibit these individuals from applying for coverage or refuse to renew their coverage (Enthoven 1988, 309-310). Insurance companies may also “risk-rate” by adjusting the premium dependant on the individual’s risk level (Van de Ven and Schut 2008b, 605). The considerable information that is required about each patient makes risk-rating expensive, however. Product differentiation is another tool insurers use to prevent losses via high-risk individuals through simply offering them less generous benefit packages. Another benefit of product differentiation, from the insurer’s perspective, is that it makes comparison of competing health plans quite difficult. It is thus easier to charge consumers a higher premium than that to which the market would naturally tend for a given plan. Insurers may also intentionally complicate information about benefits and costs, again making it difficult to compare plans (Enthoven 1988, 310).

To counteract these market failures, there are several tools available. Sponsors may require insurers to offer a standardized benefit package (Enthoven 1988, 313). This ensures that all enrollees receive adequate coverage and makes competing plans easily comparable. Sponsors may also insist that contracts guarantee that enrollees can keep their coverage for at least one year with the option to renew in subsequent years (Enthoven 1988, 314). This guaranteed renewability has some drawbacks, however. First, it acts as a disincentive for insurers to be efficient or maintain quality. It also removes any incentive for individuals to limit high-risk behaviors (Van de Ven and Schut 2008b, 611).

Sponsors should also consistently monitor insurance companies to determine whether risk-selection or other inappropriate behaviors are taking place (Enthoven 1988, 314). In addition, sponsors should monitor the quality of the health care itself. They are better able than individuals to do this because of the complexity and episodic nature of medical care (Enthoven 1988, 315). Sponsors will thus also be more effective in their efforts to incite quality improvements.

Finally, regulating pricing is another tool that sponsors can use to counteract market failure (Enthoven 1988, 312). Sponsors may use explicit cross-subsidies to alter the effective prices that consumers pay or insurance companies receive. These subsidies can be risk-adjusted or premium-based. Risk-adjusted subsidies are preferred because the consumer remains sensitive to price and also has an incentive to limit risky behavior (Van de Ven and Schut 2008b, 607-609). In both situations, the premium is paid partly by the insured and partly by the sponsor's subsidy fund. Rate bands and community rating create implicit cross-subsidies from low-risk individuals to high-risk individuals. Rate bands limit the amount insurers can vary premiums, while community rating requires that insurers charge the same premium to all enrollees in a given region (Van de Ven and Schut 2008b, 612). A major drawback of these premium restrictions is the creation of substantial predictable profits and losses. If the insurer can identify the high-risk individuals, it is easy to determine how much will be lost via those individuals' medical costs. Likewise, it becomes clear how profitable low-risk individuals will be by comparing their expected or nonexistent medical costs with the premium rate. This situation gives the insurance companies an incentive for risk selection (Van de Ven and Schut 2008b, 612-613). Because these restrictions may increase premiums for low-risks, these individuals may drop their insurance coverage. This in turn limits the risk pooling amongst high and low-risk individuals. If the insurer's enrollees are disproportionately high-risk, the company will need to increase premiums further to cover costs. This "premium spiral" can eventually lead to exorbitantly high premiums or bankruptcy for the insurer (Baicker and Dow 2009, 219). Introducing an individual mandate, which requires all individuals to carry health insurance, may prevent this phenomenon. The mandate should impel individuals to maintain coverage, even with higher than actuarially fair premiums, instead of paying a fine.

Risk equalization, more generally referred to as risk adjustment, is another tool that sponsors can use to counteract the risk selection caused by premium rate restrictions. Here, insurers make a payment for each low-risk enrollee and receive a payment for each high-risk enrollee (Van de Ven and Schut 2008b, 613). If done correctly, the insurer should have no

incentive to enroll one individual over another on the basis of risk because expected profits would be equal for all applicants. The largest drawback of risk adjustment is the substantial information that is required to determine the level of risk and corresponding payment for each enrollee. Risk adjustment schemes may use retrospective and/or prospective information about patients' health (Baicker and Dow 2009, 223). Prospective information, which generally entails the previous year's health condition and spending for each patient, may be preferred because it is the same information that insurers use to set premium levels. However, prospective information does not necessarily accurately predict what an individual's health will be for the coming year. Basing risk adjustment on retrospective information will protect insurers against adverse selection by patients with private information, such as a pregnancy (Baicker and Dow 2009, 225). Using both prospective and retrospective information, while potentially complex and time-consuming, is likely to produce the most accurate risk-adjustment scheme.

Reinsurance is a special form of risk-adjustment. Here insurers contract with reinsurance entities that provide additional coverage for high-risk enrollees (Baicker and Dow 2009, 222). Again, this should limit the incentive for cream skinning and reduce premiums levels for all enrollees (Swartz 2003, 285). A potential drawback of reinsurance is that it may create moral hazard on the part of the insurer. Since the insurer is no longer fully responsible for high-risk individuals' excessive costs, the company has less incentive for cost containment and investment in disease management processes (Baicker and Dow 2009, 223).

## **5 THE HEALTH CARE REFORM LEGISLATION**

In late 2009, both houses of the U.S. Congress proposed health care reform plans. The House of Representatives passed H.R. 3962, entitled the "Affordable Health Care for America Act" on November 7 and sent the bill to the Senate for a vote of approval. On Christmas Eve, the Senate followed suit by passing a separate bill, H.R. 3590, the "Patient Protection and Affordable Care Act" ("Senate Plan") and presenting it to the House of Representatives for approval.<sup>1</sup> The plans are quite similar and each contain over two thousand pages of proposed reforms, several of which would move the U.S. population closer to universal coverage. On March 21, 2010 the House of Representatives approved the Senate legislation by a vote of 219 to 212. This vote was contingent, however, on the inclusion of several provisions outlined in the "Health Care and Education Affordability Reconciliation

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<sup>1</sup> The original Senate reform proposal was presented as an attachment to pending House Resolution 3590 and therefore is not listed by a separate Senate Resolution number.

Act of 2010” (“Reconciliation Act”), which was then passed by the Senate on March 25. A few days later, on March 30, President Obama signed the Senate Plan as amended by the Reconciliation Act (together, “Reform Act” or “Act”), which federal and state governments will implement over the next several years.

### **5.1 Guaranteed Renewability and Open Enrollment**

The Reform Act limits insurers’ freedom to set premium levels. They will no longer be able to adjust premiums based on health status. Instead, premiums can only vary by an enrollee’s age, location of residence and family size (Senate 2009, 82). In addition, preexisting conditions cannot be excluded from coverage (Senate 2009, 81). Of course premiums will vary based on the level of benefits included in the insurance plan. The Reform Act, however, introduces minimum benefits that must be included in all plans. Coverage of preventative care, hospitalization, outpatient services, emergency services, prescription drugs, mental health services, maternity care and pediatric services is required (Senate 2009, 105). However, the Reform Act offers little description of these benefits. Determining the specifics of the essential benefits package is left to the Secretary of Health and Human Services to complete by 2014. He or she must “ensure that the scope of the essential health benefits...is equal to the scope of benefits provided under a typical employer plan” (Senate 2009, 106).

The Reform Act also significantly limits insurance companies’ abilities to deny or rescind coverage. Section 2702 of the Act requires that each insurer “accept every employer and individual in the State that applies for such coverage” (Senate 2009, 85). Likewise, the insurer “must renew or continue in force such coverage at the option of the plan sponsor or the individual” (Senate 2009, 86). The Reform Act specifically states that at the time of implementation, any existing coverage is protected. This stipulation means that insurance companies may not use the reforms as an impetus to alter anyone’s current insurance plan (Senate 2009, 99). Only in the case of fraud may an insurance company withdraw coverage (Senate 2009, 19-20). The insurers are also forbidden from imposing waiting periods of longer than ninety days on applications for coverage (Senate 2009, 99). Furthermore, an insurer cannot “dump risks,” meaning they cannot discourage high-risk individuals from remaining enrolled (Senate 2009, 48). Likewise, insurance companies may not “determine reimbursement rates, establish incentive programs, or design benefits” in ways to attract only low-risk individuals (Senate 2009, 107).

## **5.2 Extending Eligibility**

There are several approaches to extending eligibility to the currently uninsured in the Reform Act. One mechanism is to allow adult children to be treated as dependants for longer: until the child turns twenty-six in the Senate Plan and until the age of twenty-seven in the Reconciliation Act (Reconciliation 2010, 16; Senate 2009, 22). Young adults between the ages of eighteen and thirty-four make up forty percent of the uninsured population often because they do not yet have full time jobs that offer health insurance (CBO 2008, 12). Since insurers are permitted to modify premiums according to family size, additional dependents will raise costs for parents. The reforms also oblige states to extend Medicaid coverage. Currently, states are required to provide Medicaid only for those below the Federal Poverty Level (FPL). With the Reform Act, Medicaid must be available for those up to 133 percent of the FPL.

The Act also requires that each state immediately establish a temporary high-risk pool. This pool will guarantee access to health insurance for anyone who has been without coverage for at least six months because of coverage denial, exclusions or excessive premiums associated with preexisting conditions (Senate 2009, 45-51). More than half of the states have already established such pools and those that have not must establish one upon passage of the reforms (Baicker and Dow 2009, 220). Within these high-risk pools, premiums may only vary by age and geographic location. Since the expected costs of these high-risk individuals will most certainly exceed the premium income, the federal government has appropriated \$5 billion to cover the excess claims (Senate 2009, 50). Upon the establishment of the Health Benefits Exchange in 2014, which will be discussed in Section 5.3 the high-risk pool will end and all enrolled individuals will transfer to the Exchange.

## **5.3 Improving Access and Affordability**

Other reforms strive to make selecting an insurance plan and enrolling simpler. Although over half of insured people in the United States receive insurance through their employers, millions of people are only able to enroll in individual insurance plans (Blewett et al. 2009, 168). A major provision of the Reform Act calls for the creation of an American Health Benefits Exchange in each state that would assist these individuals and small employers by clearly presenting a variety of affordable, accredited plans that all use a single enrollment form (Senate 2009, 131-132). The Exchanges would present information on the coverage options through Internet portals (Senate 2009, 136). The information in the portals, as well as documents provided by insurance companies, must be written in simple,

appropriate language (Senate 2009, 24). Furthermore, when enrolling in an Exchange, if an individual is actually eligible for Medicaid or SCHIP, he or she will be notified and automatically enrolled (Senate 2009, 193).

To improve affordability, the Act includes tax credits, limits on cost sharing and a ban on lifetime limits. Certain individuals with incomes below 400 percent of the FPL would be given tax credits to offset the cost of health insurance (Senate 2009, 239). Cost sharing, including premiums, deductibles and copayments, would be limited for everyone with more stringent limitations for those under 400 percent of the FPL. The Reform Plan also eliminates cost sharing entirely for certain types of preventative care and childcare (Senate 2009, 20). Finally, the Act forbids insurance companies from imposing “lifetime limits on the dollar value of benefits” and “unreasonable annual limits” (Senate 2009, 19).

#### **5.4 Mandates**

Congress also aimed to increase coverage through compulsion, by establishing individual and employer mandates. All individuals, with just a few limited exceptions, would be required to maintain minimum coverage or else pay a penalty (Senate 2009, 333). Any government health plan, Exchange plan or qualified employer-sponsored plan would meet the criteria for this basic coverage. If an individual does not have adequate coverage, he or she will be penalized for each month without insurance (Senate 2009, 321). The penalty will be assessed through the individual’s annual tax return (Senate 2009, 322). In the initial proposal, the fine begins at a modest \$95 per year in 2014, increasing to \$350 in 2015 and \$750 in 2016 (Senate 2009, 323). The Reconciliation Act, however, limits the fine to \$695 in 2016 (Reconciliation 2010, 8). Thereafter the fine will rise with the cost of living. The fine may not, however, exceed eight percent of one’s household income (Senate 2009, 329). If an individual has dependents, such as a spouse or children, he or she will also face a penalty for their lack of insurance as well (Senate 2009, 324). The fine should not be unaffordable for anyone since those with low incomes can obtain coverage through Medicare or Medicaid. The Reform Act does, however, contain an exception in cases of “hardship” (Senate 2009, 332-333). There is limited information concerning the enforcement mechanisms for the penalty, except for the prohibition of the use of criminal penalties, liens and levies (Senate 2009, 336).

Most medium and large employers currently offer health insurance coverage because contributions to employee health insurance are tax-exempt (Lambrew and Gruber 2006/2007, 335). The number of employers offering these benefits has been decreasing recently because



of rising premiums, which makes these mandates a necessity (Blewett et al. 2009, 168). According to the new legislation, employers with over fifty full-time employees will be required to offer health insurance to employees or else pay a penalty based on the number of employees (Senate 2009, 342-346).

The Senate Plan is not particularly explicit in its definition of what “offering coverage” really means. The text takes an indirect approach to eventually assert that employers must cover sixty percent of the actual value of the health care benefits received by their employees. First, the Reform Act states that employees whose employers do not pay for at least sixty percent of the actuarial value of the health care benefits are eligible for premium tax credits and participation in a state Exchange (Senate 2009, 343-344). In a subsequent section, the legislation states that if “at least one full-time employee...has enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed...then there is hereby imposed on the employer an assessable payment” (Senate 2009, 345). Thus, employers will indeed be fined for covering less than sixty percent of the benefit costs. Furthermore, if the employer-sponsored coverage is deemed “unaffordable,” which is defined as costing over 9.5 percent of the employee’s income, the employee is again eligible for subsidies and participation in an Exchange (Internal Revenue Code Sec. 36B). In this situation, employers are again penalized.

The Senate Plan required that for each month in which an employer fails to offer insurance coverage, the employer must pay one twelfth of \$750 multiplied by the number of employees (Senate 2009, 345-348). Recognizing that this would be an insufficient motivator, the Reconciliation Act increased the penalty to one twelfth of \$2000 per employee (Reconciliation 2010, 10). Furthermore, employers will be fined for imposing excess waiting periods to enroll in coverage (Senate 2009, 345). The fines here are \$400 per employee for waiting periods of thirty to sixty days and \$600 per employee for waiting periods longer than sixty days. Finally, large employers, those with over 200 full-time employees, that currently offer health insurance must automatically enroll new employees in a plan and maintain coverage for existing employees (Senate 2009, 342). The Reconciliation Act (2010, 11) ensures that part-time employees are also accounted for when determining employer size.

Employers with fewer than fifty employees are exempt from all aforementioned fines. To encourage these employers to offer coverage, however, the Reform Act establishes tax credits to offset the cost of sponsoring health insurance (Senate 2009, 307). Employers with twenty-five or fewer full-time employees are eligible and receive a credit based on the

number of employees and the average annual wages (Senate 2009, 305-309). This is in response to the general lack of enthusiasm among small employers for providing insurance because of the comparatively higher administrative costs (Executive Office 2009, 8).

### **5.5 Risk Adjustment**

Recognizing that community rating incentivizes insurance companies to engage in risk selection, the Reform Act mentions risk adjustment as a way to counteract this behavior (Senate 2009, 235-237). The reform explicitly describes the standard risk adjustment mechanism. It requires each state to assess a fee on insurers in the individual and small group markets whose enrollees' total risk is less than the average risk for all plans in that state. Conversely, insurers will receive a payment from the state if their enrollees' risk is higher than the average (Senate 2009, 236). The particulars of how the payments will occur and which criteria will be used to assess risk level are to be determined after the Reform Act's implementation. The reform also describes a temporary reinsurance scheme that is intended to maintain organization and limit adverse selection during the first few years of community rating (Senate 2009, 226-233). Starting in 2014, health insurers in the individual and small group markets are required to make payments to an "applicable reinsurance entity" (Senate 2009, 227). The reinsurance entity then issues payments to insurers that cover high-risk individuals. For this purpose, high-risk individuals are identified based on a list of between fifty and one hundred medical conditions (Senate 2009, 228). The reinsurance scheme is to phase out at the end of 2016, by which time the risk adjustment mechanisms should be effectively functioning. Whereas the temporary high-risk pools aim to expand coverage for currently uninsured high-risk individuals, the risk adjustment and reinsurance schemes aim to ease the burden on insurers who then enroll these high-risks once the temporary pools expire. Although the risk adjustment and reinsurance programs receive limited discussion in the Act, their importance is emphasized by the request that the Secretary establish the guidelines for both programs "as soon as practicable after the date of enactment of this Act" (Senate 2009, 165).

### **5.6 Funding**

A major concern in the United States is how the government proposes to fund these reforms. The Senate Plan presents a comprehensive plan for financing the reforms, instituting taxes on high-income individuals, medical devices, elective cosmetic procedures, high cost employer-sponsored plans and non-profit hospitals that fail to meet the requirements for non-

profit status (Senate 2009, 1941-2004). The Reform Act also levies a fee on manufacturers and importers of branded pharmaceuticals based on annual sales and on health insurance providers based on net premiums (Senate 2009, 1980-1987). The Reconciliation Act (2010) adjusts these revenue provisions slightly. It delays the initial date for levying many of the taxes, presumably because passing and enacting the reforms has taken longer than anticipated. It also exempts eyeglasses, contact lenses and hearing aids from the medical device tax (Reconciliation 2010, 98). While these two changes will decrease total revenue, especially in the first few years, the Reconciliation Act also establishes a new Medicare Tax to be paid by high-income individuals (Reconciliation 2010, 88). The Congressional Budget Office (CBO) estimates that the insurance coverage provisions in the Reform Act will cost \$624 billion between 2010 and 2019. The various revenue-generating tactics, however, should bring in \$742 billion for a net deficit decrease of \$118 billion (CBO March 11, 2010, 3). This income includes the above-mentioned taxes as well as reductions in Medicare spending of \$430 billion, which arise from improved efficiency (CBO March 11, 2010, 8).

## **6 MASSACHUSETTS: A CASE STUDY**

In 2006, Massachusetts, a state known for its progressive, liberal stance on social issues, passed “An Act Providing Access to Affordable, Quality, Accountable Health Care,” commonly referred to as Chapter 58 (Commonwealth of Massachusetts 2006). This act has many similarities to the Reform Act and has thus been widely researched and discussed as a potential case study for national reform (Hager 2008; McDonough et al. 2008; Wilson 2008). Chapter 58 focuses on a “shared responsibility” between individuals, health care providers and the state. In particular, Chapter 58 created the Commonwealth Health Insurance Connector Authority, known as the Connector, which is the state body responsible for implementing and maintaining the majority of the reorganization (McDonough et al. 2008, 286). Although never referred to as such in the text of the act, the Connector acts as a managed competition sponsor. The reforms in Chapter 58 include increased eligibility for Medicaid from 200 percent to 300 percent of the FPL, a single application form for all government health care programs, an individual mandate, subsidized insurance and limited cost-sharing for low-income individuals, increased employer responsibility and a minimum benefits package (McDonough et al. 2008, 286-290). These reforms are all present in the national Reform Act as well, albeit with slightly different particulars. Massachusetts already required open enrollment, guaranteed renewability and community rating so those practices

are only briefly mentioned in Chapter 58 (Hager 2008, 13). The document does confirm, however, that insurers may not vary premiums due to health status, but only for “age, group size, industry, participation rate, geographic area, wellness program usage, tobacco usage, or benefit level” (Commonwealth of Massachusetts 2006, sec. 76).

Within one year of the enactment of Chapter 58, Long (2008, 277-279) reported improved access to and increased use of care, diminished unmet need for health care and decreased out-of-pocket spending, especially for low-income individuals. By 2008, 355,000 previously uninsured people were now insured (McDonough et al. 2008, 294). This brought Massachusetts’ uninsurance rate to a mere 2.6 percent (Massachusetts DHCFP 2008, 1). Prior to Chapter 58, the state’s uninsurance rate was estimated between 8.6 percent and 11.2 percent (Steinbrook 2008, 2758). As a result of the drop in the uninsurance rate, it is thus generally accepted that the reforms have been successful. In addition, there does not appear to be evidence of risk selection by insurers. With community rating, insurers have an incentive to attract low-risk individuals. This would suggest that many of the 165,000 uninsured individuals in Massachusetts might be in poor health. In contrast, the majority of the remaining uninsured individuals report above average health status (Long 2008, 281). These individuals are mostly male, low-income and under the age of thirty-five (Long 2008, 281). Although cost is most often cited as the reason for lacking insurance, it is also interesting that a third of the uninsured individuals Long surveyed did not even know about the individual mandate (Long 2008, 281). While Massachusetts does subsidize premiums for those below 300 percent of the FPL through its Commonwealth Care Health Insurance Program, the costs may still be too high for some individuals (Hager 2008, 20). In 2008, the average premium for those with subsidized insurance was \$355 (McDonough et al. 2008, 287).

The most significant obstacle that Massachusetts has faced has been higher than expected costs (McDonough et al. 2008, 293). Three of the four largest health insurance companies in the state operated at a loss in 2009 (Sack 2010, A14). The community-rated premiums simply do not meet the health care costs of all enrolled individuals. These insurance companies are expected to struggle even more in 2010 now that the state insurance regulators have rejected almost all requests for premium increases (Sack 2010, A14). In the public sector, expenses have been an even more serious challenge. Enrollment in state-funded programs, such as Medicaid, has been higher than expected. Although this is certainly positive, given that it helps lower the uninsurance rate, it costs the state more than if these people were insured through employer-sponsored programs. Fortunately, there is no

evidence that this increase in Medicaid enrollment is the result of crowding out of employer coverage (Long 2008, 276). Instead, from 2006 to 2007, Long finds a simultaneous increase in both Medicaid enrollment and employer-sponsored coverage. The following year, there again appears to be an increase in the number of individuals insured through employers (Kaiser 2008). From the perspective of reducing the uninsured population, these initial results are generally positive. However, just three years after the implementation of Chapter 58, it is still too early to say whether Massachusetts' reforms were successful in decreasing and stabilizing the uninsurance rate. The long-term financial sustainability of the system is also questionable.

The success of the Massachusetts reform in reducing the uninsurance rate has provided inspiration for the federal Reform Act. Unfortunately, Massachusetts is somewhat of an anomaly in terms of health care, which makes the transferability questionable. For instance, Massachusetts' uninsurance rate was significantly lower than the national uninsurance rate of fifteen percent even before the passage of Chapter 58 (Kaiser 2008). This can be attributed to the state's high median income, high rate of employer-sponsored health insurance and generous Medicaid eligibility regulations (Hager 2008, 13; Kaiser 2008). Massachusetts also has many academic medical centers and few rural areas making access to care easier than in other states (Hager 2008, 13). Perhaps most importantly, prior to the passage of Chapter 58, Massachusetts had already instated community rating and guaranteed renewability (Hager 2008, 13). Furthermore, Massachusetts' premium rate regulations are less restrictive than those included in the federal reform plan. By allowing premiums to vary based on industry or wellness program participation, for example, the incentive for risk selection by insurers is somewhat diminished. Insurers are also permitted to refuse coverage for preexisting conditions for up to six months after enrollment, which may help limit adverse selection by patients (Commonwealth of Massachusetts 2006, sec. 83). Therefore, implementing these reforms in Massachusetts was a less drastic transformation than implementing the national reforms may be.

Beyond health care, Massachusetts differs from much of the United States in several ways. It is a staunchly liberal state. A 2009 Gallup poll rated Massachusetts as the second most democratic-leaning state after neighboring Rhode Island (Jones 2009, 1). This suggests that even though the Massachusetts population was supportive of health care reform, the nation as a whole may not have the same opinion. Obviously, however, less liberal states are still required to implement these reforms regardless of their population's political leaning. Finally, Massachusetts is a small, wealthy state. Median annual income is \$60,038 compared

to the national average of \$49,901 (Kaiser 2008). Per enrollee Medicaid spending is also fifty percent higher than the national average (Kaiser 2008).

## **7 ANALYSIS**

Within the U.S. government and among the general population there are concerns about the effectiveness and affordability of the various strategies for expanding health insurance coverage in the Reform Act. This section will first analyze the legislation in light of the relevant health economics theory. It will then explore the Act's effects on employment followed by its financial, political and cultural feasibility.

### **7.1 Potential to Expand Health Insurance Coverage**

As presented in Section 5, the Reform Act aims to increase health insurance coverage through several mechanisms. These include the establishment of a temporary high-risk pool, subsidies for low-income individuals, increased Medicaid eligibility, guaranteed renewability, open enrollment, community rating, and individual and employer mandates. In isolation, each of these mechanisms has the potential to reduce America's considerable uninsurance rate to some degree. In combination they should be able to substantially minimize, but unfortunately not eliminate, the uninsured population.

#### *High-Risk Insurance Pools*

While some of the reforms will not take effect for several years, one important almost immediate change is the requirement for all states to establish temporary high-risk insurance pools. As described in Section 5.2, individuals with pre-existing conditions who have been uninsured for at least six months will be eligible for the pool. It will operate from June 2010 until January 2014, which is when the open enrollment requirement goes into effect. Thirty-five states already have high-risk pools. The thirty-four pools that were operational in 2008 had a total enrollment of almost 200,000 individuals (U.S. Government Accountability Office 2009, 8)<sup>2</sup>. Although these pools do limit premiums through subsidies from the state and federal governments, many eligible individuals are still unable to afford the average monthly premium of \$485. The U.S. Government Accountability Office (2009) estimates that almost four million people are actually eligible for high-risk pools in these thirty-four states alone. If so, this means only five percent of eligible individuals are currently enrolled, suggesting that

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<sup>2</sup> North Carolina's High-Risk Pool was not operational in 2009 and was thus not included in the GAO study.

in their present condition, these pools are not successful at covering the high-risk population. With the addition of eligible individuals from the other sixteen states, this group of high-risk individuals grows to over five million, a significant portion of the current uninsured population<sup>3</sup>. The Senate legislation assumes that these individuals will enroll in the newly created or newly administered high-risk pools. By requiring that states pay at least sixty-five percent of enrollees' medical costs, the average premium level should decrease and subsequently the enrollment rate should increase (Senate 2009, 46). In the existing pools, total claims for all enrollees in 2008 were \$1.9 billion, or approximately \$9,440 per patient (U.S. Government Accountability Office 2009, 8-27). With the new regulations, states would have to cover at least \$6,136 of that amount, leaving a maximum of \$3,304, or \$275 per month, to the individual in premium payments and out-of-pocket expenses. Clearly, this is much less than the current average premium of \$485. In addition, many of these individuals may be eligible for premium subsidies. Still, it is likely that in the first few years, some may opt to pay the low individual mandate fee instead of enrolling. Perhaps more problematic than affordability for individual enrollees is whether these pools will be affordable for the state governments. To help cover these additional costs, the federal government will contribute five billion dollars. Unfortunately, considering the nearly two billion dollars in claims in 2008, this amount may be too small to make a substantial impact. Especially since that figure was only for 200,000 enrollees, one would expect the total claims to rise dramatically as more Americans become eligible for the pools and are mandated to carry health insurance. Assuming the average cost per patient of \$9,440 does not rise throughout the operation of the pools, the total cost if all eligible individuals enrolled would be \$50.2 billion per year. Since enrollees cannot be forced to pay more than thirty-five percent of these costs, to operate the pools will need \$32.6 billion each year. Furthermore, the federal contribution is a one-time only payment, yet the high-risk pools will operate for three and a half years. Therefore, the five billion dollars makes up a mere 4.4 percent of the necessary funding. The legislation states that if the pools' available funds are insufficient, "the Secretary shall make such adjustments as are necessary to eliminate such deficit" (Senate 2009, 51). This simple statement does not seem to grasp the immense potential shortcomings of the funding strategy. The sources of revenue for the current thirty-four pools are shown in Table 1. Without additional sources of revenue, these high-risk pools will be unaffordable

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<sup>3</sup> The fifteen states without high-risk pools and North Carolina have a combined population of approximately 110 million. This is just over one-third of the U.S. population of 307 million (U.S. Census Bureau 2010b).

for many eligible individuals as well as for the state governments. The pools will thus be less effective than anticipated in decreasing uninsurance.

TABLE 1 SOURCES OF HIGH-RISK POOL FUNDING NATIONWIDE, 2003 & 2008 (IN THOUSANDS)

Type of funding	2003		2008	
	(\$)	Percentage of total funding	(\$)	Percentage of total funding
Premiums	763,850	57.4	981,882	54.0
Assessments on health insurance carriers	428,288	32.2	422,815	23.2
Other assessments	28,137	2.1	135,073	7.4
State general revenues	16,683	1.3	93,426	5.1
State tobacco tax	40,000	3.0	39,771	2.2
Federal grants <sup>a</sup>	1,844	0.1	31,487	1.7
Other	52,248	3.9	115,063	6.3
<b>Total</b>	<b>1,331,050</b>	<b>100</b>	<b>1,819,517</b>	<b>100<sup>p</sup></b>

Source: GAO data collection instrument administered to all 34 HRP's operational in 2008.

### *Premium Tax Credits*

Many uninsured Americans would prefer to have health insurance but remain uninsured because the costs are too high. For the individuals in this situation who fall between 100 percent and 133 percent of the FPL, the extended Medicaid eligibility will enable them to receive insurance coverage. For those over 133 percent but below 400 percent of the FPL, premium tax credits will make purchasing health insurance more affordable. The credits decrease as income increases, but can cover almost the entire premium for those just above 133 percent of the poverty line. Table 2 shows that the vast majority of uninsured Americans will be eligible for tax credits. Of the total uninsured population, only eight percent are above 400 percent of the FPL. Everyone who qualifies for tax credits will also have limited cost sharing. For some people, these credits and limits will be sufficient. Others may still find health insurance too expensive. One reason for this is that the FPL is inherently a nation-wide construct, but the cost of living varies by state.<sup>4</sup> Therefore, those residing in pricier states will have less money remaining after living expenses to pay for health insurance. For example, in 2009, the cost of living index was 88.1 in Oklahoma and 125.8 in Maryland, indicating that it is almost fifty percent more expensive to live in Maryland (Council for Community and Economic Research 2009).

<sup>4</sup> The U.S. government establishes one set of Federal Poverty guidelines for the forty-eight contiguous states and individual guidelines for Alaska and Hawaii. The Federal Poverty Level is higher in Alaska and Hawaii.



TABLE 2 DISTRIBUTION OF THE NONELDERLY POPULATION, BY INSURANCE STATUS, FAMILY INCOME AND FAMILY STRUCTURE, 2009

(Millions)

Family Income Relative to Poverty Level (Percent)	Children		Adults				Total	
	Insured	Uninsured	With Children		Without Children		Insured	Uninsured
			Insured	Uninsured	Insured	Uninsured		
Below 100	17.2	2.7	6.5	3.5	7.3	6.9	30.9	13.1
100 to 200	15.5	3.4	10.8	5.8	9.1	6.6	35.3	15.8
200 to 300	11.9	1.8	12.9	2.9	10.9	3.6	35.7	8.3
300 to 400	9.6	0.9	12.3	1.3	10.3	2.0	32.2	4.2
Above 400	17.2	0.8	28.9	1.0	36.1	1.9	82.2	3.7
<b>Total</b>	<b>71.3</b>	<b>9.6</b>	<b>71.3</b>	<b>14.5</b>	<b>73.7</b>	<b>20.9</b>	<b>216.3</b>	<b>45.1</b>

Source: Congressional Budget Office's health insurance simulation model.

### *Selection and Risk Rating*

Guaranteed renewability, open enrollment and community rating are all managed competition tools. When launched along with a comprehensive basic benefit packages, as is included in the Reform Act, these provisions together should prevent much of the selection and risk rating that insurers currently carry out. However, insurance companies may still find ways to engage in limited forms of these behaviors. Because the insurer is now quite restricted in its freedom to differentiate premiums, high-risk individuals represent a guaranteed, or at least more likely, loss. Therefore, to make a profit, the insurer must either charge the high-risk enrollee a higher premium, offer him fewer benefits or avoid enrolling high-risk individuals all together. While the Reform Act largely prohibits the first two options, the insurer still has some freedom with the latter option. Although open enrollment forces insurers to accept all applicants, the insurer can attempt to risk select through marketing. By advertising plans in ways to attract the healthy and hide from the sick, individual insurance companies can attempt to dump the high-risk individuals on other insurers. Insurers can also try to dissuade high-risk individuals from enrolling in their plans by contracting with only a limited selection of providers. If the top specialists for a particular illness are not included in the insurance plan, one who has the illness will generally reject that insurer. Profitability will thus depend on how well the company markets itself to the healthy, not on efficiency.

### *Risk Adjustment*

As discussed in Section 4.3, one potential way to prevent this type of selection is risk adjustment. With risk adjustment, the insurer can essentially obtain a higher premium for high-risk individuals without directly charging the individual more. In contrast, low-risk enrollees become relatively less attractive since they necessitate the insurer to make payments to the risk adjustment fund. This mechanism will decrease an insurer's incentive to market only to low-risk individuals. A well-functioning risk adjustment scheme is thus imperative to the success of these reforms. Establishing such a scheme, however, requires a great deal of information about the applicants. Basic risk adjustment schemes, for example, assess an individual's risk level based on his or her age and gender. Slightly more advanced schemes may consider the individual's place of residence and disability status. Finally, the most sophisticated schemes, such as the one in the Netherlands, incorporate Pharmacy-Based Cost Groups (PCG) or Diagnosis Cost Groups (DCG) (Van de Ven October 14, 2009). PCGs and DCGs provide information on one's previous diagnoses and prescribed medications. Cataloging this information for the 300 million people in the United States would certainly be more challenging than for a smaller country such as the Netherlands. This process would require each state to collect and standardize claims information from each of the state's insurance companies. Furthermore, once this information is amassed, state governments and insurance companies must agree on the corresponding payment level to be assigned for each DCG, PCG or other relevant measure. Although the Reform Act leaves much of the specifics to be determined, it may be safe to assume that state governments will initially use basic risk adjustment mechanisms. In the Netherlands, for example, it took ten years to move from using only age, gender, region and disability to including PCGs (Van de Ven October 14, 2009). As a result, the risk adjustment scheme will be imperfect, leaving some lingering incentive for risk selection and cream skimming. Shen and Ellis (2002) demonstrate that insurers can still earn considerable profits when only age and sex are used, but that profits drop significantly, but are still substantial when DCGs are used as risk adjusters. Nevertheless, perfecting this risk adjustment mechanism will take time and the federal requirement for states to establish such a scheme is a huge first step in the right direction.

### *Community Rating and Adverse Selection*

Community rating also incentivizes healthy individuals to engage in adverse selection. By forcing insurers to charge the same premium to all enrollees, community rating essentially establishes a payment transfer from low-risk people to high-risk people (Pauly

2010, 672). This is because the low-risks are now paying a higher premium to offset the additional costs of the high-risks. A young, fit person has no incentive to pay a high premium now if he knows that he can obtain insurance at that same rate later in life when he is older or less healthy. There are several options to combat this problem. Insurers can charge low community-rated premiums to encourage enrollment by the young and healthy, but that will likely prevent the insurance companies from covering their costs, eventually driving them out of business. The second option is to allow for some premium differentiation based on risk level and focus instead on guaranteed renewability. Pauly (2010) advocates “guaranteed renewability at class average rates,” which mandates that insurers cannot increase an individual’s premium because of changes in his or her health or use of medical care. Pauly assumes, however, that these young, healthy individuals are prudent planners who understand that by forgoing insurance now, they risk paying a higher premium later in life. Pauly may be overly optimistic to presume that a twenty-six year-old who works part-time at a low-wage job would voluntarily purchase health insurance now so that he can save money in twenty years. Perhaps recognizing the lack of foresight of many Americans, the U.S. government, however, is pursuing a third method to combat adverse selection: the individual mandate.

### *Individual Mandate*

Discussions about the individual mandate range from the political (*i.e.*, should the government be able to *force* citizens to purchase health insurance?) to the practical (*i.e.*, is a \$695 penalty enough to impel a high risk, self-employed individual to purchase insurance?). Other countries that have individual mandates, such as the Netherlands, struggle with enforcement (Van de Ven and Schut 2008a, 776). The United States is likely to also face this issue. The legislation plans to collect the penalty for violating the mandate through individuals’ annual tax returns (Senate 2009, 322). All legal residents over age eighteen who earn more than \$9,350 in a given year must file a tax return (IRS 2009)<sup>5</sup>. While some very low-income adults are thus exempt, the vast majority of Americans should file tax returns annually. While it is certainly illegal to forgo filing your taxes, each year tens of thousands of people do so. However, it is difficult to estimate exactly how many people fail to file their income tax returns. The Internal Revenue Service (IRS) keeps close track of those who filed in the previous year but for some reason did not file in the current year. Long-term evaders

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<sup>5</sup> This minimum income changes slightly for those aged sixty-five and over as well as for heads of households and widow(er)s with dependent children.

and recent immigrants, though, are more difficult to track. The IRS estimates that in 2000, only 90.7 percent of taxpayers filed their tax returns, leaving eleven million people skirting the system (Brown and Mazur 2003, 4). These individuals will now also be evading the incentive for maintaining health insurance coverage. The mandate's penalty also provides an incentive for the number of evaders to increase. Furthermore, in the first few years after implementation, it is unlikely that the penalty will be severe enough to impel the voluntarily uninsured to obtain coverage. Thereafter, however, when the penalties reach \$695, rational people should understand that purchasing health insurance is the financially responsible decision.

### *Employer Mandate*

The employer mandate is predominantly a concern for smaller employers with just over fifty employees since the vast majority of medium to large employers already offer health insurance. Most large employers actually pay for substantially more than the now required sixty percent of costs (Merlis 2010, 2). Small employers, however, traditionally do not offer health insurance because of the high costs, which will be discussed in section 7.3. Assuming all employers are able to offer health insurance thanks to the insurance exchange, this would greatly increase the insured population. As of 2006, sixteen percent of full-time workers lacked health insurance (Merlis 2010, 1). This is a substantial portion of the uninsured population. Moreover, when broken down by firm size, it is clear that large employers are much more likely to offer health insurance than small employers. Only fifty-nine percent of firms with between three and 199 employees offer health insurance whereas that figure is ninety-eight percent at companies with over 200 workers (Kaiser 2009, 38). In addition, over the past ten years, the number of firms with three to 199 employees that offer insurance coverage has actually declined.

The employer mandate will also affect firms that employ low-wage workers. Even if the employer offers insurance coverage, if it is unaffordable for any employees, the employer must pay a penalty. According to Merlis (2010), thirty percent of uninsured workers do have access to health insurance but choose not to participate, usually because of cost. Therefore the mandate may incite employers to cover a more substantial portion of their employees' costs to avoid the fines. This will enable these low-wage employees to enroll in coverage, thus decreasing the uninsurance rate.

Unfortunately, because the Reform Act makes no requirements of companies with less than fifty workers, there is a strong possibility that the expansion of coverage will not be

that substantial. The effects will really only be felt by workers at the few medium to large companies that do not currently provide insurance coverage and then opt to do so instead of paying the penalty. While small employers are certainly encouraged to offer health insurance, the tax credit may be an ineffective incentive. The credit starts at a maximum of fifty percent of premium payments and is reduced as the number of employees and the average annual wages increase. The phase-out is so severe, however, that if a firm has twenty-four employees and pays each \$25,000 per year it will not qualify for any credit. Thus, the tax credit will really only be effective for very small (less than ten workers) employers and those who pay at or just above minimum wage.

Experts at RAND Health estimate that 2.3 to 2.6 million businesses, a third of those in the country, will either be exempt from the mandate or will elect to pay the penalty instead of providing coverage (Seelye 2009, 1). In addition, many of the conditions of the employer mandate and the small-business tax credits depend on the size of the firm. Unfortunately, the IRS lacks sufficient information to verify the number of employees at all businesses (CBO 2008, 36). There is therefore a possibility that employers will claim to employ fewer people either to avoid penalties or to qualify for subsidies. Overall, instead of directly increasing insurance coverage, the employer mandate is likely to be most effective at halting the trend of small to medium employers dropping their existing insurance offerings.

### *CBO Estimations and Assumptions*

The interaction of all the aforementioned mechanisms will greatly increase health insurance coverage in the United States, but will not, however, be able to ensure that all Americans have adequate health insurance. The CBO and the Joint Committee on Taxation (JCT) estimate that by 2019 the Reform Act will reduce the number of uninsured Americans by thirty-two million people (CBO March 20, 2010, 21). Taking into account population growth, this would leave six percent of the U.S. population, or twenty-three million people, still uninsured in 2019 (see Table 3).

To ascertain these figures, the CBO used a microsimulation model that it developed in 2007 (CBO 2008, 43). Prior to the passage of H.R. 3590, the CBO used this model, with consistent assumptions, to analyze the effects of various proposals for improving health care in the United States. The model can be manipulated to reflect the effects on health insurance coverage of different levels and types of subsidies, mandates and changes in various costs. To determine the likelihood that an employer will sponsor health insurance, the CBO considers the price of insurance, the size of the firm and other coverage options for employers (CBO

TABLE 3 ESTIMATED EFFECTS OF THE INSURANCE COVERAGE PROVISIONS IN H.R. 3590  
COMBINED WITH H.R. 4872

EFFECTS ON INSURANCE COVERAGE /a		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
(Millions of nonelderly people, by calendar year)											
Current Law Coverage /b	Medicaid & CHIP	40	39	39	38	35	34	35	35	35	35
	Employer	150	153	156	158	161	162	162	162	162	162
	Nongroup & Other /c	27	26	25	26	28	29	29	29	30	30
	Uninsured /d	<u>50</u>	<u>51</u>	<u>51</u>	<u>51</u>	<u>51</u>	<u>51</u>	<u>52</u>	<u>53</u>	<u>53</u>	<u>54</u>
	TOTAL	267	269	271	273	274	276	277	279	281	282
Change (+/-)	Medicaid & CHIP	*	-1	-2	-3	10	15	17	16	16	16
	Employer	*	3	3	3	4	1	-3	-3	-3	-3
	Nongroup & Other /c	*	*	*	*	-2	-3	-5	-5	-5	-5
	Exchanges	0	0	0	0	8	13	21	23	24	24
	Uninsured /d	*	*	-1	-1	-19	-25	-30	-31	-31	-32
<u>Post-Policy Uninsured Population</u>											
	Number of Nonelderly People /d	50	50	50	50	31	26	21	21	22	23
	Insured Share of the Nonelderly Population /a										
	Including All Residents	81%	82%	82%	82%	89%	91%	92%	92%	92%	92%
	Excluding Unauthorized Immigrants	83%	83%	83%	83%	91%	93%	95%	95%	95%	94%
<u>Memo: Exchange Enrollees and Subsidies</u>											
	Number w/ Unaffordable Offer from Employer /e					*	1	1	1	1	1
	Number of Unsubsidized Exchange Enrollees					1	2	4	5	5	5
	Average Exchange Subsidy per Subsidized Enrollee						\$5,200	\$5,300	\$5,500	\$5,700	\$6,000

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

2008, 44-45). Specifically, the CBO assumes that all firms, depending on their size, have an “elasticity of offer,” which reflects the firm’s response to a change in the price of insurance. The elasticities used by the CBO, which are shown in Table 4, reflect the total cost of insurance, not just the portion paid by the employer, minus any federal or state subsidies (CBO 2008, 44). Clearly small employers are much more responsive to changes in the price of insurance. The CBO does not, however, consider how changes in the price of insurance affect the proportion that employers elect to pay. The cost that employees face is often just as important as whether the employer offers health insurance at all. As for the availability of other coverage options, the CBO assumes that if the share of employees eligible for Medicaid increases from twenty percent to forty percent a firm would increase the portion of the premium costs paid by employees by two to three percent (CBO 2008, 45). This suggests that if an employer is aware that employees can obtain coverage elsewhere, it will be come slightly less generous.

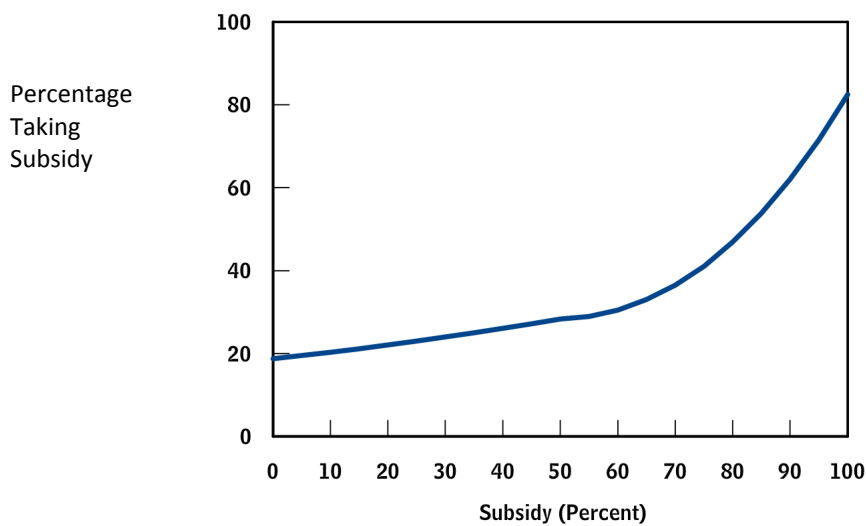
TABLE 4 EFFECT OF CHANGE IN PRICE OF INSURANCE ON OFFER RATES FOR EMPLOYER  
 COVERAGE BY SIZE OF FIRM

<b>Size of Firm</b> (number of employees)	<b>Elasticity of Offer</b>
Fewer than 25	-1.14
25 to 99	-0.38
100 to 999	-0.15
1,000 or More	-0.07
All	-0.28

The CBO also considers the factors that affect an individual’s likelihood of enrolling in different types of coverage. Specifically, it assumes that with employer-sponsored coverage, if the employee’s share of the premium were cut in half, twenty-five percent of those who have opted out of employer-coverage would then choose to enroll (CBO 2008, 46). Interestingly, the CBO also assumes that even if the employee’s share were reduced to zero, several million individuals would still decline coverage. Most likely, these individuals would choose to turn down the employer-sponsored insurance because they are eligible for other forms of coverage, such as Medicare, Medicaid or a spouse’s insurance plan. Similarly, in the individual market, the CBO assumes that increasing subsidy levels will increase enrollment. Figure 2 shows that a fifty percent subsidy raises enrollment through the individual market by approximately six percent. Like in the employer market, the CBO assumes that even a one hundred percent subsidy would not achieve universal coverage. Due to a lack of academic literature on the topic, the CBO bases this estimation on current enrollment rates in existing public programs (CBO 2008, 46). Because the CBO includes all “U.S. Residents” in this estimation, it is likely that undocumented immigrants makes up a substantial portion of the nearly twenty percent who would not be eligible for, and would thus obviously not enroll in free coverage.

One important aspect of the Reform Act that is not included in the CBO’s 2008 microsimulation model is risk adjustment. The CBO has not released any information discussing the specific assumptions it used in analyzing H.R. 3590 and H.R. 4872. Because the current reforms do contain a risk adjustment mechanism, one would hope that the CBO considered this when estimating the effects of the reform on insurer behavior, premium levels and total health care spending.

FIGURE 2 PROBABILITY OF ENROLLING IN AN INDIVIDUALLY PURCHASED INSURANCE PLAN WITH SUBSIDY



Source: Congressional Budget Office's health insurance simulation model.

Considering all of the aforementioned assumptions, the CBO estimates that the uninsurance rate will decrease over the next ten years to a low of six percent in 2019, as shown in Table 3. Approximately one-third of the anticipated uninsured individuals in 2019 are expected to be unauthorized immigrants (CBO March 20, 2010, 9). Because the provisions in the Reform Act do not cover these immigrants, their lack of insurance should not be considered a failure of this particular reform. The substantial problems surrounding the United States' enormous unauthorized immigrant population and the right to health care for those individuals are beyond the scope of this paper. The fifteen to sixteen million American citizens and authorized immigrants who the CBO projects to still be without insurance in 2019 are, however, a significant problem. Approximately 3.3 million of these individuals will be exempt from the individual mandate's penalty because they are Native American, while others will be exempt because they have specific conflicting religious beliefs or have income low enough that they are not required to file tax returns (CBO 2008, 126-127). Although the CBO does not specifically break down the composition of the remaining group, it is likely that these other uninsured people will be low-income individuals who work for small employers and their dependents. If one does not receive insurance through an employer, the onus is on the individual to seek out coverage through the Exchange. Even though the reforms greatly simplify this procedure, some may still find it burdensome. Many of these individuals may also be tax-evaders. In that case, enforcing the



individual mandate will actually fall on the IRS. The CBO (April 22, 2010) estimates that in 2016, four million Americans will pay the individual mandate penalty instead of obtaining health insurance. There will therefore be at least several million individuals who are bound by the individual mandate but are neither insured nor paying the penalty.

The weaknesses of the individual mandate are predominately to blame for the estimated remaining four percent uninsurance rate. For some people, the \$695 penalty, and certainly the lower fines in the first few years, will not be a severe enough punishment. Whether the cost of compliance (enrolling in health insurance) outweighs the cost of noncompliance (the penalty) depends on how an individual values insurance coverage and also on the likelihood of getting caught. The actual cost of compliance depends on one's community-rated premium and expected benefits. Since premium costs usually exceed the annual penalty, only those who expect to incur medical costs greater than the difference between the penalty and the premium will comply with the mandate. As for enforcement, the mandate will have no effect on people who do not file annual income tax returns or those who believe they can misreport their insurance status on their return forms. The IRS has described how misreporting is quite high when there is no third party verification, such as in the case of income through self-employment (CBO 2008, 52-54). The mandate would create a similar situation for those enrolled in insurance through the individual market. In addition, the employer mandate, as previously mentioned, does not impose any fines on employers with fewer than fifty full-time employees. Therefore, the many employees at these firms will be accountable to only the individual mandate.

While a six percent uninsurance rate, as the CBO predicts, would be a vast improvement over the current situation, it is important to keep in mind that this figure is merely a prediction. It is a well-calculated predication certainly, but there are many unknowns that could significantly improve or worsen the outcome. The CBO acknowledges that this estimation assumes that the Reform Act is enacted exactly as it is currently written and remains unchanged for the next ten years, but that is rarely the case for significant legislation (CBO March 20, 2010, 13-14). Furthermore, non-health care factors could also affect the actual number of uninsured Americans over the next ten years. For example, changes in immigration or citizenship laws or immigration patterns could either increase or decrease the uninsured population. In general, the federal government has the right to be confident that the reforms will dramatically lower the U.S. uninsurance rate, but they will not be able to conclude the precise extent of the reform's success for several years.

## 7.2 Financial Feasibility

Expanding insurance coverage will most certainly increase some health care costs and decrease others. President Obama's Council of Economic Advisors (2009) asserts that the net effect will be a gain of between \$75 and \$125 billion per year. The increase in costs comes from government subsidies to low-income individuals and small employers, expanded Medicaid spending, new administrative responsibilities, risk adjustment payments, higher premiums for expanded benefit packages to meet the essential benefit requirements and premium payments by the newly insured. Cost savings arise from reduced uncompensated care spending, lower premiums thanks to an expanded risk pool, decreased Medicare spending and an increase in labor force participation and productivity.

Many Americans fear that increasing the number of insured people in the country will further increase total health care spending. It may seem counter intuitive that expanding coverage could decrease total costs, as President Obama's Advisors purport. This is because when insured, individuals are likely to consume more health care than without insurance. Furthermore, the new minimum benefits package and the caps on cost-sharing may increase medical care consumption by those who are already insured. This phenomenon known as moral hazard is a result of the lower, or possibly nonexistent, prices that an insured individual faces (Folland, Goodman and Stano 2007, 166). Moral hazard is generally viewed quite negatively with the assumption that the additional consumption of care is unnecessary or perhaps wasteful and thus produces an overall welfare loss. Nyman (2004, 196) points out, however, that some of this additional care may actually greatly improve the health of the previously uninsured individual. In addition, people who lack insurance and now only use emergency care would be able to regularly visit a general practitioner and engage in preventative care. Baicker and Chandra (2008) indicate, however, that preventative care is not always cost-effective. Hypertension screening and annual pap smears, for example, are generally less cost-effective than the treatments to care for the diseases they aim to prevent. Although preventative care undoubtedly improves health, it may do little to decrease costs.

Recognizing the inherent uncertainty, the CBO has attempted to estimate how much additional medical care will be consumed as insurance coverage expands. Based on the findings from the famous RAND Health Insurance Experiment from the 1970s and 1980s, the CBO assumes that a ten percent decrease in out-of-pocket expenses will increase an individual's total health care spending by one to two percent (CBO 2008, 62). Furthermore, the CBO estimates that if a currently uninsured individual enrolls in coverage, he or she will consume seventy-five to ninety-five percent as much medical care as a similar person who is

currently insured. This is in contrast to the amount of care used by an uninsured individual, which is estimated to be fifty to seventy percent of the care used by an insured individual (CBO 2008, 71). These estimates are based on the CBO's analysis and synthesis of the results of several empirical studies, including the RAND Health Insurance Experiment, "natural experiments" that analyze the effects of Medicaid eligibility expansion or change in behavior upon reaching eligibility for Medicare, and studies that compare the behavior of the insured and the uninsured (CBO 2008, 72). The CBO recognizes, however, that all of the studies have serious methodological flaws and thus presents a sizeable range for their estimate of the increased use of care by the previously uninsured. The suggested reasons for the more limited use of health care by the newly insured include the disproportional number of young adults in the current uninsured population who might have above average health, a low value placed on health care or habit. It is certainly possible, however, that the true increase in care will be greater because of moral hazard. The uninsured are more likely to report being in poor to fair health than the insured which indicates that they may have untreated medical conditions for which they will seek care once they are insured (CBO 2008, 72).

The emergency care the uninsured still consume is often uncompensated. The federal and state governments reimburse health care providers for a portion of this charity care and other unpaid medical bills. In 2008, total government spending on uncompensated care costs reached \$42.9 billion (Executive Office 2009, 8). Expanding insurance coverage would thus bring substantial savings. Unfortunately, insuring all Americans would still not completely erase uncompensated care costs. Unauthorized immigrants also use emergency room care. Unable to qualify for federal and state health care programs, illegal residents know that emergency rooms are prohibited from turning them away. Since the proposed individual mandate and subsidies only apply to U.S. citizens and legal residents, illegal immigrants may still be able to take advantage of the health care system. The use of false social security numbers and other forged documentation makes estimating the exact amount of uncompensated care that unauthorized immigrants use virtually impossible (GAO 2004, 21). However, a 2002 report from the United States/Mexico Border Counties Coalition (USMBCC) attempted to make such estimation for twenty-four border counties. In this area, which has a substantially greater immigrant population and more poverty than the majority of the other three thousand or so counties in the United States, hospitals and emergency medical service providers spent over \$200 million on health care for undocumented immigrants

(USMBCC 2002, 30). Although most other counties will spend less, this still indicates a considerable sum that will not be affected by the new legislation.

At the level of the individual and small group market, increasing the insured population could decrease premium costs for many by increasing the size and diversity of the risk pool. This is because the risk of high medical costs will be spread among a larger population. In addition, when low-risk individuals obtain coverage, they generally increase revenue for the insurer. This allows the insurer to set the community-rated premium at a lower level than would be possible with only average and high-risk individuals in the pool. Although open enrollment creates an incentive for adverse selection by high-risks, by combining it with the individual mandate, however, people of all risk-levels should be enrolling in insurance coverage. While the true effect on costs will depend on the precise risk level of the current uninsured population, the entry of the large number of young, healthy uninsured individuals in the United States into the insurance market should help keep premiums low. While young adults aged eighteen to thirty-four make up only one-fourth of the nonelderly population, they constitute forty percent of the uninsured population (CBO 2008, 12)<sup>6</sup>. In addition, insurers that compete in the Exchanges will have an extra incentive to make their plans as appealing as possible in terms of both cost and quality. By forcing insurance companies to present their plans in an easily comparable manner, the Exchanges should improve overall efficiency.

One potential financial issue that the public does not appear concerned with is the effect of the reforms on insurance companies. Open enrollment, guaranteed renewability and community rating all diminish an insurer's ability to earn profits. These mechanisms can even cause premium "death spirals," discussed briefly in Section 4.3, which occur when an influx of high-risk individuals raises the average risk level for a given insurer and the insurer in turn, raises premium levels (Buchmueller and DiNardo 2002, 280). The new higher premiums drive healthier individuals to drop their coverage. This further increases the average risk level in the enrollee population, once again pushing premiums up. If this cycle continues, the insurer will lose so many enrollees that it will no longer be able to stay in business. There is evidence that this is happening now across the United States. Earlier this year, major insurers announced a premium hike of eighteen percent in Iowa and 17.2 percent in Wisconsin (Berry 2010). Most shocking was the news of a thirty-nine percent premium increase by California's Anthem Blue Cross (Rogers 2010). This drew criticism from

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<sup>6</sup> Only the nonelderly population is relevant here because all adults aged sixty-five and older are eligible for Medicare.

enrollees, local government and even President Obama. Anthem has since withdrawn the proposal and is revising this year's rate increase.

News like this feeds into the general public perception that insurance companies are hugely profitable and insatiably greedy. In reality, however, the profit margin for health insurance companies was just 3.4 percent in 2009 (Newman 2009). This is slightly above the median for all industries, but far from the excessive levels assumed by the public. The beverage industry, for example, had a 25.9 percent profit margin that year (Newman 2009). Furthermore, as mentioned in Section 6, insurers in Massachusetts, where these types of reforms are already in place, tend to operate at a loss. There is therefore a real concern that the reforms will exacerbate the nation's already rising premium rates. While the individual mandate should prevent low-risks from giving up coverage, the \$695 penalty may be insufficient if premiums continue to rise so dramatically. For the U.S. health care system to function, and remain primarily private, insurance companies must be allowed to profit. The system relies on the assumption that insurers want to provide the best coverage to as many people as possible in order to earn revenue. If the reforms excessively limit their ability to profit, there is the risk of bankruptcy. The consequences of which might be a move to a more public system or increased monopoly power of the remaining insurers, neither of which are likely to improve the U.S. health care system. Establishing an effective risk adjustment scheme is integral to preventing this outcome (Baicker and Dow 2009, 224). Here, insurers with many high-risk enrollees receive a payment from the state risk adjustment entity. This funding should help the insurer keep premiums at a reasonable level, thus preventing the death spiral.

There is no doubt that striving for universal coverage carries an enormous expense. Most other developed countries have decided that ensuring the health of all citizens is worth the cost. In the United States, there is still an emphasis on reining in health care costs while simultaneously expanding coverage. Although a challenging feat, the Reform Act is expected to achieve that goal. As mentioned earlier, the CBO estimates a net deficit reduction of \$118 billion (CBO March 11, 2010, 3). This would surely be a commendable achievement, but we must recognize the inherent uncertainty in these figures. The CBO does consider many important variables such as the new administrative costs of health promotion programs and preventative care, the agency problem when state governments spend federal money, such as in the high-risk pools, and the changing incentives for employment (CBO 2008, 120-164). Yet, there are far too many unknowns in health care to accurately predict the ten-year effects of the Act. Since President Obama's inauguration, both political parties,

both houses of Congress and a variety of other committees and independent organizations have offered their estimates of the total costs of the reforms. For example, Republican members of the Senate budget committee project the total costs to exceed \$2.5 trillion, far from President Obama's limit of \$900 million and the CBO's estimate of \$624 million (U.S. Senate Republican Policy Committee 2009, 20). All of these are merely educated guesses, however, since it is impossible to predict future disease incidence, obesity prevalence or changes in medical technology. Furthermore, Fuchs (2010) points out that external factors, such as the state of the economy and current defense expenses, also affect health care spending. Thus, while the specific financial effects of the reforms are still unknown, it seems that the United States can assume with some confidence that health care spending will increase over the next several years, but the long-term effect will hopefully be a national deficit reduction. However, if health care costs and premiums continue to rise and if the currently uninsured consume more health care than the CBO estimates, it is likely that the long-term costs will be greater than President Obama's advisors predict. Furthermore, the temporary high-risk pools will most certainly require additional federal support. Thus, the overall effect on the federal budget depends on how these increased costs compare to the savings from cuts to Medicare and the income through new taxes.

### **7.3 Effects on Employment**

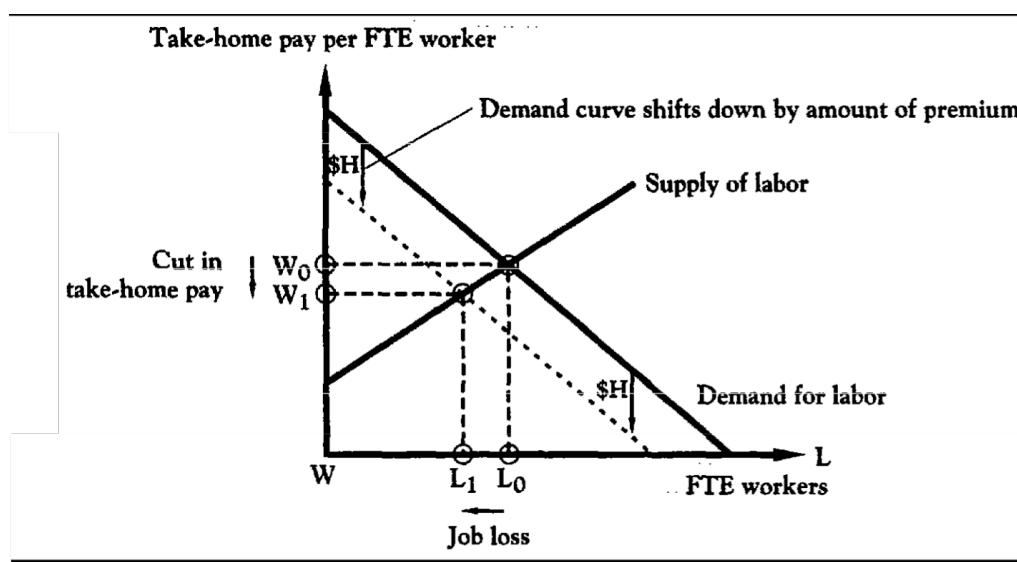
Section 7.1 briefly discussed the employer mandate's potential to increase insurance coverage. Clearly there is a substantial portion of currently uninsured individuals who should be able to obtain coverage as a result of this mandate. However, there are additional factors that will counteract this expansion in insurance coverage. By forcing employers to offer health insurance to all full-time employees, the mandate incentivizes employers to fire full-time employees and hire more part-time and temporary employees (Baicker and Chandra 2008, 539). The Reform Act does not require employers to provide any benefits to part-time employees, defined as those working fewer than thirty hours per week, or seasonal workers (Senate 2009, 348-350). Small employers also face a disincentive to expand since they can receive a government subsidy for premium payments if they have fewer than twenty-five employees (CBO 2008, 36). Furthermore, since the employer will now essentially be paying a higher net wage through increased benefits, he or she also has an incentive to lower the money wage (Krueger and Reinhardt 1994, 41-43). The Reform Act makes note of this possibility and requires that the Secretary of Labor conduct a study to determine whether

employees' wages are indeed reduced as a result of the mandate (Senate 2009, 352-353). The Act does not, however, specify what the remedy will be if wages are declining.

Figure 3 illustrates this job loss and wage decrease. A firm that does not offer its employees health insurance would hire  $L_0$  workers and pay each a wage of  $W_0$ . With the employer mandate, this firm is essentially forced to pay at least sixty percent of the insurance premium  $\$H$  for each employee. Assuming the firm has a fixed budget for wages and benefits, this added cost would shift the demand curve for labor down by the amount of the premium. The firm reduces wages in order to compensate for its additional spending on health insurance. Since wages have decreased, some workers choose to leave the firm. Now, the firm employs  $L_1$  workers and pays each  $W_1$ . The job loss is shown by  $L_1L_0$ .

While job loss is a real phenomenon that will likely occur with the implementation of an employer mandate, it will probably not be as severe as the simple model in Figure 3 suggests. Since all employers with more than fifty employees, which comprise the employers of most Americans, will be subject to the mandate, it is not as though the employees who leave this firm can simply find another that still pays sufficiently high wages. Furthermore, the United States is just now slowly emerging from a massive recession. The unemployment rate is 9.7 percent (BLS 2010). Therefore, the slope of the labor supply curve, which is determined by wage-elasticity, is probably actually much steeper. In this situation, when the demand curve shifts down, there is only a small job loss.

FIGURE 3 IMPACT OF EMPLOYER MANDATE IN AN UNINSURED INDUSTRY



(Krueger and Reinhardt 1994, 41)

Another concern is that the employer mandate will detrimentally increase costs for smaller employers, namely those with just over fifty employees. Many small businesses do not currently provide health insurance because of the high costs of premiums (Dennis 2000, 249). Over the past ten years, premium costs have grown three times as fast as earnings (Merlis 2009, 3). Administrative costs can also be prohibitive for small employers since they cannot benefit from economies of scale like large employers. Although the proposals will almost certainly increase costs for small employers, either through premiums or the penalty, the employers should be able to find lower cost plans through an Exchange than is currently possible.

One potential extra benefit of the employer mandate, beyond increased insurance coverage, is a reduction in job lock. If a larger proportion of employers offer coverage, workers will be able to change jobs without fear of losing their health insurance.

Beyond the employer mandate, several other provisions in the Reform Act will also affect employment. Increasing insurance coverage and improving access to care will increase the size and improve the productivity of the labor supply. There are currently 17.7 million non-elderly adults in the United States who claim that a disability prevents them from work or limits the amount they can work (Executive Office 2009, 34). Approximately three million of these individuals are uninsured, which suggests substantial work force benefits from increasing coverage. Furthermore, without health insurance and adequate care, illnesses may cause longer absences from work, which reduces productivity.

#### **7.4 Political Feasibility**

The U.S. federal government is an enormous, complex and generally slow-moving entity. The mere passage of the Reform Act was an accomplishment of the Obama administration in itself. Powerful interest groups representing insurance and pharmaceutical companies certainly vigorously tried to impede the legislation (Eggen 2009). In addition, the reform lacked the support of much of the American public. In contrast, the reforms do have some significant advocates. The AFL-CIO, the United State's largest union and Wal-Mart, the world's largest retailer, have publicly put their support behind the employer mandate (Merlis 2010, 1). Yet even supporters have argued that the Act was trying to do too much at one time. Vladeck (2003) describes how other countries, and even the United States when implementing Medicaid, reformed health care in stages. Several years before the Obama administration's initial proposal, Vladeck claimed that you could not reform health care delivery and health insurance at the same time (2003, 18). Yet, the Reform Act, which



attempts to do just that, made it through Congress. The Act's supporters seem to be proving Vladeck wrong. Now, however, the nation faces the challenge of implementing the reforms.

Immediately after its passage, Senate Republicans began making claims about how they would stop or alter some of the provisions of the Act (Khan 2010). If the Republican Party increases its Washington presence through the upcoming November mid-term elections, these Congressmen may be able to follow through on their threats. To prevent these provocations from becoming reality, Democrats need some slight proof of success in the short term. Of course the true success of the changes will not be discernable for at least a decade, but there needs to be some immediate reason for the doubters to buy into the reform. Alternatively, or better yet, in addition, the Democratic Party could make a concerted effort to explain the many misconceptions about the reforms held by the American public. Many individuals believe that the Reform Act will increase, not reduce the deficit and that it is actually a government takeover of the United States' private health care system. When focus groups are used to inform individuals about the intricacies of the legislation, support for the reforms grows (Aaron 2010, e23 (2)). Improving the public's understanding of the reforms will certainly help with implementation and compliance.

Several states have already passed legislation opposing aspects of the Reform Act (Jost 2010, 870). For example, in February the Virginia Senate passed a bill attempting to exempt its residents from the individual mandate. To support this bill, Virginia uses the argument that the mandate is unconstitutional and unenforceable. Although there is no precedent for this mandate in U.S. legislation, it is in fact definitively constitutional (Balkin 2010, 482-483). In addition, and perhaps more importantly, Virginia's bill has no legal power. The U.S. Constitution clearly establishes supremacy of federal law over state law (art. VI, cl. 2). Thus, while Virginia's new law and similar ones in several other states have no official authority, they may have a negative impact on the implementation and enforcement of certain aspects of the health care reform. These laws make a political statement that the state government is going to limit its support for the federal reform as much as is legally possible. Jost (2010, 871) asserts that these nullification bills can be seen as "invitations to civil disobedience." The number of tax-evaders in the United States should already make enforcing the individual mandate difficult. A lack of state government support will add yet another challenge.

## 7.5 Cultural Feasibility

Culture is a major reason why the United States lacks universal health insurance coverage. The United States spends significantly more on health care than any other country in the world so blaming insufficient funding does not seem plausible. Something else must differentiate Americans from their universally insured neighbors to the north in Canada and across the Atlantic in Western Europe. The nation's history has produced individualistic and independent citizens, many of whom have a negative attitude toward government (Vladeck 2003, 17). This sentiment can be attributed to years of fighting off British rule and creating a nation free of royalty or traditional aristocracy. The U.S. government is thus generally less paternalistic than other nations' governments. In opposition to the Reform Act, Representative Mike Burgess claims "mandates have no place in a free society" (Jaffe 2009, 6). Many Americans who recognize that there is no other situation in which the federal government essentially forces citizens to purchase something also hold his attitude. For example, other social services, like education, are compulsory but also without charge. On the other hand, most states require drivers to purchase auto insurance, but that is dependent on individuals making the choice to drive in the first place. Yet the CBO estimates that only 85.4 percent of drivers are insured (CBO 2008, 52). Nevertheless, many Americans are in favor of the mandates recognizing their necessity for achieving universal coverage. Ironically, the parts of the country least in favor of the reform, such as the South and Midwest, are generally poorer, more rural regions that would benefit most from the changes (Vladeck 2003, 19).

A study by Isaksson and Lindskop (2009) confirms the commonly held stereotype that compared to other developed countries, U.S. citizens do not believe redistribution of wealth is the responsibility of the government. This can be explained by the strong belief amongst Americans that people should be rewarded for their effort, intelligence and skills (Isaksson and Lindskop 2009, 893-894). To grossly oversimplify, many Americans feel that redistributing wealth from high to low-income individuals does not necessarily improve equity because the high-income individuals earned their wealth through hard work and skill. This sentiment explains why some Americans may disapprove of premium subsidies for low-income individuals and community rating since they create redistribution.

Once the government implements these reforms, however, it will be more difficult for individuals with opposing attitudes to exert their opinions. Certainly many people would prefer not to pay Social Security payments, but they do so anyway because law requires it. In contrast, however, those payments are deducted automatically from paychecks. Unless one is

automatically enrolled in an insurance plan through his or her employer, purchasing health insurance, on the other hand, takes effort. One must select a plan through an Exchange and pay the premium. There is the possibility that some people may feel that that process is not worth the effort and that they would rather spend their money elsewhere despite the mandate. Furthermore, as previously mentioned, while not lawful, individuals can oppose the reforms through tax evasion and other attempts at civil disobedience. Finally, the election of a Republican majority in Congress in November or a Republican president in 2012 would have the potential to revoke or amend some of these reforms. Individuals who oppose the current legislation may exhibit unprecedented support for the Republican Party on upcoming Election Days.

## **8 CONCLUSION**

Without a federally regulated health care system, it will never be possible to provide adequate care for all Americans. An unregulated private health insurance market has no incentive to offer coverage to high-risk individuals with high expected losses or to ensure affordable premiums for low-income individuals. Government regulation is necessary to decrease the uninsured population and increase access to and quality of care for all. Fortunately, the U.S. government is now closer than ever to instigating the necessary reforms to achieve these goals. If implemented according to its current design, the Reform Act analyzed in this thesis will undoubtedly be successful in reducing the United States' uninsured population. These reforms will not, however, achieve completely universal coverage. Whereas now individuals are usually uninsured because of problems with either affordability or access, affordability will be the dominant cause of uninsurance after the implementation of the reforms. Thanks to the open enrollment and guaranteed renewability provisions and the establishment of temporary high-risk pools, no one will be simply turned down for coverage. However, for some, even with government subsidies and expanded Medicaid eligibility, the cost of insurance will still be too high. For others, income may be low enough to avoid the penalty and thus the incentive for obtaining insurance. Yet others will be exempt from the mandate because of religion or Native American ethnicity. Another substantial group that will remain uninsured, due to their exclusion from this legislation is the population of undocumented immigrants.

As for the feasibility of this reform, politically, the passage of the Reform Act was a major step for the U.S. government. Now, the Democratic Party needs to maintain control of

Congress to ensure that the reforms are implemented according to plan. For many Americans, these changes represent a significant cultural assault. Hopefully, through education and comparison with peer nations, this reform will be the first step towards the United States public recognizing access to health care as a basic human right. This opinion, which is widely accepted in Europe and many other countries, will make the public more accepting of spending federal funds for and increasing federal regulation of the health care system. Finally, the financial feasibility of these reforms is perhaps the most uncertain and potentially problematic hurdle. President Obama's advisors are optimistic that over the next decade, this restructuring will bring a net deficit decrease. However, given my findings, I would advise a more cautious outlook. Giving millions of Americans greater access to health care will most surely instigate a spate of moral hazard. Furthermore, restricting insurance companies' ability to select risks and vary prices may have a more substantial impact on premium levels than has been suggested by the legislation's supporters.

The enormous number of variables and uncertainties involved in this comprehensive plan make predicting the actual costs and benefits quite challenging. Yet my analysis suggests that the general results will be both an increase in health insurance coverage, improving the health of millions of Americans, as well as an increase in short-term costs for state and federal governments, some employers and insurance companies. To achieve truly universal coverage, however, subsequent reforms will need to build upon this Act to continue to improve the quality and efficiency of health care and increase access for all residents of the United States.

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