Policy Options for Expanding Health Insurance Coverage in Wyoming

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In the wake of the failure of the Clinton Health Security Act in 1994, efforts to move towards universal health insurance coverage at the federal level have been largely dormant for the past decade. Major health reforms have started to percolate upwards from the states, however. Numerous states have introduced major health reform proposals, and several have implemented them. These approaches range from large expansions in public insurance (such as in Illinois) to subsidies to employers and employees (such as in Maine) to new insurance pools with large subsidies for low income populations and an individual mandate (Massachusetts, California). These efforts have shown that states can move forward on their own to provide the health insurance coverage so needed by their citizens.

While Wyoming is the smallest state in the nation, the share of its non-elderly population that is uninsured (17%) is equal to the national average. This means that almost 100,000 state residents lack the health insurance that is vital to both income security and health maintenance. Thus, it is important for the state to consider as well approaches to dramatically increasing insurance coverage within its borders. Wyoming faces unique challenges, particularly due to its very low population density in most of the state. But the general principles of health insurance coverage expansion are similar to other states.

In this report, I discuss options that the state of Wyoming can consider as it considers dramatically expanding the share of its population with insurance. There are a very wide range of options to consider, with correspondingly varying impacts on the change in insurance coverage. The first critical step for the state is to decide whether it is

prepared to inject significant public dollars into this effort. If so, there are a variety of routes that can be followed to raise insurance coverage by a large margin.

I. Background on Wyoming

Wyoming is a very typical state in many aspects of its insurance market. The share of its population with employer-provided insurance coverage, 60%, is only slightly below the national average of 62%, while the share that individually purchase insurance coverage, 10%, is somewhat higher than the national average of 7%. Coverage by public insurance by Medicaid, at 12% of the population, is only slightly below the national average, while the share uninsured, as noted above, is right at the national average.

Government policy towards insurance coverage in the state also mirrors basic national trends. Children are eligible for insurance coverage up to twice the poverty line, which is typical in most states under the S-CHIP expansions; parents are not eligible, however, as they now are in a number of other states.

The distribution of age and incomes in the state are fairly similar to the rest of the country. Median family income, at $41,500, is only slightly below the national average of $43,300. The share of the population that is below 18 (23%) is also slightly below the national average (25%), but the share of the population that is over 64 is almost identical (12% both locally and nationally).

In other respects the state is significantly different. The most important for our purposes is the structure of medical markets. Managed care penetration is only about a tenth as high as the nationwide average. This may be due to the difficulty of putting

together provider networks given the low choices of providers faced by many residents: there are only 0.009 physicians per square mile, compared to 0.0202 nationwide.

II. Incremental Options

As noted above, the first question the state must ask as it considers health insurance reform is whether it wants to use an incremental approach, minimizing the risk to the state budget, or a more aggressive approach with more state spending. The actual effects of the alternatives discussed in this report will be revealed by the modeling I will do later in this contract. But the trade offs between these approaches will be discussed in this report.

I begin by considering some "incremental" reforms, changes to the system that will have little or modest government cost. I then move on to consider more fundamental, and costly, reform options

Background: Targeting and Efficiency

Given the budgetary limitations on any public approach to expand health insurance coverage, a key concept that drives reform is the *efficiency* of the policy. There are several different means of defining efficiency, which I will review below, but the basic concept is the extent to which new public spending is directed to those who would otherwise be uninsured, as opposed to "buying out the base" of existing insured individuals.

The issue that is central to all of these definitions is *targeting*. If individuals were indelibly labeled as "insured" or "uninsured", then the government could easily target

new tax subsidies to those labeled uninsured, with no spending on those labeled insured. In fact, this is not the case: insurance status is a choice of the individual, and can respond to government policy in a way which causes the policy to have lower efficiency.

It is useful to think about the uninsured as tuna and those who already have insurance as dolphins. The goal of environmentally conscious fishermen is to catch as many tuna as possible in their nets, while minimizing the number of dolphins who are caught by those nets (which happens since tuna and dolphins swim together in the ocean). If the uninsured tunas were swimming in a separate ocean than the insured dolphins, the problem would be minimized. And if the uninsured tunas greatly outnumbered the insured dolphins, then there would also be a minimal dolphin catch. But, in reality, the 100,000 uninsured tunas in Wyoming mostly swim in a part of the ocean where there are 400,000 insured dolphins, making it difficult if not impossible for policymakers to design insurance nets to capture the tuna without pulling in the much more numerous dolphins.

Any policy to expand insurance coverage faces three potential sources of inefficiency. The first is spending on those who already have coverage through the subsidized form of insurance. Consider tax subsidies for the purchase of insurance in the individual market. The group that will benefit most clearly from these subsidies is those already holding purchasing insurance in this market, for whom this is just a pure income transfer. Yet the use of subsidies by this group does nothing to reduce the number of the uninsured.

The second is the crowd-out of other forms of insurance through subsidizing a particular form of insurance. For example, when the government expands public insurance, it can lead those with group insurance to move to move to public insurance,

either by their decision (switching out of employer-provided insurance) or by their employer's decision (dropping the offering of insurance at the firm).

The third source of inefficiency is the possible reduction in coverage for those who are insured before the policy is put into place. For example, suppose that a firm has a workforce that is predominantly, but not universally, eligible for expanded public insurance. This firm might decide to stop offering health insurance, since the majority of its employees can use public insurance instead. The minority of employees that cannot use the credit is then out of luck, however, since they have lost their employer insurance with no public alternative, and these individuals may become uninsured. This rise in uninsurance offsets the reductions in the ranks of the existing uninsured, reducing the efficiency of the program by raising spending per newly insured person.

Expanded Public Insurance Eligibility

It is very clear from past research (and past results using my model) that if the state's goal is to cover the most people for the fewest dollars, the best route to go is to expand entitlements for public insurance to low income residents now not eligible. Public insurance eligibility expansions are the most efficient source of increasing insurance coverage for two reasons. First, they are very targeted, in that they are aimed at the lowest income groups in society. Second, they avoid the first source of inefficiency above, since there is no incremental spending on those already covered by public insurance.

By the logic of targeting, the most efficient public insurance expansions are those aimed at the very lowest income groups: poor adults. Children are already entitled to

public insurance up to twice the poverty line, while adults are not entitled (unless disabled) at any income level. Moreover, covering parents can help address an important shortcoming of existing expansions to children, which is limited take-up of the insurance entitlement. When entire families are covered, take-up is much higher. Thus, expanding coverage to low income adults would provide a much larger "bang for the buck" than further expansions for children.

Tax Credits to Individuals

Another alternative that is very popular at the federal level is to provide tax credits to individuals to purchase health insurance. These credits come in two flavors. The first is credits that are only applicable to the non-group market; individuals with employer insurance are not eligible for such credits. Such an approach has been shown in previous analyses to be very expensive per person newly covered, however. Given the very high cost of insurance in the individual market, such tax credits will only be taken up by uninsured individuals if they are very large. Thus, if credits are modest (e.g. less than 50% of the full cost of non-group insurance), then they will be used only rarely by the uninsured, and will instead simply serve as a transfer to those already using the non-group market (the first type of inefficiency noted above). If credits are large enough to be used by the uninsured, however, then those who now have group insurance may find it attractive to leave those group arrangements to take this large subsidy instead (the second and third types of inefficiency noted above).

Another frequently suggested option is to provide tax credits to employees to enroll in their existing employer-provided insurance. This is an attractive option, in

principle, since it appears to grab the "low-hanging fruit": those individuals who already have insurance available but are not enrolled. In practice, however, this is a very expensive option for two reasons. First, it is very poorly targeted, in that the vast majority of individuals offered employer insurance are actually insured, so providing a subsidy to employees will mostly subsidize those already insured. Among all employees who are offered insurance, 93% are insured (either through that employer or some other source), so that more than 90% of a subsidy to employees to take up insurance would accrue to those already enrolled. Even among those below the poverty line who are offered insurance, 75% are insured; for those between 100 and 200% of the poverty line, 87% are insured. Second, a clear finding of past literature has been that those who are offered but uninsured are not very price responsive to additional subsidies. This should not be surprising; these individuals have already turned down heavily subsidized employer insurance, so they clearly do not value coverage. Taken together, these two facts imply that subsidizing employees to take up their employer coverage is a very inefficient use of public dollars.

In any case, neither of these options is really available to Wyoming since the state does not have an income tax system. Thus, there is no ready way to offer tax subsidies to individuals to purchase insurance. Thus, these approaches are not in the near term portfolio of options for the state.

Tax Credits to Employers

A more promising tax credit approach is to subsidize employers to offer health insurance. Most of the problem of uninsurance in the United States arises from

individuals not having access to employer-provided insurance; conditional on having access, uninsurance is modest.

Such a tax credit must be tightly targeted, however. Forty-one percent of firms in Wyoming, representing 73% of employees, already offer health insurance, so that if a broad employer credit is offered it will once again run into the problem of poor targeting and high cost per newly insured. At the same time, only 20% of small (1-10 employees) employers, representing 29% of employees, offer health insurance. Thus, a tax credit focused on small firms will be much more efficiently targeted. Moreover, within small firms, insurance offering is also closely related to average wage levels in the firm; high wage small firms (law offices or physician practices) are much more likely to offer than low wage small firms (auto body shops or convenience stores). Thus, the most efficient design would be to target tax credits by both employer size and average wage levels.

Existing research suggests that small employers are fairly price sensitive in their decision to offer health insurance. Thus, by targeting credits to small and low wage firms, they can effectively promote employer provision of insurance.

III. Fundamental Reform Options

In this section, I discuss moving beyond incremental reform to more fundamental reform options. In this context, there are really three major questions to answer:

Pooling: The efficient provision of insurance requires large pools of participants that are created independently of health status. Absent such pools, insurers will be reluctant to offer insurance, or will do so only at very high prices, for fear of adverse selection and

high cost exposure. The majority of Wyoming residents can access insurance through such pools, either through large firms, or publicly-provided insurance. But most of the uninsured do not have access to any such pooling mechanism (for example, most uninsured do not work for an employer that offers insurance). These individuals face prices that are much higher than are available in the group market. Moreover, without guaranteed issue or rate regulation, these individuals are subject to losing their insurance or seeing dramatic price increases if they get sick, which defeats the whole purpose of insurance.

Solving the problem of the uninsured requires developing some new pooling mechanism, either through government insurance, or through private insurance pools such as that used by federal employees. The success of attempts to create a new pool will depend on its scale; existing attempts to create state-level pools for small businesses have generally failed because they did not attract a sufficient number of enrollees to deal with concerns about adverse selection and to spread administrative costs.

Affordability: Health insurance is expensive. In 2007, the typical employer-provided insurance plan in Wyoming will cost about $4500 per individual and $12,000 for a family. For a family of four with income of $40,000 (200% of the poverty line), for example, family coverage would cost about 30% of family income, a huge share of income to devote solely to health care. What is an “affordable” level of health insurance spending? There is no right answer, but these high costs highlight the fact that it is impossible for the government to substantially reduce the number of uninsured individuals without providing large subsidies to low-income groups to cover those costs.

Mandates: Even large subsidies to health insurance coverage will not be sufficient to end the problem of uninsurance. As noted above, many of the uninsured are today eligible for either free public insurance or highly subsidized employer-provided insurance and still do not take it up. To come close to full insurance in Wyoming would require a *mandate*, a requirement on employers to offer insurance or on individuals to obtain some type of insurance coverage. This mandate would be similar to auto insurance in most states, where individuals are required to have insurance if they want to drive a car.

The Massachusetts Model

A good starting point for thinking through these issues is the model of fundamental reform adopted in Massachusetts.

Pooling Mechanism: Massachusetts' reform addressed problems of pooling in two ways. First, the state merged its small group and non-group markets, requiring common rates in both markets, and limiting rating variation in both markets to a 2:1 band on age/sex, with no adjustments allowed for health status (and with guaranteed issue). Second, the state set up a new pooling mechanism, the Connector, which will provide a forum for individuals and small groups to purchase insurance in a large group-like environment. All large insurers (more than 5000 lives) in the state are required to offer plans through the Connector, so that workers in small firms (who are typically offered only one plan to choose from by their employers) and individuals have a wide range of choices of insurance plans. But the Connector itself has no special privileges in the market; it must

compete with existing distribution channels on an even footing, and prices charged inside and outside of the Connector must be identical. Its main advantage, therefore, is the ability to provide a convenient shopping forum for small firms and individuals.

Affordability: The Massachusetts legislation specified that the state would pay the full cost of a comprehensive package of benefits for those below the poverty line (roughly $10,000 for a single and $20,000 for a family of four). The legislation then stated that subsidies should be provided between 100% and 300% of the poverty line, but did not specify the level of those subsidies. The Connector Board (of which I am a member) voted this past summer to impose charges of $18 to $106 per month per adult, rising with income, in this range. Children up to 300% of the poverty line were made eligible for free public insurance under the legislation.

While this approach has solved problems of affordability below 300% of the poverty line, important problems remain above that level. The typical family insurance plan in Massachusetts costs over $12,000 per year; that is more than 20% of family income at 300% of the poverty line, and is clearly unaffordable. Thus, the legislation includes an "affordability loophole": the mandate is only imposed on those for whom insurance is deemed "affordable". The definition of "affordable" will be decided by the Connector Board later this Spring.

This decision will have two key components: the minimum level of insurance coverage which is mandated for individuals, and the quantification of affordability. There is a natural tradeoff between these. The more generous is the mandated minimum insurance, the more costly it will be, and therefore the less affordable for middle-income

individuals. While the decision on affordability standards has not yet been made, the board has laid out some principles for minimum insurance levels. First, insurance should cover all medical services without limits – that is, insurers cannot place lifetime limits on expenditures or per visit limits on covered hospital costs. Such limits depart from real insurance by placing the individual at risk for very high costs. The board seems to have agreed at this point as well on a maximum level of out of pocket spending for individuals of $5000 and for families of $10,000. Finally, the board has agreed that some care should be provided up front, before any deductibles are applied, to encourage appropriate medical care. We are currently contemplating a plan with generic drug coverage and 2 physician visits at minimal copays, to encourage appropriate utilization. Such a plan would cost roughly 60% as much as the generous insurance plan.

Mandate: The state has mandated that, as of July 1, 2007, all individuals must have insurance coverage at least as generous as the minimum standards noted above. The enforcement of this mandate is through financial penalties. For the first six months, the financial penalty is a small one: the loss of the individual exemption on the state income tax. But starting in January, 2008, individuals are subject to a tax penalty of one-half of the cost of the minimum insurance plan, so that their choice will either be to obtain insurance coverage or pay one-half of the cost in penalty.

What are the Moving Pieces?

Relative to the Massachusetts example, there are a large number of moving pieces that can be reconfigured to meet the needs of Wyoming.

Pooling Mechanism: There are a wide variety of possible pooling mechanisms for the state. At one extreme, the state could simply improve the pooling features of its existing insurance market. There are several routes to doing so:

- *Regulation in non-group market*. The minimally invasive approach would be to impose guaranteed issue and rate regulations in the nongroup market, such as by restricting the ability of insurers to vary rates by health status. This has the problem that costs, on average, in the nongroup market will rise from such a reform, as insurers must price to cover their costs of sick enrollees. Absent a mandate, this will lead healthy enrollees to drop insurance, so that insurance coverage may not rise. With a mandate, this will raise affordability concerns as it is difficult to mandate that middle-income individuals buy such expensive insurance.
- *Merge small group and non-group insurance markets*: A more aggressive approach is that followed by Massachusetts, which is to merge the small group and non-group markets (incorporating the factors above by imposing small group regulations on the reformed market). Given that the non-group market is relatively large in Wyoming, this would imply a fairly sizeable rate rise in the small group market, and a large rate reduction in the non-group market. Once again, absent a mandate, this would have ambiguous effects on insurance coverage, as rates would rise for some and fall for others. In the context of a mandate, this would provide a broader marketplace with fairer prices for individuals.

- *Expand high-risk pool*. The existing high risk pool serves a small number of Wyoming residents. This could be expanded by further public subsidization of the premiums paid in this risk pool. Unlike the reforms above, this would unambiguously increase insurance coverage by making it more affordable than in the non-group market. But this is also the only of these three options that involves public expenditures. High risk pool expenditures can be quite large given that only the most ill individuals will enroll in the pool. Spending in this area raises the question of whether these expenditures are better devoted elsewhere within health reform, in a way that can more broadly expand coverage to both the healthy and sick.
- *Allow individuals to buy in to state employees plan*: The state already runs the State Insurance Plan for Employees, which offers state employees a choice of four insurance options. Another option is to allow any non-group purchaser to access this pool as well. This would solve many of the problems in the non-group market, but at a cost to either state employees or the state itself through bringing a worse mix of risks into the state program.

At the other extreme, the state could use its public insurance plan as a pooling mechanism by expanding public insurance coverage. Above I discussed the benefits of an incremental expansion in public insurance coverage. A broader expansion would also be possible, for example covering everyone in the state up to 300% of poverty. The problem with this approach is that it creates significant “cliffs”, whereby individuals have complete insurance coverage up to some level, and none thereafter.

Finally, the state could set up a new pooling mechanism such as the Connector through which individuals could purchase insurance in a group-like setting. In such a context, there are a number of difficult decisions to make, such as how much choice to offer individuals across plans, and what minimum standard to set for insurance.

Public Subsidy Levels and Affordability: If Wyoming moves forward with a comprehensive plan to insure much or all of its population, it faces an important problem with respect to affordability I have labeled the "iron triangle" problem. The state ultimately has three mechanisms it can use to ensure that insurance is affordable for its population, and none are ideal. The first is to provide generous public subsidies so that insurance is affordable for all citizens. But this is quite expensive. For example, a typical employer-provided insurance policy in Wyoming will cost about $12,000 for a family in 2007. If "affordable" is deemed to be a family spending less than 10% of its income on health insurance, this would require the insurance costs be subsidized at incomes up to $120,000, or 600% of the poverty line!

The second is to mandate less than comprehensive insurance. As discussed earlier, in Massachusetts the state is contemplating a minimum benefits package that is about 60% as expensive as typical coverage in the state, mostly through having high out of pocket payments. But this approach has the important drawback that individuals may pay less for premium, but they will pay more out of pocket. A difficult question is how those out of pocket payments get factored into affordability discussions. This approach will also raise criticisms from those who believe it is important for insurance to be very comprehensive. In my recent paper for the Kaiser Family Foundation, I show that these

criticisms are not warranted by the evidence, and that insurance with high cost sharing (while allowing some exemptions for preventive care) lowers costs without sacrificing health.

Finally, the most direct means of addressing affordability is to either not have a mandate, or to exclude individuals from the mandate if insurance is "unaffordable". This has the twin disadvantages that insurance coverage increases are mitigated and that any moral imperative for "universal coverage" is lost.

Another issue in affordability is the treatment of those who are offered employer-provided insurance. The subsidies in the Massachusetts plan for those below 300% of the federal poverty line are only available to those who are not offered employer-provided insurance. The Connector board has been given the authority under law to waive this restriction and to allow those with employer-provided insurance available to access these subsidies, bringing with them to the pool their employer contribution (so that the state pays only the costs that remain after counting the employer contribution and the employee premium cost of the new plan). The rationale for doing so is that some low-income individuals who are offered employer-provided insurance might be charged more for such insurance that they would pay as part of the new state program, so that employer-provided insurance might be unaffordable. On the other hand, allowing more individuals into the state-subsidized plan raises costs.

Mandate: The final major issue faced by the state is whether or not to mandate that individuals have insurance coverage (perhaps subject to an affordability "loophole", as discussed above). There are two arguments for mandating insurance coverage. The first

is that it is a social imperative to have all individuals be insured against health risks, both as financial protection and as a means of insuring that they get necessary medical care. The second is financial responsibility. Many individuals who now do not get insured still use the medical system in emergencies, with their costs being paid by others in the form of uncompensated care. A mandate would require that such individuals pre-pay for the medical costs they might ultimately incur.

Such costs, however, are a small fraction of the total cost of insurance that would be paid by healthy individuals who are forced to buy through the mandate. That is, mandating coverage is a means of capturing the health insurance dollars of healthy individuals who are now avoiding the system. For example, in estimates I did for the state of Massachusetts, I found that moving from a system without a mandate (but with a pool and subsidies) to the same system with a mandate raised the number of insured three-fold, but raised costs only by 50%.

By this same token, however, mandates will raise significant opposition from healthy individuals who do not want to be "forced" to buy insurance. The state must weigh the power of those objections against the benefits of spreading medical risk more broadly across the state's population.

IV. Financing

Under most of the options discussed above, significant new public dollars must be injected into the system. In this section, I discuss some of the financing alternatives the state can consider for these new public funds.

Federal Governmental Transfers

The state of Wyoming currently receives a significant amount of federal transfers. A first step in covering the uninsured would be to maximize such federal transfers. A natural means of doing so is to expand public insurance coverage that can be matched at 58% rate by the federal government. Whatever route is pursued by the state, it should be creative in maximizing the ability to draw down federal matching dollars to finance reform.

Uncompensated Care Pool

Hospitals in Wyoming deliver more than $85 million dollars per year in uncompensated care, which amounts to more than 6% of hospital revenues. Available evidence suggests that those costs are passed on to insured patients. In principle, as the state expands insurance coverage, there is less need for such uncompensated care expenditure. Thus, the state could endeavor to recapture those funds to pay for insurance expansion without placing any net burden on the system.

There are a number of means of doing so. Perhaps the most straightforward would be to have an assessment added on to hospital bills that is tied to either (a) reductions in uncompensated care or (b) increases in insurance coverage in the state. The advantage of the former approach is that it is directly tied to hospital financing, but the

disadvantage is that uncompensated care charges are subject to hospital financial reporting, and this reporting can be manipulated to minimize the assessments. Increases in insurance coverage are outside of the hospital's control and therefore might provide a more reliable basis for setting this assessment. A blunter approach, followed by the Governor's reform proposal in California, is simply to levy a new assessment on providers that implicitly offsets their gains from reduced uncompensated care (the proposed levy in California is 2% of gross revenues for physicians and 4% of gross revenues for hospitals).

Employer Assessments

A major issue in state debates over fundamental health reform has been the role of employer financing, either through broad assessments on all employers, or through assessments specifically targeted to employers that do not offer health insurance. This issue is raised in three ways in such debates. First, even rapidly rising insurance costs remain a small share of total payroll, so that relatively modest assessments on the base of payroll in the state could raise much of the funds needed for fundamental reform. Second, there is a fairness argument for assessing employers who don't offer insurance some penalty to level the playing field with employers who do offer insurance. Finally, most reforms of the type contemplated in Massachusetts have the effect of reducing employer-provided insurance, as it is replaced with other pooling mechanisms. An assessment on employers who don't offer insurance could offset that erosion in employer-provided coverage.

At the same time, there are clear arguments against employer assessments. They can be, and will be, attacked as barriers to job growth in the state. In fact, this argument is inconsistent with available economic evidence, which suggests that such assessments would not lead to lower hiring, but rather lower worker wages. Nevertheless, the argument will be made on a jobs basis, and even on a wage basis there is a clear cost to lowering cash compensation. Moreover, assessments just on employers that do not offer insurance are subject to a challenge under the ERISA statutes. This has been a barrier to efforts to tax large employers (fair share or "Wal-Mart" legislation) in states such as Maryland.

If employer assessments are pursued, there will be extensive pressure to exclude small businesses from the assessment; both the assessment in Massachusetts and the proposed assessment in California exclude firms with fewer than 10 employees. This may help politically, but it is very problematic from a policy perspective, for two reasons. The first is equity, there is no reason to strongly favor firms on one side or another of an arbitrary firm cutoff; there are many firms below 10 employees who are high wage firms not struggling to make ends meet. For example, the median earnings of workers in all firms in Wyoming in 2004-2005 was $25,750. The median earnings in firms with fewer than ten employees was lower, at $20,600. Yet a quarter of firms with fewer than ten employees have average earnings of more than $36,000 per year, well above the average for larger firms. It is unclear why those firms should be favored over larger firms simply because they have fewer employees. The second is efficiency. If there is a sharp cutoff in assessments at ten employees, then there will be a great disincentive for firms to hire their tenth employee.

A more sensible structure for assessments would be to levy them on firms equally, or, if concerned about cross-firm equity, based on average payroll (perhaps as well as size). A payroll assessment that gradually rose with both firm size and average payroll could raise sufficient funds without causing either the equity or efficiency problems noted above.

V. Conclusions

The state of Wyoming faces a number of challenges in endeavoring to cover its uninsured population. But these challenges provide opportunity for creative thinking on how to move towards universal coverage within the constraints of the existing political system. The options discussed here can hopefully promote such creative thinking.

I look forward to working with the state as you consider the types of options discussed here. All of the options discussed in this report can be modeled through the micro-simulation modeling I have done for other states, and I would be eager to help explore the best combination of policy options for Wyoming.