Building A Consensus For Expanding Health Coverage

A first-step proposal from some “strange bedfellows” that transcends ideological, partisan, and interest-group boundaries.

by Charles N. Kahn III and Ronald F. Pollack

ABSTRACT: Despite a flourishing economy and recent growth in employment-based health coverage, forty-three million Americans remain uninsured. Extending coverage to the uninsured is not an intractable public policy problem but could be addressed if the various health care stakeholders could only find common ground. We argue that to win broad-based support from across the ideological and political spectrums, a meaningful proposal should achieve a balance between public- and private-sector approaches, focus attention on those who are most in need of assistance (low-income workers), and build on systems that work today. With the aim of pulling together a political coalition, we present a proposal specific enough to attract support but whose details will arise later, in the context of the legislative process.

Almost forty-three million Americans (approximately one of every six) are without health insurance today. This number has remained high despite a thriving economy—with unemployment and inflation down and individual and business incomes up. Once an inevitable slowdown occurs in the longest peacetime economic expansion in U.S. history, today’s unacceptably high levels of uninsurance will undoubtedly get worse. Our nation’s uninsurance epidemic deserves to be at the top of the policy-making agenda.

Efforts to broaden access to health coverage in the twentieth century have repeatedly ended in failure. In addition to Bill Clinton’s unsuccessful attempt in 1993–1994, other presidents—including Franklin D. Roosevelt, Harry Truman, John F. Kennedy, Richard Nixon, and Jimmy Carter—have sought and failed to achieve meaningful coverage expansions.1 (The lone exception is Lyndon Johnson, who, after an electoral landslide that was accompanied by overwhelming Democratic majorities in both chambers of Congress, suc—

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A combination of factors led to these failures. In each of those efforts, one or more of the large health interest groups strongly opposed the legislation and spent significant amounts of political and financial capital to rouse the public and mobilize members of Congress. Similarly, the pro-reform groups often overreached and were unwilling to compromise, which also contributed to defeat.

In effect, all of the players in health care reform—from the ideological right to the left, from the special interests to the reformers—came to the political process with strong convictions in support of their first-choice proposal. For each of these groups, their second-favorite choice was the status quo. And, indeed, the ultimate result of these efforts was the status quo, with more and more Americans losing health coverage.

If there is a lesson to be drawn from this history, it is that proposed changes to health care financing can easily alarm stakeholders, who may then erect roadblocks. Moreover, while the public's support for health coverage expansions is encouragingly broad, it is discouragingly thin and, as a result, is susceptible to a well-financed opposition campaign. Meaningful health coverage expansions, therefore, require broad-based support, transcending ideological, partisan, and interest-group boundaries.

The political landscape in our nation's capital today underscores this conclusion. In contrast to 1965, when Medicare and Medicaid were enacted, today neither the Democrats nor the Republicans truly control Congress, no matter which is in the majority. Without strong champions from both sides of the aisle, in both the House and the Senate, it will be virtually impossible to achieve significant coverage expansions. Indeed, considerably less ambitious proposals, such as the State Children's Health Insurance Program (SCHIP) in 1997 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996, succeeded only because they had substantial bipartisan support.

It is critical, therefore, that common ground be sought for a proposal that can attract the key stakeholders in health care policy making. Further, we believe that providing health coverage for everyone will occur neither through tiny increments nor through one comprehensive package. Rather, progress will be made step by step. We are convinced that the first of these steps must achieve signifi-
ciant expansion of coverage.

We propose to accomplish that, and have begun by initiating a process designed to involve key stakeholders, many of them "strange bedfellows." We believe that the proposal and process we are pursuing are substantively sound and politically achievable.

**Guidelines For Developing A Viable Proposal**

To develop this proposal to expand health care coverage, we have followed four guidelines that we believe to be fundamental to success. We address each of these in turn.

- **Maintain current coverage levels.** The proposal cannot take away, or appear to take away, health coverage from people who have it today. Any proposal that appears to threaten existing health coverage for people who are insured is a political nonstarter. Simply stated, if asked to make a change that affects their own health coverage, many of those who are insured will not support reform efforts. This means that any proposal that changes the form of people's health coverage, appears to diminish the scope or quality of that coverage, or threatens to result in increased costs for that coverage is likely to provoke unbeatable opposition.

- **Build on existing structures.** The proposal should build on the health coverage structures that currently work. There are fundamental reasons, both technical and political, for building on what works. Using existing structures, whether public or private, will allow for quicker and more effective implementation and avoid the creation of new bureaucracies and further fragmentation of the health care system. Additionally, building on what currently works has a much better chance of gaining support from the public, policymakers, and interest groups.

  **Employment-based coverage.** In the private sector this means building on employment-based health coverage. Today, 91 percent of privately insured Americans receive health coverage at the workplace. Even if one questions whether it made sense to build America's health coverage system on an employment-based model, it is the model with which most people feel comfortable. Replacing it will not only result in political turmoil, it may also do considerably more harm than good. Undermining the employment-based health coverage system could result in lost cost efficiencies realized today through group purchasing and would require greater government regulation to ensure that sick and frail persons retain affordable access to coverage. Moreover, it would engender enormous political opposition from workers, who might fear that employers' diminished health coverage contributions would not be offset by wage increases or other benefits.
Medicaid and SCHIP. In the public sector the proposal should build on Medicaid and SCHIP. Today, Medicaid covers forty-one million low-income persons, and the newly implemented SCHIP has already enrolled 2.5 million children. These two programs constitute the bulwark of health coverage for America's most vulnerable populations, the groups least likely to afford health coverage through the private sector. Moreover, as a recent Henry J. Kaiser Family Foundation survey indicates, the overwhelming majority (94 percent) of parents of children enrolled in Medicaid view it as a good program. Thus, by building on employment-based coverage as well as Medicaid and SCHIP, the first-step proposal would be based on what works today and would not need to create new bureaucracies or coverage structures.

**Maximize public funds.** The proposal should use public resources in a way that maximizes new health coverage. Providing coverage for the uninsured is not inexpensive. And since there are many competing demands for government resources—including those of other health care matters such as Medicare and prescription drugs—it is unlikely that sufficient funds would be made available in the near term to cover all of the uninsured. Therefore, a first-step proposal should make the best use of available resources to maximize coverage of the uninsured.

For all aspects of the proposal, the substitution of taxpayer funds for coverage already provided through private spending (“crowding out”) must be minimized. Since crowding out occurs more frequently among higher-income populations, it is best to first focus expansion efforts on those with incomes below 200 percent of the federal poverty level. This is consistent with our next guideline.

**Focus on those with greatest need first.** The proposal should focus on low-wage workers, their families, and other low-income populations that are least capable of obtaining health coverage on their own. Low-wage workers are less likely to be offered coverage through the workplace than are higher-paid workers: 93 percent of U.S. workers who earn more than $15 an hour are offered health insurance by their employer, whereas only 43 percent of those earning $7 an hour or less are offered such coverage. Even when coverage is offered, it is often too expensive for low-wage workers to purchase. In fact, such benefits are often more expensive for low-wage workers than they are for higher-paid workers. The average monthly contribution required for the lowest-cost family coverage plan is $130 in firms where the typical wage is less than $7 an hour but only $84 in firms where the typical wage is more than $15 an hour. As a result, almost a quarter of workers with incomes below 200 percent of poverty turn down coverage when offered.
In effect, low-wage workers experience a “triple whammy”: They are less likely to be offered coverage by their employers, they have to pay considerably more for coverage when employers do offer it, and they have the least discretionary income available to pay for it.

Public-sector programs such as Medicaid and SCHIP also leave a large number of low-income persons without health coverage. In effect, these programs divide low-income populations into three groups—children, parents of children, and childless adults—and treat each group very differently. This categorization and differential treatment is an unfortunate vestige of the sixteenth-century Elizabethan Poor Laws that formed the basis of our nation’s welfare system and, starting in 1965, the Medicaid program as well.10

Children, who in recent years have aroused the greatest political sympathy, are accorded better coverage than the two adult groups. Most states now consider children eligible for public-sector coverage if they live in families with incomes below 200 percent of the federal poverty level ($28,300 for a family of three in 2000).

While low-income parents are viewed with some sympathy, they receive considerably less coverage protection than their children do. In thirty-two states a parent working at the minimum wage ($5.15 per hour) has “too much income” to qualify for Medicaid if he or she works full time.11 In Louisiana, for example, a parent is ineligible for Medicaid if his or her income exceeds 22 percent of poverty. In Texas, it is 33 percent; in Michigan, 47 percent; and in Illinois, 51 percent. As a result, when parents leave welfare for work, they often lose their Medicaid coverage even though they are likely to wind up in entry-level jobs that provide no health benefits.

Single adults or childless couples, no matter how poor, are excluded from Medicaid coverage in the vast majority of states, unless they are severely disabled. As a result, many millions of low-wage working people and families who have no access to employment-based health coverage or cannot afford such coverage remain ineligible for Medicaid.

Thus, placing a priority on expanded health coverage for low-wage workers and others with low incomes makes good sense. This group is in greatest financial need and will have the most difficulty securing health coverage without public intervention and support. Moreover, although this group has little or no political clout, we believe that it will be much easier to achieve a consensus on its behalf than is true for other segments of the uninsured population.

A Proposal For Common Action

Our proposal was designed as a policy framework, not a set of legislative specifications. We chose this approach for two reasons.
First, we wanted to articulate a clear vision for action. Second, we deemed it important as part of the initial consensus-building process to start out with a framework that would later involve additional stakeholders in the development of legislation.

Our policy framework focuses on the low-wage working population with incomes below 200 percent of the federal poverty level. The proposal has three parts.

- **Medicaid expansion.** First, the proposal would require an expansion of Medicaid to cover all persons with annual incomes below 133 percent of the federal poverty level (approximately $18,820 for a family of three in 2000). Eligibility for such coverage would be based exclusively on income, no longer on membership in one of several prescribed categories that are, in fact, the absurd vestiges of long-obsolete laws. To ensure that states have the financial resources necessary to implement this expansion (and continue to support it even during economic downturns), federal matching funds would be provided well in excess of the current Medicaid funding formula. To the extent that funds are limited, this part of our proposal would be phased in first.

- **Expansions for higher-income persons.** Second, we propose that states be given the option of establishing Medicaid or SCHIP-type coverage for adults with incomes between 133 and 200 percent of the federal poverty level. For states that choose this option, coverage would be based on income, not parental status. Similar to the Medicaid proposal for lower-income persons, more federal matching funds would be made available.

The public program expansions will be developed to ensure optimal enrollment of those newly eligible for coverage. As we develop legislative specifications, several mechanisms will be considered to achieve this, including the implementation of “presumptive eligibility” mechanisms that enable social service agencies to temporarily enroll eligible persons; fiscal “carrots and sticks” to state agencies so that they meet enrollment targets; elimination of resource standards of eligibility; mail-in application processes; putting state certification officials in the field; and the establishment of one-year (or longer) certification periods.

- **Tax credits.** Third, we propose a nonrefundable tax credit for businesses to encourage them to make coverage affordable for their low-income workers. This tax credit should be established in tandem with the implementation of public program expansions for persons with incomes between 133 and 200 percent of poverty. The credit would be available to those employers that pay a larger share of the premium (than what is offered to other workers in the company) for workers with family incomes between 133 and 200 percent.
"From the perspective of the uninsured, any so-called ideal plan that cannot get enacted is no solution at all."

of poverty. For example, if a business currently pays 70 percent of the premiums for all workers and decides to pay all or part of the remaining premium for low-income workers, that business would receive a tax credit for that additional amount.

The employer tax credit would be available only to companies that make contributions to their health plans commensurate with the contribution levels of other similarly situated employers. To ensure that this facet of our proposal strengthens existing coverage, the legislation would seek to secure, not weaken, current employer coverage and contributions that workers receive through their jobs.

Although the tax credit constitutes a new approach to expanding coverage, it is a familiar element to the business community. It is comparable in structure to the Work Opportunity Tax Credit designed to encourage companies to hire persons from low-income communities. It can work to help extend coverage precisely because employers are familiar with it, and it will enable businesses to extend help to their low-wage workers at no cost to them.

A Good Second Choice

This proposal is neither Families USA’s nor the Health Insurance Association of America’s (HIAA’s) ideal plan. For Families USA, health coverage expansion proposals based on tax incentives have never been a favored option. Indeed, Families USA would not have agreed to even the tax credit approach in this plan without its linkage to the Medicaid and SCHIP expansions. Similarly, HIAA’s original “InsureUSA” plan envisaged a larger private-sector approach and a much more modest Medicaid and SCHIP expansion.

We expect that this proposal will not be considered ideal by other major health care organizations as well. However, from the perspective of forty-three million uninsured persons, any so-called ideal plan that cannot get enacted is an illusionary ideal. It is no solution at all.

The proposal outlined above presents a good second choice to our two organizations, and to others as well. It has the potential for increasing health coverage for a very large portion of persons who are uninsured today. It achieves a reasonable balance between public-sector and private-sector approaches. It focuses priority attention to those most in need of assistance. It builds on systems that work today and, therefore, does not create new bureaucracies or
cause further fragmentation of our health care system. It eliminates the cumbersome and unfair poverty categorizations in a way that is consistent with experimentation undertaken by a number of states. It is designed to eliminate work disincentives by providing new health coverage opportunities to support low-income workers and people moving from welfare to jobs.

It also does not trespass on the interests of key stakeholders in the health care system. Indeed, based on our preliminary discussions with numerous major stakeholder organizations, it can gain broad support and, hence, is politically achievable. It can be enacted, and it can provide prompt coverage for many uninsured Americans, individuals and families alike.

To be sure, this proposal, like any other that would result in a major increase in health coverage for lower-income Americans, will require a significant public investment. Although no reliable cost estimate can be made until detailed legislation is developed, it is obvious that this proposal will be expensive. But there has never been a better time to take on such an investment. The federal budget has a large projected surplus, and most state budgets are in good shape as well. Our economy continues to grow, while inflation remains moderate. There is a palpable thirst among many health interest groups to find common ground on a significant health coverage expansion. Thus, as a new president and Congress begin their work, this balanced proposal is well suited for inclusion as part of a blueprint for our nation's immediate future.

We believe that this proposal, and the broad coalition-building effort to which we are committed, constitute our best—perhaps our only—near-term chance to expand health coverage for many millions of uninsured Americans. Certainly if our two organizations can find common ground for this noteworthy objective, it augurs well for many other groups to do likewise. Through a common effort, we have a real chance to proceed down the road toward health coverage for all Americans.

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