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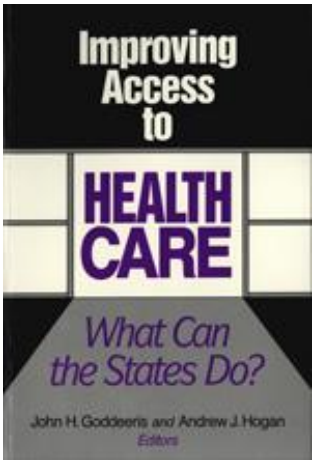

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Chapter 5.1 (pp. 99-102) in:
Improving Access to Health Care: What Can the States Do?
John H. Goddeeris, and Andrew J. Hogan, eds.
Kalamazoo, MI: W.E. Upjohn Institute for Employment Research, 1992
DOI: 10.17848/9780880995733.ch5.1

5.1
Piecemeal Programs of Health Insurance for the Uninsured

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The financing mechanisms of the U.S. health care system have developed in a piecemeal fashion over the last five decades to meet the needs of particular groups whose access to health care has differed significantly from the rest of the population at some point in time. These piecemeal programs are supplemented by individually purchased (nongroup) health insurance coverage. There is also a growing number of "free-riders" who do not maintain any insurance coverage and who lack the financial resources to meet the expenses of a serious illness. These uninsured "free-riders" account for a significant proportion of the uncompensated care hospitals are required to provide under emergency conditions.

This combination of piecemeal programs, nongroup coverage, and free-riding has, over the years, created a paradoxical stability for the current financing system, even as it appears to be spiraling toward collapse. Proposals such as those reviewed in the previous chapter face an enormous financial inefficiency, in that to increase health care spending for the uninsured by $1, current financing of $3 to $7 must be reorganized. For example, Needleman, et al. (1989) estimated that to increase spending for the uninsured in Pennsylvania by $393M, expenditures by employers would need to be increased by $779M, from individual insurance by $152M, from medicaid by $142M, with decreasing contributions by household out-of-pocket (-$334), charity care (-$189M), Medicare (-$74) and other government payments (-$82M). In total, $1,751M of health care spending has to be reorganized to increase spending for the uninsured by $393M, or $4.5 reorganized for each $1 of incremental spending. In a similar vein, Thorpe and Siegel (1989) estimate sizable differences in public and private costs when a

Medicaid expansion, a Medicaid Buy-In, and an employer-mandated approach are considered for adoption in different combinations.

Further piecemeal adjustments to the current system are significantly more manageable than large-scale reforms, politically if not financially. It may be that such piecemeal reforms can only postpone an inevitable collapse of the current system and the necessity of a large-scale reform or an overtly two-tiered system. A state not able or willing to undertake a major reform, however, might analyze its health care financing system to identify the major points of destabilization: the working poor, children, nonworking adults, high-risk individuals, providers of uncompensated care. The state could then implement a program to minimize the destablization of those critical points. Such piecemeal measures might actually stabilize a state health care system, at least for a time.

One area where special needs may exist is in the employed single-parent household. In Michigan, almost one-third of the uninsured children live with employed single parents. These uninsured single-parent families tend to have lower incomes than full families. Single parents are faced with a choice of an individual or a full-family (two-parent) health insurance policy, which is often actuarially unfair to the single-parent family and often involves unaffordaly high premiums. A piecemeal approach to lower the cost of health insurance to single-parent families is to mandate that insurers offer a single-parent policy. Such a mandate should require little administrative effort beyond the normal insurance commission monitoring of policies. The State of Michigan Employees Health Plan offers a parent-child option with premiums less than those for the two (dual) adult option and only 60 percent of the full-family premium.

Before undertaking any of the programs described in the rest of this chapter, a state should consider using all existing programs to their fullest extent, especially the Medicaid expansion for children, pregnant women, and the working poor. Some of the Medicaid expansions enacted during the 1980s include (National Health Policy Forum 1989):

- Deficit Reduction Act of 1984: coverage of children under age 5 where family income falls below AFDC eligibility thresholds; coverage of pregnant women who would become eligible if their children were born, and pregnant women who would qualify for the AFDC unem-

ployed spouse program if the state were to offer it; automatic eligibility for infants born to Medicaid-eligible mothers.

- Consolidated Omnibus Budget Reconciliation Act of 1985: coverage of pregnant women with family incomes below state AFDC standards, even if not receiving AFDC, AFDC (unemployed), or SSI; 60 days of post-partum coverage for women eligible for Medicaid solely due to pregnancy; option to enhance the benefit package for pregnant women; extended coverage for adopted children with special health needs; sanctioned use of Medicaid case-management services.
- Omnibus Budget Reconciliation Act of 1986: extended coverage to pregnant women, children under 5 years, aged and disabled with incomes below 100 percent of poverty line; use of "presumptive eligibility" where designated prenatal care providers can screen and qualify pregnant women for temporary Medicaid coverage immediately.
- Omnibus Budget Reconciliation Act of 1987: permitted coverage of pregnant women and infants (< 1 year) in families with incomes below 185 percent of the federal poverty line; permitted coverage of all children under 8 years below poverty line.
- Medicare Catastrophic Coverage Act of 1988: mandatory coverage of pregnant women and children under 1 year with incomes below the poverty line.
- Family Support Act of 1988: mandatory continuation of Medicaid coverage for next 12 months for families receiving AFDC in three of previous six months; mandatory AFDC unemployed spouse program.

Some proportion of the uninsured population can be reduced by full implementation of all of these Medicaid expansions and aggressive outreach to find eligibles not currently participating. The remaining sections of this chapter will discuss the major options available to states that are willing and able to do more without undertaking large-scale reform: small employer pools, Medicaid Buy-In programs, high-risk pools, and uncompensated care programs.

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