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Approaches to Financing Care for the Uninsured

S. E. Berki, MA*

About 1 million people in Michigan, or 10% of the state's population, have no health care coverage, whether private or public. A much larger percentage has inadequate insurance, which is defined as not having coverage sometime during the year or having insurance that does not cover ambulatory care costs.

Of those in Michigan who have no health insurance coverage, 47% are employed either full- or part-time. Among those who are 18 years of age or older, 67% are employed either full- or part-time. About 28% of all the uninsured are people under age 18 years.

Health insurance coverage varies significantly by industry. The rates for those who have no coverage are 32% in the repair industry, 31% in personal services, 26% in agriculture, 24% in construction, and 3% in manufacturing.

To a great extent, the issues related to the lack of health insurance are issues of poverty and of urban poverty. More than half (53%) of the uninsured population in Michigan live below 150% of the poverty level, and 81% live in urban areas.

Thus the great bulk of the poor, working or nonworking, uninsured population is concentrated in the major cities. While one aspect of the urban health care problem is that a large number of poor people have no coverage, an additional aspect is the inadequacy of Medicaid payment rates.

Consequences for the uninsured are seen primarily in terms of access; for providers, the consequences appear as uncompensated care; for employers who do provide coverage, the consequences are felt in terms of cost-shifting. About 15% of the cost of health care coverage paid by employers who do provide insurance is a hidden tax in payment for those who are not covered.

Approaches to the Problems of the Uninsured

To assess the nature and magnitude of this problem, two years ago the Governor of Michigan established the Task Force on Access to Health Care. The Task Force includes representatives of all major interest groups, including big and small businesses, as well as individuals who represent the Governor. In fact, the two co-chairpersons of the Task Force are the Secretary of the Department of Social Services and a vice president of one of the automakers. A number of economists and researchers

worked with the Task Force in gathering data and in developing options. After several false starts, the Task Force decided to consider three types of approaches to deal with the problems of lack of coverage.

The first approach was much like Senator Edward Kennedy's (D-Mass) plan in which all employers, except some very small and high-risk businesses, would be required to provide a fairly comprehensive level of health care benefits. This would be combined with a publicly subsidized plan to cover others under 200% of the poverty level.

The second approach was a less comprehensive, voluntary approach, of which one component would encourage parents of children living at or below 200% of the poverty level to buy into Medicaid for their children. The state would fully subsidize families with incomes up to 100% of the poverty level, and families with incomes over 100% of the poverty level would pay a graduated premium based on their income. In this kind of patchwork, voluntary approach, small businesses would be encouraged to participate in risk pools which might be subsidized, although to what extent is not yet clear.

The third approach involves a universal, publicly financed insurance plan that would provide comprehensive benefits to all Michigan residents. This state plan would be somewhat similar to the Canadian model.

The Task Force quickly eliminated what Senator Kennedy is now proposing. Wisely so, in my opinion. Mandating benefits increases labor costs which results in increasing unemployment, particularly at the state level and among small businesses. Depending on how this type of approach is structured, there would also be a shift from full-time to part-time employment, although that might be overcome in a variety of ways. In addition, mandating benefits does nothing to eliminate uncompensated care or to mainstream Medicaid, and it maintains all of the difficulties and the problems that are associated with Medicaid. It does nothing to improve the business climate in terms of domestic or

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foreign competition, and it does nothing for cost containment except perpetuate the failure of certain types of approaches.

The second approach, the patchwork, voluntary approach which includes the "kiddie plan" for the poor, insurance pools for small businesses, and managed care plans, is not much better. It would be some improvement for extremely poor children but would do nothing or very little for the 500,000 people who are uninsured and unemployed. Small businesses would have to act against their own best interest to buy into these pools, because they would voluntarily have to increase their labor costs. Unless they have to increase these costs, we have little reason to expect that the majority would do so, unless they faced a tight labor market. This approach would do nothing for those who are not in the labor force, the poor, and the near poor who are neither employed nor qualify for the current welfare programs. It would also do little to reduce the need for cost-shifting because it would retain the current inequitable level of Medicaid payment rates. This approach does have one major advantage: it would cost very little to the state. In fact, in Michigan this kind of a plan could be paid for by increasing some "sin" taxes, essentially those on cigarettes and alcohol.

The need for reform in the health care system is widely accepted. We may not agree on the methods, but we do agree on the outcomes of assuring access to quality services, stopping cost escalation, preserving the best aspects of our present system, compensating providers fairly, and maintaining freedom of choice and private initiatives.

The third approach, the universal health insurance plan, is based on four principles. First, it would provide a comprehensive benefit package to all residents in the state. Second, it would uncouple health insurance from employment and shift financing from the employment base to a broad tax base. Third, it would fold existing public programs into a single statewide program and eliminate the kind of invidious distinctions and the stigmas currently associated with welfare health care programs, such as Medicaid and county programs. Fourth, it would have effective cost containment built into it.

In my opinion, the principal lesson of the Canadian experience is that universal access is affordable only if effective policies for health cost containment are in place.

Approaches to Cost Containment

The need for reform in the health care system is widely accepted. We may not agree on the methods, but we do agree on the outcomes of assuring access to quality services for everyone who needs it, stopping cost escalation by improving efficiency and eliminating waste and redundancy, preserving the best aspects of our present system by relying on the private delivery of services, compensating providers fairly, and maintaining free-

dom of choice and private initiatives. However, without effective policies to contain costs, neither the private nor the public sector can afford equitable access to health care for all.

Cost containment has traditionally been targeted on demand, based on the economic theory of traditional markets, even though none of this theory's assumptions fit the health care sector. Increasing the financial burden on consumers has until recently been the major thrust of both public and private policies to contain costs. Increasing deductibles, copayments, and coinsurance was expected to reduce cost escalation by making people more cost-conscious and thus more careful consumers. The evidence is overwhelming that this does not work. This year we'll be spending about 12% of our gross national product on health care, which is strong testimony to the failure of these approaches to cost containment.

The demand approach to cost containment fails basically for one key reason: to be effective in reducing expenditures, it is not enough to shift cost from one pocket to the other; to reduce expenditures we must reduce either the use of services, or their prices, or both. By reducing or even containing either utilization or price, providers' incomes are inevitably reduced because, just as in every other business, their incomes are determined by services sold and the prices of these services. When sellers can largely determine which services to sell, in markets which are rife with ignorance, fear, and dependency on the demand side, and which are characterized by uncertainty and the lack of outcome standards on the supply side, there are ample opportunities to maintain or increase incomes by selling more and more technically sophisticated services, particularly during a period when medical technology, medical science, and medical knowledge are increasing rapidly. Indeed, only when the bankruptcy of this kind of a demand approach became obvious did cost-containment advocates begin to consider constraints on supply. After a half-hearted and eventually abandoned initiative at regional planning, the supply-side approaches to cost containment took one of two forms: changing financial incentives or micro-managing providers.

Medicare's prospective payment system (PPS) and the large-scale introduction of health maintenance organizations (HMOs) were designed to upend the financial incentives dominant in the fee-for-service market. Providers would do better not by providing more services but by providing less. In an HMO setting, reduced hospitalization rates, reduced use of sophisticated and expensive diagnostic techniques, and reduced referrals increase incomes. For hospitals with patients on the PPS, reduced services, fewer services, and shorter lengths of hospitalizations reduce costs and therefore increase net revenues.

In the fee-for-service system, supply-side cost containment took the form of micromanaging individual physician decisions. Mandatory second opinions, precertifications, recertification, managed care, gate-keeping, and concurrent review all are intended to reduce utilization by constraining individual physician decisions with respect to individual patients. These constraints on physicians, which encourage patients to seek second or even third opinions and which undermine the trust in the patient/physician relationship, should make none of us surprised by the increasing rate of malpractice litigation.

Neither changing incentives nor micromanaging has been successful. Expenditures for physician services have been rising more and faster in the last three years than ever before. HMO costs, while somewhat lower than fee-for-service costs, have been rising at a similar, sometimes faster rate. The downturn in admission rates and the reduction in lengths of inpatient stay have about leveled off, while services rendered in hospitals are increasing. Clearly, effective cost containment must take a different approach. Demand-side approaches to containing costs have failed, and cost-shifting does not work. We need a new and different approach.

By eliminating the burden of uncompensated care, both the need for and the possibility of cost-shifting by hospitals, and underpayment by Medicaid, an all-payer system increases access to care by the poor and uninsured while simultaneously removing the threat of financial disaster from hospitals.

Effective cost containment must address both the stock and supply of services as well as the flow of services. The capital stock and the incentives inherent in the payment system influence the rate at which capacities are used. Cost-containment policies have to be designed to limit and rationalize the rate of growth of capital, both materially and physically, that is, in the supply and specialty distribution of physicians. However, no matter how effective these policies are, they are going to be effective only in the long run. In the short run, we need effective policies that rely on uniform payment rates and expenditure targets as well as reforms of certain incentives that now encourage excessive use, such as a reform of medical malpractice liability litigation.

The basic aspect of uniform payment rates is the establishment of all-payer systems. Hospital all-payer systems, such as the one in New Jersey, pay at the same rate for all patients within a given diagnosis-related group, regardless of the source of payment. Whether Medicare, Medicaid, Blue Cross and Blue Shield, or Aetna is responsible for the patient's bill, the hospital receives the same level of payment. This helps to mainstream Medicaid because its payment rate becomes the same as everyone else's.

A most important component of all-payer systems is an uncompensated care pool: a statewide pool, possibly subsidized, essentially financed by a surcharge on all third-party payers, covers payment to the hospital for uncompensated care and thus basically eliminates uncompensated care in hospitals. By eliminating the burden of uncompensated care, by eliminating both the need for and the possibility of cost-shifting by hospitals, and by eliminating underpayment by Medicaid, an all-payer system increases access to care by the poor and the uninsured while simultaneously removing the threat of financial disaster from hospitals which would otherwise bear the overwhelming burden of uncompensated care.

A similar all-payer system can be designed for physicians.

We have developed such a plan for Michigan. The problem is that effective implementation of this strategy requires that there be a single payer. Having a single payer for the entire system could also potentially provide significant administrative cost-savings. A single plan reduces administrative costs in two ways. First, it reduces the administrative costs of health insurance itself. We estimate that the administrative costs in health insurance could be reduced from the current national level of 14.3% to probably about 6% or even lower. Currently, 6% is about double the rate of the administrative costs of Medicare. By going to a single-payer system, we have estimated that Michigan alone could save about \$500 million a year in direct administrative costs. Second, the current health insurance system has a welter of overlapping, inconsistent billing systems, reporting requirements, exceptions, eligibility certifications, etc., which impose an indirect cost of administration on the delivery organization. These indirect administrative costs imposed by the current system of insurance on delivery organizations amount to about \$900 million annually in Michigan.

Transforming the Health Care System

Once such cost-containment mechanisms are in place, some problems of access will have been solved by reducing the problems of uncompensated care and the Medicaid mainstream differential. Once this is achieved, we can begin the second phase which is decoupling insurance from employment. This may be a difficult problem, but it is not an impossible problem.

If it were possible simply to eliminate current employer contributions by converting them into wages at one time, the Federal Treasury would receive an income-tax windfall because incomes would go up an estimated \$1 billion per year in Michigan alone. Employers currently providing health insurance benefits would also receive a windfall because they would have simultaneously removed not only the current costs but also the future costs of health care for their employees. Employers not providing health care benefits would also receive a windfall because they should be able to escape what is essentially their fair share of the social costs of health care.

We have developed a transition plan to eliminate these inequities. A transition tax would be imposed on businesses, and a graduated income tax would be introduced simultaneously. Whether called the health security tax or the health security fee, it is a tax, which most people, certainly the lawmakers in Lansing, would recognize. However, this income tax would begin at a fairly nominal level. Over several years it would begin to pick up the entire cost of the health insurance plan. Obviously, other scenarios are possible, but clearly reliance on "sin" taxes is not enough since the entire cost of health care cannot be raised by increasing taxes on cigarettes and alcohol. Other possible plans would rely more heavily on sales and business taxes.

It is important to remember that we are not talking about *new* costs but about transforming the cost base from employment and existing public programs to a broad tax base. These are not additional costs. In fact, if the proposed cost-containment approaches were introduced, the total cost would be less under the

public or universal plan than under the current system, which in 1987 dollars would save about \$45 billion in ten years in Michigan alone, not counting inflation. Most would say that this is impossible. However, if our health care cost patterns were to follow that of the Canadians, we would be spending 22% less than we do now. In 1989, this would total \$130 billion nationally. While we are similar to the Canadians in terms of living standards, cultural patterns, demographics, and health status, Canada spends about 8.6% of its gross national product on health care whereas we spent about 12% in 1989. Yet the Canadian system provides comprehensive benefits universally for everyone, with little cost-sharing.

Publicly financed insurance that provides comprehensive benefits for everyone is not the solution to all of our urban problems. The crisis in the emergency room, the pregnant teenager who sees the doctor for the first time an hour before she delivers, the second heart valve replacement for the intravenous drug addict, the patients with the acquired immunodeficiency syndrome, most of whom are likely to be uncompensated care cases anyway, all present major problems. The health care system must deal with some manifest consequences, but it cannot solve by itself the underlying social problems—the drug epi-

demio, unemployment, poverty, breakdown of the nuclear family, and violence.

These problems, or perhaps this syndrome, could be characterized as hopelessness and helplessness. A health care system cannot deal with that, but we can help ameliorate at least some of its effects by assuring access to everyone on an equal basis, regardless of a person's economic circumstance, while simultaneously not bankrupting the providers or forcing them to flee the city because they bear too much of the financial burden. The cities themselves are badly in need of fundamental social change, and some of the change must be economic.

The types of approaches which are being considered by the Governor's Task Force on Access, as well as those being considered in Washington, DC, are band-aids. They do not address the fundamental causes of urban health care problems crushing the health care system and offer neither the hope nor the resources needed to provide adequate access to all who need it. If the economic and social health of the cities continue to deteriorate in the 1990s, further increasing the stresses on the health care system, the day will come when we will look back on these band-aid approaches and recognize them to be what they are, the futile results of the lack of political courage.