The Kerry-Bush Health Care Proposals: A Characterization and Comparison of their Impacts on Connecticut

Report

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I.1 Introduction

In Connecticut, approximately 357,000 people (of whom 71,000 are children) have no health insurance, 10.4% of the state's population.[1] In part, rising health insurance premiums make insurance unaffordable to many employers and individuals alike, increasing the ranks of the uninsured. Uninsurance poses costs on society, businesses, and those individuals without insurance. The uninsured may delay seeking treatment because of cost concerns. This delay can lead for the uninsured to higher health care costs and worse health outcomes. This can impose costs on employers through lower productivity or employee absences. And health care providers or taxpayers bear the cost for providing uncompensated health care services. Both major party presidential candidates have plans to address the costs of health insurance and the number of uninsured. Neither candidate proposes comprehensive changes to the current health insurance system.

The Universal Health Care Foundation of Connecticut commissioned the Connecticut Center for Economic Analysis (CCEA) to, estimate the Connecticut-specific impacts, in terms of the numbers of newly insured and the associated costs and savings, of the two presidential candidates' plans for firms, households, and government.

CCEA examines the Bush and Kerry healthcare proposals as if each one were simultaneously passed into law. In order to compare their plans effectively, we need to be able to add up the numbers of newly insured for each candidate's plans and associated costs as if each component of their plans were actually in effect for the elected candidate. This process involves a hierarchy of consumer choices that successively exhaust the eligible populations. This approach is necessary because certain groups of Connecticut's population would be eligible for more than one plan within each candidate's array of proposals. In this way, we eliminate overlap (double counting) and obtain the total number of newly insured and associated public (federal and state government) and private (individuals and firms) sectors' costs for each candidate's array of proposals. However, it is possible that not all of the elected candidate's proposals would be enacted into law simultaneously. In that event, our results would not apply. If only some of the

[1] National and state figures based on most recent 2004 release of the U.S. Census Bureau's Annual Social and Economic Supplement to the Consumer Population Survey (CPS) at http://www.census.gov/hhes/www/hlthin03.html

elected candidate's proposals' components were enacted, the number of newly insured would be less still than is estimated under a full implementation scenario.

To calculate the results described above, CCEA assumes that Connecticut residents' decision of whether to purchase health insurance and what plan to purchase depends on the price of a particular plan for which they would be eligible relative to other plans and their income. We define the price of insurance for a household as their out-of-pocket premium cost. Thus, we exclude other out-of-pocket expenses such as co-pays and deductibles, employer contributions to premiums, costs of travel, and opportunity costs. In other words, CCEA does not estimate changes in total resource usage within the health care system based on these policies. Therefore, the cost estimates presented here are actually lower than they would be were these other costs incorporated.

CCEA compares Connecticut-specific effects of the Bush and Kerry health care proposals by building an analytical model for each policy. To analyze the policies on equal footing, we use the same data across policies when possible. All numbers reported derive from analytical models for Connecticut.

The crisis in health care insurance results in part from increasing income inequality in the United States, with the majority (60%) of households seeing their share of national income decline. According to the U.S. Census, the poorest forty percent (40%) of American households have seen their share of income decline systematically, by nearly a fifth, between 1970 and 2003. In 1970, the poorest forty percent of households had 14.9% of total household income; by 1990, it had fallen to 13.5%; in 2003, it was a mere 12.1%. Even the middle-income group saw their share fall by nearly a quarter in the same years, from 17.4% to 14.8%. The wealthiest 40% of households took home much more, raising their share from 67.8% to 73.2%. To put this pattern in its starkest terms, forty percent (40%) of households have nearly three quarters of all income and their share is rising; the remaining sixty percent (60%) have barely more than a quarter of all income, and their share is falling.

The issue is equally striking in terms of constant dollars, that is, taking out the effects of inflation. In 1970, the poorest 20% of Americans had an average income of $8,010; that increased by 2001 to $10,136, a gain of about one quarter. In the same period, the top 20% of Americans' incomes went from $85,607 to $145,970, a gain of

more than two thirds. Given weak income growth for the majority of Americans and the fact that health care costs and premiums have gone up more rapidly than overall inflation, it is clear that health insurance is becoming increasingly less affordable for the majority of Americans. In the face of such income statistics, it is hard to visualize how a modest increase in incentives for self-insurance would do anything more than slow the rate of decline in total coverage. Appendix I from the Center for Budget Policy and Priorities provides detail for Connecticut.

I.2 Health Care Platforms: Two approaches to reduce costs and increase coverage

Both Bush and Kerry propose to increase health care coverage through incentives to households and businesses and through restructuring the health insurance market. These initiatives are designed to make the health care system more efficient, ultimately reducing health insurance premiums. The candidates' proposals are similar in targeting small businesses and low-income individuals, which account for the majority of uninsured, both nationally and in Connecticut.

However, the two candidates' proposals differ significantly in their approach. The Kerry plan has a much larger scope than President Bush's plan and consequently larger federal costs. Philosophically, the Kerry plan accepts the current predominantly employer-based health insurance system with government programs patching the gaps. Kerry works within this system and seeks to expand it. President Bush, on the other hand, advocates personal ownership, emphasizing non-group and high-deductible insurance together with exemptions from state mandates on coverage regulation. While the Kerry plan is more likely than the Bush plan to insure larger numbers of people, the Kerry reforms still leave many individuals without affordable insurance options and eligibility. (In the long run—but not in the short-run—that emphasis has the potential to move coverage largely away from the current system of employer-based insurance.) Neither plan proposes the kind of comprehensive reform needed to change fundamentally the current system, to reduce health insurance costs significantly (or the rate of increase in the underlying cost of medical care), or to provide insurance to all Connecticut residents. That is, both plans fall short of insuring the 357,000 people currently

uninsured in Connecticut. Furthermore, neither candidate's proposals fundamentally change Connecticut's current employer-based health insurance system.

Overall, cost savings result from efficiency gains in the health insurance market. Both the Association Health Plans and the Congressional Health Plan promote efficiency gains. In addition, the extent to which each policy reduces the number of uninsured, losses associated with worse health outcomes and uncompensated care will be reduced. The Kerry and Bush plans both purport to improve the appropriateness of care and reduce overall costs. The Bush proposal does this by promoting prudent use of care through the high-deductible plan-health savings account combination. The Kerry proposal calls for expanding disease management programs. Neither policy, however, places a premium on preventive care. Only Kerry explicitly includes converting the insurance claims system to an electronic system. Other costs saving measures are beyond the scope of this analysis because they do not directly impact the insurance system.

Both plans reduce the number of uninsured in Connecticut. The uninsured impose costs on the health care system in terms of uncompensated care, which includes care provided at a reduced fee or no charge, and health care bills written-off as bad debt. Connecticut's disproportionate share payment programs originally subsidized providers who treated a larger share of Medicaid patients. Reimbursement rates for Medicaid programs were lower than private health insurance reimbursement rates and placed a financial burden on institutions whose patients were more likely to be Medicaid enrollees. The disproportionate share payment program (DSH) has expanded to compensate healthcare providers[2] treating large numbers of uninsured. In 2004, Connecticut providers will receive $115.2 million[3] in disproportionate share payments funded equally by the federal and Connecticut state governments. CCEA assumes there will be savings to the federal and state governments in reduced disproportionate share payments based on the number of newly insured under each plan, because increases in insured people imply reductions in uncompensated care.

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[2] These include hospitals, federal- and state-funded clinics, and physicians' and specialized practitioners' practices.

[3] Number excludes State-Administered General Assistance (SAGA) disproportionate share payments (DSH). Without additional plan specifications, CCEA assumes SAGA remains outside our analysis.

The Bush Plan: Incentive-based approach to increasing coverage

The Bush proposal involves three strategies to reduce health care premiums and increase coverage: tax credits for 'low income' households, tax deductions for those purchasing high-deductible health insurance, and exempting Association Health Plans from state health care mandates. In addition, the Bush plan proposes $1 billion in grants nationally to increase children's enrollments in Medicaid and enhanced Medicaid. In Connecticut, these are the HUSKY plans.

Tax Credits: The Bush Administration proposes tax credits for households purchasing non-group health insurance. The maximum credits range from $1,000 for a single adult making less than $15,000 to $3,000 for a family of four earning less than $25,000 per year. The credits phase out at incomes higher than those described above, reducing to zero for individuals making more than $30,000 and households making more than $60,000.

Average employer-based insurance premiums for individuals and families, respectively, are roughly $3,500 to $9,000 (MEPS, 2002). Assuming households can find similarly priced policies, individuals would still have to spend 16% of their income and families would spend 24% of their income on insurance premiums alone to utilize this tax credit. ***Furthermore, without indexing, the real (inflation-adjusted) value of this credit would diminish as premiums continue to rise over time. As the introduction makes clear, as real incomes of low- to moderate-income households decline, the share of household income taken by health insurance rises and makes it relatively less affordable to these households. That means, in turn, such households are progressively less likely to purchase insurance, despite the credits.***

Tax Deduction: Under the Bush proposal, individuals purchasing high-deductible health insurance in conjunction with a health savings account would be able to claim an above-the-line-deduction (before tax) for their insurance premium. The deduction is available regardless of whether the filer itemizes deductions. Health Savings Accounts have been available since January 1, 2004 through Medicare legislation. Qualifying health care purchases and deductibles may be paid from these savings accounts untaxed. High-

deductible insurance is defined as a minimum of $1,000 deductible for individuals and $2,500 for family insurance.

In keeping with the Bush 'personal ownership' philosophy, consumers pay the costs of routine care from their tax-free health savings account and the high deductible premiums cover the cost of major illnesses. This combination promotes 'prudent' use of health care services and 'rewards' healthy lifestyle choices. To some extent, this policy shifts health care costs from insurers to individuals. However, the "value" of the tax credits is directly proportional to the federal income tax liability of the household, a liability that rises with income. Thus the policy has no value to low-income individuals and households; indeed, it hurts them Only individuals with relatively high incomes—and thus the necessary tax liability--and the fewest medical needs would be attracted to such a program, leaving traditional health care plans to care for sicker individuals with higher health care costs. This situation creates adverse selection, pulling healthy people out of group-based plans and potentially raising traditional insurance premiums.

Association Health Plans. Trade groups or small business associations currently offer association health plans. These plans allow small businesses to band together to reduce insurance costs to be competitive with costs to large businesses and to pool administrative costs. The Bush proposal would allow small businesses to offer health insurance through association health plans located anywhere in the United States, thus specifically exempting insurance offered through these associations from state mandated coverage and risk-compression laws. "In their traditional role as the primary regulators of health insurers, states have enacted these and other consumer protections to assure appropriate access to health care, ensure fair insurance premiums for all small groups and shield consumers from fraudulent marketing schemes. In short, state regulations ensure that consumers, small firms and providers hold onto these protections – protections that provide health care reliability. Consumers in the various states have demanded these protections in order to assure the security and dependability of health care coverage."[4]

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[4] From the Blue Cross Blue Shield report 'Association Health Plans: No State Regulation Means Loss of Protections for Consumers, Small Firms and Providers,' http://bcbshealthissues.com/relatives/20424.pdf.

Appendix II contains a comparison of Connecticut's mandates with the other states and Connecticut's specific mandates.

A consequence of this exemption is that firms' insurers offering health insurance through Association Health Plans could choose to exclude sicker and higher cost individuals, as well as selected procedures. While these characteristics would both reduce costs and the risk-rating for the Association Health Plan pool, these sicker individuals would either fall into non-Association Health Plans, increasing their risk-rating and their premium costs, or lose coverage altogether. As with the proposals discussed above, this approach suffers from adverse selection. CCEA estimates Association Health Plans could reduce premiums for participating businesses by as much as 13%, and *increase* premiums for non-Association Health Plans by 2%.

Kerry Plan: Expanding coverage by increasing access to existing government programs

Democratic presidential candidate John Kerry offers an array of subsidies and tax credits to business and target population groups. The Kerry proposal would expand Medicaid for 'low-income' individuals and include several cost-saving measures related to health expenditures.

The Congressional Health Plan (CHP) and Tax Credits: Small businesses, unemployed workers, individuals aged 55-64, and anyone not covered by other proposals, would be able to buy into the Congressional Health Plan. Kerry's most recent information implies that the Congressional Health Plan would be based on the Federal Employees Health Benefit Plan and allow individuals or businesses to create a sizeable insurance pool to purchase health insurance policies, including comprehensive policies. The Kerry plan would also offer the following tax credits: (1) small businesses would receive a 50% refundable tax credit toward their premium contributions; they must contribute at least of 50% of the total premium; (2) low-to-moderate-income unemployed would receive a 75% premium subsidy for up to 6 months; (3) Low-to-moderate income individuals aged 55-64 would receive a 25% tax credit toward premiums; and , (5) expenditures on

insurance premiums would be capped at no more that 6% of family income at 100% of the Federal Poverty Level (FPL), increasing to 12% of family income at 300% FPL.

The Congressional Health Plan would be open to small businesses and anyone purchasing non-group insurance. Modeled on the current Federal Employees Health Benefit Plan, the Congressional Health Plan would spread risk and administrative costs over a national cohort. Creating this kind of exchange increases competition among insurers to provide more insurance for lower premiums. The Congressional Health Plan could reduce costs by 10% or more than $600 annually, from the average Connecticut premium, $6,140. Based on the most recent state-level data from the MEPS 2002, this premium is a weighted average of single, single plus one, and family premiums for small businesses.

The Kerry plan offers a series of tax credits targeting the unemployed and 'near-elderly'. These groups are less likely to be covered by the employer-based health insurance system and the 'near-elderly' may, in fact, choose to switch jobs or retire once they have access to competitively priced non-group insurance. Overall, premium reductions would range from a maximum of 81% for the unemployed in poverty to 17% for households between 200-300% FPL who are not 55-64, or are unemployed. No household in poverty would spend more than 6% of their income on health insurance premiums.

Stop-loss health care pool. Under the Kerry proposal, the federal government would act as a re-insurer for employer-based health insurance for up to 75% of the catastrophic costs insureds incur per episode of care above $50,000.[5] This will reduce the cost of health insurance to employers by 10% in exchange for expanding coverage and implementing disease management (HR Policy Association, 2004, Thorpe, 2004). Firms enrolling in this program must meet three conditions:

(1) employers must cover all workers in their firms;[6]
(2) employers must encourage the introduction of disease management[7] programs; and

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[5] Thorpe (2004) and others have estimated that a threshold of costs above $36,000 would be needed for the first year to reach the 10% premium reduction target.

[6] It is not clear whether this includes part-time workers, early retirees, etc. (HR Policy Association, 2004) For the purposes of this analysis, we follow Thorpe (2004) by including part time workers at pro-rated support and excluding early retirees.

(3) employers must demonstrate how they will share the savings from these programs with workers.

Expansion of Medicaid and S-CHIP (HUSKY) programs to include: (1) children in families under 300% (FPL); (2) parents in families under 200% FPL; and (3) single adults and childless couples in poverty. The federal government would cover the cost of insuring children in HUSKY A and B programs and ask states to cover the cost of expanding coverage to adults (Kerry and Edwards, 2004). The enrollment processes will be simplified and the five-year eligibility time limit for legal immigrants will be removed. States that reach 90-95% of potential enrollment will receive additional federal bonuses worth an anticipated national total of $5 billion dollars. Below this enrollment threshold, however, the policy could act as an unfunded mandate to states. See the section below on low-income household impacts. For Connecticut, only parents between 100-200% FPL and childless adults under 100% FPL who are not eligible for State-Administered General Assistance (SAGA) would be newly eligible. There would be 53,211 newly eligible Connecticut adults.

Cost Reduction Strategies: The Kerry proposal involves cost reduction strategies to help defray program costs. It proposes expanding current electronic insurance claims systems to reduce the adjustment cost per claim, requiring public insurers (Medicaid and Medicare) to adopt this system and providing incentives for other providers to switch. Kerry plans to implement disease management programs, both expanding current public initiatives and encouraging the private sector to do so through the Stop-Loss Reinsurance Pool. Other Kerry *cost reduction* strategies include cost containment programs for prescription drugs. Kerry proposes *quality assurance* programs for the privately insured through a patient's bill of rights. For federal health care programs, Kerry proposes to ensure quality by maintaining funding and ensuring a choice of health insurance plans.

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[7] The term 'disease management' is an umbrella term that incorporates very different types of programs. The Kerry plan does not specify what type of disease management programs would be implemented. To estimate cost savings, CCEA models potential cost savings based on state level experiences in Washington, and Florida, which mandated cost savings in contracts with private disease management companies. These programs target individuals with specific chronic illnesses, like congestive heart failure, diabetes, etc. and encourage the use of best practice treatment standards for patients and their physicians alike.

I.3 Methodology, Data and Limitations

Recapitulating the introduction, CCEA examines the Bush and Kerry healthcare proposals as if each one were simultaneously passed into law. In order to compare their plans effectively, we need to be able to add up the numbers of newly insured for each candidate's plans and associated costs as if each component of their plans were actually in effect for the elected candidate. This process involves a hierarchy of consumer choices that successively exhaust the eligible populations. This approach is necessary because certain groups of Connecticut's population would be eligible for more than one plan within each candidate's array of proposals. In this way, we eliminate overlap (double counting) and obtain the total number of newly insured and associated public (federal and state government) and private (individuals and firms) sectors' costs for each candidate's array of proposals. However, it is possible that not all of the elected candidate's proposals would be enacted into law simultaneously. In that event, our results would not apply. If only some of the elected candidate's proposals' components were enacted, the number of newly insured would be less still than is estimated under a full implementation scenario.

To calculate the results described above, CCEA assumes that Connecticut residents' decision of whether to purchase health insurance and what plan to purchase depends on the price of a particular plan to them relative to other plans and their income. We define the price of insurance for a household as their out-of-pocket premium cost. Thus, we exclude other out-of-pocket expenses such as co-pays and deductibles, employer contributions to premiums, costs of travel, and opportunity costs. In other words, CCEA does not estimate changes in total resource usage within the health care system based on these policies. Therefore, the cost estimates presented here are actually lower than they would be were these other costs incorporated.

CCEA compares Connecticut-specific effects of the Bush and Kerry health care proposals by building an analytical model for each policy. To analyze the policies on equal footing, we use the same data across policies when possible. All numbers reported derive from analytical models for Connecticut.

We draw primarily on three data sources for Connecticut: the Current Population Survey (CPS), the Medical Expenditure Panel Survey (MEPS), and Kaiser Family Foundation (KFF) State Health Facts Online. To build the analytical models, CCEA utilizes existing research relevant to each specific policy, drawing on both technical literature and policy-oriented research. As appropriate, CCEA holds relevant assumptions consistent across analyses. In some cases, lack of detail in the proposed policy or lack of relevant existing research requires us to make reasonable additional assumptions. The technical appendix accompanying this report provides details of this analysis.

Estimates are for a 'typical' one-year implementation based on current Connecticut demographics. Total costs include the broader financial costs of insurance paid by employers, individuals, and governments. We report federal and state governments' cost estimates separately. Private (sector) costs include those costs that households and firms would incur.

Limitations

The analyses flow from the proposed health reforms as stated during August 2004 and focus on those policies affecting the number of uninsured in Connecticut. Subsequent changes to the platforms have been incorporated in our analysis to the extent possible. However, we omit the Bush refundable tax credits proposal that would offer credits ranging from $200 to $500 to small business contributions to health savings accounts, and we omit the Bush proposal to allow individuals to purchase health insurance from other states from the analysis. (The latter proposal implies eliminating ***ALL*** state mandates on coverage, eligibility, and premium compression, creating a single national market for health insurance.) CCEA also excludes policies unrelated to health insurance or relating to incentives. Both sides advocate malpractice reform, electronic medical records, Medicare and prescription drugs plans, but these issues are beyond the scope of this analysis.

II. Results: Costs and Effects of the Candidates' Proposals

Tables 1 and 2 summarize the Bush and Kerry plan costs and effects.

Table 1: Costs and Effects of the Bush Plan in Connecticut

	Enrollees	Change in Insured	Total Cost of Insurance[a]	Federal Cost[a]	State Cost[a]
Tax Credit	49,536	9,328	$275.8	$62.4	-
Tax Deduction	82,936	-749	$485.8	$79.2	-
Association Health Plan	59,667	2,869	$255.5	-	-
Total	192,139	11,448	$1,017.1	$141.6	-
Cost Savings:					
Disproportionate Share Payments			-$7.2	-$3.6	-$3.6
Total Savings			-$7.2	-$3.6	-$3.6
Total Net Cost			$1,009.9 [b]	$138 [b]	-$3.6 [b]

Table 2: Costs and Effects of the Kerry Plan in Connecticut

	Enrollees	Change in Insured	Total Cost of Insurance[a]	Federal Cost[a]	State Cost[a]
Small Business Tax Credit and Congressional Health Plan	96,440	70,722	$433.4	$108.3	-
Stop Loss Reinsurance Pool	204,692	88,263	$907.5	$90.8	-
Medicaid Expansion and Cost Swap	13,303	11,374	$30.5	$263.3	-$232.9
Tax Credits:					
Unemployed	5,269	1,658	$34.7	$12.6	-
55-64	5,537	732	$33.5	$8.4	
Those not qualifying for other plans	43,914	9,186	$265.4	$38.6	-
Total	369,154	181,936	$1,705 [b]	$522 [b]	-$232.9 [b]
Cost Savings:					
Information Technology			-$24.2	-$7.3	-$2
Disease Management			-$39.1	-$30.3	-$8.8
Disproportionate Share Payment			-$58.7	-$29.4	-$29.4
Total Savings			-$122	-$67	-$40.2
Total Net Cost			$1,582.9 [b]	$388 [b]	-$313.3 [b]

Table Notes: [a] All costs in $ millions; [b] Numbers may not add due to rounding.

As Tables 1 and 2 suggest, under the Kerry plan, 181,936 currently uninsured Connecticut individuals would gain insurance. Under the Bush plan, 11,448 Connecticut individuals would gain insurance. Although the Kerry plan clearly expands coverage more than the Bush plan, both plans fall short of insuring the 357,000 currently uninsured in Connecticut.

The Kerry plan costs more than the Bush plan but insures proportionately more people. The *federal* costs of the Kerry plan are almost four times that of the Bush plan, but the *total* costs—including state, business, and households' costs--of the Kerry plan are only 1.5 times the Bush plans' costs. This suggests that although the Bush plan costs the federal government less than the Kerry plan, the private sector (households and firms) pays disproportionately more of the Bush plans' implementation costs than the private sector pays for the Kerry plans' implementation costs. These costs include the costs of insuring individuals and do not include additional out-of-pocket, time, or opportunity costs.

Under the Kerry plan, 181,936 Connecticut individuals who were previously uninsured would gain insurance. Under the Bush plan, 11,448 Connecticut individuals would gain insurance. Although the Kerry plan clearly expands coverage more than the Bush plan, both plans fall short of insuring the 357,000 currently uninsured in Connecticut.

Each candidate's plans affect specific groups disproportionately. Below, CCEA highlights the impact on specific Connecticut groups.

Small Business

In Connecticut, 52.5% of Connecticut's 60,755 small businesses (firms with less than 50 employees) presently offer insurance to their employees (MEPS, 2002).[8] Under the Kerry plan, 8,912 (13.48%) Connecticut small businesses would begin to offer insurance. Under the Bush plan, 471 (0.775%) Connecticut small businesses would begin to offer insurance. Another 12,153 Connecticut small businesses would switch from their current insurance provider to the Kerry Congressional Health Plan to realize

[8] This contrasts with 100% of firms with more than 100 employees that offer insurance to their workers (MEPS 2002).

savings. Under the Bush plan, 9,804 Connecticut small businesses would switch from their current insurance provider to join the proposed Association Health Plans.

The Bush plan would enroll an estimated 59,667 Connecticut residents and insure an additional 2,869 residents. This newly insured figure accounts for individuals with greater health care needs that would either lose their insurance or fall on the traditional health care system, raising costs for everyone enrolled in those plans. The Kerry plan would cover 96,440 employees of small businesses, including 70,722 newly insured.

For Connecticut, the Kerry plan will cost the federal government $108.3 million to implement, while the Bush plan costs the federal government nothing. By exempting Association Health Plans from existing state mandates, however, the Bush plan may reduce the comprehensiveness of coverage firms offer and raise insurance premiums for non-Association Health Plan coverage.

Low-Income Households

Connecticut and 34 other states have computed a "self-sufficiency wage" standard as an alternative to the federal poverty formula. This approach takes into account variations in cost of living in different parts of the country or in a state. The Connecticut analysis calculates the self-sufficiency wage for twelve (12) regions and five (5) family structures, with multiple subdivisions for the age structure of children. In 1998, the sufficiency wage for these different family structures ranged from roughly $30,000 to $40,000 on an annual basis. Adjusting for inflation in the past six years, one may reasonably estimate that the current range is $33,000 to $44,000. Yet if Connecticut patterns of income growth are similar to national patterns, many Connecticut households will experience their incomes stagnating or even declining, making purchasing health insurance an increasing challenge.

Low-income households in Connecticut are more likely to be uninsured than higher-income households. Thirty-five percent of households with incomes below the FPL are uninsured (KFF, 2004). For households between 100% and 200% FPL, 22% are uninsured (KFF, 2004). This figure contrasts with 4% of individuals without insurance in households with incomes above 300% FPL. For a family of three, 300% FPL is an income of roughly $50,000 per year.

The Bush plan addresses low-income uninsured through his tax credit for non-group insurance purchases. As mentioned above, this tax credit covers only one-third of the average insurance premiums. Households poor enough to receive the maximum credit would need to spend a minimum of between 16% to 24% of their household income to take advantage of this credit.

In Connecticut, CCEA estimates that 49,638 individuals would use this tax credit. Only 9,317 of these individuals would be newly insured. Most households likely to use the tax credit already purchase non-group insurance; for them, this tax credit represents a premium subsidy. For Connecticut, the total cost to the federal government is $62.5 million, with Connecticut households bearing $213.9 million in insurance premiums.

The Kerry plan offers an array of programs for low-income households. In Connecticut, the Medicaid expansions target parents with incomes less than 200% FPL and childless adults below 100% FPL. The tax credits (for unemployed and 55-64 year olds) and the health insurance expenditures cap target low-to-moderate income households (incomes less than 300% FPL). In total, the Kerry proposals would insure 22,950 Connecticut low-income individuals who currently have no health insurance. For Connecticut, the federal cost of these changes is $64.3 million and the state cost is $25.7 million. This compares favorably with the Bush proposals that cost $62.5 million federally (for Connecticut) but insure less than half the number of previously uninsured.

The Kerry plan proposes to relieve states of the burden of the state costs of the children's Medicaid program (HUSKY, in Connecticut) in exchange for implementing the proposed Medicaid expansion to parents (100-200% FPL) and childless adults (less than 100% FPL). Adding the costs of this swap to the costs of the low-income programs described above, Connecticut's share of the federal cost of the Kerry low-income plans is $263.3 million. Connecticut experiences a net reduction (savings) of $232.9 million in its Medicaid expenditures.

Both candidates offer states incentives to increase Medicaid enrollment among children. President Bush proposes $1 billion in grants nationally to increase enrollments. Senator Kerry proposes $5 billion in new bonuses for states that enroll 90%-95% of

eligible children. Neither plan gives sufficient detail on how these funds would be distributed to include their impact in the summary tables presented above.

However, CCEA does estimate how much Connecticut would need to cover 90-95% of Medicaid eligible children who are uninsured. There are 53,065 uninsured children who are Medicaid-eligible in Connecticut. Under the existing HUSKY A and HUSKY B programs, it would cost $109 to $115.1 million to insure 90% to 95% of these children. The federal and state governments would need to spend $108.7 to $114.7 million and enrolled households would altogether pay $351,000 to $371,000 in shared premiums. Households would also pay out-of-pocket charges such as health service co-payments, etc., but these are not included in this estimate. In addition to program costs, Connecticut would need to engage in outreach and enrollment activities that would require additional funds.

In order to remain cost-neutral in such an expansion, Connecticut would need to receive *at least* $109 to $115.1 million from government. Given that all states would share in the grants and bonuses, both plans fall short of fully funding the expansion. The Kerry plan does provide some additional funding in the Medicaid cost swap, which, in combination with his bonuses could potentially fund the expansion.

Demographic Effects

CCEA presents key findings for three age groups: children, young adults, and the 'near elderly'. Neither candidate's program increases health insurance coverage for children disproportionately. Healthy young adults are more likely to gain insurance under the Bush high deductible, health savings account combination. The 'near-elderly' benefit from the Kerry tax credit.

The Kerry plan proposes a Medicaid expansion for children under 300% FPL. Connecticut covers this population of children under the HUSKY program. Therefore, there may not be an increase in the absolute numbers of children insured. To some extent, including parents in the Medicaid system (up to 200% FPL) may increase the take-up rate among Connecticut's uninsured children (under 300% FPL). Yet, the new programs do not substantially increase eligibility in this group.

In the 'Low-Income' section above, we discuss grants under the Bush and Kerry plans' incentives to increase children's enrollment in HUSKY. Given that all states would share in the grants and bonuses, both plans fall short of fully funding the expansion. Insuring children is particularly important because children without health insurance have poorer educational attainment and developmental outcomes (CCEA, 2004).

Young adults (18-34) are most likely to be uninsured in Connecticut.[9] Overall, this population has fewer health care needs than other population segments. This population is ideal for the Bush high deductible, health savings account combinations or Association Health Plans that target healthier individuals. Qualitatively, CCEA expects this population to increase its insurance enrollment.

A small number of Connecticut 'near-elderly,' who would not be otherwise eligible or insured, is eligible for the Kerry tax credit. A total of 5,537 Connecticut 'near-elderly' individuals purchase non-group insurance under the Kerry proposal, including 732 newly insured Connecticut 'near-elderly'. This represents about a 50% take-up rate among those eligible for only this program. Health insurance is particularly critical for this group because their health care costs are large and uncertain (Gruber and Madrian, 1993). The Kerry plan helps reduce the number of uninsured in this age category.

Minorities

Currently, minorities in Connecticut are disproportionately less likely to have health insurance than non-minorities. According to CDC (2003), Hispanics are almost *five* times as likely as Caucasian Connecticut residents to be uninsured while African-Americans are *2.3* times more likely to be uninsured than Caucasian people in Connecticut. These racial and ethnic disparities are an on-going problem for the state. Neither candidate's plan sufficiently addresses this gap.

Both platforms rely heavily on tax credits and tax deductions for non-group insurance purchases. Studies have found Hispanics were half as likely as Caucasian individuals to purchase non-group insurance and African-Americans were 41% as likely

[9] According to CCEA (2004), 24% of adults aged 18-24 and 17.3% of adults aged 25-34 are uninsured in Connecticut.

as Caucasians to purchase non-group insurance (Saver, et al., 2003). This finding suggests that tax credits will benefit Caucasian Connecticut residents relative to Hispanics and African-Americans.

The Kerry Medicaid expansion targets low-income individuals and, to the extent that minorities are disproportionately in poverty (28% of Connecticut's African-Americans and 32% of Connecticut's Hispanics compared to 7% of Connecticut's Caucasians), they could benefit from the Kerry program. Both Kerry and Bush offer incentives for increasing enrollment, especially in the S-CHIP (HUSKY) program. Additionally, Kerry proposes to reduce enrollment restrictions by allowing registration through schools and community clinics. Further, Kerry would remove the five-year wait period for legal immigrants to enroll in Medicaid. All of these proposals are a step in the right direction. To illustrate the case for Connecticut, the Center for Survey Research and Analysis (CSRA, 2000) at the University of Connecticut conducted a survey in Hartford in which 41% of Medicaid (HUSKY A) enrollees were Hispanic, 48% were African-American and 4% were Caucasian. Increasing outreach in minority communities and reducing 'red-tape' surrounding enrollment is key to expanding coverage (CSRA, 2000).

The extent to which these proposals would increase enrollment in Connecticut depends on how energetically they are implemented. In Connecticut, the overall expansion in Medicaid eligibility is modest (see above). Enrolling those currently eligible appears to be essential to increasing substantially the number of low-income minority households with health insurance.

CCEA assumes that employer based health insurance expansions would increase coverage for minorities and non-minorities alike. Even so, Bush employer-based health insurance proposals newly insure 2,869 Connecticut residents while the Kerry employer-based health insurance proposals newly insure 158,985 Connecticut residents. Minorities would benefit in absolute numbers more under the Kerry plan than under the Bush plan.

III. Conclusion

We conclude that the Bush and Kerry plans offer a range of proposals that attempt to increase health insurance coverage and reduce healthcare costs to individuals and firms. In Kerry's case, this occurs by expanding the existing partnership between

employers and the federal and state governments. Kerry emphasizes shared responsibility. President Bush's plans promote individual responsibility through tax credits and deductions and an expansion of association health plans into a national market. The latter component of the Bush plans has a negative consequence of exempting association health plans from state mandates that protect consumers from exclusionary practices among other things.

Our task has been to estimate the impact of these candidates' proposals as they relate to Connecticut. To do so, we estimate the relevant populations of Connecticut individuals and firms eligible for each proposal. Our focuses are Connecticut firms with fewer than 50 workers, Connecticut's 'near-elderly', unemployed, and low-income households, and Connecticut's Hispanic and African-American households. Our operating premise is that firms and individuals measurably respond to health insurance price changes and, combined with take up rates, imply changes in the number of uninsured Connecticut people. The changes in the uninsured population then imply changes in costs to individuals and firms as well as to the federal and Connecticut state governments.

The most significant message of our analysis is that neither candidate's proposals, even if all of them were enacted simultaneously, would cover all of Connecticut's currently 357,000 uninsured. The Kerry plans come closest adding 181,936 newly insured, while the Bush plans add 11,324 newly insured, that is, the Kerry plans increase health insurance coverage 16 times more than the Bush proposals do. The Kerry plans would insure 70,722 currently uninsured workers in Connecticut's small businesses, while the Bush plans would insure 9,804 more small businesses' workers, that is, the Kerry plans would insure 7.21 times more workers than the Bush plans would. CCEA estimates that 156,986 low- to moderate-income Connecticut individuals would participate in the Kerry tax credit plan, health insurance expenditure cap and his Medicaid expansion plan that altogether would increase Connecticut's insured by 22,950 people.

The total (public and private) cost of implementing the Kerry plans is $1,582.9 million, while the total (public and private) cost of implementing the Bush plans is $1,019.6 million. Connecticut's share of the federal cost of implementing the Kerry

plans is $528.1 million and Connecticut's share of the federal cost of implementing the Bush plans is $139.9 million. Under the Bush plans, Connecticut realizes savings of $3.2 million, while under the Kerry plans, Connecticut realizes savings of $346.2 million which is more than 108 times as much savings than the Bush plans pass along to Connecticut.

APPENDIX I: Center for Budget Policy and Priorities Report

INCOME INEQUALITY HAS INCREASED IN CONNECTICUT SINCE THE 1970s

Inequality has increased in Connecticut over the past two decades. This can be observed by ranking all Connecticut families according to their income level, dividing them into five of equal size, and calculating the average income of each fifth of families. This analysis shows by the late 1990s:

- The richest 20 percent of families had average incomes 9.4 times as large as the poorest 20 percent of families.
- The richest 20 percent of families had average incomes 2.7 times as large as the middle 20 percent of families.

The Long-Term Trend

Since the late 1970s, income inequality has increased in Connecticut. The economic growth of the 1980s and 1990s was not shared evenly among the poor, the rich, and the middle class. Instead, the top fifth of families fared substantially better than other income groups. In the late 1970s, the richest 20 percent of families had average incomes 6.1 times as large as the poorest 20 percent of families. By the late 1990s, that ratio had grown to 9.4. This increase in inequality was the sixth greatest in the nation.

- The average income of the poorest fifth of families increased by $1,130 between the late 1970s and the late 1990s, from $18,220 to $19,350.
- The average income of the middle fifth of families increased by $16,160 between the late 1970s and the late 1990s, from $49,990 to $66,150.[10]
- The average income of the richest fifth of families increased by $70,150 between the late 1970s and the late 1990s, from $111,040 to $181,190.

The Recent Trend

Over the past decade, income inequality has increased in Connecticut. In the late 1980s, the richest 20 percent of families had average incomes 6.2 times as large as the poorest 20 percent of families. By the late 1990s, that ratio had increased to 9.4. This

[10] The direction of this change is not statistically significant at the 95 percent level of confidence.
Source: Economic Policy Institute/Center on Budget and Policy Priorities, *Pulling Apart: A State-by-State Analysisof Income Trends*, April 2002.

increase in inequality was the largest in the nation. The gap between the rich and the middle class also increased. This increase was the fifth greatest in the nation.

• The average income of the poorest fifth of families decreased by $4,670 between the late 1980s and the late 1990s, from $24,020 to $19,350.

• The average income of the middle fifth of families increased by $1,020 between the late 1980s and the late 1990s, from $65,130 to $66,150.[13]

• The average income of the richest fifth of families increased by $31,640 between the late 1980s and the late 1990s, from $149,560 to $181,190.

APPENDIX I: Blue Cross Blue Shield Report on State Mandates

50-State Summary:
Consumer Protections Lost under
Association Health Plan Legislation

Consumer protections that:	Number of States
Ensure access to independent review:	
• Consumers can demand independent external review of claims denials	43
Ensure appropriate access to care. Insurers must:	
• Cover emergency services that a "prudent layperson" thought necessary	42
• Cover transitional care from a provider who leaves a network	37
• Cover non-formulary prescription drugs in certain situations	29
• Offer point-of-service option	19
• Plans must allow direct access to OB-/GYNs	41
• Cover clinical trials	18
• Not "gag" providers' communications with patients	47
Ensure fair insurance premiums for small groups:	
• Insurers must limit how much they charge sicker groups	48
Ensure marketing protections:	
• Insurers must follow detailed requirements for marketing materials	50
Ensure health plans cover important benefits, such as:	
• Mental health parity that goes beyond federal requirements	33
• Substance abuse treatment	31
• Alcoholism treatment	43
• Mammography screening	49
• Minimum mastectomy stay	23
• Invitro fertilization	11
• Well-child care	31
• Prompt payment rules	49
Ensure appropriate oversight of insurers:	
• State handles complaints from consumers & providers	50
• State investigates, oversees, enforces rules (including financial penalties)	50
Prevent plan failures and ensure payment of claims:	
• Insurers must maintain surpluses that grow with size of insurer	50
• State oversees corrective action once insurer nears minimum standards	50
• State acts quickly to seize assets to pay claims	50
Promote access for the uninsured:	
• Mini-COBRA rules for small employers with fewer than 20 employees	39
• Insurers help fund state high-risk pools	26

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Denotes a mandated offer requirement

Connecticut: Consumer Protections Lost under Association Health Plan Legislation

Connecticut has consumer protections that:	Comparable Federal Rule for AHPs
Ensure access to independent review:	
• Consumers can demand independent external review of claims denials	No
Ensure appropriate access to care. Insurers must:	
• Cover emergency services that a "prudent layperson" thought necessary	No
• Cover non-formulary prescription drugs in certain situations	No
• Allow direct access to OB-GYNs	No
• Cover cancer clinical trials	No
• Not "gag" providers' communications with patients	No
Ensure fair insurance premiums for small groups. Insurers cannot:	
• Vary premiums averaged on health status[1]	No
• Increase an employer's premiums when an employee gets sick	No
Ensure marketing protections:	
• Insurers must follow detailed requirements for marketing materials	No
Ensure health plans cover important benefits, such as:	
• Mental health parity that goes beyond federal requirements	No
• Substance abuse treatment	No
• Alcoholism treatment	No
• Mammography screening	No
• Minimum mastectomy stay	No
• Invitro fertilization*	No
• Well-child care	No
• Prompt payment rules	No
Ensure appropriate oversight of insurers:	
• State handles complaints from consumers & providers	No
• State investigates, oversees, enforces rules (including financial penalties)	No $
Prevent failures and ensure payment of claims:	
• Insurers must maintain financial surpluses that grow with size of insurer	No ($2M cap)
• State oversees corrective action once insurer nears minimum standards	No
• State acts quickly to seize assets to pay claims	No
Promote access for the uninsured:	
• Mini-COBRA rules for small employers with fewer than 20 employees	No
• Insurers must help fund state high-risk pool	No

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[1] Prohibits use of health status. Community rating with adjustments for age, gender, area, family size and limited adjustment for industry.

*Denotes a mandated offer requirement

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