Financing Healthcare for Indiana Families

Indiana Family Impact Seminars

November 20, 2006

Sponsoring Organizations

Center for Families, Purdue University
Department of Family Relations, Ball State University
Family Service Council of Indiana
Indiana Association of Family and Consumer Sciences
The Institute for Family and Social Responsibility, Indiana University
Indiana Association for Marriage and Family Therapy
Indiana Extension Homemakers Association®
Purdue Extension, Consumer and Family Sciences
Indiana Youth Institute

For a description of the organizations see pages 11& 12.

Purpose, Presenters and Publications

Family Impact Seminars have been well received by federal policymakers in Washington, DC, and Indiana is one of several states to sponsor such seminars for state policymakers. Family Impact Seminars provide state-of-the-art research on current family issues for state legislators and their aides, Governor's Office staff, state agency representatives, educators, and service providers. One of the best ways to help individuals is by strengthening their families. Therefore, the Family Impact Seminars speakers analyze the consequences an issue, policy or program may have for families.

The seminars provide objective, nonpartisan information on current issues and do not lobby for particular policies. Seminar participants discuss policy options and identify common ground where it exists.

Financing Healthcare for Indiana Families is the ninth in a continuing series designed to bring a family focus to policymaking. The topic was chosen by the very legislators these seminars are intended to inform. This year's topic focuses on two policy approaches—One State's Bold Initiative and The Healthcare Landscape. This ninth seminar features the following speakers:

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We hope that this information is useful to you in your deliberations, and we look forward to continuing to provide educational seminars and briefing reports in the future.

In Fiscal Year 2004, Indiana's health care expenditures from both private and public funding sources were $32,957,000. This amount reflects 15% of the state's Gross State Product (GSP).

- Between 1980-2004, health care expenditures in Indiana have grown by 8.6%, which is the same as national averages.
- Hospital care represents 38% of Indiana's health care expenditures, followed by physician and other professional services (27.7%), and prescription drugs (13.4%).

Sources: National Health Expenditure Data, Health Expenditures by State, Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, released June 2, 2006; available at http://www.cms.hhs.gov/NationalHealthExpendData/05_NationalHealthAccountsStateHealthAccounts.asp#TopOfPage

Health Insurance Coverage of the Total Population, Indiana (2004-2005), U.S. (2005)

	Indiana Number	Indiana %	US Number	US %
Employer	3,539,530	58	156,326,430	53
Individual	251,020	4	14,162,970	5
Medicaid	724,700	12	37,868,010	13
Medicare	706,350	12	34,654,120	12
Other Public	34,370	1	3,358,460	1
Uninsured	877,240	14	46,577,440	16
Total	6,133,210	100	292,947,440	100

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2005 and 2006 Current Population Survey (CPS: Annual Social and Economic Supplements).

- Of the 6.1 million people in Indiana, an estimated 86% have health insurance of some kind.
- Indiana does slightly better than national averages in providing employer health insurance (58% vs. 53%) to its residents.
- Indiana also has a smaller percentage of people that are uninsured (14% vs. 16%) compared to national averages.

Health Insurance Coverage of Children 0-18, Indiana (2004-2005), U.S. (2005)

	Indiana Number	Indiana %	US Number	US %
Employer	1,002,540	60	43,934,050	56
Individual	56,300	3	3,459,740	4
Medicaid	449,430	27	20,354,580	26
Other Public	10,320	1	1,124,430	1
Uninsured	161,260	10	9,035,420	12
Total	1,679,850	100	77,908,220	100

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2005 and 2006 Current Population Survey (CPS: Annual Social and Economic Supplements).

- Hoosier children birth – 18 are more likely to have access to health insurance from their parent's employer compared to children nationally (60% vs. 56%, respectively).
- Partly because of Hoosier Healthwise, Indiana's State Children's Health Insurance Program (SCHIP), Indiana has a smaller percentage of children – 10% -- without health insurance, compared to the national average of 12%.

Health Insurance Coverage of Adults 19-64, Indiana (2004-2005), U.S. (2005)

	Indiana Number	Indiana %	US Number	US %
Employer	2,555,070	67	112,496,040	63
Individual	190,340	5	10,468,350	6
Medicaid	255,760	7	14,448,170	8
Other Public	104,220	3	5,039,050	3
Uninsured	711,660	19	37,082,810	21
Total	3,817,040	100	179,534,430	100

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2005 and 2006 Current Population Survey (CPS: Annual Social and Economic Supplements).

- Most adults (66%) aged 19-64 have health insurance through their employers, compared to 63% nationally.
- Adults are twice as likely to be without health insurance (19%) as children ages 18 and under. This is slightly less than the national average of 21%.

Distribution of the Non-elderly Uninsured by Family Work Status, states (2004-2005), U.S. (2005)				
	Indiana Number	Indiana %	US Number	US %
At least 1 full time worker	633,360	73	31,981,250	69
Part time workers	111,200	13	5,238,090	11
Non workers	128,360	15	8,898,890	19
Total	872,920	100	46,118,230	100

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2005 and 2006 Current Population Survey (CPS: Annual Social and Economic Supplements).

- Full time employment does not always translate into having health insurance for full-time workers.
- Uninsured persons in Indiana are more likely to be employed than uninsured persons in the U.S. as a whole.

Indiana has higher-than-average rates of people in poverty who have health insurance compared to the U.S. as a whole. Indiana has lower-than-average rates of working poor who have health insurance (i.e., those who make 200% or more of the federal poverty level).

- In Indiana, 60% of people who make less than 200% of the federal poverty level are uninsured, compared with 65% of people in poverty nationally.
- In Indiana, 40% of people who make 200% or more of the federal poverty level are uninsured, compared to 35% nationally.

Health Insurance Coverage of Children 0-18 Living in Poverty (under 100% FPL), Indiana (2004-2005), U.S. (2005)				
	Indiana Number	Indiana %	US Number	US %
Employer	53,510	14	2,364,970	13
Individual	9,000	2	585,310	3
Medicaid	256,810	69	10,542,470	59
Other Public	920	0	272,880	2
Uninsured	51,360	14	3,956,040	22
Total	371,600	100	17,721,680	100

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2005 and 2006 Current Population Survey (CPS: Annual Social and Economic Supplement). Persons in poverty are defined as those who make less than 100% of the Federal Poverty Level (FPL). The federal poverty level for a family of three in the 48 contiguous states and D.C. was $15,067 in 2004 and $15,577 in 2005.

- While 10% of all children in Indiana are uninsured, 14% of children who live in poverty are uninsured. This compares favorably to the national average of 22% of children in poverty who are uninsured.
- Indiana children who live in poverty are more likely to receive health insurance coverage through Medicaid (69%), compared to 59% nationally.

Another concern is people who do not have adequate health insurance coverage, defined as: having insurance all year but inadequate financial protection to meet out-of-pocket medical expenses, having incomes below 200% poverty level, or having high health plan deductibles.

- In a 2003 survey, 12% of adults (16 million people) nationally are underinsured.
  Source: Insured But Not Protected: How Many Adults are Underinsured? Cathy Schoen, Michelle Doty, Sara Collins, and Alyssa Holmgren, Health Affairs Web Exclusive, June 14, 2005 W5-289-W5-302.

Larger employers (those with 50 or more employees) are more likely than their smaller counterparts to provide health insurance to their employees. Similar to employers across the nation, 95% of larger employers offer health insurance.

- In Indiana, smaller firms lag behind national averages in offering health insurance to its employees. In Indiana, 35.5% of firms with fewer than 50 employees offer health insurance, compared to 43.3% nationally.
  Sources: Agency for Healthcare Research and Quality, Center for Cost and Financing Studies. 2003 Medical Expenditure Panel Survey - Insurance Component. Table II.A.2: http://www.meps.ahrq.gov/MEPSDATA/ic/2003/Tables_II/TIIA2.pdf

As health care costs rise, fewer employers will be able to offer health insurance to their employees.

- Health insurance premiums for families who have insurance through their private employers, on average, are $922 higher in 2005 due to the cost of health care for the uninsured that is not paid for by the uninsured themselves or by other sources of reimbursement.

Source: *Paying a Premium: The Increased Cost of Care for the Uninsured. Families USA, www.familiesusa.org/resources/publications/reports/paying-a-premium-findings.html*

People who lack health insurance are in poorer health, are less likely to receive preventive screenings, are more likely to forgo needed medical treatment, are less likely to adhere to their medical treatments, and have poorer outcomes when diagnosed with an illness.

- In 2005, the cost of providing health care to the uninsured that is not paid out-of-pocket by the uninsured themselves will exceed $43 billion nationally.
- By 2010, projections estimate that Indiana's proportion of the cost of care that the uninsured are unable to pay will be $1.3 billion.

Sources: Institute of Medicine. (2002). Care without coverage: Too little, too late. Washington, DC: National Academy of Sciences.
Paying a Premium: The Increased Cost of Care for the Uninsured. Families USA, www.familiesusa.org/resources/publications/reports/paying-a-premium-findings.html

FOR MORE INFORMATION

The Indiana Family Social Service Administration

Health Insurance for Indiana Families Committee Reports
http://www.in.gov/fssa/programs/chip/insurance/

The Health Insurance for Indiana Families Committee was formed to review and propose strategies for covering the uninsured through no- or low-cost expansions of existing programs or the creation of new options. From 2002-2004, the committee helped oversee the FSSA's Health Resources and Services Administration (HRSA) State Planning Grant to study the uninsured in Indiana and propose coverage options. The committee's recommendations for expanding access and coverage to insurance, as well as an executive summary of the research received can be found on this site.

The Henry J. Kaiser Family Foundation

www.statehealthfacts.org

This site gives comprehensive state information on health status, health coverage and the uninsured, Medicaid and SCHIP, Medicare, health costs and budgets, managed care and health insurance, providers and service use, minority health, women's health, and HIV/AIDS.

The Institute of Medicine

Crossing the Quality Chasm: The IOM Health Care Quality Initiative
http://www.iom.edu/CMS/8089.aspx

The Institute of Medicine (IOM) provides unbiased, evidence-based, and authoritative information and advice concerning health and science policy to policy-makers, professionals, leaders in every sector of society, and the public at large. This first phase of this series addressed the serious nature of the nation's overall health care quality problem, and subsequent publications have focused on how to close the gap between what we know as quality care and what the norm is in practice.

The Heritage Foundation

http://www.heritage.org/Research/HealthCare/index.cfm

This site has a series of reports on Medicaid, Medicare, the uninsured, and state initiatives that have reformed their health care systems.

Urban Institute

http://www.urban.org/health/index.cfm

This site provides a series of reports on health statistics, Medicaid, Medicare, the uninsured, SCHIP, health insurance, and other health-related issues.

Commonwealth Fund

Quality of the US Health Care System
http://www.cmwf.org/publications/publications_show.htm?doc_id=401577

Created by the Commonwealth Fund Commission on a High Performance Health System, the National Scorecard on U.S. Health System Performance is the first-ever comprehensive means of measuring and monitoring health care outcomes, quality, access, efficiency, and equity in one report.

http://www.cmwf.org/statesinaction/
This link provides information from the Commonwealth Fund's "States in Action: A Quarterly Look at Innovations in Health Policy".

The Century Fund

http://www.tcf.org/print.asp?type=NC&pubid=1290

This link provides an opinion piece on reaching the tipping point in universal health care coverage.

Lewin Group

http://www.lewin.com/NewsEvents/Publications/

This link provides reports from different state efforts on various aspects of health care and health care coverage.

A Checklist for Assessing the Impact of Policies and Programs on Families

The first step in developing family-friendly policies is to ask the right questions:

- What can government and community institutions do to enhance the family's capacity to help itself and others?
- What effect does (or will) this policy (or proposed program) have for families? Will it help or hurt, strengthen or weaken family life?

These questions sound simple, but they can be difficult to answer.
The Family Criteria (Ad Hoc) Task Force of the Consortium of Family Organizations (COFO) developed a checklist to assess the intended and unintended consequences of policies and programs on family stability, family relationships, and family responsibilities. The checklist includes six basic principles. These principles serve as the criteria for evaluating policies and programs for sensitivity to and support of families. Each principle is accompanied by a series of family impact questions.
The principles are not rank ordered and sometimes they conflict with each other, requiring trade-offs. Cost effectiveness also must be considered. Some questions are value-neutral and others incorporate specific values. People may not always agree on these values, so sometimes the questions will require rephrasing. This tool, however, reflects a broad nonpartisan consensus, and it can be useful to people across the political spectrum.

For the questions that apply to your policy or program, record the impact on family well-being.

Principle 1. Family support and responsibilities.

Policies and programs should aim to support and supplement family functioning and provide substitute services only as a last resort.

Does the proposal or program:

- support and supplement parents' and other family members' ability to carry out their responsibilities?
- provide incentives for other persons to take over family functioning when doing so may not be necessary?
- set unrealistic expectations for families to assume financial and/or caregiving responsibilities for dependent, seriously ill, or disabled family members?
- enforce absent parents' obligations to provide financial support for their children?

Principle 2. Family membership and stability.

Whenever possible, policies and programs should encourage and reinforce marital, parental, and family commitment and stability, especially when children are involved. Intervention in family membership and living arrangements is usually justified only to protect family members from serious harm or at the request of the family itself.

Does the policy or program:

- ❖ provide incentives or disincentives to marry, separate, or divorce?
- ❖ provide incentives or disincentives to give birth to, foster, or adopt children?
- ❖ strengthen marital commitment or parental obligations?
- ❖ use appropriate criteria to justify removal of a child or adult from the family?
- ❖ allocate resources to help keep the marriage or family together when this is the appropriate goal?
- ❖ recognize that major changes in family relationships such as divorce or adoption are processes that extend over time and require continuing support and attention?

Principle 3. Family involvement and interdependence.

Policies and programs must recognize the interdependence of family relationships, the strength and persistence of family ties and obligations, and the wealth of resources that families can mobilize to help their members.

To what extent does the policy or program:

- ❖ recognize the reciprocal influence of family needs on individual needs, and the influence of individual needs on family needs?
- ❖ recognize the complexity and responsibilities involved in caring for family members with special needs (e.g., physically or mentally disabled, or chronically ill)?
- ❖ involve immediate and extended family members in working toward a solution?
- ❖ acknowledge the power and persistence of family ties, even when they are problematic or destructive?
- ❖ build on informal social support networks (such as community/neighborhood organizations, religious communities) that are essential to families' lives?
- ❖ respect family decisions about the division of labor?
- ❖ address issues of power inequity in families?
- ❖ ensure perspectives of all family members are represented?
- ❖ assess and balance the competing needs, rights, and interests of various family members?
- ❖ protect the rights and safety of families while respecting parents' rights and family integrity?

Principle 4. Family partnership and empowerment.

Policies and programs must encourage individuals and their close family members to collaborate as partners with program professionals in delivery of services to an individual. In addition, parent and family representatives are an essential resource in policy development, program planning, and evaluation.

In what specific ways does the policy or program:

- ❖ provide full information and a range of choices to families?
- ❖ respect family autonomy and allow families to make their own decisions? On what principles are family autonomy breached and program staff allowed to intervene and make decisions?
- ❖ encourage professionals to work in collaboration with the families of their clients, patients, or students?
- ❖ take into account the family's need to coordinate the multiple services they may require and integrate well with other programs and services that the families use?
- ❖ make services easily accessible to families in terms of location, operating hours, and easy-to-use application and intake forms?
- ❖ prevent participating families from being devalued, stigmatized, or subjected to humiliating circumstances?
- ❖ involve parents and family representatives in policy and program development, implementation, and evaluation?

Principle 5. Family diversity.

Families come in many forms and configurations, and policies and programs must take into account their varying effects on different types of families. Policies and programs must acknowledge and value the diversity of family life and not discriminate against or penalize families solely for reasons of structure, roles, cultural values, or life stage.

How does the policy or program:

- ❖ affect various types of families?
- ❖ acknowledge intergenerational relationships and responsibilities among family members?
- ❖ provide good justification for targeting only certain family types, for example, only employed parents or single parents? Does it discriminate against or penalize other types of families for insufficient reason?
- ❖ identify and respect the different values, attitudes, and behavior of families from various racial, ethnic, religious, cultural, and geographic backgrounds that are relevant to program effectiveness?

Principle 6. Support of vulnerable families.

Families in greatest economic and social need, as well as those determined to be most vulnerable to breakdown, should be included in government policies and programs.

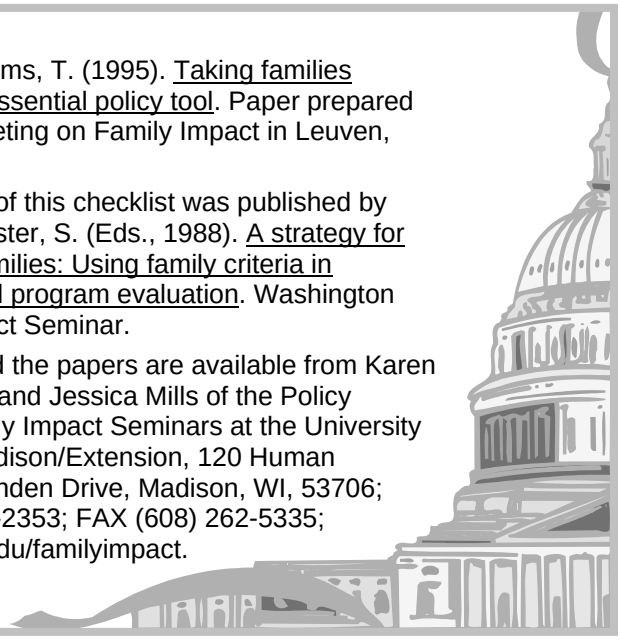
Does the policy or program:

- ❖ identify and publicly support services for families in the most extreme economic or social need?
- ❖ give support to families who are most vulnerable to breakdown and have the fewest resources?
- ❖ target efforts and resources toward preventing family problems before they become serious crises or chronic situations?

Adapted from Ooms, T. (1995). Taking families seriously as an essential policy tool. Paper prepared for an expert meeting on Family Impact in Leuven, Belgium.

The first version of this checklist was published by Ooms, T., & Preister, S. (Eds., 1988). A strategy for strengthening families: Using family criteria in policymaking and program evaluation. Washington DC: Family Impact Seminar.

The checklist and the papers are available from Karen Bogenschneider and Jessica Mills of the Policy Institute for Family Impact Seminars at the University of Wisconsin-Madison/Extension, 120 Human Ecology, 1300 Linden Drive, Madison, WI, 53706; phone (608) 263-2353; FAX (608) 262-5335; http//sohe.wisc.edu/familyimpact.



Sponsoring Organizations and Descriptions

The Center for Families at Purdue University focuses on improving the quality of life for families and strengthening the capacity of families to provide nurturing environments for their members. To accomplish this, the center works with four important groups whose efforts directly impact quality of life for families: educators, human service providers, employers, and policymakers. With informed sensitivity to family issues, these groups have the power to improve the quality of life for families in Indiana and beyond.

The Department of Family Relations at Ball State University includes a variety of majors from interior design and residential property management to nutrition and marriage and family relations. We offer courses in family relations, infant/toddler, child development, marriage, life-work management, family stress and family policy. Students are also required to take interdisciplinary coursework. In addition, students are required to complete a 400 hour internship at a family or child related facility which also includes government internships. Our curriculum has been designed to fulfill the academic requirements to become a Certified Family Life Educator (CFLE). CFLEs have received academic training in ten substantive areas related to the family, one of which is family policy, and are certified by the National Council of Family Relations, a professional organization.

The purpose of the Family Service Council of Indiana is to represent families and respond to their needs by strengthening member agencies and creating alliances to promote excellence in advocacy and service for families throughout Indiana. With 12 member agencies, the Family Service Council serves the citizens of nearly 60 Hoosier counties. FSCI member agencies offer a wide variety of programs, including counseling, sexual abuse assessment, homemaker services, children's programs, services for victims of domestic violence, as well as many other diverse programs for over 90,000 individuals, approximately 80 percent of whom are low income. These services are offered regardless of race, creed, or color on a sliding fee scale supported by local United Ways and governmental grants. Statewide, FSCI members employ approximately 1,000 people with various professional degrees and specific skills to assist clients in resolving their life issues. The total operating budgets for these member agencies range from $220,000 to $3.5 million.

The members of the Indiana Association of Family and Consumer Sciences focus on an integrative approach to the relationships among individuals, families and communities as well as the environments in which they function. The association supports the profession as it provides leadership in: improving individual, family and community well being; impacting the development, delivery and evaluation of consumer goods and services; influencing the creation of public policy; and shaping social change. The Indiana Association is part of the American Association of Family and Consumer Sciences.

The Indiana Association of Marriage and Family Therapy is part of the American Association of Marriage and Family Therapy. Since the founding of AAMFT in 1942, they have been involved with the problems, needs and changing patterns of couples and family relationships. The association leads the way to increasing understanding, research and education in the field of marriage and family therapy, and ensuring that the public's needs are met by trained practitioners. The AAMFT provides individuals with the tools and resources they need to succeed as marriage and family therapists.

The Institute for Family and Social Responsibility is a joint venture of the Schools of Social Work and Public and Environmental Affairs designed to bring the resources of Indiana University researchers to the assistance of public policy makers on issues impacting Hoosier families. The Institute's mission is to bring together the resources of citizens, governments, communities and Indiana University to better the lives of children and families. Ongoing research projects have examined the impacts of welfare reforms, the efficiency of the township system of government, the adequacy of child support guidelines, community responses to the Temporary Assistance to Needy Families legislation, performance contracting for intensive family preservation services, and AIDS education for incarcerated youth. The Institute serves as the National Child Support Enforcement Research Clearinghouse.

It is the mission of the Indiana Extension Homemakers Association® to strengthen families through continuing education, leadership development, and volunteer community support. We share information on new knowledge and research with our members and communities, promote programs on developing skills and family issues, and we support projects which help children and families in today's world.

Purdue Extension Consumer and Family Sciences provides informal educational programs that increase knowledge, influence attitudes, teach skills, and inspire aspirations. Through the adoption and application of these practices, the quality of individual, family, and community life is improved. Consumer and Family Sciences Extension is a part of the mission of the College of Consumer and Family Sciences at Purdue University and the Purdue Extension Service

Indiana Youth Institute promotes the healthy development of children and youth by serving the institutions and people of Indiana who work on their behalf. It is a leading source of useful information and practical tools for nonprofit youth workers. Secondary audiences include educators, policymakers, think tanks, government program officials, and others who can impact the lives of Hoosier children. In addition, it is an advocate for healthy youth development on the local, state, and national level.

The Health Insurance Landscape

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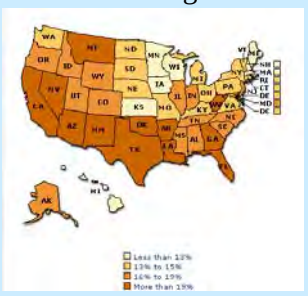
The Uninsured
How Big is the Problem?



Indiana: 16%
U.S.: 18%
Max: Texas 27%
Min: Iowa and Minnesota 10%

Uninsured Percentages by State
Nonelderly (0-64) 2005

- "The Kaiser Family Foundation, statehealthfacts.org. Data Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2005 and 2006 Current Population Survey (CPS: Annual Social and Economic Supplements).

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Major Sources of Coverage
Percentage of Nonelderly 2005

	Employer	Individual	Medicaid/ SCHIP
Indiana	65%	4%	13%
U.S.	61%	5%	14%

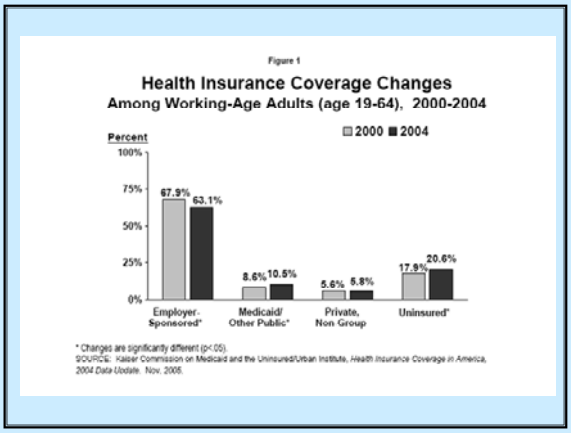
- "The Kaiser Family Foundation, statehealthfacts.org. Data Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2005 and 2006 Current Population Survey (CPS: Annual Social and Economic Supplements).

4

Paying for Employer-Sponsored Health Insurance
Premiums for Family Coverage

	Indiana	U.S.	Min	Max
% paid by employer	79%	76%	67% MS	84% NJ
% paid by employee	21%	24%		
Total premium	$9,869	$10,006	$7,800 ND	$11,742 DC

The Kaiser Family Foundation, statehealthfacts.org. Sources: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2004 Medical Expenditure Panel Survey (MEPS) -Insurance Component. Tables II.C.1, II.C.2, II.C.3 available at: Medical Expenditure Panel survey (MEPS), July 2006.



5

Some Ideas that Seemed Good But Have Not Worked

- Subsidies
  - to Workers Already Offered Employer Insurance.
  - to Small Employers Not Offering Insurance.
- Small Group Reforms
  - State policies designed to increase access and affordability of insurance for workers at small firms.

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Subsidies to Workers

- In 2004, 20% of workers eligible for offered employer health insurance did not enroll.
  - 23% in Indiana
- Research shows that these workers are not likely to enroll voluntarily even with sizeable subsidies.
  - 75% subsidies increased participation by 3 pct points.

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Subsidies to Firms

- 45% of private establishments and 65% of establishments with < 10 workers do not offer HI to their workers.
  - 49% and 75% in Indiana
- Studies have found only a small impact on firm offer rates of moderate to large subsidies.
  - "few takers" for a 50% subsidy in New York State.

8

Small Group Reforms

- Problem most severe for small firms
  - Private sector establishments offering health insurance
    - Only 43% with < 50 employees
    - 95% of those with > 50 employees
- Many reform efforts are aimed at small firms
  - Small group reforms – early 1990's
    - Guaranteed issue
    - Guaranteed renewal
    - Rating restrictions

9

Small Group Reforms

- Research on effect of these policy reforms shows very little or no increase in the number of insured workers after implementation.
  - In fact, some evidence of a decrease in coverage.
- Unintended Consequence
  - Premium increases

10

Beware of Unintended Consequences

- Inadvertently making health insurance more expensive.
- Changing the risk pool.
- Subsidizing too many of those who would have bought insurance anyway.

11

Voted Most Likely to Succeed

- Public Insurance Expansions
- Individual Mandate

12

Public Expansions – Recent History

- SCHIP/Medicaid expansions have increased coverage, especially for children.
- More expansive eligibility for children allowed SCHIP/Medicaid to offset recent declines in employer sponsored coverage for children.
  - Indiana: Low Income Children (< 200% pov) 2000-2004
    - 10 point decline in employer sponsored coverage
    - But 9.9% DECREASE in uninsured low-income children due to 22.7 point increase in coverage by Med/SCHIP

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Voted Most Likely to Succeed Public Insurance Expansions

- Builds on current public programs
  - Infrastructure already in place.
  - Incremental reform that could be implemented relatively quickly.
- Could expand eligibility to some targeted groups:
  - Extend SCHIP eligibility to parents in all states.
  - Extend Medicaid to more poor adults.
  - Allow 60-64 year olds to buy into Medicare or Medicaid.
- Drawbacks:
  - Full cost borne by government.
  - Does not achieve universal coverage.

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Individual Mandate

- Individual Mandate
  - Legal requirement that everyone obtain health insurance coverage.
  - Usually includes sliding scale premiums or some assistance for the low-income.
  - Often discussed in a framework that encourages development of "bare-bones" or catastrophic coverage (to keep premiums lower).
- Politically Feasible (outside Mass.) ?
  - Individual responsibility (rather than employer responsibility) may make it more politically feasible.
  - Model of mandated auto insurance.
  - Has seen some bipartisan support but, even those who support it do not necessarily agree that it is politically feasible.

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Voted Most Likely to Succeed Individual Mandate

- Has Potential to Achieve Universal Coverage
  - Doesn't target only employed or only low-income.
- Alleviates problem of uncompensated care.
- Creates a more stable risk pool in individual and small group markets.
- Those who can afford it bear their own costs.
- Drawbacks:
  - Political objections.
  - Enforcement difficult?
  - What would be the public cost?

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Keep on the Radar Screen

- Reinsurance
  - Government pays most costs of those with highest 1% of health expenditures.
  - Alleviates insurers' need to avoid high risks.
  - Meant to increase access in small group and individual market and keep premiums lower.
- "Buy-in" to Federal or State Employee plans
  - Others could participate or "buy in" to these plans.
  - Large risk pool.
  - Wide variety of plans; many choices.

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Conclusions

- These are promising options.
- Will probably take a multi-pronged approach.
- Some combination of those "voted most likely to succeed" and other smaller complementary reforms such as reinsurance.
- Also strong political will.

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Sources

- Buchmueller, Thomas and John DiNardo. 2002. "Did Community Rating Induce an Adverse Selection Death Spiral? Evidence from New York, Pennsylvania, and Connecticut." American Economic Review 92:1, pp. 280-294.
- Chernew, Michael, Kevin Frick, and Catherine McLaughlin. 1997. "The Demand for Health Insurance Coverage by Low-Income Workers: Can Reduced Premiums Achieve Full Coverage?" Health Services Research 32(4):453-470.
- Gruber, Jonathan and Ebonya Washington. March 2005. "Subsidies to Employee Health Insurance Premiums and the Health Insurance Market." March 2005. Journal of Health Economics, vol. 24, no. 2, pp. 253-76
- Marquis, Susan and Stephen H. Long. 2001. "To Offer or Not to Offer: The Role of Price in Employers' Health Insurance Decisions." Health Services Research 36:5, p. 935-958.
- Monheit, Alan and Barbara Steinberg Schone. "How Has Small Group Reform Affected Employee Health Insurance Coverage?" Journal of Public Economics, 2004, 88(1-2): 237-254.
- Simon, Kosali. 2005. "Adverse Selection in Health Insurance Markets? Evidence from State Small-Group Health Insurance Reforms." Journal of Public Economics 89, pp. 1865-1877.
- Thorpe, K. E., Hendricks, A., Garnick, D., Donelan, K., Newhouse, J. 1992. Reducing the Number of Uninsured by Subsidizing Employment-Based Health Insurance. Journal of the American Medical Association 19, 945-48.
- Zuckerman, Stephen and Allison Cook. August 2006. "The Role of Medicaid and SCHIP as an Insurance Safety Net." Urban InstituteWorking Paper.

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Links

- http://www.statehealthfacts.org
- http://www.statecoverage.net/index.htm
- http://www.citizenshealthcare.gov/

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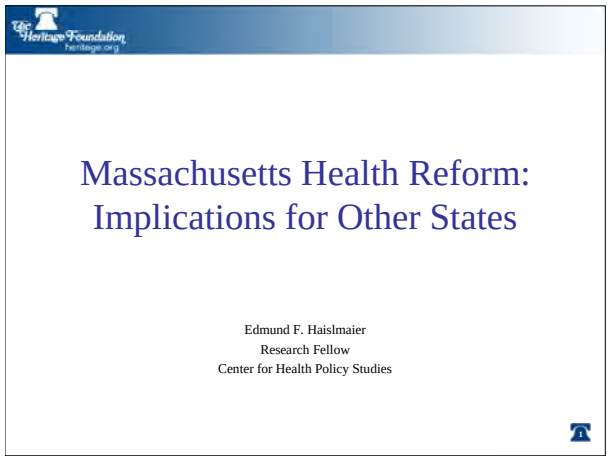
One State's Bold Initiative

Ed Haislmaier

The Heritage Foundation
Washington D.C.



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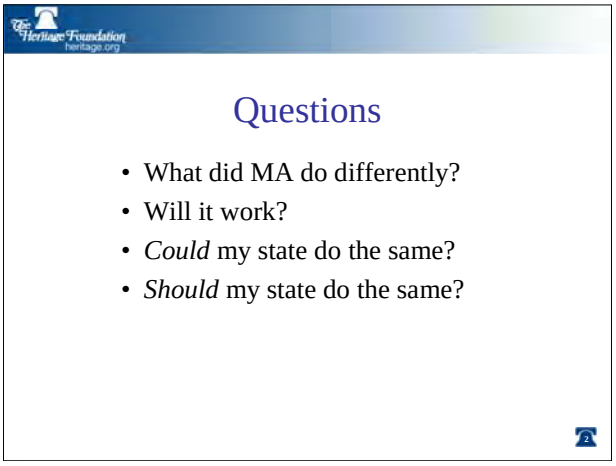

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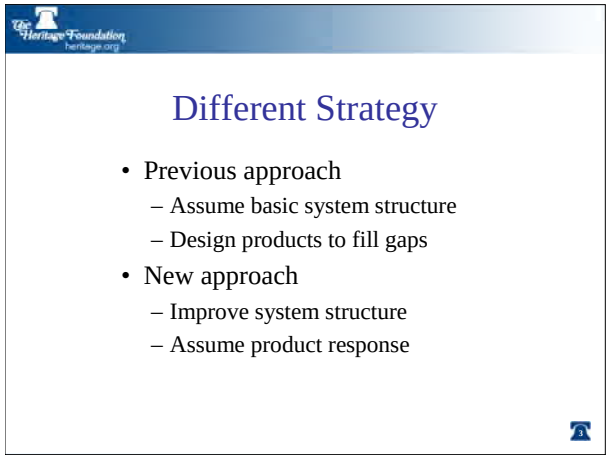

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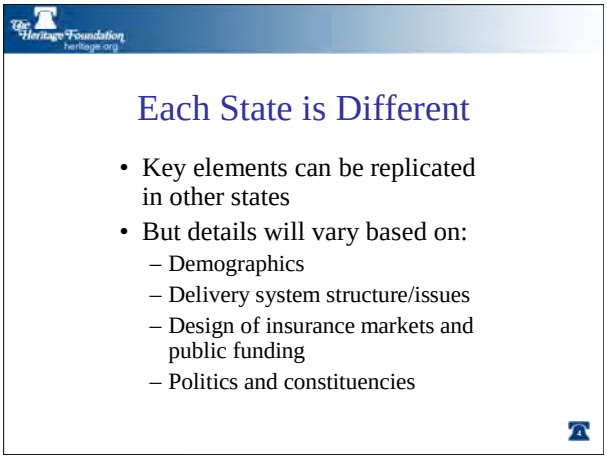

4

Two Key Elements

- Restructure insurance markets
  - Create true portability and continuity of coverage
- Restructure public subsidies
  - Shift from provider-focus to consumer-focus

5

"Connector"

- A clearinghouse/exchange
- Standardizes administration, not products
- Not the product regulator
- Not a purchaser
- Content: state regulated, portable, individual coverage
- Wrapper: 'employer-group plan' status = tax-free premiums

6

"Commonwealth Care"

- Premium support for working families <300%FPL & not categorically eligible
- Uses existing uncompensated care funding
- Buys same portable, private coverage
- Other states could expand to include some of the categorically eligible

7

Mandates?

- Supplement, not starting point
- Employers - With Sec. 125 plans no need for minimum contribution
- Individuals - A rating trade-off
  - Broad variation = less need to require coverage, more need for risk adjuster
  - Little or no variation = more need to require coverage, less need for risk adjuster
- Increases support for funding shift?

8

Synergistic Reform

- Connector improves coverage continuity and plan competition
- Connector offers administrative platform for premium support
- Premium support shifts focus from providers to consumers
- New incentives to seek value from plans and providers
- Value seeking = cost ⇩ benefit ⇧

9

Coverage Instability Problem

Coverage Patterns of Uninsured (48 month period)	Number (millions)	Share	Potential to Solve
Repeatedly uninsured	28.2	33%	Easiest (62%)
One coverage gap	24.4	29%	
Transition in or out of coverage	17.2	20%	Varied
Temporary coverage	4.8	6%	Hardest (18%)
Always uninsured	10.1	12%	
TOTAL	84.8	100%	

Source: 1996-1999 SIPP data as reported in: P. F. Short and D. R. Graefe, "Battery-Powered Health Insurance? Stability In Coverage Of The Uninsured," *Health Affairs* 22, no.6 (2003): 244-255.

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Implications

"The overarching implication of these data is that stability merits consideration as an explicit and important goal of coverage reforms."

"Continuity of coverage is also likely to facilitate continuity of care."

"One can imagine arrangements where employers might sometimes contribute to the cost, when a person's employment situation warrants, without actually administering the coverage."

P. F. Short and D. R. Graefe, "Battery-Powered Health Insurance? Stability In Coverage Of The Uninsured," *Health Affairs* 22, no.6 (2003): 244-255.

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Subsidy Implications

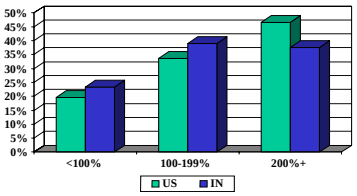
Coverage Patterns of Uninsured (48 month period)	Income as % of FPL			
	<100	100-199	200-399	400+
Repeatedly uninsured	8.0%	12.1%	10.1%	3.0%
One coverage gap	4.5%	7.1%	11.5%	5.7%
Transition in or out of coverage	3.3%	6.7%	7.4%	2.9%
Temporary coverage	1.2%	2.4%	1.7%	0.4%
Always uninsured	2.7%	5.4%	3.0%	0.8%

Little or none = 41%	Some = 43%	Substantial = 16%

12

The Indiana Difference

Relative Distributions of the US and IN Uninsured Populations by Family Income as Percent of FPL



Source: US Data derived from Survey of Income and Program Participation, 1996-1999 panel. IN data derived from 2003 Health Insurance for Indiana's Families Survey.

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IN Subsidy Implications

Coverage Patterns of Uninsured (48 month period)	Income as % of FPL		
	<100	100-199	200+
Repeatedly uninsured	9.6 %	14.0%	11.2%
One coverage gap	5.4%	8.2%	12.7%
Transition in or out of coverage	4.0%	7.8%	8.2%
Temporary coverage	1.4%	2.7%	1.9%
Always uninsured	3.3%	6.2%	3.4%

Little or none = 32%	Some = 49%	Substantial = 19%

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Conclusions

- The more people that never lose coverage, the fewer the uninsured.
- Covering the remaining 'hard to insure' becomes easier and cheaper.
- More stable health care financing is the precondition for realigning system incentives toward better value and outcomes.

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