Cite this article as:
G R Wilensky
Viable strategies for dealing with the uninsured
*Health Affairs* 6, no.1 (1987):33-46
doi: 10.1377/hlthaff.6.1.33

The online version of this article, along with updated information and services, is available at:
http://content.healthaffairs.org/content/6/1/33.citation

For Reprints, Links & Permissions :
http://content.healthaffairs.org/1340_reprints.php

Email Alertings :
http://content.healthaffairs.org/subscriptions/etoc.dtl

To Subscribe :
https://fulfillment.healthaffairs.org

Not for commercial use or unauthorized distribution
VIABLE STRATEGIES
FOR DEALING WITH
THE UNINSURED

by Gail R. Wilensky

Prologue: One of the stunning realities of the indigent care problem facing the United States is that the majority of its victims are not on the public dole, but are employed workers and their dependents. Many of these people are employed by small businesses that offer a far more modest package of fringe benefits than the large American corporation. As the service industry has burgeoned, and with it the proliferation of more jobs requiring fewer skills, the number of uninsured workers has increased, too. In this essay, Gail Wilensky outlines strategies that could be pursued on behalf of reducing the number of uninsured people. There have always been a substantial number of people without health insurance. The estimated size of this population has increased from 25 million in the 1970s to more than 31 million today. As Wilensky points out, one of the major forces propelling this issue is the introduction of more competitive pressures in health care. She says: “As business and government continue to demand better value for their dollar, the uninsured can expect to find it increasingly difficult to gain access to the health care system.” Wilensky, who has closely tracked indigent care issues for a number of years and developed a national reputation in the process, places the greatest emphasis in her paper on incremental strategies for pursuing the indigent care issue. This emphasis places in sharp relief the absence of political will that exists for considering the indigent care problem as a crisis calling for a bold and uniform national response. Wilensky received her doctorate in economics from the University of Michigan. She was instrumental in designing and implementing the National Medical Care Expenditure Survey while working (1975-1983) at the National Center for Health Services Research. Since 1983, she has been in charge of Project HOPE’s domestic division and director of its Center for Health Affairs.
The problem of providing medical care to individuals who lack insurance has become a staple of the health policy diet, but no ready solutions have emerged. Several truths seem apparent, though, for anyone who has wrestled with this question. There is no silver bullet that will somehow emerge as the answer to our policy dream. America’s pluralistic health care system dictates that any solution must involve both the public and private sectors, and any answer will not be forever but rather the next chapter in an evolving saga of public policymaking.

The number of uninsured and their characteristics, the amount and distribution of uncompensated care and its consequences, and the nature of the problem in a competitive environment have been discussed innumerable times. It is therefore sufficient to summarize these issues before considering strategies to deal with the uninsured.

The Problem

The United States has always had many individuals without health insurance. Most estimates indicate that there were about 25 million people uninsured at any point throughout much of the 1970s. These were not, of course, always the same people—some were uninsured for only a few months, while others were uninsured for long periods. Since the end of that decade, the number of uninsured has increased at least moderately and maybe substantially, as has the amount of uncompensated care, most but not all of which is associated with the uninsured.

These increases, coupled with health care costs that have continued to rise faster than wages, profits, and government revenues, have exacerbated the present problem and led to an increased awareness about the issue. However, the fundamental reason the problem has worsened and the cause for the heightened concern is not the change in the numbers but the change in the financial environment of health care. This change has been characterized by the adoption, by all the major purchasers of health care, of a “prudent buyer” mentality—both in government and in the private sector. This mentality is hardly an unreasonable attitude for purchasers to adopt, but it has meant that the traditional way of financing care for the uninsured—by including the charges in the bills of private paying patients (the so-called cost shift)—is increasingly difficult. The movement away from cost-based reimbursement and the introduction of more competition into health care has meant that the problems of the uninsured that were more or less masked before the 1980s can no longer remain hidden. Nor is it just a problem of “who will pay.” Research has shown that the uninsured systematically use less medical care than the insured population, and that they are less likely to seek care when sick. This means that as business and government continue to
demand better value for their dollar, the uninsured can expect to find it increasingly difficult to gain access to the health care system.

The number of uninsured in 1980 was only slightly higher than in the 1970s—about 26 million. There is some dispute about how much that number increased during the recession of the early 1980s. Estimates have ranged from 29 million to 34-35 million in 1983.3

There is greater discrepancy regarding the number after the recession. Two sources, the Current Population Survey (CPS) and the Survey of Income and Program Participation (SIPP) reported that there were 34-35 million uninsured in 1983. In 1984, however, the CPS indicated that the number had increased to 37 million; SIPP meanwhile reported that the number had fallen to 31 million, a substantial decline though still higher than prerecession levels.4 The lower estimate seems to make more sense given the 3 percent decline in the unemployment rate since the depths of the recession, even acknowledging the shift out of manufacturing and into service sectors. However, only additional data and further analysis will resolve this debate.

Despite the dispute about the absolute number of the uninsured, the characteristics of this population appear surprisingly stable from survey to survey: (1) About half of the uninsured are employed either full or part year; when their dependents are included, the employed uninsured account for 70 to 75 percent of the uninsured population; (2) While 35 to 40 percent were in families who are poor, at least one-third of the uninsured were in families whose income was twice the poverty line; and (3) Almost 90 percent of the employed uninsured worked for employers who did not offer health insurance.5

A question often raised is whether a market-oriented strategy can accommodate the poor. The answer seems to me to be clear—yes, but only if we recognize explicitly how health care for the poor is to be financed, What a market-oriented system cannot do is continue to finance implicitly, that is, by hidden subsidies, the care of the uninsured. This means that we cannot avoid decisions about how much we as a society are willing to spend on those who cannot finance their own health care and the circumstances under which they will receive their health care. Those who most support market-oriented reforms need to understand that clear decisions about how the uninsured will be cared for must be made if these reforms are to succeed.

Restructuring The System

Two basic strategies could be followed to cover the uninsured: completely restructuring the system or incremental “gap filling.” The major advantage to restructuring is that a new system could be more rational than the one that has developed historically. In addition, it can provide
mechanisms to cover all of the poor and/or uninsured. There is, of course, no guarantee that, just because we deliberately set out to redesign a system, the result will end up more rational or efficient than the system it replaced, though presumably we will have learned from previous mistakes. The obvious disadvantage is that a major restructuring is much more difficult to accomplish politically, since it threatens an existing power structure and must overcome current inertia.

When policy analysts speak of a new health care structure, most people think of national health insurance. Predicting major changes in political and economic systems is obviously very difficult, but, at least in the near future, national health insurance, at least as it exists in Great Britain or in Canada, does not seem likely. Nonetheless, the pressures being generated by the uninsured in a competitive environment, particularly if costs continue to increase at a rate twice as fast as the rest of the economy, will be very great. The possibility of national health insurance, particularly an American adaptation of the Canadian version, may therefore be regarded as an option for at least a segment of the electorate.

The Enthoven proposal. A strategy that has always seemed much more consistent with the American way of doing things—emphasizing competition, free enterprise, decentralization, and limited government—is the health plan advocated by Alain Enthoven. The restructuring he envisions is that our current open-ended tax exclusion of all employer-provided health insurance coupled with a Medicaid program for a limited number of the poor be replaced by a system of vouchers for the poor and a refundable tax credit for the nonpoor, which would be applicable to the purchase of health insurance. The vouchers or tax credits could only be applied to policies that met certain minimum requirements. If the employer paid part of the cost of the premium, the employee could receive the credit from the government in the form of cash. Unlike most national health insurance systems, this approach allows for a variety of insurance plans suited to different tastes and permitting different forms of medical practice. Enthoven believes that prepaid group practice, because of the efficiencies it permits, will become the dominant form of practice, but that is a decision that would be made in the marketplace based upon consumer and provider preferences.

By introducing vouchers for the poor and tax credits for the nonpoor, which are not related to the specific job held at any point in time, a strategy such as the Enthoven plan would provide for explicit financing of all those currently uninsured. However, this plan has yet to be given serious consideration politically. Apparently a consensus still exists that the present system works well enough not to justify a complete restructuring to solve the problems of the 13 to 15 percent of the population who are currently disenfranchised. At the very least, there seems to be no consensus about what would be an acceptable replacement.
Incremental Strategies

The alternative to restructuring the system is developing a series of policies that are designed to “fill in the gaps” of our present structure of employment-based insurance for the working population and limited public programs for some of the nonworking population. Implementing such a policy requires an understanding of the uninsured population, particularly that most of the uninsured are neither poor (that is, below the poverty line) nor unemployed. There are at least three relevant groups to consider when devising policy strategies for the uninsured: the nonworking uninsured, the medically uninsurable, and the employed uninsured.

**Group one: the nonworking uninsured.** The group most of us think about when we think of the uninsured are the jobless, the very poor, and the chronically ill. Fortunately, they are not the majority of the uninsured. They do, however, represent at least 25 percent of the uninsured population, or some eight or nine million people. These people are the homeless, the deinstitutionalized mentally retarded, and the millions of people who, although poor, do not qualify for Medicaid because they are not “categorically eligible” or because they have income that is above the Medicaid cutoff level for their states.

The fundamental problem of our current Medicaid system is that eligibility is tied to the receipt of cash assistance and that each state can set the income limit wherever it deems appropriate and/or affordable. Additionally, cash assistance levels have not kept pace with inflation. Thus, Medicaid, which initially covered over 60 percent of the poor, now covers about 45 percent.7 While some of the poor not covered by Medicaid have private insurance or at least Medicare, many are uninsured.

Although it is unlikely that Medicaid as it is now designed will ever be expanded to cover all of those below the poverty line, some expansion is necessary. Two of the most important changes needed are minimum federal standards for Medicaid income eligibility levels and cutting the link between categorical eligibility and the receipt of cash assistance. These two changes would mean that states such as Kentucky and Tennessee, which have Medicaid eligibility levels at 35 and 25 percent of the poverty line for a family of four, would have to raise their eligibility limits. And all of those falling below whatever lower limit is set should be eligible for Medicaid, irrespective of their family or employment status.

For individuals who are above the federal threshold or whatever level states choose above that threshold, a state should be able to institute an income-related buy-in program for Medicaid for which the federal government would pay part of the costs. This option would allow a transition phase between Medicaid, which provides extensive coverage,
and the completely unsubsidized coverage frequently available to those just above the Medicaid cutoff.

Both the expansion of Medicaid and the introduction of a Medicaid buy-in program are based on insurance principles rather than on a system of direct payment to providers. Wherever possible, this should be the preferred strategy. Nonetheless, for some populations—those who are difficult to reach or who have special needs, such as the homeless or the high-risk prenatal population—specially targeted programs directed toward providers who are trained and equipped to deal with these special populations may be more efficient and effective. And in the end, no matter how much progress we make toward filling in the gaps, grants to at least some providers will be needed to establish a place of care of last resort.

**Financing care for the nonworking uninsured.** How much all of these changes will cost and how they should be financed are obviously important issues. The cost of the Medicaid expansion will depend on the federally defined minimum level. If it were set at 50 to 60 percent of the poverty line, the states with large Medicaid populations such as New York, New Jersey, and California would not be affected, but many states in the South and Southwest would be. The higher the federal minimum, the larger the number of people affected. And breaking the link with the receipt of cash assistance would mean that substantial numbers of new people would be eligible for Medicaid even in states that have minimum levels above 50 or 60 percent of the poverty line.

Estimating the costs of the Medicaid expansion with any precision will be difficult because it will require information about the numbers of people on and off Medicaid at various income levels near the poverty line, by state, and that information is not available. Nonetheless, some approximate costs could be estimated, as they are whenever a Medicaid expansion is introduced. The increased Medicaid expenditures should retain joint financing by the federal and state governments. In general, Medicaid expenditures at both levels of government should be financed by general fund taxes, as they are now in almost all states. In states where additional general fund financing is regarded as politically impossible, some specific excise taxes could be used, but, in general, the more broadly based they are, the better.

The funds for targeting providers and the remaining indigent care pool should also be a combination of federal and state funds. Here the federal funds might be provided as an additional block grant with the amounts determined by some combination of infant mortality, homelessness, and unemployment rates. These federal funds could also be general fund revenues or the revenues generated by a cap on the amount of employer-provided insurance provided tax-free. The rationale for using the latter as a funding mechanism for indigent care is contained in
my earlier article on uncompensated care in *Health Affairs*.8

Funding at the state level should follow the general dictum of the more broadly based, the better. In this case, however, it may be possible to put together a series of specific excises to form a broader base than any one excise tax would represent. If hospital excise revenue were used, which seems to be a politically popular, although not otherwise very logical, base for a tax, it should be done with the clear intent of having it passed on to all insured patients as is done with a sales tax. If a premium tax is used, self-insured companies who are otherwise protected by the preemption clause of the Employment Retirement Income Security Act (ERISA) must be included. The optional use of an excise tax on employers who don’t participate in a funding pool is a workable strategy that has been included in proposed legislation (S2403). If possible, funding by more general tax revenue such as income or sales tax is preferable.

**Group two: the medically uninsurable.** A small group of individuals, sometimes estimated at about 0.5 percent of the population, is unable to obtain insurance because of preexisting conditions. A strategy nine states have adopted is to establish an insurance pool for these individuals through which they can buy insurance, generally at a subsidized rate. This is an appropriate mechanism for dealing with this small but highly vulnerable population, although sometimes the existing programs have left these individuals with high deductibles and copayments or with high premiums because of the systems unwillingness to be explicit about subsidizing the insurance of this vulnerable group.

States have differed in how they set eligibility: some have required being turned down by one or two insurance companies or having a specified medical condition; at least one state, Connecticut, has defined eligibility in terms of a willingness to pay a high enough rate, such as 150 percent of a standard premium. This strategy also was included in the two access to care bills introduced last summer (HR4740 and S2403). While determining inability to obtain insurance in the private market is difficult, it is important in being able to offer subsidized insurance to low-income medically uninsurable people without risking interference with the private insurance market. The potential problem is not with the medically uninsurable, since there is no market for them, but rather with the low-income uninsured, for whom there is a market, albeit a difficult one for them to enter. This problem is explained further in the next section. As an alternative to using a sliding-scale premium, medically uninsurable people near the poverty line could be allowed into a Medicaid buy-in program.

**Financing care for the medically uninsurable.** A major question handled unsatisfactorily by most states is how to finance the subsidy associated with medically uninsurable people. Most states force the carriers writing insurance in their state to participate in the pool. The
losses are then partly financed by spreading them to the rest of the insured population (except that they are not spread to those who get their insurance from an employer who self-insures) and partly by forgiving part of the company’s premium tax. This tax represents a back-door method of financing the subsidy through general funds. In general, the most appropriate way to finance the loss associated with the medically uninsurable is to use the broadest possible tax base. This could be a surtax on the income tax, a portion of a sales tax, or a value-added tax. It could also be financed by a specific excise tax such as a luxury tax or even a tax on restaurant meals. The financing of a Medicaid buy-in option has already been described.

A pool for medically uninsurable people will not directly affect many of the uninsured. However, it is likely to be an important part of any incentive-based strategy directed at the employed uninsured because it will remove an important element of risk for small employers.

**Group three: the employed uninsured.** Data indicate that approximately half of the uninsured, or about 15-17 million people, work at least some time during the year. These individuals and their dependents account for approximately 70 percent of the uninsured population. The employed uninsured tend to be low-wage, semieducated individuals working in small firms particularly in the agriculture and service sectors. The firms tend to have a disproportionate share of workers earning near minimum wage, although many are not minimum-wage workers.

Why such workers are uninsured is not entirely clear. Evidence from a survey by the National Federation of Independent Business, Inc., suggests that small firms may not provide insurance for a variety of reasons: premiums are too high, employee turnover is too great, the firm is not profitable enough, the firm cannot qualify for group rates, and many of their employees are secondary workers, covered under a spouse’s policy? Still, 65 percent of firms with fewer than 100 employees do offer health insurance to their employees as do at least 40 percent of firms with fewer than twenty-five employees. An effective strategy to address the problem of the employed uninsured should attempt to target those small firms that do not offer health insurance to their employees, while not disrupting the insurance for the vast majority of workers currently covered. This is not a trivial issue, since almost 70 percent of low-income workers already have private insurance and even 50 percent of the workers who are poor already have private insurance.

There are a variety of ways to approach the problem of providing coverage to this group, including mandatory offering of health insurance by employers, mandatory funding of part of or all health insurance by employers, extending the full tax deduction of health insurance premiums to the self-employed, the use of subsidized risk pools, industry pooling mechanisms, and Medicaid buy-in arrangements for workers just
above the Medicaid eligibility level. The most basic decision is whether to use a mandatory strategy or an incentive-based strategy.

The most obvious way to ensure coverage is to mandate that employers offer health insurance to their employees. This could be entirely or primarily at the employer’s expense, shared between employer and employee, or entirely at the employee’s expense. The potential effects on employment and prices will vary substantially, according to the share that the employer is required to pay, the number of employees at the minimum wage, and technical conditions about the nature of production. In general, increasing the share that the employer must pay will increase the likelihood that at least some minimum-wage workers will be priced out of a job. For workers whose jobs are not threatened, consumers can expect to see higher product prices. Some firms, especially new and/or marginal small firms, which cannot withstand the transition to higher consumer prices or whose markets are very competitive, would probably not survive.

A minimally mandatory policy would require that employers only offer a health insurance package to their employees but not be required to finance it. The rationale for this type of mandate is that it would ensure that all employees have the opportunity to purchase insurance. Historically, almost all employees who have been offered health insurance purchase it, although usually the employer pays a substantial share. Whether a requirement to offer insurance would produce lower-cost insurance than is currently available is unclear.

Either type of mandated policy will require agreement on a minimum benefit package. In other words, once the offering or provision of health insurance is mandated, it is necessary to agree on the provisions needed to qualify a policy as being “acceptable” health insurance. This means that potentially many more firms could be affected than just those not currently offering health insurance.

The primary alternatives to mandatory insurance are incentives for employers to provide insurance coverage and/or for employees to purchase insurance. The challenge in devising such strategies is to adopt new incentives without disrupting existing patterns of health insurance. A potentially serious problem in creating new incentives is that their effect may be as strong on those employees already insured as on those employees not currently covered. The consequences of ignoring this problem may be to double or triple the costs of a program.

There are a number of ways to incorporate additional incentives into the system. One is to allow tax deductions for health insurance premiums for the self-employed and owners of unincorporated businesses, provided they extend similar coverage to their employees. Until this year, these individuals could not take such deductions. The recently enacted Tax Reform Act allows these persons to deduct 25 percent of
premiums for their own health insurance plans. The extent to which they will respond to this limited provision is unclear, both because it is so limited and because the provision is scheduled to end in three years.

The idea of using risk pools has already been discussed as an important strategy in providing insurance to the medically uninsurable. Risk pools could also be directed toward the general uninsured working population. The attraction of such an approach is that it might enable small employers to share the risk involved in providing health insurance; it could also provide a mechanism for subsidizing the purchase of insurance by certain employees.

There is some debate about whether and how risk pools for the employed uninsured would result in lower insurance prices than those available by other industry pooling mechanisms, aside from directly subsidizing the purchase of insurance. The primary reasons pooling mechanisms can lower costs is that marketing costs are lower and risks can be spread over a larger group, but many have argued that industry pooling mechanisms can do this as well as a state-sponsored risk pool. What industry pooling mechanisms cannot do is offer insurance at below market rates. While subsidized insurance pools should make it more likely that small employers not currently offering insurance would do so, they may also end up attracting many of the small employers who currently offer health insurance and other employers of low-wage workers as well. This could obviously make the cost of a risk pool much greater than it would appear from the numbers of employed uninsured.

Other incentive-based strategies that may help the employed uninsured without disrupting existing insurance coverage are those that rely on the formation of multiple employer trusts (METs) or other industry pooling arrangements. These types of pooling arrangements could lower the administrative costs of health benefits and ease the burden of the small employer. METs have been attempted in a number of communities although as yet only with modest amounts of success. One of the problems that METs have reported is adverse selection. This was reported to be a significant problem by the Council of Smaller Enterprises (COSE), one of the better known METs in the country. The existence of a risk pool for the medically uninsurable, which employers below a certain size could use to enroll their high-risk employees, and which unemployed or self-employed individuals could use as well, could alleviate the threat of adverse selection.

Another possible pooling strategy would involve the development of an administrative mechanism similar to the Taft-Hartley trusts to serve as the holder of insurance and thus assist small employers with high labor turnover. The Taft-Hartley trusts were developed for unionized workers in high labor turnover industries and act as the “holders” of the workers’ health and welfare policies. Employers pay into the trust on the
basis of the number of hours employees work. Since the trust is the holder of the health and pension plans, the workers do not lose these plans as they move from job to job. A similar arrangement could be developed for nonunionized workers who change jobs frequently, thus making it easier for their employers to contribute and more likely to be attractive to the worker.

For uninsured workers who are below the poverty line but whose incomes are above the Medicaid cutoff levels, a strategy that should be given serious attention is the use of a sliding-scale, income-related premium that allows such workers to buy into Medicaid. This strategy provides health insurance to workers while reducing the disincentives whereby workers earning too much lose all Medicaid support. While some employers who currently provide insurance coverage to their below-poverty-line workers might discontinue their coverage to these workers or encourage them to apply for Medicaid, it should not be too serious a problem as long as the range of eligibility was limited and the subsidy declined rapidly.

How much would these various incentive-based strategies result in increased insurance to employees? It is hard to know in advance. Our experience is that almost all employees who are offered health insurance, even if they have to pay part of the cost directly out of pocket, purchase the insurance. Thus, if we can devise strategies that make it easier and cheaper for employers to offer health insurance, we may be able to substantially reduce the number of employed uninsured. But to the extent that some of the small employers do not offer health insurance because their low-wage employees would prefer to take all of their wages in cash or because several of their employees are covered by a spouse’s insurance, the incentives discussed here will have little effect on increasing the coverage of uninsured workers. Should this be the case, we will be left with two alternatives short of a major restructuring of the system: either mandate employer-provided coverage or expect substantial numbers of workers to show up as “generators of uncompensated care,” and pay selected providers to cover this function.

**Financing care for the working uninsured.** In general, the employed population finances its own insurance, as workers take part of their compensation in the form of health insurance. The tax exclusion associated with employment-related insurance means that part of the costs are also borne by a loss in general revenues, which means that part of the costs are subsidized by all of us through general fund taxes. Any strategies that increase the likelihood of small employers’ offering health insurance will continue this mode of financing.

If, in addition to the existing strategies concerning employment-related insurance, special incentives are introduced such as subsidized risk pools or Medicaid buy-in programs for the poorest workers, these
additional subsidies would also have to be financed, and the previously stated dictum, "the more broadly based, the better," still applies.

Finally, if insurance were mandated, the financing would combine employee financing and general fund financing, as previously indicated; some financing would also come from consumers. The latter occurs because some of the costs of the mandated insurance would be borne by consumers in the form of higher product prices. In addition, there are a variety of implicit costs associated with this type of strategy, such as workers who would lose their jobs, small employers who would go out of business, and so forth. As with any program that is at least partly implicitly financed (such as our old cost-shifting strategy), it is difficult to know exactly who ultimately bears the full cost of this type of strategy.

The Limits Of Private Voluntary Insurance

The 1980s are regarded as a time when market elements and competitive prices have become an accepted and welcome part of the landscape of the U.S. health care system. Employers have redesigned the health plans offered their employees, introduced utilization review programs, encouraged alternative delivery systems, and adopted various other strategies to obtain a good value for their health care dollar. The federal government has adopted a prospective pricing system for its Medicare population and encouraged states to adopt cost-saving strategies for their Medicaid populations. While those who are insured are likely to be better off as a result of these changes, those who are uninsured will be placed at increased risk of being shut out of the health care system as providers feel more pressure to compete for the paying patient.

These pressures have led to questions about the limits of private insurance and the need for increased governmental programs. There are, to be sure, compelling reasons to expect that more public sector dollars will have to be spent. We need to use public funds to change a Medicaid system that allows some states to set the cutoff level at 25 percent of the poverty line and that excludes many people, no matter how low their income, because of their family or employment status. Other public sector dollars are needed to subsidize risk pools for the uninsurable and to provide places of care of last resort.

The more difficult question is whether our system of private insurance for the employed population can remain voluntary, based on incentives, or whether we will need to impose a mandated system based on regulation. The United States already provides strong incentives to obtain employer-provided insurance by excluding it from employees' taxable income. This system has provided insurance for the vast majority of the working population. Similar incentives could be extended to the self-employed and sole proprietors, and assistance could be offered small
employers who wish to engage in pooling arrangements.

Some may say that these strategies have already been tried and found wanting, but there are a few instances of communities or employer groups trying creative solutions, either for the large numbers of employed uninsured or for the medically uninsurable. Although the latter represent a very small proportion of the population, problems of adverse selection have been the Achilles’ heel of industry pooling arrangements, and the uninsurable risk pools may represent just the safety valve needed for them to work. If these purely incentive-based strategies are found to be insufficient, some form of subsidization could be offered to small employers and/or employers of low-wage workers, either by directly subsidizing the employer or by establishing subsidized risk pools. The problem with this type of subsidization is that many small employers already offer insurance and most low-income workers already have private insurance–and they will want the subsidy. Whether a subsidy can be targeted only to those not now offering insurance is unclear, but some of the demonstrations being funded by The Robert Wood Johnson Foundation may provide the answers. Even if there is some spillover into the currently insured population, it may represent a cost we as a society are willing to bear rather than facing the alternatives. For if these various strategies, coupled with the pressures providers can be expected to bring to the uninsured population, cannot greatly reduce the number of uninsured, the only alternative is mandatory insurance or restructuring the system.

What would be the consequences of a mandatory program of employer-provided health insurance? It obviously depends on whether employers are required to only offer health insurance or are also required to pay a substantial share of the premium. A policy that requires substantial employer contributions has the potential of significantly affecting the employment of low-skilled workers and the competitive position of new and/or small firms. An “offer only” policy—one that allows employers to pay part of the premium but does not require them to do so—should affect neither consumer prices, the firm’s competitive position, nor the employment potential of low-skilled workers, and thus should have only minimally adverse effects, if any. Even here, however, Congress will be required to define what qualifies as health insurance, and thus its decisions may affect not only those employers who currently do not offer health insurance but also many employers who already offer insurance. Furthermore, I believe that this type of strategy is not politically possible. If we are willing to mandate the offering of insurance, I think the political pressures to mandate significant employer contributions will be too great to resist.

Perhaps the threat of mandating insurance will be sufficient to push the employer community into greater levels of creativity than it has
exhibited in the past. Even so, some members of the employed population will be left uninsured. We may need to recognize that the price of pluralism is to allow some people (although certainly not 31 million) to slip through the system as long as we make sure that there are places of care of last resort. Or perhaps the threat of mandated insurance will be enough to make a restructuring that includes refundable tax credits to the working population and vouchers for the poor—thus allowing for decentralization, pluralism, and a population of mobile, two-worker families—more politically palatable than it has been in the past.

NOTES


5. Wilensky, “Solving Uncompensated Hospital Care;” and Sulvetta and Swartz, The Uninsured and Uncompensated Care.


8. Wilensky, “Solving Uncompensated Hospital Care.”
