LABOR CENTER
Reporter
May 1989 Number 266

HEALTH POLICY AND THE UNINSURED

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The United States faces a problem in the area of health insurance. Most working Americans receive some form of health insurance through their place of work. Yet, at last count, more than 37 million Americans (15.6% of the total population) had no health insurance at all. One might ask why the lack of health insurance is a problem. Certainly, private health insurers will sell health insurance to those without it . . . won't they? Health insurance *is* available through the private market for most of those able to pay for it. But, because health insurance is expensive, people without health insurance can not always afford to pay market insurance premiums. This article will attempt to define the problems facing those without employer-sponsored health insurance. It should help to describe who these people without health insurance are. The article will also describe several recently discussed approaches to alleviating the problem.

Why Is the Lack of Health Insurance A Problem?

Health care is expensive. Even a rather simple inpatient surgical procedure without complications can be priced in the neighborhood of $5,000 for a two-day hospital stay in the San Francisco bay area. Anyone who has witnessed a recent hospitalization is familiar with the price of health care. Fortunately, most people faced with a hospitalization pay only a small portion of their bill since their health insurance pays the bulk of their hospital and physician charges. For those without health insurance, the prospect of paying thousands of dollars for health care may be unaffordable. Because of this fact, many without health insurance forego or are denied needed health care. In some instances, foregoing treatment might result in even more expensive emergency treatment later. In more desperate cases, the emergency care may come too late. If the bill for the original treatment was too much for the patient to bear, presumably the emergency treatment would be so as well. Ultimately, society will bear the burden of the medical costs for more acute care incurred by those unable to afford adequate preventive care. In a moral sense, society also bears the burden of deaths which might have been preventable. It might make sense to devise some way to finance the preventive needs of those currently without health insurance.

The questions raised by the absence of health insurance are difficult to answer. Is it fair that only those able to afford health care should get it? Is it fair that those constrained to certain types of jobs should live without health insurance and access to adequate health care? Can America afford to sacrifice the health of future adults because of the types of jobs available to their parents? If we decide that the answers to these questions contradict current practice, an equally difficult question is how to best restructure the current system.

Who Are Those Without Health Insurance?

As mentioned before, most employed Americans receive health insurance through their workplace. Trade unions have been very successful in securing workplace health care coverage for employed members. Elderly Americans are publicly insured through the Medicare program. Americans receiving support through Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) and a few others are covered through the Medicaid program.

The inpatient hospital care needs of those with adequate workplace health insurance and Medicare are met most comprehensively. Medicaid recipients face more limited health

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care access. Those persistently uninsured (approximately one-quarter of those uninsured at any one time) might experience the largest problem gaining adequate health care. The problems faced by the uninsured might have been aggravated in recent years. The current focus of policy has been to control the costs of health care. In this process, insurers have become more conscious of the costs generated by their own insured populations and less willing to share the costs generated by those without insurance. As a result, there is less of an incentive for health care providers to treat patients without the means to pay for care. Those with insurance used to subsidize those without insurance to a larger extent in the past. Now it might be harder for hospitals to find the financial means to treat patients without insurance. This makes health care access increasingly tight for those unable to afford market health insurance rates.

A 1988 report by Health Access, a health insurance policy group in San Francisco, emphasized that the greatest feature separating those with private health insurance in California from those without is employment. Not everyone with a job has health insurance. The type of job held influences whether a person will have adequate private health insurance or not. Large companies offer health insurance as a fringe benefit more often than small companies. Higher wage jobs are more likely to include health insurance coverage than low wage jobs. Full-time employees are more likely to have health insurance coverage than part-time employees.

Whatever the reason, the sheer facts about health insurance coverage are startling. At last count 36.8 million Americans under 65 years of age (17.5% of all Americans under 65) had no health insurance. Many of the uninsured work in small companies or are unemployed. One-third of uninsured Americans are children. Of the uninsured, 21.8 million live in families. Approximately 12 million of these people live in families where at least one adult works full-time. Less than 6% live in a family where neither adult works at all. The rest live in families where an adult works either part-time or full-time for part of the year. The problem of limited health insurance is a problem faced by families of many *working* Americans. Of those uninsured who do not live in families, more than one-fifth are unemployed all year and approximately the same share work full-time. The remaining, nearly 57%, work at least part-time or for part of the year.

Some of the uninsured already suffer from illness so that insurers opt not to insure them. These people are a particularly needy group. Their health needs are immediate, yet the private health insurance market is not inclined to insure them because of their health needs. While the problem is serious, these cases are a surprisingly small (1 to 2 million) but visible share of the total insured population. Many states address this problem by offering insurance at subsidized rates for those who cannot attain other insurance at affordable market rates.

What Can Be Done?

One idea behind health insurance is to combine many people into a group so all of them can share the costs of the collective health care needs. Everyone benefits from knowing that their unexpected illnesses will be paid for by the group. Those fortunate enough to be healthy help to alleviate the burden of illness for those less fortunate. Right now, we exclude those without health insurance from the sharing process until their unavoidable health care needs can be financed by tax revenues or charity, those with insurance, or left as unpaid bills to physicians and hospitals.

In 1987, the federal legislature considered a bill called the Minimum Health Benefits for All Workers Act. The act stipulated that many employers who currently fail to provide health insurance to their workers be required to do so. The legislation never became federal law. Those opposed to the bill feared that the requirement would cause the affected employers harm and that affected companies would cut back on employment. Supporters of the act challenged the job loss predictions of the opposition by pointing to offsetting job gains which might also result. For example, the act might have expanded jobs in health care and in those industries already supplying health insurance to their workers. Arguments in favor of the employer-mandate approach to health insurance usually mention that such legislation would provide more widespread health insurance coverage while limiting expansion of public budget responsibilities. Those in favor of maintaining a largely private sector health insurance system consider this feature of the system to be attractive.

The Case of Massachusetts

The state of Massachusetts adopted its own state-wide health insurance law in 1988. The Massachusetts law is similar to the proposed federal legislation in that it is based on employer responsibility. The law requires all except for very small employers in the state to provide health insurance to their employees or to contribute to a state insurance fund. The Massachusetts law requires a small tax to finance health insurance for the unemployed and ensures that all residents of Massachusetts will have a minimum standard of health coverage in the coming years. The Massachusetts plan has widespread appeal since it leaves as much of the health care industry "private" as possible while expanding health insurance to many who wouldn't have it otherwise. Mechanisms have been built into the program to soften the impact of the legislation on vulnerable small businesses. Potential concerns include possible relocation of businesses to the other states without more widespread health insurance and the burden of the legislation on smaller employers.

Proposed Innovations

In two January 1989 issues of the *New England Journal of Medicine*, Alain Enthoven and Richard Kronick of Stanford

University outlined a proposal for national insurance program. In some ways, their proposal resembles that enacted in Massachusetts last year. They propose that public agencies be established to combine those without health insurance into insurable groups and that the plan be financed through a payroll tax.

Their plan focuses on the concept of "consumer-choice" to encourage health care providers to compete against each other for patients. A crucial feature of the plan is that higher priced health insurance schemes should be more costly to the consumers. This way, consumers can choose to pay for more expensive insurance but they will have to pay the full cost difference between their plan and those which are as adequate but less expensive. Our current federal tax system allows exclusion of the full cost of health insurance from taxable income. Thus, the larger the amount of income received as health insurance rather than salaries and wages, the smaller the tax bill to the individual. The authors would like to impose a limit on the exclusion of health insurance benefits from employee compensation. This way, there is less of an incentive to offer higher priced and potentially inefficient health insurance plans. The authors argue that their plan is more politically feasible than a more radical restructuring of the current health insurance system.

In January 1989, another approach to the problems facing the health insurance system in the United States was described in the *New England Journal of Medicine*. A group of physicians, Physicians for a National Health Program, described the establishment of a national public health insurance system. Under their proposed program, the federal government would initiate a national health insurance plan. The plan would resemble the Canadian system. In Canada, the national government plays a role in funding the program but the provinces (states, in the U.S. case) devise budget limits for individual hospitals and administer the public health insurance system within their jurisdiction. A budget would be allocated by the state to each hospital within it. Each hospital would be responsible for providing adequate health care to all those who need it within the allocated budget. Physicians would be salaried in some cases. Others would be unable to charge more than rates negotiated between them and the state government. Thus, adequate health care would be available within a financing system which discourages unnecessarily expensive care.

Since private health insurance companies tend to have much higher overhead costs than public insurance programs, cost savings would result from public administration of a basic health insurance program for all Americans. Private insurers would be prevented from insuring for those services already covered by the national health insurance plan. The plan would also eliminate the need for hospitals to bill public insurance, private insurance, and patients, thus saving further administrative costs. Presumably, some of these cost savings could contribute to financing health care for those currently uninsured. Another important aspect of this plan is to fund health care operating budgets and capital budgets separately. This feature discourages hospitals from using operating funds for investment in new hospital equipment. It also suggests a state role in planning the allocation of medical equipment.

The problems faced by those without health insurance are not likely to go away without some concerted policy effort. These recently discussed proposals by no means exhaust the possible remedies to this problem. Instead, they outline some of the types of policies likely to be debated and considered in the coming years. Of course, another option would be to increase the numbers of those eligible for Medicaid. In the meantime, it is important that health insurance coverage (or rather, the lack of it) be understood as a problem facing both employed and unemployed persons. Except for the publicly administered cases of Medicaid and Medicare, health insurance coverage is usually determined at the workplace. Not all employers provide health insurance to their workers and health insurance purchased by small groups is more expensive than that purchased by large groups. Health care is different from many other consumer commodities. Along with food and housing, it can be categorized as a basic necessity. From that perspective, a case can be made for public intervention to secure health insurance for those who want it as long as the private market fails to satisfy this need.

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