Health and Income Security Brief

March 2008 • No. 11

NATIONAL ACADEMY OF SOCIAL INSURANCE

Achieving Universal Participation in Social Insurance Systems

By Paul N. Van de Water

Summary

Social insurance protects families against common risks to their economic security, such as the loss of earnings and the cost of health care. To share these risks as widely as possible, social insurance programs aim to be universal in their coverage. Approaches to achieve broad coverage include tax-financed public programs, subsidized voluntary programs, requirements for employers to provide for their employees, and requirements for individuals to obtain insurance. This issue brief summarizes these approaches. An appendix considers the role that an individual mandate might play in expanding health insurance coverage.

What is social insurance?

Social insurance encompasses broad-based systems for insuring workers and their families against economic insecurity. Everyone faces risks to economic security throughout his or her lifetime—the death of a parent in one's childhood or youth, loss of wages during the working years, outliving one's savings in retirement, the cost of long-term care near the end of life, and high health care costs at any age. Social insurance offers society-wide solutions to these society-wide problems.

Social Security and Medicare are the best known examples of social insurance, and many people regard them as the model, but social insurance has evolved over the years and comes in many forms. Workers' compensation for industrial accidents and illnesses is the oldest form of social insurance in this country. The first workers' compensation law was enacted in 1908 to cover certain federal workers, and the first state laws were passed in 1911.

The Social Security Act of 1935 is the "foundation on which modern social welfare policy rests" (Berkowitz 1991). The principal element of the act was the program of old-age insurance that has come to be known as Social Security, but the act also established the federal-state system of unemployment compensation, as well as an old-age assistance program (the precursor of today's Supplemental Security Income). Family benefits for dependents and survivors were made part of Social Security in 1939, and disability insurance was included in 1956.

When the Congress added health insurance coverage for the elderly to the Social Security Act in 1965, it combined three different programs and approaches. A contributory payroll-tax financed

Paul N. Van de Water is Vice President for Health Policy at the National Academy of Social Insurance.

system (Medicare Part A) provided protection against the cost of hospital and related care. A supplementary insurance plan financed by premiums and general revenues (Medicare Part B) covered physicians' and other health services. And a new program of medical assistance (Medicaid) consolidated and expanded several earlier programs for the medically needy.

"Social insurance," writes columnist E.J. Dionne, "was a wise admission on the part of supporters of competitive economies that citizens would take the risks such economies require only if they are provided with a degree of security against old age, unemployment, the sudden death of a spouse, and the vicissitudes of health. The basic idea behind [social insurance], the need for collective provision against certain forms of insecurity, remains deeply popular despite the rise of the ideology of privatization" (Dionne 1999).

Why does social insurance aim to be universal?

To fulfill their social purposes effectively, social insurance programs aim to be universal, or close to universal, in their coverage. Indeed, according to Michael Graetz and Jerry Mashaw, "Social insurance's aspiration to universalism may be the feature that distinguishes it most from private insurance" (Graetz and Mashaw 1999). Only with nearly universal coverage can the risks to economic security be shared as widely as possible between the lucky and the less fortunate, the healthy and the sick, the rich and the poor, as well as between those who are in the labor force and those who are too young or too old to work.

Universal participation not only assures shared responsibility for shared risks; it also brings important practical advantages. It reduces administrative costs because there is little or no need to spend money on advertising, sales commissions, or attempting to exclude high-risk applicants. It also avoids what insurers call "adverse selection"—the tendency for those with above average risk to be more likely to purchase insurance.

For example, people who think that they are likely to live a long time are more likely to purchase retirement annuities. Insurance companies, knowing that purchasers have personal information about their own health prospects, take account of this adverse selection in pricing annuities and therefore charge higher premiums to all purchasers for a given payout. Social Security, in contrast, can offer a higher annual payout because almost everyone is in the risk pool, all benefits are paid in the form of lifetime income, and no funds leak out in lump-sum payments or bequests (Reno *et al.* 2005).

Health insurance offers another example of adverse selection. When health insurance must be purchased individually, it may prove prohibitively expensive or even unavailable. When health insurance covers everyone in a large group, such as members of a union or employees of a firm, however, it tends to be more affordable. Since these groups are not formed primarily for the purpose of obtaining insurance, insurers can have confidence that they are covering people in a wide range of circumstances—not a just a self-selected set of people with high health care costs.

What are the ways of achieving universal or near universal participation?

Universal or near universal participation in social insurance systems may be achieved in different ways. Four are considered here:

1. A tax-supported public program,
2. A voluntary program that requires the payment of premiums but whose benefits are sufficiently subsidized that almost everyone chooses to participate,
3. A requirement that employers insure their employees, and
4. A requirement that individuals obtain insurance coverage.

Which approach or combination of approaches is selected in a particular case is sometimes less a matter of principle than of practicalities, such as the political and budgetary context, the details of the program, and ease of administration.

Contributory or Tax-Financed Public Programs. The largest social insurance programs in the United States—Social Security and Medicare's Hospital Insurance program (Part A)—are public programs operated by federal agencies, although Medicare relies on private insurance companies and other contractors to process and pay claims. Social Security and Medicare Part A cover almost all workers in the U.S. They are financed by mandatory payroll tax contributions paid by workers and their employers. Unemployment compensation, a federal-state program, is also contributory, although the taxes are paid only by employers.

Social Security, Medicare's Hospital Insurance, and unemployment insurance are based on some common principles. The programs achieve near universal coverage through compulsory participation. Contributions are wage-related and scaled to ability to pay. Employers share in their financing. Benefits are paid as an earned right to everyone who has made the requisite contributions and has experienced the insured event—disability, retirement, hospitalization, unemployment, and so forth. Virtually every eligible person claims his or her benefit.

Many experts include public assistance programs in their definition of social insurance, although such programs are based on different principles than Social Security. These means-tested programs receive broad-based support through general tax revenues and provide protection against the risk of having low income. For example, the Supplemental Security Income program, administered by the Social Security Administration, provides assistance to low-income aged and disabled persons. Everyone who is required to pay taxes implicitly participates in the financing of these programs. Everyone who meets the test of need (based on income and, often, assets) and the categorical requirements for eligibility may receive benefits, and no prior contributions are required. Means-tested programs, however, have generally had difficulty in achieving high rates of participation among those eligible (Ebeler and Van de Water 2006).

Subsidized Voluntary Systems. Medicare's Supplementary Medical Insurance (SMI, or Part B), which pays doctors' bills, and prescription drug benefit (Part D) are voluntary social insurance programs that require the payment of monthly premiums. To assure near universal

participation and avoid adverse selection, premiums cover only about 25 percent of the cost of the programs, and the rest is financed through general tax revenues. Thus, most eligible people have a strong incentive to participate, because they are paying only a fraction of the cost of the benefit. (In SMI, the subsidy is phased out for upper income individuals.) Because low-income Medicare beneficiaries are likely to find the premiums unaffordable, specially targeted means-tested programs—the Medicare Savings Programs and the prescription drug subsidy—provide them assistance in paying premiums and cost sharing (Ebeler and Van de Water 2006). As a further encouragement to participate in Parts B and D of Medicare, and to avoid adverse selection, people who do not sign up at the earliest opportunity are charged higher premiums when they eventually enroll.

Employer Requirements. A third way of ensuring universal coverage of those in the workforce is to require employers to insure their employees (and, potentially, their dependents). This approach is often termed an "employer mandate." Workers' compensation, for instance, is mandated by state law but delivered primarily through private insurance carriers. Every state except Texas now requires that private employers provide workers' compensation cash benefits and medical protection for most employees who are injured on the job. States generally require employers to obtain insurance or prove they have the financial ability to carry their own risk (Sengupta, Reno, and Burton 2007).

Since 1975, Hawaii's Prepaid Health Care Act has required nearly all employers to provide health insurance to employees who work 20 hours or more a week for four consecutive weeks. Employers must pay at least half of the premium for single coverage, but the employee's contribution cannot exceed 1.5 percent of his or her wages.

Individual Requirements. A fourth way of achieving widespread participation in a social insurance program is to require individuals to obtain coverage (an "individual mandate"). Unlike an employer mandate, an individual mandate can reach those who do not have a current connection to the workforce.

Compulsory automobile insurance is the only widespread example of an individual insurance mandate in the United States. Forty-six states (and the District of Columbia) require automobile owners to maintain some form of insurance coverage, and all states hold motorists accountable for bodily injury of other people and damage to other vehicles. "Automobile liability insurance is not usually considered social insurance," note Graetz and Mashaw, "but individual mandates are quite common in the pension and health regimes of other countries" (Graetz and Mashaw 1999).

Both Switzerland (since 1996) and the Netherlands (since 2006) assure nearly universal health insurance coverage through systems that require all residents to purchase health insurance from one of several tightly regulated insurance carriers. In the United States, an individual mandate to purchase insurance is part of the comprehensive health care financing reforms enacted by Massachusetts in 2006.

Affordability is a key issue for an individual health insurance mandate. The cost of complying with the mandate will depend on the scope of the required insurance policy, the rules governing the pricing of policies, other aspects of the health care financing system, and the overall cost of the health care delivery system. In the Netherlands, the average premium in 2007 is about $1,650 a year. In Switzerland, the premium varies by canton and averages about $3,100 a year for an adult. In Massachusetts, the cost of minimum creditable coverage (which may have a deductible of up to $2,000) can reach $4,920 for an individual age 50 or over in the most expensive region of the state. Premiums are relatively low in the Netherlands partly because employers pay half of the cost of insurance through an income-related contribution.

Employment-Based Coverage. Private employee benefit plans, whether collectively bargained or employer sponsored, share some of the attributes of social insurance and receive public subsidies through the tax system. Employment-based retirement plans often require all members of the covered group to participate. Employees who work for employers that contribute to pension plans do not have the choice of foregoing coverage and turning the employer's contribution into cash wages. Because these plans receive favorable tax treatment, they are also subject to elaborate non-discrimination rules that aim to assure that the benefits do not go disproportionately to highly paid individuals.

Health insurers generally require employers to pay at least half of the insurance premium and to achieve minimum rates of participation among their employees (typically, 75 percent) to assure a broad risk pool and guard against adverse selection. If an employer pays the entire premium, the insurer may require all workers to be covered (excluding those covered by a spouse's policy).

Conclusion

No social insurance system ever quite achieves 100 percent coverage of its target population. And the incentives, benefits, and subsidies built into a social insurance program can achieve near universal coverage without mandatory participation, as is true of Part B of Medicare. How close to universal coverage is close enough to serve the purposes of a social insurance system depends importantly on what parts of the population would remain uncovered and how their non-participation would affect the economic and political viability of the program.

Appendix—Individual Mandates to Purchase Health Insurance

Some current proposals to expand health coverage contain mandates that would require individuals to buy health insurance. Other proposals would impose requirements on employers to provide or pay for coverage (called "play or pay") in addition to or instead of an individual mandate. Still others would create new tax-financed public health insurance programs.

Tax financing, employer mandates, and individual mandates thus represent different tools that can be employed in the search for universal health insurance coverage. Like other tools, none can do the job alone. Just as building a house requires more than a hammer or a screwdriver, achieving universal health insurance coverage requires more than simply levying a tax or imposing a mandate. Many pieces must be assembled, and the details matter. In the case of individual health insurance mandates, the mandate must form part of a system of regulations and subsidies that assure that insurance is available and affordable to all.

The system put in place in the Netherlands in 2006 illustrates one way in which an individual mandate can be part of a package for achieving universal health insurance coverage. The new Dutch system aims to strengthen social solidarity by replacing the former mixed public-private system of health insurance with a single system that applies equally to everyone. In addition to the individual mandate to purchase health insurance, its key elements include the following (Capozza 2007; Okma 2008; Steuerle and Van de Water 2008):

- Insurers must offer a standard benefit package—a comprehensive plan that covers primary care, inpatient and outpatient care, prescription drugs, maternity, and emergency services.
- Patients face minimal cost-sharing in the form of deductibles, co-payments, or other out-of-pocket costs.
- Every insurer must accept anyone who applies for insurance and must charge everyone the same premium for the same policy, regardless of age or health status.
- Most people are covered by group insurance contracts through employers, unions, or patient organizations. Under these contracts, insurers may offer a discount of up to 10 percent.
- Employers pay half of the cost of insurance through an income-related contribution of 6.5 percent of their employees' earnings, up to $42,000.
- The government pays the premiums of children up to age 18.
- Individuals must pay a premium to their insurer that covers the remaining costs. Premiums do not vary widely between plans, ranging from roughly $1,500 to $1,750 a year in 2007.
- Generous subsidies are provided and extend to families earning up to $58,000. Almost 40 percent of the population received a premium subsidy in 2007.

- The government allocates the proceeds of the income-related contribution so that insurers receive extra funding for enrolling elderly, chronically ill, and other high-risk patients.
- The government is currently developing enforcement mechanisms to deal with those who fail to take out insurance or are delinquent in paying their premiums.

As this list makes clear, the individual mandate in the Netherlands forms just one part of a comprehensive social health insurance system, in which the financial risks of ill health are widely shared among individuals, employers, and the government. Similarly, proposals for an individual health insurance mandate in the U.S. include many other moving parts, such as the creation of insurance purchasing pools, regulation of insurance policies and rates, provision of premium subsidies, and the imposition of play-or-pay requirements on employers. How well an individual mandate would work, and whether it is viewed as an acceptable way of achieving universal health insurance coverage, will ultimately depend on these other critical provisions.

References

Berkowitz, Edward. 1991. *America's Welfare State: From Roosevelt to Reagan*. Baltimore: Johns Hopkins University Press.

Blumberg, Linda J., and John Holahan. 2008. *Do Individual Mandates Matter?* Washington: Urban Institute.

Capozza, Korey. 2007. *Individual Mandates: Lessons from Abroad*. Berkeley, CA: University of California, Center for Labor Research and Education. Policy Brief.

Dionne, E.J., Jr. 1999. *Why Social Insurance?* Washington: National Academy of Social Insurance. (Social Security Brief No. 6).

Ebeler, Jack, and Paul N. Van de Water. 2006. *Improving the Medicare Savings Programs*. Washington: National Academy of Social Insurance.

Graetz, Michael J., and Jerry L. Mashaw. 1999. *True Security: Rethinking American Social Insurance*. New Haven: Yale University Press.

Okma, Kieke G.H. 2008. "Recent Changes in Dutch Health Insurance: Individual Mandate or Social Insurance?" Paper prepared for the National Academy of Social Insurance and the National Academy of Public Administration.

Reno, Virginia P., Michael J. Graetz, Kenneth S. Apfel, Joni Lavery, and Catherine Hill (eds.). 2005. *Uncharted Waters: Paying Benefits from Individual Accounts in Federal Retirement Policy*. Washington: National Academy of Social Insurance.

Sengupta, Ishita, Virginia Reno, and John F. Burton, Jr. 2007. *Workers' Compensation: Benefits, Coverage, and Costs, 2005*. Washington: National Academy of Social Insurance.

Steuerle, C. Eugene, and Paul N. Van de Water. 2008. "Administering Health Insurance Mandates." Paper prepared for the National Academy of Social Insurance and the National Academy of Public Administration.

Thompson, Lawrence H. 1994. "The Roles of Social Insurance, Tax Expenditures, Mandates, and Means-Testing," in Robert B. Friedland, Lynn M. Etheredge, and Bruce C. Vladeck (eds.), *Social Welfare Policy at the Crossroads*. Washington: National Academy of Social Insurance.

Also of interest from the National Academy of Social Insurance website at *www.nasi.org*...

Children's Stake in Social Security
Social Security Brief No. 27 ~ April 2007

Social Security: An Essential Asset and Insurance Protection for All
Synthesis Report ~ January 2008

Social Insurance Need Not Limit Economic Growth: New Evidence
Health and Income Security Brief No. 10 ~ September 2007

Social Security and Retirement Income Adequacy
Social Security Brief No. 25 ~ May 2007

Medicare Finances: Findings of the 2007 Trustees Report
Medicare Brief No. 17 ~ April 2007

Social Security Finances: Findings of the 2007 Trustees Report
Social Security Brief No. 24 ~ April 2007

Strengthening Medicare's Role in Reducing Racial and Ethnic Health Disparities
Report of the Study Panel on Medicare and Disparities ~ October 2006

Medicare, the National Quality Infrastructure, and Health Disparities
Medicare Brief No. 14 ~ October 2006

Survivor Benefits for Families of Deceased Servicemembers and Overseas Contract Workers
Social Security Brief No. 23 ~ October 2006

Improving the Medicare Savings Programs
Report of the Study Panel on Medicare/Medicaid Dual Eligibles ~ June 2006

Can We Afford Social Security When Baby Boomers Retire?
Social Security Brief No. 22 ~ May 2006

Developing a Better Long-Term Care Policy: A Vision and Strategy for America's Future
Report of the Long-Term Care Study Panel ~ November 2005

The National Academy of Social Insurance is a nonprofit, nonpartisan organization made up of the nation's leading experts on social insurance. Its mission is to promote understanding and informed policymaking on social insurance and related programs through research, public education, training, and the open exchange of ideas. Financial support for this brief was provided by the AFL-CIO.

NATIONAL ACADEMY OF SOCIAL INSURANCE

1776 Massachusetts Avenue, NW, Suite 615 • Washington, DC 20036-1904
(202) 452-8097 • (202) 452-8111 Fax • nasi@nasi.org • www.nasi.org