Steps Toward Universal Coverage

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The health care reform debate of 1993-1994 revealed widespread recog nition that our nation's health care system has significant problems. These problems did not end with the debate's end in the 103d Congress. We therefore have no choice but to try again. Our new effort will reflect not only values and policy judgments but also political lessons from our recent experience.

In this paper we argue that the fundamental goal of universal coverage can be pursued in steps. But these steps must be chosen with a clear eye toward building public support for and confidence in policy initiatives. Further, as we move, we must be sensitive to the risks of unintended consequences and invest in public education about costs and benefits. In legislation as well as in implementation, we must be sure that we are indeed moving forward, not backward.

Where Are We Going?

For reasons of policy and values, we remain firmly committed to guaranteeing affordable health insurance for all Americans. This commitment to universal coverage reflects both human and economic concerns.

Clearly, health care reform should aim to ensure access to appropriate health care. Although evidence tying insurance to specific health outcomes is limited, there is ample evidence that insurance makes a difference in the timing, type, and, in some cases, quality and outcomes of health care.[1] Universal coverage is therefore a necessary if not sufficient condition for everyone's getting health care when they need it.

Universal coverage is just as crucial to achieving equitable health care financing and efficient delivery of health care services. As we aim to ensure access, we should aim to control costs through improvements in efficiency, rather than through the shifting of costs from one payer to another or through reductions in access to necessary care. Minimizing uncompensated care by expanding coverage is critical to the success of promoting competition as a means of cost containment.

Stating our objectives, in part, clarifies our values about the security of coverage we believe Americans ought to have (and seem to want).[2] Stating the goal is also important to guiding our strategy for moving in steps. Knowing where we want to go helps to keep us from declaring victory prematurely. And while it leaves ample room for differences of opinion-for example, defining operationally what it means for coverage to be affordable, or determining whether to support or move away from an employer-

based system-it enables us to distinguish proposals and actions that will genuinely move us forward from those that would move us backward.

The case for incremental reform. Our experience in the 103d Congress tells us that we will have to move in steps if we are going to move at all. But clarifying why the political process directs us toward an incremental approach can also help us to identify the kinds of steps we ought to take,

Health care reform arose as a major political issue because the majority of Americans, most of whom have insurance, became concerned that their coverage would not be there when they needed it.[3] However, fears about the current system in no way precluded fears about reform. Our inability to enact comprehensive reform legislation is due, at least in part, to the fact that people became more worried about their prospects under reform than under the status quo.[4] The policy debate suggests that it is easier to communicate the risks of disruption than it is to communicate the benefits of secure coverage. For a variety of reasons, the public perceived (rightly or wrongly) that the risks of reform outweighed its benefits.

We can draw two lessons from this experience for a step-by-step approach to reform: (1) Minimizing disruption-particularly in the short term-is necessary to building public comfort and confidence in taking action. (2) The benefits of each step must be readily understood as improving the status quo in terms of security of coverage and affordability.

From a political perspective, there may be an advantage to incremental reform. It may be easier to communicate the net value of each step than the net value of a more comprehensive and complicated proposal. But incremental reform poses its own political and policy risks. Indeed, our pursuit of comprehensive reform reflected not only the basic concerns outlined above, but also a desire to avoid certain unintended consequences associated with partial change.

Insurance reforms, for example, present a greater risk of disruption under incremental reform than under comprehensive reform with universal coverage. Without universal coverage, there is a risk that increasing access will result in higher premiums overall. This is because sicker people, who have been excluded from the system, are most likely to become covered. Younger and healthier persons (and the businesses that employ them) may tend not to purchase coverage as the price for them rises. In a universal system, in which both the sick and the healthy are covered, this cannot occur.

Also, compressing premiums-that is, limiting the ability of insurers to charge persons who are sick or old substantially more than those who are healthy or young-means that while older and sicker people will pay less than under the status quo, younger and healthier people will pay more. Although universal coverage cannot eliminate this disruption, it can cushion it by reducing cost shifting and, therefore, premiums. An effective cost

containment strategy-which most believe is aided by universal coverage-can further cushion the effects of premium compression.

The risks of disruption from incremental reform cannot be ignored but also cannot be eliminated. In moving forward, however, we can take several precautions. First, policy can and should be designed to mitigate the risk of disruption. Second, we should not overpromise. Rather, we should acknowledge the risks as well as the benefits of policy initiatives and monitor their effects over time, as we attempt to build the public confidence needed for broader reform.

What Steps Should We Take?

There are many possible paths to the objective of secure, affordable coverage. Based on our desire to address widely perceived problems in a way that builds public confidence and moves us toward our objective, we highlight three prime candidates as initial steps: insurance reforms, expanded coverage for working families (especially children in working families), and support for long-term care.

Insurance reforms. There is general agreement that the current system is unfair. People who are sick-and who, arguably, have the greatest need for health coverage-can be charged higher premiums or denied coverage altogether. There is also agreement that the current insurance marketplace works against efficient competition.

Two types of reforms would address these problems. The first would require insurers to guarantee access to coverage regardless of health status. This would include guaranteeing issuance and renewal of coverage, limiting preexisting condition exclusions for persons newly purchasing coverage, and eliminating preexisting condition exclusions for persons changing insurers (for example, when changing jobs). Outright elimination of preexisting condition exclusions would be desirable, but it is not possible in the absence of universal coverage because people would tend to wait until they were sick to obtain coverage. However, eliminating exclusions for persons changing insurers would largely address concerns about the current system. Every major health or insurance reform bill introduced in the 103d Congress (by both Democrats and Republicans) included reforms similar to these. We advocate them as well.

The second type of reforms would limit or prohibit rating practices that permit insurers to charge some people (such as those who are sick) more than they charge others. Some type of rating reform is necessary to make the promise of guaranteed access to coverage real. Otherwise, insurers could simply charge unaffordably high premiums to persons who are sick, effectively denying them access to care.

The issue at the heart of insurance rating reforms is who should be pooled with whom. To make insurance accessible and provide the rudiments of competitive pressure, it follows that the sick should be pooled with the healthy. That is, insurers should be prohibited from experience rating-charging higher premiums to those who become ill. Pure community rating would go further in limiting the rating factors that an insurer could use, generally to standard family size and geography categories. In other words, the old would be pooled with the young, blue-collar workers with white-collar workers, and so on. The more factors that are eliminated, the more risks are shared and the more current practices are disrupted.

To eliminate the most discriminatory of current insurance rating practices and to make access to coverage real, we recommend that experience rating be eliminated or, at least, phased out over a short period of time. To mitigate some of the disruption created by compressing premiums and to avoid the chance that younger persons would drop coverage in the face of higher rates, maintaining age-based premium variations is necessary. Such variations could, however, be limited-for example, insurers could be permitted to charge an older person no more than two or three times the charge to a younger person.

Insurance reforms are often touted as the "motherhood and apple pie" issues in the health care reform debate, issues on which everybody seemingly agrees. But that perception is more a reflection of the limited policy debate these issues received (relative to employer mandates, for example) than of a genuine consensus. The fact is that the specifics of insurance reform are highly controversial. Most (if not all) parties to the debate support the first type of insurance reforms-those that provide nominally greater access to coverage. But without the second type of reforms-those that change insurers' rating practices-the promise of greater access is largely an illusion, and there is hardly any consensus around the issue of how to accomplish this type of reform.

Perhaps even more controversial than the reforms themselves is the decision about the population to whom they should apply. Here perhaps are the most profound conflicts over the distribution of health care costs and who should share risk and costs with whom. An obvious issue is the business size to which the reform would apply. Two of the less obvious but equally significant of these distributional issues are the treatment of self-insurance and trade associations and the handling of individually purchased insurance.

Self-insurance and trade associations. There is a great deal of support for permitting small businesses to self-insure or to purchase coverage though a self-insured or experience-rated trade association. In either case, if small firms with healthy workers are permitted to avoid being pooled with small

firms with sicker workers, the benefits of rating reforms will be attenuated.

Individually purchased insurance. If insurance reforms were applied to individual purchasers of insurance (for example, the self-employed), premiums likely would rise significantly because of adverse selection. The difficult distributional question is, Who should bear this higher cost? Is it the individual purchasers themselves (for example, by creating separate risk pools for individuals and employers)? This approach would likely make insurance prohibitively expensive for individual purchasers. Is it individuals and small businesses (for example, by creating a single risk pool for individuals and small businesses)? This would raise costs for small businesses-which may be unfair and politically difficult. Finally, is it individuals and all businesses (for example, by creating a risk pool for individuals and small businesses and by requiring larger businesses to pay an assessment to cover a portion of these costs)? This approach was advocated by Senate Majority Leader George J. Mitchell (D-ME) in the 103d Congress. It may be the fairest approach, but it obviously is politically difficult. As with most distributional questions, this one has no easy answers. However, avoiding the question, by leaving individual purchasers out of insurance reform, also is not appealing.

Insurance regulation. Finally, these issues cannot be fully addressed without reconsidering how the states and the federal government share responsibility for regulating insurance. Although states have generally enacted certain insurance reforms for small businesses, federal policy is required to address many of the more difficult distributional issues. The Employee Retirement Income Security Act (ERISA), for example, largely prevents states from prohibiting self-insurance for individual firms or from assessing large employers to cover a portion of the cost of individually purchased insurance.

There should be no illusion that insurance reform will be politically easy. As we address these issues, it is important not only that we weigh risks and benefits, but also that we distinguish between acceptable and unacceptable risks. There are in fact two types of risks when it comes to insurers' rating practices. The first risk is inevitable: There will be winners and losers, even if we are cautious in our policy design. But even the losers in this context have something to gain: the security of knowing that their premiums cannot be raised in the future if they become ill. Although the benefits of security may be harder to convey than the costs of immediately higher rates, they are nevertheless real.

The second type of risk represents a collective loss, with little or no compensating benefit. For example, if we were to try to compress premiums for small businesses too much and at the same time create opportunities for larger firms to escape the community risk pool through self-insurance or

trade associations, we could end up creating less pooling, not more.[5] Indeed, states now have authority under ERISA to regulate associations of small employers that self-insure. New legislation that undermined this authority could worsen insurance pools, instead of improving them.

Efforts to mitigate the risks associated with specific policy proposals should not be viewed as obstructionist. Rather, they are critical to achieving positive policy change.

Expanded coverage. If our objective is universal coverage, insurance reform alone is insufficient. Proposed legislation in the 103d Congress by both Democrats and Republicans recognized that many people cannot afford insurance coverage even if it is available, and that financial assistance should be provided to help them buy insurance. If we are to move in steps, the key question is where to focus our resources at the outset.

With an eye toward legislative agreement, we should consider targeting resources based not only on need but also on our ability to generate political support. Need suggests targeting based on some degree of means testing and on beneficiaries who lack access to some other form of coverage. Generating political support suggests targeting primarily children in middle-income working families. Under current law, Medicaid is phasing in coverage for all children in families with incomes below poverty. An expansion would aim at covering children in middle-income families who now lack insurance.

Medicaid's expansions in the past decade indicate political support for targeting aid to children, as do recent initiatives in several of the states. Expanding that coverage also is consistent with the current debate on welfare-with both assuring continued protection of children and improving the incentive to leave welfare for work. Further, such an initiative could build on a number of state programs that involve private insurers in covering children.[6]

As with insurance reforms, expanding coverage for children will pose risk and controversy. However, here the risk is not so much disruption or harm to people, but rather that some portion of the new financing allocated to expanding coverage might in fact substitute for existing public or private funding sources. For example, states that have expanded Medicaid beyond the mandated levels for children or created state-only programs for providing coverage to children would be likely to drop coverage if a new program were available (unless, of course, there were a maintenance-of-effort requirement, which carries its own controversy).

Similarly, some children eligible for the new program might have otherwise received an employer contribution toward coverage, if not for the existence of the new public subsidy. This substitution could be mitigated-for example, by making ineligible children who have some threshold employer contribution available-but not eliminated.

These risks will be raised and should be debated. But they cannot become barriers to action. Without required employer contributions toward health care coverage-which seem quite unlikely in the near future-some substitution is inevitable with any subsidy program. In addition, substitution is not necessarily bad. Substitution for current state spending provides fiscal relief to states. Also, working families who substitute publicly subsidized coverage for employer-financed coverage for their children should see an increase in wages.

In pursuing this step of reform, it is important that we pursue policy design that promotes broader coverage with sensitivity to the efficient use of limited resources. But the fact that some funds will go to persons already insured-that is, that we are unable to target with perfect efficiency-should not become an obstacle to moving forward.

Long-term care. If our ultimate objective is to provide secure and affordable protection against the costs of illness, long-term care cannot be ignored. The financial and emotional burdens of addressing the nonmedical costs associated with chronic illness are at least as compelling as lack of protection for acute care services. Including a long-term care initiative as a health care reform step also makes sense from the perspective of generating broad political support, particularly if Medicare savings are a major financing source for expanded coverage.

Republicans and Democrats alike have advocated changes in the tax treatment of long-term care insurance as an element in addressing long term care needs. Clarifying that tax preferences for health insurance and medical care apply to long-term care as well may strengthen the demand for these policies. That action also has value as a consumer protection if, as it should be, it is accompanied by standards that assure consumer information and prohibit abusive marketing practices that have existed in the long-term care insurance market.[7]

Improving value for the dollar in private long-term care insurance, however, is at best a long-term strategy for reducing the financial burdens of long-term care. Such insurance is in the early stages of development, too expensive for many seniors, and generally not available to persons who are already impaired.[8] To address current long-term care needs, it thus is necessary to pursue a further initiative. We recommend addressing what is now the most glaring gap in our system of long-term care financing: support for home and community-based care.

Although states have expanded their provision of these services under Medicaid, there is tremendous variation in the availability of support across the country. Matching grants to states, with more substantial federal participation than Medicaid now provides, would enable all states to develop home and community-based services. A new program could establish cer-

tain minimum federal eligibility and service requirements but allow states broad flexibility to tailor support to the varying needs of individuals. Such flexibility also would recognize differences in the way communities are providing services, for example, some relying more on agencies, others on individual providers of care.

Concern about existing, let alone new, entitlement programs has been a barrier to expanded public financing for long-term care. This approach would address that concern by capping the federal funds available for the program, with amounts made available to each state based on its share of the nation's disabled population. States, not individuals, would have entitlements to funds.

Designing a home and community-based care program, like other steps in health care reform, poses risks. As with children's coverage, there are issues of substitution of new federal funds for existing state dollars, Decisions would be required about how to relate existing Medicaid coverage to new programs so as to balance the desire for expanded service with states' interest in fiscal relief. Controversy would exist as to how limited funds should be targeted. Means-tested programs have the advantage of efficiency but the disadvantage of limited political support. Furthermore, the disabled population is made up of various subpopulations-children with disabilities and chronic illnesses, persons with mental illness, persons with developmental disabilities, other working-age adults with disabilities, and the disabled elderly-with stakes in resource allocation. Here too any action will be controversial. But progress can be made.

Pitfalls In Incremental Reform

As we have argued throughout this paper, risks are inherent in every step of health care reform. A commitment to move toward universal coverage behooves us not only to be sensitive to the particular risks of each step but also to avoid two more general risks of a step-by-step approach.

First, we must be wary of cutbacks in benefits that are masquerading as expansions. In the 103d Congress, for example, some reform bills included caps on funding (generally called entitlement caps or fail-safe mechanisms), which generally reduced eligibility for subsidies if costs exceeded the authorized funds. Some of these bills included current beneficiaries (for example, persons receiving Medicaid) under these caps. Capping new programs may be appropriate. But we should not allow such caps to jeopardize coverage under existing programs. Existing coverage would be particularly at risk if a new program's funding is tightly constrained or its costs are uncertain or unstable.

Second, we must be wary of straightforward cutbacks in public programs

that provide valued protection– Medicare and Medicaid in particular. No one would deny that Medicare provides universal coverage for the nation's senior citizens (and many persons with disabilities). Cuts that destroy this basic mission of Medicare, or that undermine its capacity to achieve it, clearly would be a step backward. Similarly, although there is considerable interest in Medicaid reform, Medicaid must be recognized as an important safety net for poor children, the elderly, and persons with disabilities. Indeed, without the recently legislated expansions in Medicaid the number of uninsured Americans would have increased even faster than it has, given the decline in employer-based coverage.[9]

Conclusion

The last round of health care reform made clear that proponents of reform must turn their immediate attention to moving a step at a time. Although this is not our first choice, for now it is our only choice. We must, however, take individual steps with an eye toward the ultimate objectives: providing secure and affordable coverage for all Americans.

Certain initial steps are consistent with any number of paths toward secure and affordable coverage. Reforming the insurance market–with a particular focus on the most discriminatory of current practices that erect barriers to access-provides a foundation for broader coverage and more efficient service delivery. Few dispute that some people lack insurance because they cannot afford it, and beginning with children in working families may serve to generate broad support. Finally, some movement to address long-term care problems is an important substantive and political element of any incremental step taken.

We also must be mindful of the risks of disruption that we create with each incremental step and do our best to mitigate the risks and ensure that they are balanced with benefits. Moving step by step requires, and offers us the opportunity for, public education as we move along. Lest we lose sight of our fundamental commitment to broader coverage, we should not allow a step-by-step approach to reform to become an excuse for action that would reduce, rather than improve, health care coverage. Cutbacks must never be accepted as reforms.

The views expressed in this paper are those of the authors and do not necessarily represent those of tk Department of Health and Human Services. The authors thank Gary Claxton, Mary Harahan, Chris Jennings, and Judy Whang for their valuable comments on this paper.

NOTES

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2. CBS/New York Times poll, cited in "CBS/NYT: Clinton and Congress Share Health Care Blame," Healthline, 13 September 1994. Also, Princeton Survey Research Association survey, cited in "Newsweek: Health Debate Makes More People Unsure," The Hotline, 8 August 1994.
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4. A Washington Post survey, cited in "Washington Post: Assesses Impact of Delay," *Healthline,* 7 July 1993.
5. Similarly, if we enacted tax-preferred medical savings accounts, we could further segregate the sick (who would tend to choose plans with little cost sharing) from the healthy (who would tend to choose plans with high cost sharing).
6. P. Butler, R.L. Mollica, and T. Riley, "Children's Health Plans" (Unpublished paper, National Academy for State Health Policy, July 1993).
7. The Health Insurance Association of America testified before the Ways and Means Subcommittee on Health that consumer confidence in these products will be increased if tax clarification is accompanied by "reasonable Federal standards." See Health Insurance Association of America, "Tax Incentives for Long-Term Care Insurance as Part of the Senior Citizens Equity Act," testimony before U.S. House of Representatives, Ways and Means Subcommittee on Health, 20 January 1995. Also see U.S. General Accounting Office, *Long-Term Care Insurance: High Percentage of Policyholders Drop Policies,* Pub. no. GAO-HRD-93-129 (Washington: U.S. GPO, August 1993); and U.S. General Accounting Office, *Long-Term Cure Insurance: Risks to Consumers Should Be Reduced,* Pub. no. GAO-HRD-92-14 (Washington: U.S. GPO, December 1991).
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