Health Care Reform and Implications for Illinois

How will Illinois be affected by major reforms in health care?

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By Anthony T. Lo Sasso

Introduction

When President Obama swept into the White House with large majorities in both houses of Congress, it was widely believed that reform of the health care system would, after many false starts over the decades, be achieved. Debate over how this reform will be shaped has dominated much of 2009. However, as 2009 ended, a bill was passed by the Senate and, pending reconciliation with an earlier House bill, it is likely that health care reform will be signed into law early in 2010. This chapter will not be devoted to the potential impact of the specific bills passed by Congress; instead we will explore four common features of bills being discussed, the perceived shortcomings of the health care system they are intended to address, and the specific implications for residents and businesses in the state of Illinois. The findings of our study will highlight the challenges inherent in the problem – if it was easy, reform would have been accomplished long ago. We will examine a number of the potential unintended consequences of the policy interventions being discussed.

Table 1
Illinois and National insurance shares by insurance type for individuals under age 65, 2008

	Illinois	National
Uninsured	14.3%	17.3%
Insured	85.7	82.7
Employer-Sponsored Insurance	62.2	57.1
Individual Insurance	5.6	5.9
Public Insurance	17.9	19.7
Observations	11,312,769	263,695,093

Source: 2009 Current Population Survey, Census Bureau. Statistics weighted using March supplement household weights.

Of course, it is nearly impossible to summarize all the effects of a 2,000-page bill in this chapter, so we focus on four of the most commonly discussed aspects of bills under consideration as 2009 ended: 1) community rating in health insurance markets; 2) the employer mandate to offer health insurance; 3) the tax on so-called "Cadillac" health insurance plans; and 4) health insurance market competition and the need for a public option.

Background

In order to assess the likely impacts that health care reform at the national level will have on Illinoisans, we need to first provide the basic context of the health insurance coverage landscape in Illinois as it relates to national averages. Table 1 provides a breakdown using the most recent available data of health insurance coverage overall and its sources in Illinois relative to the nation for 2008 for individuals under 65 years of age.

Note that the percentage of uninsured Illinoisans under age 65 is three percentage points lower than the national average. The difference comes from having a higher fraction of residents with employer-sponsored health insurance than the nation broadly, 62.2 percent versus 57.1 percent. Illinois enjoys some advantage because employers here are more likely than the nation as a whole to insure their employees.

To explore in more detail the characteristics of the uninsured in Illinois, we break out the uninsured by race, age, and income and compare once again to national averages. Table 2 displays rates of uninsured by race/ethnicity. The percentage of whites in Illinois without insurance is less than the national average (13.1 percent

Table 2
Uninsurance Rates by race/ethnicity, Illinois and Nation, individuals under age 65, 2008

	Illinois	National
White	13.1%	16.6%
Black	19.9	20.6
Hispanic	37.3	28.8
Other	13.8	18.4
Total	14.3	17.3
Observations	11,312,769	263,695,093

Source: 2009 Current Population Survey, Census Bureau.
Statistics weighted using March supplement household weights.

versus 16.6 percent), but the percentage of Hispanics without insurance is strikingly higher (37.3 percent versus 28.8 percent).

Table 3 displays the percentage of those within 5-year age groupings who are uninsured. The uninsured rate for young children in Illinois is lower than the national average, but Illinois and the nation as a whole are equally troubled by the high rate of young adults aged 21-25 who lack insurance: more than one-third. These young adults in particular are a target of health care reform legislation, mostly through expanding age limits for "children" on family health insurance policies.

Table 4 presents the breakdown of uninsured by family income category using the Federal Poverty Level (FPL) as a guide. The FPL provides a uniform measure of income adjusted by family size. For example, 200 percent of FPL for a family of four represents annual income equal to $44,100 in 2009. Illinois has a lower fraction of uninsured below the FPL relative to the nation, with just over one-fourth of Illinois residents under the poverty line lacking health insurance versus nearly one-third in the nation as a whole. However, it should be noted that these poorest families represent roughly 13 percent of the population in the state.

Table 3
Uninsurance Rates by age, Illinois and Nation, individuals under age 65, 2008

	Illinois	National
Less than 5	6.4%	8.7%
6 to 10	5.3	9.1
11 to 15	7.0	10.9
16 to 20	15.8	18.4
21 to 25	33.9	32.6
26 to 30	21.3	28.2
31 to 35	16.4	22.7
36 to 40	13.8	19.7
41 to 45	15.6	18.3
46 to 50	14.2	16.6
51 to 55	13.3	14.3
56 to 60	10.5	12.7
61 to 65	8.3	12.1
Total	14.3	17.3
Observations	11,312,769	263,695,093

Source: 2009 Current Population Survey, Census Bureau.
Statistics weighted using March supplement household weights

Table 4
Uninsurance Rates by percentage of Federal Poverty Level, Illinois and Nation, individuals under age 65, 2008

	Illinois	National
Less than 100 FPL	26.5%	32.8%
100 to 199 FPL	26.3	29.2
200 to 299 FPL	16.5	20.3
300 to 399 FPL	10.9	12.7
greater than 400 FPL	5.8	6.5
Total	14.3	17.3
Observations	11,312,769	263,695,093

Source: 2009 Current Population Survey, Census Bureau.
Statistics weighted using March supplement household weights

These statistics demonstrate that, in general, Illinois does slightly better than national averages, but that 1.6 million

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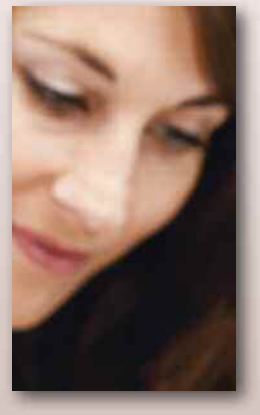

Illinois residents lack health insurance. Many of the uninsured are immigrants and their families who can typically be very hard to reach with insurance expansion efforts, while others are healthy young adults who might be particularly price sensitive and not perceive the value of health insurance.

Community Rating in Health Insurance Markets

One of the widely discussed aspects of health care reform deals with the common complaint that health insurance is "unaffordable" for the people who "need it most," i.e., those with pre-existing health conditions. This is an issue that evokes a visceral response from the public, and it was widely believed as of this writing that some type of law prohibiting insurers from charging differential health insurance premiums for those in poor health (known as community rating) paired with a requirement that health insurers offer plans to anyone who desires one (known as a guaranteed-issue requirement) would be a part of a successful bill.

Based on the lessons from state-level experiments with community rating, it is possible to predict some of the effects of a national community rating law. Presently there are seven states that have community rating in their individual health insurance market (Maine, Massachusetts, New Jersey, New York, Oregon, Vermont, and Washington). Insurers in these states are not allowed to charge differential premiums based on the health of applicants. Community rating regulations are subdivided between so-called pure community rating requiring insurance carriers to charge the same premiums for all plan participants regardless of age, gender, health status, or other factors, and adjusted or modified community rating which allows for some premium differentials typically by age or gender. Of the states mentioned here, only New Jersey, New York, and Vermont are pure community-rated states. The other four states, however, implemented adjusted community rating regulations, which still allow limited premium variation by specified amounts. The final bill to emerge from Congress would likely allow for some variation in premiums based on a limited set of demographic attributes. In addition to the seven currently community-rated states, New Hampshire and Kentucky previously implemented community rating along with guaranteed issue, but later eliminated both requirements. Both Kentucky and New Hampshire maintain restrictions on rating, but allow premium variation for health status and other characteristics. An additional four states implemented community rating restrictions, but did not have a guaranteed-issue requirement.[1]

Prior research has examined how state community rating regulations combined with guaranteed-issue laws affected the purchase of individual insurance by different risk groups and how the composition of the risk pool changed as a result of the regulations.[2] The results suggest that community rating of the individual health insurance market was associated with a significant change in the risk composition of the individual market: community rating made younger, healthy people less likely to purchase individual health insurance and more likely to be uninsured. Unhealthy individuals were more likely to purchase individual health insurance policies, but there was only limited evidence suggesting that insurance increased among the unhealthy. On balance, the effects on the two "tails" of the distribution canceled each other out so that no overall effect on coverage was evident.

The prior work on the subject of community rating provides a compelling portrait of the predictable distortions that can result from regulations aimed at improving perceived deficiencies in the individual and small-group health insurance markets.

[1] New Mexico (January 1995), Oregon (October 1996), North Dakota (August 1995), and Ohio (January 1993) implemented modified community rating regulations without a guaranteed issue requirement.

[2] See Anthony T. Lo Sasso and Ithai Z. Lurie, "Community Rating and the Market for Private Non-Group Heatlh Insurance," *Journal of Public Economics* 2009: 93(1-2): 264-279.

The predictions from economic theory are unambiguous and much of the scholarly literature consistently points to decreases in coverage for young and healthy individuals, increasing health insurance premiums, and a disturbing and potentially unsustainable trend toward a sicker pool of enrollees in the market.

There are at least two wildcards to consider for state policymakers envisioning reform efforts. The first is the potential efficacy of individual insurance purchase mandates to increase, through admittedly heavy-handed methods, the take-up of health insurance. The insurance industry originally seemed prepared to support community rating, but only with a strong individual mandate. A strong mandate, that is higher penalties for non-compliance, would induce more relatively healthy people to purchase coverage thus creating a broader pool of enrollees and allowing for lower premiums for all. Stronger mandates are clearly politically difficult as they are inherently punitive and coercive, thus as the strength of the individual mandate weakens, support from insurers wavers and the likelihood of significantly higher premiums resulting from the legislation grows.

The second wildcard is the potential role of high-deductible health savings accounts in making insurance more attractive or at least more affordable to an expanded spectrum of the country. Noting that the bulk of the uninsured are actually healthy young people, some health reform bills recognized the need for cheaper health insurance products aimed at the young and healthy – the so-called invincibles – who feel that the need for health insurance coverage does not justify the expense. Such benefit designs could be modeled on Health Savings Accounts and other "consumer-driven" health insurance options. However, other aspects of bills being considered have much stricter requirements on what services must be covered and at predefined coverage levels. Such proscriptive approaches would very likely only lead to fewer and more costly health insurance options that would either require greater subsidies to induce people to purchase coverage or lower take-up/compliance rates among the young and healthy.

Employer Mandates to Offer Health Insurance

Another widely discussed aspect of legislation under consideration was the employer "pay or play" mandate to offer health insurance benefits to workers. "Play" refers to offering health insurance to workers while "Pay" refers to paying a tax per worker if the employer does not offer health insurance. The amount of the tax varies in bills but a frequently discussed number is $750. Both the House and Senate bills exempt businesses with fewer than 50 employees. Critics have derided this provision as a "job-killer" that only succeeds in making it more costly to hire workers, while others view this as a sensible policy that works within the existing framework of employer-sponsored health insurance in the United States.

It is worthwhile to consider the landscape of employer-sponsored health insurance provisions in the state of Illinois. Figure 1 *(on page 66)* displays employer-sponsored health insurance offer rates in Illinois relative to the rest of the nation. Several takeaway points are apparent from the figure. The first is that employer size is an extremely important predictor of health insurance offer rates. Indeed, for the smallest firms, those with fewer than 10 workers, both nationally and in Illinois, only 35 percent of such employers offer health insurance to workers. In the largest firms, those with 1,000 or more workers, offer rates are nearly 100 percent. The figure also displays offer rates by less than/greater than 50 workers representing the categories of firm size most commonly discussed by lawmakers. It is clear that employer-sponsored health insurance offer rates are quite

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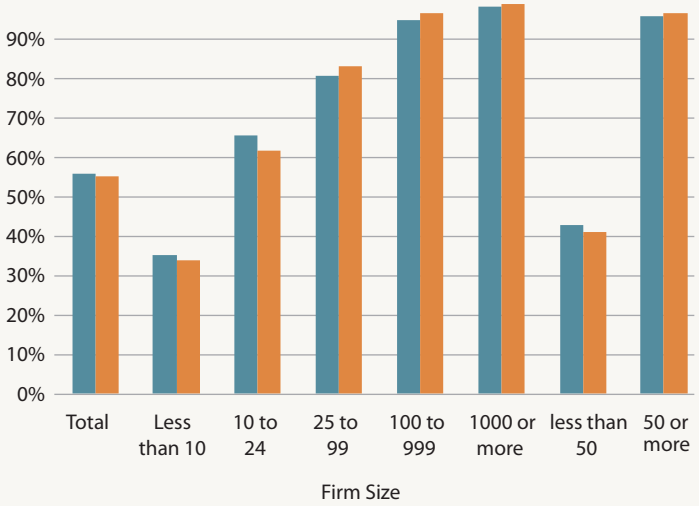
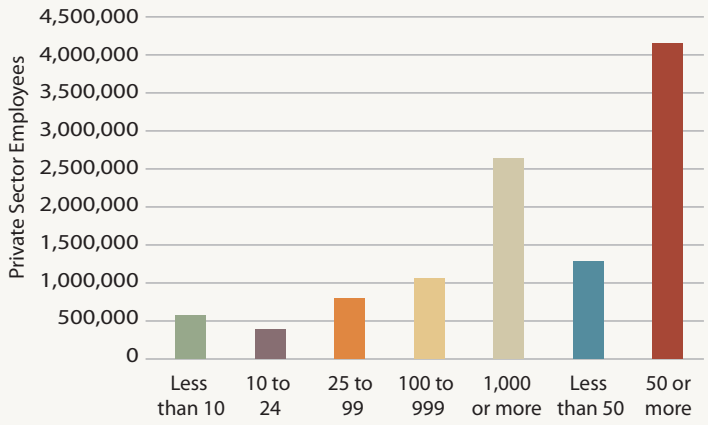
Figure 1
Establishment-level Employer-sponsored Health Insurance Offer Rates by Firm Size, Illinois and Nationally, 2008



Source: 2008 Medical Expenditure Panel Survey – Insurance Component

Figure 2
Number of Private Sector Employees by Firm Size, Illinois, 2008



Source: 2008 Medical Expenditure Panel Survey – Insurance Component

low, at just over 40 percent for the firms commonly thought to be exempted from the pay-or-play mandate.

Figure 2 displays the number of private sector employees in each of the firm-size groupings in order to provide an appreciation for the number of workers in the affected groups. Illinois has roughly 5.4 million private sector employees of which roughly 1.3 million work in firms with fewer than 50 workers. (While not tabulated, the proportion of workers in the employer size categories in Illinois is quite comparable to the distribution for the United States.) The data imply that roughly a half-million Illinoisans employed at private-sector firms that are not presently offering health insurance could stand to gain coverage if the pay-or-play mandate works as advertised. Another roughly 750,000 Illinoisans who work for firms with fewer than 50 workers that do not offer health insurance benefits would not be affected by the mandate as it is currently being discussed.

One concern is that there might be unintended consequences from the law. In particular, given that the premium associated with the average family health insurance plan offered in the state of Illinois in 2008 was $12,600, it is not obvious that the most frequently discussed penalty for not offering coverage will induce many firms to play. Indeed, there is concern that some firms might realize that they can get out of the costly and often distracting business of managing health insurance benefits for workers for the relatively *low* price of $750 per person (at least compared to the premiums for employer-sponsored health insurance). Doing so could be risky as it could lead to retention issues for the best employees and could subject employers to more onerous penalties for not "playing" later.

The remaining 700,000 Illinoisans, or about 13 percent of all private-sector workers in the state, are predicted to be subject to the tax on high-value employer sponsored health insurance benefits.

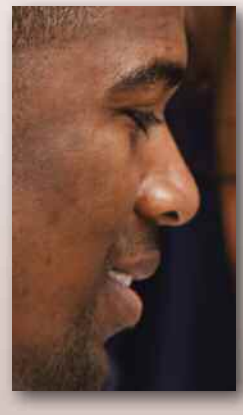
Tax on "Cadillac" Health Insurance Plans

Also among the policy options is taxing the value of high-cost, "Cadillac" employer-sponsored health insurance plans. One factor that has historically encouraged the growth of health insurance premiums over time is the fact that the value of employer-sponsored health insurance is not treated as taxable income for employees. Thus if the employee received an additional $12,600 (the mean premium of an employer-sponsored family health insurance plan) in wages, it would be taxed as earnings; when the worker is "paid" in the form of a product called "health insurance" it is not subject to any tax. Economists and other policymakers have long decried this differential treatment for employer-sponsored health insurance as it represents an estimated $250 billion implicit tax subsidy. Moreover, given that the income tax system is largely progressive in nature (that is, higher income individuals pay higher marginal tax rates) the value of the subsidy, in the form of forgone taxes paid, is *greater for higher income individuals*.

The Congressional Budget Office (CBO) has repeatedly recognized that some effort to curtail this subsidy is necessary in order to "bend the cost curve" in health care costs, but it is difficult to portray recognizing the value of health insurance benefits as income (and thus taxable) as anything other than an increase in taxes that will affect the vast majority of families. So the Congress has resorted to a strategy of taxing the value of benefits above some cap (hence the use of the term "Cadillac" to describe costly health insurance plans). Because it is still politically difficult to justify a tax increase on potentially middle-class workers with high-value plans, they have resorted to proposing not to tax individuals for the value of high-cost plans, but rather to tax the employer who offered the plan or even the insurer who sold the plan to the employer. In the case of taxing employers or insurers, virtually all policymakers agree that the cost of the tax will immediately be passed on to the employee, but the subterfuge apparently has political value. The annual premium threshold value that is most commonly discussed is $21,000 for a family plan and $8,000 for a single plan, but numerous exceptions have been discussed. Importantly, the bills under consideration frequently involve allowing the cap to grow at the rate of general inflation and not the rate of health care inflation (which is usually higher). This provision will allow the cap to have more bite over time.

There are no precise figures for Illinois regarding the number of workers whose employers offer high-value health plans, but it is possible from existing data to make some estimates. According to the best available data, the mean employer-sponsored premium is $12,600 for a family plan and $4,643 for a single plan in 2008. Under reasonable assumptions based on Medical Expenditure Panel Survey Insurance Component data for the year 2008, of the 3.7 million Illinoisans who work for firms that offer health insurance and are eligible for those benefits, roughly 3 million workers will be under the caps mentioned above and thus not subject to the tax on high-value plans. The remaining 700,000 Illinoisans, or about 13 percent of all private-sector workers in the state, are predicted to be subject to the tax on high-value employer sponsored health insurance benefits. Of course, given the relatively rapid growth rate in premiums over time, this fraction will grow.

It is very likely, however, that employers and their employees will rapidly move away from such costly plans in order to avoid the tax. This will necessitate less-generous health insurance plans being offered to employees, meaning higher cost-sharing and more supply-side limitations on care (e.g., gate-keeping of specialty providers, smaller provider networks,



The reform efforts being discussed thus far in Congress likely fall far short of perfect and there will be numerous areas in which state policymakers and regulators will be called upon for additional laws and oversight.

etc.). Such changes will not please workers, but employees in general show surprisingly high responsiveness to higher premiums in their health insurance plan choices. While some would argue that movement away from costly health plans is precisely what is needed to rein in costs, lower health care costs almost always means lower health care use and it is unclear what effect this reduction would have on the health of enrollees.

Health Insurance Market Competition and the Need for a "Public Option"

The "public option" has probably received the most attention throughout the health care debate, and while it appears that the final bill to emerge from Congress will likely not include a public option, many advocates will continue to call for more public involvement once the law moves toward the implementation phase. Of course, given the depth of rancor it is easy to lose sight of the fact that the nation already has two very large public options already in play: Medicare and Medicaid. (The Veteran's Administration system could easily be considered a third.) However, it is also evident that these two large public options have not achieved noteworthy cost savings and are generally viewed as long-term fiscal failures. Medicare's unfunded liability over the next 75 years is estimated by the Medicare trustees to be a staggering $38 trillion. Actuaries at the Centers for Medicare and Medicaid Services have predicted that, under present law, Medicaid expenditures are expected to grow at about 8.4 percent per year and increase from $352.1 billion today to $800.7 billion in 2018; and expansion proposed in reform legislation could make the growth in Medicaid far larger. So even public option supporters can find little comfort from 40-plus years of experience from these public options, at least as far as cost containment is concerned.

While various forms of public options are conceivable, from a public policy standpoint the need for the public option hinges on the perception surrounding the extent to which insurance markets are sufficiently competitive in order to provide consumers with adequate options for their health insurance. For example, the Medicare Part D drug insurance program contains a "triggered" public option that is intended to take effect should there not be sufficient plan choice for seniors in their drug benefits. This Part D public option has never been triggered.

The question as to whether there are sufficient private insurer options is an empirical one. A brief perusal of the website ehealthinsurance.com, an online purveyor of health insurance to individuals and small businesses, reveals at least 20 different plan options from five large health insurance companies would be available for a hypothetical small business looking for a group health insurance policy in Illinois. An individual seeking health insurance coverage would find some 100 different plan options from no fewer than six health insurance companies. This information should not be construed as proof that competition exists in the small-group and individual insurance markets in Illinois, but it is certainly suggestive of that conclusion.

Summary

This chapter has reviewed four of the major themes of the health care reform debate that is ongoing in Congress with particular emphasis on the implications for Illinois residents and small businesses. It is clear that while the status quo is untenable (1.6 million Illinois residents lacking health insurance), options to expand coverage are equally fraught with peril – and they are certainly likely to be costly. Clearly if and when a reform bill is enacted, state policymakers, businesses, and residents will be very busy complying with the new requirements and responsibilities. The reform efforts being discussed thus far in

Congress likely fall far short of perfect and there will be numerous areas in which state policymakers and regulators will be called upon for additional laws and oversight. For example, community rating requirements will put pressure on insurers to increase premiums, particularly if an individual mandate is weak. Higher premiums could seriously tax individuals currently receiving their insurance in this market. Employer mandates, if poorly constructed, could lead to *reductions* in coverage, potentially necessitating greater expenditures for state programs aimed at the uninsured. Taxes on high-value plans could have a disproportionate effect on predominantly union workers, either in manufacturing or public sectors. Medicaid expansions, which are important parts of the bills being considered, will come with unfunded state spending requirements even though generous federal matching rates are likely to be included.

In the unlikley event that reform should fail, it is clear that existing trends will continue and there will be a need for states to consider potentially following in Massachusetts' footsteps to enact state-level reforms aimed at greatly reducing the numbers of uninsured. State-level efforts to decrease the costs of care are possible, but probably achievable only with bold thinking about how to restructure the Medicaid payment system and finding ways to reduce insurance regulations – both very difficult politically to carry out.

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