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Introduction

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Introduction

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With the 1992 presidential election approaching, deficiencies in the U.S. system of health care finance are beginning to draw national attention. The recent upset election of Harris Wofford (who made support for national health insurance a key plank in his platform) over Richard Thornburgh in Pennsylvania has catapulted health care reform near the top of the political agenda (“Wofford: Costs Are Voters’ Key Health Reform Concern” 1991).

A very substantial minority of the population has no insurance coverage of any kind to assist them in buying health care, at a time when one episode of illness requiring hospitalization can easily generate bills in the tens of thousands of dollars. This situation did not suddenly arise in the 1990s. While there has always been at least a significant segment of the population with no health coverage, a combination of trends has begun to bring the problems of access to a head.

- The size of the uninsured population grew substantially in the early 1980s. Although estimates vary on how many are uninsured and how that has changed over time, the number of uninsured under age 65 (almost all of those 65 and over have at least basic coverage through the Medicare program) apparently increased by at least 6 million between 1978 and 1986 (Brown 1989; Congressional Budget Office 1991; see also chapter 2 of this volume).
- The problem of lack of health insurance has been gradually creeping up the income ladder. In the 1970s, the working poor experienced the greatest problems. In the 1980s, the problem was extended to the near poor. A recent study based on the 1991 Current Popula-

tion Survey found that nearly three-fourths of the most recent increase in the uninsured came from families with annual incomes of \$25,000 or more (Pear 1991, p. A16).

- Health care costs continue to rise at rates much faster than the general price level or the economy's productive capacity. Cost increases are of great concern in their own right, but they also contribute to fears about access. For one thing, as the cost of health care (and its power to extend life and improve its quality) expands, so may the gap between the standard of care for the well-insured and the uninsured. And as health insurance premiums increase as a share of labor costs, from less than 0.5 percent of total compensation in 1948 to almost 6 percent in 1988 (Piacentini and Cerino 1990, p. 190), many employers who want to provide coverage must seriously consider dropping it, thereby adding to the numbers of the uninsured.
- The old system of implicit subsidies for financing indigent care has eroded. In the past, health care providers could, with relative ease, pass the cost of the care they delivered to the poor uninsured on to the bills paid by the privately insured. But as premium increases mount, employers become far less willing to passively accept this cost shift.

Policymakers in many of the states perceived these trends by the mid-1980s. They were well aware of complaints about the existing financing system from diverse elements of their constituencies: employers, large and small, who were finding it increasingly difficult to maintain coverage for their workers; doctors and hospitals, who felt a moral obligation to provide care but were encountering increasing numbers with no means to pay; and the uninsured and their advocates. But the states also observed a national government that had just slashed income tax rates and was battling large deficits without much success. There appeared to be no federal appetite for considering new social programs or the higher taxes that they might entail.¹

State policymakers saw no reason to expect prompt action on access to health care at the federal level. A number of states began to look very seriously at the problems of the uninsured to see what they might

do on their own. Among them was Michigan, where then-governor James Blanchard convened the Governor's Task Force on Access to Health Care in late 1987. The Task Force was assisted in its deliberations by an Academic Consortium of researchers from the state's major universities. This Consortium was charged with exploring the state's options for expanding access and how much they would cost.

This volume grows out of the Consortium's work. Although the original research was done for the State of Michigan, the authors have tried to distill from what they learned lessons applicable to any state attempting to deal with problems of access. Frequently they use Michigan data for illustrative purposes. While the numbers should be of interest to those in other states, at least as an indication of orders of magnitude, some readers may be more intrigued with the methods of analysis as models that could be applied elsewhere.

In chapter 2, Rashid Bashshur and Cater Webb take a broad look at the problems of access to health care. They provide some background on the U.S. system of health care financing and the increase in the 1980s in the share of the under-65 population with no health coverage. Bashshur and Webb also report data on the makeup of the uninsured population, finding it a diverse group, predominately young and with some connection to the labor force. The employed uninsured, however, tend to work for small firms and to be paid relatively low wages. Bashshur and Webb also note wide variation in the extent of access problems, as measured by lack of coverage, across regions and states. They argue that an important first step for a state attempting to address its problems is to gather data on the nature of its own target population.

Andrew Hogan and John Goddeeris consider in chapter 3 the most radical kind of state response to access problems—the creation of a single-state insurance plan to cover the entire population, perhaps along the lines of those operating in Canadian provinces. Their chapter reviews some of the arguments in favor of a state plan, including those related to more rational delivery of health care from a public health perspective, the potential for administrative savings, and other possible advantages of a single payer for cost control. The authors are, however, skeptical that a politically feasible state plan (see Aaron 1991) would prove effective in controlling cost growth. They emphasize also that a state

plan is likely to have substantial redistributive effects as compared with the current system, increasing burdens on the wealthier segments of the population while benefiting the current uninsured or poorly insured poor. Another important issue they identify is the possible loss of significant federal tax subsidies as the financing of health care shifts out of the workplace and onto personal taxes. They illustrate these ideas using data from Michigan.

In chapter 4, Goddeeris looks at another route to universal coverage. The idea is to build on the current employment-based system of health insurance by encouraging employers to cover their workers, and then pick up the remaining uninsured through new public programs. The most likely method for extending employment-based insurance is a “play or pay” tax, whereby employers who do not cover their workers must pay a tax equal to some share of wages. This idea is at the heart of several recent proposals at the national level and has been partially implemented in Massachusetts. Goddeeris discusses a number of issues that arise with this approach. While it might be the most politically feasible route to universal coverage, he argues that it is likely to require more new tax revenue than appears at first glance, as large numbers of individuals who are currently insured find it advantageous to switch to subsidized public coverage. These predictions are borne out in an analysis of Michigan data.

The next chapter considers a more piecemeal approach to dealing with problems of access, one which targets specific populations. One target group includes those small employers who would like to offer insurance but are deterred by costs that are higher for the same coverage than they would be for a larger firm. Hogan and Stephen Woodbury look at the use of pools of small employers, possibly subsidized, as a way of making health insurance more affordable for them. Hogan and Woodbury next consider the implications of making Medicaid available on a buy-in basis for low-income uninsured who do not currently qualify. Another subgroup of the uninsured are those considered uninsurable due to preexisting conditions. Dianne Wolman discusses the experience of a number of states in setting up special pools for these high-risk groups. Finally, if policy initiatives chosen leave some segments of the population uninsured, serious need for care will still exist on the part

of individuals with no means to pay. Society may wish to make arrangements for financing what would otherwise be uncompensated care. John Herrick and Joseph Papsidero discuss the uncompensated care problem and approaches that various states have taken to dealing with it.

Chapters 6, 7, and 8 deal with more generic issues broadly relevant to policies that attempt to expand access. In chapter 6, David Nerenz and his colleagues discuss the design of benefit packages in health insurance plans, including considerations of the scope of coverage and the role of cost-sharing. They also discuss how costs of coverage are likely to vary depending on the nature of the benefit package and other factors, and they provide some illustrative calculations based on data from a large Michigan health maintenance organization.

John Anderson takes a public finance perspective in chapter 7. Most public policy initiatives to expand health care access require additional government revenue. Anderson discusses alternative tax instruments, including both increases in rates and expansions of the base for existing taxes, and explores their revenue potential and economic effects. While the amount of revenue needed will influence the choice of instrument, Anderson also emphasizes that it is sound tax policy to look for taxes that distribute the burden fairly and do not unduly distort economic activity.

In chapter 8, Woodbury and Hogan focus on the labor market impacts of policies aimed at broadening health care coverage. They offer one of the most comprehensive analyses available of these important issues. The chapter begins with some descriptive analysis of the relationships between health insurance coverage and wage levels, industry of employment, and other factors. The authors go on to analyze the effects of policies like those discussed in chapters 3 through 5, using labor demand and supply analysis. They conclude that for the most part added costs of health insurance, whether imposed on the employer or financed through taxes, will ultimately be borne by the worker in lower after-tax wages (an exception occurs when minimum wage laws prevent full backward-shifting of the cost of insurance to workers). A claim is sometimes made that removing health care costs from the workplace, as the creation of a universal tax-financed system could do, would reduce labor costs and thereby improve competitiveness of American business.

Woodbury and Hogan find that unlinking of health insurance from employment is more likely to have the contrary effect of raising labor costs and reducing employment.

Most of the discussion in this volume is in some degree short run, focusing on the needs of the uninsured and the costs of meeting them within a health care delivery system not radically different from what we have. In the final chapter, medical ethicist Leonard Fleck takes a longer view. He argues that deliberations over the future of our health care systems ought to be guided by a well-thought-out vision of what a just society requires. As he points out, asserting that “health care is a right of all” does not take us very far, and we as a society must face up to difficult questions of how far that right extends in cases where care is extremely costly and of positive but very limited benefit. Fleck believes that basic moral questions about health care need to be confronted and discussed in public forums, in a process that attempts to reach some consensus on how a just society would set limits on access. He describes in some detail a project he has proposed that might serve as one model for such a process of moral conversation and consensus-building.

The Michigan Governor’s Task Force issued its report in June 1990. Much of the empirical work on the chapters of this volume was conducted around that time. Since then, a major recession has struck Michigan and many other states. State budget deficits have soared, as has the federal budget deficit. Most states are struggling to fund the expansions of the Medicaid program mandated by the federal government during the late 1980s and have backed away from new initiatives to improve access to health care. The Massachusetts Miracle turned into an economic nightmare, and the new governor has prevented the full implementation of the mandated benefit program passed by the Dukakis administration. In Michigan, tight state finances have led to a backward movement on health care access improvement through the elimination of the General Assistance program. Other states have taken similar measures.

The dire financial predicaments of many of the states have clearly shifted the focus of health care reform back to the federal level. The

Bush administration is being forced, reluctantly, to address the issue. If federal action is not forthcoming as the result of the presidential election, however, and if the economy recovers in 1992, renewed interest at the state level is likely. It is hoped that this volume will assist state policymakers in their deliberations.

NOTE

1. Actually, there was one failed attempt at improving coverage at the federal level. The Medicare Catastrophic Coverage Act expanded Medicare coverage for the elderly through an income-related premium surcharge. The legislation was later repealed due to a groundswell of opposition to the surcharge.

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