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A Rural-Urban Comparison of a Building Blocks Approach to Covering the Uninsured

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A range of proposals are now being considered to reform the health care system, specifically to provide access to health insurance coverage for the uninsured. Proposals from President Obama and members of Congress include a range of public-private approaches, typically called “building blocks” approaches, which build upon our current system of health insurance to provide access to health insurance for all Americans. This report uses a RUPRI health insurance model to compare the effects of a building blocks approach on health insurance coverage and health spending, focusing on the geographic differences (by metro and non-metro) of this approach.

Covering the Uninsured. Under a building blocks approach, affordable access to health insurance would be achieved by a range of proposals. The following are options under consideration that were included in our comparison.

- **Health insurance exchange (HIE).** Individuals could keep their current health insurance, or individuals or employers could purchase from a range of private health insurance plans through a new health insurance exchange, designed to make health insurance more accessible and affordable. In addition to a range of private plans available through the exchange, the exchange could also include a public plan.
- **Subsidies for health insurance purchased through the insurance exchange.** Subsidies would be available for low- and moderate-income persons purchasing insurance through the exchange; for example premiums could be limited to 6% of family income, with the rest covered by a federal government subsidy.
- **Employer pay or play.** Employers with 10 or more employees would be required to either cover their employees or pay for 80% of the premium in the HIE up to 6% of wages, or if they chose to do so, could pay the equivalent amount to the government.
- **Refundable credits for small employers.** Small employers with fewer than 25 employees would receive tax credits to assist them in the purchase of health insurance.
- **Expand public health insurance eligibility.** Public insurance (most likely Medicaid) would be available to all persons with incomes at or below 100% of the federal poverty level (FPL) (\$22,050 for a family of four in 2009), and CHIP would be extended to include all children under age 18 in families with income up to 300% of FPL. Parents would be required to obtain qualifying insurance for their children (either through a public plan or a private plan).



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The analysis presented here is not based on any specific proposal being considered now on Capitol Hill, as the details of the building blocks approach could not be based on the specifics of proposals until these specifics were released.

Effects on Coverage and Health Spending. Results are shown here for two alternative baselines: (a) one based on the March 2008 Current Population Survey (CPS) estimate of 45.7 million uninsured in the United States, and (b) a second updating the first to account for the effects of the recession and the possible impacts of increased unemployment on the number of uninsured, leading to an estimate of 51.0 million uninsured in the United States (Table 1). For the remainder of this discussion, we will highlight only the updated estimates, baseline (b), which is the more likely current scenario. The RUPRI health simulation model, built on the CPS data and a range of other data sources described in the appendix, is based on a series of assumptions about the policies described here, and the responses of individuals to those policy settings, such as the likelihood of taking up coverage (based on a probability model and the characteristics of individuals). Further details about the results and the RUPRI health insurance model are presented in the appendix.

The approach to covering the uninsured that includes the options described on page 1 would cover 42.7 million persons, leaving 8.3 million persons uninsured because they would not take up insurance. In non-metro areas, the approach would cover 6.8 million persons, leaving 1.5 million uninsured, approximately 18% of the uninsured. The model shows that the approach would do a slightly better job of reaching the uninsured in metro areas than in non-metro areas, since in metro areas only 16% of the uninsured would remain.

The approach would cost \$141.8 billion in government spending, \$102.8 billion of which would be federal dollars (assuming a portion of the spending would be covered by the states) and would include spending to pay for subsidies, Medicaid expansion, tax credits for employers, and other costs. As noted in the appendix, it is not assumed that public spending to finance medical care for the uninsured (e.g., DSH spending) will be reduced as a result of these policy changes, though it may be likely that legislation would include these shifts in public spending.

Private expenditures would increase by \$11.2 billion, including \$6.7 billion for employers and \$4.6 billion for individuals. The employers' costs would be almost entirely a result of the "pay or play" mandate, while the individuals' costs would be the out-of-pocket costs of premiums individuals would pay to obtain insurance, net of savings resulting from lower uncompensated care costs and cost-shifting.

As shown in Table 1, the cost of covering the uninsured has increased significantly as a result of the recession. With the estimated increase in the uninsured from roughly 46 million to 51 million, the government costs of insuring the uninsured have increased from roughly \$98 billion to \$142 billion and the overall costs have increased from \$102 billion to \$153 billion.

Summary. The 110th Congress is now considering a range of proposals for reforming the health care system and creating access to affordable health insurance. The estimates shown here demonstrate that these proposals may cover about 42.7 million of the 51.0 million currently uninsured overall, and 6.8 million out of the 8.3 million currently uninsured in non-metro areas. These proposals are projected to cost about \$142 billion in increased government spending.

Table 1. Coverage of the uninsured, and costs of covering the uninsured

	ALL PERSONS	Metro	Non- Metro	ALL PERSONS	Metro	Non- Metro
	BASED ON 2008 ESTIMATES OF UNINSURED			BASED ON 2009 ESTIMATES OF UNINSURED		
Number of uninsured (millions of persons)	45.7	38.3	7.4	51.0	42.7	8.3
Number obtaining coverage	38.2	32.1	6.1	42.7	35.9	6.8
Remaining uninsured	7.5	6.1	1.3	8.3	6.9	1.5
TOTAL COSTS of coverage (\$Billions)	\$102.0	\$84.5	\$17.5	\$153.0	\$126.2	\$26.8
Government costs	\$98.3	\$81.4	\$17.0	\$141.8	\$116.6	\$25.2
Federal	\$74.5	\$61.6	\$12.9	\$102.8	\$84.3	\$18.4
State	\$23.8	\$19.7	\$4.1	\$39.0	\$32.3	\$6.7
Private Costs	\$3.7	\$3.2	\$0.5	\$11.2	\$9.5	\$1.7
Employer	\$2.2	\$1.8	\$0.3	\$6.7	\$5.7	\$1.0
Individual	\$1.5	\$1.3	\$0.2	\$4.6	\$3.9	\$0.7
PERCENT DISTRIBUTION						
Number of uninsured (millions of persons)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Number obtaining coverage	83.6%	84.0%	82.4%	83.7%	84.0%	82.1%
Remaining uninsured	16.4%	16.0%	17.6%	16.3%	16.0%	17.9%

SOURCE: Simulation model, RUPRI Center for Rural Health Policy Analysis, see appendix.

Appendix

RUPRI Health Insurance Model. The microsimulation of insurance coverage and the costs of covering the uninsured are based on a combination of individual-level data drawn from the Current Population Survey (CPS) and data from a number of other sources as specified below. In particular, the simulation starts with the estimates of the uninsured from combined years of the CPS survey (covering the March 2007-2008 surveys, well over 400,000 observations nationally from these two surveys). Individuals are assumed to be insured by one of the strategies described below, with eligibility for the strategy determined by income relative to poverty, employment status, disability status, age, and family status. Then for each eligibility group, the simulation model makes an assumption about the costs of insuring persons in that eligibility group (described below). The RUPRI health simulation model is based on a blending of the following specific policy assumptions and other model settings:

- **Health insurance exchange (HIE).** Premiums are obtained from the Federal Employees Health Benefits Program (FEHBP) plans nationwide to simulate what might be available under an HIE. For each state, FEHBP plans offer nationwide plans and statewide plans. The simulation model assumes that a range of these plans are offered to the individual and the individual chooses from this range of plans. Individuals are guaranteed coverage in the insurance exchange and employers may purchase insurance through the exchange.
- **Public plan.** The simulation model assumes the availability of a public plan, in addition to the range of private plans available through the HIE. The public plan's premiums are assumed to be equal to the array of benefits available to Medicare recipients, with the costs of the Medicare plan.
- **Subsidy for health insurance purchased through the insurance exchange.** It is assumed that a subsidy is offered through purchases offered through the HIE. Families with income above 400% of FPL receive no subsidy. Below 400% of FPL, premiums are limited to 6% of family income, with the rest covered by a federal government subsidy.
- **Employer's penalty (pay or play).** Employers with 10 or more employees either pay for 80% of the premium in the HIE up to 6% of wages, or if they choose to do so, can pay the equivalent amount to the government.
- **Refundable credits for small employers.** Small employers with fewer than 25 employees receive a credit equal to 50% of premiums paid by firms with 9 employees or fewer and 10% of premiums for firms with 11 to 24 employees.
- **Expand public health insurance eligibility.** It is assumed that Medicaid is available for all persons with incomes at or below 100% of FPL and that CHIP is extended to include all children under age 18 in families with income up to 300% of FPL. Medicaid costs are obtained from recent estimates at the state level, obtained from the Kaiser Family Foundation (KFF), differentiated by eligibility category (children, adults, and disabled). KFF data are also used to obtain Medicaid matching rates to allocate costs between the state and federal governments.
- **Take-up rates.** For the purposes of estimating whether individuals who have access to public and private plan coverage actually will purchase and obtain coverage, the model computes take-up rates for Medicaid coverage (for non-elderly adults) and for all others with the option of choosing employer or other coverage through the HIE. The model starts with the microanalytic database sample described above, drawn from the March 2007-08

CPS file. The CPS sample includes a range of variables on individuals, including their insurance coverage, demographic, employment, and family characteristics. Using these variables, the simulations use a model drawn from the literature to estimate the probability that an individual will “take up” or accept the offer of insurance and become insured, given that they have been offered health insurance.¹ However, the multivariate models were re-estimated for this RUPRI simulation model using more current data. The model relies on several important assumptions, or adjustments to the models from the literature. Perhaps most important, the model relies on the estimates of the policy parameters (especially the health insurance premiums and subsidies) individuals would face under a program described above. It is assumed that the parameters in the model for insurance take up have not changed, but that only the premium amounts and person characteristics have changed over time.

- **Mandate all parents to cover children under age 18.** Parents are required to obtain qualifying insurance for their children (either through a public plan or a private plan). Thus, parents with income above 300% of FPL must buy private health insurance to cover their children through the HIE, and parents below 300% of FPL must buy insurance through CHIP/Medicaid.
- **Reductions in spending by the uninsured.** It is assumed here that some of the private spending on the costs for the uninsured would decline as a result of these policy changes; in particular the (a) out-of-pocket spending by the uninsured, and (b) other private and implicitly subsidized (cost-shifted) spending by the uninsured. Using estimates derived from Hadley et al.,² it is assumed that current spending on the uninsured is reduced to a level consistent with the out-of-pocket spending by the insured population for those who obtain insurance. No assumptions are made here about reductions in current public expenditures (e.g., DSH and other public spending) for the uninsured, though it may be likely that legislation would reduce this spending if the number of uninsured falls.

¹ Linda J. Blumberg, Yu-Chu Shen, Len Nichols, Matthew Buettgens, Lisa Dubay, Stacey McMorrow. 2003. The Health Insurance Reform Simulation Model (HIRSM): Methodological Detail and Prototypical Simulation Results. Research Report, the Urban Institute, July 31, 2003. Available at <http://www.urban.org/url.cfm?ID=410867>.

² Jack Hadley, John Holahan, Teresa Coughlin and Dawn Miller. 2008. Covering the Uninsured in 2008: A Detailed Examination of Current Costs and Sources of Payment, and Incremental Costs of Expanding Coverage. Report Prepared for the Kaiser Commission on Medicaid and the Uninsured, Henry J. Kaiser Family Foundation, August.