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EXAMINING THE DYNAMICS OF HEALTH INSURANCE LOSS: A TALE OF TWO COHORTS

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TABLE OF CONTENTS

PREFACE

Past research has characterized the size and circumstances of the uninsured population in fairly static terms. In particular, survey data have provided both annual and point-in-time estimates of the number of uninsured persons, but little is known about the transition between insured and uninsured states. Data limitations have also precluded a full examination of the pattern of health insurance loss over an extended period of time, in terms of the duration of loss of coverage, the degree to which persons reacquire health insurance, and the frequency of multiple spells of health insurance loss. These dynamic aspects of the changes in health insurance status are examined for a cohort of privately insured persons over a 32 month period using the 1984 panel of the Survey of Income and Program Participation (SIPP). The experience of this group is compared to a cohort of persons uninsured at the beginning of the SIPP panel. Our analysis reveals that the uninsured population is quite heterogeneous, consisting of many persons who lose coverage for relatively short periods of time, others who experience periodic spells without insurance coverage, and many who are persistently uninsured.

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I. Introduction

The emergence of the problem of lack of health insurance coverage as a public policy issue has led to a variety of proposals to reduce the number of uninsured, estimated at about 31 million persons or over 13 percent of the population (U.S. Bureau of the Census, 1986). These proposals encompass a number of initiatives, including voluntary coalitions of employers, labor unions, insurers and providers, the formation of state risk pools for the medically uninsurable and indigent care populations, proposed expansion of Medicaid eligibility criteria, legislative proposals to mandate employer-provided health insurance and state insurance pools, and a federal mandate to continue lost employment-related coverage (Cohodes, 1986; Lewin and Lewin, 1984; Wilensky, 1987). All such proposals, however, are based upon a static picture of the uninsured population generally derived from household survey data. Although these data provide a useful snapshot of the size and characteristics of the uninsured population, they are unable to measure a number of factors which are crucial to establishing effective policy initiatives. Such factors, which include the length of time a person lacks coverage, reasons associated with the transitions between insured and uninsured states, and the existence of multiple spells of health insurance loss, would provide important information as to whether lack of coverage is largely a transitory phenomenon associated with specific, well-defined events

or a long-term, more deeply rooted condition. Consideration of these more dynamic aspects of the lack or loss of health insurance is essential for well-designed policy initiatives which would provide coverage for appropriate periods of time and target persons who truly have difficulty acquiring or retaining health insurance coverage.

Measurement issues associated with the duration and multiplicity of "uninsurance" spells are similar to those that have emerged from research on the persistence of spells of poverty and unemployment. Recent analyses of the poverty population which have used longitudinal data and statistical techniques to estimate the entire spell of poverty have found that while many persons may experience a spell of poverty, most do so for short periods of time. However, when the poverty population is observed at a given point in time, the majority of poor persons are found to be experiencing a fairly long spell of poverty (Corcoran et al., 1985; Bane and Ellwood, 1986). Research regarding AFDC recipients has also found that the majority of welfare spells are of short duration (a year or less) but that a nontrivial minority of spells are quite long (O'Neill, Bassi, and Wolf, 1987). These results suggest that persons experiencing a spell of poverty represent a very heterogeneous population with a high degree of turnover and that efforts to reduce poverty and end welfare dependency should be targeted to persons most likely to experience long-term poverty. Analyses of unemployment spells have distinguished between single and multiple spells, finding that the average length of a completed spell can seriously understate unemployment experience by ignoring multiple spells of shorter duration during a calendar year (Akerlof and Main, 1980). In each case, these analyses have helped clarify perceptions of the poor and unemployed populations by considering more dynamic

aspects of their poverty or unemployment experience. Such research also points to the fact that analyses based upon point-in-time population estimates, as are frequently used in describing the uninsured population, may mask a high degree of instability and turnover among population members. Characterizing the uninsured population in more dynamic terms, together with the reasons associated with the loss and retention of coverage, should contribute to an understanding of the composition of the uninsured population and the degree to which policy intervention on their behalf is required.

Examining health insurance loss and the uninsured population in a more dynamic context is particularly relevant given the recent federal mandate for continued health insurance coverage contained in the Consolidated Omnibus Reconciliation Act of 1985 (COBRA P.L. 99-272). Under this mandate, employers with 20 or more employees are required to make previously held employment-related group health insurance available to workers who have been laid off, dependents of deceased workers, former spouses of a divorced worker, dependent children ceasing to be dependents, and covered employees who become eligible for Medicare. Unemployed workers can continue coverage up to 18 months and the other groups up to 3 years. The former employee or dependent can be required to pay up to 102 percent of the premium. Given the rather static perspective available in most survey data on the uninsured population, especially with regard to a health insurance loss, the targeted populations and time limits established by COBRA seem rather arbitrary. Since we have very little knowledge of how long persons go without health insurance and the circumstances (especially financial) associated with a loss of coverage, it is unclear whether the COBRA time limits, groups covered, and required out-of-pocket premium payments are appropriate. In addition, apart from any

legislative initiative, we have little evidence to suggest the degree to which market and social processes (e.g., new or alternative employment, presence of an insured spouse, new household formation, etc.) are successful in restoring health insurance to persons who lose coverage.

In this paper, we consider health insurance coverage in a more dynamic context by examining transitions in health insurance status among cohorts of privately insured and uninsured persons over a 32 month period. Our analysis indicates that persons with private insurance at the outset of our panel exhibit far less volatility in health insurance status than persons who are uninsured. We also find that the majority of persons losing private coverage are likely to experience completed spells of health insurance loss. Over half of all losers have a single completed spell and reacquire private or public health insurance in an average of five months. Most uninsured persons also acquire some form of insurance for at least part of this period, although acquisition of this coverage appears to be on a temporary basis and over a quarter of the uninsured cohort are persistently without coverage during 32 months of observations. By the end of our observation period, over 30 percent of the uninsured cohort who obtained coverage and half of the entire uninsured group remain uninsured. Data on the duration of spells without coverage again demonstrate the differences between the two cohorts; the majority of persons uninsured at a point in time are found to be without coverage for well over a year, while most persons observed to lose private insurance are able to obtain new insurance coverage within several months. These differences between cohorts in the number of transitions, the likelihood of reacquisition, and the duration of lack of coverage stem from the composition of the group of persons observed to be uninsured at a point in time. As suggested earlier, such a

snapshot captures a larger proportion of those with longer periods without insurance. These long-term uninsureds, compared to persons who lose coverage, are a much more economically disadvantaged group with far less labor market attachment and less access to employment-related insurance.

II. Data Considerations

If health insurance coverage is indeed dynamic in nature, then we need to try to observe an individual's health insurance status over an extended period of time as well as the concurrent life events as they lose insurance, regain their coverage, or remain uninsured over a long period of time. The 1984 panel of the Survey of Income and Program Participation (SIPP), a longitudinal household survey designed to provide detailed information on the economic circumstances of the noninstitutionalized civilian United States population, meets many of these criteria. SIPP will be used in this paper to explore the dynamic nature of health insurance coverage for the following reasons. First, SIPP collects information on whether an individual has health insurance coverage on a monthly basis, so that changes are discovered quickly and even temporary states are not likely to be missed. Secondly, SIPP follows individuals over a 36-month period so that coverage, lack of coverage, or changes in coverage can be observed over an extended period of time. In addition, the other data collected in SIPP allow one to trace employment status and income, marital status and household composition over this same time period, and thus enable establishment of linkages between changes in insurance status and in other related facets of an individual's life.

For this analysis, we have used the 1984 SIPP panel to construct a

longitudinal data base consisting of 32 months of observations between June 1983 and March 1986. Our data base includes all persons less than 65 years of age at the first SIPP reference month and who are present throughout the 1984 panel. Our analytical strategy is to begin with a cohort of persons privately insured in their first SIPP reference month (June to September 1983) and to examine their subsequent health insurance experience over the entire 32 month period. This provides a maximum opportunity to observe both completed spells of lack of coverage and the events associated with the loss and retention of coverage. We further observe the experience of a cohort of persons uninsured at the first SIPP reference month; this cohort serves as a benchmark and represents, in essence, the usual snapshot of the uninsured developed from most survey data. Within this cohort, we are able to observe the extent of the chronically uninsured among persons lacking coverage at a particular point of time. Since we cannot observe the onset of lack of coverage for this group (i.e., their insurance experience prior to SIPP) or the end of spells for some members of both cohorts, we are at a disadvantage in assessing the true distribution of duration without coverage. Approximation of this distribution requires the application of statistical techniques to determine the beginning and end of health insurance spells that are, respectively, prior to and after our period of SIPP observations.

There are three reasons why the estimates of the insured and uninsured populations in this paper may differ somewhat from SIPP published estimates. First of all, we have developed longitudinal weights, post-stratified to yield population totals for the noninstitutionalized civilian U.S. population for the first reference month of SIPP (June-September 1983, where a quarter of the population is present each month). Since our data base includes persons who

are present throughout the SIPP panel (i.e., those who have continuous data) our predictions may be viewed as national estimates from a longitudinal survey of the U.S. population whose members are present throughout this 32 month period. Second, since the nature of the question used to ascertain insurance coverage allows dependent coverage to be attributed to other than immediate family members, we have developed our own algorithm to assign family coverage to dependent spouses and children.[1] The third difference is a result of an additional algorithm to account for CHAMPUS/CHAMPVA coverage. Since the SIPP core questionnaire fails to include questions regarding CHAMPUS, we have applied a methodology used by the Bureau of the Census to designate such coverage.[2] In doing so, we have also used a revised SIPP variable to measure the number of persons in the military. This variable corrects an earlier overestimate of this population and has the effect of reducing the number of persons with CHAMPUS coverage below that reported in initial SIPP estimates of the insured population. With these changes, our estimates of privately insured and uninsured persons for September 1983 remain quite close to published SIPP estimates for the fourth quarter 1983. Both sets of estimates yielded 15.2 percent of the population uninsured. Our estimate of the percent of persons with private insurance was 74 percent compared to the published estimate of 74.7 percent, and we predicted that 60.3 percent of the population

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1. The algorithm checks relationships between household members and the primary insured person and also examines the age and educational status of dependent children. Spouses of primary insured persons reporting family coverage and dependent children less than age 20 or students between 20 and 23 years of age were included as covered by family health insurance. This check resulted in the invalidation of the private insurance assigned in SIPP for 383 persons in the entire Wave 1 file and 233 from Wave 1 of our restricted eight wave analysis file.

2. A person was assigned CHAMPUS if he/she was a dependent of a person on active military duty, the recipient or dependent of a person receiving military retirement benefits, or the dependent of a person receiving more than $1000 per month in veterans benefits.

held employment-related coverage compared to the Census Bureau estimate of 60.7 percent. National estimates for persons in our longitudinal panel for September 1983 are 14.1 percent uninsured, 75 percent with private coverage and 62 percent with employment-related coverage.

III. Transitions in Health Insurance Status: Privately Insured and Uninsured SIPP Cohorts.

To discern the relative stability or volatility of an individual's health insurance coverage over time, pairwise comparisons of monthly health insurance status over 31 months of SIPP data were made and the results are presented in Table 1. These data are used to describe the total number of transitions or changes among private health insurance coverage, public coverage and no health insurance coverage. As the table reveals, persons possessing private health insurance at the outset of the SIPP panel exhibit a relatively stable pattern of coverage, with over three-quarters retaining private coverage for the entire 32-month period. However, there is evidence of a fair degree of change in health insurance status within the privately insured cohort, with 17.2 percent or 26 million persons expected to change insurance status more than once. Thus when persons possessing private health insurance at a specific time are observed over an extended period, a sizeable proportion experience some turnover in their health insurance coverage.

In contrast, persons uninsured at the first SIPP reference month exhibit much more instability in their health insurance status. However, these changes should not necessarily be viewed pejoratively for some of these changes indicate contact with the private or public health insurance system. Almost three-quarters of such persons will acquire some form of health insurance within the 32 months of observations although almost forty-five

percent will experience additional changes in their health insurance status. Overall, more than a quarter of those in the uninsured cohort (about 8.4 million persons) appear to be persistently without coverage during the entire period.

Table 2 extends the analysis of health insurance transitions by examining two kinds of changes in health insurance status: (1) movements by our privately insured cohort from private insurance to no coverage and (2) changes by our uninsured cohort from no coverage to any health insurance. Almost a fifth of our privately insured cohort (Panel A of Table 2) become uninsured within the 32 month period and about five percent of the cohort, representing about a quarter of the losers, experience multiple transitions from private to no insurance coverage. With regard to our uninsured cohort (Panel B), almost three-quarters will acquire some form of health insurance coverage, with the majority of gainers (64 percent) obtaining insurance once over the 32 month period. However, over a third of the gainers experience additional periods without insurance coverage and will reacquire insurance several times over this period.

Since the transitions described in Tables 1 and 2 are unidirectional- - from privately insured to uninsured for the privately insured cohort and from no coverage to any coverage by our uninsured cohort- - they do not provide a full picture of the health insurance experience of either group. Table 3 provides a more detailed description of this experience by examining the type of coverage obtained as well as health insurance status at the last month of the panel. The data are presented for each cohort and broken down by number of health insurance transitions. As the table reveals, almost two-thirds of

persons with a single loss of private insurance subsequently reacquire this coverage and remain insured. Public insurance plays a far less important role for this group, with just over 7 percent acquiring this form of insurance. Finally, it is disturbing to note that over a quarter of all persons with a single loss of private coverage (6.2 million persons) remain uninsured. However, this estmate must be interpreted cautiously. Since a portion of this group may have lost coverage late in the panel, some are likely to reacquire coverage at a date beyond our period of observations.

Persons losing private insurance more than once do not fare as well as persons experiencing a single loss. Over half of persons with multiple losses fail to reacquire private or public coverage and remain uninsured at the completion of 32 month period. Public coverage again plays a very small role in protecting such persons against medical expenses. The relatively high proportion of multiple losers who remain uninsured suggests that many adult members of this group may be marginally attached to the private health insurance system. As a result, they can be expected to exhibit continued volatility in health insurance status throughout their life cycle.

Panel B of Table 3 indicates that a large proportion of persons uninsured at a point in time will obtain private health insurance at a future date. Over half of all persons with one transition from no coverage to some health insurance, and about 60 percent of persons with multiple transitions, are observed to acquire private insurance and remain insured. An additional 30 percent of the former and 18 percent of the latter will also acquire but subsequently lose private coverage. Public health insurance plays a much greater role as a "safety net" for the uninsured cohort than for the privately

insured cohort, with 14.5 percent of persons with single transitions and 23 percent with multiple transitions acquiring some public coverage.

Although the data in Tables 2 and 3 indicate that the majority of privately insured losers and persons uninsured at a point-in-time will subsequently obtain health insurance, it is important to observe that the experience of the two cohorts differs. In particular, members of our uninsured cohort are much more likely to remain uninsured at the conclusion of our panel than are losers of private coverage. Despite contacts with health insurance by roughly three-quarters of persons uninsured at the first SIPP reference month, 30 percent of those subsequently acquiring coverage and half of the entire cohort (about 15 million persons) remain uninsured at the last observation month. In contrast, just over a third of all privately insured losers (some 10 million persons) are without coverage at the last month. Thus two-thirds of all losers of private coverage reacquire and retain health insurance by the end of the SIPP panel compared to only half of the uninsured cohort. These data indicate that private and public coverage play more of a transitory role for the uninsured cohort and that such persons are somewhat more predisposed to periodically lack coverage.

IV. Demographic and Economic Characteristics

Our examination of transitions in health insurance status has revealed that members of our insured cohort observed to lose private coverage are far more likely to reacquire insurance and remain insured than persons in the uninsured cohort. To gain an understanding of this difference, we compare the two groups in terms of selected demographic and economic characteristics, as

measured at the first SIPP reference month. In addition, a subset of the uninsured cohort -- persons who remain uninsured throughout the entire 32-month period -- is highlighted alongside the other two groups. Our findings reveal that the cohorts differ rather dramatically in terms of their economic status and labor force attachment.

To begin our characterization of each group, it is instructive to examine the type of health insurance coverage held by persons losing coverage as well as their status as policyholder or dependent. Overall, almost a fifth of persons with private health insurance in their first SIPP reference month lost that coverage at some point over the next thirty-one months. In focusing on those persons losing their private coverage, two points stand out. First, those with nonemployment-related plans tended to lose their coverage disproportionately relative to persons with employment-related coverage (33.9% versus 17.5%). Although employment-related coverage is far more widespread in absolute numbers than other private insurance, 87 percent of our privately insured cohort was covered under an employment-related plan but they constituted only 78 percent of those who lost coverage. For those without access to employment-related insurance, not only is the initial acquisition of insurance more difficult and costly but maintaining coverage seems to be less certain.

The second aspect of the data which is particularly interesting relates to dependents versus primary insureds. Within each type of coverage (employment-related and nonemployment-related), dependents were proportionally bigger losers of coverage. Clearly, this is because more than one dependent may be affected by each primary insured that loses coverage. Of all those who

lost coverage, sixty-three percent had dependent coverage while only fifty-three percent of all the privately insured were dependents. Again, we see persons without independent access to insurance coverage comprising the largest segment of losers.

It is in Table 5 where the underlying differences between the two cohorts become apparent. As described above, this table lays out selected characteristics of persons in the privately insured cohort who lose coverage as well as persons in the uninsured cohort. Characteristics of primary insured "losers" and the long-term uninsured are also shown. The preponderance of limited access to insurance coverage among the young is demonstrated in the age distribution across all three groups which include dependents. Over thirty-five percent of those who lose coverage and those uninsured in the first month are 18 years of age or younger, and another twenty percent are between the ages of 19 and 24.

In terms of the other characteristics shown, the variation across groups is striking. It is clear that members of the privately insured cohort who lose coverage are, in general, better off than those who are observed to be uninsured at a point in time. The comparison to persons uninsured throughout the entire period is even more dramatic. The proportion of persons classified as poor is three times as high in the uninsured cohort as in the cohort of persons losing coverage (12 percent compared to 37 percent). Similarly, while almost sixty percent of those who lost coverage were middle or high income, only thirty percent of those uninsured in the first month were in the upper income classes. These results are even more extreme for the subset of the uninsured cohort -- those uninsured throughout the entire period. For these

persons, forty-five percent were poor, and less than a quarter were classified as middle or high income.

The direction and extent of the differences are similar for employment status. Persons who held private coverage in the first month of the panel were more likely to exhibit some labor force attachment, with fifty percent employed on a full-time basis, compared to thirty-six percent of the uninsured cohort and thirty-two percent of the chronically uninsured. While the latter two groups had similar proportions unemployed (18.3 and 15.5 percent, respectively), the long-term uninsured were somewhat more likely to have no labor force attachment at all (almost forty percent). As might be expected from the descriptions above, persons in the uninsured cohort were slightly less likely to be white than those who were initially insured, and were not as highly educated. Again, the group of persons who remained uninsured for at least 32 months seems to represent an extreme and more disadvantaged subset of the uninsured cohort.

V. Spells without Health Insurance

Perhaps the most crucial element in understanding the problem of lack of health insurance coverage and in framing appropriate policy responses is the amount of time persons are without coverage. In an attempt to address this question, we have computed two measures of the duration of time without insurance.[3] For persons observed to lose private coverage, we compute the

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3. As mentioned previously, our inability to observe the onset of spells for the uninsured cohort and the termination of some spells for both groups precludes an assessment of the actual distribution of spells. Thus, the durations noted here tend to underestimate actual times spent uninsured.

average number of months per spell without insurance (where a spell is defined as the number of months between the loss of private coverage and the reacquisition of any kind of coverage) and examine the mean and distribution of this measure. Since we cannot observe the beginning of an initial spell without coverage for our uninsured cohort, we examine the mean and distribution of total months uninsured throughout the SIPP panel. For comparision, we also compute a similar measure for privately insured losers. In general, we find that most persons losing private insurance have a spell without coverage which lasts about five months and on average spend about eight total months uninsured. In contrast, members of our uninsured cohort spend a considerably longer period without health insurance coverage, with most persons uninsured for well over a year.

These measures of length of time without health insurance are displayed in Table 6. Persons with a single completed spell of health insurance loss, representing the majority of privately insured losers, reacquire health insurance in just under 5 months on average with only a quarter of this group experiencing spells of 5 or more months. Only a relatively small proportion of this group (6.6 percent) experience spells which last in excess of a year. Persons with completed multiple spells (who have completed each spell) reacquire coverage in just over 4 months on average, but are more likely than persons with a single completed spell to have spells lasting between five months and a year. The data indicate that the majority of persons with completed spells are likely to obtain insurance within four months.

To obtain some indication of the experience of persons with incomplete spells (spells which do not end in our period of observation), we have also

computed spell lengths which include the months of the incomplete spells. These data yield a much different picture of the experience of private insurance losers, especially for persons with single incomplete spells. Such persons are uninsured on average just over a year, and the distribution of months without coverage is heavily skewed to spell lengths of more than a year (over 40 percent of this group). Consequently, it appears that many persons in this group are likely to resemble the chronically uninsured and will experience long periods without coverage.

Among persons with spells in progress, those with multiple spells (all but the last spell completed) more closely resemble persons with completed spells. This reflects the fact that members of both groups are able to reacquire coverage one or more times within the 32-month period. Persons with multiple incomplete spells do, however, remain uninsured longer than those with completed spells, and this may reflect an increased difficulty of obtaining coverage as the number of spells increase.

In Panel B of Table 6, we compare total months without coverage by losers of private coverage to that of our uninsured cohort. It is apparent that persons observed to be uninsured at a point in time display much more difficulty in obtaining coverage than persons who have lost coverage. The latter are without coverage an average of 8 out of 32 months compared to 20 months for persons in the uninsured cohort. Moreover, the distribution of total months without coverage for the privately insured losers is much more heavily skewed toward a period of less than a year without coverage. In contrast, persons in the uninsured cohort are much more likely to be uninsured for well over a year, reflecting the experience of the large number of

chronically uninsured.

VI. Conclusions and Policy Implications

In this paper, we have examined transitions in health insurance status among cohorts of privately insured and uninsured persons over a 32 month period between 1983 and 1986. Our analysis has revealed that the uninsured population is quite heterogeneous, consisting of many persons who lose coverage for relatively short periods of time, others who experience periodic spells without insurance coverage, and many who are persistently uninsured. We also find that most persons observed to lack or lose insurance coverage will reacquire health insurance at some point within our 32 month observation period. However, we do find that losers of private coverage more quickly resolve their uninsured spells than do members of the uninsured population in general. Consequently, when observing the uninsured population at a point in time, there will be a segment who will quickly reacquire coverage and another component that remain uninsured for a relatively long period. In this regard, our findings resemble research on the turnover among members of the poverty population and demonstrate the usefulness of data that can follow a population at risk over an extended period of time.

Rather than yield a resolution to the public policy debate on the uninsured population, our findings raise a troublesome set of questions regarding the equity and efficiency of efforts to redress the problem of lack of health insurance coverage. For example, should public policy deal with short-term losers of health insurance, many of whom will reacquire coverage in a few months? How should the dilemma of the persistently uninsured be

resolved, given their weak labor force attachment and poor access to both employment-related and public coverage? Since existing public insurance programs play a relatively small role in reducing periods without insurance, should such programs expand their safety net to accomodate more of the long term losers and chronically uninsured? Finally, how will legislation such as COBRA which mandates rather generous periods of insurance coverage (although at some expense to the recipient) affect incentives to seek coverage independently, especially by the majority of losers of private coverage?

In sum, our findings indicate that point-in-time estimates of both the insured and uninsured populations can mask many important aspects of the dynamics of health insurance status. While this paper has made an initial attempt to portray this process, a complete understanding will require an examination of the events which precipitate such transitions as well as an assessment of the economic well-being of persons who experience changes in health insurance coverage.

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Table 1. Transitions in Health Insurance Status over 32 months: Number of Changes Among Private, Public and No Insurance Coverage.

	Persons with Private Insurance, First SIPP Reference Month	Persons Uninsured, First SIPP Reference Month
Numbers in Thousands	151,649	30,755
	Percent Distribution	
Number of Transitions		
0	78.0	27.4
1	4.8	28.1
2	10.4	17.2
3	2.8	15.2
More than 3	4.0	12.1

8.42 million

Source: 1984 Panel of Survey of Income and Program Participation: NCHSR Longitudinal 32 Month File.

Table 2. Transitions in Health Insurance Status over 32 Months: Persons with Private Coverage and Persons Uninsured at the First SIPP Reference Month.

A. Transitions from Private Insurance to No Coverage.

	Percent of All Privately Insured	Percent of All Privately Insured Persons Losing Coverage
Population in Thousands:	151,649	29,778
Number of Transitions:		
0	80.4	-
1	14.5	73.6
2	4.2	21.2
3 or more	1.0	5.2

B. Transitions from Uninsured to Insured Status.

	Percent of all Uninsured	Percent of Uninsured Obtaining Private or Public Coverage
Population in Thousands	30,755	22,342
Number of Transitions		
0	27.3	-
1	46.6	64.1
2	20.5	28.3
3 or more	5.6	7.6

Source: 1984 Panel of Survey of Income and Program Participation: NCHSR Longitudinal 32 Month File.

Table 3. Type of Coverage Obtained After Transition in Health Insurance Status.

A. Transitions from Private Insurance to No Coverage

Number of Transitions	1	2 or more*
Population in Thousands	21,912	7,866
	Percent Distribution	
Coverage Status:		
Remain Uninsured	28.1	50.6
Reaquire Private Coverage Only, Remain Insured	64.4	46.9
Acquire Public Coverage Only, Remain Insured	3.5	2.5
Acquire Private and Public Coverage, Remain Insured	2.3	-
Acquire Private and Public Coverage, Remain Uninsured	1.7	-

B. Transitions from No Coverage to Any Health Insurance Coverage

Number of Transitions	1	2 or more
Population in Thousands	14,323	8,019
	Percent Distribution	
Coverage Status:		
Gain Private Insurance, Remain Insured	51.4	59.6
Gain Private Insurance, Become Uninsured	29.7	17.6
Gain Public Coverage, Remain Insured	8.9	5.4
Gain Public Coverage, Remain Uninsured	5.0	2.4
Gain Private and Public Coverage Remain Insured	4.3	11.6
Gain Private and Public Coverage, Become Uninsured	0.6	3.5

*Status after last transition.

Source: 1984 Panel of Survey of Income and Program Participation: NCHSR longitudinal 32 Month File.

Table 4: Persons with Private Health Insurance, First SIPP Reference Month: Percent Losing Private Health Insurance over Next 31 Months. By Type of Coverage and Relationship to Primary Insured.

Privately Insured Persons	Number	Percent Lost Coverage
Total	151,649	19.7
A. Employment-related	131,783	17.5
Primary Insured	51,712	15.4
Dependents	69,152	20.3
Primary Insured/Dependent	10,919	10.0
B. Other Private Insurance	19,866	33.9
Primary Insured	7,734	26.2
Dependents	11,525	39.6
Primary Insured/Dependent	607	23.3

Source: NCHSR Longitudinal File of 1984 Panel of Survey of Income and Program Participation.

Table 5. Selected Characteristics of the Uninsured. Comparisons of Persons Losing Private Coverage after First SIPP Reference Month, Persons Uninsured during First SIPP Reference Month, and Persons Uninsured throughout Panel.

	Persons Losing Private Coverage		Persons Uninsured in First Month	Persons Uninsured Throughout
	All Persons	Primary Insured		
Population in Thousands	29,778	11,197	30,755	8,412
Characteristics[a]				
Age 18 or younger	37.7	0.7	35.3	35.6
19-24	20.6	23.9	19.9	15.7
25-44	29.6	52.6	30.1	27.3
45-54	6.5	11.9	6.9	10.7
55-64	5.6	10.9	7.7	10.7
Race/Ethnicity				
White	76.5	76.9	69.0	67.0
Black	14.8	14.4	16.6	16.5
Hispanic	6.2	5.6	10.9	14.1
Other	2.5	3.1	3.5	2.4
Education[b]				
Elementary	7.2	8.2	15.1	22.9
High School	59.4	55.1	61.0	60.0
Some College	22.2	21.7	15.2	12.1
College Graduate	11.3	15.0	8.7	5.0
Relationship to Poverty Level				
Poor	12.2	10.0	37.0	44.7
Near Poor	13.3	11.7	17.4	19.1
Other Low	14.5	13.3	13.7	12.7
Middle Income	40.4	40.4	23.8	18.1
High Income	19.6	24.6	8.2	5.3
Employment Status[c]				
Full-time	50.1	77.9	36.3	31.6
Part-time	17.5	10.2	14.9	15.7
Unemployed	8.3	4.6	18.3	15.5
Not in labor force	24.1	7.4	30.5	37.2

[a]Based on first SIPP reference month.
[b]Does not include persons who did not attend elementary school.
[c]Does not include persons 15 years of age and under.
Source: 1984 Panel of Survey of Income and Program Participation: NCHSR Longitudinal 32 Month File.

Table 6. Duration of Health Insurance Loss: Spells without Insurance and Total Months Uninsured.

A. Type of Health Insurance Loss	Population in Thousands	Average Months Per Spell	Distribution of Months Per Spell			
			1-3	4	5-12	>1 yr
Completed Spells						
Single Spell	15,633	4.9	41.4	33.2	18.8	6.6
Multiple Spells	3,833	4.3	41.5	18.2	40.3	-
Spell in Progress						
Single Spell	6,294	12.3	10.3	20.6	27.7	41.4
Multiple Spells	4,018	6.7	14.4	16.3	65.3	3.9

B. Total Months Without Coverage	Number in Thousands	Average Total Months	Distribution of Total Months Without Coverage					
			1-4	5-8	9-12	13-24	25-31	32
Losers of Private Insurance	29,778	8.3	48.6	17.7	10.9	19.1	3.7	-
Uninsured Cohort	30,755	20.2	12.2	10.5	9.6	24.3	16.1	27.4

Source: 1984 Panel of Survey of Income and Program Participation: NCHSR Longitudinal 32 Month File.

MEETING THE HEALTH CARE CRISIS

An NAM White Paper by Jerry Jasinowski and Sharon Canner

with

A Survey of the NAM Membership

prepared by A. Foster Higgins & Co., Inc.

National Association of Manufacturers
1331 Pennsylvania Avenue, NW
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TABLE OF CONTENTS

EXECUTIVE SUMMARY

This paper reviews the problems of the U.S. health care system and offers proposals to improve that system. The core strategy focuses on cost control and quality improvement, particularly in the buying decisions for health care, in conjunction with a phased expansion of access for those who do not have health care coverage. It is the National Association of Manufacturers' view that cost, quality and access should be dealt with in an integrated fashion.

Escalating health care costs currently are the number-one concern of American manufacturers relative to their ability to compete in world markets. In surveys in September 1988 and again in February 1989, the NAM board of directors, by wide margins, found rising health costs more threatening to their companies' economic competitiveness than higher interest rates and the federal budget deficit. In January 1989, NAM's more than 9,000 small manufacturers' members listed rising health care costs as the greatest threat to their economic viability and ability to compete.

Most manufacturers believe escalating health care costs represent an issue of extraordinary concern for several reasons.

First, according to a January, 1989 survey of more than 11,500 NAM member firms, the magnitude of health care benefit costs is on average equal to 37 percent of net profits, the largest nonwage labor costs in the typical manufacturing corporation, and costs are escalating more rapidly than any other corporate expenses. During the last year, the cost of providing health care benefits has risen an average of 29 percent for manufacturing firms. At the same time, offsetting quality or service gains have not emerged to justify these cost increases.

Second, a broad range of new legislative and regulatory changes--some already in place--will make the cost escalation problem worse. Mandated employer-provided health insurance legislation, first proposed by Senator Kennedy (D-MA) in 1987, was reintroduced in April 1989. Section 89 nondiscrimination rules enacted under the Tax Reform Act of 1986, effective January 1, 1989, require employers to collect copious amounts of data and perform a series of compliance tasks that will significantly increase their costs. New accounting standards for retiree health obligations, if they become effective in 1992 as proposed, will lead to substantial decreases in corporate net worth for many companies.

Related to these two concerns is the broader social issue of extending health care to individuals without coverage. While the NAM supports extended coverage, it strongly believes this must be based on a careful understanding of the composition and related needs of the estimated 37 million without coverage; and phasing in expanded coverage based on priorities that recognize need and strive for greater efficiencies in quality and delivery of care.

This paper is based on an NAM evaluation of various proposals and studies of the health care system. The positions taken are NAM's initial assessment of what may be

a workable strategy. Specifically, this paper: a) identifies the major deficiencies in the system; b) reviews how other countries manage their health care systems and provides options for reforming the U.S. health care system; c) articulates a strategy for improvement that focuses on getting costs under control by improving buying decisions; and d) proposes a package of specific reforms to improve the U.S. health care system overall.

The underlying causes of inefficiencies in the U.S. health care system are explored, including: a payment system that encourages uneconomical buying decisions; uneven quality and appropriateness of care; a bias toward excessive and sometimes inappropriate use of new technologies; excess capacity and high production costs of the health care delivery system; and a malpractice liability environment that significantly escalates health care costs. Additionally, a changing age structure and new disease patterns that will aggravate cost pressures in the years ahead is discussed.

International comparisons point out the excessive cost of our health care system; the United States spends more on health care as a proportion of total resources than any other industrialized country. In 1986, for example, the United States spent approximately 11.1 percent of its gross domestic product (GDP) on health care, compared with an average of 7.2 percent for 24 OECD countries--35 percent less than the United States. Canada spent 8.5 percent of gross domestic product (GDP) on health care, while in the United Kingdom the figure was 6.2 percent.

After extensive review, NAM concludes that the best approach for improving the health care system is through greater discipline on costs and improved quality. We believe that major costs and quality gains can be achieved by improving the competitive dynamics of the market for health care. There are three fundamental elements for improving the competitive environment and health care efficiency.

First, the provision of new resources for expanded health care must be conditioned on improvements in efficiency and quality. In the short run, this means no major tax increases or federal programs to increase the resources for health care until clear progress is demonstrated in controlling costs and improving quality. In the long run, it means striving to hold the growth in health care spending to the rate of economic growth. This is necessary if we are to meet our other national priorities and remain internationally competitive.

Second, the competitive dynamics of the health care buying decision can be improved by pursuing a competitive cost-management strategy. Once we develop the means to compare provider performance on the basis of quality and costs, we can then reward cost-effective, high-quality providers by sending them more patients. More broadly, such a strategy focuses on a range of public and private actions that improve the information, competitive environment, and buying decisions for health care.

Third, while we believe that access to health care must be extended to the uninsured, such access must be extended on a phased basis, with first priority given to children.

A phased plan is necessary for two reasons. Recent statistics suggest that health insurance coverage in the manufacturing industry is extensive. An NAM survey found that more than 98 percent of responding manufacturing firms currently provide health care benefits to their employees and families. Independent analyses by the Bureau of Labor Statistics and the Small Business Administration also found most manufacturing industries had high health insurance coverage rates. Therefore, before access is significantly extended, specific information is needed on coverage gaps to assure that assistance is provided where it is most needed.

A phased plan is also important because expanded access--indeed, an efficient health care system--can only be successfully achieved through improvements in cost containment and better quality.

Such an efficiency strategy would encourage all of us to confront the difficult decisions about reallocating resources within the existing health care system. We cannot afford expansions of the system without making tough choices about who gets coverage first, the extent of coverage for specific illnesses and who pays. Failure to address these difficult choices now will eventually lead to future rationing of health care, through either a Canadian-style system or massive and unproductive increases in government intervention.

The success of system reforms depends on a sustained and coordinated effort by all concerned parties--business, labor, government, providers, insurers and consumers. It would be a serious mistake to search for scapegoats when we all bear some of the blame and therefore the responsibility for solving this complex societal problem. Fundamentally, this means as consumers of health care we all must take greater responsibility for our own health and use of health services as a means to improve the current system.

The following specific public policy and private actions will help implement a competitive cost-management strategy:

- All purchasers and providers of health care should cooperate to achieve a cost-management system that defines the health care product and judges its quality. Elements of such a program should include sound public information on providers, incentives to encourage employer-based coverage and improved management of public programs. A major effort should be made to develop a process to provide continual information on health care quality and appropriate treatment.

- Data on individual hospitals and physicians should be publicly available to assist purchasers in making intelligent buying decisions. All states should enact such laws, and compliance should be a condition of receiving federal Medicaid funding.

- Employees should be educated consumers of health care. Individual responsibility for one's own health should be stressed. Employees should be instructed on how to use the health care system and health benefits better, and greater emphasis should be placed on preventive health care.

Where appropriate, labor unions should strive to support these education efforts.

- Medical liability reform should be pursued at the national level with limits placed on contingency fees and punitive damages. We should strengthen standards for negligence and establish no-fault compensation for certain areas of liability.

- Medicare should continue to refine the Diagnostic Review Groups (DRGs), a payment system for hospitals--to smooth out irregularities and update payment rates. New methods should be developed to replace the current prevailing fee environment for paying doctors.

- The federal government should use its purchasing power under Medicaid and Medicare to encourage a more efficient marketplace. Public programs should stress the use of managed care to hold down costs and improve efficiency.

- We should encourage insurance arrangements, such as multi-employer trusts (METs), that enable groups of firms and workers to join together to obtain more favorable underwriting terms. Similarly, basic catastrophic plans that exempt state benefit mandates should be made available to make coverage more affordable to small firms.

- Employers should be provided with tax incentives to voluntarily prefund health benefits for their retirees. Proposed Financial Accounting Standards Board (FASB) rules for retiree health obligations serve to highlight the immense growth in future employer health care spending--spending that will restrict the availability of health care for all employees. These standards underscore a need for employer tax incentives.

- Section 89 nondiscrimination rules of the tax code should be repealed. The law requires employers to meet unrealistic standards to prove nondiscrimination. These rules create costly administrative burdens that discourage employers from expanding health benefits coverage and may lead to termination of insurance altogether, particularly for some small businesses.

- Employers must make a greater effort to control the costs of their health care programs, focusing on employee education, quality and appropriate care, and adopting health plans that yield the best health outcomes and make judicious use of deductibles and cost-sharing.

MEETING THE HEALTH CARE CRISIS

Jerry Jasinowski
Sharon Canner

National Association of Manufacturers
May 1989

I. THE FUNDAMENTAL PROBLEMS WITH THE U.S. HEALTH CARE SYSTEM

As we approach the end of the 1980s, the U.S. health care system still has the same fundamental problem as in the early 1970s, when the great debate over health care--and a spate of remedial policy measures--began. The present system costs so much yet leaves too many people vulnerable to inadequate health care coverage. This paradox--the coexistence of soaring costs and large gaps in protection--has been the hallmark of health care in the United States for the past two decades.

Our health care system costs more than half a trillion dollars per year and currently constitutes more than 11 percent of gross national product (GNP), compared to about 6 percent in the mid-1960s. Yet, the sad fact is that the problems of cost and access continue and have been joined by a third serious problem of quality--the appropriateness and effectiveness of care. After a brief respite, the cost of private health coverage jumped sharply over the past year. Yearly premium increases (or the equivalent cost for self-insured employers paying claims) of 20 percent or more are not uncommon, even in health plans where payers are tightening up on reimbursement and shifting some costs to consumers. Joseph Califano, a former Secretary of Health, Education, and Welfare, has predicted that premium increases could reach 30 percent in 1989. Medicare outlays are now approaching $100 billion per year, or four times their 1977 level, even though the federal government has shifted some costs to employers and sharply increased premiums.

A decade ago, about 25 million Americans lacked health insurance coverage. Recent estimates place the number of uninsured at 37 million people, although there is considerable dispute about these estimates. About one-third of today's uninsured live in households with incomes below the poverty line, and about 11 million children have no health insurance. Moreover, to be uninsured in America today is to be more vulnerable to denial of health care. Stated simply, the free-care system is drying up. Hospitals and doctors can no longer so easily load the cost of uncompensated care, or nonpaying patients, into the charges of paying patients with the more "bottom-line" approach to bill-paying that now governs the health care marketplace. Ongoing budget pressures are also shrinking the network of community health centers and neighborhood clinics.

The problems of sharply rising costs, uncertain quality and inadequate access are interrelated. As third-party payers seek to control costs by screening out people with serious health problems, higher costs are jeopardizing coverage or making its cost prohibitive. The ''good risks'' are readily enrolled in health insurance plans, while the ''bad risks'' are often excluded from coverage.

At the same time, uncertainties about the appropriateness and effectiveness of care are a major cause of rising costs. Because payers cannot properly evaluate "quality" in this broad sense, they simply cannot determine the value of the services they are purchasing. Not surprisingly, the provision of whatever care physicians have deemed "necessary" remains virtually unquestioned and leads to heavy overutilization of services and higher costs. To some degree, physicians also overprescribe tests and certain other services, fearing malpractice suits.

Although the private sector and government have taken steps to control costs, increases continue to exceed the rate of inflation year after year. Many large employers have introduced utilization-review programs; increased cost-sharing by employees; redesigned their health plans to encourage care in less expensive ambulatory settings; and created opportunities for employees to enroll in alternative health plans such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs). The federal government has developed a new system for paying hospitals under Medicare that penalizes higher-cost providers and rewards cost-reducing measures. And some states have introduced "prudent" purchasing and case management into their Medicaid programs. Yet, the current mix of regulatory and market forces is not working efficiently to provide high-quality health care to the user at a reasonable cost.

U.S. Health Care Costs vs Other Industrialized Nations

The United States spends more on health care as a proportion of its total resources than any other industrialized nation. For example, in 1986, the United States spent 11.1 percent of its gross domestic product (GDP) on health care. (GDP, similar to GNP is an economic measure used by European countries.) By comparison, Sweden spent 9.1 percent, Canada 8.5, France 8.5, Switzerland 8.0, and the United Kindgom 6.2 percent. The mean share of GDP devoted to health care among 24 OECD countries reporting data was 7.2 percent, or 35 percent less than the U.S. figure. In 1960, Canada and the United States spent about the same proportion of GDP on health care (5.5 and 5.3 percent, respectively), which jumped to 8.5 and 11.1 by 1986.

Of course, a rising proportion of domestic product devoted to health care does not, by itself, suggest that a country is spending too much of its wealth for this purpose. If the increase in relative spending for health care translates into a healthier workforce, which leads to a greater rate of growth in output, more resources would be available for the purchase of all goods and services, including health care. Thus, if health care outlays enhance productivity, we do not have a zero sum game in which more for health care means less for something else.

In addition, if spending more on health care can be shown to result in better health outcomes and an increase in the quality of life, it may reflect a conscious choice by society to shift resources in the direction of health to relieve suffering and to lengthen life.

What brings the issue of health care costs into high relief is the growing feeling that we are not getting our money's worth, either in terms of increased productivity or better health. This is due in part to a very large concentration of increased spending among the elderly, combined with the increase in life expectancy. Because a larger share of our population will be elderly in the furture, these problems will multiply.

While increased life expectancy is a good development, it does not necessarily lead to increases in productivity and GDP. However, if increased life expectancy brings with it improved quality of life--prolonging one's working years at a time of expected labor shortages, for example--such resource use seems consistent with our

national values and goals.

Ironically, life expectancy in the United States is no higher than in countries that spend far less than we do on health care. The case for higher U.S. costs seems to rest on the contention that health care is more accessible and of better quality in the United States. But these assertions are difficult to prove, particularly when one of seven Americans lacks health coverage altogether. Not all extra spending on health care in the United States is waste, however. Indeed, there is much to praise about our system. For the most part, Americans are given freedom of choice in selecting physicians, although that may be changing as employers enter into preferred provider arrangements. The United States enjoys a worldwide reputation for excellence in training physicians and medical researchers, and frequent medical and technological breakthroughs are envied internationally.

But overall, we are compelled to ask tough questions about whether physicians and other providers of health services in the United States are paid more than necessary for an adequate supply of high quality services and whether our health care payment system leads to unnecessary tests, procedures, hospital admissions, etc.

In any event, the high cost of health care in the United States, relative to other countries, is hampering the competitive position of U.S. firms in an increasingly global economy--and absorbing a disproportionate share of GNP for a system with excess capacity and significant identifiable inefficiencies.

II. THE UNDERLYING CAUSES

What forces are causing health care cost increases to exceed the rate of general inflation year after year? The answer is a complex mix of inefficiencies in the system and the high cost of giving the American people what they seem to want--virtually unlimited health care, a significant percentage with marginal or even dubious benefits at a very high price tag.

The Payment System

Many efforts have been made to reform the system of paying for health care: from Medicare instituting Diagnostic Review Groups (DRGs) or set payments based on procedures, to private payers increasing cost-sharing by employees and making greater use of HMOs and PPOs. Despite these efforts, the payment system remains a major cause of inefficiency and rising costs. The majority of payments--especially for physicians--are still based on cost or customary fees that are determined largely by providers. States underpay providers for Medicaid services and, to a growing extent, so does the federal government for Medicare--resulting in heavy cost-shifting to private payers. Consumers still pay a relatively small share of the cost of services, giving them little incentive to use those services judiciously, which leads to overutilization and higher costs. Moreover, few companies have adopted the more innovative and aggressive techniques of cost management. The payment system was designed--or, more accurately, evolved--when total health care spending as a share of GNP was little more than half of what it is now, and its cost-generating incentives were generally ignored.

Quality of Care and the Value of Services

Some medical care is ineffective or even inappropriate and potentially injurious, largely because we lack a mechanism for defining just what "effective," "appropriate" and "necessary" services are. As Dr. Marcia Angell, deputy editor of the New England Journal of Medicine, phrased it, "much of the medical care in this country is unnecessary, is of no demonstrated value to those who receive it, and some of it is harmful." Dr. John Wennberg's studies have revealed wide variations in the frequency with which certain common medical procedures are performed within small geographical areas in close proximity to each other, while finding little or no difference in health status. Employers as purchasers of these services have been questioning prices without actually questioning the services themselves. Not surprisingly, they have had little success in controlling the frequency of utilization.

Until recently, we lacked a definitive mechanism for ascertaining what these questionable services are and for communicating such knowledge to consumers and providers. Now the work of health service researchers Wennberg and Caper, Gertman, Horn, Jacobs and Brewster and others is making it possible for purchasers to measure quality and efficiency and to develop "profiles" of providers based on these measurements. Purchasers must demand that providers be evaluated by these systems as a condition of patient referrals. Patients can be encouraged to use efficient providers through financial incentives in their health benefit plans.

New Medical Technologies

There is a significant increase in the rate of medical advances being made, with new technologies emerging daily from rapid scientific breakthroughs. Equipment with seven-figure price tags is purchased widely, only to be supplanted shortly by more sophisticated equipment-- as in the instance of CAT Scanners giving way to Nuclear Magnetic Resonance machines. But providers do not behave this way arbitrarily. They are responding to Americans' demand for the "best care that money can buy." Some new technologies reduce costs by improving the efficiency and effectiveness of treatments--for example, eliminating the need for surgery or decreasing hospital stays and improving the quality of life by relieving suffering and disability are the most important outcomes of technology.

The critical factor in determining whether a technology will be cost-saving or cost-raising is how "appropriately" it is used. Such determinations will depend increasingly on the kinds of quality measures just discussed. But any effort to change expectations about the universal availability of such technologies will raise bioethical issues in the United States that might not arise in other nations where health care systems are perhaps more modest.

Excess Capacity and Labor Intensive Production

Our health care delivery system is obviously overbuilt. The hospital industry, for example, has at least one-third of its beds empty today. In addition, the industry is extremely labor-intensive, with rising wage costs driving up total costs. Ordinarily, pressure from buyers in a market economy would shrink and rationalize an over-built sector. But closing a hospital that is half-full, then distributing its

patients among other hospitals with plenty of capacity, is not like closing an obsolete steel plant (and even that has been painful). In health care, there is a clear and understandable conflict between what is economically rational and what is socially acceptable and, therefore, politically feasible. Traveling 50 miles for health care is not acceptable to most Americans.

Malpractice Liability

Interacting with all of these factors is a medical malpractice system that, like the tort liability system in general, is badly in need of reform. The number of claims and the size of awards in the nonauto sector of our liability system have soared over the past decade. Premiums for malpractice insurance are now about 1 percent of health care costs, and the secondary costs of malpractice suits add substantially to that figure. In addition, the fear of such suits has led to the practice of costly "defensive medicine," and in areas such as obstetrics, access is threatened by physicians abandoning the field.

Demographics and Other Factors

Demographic factors have played a relatively small role in health care cost increases so far, but this will change. The aging of a large portion of our population in the years ahead will drive up the cost of Medicare, company-sponsored retiree health benefits, and long term care for the elderly. Acquired Immune Deficiency Syndrome (AIDS), and the HIV virus will add to what employers and federal and state governments pay for health care. The average cost of treatment for a person with AIDS ranges from $40,000 to $90,000 per case. More than 65,000 cases and 37,000 deaths were reported in 1988 and the numbers are expected to grow to 270,000 cases and 179,000 deaths by 1991.

III. GOALS/STRATEGY FOR CHANGE

Once the need for major change in the health care payment and delivery systems is agreed upon, we need to debate and establish goals and a strategy for achieving improvements in the system. As such, NAM believes:

> This nation should strive to reduce the rate of increase in health care costs, the numbers of people and proportion of the population that lack health insurance coverage, and the cost of uncompensated health care. At the same time, we should develop better means of measuring the quality of health care and find ways to improve that quality.

A national goal for bringing costs under control can be quantified in two ways: (1) reduce the rate of increase in medical care prices as measured by the medical care component of the Consumer Price Index (CPI); and (2) reduce the growth rate of total spending on health care.

We deliberately include two measures of progress toward bringing escalating health care costs under control--the rate of increase in the medical care component of the CPI and total spending on health care as a proportion of GNP. Both are important. Merely slowing the rate of increase in medical care prices would be of little

significance if total spending continued to grow rapidly because we were unable to control utilization of services.

Indeed, slowing the rise of medical care prices is the easier of the two goals to attain. General price increases are responsible for most medical price increases, and as private purchasers grow more aggressive--as seen in the rapid spread of price discounting arrangements with "preferred providers"--the portion of price "inflation" generated within the health care sector may decrease. Of course, as discounting spreads, most large private purchasers will no longer be paying "list" prices, so that the CPI overstates the extent of medical care inflation in the first place.

The more difficult goal is getting total health care spending on the same growth track as GNP, which would mean that health care would stop consuming an increasing share of total output (currently more than 11 percent of GNP). The aging of the population and the continuing rapid rate of technological innovation in medicine will both be working to increase total demand for services. To slow the rise in total spending, it will be necessary to reduce per capita use of services. Such a goal cannot be reached through gains in efficiency alone, but will require us to define--or redefine--what is "necessary" or "appropriate" care. This involves tradeoffs and cuts against the grain of existing consumer and even provider conceptions of what is "necessary." The point is that we cannot have it both ways: there will be some "costs" to cost control itself.

The NAM cannot presume to resolve these tradeoffs and set goals for the nation as a whole. Instead, we believe that the first steps in reforming the system require all parties to recognize that priorities must be set, given the limited resources available for improving health care. It is clear we cannot simply continue to expand health care spending faster than the rate of economic growth without seriously weakening our ability to compete and meet other important material needs.

While the nation is striving to set goals for restraining health care costs, individual companies should be setting their own goals. Strategic planning in any business involves establishing objectives, yet few companies do this for health care spending, which demonstrates clearly that they have lost control of it. Companies must tailor their goals to suit differences in the makeup of their work forces and regional variations in health care costs and utilization. But every company should aim to bring its own costs under control, using, for example, health care expenditures as a percent of sales or total net revenues. Like our national goals that relate total spending on health care to GNP, company goals can serve as policy statements even if they prove difficult to attain.

A January 1989 survey of NAM members indicated that firms use a range of cost-management devices, including percertification, secondary opinions on surgery and others. However, corporate cost increases exceeded 29 percent in the last year, certainly an indication that these efforts have not been adequate. These findings underscore the belief that companies need to set spending goals and develop a strategy to achieve these goals.

Decisions to reduce the use of services will be easier to bear, however, if private purchasers develop effective means to measure the quality of services to make rational choices about their "value." Purchasers must be able to discuss cost and quality issues on even terms with providers if we are going to graduate from haggling over price to actually controlling the use of services. Goals in this area cannot be stated in quantitative terms; rather, employers need specialized information to make judgments:

(1) Measures of effectiveness -- whether treatment improves the patient's condition/outcome;

(2) Measures of appropriateness -- whether the intensity of treatment is consistent with the severity of the condition;

(3) Measures of efficiency -- whether the cost of treatment is consistent with the outcome.

Quality and value will never be as simple to measure as cost, but we must improve employers' abilities to make these judgments if they are to gain control of costs.

Judging quality and appropriateness is also a responsibility of employees, who are the consumers of health care services. Their awareness and attention to the type of care received and the cost of services made more apparent by cost-sharing--is critical in this endeavor.

With respect to the problem of access to health care, only a universal coverage scheme, such as national health insurance, would immediately cover all the uninsured, but that is not an option in America's current political and fiscal environment. All other advocated approaches would reduce the number of uninsured but not eliminate them entirely. NAM is clearly on record in opposition to the sweeping mandates that various legislative proposals would impose on employers.

However, the problem of access to health care remains a major societal issue that will require a range of approaches. As such:

> We should strive as a nation to extend health insurance coverage to all our citizens, but on a phased basis, as we attain the primary goals of improving quality and thereby bringing utilization and costs under control.

In working toward this goal we should avoid the more sweeping, immediate "solutions" to the problem of access that would impose a further layer of costs on a system that is already ruinously expensive.

IV. BROAD OPTIONS FOR REFORM

Reform of the health care system could take several directions, depending on the mix of government intervention or private control we choose as a nation. Members of Congress, health policy experts and business leaders have suggested a range of

options aimed at improving access, including a government mandate on all employers to provide health insurance to workers, payroll taxes on employers who do not provide insurance, a national health plan and a procompetition plan developed on a national basis. These proposals primarily focus on expanding access and do not specifically address cost. NAM believes that a phased approach combining public sector reforms such as a Medicaid buy-in and private sector initiatives such as group purchasing for small employers, along with certain measures to improve quality and better manage costs, will be the best way to achieve long term reform of the health care system.

Mandated Employer-Provided Health Benefits

A mandated benefits approach would require employers to offer health insurance to persons working a minimum number of hours per week. Under some proposals, employers would be required to offer a benefit package equal in value to a government-specified set of benefits and pay the major share of the premium cost. Other proposals would give employers the choice of offering such a package or paying a tax into a fund that would then be used to purchase coverage for the uninsured. A version of the latter approach was recently enacted into law in Massachusetts.

Government mandates on employers would provide access for a majority of the uninsured in this country (workers and their dependents) at no apparent costs to the public--and without imposing a centralized national health plan. Some tax revenues would be lost, however, since the cost of insurance is a deductible expense for business. At the same time, these mandates would still leave many uninsured (the unemployed) and would hold the business sector responsible for solving a societal problem.

The estimated costs of mandated benefits legislation introduced by Senator Kennedy (D-MA) in 1987 ranged from $33 billion in employer costs alone for covering workers not previously covered to more than $100 billion, which included the loss in federal tax revenues, cost for bringing employer plans up to the so-called minimum and the costs for dual coverage in two-wage-earner families. The Congressional Budget Office estimated the legislation could cost $27 billion. Exact estimates are difficult as witness this broad range of numbers. (Cost estimates for the 1989 proposal are not yet available, but inflation can be expected to increase those costs.)

The added costs for many smaller employers would result in a loss of job opportunities for low-wage workers, but the greater drawback would be a large increase in total costs added to a system that is already out of control. On the jobs front, it is estimated that one million jobs would be lost as a result of the Kennedy proposal.

The idea of mandating that all employers provide health insurance to their workers actually appeals to some larger companies, which already pay for much uncompensated care indirectly through cost shifting. But any gains from reduced cost shifting must be weighed against the new costs generated by a fresh infusion of payments into the system without any accompanying mechanisms for controlling either the costs or quality of new services. Compliance costs for government regulation would be

considerable, as witness Section 89 for example, which must be added.

Canadian Model Health Insurance System

A centralized, public-sector health plan might follow either the Canadian or British model. The National Health Service in Britain is financed almost entirely from public funds. Hospital-based physicians and many specialists are salaried employees of the national government, which sets a fixed budget adjusted from the previous year for inflation and, perhaps, for some increment of real growth. Such a heavily centralized organization of health care could not be imposed on the medical "culture" of the United States without massive resistance from providers and consumers alike and is not a feasible option--especially given the well-publicized access problems and policies of explicit rationing that exist in the British system.

The Canadian model is quite different, centralizing the financing but not the delivery of care; as such, it would not be nearly so alien. Health care is purchased by the provincial governments, which negotiate fee schedules with local medical associations and prospective "global" budgets with hospitals. Financing comes from general revenues and, in several provinces, from premium contributions by beneficiaries and from payroll taxes on employers. There is a private insurance market as well, for items not covered by the national system. The latter plans are often bargained between employers and their unions just as in the United States.

The provincial governments are what economists call "monopsonistic" purchasers of health care, i.e., effectively the only ones. As such, they have considerably more market power than providers, with the ability to keep exerting substantial downward pressure on prices. While such power may put a lid on prices--at least for a while, it does not necessarily control costs in the long run. As discussed in an earlier section, cost control depends on utilization control--which, in turn, requires the ability to measure quality. Otherwise, cost pressures will build under the price lid, as they have in states like New York that have long regulated hospital prices through all-payer systems. The result will then be either a financial squeeze on hospitals or a deterioration in availability of services--the "British disease."

Canada has not exhibited such symptoms yet, and there is evidence that use of services is less intense there than here. There is also evidence that administrative costs are significantly lower than in the United States. But there is no evidence that "quality" is any better understood or subject to measurement there, so we really cannot judge whether Americans would be satisfied with the quality of care received by Canadians. Until the quality question can be answered--in its broader sense, which includes patient satisfaction that the "best possible care" is being received including use of the latest technologies--comparisons on the basis of total costs alone will be misleading.

A problem with trying to administer a Canadian-style system in the United States is the differences in the size and number of "administrative units." Canada has a dozen or so provinces and a tenth of our population. We have 50 states, and one of them--California--has more people than all of Canada. The Medicaid program could be offered as an organizational model, but the states hardly are prepared to start dealing with 10 times as many eligibles--nor, with a few exceptions like California,

which negotiates hospital prices, are they prepared to bargain with providers.

The Canadian system admittedly offers comprehensive coverage that leaves no one uninsured. Furthermore, global budgeting permits control of total hospital spending (although physicians are still paid fee-for-service), and centralized administration results in cost savings as well. The case for centralization of health care payment needs to be weighed carefully against that for a strategy favoring decision-making in a pluralistic marketplace. A Canadian-style system would involve a complete government takeover of health care financing, a change too radical to be politically feasible here, at least in the current environment. Moreover, the Canadian system has the drawbacks of retarding innovation, reducing consumer choice and creating a bureacracy that would cause some efficiency loses.

National Pro-Competition Plans

Alain Enthoven, Professor of Public and Private Management at Stanford University, offered the Consumer Choice Health Plan 10 years ago. It would have replaced the current open-ended, employer-financed private health-insurance system and the Medicaid program with universal tax credits (refundable for lower-income individuals) for the purchase of health plans. Medicare would be kept but changed into a voucher program. Enthoven's plan would have provided universal coverage, while leaving market incentives and competitive forces to control costs instead of imposing a national regulatory scheme. One approach would place a cap on the amount of employer contributions for health insurance that is tax-free to employees. This tax cap is designed to give consumers incentives to choose less costly insurance plans.

One problem with Enthoven's earlier plan is that individual consumers are neither knowledgeable enough nor economically powerful enough to challenge providers' control of the health care system. Only private employers or a government acting as purchaser can do this. Now Enthoven has offered a revised version of his plan that maintains the employer-based system of insurance for the employed population, but requires both employers who do not currently provide health insurance and their workers to pay a payroll tax for this purpose. Meanwhile, the nonworking population would be covered by public sponsors at the state level.

Enthoven's new proposal would provide universal coverage and still leave private employers incentives to encourage providers to organize and deliver care more efficiently and effectively--unlike a Canadian-style system. In this regard, it is an improvement on his earlier consumer-based approach that left insufficient countervailing power to confront providers. But it is also a "mandated benefits" approach of the Massachusetts-plan variety, using taxes on employers (and workers) to finance coverage. As such, it is subject to the same serious flaw of failing to get costs and quality under control before expanding access.

Uwe Reinhardt, Professor of Political Economy at Princeton University, has suggested his own system, called "Fail-Safe." He would create a basic catastrophic insurance program for all citizens and charge participants a progressively rising tax on their incomes to finance it. Those with adequate private coverage--presumably through their employers--would be excused from the tax, as would people below the poverty

line. In effect, individuals rather than employers would be mandated to have health insurance, and financing would be available to make it affordable for all. Reinhardt suggests that the Fail-Safe program be administered through the states, like Medicaid.

Fail-Safe would provide access for all Americans without imposing the cost directly on employers. But like similar proposals, it leaves the larger cost and quality problems unsolved, and like other tax-based schemes, rising costs would presumably lead to increased taxes. Futhermore, employers would have strong incentives to discontinue coverage, forcing workers into the new program. The only check on this would be pressure from the workers themselves, as a steeply progressive income tax drove them to demand continued coverage from their employers. This puts workers in a potentially untenable position and raises serious employee-relations issues.

National Leadership Commission on Health Care Proposal

The National Leadership Commission on Health Care, cochaired by former Congressman Paul G. Rogers and former Iowa Governor Robert Ray, was formed two years ago to examine the health care system and make recommendations on access, quality and cost. The commission, which consists of providers, insurers, labor and business, issued its proposal in January 1989. Some business members strongly dissented over the choice of an employer tax to finance coverage for the uninsured, although the proposal calls for contributions by employees as well. The commission addresses the problem of defining and measuring quality by significantly increasing research on the appropriateness, effectiveness and quality of care. Results would be published to help patients and purchasers assess treatment.

The National Leadership Commission Proposal, like various other versions of mandated benefits already discussed, would have the advantage of immediately providing universal access for all the uninsured. It is also the only such proposal to give serious attention to the problem of quality. But it falls into the same trap of inadequate attention to cost before expanding the system to the whole uninsured population. This proposal should be viewed alongside other ideas being carefully studied to address this complex problem.

Competitive Cost Management System

A competitive, pluralistic health care system shows the most promise for managing health care costs and quality while improving access for the uninsured. Elements of such a system already exist, but concerted and sustained efforts by business and government are necessary to bring these elements together into a functioning system that will achieve our goals, while preserving the values associated with pluralism -- choice, diversity and innovation.

The critical need for business purchasers of health care--and for government--is to reach a position of parity with providers in controlling the system. This requires that purchasers be able to define the product--health care--that they are buying and to judge its quality. Only in this way can they make the necessary tradeoffs between costs and quality required to bring utilization of health care services under control.

This approach to purchasing, focusing first on what is being purchased and then on its price, is being promoted by a few leaders around the country. In Pittsburgh, Cleveland and elsewhere, Walter McClure's Center for Policy Studies is developing this approach under the name of "Buy Right." The essence of Buy Right is developing the means to compare provider performance on the basis of quality and costs, and then rewarding cost-effective, high-quality providers by sending them more patients. Consumers are given information on providers and financial incentives--in the form of reduced cost-sharing--to choose the most efficient and effective ones.

Honeywell is pursuing a similar strategy, seeking data from Blue Cross in Minneapolis to make such judgments, and the Midwest Business Group on Health, based in Chicago, is working to develop usable measures of quality for its hundred-or-so corporate members. Public policy can aid this private sector effort to improve cost control by requiring provider-specific data to be made public. The state of Pennsylvania, through legislation, is helping support the implementation of the Buy Right approach. Iowa and Colorado have similar laws, but all states should enact them to promote the competitive system.

Public programs can pursue this strategy as well, with quality assessment mechanisms such as Professional Review Organizations (PROs), already in place. Some states already have shown initiative by experimenting with new approaches to serve Medicaid recipients. Both Medicaid and Medicare should start identifying and directing recipients to "preferred" providers, just as more private employers are doing. Their enormous purchasing power could speed the movement to a more efficient health care system if they would use it as part of a Buy Right strategy. A more cost-effective system also can serve more people with existing resources, so access can be extended to more of the uninsured through Medicaid.

Small employers can also follow this strategy by grouping their workers together in larger insurance arrangements. A leading example is the Council of Smaller Enterprises, an affiliate of the Greater Cleveland Growth Association, that insures more than 70,000 employees and their dependents for hundreds of small businesses.

A competitive cost-management system can only be built progressively, locality by locality. But it represents real change, whereas a sweeping mandate does nothing to change the system other than make it instantly larger. Specific policy reforms can speed the progress of this effort to build a competitive, efficient system that will better control costs and thereby enable a major expansion of access. However, they must be part of an overall strategy, so that a phased approach to reform does not mean a piecemeal approach.

The United States should combine a new approach to financing health care for the poor, either through Medicaid expansion or new tax credits, with a series of public/private measures designed to expand the population in the private group health insurance system. The latter should include incentives for forming statewide insurance pools, for the self-employed to purchase health insurance, for companies to prefund health benefits for retired workers, for insurers to provide more long term care options and for employers to take advantage of options to finance long term care insurance. Noninsurance financing options should also be explored.

including defined contribution plans and individual medical accounts.

The health care system we envision is a pluralistic one in which most Americans continue to receive insurance coverage through the workplace, with benefit levels, the extent of cost-sharing and patterns of care determined by employers and workers--subject to limited government interference. A fair and complete safety net would be maintained by government to assure that people are not denied care because they are poor or in a high-risk category and government would also pursue policies to foster open and competitive markets. Finally and most importantly, both private and public purchasers of health care would pursue a Buy Right strategy, employing reliable measures of quality and effectiveness to identify cost-effective providers of high-quality care, then designing payment policies that give consumers incentives to choose these providers. This emphasis on quality and value in purchasing decisions must permeate the entire system if we are to get utilization and costs under control.

o Specific Policy Reforms in Support of A Competitive Cost Management System.

Employee Responsibility. Just as employers must strive to be better purchasers of health care and government must accept its responsibilities not to shift costs to the private sector, so must employees assume certain responsibilities. This includes attention to good preventive health measures; making judicious use of health benefits; asking questions about medical alternatives, medications and diagnostic tests; evaluating physician and hospital bills; and generally learning to make intelligent choices about health care. Where available, employees (and dependents if appropriate) should be required to accept health benefits, unless covered elsewhere. This not only assures a healthy workforce and U.S. citizenry, but will discourage shifting the burden of care to government and other employers and increasing uncompensated care costs.

Labor unions have a major interest in employee health care. While union representatives during collective bargaining strive to secure the best combination of wages and benefits, many acknowledge that health care cost increases are eroding the value of these agreements. Labor-management cost-containment committees--for example, the UAW/GM Corporate-Union Committee on Health Care Benefits established in 1984, focuses on achieving maximum health benefits coverage for the dollars spent. Both union and management share a cost-savings goal that is reflected in education programs, promotion of HMOs and PPOs and quality/performance standards for health care providers. Among the projects currently underway is a nationwide substance abuse program begun in 1985. Its separation from conventional mental health programs and use of a gatekeeper approach have shown cost savings and drawn praise from both union leaders and employees. Cooperation of this nature must be encouraged and broadened if this nation ever hopes to effectively manage health care costs.

Medical Liability. The patchwork of state medical liability laws have thus far been inadequate in their ability to hold down liability costs. Federal

legislation should seriously be considered. Areas for reform include placing limits on the contingent fees charged by plaintiffs' attorneys, strictly limiting awards of punitive damages to flagrant cases and even establishing no-fault compensation for certain areas of liability--such as the recent federal legislation that removed cases of vaccine-related injuries from the tort system altogether.

Availability of Data. If employers are to develop measures for effectiveness, appropriateness and efficiency, they will need provider-specific data. A few states now require hospitals to make such data publicly available, but many gaps remain. To remedy this situation, we believe that all states should require that provider-specific data be made available to the public to assist in making intelligent buying decisions. Receipt of Medicaid funds should be conditioned on the enactment of such laws.

Uses of Regulation, e.g. Section 89. Current government "anti-discrimination" rules governing health and welfare plans (Section 89 of the IRS code enacted under the Tax Reform Act of 1986) that became effective January 1, 1989, should be repealed. Section 89 requires employers to collect copious amounts of data and perform a series of tests to determine whether such benefit plans discriminate in favor of the highly-compensated verses the rank and file. These rules are creating costly administrative burdens and will discourage firms from offering a choice of health plans to their employees or subsidizing dependent coverage, and could lead to termination of health benefits altogether, particularly by small companies.

Regulatory barriers that block certain service providers from competing in health care markets should be relaxed. For example, hospital staffing privileges should be offered to a wide range of health care workers, including such groups as nurse practitioners. Licensing requirements should not discriminate against one type of service provider to protect the economic interest of another type. However, allowing a wider range of providers to offer services does not mean that states should require insurers to include all such services in their coverage plans. In general, government ought to engage in less economic regulation of health care, while paying more attention to the quality of services.

Antitrust laws should not be interpreted so narrowly as to prevent business coalitions or multi-employer groups from pursuing coordinated efforts to purchase health care more prudently--such as a Buy Right strategy. Federal regulatory powers could be used to promote a competitive marketplace by requiring states to follow the lead of Iowa and Pennsylvania in mandating collection and publication of data on providers' costs and outcomes as a condition of receiving Medicaid funding.

Many state insurance laws require that insurance companies include a certain benefit in all policies sold in that state. These mandates include such items as alcohol and drug abuse services, nutrition services, and genetic counseling. These mandates increase the cost of health insurance. In general, small

companies that purchase insurance commerically have little choice but to accept these mandates. Providing an exemption from state mandates under the Employee Retirement Income Security Act (ERISA) for basic catastrophic plans would help lower the cost of insurance for small firms.

Insurance Pools, Group Purchasing and Employer Coalitions. We should encourage insurance arrangements that enable groups of firms and workers to obtain the more favorable underwriting terms and lower administrative costs available to larger groups. Such efforts can build on existing arrangements such as multi-employer trusts and state-level insurance pools. In some cases, government subsidies could defray a portion of the costs. For example, in Illinois, some state revenues are used to defray the cost of serving high-risk patients with pre-existing health conditions in a statewide pool. Such subsidies can keep out-of-pocket insurance costs from being prohibitive for some patients. In the case of state pools, financing must be broad-based and not single out employers to shoulder the burden. In designing such arrangements, we should be careful not to discourage employers who might otherwise seek to provide insurance through conventional means.

Coalitions of employers formed to improve health care cost management and to pool and review claims data have been organized in many communities. Good examples of such groups are the Chicago-based Midwest Business Group on Health, with membership covering firms in ten states, and the Health Policy Corporation of Iowa. The business community should expand such efforts to include the important question of indigent health care.

Retiree Health and Employer Plans. Proposed new accounting standards will require firms to reflect on their balance sheets future obligations to pay for retiree health benefits. As a result of these standards recently released by the Financial Accounting Standards Board, corporations face an estimated $227 billion to $400 billion in unfunded retiree health liabilities. Given this, we believe employers should be provided with tax incentives to voluntarily prefund health benefits for their retirees.

o Specific Policy Reforms to Improve Public Programs and Expand Access

Medicaid Buy-In and Federal Eligibility Standards. Medicaid coverage should be extended to more of the poor, and individuals should be allowed to maintain coverage as their earnings rise, with declining government contributions. Priority should be given to children, beginning with those under five years of age (which some states have already elected to do under recent changes in the law) at a cost of $1.5 to $2.0 billion-a-year. Older children and adults could be phased in later. Households with incomes below the poverty line could make a nominal contribution to the premium, while those in the near-poor range would pay a higher share. Those with incomes above 130 or 140 percent of poverty would receive no subsidy, but between this level and perhaps 175 percent of poverty, individuals could buy into Medicaid by paying the full premium--which is preferable to buying individual coverage.

Currently, states set income criteria for eligibility leaving some medically needy people uncovered and encouraging migration between various states. To assure that place of residence does not deter access, federal standards for Medicaid should be established.

Cost Management in Medicaid. Medicaid should be encouraged to establish more prudent purchasing and more incentives for consumers and providers to engage in cost-conscious behavior--again, in pursuit of a Buy Right strategy. This includes a greater emphasis on guiding Medicaid beneficiaries to primary-care doctors, such as general practitioners or pediatricians. Obtained early, primary and preventive health care can avoid subsequent costlier or unnecessary care. Such a strategy also requires financial incentives for providers in the form of adequate reimbursement to participate in Medicaid, along with arrangements under which such "case managers" share the risk of excessive costs with the government.

Medicare Reform. Medicare should continue to refine DRGs to smooth out inequities, including properly updating payment rates for inflation and changing technology. It is also time to develop a new method for paying doctors to replace the current basis of customary and prevailing fees. Major options for reform include a fee schedule based on the amount of resources used to deliver a service; regional cost or budget caps; and and a "capitation" system under which doctors receive a fixed amount of money to provide care for a group of patients during a year. Medicare should also pursue a Buy Right strategy by continuing to create incentives for patients to participate in managed-care systems by broadening the scope of available choices beyond HMOs.

The federal government should deal with its budgetary pressures under Medicare through the fundamental structural reforms just discussed and not by shifting the cost of its obligations to business.

Tax Incentives to Expand Access. Tax incentives should be offered to encourage the self-employed to purchase health insurance. Currently, self-employed people cannot take advantage of the tax preference accorded to employees, who can exclude the full amount of their employer's contribution to health insurance. In the last Congress, legislation on this topic was considered but there was no action.

Tax incentives could also be used to help very small or new firms. This might entail tax credits to employers in a start-up phase designed to defray some of the initial costs of implementing and administering employer health plans. These credits could be phased out as the firm becomes more economically viable. Oregon has recently made such credits available to employers of 25 or fewer workers and other states such as Pennsylvania are considering similar actions.

Long Term Care. Moving toward an expensive, front-loaded government entitlement program for long term care would be a serious mistake. Rep. Claude Pepper's (D-FL) home health care proposal was defeated on procedural grounds by

a House vote in June 1988. The Pepper proposal only dealt with home health care, yet nursing-home care is the largest cost item for the elderly, averaging between $25,000 and $30,000 a year. Financing for the $63-billion program would have come from removing the wage ceiling on the Medicare payroll tax, but the estimated revenue of $29 billion would have left a $34 billion shortfall.

The current system for financing long term care--in which half of total outlays are paid for out-of-pocket by individuals and about half through Medicaid after a family is impoverished--must be changed. The federal government should offer tax incentives to spur the development of the private market for long term care insurance--such as creating a tax-favored status for employer contributions to such plans offered as an option to their workers. Both federal and state governments could subsidize premiums, deductibles and copayments for people who cannot afford the full costs of such insurance. Individuals should be allowed to make tax-favored transfers from life insurance or annuity contracts, IRAs or defined contribution pension plans to purchase long term care policies.

V. FINANCING OPTIONS

One of the arguments for pursuing a phased or progressive approach to reforming health care is that it does not require a large infusion of new money, which would have to be taken from other places and put into a system that virtually has become a financial black hole. Gradual expansion of Medicaid coverage--modest at first--through a buy-in approach could be financed without a major tax increase. Tax credits for the self-employed and for small employers would entail some revenue losses. The ability to finance any significant expansion of access through insurance coverage is severely constrained by the budget deficit on one hand and the political infeasibility of raising taxes on the other. This policy dilemma, of course, helps to explain the popularity of proposals to mandate that private employers provide insurance to all workers.

Relatively few alternatives exist for financing a large expansion of coverage, and they have the common characteristic of constituting some form of tax. One such idea often raised in Congress is taxing some portion of health benefits by "capping" the tax exclusion for employer-paid health insurance premiums. The potential revenue from this measure is significant--nearly $10 billion annually under one proposal, a sum that could help finance a major expansion of Medicaid under a graduated buy-in approach. But taxing health insurance premiums would open the door to wider taxation of employee benefits, an idea opposed strongly by American workers and their employers. Taxing health benefits could also lead to adverse selection, as healthy young workers select less expensive coverage and leave sicker and older workers in the traditional health plan.

The burden of financing expanded coverage could be distributed differently through an excise tax (for example, increasing existing excise taxes on certain products) or through a general consumption tax. Increased excise taxes on tobacco and alcohol are advocated by some, given causal links between the use of these products and subsequent health care expenses. A broad-based consumption tax is advocated by

those who see the problem of the uninsured as a social responsibility to be borne by the larger society. NAM is not prepared to support any major tax increases to finance a significant expansion of health care until we have seen progress in efficiency and quality. If we lack the patience and determination as a nation to pursue the cost-control strategy outlined here--controlling the use of services by determining which are appropriate and effective--then any expansion of access should be financed by the broadest possible means.

VI. FUTURE DIRECTIONS

With a health care system that is costing over $200 million a day, socking business with health care premium increases of 20 to 30 percent yearly, delivering care of questionable quality and value and leaving an estimated 37 million uninsured, it is incumbent on us as a nation to conscientiously work together to solve this major crisis. A competitive cost-management system, many elements of which exist in our current system, shows promise for lifting us out of this quagmire. Setting goals and working in a phased, deliberate manner can help us with this task.

For our part, we have surveyed our members on corporate costs and strategies to attack those costs and are sharing this information with the greater business community, encouraging efforts to develop quality measures to improve prudent purchasing decisions, working with the Congress on access alternatives, spearheading a broad-based coalition to support this position and otherwise trying to bring needed reforms to the health care system.

Additionally, we will gather information on successful private sector efforts to manage costs, and identify models by company size, industrial and employment patterns and geographical circumstances. These case studies will be shared with members and the rest of the business community in an effort to foster the development of a competitive cost management system that addressess the cost and quality goals of today and works toward future needs.

NATIONAL ASSOCIATION OF MANUFACTURERS

HEALTH CARE SURVEY

SUMMARY OF FINDINGS

Prepared by:

A. Foster Higgins & Co., Inc.
Princeton, New Jersey
May, 1989

TABLE OF CONTENTS

I. EXECUTIVE SUMMARY

The National Association of Manufacturers, in association with the consulting firm A. Foster Higgins & Co., Inc., is pleased to provide the findings of a survey of health benefits among the NAM membership. This Survey was conducted in January, 1989.

Among the significant findings of the survey are the following:

- Of the NAM members responding to the survey, 99.3% currently offer group health benefits to their employees, and 98.4% extend those benefits to dependents.

- For employee-only coverage, 55.7% of the responding companies paid the entire cost of such coverage (that is, premium cost or equivalent for self-insured companies), while 43.4% shared such costs with the employee. Only 0.9% required the employee to pay all of the cost of such coverage.

- For dependent coverage, 31.7% of the responding companies paid the entire cost of such coverage, while 53.7% shared such costs with the employee. 14.6% required the employee to pay all of the cost of such coverage.

- The average increase in the cost of health benefits in the past year by the survey respondents was 29.6% over the previous year's cost.

- The cost of providing health benefits represented an average of 37.2% of the respondents' net profits.

- An overwhelming 84.2% of the respondents opposed mandated benefits as a means of providing insurance for the working uninsured. 11.9% of the respondents favor such legislation while 3.9% did not respond to this question.

The survey demonstrated that nearly all of the responding members of the NAM currently offer health benefits to their employees and dependents, pay for or share the cost of such coverage in most instances, and are actively working to contain the rising costs of such benefits.

Providing such benefits in the face of significant price inflation for medical services appears to be adversely affecting the responding members' profitability and competitiveness.

Federally mandated health benefit coverage would, in the opinion of many of the respondents, reduce the ability of employers currently providing such benefits to administer cost-effective programs. Other alternatives should be considered in the effort to provide the working uninsured with adequate health care insurance protection.

II. BACKGROUND

In January, 1989 the National Association of Manufacturers (NAM) surveyed its membership with respect to:

- The extent to which health care benefits are offered to employees and their families
- How health benefits are funded
- Recent increases in health benefit costs
- How health benefit costs affect company profits
- Which cost containment efforts are currently in use

In addition, the respondents' attitudes toward the prospect of mandated health care benefits were assessed by inquiring whether they favored or opposed such legislation. It must be noted that specific provisions of a proposed mandated benefit program were not provided to the survey respondents. Alternatives to such legislative action were requested by means of a write-in opportunity for the respondents.

The National Association of Manufacturers is a voluntary business association of more than 13,500 member companies and subsidiaries, large and small, located in every state. The survey was mailed to 11,569 non-subsidiary member companies. 2,029 companies had responded to the survey by the cut-off date, representing a 17.5% response rate.

In this report, consultants from A. Foster Higgins & Co., Inc., an employee benefits consulting firm, have prepared a summary of the findings of the NAM Health Care Survey. Foster Higgins has also provided an analysis of these findings so that meaningful information may be disseminated to the NAM membership.

In addition to the summary of findings, this report contains appendices containing tabular displays of all survey responses, a copy of the survey instrument and graphic displays of the key findings of the Health Care Survey.

III. METHODOLOGY

In order to conduct the Health Care Survey, the National Association of Manufacturer's staff compiled the questionnaire and mailed it to 11,569 of its member organizations. By the cut-off date, 2,029 respondents had returned completed surveys, for a 17.5% response rate.

This sample was then merged with the NAM membership data base so that comparisons of responses could be made by geographic region, employer size and Standard Industrial Classification (SIC). The geographic regions used are the seven U.S. Census regions. Industry codes were derived from the Standard & Poor's coding scheme. Employer size groups were constructed jointly by NAM staff and the Foster Higgins consultants.

Of the 2,029 respondents, all were assigned a geographic region. An SIC was assigned to 1,542 records, of which 133 were classified as "Non-Manufacturing" companies. An employer size classification was assigned to 1,391 records. The responses to each question were then broken out by all three methods of employer classification.

Estimates of health benefit cost increases were determined by conducting a weighted averaging of the midpoints of the response ranges, as were the estimates of health benefit cost as a percentage of net profits.

The attached tables indicate the entire range of responses to each question for further evaluation by the reader. A copy of the Survey Instrument follows on the next page.

The results of the survey should be qualified in two areas. In question number one, a degree of self-selection was probably encountered as firms not providing health care probably did not return the survey. While this may have overstated the extent of manufacturing coverage, high coverage rates for manufacturing tend to be confirmed by other sources, such as the U.S. Small Business Admininstration.

The calculation of averages for questions three and four was accomplished by means of determining the midpoints of the ranges presented in the questionnaire. A weighted average was then computed. The resulting averages may have appeared to overstate both the increases in medical plan cost and the percentage of net profits that medical benefits represented. However, analysis of the distribution of responses, e.g., 49% of the respondents to question three stated that their medical plan costs increased 26% - 100%, demonstrated that the averages calculated in this fashion were reasonable.

SURVEY INSTRUMENT

Please answer the following questions about health care and your company tc help us in our cost containment campaign. Specific information about your company will be kept confidential unless we obtain your permission.

1. Does your company offer employee medical coverage? (circle one)

   a) YES, employer-paid
   b) YES, employer/employee share costs
   c) YES, all employee-paid
   d) NO, but we're considering it
   e) NO

2. Does your company also offer medical coverage for dependents?

   a) YES, employer-paid
   b) YES, employer/employee share costs
   c) YES, all employee-paid
   d) NO, but we're considering it
   e) NO

3. If the answer to Number One is YES, how have your premium costs (or equivalent, if self-insured) been affected over the past year?

   a) Up 5-25%
   b) Up 26-50%
   c) Up 51-75%
   d) Up 76-100%

4. Medical costs represent what percent of your annual net profits?

   a) 5-25%
   b) 26-50%
   c) 51-75%
   d) 76-100%
   e) More than 100%

5. What cost-containment techniques is your company now using?

   a) Mandatory second surgical opinions
   b) Precertification for hospitalization
   c) Case management and utilization review
   d) HMOs-PPOs
   e) Other (Please specify) _____

6. Congress has proposed mandating employer-provided health benefits. Do you favor or oppose such a move? _____ Favor _____ Oppose

   If opposed, what alternatives would you prefer?

   _____
   _____
   _____

   How would your company be affected if mandatory benefits passes?

   _____
   _____
   _____

7. May we call you for further information? Yes _____ No _____

IV. THE EXTENT TO WHICH HEALTH CARE BENEFITS ARE OFFERED TO EMPLOYEES AND THEIR FAMILIES

Of the respondents to the NAM membership survey, it was found that 99.3% currently offer group health care benefits to their employees. Fully 98.4% also make such coverage available to the families of their employees. Only fifteen survey participants (0.7%) did not offer their employees health care benefits. Eleven respondents did not answer this question.

It must be noted that a degree of self-selection was probably encountered in these statistics, i.e., that some companies not offering health insurance to employees may not have bothered to fill out and return the survey.

Even among the smallest responding NAM companies, health insurance is offered to employees in the overwhelming majority of cases. All employers with more than 300 employees made health benefits available.

Table 1a

"Percentage of Respondents Offering Health Insurance by Company Size"

Company Size		Percentage Offering Health Benefits To Employees	To Dependents
Unclassified Size	(n=630)	98.9%	98.3%
< 25 employees	(n=165)	96.3	94.4
25 - 50	(n=288)	99.2	98.7
51 - 100	(n=281)	99.2	98.3
101 - 300	(n=303)	99.6	98.8
301 - 1,000	(n=137)	100.0	100.0
1,001 - 5,000	(n=102)	100.0	100.0
5,001 - 20,000	(n= 65)	100.0	100.0
20,000 or more	(n= 46)	100.0	100.0
	(n=2,017)	99.3%	98.4%

No substantial variation was noted when these data were examined by geographic region and by the type of industry surveyed.

Table 1b

"Percentage of Respondents Offering Health Insurance by Region"

REGION	Percentage Offering Health Benefits: To Employee	To Dependents
Pacific (n=140)	99.3%	99.3%
Mountain (n=54)	96.3	96.3
North Central (n=879)	99.4	98.5
South Central (n=304)	98.4	97.3
New England (n=125)	99.2	99.2
Mid Atlantic (n=251)	100.0	99.2
South Atlantic (n=265)	99.6	98.1
(n=2,018)	99.3%	98.4%

Table 1c

"Percentage of Respondents Offering Health Insurance by Type of Industry"

TYPE OF INDUSTRY	Percentage Offering Health Benefits: To Employees	To Dependents
Unclassified (n=481)	99.2%	97.7%
Non-Manufacturing (n=131)	100.0	100.0
Food & Kindred Products (n=52)	100.0	100.0
Textile Mill Products (n=43)	97.7	97.6
Apparel & Leather Products (n=38)	97.4	89.5
Lumber & Wood Products (n=69)	98.6	98.5
Furniture & Fixtures (n=39)	100.0	100.0
Paper Products (n=49)	100.0	100.0
Printing/Publishing (n=46)	97.8	95.5
Chemical Products (n=87)	100.0	100.0
Rubber Products (n=79)	100.0	100.0
Stone, Clay, Glass & Concrete (n=75)	100.0	98.6
Primary Metal Industries (n=70)	98.6	98.6
Fabricated Metal Products (n=234)	99.6	97.4
Indust./Comm. Machinery/Computers(n=249)	99.6	100.0
Electronic & Electrical Products (n=113)	99.1	96.5
Transportation Equipment (n=60)	98.3	98.3
Measuring/Analyzing/Controlling Inst. (n=50)	100.0	100.0
Miscellaneous (n=51)	100.0	100.0
(n=2,016)	99.3%	98.4%

V. HOW HEALTH BENEFITS ARE FUNDED

More than half (55.7%) of the companies offering health benefits pay the entire cost (that is, premium cost or equivalent for self-insured companies), of those benefits for employees. Employees share the cost of their coverage among 43.4% of the respondents, while employees pay the entire cost in 0.9% of the companies surveyed. When arrayed by company size, it is noted that smaller employers were more likely to pay the entire cost of employee health coverage than larger companies.

This survey question sought information on the employer/employee share in payment for the premium (or equivalent for self-insured) only. Thus, the requirement that an employee pay the cost of a deductible (or similar employee cost obligations) before becoming eligible for insurance benefits, was not considered for purposes of this question.

Regional variations were also noted, with 70.5% of respondents in the Pacific region paying for employee health coverage in full, compared to 52.4% in New England. This may be partially attributable to regional competitive pressures resulting from traditionally generous benefits offerings. Also, the prevalence of unionized work forces in specific regions could account for some of the variation.

Less than one-third (31.7%) of manufacturing companies paid the entire cost of providing dependent health benefits. This also varied by employer size, with smaller companies more likely to pay dependent costs in full than larger companies.

While most (53.7%) of the respondents shared the cost of dependent health benefits with their employees, 14.6% required the employee to pay the entire cost for such coverage, with regional and employer size variations again noted. Manufacturers in the South Atlantic region and South Central region are more likely to require employees to pay the entire cost of dependent health benefits, while those in the New England and Mid-Atlantic regions are least likely to require this - again, owing to traditional benefit behavior and the degree of unionization present.

It must be pointed out that the Health Care Survey did not measure the scope of benefits offered by the respondents. Thus, employer contributions for lesser coverage might be higher than those of employers with more comprehensive plans.

Table 2a

"Health Plan Funding for Employee and Dependent Coverage by Employer Size"

	-- Employee Coverage --			--Dependent Coverage --		
	Employer Paid	Shared Cost	Employee Paid	Employer Paid	Shared Cost	Employee Paid
EMPLOYER SIZE						
Unclassified (n=627)	58.5%	40.7%	0.8%	31.2%	49.8%	19.0%
< 25 employees (n=161)	60.2	36.7	3.1	45.8	37.9	16.3
25 - 50 (n=288)	54.9	44.4	0.7	33.0	50.5	16.5
51 - 100 (n=278)	59.4	39.2	1.4	29.8	51.5	18.7
101 - 300 (n=302)	58.6	41.1	0.3	32.2	56.5	11.3
301 - 1,000 (n=137)	49.6	51.4	0.0	31.1	65.2	3.7
1,001 - 5,000 (n=102)	39.2	59.8	1.0	21.6	72.5	5.9
5,001 - 20,000 (n=65)	36.9	61.6	1.5	23.4	73.4	3.2
20,000 or more (n=43)	44.2	55.8	0.0	27.9	72.1	0.0
(n=2,003)	55.7%	43.4%	0.9%	31.7%	53.7%	14.6%

Table 2b

"Health Plan Funding for Employee and Dependent Coverage by Region"

	-- Employee Coverage --			-- Dependent Coverage --		
	Employer Paid	Shared Cost	Employee Paid	Employer Paid	Shared Cost	Employee Paid
REGION						
Pacific (n=139)	70.5%	28.8%	0.7%	36.7	48.9	14.4
Mountain (n=52)	48.1	51.9	0.0	26.9	63.5	9.6
No. Central (n=874)	53.8	45.0	1.2	35.3	56.2	8.5
So. Central (n=299)	48.2	50.2	1.6	13.8	55.5	30.7
New England (n=124)	52.4	47.6	0.0	37.0	58.0	5.0
Mid-Atlantic (n=251)	66.5	33.1	0.4	48.4	45.2	6.4
So. Atlantic (n=264)	55.3	44.3	0.4	19.4	50.2	30.4
(n=2,003)	55.7%	43.4%	0.9%	31.7%	53.7%	14.6%

Table 2c

"Health Plan Funding for Employee and Dependent Coverage by Type of Industry"

-- Employee Coverage --			-- Dependent Coverage --		
Employer Paid	Shared Cost	Employee Paid	Employer Paid	Shared Cost	Employee Paid
TYPE OF INDUSTRY					
Unclassified (n=477)					
61.4%	37.7%	0.9%	36.2%	45.2%	18.5%
Non-Manufacturing (n=131)					
45.0	54.2	0.8	20.9	71.3	7.8
Food & Kindred Products (n=52)					
50.0	48.1	1.9	24.5	60.4	15.1
Textile Mill Products (n=42)					
54.8	45.2	0.0	19.5	48.8	31.7
Apparel & Leather Products (n=37)					
29.7	67.6	2.7	5.9	44.1	50.0
Lumber & Wood Products (n=68)					
50.0	47.1	2.9	16.4	59.7	23.9
Furniture & Fixtures (n=39)					
56.4	41.0	2.6	15.4	53.8	30.8
Paper Products (n=49)					
49.0	51.0	0.0	24.4	69.4	6.2
Printing/Publishing (n=45)					
46.7	53.3	0.0	29.5	56.9	13.6
Chemical Products (n=87)					
57.5	42.5	0.0	33.3	58.6	8.1
Rubber Products (n=79)					
48.1	49.4	2.5	26.0	63.6	10.4
Stone, Clay, Glass & Concrete (n=75)					
57.3	42.7	0.0	37.0	50.7	12.3
Primary Metal Industries (n=69)					
62.3	37.7	0.0	52.9	41.2	5.9
Fabricated Metal Products (n=233)					
57.1	41.2	1.7	36.4	50.7	12.9
Indust./Comm. Machinery/Computers (n=248)					
60.5	38.7	0.8	40.0	52.2	7.8
Electronic & Electrical Products (n=112)					
50.0	50.0	0.0	27.5	59.6	12.9
Transportation Equipment (n=59)					
59.3	39.0	1.7	27.6	56.9	15.5
Measuring/Analyzing/Controlling Inst. (n=50)					
60.0	40.0	0.0	18.4	63.3	18.3
Miscellaneous (n=51)					
47.1	52.9	0.0	29.2	56.3	14.5
(n=2,003)					
55.7%	43.4%	0.9%	31.7%	53.7%	14.6%

In all, NAM members responding to the survey now make health care coverage available to employees and their dependents in nearly all instances. These employers pay at least part of the cost for such coverage in the overwhelming majority of instances.

VI. RECENT INCREASES IN HEALTH BENEFITS COST

Over the last year, the cost of providing health care benefits has risen an average of 29.6% for the survey respondents. Increases of this magnitude were seen in nearly every category of manufacturing, across all regions of the country and among all sizes of employers.

Table 3a

"Percentage Increase in Health Benefit Cost by Employer Size"

EMPLOYER SIZE		PERCENTAGE INCREASE IN HEALTH BENEFIT COST
Unclassified	(n=613)	30.1%
< 25 Employees	(n=156)	33.3
25 - 50	(n=286)	33.2
51 - 100	(n=295)	30.6
101 - 300	(n=295)	29.3
301 - 1,000	(n=132)	26.8
1,001 - 5,000	(n= 97)	23.4
5,001 - 20,000	(n= 64)	19.1
20,001 or more	(n= 45)	20.1
	(n=1,983)	29.6%

Smaller employers, who must typically buy insurance coverage on the market, saw higher increases in health benefit costs than the larger, self-insured employers, who pay health claims from their operating funds. The smaller employers, most likely to be affected by mandated health benefits, have little flexibility in designing or controlling the cost of health benefits, since they must purchase coverage offered by commercial insurance companies or Blue Cross organizations. Also, these smaller employers are already subject to state mandated coverages in many cases. Larger companies who self-insure, on the other hand, are generally exempt from state mandates for coverage and can design their own coverages and cost-management programs and thus have a greater degree of control over their cost.

Table 3b

"Percentage Increase in Health Benefit Cost by Region"

REGION		PERCENTAGE INCREASE IN HEALTH BENEFIT COST
Pacific	(n=139)	29.9%
Mountain	(n= 51)	28.0
No. Central	(n=850)	28.3
So. Central	(n=292)	34.1
New England	(n=122)	31.4
Mid Atlantic	(n=247)	26.7
So. Atlantic	(n=256)	34.1
	(n=1,957)	29.6%

Table 3c

"Percentage Increase in Health Benefit Cost by Type of Industry"

TYPE OF INDUSTRY	PERCENTAGE INCREASE IN HEALTH BENEFIT COST
Unclassified (n=468)	30.6%
Non-Manufacturing (n=128)	24.8
Food & Kindred Products (n=52)	32.1
Textile Mill Products (n=39)	34.9
Apparel & Leather Products (n=36)	29.7
Lumber & Wood Products (n=65)	32.1
Furniture & Fixtures (n=38)	30.9
Paper Products (n=48)	26.7
Printing/Publishing (n=45)	31.7
Chemical Products (n=85)	26.5
Rubber Products (n=74)	31.3
Stone, Clay, Glass & Concrete (n=72)	28.5
Primary Metal Industries (n=71)	24.4
Fabricated Metal Products (n=227)	31.2
Industrial/Commerical Machinery (n=245)	29.5
Electronic & Electrical Products (n=105)	30.5
Transportation Equipment (n=59)	26.9
Measuring/Analyzing/Controlling Inst. (n=50)	29.5
Miscellaneous (n=50)	28.3
(n=1,957)	29.6%

It is clear that the rising cost of health benefits is a systemic, rather than an industry-specific or regional phenomenon. While some variation in the exact rate of cost inflation is noted in the regions and among the industry groups during the past year, the magnitude of the increases across all of these categories demonstrates that substantial inflation exists in the health benefits arena.

VII. HEALTH BENEFITS COSTS AS A PERCENTAGE OF NET PROFIT

When health benefit costs are computed as a percentage of the manufacturers' net profits over the past year, the magnitude of these expenditures is clearly seen. Among the survey respondents, these costs represented 37.2% of the companies' net profits during the period. While we don't know whether this percentage differs from the percentage seen in previous years, it is clear that the cost of providing health benefits exerts a major impact on company profits.

This percentage did vary when examined by the size of the company, with smaller companies' profits hit harder by health plan costs than larger companies'.

Table 4a

"Medical Costs as a Percentage of Net Profit by Employer Size"

EMPLOYER SIZE		MEDICAL COSTS AS A PERCENTAGE OF NET PROFIT
Unclassified	(n=569)	37.4%
< 25 Employees	(n=141)	35.8
25 - 50	(n=227)	39.3
51 - 100	(n=255)	38.4
101 - 300	(n=275)	39.1
301 - 1,000	(n=118)	37.6
1,001 - 5,000	(n= 91)	32.8
5,001 - 20,000	(n= 60)	28.9
20,001 or more	(n= 43)	25.9
	(n=1,819)	37.2%

Table 4b

"Medical Costs as a Percentage of Net Profit by Region"

REGION		MEDICAL COSTS AS A PERCENTAGE OF NET PROFIT
Pacific	(n=126)	37.7%
Mountain	(n= 51)	35.6
No. Central	(n=800)	38.3
So. Central	(n=271)	34.8
New England	(n=106)	41.8
Mid Atlantic	(n=239)	35.6
So. Atlantic	(n=226)	35.9
	(n=1,819)	37.2%

There were significant variations among the various industry groups represented in the survey sample.

Table 4c

"Medical Costs as a Percentage of Net Profit by Type of Industry"

TYPE OF INDUSTRY	MEDICAL COSTS AS A PERCENTAGE OF NET PROFIT
Unclassified (n=431)	37.9%
Non-Manufacturing (n=115)	28.4
Food & Kindred Products (n=49)	30.6
Textile Mill Products (n=32)	38.1
Apparel & Leather Products (n=35)	42.9
Lumber & Wood Products (n=58)	28.4
Furniture & Fixtures (n=35)	38.0
Paper Products (n=46)	27.3
Printing/Publishing (n=43)	46.8
Chemical Products (n=82)	28.5
Rubber Products (n=66)	36.3
Stone, Clay, Glass & Concrete (n=67)	44.5
Primary Metal Industries (n=64)	39.1
Fabricated Metal Products (n=213)	40.1
Industrial/Commerical Machinery (n=235)	35.8
Electronic & Electrical Products (n=100)	40.8
Transportation Equipment (n=52)	44.1
Measuring/Analyzing/Controlling Inst. (n=47)	33.3
Miscellaneous (n=49)	40.0
(n=1,819)	37.2%

The variations seen among industry types may result not only from the cost of providing health care benefits for those groups but also from the variations in profitability among those industries during the study period. Also, the extent to which industry types include collectively bargained plans is an important fact. In general, such plans utilize first dollar coverage--a practice that discourages efficient cost-management.

In some industry categories, however, health benefit costs are approaching 50% of net profits. As these costs continue to rise, manufacturers' profitability will likely be even more compromised. This fact will almost certainly reflect on the industry's ability to compete with foreign manufacturers. Adverse impacts on employer staffing abilities and wage levels may also result from higher health benefit costs, as will the companies' ability to grow and expand their businesses.

VIII. WHICH COST CONTAINMENT EFFORTS ARE CURRENTLY IN USE

In the survey, respondents reported on the use of various health plan cost containment measures prevalently currently. Of the choices offered, more of the responding employers (54.6%) utilized the precertification of hospital admissions in the attempt to control cost than Second Surgical Opinion (53.9%), alternative delivery systems such as Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) (35.5%), or Case Management of catastrophic illness and injury (30.3%).

A wide variation in the use of these cost-containment alternatives is seen when the respondents are examined by the size of the company. This, again, is reflective of the way in which the health benefit is administered and funded. Smaller employers, who buy health insurance for their employees from commercial insurance companies and Blue Cross organizations, are subject to whatever cost-containment measures those organizations include in the insurance policies. Larger companies who self-insure, on the other hand, may implement whatever cost management activities they deem useful in the fight to control their outlays for health care.

Therefore, it is seen that those larger companies are more apt to employ a wider range of cost management measures.

Table 5a

"Cost Containment Efforts Currently in Use by Employer Size"

		SECOND SURGICAL OPINION	HOSPITAL PRECERTI-FICATION	CASE MANAGEMENT	HMOs PPOs
EMPLOYER SIZE					
Unclassified	(n=638)	51.1%	53.0%	23.4	32.0%
< 25 employees	(n=165)	42.4	38.8	10.3	21.8
25 - 50	(n=290)	47.6	48.3	16.2	27.9
51 - 100	(n=283)	54.4	48.1	19.4	27.2
101 - 300	(n=303)	58.8	59.1	38.0	35.3
301 - 1,000	(n=137)	61.3	67.2	54.7	43.8
1,001 - 5,000	(n=102)	63.7	69.6	68.6	62.8
5,001 - 20,000	(n= 65)	70.8	80.0	72.3	81.5
20,001 or more	(n= 46)	71.7	76.1	87.0	84.8
	(n=2,029)	53.9%	54.6%	30.3%	35.5%

Table 5b

"Cost Containment Efforts Currently in Use by Region"

		SECOND SURGICAL OPINION	HOSPITAL PRECERTI-FICATION	CASE MANAGEMENT	HMOs PPOs
REGION					
Pacific	(n=140)	55.0%	51.4	29.3	69.3
Mountain	(n= 54)	51.9	57.4	33.3	57.4
No. Central	(n=884)	53.3	53.6	31.4	32.7
So. Central	(n=304)	57.6	66.1	26.3	27.6
New England	(n=126)	50.8	35.7	27.8	44.4
Mid Atlantic	(n=254)	49.6	38.6	31.5	37.8
So. Atlantic	(n=267)	57.3	69.7	31.1	25.4
	(n=2,029)	53.9%	54.6%	30.3%	35.5%

Variations in responses within regional groupings and industry categories are most likely the result of size of employer variations within those categories.

Table 5c

"Cost Containment Efforts Currently in Use by Type of Industry"

TYPE OF INDUSTRY	SECOND SURGICAL OPINION	HOSPITAL PRECERTIFICATION	CASE MANAGEMENT	HMOs PPOs
Unclassified (n=487)	48.3%	46.6%	19.3%	32.7%
Non-Manufacturing (n=133)	61.7	61.7	48.9	54.1
Food & Kindred Products (n=53)	62.3	71.7	47.2	35.9
Textile Mill Products (n=43)	65.1	62.8	37.2	23.3
Apparel & Leather Products (n=39)	59.0	66.7	20.5	10.3
Lumber & Wood Products (n=69)	62.3	65.2	36.2	10.1
Furniture & Fixtures (n=39)	46.2	61.5	28.2	15.4
Paper Products (n=49)	57.1	57.1	46.9	46.9
Printing/Publishing (n=46)	60.9	65.2	28.3	21.7
Chemical Products (n=87)	51.7	59.8	44.8	52.9
Rubber Products (n=79)	57. 0	55.7	27.9	41.8
Stone, Clay, Glass & Concrete (n=75)	44.0	50.7	34.7	41.3
Primary Metal Industries (n=72)	58.3	61.1	36.1	34.7
Fabricated Metal Products (n=234)	55.1	53.4	29.1	29.5
Industrial/Commerical Machinery (n=249)	47.8	51.4	26.1	37.0
Electronic & Electrical Products (n=113)	58.4	55.8	28.3	38.1
Transportation Equipment (n=61)	57.4	55.7	36.1	41.0
Measuring/Analyzing/Controlling Inst. (n=50)	64.0	50.0	30.0	50.0
Miscellaneous (n=51)	58.8	52.9	39.2	43.1
(n=2,029)	53.9%	54.6%	30.3%	35.5%

IX. ATTITUDES TOWARD MANDATED HEALTH BENEFITS

The overwhelming majority of manufacturing companies responding to the Health Care Survey oppose legislative efforts to mandate employer-sponsored benefits. The survey responses showed that 84.2% of these companies oppose mandated benefits, 11.9% favor such legislation and 3.9% offered no response. It must again be pointed out that respondents were not provided with specific provisions of a proposed mandated benefit program.

While this pattern of responses did not vary significantly by the size of the responding employers - with the exception of the very largest category, 20,000 or more employees - there were relatively minor regional variations in the response patterns.

In the Pacific region, 15.7% of the respondents favored mandated health benefits, compared to only 7.9% of the employers located in the South Central region and 8.7% of the South Atlantic region respondents.

Table 6a

"Attitudes Toward Mandated Benefits by Employer Size"

EMPLOYER SIZE		FAVOR	OPPOSE	NO RESPONSE
Unclassified	(n=638)	10.5%	85.7%	3.8%
< 25 Employees	(n=165)	13.9	81.2	4.9
25 - 50	(n=290)	11.0	86.6	2.4
51 - 100	(n=283)	13.1	84.5	2.4
101 - 300	(n=303)	14.5	80.9	4.6
301 - 1,000	(n=137)	12.4	83.2	4.4
1,001 - 5,000	(n=102)	11.8	85.3	2.9
5,001 - 20,000	(n= 65)	10.8	83.1	6.1
20,001 or more	(n= 46)	4.4	82.6	13.0
	(n=2,029)	11.9%	84.2%	3.9%

Table 6b

"Attitudes Toward Mandated Benefits by Region"

REGION		FAVOR	OPPOSE	NO RESPONSE
Pacific	(n=140)	15.7%	76.4%	7.9%
Mountain	(n= 54)	13.0	83.3	3.7
No. Central	(n=884)	12.9	83.6	3.5
So. Central	(n=304)	7.9	88.5	3.6
New England	(n=126)	11.1	83.3	5.6
Mid Atlantic	(n=254)	14.6	82.3	3.1
So. Atlantic	(n=267)	8.7	88.0	3.3
	(n=2,029)	11.9%	84.2%	3.9%

Table 6c

"Attitudes Toward Mandated Benefits by Type of Industry"

TYPE OF INDUSTRY	FAVOR	OPPOSE	NO RESPONSE
Unclassified (n=487)	11.1%	85.4%	3.5%
Non-Manufacturing (n=133)	15.0	80.5	4.5
Food & Kindred Products (n=53)	9.4	90.6	0.0
Textile Mill Products (n=43)	11.6	83.7	4.7
Apparel & Leather Products (n=39)	5.1	94.9	0.0
Lumber & Wood Products (n=69)	7.3	92.7	0.0
Furniture & Fixtures (n=39)	10.3	84.6	5.1
Paper Products (n=49)	12.2	81.6	6.2
Printing/Publishing (n=46)	17.4	80.4	2.2
Chemical Products (n=87)	12.6	83.9	3.5
Rubber Products (n=79)	10.1	86.1	3.8
Stone, Clay, Glass & Concrete(n=75)	12.0	80.0	8.0
Primary Metal Industries (n=72)	12.5	81.9	5.6
Fabricated Metal Products (n=234)	13.7	82.9	3.4
Industrial/Commerical Machinery (n=249)	12.5	83.1	4.4
Electronic & Electrical Products (n=113)	15.0	83.2	1.8
Transportation Equipment (n=61)	11.5	82.0	6.5
Meas/Anal/Controlling Inst. (n=50)	4.0	90.0	6.0
Miscellaneous (n=51)	11.8	80.4	7.8
(n=2,029)	11.9%	84.2%	3.9%

When the respondents were asked to offer alternatives to mandated benfits as a means of providing coverage for the working uninsured, a number of different approaches were discussed. Among the most frequently mentioned were the following:

- Special tax incentives for small businesses to offer health benefits
- Expansion of state Medicaid benefits
- Multi-employer trusts (Mets) along with statewide insurance pools for the uninsured

Less frequently mentioned approaches included:

- Mandated but affordable "catastrophic" coverage combined with an exemption from state mandates
- Mandated employer contributions for health benefits rather than mandated benefit levels
- Government sponsored health insurance programs

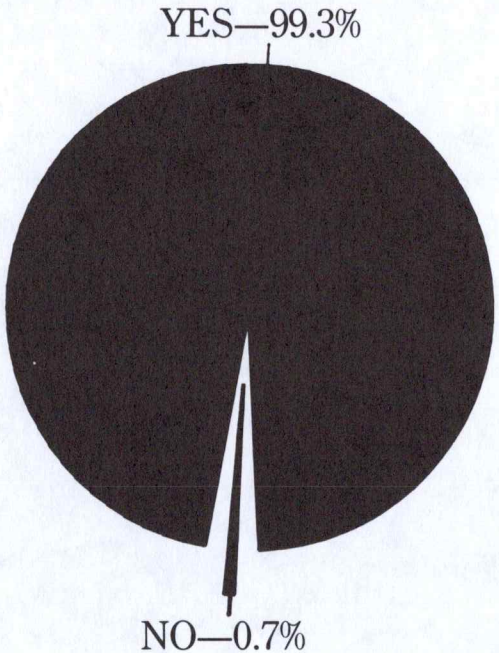
Generally, however, the respondents felt that private sector employers should be free to decide whether and at what level health benefits should be offered. When asked to estimate the impact of mandated benefits on their particular companies, the responses ranged from "minimal" to "it would put us out of business." It must be noted, however, that survey participants were not offered specific provisions of a mandated program, so that the estimate of the impact on their businesses could not be made with such knowledge.

However, many respondents did foresee adverse effects of such legislation on their companies. Frequently mentioned effects included:

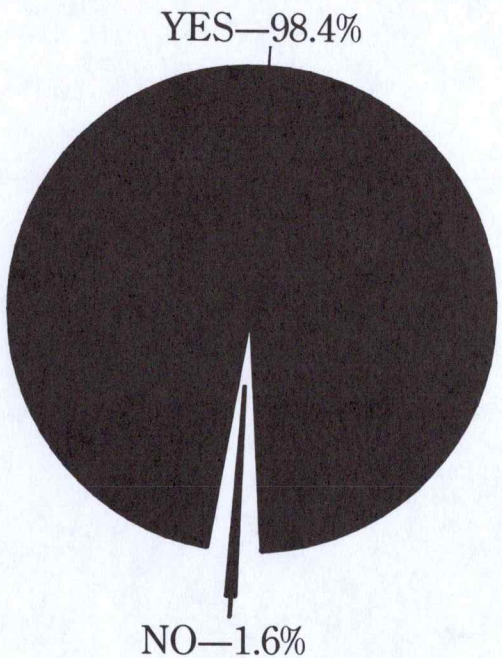
- Increased cost to the employer
- Decreased competitiveness, especially with foreign producers
- Reduced flexibility in benefits design
- Reduced ability for start-up companies to survive
- Increased paperwork associated with legal compliance
- Decreased resources for corporate expansion

It is clear from the survey that opposition to mandated benefits may be characterized by the feeling that nearly all NAM members responding to the survey currently provide benefits and share in the employees' cost for such programs. Additional legislative mandates would not significantly increase the availability of health benefits but could increase administrative costs and reduce the flexibility currently enjoyed by employers to design cost-efficient health plans.

National Association of Manufacturers
Health Care Survey



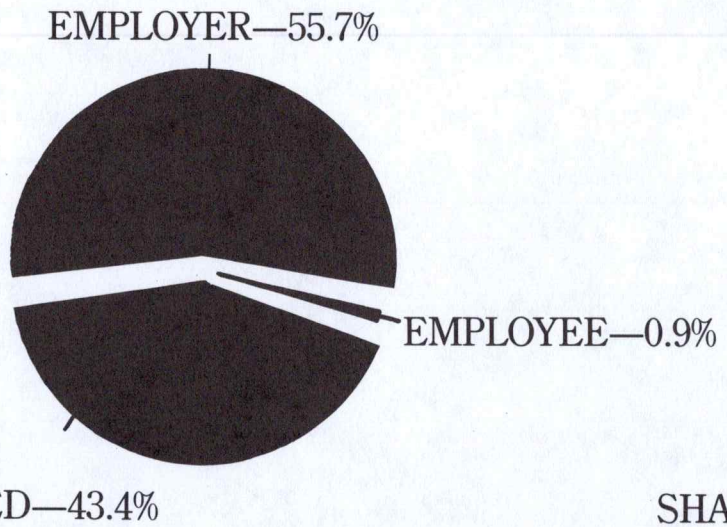
OFFER EMPLOYEE
HEALTH COVERAGE?



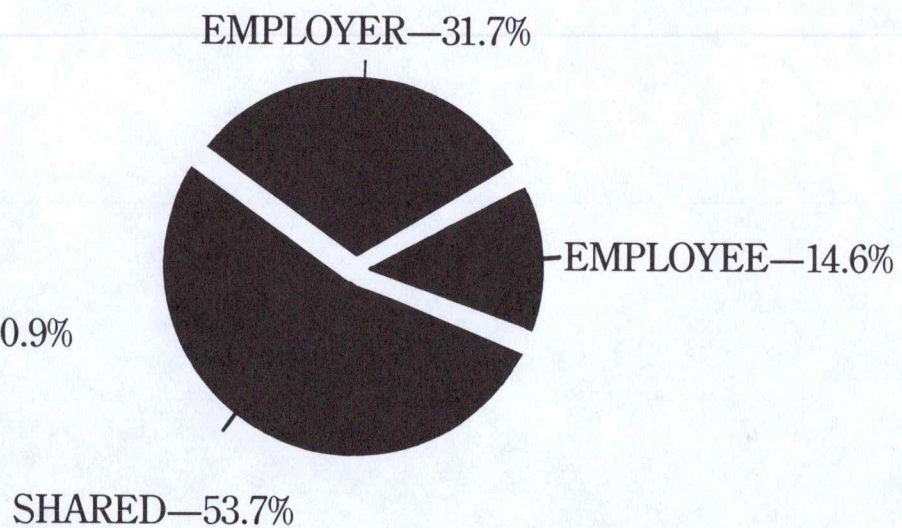
OFFER DEPENDENT
HEALTH COVERAGE?

Source: NAM/Foster Higgins

National Association of Manufacturers
Health Care Survey



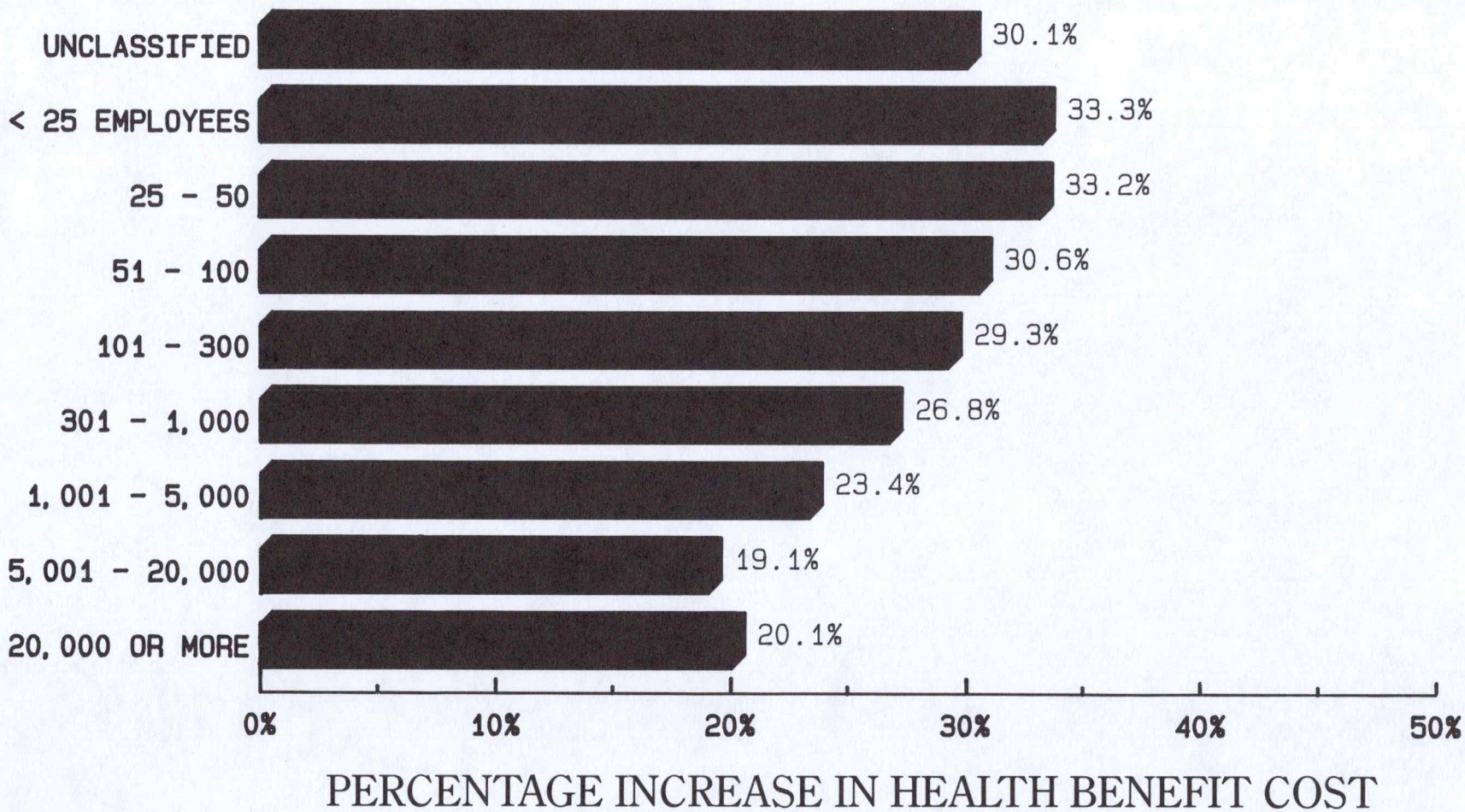
WHO PAYS FOR EMPLOYEE HEALTH COVERAGE?



WHO PAYS FOR DEPENDENT HEALTH COVERAGE?

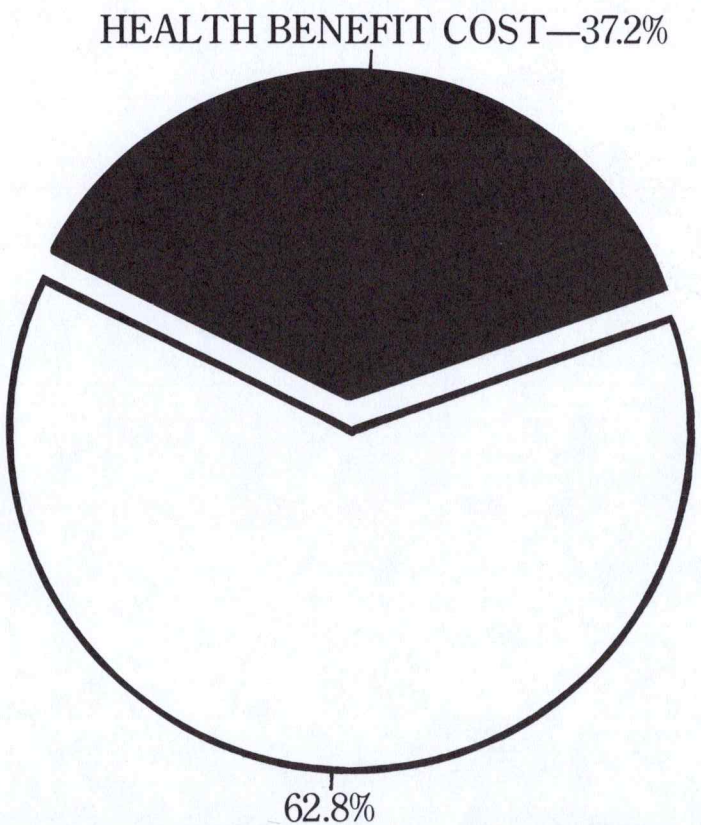
Source: NAM/Foster Higgins

National Association of Manufacturers
Health Care Survey



Source: NAM/Foster Higgins

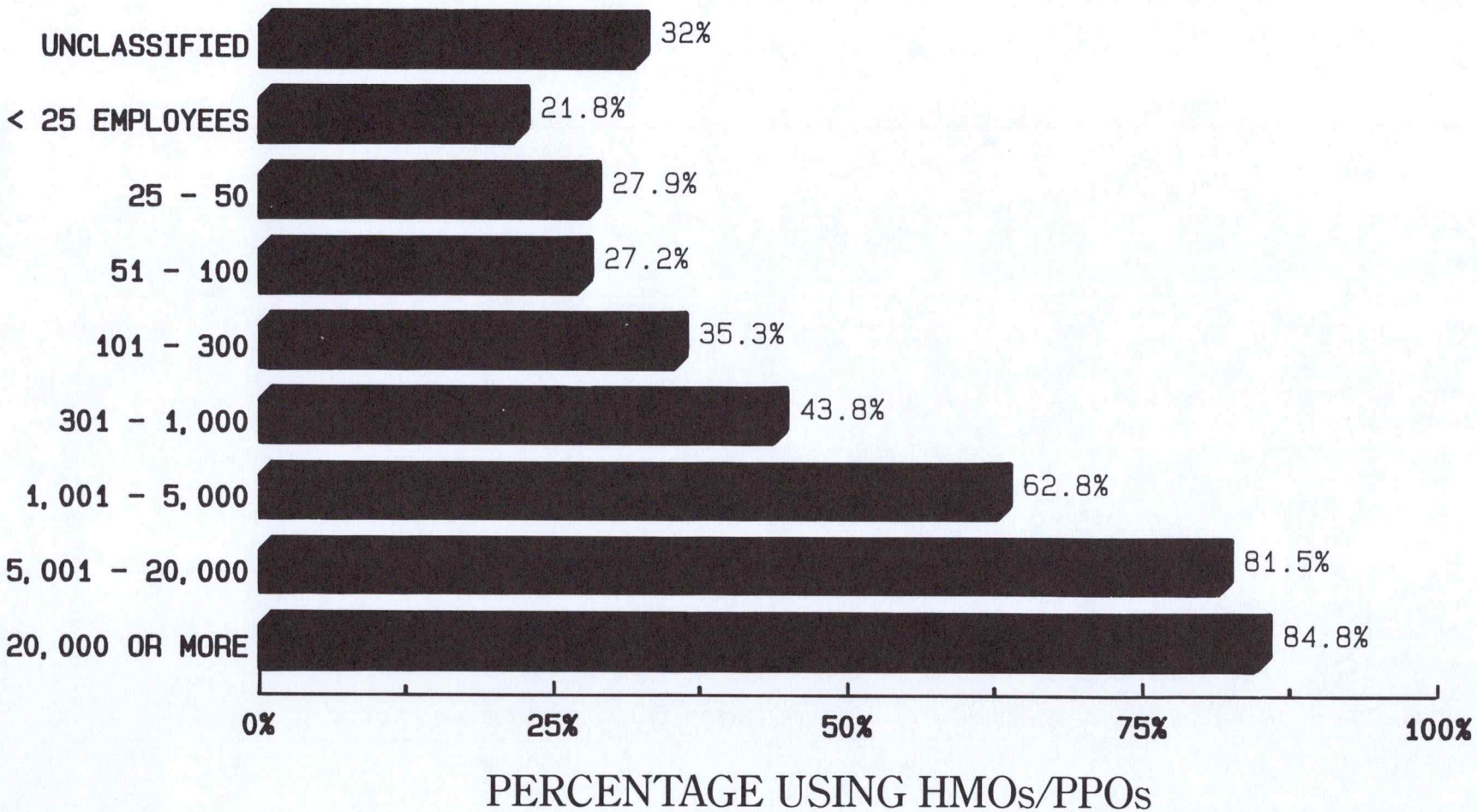
National Association of Manufacturers
Health Care Survey



NET COMPANY PROFITS

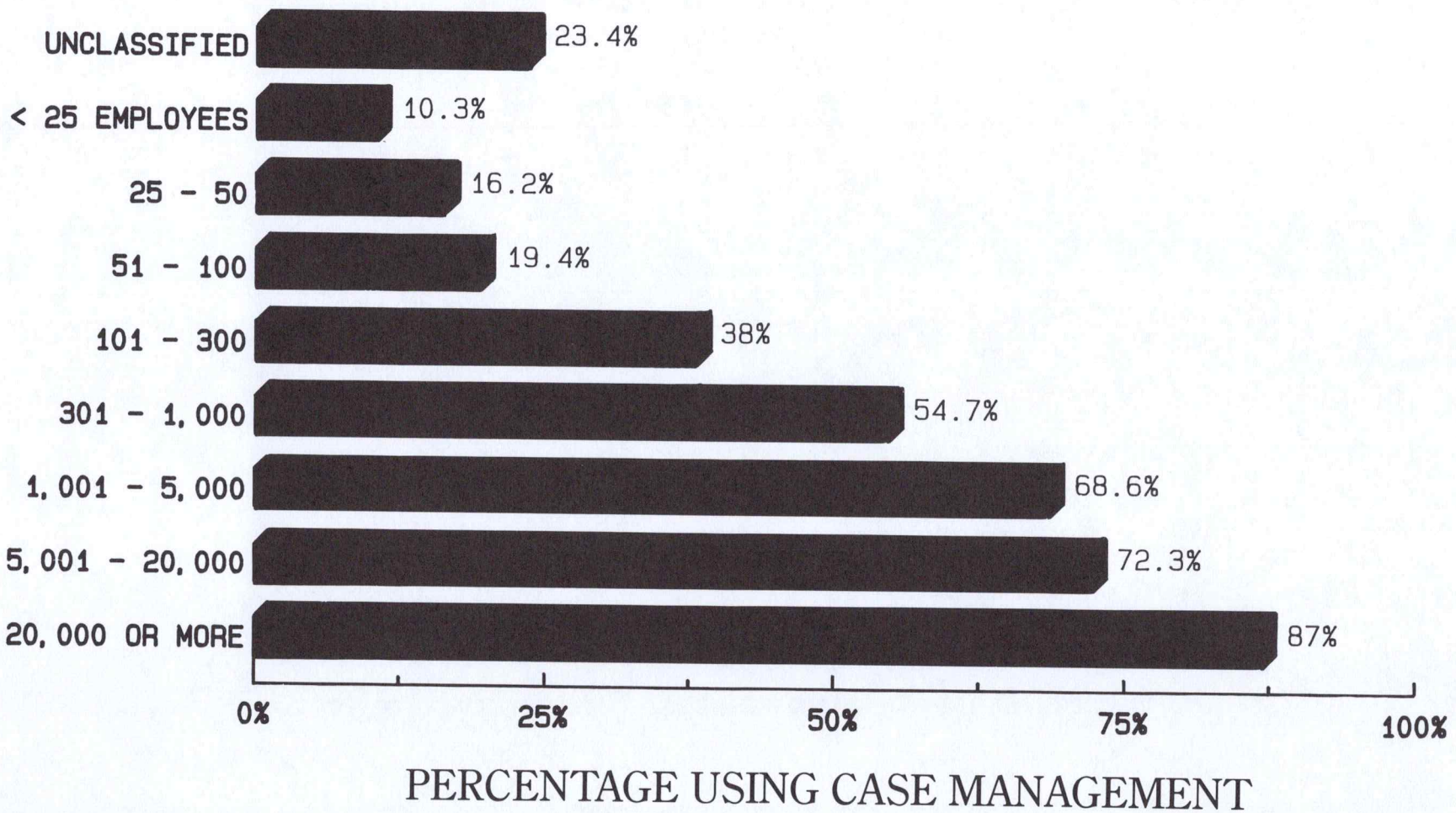
Source: NAM/Foster Higgins

National Association of Manufacturers
Health Care Survey



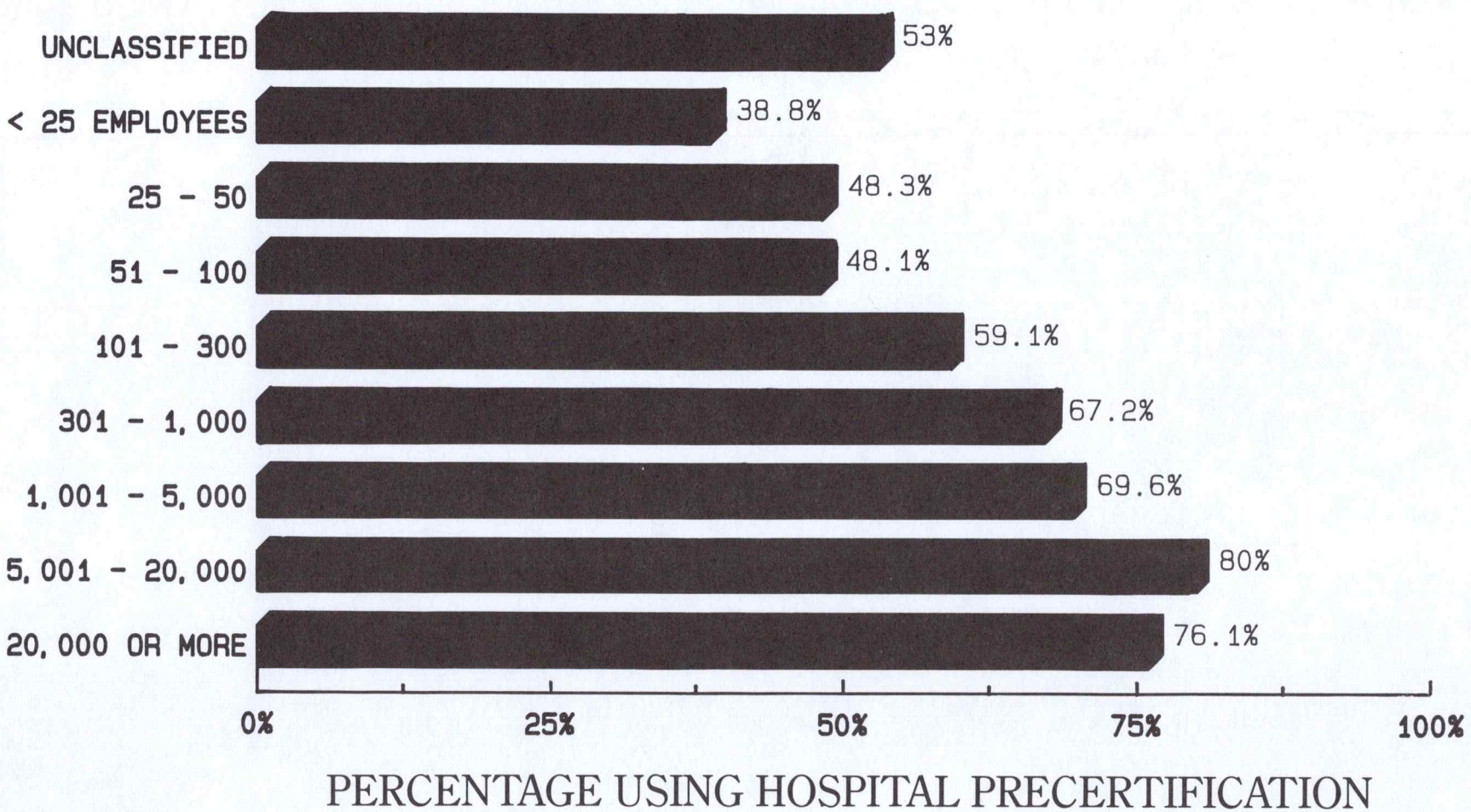
Source: NAM/Foster Higgins

National Association of Manufacturers
Health Care Survey



Source: NAM/Foster Higgins

National Association of Manufacturers
Health Care Survey



Source: NAM/Foster Higgins

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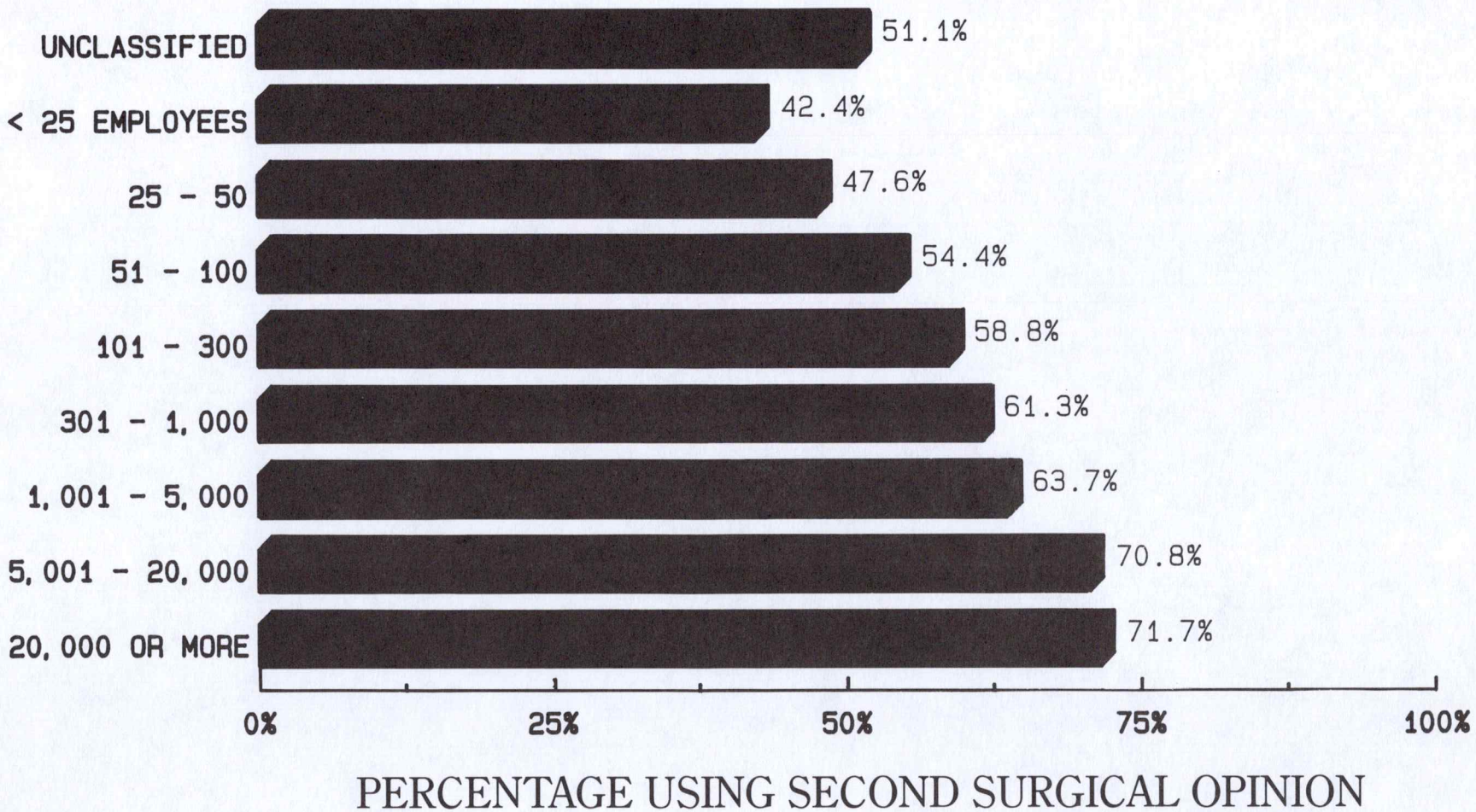
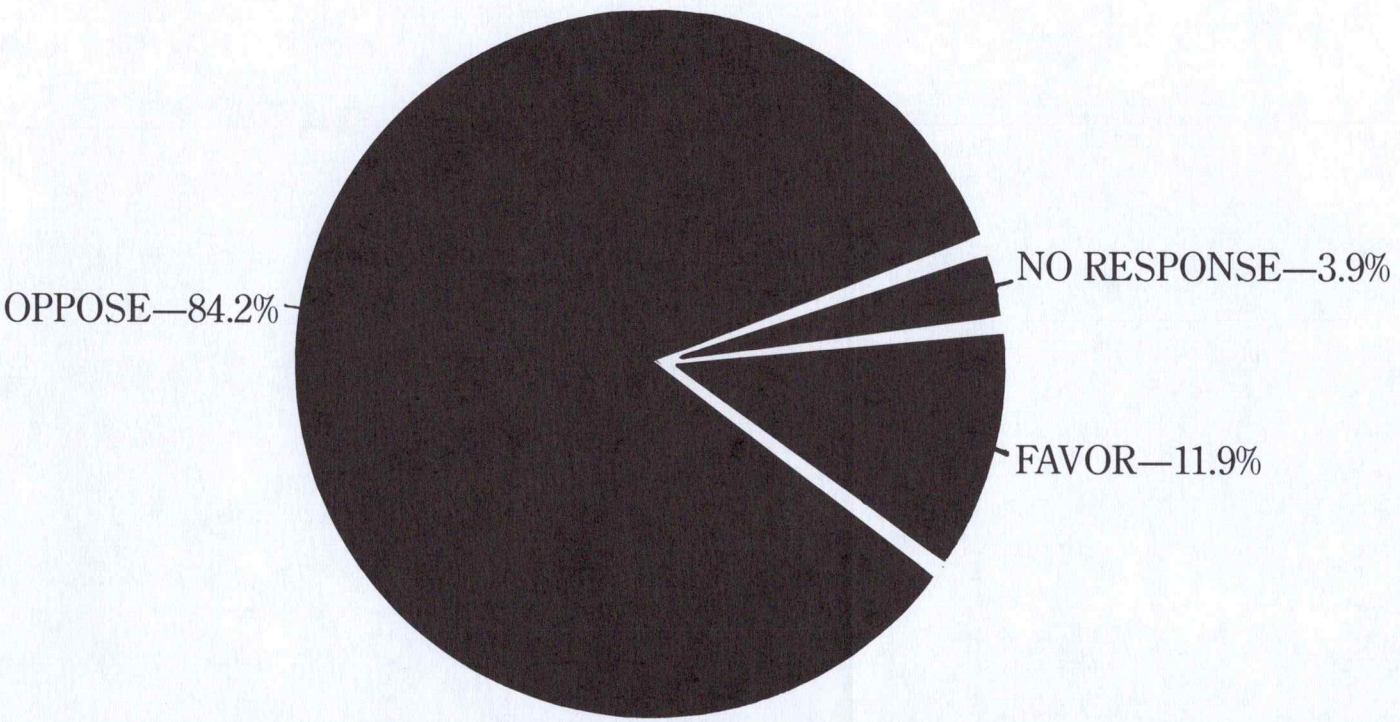


Source: NAM/Foster Higgins

National Association of Manufacturers

Health Care Survey



ATTITUDES TOWARD MANDATED BENEFITS

Source: NAM/Foster Higgins

A CHARTBOOK

THE MEDICALLY UNINSURED

Special Focus on Workers

Katherine Swartz

July 1989

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Conclusions or opinions expressed are those of the author and do not necessarily represent the views of The Urban Institute, The National Health Policy Forum, or their sponsors.

AUTHOR'S NOTE ON DATA

Preliminary versions of the March 1988 Current Population Survey (CPS) are now available. I decided to proceed with publication of the 1987 estimates of the medically uninsured rather than delay publication in order the update the estimates. Two reasons guided my decision.

First, several legislative proposals addressing the issue of coverage of the uninsured--particularly through employment-related insurance--are now before the Congress. In order for the relative merits of these proposals to be properly debated it is essential to know the proportions of workers that would be affected under different alternatives. Timely publication of the estimates in this chartbook helps contribute to the current debate. Second, two sets of changes to the CPS survey instrument were incorporated into the 1988 survey that have led to several coding uncertainties. These uncertainties have yet to be satisfactorily resolved.

The first set of such question changes is about private health insurance coverage and affects the estimates of health insurance coverage of children 15 years of age or older who are still living in their parental households. Responses for them include the possibility that they have private health insurance. If these responses are taken at face value, about one and a half million more persons in this age group may be covered by insurance than the 1987 estimates would indicate. It is not clear that the responses should be so interpreted, however, because many of them were not confirmed by the questions asked of the parent about who else was covered under the parent's policy, and no information was asked that could elicit information about coverage under an absent parent's policy.

The second set of questions that cause uncertainty in the 1988 estimates concerns coverage of children less than 15 years of age. Inconsistent responses were received for about 15 percent of these children. Alternative decisions on how to code these questions could lead to estimates of additional children covered in 1988 relative to the 1987 estimates of anywhere from about half a million to about three and a half million.

Whichever way these coding issues are resolved, the 1988 estimates for adult workers--the primary focus of this chartbook--are essentially unchanged from the 1987 estimates. It is also important to note that the changes in the numbers do not indicate real increases in coverage during the 1987-1988 period. Whatever coding conventions are ultimately adopted for the 1988 CPS will, if applied to the 1987 figures, yield similar numbers in the two years. Thus, the *proportions* covered will be unchanged. These relative shares are the major issue covered in this chartbook.

ACKNOWLEDGMENTS

The graphic illustrations for this chartbook were prepared by Carlos Cornelio. Computer assistance was provided by Laura Wheaton and Thy Dao. The research on which this chartbook is based was supported by the Office of Research and Economic Analysis, Pension and Welfare Benefits Administration, U.S. Department of Labor.

CONTENTS

List of Charts

THE MEDICALLY UNINSURED: SPECIAL FOCUS ON WORKERS

Expanding access to health care by increasing the number of people with health insurance remains one of the top health initiatives on the national agenda. In 1987, 37 million Americans were without any type of private or public health insurance. They represent 17.6 percent of our nonelderly population--one in six of the people below the age of 65.

Who are these uninsured people? How many of them work and would be affected by one strategy for giving them health insurance--requiring employers (or encouraging them via tax incentives) to provide health insurance for their workers? In this paper I look at the characteristics of the uninsured in an attempt to get a multidimensional picture of this group. I then focus on adults who are employed but do not have employer-group health insurance and examine their characteristics. *This will enable us to understand what types of employees and their employers would be affected by legislation requiring or encouraging employers to provide health insurance as part of the wage-compensation package to their employees.*

I focus on three groups of workers in particular: those without any employer-group health insurance, those with employer-group coverage but not from their own employer, and self-employed workers.

Background

Why is improving access to health insurance an issue in the United States? There are at least four reasons for concern about the uninsured. First, the uninsured population as a proportion of the total population has grown in the past decade. In the late 1970s the uninsured represented about 13 percent of the nonelderly population; by 1987 the proportion had grown to 17.5 percent.[1] This upward movement is a reversal of the steady downward trend that characterized the period after World War II.[2]

Second, when the uninsured seek medical care and cannot pay for it, medical care providers use other revenue sources to meet the real costs of providing the care. We all pay into these other revenue sources. We explicitly contribute to some of them when we pay property taxes and income taxes for public hospitals and public health clinics. We pay into other revenue sources in hidden ways when we pay higher health insurance premiums or charges that exceed economic costs for the provision of care.

A third reason for concern for the uninsured relates to the argument that access to medical care leads to use of medical care, and use of medical care leads to a healthier population. There are two caveats to this argument. One is that we do not know the optimal level of medical care; we only know how much medical care is used by insured versus uninsured people. People without health insurance have repeatedly been shown to obtain less medical care than people with health insurance.[3] The second caveat is that we do not know whether medical care per se is the most efficient route to a healthier population. Immunizations for specific diseases and medical attention for infections such as streptococcus or tuberculosis clearly are efficacious uses of medical care for obtaining a healthier population. Similarly, many chronic conditions such as arthritis and hypertension can be relieved through medical treatment; *that* medical care clearly leads to a healthier population. We do not know what the optimal level of medical care utilization is and we know that not all medical care leads to a healthier population. But we *do* have the sense that people who receive no medical attention are often less healthy. This in turn leads to lower productivity and to other social costs.

Finally, concern about the uninsured is increasingly affected by forces lobbying for special treatment for people with HIV/AIDS. If predictions hold true, some areas of the United States and some hospitals will be financially strapped to care for people with HIV within the next five years. Pressures to

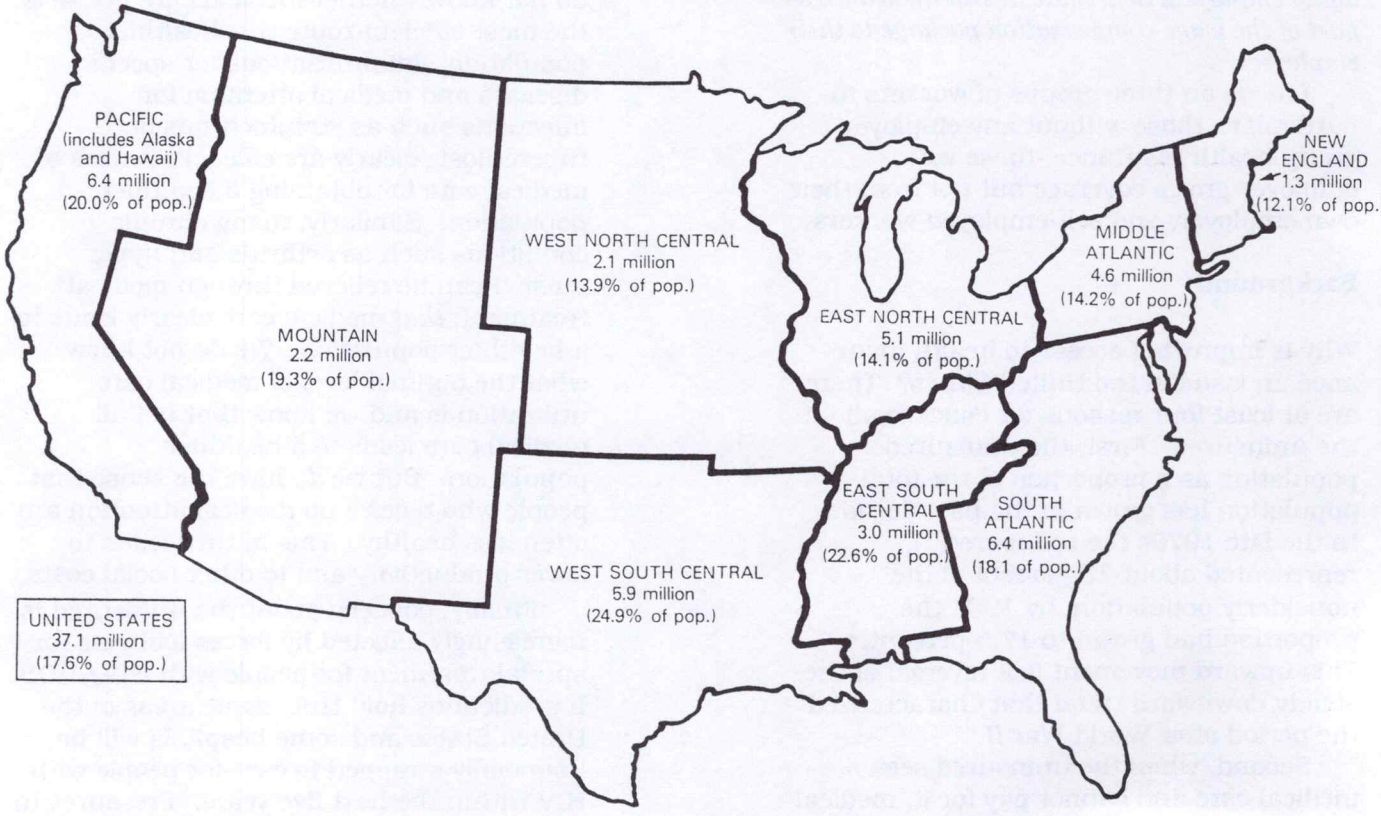
assist such hospitals and cities may cause us to provide Medicare to people with HIV who are outside the current insurance system. In particular, it has been suggested that we amend the Social Security Act so as to cover people with HIV under Medicare, just as we started to cover people with end stage renal disease in 1972. This proposal raises real questions of equity: Why are we covering the medical expenses of people with HIV ahead of the medical expenses of uninsured people who have heart attacks or pregnancies or cancer? Concern for equity--as well as for the financial viability of hospitals and cities with higher incidences of HIV infection--may drive us to resolve the access-to-care problems of most, if not all, of the 37 million Americans without health insurance.

Characteristics of the Uninsured

The population without health insurance is diverse. As can be seen in chart 1, they live where large segments of our population live. A quarter of the uninsured, for example, live in the industrial states of the Middle Atlantic and East North Central regions of the country. However, the uninsured live disproportionately in the South, Southwest, and West.

It is difficult to say precisely why these disproportions exist, but two explanations are readily seen. The first is that, with the exception of California, states in the South, Southwest, and West do not have generous Medicaid eligibility criteria; in particular, the Medicaid income eligibility ceilings are low. Hence, given the income distribution in these regions, the size of the population covered by Medicaid is small relative to what it would be in the more generous Medicaid states.[4] The second reason for the disproportion is that these areas do not have a tradition of strong unions. Union activity in the industrial states of the Northeast caused health insurance to become a standard part of the wage-compensation package in these regions after World War II.[5]

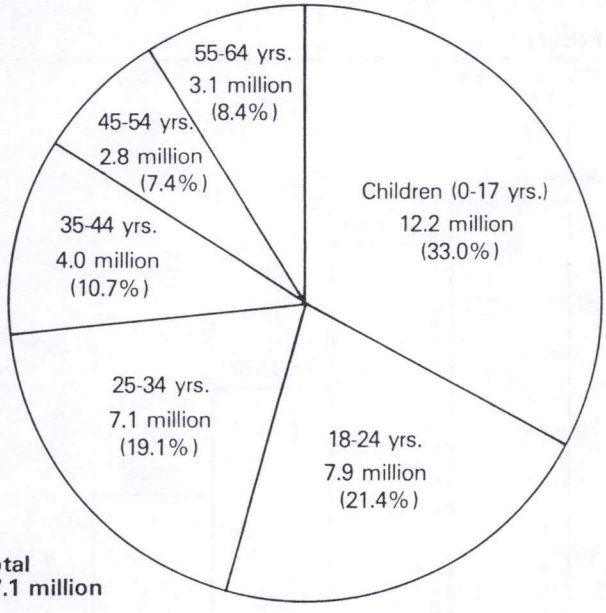
Chart 1 NONELDERLY UNINSURED BY REGION, 1987



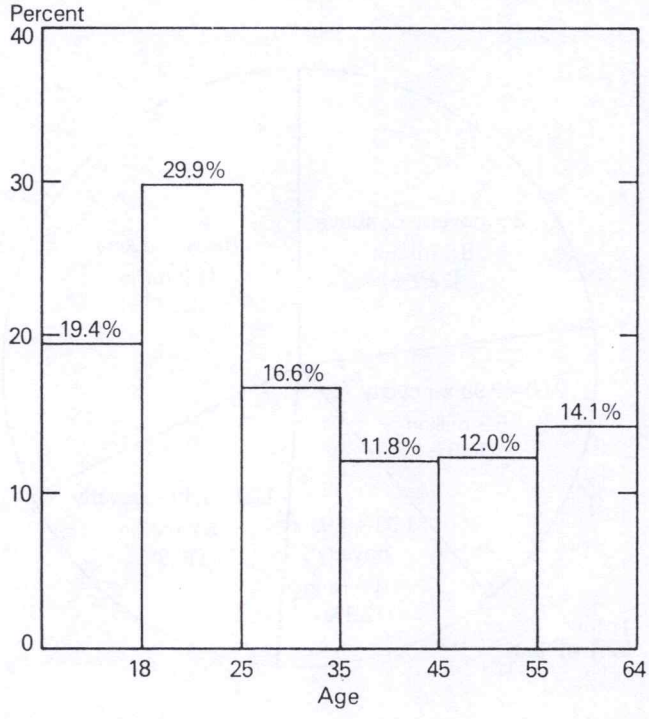
Source: 1987 CPS; Swartz, Urban Institute.

Chart 2 NONELDERLY UNINSURED BY AGE, 1987

A. As Percentage of Total Nonelderly Uninsured



B. As Percentage of Age Group

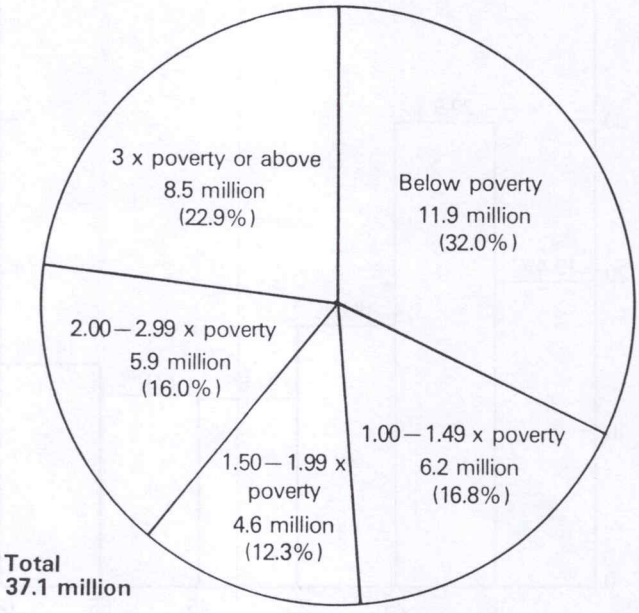


Source: 1987 CPS; Swartz, Urban Institute

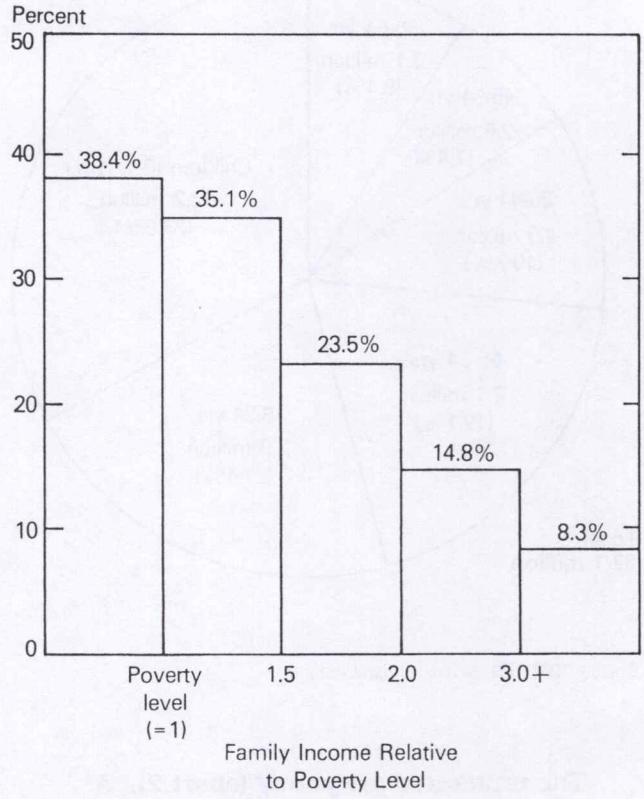
The uninsured are young (chart 2). A third are children younger than 18 years of age. Another fifth are young adults between the ages of 18 and 24. Still another fifth are 25 to 34 years of age. If we look at the proportion of all people in each age cohort who lack health insurance, we find that 18- to 24-year-olds have the highest incidence of being uninsured. About 30 percent of these young adults lack health insurance. Children (at 20 percent) are the only other group above the national average of 17.6 percent.

Chart 3 NONELDERLY UNINSURED BY FAMILY INCOME RELATIVE TO POVERTY, 1986

A. As Percentage of Total Nonelderly Uninsured



B. As Percentage of Family Income Group



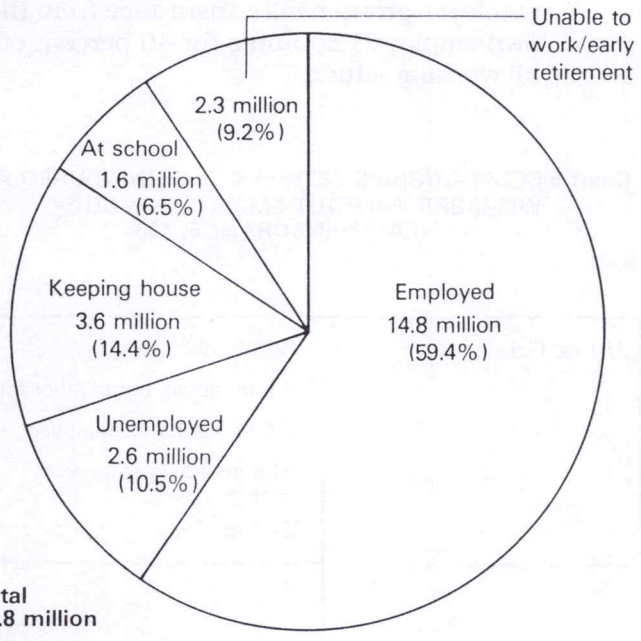
Source: 1987 CPS; Swartz, Urban Institute

When we look at the family incomes of the population without health insurance, we find that a third of the uninsured have incomes below the federal poverty line (chart 3). The popular assumption that everyone who is poor is covered by Medicaid is not true--only four out of ten people in poverty are covered by Medicaid.[6] Almost three out of ten of the uninsured are what might be called "near poor," those with family incomes between one and two times the poverty level. But what is perhaps most surprising is that almost four out of ten of the uninsured are people with family incomes above two times the poverty level, and more than half of these people have family incomes above three times the poverty level. These proportions are higher than in 1980.[7]

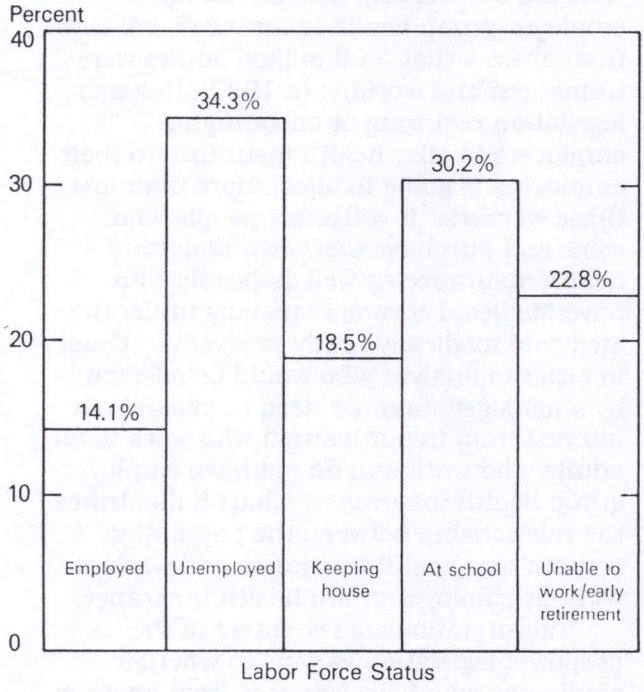
When we look at the proportion of people in each income group who do not have health insurance (the incidence rate of being uninsured), we find that income does indeed play a role in whether or not a person has health insurance. People in poverty and those with incomes between one and 1.5 times the poverty level have the highest incidence rates of being without health insurance. More than a third of all people in these two income groups lack health insurance, and almost a quarter of all people with incomes between 1.5 and two times the poverty level are uninsured.

Chart 4 ADULTS AGES 18-64 WITHOUT INSURANCE BY LABOR FORCE STATUS, 1987

A. As Percentage of Total Prime Age Uninsured



B. As Percentage of Labor Force Group



Source: 1987 CPS; Swartz, Urban Institute

In contrast, 15 percent of the people with incomes between two and three times the poverty level are without health insurance, and only 8 percent of all the people with incomes above three times the poverty level are uninsured.

In multivariate probability models for predicting who has health insurance, income is the most important factor in explaining who has health insurance.[8] One effect of including income in such models is that race is shown not to be a significant factor.[9] The implication for policy strategies is that boosting income and employment for nonwhites will significantly increase their health insurance coverage.

Finally, when we look at the labor force status of adults without health insurance, we find that 60 percent of the uninsured adults are employed and another 10 percent are unemployed (chart 4). Thus, 70 percent of the almost 25 million uninsured adults are in the labor force (i.e., working or looking for work). Only 10 percent either are unable to work or in early retirement. *The fact that 60 percent of all uninsured adults are employed is behind the recent legislative initiatives to require or create tax incentives for employers to provide health insurance to their employees.*

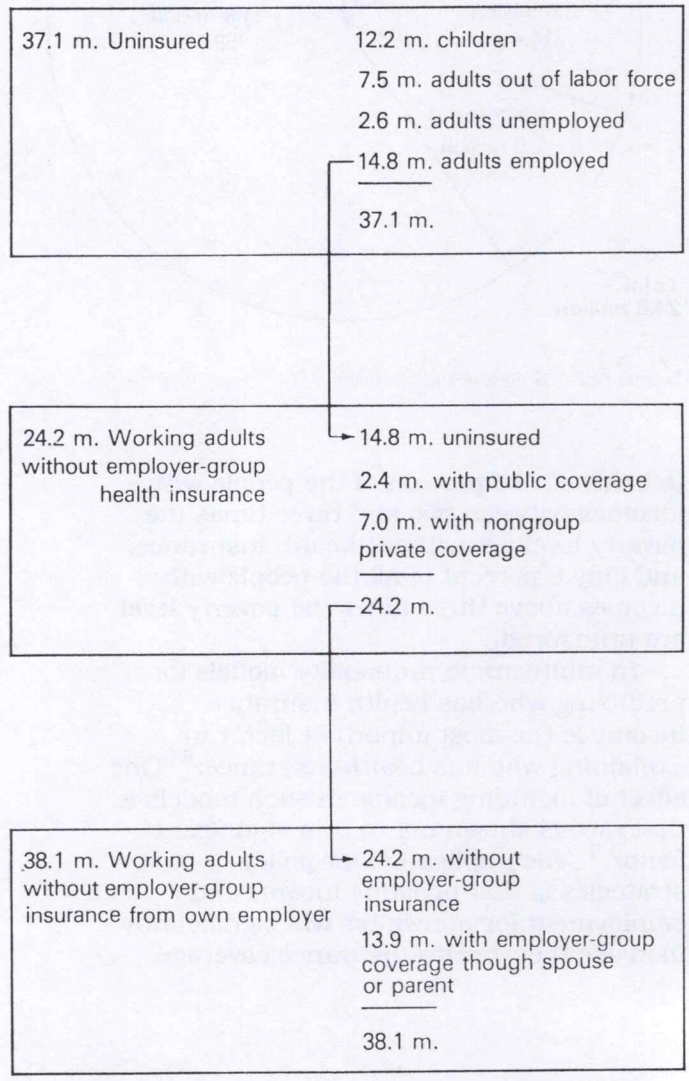
Workers without Employer-Group Health Insurance

Who are the workers who do not have employer-group health insurance? We saw from chart 4 that 14.8 million adults were uninsured and working in 1987. However, legislation requiring or encouraging employers to offer health insurance to their employees is going to affect more than just these workers. It will affect people who work and purchase their own nongroup health insurance as well as people who have Medicaid coverage, usually under the Medicaid medically needy programs. Thus, in order to analyze who would be affected by such legislation, we need to expand our interest from the uninsured who work to all adults who work and do not have employer-group health insurance. Chart 5 illustrates the relationship between the population without any health insurance and workers without employer-group health insurance.

Interpretations of the intent of the proposed legislation vary as to whether employees who have coverage from another family member (that is, a spouse or parent) can be exempted from an employer's group. The original interpretation was that double coverage was not desirable and that such exemptions would be allowed. More recently, however, some have advocated that primary health insurance coverage ought to come from the employee's own employer, whatever other coverage an employee might have. I first use the original interpretation and look at adults who work and do not have employer-group coverage from any source. I then look at workers who have employer-group coverage but not from their own employer, to determine if there are significant differences between them and the people who work but do not have employer-group health insurance of *any* kind.

In 1987, 24.2 million workers were without employer-group health insurance from either their own employer or the employer of a relative. They account for 23 percent of the employed adults in March 1987. Another 13.9 million adults worked and were covered by employer-group health insurance but the insurance was not from their own employer (chart 5). The sum of these two groups (i.e., workers without employer-group health insurance from their own employer) accounts for 40 percent of all working adults.

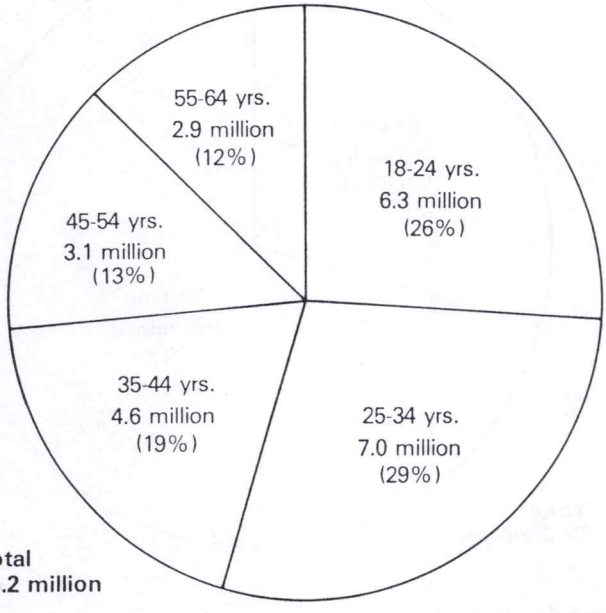
Chart 5 RELATIONSHIPS BETWEEN THE UNINSURED AND WORKERS WITHOUT EMPLOYER-GROUP HEALTH INSURANCE, 1987



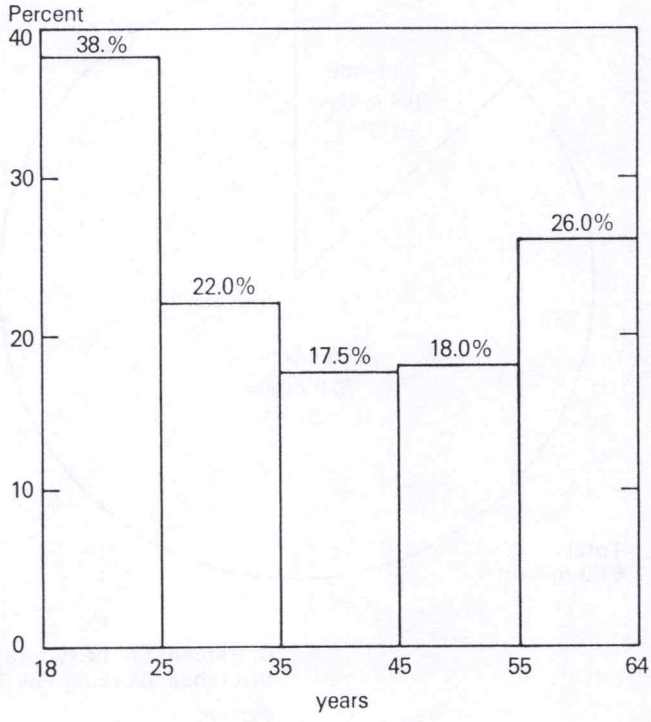
Source: 1987 CPS; Swartz, Urban Institute

Chart 6 WORKERS WITHOUT EMPLOYER-GROUP INSURANCE BY AGE, 1987

A. As Percentage of Total Workers without Employer-Group Insurance



B. As Percentage of Workers in Age Group

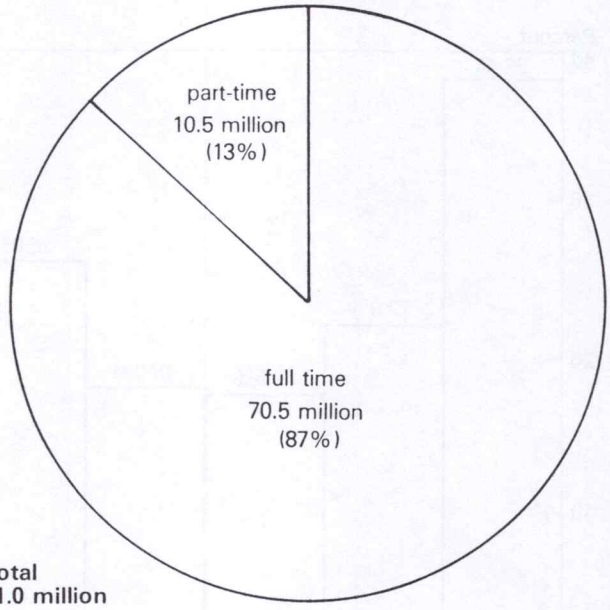


Source: 1987 CPS; Swartz, Urban Institute

Young adults dominate workers without employer-group health insurance from any source: 55 percent are between 18 and 34 years of age (chart 6). That almost 30 percent of the workers without employer-group coverage are 25 to 34 years of age is a reflection of the size of that cohort: About 30 percent of all nonelderly adults between 18 and 64 years of age are 25 to 34 years of age. When we look at the *proportion* of workers in each age cohort who do not have employer-group health insurance, we see that the 18- to 24-year-olds have by far the highest incidence (with 38 percent lacking employer-group insurance). The incidence rate for the 25- to 34-year-old cohort is just about the rate for all workers. The incidence of being without employer-group insurance declines again for the next age cohorts to 17 or 18 percent. It rises for the 55- to 64-year-old cohort, with just over 25 percent having no employer-group health insurance.

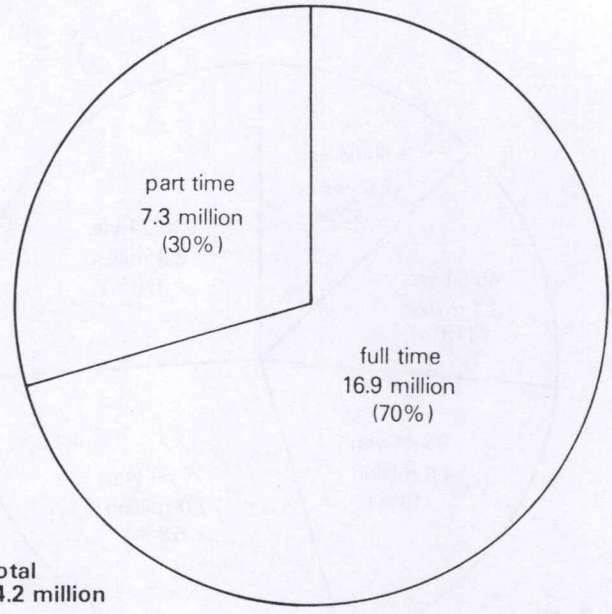
Chart 7 EMPLOYER-GROUP COVERAGE OF FULL- AND PART-TIME WORKERS BY AGE, 1987

A. Workers with Employer-Group Insurance



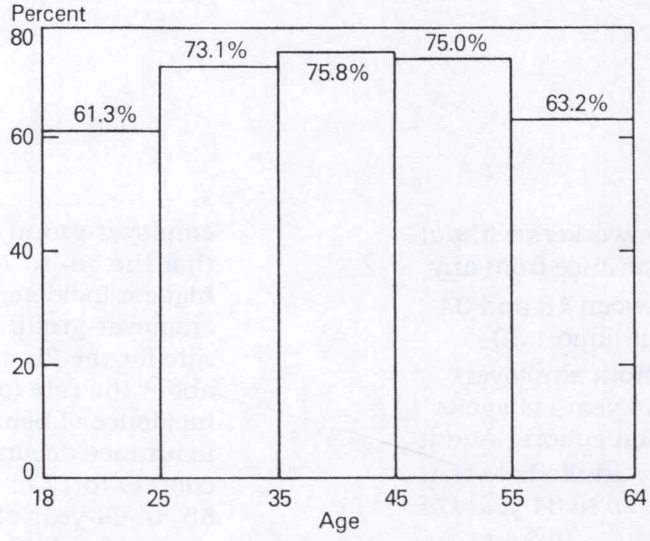
Total
81.0 million

B. Workers without Employer-Group Insurance



Total
24.2 million

C. Percentage of Workers without Employer-Group Insurance Working Full Time in Age Group



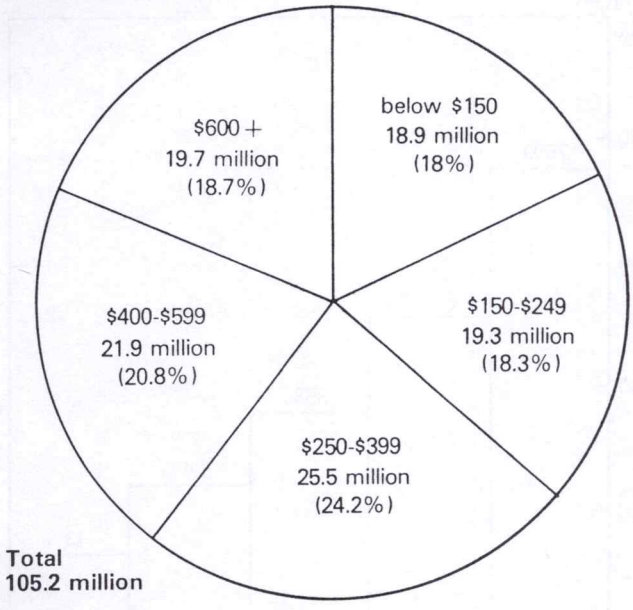
Note: Full time means 35 hours or more per week

Source: 1987 CPS; Swartz, Urban Institute

Chart 7 shows part of the reason why 18- to 24-year-olds and 55- to 64-year-olds have higher incidence rates of being without employer-group health insurance. Both cohorts have the lowest proportions of workers working full time, which is defined as working at least 35 hours per week.[10] It is often assumed that a majority of uninsured workers work part time, but as can be seen in chart 7, that is not true.

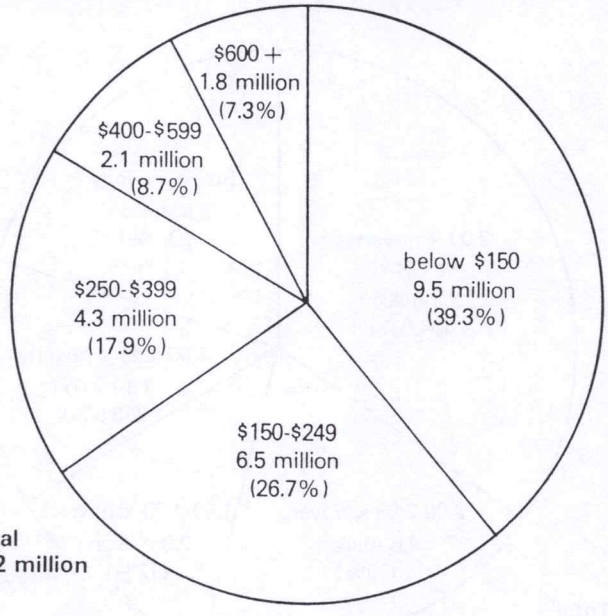
Chart 8 ALL WORKERS AND WORKERS WITHOUT EMPLOYER-GROUP INSURANCE BY WEEKLY EARNINGS, 1986

A. All Workers



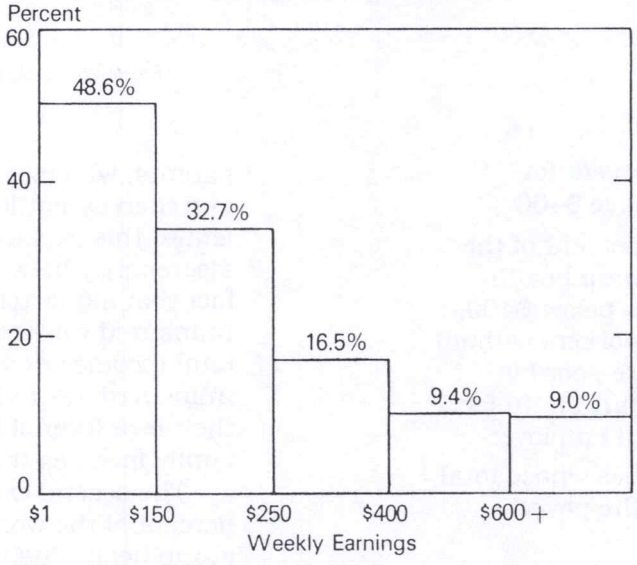
Total
105.2 million

B. Workers without Employer-Group Insurance



Total
24.2 million

C. Workers without Employer-Group Insurance as Percentage of All Workers in Earnings Group



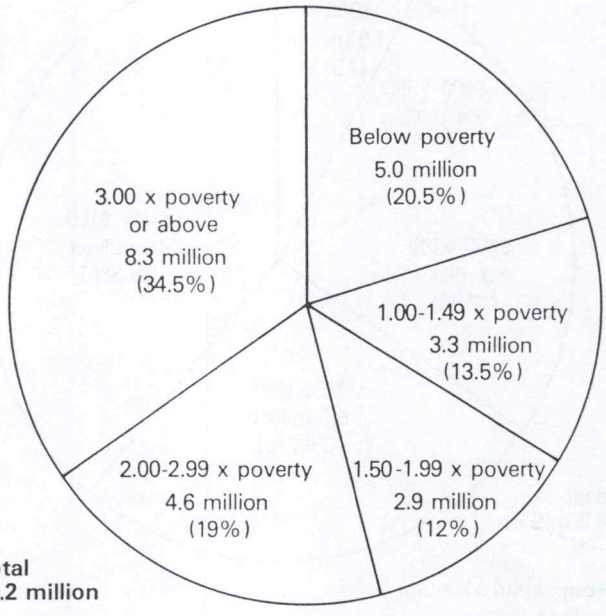
Source: 1987 CPS; Swartz, Urban Institute

More than a third of the workers without employer-group health insurance have weekly earnings between $1 and $149 in 1986 (chart 8.) More than another quarter have weekly earnings between $150 and $249. Altogether, roughly four out of five of the workers without employer-group insurance have weekly earnings below $400, which is less than $21,000 per year.

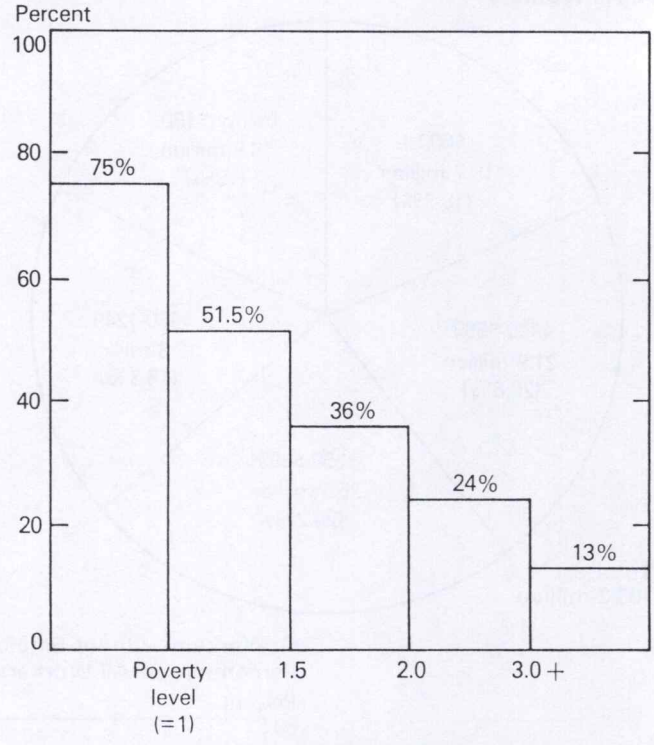
We can also see from chart 8 that about half of all workers earning between $1 and $149 per week do not get employer-group insurance, and a third of all workers earning between $150 and $249 per week do not have employer-group insurance. The incidence rate of being without employer-group insurance declines markedly as weekly wages rise, but it levels

Chart 9 WORKERS WITHOUT EMPLOYER-GROUP INSURANCE BY FAMILY INCOME RELATIVE TO POVERTY, 1986

A. As Percentage of Total Workers without Employer-Group Insurance



B. As Percentage of Workers in Family Income Group



Source: 1987 CPS; Swartz, Urban Institute

off at a little less than ten percent for people with weekly wages above $400.

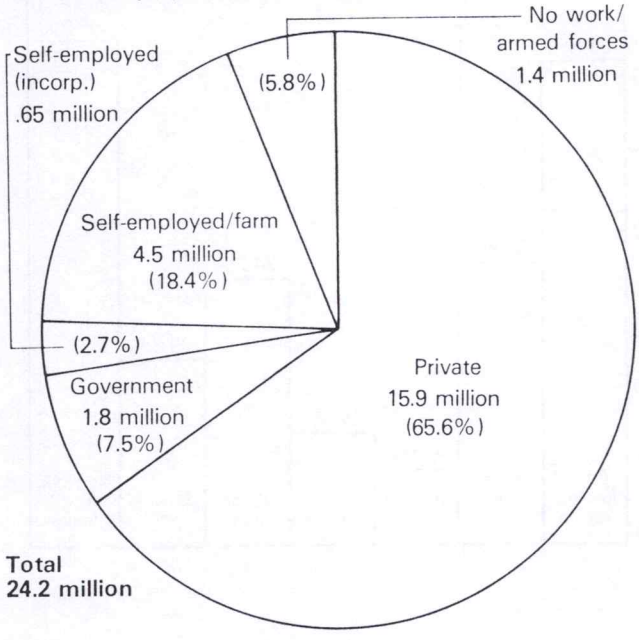
Despite the fact that 80 percent of the workers without employer-group health insurance have weekly wages below $400, relatively few (a fifth) of the workers without employer-group insurance are poor by official poverty standards (chart 9). In fact, a third of the workers without employer-group insurance live in families whose total incomes exceed three times the poverty level.

There are at least two explanations for why relatively few of the workers without employer-group health insurance live in poverty and yet a majority have weekly wages below $250. The first is that many of the very young adults live with their parents. When a person lives with a relative, the incomes of all the relatives are summed to obtain the person's family income. Thus, a person could have low weekly wages but live with his or her parents, who may have higher earnings, and thereby not live in poverty. Credence is lent to this explanation of the seeming discrepancy between charts 8 and 9 by the fact that a quarter of the 18- to 24-year old uninsured workers live in families whose total incomes exceed $35,000--and very few uninsured 18- to 24-year-olds who live on their own (even if they are married) have family incomes that high.

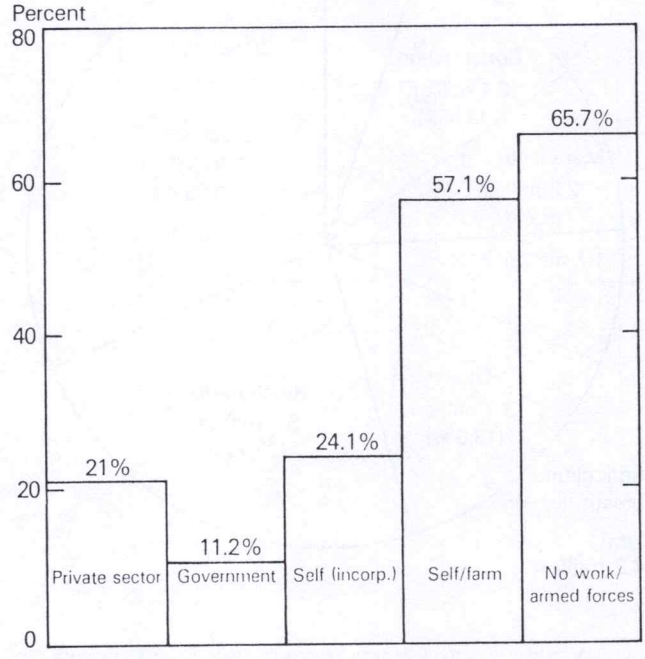
The second explanation for why 80 percent of the workers without employer-group health insurance are not in poverty is that it does not take high weekly wages for a single person or a two-person family to be above the poverty level. In 1986, the poverty level for a single person was about $5,500; consequently, any single person earning more than $105 per week had an income above the poverty level. (If he or she earned more than $315 a week he or she would be above three times the poverty level.) The poverty level for a family of two in 1986 was just over $7,000.

Chart 10 WORKERS WITHOUT EMPLOYER-GROUP INSURANCE
BY SECTOR OF LONGEST JOB IN 1986

A. As Percentage of Total Workers without Employer-Group Insurance



B. As Percentage of Workers in Sector



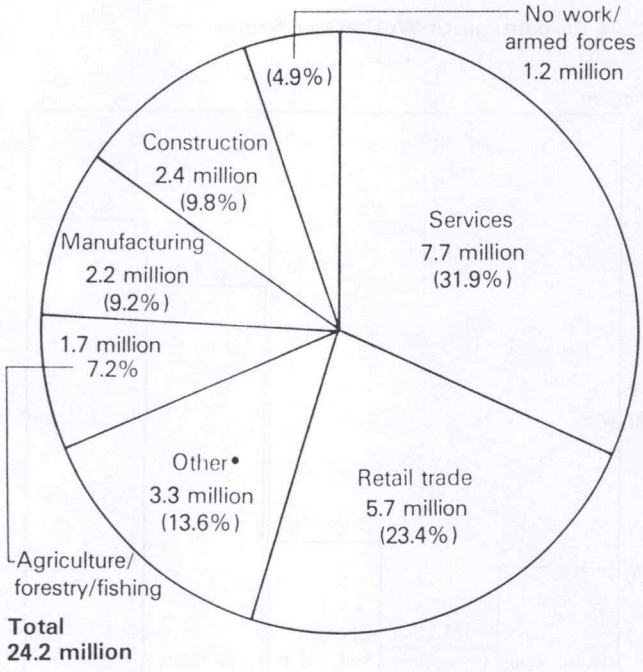
Source: 1987 CPS; Swartz, Urban Institute

Where do the workers without employer-group health insurance work? The private sector employs 66 percent of them and another 20 percent are self-employed (chart 10). The incidence rates for being without employer-group insurance are deceiving for the self-employed, because about half the self-employed purchase nongroup health insurance. This still leaves 5.1 million self-employed workers without health insurance (we look more closely at them below). We can also observe from chart 10 that slightly less than 2 million workers without employer-group insurance are employed by some level of government. People who work in "temporary" government positions, for example, do not receive fringe benefits--such as health insurance--as part of the compensation package.

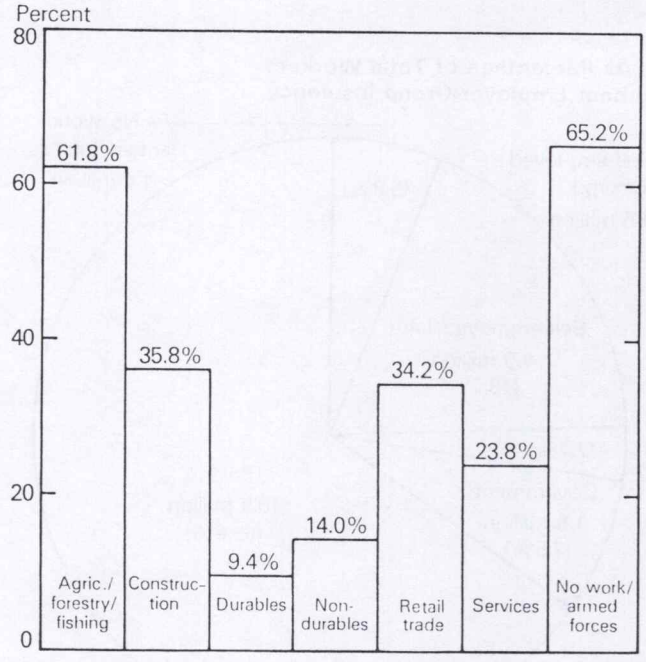
Almost a third of the workers without employer-group health insurance are employed in the service sector of the

Chart 11 WORKERS WITHOUT EMPLOYER-GROUP INSURANCE BY INDUSTRY OF LONGEST JOB IN 1986

A. As Percentage of Total Workers without Employer-Group Insurance



B. As percentage of Workers in Industry



• Mining, Transportation/Communication, Wholesale Trade, Finance/Insurance/Real Estate, Public Administration

Source: 1987 CPS; Swartz, Urban Institute

economy (chart 11). But these 7.7 million workers are by no means mostly domestics and housekeeper/babysitters. About half are in "professional and related" services--personnel in the offices of physicians and dentists, schools and colleges, libraries, day care centers, museums, and so forth. However, the incidence rate of being without employer-group insurance for people in "professional and related" services is less than half the incidence rates for people in the other three service categories.

Another 5.7 million workers without employer-group insurance are in the retail trade sector. This sector includes people in hardware stores, department stores, supermarkets, bakeries, auto dealerships, restaurants, and so on. Almost a third of the people who work in retail trade do not have employer-group insurance. Construction accounts for 10 percent of the workers without employer-group insurance, and agriculture-forestry-fishing accounts for another 7 percent. Both these sectors have high incidence rates of workers without employer-group insurance. Finally, if we combine durable and nondurable manufacturing we find another 9 percent of the workers without employer-group insurance. Apparel manufacturing is a subsector within nondurable manufacturing with a particularly high incidence rate.

Summary. The 24.2 million workers without any employer-group health insurance are predominantly young, have relatively low weekly wages, and work mostly in the service, retail trade, construction, and agriculture-forestry-fishing sectors of the economy.

Workers with Employer-Group Coverage but Not from Their Own Employer

Some employers argue that they face higher health insurance costs per employee because employed spouses of their employees choose not to receive health insurance from their own employers.[11] As a result, some argue that the Kennedy-Waxman bill, for example, should require all employees to receive their primary health insurance coverage from their own employers. Clearly, this interpretation of proposed legislation requiring employers to provide health insurance has major implications for which groups would be affected by such legislaton. We need to know more about the people who are not in the group discussed in the previous section but who would be affected under this broader interpretation because they do not have employer-group health insurance from their own employer.

Almost 14 million employed adults have employer-group health insurance coverage that does not originate from the worker's own employer. Just over 800,000 of these people (6 percent of the 13.9 million) also have self-purchased, nongroup health insurance coverage as well as the employer-group coverage from a spouse or other family member's employer.

The vast majority (70 percent) of these workers are women. Almost 90 percent of the women are married, in contrast to less than 75 percent of the men having ever been married (chart 12). Thus, working women who have employer-group health insurance from an employer other than their own are more likely to have it from a spouse than are men. Working men who do not have employer-group health insurance from their own employer, in contrast, are more likely than women to receive it from their parents.

Chart 12 WORKERS WITH EMPLOYER-GROUP INSURANCE THROUGH OTHERS BY CHARACTERISTIC, 1987

A. Marital Status

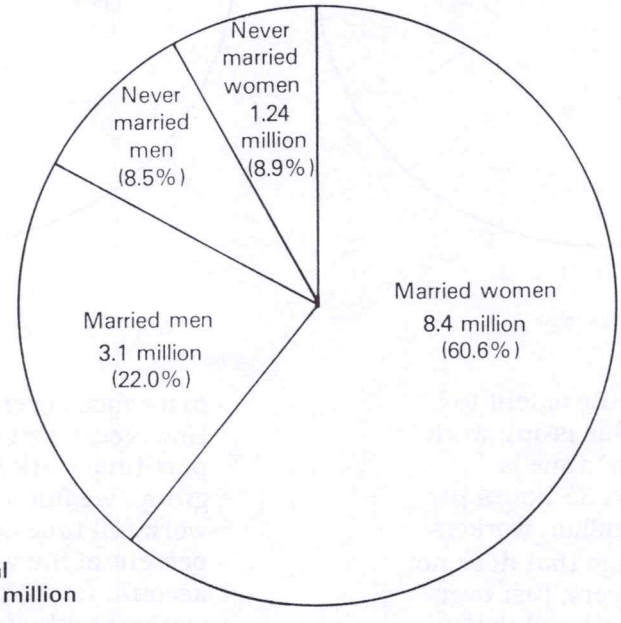
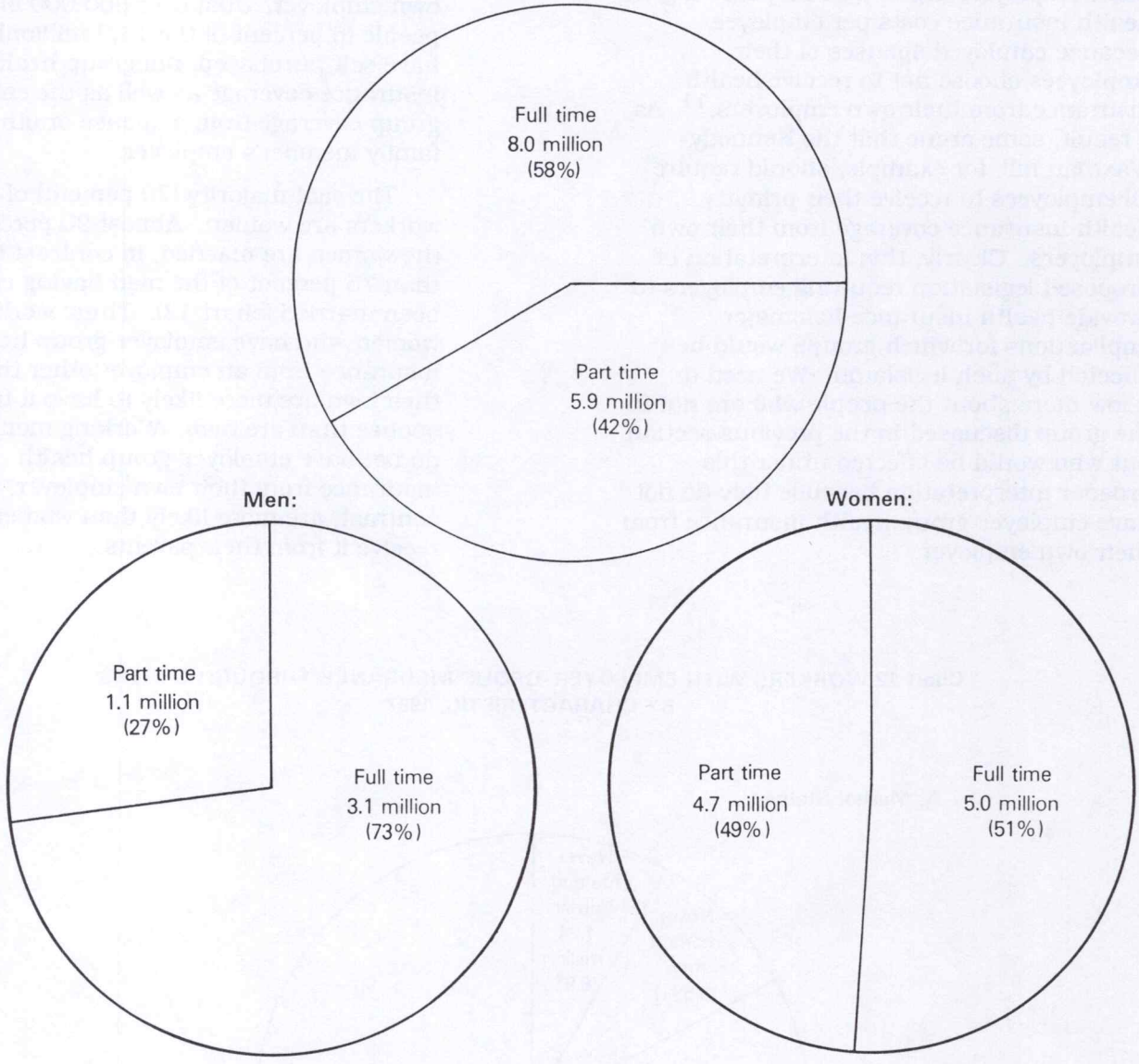


Chart 12 WORKERS WITH EMPLOYER-GROUP INSURANCE THROUGH OTHERS BY CHARACTERISTIC, 1987

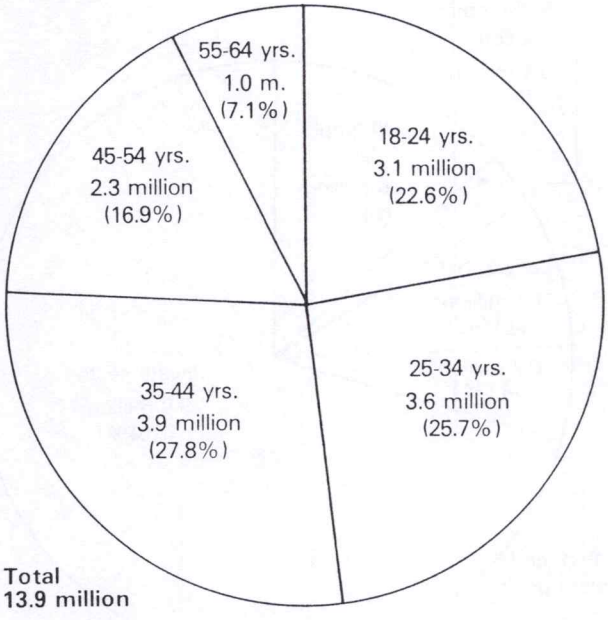
B. Full-and Part-time Workers, by Sex



Source: 1987 CPS; Swartz, Urban Institute

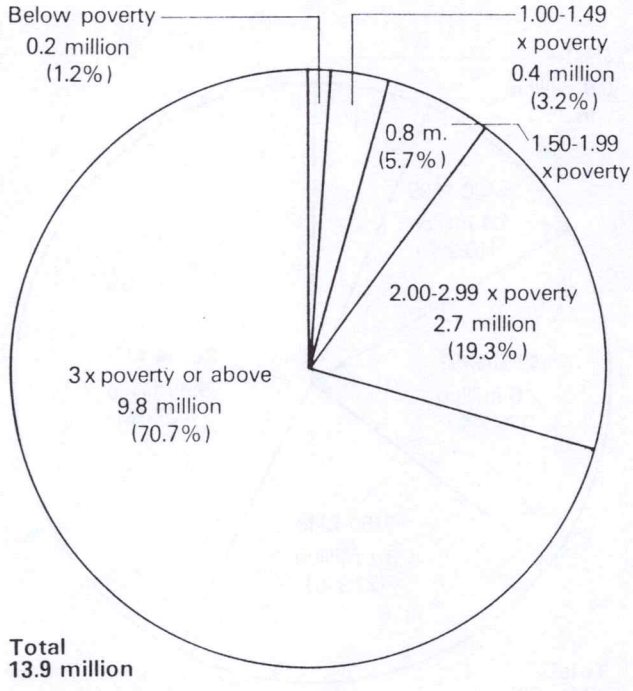
Chart 12 also indicates the extent to which men and women in this group work full time and part time. (Part time is defined as working less than 35 hours per week.)[12] Among the 13.9 million workers with employer-group coverage that does not come from their own employers, just over 40 percent work part time. (Recall that only 30 percent of the 24.2 million workers without any employer-group health insurance coverage work part time). However, when we look at full-time versus part-time work *by sex* of workers in this group, we find that 73 percent of the men work full time compared with only 51 percent of the women. It is because women account for 70 percent of the 13.9 million workers with employer-group coverage that part-time employment is a factor for 40 percent of the total.

Chart 13 WORKERS WITH EMPLOYER-GROUP INSURANCE THROUGH OTHERS BY AGE, 1987



Source: 1987 CPS; Swartz, Urban Institute

Chart 14 WORKERS WITH EMPLOYER-GROUP INSURANCE THROUGH OTHERS BY FAMILY INCOME RELATIVE TO POVERTY, 1986

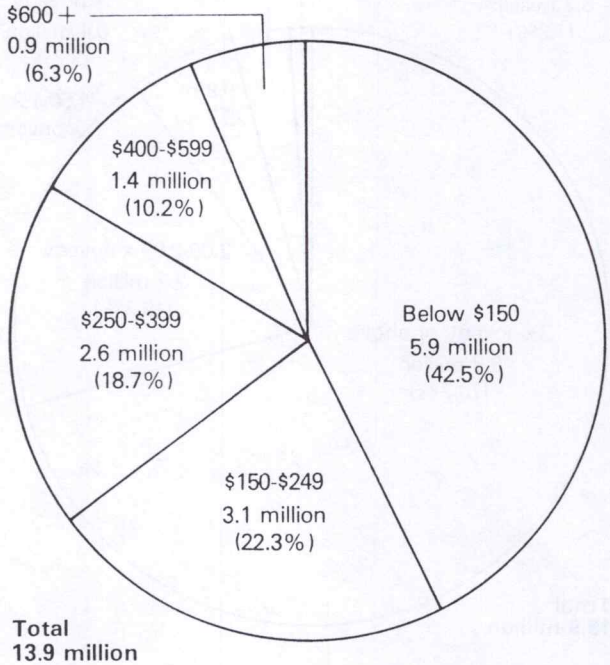


Source: 1987 CPS; Swartz, Urban Institute

When we look at the age distribution of this group, we find that it is concentrated more in the three middle age cohorts than is the age distribution of the 24.2 million workers without any employer-group health insurance (chart 13). In particular, 45 percent of the workers with employer-group health insurance from an employer that is not their own are between the ages of 35 and 54.

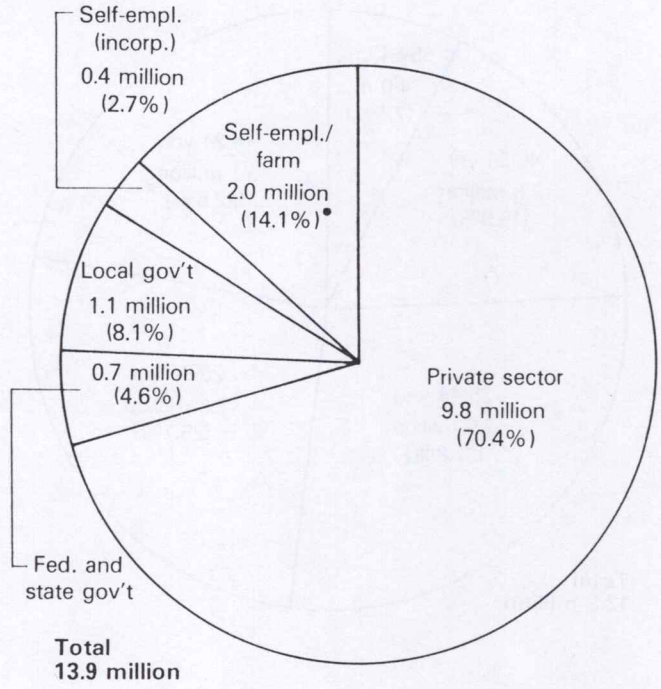
Chart 14 indicates the distribution of the family income relative to the poverty level of the workers with employer-group health insurance that does not come from the workers' own employers. Only 10 percent of this group have family incomes below two times the poverty level. This is significantly different from the family income distribution of workers without any employer-group health insurance. Among the latter group, 45 percent have family incomes below two times the poverty level (refer back to chart 9). Further, 70 percent of the workers with employer-group health insurance from a relative's employer have family incomes at or above three times the poverty level, whereas only a third of the workers without any employer-group health insurance have family incomes at or above three times the poverty level. Clearly, the economic resources of the two groups differ substantially.

Chart 15 WORKERS WITH EMPLOYER-GROUP INSURANCE THROUGH OTHERS BY WEEKLY EARNINGS, 1986



Source: 1987 CPS; Swartz, Urban Institute

Chart 16 WORKERS WITH EMPLOYER-GROUP INSURANCE THROUGH OTHERS BY SECTOR OF LONGEST JOB IN 1986



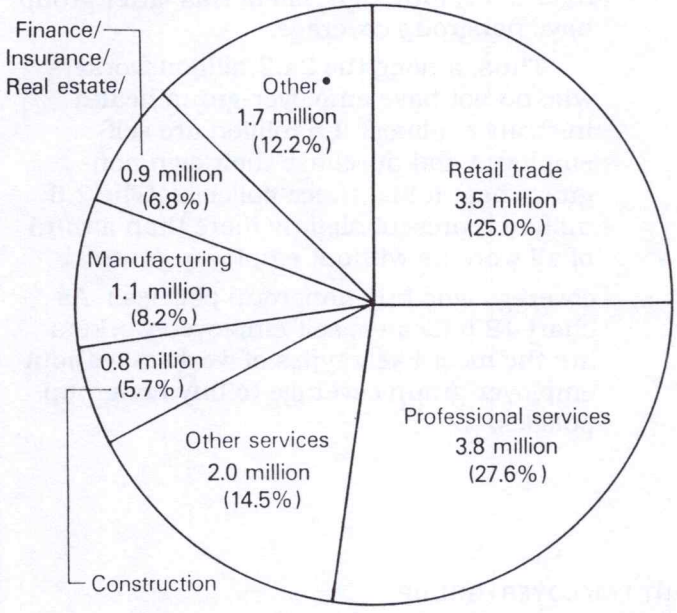
•Includes .08 million who said they did not work.

Source: 1987 CPS; Swartz, Urban Institute

When we look at the weekly wages of the workers with employer-group health insurance from a relative's employer, we find that just over 40 percent of them have weekly earnings below $150 (chart 15). Almost another quarter of this group have weekly earnings between $150 and $249, and not quite 20 percent have earnings between $250 and $399 per week. This is not substantially different from the weekly earnings distribution of the workers without any employer-group health insurance (refer back to chart 8).

Chart 16 shows the employment distribution of those workers with employer-group health insurance from a relative's employer. Seventy percent of this group work in the private sector compared with 66 percent of workers without any employer-group health insurance. Almost 13 percent of the workers with employer-group health insurance from a relative's employer work for some level of government; only 7 percent of the workers without any employer-group health insurance are government employees. Just over 13 percent of the workers with employer-group insurance are self-employed or work on farms compared with 18 percent of workers without any employer-group health insurance.

Chart 17 WORKERS WITH EMPLOYER-GROUP INSURANCE THROUGH OTHERS BY INDUSTRY OF LONGEST JOB IN 1986



Total
13.9 million

•Agriculture/Forestry/Fishing, Mining, Transportation/Communication, Wholesale Trade, Public Administration

Source: 1987 CPS; Swartz, Urban Institute

Chart 17 indicates the distribution of the industry of the employer of workers who have employer-group health insurance from a relative's employer. A little more than two out of five of the workers in this group are in the service sector of the economy, compared with just under a third of the workers without employer-group health insurance. The big difference between the two groups comes from the professional services. More than a quarter of the workers with employer-group health insurance from a relative's employer are employed in the professional services sector--much higher than the 15 percent of workers without any employer-group health insurance who work in professional services. Another quarter of the workers with employer-group coverage from a relative work in retail trade--almost the same as the proportion of workers without any employer-group health insurance who work in retail trade. Each of the remaining industrial sectors employs less than 7 percent of the workers who have employer-group health insurance from a relative's employer. Thus, with the exception of the professional services sector, the distribution of workers among the industrial sectors does not differ substantially between those without any employer-group insurance and those with insurance through a relative's employer.

Summary. Workers with employer-group health insurance that is not from the worker's own employer differ from workers without any employer-group health insurance in four important respects. First, workers with employer-group health insurance from a relative's employer have higher family incomes--71 percent live in families with incomes at or above three times the poverty level. Second, they are more likely to be women and to work part time. Third, they are more concentrated in the age cohorts of 35 to 54 years of age. Finally, they are more likely to be employed in the professional services sector.

Self-Employed Workers without Employer-Group Health Insurance

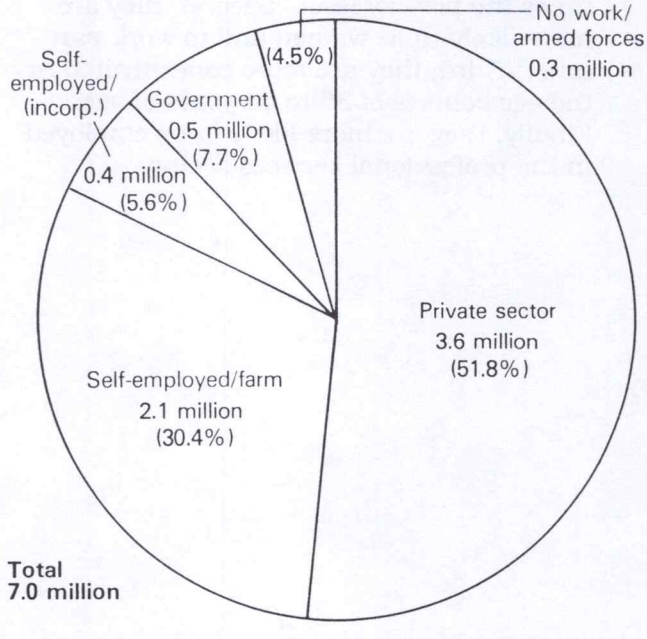
In looking at the 24.2 million workers who do not have employer-group health insurance, it is important to remember that one in five of them are self-employed. Self-employed workers can have employer-group health insurance only if they are members of a "group" (e.g., farmers in a cooperative) or dependents of another family member who has employer-group health insurance. Proposed versions of legislation to require or encourage employers to provide health insurance to employees have provisions for assisting self-employed workers. Therefore, I analyze the characteristics of this group of workers, too.

In 1987, there were 10.5 million self-employed workers in the U.S. labor force. The vast majority (74 percent) of these self-employed workers are either not incorporated or are self-employed on farms. Almost half of all self-employed workers (5.1 million) are without employer-group health insurance, although half of this latter group have nongroup coverage.

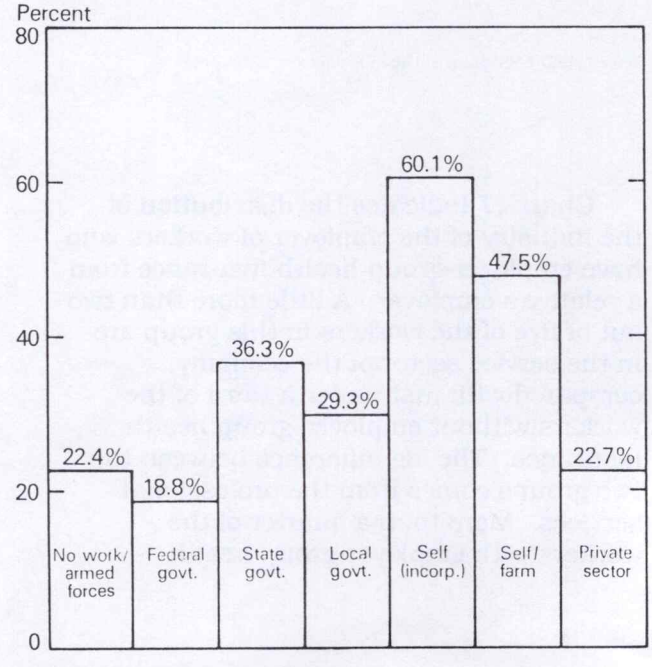
Thus, among the 24.2 million workers who do not have employer-group health insurance, almost 2.5 million are self-employed and purchase their own nongroup health insurance policies. (The 2.5 million represent slightly more than a third of all workers without employer-group coverage who buy nongroup policies.) As chart 18 indicates, self-employed workers are the most likely types of workers without employer-group coverage to buy nongroup policies.

Chart 18 WORKERS WITHOUT EMPLOYER-GROUP INSURANCE WHO HAVE NONGROUP COVERAGE BY SECTOR OF LONGEST JOB IN 1986

A. As Percentage of Total Workers without Employer-Group Insurance who have Nongroup Coverage



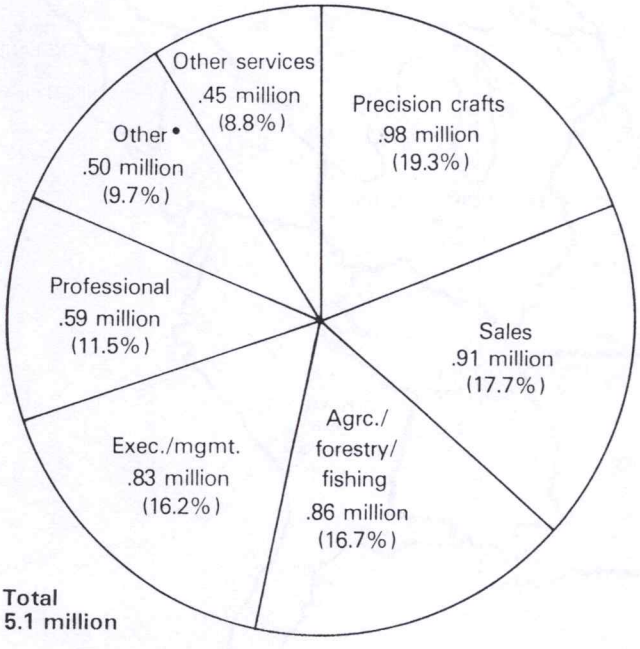
B. Workers with Nongroup Coverage as Percentage of Workers in Job Category without Employer-Group Coverage



Source: 1987 CPS; Swartz, Urban Institute

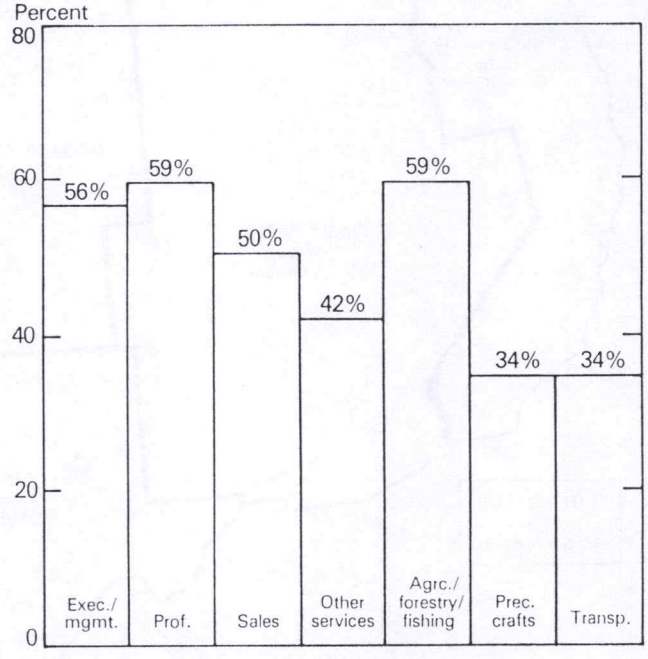
Chart 19. SELF-EMPLOYED WORKERS WITHOUT EMPLOYER-GROUP INSURANCE BY OCCUPATION AND INSURANCE STATUS,1987

A. Occupation Group as Percentage of Total Self-Employed Workers without Employer-Group Insurance



• Transportation, machine operators and handlers/laborers, and technical and administrative support.

B. Percentage of Self-Employed Workers without Employer-Group Insurance in Occupation Who Buy Nongroup Coverage

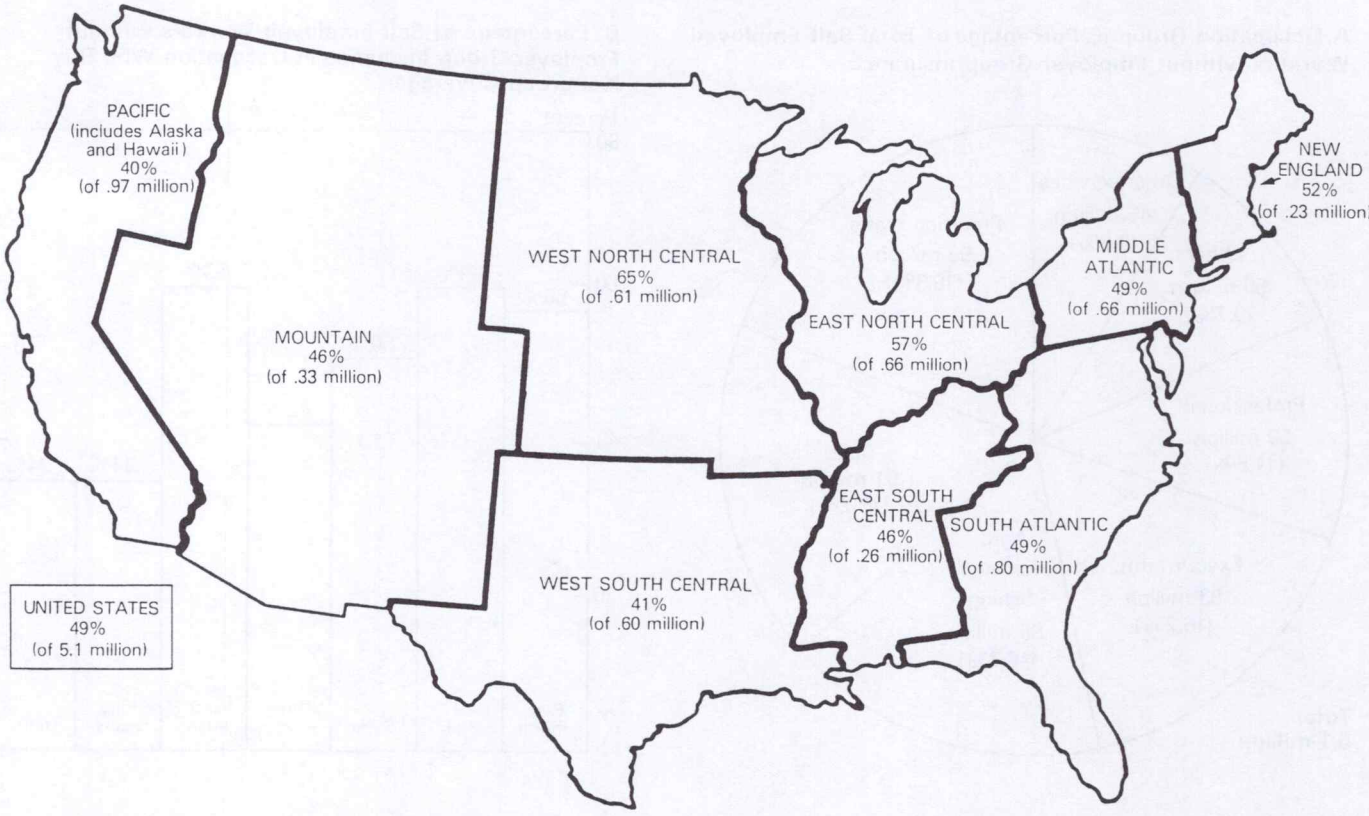


Source: 1987 CPS; Swartz, Urban Institute

Seventy percent of the 5.1 million self-employed workers without employer-group coverage are in four major occupations: executive-administration-managerial, sales, agriculture-forestry-fishing, and precision crafts (chart 19). Among these occupations, only precision craftsmen have fewer than half with nongroup coverage.

Almost a fifth of the self-employed without employer-group coverage live in the Pacific states, with the second largest region for residence being the South

Chart 20 PERCENTAGE OF SELF-EMPLOYED WORKERS WITHOUT EMPLOYER-GROUP INSURANCE WHO BUY NONGROUP COVERAGE BY REGION, 1987

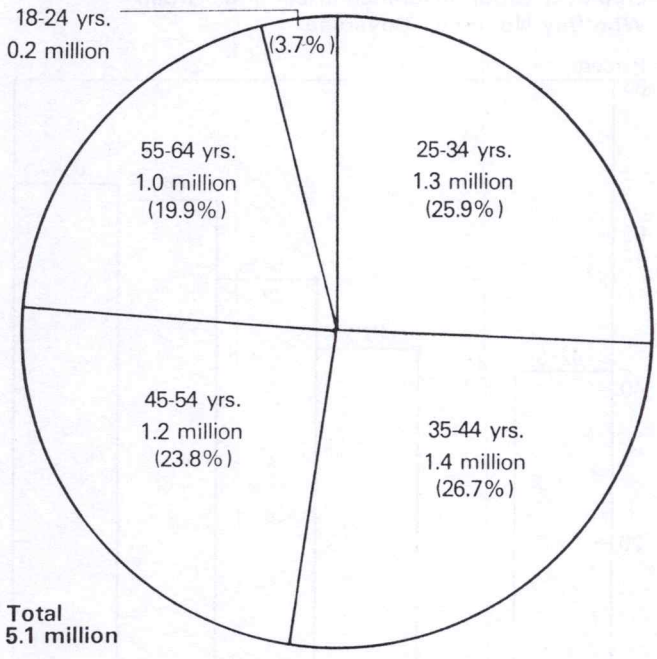


Source: 1987 CPS; Swartz, Urban Institute

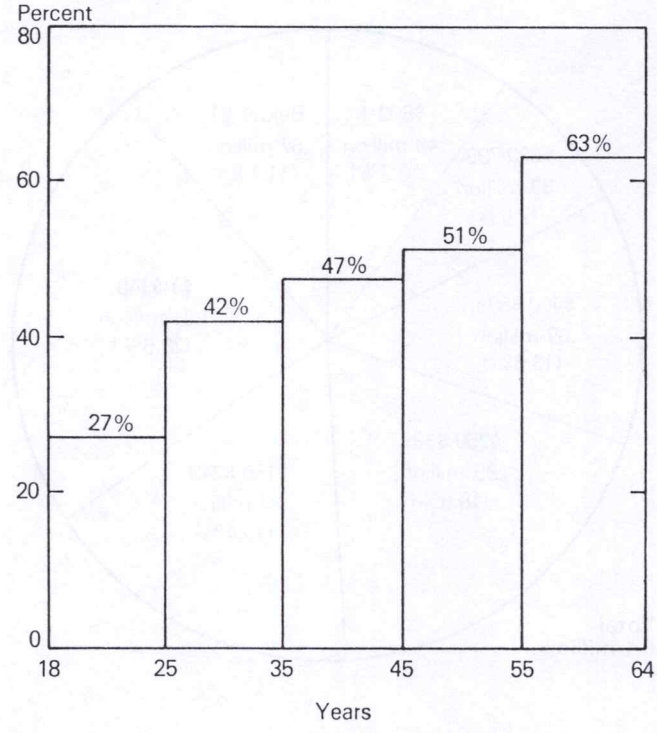
Atlantic (chart 20.) The East North Central and West North Central regions are the two regions with the highest proportion of coverage by nongroup insurance among self-employed workers without employer-group coverage.

Chart 21 SELF-EMPLOYED WORKERS WITHOUT EMPLOYER-GROUP INSURANCE BY AGE AND INSURANCE STATUS,1987

A. Age Group as Percentage of Total Self-Employed Workers without Employer-Group Insurance



B. Percentage of Self-Employed Workers without Employer-Group Insurance in Age Group Who Buy Nongroup Coverage



Source: 1987 CPS; Swartz, Urban Institute

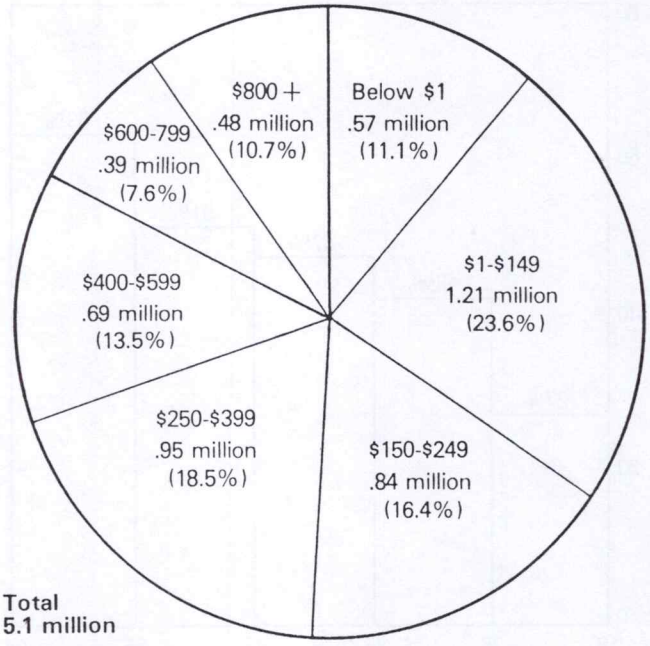
As chart 21 shows, fewer than four percent of the self-employed without employer-group health insurance are younger than 25 years of age. Thus, this group of workers is not predominantly young as is the case with the 24.2 million workers without employer-group coverage.

The proportion of self-employed workers without employer-group coverage who have nongroup coverage rises with age, so that almost two-thirds of the 55- to 64-year-old cohort have nongroup coverage.

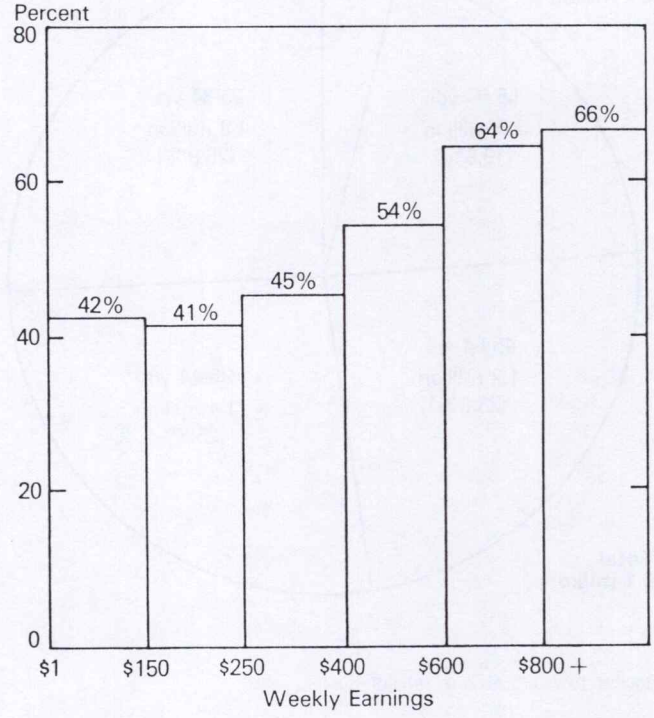
When we look at the weekly wages of the self-employed without employer-group

Chart 22 SELF-EMPLOYED WORKERS WITHOUT EMPLOYER-GROUP INSURANCE BY WEEKLY EARNINGS,1986, AND INSURANCE STATUS, 1987

A. Earnings Group as Percentage of Total Self-Employed Workers without Employer-Group Insurance



B. Percentage of Self-Employed Workers without Employer-Group Insurance in Earnings Group Who Buy Nongroup Coverage

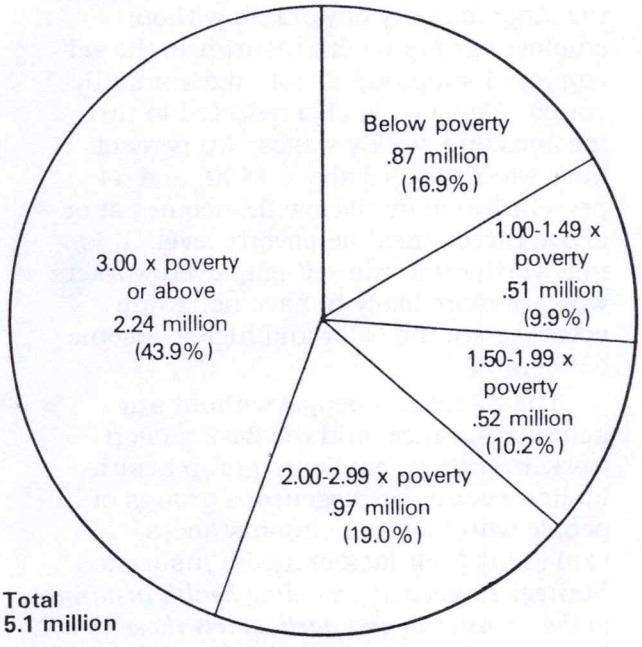


Source: 1987 CPS; Swartz, Urban Institute

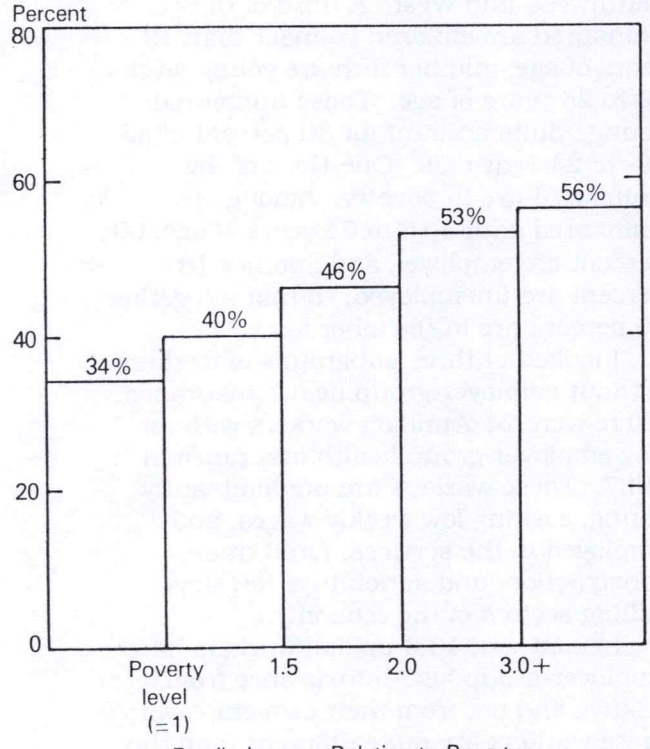
coverage, we find that a third have weekly wages below $150 (chart 22). A third of this group have incomes below $1, indicating that either they did not work in the previous year or they had negative incomes; this may be an accounting phenomenon particular to the self-employed.[13] Thirty percent of the self-employed without employer-group coverage have weekly wages in excess of $400 per week. The proportion of self-employed who have nongroup coverage is above 50 percent only in the groups earning above $400 a week.

Chart 23 SELF-EMPLOYED WORKERS WITHOUT EMPLOYER-GROUP INSURANCE BY FAMILY INCOME RELATIVE TO POVERTY, 1986, AND INSURANCE STATUS, 1987

A. As Percentage of Total Workers without Employer-Group Insurance



B. Percentage of Workers without Employer-Group Insurance in Family Income Group Who Buy Nongroup Coverage



Source: 1987 CPS; Swartz, Urban Institute

Twenty-six percent of the self-employed workers without employer-group health insurance live in families with incomes below 1.5 times the poverty level (chart 23). In contrast, 44 percent of the self-employed workers without employer-group coverage live in families with incomes at or above three times the poverty level. The proportion of workers in each income group who have nongroup coverage increases steadily as family income rises, repeating the familiar story that income is the dominant variable in predicting who has health insurance coverage.

Summary. The 5.1 million self-employed workers without employer-group coverage are older and have higher family incomes than the 24.2 million workers without employer-group health insurance. Half of the 5.1 million self-employed workers buy nongroup health insurance policies, indicating a demand for health insurance coverage. The demand for nongroup health insurance is greater among the older and higher income self-employed workers.

Overall Summary

Thirty-seven million Americans were without any health insurance in 1987. The uninsured live where large segments of the population live, but they represent large proportions of the populations in the South, Southwest, and West. A third of the uninsured are children younger than 18 years of age; another fifth are young adults 18 to 24 years of age. These uninsured young adults account for 30 percent of all 18- to 24-year-olds. One-third of the uninsured live in poverty. Among uninsured adults 18 to 64 years of age, 60 percent are employed and another 10 percent are unemployed, so that altogether 70 percent are in the labor force.

I looked at three subgroups of workers without employer-group health insurance. There were 24.2 million workers without any employer-group health insurance in 1987. These workers are predominantly young, earning low weekly wages, and employed in the services, retail trade, construction, and agriculture-forestry-fishing sectors of the economy.

In contrast, 13.9 million workers have employer-group health insurance from a relative and not from their own employer; these workers are quite different from the first group. They are predominantly women, have higher family incomes than workers in the first group, are more likely to work part time, are more concentrated in the 35- to 54-year-old age cohorts, and are more likely to be employed in the professional services sector. In short, the second group appears to consist of "secondary" workers in a family.

Twenty percent of the 24.2 million workers without any employer-group health insurance are self-employed and therefore are not likely to have employer-group health insurance coverage. However, half of these self-employed workers have nongroup coverage. Because provisions exist in the various legislative proposals to include self-employed workers in insurance pools for small employers, it is useful to understand who among the self-employed do not have employer-group health insurance. Seventy percent of these workers are in four major occupations: executive-administrative-managerial, sales, farming-forestry-fishing, and precision crafts. Almost a fifth of the self-employed without employer-group coverage live in the Pacific states, with the second largest group living in the South Atlantic states. Unlike the large majority of workers without employer-group health insurance, the self-employed subgroup is not predominantly young. This fact is also reflected in their incomes and weekly wages: 30 percent have weekly wages above $400, and 44 percent live in families with incomes at or above three times the poverty level. It is noteworthy that the self-employed workers who are more likely to have nongroup coverage are the older and higher-income workers.

The 37 million people without any health insurance, and the 24.2 million workers without employer-group health insurance, are heterogeneous groups of people with different circumstances explaining their lack of health insurance. *Strategies aimed at providing health insurance to the uninsured, and particularly those strategies that focus on health insurance as a fringe benefit of working, need to take account of the diversity of people who are the targets of the strategies.* The advantage of a strategy centering on employers is that it will assist a majority of the uninsured; no other strategy does that. However, such a strategy must make provisions for the self-employed and small employers, or it will not assist nearly as many people as might be expected on first examination of the uninsured.

Similarly, from what we know now about the differences between workers without any employer-group health insurance and workers who have employer-group coverage through a relative's employer, it is clear that a strategy focusing on employers must take account of the fact that we do not know why some workers don't have employer-group health insurance from their own employer. It appears that many of the 13.9 million workers who have coverage from a relative's employer are "secondary" workers, and may prefer to have only one employer-group

policy for the entire family. Just as employers are sensitive to paper-work burdens imposed by government agencies, families also may not wish to deal with more than one insurance company's requirements for reimbursement. This desire may be particularly strong as family heads age.

Notes

1. Sources: 1970s, Sulvetta and Swartz (1986); 1987, author's tabulations from the March 1987 Current Population Survey.

2. Swartz (1989).

3. Wilensky, Walden, and Kasper (1981); Robert Wood Johnson Foundation (1983).

4. Swartz (1989).

5. In 1948, in a case involving Inland Steel Corporation, the Supreme Court ruled that benefit plans did come under the Wagner Act and the Taft-Hartley Act phrase "conditions of employment." This decision marks the beginning of the rapid growth in employment-based health insurance in the U.S. See also Starr (1982) for further commentary on the history of health insurance coverage.

6. Swartz (1989).

7. Swartz (1984).

8. Ibid.

9. This evidence contradicts the frequently seen analyses of two or three variable tabulations with race and health insurance coverage. See, for example, Long (1987) and Davis and Rowland (1983).

10. Twelve percent of workers without employer-group health insurance worked 17 hours per week or less, and another 7 percent worked 18 to 20 hours per week.

11. The Chrysler Corporation and American Airlines, for example, have argued that they are carrying too much of the burden for health insurance of their employees' employed dependents. (Testimony by R. Crandall, President and Chairman of American Airlines, and W. Maher, Director of Employee Benefits of Chrysler Corporation, before the Senate Labor and Human Resources Committee, June 24, 1987. [Senate Hearing 100-376]). Others have argued that the employees could pay for the premium portion for their dependents' health coverage.

12. Eleven percent of these workers worked 18 to 20 hours per week, and another 14 percent worked 17 hours per week or less.

13. That is, the self-employed may be more likely to have businesses that lose money in any given year.

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Health Care
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Ways to cut America's health bill

by Joseph A. Califano Jr.

Joseph Califano, Jr.

This year, Americans will spend $660 billion on health care, up from $550 billion in 1988. At least $60 billion of this amount will be financed by state and local governments. Spending is climbing so fast that by year's end, Americans will break the $2 billion-a-day barrier in health care spending.

Most troubling, the evidence is overwhelming that at least 25 percent of the money Americans spend on health care is wasted. And those wasted billions would be more than enough to fill the gaps and provide all the health and long-term care our people need.

After a decade of trench warfare over health care costs, shell-shocked combatants — hospital administrators, doctors, nurses, insurers, employers, government bureaucrats, state legislators and patients — have a sense that they are winning some battles but losing the war.

According to a former secretary of Health, Education and Welfare, Americans are not receiving their money's worth under the current health care system.

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have a sense that they are winning some battles but losing the war.

The battles won, however, have not been insignificant. Medicare's system of paying hospitals pre-set amounts based on the patient's ailment rather than picking up whatever tabs hospitals submit has cut admissions and lengths of stay. Since enacting this change in 1983, Medicare has logged savings of at least $25 billion. Businesses also have saved money by making changes in their health care plans. For example, from 1982 through 1988, Chrysler Corp.'s health care costs increased just as they had for most U.S. businesses. Chrysler spent $1.3 billion less for health care than it would have if its costs had risen at the same rate as other businesses.

That's the good news for taxpayers and Chrysler shareholders. But the bad news for taxpayers is that Medicare spending is rising so rapidly it will top $600 billion and . . . top the cost of Social Security just after the year 2000. The bad news for Chrysler shareholders is that the company is facing a 12 percent run-up in 1990 health care costs, more than twice the expected rise in the consumer price index.

With cost pressures so great and results so mixed, it was inevitable that some health care buyers would invoke the specter of rationing and triage. Oregon and Alameda County, Calif., are planning to ration care for the poor.

Others scramble to shift health care costs to someone else. The feds dump more Medicaid costs for poor patients on states, and more health care costs for elderly retirees on large employers. Employers, frustrated by diminishing returns on their managed health care plans — such as

HMOs or other plans where the appropriateness of health care is reviewed before services are rendered – dump costs on their workers and retirees. Insurers try to dump costs back on the federal government.

But wallowing in the despair of rationing and tossing the hot potato of costs to the next guy are unconscionable cop-outs. This year, we are spending $165 billion, including at least $30 billion of the taxpayers' money, for tests and treatments that will have little or no impact on the patients involved.

What are we buying for all those billions?

• **Excess hospital capacity.** Hospital occupancy rates have been hovering at just over 60 percent nationally for the last three years. Despite the unprecedented pressures of excess capacity that would force any other business to cut back, close down or slash prices, the number of hospital beds actually increased by 21,000 between 1981 and 1987. And, in 1989, hospital room prices jumped 11 percent. That was the largest hike since 1982.

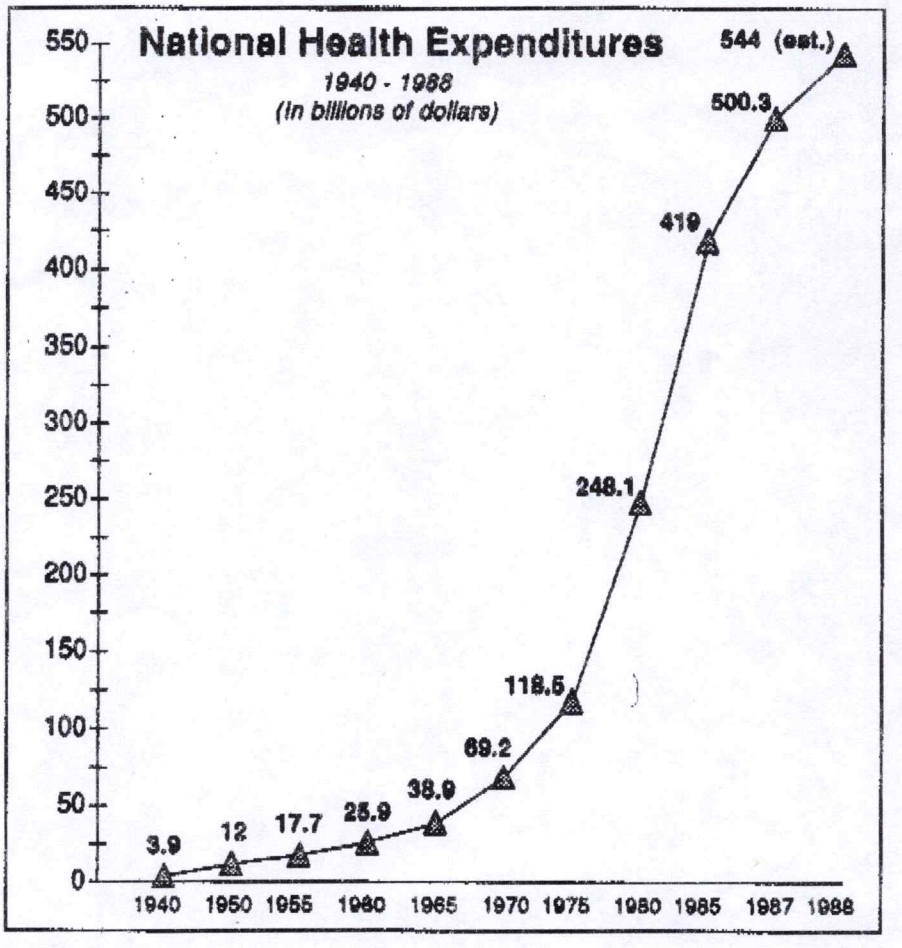
• **Millions of unnecessary procedures.** There is growing consensus among medical experts that half the coronary bypasses, most Cesarian sections and a significant proportion of many other procedures, such as pacemaker implants and hysterectomies, are unnecessary. A former editor of the *Journal of the American Medical Association* is convinced that more than half of the 40 million medical tests performed each day "do not really contribute to a patient's diagnosis or therapy."

• **A medical malpractice protection racket.** Doctors and hospitals paid at least $8 billion in malpractice insurance premiums in 1987. Malpractice insurance costs for each baby delivered were $572 in New York and $448 in Oregon. Less than half of these premium dollars ever get to injured patients; almost 60 percent of them go to lawyers, insurers and the courts.

Moreover, insurance premiums are the smallest part of the cost of the medical malpractice system. To protect themselves in case of a lawsuit, doctors perform millions of useless tests and procedures, at an annual cost estimated at $20 billion.

• **Frenetic and increasingly expensive paper and computer chases.** America's health care system is the world's most expensive to administer. We spend $100 per person in administrative costs compared to $21 in Canada. The growth of efforts to screen and track every procedure, prescription and physician has made it more important for doctors and hospital administrators to master the manipulation of accounting and regulatory practices than to master medicine.

Most ominously, the explosion of paperwork is discouraging some of our best young minds from entering medicine and encouraging top specialists to retire early.



What isn't America buying for all those millions?

• **Not better health care.** The $2,600 that will be spent this year for each man, woman and child in the United States is 50 percent more than will be spent in the next highest spending nation, Canada; more than twice Japan's health care spending and almost triple Britain's. Yet each of these nations had lower infant mortality rates and similar longevity.

• **Not care for the neediest citizens.** From 1981 to 1988, while the cost of Medicaid more than doubled, to $55 billion, the number of people participating remained virtually unchanged. And America's enormous expenditures do not buy health care for some 37 million uninsured citizens, most of whom work or are dependents of workers.

• **Not public satisfaction.** A recent survey found that 89 percent of Americans believe the health care system needs fundamental change.

What can we do?

• **Subject patients only to treatments that work.** It's time for a rigorous effort to establish what procedures produce beneficial out-

comes under what conditions. That means leadership and funding for Medicare and cooperation from America's physicians to set standards of care.

There is increasing evidence that such standards change physician conduct. In Maine, a group of pediatricians was told its hospital admissions rate was 250 percent higher than the lowest rate in the state. They cut such admissions almost in half within three years.

At four Utah hospitals, medical researchers found that average lengths of stay for prostatectomy ranged from 2.7 to 4.9 days with no difference in outcome. Feedback to surgeons on these practice variations reduced the average length of stay by two days.

America's health care system is the world's most expensive to administer. We spend $100 per person in administrative costs compared to $21 in Canada.

• **Revamp the medical malpractice system.** Medical professionals should be held accountable for negligence and incompetence, but not for disappointment and grief over events only God can control. States should limit the amount of financial recovery to modest payment for pain and suffering, as in California and elsewhere; link legal damages to costs of health care and compensation for lost income and lingering disability; and sharply reduce contingent legal fees. Federal Medicaid contributions should include incentives for reform of medical malpractice.

• **Take better care of ourselves.** Two-thirds of all disease and premature death is preventable but only if we recognize the responsibility to take care of ourselves. The priorities are obvious: quit smoking, stick to proper diet, control drinking alcohol, stay away from drugs, exercise, learn to handle stress and take preventive measures such as regular checkups.

• **Close excess hospital beds.** Hospitals are harder to close than post offices. But doctors, hospital administrators, community leaders and politicians must honestly access regional health care needs and eliminate unneeded hospital capacity or convert it to new uses, such as long-term care.

• **Stop playing the health care cost shell game.** It's time to stop the cost shifting. Merely shifting health care costs from government to employers does not reduce total costs, and makes it even more difficult for American industry to compete in the world marketplace. Proposals before Congress to increase Medicaid payments to states that adopt managed care systems would be a cost-saving step. In the future, caps imposed by Medicare should be coordinated with the states and the private sector to prevent cost shifting.

• **Dramatically reorder medical research priorities and direct money to the United States' two largest problems: aging and addiction.**

The key to an economically viable long-term care program is to reduce the number of people who need such care and the length of time they need it. We need a massive effort, a project independence for older Americans to reduce and, for many elderly, eliminate the chief threats of their independence. A project independence research program should focus on at least three areas: incontinence, mental disorientation and immobility.

The payoff of project independence for older Americans is enormous. Each reduction of one month in the period of dependence for citizens over 65 means a savings of $4 billion in health care and custodial costs.

The other major reordering of medical research priorities involves addiction.

The economic cost of addiction easily exceeds $300 billion in health care, disability payments, lost productivity, accidents and crime. Yet the federal government's research effort amounts to only $500 million out of a budget of $7.2 billion.

America needs a national institute of addiction in the National Institutes of Health. Such an institute would combine the research work of the National Institutes of Drug Abuse and of Alcohol Abuse and Alcoholism, and conduct research on all substance abuse and multiple addiction, including cigarette smoking. Creating one national institute for all addiction would help generate a steady stream of money for research, make clear our national commitment and attract the best minds.

The alternative to action on these fronts is a grim future. Many workers and retirees will lose their employer-based coverage or have it drastically reduced; Medicare beneficiaries will wait in line for lower-quality care; millions of citizens will continue to be denied access to basic health care; millions more will fall victim to addiction; and only the wealthiest Americans will be able to afford long-term care.

This future is not a fantasy and it's not far away. Fortunately, the money needed to avoid it is already allocated to health care. We need only spend that money wisely. If we do, we can provide higher quality health care for all our citizens at the same price we're now playing to provide a declining quality of care for some. □

(A) = Enrich services

(B) = Info campaign

(C) = increase use + participation in prenatal care

COST-EFFECTIVENESS	TARGETING AT-RISK POPULATIONS	PUBLIC OPINION	COMPREHENSIVE	PROGRAM EFFECTIVENESS
Enriching services; Smoking cessation; Drug treatment / National and school education campaign	In 20 to 50 areas: - expand access - one stop shopping/ presump elig, etc. - enriching services - info campaign	- Medicaid for all - Smoking/drugs/info campaign	-Access -Increased use of prenatal services. -Enhanced content -National and school info campaign.	- one-stop shopping with program simplification, presumptive eligibility - enhance content (smoking, drugs) - national + school information campaign
A + B	B + C	A + B	A + B + C	A + B + C
cost-eff is sole criteria	20-50 worst places	What people tell pollsters they worry about	Do it all.	not expanding 'caid population → not getting care we hoped for.

ELEMENTS

1) Enriched services REALLY... appropriate services for needs of women.

Smoking cessation → no insurance plans cover.

Drug abuse programs

? Counseling, nutrition, education, potentially a home visit, treatment of risk factors (asthma)

Target communities

- Lack of infrastructure to provide reimbursable service.

2) Expand financial access to care

- OPTION A: If you go into clinic, appropriate referral.

1115 waivers

outright expansion of Medicaid

- CASE MANAGER

3) Increase use of and participation in prenatal care

One-stop shopping

Program simplification

Presumptive eligibility

Case-management

Increase provider participation in Medicaid

4) National and school information campaign