WINNERS AND LOSERS IN REFORMING THE U.S. HEALTH CARE SYSTEM

Selected Papers and Discussion from the October 1990 EBRI-ERF Policy Forum

"Proposals for reform of the U.S. health care system require that some groups be made worse-off so that others benefit."
—William Custer, Employee Benefit Research Institute

"(Large) employers probably would not be seriously affected by mandated insurance, especially if the policy is sensibly announced in advance, so adjustments can be made."
—Stephen Long, Rand Corporation

"Workers without health insurance would pay the bulk of the costs of mandated health insurance."
—Michael Morrissey, University of Alabama at Birmingham

"One of the reasons we seem to have the problem of the uninsured is rapidly rising cost. And, yet, we are focusing our attention on two things—mandates and expanded Medicaid—both of which add considerable demand to the entire market process. So, we're sitting there with a problem that we're going to exacerbate to stop another problem, and in my judgment that doesn't make a lot of sense."
—William Dennis, National Federation of Independent Business

"Any discussion of cost is nonsensical unless you also ask the question of value. In other words, what is it you are buying and getting for this cost?"
—John Rother, American Association of Retired Persons

"In the view of the American Medical Association, access to essential health care of high quality should be a right of all Americans."
—Dr. John Ring, American Medical Association

"If we're going to make progress we have to expect institutions to change. You don't wrest change through glib changes in economic rules if you don't look clearly at how institutions will respond to those rules."
—Carl Schramm, Health Insurance Association of America

"We simply cannot afford to sustain the percentage of Gross National Product going into health care relative to everything in the country. There are a lot of other industrialized countries that have lower rates of [health care cost] inflation than ours. They seem to be providing universal access with far less technology and different kinds of use patterns than we have. I don't think we should continue to put so much money into a system that is simply crowding out too many other resources that we have to address, particularly in education and other issues."
—Karen Ignagni, AFL-CIO
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In October 1990, the Employee Benefit Research Institute (EBRI) and its Education and Research Fund convened a policy forum to explore the issue of reforming the U.S. health care system. The forum, *Winners and Losers in Reforming the U.S. Health Care System*, brought together representatives from government, business and industry, special interest groups and the health care field to discuss five generic reform proposals and their potential impact on the government, insurance industry, health care providers employers, and consumers. This report integrates some of the material presented at the forum including the papers presented by Stephen Long, a senior economist with the Rand Corporation, and Michael Morrissey, a professor in the Department of Health Care Organization and Policy at the University of Alabama at Birmingham. Previous EBRI activities relating to health care in the United States helped to formulate the discussion at the Fall 1990 Policy Forum (A complete list of EBRI publications about health care is located in the back of this report.).

The views expressed in this report are solely those of the forum participants. They should not be attributed to the officers, trustees, members of EBRI, its staff or Education and Research Fund.

Dallas L. Salisbury
President
Employee Benefit Research Institute

June 1991
Executive Summary

The U.S. health care system performs miracles daily. Patients who would not have survived 20 years ago recover today to lead active lives. Imaging technologies permit diagnoses that would have been possible only through surgery a few years back. Genetic defects are corrected while a fetus is still in the womb.

Yet, in spite of these miracles—or perhaps because of them—the U.S. health care system faces tremendous challenges, with mounting calls for reforms to cope with rising costs, concerns about quality and the increasing number of Americans without health insurance protection.

Health care costs have been climbing twice as fast as general price inflation for more than a decade. Aggregate measures of health, such as life expectancy and infant mortality, are no better in the U.S. than in countries that spend far less per capita on health care. Between 20 percent and 40 percent of selected medical procedures may be performed unnecessarily. More than 34 million Americans lack health insurance and must endure limited access to health-care services.

The problems, moreover, multiply and feed on each other. Because of rising costs, health insurance grows more expensive for both private and public payers. As a result, coverage is reduced. Simultaneously, public and private efforts to control costs limit the ability of providers to offer uncompensated service to the poor and unprotected. Many argue that the mix of health care services offered is not the combination that a fully informed consumer would want. Nor is this service provided at a minimum cost.

Proposed solutions for the problems range from essentially fine-tuning the market through tax or regulatory policy to the suggestion that the market is an inappropriate way to allocate health care resources.

On October 4, 1990, the Employee Benefit Research Institute-Education and Research Fund convened a policy forum to consider the “Winners and Losers in Reforming the U.S. Health Care System.” Five generic proposals developed by the Institute of Medicine were evaluated for their impact on the uninsured, employers, insurers, providers, taxpayers and society at large. These proposals are:

**Employer-mandated insurance.** Under this proposal, the government would require employers to either offer health insurance to their employees or pay a special tax. Suggested plans vary by eligibility, the size of companies required to participate and the value of the benefits that would be mandated.

**Universal Health Insurance.** Considered at the forum were features of the Canadian system that might be adapted for the U.S., including federally centered financing and negotiated fee schedules. The aim would be to create a payer, either the government or a regulated insurance industry, that would have the market power to exert downward pressure on costs.

**Medicaid Expansion.** This approach would selectively adjust eligibility criteria to include children and pregnant women, and perhaps the working poor and medically uninsurable who might be required to make a small contribution. Medicare also might be extended.

**Publicare.** Built on the premise that broad financing reforms are unlikely, this strategy would strengthen the public hospitals, community health centers, public health departments and voluntary institutions that now provide large volumes of care as a charity service or under government contract.

**Market-based reforms.** Tax incentives and deregulation are key elements of this proposal to encourage an open and competitive market with a minimum of government intervention and a maximum effort to foster consumer cost-consciousness. The needy would be assisted by a reformed Medicaid program or a voucher system to help them purchase insurance.

This report begins with an introduction by William S. Custer of the Employee Benefit Research Institute.

On the following pages are excerpts from the comments and observations made by a distinguished group of commentators representing a wide variety of views and constituencies on the nation’s will to change.

Next come the assessments presented to the forum by Stephen Long, a senior economist at the Rand Corporation and Michael Morrisey, a professor in the Department of Health Care Organization and Policy at the University of Alabama at Birmingham.
Introduction
by William S. Custer, EBRI

The health care delivery system in the United States has performed a number of miracles. People who would not have survived illnesses 20 years ago are recovering to lead active lives today. Diagnoses are being made with information provided by imaging technologies that would have only been available through surgery just a short time ago. Genetic defects are being repaired while the fetus is still in the womb. Yet, in spite of these miracles (and perhaps as a result of these miracles), the U. S. health care delivery system is faced with tremendous challenges.

Increasing health care costs, increases in the number of people without health insurance, and concerns about the quality of health care have led to proposals for the reform of health care financing and delivery in the United States. Health care costs have been increasing at twice the rate of general price inflation for over a decade. More than 34 million Americans lack health insurance, which limits their access to health care services. Concern about the quality of care received by Americans has arisen from studies that found that between 20 percent and 40 percent of selected procedures are inappropriately or unnecessarily performed. Aggregate measures of health, such as life expectancy and infant mortality, are no better in the United States than in other countries that spend much less per capita on health care.

The meteoric rise in health care costs has caused or exacerbated many of the problems in the health care delivery system. Increases in health services costs to both public and private payers have led to increases in the costs of private and public health insurance coverage to the beneficiary. The result has been a reduction in health insurance coverage. Concurrently, both public and private payers introduced cost management techniques that reduced the providers' ability to subsidize uncompensated care. As a result, both the numbers of individuals without health insurance and the consequences of noninsurance in terms of access to care have grown.

The importance of quality of care as an issue has grown with health care costs as well. Whereas it once was often asserted that Americans had the finest health care in the world, increasing costs have prompted payers to attempt to ascertain the value of the health care services they have purchased. Researchers examining the quality of medical evidence found that, "...for at least some important practices, the existing evidence is of such poor quality that it is virtually impossible to determine even what effect the practice has on patients, much less whether that effect is preferable to the outcomes which would have occurred with other options." The inability to assess the relative efficacy of health care services has important implications for health care cost inflation, access to health care services, and efforts to reform the health care delivery system.

The Issues

There is general, though not universal, agreement that the market for health care services has failed in the sense that the mix of health care services provided is not necessarily the mix fully informed consumers would wish to purchase, and the services provided are not produced at minimum cost. There is considerable disagreement over the remedy for that market failure. Proposed solutions range from essentially fine tuning the market through tax or regulatory policy to the suggestion that the market is an inappropriate way to allocate health care resources. One of the fundamental issues in health care reform is the ability of the health care services market to meet society's objectives for access, quality, and costs of health care.

The sources of market failure relate to the allocation of risk. There is uncertainty not only in an individual's expected need for health care services, but also in the effects of any given set of health care services on an individual's health. Indemnity health insurance purchased to mitigate the risks of illness also reduces the risks associated with the uncertainty in the efficacy of treatment to both the patient and provider. Reimbursement policies that pay providers on a per service basis shield both supplier and consumer from the financial costs of inefficient production of health. If procedure A

Tax policy encouraged the spread of health insurance. The characteristics of health insurance, in which the insurer bears the risks associated with the uncertainty in the efficacy of treatment, increased the demand for health care services and stimulated the development of new procedures and techniques. Hospitals and physicians competing not on the basis of price, but on quality signals such as the range of services they can provide are quick to adopt new technology. New procedures only needed to show effectiveness in order to be adopted; they did not need to be more effective than existing technology, or less expensive, or even similar in costs. Providers, given a longer list of potential procedures for a given condition, provide more intensive, specialized and costly care. The increased cost of health care services increases consumer demand for health insurance. Attempts to break this cycle confront the lack of information needed to evaluate the efficacy of new and existing treatment practices. The prices of health care services do not convey the same information as prices in other markets: higher prices do not necessarily indicate higher quality.

Although most Americans would agree with the notion that the market system, when it works, is the most efficient way to allocate most goods and services, there is considerable disagreement over when markets fail and when it is appropriate to use the market as an allocation mechanism. Even when a market works perfectly, it excludes some segment of the population due to low income. If access to health care is a right, as many have asserted, then those excluded from the market must be given the means to reach some minimum standard of care. It is often said that the U.S. is the only industrialized country without universal health care, but we do provide a minimal level of health care to all Americans. It is just that many believe that minimum level is unacceptably low.

Proponents of a universal health care system have argued that since the market is by its nature exclusionary, even if the poor are subsidized they will never be able to reach an acceptable level of health care because the political process would work against them. The argument is that the majority will be able to afford adequate health care, and there are competing uses for tax dollars. The majority will thus be reluctant to vote for health care that they do not share. Therefore to assure adequate health care for all, all must be affected equally by the majority’s decisions.

Economists, looking at the development of policy through the prism of narrow self interest, assert that rights are granted by society to the individual in cases where giving the individual that right makes society better off. Thus, by this logic, Americans consider education a basic right because everyone benefits from an educated work force and electorate. Although this argument clearly applies, for example, to services that insure a healthy work force, and to the eradication of infectious disease, it is not clear that this logic would apply to hip replacements for elderly patients or to liver transplants for alcoholics.

If the market is an inappropriate allocation method for health care even when it works, it is clearly problematic if the market for health care services fails. The money required to purchase administrative services, marketing, duplicative investment in expensive technology, and wasteful medical practice in a failed market system could be used to provide more health care or other social goods in a publicly sponsored health care system. Market incentives that contribute to health care cost inflation, such as competition to adopt new procedures and the incentives to providers to offer more intensive care, are not present in such a system. Countries that have national health systems have had lower rates of health care cost increases than the United States over the last 20 years.

Universal health care systems alter the incentives to providers. One model completely nationalizes the entire production of health care services with government run hospitals and physicians as employees; this is the English model. Another model reduces the number of buyers of health care services to one. The Canadian health care system and a recent proposal by the New York State Department of Health incorporate this model.2 These models radically alter the relative market power of purchaser and provider of health care services. They remove competition as a factor in the provision of

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hospital services, if not in all services. Hospitals are given fixed yearly budgets. New technology is allocated by committee or commission.

National health care systems must, however, develop some process for rationing care. The system must determine not only who receives care but which of the competing procedures for a given set of symptoms is appropriate. Most national health care systems are characterized by queues for elective procedures. Moreover, the mix of health care services provided in Canada, England, and in the countries of northern Europe are different than those provided in the United States. For example, the average length of a hospital stay in Sweden is almost twice as long as that in the United States. The diffusion of new technology is also much faster in the United States than in other countries; the United States has slightly more than four times the capacity for open heart surgery per capita as Germany, and almost three times the capacity as Canada. Although there is considerable variation in the technology available to practitioners across countries with centralized systems, the United States is at or near the top in investment in technology per capita. How this difference in practice style affects the quality of health care is unknown; the information problems which have affected the performance of the market for health care services in the United States do not disappear under a universal health care system.

Are health care services produced and distributed more rationally under a universal system than in a market system? Even without being able to assess accurately the differences in the relationship between health care services and health outcomes it is clear that there are several tradeoffs between the two systems. National health care systems offer both universal access and the means to cap health care costs. Market systems offer different levels of access to care by ability to pay, but for insured patients the range of procedures available, and the speed with which treatment is provided, are almost unconstrained. The excess capacity in the U.S. hospitals, for example, prevent the formation of queues for treatment. National health care systems that cap costs must find some mechanism for determining an individual's position in a queue, which does not exist in a market system. The rationing scheme in a national system may be developed through a rational and informed process that allows more care to be provided to more people. It may also be subject to political pressures in an environment where special interests gain control of the process.

Ultimately, under every system of financing and delivering health care services we must make tradeoffs. Dollars spent on health care are unavailable for national defense, education, or private and public investment. Money saved by forcing a 75-year-old to live in discomfort for six months longer under a national system of health care delivery than would be the case in a market system may be spent on prenatal care, defense, education, or investment. Care denied to workers and their families may increase the costs of production and slow economic growth. Limiting access to medical technology and slowing the diffusion of innovations may result in preventable suffering and death.

These are some of the broader tradeoffs health policy makers face. Proposals for reform of the U.S. health care system that do not involve such a fundamental change as a universal health care delivery system still require that some groups be made worse off so that others benefit. Mandated coverages change the ability of employers and employees to find their optimal wage–benefit mix, disrupting the labor market and altering the competitiveness of firms in their output markets. Expanding public programs changes the relative market power of the purchasers of health care services, changing the incentives faced by providers and, perhaps, treatment patterns. No reform of the health care delivery system preserves health care cost inflation, differential access to care, and rapid development and diffusion of new medical technology.

The absence of national health care reform does not imply a static health care delivery system. Public and private purchasers are independently developing and implementing cost management strategies that could potentially have profound effects on cost, access, and quality. Changes in the way Medicare reimburses physicians may alter the willingness of physicians of different specialties to accept Medicare patients, and thus the type of treatments available to them. Both public and private payers are refining and implementing utilization management procedures that may alter the incentives to providers and to researchers developing new techniques. Private payers are beginning to selectively contract with

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providers in the hope of encouraging cost effective practice styles. These changes may segment the market, further differentiating the care received by those with private health insurance and those who are beneficiaries of public programs and the uninsured.

The development and refinement of utilization review and the initial attempts to selectively contract with providers are creating a new market for information that did not exist 10 years ago. This new market provides incentives for researchers to assess the relative efficacy of competing treatments, develop new measures of severity of illness and health status, and formulate new indicators of quality of care. All of this information is necessary if the market for health care services is to function properly. It is also expensive to develop this information and, perhaps most importantly for health care reform, it cannot be developed quickly.

In the interim, these cost management techniques impose administrative costs on both the insurer and provider. Providers assert that the administrative costs of utilization review and the intrusion into the physician-patient relationship have both increased costs and lowered the quality of care. Moreover, they claim that the proliferation of different entities performing utilization review, and the reluctance of utilization review organizations to make their criteria public, have hindered rather than aided the improvement in the efficacy of treatment.

◆ The Policy Forum

The making of all public policy involves evaluating the costs and benefits of alternative proposals. Ideally, public policy debates should focus on the values placed on the outcomes of alternative policies. For example, what is the relative value of old growth forests versus the economic development of the Pacific Northwest. One of the problems in formulating health care policy, however, is that the proposals for reform reflect both their proponents' diagnoses of the root causes of the problems and their implicit calculation of the benefits and costs of the proposal. It is clear any change in the health care delivery system will affect various populations differently. To the extent that the sources of the problems are correctly determined and the impact of each proposal known, the public debate can focus on the tradeoffs inherent in making public policy. The winners and losers are then determined by the political process. Often, however, there are fundamental disagreements over the causes of problems in the health care delivery system and incomplete information on the impacts of the reform proposals.

The goal of this policy forum was to elucidate the tradeoffs inherent in various reform proposals and examine the basic assumptions that lead to the formation of the proposals. To accomplish this goal we asked two distinguished economists, Stephen Long and Michael Morrisey, to analyze the effects of five generic proposals on access to health care services by different populations; the financial burden borne by employers, employees, taxpayers, the uninsured, providers, government, and society at large; and the effect of each proposal on the utilization of health care services and quality of care. The generic proposals were developed by the Institute of Medicine and were intended to provide a framework for discussion, encompassing the range of reform proposals that have been advanced rather than accurately describing any particular proposal. We did, however, urge our analysts to specify a specific proposal when the details were important to their analysis.
The Will To Change
by Selwyn Feinstein, EBRI Fellow

One would have hoped, after decades of debate, that policy planners would have achieved some degree of consensus on America's health care system. As this forum clearly demonstrates, no such accord is even close at hand.

Health care users, buyers, providers and thinkers agree tensions strain the system. But they continue to argue about the nature of the problem and its roots. They still differ about what works today and what will work tomorrow. They persist in questioning whether now is the time to act or the time to fall back for yet more research.

And, further fracturing the inquiry, sides change. Robert Friedland of the American Association of Retired Persons reminded the forum that President Richard Nixon 20 years ago won business support for a measure mandating employer-provided health insurance largely because Sen. Edward Kennedy (D-MA) at the time wanted national health insurance. Now, he said, Sen. Kennedy backs mandates and "the opposition seems to be, or at least initially had been, business."

This report suggests the cause of the continuing controversy may lie within ourselves.

There can be little doubt about the differences. Participants at the forum could not even agree on the language of their debate.

To Harold Bell of Quantum Chemical Corp., quality medical care meant "conforming to requirements and not necessarily goodness." Gene Moyer of the Department of Health and Human Services, however, said physicians would reject any such "specs laid down by a third party." For the physician, he insisted, the only acceptable yardstick for quality is "what, in his judgment, is best for his patient."

William Custer of EBRI similarly drew an objection when he invoked life expectancy and infant mortality as aggregate measures of health that might be compared internationally. John Goodman of the National Center for Policy Analysis countered that such a number "doesn't tell you anything about differences in health care." The "right question," he said, is "what is the life expectancy of a premature baby or cancer patient once under the control of doctors in hospitals."

In searching for the root cause of mounting costs, John Ring of the American Medical Association ascribed part of the blame to "excessive demand caused by market failure. This failure is a result of government programs and insurance that insulate the consumers from economic consequences based on decisions made regarding their health care." To Robert Chernow of Metropolitan Life Insurance Co., the system—while overused—is also "very high priced." Our doctors, he asserted, "are the most highly compensated in the world, relative to average employee compensation."

Many of the forum's participants laid the problem on consumers. "We don't have incentives to look for appropriate-quality care," declared Michael Morrisey of the University of Alabama at Birmingham. "There is very little pay-off because we are insured as well as we are."

Chernow, however, faulted employers who finance much of the care, arguing they fail to organize their health purchases as well as they handle the other goods and services they buy. Danville Spiller of Mead Corp. had yet another culprit. He asserted that the real buyer of health care is neither the consumer nor the employer. It is the physician, he said, who prescribes the medication, orders the hospitalization and decides when specialists need be summoned for consultation. The physician is both buyer and seller in our health care system.

Richard Merrill of Prudential Insurance Co. and the Business Roundtable saw the one-on-one relationship between patient and doctor as a source of the trouble. The patient, he declared, "has no economic clout" and no way of assessing the appropriateness of his care.

How much can we afford to spend for a health care system incapable of meeting the needs of all Americans, including the 34 million currently uninsured? Karen Ignagni of the AFL-CIO argued that the nation "simply cannot afford to sustain the percentage of GNP going into health care." But James Henderson of Pacific
Telesis suggested such spending looks less menacing when matched against outlays for national defense.

Any discussion about how to cope with rising costs quickly bogged down in disagreements over whether cost-paring efforts are proving effective now. Consider the debate about increased deductibles and coinsurance, two techniques used by employers to make workers more aware of the health costs they incur.

Leah Young of the House Small Business Committee challenged their effectiveness. “I have never known a mother with a sick child who calculated first whether or not her family deductibles were met before she decided whether or not to take the child to the doctor,” she declared, adding: “There are a lot of things that your economic theory may point to that just don’t exist in the real world.”

Merrill contended that deductibles and coinsurance do not eliminate inappropriate care and sometimes encourage the “gaming” that he said often occurs in doctors’ offices when clerks tailor insurance submissions to increase the likelihood that a carrier will pay.

Yet Morrisey insisted that the Rand Health Insurance Experiment documented that deductibles and coinsurance do work. "They do reduce utilization," he said. At Quantum Chemical, deductibles are effective, Bell agreed.

Robert Crane of Kaiser Permanente said, “Copayments may defer needed care and create long-term problems.”

There was little agreement on possible winners and losers from the five health care proposals considered by the forum: employer-mandated insurance, Medicaid expansion, universal health insurance, expanded public delivery and market-based reforms.

Morrisey said uninsured workers would be losers with employer mandates because their companies would offset the cost of the added benefit by offering lower pay.

To Stephen Long of the Rand Corp., however, uninsured workers would be “Big Winners” (Long, table 1). They would be hurt by employer mandates only if they did not want the coverage offered, a relatively slim possibility, he suggested, since only 1 in 13 workers without health insurance rejects such coverage if offered it now. (Long, table 3)

Much of Morrisey’s analysis is built on what he called “compensating differentials,” the economic theory that holds that workers are paid what they are worth and they accept health care in lieu of a portion of their cash wages because they “sort of value health insurance coverage.”

But Dallas Salisbury of EBRI asserted that no compensat-

ing differential appeared to be in play for the one in three Marriott Corp. full-time workers who rejected health care coverage that required a copayment. They did not receive a cash wage increase for the benefit they forsook, he said.

Long’s analysis of employer mandates received no kinder treatment. William Dennis of the National Federation of Independent Business challenged Long’s estimate (Long, table 8) that the overall increased cost of employer mandates for the nation would be $15 billion. If the uninsured receive the same care as most middle-class Americans receive currently, Dennis figured, the real cost of mandates would be closer to $40 billion.

Goodman, moreover, said he was “astounded” that Long (Long, table 1) had listed uninsured workers as Big Winners from mandates and the employer impact as largely a draw. “We’re talking about taking $40 billion away from small business and its employees and giving it to Blue Cross,” Goodman declared. Now “we’re going to add insult to injury by declaring them all winners.”

For Merrill, expressing the conclusion of the Business Roundtable, the implication was clear: “Employer mandates are bad policy.”

On the Medicaid proposal, participants were similarly divided. Morrisey estimated that an expanded system offering benefits to anyone below the poverty line could add at least $10.6 billion to the national health bill. But Long, using a somewhat different plan that allowed some of those above the poverty line to buy in, put the net cost again at closer to one-half more.

Long suggested that combining employer mandates with expanded Medicaid could come close to providing universal coverage. But such a combination stuck Morrisey as “sort of an odd way” to solve the problem.
"What you are doing is saying that low-income folks can't afford to play the Medicaid buy-in game, but we'll let them pay the full cost through compensating differentials on the wage side."

Many participants were leery of any increased government role, either through expanded Medicaid, a public-hospital delivery system or other such plan. "For lack of other options, government is going to continue to seek to resolve the budget problems on the backs of public programs," said Deborah Chollet of Georgia State University's Center for Insurance Research. If given a bigger role in health care, she predicted, government "could impoverish the system if we fail to limit structuring it's ability to do so."

Goodman faulted Morrisey and Long for failing to give sufficient attention to market-based reforms or more-equitable taxation. Arthur Lifson of Equicor Inc. invoked private capital's role. "Unless we invest and create value, we are not going to get our arms around this thing," he said.

Some forum participants blamed the fractious debate on a lack of hard facts. Talk to companies to learn how they are controlling health care costs, urged Robert Nash of Phillips Petroleum Co. "There is a whole source of data out there, but you have to start tapping it."

Paul Millholland of The Upjohn Co. suggested we need to talk more about goals. "I dare say that most of us could not agree upon those, and that if we cannot agree upon objectives, how do we ever expect to agree upon solutions to this problem?"

But Henderson insisted that cracks in the health care system cried for change now. "We really do need to commit to action and not much more study," he declared. To John Rother of AARP, "the status quo is the least desirable of all options."

Ignagni suggested that a major stumbling block to action may be a lack of "political will" for change. But our government and institutions, including business and organized labor, may not be the obstacle. The barrier may be us.

◆ Conclusion

An EBRI survey conducted in November 1990 by the Gallup Organization shows that most Americans give low marks to the nation's health care system but are overwhelmingly satisfied with the quality of health care they receive. Two out of three of us judge the system to be fair to poor. But three-quarters of us say the quality of our own care is good to excellent. Why fix a system that, in our house, isn't broken?

Clearly, though, faults in the system do threaten our care. A weak structure cannot long sustain the weight of mounting costs before crashing in on all the clients it serves. Nor can a system pay inadequate attention to the health of a minority without tainting the well-being of the rest. The message, however, has yet to strike home.

Therein lies the challenge for American health care strategists. They must educate consumers to the nature and extent of the problems and the immediate relevance to every person in this land.

Only with a public demand for change will the debate finally end and some corrective course be launched.
Winners and Losers in Reforming the U.S. Health Care System

by Stephen Long, Ph.D., The Rand Corporation

Editor's Note: The following transcript is an edited version of Stephen Long's presentation.

◆ Introduction

Table 1 declares who wins and loses from each of these health care system reform options and is intended to provoke discussion rather than provide definitive answers. I will refer to this table as we go through the options. Table 2 describes insurance sources. Of a total U.S. population in 1989 (about 244 million people), tabulations of the CPS suggest that 32.7 million, or about 13.5 percent, were uninsured. The uninsured were somehow missed by the network of employment-based and other kinds of coverage. Clearly, being uninsured is not an elders' problem but is a nonelderly problem, as can be seen by those percentages under None (which represents the uninsured throughout all of these tables). In fact, from the current population survey, we don't actually know that people are uninsured. They don't answer the question “Yes, I am uninsured.” If they simply fail to answer in the affirmative any other question about health insurance, then they fall into this residual category of having no insurance.

◆ The Uninsured

Many people have more than one source of insurance, so in these tables people have been classified in accordance with the insurance source that would be the primary payer. For example, in the case of elderly people who have Medicare and either an individual supplement or an employer-based supplement, they are classified as Medicare even though they may have some employer-based retiree plan. However, if they are working elderly, then they have been moved up into employment-based coverage. In the case of people who have Medicaid and

| Table 1 | Effects of Alternative National Health Proposals on Specific Groups—Win, Lose, Draw, or Uncertain<sup>a</sup> |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
|                | Employer-Mandated Insurance | Medicaid Expansion | Universal Insurance | Public Care | Market-Based Reforms |
| Uninsured       |                           |                 |                  |                  |                  |
| Workers and dependents |                        |                 |                  |                  |                  |
| higher-income  | W                      |                 | W                |                 |                  |
| lower-income   | W                      | W, =             | W                | ?                | ?                |
| Nonworkers and Dependents | W                      | W               | W                | W                | ?                |
| Employer       |                           |                 |                  |                  |                  |
| Offer insurance|                           |                 |                  |                  |                  |
| Don't offer insurance |                   |                 |                  |                  |                  |
| Private Insurance |                         |                 |                  |                  |                  |
| Hospitals      | W                      | W                | c                | W                | L                |
| Physicians     | W                      | W                | c                | -                | L                |
| Taxpayers      |                           |                 |                  |                  |                  |
| Higher-income |                           |                 |                  |                  |                  |
| Middle-income |                           |                 |                  |                  |                  |
| Lower-income  |                           |                 |                  |                  |                  |

Source: Author's speculations; see text for reasoning.
<sup>a</sup>W = big winner, w = little winner, L = big loser, l = little loser, = draw, ? = uncertain. All effects are relative to a group's situation under current law.
<sup>b</sup>Possible short run losses until burden can be shifted to workers.
<sup>c</sup>Two offsetting effects—win from increased market demand but potential loss from reimbursement controls makes net effect unclear.
some group insurance, and there are some of these, they have been moved up into employment-based because employment-based coverage should be the primary payer to Medicaid. In cases where people have Medicare and Medicaid, they've been moved into the Medicare category because Medicare should be the primary payer there. Medicaid represents a supplement in that case.

The current population survey has a special supplement that asks workers about offers of health insurance from their employers, not just whether they had insurance (table 3). One of the nagging questions in the ongoing analysis of mandates has been how many individuals have received an offer of health insurance from an employer but turned it down. Clearly, for them, a mandate would make their situation worse unless the mandated insurance was a better package. There's been concern that mandating insurance might force some people to accept insurance they may have voluntarily passed up. However, in the past, the large national databases have not been able to compare the number of people who were offered health insurance but passed it up with the number of those who were working and uninsured and never received an offer for insurance from their employer.

About two-thirds (76 percent) of all employees are offered health insurance by their employers, and of these only about 5 percent turn it down for some reason other than receiving coverage through a spouse's insurance plan. The remaining 24 percent of workers are people who don't have employer-sponsored health insurance either because they are ineligible for the plan or the employer doesn't offer health insurance. This information will continue to be helpful as the winners and losers of the various options are examined.

Table 2 looks at the uninsured population by age and sex, providing the percentage of each group that is uninsured. The overall uninsured rate is 13.4 percent of the nonelderly population. Among 18–24 year olds (sometimes referred to as "Invincibles"), 24.5 percent are uninsured. Many of these people are, in fact, people who may forego insurance offers they receive. Another group that stands out as having a disproportionately high share of uninsured is men between ages 25 to 44 years.
care of the uninsured do not have access to health care; therefore health care

Another important question raised in the health care debate is how much health care do the uninsured use? Some people are focusing on the need for mandated insurance because they believe it will promote access to health care. This belief gives the impression that the uninsured do not have access to health care; therefore, any policy mechanism would be wonderful. On the other hand, some people perceive the problem to be that insured persons are paying for all this uncompensated care the uninsured receive. This group wants to redistribute the payments for uncompensated care. So now the question becomes how full is this glass?

Table 5 presents some estimates (Long and Rodgers, 1989) using recent Census data to measure total health care use and the access gap for the uninsured—the difference in the percentage of health care used by the insured and that used by the uninsured. In physician services, we estimate the uninsured have about one-third less physician access in a year than insured people. For inpatient hospital services, the gap is much wider. In fact, the uninsured may have only about one-third of the access to inpatient hospital services that insured people have. Compared with the total amount of uncompensated care reported by hospitals, this figure seems inconsistent. However, a lot of uncompensated care that hospitals provide is outpatient and ambulatory care, rather than inpatient. This could be the major reason why the physician services gap is smaller than the inpatient one.

These gaps in access may suggest that if people without insurance do receive insurance, their use of health care services will rise, costing money to provide these services. However, part of the cost will be simply shifting resources around the system. About one-half of the costs associated with providing insurance to those previously uninsured would be new costs, the other half would have to be paid for by another group. So, there’s some base and some incremental costs involved, suggesting that if health care has value to the insured, then when the uninsured gain access to it, they may be better off. How much of this actually improves their health status is

<table>
<thead>
<tr>
<th>Table 3</th>
<th>Employer Offers of Health Insurance and Employee Responses, 1988</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Employees (in millions)</td>
<td>Percentage of All Employees</td>
</tr>
<tr>
<td>All Employees</td>
<td>105</td>
</tr>
<tr>
<td>Employer Offered Insurance to Employee</td>
<td></td>
</tr>
<tr>
<td>Turned down, covered by spouse’s employer</td>
<td>69</td>
</tr>
<tr>
<td>Turned down by employer</td>
<td>5</td>
</tr>
<tr>
<td>Employer Did Not Offer Insurance to Employee</td>
<td></td>
</tr>
<tr>
<td>Firm offers insurance, but employee is ineligible</td>
<td>6</td>
</tr>
<tr>
<td>Firm does not offer insurance</td>
<td>19</td>
</tr>
</tbody>
</table>


Health Care Use by the Uninsured

Women, on the other hand, tend to be about on the average because Medicaid coverage picks up a lot of women that employment plans don’t. The percentage of uninsured children is similar to the overall percentage of uninsured. This number has changed in recent years because of changes in the current population survey that improve our ability to measure uninsured children. The Census, specifically, the Current Population Survey, asks questions to determine if a child’s source of insurance comes from outside the household, perhaps from an absent parent. Consequently, the estimates of uninsured children are lower than they were in the mid ‘80s, presumably because of more accurate measurements.

<table>
<thead>
<tr>
<th>Table 4</th>
<th>Characteristics of the Uninsured under Current Law, 1989</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Individual (in millions) (percentage)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>32.7</td>
</tr>
<tr>
<td>Children</td>
<td>8.4</td>
</tr>
<tr>
<td>Young Adults, 18–24</td>
<td>6.3</td>
</tr>
<tr>
<td>Women, 25–44</td>
<td>5.3</td>
</tr>
<tr>
<td>Women, 45–64</td>
<td>2.9</td>
</tr>
<tr>
<td>Men, 25–44</td>
<td>7.2</td>
</tr>
<tr>
<td>Men, 45–64</td>
<td>2.3</td>
</tr>
<tr>
<td>Elderly, 65 and over</td>
<td>0.3</td>
</tr>
</tbody>
</table>


Note: Details may not add to totals because of rounding.
uncertain. It’s one of those nagging questions that has plagued this area of research for some time. Ten or 12 years ago, Alain Enthoven suggested that until we could better measure quality, if the care was good enough for the middle class, it was probably good enough for the poor. So, I’m inclined to think that until proven otherwise, the uninsured probably get some benefit from this extra care.

The newest information here is not the numbers from the CPS, but the two perspectives—most uninsured workers never received an offer of insurance rather than not accepting an offer, and the use levels of health care services of the uninsured compared with the insured is about one-half.

◆ Policy Options

There are plenty of policy options currently being debated in public circles. While some have more substance to them than others, each will be mentioned here. In particular, we’ll look at the mandated insurance and Medicaid expansion options and how different decisions can alter those options.

For the purpose of this discussion, the mandated insurance option would cover 25-hour-per-week workers. The benefit package is a minimum one—more than 90 percent of all employer plans in the country provide more insurance. The cost-sharing for the premiums is 75 percent paid by the employer, 25 percent paid by the employee. Again, this type of cost-sharing arrangement is toward the less generous end.

The purpose of this comparison is to determine what a mandate would cost if it largely affected the uninsured rather than involved lots of upgrade costs rolling through the existing system. But clearly, the more generous the mandate gets, the more it’s going to overlap and cause a lot of existing coverages to change in various ways. One factor that impacts the number of uninsured affected by a mandate is whether this coverage is deemed the primary payer. Another factor concerns the types of requirements placed on the coordination of benefits within the family. For example, in two-worker families, decisions need to be made if every employee has to get insurance through the workplace and to what policy children are assigned.

Mandates can also generate movement of insured people across firms, depending on the amount of intervention. This particular mandate is nonintervening. If the family already had group coverage, nobody has to move anywhere. So, the mandate says only the workers and dependents who weren’t covered by some group policy in

<table>
<thead>
<tr>
<th>Services</th>
<th>Probability of Any Used</th>
<th>Level of Use by Usersc</th>
<th>Interactiond</th>
<th>Total Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians’ Services</td>
<td>−25%</td>
<td>−16%</td>
<td>+4%</td>
<td>−37%</td>
</tr>
<tr>
<td></td>
<td>(12.48)</td>
<td>(4.74)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Services</td>
<td>−54%</td>
<td>−33%</td>
<td>+18%</td>
<td>−69%</td>
</tr>
<tr>
<td></td>
<td>(7.29)</td>
<td>(3.57)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


aThese estimates are based on 19,904 observations reporting insurance information for the full 12 months prior to the SIPP third topical module interview. One of the four waves of the SIPP panel had only eight months of prior insurance, and, therefore, was excluded from the sample for these estimates.

bThe percent differences shown are based on the predicted likelihood of use for the insured and the uninsured, all other variables held at the sample means, from multivariate probit equations described in the text. All differences in the likelihood of use are statistically significant at a 99 percent level of confidence for a two-tailed test.

cThe percent differences shown are based on ordinary least squares equations for the log of physician contacts and the log of nights in the hospital, controlling for other characteristics discussed in the text. The estimates have not been retransformed into the original units. All differences in the log of use are statistically significant at a 99 percent level of confidence for a two-tailed test.

dTotal use for all people is the product of the probability of any use and the level of use by users. The difference in total use is the sum of the difference in probability of any use, the difference in the level of use by users, and an interaction term (to avoid double-counting).
the past will be put under a new policy, and previously covered spouses will not be moved onto their own employer plan. While this movement can have interesting distributive effects across industries and across workers, this illustration does not deal with it.

The Medicaid expansion discussed here is one that would offer free coverage for people up to the poverty line. The only eligibility requirement would be an income standard using a sliding scale to collect trivial contributions from people between 100 percent and 200 percent of poverty. In fact, these contributions are even more trivial than the ones cited by Michael Morrissey (Morrisey, 1990), simply because in addition to having some thresholds of people’s income in excess of poverty, this option says people can’t be asked to pay more than 5 percent of income if 1 person is being covered, or 10 percent of family income over the poverty line if 2 or more people are covered. Contributions are also capped at one-third of the cost of covering these people. This cap is less generous than the typical employer plan, which is about 15 percent of the cost of covering people.

If there is a buy-in and people are asked to pay full cost, no one will take advantage of the program. Therefore, it is reasonable to have these contributions fairly limited, looking for the maximum cost and maximum mobility that is possible under the plan, with the estimates at the higher end of maximum participation. If you raise contributions to any reasonable higher level, participation would fall way off. The dollars wouldn’t fall off nearly so much because the sick tend to show up, but participation would decline. So, the estimates reported here tend to be generous with regard to participation levels.

And finally, there is an option that combines these two approaches, which is demonstrated with numbers based on the 1989 March CPS (Long and Rodgers, 1989). Table 6 is intended to show the population effects of this particular mandate. The first column arrays people by current law coverage and is essentially the same as table 2. The second column shows the number of people by coverage after enactment, and the third one shows the change. Focusing on the change column shows the full impact of the mandate would be to move about 36.5 million people into employment-based coverage. About 21.5 million of those under these standards would have been previously uninsured (the None row). The balance of these numbers show what other categories of insurance people would either be giving up or having become second payer to this employment-based plan that would be required for them.

There is interaction with Medicare and Medicaid and considerable interaction with the other private category. The best guess about what people meant when they responded that they have private insurance but it is not provided by their employer is there are many individuals with policies, probably not very good or comprehensive policies, and in some cases pretty expensive for the coverage received. If they are individual policies, of course, there is no employer sharing in the contribution.

In this mandate, the mandated employer group coverage becomes primary payer to those individual policies if people would otherwise drop the individual policy and take the employer mandate insurance. But there is a substantial decline in the number of people in this category after the enactment. These 15 million people, who seem to have some kind of insurance, are a group we don’t know enough about. Perhaps another way to think of this group is maybe they are underinsured. Thus, when these mandates come along, they do some good.

There are always about 10 million of these people (who tend to be low-income folks), affected by any one of

<table>
<thead>
<tr>
<th>Source of Insurance</th>
<th>Current Law</th>
<th>After Enactment</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment-Based</td>
<td>151.3</td>
<td>187.8</td>
<td>36.5</td>
</tr>
<tr>
<td>Medicare</td>
<td>29.9</td>
<td>27.9</td>
<td>-2.9</td>
</tr>
<tr>
<td>Medicaid</td>
<td>14.7</td>
<td>11.7</td>
<td>-3.0</td>
</tr>
<tr>
<td>VA</td>
<td>0.8</td>
<td>0.4</td>
<td>-0.4</td>
</tr>
<tr>
<td>Other Private</td>
<td>14.3</td>
<td>4.6</td>
<td>-9.7</td>
</tr>
<tr>
<td>None</td>
<td>32.7</td>
<td>11.2</td>
<td>-21.5</td>
</tr>
</tbody>
</table>


Note: Details may not add to totals because of rounding.

In general people covered by more than one source of insurance are classified by the primary source. For example, elderly are classified as having Medicare, regardless of various forms of supplementary coverage from former employers, other private plans, or Medicaid. Only the working aged, whose plans are primary payer to Medicare, are classified under employment-based coverage.
these policies. About one-half of those 10 million are workers who weren’t offered employment-based plans and picked up individual plans instead until the mandates come along.

◆ Effects of Mandates

About two-thirds of the uninsured get picked up by a mandate no matter what its definition. Changing the definition of a worker based on the number of hours worked may change those numbers a little bit. For example, by using 17 1/2 hours worked per week, the number of uninsured drops under a mandate, but there’s still 21 million–23 million people picked up by the mandate.

Some estimates show that 75 percent of the uninsured live in a family with a worker. This figure may be explained by a couple of things. First, there is no test for a reasonable number of hours worked; instead, a worker is defined with any hours. The second reason is that some people use an inconsistent definition of families, including people who would not be included under the narrower definition of family units that most employment-based plans use. Typically, this unit consists of a head of household, spouse, and dependent kids, looking more like a tax-filing unit. So, there will be a few other individuals who the Census calls a family but wouldn’t receive insurance as part of a mandate. The simulation used in this study is correct as far as family definitions are concerned, coming as close as possible to a health insurance unit.

Table 7 examines the people who would still be uninsured even after enacting a mandate. The tables look very much like the ones used previously to show the age-sex characteristics of the uninsured. Of the 32.7 million uninsured under current law, 11.2 million would still be left over after enactment of this illustrative mandate—about 34 percent. The groups that seem to miss out under the mandate, or disproportionately left over, are women and men between ages 45 and 64. These individuals have less of a connection to the workforce than other groups.

The next question is what would all this mandated insurance do to national health spending? Using HCFA’s projections of national health spending for 1991 under current law national health spending would be about $685 billion. The distribution of spending by source of payment is shown in table 8. Assuming the policy is implemented in 1991, under an employer mandate, national health spending would rise to $700 billion, or about $15 billion in incremental health spending, even though the gross effect on employment-based coverage (the third line of the table 8), would be a change of about $42 billion in addition employer and employee premiums.

A mandate will transfer some people from other sources of insurance to employer-sponsored coverage. The net incremental cost will reflect the extra cost of treating newly insured people, but the balance of how they pay for their care is simply being transferred into the employment mechanism from somewhere else. The costs of employment-based insurance rise by $42 billion, other health insurance (individual policies), dropping by $5 billion, government declining by $11 billion, and other payments (largely direct patient payments), dropping by about $10 billion. The gross cost of a mandated insurance program is almost three times the net cost, with the net cost about $15 billion to pick up two-thirds of the uninsured. This expenditure is relatively cheap compared with the size of national health spending.

Cost is not the real issue. The distribution of those costs and how you balance the interests of the various parties involved is far more interesting than cost. This issue brings back the topic here—the winners and losers (table...
The reason there aren’t any losers in the first column of were offered a buy-in at very generous sliding scales, and compensating differentials that they would not have buyers essentially nothing, would pick up about 20 million of the uninsured. This number is almost the size purchased on their own. Both the benefits and costs are directly through premiums or through

They are being required to pay for the insurance either shown in table 9. This mandate, which goes up to twice signed up voluntarily, then probably they are losers. The next option is an illustrative Medicaid expansion, winners under this plan. If these people wouldn’t have that opportunity), then those individuals are when forced. If a lot of them would have enjoyed having this opportunity to pick up employer-based coverage create a friendly environment has to do with the question of how many workers want greater market and generous reimbursement tends to have that opportunity. Medicaid expansion

Employers probably would not be seriously affected by mandated insurance, especially if the policy is sensibly announced in advance, so adjustments can be made. True, if it strikes like a bolt of lightening, it would create a lot of disruption. But, if it is announced with a few years’ advance warning, and people have an opportunity to alter compensation packages, then most of this cost ends up being borne by workers. Certainly it can’t be the case that workers bear 100 percent of the burden, 100 percent goes into higher prices, and 100 percent overburdens the owners of small businesses all simultaneously. Sometimes the debates on this issue make it sound like all this is true, and that simply can’t be the case. There can’t be that many losers from this policy.

Most likely, private insurance companies, end up being winners, with the exception of the people who sell all those individual policies or whatever else is under other insurance in the CPS. Although some people could fear that a mandate is the foot in the door for mandated benefits, rather than just mandated insurance and lots of things could follow to make insurance a less appealing business than it was before.

Providers would probably gain from this policy because it just mimics existing insurance coverage and existing insurers tend to be reasonably generous to providers. A greater market and generous reimbursement tends to create a friendly environment. Taxpayers are unaffected.

<table>
<thead>
<tr>
<th>Table 8</th>
<th>National Health Expenditures under Current Law and under an Illustrative Employer Mandate</th>
<th>(In billions of 1991 dollars)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source of Payment</td>
<td>Current Law</td>
<td>Employer Mandate</td>
</tr>
<tr>
<td>Total</td>
<td>685</td>
<td>700</td>
</tr>
<tr>
<td>Private Insurance</td>
<td>222</td>
<td>258</td>
</tr>
<tr>
<td>Employment-based</td>
<td>197</td>
<td>238</td>
</tr>
<tr>
<td>Employer-share</td>
<td>167</td>
<td>199</td>
</tr>
<tr>
<td>Employee-share</td>
<td>30</td>
<td>40</td>
</tr>
<tr>
<td>Other</td>
<td>25</td>
<td>20</td>
</tr>
<tr>
<td>Government</td>
<td>278</td>
<td>267</td>
</tr>
<tr>
<td>Federal</td>
<td>205</td>
<td>198</td>
</tr>
<tr>
<td>Medicare</td>
<td>128</td>
<td>123</td>
</tr>
<tr>
<td>Medicaid</td>
<td>42</td>
<td>40</td>
</tr>
<tr>
<td>Other</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>State</td>
<td>73</td>
<td>69</td>
</tr>
<tr>
<td>Medicaid</td>
<td>33</td>
<td>31</td>
</tr>
<tr>
<td>Other</td>
<td>40</td>
<td>38</td>
</tr>
<tr>
<td>Other</td>
<td>185</td>
<td>174</td>
</tr>
<tr>
<td>Direct Patient</td>
<td>162</td>
<td>152</td>
</tr>
<tr>
<td>Other</td>
<td>23</td>
<td>23</td>
</tr>
</tbody>
</table>

Source: Preliminary Congressional Budget Office calculation based on data from the Health Care Financing Administration.

Note: Details may not add to totals because of rounding.

1). The most interesting unresolved issue in the mandate has to do with the question of how many workers want this opportunity to pick up employer-based coverage when forced. If a lot of them would have enjoyed having insurance before (table 3 shows many of them don’t have that opportunity), then those individuals are winners under this plan. If these people wouldn’t have signed up voluntarily, then probably they are losers. They are being required to pay for the insurance either directly through premiums or through foregone wages and compensating differentials that they would not have purchased on their own. Both the benefits and costs are largely concentrated in these workers.

The reason there aren’t any losers in the first column of table 1 is because these workers are winners. If there are losers in column one they would also be here. Workers are declared winners here primarily because the CPS tabulation of how many were never offered insurance. The fact that almost everybody who is offered it picks it up, or has a spouse who is covering them already, is persuasive evidence that most of these people are interested in having insurance.

Employers probably would not be seriously affected by mandated insurance, especially if the policy is sensibly
portionately because they tend to reside in families with higher income and wouldn’t qualify under the 200 percent guideline. Similarly, some of those males are workers with incomes above the poverty guidelines as well. On the face of it, the leftovers are everybody who was uninsured and had a family income above 200 percent of poverty.

The cost for Medicaid to pick up these 25 million people would run in the $25 billion-30 billion range—about $1,000 a head. There’s not much difference between this number and the mandate numbers.

Contributions might run 10 percent of that number; about $3 billion is all that could be collected using a sliding scale adjusted to income and capped so people don’t have to pay more than one-third of the cost. So, contributions might have very important political and symbolic value. A buy-in might be terribly important to selling this to taxpayers, but a buy-in that least discourages participation couldn’t raise a lot of money. As previously pointed out, this option is largely a taxpayer provided transfer to people with incomes up to 200 percent of poverty. The net cost of this option would be similar to the order under the mandate because a lot of these people who would be shifted onto Medicaid were previously uninsured and received about one-half the care that they’d get under this new insurance plan. Of the total cost, about one-half are new costs and about one-half are transfers for other payers. So, estimates may be closer to $15 billion net cost.

Who are the winners and losers? Obviously the beneficiaries are the uninsured and the underinsured who have incomes below 200 percent of poverty. They are almost clear winners here. The losers are, of course, the taxpayers who pay for them. Private insurance wouldn’t be affected much with the exception that it loses some of the individual business that Medicaid would surely be preferred over if it’s offered free or at very low cost. Providers presumably face a market expansion story similar to the mandate, but at considerably less generous reimbursement terms. Although on net presumably it must represent a gain.

Looking at the public positions of the American Hospital Association (AHA) and the American Medical Association (AMA) through the Health Policy Agenda, Medicaid expansions are viewed as positive ways to solve the uninsured problem. This probably means that providers overall would be in favor of a Medicaid expansion. They could design the program to be even more generous but, on net, they view it as a positive thing.

Employers would be largely unaffected unless some took advantage of this cheap source of insurance to drop their employer coverage and let their employees receive

<table>
<thead>
<tr>
<th>Source of Insurance</th>
<th>Current Law</th>
<th>After Enactment</th>
<th>Change</th>
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<tbody>
<tr>
<td>Employment-Based</td>
<td>151.3</td>
<td>151.3</td>
<td>0.0</td>
</tr>
<tr>
<td>Medicare</td>
<td>29.9</td>
<td>29.9</td>
<td>0.0</td>
</tr>
<tr>
<td>Medicaid</td>
<td>14.7</td>
<td>39.9</td>
<td>25.2</td>
</tr>
<tr>
<td>VA</td>
<td>0.8</td>
<td>0.4</td>
<td>-0.4</td>
</tr>
<tr>
<td>Other Private</td>
<td>14.3</td>
<td>9.4</td>
<td>-4.8</td>
</tr>
<tr>
<td>None</td>
<td>32.7</td>
<td>12.7</td>
<td>-20.0</td>
</tr>
</tbody>
</table>


Note: Details may not add to totals because of rounding.

In general people covered by more than one source of insurance are classified by the primary source. For example, elderly are classified as having Medicare, regardless of various forms of supplementary coverage from former employers, other private plans, or Medicaid. Only the working aged, whose plans are primary payer to Medicare, are classified under employment-based coverage.

Table 9
Insurance Status of People under Current Law and after Enactment of an Illustrative Medicaid Expansion, 1989

<table>
<thead>
<tr>
<th>Source of Insurance</th>
<th>Current Law</th>
<th>After Enactment</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment-Based</td>
<td>151.3</td>
<td>151.3</td>
<td>0.0</td>
</tr>
<tr>
<td>Medicare</td>
<td>29.9</td>
<td>29.9</td>
<td>0.0</td>
</tr>
<tr>
<td>Medicaid</td>
<td>14.7</td>
<td>39.9</td>
<td>25.2</td>
</tr>
<tr>
<td>VA</td>
<td>0.8</td>
<td>0.4</td>
<td>-0.4</td>
</tr>
<tr>
<td>Other Private</td>
<td>14.3</td>
<td>9.4</td>
<td>-4.8</td>
</tr>
<tr>
<td>None</td>
<td>32.7</td>
<td>12.7</td>
<td>-20.0</td>
</tr>
</tbody>
</table>


Note: Details may not add to totals because of rounding.

<table>
<thead>
<tr>
<th>Type of Individual</th>
<th>Under Current Law</th>
<th>After Enactment</th>
<th>Remaining Uninsured (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>32.7</td>
<td>12.7</td>
<td>39.0</td>
</tr>
<tr>
<td>Children</td>
<td>8.4</td>
<td>2.2</td>
<td>26.0</td>
</tr>
<tr>
<td>Young Adults, 18–24</td>
<td>6.3</td>
<td>2.8</td>
<td>45.0</td>
</tr>
<tr>
<td>Women, 25–44</td>
<td>5.3</td>
<td>1.9</td>
<td>36.7</td>
</tr>
<tr>
<td>Women, 45–64</td>
<td>2.9</td>
<td>1.2</td>
<td>40.5</td>
</tr>
<tr>
<td>Men, 25–44</td>
<td>7.2</td>
<td>3.4</td>
<td>47.3</td>
</tr>
<tr>
<td>Men, 45–64</td>
<td>2.3</td>
<td>1.1</td>
<td>46.2</td>
</tr>
<tr>
<td>Elderly, 65 and over</td>
<td>0.3</td>
<td>0.1</td>
<td>47.2</td>
</tr>
</tbody>
</table>


Note: Details may not add to totals because of rounding.
Medicaid. That's been a big worry of people who are worried about the government substituting for the private sector activity. I see no convincing evidence that there are lots of employers who employ only workers who would qualify for Medicaid and employ nobody else like themselves who they want to have a decent group insurance package. Most workplaces have distributions of wages that get way beyond this range, so there's somebody working for the employer who wants better insurance than Medicaid provides, but this issue has been a big worry.

The further up the income distribution this generous buy-in of Medicaid goes, the more worry there is that some private-sector coverage will be lost and taxpayers will end up picking up a bunch of it. The most interesting unresolved issue is how responsive will the low-income uninsured be to this voluntary buy-in, and how will that affect the participation, the costs, and success of the Medicaid expansion.

**Comparing Employer-Mandated Insurance and Medicaid Expansion**

Table 11 compares Medicaid expansions and mandates. In this particular table, employment-based mandate is the primary payer and comes first. The Medicaid comes as a residual. Turned around, there are different distributions of who picks up the bodies. Doing the mandate, however, and making it first payer, does guarantee that people won't drop coverage so they can take advantage of the public program. One way that these programs work nicely together, in the simulations anyway and maybe in somebody's values, is that all the burden is in the private sector where it can be handled through wages and employer bargains rather than on taxpayers. Of the uninsured, the same 21.5 million would show up under the mandate. Another 8 million who are not working and subject to the mandate at the margin could be picked up by the Medicaid expansion up to 200 percent of poverty. There would only be 3 million uninsured left. Likewise, the other private category of insurance (which I think consists of individual plans) would be largely wiped out.

The characteristics of the remaining uninsured are shown in table 12. Disproportionately, they are this troublesome group of young adults who aren't all working but are in families of some reasonable income. There may be an insurance access problem, or maybe the CPS just isn't measuring insurance properly in that group. They keep popping up over and over again as not taking up health insurance offers. And, women between ages 45 to 64 are again disproportionately uninsured even after all this policy effort.

| Table 11 |
|-----------------|-----------------|-----------------|-----------------|-----------------|
| **Insurance Status of People under Current Law and after Enactment of Both an Illustrative Medicaid Expansion and an Illustrative Employer Mandate, 1989** (In millions) |
| **Total** | **Total** | **Total** | **Total** |
| **Continuing Existing Coverage** | **New Coverage** | **Coverage after Options** |
| **Employment-Based** | **Medicaid** | **Total** | **Employment-Based** | **Medicaid** | **Total** |
| **Total** | 243.7 | 199.2 | 36.9 | 10.6 | 243.7 |
| **Employment-Based** | 151.3 | 151.3 | 36.9 | 10.6 | 187.8 |
| **Public** | | | | | |
| **Medicare** | 30.3 | 27.9 | 2.4 | 27.9 |
| **Medicaid** | 14.7 | 11.7 | 3.0 | 22.4 |
| **VA** | 0.8 | 0.2 | 0.4 | 0.2 |
| **Other Private** | 14.3 | 2.4 | 9.7 | 2.3 | 2.4 |
| **Uninsured** | 32.7 | 21.5 | 8.1 | 3.1 |


Note: Details may not add to totals because of rounding.

In general people covered by more than one source of insurance are classified by the primary source. For example, elderly are classified as having Medicare, regardless of various forms of supplementary coverage from former employers, other private plans, or Medicaid.

Only the working aged, whose plans are primary payer to Medicare, are classified under employment-based coverage.

Works 25 or more hours per week.
One thing to notice in this table is the trouble experienced in coming up with another, let's say, third policy thrust that would offer universal eligibility by swooping up these remaining individuals. It would be like saying after all this is done we're going to drop eligibility cards from airplanes for anybody left over. It does become difficult with incrementalism to make insurance universal, even though some policies go a long way toward that direction. This last combination gets close to something like universalism, but isn't the universal insurance that was raised for this policy forum as an option.

**Alternative Reform Options**

For universal insurance of the more ambitious sort, eligibility is just simply required and the financing is quite different than under the previously mentioned combination plan. But this option is more taxpayer-oriented, so the uninsured are surely winners most of the time, and the taxpayers are the ones who are contributing for their cost. Hence, the "Ws" at the top of the column and the "Ls" at the bottom (table 1).

The private insurance, depending on how this universal program is administered, might be reduced even further to a bill paying role rather than an underwriting role, something the employer-self insurance trend has been doing all by its own anyway. Providers' roles clearly depend on the nature of the reimbursement system. They would get an expanded market under universal insurance. At the same time, the universality of buying might well lead to some cost-containment clout that might or might not have effect. The effect of this option on the providers depends on the net of these two fairly obvious things, expansion and market, but not buyer clout.

Regarding public care reform, the big worry here is on what the public finance economists call fiscal substitution. We've got a bunch of nonprofit hospitals and public hospitals that provide a lot of care. Will the hospitals continue to provide care at the same level or do local taxpayers, who seem particularly pressed, simply reduce the amount of resources they provide for health care. Therefore, the uninsured are not necessarily any better off than they were before, but local taxpayers may be better off. That's the big worry. How do you promote same level of effort? It's always a problem in these kinds of intergovernmental activities.

It's the same kind of thing regarding the uncompensated care story in mandates or anywhere else. Understanding the behavior of the providers when all this is going on will help understand whether they are going to provide uncompensated care to the remaining uninsured or whether they will pull back on that effort now that someone else is paying. The implications are quite different, depending on their behavior.

In the market-based reform the essential questions are, in technical terms, elasticities of demand, or, in nontechnical terms, who is going to pony up and buy the stuff.

Economists design optimums and tax incentives. They demand compliant, well informed and optimizing consumers to behave the way they are supposed to and buy only catastrophic coverage while not worrying about front-end coverage that we observe everybody really wanting. If people don't comply, then none of the wonderful cost-containment benefits and coverage happens. So, as an economist who has spent a lot of years watching people behave in health markets, even though I know in my heart catastrophic coverage is the right thing for everybody, they just don't seem to behave that way.
Health Care Reform: A Review of Five Generic Proposals

by Michael A. Morrisey, Ph.D., University of Alabama at Birmingham

Eli Capilouto, Robert Ohsfeldt, and William Custer provided valuable advice and comment for this paper. Stephen Henderli provided able research assistance. The remaining errors are, of course, my own.

♦ Introduction

The purpose of this paper is twofold. First, it reports and reviews the existing literature on the access, cost, and quality implications of alternative approaches to reforming the U.S. health care system. Second, it focuses on the role of health insurance in the employer-employee relationship. Health insurance is a part of the compensation bundle provided by some employers. Proposals that force health benefits into the compensation bundle result in reductions in other components. Attempts to take health insurance out of the workplace also lead to compensating changes in other dimensions of payment. This relationship provides insight into: (a) who pays for mandated employer benefits, (b) whether firms offering health insurance subsidize the health care benefits of those that do not, (c) whether the international competitiveness of U.S. firms would be enhanced by a national health insurance program, and (d) whether taxing health benefits but providing a tax credit for the purchase of health insurance or medical services would affect access to care.

Five generic approaches to health care reform are considered: mandated employer-sponsored health insurance; Medicaid expansion, including a buy-in provision for the near poor; expanded public provision of medical services; universal health insurance underwritten by the government; and market reforms designed to provide complete coverage through a system of tax incentives and redefined Medicaid options.

The report begins by reviewing the current estimates of the number of uninsured and the trends through the 1980s. It is now clear that we have overstated the number of uninsured. However, the number is still very large and is substantially larger than it was at the beginning of the decade. Section II develops the economics of employer-sponsored health insurance, providing the background for a review of the major proposals. Section III examines employer mandates. Section IV considers the literature on Medicaid expansions. Section V discusses the expansion of publicly provided health services. Section VI analyzes government underwriting and administration of universal coverage. Section VII explores proposals for market reforms. The final section briefly draws some conclusions.

♦ The Number of Uninsured

Estimating the number of the uninsured has become something of a growth industry, with at least six or seven estimates having been suggested. Estimates by Swartz (1988) and Chollet (1987) used the 1987 and earlier versions of the Current Population Survey (CPS) and found 37 million uninsured. Monheit and Short (1989) used the 1987 National Medical Expenditure survey and reported that 36.8 million people lacked either private or public health insurance coverage. However, these estimates appear to be much too large. Moyer (1989) carefully documents the change in survey design in the 1988 version of the CPS and argues that, more properly measured, the number of uninsured is in the range of 31.1 million. Needlemen et al. (1990) concur, arguing that their estimates, based on the 1988 CPS, yield 31.8 million uninsured. Holahan and Zedlewski (1989) go even further, asserting that the 1988 CPS does not fully consider the effects of the recent Medicaid expansions. Their model makes adjustments for these expansions and finds the number to be 29.5 million. Given all of these considerations, it would appear that, in round numbers, there were 30 million uninsured persons in the United States in 1987.

Thirty million is still a large number of people. It represents 12.4 percent of the population, or more impor-
stantly, 14.1 percent of the under-age-65 population. Aside from the relatively minor reductions resulting from the Medicaid expansions, this number is not a reduction from earlier values as much as it is a more accurate estimate. It still is the case that the number of uninsured has increased rather dramatically. The increase between 1980 and 1985 was almost 22 percent (Long, 1987). Needleman et al. (1990) find the increase to be on the order of 30 percent between 1980 and 1984, with the proportion of the uninsured population remaining fairly stable between 1985 and 1987.

Regardless of the estimates of their number, the distribution of the uninsured is generally agreed upon. (Data are from Needleman et al. (1990) unless otherwise noted.)

- Seventy-eight percent are white (however, 19 percent of blacks and 31 percent of Hispanics are uninsured).
- Fifty-three percent are male (however, 14 percent of males and 12 percent of females are uninsured).
- Twenty-three percent are aged 25–34, the single largest age category.
- Thirty percent have incomes below the poverty line: 17.8 percent are within 100 percent and 149 percent of the poverty line; and 13.8 percent are between 150 percent and 200 percent of the poverty level.
- Forty-three percent live in the South, 25 percent in the West, 18 percent in the Midwest, and 14 percent in the Northeast (Moyer, 1989).

However, there is some important disagreement about the proportion of the uninsured who are affiliated with the work force as workers, spouses, or dependents. Using 1985 data, Long (1987) reports that 65 percent of the uninsured have a work place affiliation. Using the 1987 National Medical Expenditure Survey, Monheit and Short (1989) report 77.9 percent. Using the 1987 CPS, Thorpe (1989) reports 66.5 percent. Using the 1988 CPS, Moyer (1989) reports that 80.5 percent of the uninsured are affiliated with an employer. Using the same source, Needleman et al. (1990) report 81.4 percent. This parameter is crucial because it drives the access and cost estimates of Medicaid expansions relative to employer mandates.

There are also estimates of the number of underinsured. Definitions, of course, are critical. Some have used definitions based on coverage for particular types of care or treatment. A definition that included coverage for long-term care, for example, would classify the vast majority of the population as underinsured. More useful studies tend to define the term based on large medical expenses relative to income. Farley (1985) defines a catastrophic loss alternatively as having a 1 percent or 5 percent chance of expending 10 percent of an individual's income for medical care. Needleman et al., 1990 use Farley's parameters to estimate that in 1988 approximately 20.1 percent of the under-age-65 population had a 1 percent chance of such expenditures, and 12.6 percent had a 5 percent chance. Of course, this approach has flaws as well; someone who buys a policy with a large deductible but otherwise excellent coverage can easily be underinsured by the Farley definition.

In short, about 30 million people, or approximately 14 percent of the under-age-65 population, have neither private nor public health insurance. Perhaps another 20 percent of the under-age-65 population are “underinsured.”

Economics of Employer-Sponsored Health Insurance

The theory of labor compensation has a long history in economics. However, rigorous study of employer-sponsored health insurance in this context is relatively recent, appearing in the work of Goldstein and Pauly (1976), Jensen (1986), and Danson (1989). Firms hire workers and, at the margin, pay them what they are worth. “Worth” is defined precisely as the amount of extra revenue that the firm receives from the efforts of the last worker in the job class. The firm would like to pay less, of course, but if it did so workers would tend to work for other employers.

Why would an employer ever offer health insurance in this simple world? The answer is equally simple: it costs less to do so. More precisely, workers place some value on health insurance and are willing to accept a compensation bundle that includes health insurance and somewhat lower wages rather than wages alone. If a firm finds that it can get health insurance at a price lower than what the worker is willing to give up in wages, the worker is happy with the new insurance-wage bundle and the firm has lowered its labor costs.
Health insurance tends to be less expensive when purchased through an employer. There are three reasons for this. The first has to do with insurance underwriting. Employed people tend to be healthier, on average, than those who are unemployed. Employment serves as a good signal of lower expected claims costs, and consequently an employer group can purchase coverage at lower cost than can an individual. The second reason has to do with the nature of the existing tax laws. Health insurance is not taxed as federal or state income, nor is it subject to FICA taxes. Thus, if an employee were to value a dollar of health insurance as equivalent to a dollar of take-home pay, an employer need only spend a dollar on health insurance rather than a dollar plus tax on money compensation. Third, there are economies in the marketing and administration of group and employer-group plans relative to individually purchased insurance.

From the workers' perspective, wages adjust to reflect the change in the other form of compensation now provided. Other things being equal, more health insurance means lower money wages, and attempts to reduce health insurance—for instance, through the use of increased deductibles—require that workers be "made whole." This concept of compensating differentials is the key to understanding insurance in the employment setting.

Compensating differentials, for example, imply that large firms that provide dependent health insurance do not subsidize the labor costs of smaller firms that do not offer health insurance. Rather, workers in both sets of firms are paid what they are worth. Those in larger firms take their compensation in the form of lower wages and more (perhaps much more) health insurance. Workers in smaller firms take higher wages and little or no health insurance.

But if health insurance lowers labor costs, why do not all firms offer this insurance? The answer is twofold. First, not all firms face the same costs of offering health insurance. Firms with high turnover face higher administrative costs, and smaller firms have higher administrative costs per worker. Further, as Chollet (1988) notes, small firms are particularly prone to adverse selection, including on occasion the employment of family members for the explicit purpose of insuring anticipated future medical expenses. Second, firms may be willing to offer health insurance, but minimum wage statutes prevent the compensating differential from taking place.

If some firms have lower labor compensation costs because they can offer health insurance more cheaply than others, why do not these lower cost firms drive the others out of business? The answer is that different workers place different values on having health insurance. There are several possible reasons for this. First, some workers prefer to spend their limited income on food and shelter rather than on health insurance; even given the lower price of insurance available through an employer plan, they would prefer the cash. Second, some workers are less likely than others to become ill. If they do not expect to use the benefit, it is of little value to them, and they would prefer the cash. Third, they may be covered under a spouse's or a parent's plan. The insurance is largely redundant, and they would prefer the cash. Finally, their income and assets may be near the Medicaid eligibility threshold in their state. A good Medicaid program would then be a substitute for private coverage; they too would prefer the cash.

The economic reasoning argues that firms that incur relatively low costs in providing health insurance will attract persons with stronger preferences for this coverage, and firms with higher costs in providing health insurance will attract workers who value insurance less intensely.

Employer Mandates

From 65 percent to 81 percent of the uninsured are either employed or live in a household in which there is a working adult. A seemingly straightforward way of expanding health insurance coverage would be to require employers to provide health insurance within the bundle of compensation that they offer their workers. The states of Hawaii and Massachusetts have enacted such legislation, and the Kennedy-Waxman bill and other bills propose a similar law for the entire country. The generic proposal requires that employers provide at least a minimum benefit package for their employees. Embellishments include the definition of covered workers (most importantly, a distinction between full time and part time), the required coverage of spouses and dependents, and the extent to which employers and employees "share" the premium. For example, the Kennedy-Waxman bill would require coverage for all workers.
employed 17 1/2 or more hours per week and for dependents unless they are covered by another employer plan. Eighty percent of the premium would be paid by the employer (unless the worker earns less than 125 percent of the minimum wage). The plan would cover medically necessary inpatient and outpatient care to a $3,000 stop loss (Kennedy, 1988).

The theory of compensating differentials has several implications for policy with respect to mandating employer-sponsored health insurance. First, it says that forcing an employer to provide health insurance means that money wages or other benefits of those workers currently without health insurance must fall. Workers currently without health insurance would pay the bulk of the price of mandated benefits.

Second, the theory implies that federal and state income taxpayers will shoulder a significant share of the cost. If a typical worker faces a 15 percent federal income tax rate, a 3 percent state tax rate, and a 14.9 percent (combined) FICA tax rate, taxpayers as a group would pay roughly 33 percent of the “employer-paid” mandated benefit cost in the form of tax revenue losses. Obviously, the taxpayer share depends on the relevant marginal tax rates.

Third, this approach clearly indicates that the predominant effect of introducing premium sharing between the employer and employee is to reduce the tax revenue loss. If the “employer pays,” the worker actually pays with pretax dollars. If the “employee pays,” the employee pays with post-tax dollars.

Fourth, firms forced to offer health insurance would be worse off. They did not offer health insurance initially because it was more costly than offering wages only. After the mandate, they would need to reduce wages more than others (since insurance is more costly to them), if they are to have no change in labor costs. However, since their workers value health benefits relatively less intensely, the cash wage decrease must be less than the cost of the benefits if these workers are to perceive themselves as being as well off as they were before the mandate. As a consequence, these firms face higher labor costs. They hire somewhat fewer workers. Some of these displaced workers migrate to other, most likely larger, firms. Others become unemployed.

Fifth, the presence of a minimum wage constraint further complicates the analysis. A worker earning the minimum wage is unable to legally absorb the compensating differential of a newly required health insurance mandate. More of these people lose their jobs, or they begin working in positions offering too few hours to qualify for the mandate.

**Access under a Mandate**

There are four groups of people who would be affected by a mandate. First are the uninsured who now get coverage. Second are those who previously had coverage through a public program, that is, Medicaid, Medicare, or CHAMPUS. Third are those who currently have coverage through an individually purchased plan or through a spouse or dependent. Last are those who have expanded benefits as a result of the definition of a minimum benefit package that could be identified in a mandate.

The various simulations disagree on both the number of uninsured and the proportion that have affiliations with the work place. These disagreements tend to cancel out; those with high estimates of the uninsured have low estimates of the labor force affiliation (table 1). Needleman et al. (1990) estimate that 25.9 million formerly uninsured persons would have coverage under a mandate. The Long (1987), Thorpe (1989), and Monheit-Short (1989) estimates are in the 24.2 million to 24.6 million range, although the Monheit-Short calculation excludes the self-employed. Only Danzon and Sloan (1986) are at odds with the other studies, with an estimate of 16.6 million. When estimates of part-time workers are added, however, their findings approach the others. Roughly, 24 million to 25 million formerly uninsured persons would have coverage.

The second group affected currently has coverage under a public program. These people would switch to coverage sponsored by an employer because the public program would become the secondary payer under most mandates. Most analysts assume that the bulk of those with privately purchased individual plans will likely drop that coverage since the mandate will make it largely redundant. Those with private group plans are more problematical. The issue is one of estimating the number of spouses and dependents who may change plans as a result of the mandate. Here the details of the differences in data sources produce divergent estimates. Essentially three of the four studies agree in aggregate that about 50
Table 1
Persons Affected by Mandate
(in millions)

<table>
<thead>
<tr>
<th>Source</th>
<th>Uninsured</th>
<th>Previously Insured</th>
<th></th>
<th></th>
<th>Total</th>
<th>Benefit Expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Danzon and Sloan [1986]</td>
<td>16.6</td>
<td>a</td>
<td>a</td>
<td>a</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>Long [1987]</td>
<td>24.2</td>
<td>a</td>
<td>a</td>
<td>a</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>Gramlich [1989]</td>
<td>23.0</td>
<td>5.3</td>
<td>29.0b</td>
<td>21.0</td>
<td>50.5</td>
<td>a</td>
</tr>
<tr>
<td>Monheit and Short [1989]</td>
<td>24.2</td>
<td>8.2</td>
<td>29.3c</td>
<td>62.1</td>
<td>a</td>
<td>a</td>
</tr>
<tr>
<td>Thorpe [1989]</td>
<td>24.6</td>
<td>9.5</td>
<td>14.3</td>
<td>49.7</td>
<td>25.9</td>
<td>a</td>
</tr>
<tr>
<td>Needleman et al. [1990]</td>
<td>25.9</td>
<td>9.5</td>
<td>14.3</td>
<td>49.7</td>
<td>a</td>
<td>a</td>
</tr>
</tbody>
</table>

a Not estimated by this source.
b This figure represents previously insured persons under public and private plans combined.
c This version of Thorpe's estimate assumes all eligible group members switch. If none do, this value is 10.3. Thorpe and Siegel, 1989, estimate only 13.3 million group switches instead of the 19.0 million reported here. If the alternative Thorpe numbers are used, his total estimate is 56.4 million.

A million people with one form of health insurance or another would switch plans. The Thorpe estimate represents an upper bound on the number of group insurance switchers. The estimates of Needleman et al. find a considerably larger effect among public switchers and commensurately smaller private switching. This results partly from the more recent data used in the Needleman report, which finds more people enrolled in Medicaid and thus more who would be affected by the mandate.

The Needleman report also provides an estimate of the fourth group of affected individuals: another 25.9 million people would be affected because their employer-sponsored benefit package would have to be expanded to meet the minimums of the proposed mandate.

The irony of these estimates is that the uninsured are asserted to be better off as a consequence of the policy change. That need not be the case. Clearly, those whose wages were constrained by the minimum wage and who kept their jobs would be better off. They would have their current wage and health insurance. (Over time, however, their money wages would not keep pace with inflation because the minimum wage is not indexed for inflation. In addition, the high turnover in minimum wage jobs tends to make this adjustment easier to implement.) Most currently uninsured workers would find that the compensating differential of wage reductions to pay for the health insurance would leave them worse off. If they perceived themselves better off by an insurance-lower-wage package, one would expect them to have taken employment opportunities that reflect that preference.

The switching of one sort of private coverage for another would also, in general, make workers worse off. Consider a family with two wage earners. Both are currently covered under the husband's policy. He receives lower wages and family coverage; she receives higher wages but no insurance coverage through her employer. The mandate proposals often require each person to have coverage provided by his or her own employer. The husband would now get higher wages and less insurance, the wife lower wages and more insurance in her compensation bundle. If there is the "separating equilibrium" Goldstein and Pauly (1976), Jensen (1986) and others believe, it implies that the husband's firm could not take full advantage of its lower cost advantage in acquiring health insurance, and the wife's employer could not take advantage of its cost advantage in paying strictly in money form. In a competitive labor market, both spouses are necessarily worse off.

Costs of a Mandate

The cost estimates of a mandate are generally described in terms of gross expenditures and offsets. The gross
expenditures relate to the cost of providing the mandated coverage. Offsets are spending that is currently taking place that would be eliminated by the presence of a mandate. Table 2 presents my attempt at reconciling the estimates of three most recent cost estimates. The Gramlich (1987) and Thorpe (1989) numbers are in 1988 dollars; the Needleman estimates are reported as 1989 dollars. Even without adjusting for inflation, the gross costs of the program are much higher under the Thorpe model. He estimates gross costs at $42.5 billion, over $4 billion more than the Needleman finding. Both models then subtract offsets for the uninsured and insured. Uninsured offsets are medical expenses that the uninsured would have paid out of pocket had a mandate not been imposed. Some uninsured individuals would now have to pay "their share" of the employer-sponsored premium and would face the deductibles and co-pays in any plan. Thorpe finds a net savings to the uninsured of $2.2 billion from these two effects.

Insured offsets reflect premiums and out-of-pocket costs that people are currently paying, whether through an individually purchased plan, a current group plan, or Medicare, Medicaid, or CHAMPUS. Subtracting these offsets yields estimates of between $21 billion and $32 billion in costs. The Thorpe estimates move from the most costly to the least costly, largely because his large estimates of affected insured people generate large potential offsets to the mandate. Needleman and company explicitly included many people who would obtain benefit expansions, but the marginal costs of these benefits are apparently quite small.

To greater or lesser degrees, the various studies attempt to go further in estimating the distribution of costs among firms, individuals, and the public sector. Some of the estimates are reasonable. Some are questionable. Some are simply wrong. Much of what is wrong has to do with ignoring compensating wage differentials.

The analysis of public-sector offsets appears largely correct. The effect of a mandate that makes employer-sponsored plans the primary payer, to the extent this can be enforced, would reduce the program costs of Medicare, Medicaid, and other public programs. In addition, state and county subsidies to providers for indigent care should fall. Gramlich and Thorpe estimate these potential savings at $5.1 billion and $8.0 billion, respectively. The Needleman report makes no estimate, but if its argument in favor of incorporating the recent Medicaid expansions is correct, the potential programmatic savings should be greater than the Gramlich and Thorpe estimates.

The questionable analysis has to do with the cost-shifting offsets. The implicit argument is that providers of health services charge higher prices to insured patients to cover the cost of uninsured patients. When there are fewer uninsured, there are fewer costs to shift. The questionable aspect of this offset is that there is little strong empirical evidence to support it and some good economic theory to suggest that prices to insured patients would not fall as a result of payments for the uninsured. Briefly, the economic argument is that a hospital concerned about the poor would do best by charging profit-maximizing prices to paying patients and using some or all of its profits to provide service to the poor. If the number of poor declines (due to the mandate), one expects the profits to be used for other purposes. However, reducing the price to paying patients would not seem to be one of the first options. The strongest evidence supporting cost shifting is the work of Dranove (1988). Using data from Illinois hospitals in the 1981–1983 period, he found that the state's reduction in the Medicaid program resulted in about 70 percent of the loss being shifted to private payers. On the other hand, Scheffler et al. (1988) examined the effect of the prospective payment system (PPS) on Blue Cross over the 1980–1986 period. They found that in 1986 Blue Cross achieved a $506.8 million savings as a result of the Medicare program. (Morrisey and Sloan, 1989, discuss alternative theories of cost shifting, review

<table>
<thead>
<tr>
<th>Table 2</th>
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<tbody>
<tr>
<td><strong>Cost of an Employer Mandate</strong></td>
</tr>
<tr>
<td>(in billions of dollars)</td>
</tr>
<tr>
<td><strong>Cost</strong></td>
</tr>
<tr>
<td>Gross</td>
</tr>
<tr>
<td>Offsets</td>
</tr>
<tr>
<td>Uninsured</td>
</tr>
<tr>
<td>Insured</td>
</tr>
<tr>
<td>Net</td>
</tr>
<tr>
<td>Cost Shift</td>
</tr>
<tr>
<td>Program Savings</td>
</tr>
<tr>
<td>Tax Cost</td>
</tr>
</tbody>
</table>
empirical findings, and provide some new estimates.) We failed to find evidence of cost shifting as a result of PPS in hospitals overall. There was some evidence supporting the cost-shifting hypothesis in urban hospitals. Frankly, I doubt that there would be substantial savings from reduced "cost shifting."

The wrong analysis relates to the distribution of the cost of a mandate across firms, the government, and employees. The Needleman report is the most naive in this regard. It argues that the net costs would be split between firms paying $26.8 billion in extra expenses, employees' expenses would be reduced by $1.1 billion, and governmental tax revenues would decrease by $7.2 billion. The correct analysis is to account for compensating differentials. If all of the insurance costs are reflected in lower wages, employees would face the entire cost of $32.9 billion. Because of federal and state personal income taxes and the FICA tax, the cost would be shared by the government (that is, by taxpayers generally) in the form of lost tax revenue. I assumed a 33 percent tax rate earlier. Since the "worker" is to pay for 20 percent of the new premium with after-tax dollars, this implies that approximately one-fourth (80 percent of 33 percent) of the cost would be borne by the government. The principal effect of worker/employer premium sharing would be on the proportion of the health benefits costs borne by the government.

Thorpe is also naive in allocating costs between "firms," "individuals," and "government." He is saved (but not exonerated) by his emphasis that these allocations are short run and that in the long run compensating differentials will be obtained.

Gramlich is correct in recognizing the nature of compensating differentials. His Congressional Budget Office study assumes that insurance costs are fully shifted except for those workers facing a minimum wage. The proportion of the costs borne by the government in their model seems low, however, at 18.4 percent, perhaps because they ignore state taxes. Danzon and Sloan (1986) also fully adjust for compensating differentials and the tax rate, assuming a 33 percent federal only marginal tax rate.

In short, the gross expenditure estimates from a variety of sources are reasonably consistent with respect to the gross costs of an employer mandate. The values tend to differ because of underlying differences in the data and sophistication of the modeling. I tend to believe the Needleman cost estimates of $32.9 billion. I believe that virtually all mandate costs would be shifted to workers in the form of lower wages. (It is worth emphasizing that this burden would not be shared by all workers equally. Rather, those currently employed persons without employer-sponsored coverage would pay as would those workers who are otherwise affected by the mandate.) However, as a consequence of the tax laws, the various federal and state governments ultimately would bear about one-quarter of these costs. The federal and state governments would also experience program budget reductions of something greater than $8 billion. Ironically enough, these costs would be largely transferred to the currently uninsured in the form of lower wages.

One might reasonably ask how quickly firms are likely to be able to complete their wage adjustment. Gramlich and Danzon-Sloan assumed that the effect would be complete in the first year. Phelps (1980) analyzed the same issues in the last wave of universal health insurance proposals. He argued at that time that, even in the presence of downward sticky nominal wages, the rate of inflation was such that a single year without money raises would allow real wages to adjust. I am not convinced that money wages are that sticky, particularly in the internationally competitive sectors that would be most affected by a mandate. I too subscribe to the one year adjustment period; nonetheless, the current rate of inflation suggests that two years without wage increases would certainly be sufficient to accomplish the real wage adjustment.

Other Issues

A consequence of a mandate and the existing minimum wage is that the wage for some workers could not adjust to reflect the newly imposed health benefits. Many of these workers would lose their jobs or see the nature of their positions redefined to less than 17 1/2 hours. Gramlich (1987) estimates that 6 million workers earning less than $4.00 per hour might face layoffs or reductions in hours. Most other estimates of the unemployment effect indicate that 100,000 to 250,000 jobs would be lost. These estimates focus on the low elasticity of demand for labor. They do agree, however, that most of the effect would be among part-time workers and teenagers. These are precisely the easiest jobs and workers to convert to 17 hour employment. Expect to see more teenagers with two very part-time jobs!
Most discussions of mandated benefits note that small firms are particularly harmed. How can this be if the employees bear the costs in the form of lower wages? The answer is to recall that firms face differential costs of acquiring insurance. With the forced change in the compensation bundle, small firms face relatively higher labor costs vis-a-vis larger firms. Because they cannot buy insurance as cheaply as others, they have to make larger wage cuts; their workers seek employment elsewhere, particularly in larger firms.

Finally, a fundamental reason why many workers do not have insurance through the work place has to do with their inability to produce enough of value to their employer. One long-run approach to deal with the root problem is to improve the productive capabilities of these workers, for example, by improving the primary and secondary educational system.

◆ Expanding Medicaid

Medicaid is the federal-state matching program that provides medical care to those who are eligible under various categorical programs, particularly Aid to Families with Dependent Children (AFDC) and Supplemental Security Income. Within each category, individuals and families that satisfy income and, generally, asset limits are eligible for coverage. States have reasonably wide latitude in setting both the limits on eligibility and the extent to which services are covered within the broad service categories identified in the federal legislation. States also have the option to cover other groups, such as the so-called medically needy. As of July 1989, the median state AFDC eligibility level was 46.2 percent of the federal poverty line. Only four states have levels above 75 percent of the federal threshold (Holahan and Zedlewski, 1989). Recent expansions of the Medicaid program have served to decouple Medicaid and the AFDC program for pregnant women and children under age five.

Calls for the expansion of Medicaid generally have several features: uniform eligibility standards set at the federal poverty level and decoupled from categorically needy programs. Some also call for a standard benefit package and modifications in the way providers are paid for services. Perhaps the best known example is the American Medical Association’s Health Policy Agenda for the American People (American Medical Association, 1989).

The economics of Medicaid expansions are relatively straightforward. The plans essentially provide public health insurance to those without it (subject to eligibility) at a zero price. Those without coverage get it. Conceptually, it is an easy step to further expand eligibility by allowing those with incomes above some threshold to buy into the program, paying a portion of the premium out of pocket. There is an incentive for those with private insurance coverage either individually purchased or obtained through an employer to drop their private coverage and take Medicaid. It is important to note that such expansions do not save labor costs for employers. Compensating differentials imply that workers opting for Medicaid coverage would gravitate toward firms that paid higher wages and did not offer health insurance.

Access under Medicaid Expansion

Holahan and Zedlewski (1989) estimate that in 1989 there were just under 28.1 million persons eligible for coverage for at least one month under the then current rules. Needleman et al. (1990) estimate some 32.2 million eligibles. Not everyone eligible for coverage will enroll. Needleman et al. conclude that about 72.5 percent actually enroll; Holahan and Zedlewski report 76.3 percent.

Table 3 presents the available estimates of the effects of Medicaid expansion. The comparisons become difficult because of alternative assumptions about the extent to which currently insured individuals drop private coverage. Danzon and Sloan (1986) provide the simplest estimate, the number of newly eligible uninsured, approximately 10.8 million. This is about one-third of the uninsured. Thorpe et al. (1989) reach a similar estimate for the uninsured (10.9 million). The estimates of both groups are biased upward by their use of the 1986 and 1987 CPS (respectively) with their inflated estimates of the uninsured.

The Thorpe team explicitly considers possible switchers from individual and group policies. Whether they switch or not depends upon the price of current policies and the actual benefits available under Medicaid in the state in which they reside. The number of currently insured estimated by the Thorpe team is biased downward for
the usual reasons relating to the early CPS data. However, their estimate of the total number of people affected is probably unaffected.

Holahan and Zedlewski (1989) arrive at a much larger number of total eligibles. However, they include 6.6 million currently eligible but unenrolled persons in their estimate. If these are netted out, their total of 21.1 million newly eligible persons is reasonably consistent with the Thorpe group finding.

Needleman et al. (1990) provide a single estimate of the effect of an expansion of eligibility, 25.1 million persons. Of these, they estimate that 13.4 million would actually enroll. This estimate exceeds that of the others in part because it is predicated upon all states also having a program for the medically needy. The table 3 notation estimates the new cost of enrollment increases from the medically needy expansion. Thus, their comparable estimate is 23.4 million persons.

It appears that about 18 million to 23 million persons would be newly eligible for coverage under a Medicaid program that set eligibility at 100 percent of the federal poverty level. It is unlikely that more than 72 percent to 75 percent of those eligible would enroll. In fact, since the propensity to enroll declines with income, a good case can be made that actual enrollment may be as low as 63 percent of the newly eligible.

The expansion of Medicaid will not be evenly distributed nationally. Those states with lower thresholds currently will see the largest increase in eligibility. Indeed, the various studies agree that the South and the mountain states, particularly, followed by the North Central regions gain the most in terms of eligibles.

Costs under a Medicaid Expansion

Table 4 presents the cost estimates of a Medicaid expansion that establishes the income eligibility threshold at 100 percent of the federal poverty level. Again, the available studies use different methodologies. As with the access estimates, the results depend critically on the number of persons who switch from private coverage. Danzon and Sloan (1986) ignore the switchers; they estimate $10.4 billion (1986 dollars) as the upper bound estimate of the cost of covering the uninsured only if all newly eligible persons actually enroll. The other studies make alternative assumptions. In the upper bound estimate from the Thorpe team, everyone newly eligible enrolls, leading to $14.8 billion in new costs (1989 dollars). Holahan and Zedlewski take a similar approach but have included those currently eligible but unenrolled as new eligibles; thus, they have a higher estimate of $18.7 billion (1989 dollars). The Needleman report estimates the new cost of those newly eligible who are estimated to enroll. Because everyone eligible does not enroll and because the newly eligible have higher

Table 3

<table>
<thead>
<tr>
<th>Source</th>
<th>Uninsured</th>
<th>Individual</th>
<th>Group</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thorpe et al. [1989] a</td>
<td>10.9</td>
<td>3.1</td>
<td>3.7</td>
<td>17.7</td>
</tr>
<tr>
<td>Holahan and Zedlewski [1989]</td>
<td>16.9 b</td>
<td>10.5</td>
<td></td>
<td>27.7</td>
</tr>
<tr>
<td>Danzon and Sloan [1989]</td>
<td>10.8</td>
<td>e</td>
<td>e</td>
<td>e</td>
</tr>
<tr>
<td>Needleman et al. [1990] d</td>
<td>0</td>
<td>e</td>
<td>e</td>
<td>23.4</td>
</tr>
</tbody>
</table>

a Thorpe's data are biased due to the use of the 1987 Current Population Survey. There are too many uninsured, and too few insured are eligible.

b This figure represents uninsured persons and persons insured under an individual plan combined.

c The Holahan and Zedlewski estimate is inflated by the inclusion of 6.6 million persons who are currently eligible for Medicaid.

d The Needleman et al. estimate is obtained by subtracting expanded mandate results (their table 33) from total new eligibles (their table 37).
e Not estimated by this source.
incomes and are less likely to enroll, the Needleman estimate of $10.7 billion is lower and perhaps closer to the likely actual result.

The regional distribution of these costs depends not only on the distribution of uninsured (and switchers) but also on the federal-state cost sharing provisions put in place. If the current sharing arrangements are maintained, states such as California, New York, Texas, and Florida face the largest state budget expenses (Holahan and Zedlewski, 1989).

Two of the studies also estimate cost offsets under Medicaid expansion. These are said to be of two kinds. Out-of-pocket offsets are expenditures that the newly eligible currently made for health services that would be covered by the expansion. Uncompensated care consists of expenditures for public indigent care funds and "cost shifting" to private payers that are no longer made (table 4). I discussed the questionable nature of cost shifts previously.

A second major issue in Medicaid expansions has to do with equalizing the benefit package that is available in each state. Thorpe and colleagues (1989) address this issue by considering the consequences of two alternative benefit packages. The Washington model reflects the Medicaid median benefit plan currently in use; the Minnesota model reflects the most generous Medicaid program. Adopting the Washington model would add $5.2 billion in costs for the currently covered plus $10.4 for the uninsured. If those with private individual and group coverage were also to switch en mass, this would add another $3.0 billion and $3.5 billion in costs, respectively. This total of $22.1 billion in new costs is in addition to the Thorpe et al. estimate of $14.8 billion (table 4) in costs of merely expanding eligibility to 100 percent of the poverty level. The Minnesota model is even more costly, adding $40.4 billion to the Thorpe et al. estimate. Two other states currently have programs similar to Washington's; thus adopting the Washington model as a minimum would affect 22 states. The Minnesota model affects the other 49 states. It is worth noting that a benefit expansion is likely to expand enrollment and costs. It is an open question how many people would switch from their current private coverage. However, if the Medicaid benefit package expands to the Washington or Minnesota model, it is increasingly likely that more people will switch. Consequently, the upper bound estimates become more important in these scenarios.

**Medicaid Buy-In**

It is clear from the foregoing that only about one-third of the uninsured would be covered by a simple Medicaid expansion to 100 percent of the poverty line. It is also the case that this sort of expansion would be quite costly,
incurring extra costs of $10.7 billion to perhaps as much as $15 billion. One approach to lowering these costs and to further expand eligibility is to develop a Medicaid buy-in. Under this mechanism, an individual would receive Medicaid benefits up to some income level, for instance, 100 percent of the federal poverty line. Above that level, there would be some form of sliding scale in which those with higher incomes would pay progressively less subsidized Medicaid premiums.

The principal economic issue in this expansion is the tradeoff between expansion of eligibility and premium sharing. The proposal provides a mechanism to expand eligibility to many more people. Expanding eligibility to 200 percent of the poverty line rather than 100 percent provides access to 33.7 million additional persons (Holahan and Zedlewski, 1989). The extent to which people will enroll in Medicaid depends on the premium subsidy they receive. At a higher subsidy more will enroll, but government costs will be higher.

Holahan and Zedlewski (1989) provide the most detailed analysis of these policy alternatives. They estimate, for example, that an expansion of Medicaid eligibility to 200 percent of the poverty line, holding benefits at current levels, would increase eligibility by 285 percent and program costs by 213 percent over the current system. They consider four buy-in rules: (1) people between 100 percent and 200 percent of the poverty level pay a Medicaid premium of up to 3 percent of their income; (2) they pay a premium of up to 10 percent of their income; (3) they pay a sliding premium of from 10 percent to 50 percent of the Medicaid premium; (4) they pay a sliding Medicaid premium based on a scale that runs from 10 percent of the premium at 75 percent of the poverty line to 100 percent of the premium at 200 percent of the poverty line. Under these options, the Medicaid program costs would decrease to 187 percent, 129 percent, 176 percent, and 132 percent, respectively. That is, the first policy option would reduce the cost of expanding Medicaid eligibility to 200 percent of the poverty line from 213 percent of current costs to 187 percent; the fourth option would cut costs to 132 of present costs. Holahan and Zedlewski conclude that "it is difficult to conceive of a buy-in strategy that would bring in substantially more revenues without imposing unrealistically high burdens on the poor."

Similarly, Needleman et al. estimate that 20.7 million people (16.1 million average monthly enrollment) would be added through a buy-in extending Medicaid eligibility to 185 percent of the federal poverty level. The cost was estimated at $20.7 billion, of which less than 14 percent would be paid as premium contributions by Medicaid participants.

Combining a Mandate with Medicaid

A number of analysts have considered combining an employer mandate with an expansion of Medicaid. The rationale is generally twofold. The combination reaches more of the uninsured than either feasible plan separately, and the employer mandate reduces the cost of the Medicaid program. There is a certain irony in this. One reason the Medicaid program becomes so expensive is that the levels of premium sharing in the program cannot go higher without becoming a burden on the poor. When it is such a burden, there is fear (but little hard research evidence) that people will ignore the buy-in and remain uninsured. The solution is said to be employer-mandated insurance. The irony is that many of the people who are uninsured now and who are thought to ignore a Medicaid buy-in are the very ones who would pay the full price (less tax subsidy) of mandated employer insurance as a result of compensating wage differentials.

Briefly, consider the numbers. Table 5 presents the results of the Thorpe, Holahan, and Needleman simulations for a program that includes an employer mandate, Medicaid eligibility expansion (only) to 100 percent of the poverty level, and a Medicaid buy-in for the near poor (generally up to 200 percent of the poverty line, with a maximum payment of 3 percent of income). Given the differences in methods and data in the earlier policy options, it should come as no surprise that the estimates are widely different. Indeed, the differences tend to be compounded when the policy options are integrated.

The important point, from my perspective, is that by any of the estimates no more than 37 percent of the cost of this dramatic expansion in coverage is borne by the Medicaid program. As a result of compensating differentials, the remaining costs are incurred by individuals, many of whom do not have insurance currently. Very roughly, 37 percent of the program costs are borne by Medicaid, 17 percent by lost federal and state tax revenues, and the remaining 46 percent by essentially low-income workers.
Quality of Care under Medicaid Expansion

The consequences of any expansion of Medicaid for quality of care depend upon one's beliefs about the differences in the quality of care between privately insured care and Medicaid. To my knowledge, there is no empirical literature that directly addresses this issue. There are some hints, however. Fosset and Peterson (1989), among others, have argued that physicians tend to specialize in either private or Medicaid patients. The style and costs of practice (and perhaps the quality) are different. Sloan et al. (1988) argued that hospitals tend to specialize in paying patients, particularly when there is a public facility in the community. This specialization may be an indication of differential quality. At the theoretical level, Morrisey et al. (1984) show that in a profit-maximizing competitive world a reduction in a governmentally imposed price necessarily results in a degradation of quality. If Medicaid does pay less, then the quality of care will be below that of other payers, at least in the context of this model. The appropriate comparison, however, may not be relative to private markets. Rather, is not the relevant comparison between Medicaid and the care the uninsured would otherwise be getting? However, in the absence of empirical measures of quality (be they clinically or satisfaction based), research will be unable to address this issue.

◆ Expand Public Provision

A third alternative is to seek to expand the public-sector provider systems already in place. This could include a

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Table 5

Combined Mandate, Medicaid Expansion, and Buy-In

<table>
<thead>
<tr>
<th>Persons Affected (in millions)</th>
<th>Mandate</th>
<th>Medicaid</th>
<th>Buy-In</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thorpe and Siegel(^a)</td>
<td>48.2(^b)</td>
<td>7.2</td>
<td>6.5</td>
</tr>
<tr>
<td>Needleman et al.(^c)</td>
<td>49.7</td>
<td>11.8</td>
<td>4.1</td>
</tr>
<tr>
<td>Holahan and Zedlewski(^d)</td>
<td>e</td>
<td>8.2</td>
<td>3.4</td>
</tr>
</tbody>
</table>

Gross Costs (billions of 1989 dollars)

<table>
<thead>
<tr>
<th>Mandate</th>
<th>Medicaid</th>
<th>Public</th>
<th>Private</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thorpe and Siegel(^f)</td>
<td>$33.0</td>
<td>$11.5</td>
<td>$7.6</td>
<td>$1.6</td>
</tr>
<tr>
<td>Needleman et al.(^h)</td>
<td>39.4</td>
<td>15.4</td>
<td>9.2</td>
<td>2.6</td>
</tr>
<tr>
<td>Holahan and Zedlewski(^j)</td>
<td>e</td>
<td>7.7</td>
<td>10.9</td>
<td>1.4</td>
</tr>
</tbody>
</table>

\(^a\)From Thorpe and Siegel, 1989, table 8. Buy-in assumes a 3 percent of income maximum to 200 percent of the poverty level.
\(^b\)Value ignores 8.2 million persons who switch from public to private plans. See Thorpe and Siegel, 1989, table 2 footnote. Even this inflated value is below that of Thorpe, 1989, which reports a 5.7 million higher value. Apparently this results from fewer group switchers but the rationale is unclear.
\(^c\)From Needleman et al., 1990, tables 49 and 57. Buy-in assumes a 5 percent of income maximum to 185 percent of the poverty level. Values are for enrollees.
\(^d\)From Holahan and Zedlewski, 1989. Buy-in assumes 3 percent of income maximum to 200 percent of the poverty level.
\(^e\)Not estimated by this source.
\(^f\)From Thorpe and Siegel, 1989, table 8. Mandate cost does not correspond to Thorpe, 1989, even with inflation adjustment. Appears to be drawn from alternative source; see page 2115, column 3, paragraph 2.
\(^g\)There is also an estimated $2 billion in savings from the mandate-induced switch from public to private coverage. See Thorpe and Siegel, 1989, table 8.
\(^h\)From Needleman et al., 1990, tables 50 and 58.
\(^i\)There is also an estimated $6.5 billion savings from plan switchers. See Needleman, 1990, table 50.
\(^j\)From Holahan and Zedlewski, 1989, pages 55 and 87.
variety of options: provide greater subsidies to public general hospitals, expand the charge of the Veterans’ Affairs’ hospitals and clinics, or expand the role of public health departments in caring for the uninsured. These proposals tend to be less well articulated and have little in the way of formal research and policy simulation designed to identify the implications of the actions.

One way to phrase this policy option is to consider it as a literal alternative to Medicaid or to Medicaid expansion. Then the fundamental issue is: for the cohort of the population likely to use the services of these providers, would this approach be more or less efficient than, for instance, a Medicaid expansion? The issue of cost is involved in this question, and there is also an assumption that services and quality would be identical to those of the Medicaid program. This phrasing of the problem also ignores the access issue, because it assumes that care from a public provider would be as readily available as it would be through a Medicaid expansion. In the short run, such is surely not the case. This leads to questions of public-sector construction or, alternatively, public-sector contracting with private providers for the provision of care. In fact, the difference between an employed physician and a public preferred provider in this context is only the “details” of the provider contract.

I know of no systematic studies designed to explicitly address these issues. Again, we have hints from studies designed for other purposes. The cost literature is perhaps most complete. There is a long history of studies of hospital cost and production functions in the United States. These studies tend to find that short-term, general, acute care hospitals owned by state or local governments have lower costs. Grannemann et al. (1986) is perhaps the best recent example. They use 1981 American Hospital Association data and a sophisticated multiple output translog cost function and find, among other things, that public general hospitals have inpatient costs that are 8 percent lower than those of other nonprofit hospitals. Grosskopf and Valdmanis (1987) use frontier production functions to demonstrate that state and local government-owned short-term acute care hospitals were marginally more efficient relative to other nonprofit hospitals in a sample of California metropolitan area facilities. Both studies, however, suggest that the differences may be attributable to differences in case mix or quality of care that the studies were not able to control for adequately. Nonetheless, there is some evidence that public hospitals may be less costly than private facilities. One would have preferred, of course, to see studies that both controlled for case mix and quality of care and reflected changes in technical efficiency that may have taken place since the advent of Medicare prospective payment.

A second body of literature relating to the issue of public provision of hospital care has to do with the relative performance of Veterans’ Affairs’ (VA) hospitals. The VA represents a large federally administered health care system and as such could be viewed as either a prototype of an expanded system of public hospitals for the uninsured, or indeed, as a system that could be expanded to provide care for the uninsured. Again, the research literature is far from definitive. Rogers et al. (1989) used data on patients with 10 common diagnoses treated at a VA and private hospital with a common set of house officers. After controlling for severity of illness, age, race, and physician, they found that the VA patients had an average length of stay that was 3.2 days longer than private hospital patients. This confirmed earlier results based upon Health Interview Survey data (Wolinski et al., 1985). The findings suggest that VA hospitals may be less efficient inpatient care providers than private facilities. A VA staff study of cost differences between VA and non-VA facilities used several approaches to comparing VA costs with private-sector costs and reimbursements (Graham, 1986). It found that, under some comparisons, VA hospitals were more costly, under others less costly. No unambiguous conclusion could be drawn. It has also been suggested that VA hospitals provide lower quality care than that provided in private-sector facilities. These conclusions, however, are based upon the Health Care Financing Administration mortality-outcomes methodology and have been severely criticized as an inappropriate approach to analyzing VA hospitals. See Iglehart (1985) for a discussion.

While the evidence is far from definitive, there is no overwhelming evidence that the public-sector providers are less expensive, and there is some suspicion that the differences that do exist may be attributable to differences in the product that public facilities provide.

However, this approach does not avoid the access and cost burden issues of mandates or Medicaid expansions. Eligibility still has to be defined and benefits specified. If
the benefit package is at all attractive, it means that some currently insured individuals will drop their existing coverage and some employer-sponsored plans will cease to exist. (And, of course, wages for these workers will rise.) If the eligibility and benefits are identical to a Medicaid expansion and physical access is no different, one should expect the same degree of switching.

♦ Universal Coverage

Universal health insurance proposals generally envision an expanded role for the government as the underwriter/administrator of a single insurance plan that provides coverage for all or virtually all citizens. The proposal of the Physician's for a National Health Program (1989) is an example that borrows heavily from the Canadian model. Indeed, the Canadian system can serve as a generic example.

The system, established in the early 1970s, consists of 10 provincial plans that cover the hospital and physician services, generally with no out-of-pocket payments. While people are effectively prevented from purchasing private insurance coverage for covered services, they have free choice of physician and hospital. The provincial health plans negotiate a global budget with individual hospitals and a fee schedule with the provincial medical society. The plans are financed by provincial and federal general tax revenues. The federal share has been declining but is currently about 38 percent.

The economics underlying such proposals are straightforward. It is argued that a single underwriter/administrator will be able to exercise monopsony power over providers; that is, because the plan is the sole purchaser of services, it will be able to arrange prices that are below those that would otherwise prevail in the market. (In the monopsony model, this result follows naturally from the purchaser's explicit decision to reduce the quantity of the service to be purchased.) Advocates argue that cost savings also (and perhaps primarily) result from administrative savings from reduced paperwork and multiplan redundancy. I will limit my comments to two issues: the evidence with respect to the lower costs available from these systems and the effects on employers and employees.

Cost and Quality of a Universal System

The relevant question is whether such a system can provide the same outcome at a lower cost. The answer from the research literature is that we do not know and are only beginning to look. The problem is quite complex. First, one might ask whether the prices of medical inputs are lower under the centralized system. Is the average cost of a hospital day lower, for example? This does not really answer the relevant question. There are many ways to produce equivalent health care; a monopsony system may be expected to use a different mix of physician or hospital services because both inputs are equally well insured. Thus, health care costs per capita would seem a better measure, since it allows for differences in the volume of services used. But different volumes of health services do not necessarily imply the same amount of health care. Thus, a better measure may be costs per some measure of clinical outcome. Clinical outcome is not the ultimate denominator, either. Individuals have different tastes and preferences for specific procedures, treatment styles, and amenity levels. A system that provides the "wrong" output at a lower cost is not, necessarily, better (or worse) than one that provides the "right" output at a higher cost. Finding nirvana, much less the constrained bliss point, is not an easy task.

Nonetheless, work has begun on addressing some of the easier versions of the relevant question. It is well known that Canadian health care expenditures as a percentage of gross domestic product are lower than those of the United States and have been lower since the implementation of the Canadian universal coverage system. Schieber and Poullier (1989) report that in 1987 the Canadians spent 8.6 percent; the United States spent 11.2 percent. However, while the percentage is lower, Neuschler (1990) argues that much of this difference is an artifact of a more rapidly growing Canadian economy. Examining inflation-adjusted growth in health care costs between 1977 and 1987, he finds that the average annual increase in Canada was 4.28 percent, compared with 3.93 percent in the United States.

Recently, Newhouse et al. (1988) examined cross-country differences in hospital cost and usage for those over age 65. They argue that the United States spent about 50 percent more per person than Canada through-
out the first part of the 1980s. (Evans [1988] argues convincingly that a more appropriate exchange rate consideration makes the difference 25.6 percent.) The Newhouse analysis suggests that admission rates and case mix of admissions were similar. The Canadians had longer lengths of stay, but the United States appears to use more inputs and/or pay higher prices for those inputs. Rublee (1989) provides evidence that the per capita levels of selected high technology inputs such as magnetic resonance imaging, cardiac catheterization, and open-heart surgery are much higher in the United States than in Canada.

There are, of course, two interpretations of these findings. One view holds that the Canadian system has a lower quality of care. The alternative is that the U.S. system is wasteful. The as yet unanswered question is what, if anything, the United States buys for its additional intensity.

The evidence with respect to the quality of care in the Canadian system is far from definitive. The American Medical Association (1990), Neuschler, (1990), and Brown (1989), among others, cite numerous examples of waiting lists for postponable surgery, diagnostic tests, and specialty visits. Evidence of temporary hospital bed closures to meet budget constraints and overcrowding of emergency rooms is also presented. It is also argued that one reason for the apparent success of the Canadian system is that the U.S. medical market serves as a safety valve for Canadian citizens; those with intense demands for immediate care can cross the border and obtain it. The evidence on quality of care, however, is largely anecdotal. We have little hard evidence as to extent of such problems. The best hard data deal with the quantity of high technology capital reported by Neuschler (1990) and Rublee (1989). These measures, unfortunately, relate to medical inputs, not outputs. We simply do not know if these differences matter to quality of care and patient satisfaction. The data do suggest that there is cause for concern, however.

Employer and Employee Effects

The adoption of a universal model of health insurance has virtually no effect on employers as a group. Adjustments in the compensation package again serve to mitigate the effect. Consider a universal health plan funded from general tax revenues. Workers would find that they get the same health insurance whether they work or not. Thus, health benefits are not a valued form of payment. Since firms still wish to hire as many workers as formerly (or indeed more if they believe that their labor bill will decline), competition in the labor market forces employers to pay workers more—in fact, to pay them, after taxes, the equivalent of what they were making prior to the universal health plan. Money wages and other benefits must fully adjust for the value the workers formerly placed on the health benefits. As a consequence, no international competitive windfall would be gained by U.S. producers through the enactment of universal coverage.

There is at least one way that some U.S. employers could gain. This is the relative advantage of small versus large employers. I argued above that small firms do not offer health insurance because it is relatively more expensive for them. A mandated benefit would work to their disadvantage because they would have to provide health coverage, which is a relatively more costly form of compensation. Under a universal model, larger firms would lose their compensation cost advantage relative to small firms. The large firms would find that, to make workers whole, they would have to pay more in gross wages than they pay in wages plus health benefits. Thus, large employers would be made (somewhat) worse off, and small firms would find it (somewhat) easier to hire workers.

Employees would not be clear gainers, however. Their wages and nonhealth benefits would rise as a result, but so would the tax rate. If the universal plan would be less costly, as its advocates assert, the average worker would find that he or she is better off. On the other hand, if the program is more expensive, the average worker would end up worse off because the tax burden would now be greater than the value of the former insurance.

There are other important factors in considering gainers and losers. Low-income uninsured workers would gain (and certainly gain relative to an employer mandate), because the tax burden would be more broadly distributed. Actual tax incidence would depend on the ability of workers and their employers to devise alternative nontaxed forms of compensation.

◆ Market Mechanisms

A final category of health care reform relates to market-based approaches to reform. These approaches also call
for universal coverage, but they rely on governmental incentives and competition in the market rather than on governmental provision of services or insurance underwriting. One of the more articulate of these proposals is that of the Heritage Foundation (Butler and Haislmaier, 1989). It proposes three goals: universal access to care, market-based incentives to moderate costs, and a governmental guarantee that families would not suffer catastrophic loss due to illness. Their package of reforms includes legislation requiring all individuals to be enrolled in a health insurance plan; redirecting tax incentives away from the employer and toward the individual, with an eye toward encouraging the purchase of policies with large deductibles and assisting families with catastrophic illness; targeting Medicaid on the indigent regardless of age and giving states more flexibility to design programs; and redesigning Medicare to provide incentives for people to buy private-sector health and long-term care coverage. Included in this strategy is the removal of state-specific coverage mandates.

Conceptually, this plan has much to recommend it. However, in execution it suffers from some misunderstanding as to the workings of the labor market. I will limit my remarks to the elements of the plan that will affect most U.S. residents: the tax incentives and the changing role of the employer in the provision of health insurance.

**Tax and Employer Health Benefit Issues**

I noted above that insurance is offered through the workplace for two fundamental reasons. Employees value health insurance, and it is cheaper for both the employer and the employee to get health insurance through the workplace. There are three reasons for the lower cost through an employer: health benefits are tax exempt, lower claims experience by virtue of the employment signal, and lower costs of sales and administration.

The Heritage proposal removes the tax exemption by treating health benefits provided through the employer as taxable income. Instead, the tax paying unit (individual or family) is given a tax credit equal to, for instance, 20 percent of its health insurance premiums and 30 percent of its out-of-pocket health care expenditures. The argument is that such a system of incentives would force consumers to face the actual premium costs of their health insurance policy and give them an incentive to search for a policy and premium that better fit their needs. The higher out-of-pocket tax credit is designed to encourage people to purchase health insurance plans that cover unexpected catastrophic illness. A plan with a large deductible would be an example.

Consider the economics of the proposal’s tax elements. Suppose the proposal simply called for health benefits provided through the employer to be treated as taxable income. The incentive to provide employer-sponsored insurance would be reduced, and employers would provide less of it. However, workers would still have to be paid the value of the services, and other forms of compensation would increase. Now suppose that the government allowed workers to deduct their health insurance expenses from their taxable income. This would have the effect of making the tax-adjusted price of health insurance exactly the same as it was before. At the same tax price, the same quantity would be purchased.

The Heritage plan is a bit more complex. Rather than a tax deduction, it proposes a tax credit. If the size of the tax credit were set at a level identical to the value of the (implicit) deductible for the average formerly employer-insured worker, the average worker would be unaffected. Lower-income workers would have a greater incentive to purchase insurance, and higher income workers would have a reduced incentive because the tax credit is not tied to income the way a deduction is. This leads to my first point. The incentive to alter the health insurance plan comes from the difference in the tax subsidy imposed under the Heritage plan. If the average worker currently faces a total marginal tax rate of 33 percent, a tax credit of 20 percent of the premium on health insurance would reduce the incentive to buy health insurance. The key issue is not that the tax subsidy is directly given to the worker, but that the tax subsidy relative to the current subsidy is smaller.

A second contention of this proposal is that, by shifting the tax incentives directly to the individuals, they will shop for health insurance and purchase less complete coverage. This is unlikely to happen. In fact, at the same level of tax subsidy, most workers will continue to buy the same insurance bundle through their employer. Search theory suggests that one spends time in search up to the point where the expected savings from further search just equals the opportunity cost of time. One then
buys the best option discovered. Employers have precisely the same search incentives. If, by continued search, they can find insurance packages that are equally attractive to their workers but costs less, they can switch coverage and pocket the cost savings. With even moderate-sized firms, they are likely to search harder than any individual because they have more to gain. Thus, employers are likely to be able to find the better insurance deals. Furthermore, recall that employers have other reasons to offer health insurance than the tax incentive: lower expected claims experience and economies of scale in enrollment and plan administration. Thus, employers will most likely continue to be the low-cost source of health insurance for the employed.

Because of the lower tax subsidy in the Heritage plan, however, employers will have an incentive to alter the benefit package they do offer. Phelps (1984) and Wilensky et al. (1984) present data supporting the view that, in the face of reductions in tax subsidies to health insurance, employers would tend to drop “fringe” benefits (that is, coverage for such things as dental and vision care). Only with major tax subsidy changes should one expect to see reductions in coverage for physician and hospital care.

The Heritage plan also provides for larger tax credits for out-of-pocket health care expenditures by individuals. The argument is that this will further spur the choice of large deductible type benefit packages. First, the plan in effect makes the government an insurer of front-end health insurance. It offers a single policy that has a 30/70 copayment feature. That is, the government will pay 30 cents on the dollar for all uninsured health care expenditures. This does provide increased incentive to offer only higher deductible policies. However, it is not at all clear that such a government subsidy (and an expensive one at that) is necessary to achieve the goal. Simply decreasing the tax credit on health insurance still further should achieve the same goal.

The Uninsured and Indigent

The Heritage model provides several means of dealing with these individuals. First, it proposes that the tax credits be refundable. If an individual lacks sufficient income on which to pay tax, he or she would receive a government check for the 20 percent or 30 percent of relevant expenses eligible for the tax credit. Individuals would be allowed to receive the same tax credits if they buy health insurance for family members or other individuals. Similarly, they would receive tax credits for paying the medical expenses of others. This serves to encourage the purchase of insurance for children by parents and for parents by children. For those with catastrophic illness events, they propose that the tax credit could rise to 50 percent or 75 percent of the medical expenses above income thresholds. Thus, for someone with medical expenses above, for instance, 5 percent of income, the refundable tax subsidy would be 50 percent of medical expenses. They also propose that states be given flexibility under Medicaid to offer vouchers or to provide services for those unable to buy health insurance with their own income.

The economic issue partly revolves around the plan’s cost. The key cost distribution issue, however, is how much insurance an individual must purchase. In the absence of the Heritage requirement that everyone enroll in a plan, the tax subsidy for out-of-pocket expenses and the sliding scale catastrophic measure provides strong incentives to substitute out of privately purchased insurance and into the government plan. Thus, a key policy element would seem to be some government provision for what constituted an adequate private plan. A bare bones plan requirement implies potentially high government costs. Low government costs require more substantial “meddling” in the private benefit package.

◆ Conclusion

This paper has considered five generic approaches to health care reform. With the exception of the Medicaid expansion proposal, all of the plans tend to be somewhat naive in their anticipated effects. This is often the result of ignoring compensating differentials in the employment setting. Employers do not pay for the coverage of their workers under an employer mandate. An employer mandate would not be less costly to a worker than a Medicaid buy-in. Universal health insurance would not make U.S. industry more competitive internationally. Taxing health benefits and providing an equal-sized tax credit for health insurance would not change the average worker’s insurance coverage.

To make better policy, policymakers and policy analysts must more seriously consider the functioning of the
markets they wish to change. Institutional arrangements do not come into being, or at least do not remain over time, by accident. Good-hearted attempts to change these arrangements can end up harming the very people the program was supposed to help.

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