

Most think of health reform options in terms of an employer mandate versus the individual mandate. They can be alternative reform models or they can be complementary. I think they have their best impacts when done in complementary fashion. The employer mandate assures that existing financing stays in the system and levels the playing field among all employers, but it lacks the next realistic step to basic coverage for all. The individual mandate assures that individuals enroll in offered employer or public coverage, that individuals without eligibility for public or private coverage actually purchase available and affordable coverage and that transitional coverage is available for those losing employment-based coverage when jobs end or public coverage when income exceeds programs' income limits.

- Who is covered/impacted by an individual mandate and yet would not be reached through an employer mandate? -- The uninsured self-employed, early retirees, college and graduate students, flex workers, those in transitions from job to job or school to work and the unemployed.¹
- Which groups are most likely to have incomes in excess of 300% of FPL and are thus not eligible for premium subsidies in the plans put forth by the Governor and legislative leadership? – Some of the self-employed and the early retirees.
- Which groups have no federal or state tax deductibility for their individual health insurance premiums? -- Early retirees, students, flex workers and the unemployed.

What's wrong with the individual market and what can be done to fix it? The market has no rules assuring the individuals mandated to purchase will actually be able to purchase and insufficient protections that those who have purchased are able to continue their coverage when they become ill and need it.² Too large a share of individual market premiums is used for non-benefit costs and too little to pay for covered benefits.³ Only the self-employed have the tax breaks of tax deductibility to partially offset the costs of their premiums in the individual market. The employment-based markets terminate your coverage when your job ends while the individual market covers you as long as you keep paying your premiums. Average costs of coverage for a given set of benefits are higher in the individual market than in employment-based coverage.

Availability

What fixes are possible and what sense do they make?⁴ One solution contained in the Governor's plan would apply the small business underwriting rules of guaranteed issue and renewal to the individual market; this assures availability and continuity of coverage, but it adds the costs of previously excluded high risk individuals to an already over-priced market along with the costs of healthy young immortals; it is unclear how the two balance out. Another option contained in the measures supported by the legislative leadership (and potentially a companion approach) would be for the state to re-insure the highest cost individuals in the market, thus spreading the cost more broadly and reducing premiums commensurately. Re-insurance could be paid for with increases in taxes (targeted to contributors to a higher risk of disease such as tobacco) or with increases in fees and assessments (on health plans as proposed). A third approach is to allow further segmentation of that market by giving carriers increased flexibility to charge higher premiums for high risk individuals while lowering the prices for healthy individuals. This has

obvious appeal for the 90% of individuals who at a given time are quite healthy while pricing out of the market those who have serious accidents or develop severe illness and are most in need of care and coverage at the very time when they can least afford an increase in premiums.

If accompanied by an individual mandate, we recommend adoption of the guaranteed issue and renewal reforms and rate bands applicable to the small employer market. They are the easiest for subscribers and plans to understand and the state to enforce.

Affordability

The individual market is already unaffordable to many low and moderate-income individuals and to some middle-income individuals and families, and is particularly unaffordable to individuals over 50 and couples with children. We assume for purposes of this paper that the Legislature and Governor will cover everyone with incomes less than 300% of poverty with sliding fee scale premiums.

In Table 1 we compare the cost of individual coverage in Los Angeles in a Kaiser Health Plan with \$25 co-payments for individuals and families of four with incomes at 300% of FPL (i.e. \$30,000 for an individual, \$60,000 for a family of four) and 400% of FPL (\$40,000 for an individual and \$80,000 for a family of four). Prices for other markets and other health plans may be higher or lower.

Assuming the test of affordability is 7% of income⁵ (the threshold for tax deductibility of medical expenses under federal income tax guidelines), basic individual coverage is “affordable” for 20 year olds with incomes of 400% of FPL or higher. Many others would need a subsidy.

Table 1: Individual Plan Monthly Premiums - 2007

Los Angeles

| | <i>25 year-old single</i> | <i>35 year-old single</i> | <i>55 year-old single</i> | <i>25 year-old married couple, 2 children</i> | <i>35 year-old female, married, children</i> | <i>55 year-old female, married, children</i> |
|---|---------------------------|---------------------------|---------------------------|---|--|--|
| HMO Products | | | | | | |
| Kaiser-\$25 Copay Plan | \$202 | \$242 | \$394 | \$704 | \$797 | \$895 |
| Premium as a percent of monthly income for individual or family of four with income at 300% of FPL | 8% | 10% | 16% | 14% | 16% | 18% |
| Premium as a percent of monthly income for individual or family of four with income at 400% of FPL | 6% | 7% | 12% | 10% | 12% | 13% |

In Table 2, we compared the cost of individual coverage for a Kaiser Health Plan with \$30 copays and a \$2700 deductible with an HSA option in Los Angeles. Fifty-five year old individuals with incomes at 300% of FPL exceed the 7% test of affordability. Fifty-five year old couples with two children and incomes at 300 and 400% of FPL also exceed the federal income threshold for affordability. Both groups would need a premium subsidy.

Table 2: Individual Plan Monthly Premiums - 2007

Los Angeles

| | <i>25 year-old, female, single</i> | <i>35 year-old, female, single</i> | <i>55 year-old, female, single</i> | <i>25-year-old, female, married, children</i> | <i>35 year-old, female, married, children</i> | <i>55 year-old, female, married, children</i> |
|---|------------------------------------|------------------------------------|------------------------------------|---|---|---|
| HMO Products | | | | | | |
| Kaiser-\$30 Copay/ \$2700 Deductible Plan with HSA option | \$68 | \$99 | \$205 | \$201 | \$267 | \$480 |
| Premium as a percent of monthly income for individual or family of four with income at 300% of FPL | 2.7% | 4% | 8% | 4% | 5.3% | 9.6% |
| Premium as a percent of monthly income for individual of family of four with income at 400% of FPL | 2% | 3% | 6% | 3% | 4% | 7.2% |

If an individual mandate is part of the grand bargain struck by the Legislature and Governor, what are the choices to assure affordable premiums and access to medical care in the individual market? There are several obvious choices: 1) exempt from the mandate those whose premiums exceed a certain percent of income, 2) subsidize those whose premiums exceed a certain percent of income, 3) increase deductibles to the point that premiums are affordable but access to care is not, or 4) create new, less costly models of coverage. Massachusetts used yet a fifth option of combining the risk pool for individuals with the risk pool for small employers.

Exemption is in essence an admission of policy failure. It says, “We think all Californians should have affordable coverage except your group because we cannot design or afford the premium subsidy”.

Premium subsidy would appear to be the right choice if revenues are available, but it is not so easy to design, and a number of issues need to be considered and resolved.

- Should the subsidy be based on the lowest cost basic coverage; should it be adjusted for regional price variations? What are the proper incentives for competition and efficiency?

- Should the subsidy be net of federal tax advantages thus requiring different calculations for the self-employed?
- Would employers drop their contributions for early retirees if the state offers subsidies; would parents stop paying premiums for their adult children in higher education?
- Should there be rough equity between employment and self-employment, following the Social Security model where the self-employed pay an amount equal to the combined employer and employee contribution?
- What are the right payment incentives for those who choose early retirement as opposed to work?
- How would this administered and the premium subsidy distributed?

In our view, the premium subsidy is most easily distributed through the purchasing pool, rather than as a refundable tax credit through the tax system in part because of the complexity of the policy decisions involved. Premium subsidies should be capped at the cost of California's most cost efficient basic health plans; in other words individuals pay for the incremental cost of more extensive services or more costly plans without the subsidy. Premium subsidies should be adjusted to take full advantage of any available federal tax or program subsidies and make the state's contribution net of the federal tax or program advantages and to create rough equity among individuals purchasing in this market. There might need to be a further adjustment in premium subsidies to reflect work incentives and assure rough equity between the contributions from the self-employed and employees so that there are no incentives to shift employees to self-employment.

Individual purchasers should have important flexibility in deciding the coverage they want, the price they want to pay and the vital information and incentives to make informed choices. The coverage priorities for a family switching jobs are likely quite different from young graduate students or 59 year-old early retirees or self employed professionals. All individuals need basic coverage of hospital care, doctors' visits and essential medicines, but they do not need identical coverage. Higher deductibles and co-payments are one way individuals can decide to reduce individual premiums to more affordable levels. Yet another is the choice of more affordable provider networks. Some may prefer a reduced scope of covered benefits as Marge Ginsburg has described.⁶ Others will prefer HSAs and high deductible plans.⁷

The premium subsidy should be pegged to the cost of a basic individual plan with clear information to individuals about their coverage options and the prices associated with selecting more or less costly options. Each option attracts a different risk pool of healthy or less healthy individuals. It is crucial that carriers not be allowed to re-segment the individual market into many different mini risk pools. Price comparability can be assured for consumers by setting premiums based on published and easily accessible information on discounts or upgrades from a basic package of covered services.

Plans do need flexibility to innovate and develop better coverage for individuals that is more cost effective and improves population and individual patient health. At the same time, they must be constrained from the economic incentive to cream the market for the least costly subscribers while leaving those who most need health care with unaffordable or inaccessible coverage. Reform of the individual market should assure availability with underwriting reforms and

improve affordability by combining properly targeted premium subsidies with improved flexibility and information on coverage options for plans and consumers.

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¹ In the interests of full disclosure, ITUP has been working for many years on efforts to cover uninsured child care workers; many of whom are self-employed and uninsured.

² See Lisa Girion, "Insurer Cited in Policy Rescissions: Blue Cross Mishandled More than Half the Cases Reviewed by the State" (Los Angeles Times, July 3, 2007)

³ See Gabel et al, Trends in the Golden State: Small Group Premiums Rise Sharply While Actuarial Values for Individual Coverage Plummet, Health Affairs (June 14, 2007). The study points out that 83-85% of premiums went for benefits in small group coverage, while only 55% of premiums went to the cost of claims in individual coverage in 2002, a sharp drop from 75% in 2002.

⁴ The Governor's proposal would add about 800,000 individuals to the 2 million already covered in the individual market while the Speaker and Senate President's proposal would reduce the individual market by 800,000 lives. Gruber, Modeling Health Reform in California, May 16, 2007

⁵ While seven percent of income may well be too high -- \$2100 for an individual with \$30,000 annual income, it does have precedent. Federal tax law allows deductions from income for medical expenses in excess of 7% of income. The Governor's proposal proposes that moderate-income individuals pay sliding fee premiums into the pool up to 6% of income. The Speaker's proposal proposes that moderate-income individuals pay sliding fee premiums into the pool up to 5% of income. Another variation is to increase the percentage cap as incomes increase.

⁶ Ginsburg, M. et al, Deconstructing Basic Benefits: Citizens Define the Limits of Coverage Health Affairs, November-December 2006

⁷ HSAs and high deductible plans have only reached a small segment of the market so far. See California Healthcare Foundation, California Employer Health Benefits Survey 2006.

www.chcf.org/topics/healthinsurance/index.cfm?itemID=127480 However these plans are reportedly very popular with high-income self-employed professionals with the capacity to absorb the financial risk.