

Getting Real About the Uninsured Problem

Rick Curtis

Rick Curtis is president of the Institute for Health Policy Solutions in Washington, DC.

The number of Americans who are uninsured has continued its long-term rise despite a wide range of state coverage initiatives over several decades. As Emily Friedman notes, the problem has recently become more acute because of the combined effects of a weak economy and the escalating costs of healthcare and coverage.

Previous coverage expansions have not solved the uninsured problem because they tried to shape publicly financed patches to fill in the coverage gaps left by narrow categorical programs, a counterproductive relationship between publicly financed and private employer-financed coverage, and a Byzantine labyrinth of cross-subsidies and counterincentives. Previous efforts have neither established nor conveyed a coherent vision of the mutual and individual responsibilities needed to achieve both affordable access for and participation by all Americans.

Friedman is right to decry excessive hospital charges to low-income, uninsured patients as a moral failure. Such patients are hapless victims of our collective decision not

to extend them the coverage and financial access they need. Charitable hospitals should make sure they do not further abuse such patients through unconscionable billing practices. But the court cases brought against not-for-profit hospitals bear vivid testimony to the schizophrenic views that underlie America's uninsured problem.

We expect that everyone should be provided medical care when they urgently need it but that no one should be required to participate in or contribute to the insurance coverage needed to undergird the health delivery system. Previous coverage expansions have focused on the very real need to cover vulnerable low-income populations. But, as Chollet notes, where such expansions extend substantially above poverty levels, they often substitute publicly financed coverage for employer-financed coverage. Thus, such expansions often cost states more than expected and are too much to sustain when the economy and state revenues decline.

[A]Getting Real About What The Problems Are

Previous cover-the-uninsured proposals and campaigns have emphasized the negative effects of being uninsured. The widely supported Cover the Uninsured Week heralds the need for all Americans to have access to coverage. But many nonpoor uninsured people are, and perceive themselves to be, relatively low risk; they expect—quite reasonably—that in the unlikely event they do suffer a traumatic injury, the system is obliged to care for them.

What coverage campaigns tend not convey to the majority who *do* participate in coverage are other insights about how the system is already unfair to them, such as the following:

1. Insured people ultimately pay for uncompensated care provided to uninsured individuals;
2. As the uninsured population has grown, many hospitals' capacity to provide trauma care and other services has been stretched to the breaking point; and
3. Where emergency care providers are forced to close their doors, critical services will not be available where and when our lives may literally be at stake

Many Americans might be motivated to support reforms that ensure broad participation in coverage if they understood in such concrete terms how current coverage policies are fundamentally unfair to them and dysfunctional for the medical care system on which they rely. While a broad range of approaches is available for achieving coverage of the uninsured, any real solution must include two basic ingredients: (1) government needs to somehow ensure that coverage is readily available and affordable for everyone and (2) individuals need to participate in that coverage.

[B]Addressing Healthcare Costs and the Uninsured

Despite concerns over real and pressing cost problems, it would be both unfortunate and counterproductive to hold the uninsured problem hostage to the healthcare cost problem. Achieving accountability for costs is the essential prerequisite for any form of cost discipline. With the current unfathomably complex mix of cross-subsidies for care of the uninsured, however, there is often a disconnect between apparent and real costs for a given service . Direct coverage and associated direct financing for the uninsured are needed if this country is to achieve healthcare cost accountability and discipline.

[A] Pooling Interests

A number of federal and state proposals could use purchasing pools to make health insurance more affordable and accessible for small employers and individuals. For example, President Bush's fiscal year 2006 budget proposes \$4 billion in grants to states to establish health insurance purchasing pools as an adjunct to proposed health insurance tax credits for individuals. Strong interest across party lines suggests that pools could well be an ingredient of expanded coverage.

But purchasing health insurance through loosely defined alternative pool arrangements is, in itself, neither a new nor an effective solution to improve coverage rates or reduce costs. In 1997, one out of three small employers reported they participated in some kind of pool, such as an association, business coalition, or other multiple-employer arrangement. But their costs and coverage rates were no different from comparable employers who purchased coverage directly (Long and Marquis 1999).

[B] Federal Employee Program

The Federal Employees Health Benefits Program (FEHBP) is often proposed as a vehicle or invoked as a model. As Chollet notes, it has no experience or existing capacity to collect premiums and manage enrollment of myriad small employers and/or independent individuals. These functions are particularly challenging where worker turnover is relatively high and contributions, enrollment, and payment vary with individual worker choice of plans. But FEHBP or state-level pools could retain vendors to administer plan enrollment and premium collection. This can be done efficiently through electronic

transmission. Several existing small-employer pools that offer worker choice of competing plans successfully self-administer these functions.¹

The more critical issues for FEHBP or any other potential pool revolve around risk selection and scale. Such pools are highly unlikely to succeed if they are a voluntary, readily accessible alternative to aggressively underwritten coverage, which is unaffordable for high-cost individuals and small-employer groups in most states. Some policymakers assume the FEHBP is such a large pool that it not only offers immense purchasing clout nationally but it also can readily absorb any such risks. Not so. There are 15 times more small-firm and self-employed workers as there are FEHBP enrollees (Fronstin 2004; U.S. OPM 2004).

[B]Pools Can Be Tools If...

To be effective, purchasing pools need to be large and need to attract many healthy as well as high-risk enrollees. Without sufficient size, they cannot achieve economies of scale and operate efficiently. This would be especially true where they incur the additional administrative system costs necessary to offer and manage individual choice among competing health plans while collecting premiums and enrollment from a variety of individuals and employers. Moreover, without a large, cohesive membership that health plans can reach *only* through the pool, a purchasing pool will not constitute an attractive group with the market clout to negotiate effectively with health plans for favorable rates.

The problem is that no voluntary pool can become large and cohesive by self-declaration. There needs to be some compelling reason for healthy as well as high-risk people or businesses to obtain and retain health insurance through the pool rather than

directly from health plans.² For FEHBP, cohesion comes from the employer contributions that are available *only* for coverage through FEHBP. This attracts participation of the vast majority (84 percent) of healthy as well as high-risk workers (U.S. OPM 2004).

To create such cohesion, purchasing pools could be the exclusive venue for any public subsidies or tax credits that may be made available to help low-income people purchase health insurance. And, to avoid simply creating an additional layer of fragmentation and administrative costs, there should be only a limited number of pools.

[B]Public-Private Partnerships

Chollet notes the importance of the interface between public and private coverage and financing. A number of states have premium assistance programs in place to help SCHIP- or Medicaid-eligible people pay the worker's share for employer coverage available to them (Neuschler and Curtis 2003). These programs reduce both state costs and shifts from employer to public financing. But given current myriad employer benefit structures, and given often incompatible public coverage program strictures, these programs are administratively cumbersome and relatively small. Another useful role for pools could be to greatly streamline coordination of multiple financing sources, including public subsidies and employer contributions.

Often ballyhooed public-private partnerships have failed too many times because they do not establish complementary roles and enduring incentives. While political leaders have successfully used the bully pulpit and the spotlight of media attention to successfully launch such partnerships, a pool or other organization will not endure unless it is endowed with constructive incentives to perform a value-added role.

[A]Real Reforms

There is ample cause to be skeptical that Americans would readily embrace national reforms requiring individual participation in health insurance. But there is real potential for building toward such a system through transitional steps.

One such step would be to start with the population for whom there is the greatest precedent and support—children. Americans accept and support parental responsibility requirements in a number of other areas, such as school enrollment and associated vaccines. And SCHIP has established a structure that can be used to more broadly ensure affordable access to children’s coverage (e.g., for parents who are not eligible for good employer coverage for their family). Both Senate Majority Leader Bill Frist (R-Tenn.) and former Senator John Edwards (D-N.C.), democratic vice presidential candidate in the 2004 election, proposed that parents be required to cover their children as a condition of receiving federal income-tax exemptions for their dependent children. In addition, both proposed sliding-scale tax credits to assist lower-income parents in affording coverage.

It is encouraging that neither the Edwards nor the Frist proposal has been controversial. But overwhelming support has not been forthcoming, perhaps because a majority of uninsured children are already eligible for Medicaid and SCHIP—programs that children’s advocacy groups generally prefer over tax credits that could also be used toward employer coverage. Most healthcare providers and other interest groups also put a higher priority on other issues, such as Medicare and Medicaid financing, or broader coverage proposals. But measures such as the Frist and Edwards proposals could constitute an important precedent for coverage of the uninsured.

It would doubtless make a big difference if interest groups could come together to identify and strongly advocate doable first steps toward a coherent strategy to achieve coverage for all Americans. The best hope for such measures may well lie in federally funded state demonstrations. Such an approach has been suggested both by the Institute of Medicine (IOM 2003) and in a joint paper by Henry Aaron of the Brookings Institution and Stuart Butler of the Heritage Foundation (Aaron and Butler 2003). Such demonstrations could make constructive use of the states' role as the nation's laboratories to develop new and untested solutions.

The scope of such initiatives should constitute an elemental departure from previous healthcare coverage demonstrations. Coverage of a high percentage of all state residents (e.g., 97 percent) could be a condition for continuing federal subsidy funds after an initial implementation period of several years. Such coverage rates could be reached only through participation requirements of some form. States would have to ensure ready access to coverage that is affordable and meets coverage needs in light of family income.

Given the magnitude of the changes involved, states should be assured of demonstration periods lasting ten years or more. Federal demonstration costs for low-income subsidies/credits would be relatively modest if the number and population size of the states involved were small. Larger states might be given an option to apply for substate regions of similar scale. And federal subsidy–fund adjustments should be guaranteed in case of unforeseen economic, demographic, or other important changes beyond the control of state policy.

Such a demonstration program may seem unrealistic in light of existing state Medicaid budget crises. But there is good reason to think that at least several states would

step forward if adequate federal funds were available to cover the additional low-income assistance needed. It is noteworthy that Governor Arnold Schwarzenegger of California has publicly expressed interest in coverage expansions involving individual mandates. Other states, the uninsured, providers who care for them, and employers who bear the cost-shift burden for that care are all eager to achieve real and lasting coverage solutions. If such interests would come together to advocate for a federal demonstration framework and for state demonstration initiatives, the likelihood for making real progress in covering the uninsured seems high.

Notes

1. Examples include the Health Connections program offered by the Connecticut Business and Industry Association.
2. Since the most expensive 5 percent of the working age population accounts for 50 percent of healthcare costs (Berk and Monheit 2001), the enrollment of a relatively small proportion of high-risk individuals or small-employer groups could cause dramatic increases in costs for any pool.

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