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It's About Access to Health Care, Not Universal Coverage

Policymakers at both the state and federal levels are increasingly focusing on the uninsured and proposals that promise to achieve "universal coverage," in which everyone has comprehensive health insurance coverage. In this rush to provide everyone with coverage, they have forgotten the underlying goal — providing everyone with access to health care.

There are many developed countries that claim to have universal coverage. And in almost everyone, patients often have difficulty getting access to care — especially when treatment calls for expensive care or the newest technology or when the patients are marginal or very old.

A better goal is to ensure that every American has *access* to affordable private coverage, or a safety net where private coverage isn't feasible, to ensure they can get quality health care in a timely manner.

Can We Achieve Universal Coverage? The U.S. has a patchwork of different kinds of health care coverage. That coverage is usually provided by employers and government-run programs, but some people buy their own coverage. Moreover, some insurance plans are governed by federal law and others by state law. States have little or no control over federal law, making it hard for them to "manage" that coverage.

Thus most serious reform proposals focus on how to make the various existing parts work better in order to achieve the widest possible coverage.

As discussed below, those proposals typically include expanding government programs, new mandates to force individuals and employers to obtain coverage or pay a penalty, complicated new regulations, and most likely higher taxes.

Will all of these mandates, penalties and regulations actually achieve universal coverage? Probably not, anymore than requiring everyone to have auto insurance has resulted in universal coverage. In fact, Massachusetts, which is being touted as a model for achieving universal coverage, recently backed away from that goal.

There is a better way. We believe that when people have access to a wide range of affordable health insurance policies, and with the appropriate safety nets and subsidies for low-income people, the vast majority of Americans will voluntarily insure. And they will have a private policy *they want* that provides access to quality care, not what the government wants them to have.

Common Components of Universal Coverage Schemes. Most of the universal coverage proposals have several common components — components made popular by the passage of health care reform in Massachusetts.

Expanding Medicaid and SCHIP — While Medicaid costs are rising rapidly and straining government budgets, nearly every state is looking for ways to expand their Medicaid program and State Children's Health Insurance Program (SCHIP). The primary reason is the generous federal subsidy for the programs. Unfortunately, Medicaid is a terrible program that limits access and underpays providers. Very few people would voluntarily choose Medicaid if they had another option; and yet policymakers want to expand it rather than give the poor alternatives.

Individual Mandate — An individual mandate requires individuals to have health coverage. If their employer doesn't provide it, or they aren't part of a public program such as Medicare, then individuals must pay for the coverage themselves or face significant penalties. In Massachusetts, for example, the penalty will eventually be about half the cost of the average premium.

Guaranteed Issue and Community Rating — Guaranteed issue requires insurers to accept anyone who applies regardless of their medical condition, while community rating requires everyone to pay the same price for coverage. Seven states have some form of guaranteed issue and community rating, and they have some of the highest premiums in the country, making health insurance unaffordable for thousands of people.

The Cost of Universal Coverage. Mandates and regulations come with a cost. That's especially true of guaranteed issue and community rating, which are integral to all of the proposed universal-coverage schemes. These mandates increase the price of health insurance making it unaffordable. In other words, *universal coverage is antithetical to affordable coverage*.

But don't all the other developed countries guarantee universal coverage and spend significantly less than the U.S. on health care? Yes, but most countries set a "global budget," that is, a limit — essentially a price control — on how much the government will spend on health care. Those countries don't spend as much, but they also don't get as much. As a result, the U.S.

health care system often serves as a safety net for the wealthy in other countries, who come to the U.S. to get the care they can't get in a timely fashion.

The "Free-Rider" Problem. Proponents claim universal coverage will reduce, if not eliminate, uncompensated care and cost shifting from the uninsured to those with coverage. That's why the government must force them to "be responsible." This is the so-called "free-rider" problem. However, the journal *Health Affairs* estimates that uncompensated care is only about 3.5 percent of health care spending. While uncompensated care can impose financial strains on providers, especially on certain hospitals and clinics serving low-income populations, it is not a big portion of the health care system. Ironically, the largest cost shifting comes from government-run programs such as Medicaid and Medicare underfunding providers.

Universal Coverage Doesn't Mean Timely Access. One of the false assumptions behind the push for universal coverage is that everyone will have access to care. While that may occur initially, within a short period of time the waiting lines begin to grow and access and quality begin to decline as the government limits funding for health care. That's what has happened in Medicare and Medicaid, and in every government-run health care system.

Moreover, the uninsured do have access to care. According to Mark Litow of the actuarial firm Milliman, the average uninsured person used an estimated $2,262 in health care expenses in 2006 — some of it paid for out of pocket, some of it provided free or at discounted rates in public clinics, etc. The average insured (non-elderly) person used about $3,580. Having insurance coverage would be better, but the uninsured can and do get care.

Achieving Affordable Coverage. Ensuring people have access to care by helping them get affordable coverage is a better goal than universal coverage. The six key ingredients are:

- *High Risk Pools* — High risk pools provide coverage to those who are medically uninsurable, often the chronically ill. About 1 million Americans fall into this category. But while 34 states have implemented high risk pools, they are often underfunded. Additional state and federal funds would go a long way in stimulating this safety net at a fraction of the cost of universal coverage.

- *Tax Fairness* — Those who pay for health insurance out of their own pockets should be granted the same pretax treatment of premium payments afforded to employers and their employees. While this is primarily a federal issue, states can encourage their Washington delegations to take action.

- *Individual Tax Credits* — Low-income workers often have trouble paying for coverage. Tax credits would help them do so. And by making those credits "refundable" — essentially turning them into vouchers — low-income workers who pay no income tax would still get the full value. Tax credits should also be available to low-income enrollees in a state's high risk pool.

- *Mandate-Lite Policies* — Mandates require insurance to cover specified health care providers and benefits. And while those policies are more comprehensive, they also make coverage more expensive. By eliminating some (or all) mandated benefits, health insurers are able to offer a range of more-affordable health insurance products.

- *Out-of-State Insurance* — The fact that states regulate health insurance differently means that access to affordable coverage can vary significantly from state to state. For example, some states have imposed price controls known as community rating (which is often combined with guaranteed issue), and others have extensive mandated benefits. As a result, the health insurance rates in those states may be unaffordable for most. If those same residents were allowed to purchase plans currently being marketed in another state, thereby expanding competition, individuals might be able to find a policy that meets their needs and pocketbooks.

- *A Limited Safety Net* — A well-functioning health care system needs a safety net, not a hammock. There should be programs (e.g., high risk pools) to capture the uninsured who have been denied coverage because of a medical condition, and there should be subsidies to help those who cannot afford coverage. In other words, a true safety net should be limited and targeted to those who need help most.

Conclusion. Universal coverage should not be the goal; it is very costly and will require massive new regulations and penalties. And it will almost certainly devolve over time into a government-run health care system with waiting lines and rationing. In other words, universal coverage does not mean access to care.

If people can choose among a wide range of affordable policies, the vast majority will move into the ranks of the insured, improving their access to care and reducing the strain on government budgets. Supplemented with limited safety nets like high risk pools, free clinics and subsidized private coverage, we can ensure everyone has access to health care when they need it.

Please visit www.cahi.org to view our longer publication on the uninsured population and what can be done to help them.

Prepared by Merrill Matthews, Executive Director of The Council for Affordable Health Insurance

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Council for Affordable Health Insurance
127 S. Peyton Street, Suite 210
Alexandria, VA 22314
Phone: 703/836-6200 Fax: 703/836-6550
Email: mail@cahi.org
www.cahi.org