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One of the most volatile and complex issues to be faced in the workplace is the debate over health benefits. Fueling the fire are dollars. Employers both public and private, confront spiraling costs that, thus far, have defied attempts at control. Employees are confronted with having to pay more for their health benefits and may not be able to get coverage for themselves or their dependents. Government faces the same issue as private employers but is also trying to contain the costs of major programs such as medicare and medicaid for those who are not covered through employment.

This paper addresses the major issues surrounding employment-based health insurance, identifying a number of areas that are generating concern. The intent is to identify and discuss trends that are causing problems for employers and employees alike, and then discuss what state governments can do through health policy development and insurance regulation to address those problems.

The Issues

Employment and Health Benefits in the United States

Our health care system is a unique mix of private insurance and public programs. Since World War II there has been increasing reliance on employment-based health insurance as the primary source of coverage and a great decline in insurance purchased by an individual. Public programs serve those persons who do not get private coverage. Since
the inception of medicare and medicaid in 1965, the intent of public programs has been to serve the elderly, the poor, and the disabled.

In contrast to most other industrialized countries, our private-public system has never provided health care coverage for everyone. There are gaps that result in persons and families not having access to public or private health care coverage. While 84 percent of Americans have some form of private or public coverage, about 34 million persons under age 65 do not. About 85 percent of the uninsured are employed or living in a family headed by a worker (Foley 1991). While medicaid was intended to cover the poor, about half of those having incomes below poverty are not medicaid recipients (National Governors' Association 1991).

Our reliance on employment-based health insurance coverage has traditionally been supported by almost all segments of American society. Employers have been willing to offer health insurance to their employees and their dependents. Government has subsidized private insurance coverage by affording favorable tax treatment to health benefits and to expenditures for health services.

In our employment-based system the employer makes the decision to offer health insurance as part of the package of benefits made available to employees. Employers have looked on health benefits as a tool to recruit and retain employees; if they were not offered, the employer could be at a competitive disadvantage in the labor market. Over time the amount and range of services covered in employment benefit packages have expanded. Part of the reason for the increase is collective bargaining. Over the past 10 to 15 years, benefits have increased at a higher rate than wages, and health care benefits have become the central focus of negotiations on wages and benefits.

With the increase in benefits came an associated increase in costs. For a long time employers were able to absorb the additional costs by trading off health benefits with wage increases. Now, the rate of increase outstrips wage increases. Employers are unwilling or unable to continue paying the increases. Employees are unwilling or unable to accept fewer benefits or pay more for existing benefit packages. Gov-
ernment is unwilling or unable to fill the widening gaps. As a result, there is increasing turmoil in the health benefits system.

**Employee Dissatisfaction**

The American people are becoming more and more dissatisfied with our health care system. In an opinion poll taken in November 1988, about 89 percent of respondents believed that there needed to be a fundamental change in health care (Blendon and Donelan 1990). The degree of dissatisfaction is further demonstrated by a 1989 survey that found 67 percent favoring a government-financed national health plan, compared to 48 percent expressing such sentiments in 1982 (Blendon and Donelan 1990).

Public dissatisfaction with our health care system is being played out in the workplace. Employer efforts to share the rising health insurance premiums with employees are meeting increased resistance. Recent strikes against AT&T, three “Baby Bell” telephone companies, and the coal industry in Virginia over health benefit issues signal workplace conflict.

From the employee perspective, health care plans have evolved into a complex web of varying benefits, financial risks, new service delivery mechanisms, and constraints on the use of services. The days of first dollar coverage to go to the doctor and hospital of choice are rapidly disappearing. Today, employees need to learn about coinsurance and deductibles and maximum lifetime benefits. They have to learn a new language that uses acronyms such as IPA, HMO, and PPO. They need to know about medical underwriting and preexisting conditions. They need to know if an operation needs to have a second opinion and/or preadmission certification, and if the procedure can be covered in the hospital or would have to be performed in an outpatient setting.

**Employer Frustration**

If employees are dissatisfied, employers are frustrated. Costs are out of control. In 1990, the cost of the average health plan rose 17 percent to $3,217. Since 1985, the cost of health benefits has risen an average
of 9 percent per year (Higgins 1991). Employers frustration is understandable given their efforts to contain costs.

The past decade has witnessed major public and private efforts to control health care costs. The record of these efforts does not seem promising now or in the future. In 1980, health care expenditures totaled $249.1 billion, or 9.1 percent of Gross National Product (GNP). Though there was some slowing in the rate of increase in the mid-1980s, the rate is back to double digits with no relief in sight. In 1989 the United States spent $604.1 billion (11.6 percent of GNP) on health care. The total represents an 11.1 percent increase over 1987, more than double the rate of general inflation (Lazenby and Letsch 1990).

By 1986, an overwhelming majority of employers had implemented a wide range of cost-saving mechanisms by restricting use of some services (e.g., second surgical opinions, preadmission certification); helping employees use services more economically (e.g., differential coinsurance and deductibles); offering less expensive alternative services (e.g., home health care, outpatient surgery); and, restructuring service delivery (e.g., HMO, PPO). (See Wyatt Company 1988.) The effect of these changes has been less than promised. While there was some slowing of health care cost increases, costs have regained their rapid rate of growth (Lazenby and Letsch 1990). It may be that costs would have risen even higher without these cost-containment efforts, but that is faint praise.

Government Uncertainty

Government programs serve to supplement employment-based health insurance. This is done primarily by filling the gaps—providing health services to those who, for a variety of reasons, are unable to get employer-based coverage. At both the federal and state levels, government financial and programmatic involvement has increased over the years in response to concerns about access to care for persons not in the workforce. The most significant federal response came with the creation of the medicare and medicaid programs in 1965. Medicare was intended to serve the elderly and disabled who no longer work; medicaid was intended to serve the disadvantaged poor who were
unable to work. Since their enactment these programs have grown precipitously, both in dollars and in persons served.

Government plays an additional, and more significant, role in the employment-based system; that is, regulating health insurance. This is essentially under the purview of state government authority. Generally, the function of insurance regulation is to protect consumers. Insurance regulators do so in a variety of ways. They ensure the financial solvency of insurers by establishing capital and financial reserve requirements. States require information disclosure, auditing, bonding, and standardized definitions of terms of coverage. Finally, states also establish standards for the services required to be included in health insurance plans.

This last role—mandating benefits—has created great controversy among insurers and regulators. It is argued that mandated benefits increase the cost of insurance, thereby limiting its affordability to employers, especially small business. Moreover, it is argued, some types of benefits should not be mandated for all insurance policies, but paid for by the consumer or insurer at their choice. On the other hand, defining a set of benefits to be offered by all insurers protects the consumer by making known the minimum benefits covered by their insurance. Also, mandated benefits allow access to services that may not be affordable to the consumer, such as mental health services.

There are increasing demands for greater government involvement in health care. These demands range from making improvements in medicare and medicaid to enacting national health insurance. On the other hand, there is intense resistance to raising the revenues necessary to make those changes. There are conflicting messages coming to government from other actors in the system. As a result, government is uncertain about how to respond to the current concerns about health care access and costs.

**Reversing a Trend: Cost-Shifting**

The seeming inability to control costs and the inability to find more money to pay the increase has forced purchasers of health care, employers and government, to engage in cost-shifting. Cost-shifting,
operationally, involves one purchaser limiting his or her financial exposure for health care by shifting it to someone else. For example, an employer could reduce financial risk for health costs by not covering dependents of employees. Those dependents, then, either would have to pay for care out-of-pocket or find another source of insurance. Cost-shifting is rational economic behavior for the individual actors because it does reduce their costs; but, total health care expenditures continue to rise.

The private-public structure of our health care system creates an environment for cost-shifting. In better times, cost-shifting is seen as a healthy response to changing economic and political conditions. Over the past 50 years health care financing and coverage have evolved from an individual responsibility to a shared responsibility of the individual, the government, and the employer. Cost-shifting is becoming increasingly unacceptable—looked on as a denial of responsibility and a source of tension among the health care benefit partners.

Cost-shifting has led to a reversal of a long-term trend of business and government taking more financial responsibility for health care. According to a recent report by the General Accounting Office, the greatest proportion of recent health care cost increases has been borne by families and individuals. Between 1967 and 1982, the personal share of health expenditures declined from 65 percent to 39 percent. By 1987 the individual share had risen to over 42 percent. During the 1982–1987 period business and government share had declined, so that by 1987 business accounted for 28 percent and government just under 30 percent of total spending on health care. Employee contributions were going up at a greater rate than the price of health services (General Accounting Office 1990).

Another major player in cost-shifting is the insurance industry. Responding to complaints about skyrocketing health insurance premiums, insurers are engaging in a variety of mechanisms to minimize their financial risk. Generally, these mechanisms are aimed at avoiding or controlling their exposure to paying high cost claims. One way to do that is to exclude persons and groups from getting coverage. This can be done through medical underwriting and preexisting-condition
exclusions, or by refusal to write policies for certain occupations or groups. In order to minimize their risk of high cost claims, insurers can decrease the maximum dollar limit of the policy, either annually or on a lifetime basis. These actions impinge on access to health care coverage and shift those costs to other actors, primarily government and hospitals.

Employers who offer health insurance argue that employers who do not offer insurance are shifting costs to them in the form of increased hospital prices and the additional costs of covering working dependents who are not able to get insurance from their employers. Employees accuse employers of cost-shifting health care costs to them, reducing their income, and making it more difficult to cover their dependents. Employers argue that government's efforts to control the costs of medicare and medicaid by underpaying health care providers has forced providers to increase costs to other purchasers, mainly employers.

Cost-shifting does not offer a solution to the cost crisis. Cost-shifting is circular, causing actors in the system to shift costs to someone else or have costs shifted to them. Instead, solutions may be found in equitable ways to cost-share among all parties—employees, employers, and government.

Defining the Issues

The preceding section described our health care system and identified the cost and access concerns of the three major players—employers, employees, and government. In this section greater attention is focused on those concerns by disaggregating the characteristics of our employment-based health insurance.

Employment and Insurance

Employers vary widely on providing health benefits to employees and their dependents. Separating employers into gross categories based
on whether or not health insurance is offered to employees yields results that can suggest solutions to the cost/access problems. Generally, large employers engaged in manufacturing and mining are most likely to offer health insurance. Businesses with fewer than 25 employees who are engaged in construction, retail trade, and services are least likely to have health insurance plans (Foley 1991).

This divergence among employers also suggests different problems. For small business, access to health insurance that is affordable may be a major deterrent to having health benefit plans. Some insurers are blacklisting certain occupations and types of small employers from health insurance. The cost of buying health insurance is about 10 to 40 percent higher for small employers than for large businesses. There are higher administrative costs for insurers to service small business. Also, insurers add into the premium a risk factor associated with the lack of experience rating for a small group. Finally, the insurance offered must comply with state insurance laws on mandated benefits, which increases the cost of insurance.

These characteristics have important implications now and for the future. One of the findings of the Hudson Institute publication Workforce 2000 is that “the typical workplace will be smaller and most new jobs will be in small business” (Johnston 1987).

These are the types and sizes of businesses least likely to offer health insurance now. This could result in increased numbers of uninsured and increased cost-shifting to other purchasers of health care if ways are not found to induce small business to offer health insurance.

The issues surrounding employers who offer health insurance are different. Their primary interest is to cut health care costs. In addition to the cost spiral on premiums and costs mentioned earlier in this paper, large employers face another major issue, that is, the increasing costs of paying for health care benefits to retirees, especially in manufacturing and mining.

**Emerging Issue: Retirees**

Retiree health care plans are becoming more expensive propositions for employers. These plans, which followed active employee health
plans, originally presented a minimal expense because they were designed to integrate with medicare. However, as the workforce ages, retirees live longer, and health care costs increase, the cost of retiree coverage is rising. Some 80 percent of companies with over 1,000 employees extend health benefits to retirees. Some companies provide coverage only for medicare-eligible retirees; others usually extend coverage to early retirees.

In 1988, per-retiree medical costs averaged $2,397 for early retirees and $1,372 for medicare-eligible retirees, while medical plan costs for active employees averaged $2,160. Retiree health benefits consumed 13.7 percent of employers’ total health care benefits budget, which represented a 15 percent increase over the 11.9 percent that retiree benefits cost employers in 1987.

Despite the increasing costs related to retiree coverage only 1.3 percent of respondents to the Foster Higgins Survey on Retiree Health Care 1988 indicated that they are considering terminating these benefits (Higgins 1989). At the same time, companies are considering limiting the coverage and searching for ways to contain the costs of benefits covered. According to the same survey an average of 16 percent of participants in an employer-sponsored health plan are retired. This figure is expected to rise to 22 percent by the year 2000. Funding the future liability for these retirees is a major issue that some companies have considered, but all will have to begin to address in 1992.

The Financial Accounting Standards Board (FASB) is establishing requirements for employers to accrue the cost of postretirement welfare benefits during employees’ working careers and record a minimum liability on their balance sheets. Because most firms currently account for retiree welfare benefits on a pay-as-you-go basis, they will experience a substantial increase in accounting cost and a corresponding reduction in profits. The new accounting rules could have large impacts on state government. First, states may have to change their state employee health benefits for retirees and/or additional appropriations. Second, there may be a decrease in business tax revenue due to the FASB rules.
The Working Uninsured

Approximately half of the 34 million uninsured are employed. These working uninsured tend to be low-income—about 60 percent have incomes under $20,000—and young—almost 45 percent are under age 30 (Foley 1991).

Workforce 2000 predicts that due to contractions in the labor force firms may compete for a diminishing pool of younger workers. Some businesses may increase wages as an inducement to recruit young workers. In order to retain these workers, employers may choose to offer health insurance. Workforce 2000 also suggests that women will be entering the workforce at a greater rate than other demographic groups. To the extent that these women are single heads of households, their interest in securing health care coverage for their children will affect their choice of employment.

Recognizing the critical importance of health care for poor single women and their children, Congress authorized the provision of transitional health benefits for AFDC recipients entering employment through the Job Opportunities and Basic Skills (JOBS) training program. However, it is unclear what will happen to these women after the one-year transition period—whether they will be covered through their employers’ health insurance or revert to AFDC and medicaid.

Another issue arises when insurance is not available to cover the dependent spouse of the employee. About 30 percent of nonworking spouses are unable to get coverage through their employed spouse. Currently, the nonworking spouse tends to be female. As these women enter the workforce and receive coverage through their own plans, it will relieve some of the cost-shifting burden on those employers who currently offer dependent coverage.

The growing use of a contingent workforce by employers is another area that impacts health care access and cost issues. Employers who contract for work with temporary agencies and individuals do not offer coverage for health benefits, though the temporary agencies may offer health benefits to their employees. Other members of the contingent workforce are uninsured or are left to purchase coverage individually.
Over the past five years the number of insurers writing individual policies has greatly declined or the premium has become extremely high.

**The Working Insured**

Even though persons may have health insurance coverage, the extent of the coverage may not be sufficient to protect them from catastrophic medical expenses. This phenomenon, known as underinsurance, is difficult to measure but, according to most analysts, is increasing. Over the past 10 years one of the most widely used cost control efforts exercised by employers has been to increase the amount of out-of-pocket expenses paid by the employee. This is done by increasing coinsurance and deductibles and limiting the maximum benefit, annually or on a lifetime basis, that is covered by insurance. The use of these cost-containment measures is controversial. Employers argue that requiring employee cost-sharing makes the employee aware of health costs and will cut down on unnecessary use of services. Employees argue that cost-sharing does not reduce costs, but only shifts expenses to the employee and, therefore, reduces benefits.

To the extent that benefit cost-sharing places the employee at risk of catastrophic medical expenses, that employee is underinsured. The trend is clear. More employers are requiring greater cost-sharing by employees. In 1977, 20 percent of employees in health insurance plans had cost-sharing. By 1988, 80 percent of employees were in such plans (General Accounting Office 1990).

Underinsurance is more difficult to assess than uninsurance. Some persons and families are underinsured because they have low incomes, which makes it difficult to cost-share. This may result in forgoing needed health care, which differs from the intent of this type of cost-sharing. Others are underinsured because they have catastrophic medical expenses. For those persons costs tend to be shifted to other purchasers.
Emerging Issue: Worker Mobility

There is an increasing tendency for insurers to place severe restrictions on new employees entering an employer’s health plan. These include the use of preexisting condition exclusions and medical underwriting, and the refusal to cover dependents. This means, in the first case, that a new employee with a chronic condition is not covered for that disorder for a specified period. In the second case, a new employee may not be eligible to participate in his or her employer’s health plan based on condition or a risk factor. In the third case, a new employee may have to pay out-of-pocket expenses for dependent care.

That health benefits are not portable between employers impacts the employee and his or her present employer. For the employee, the effect is obvious. The employee is unable to leave a current job unless he or she is willing to absorb great financial risk. The employer is faced with a difficult human relations issue—having a dissatisfied employee, or terminating an employee who is facing a catastrophic medical expense.

Issue Related to Health: Dependent Care

Finding ways to assist employees who have major responsibilities for caring for their dependents is a major issue confronting the workplace in the 1990s. Initially, the issue was seen as providing parental leave so that employees would be able to care for their newborns while maintaining their connection to the workplace. Now, the issue has expanded to include establishing a benefits policy—including leave—that would allow employees to meet care responsibilities for other family members, especially parents.

The aging of the baby boom generation has far-reaching implications. One overtone that has not been fully appreciated is the extent of the baby boomers’ responsibility for their parents as well as their children. Historically, providing long-term care services to the frail elderly and disabled has been the province of the informal care network, primarily comprised of women who care for their spouses and parents. With women entering the workforce in increasing numbers there will be far fewer available to provide informal care. This will place a great
deal of pressure on the employer to address the needs of employees who must care for frail parents or spouses. The erosion of the informal care network also has profound implications for government. At present, there is no national policy on long-term care; most efforts to address this issue take place at the state level. The erosion of the informal care network will place increased demands on state governments to establish formal programs for delivering long-term supervision.

State Government

In the absence of federal action to restructure the American health care system, state governments have the opportunity to aggressively address health cost and access issues in those areas where they can have an impact. Because states are responsible for regulating insurance in certain segments, they can use regulation to make changes in the health insurance market. A major constraint, however, is that in most states the bulk of employees, including public employees, are in health insurance plans that are self-insured and, therefore, regulated by the federal government. This exempts them from state regulation. As a result, state actions taken through regulating insurance will tend to impact small employers—who are less likely to self-insure—and commercial insurers.

Another area of opportunity for state government is through state employee benefits programs. These programs make the state a major purchaser of health services, if not in the whole state, at least in the state capital. States can use this purchasing power to negotiate with providers to contain costs. States can also serve as models to other employers in developing ways to contain costs and enhance coverage. These opportunities, unfortunately, are greatly constrained given the severe fiscal situation faced by most states.

An additional initiative that could be adopted is more equitable cost-sharing on health insurance premiums. Most employers who require employees to contribute to premium costs set a flat dollar amount per employee or per family. This is regressive, adversely impacting low-wage workers. A more equitable method would be to base employee contributions on percentage of salary. This strategy is used in public
programs that set a sliding fee scale based on income to pay for services.

**State Leadership**

Perhaps the greatest opportunity for states is to provide leadership by bringing all factions together to identify issues and create an environment for reaching a consensus on problemsolving. This can be most effective in building public-private partnerships on health. The need for consensus is becoming increasingly important as cost-shifting places more burdens on our fragmented system. Reaching consensus, however, is becoming increasingly difficult. The fractures among government, employers, providers, and employees are widening. Moreover, fractures are developing within the different groups themselves.

As discussed earlier, small employers are confronting different problems than large employers and seek different solutions. State government can step in to create a structure and a process for building consensus. Governors and other public leaders can speak out about the problems in our health care system and the need for change. States can lead by example by initiating changes in their state employee health benefits programs. More and more governors are creating task forces to bring all the interested parties to the table in an effort to solve problems.

In addition, states can take an active role by using existing health promotion programs and authorities. For example, many employers are actively pursuing programs to improve employee health. Typically called "employee wellness programs," they include incentives for smoking cessation, weight loss, stress reduction, etc. These efforts are similar to health education and promotion programs supported by state health agencies. The government and employer interest in these programs could be drawn together in a campaign for health promotion and disease prevention. Other examples are current state efforts to reduce infant mortality by improving access to services through medicaid programs. States could work with private employers, sharing experiences from medicaid that could be employed to enhance prenatal care and education and reduce costs.
Resource Allocation

In addition to developing and promoting public-private partnerships, states can provide leadership in another aspect of health care financing and delivery that has important implications for employment and economic development—resource allocation.

One of the major functions of state government is to allocate human and capital resources that make up the health care delivery system. States are responsible for licensing and certifying health care providers and facilities. This means that they control provider entry into the market, but perhaps more important, they control the configuration of the providers. States have used this power to create new providers and to improve and expand sources of care.

A second state role in allocating resources is in educating and training providers. State universities educate and train physicians and nurses as well as other allied health professionals. A number of states use their educational function to influence where providers will deliver services. For example, there are a number of programs that offer scholarship or loan assistance to students who agree to practice in rural areas after graduation.

Another critical aspect of resource allocation is that most states establish criteria for capital investments in facilities and costly technology. The criteria include not only cost but the location of capital investment, making it possible for states to improve the availability of services in underserved areas. States also can create new types of facilities to contain costs and improve access. Ambulatory surgical centers, hospices, and rural medical assistance centers are examples of health care facilities developed under state purview.

The different functions within the role of resource allocation affect employment and economic development in two ways. First, health care is one of the fastest growing sources of employment. Although an oversupply of physicians exists in some areas, shortages of nurses, home health providers, and other health professionals are universal. State efforts to increase the numbers of these professionals through education and licensing will increase the number of jobs. Second, the lack of an adequate supply of physicians and hospitals may make cer-
tain areas, especially in rural America, unattractive to firms seeking new business locations. For these reasons, state officials responsible for economic development and employment policy should work closely with their counterparts in health departments.

Possible Solutions

The organization of our health care system depends on the interaction of a wide variety of actors—federal and state government, employers, employees, insurers, and providers. This pluralism—some would say fragmentation—makes it difficult to change the system. The difficulty is compounded by the fact that there are insufficient data about health care financing and coverage. No definitive information about the behavior of the various actors exists.

For example, younger adults comprise the greatest proportion of the uninsured. Little hard data are available to determine why this occurs. It is theorized that younger workers tend to work for small employers and in part-time and noncareer jobs which often lack benefits. Also, it is hypothesized that younger workers have lower wages and are less likely to take health benefits offered by the employer if there is a cost-sharing contribution. Without definitive knowledge, however, it is hard to make policy changes that can alter the behavior of those who are currently uninsured. It raises the issue of participation. What if a program were put together and no one signed up?

In this section a variety of alternatives to address coverage issues are presented and briefly discussed. The strategies tend to focus on improving access to care aimed at low-income persons and small businesses. It should be noted that the strategies represent opportunities for equitable cost-sharing among participants in the health care debate. Because of the multifaceted nature of issues and problems surrounding the uninsured, it is likely that solutions, at least in the near term, will be incremental in nature. Any potential solution aimed at these objectives must also attempt to delicately balance the needs and interests of both government and the private business community.
For these reasons, policymakers might consider taking a number of short-term, incremental approaches that aim to share the burden of costs among the numerous parties involved. A brief overview of some of these potential approaches appears below.

Play or Pay

This strategy refers to a variety of tax mechanisms that could be used to expand employer coverage. Essentially the state would define a minimum health benefit package that all employers would have to cover. Then an actuarial equivalent would be attached to that benefit package. Employers would be given a choice of making insurance available to employees or paying the state an amount equal to an average premium per employee. The state would then use that revenue to provide health benefits to those families whose employers did not offer coverage.

This strategy would have the greatest impact on small employers. Adopting the play or pay strategy would require the state to create a program to enroll persons or contract with existing organizations for enrollment and service delivery. This strategy could incur some risks for economic development if the costs to small employers are too high: they may choose to locate in a different state.

Single Payer

The single-payer concept offers two separate strategies. First, all purchasers would come together to negotiate payment rates with health care providers. This would be similar to the approach now used in Maryland to pay hospitals.

Second, the single payer could operate as one administrative authority to pay claims to providers. The authority would then bill the appropriate purchaser (e.g., insurance, medicare, medicaid) for reimbursement. This approach would streamline administrative procedures for providers and purchasers. Providers would be guaranteed prompt payment and would not be faced with multiple billing proce-
dures. Purchasers would submit reimbursement on a regular schedule which would minimize their efforts in processing payment claims.

**Medicaid Expansions**

Expanding the state medicaid program to the maximum extent permitted by law is one step that could significantly improve financial access to care for many presently uninsured low-income individuals and/or families. For example, states are currently required to provide medicaid coverage to all pregnant women and to children under age six living in families with income below 133 percent of the federal poverty level. However, additional optional authority allows a state to raise the upper income threshold to 185 percent of poverty for pregnant women and infants under age one. Further, states are also permitted to raise the upper age limit for children to age eight (with a corresponding income limit of 100 percent of poverty).

Given that some analysts have estimated that over 25 percent of all uncompensated charges and nearly 40 percent of all hospital discharges for which no payment is received are for maternity-related services, medicaid expansions for pregnant women and children could offer a valuable opportunity to reduce a prime source of cost-shifting within the current system.

**Medicaid Buy-Out**

Medicaid buy-out allows state medicaid programs to purchase employer-offered health insurance for medicaid recipients. Under this strategy, medicaid pays an employee's share of the health insurance premium for coverage offered by an employer, in hopes of encouraging medicaid-eligible persons to accept or retain employment-based coverage when it is available.

The buy-out concept can be used to address two different state policy goals. The first is directly related to employment. Under provisions of the JOBS Act, medicaid recipients who become employed under JOBS can continue to receive medicaid services for an additional 12 months. In the second six-month period of that year, states can create
programs that allow for a transition to employer-based coverage. For example, states can develop premium-sharing arrangements among the state, the employer, and the employee. Or, the state can enroll the employee in various types of managed-care environments.

The second type of buy-out applies to persons or families who are Medicaid recipients and are at risk of losing their employer-based health insurance. The most likely occurrence would be for medicaid to pay for the 18 months of coverage under employment-based insurance that employers are required to offer under COBRA rules. The buy-out would be permitted only when the cost of the premium is less than the estimated state share of the cost of providing medicaid coverage (based on average *per capita* costs). This strategy would help persons with high medical expenses—such as those with AIDS—who have lost their jobs and are incurring high medical costs. It would also help children whose parents cannot get dependent coverage or who lose their employer-based coverage.

**Public-Subsidized Individual Coverage**

Many uninsured persons face especially troubling circumstances. First, as individuals rather than members of a group, the premium costs for insurance products are often prohibitively high. Second, if these persons are presently experiencing health conditions that require care, they are essentially uninsurable. Insurance companies avoid offering coverage to, or price insurance products extremely high for, persons who are certain to incur significant medical costs.

State governments can play a role in assisting these vulnerable individuals by subsidizing the costs of their coverage. States could contract with private insurers who would offer and administer the product. Then, government funds would be spent in two ways: to help persons with part of the cost of the insurance premium, and to compensate the insurer for costs that exceed the collected premium. Premiums and state subsidies would adjust based on the individual's income and ability to pay.

Populations who could be targeted for such special coverage are pregnant women, young children, and disabled persons. These groups
currently receive relatively broad coverage under many state medicaid programs; however, many members of this pool also fall into a notch whereby they have too much income to qualify for medicaid, yet too little income to afford insurance. Income eligibility criteria would need to be set based on existing medicaid thresholds and a consensus on an appropriate upper income limit. Once again, costs for coverage would be borne by both the individual and the state, and risk for costs exceeding premiums would be borne by private insurers and state government.

Expansion of Public Direct Service Funding

To supplement funding directed at providing health coverage through insurance approaches, governments also directly finance health care providers in the community. Examples of such funding are seen in the federal Community and Migrant Health Centers grants and in state and local support for public health clinics. Expansion of such funding using federal, state, and local dollars could significantly improve uninsured persons’ access to primary care services. Funds could be awarded to providers under grant or reimbursement arrangements, based on their agreement to provide an agreed-upon set of comprehensive primary and preventive care benefits. Individuals would also be asked to pay for their care based on a sliding fee scale.

This strategy might be of greatest assistance to rural areas. Rural America is confronted with an inability to recruit and retain health care providers. Expanding the financial resources available to rural areas might assist economic development in those areas.

Improving Insurance Products for Small Groups

Many groups—governments, employers, employees, and insurers—have an incentive to improve upon the current situation with respect to small employers by developing strategies that share costs and responsibility equitably. The following sacrifices would be asked of the insurance industry:
1. Insurers would be required to guarantee availability of coverage to all small groups.

2. Insurers would be prohibited from using medical underwriting to exclude high-risk individuals from a group.

3. Insurers would be prohibited from discontinuing an employer's health benefits except under circumstances such as nonpayment of premiums.

In turn, governments could work with insurers and small business to establish the following improvements in insurance regulations:

1. To limit the exposure of insurers, a new reinsurance mechanism might be developed to cover the claims of high-risk individuals whose costs exceeded collected premiums by a certain threshold.

2. To help share the costs of this reinsurance, small businesses could be assessed a tax based on some percentage of current premiums.

3. To improve both efficiency and equity, and allow for the establishment of a lower-cost standard benefit package that emphasized comprehensive primary and preventive care services, states could act to restructure the current system of mandated benefits enforced upon insurers.

Summary

Our pluralistic system for financing health care in the United States is the focus of much concern. Uncontrollable cost increases are driving changes in access to health services. Reversing a long trend of business and government taking the greater role for health spending, responsibility is now shifting to families and individuals. This change has created a great deal of turmoil in the workplace.

There is the growing realization that none of the major players involved—employers, government, insurers, and employees—is able to address the issues individually. There needs to be a cooperative
approach to solving the problems of cost and access. The types of solutions identified in this paper require that cooperation.

It is sobering to note that the issues surrounding the cost and availability of health benefits have, thus far, avoided solution. The issues challenging the American workforce in the future may be exacerbated by the health benefits issue if consensus about addressing the problems is not reached soon.