Combining Private Insurance with Public Programs to Achieve Universal Coverage

John Henry Goddeeris
Michigan State University

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Michigan State University

For many who embrace universal health insurance as an objective, a tax-financed state plan that would cover all residents is simply too radical a restructuring of the current health care system. In 1987, the share of personal health expenditures accounted for by private health insurance amounted to about 3.1 percent of gross national product, or $552 per capita (Letsch, Levit, and Waldo 1988). This is more than half of the amount raised by all state taxes combined in that year (U.S. Bureau of the Census 1989). So even before adding in the cost of extending coverage to the uninsured, merely shifting what is now financed through private insurance into the public sector would require, on average, a more than 50 percent increase in the size of state government budgets. To the extent that financing is merely shifted, wages and profits would rise in some combination to offset the tax increase, on average, but individual businesses and workers are understandably wary of how such an enormous shift would affect them. In addition, providers of medical services tend not to look favorably on the idea of concentrating so much buying power into government hands. The health insurance industry worries about what role would be left for it to play in such a revamped system.

A natural alternative is to build on the current employment-based insurance system, requiring or encouraging more employers to provide coverage for their workers, and adding a "safety net" public program or set of programs to accommodate the remaining uninsured. Such an approach is surely less threatening to providers and to health insurers, and at least at first glance it appears that it might be accomplished with little expansion of state government budgets. Numerous studies have shown that as many as three-quarters of the current uninsured are in
households with at least one worker (Brown 1989). If employers could be induced to cover most of that group, so it is hoped, picking up the remainder with public coverage might be manageable.

What would seem to be the main virtue of this approach—the fact that it is an incremental change that builds from the system already in place—may, however, be its fatal flaw. By extending insurance coverage to all, it would boost substantially the demand for medical care in a system that already is ineffective in controlling the rate of increase of costs.1 It would be administratively simpler to implement than a single state insurance plan (because it would rely on existing institutions), but over the long run it would not reduce the enormous administrative costs of the system in the way that a move to a single plan could (Himmelstein and Woolhandler 1989). In fact, by causing many more two-earner households to get coverage for each earner, it would create additional problems of coordination of benefits and probably add overhead cost to the system.

Universal coverage by this route is also likely to require higher state expenditures than it first appears. Most of the uninsured do indeed have some connection to the workforce, but the working uninsured tend to earn quite low wages or be employed only part time or part of the year. Employers will be very reluctant to bear the cost of insuring them. It is also true that many poor individuals and families who are now counted as insured pay for their own nongroup coverage out-of-pocket or must pay the full premiums to receive coverage from employers. With a public safety net available, many of them could drop their current insurance and move to subsidized public coverage. Employers who now cover their workers only reluctantly might also find it advantageous to drop coverage and turn their employees over to the public sector. These possibilities are explored quantitatively later in this chapter, using data from Michigan.

Expanding Private Coverage

Proponents of this approach to universal coverage see private insurance at the center, expanding its current role, with the state ready to support
those who would remain uncovered. It is therefore appropriate to focus the discussion first on the steps that would be taken to expand employment-based coverage, as these will determine the size and composition of the population left to be covered publicly. There is a broad range of possibilities as to who among the current uninsured would be affected by a mandate directed at employers. Employers might be required by law to provide coverage to their employees, or they might be given an option of paying a special tax instead. Coverage of dependents might or might not be required. Exemptions or special rules might apply to some types of workers (e.g., part-time or seasonal employees) or types of firms (small or new businesses).

**Approaches Implemented or Proposed**

We can gain a sense of the range of options being considered by looking at several routes to expanding employer coverage already implemented or proposed. Hawaii is the one state with real experience; it has had mandated health insurance since the passage of its Prepaid Health Care Act in 1974 (American Hospital Association 1988). Employers there must provide health insurance for those workers who have completed at least four consecutive weeks of work, are working at least 20 hours per week, and whose monthly wage is at least 86.67 times the minimum hourly. Employees are only obligated to contribute 1.5 percent of gross wages toward the premium. The employer must offer dependent coverage, but is not required to pay for it. Some groups are exempted, including government employees, seasonal farm workers, and workers in family-owned businesses.

Massachusetts has gained much notoriety as the second state to legislate an expansion of employer-provided insurance (Enthoven and Kronick 1989). It seeks to induce coverage by taxing firms that do not provide it at 12 percent of wages, up to $1,680 per employee. The tax is not scheduled to take effect until 1992, so no experience with it yet exists. Employers with five or fewer employees, temporary or seasonal employees, and employees working less than 20 hours per week are all to be excluded. Employees with insurance coverage from some other source may also decline coverage, and the employer need not pay a tax.
Some proposals for mandating coverage at the federal level have also been widely discussed. One is the Basic Health Benefits for All Americans Act, introduced in Congress by Senator Kennedy and Representative Waxman. It would require that employers provide coverage for employees working at least 17.5 hours per week, as well as for dependents if they are not covered elsewhere. Employed dependents could retain coverage through their parents' plans. Employers would be required to pay 80 percent of the premium for employees working at least 25 hours per week and a smaller share for those working between 17.5 and 24 hours. A federal subsidy to small businesses for costs in excess of 5 percent of gross revenues is also included.

Another proposal is the "Consumer-Choice Health Plan for the 1990s" (Enthoven and Kronick 1989). Under it, employers would be required to cover all employees working at least 25 hours per week, along with their dependents not otherwise covered. For part-time and seasonal employees, the employer could instead pay a tax of 8 percent of wages up to $1,800 per worker. For small businesses, payments for health benefits would be capped at 8 percent of total payroll.

Issues Surrounding Expanded Private Coverage

The similarities and differences among these approaches provide some food for thought for states interested in expanding employer-provided coverage.

1. Legal Mandate or Tax Incentives? The federal proposals and the Hawaii law require that employers provide coverage, at least for full-time workers. This may not be an option for a state at this time; in fact, it violates the Employee Retirement Income Security Act (ERISA). When the Hawaii law was tested in court, it was ruled to be preempted by ERISA, although a later amendment to ERISA made an exception for the Hawaii case. In the current climate of strong business opposition to mandated benefits, further exceptions seem unlikely.

The alternative to a direct mandate is a so-called "play or pay" tax, to which firms not providing health insurance benefits are subject, as in Massachusetts. Even apart from the legal difficulties with mandating, this approach has certain advantages. In principle, the tax can be set
high enough that nearly all firms will provide coverage rather than pay it, so it does not necessarily lead to fewer individuals gaining coverage. At the same time, it preserves an element of choice for the employer.

More important, mandating almost of necessity involves exceptions. Employers of low-wage workers employed only a few hours a week cannot be expected to guarantee health insurance coverage, nor, perhaps, can a small start-up business not yet proven financially viable. But making exceptions means drawing lines, raising questions of fairness between similar cases that fall on opposite sides of the division. Furthermore, business decisions are distorted by the presence of these exceptions. If health insurance coverage need not be provided to those working less than, say, 20 hours per week, 25-hour employees may be shifted to 18 hours. If firms with five or fewer employees are exempt, decisions about expanding (or contracting) will be influenced by this fact.

Use of the tax may eliminate the need for all or at least most exceptions. While employers of part-time or very low-wage workers should not be expected to make the same contribution to health insurance coverage as others, they can be required to contribute in proportion to wages paid. This seems more fair than exempting some types of workers entirely, it reduces certain labor market distortions, and it provides a source of revenue for partially financing the coverage of those who will not get insurance through their employers. In the remainder of this discussion, I assume that coverage is not to be legally mandated, but rather induced through the use of a tax.

2. What Must the Employer Do to Avoid the Tax? One possibility is that employers are given a credit, dollar-for-dollar against tax owed, for payments for health care coverage made on behalf of employees. The problem with this approach is that it gives no incentive to spend less on coverage than an employer's maximum total tax liability—a dollar saved on coverage just becomes an additional tax dollar owed. The employer's incentive for cost consciousness in purchasing insurance is thereby attenuated. In addition, it is desirable to set the tax liability rather high to discourage firms from opting out of providing coverage. The combination of a high tax liability and dollar-for-dollar credit could stimulate additional spending on health coverage for those who are already well insured, contributing further to growing health costs.
The alternative is to waive the tax if some specified share (80 percent is commonly suggested) of the premium for a "qualified plan" is paid by the employer, regardless of the cost to the employer. In that way, a dollar saved in purchasing coverage goes directly back to the firm, enhancing its incentive to buy wisely. This approach requires that a qualified plan be defined, and raises the possibility that much currently held coverage may be ruled inadequate. But if truly universal coverage for a basic set of services is the goal, it makes sense to require that employer-provided coverage meet certain criteria. Defining a qualified plan also provides an opportunity to assure that particular cost-containment features be included, if that is desired.

3. Coverage of Dependents and Those Currently in Public Programs. Except for the Hawaii case, in all of the examples discussed above employers who provide coverage must cover dependents of their employees. In light of the large number of current uninsured who are dependents (mainly children) of workers (see chapter 2 of this volume), such a requirement seems a natural element of this strategy for universal coverage. In fact, it is probably good policy to let workers who are dependent children of other workers get their coverage through their parents, rather than their own employers. Families would be kept together for insurance purposes, reducing administrative costs to at least some degree. More important, very young workers usually earn low wages and have high job turnover rates. Requiring their own employers to provide insurance or even pay a tax may be particularly burdensome, and may have adverse employment effects.

Some workers or dependents of workers may have insurance coverage from existing government programs, especially Medicare or Medicaid. Because federal funds contribute heavily to the finance of these programs (Medicare is entirely federally financed, Medicaid about half, with some variation across states), it is probably not in the interest of a state to encourage that this coverage be replaced by an employer. In particular, the requirement that employers provide coverage or pay a tax probably should not extend to employees 65 and over, who are almost always eligible for Medicare. Excluding the elderly may, however, lead to political problems or charges of inequity if the basic package of
services available to all the nonelderly is perceived as more extensive than what Medicare offers.

4. Efforts to Expand Availability of Coverage. While the phenomenon of workers without insurance coverage is by no means limited to small businesses, it is well documented that small firms are much less likely to offer coverage than are larger ones. An important reason is that premium costs for similar coverage are much higher for small firms. Available evidence on the magnitude of the difference is sketchy, but a difference in cost of $40 per $100 of benefits between a firm with fewer than 10 employees and one with more than 100 employees is probably a conservative estimate (American Hospital Association 1988; Danzon 1989). These cost differences stem from higher administrative and marketing costs for insuring small firms, and from insurers' concerns about adverse selection.

A reduction in that cost differential would by itself increase the number of small businesses offering insurance. Without a reduction, even rather strong tax incentives might not be enough to induce provision by very many additional small firms. Most proposals for expanding private coverage therefore include attempts to enhance the availability of insurance and improve the terms upon which it is offered to small firms. One option is for the state to create a single large insurance pool, which might also contain those gaining public coverage. Firms could be permitted to buy into the pool on a community-rated basis (the same rates would be available for all firms within a particular area of the state), with different rates for individual, couple, and family coverage.

This approach, with one large pool encompassing most of the current uninsured, would be in essence a scaled-down version of a state insurance plan, with many of the attendant advantages and disadvantages. Marketing costs could be considerably reduced, at least some administrative economies could be realized, and if enrollment in the pool were large enough, problems of adverse selection would be minimized. Some firms would, in effect, subsidize others under such an arrangement, however. Each employer would pay premiums intended to reflect the costs of providing coverage to an "average" firm with a similar mix of workers by family type, but not all firms are average. Firms who employ workers at higher-than-average risk, due to age or
other factors, would pay the same premiums as everyone else, and the extra costs of their coverage would be spread across all participants in the plan.

The implications for health care costs of having a single large pool are also very important to consider. While the pool concentrates the buying power of small firms and thereby gives them some clout in the market, it also blunts their individual incentive to use that power effectively. If a firm has only a single option for purchasing insurance (i.e., through the pool) at rates over which it has no control, the firm has no role to play in assuring that it receives good coverage at a reasonable cost. Incentives for cost control can of course be built into the benefit package, with copayments, deductibles, and so forth. To a large extent, however, the responsibility for controlling costs (and assuring quality) would fall on the administrators of the pool.

Alternatively, market competition can be relied on for cost control and quality assurance, along the lines suggested by Enthoven and Kronick (1989). Competing qualified insurance plans might be made available to small businesses, with a state agency serving as a broker, certifying which plans are qualified, providing information to firms to facilitate comparisons among plans, managing the enrollment process, and generally administering the rules of the game. The basic idea is that giving firms a choice provides a better opportunity to satisfy individual preferences, and promotes competition among insurers to hold down costs while maintaining high quality.

But the most thoughtful proponents of this approach recognize that managing competition is essential and by no means easy (Enthoven 1986, 1988). There are difficult questions regarding the dimensions along which insurers should be permitted to compete. On what bases, for example, should they be permitted to set different premiums for different firms? Given the opportunity, insurers will compete to attract firms with relatively healthy workers. The most obvious way to do so is to charge lower premiums to firms with younger, healthier workforces. If this is permitted, firms employing workers who are bad health risks (and in a firm with few employees it may only take one case of serious illness) may find no good options available to them. They will choose to let their employees turn to public coverage, which will become a dumping ground for those at highest risk.
Combining Private Insurance with Public Programs

Requiring insurers to community rate would not eliminate all these problems. If required to community rate, insurers might attempt to tailor the benefit packages they offer to be particularly attractive to the healthy, or in subtle ways make it difficult for the chronically ill to receive covered services. Firms of moderate size expecting their experience to be better than average would have an incentive to self-insure, if that is still an option.

An important but still unanswered question about the competitive approach favored by Enthoven and Kronick is whether sufficient numbers of insurers would be willing to come forward and comply with the rules of the game, so that the potential benefits of choice and competition could actually be achieved.

Likely Effects on Firms and Workers

Employer Responses to a “Play or Pay” Tax

If employers are given a choice of providing insurance or paying a tax, it is no simple matter to predict how many individuals would gain employer-provided coverage under any particular plan. Surely the firm would look at which option, tax or coverage, is cheaper from its point of view. But employers have an interest in keeping their workers happy, so they will also be influenced by what the worker prefers. The employer will be less likely to provide insurance if good public coverage is available free to workers than if an uncovered worker faces a premium or tax for public coverage in addition to the employer’s tax. Complicating the firm’s problem is the fact that it cannot decide on an employee-by-employee basis whether to provide coverage or pay the tax, but rather must make blanket decisions that apply at least to broad groups of employees. High-wage workers in predominantly low-wage firms may end up without insurance from their employers (because it is not worthwhile to cover the entire firm). The converse would also be true.

Unless the tax rate is set very high, however, it is likely that for many low-wage and part-time workers employers will find it cheaper to pay the tax rather than provide coverage. Suppose, for example, that the tax rate is 10 percent and a worker is employed 20 hours per week
and earning $5 per hour. The tax owed would be $10 per week or about $40 per month, far less than the cost of insurance coverage, even for a single individual.

It is appealing to suppose that all firms already providing coverage would continue to do so when the additional tax inducement is added, but this is unlikely. In many cases, the current coverage may not meet the standards for a qualified plan, the employer may be paying less than the share of the premium required, or the employer may not be covering dependents. The public safety net could also provide a better alternative to employer group coverage than is currently available for most workers. For these reasons, at least some employers now paying a share of the costs of their employees’ coverage would choose to drop coverage and pay the tax instead. Many workers now counted as having employer group coverage would thus move to public coverage under this sort of package.

Incidence of the Costs of New Coverage and Labor Market Effects

Who would bear the costs of new employer-provided coverage and how the package would affect labor markets depend on the interaction of a number of factors, including the nature of public coverage and the terms upon which it is made available to those not covered in the workplace. The analysis is pursued in more detail in chapter 8. As a first approximation, however, standard economics suggests that in the long run the money wages of those who gain coverage would fall by about the cost of coverage to the employer. This conclusion is based on two presumptions. First, firms make employment decisions on the basis of total compensation per worker (wages plus benefits); they will only choose to hire the same number of workers if compensation does not change. Second, the supply of workers (and work hours) will be about the same at either wage level. This simple analysis has very strong implications. It says that those who gain employer-provided coverage will, for the most part, pay for it themselves (in the form of lower wages), and that total labor costs, business profits, and prices will therefore be little affected.
These predictions may be substantially correct, but they need to be qualified in several important ways. First, the phrase "in the long run" deliberately sidesteps the issue of what happens right away. While some employers would cut wages if forced to add insurance, others may find it impossible or unwise to do so (for example, due to existing collective bargaining agreements). Their workers would get smaller wage increases than otherwise, until eventually the difference in wage level had compensated for the cost of insurance. In the meantime, however, those firms would suffer lower profits, would (to the extent possible) pass some of their higher costs into prices, and in some cases would not survive.

Second, the presumption that labor supply is unaffected by changes in wage rates and insurance coverage is not entirely accurate, particularly for two-earner couples. Empirical studies have shown that decisions about whether and how much to work by the lower-earning spouse are rather strongly influenced by the terms of compensation. Frequently, these secondary earners already have insurance through a spouse's job. Forcing their own employers to provide coverage (or pay a tax) will reduce the money wages the employers are willing to offer, and thereby reduce the workers' incentive to work. Employers will in turn find such secondary earners more difficult and expensive to hire.

The numbers of secondary earners affected in this way are quite large. Analyses of national proposals for mandated insurance coverage (Gordon 1988; Thorpe 1989) have suggested that, of all workers gaining insurance under a federal mandate, roughly half already have coverage through an employed family member.

Finally, for workers at or near the legal minimum wage, wages cannot be reduced enough to compensate for the added costs of coverage. If wages cannot be reduced at all, the cost of coverage (or the tax) is effectively an add-on to the minimum wage. For those close to the minimum wage, it is likely that most employers will find it cheaper to pay the tax than to provide coverage, and hence the tax rate becomes an upper bound on the extra increase in labor cost felt by the employer. Recent empirical studies have found that employment of minimum wage workers declines by about 1 to 3 percent in response to a 10 percent increase in the minimum wage (Brown 1988). A 10 percent payroll tax
would have a similar effect. A higher tax rate would induce more insurance coverage on behalf of low-wage workers, but it would also create more adverse employment effects while leading to higher prices and lower profits for those firms that employ such workers.

Costs of New Public Programs

No attempt to expand the reach of insurance in the workplace can by itself lead to universal coverage. Although most of the uninsured have some connection to the labor force, there are still large numbers who have none and who do not qualify for any existing public insurance program. A universal system needs a safety net program or set of programs to assure that they are covered. Those who have no proof of other insurance could be assessed (probably through the existing state tax system) an income-based premium. They might then be given Medicaid-style coverage, or placed in a new large insurance pool that also includes employees of small businesses. If a more competitive approach is desired, this population could be given vouchers and, where possible, allowed to choose among competing qualified plans. Issues of equity (as well as work incentives) could arise if the level of coverage guaranteed is perceived as less attractive than Medicaid.

As discussed at the outset, an obvious appeal of this route to universal coverage is that it requires a much smaller expansion of government budgets than would an entirely tax-financed system. The hope—not entirely without foundation—is that the additional commitment of state dollars required might be held to an acceptable magnitude. After all, most workers and their families already have coverage, and most of the uninsured are in households with at least one worker. If coverage could be extended further in the workplace, and no one lost coverage they now hold, a relatively small residual group might be left to be picked up in the public sector.

What becomes clear on a close examination of the data, however, is that depending on exactly how the total package is designed, large numbers of individuals who are currently insured could move to heavily subsidized public coverage. The key to seeing this point is to recognize
that many individuals now have private coverage and are counted as insured, yet are quite poor. Thorpe (1989) has estimated that for the nation as a whole in 1987, 6.7 million individuals in poverty households had private insurance, as did an additional 4.5 million individuals in households under 125 percent of the poverty level. Some of them got group coverage through employers, but paid much or all of the cost themselves. Others purchased their own nongroup insurance. (Thorpe estimated that altogether about 10 million individuals had only such coverage.) Given their low incomes, it is likely that much of this coverage is quite limited and would not satisfy standards for a qualified plan. Unless the tax rate is set quite high, few in this group can be expected to gain employer-provided coverage, and many may lose the partial employer support that they now have. Depending again on the tax rate, others at incomes substantially above poverty may lose private coverage.

The split between private or public coverage might be largely a matter of indifference from a policy perspective if the taxes paid by employers plus supplemental taxes directly on individuals covered the costs of the newly publicly insured. But this too would not happen, even at quite high tax rates.

An Analysis of Michigan Data

These ideas may be illustrated with data from Michigan. For other states interested in this approach to universal coverage, the method of analysis may be of more interest than the quantitative results. I have estimated the net increase in public insurance coverage under the kind of package being discussed here, using data from the March 1988 Current Population Survey (CPS). The details assumed for the package are as follows.

All employers must provide coverage to all employees, and spouses and dependents not otherwise covered, or pay a payroll tax. The only exceptions are that any workers who have coverage under an existing government program (Medicaid, Medicare, or CHAMPUS, a federal program for dependents of military personnel) need not be covered by the employer, and workers who are under 18 and living with parents or between 18 and 22 and students are to get coverage through their
parents. Three tax rates are considered: 10, 15 and 20 percent. Presumably, a ceiling on the amount of tax owed per employee would be included in such a package. I do not specify one for my analysis, assuming instead that all workers above particular earnings levels would be provided coverage by their employers.

Those who are not already covered in a public program and do not get coverage from an employer or purchase it themselves are automatically participants in a new public insurance program. For that they are assessed a tax (which could be filed with the regular state income tax in states that have one) on all income above a $2,000 per person exemption, at a rate equal to that of the payroll tax, up to a point at which a fair premium has been paid. Any payroll tax already paid on an individual’s behalf would be credited dollar-for-dollar against income tax owed. The self-employed would, as a result of this income tax, have the same responsibility in providing for their own insurance that employers have for employees. This income tax (or income-based premium) places a rather heavy burden on the poor among the current uninsured. Despite this, we will see that it raises relatively little revenue.

To estimate who ends up with public coverage, the CPS sample of individuals must first be grouped into family units that would be kept together for insurance purposes. Each unit is classified as either already having public coverage, retaining or picking up private coverage, or (the residual) entering the new public program. In general, family units are put in the private insurance group if earnings are high enough (singly or in combination) that payroll taxes paid in 1988 would be at least as large as 80 percent of the estimated 1988 premium for a qualified plan. Workers who do not meet this test but already have employment-based coverage are assumed to keep it, if all members of the family unit have coverage and the employer pays at least part of the cost. This last assumption is optimistic, as surely some of those employers would drop coverage.

The results of the analysis for Michigan, as reported in Table 1, show substantial enrollments in the new public program, both because many of the current uninsured fail to gain private coverage (even with tax rates as high as 20 percent), and because many of the insured shift over. According to the March 1988 CPS, the total number of uninsured under
The estimated enrollment in the new program ranges from 1.2 million with a 10 percent tax to 770,000 if the tax is 20 percent. At the lower rate, only about 200,000 of the state's uninsured gain employment-based coverage, while about 490,000 of the insured move to public coverage. At the 20 percent rate, about 520,000 of the uninsured would gain coverage from employers, but about two-thirds of that number (320,000) would be leaving their current coverage to enter the public program.

Table 1
Numbers Gaining Public Coverage (100,000s)
Illustration for Michigan

<table>
<thead>
<tr>
<th>Tax rate</th>
<th>10 percent</th>
<th>15 percent</th>
<th>20 percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>11.7</td>
<td>9.5</td>
<td>7.7</td>
</tr>
<tr>
<td>Number already insured</td>
<td>4.9</td>
<td>4.0</td>
<td>3.2</td>
</tr>
</tbody>
</table>

SOURCES. March 1988 CPS for Michigan and author's assumptions about participation

Table 2 shows the expected age composition of the public program at each of the tax rates, along with comparative data on the composition of the Michigan population under age 65 and the Michigan uninsured population. The composition of the group does not change much as the tax rate changes, but it does look rather different from the current uninsured population. In particular, those aged 15 to 20 or over 44 would form a considerably larger share of the new program enrollments than they do of the current uninsured population. Both subgroups contain relatively large numbers of insured individuals who would find public coverage an attractive alternative. In the younger subgroup, many are 18 to 20 years of age and not in school, but apparently covered under parents' policies. The size of the public program could be kept down to some degree by broadening the definition of dependent and requiring that some of these individuals continue to be covered through their parents. Table 2 also shows that a relatively large share of uninsured males aged 26 to 44 would gain employment-based insurance and therefore not require public coverage.
<table>
<thead>
<tr>
<th>Age group</th>
<th>Tax rate</th>
<th>Population under 65</th>
<th>Current uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10 percent</td>
<td>15 percent</td>
<td>20 percent</td>
</tr>
<tr>
<td>0-4</td>
<td>8.2</td>
<td>8.8</td>
<td>8.9</td>
</tr>
<tr>
<td>5-14</td>
<td>12.7</td>
<td>13.1</td>
<td>12.1</td>
</tr>
<tr>
<td>15-20</td>
<td>15.4</td>
<td>15.8</td>
<td>15.0</td>
</tr>
<tr>
<td>21-25</td>
<td>16.8</td>
<td>16.6</td>
<td>17.6</td>
</tr>
<tr>
<td>26-44 (Male)</td>
<td>13.1</td>
<td>12.3</td>
<td>11.7</td>
</tr>
<tr>
<td>26-44 (Female)</td>
<td>12.1</td>
<td>10.9</td>
<td>10.3</td>
</tr>
<tr>
<td>45-64</td>
<td>21.7</td>
<td>22.5</td>
<td>24.5</td>
</tr>
</tbody>
</table>

SOURCES. March 1988 CPS for Michigan and author’s assumptions about participation.
Gross costs for the new public program under different assumptions about its size and the benefit package are reported in Table 3. The cost numbers are based on my calculations using data from Blue Cross-Blue Shield of Michigan in its Area Rated Groups line of business, sold mainly to small firms. The Basic Package is traditional Blue Cross-Blue Shield coverage, covering mainly inpatient hospital care and associated professional services. The Expanded Package adds major medical coverage of a broader set of services with deductible and copayment provisions, as well as coverage of prescription drugs with low copayments. Some advantages of these numbers are that they are based on actual cost experience, not premiums, and were available by age category. Using them does not imply that public coverage would have to be of this type.

Table 3
Gross and Net Costs of the New Public Program ($100 millions)
Illustration for Michigan

<table>
<thead>
<tr>
<th>Tax rate</th>
<th>10 percent</th>
<th>15 percent</th>
<th>20 percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Cost</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Package</td>
<td>10.6</td>
<td>8.6</td>
<td>7.2</td>
</tr>
<tr>
<td>Expanded Package</td>
<td>13.4</td>
<td>10.8</td>
<td>9.1</td>
</tr>
<tr>
<td>Revenue</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payroll Tax</td>
<td>4.3</td>
<td>3.7</td>
<td>2.8</td>
</tr>
<tr>
<td>Income Tax</td>
<td>0.7</td>
<td>1.0</td>
<td>1.2</td>
</tr>
<tr>
<td>Net Cost</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Package</td>
<td>5.5</td>
<td>3.9</td>
<td>3.3</td>
</tr>
<tr>
<td>Expanded Package</td>
<td>8.3</td>
<td>6.2</td>
<td>5.1</td>
</tr>
</tbody>
</table>

SOURCES: Author’s calculations from March 1988 CPS for Michigan and Blue Cross-Blue Shield of Michigan 1988 cost experience for Area Rated Groups line of business

Costs amount to a little more than $900 per enrollee per year for the Basic Package, and about $1,150 for the Expanded Package (in both cases, a little higher for the population mix at the 20 percent tax rate). If other estimates are available and believed more appropriate, they could of course be easily substituted. See chapter 6 for additional discussion of costs of coverage and their relationship to the benefit package offered.
Table 3 also includes estimates of tax revenues the entire program package would generate, and then nets these out against gross program costs. Payroll tax revenues fall as the tax rate increases, as substantially more firms choose to provide coverage rather than pay the tax. Income tax revenues increase with the tax rate, but still amount to only about $150 per year per enrollee at the high 20 percent rate. Most of those who end up in the public program under this tax rate are quite poor, and frequently they would have no income tax liability due to payroll taxes already paid on their behalf.

The bottom line net costs to state government (in 1989 dollars) range from about $330 million with the Basic Package and 20 percent tax rate to about $830 million with the Expanded Package and 10 percent rate. These figures are after netting out payroll tax and extra income tax revenues the program would generate. Universal coverage is not cheap. To put the numbers in some perspective, each $100 million would amount to about $12 for each Michigan resident under age 65, or would require adding roughly 0.13 percent to the state’s broad-based income tax, currently at 4.6 percent.

The experience in other states would of course be different, but not necessarily more favorable. The Medicaid program already covers a larger share of Michigan’s poor population than is the case in most states. The share of the state’s under-65 population without insurance is well below the national average. Based on 1986 and 1987 CPS numbers, the national share was over 17 percent compared with about 12 percent in Michigan.

**Concluding Comments**

The net costs to state government of taking this path to universal coverage, as identified in the previous section, do not all represent a net increase in medical services provided in the state. It is very likely that, with better financial access to medical care, the previously uninsured will consume more medical services than they currently do. But they use some care now, and pay some of the cost of it out of their own pockets. Much of that cost—for the uninsured who are poor—
would be shifted to the public sector. The same is true for those poor families now paying for their own insurance but who would switch to public coverage. Thus a share of the added costs to state government would really represent a shift from the uninsured and other poor families to the general taxpayer.

Much of the care currently received by the uninsured is also paid for in other less explicit ways, by providers accepting lower returns than they otherwise would, and by other payers paying more for the care received, to help cover the costs of care given to those who cannot pay. If state and local governments are already making payments for such uncompensated care, these could be folded into the new program and would reduce the amount of new revenue to be raised. To the extent that employers are now paying for uncompensated care, a system of universal coverage should bring downward pressure on the cost of employer-provided insurance. However, how the gains from a significant reduction in uncompensated care would be distributed among providers and various payers is not well understood.

Getting to universal coverage by expanding and supplementing the employment-based insurance system would not be easy, and would very likely require a significant increase in a state government’s budget. No state should embark on this path unless it is willing to face that fact. But given a strong commitment to coverage for all, the necessary budget increase is not entirely outside the range of plausibility, and it is certainly far smaller than what would be needed for a Canadian model state health plan.

The costs of financing a combined public-private system at the point of implementation are surely an important factor affecting its political feasibility. What is probably more important, however, for the long-run success of such an approach is whether it can be implemented in a way that promotes a better balance between cost and quality improvements in health care, or whether it would merely add to already formidable pressures for ever-increasing costs.
NOTES

1. See the comments of Johnston on the proposal by the National Leadership Commission on Health Care (Johnston and Remhardt 1989).
2. Viewing the Enthoven-Kronick proposal as merely a way of achieving universal insurance coverage does not do justice to the plan. It includes provisions (including a restructuring of existing tax subsidies for employer-provided insurance) aimed at harnessing market forces to promote cost containment and quality assurance in health care.
3. A recent survey of the membership of the National Association of Manufactures (Higgins and Co 1989) found that 84 percent opposed mandated employer-provided health insurance, despite the fact that over 99 percent of the respondents were already providing health insurance benefits to their employees.
4. A national proposal by the National Leadership Commission on Health Care (1989) also has this feature.
5. Clearly this is true when workers are unionized, but even if not, it is in the firm’s interest to provide a compensation package that is of most value to the worker for a given level of cost.
6. In the current environment, insurers usually insist on this to guard against the possibility that only bad health risks will choose to take coverage. Under the kind of program being discussed, the state would not want to permit individualized decisions for fear that bad risks would be pushed into public coverage to keep the employer’s private insurance costs low.
7. It should be noted, however, that there would be no adverse employment effects for very young low-wage workers if they are expected to get insurance coverage through their parents.
8. Earnings and income figures in the March 1988 CPS are for 1987. I have updated them roughly to 1989 by increasing them by 6 percent. Estimates of the cost of coverage are also updated to 1989.
9. In this quantitative analysis, taxes paid by the self-employed with sufficiently high incomes are counted as part of payroll taxes.
10. In more detail, the classification scheme works as follows. A family unit does not enter the new public program if it is: (a) a single individual in an existing public program, or with earnings sufficient to pay $800 annually in payroll tax, or with group health already in his or her own name, for which an employer bears at least part of the cost, (b) a two-adult couple in which one member has earnings sufficient to pay $1,600 annually in payroll tax, or each individually meets the conditions in (a), (c) a family with children in which the head or spouse has earnings sufficient to pay $2,000 annually in payroll tax, or all members are currently covered, either by public programs or group health (for which an employer of the head or spouse pays at least part of the cost), or all but the head or spouse are covered by public programs and the remaining individual meets the conditions in (a).
11. This number is a good deal lower than that obtained from other recent waves of the CPS and may be an underestimate. See discussion by Moyer (1989) and Swartz and Purcell (1989).
References


