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FILLING THE GAPS IN HEALTH INSURANCE: IMPACT ON COMPETITION

by Gail R. Wilensky

Prologue: One of the nagging problems of a society that places a heavy emphasis on individualism and free enterprise is accommodating those people who lack the means to care for themselves. This issue has become a more pronounced problem in the 1980s because private and public payers alike have been attracted to marketplace approaches to medical care finance. Such approaches, by definition, seek to remove any elements of a transaction that represent a cross-subsidy. As a consequence, the traditional method of financing indigent care—buying these costs in the revenue stream generated by paying patients—is increasingly threatened by the movement toward competition. In this article, Gail Wilensky discusses the impact of competition on the uninsured, and also the impact of strategies directed toward the uninsured on competition. Wilensky is director of Project HOPE’s Center for Health Affairs, a multidisciplinary health policy center. The center is one of four organizations that have been officially designated by the Health Care Financing Administration (HCFA) as policy support facilities. As such, these centers are called upon by HCFA to analyze health policy issues that it must address in its capacity as manager of Medicare. Wilensky holds three degrees from the University of Michigan, including a doctorate in economics, A nationally recognized health services researcher and policy analyst, Wilensky was instrumental in the design and management of the National Medical Care Expenditure Survey (NMCES) while she worked (1975-1983) at the National Center for Health Services Research and Health Care Technology Assessment. More recently, her research pursuits have included medical indigency, the nursing shortage, and the relationship between health care financing and medical technology. Wilensky’s center provided extensive technical assistance to the Department of Health and Human Services during its preparation of Secretary Otis Bowen’s report to the president on a Medicare catastrophic health insurance benefit.
Strategies to provide coverage for the uninsured represent neither new nor uncharted territory. Much remains unknown, however, about the dynamics of the uninsured population and the impact of various solutions on the health care system. This article examines gaps in health insurance, the reasons they are occurring, strategies to fill the gaps, and the effect of these strategies on competition.

The first and most obvious question to be addressed is whether gaps in health insurance coverage have been increasing and, if so, why? Although there is general agreement about the characteristics of the uninsured, there is disagreement about their numbers and, more importantly, about why these numbers have been increasing. The debate is important because it raises the possibility of increasing numbers of uninsured even when unemployment has been brought under control and reduced to more tolerable levels than have occurred in the past decade. A second issue concerns strategies for covering the currently uninsured. These strategies are directed toward the poor, nonworking population, the medically uninsurable, and the working uninsured. A third issue, a topic generally not considered, addresses the effects that the most important of these strategies will have on competition.

The Numbers Of Uninsured Americans

The first issue is whether the numbers of those either without or with limited health insurance coverage are increasing and, if so, why. The number of uninsured and their characteristics, and the amount and distribution of uncompensated care and its consequences, have been discussed in numerous publications. Nonetheless, it is important to review these trends because it is unclear whether the problem we are facing is primarily cyclical (that is, related to a downturn in the economy), or whether it represents a secular problem (that is, a problem reflective of changes occurring over time).

The simple answer to this question is that the number of uninsured has increased significantly since the late 1970s but that the characteristics of the uninsured have remained surprisingly similar. The number of uninsured in 1980 was approximately the same as it was in late 1970s—about 26 million. There is some dispute about how much the numbers increased during the recession of the early 1980s, although most estimates indicate that about 34 million people were uninsured as of 1983. The major discrepancy is what has happened to the numbers after the recession (Exhibit 1). The Survey of Income and Program Participation (SIPP) reported 34 million uninsured in 1983, but approximately 31 million in 1985. The Health Interview Survey also indicated about 31
Total Uninsured Population, Recent Estimates

<table>
<thead>
<tr>
<th>Survey</th>
<th>Date</th>
<th>Number (millions)</th>
<th>Percent of population</th>
</tr>
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<tbody>
<tr>
<td>SIPP</td>
<td>Third quarter 1985</td>
<td>31.8</td>
<td>15.2%</td>
</tr>
<tr>
<td>SIPP</td>
<td>Fourth quarter 1985</td>
<td>31.3</td>
<td>14.9</td>
</tr>
<tr>
<td>CPS</td>
<td>March 1986</td>
<td>37.0</td>
<td>17.0</td>
</tr>
<tr>
<td>CPS</td>
<td>March 1986</td>
<td>34.8</td>
<td>17.4</td>
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<td>HIS</td>
<td>1986</td>
<td>30.8</td>
<td>14.8</td>
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Despite the dispute about the absolute number of the uninsured, the characteristics of the uninsured appear to be surprisingly stable: (1) about half of the uninsured are employed; (2) when their dependents are included, the employed uninsured account for 75 percent to 80 percent of the uninsured population; (3) most of the employed uninsured are low wage earners—69 percent earn less than $10,000; (4) despite the low wages, only 35 percent of the uninsured were in families below the poverty line, and one-third were in families more than twice the poverty line.

A number of concerns have been raised about the increased number of uninsured and the implications of the increase. The increased number usually is attributed to some mixture of unemployment, lower wages, sectoral shifts, and changes in the mix of full-time and part-time employment. Before I discuss strategies, it is important to understand what the trends indicate. As is unfortunately so often the case, the trends are difficult to understand. The data presented below are from a recent paper by Ladenheim and Wilensky.

Trends In The Uninsured Population

Conventional wisdom explains the increased number of uninsured in terms of Medicaid’s failure to keep up with rising poverty levels, high
unemployment through 1982 followed by shifts in employment away from manufacturing to low-paying service-sector jobs, and increasing numbers of part-time workers. While there is some truth to the conventional wisdom, many questions remain unanswered. The most fundamental one is whether we can expect the increase in the number of uninsured over time to continue irrespective of the levels of unemployment. The percentage of uninsured who were poor peaked in 1982 and then declined; the share of the low-income uninsured has stayed constant (Exhibit 2). Thus, there has been some increase in the number and share of uninsured who are poor, but the difference is not large.

| Exhibit 2 |
| Trends In Insurance And Poverty, Population Under Age Sixty-Five, Uninsured By Family Income Relative To Poverty Level |
|---|---|---|---|---|---|
| Millions of uninsured | 8.0 | 10.3 | 11.6 | 12.6 | 12.3 |
| Percent of uninsured | 28.0% | 33.5% | 35.6% | 35.6% | 33.1% |
| 1 to 2 times poverty level | 8.3 | 9.2 | 9.6 | 10.3 | 11.0 |
| Millions of uninsured | 29.0% | 30.0% | 29.3% | 29.3% | 29.8% |


It is frequently said that a portion of the increased number of uninsured occurred because of Medicaid’s failure to rise with the increase in poverty. While it is true that the numbers on Medicaid stayed constant while the number in poverty rose, Exhibit 3 shows that the proportion of the poor population with Medicaid actually rose between 1980 and 1984. However, the number and percentage of the population above the poverty line on Medicaid fell. This is not so surprising considering the Omnibus Budget Reconciliation Act (OBRA) legislation. OBRA slowed the transition into and out of coverage, requiring a longer spend-down period and providing fewer of the working poor with Medicaid coverage due to the loss of cash assistance under Aid to Families with Dependent Children (AFDC) for two-parent families and the AFDC reduction for earned income. Thus, the growth in the poor and uninsured was not the result of a Medicaid failure perse.

The most clear-cut decline in coverage has been among workers and their dependents. In absolute terms, employer-based coverage dropped
between 1980 and 1984 (137 million to 134 million), and it also dropped in proportion to total employed workers (from an average of 1.43 employer-insured lives per worker to 1.32 lives per worker). Understanding why this happened and whether it is likely to continue has been very difficult. The unemployment rate peaked in 1982, so continued high levels of the uninsured cannot be attributed to this factor. The trends in part-time work, particularly involuntary part-time, increased during the peak of the recession and have since declined, although part-time employment currently is at somewhat higher levels than is usual at this point in the business cycle. The type of coverage and the level of employee premium sharing also changed during this period. Fewer employers pay the full premium for workers and for their families; in addition, employees' share of premiums rose. In 1977, 90 percent of the workers without coverage either were not offered coverage or were ineligible for it. Recent analyses of the SIPP data and the new 1987 National Medical Care Expenditure Survey (NMCES), when it becomes available, should be able to indicate whether this high rate of acceptance still exists. It is possible that part of the drop in employment-related coverage has been due to the increase in employee cost sharing of the premium, although the increase has not been greater than the level of inflation.

An additional reason frequently given for the increased number of employed uninsured has been the major growth in the service and retail sales sectors, plus the growth in firms with fewer than twenty workers.
Although overall coverage rates for these employers grew during the period, they are still below the average for all employers. Forty-six percent of the total growth in employment between 1979 and 1983 occurred in small firms. A slightly larger share of small firms in 1983 offered coverage than they did in 1979 (39 percent versus 36 percent). However, and perhaps more importantly, employment growth by sector is at least partly cyclical in nature. Much of the growth has been in retail sales and in the service sector. Between 1969 and 1984, there was an increase of 25 million service jobs accompanied by a slight decline in manufacturing. Precisely how much of this growth has been in lower-paying versus higher-paying service jobs is very sensitive to the time period analyzed: 1979-1984 looks very different than 1979-1986. While much employment in personal services and retail trade does have low pay and low benefits, this stereotype may be misleading because the growth also includes professional service, which is the largest part of service sector and has coverage as good as or better than average. In addition, the most rapid growth in services has been in business services, which includes highly paid, highly skilled jobs in computer-related services.

In my view, the high numbers of uninsured reported as of 1984 reflected the loss of Medicaid coverage for the near poor due to OBRA changes, the high level of unemployment through 1983, and the initial growth in low-paying service-sector jobs early in the recovery. The substantial growth in professional service and particularly in business service jobs from 1984 to 1986 is also consistent with a lower rate of uninsured after 1984. If we have been experiencing a secular trend in the growth of low-wage service-sector jobs without health insurance, it would explain how unemployment could drop four to five percentage points while the number of uninsured continued to increase. I do not believe this is what happened since 1985, although the increased number of low-wage jobs explains why the number of uninsured has stabilized around 31 million. This is clearly an issue that warrants close monitoring over the next several years.

The Problem Of The Uninsured

Although the United States has always had substantial numbers of uninsured, there are several reasons the number of uninsured currently is causing such turmoil in our society. First, there is the sense that a nation as wealthy as ours should not tolerate having more than 30 million of its citizens without direct access to health care except as their private finances or other people’s charity can and will support it. Second, health care costs have continued to rise faster than wages, profits, and govern-
ment revenues. Third, and most important, the numbers of the uninsured clash with the change in the financial environment of health care. This change has been characterized by the adoption of a “prudent buyer” strategy by all of the major purchasers of health care. It means these purchasers, in both the public and private sectors, are paying more attention to what they are purchasing and demanding a better value for their dollar. This 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–is causing increasing difficulties. It has also meant that the problems of the uninsured that were more or less masked during the 1970s are difficult to hide during the 1980s.

Gap Filling For The Insured

Most of what we think about when developing a series of policies that are designed to “fill in the gaps” of our present system of insurance are coverage strategies designed to provide insurance for the uninsured. We also must address filling in the gaps for the currently insured.

In the fee-for-service sector there has been a clear movement away from first-dollar coverage, with higher deductibles and coinsurance, but a movement toward stop-loss provisions that limit the individual’s liability for out-of-pocket costs. There also has been a substantial increase in the enrollment of managed care and alternative delivery systems, particularly health maintenance organizations (HMOs).

These trends represent an attempt by employers to make their employees more cost-conscious in their use of health care. Whether this represents a movement toward more cost-conscious behavior or an attempt to shift costs to employees and segment the insurance market is a matter of some debate. In and of itself, however, it should not necessarily be viewed as an inappropriate trend. The lack of coverage of certain types of care, particularly long-term care, and the absence of limits on out-of-pocket liabilities for some plans, represent real gaps in coverage that need to be addressed. Given, however, the amount of growth and innovation that has occurred in these areas in the private sector, there is reason to be hopeful that substantial improvements will occur here as well.

The growth in managed care, and particularly HMOs, has been very dramatic over the past few years, with current enrollment in excess of 30 million. Growth rates of 18 percent to 20 percent per year followed a relatively long period of stagnation and/or slow growth in the HMO movement. The attempts of several states to capitate all or part of their Medicaid systems also merit attention. Most of the growth, however, has
been in the individual practice association (IPA) type HMO; the long term impact of this trend is as yet unclear. Furthermore, although there is ample evidence that HMOs can deliver care at lower costs, there is little evidence that the private sector or the public sector has been able to appropriate these gains to date. This has been due, at least in part, to provisions of the 1973 HMO Act.

Whether or not preferred provider organizations (PPOs), with the use of discounted fee schedules and utilization review, will remain a stable force in the U.S. health care system also remains to be seen. Many are still in the premarketing phase or are just beginning to function, and the results of this type of organizational change have not yet been determined. Nonetheless, it is clear that strategies that provide incentives toward the delivery of more cost-effective health care should be regarded as an adjunct to strategies providing health insurance coverage for the currently uninsured.

**Strategies For Reducing Gaps In Coverage For The Uninsured**

Short of a major restructuring of the health care system and/or the introduction of national health insurance, extending health insurance coverage to the currently uninsured requires a clear understanding of the group’s characteristics. The uninsured are a heterogeneous group, most of whom are members of families with at least one worker and are not technically below the poverty line, although they frequently are lower-income families. For policy planning, it is easiest to think of the insured in terms of whether they are working and whether they are insurable, in the medical sense of the term.

**The nonworking uninsured.** The group most of us picture when we think of the uninsured are the jobless, the very poor, and the chronically ill. While this group exists, their percentage of the total fluctuates depending on whether the unemployed are included. Technically, the unemployed are part of the working uninsured as long as they are still looking for work. In this case, the number of uninsured outside the labor force is about 15 percent. It may make some sense, however, to regard the long-term unemployed as “nonworking” in the common sense of the term, which then puts the figure at around 30 percent. The nonworking uninsured are the homeless, the deinstitutionalized mentally impaired, and the millions of people who, although poor, do not qualify for Medicaid because they have income above the Medicaid cutoff level for their state or because they are not “categorically eligible.”

There are at least two fundamental problems with our current Medicaid system: (1) eligibility is tied to the receipt of cash assistance, and (2)
each state can set the income level for cash assistance wherever it deems appropriate. Two of the most important changes needed, therefore, are minimum federal standards for Medicaid income eligibility and the severing of the link between the receipt of cash, assistance and eligibility for Medicaid. This would mean that states such as Texas and Kentucky, with Medicaid eligibility levels at less than 3.5 percent of the poverty line for a family of four, would have to raise their eligibility limits, and that all those falling below whatever limit is set would be eligible for Medicaid, irrespective of their family or employment status.

An important precedent in severing the link between cash assistance and eligibility for Medicaid was contained in the Sixth Omnibus Budget Reconciliation Act of 1987. Provisions within that bill allow states, at their own option, to include pregnant women and young children on Medicaid whose incomes are up to the poverty line. This important precedent must be continued and expanded.

Even with these and other expansions, however, some provisions need to be made for people who are no longer eligible for Medicaid because of their income level and who do not have employment-related insurance. One possibility is for states to institute an income-related buy-in program for Medicaid under which the federal government would share in the cost. This option would allow for a transition phase between Medicaid’s extensive coverage and the completely unsubsidized coverage frequently available to those just above the Medicaid cutoff level.

There is also a need for programs that provide care directly. 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 are likely to be more efficient and effective than generalized insurance programs. And in the end, no matter how much progress we make toward filling the gaps, there will need to be money provided to institutions to establish a place of care of last resort.

The public programs, as have the private programs, have attempted not only to expand opportunities for coverage but also to institute incentives for delivering more cost-effective health care. The Tax Equity and Fiscal Responsibility Act (TEFRA) provided incentives for HMOs to accept Medicare beneficiaries by providing 95 percent of the adjusted average per capita cost (AAPCC) in the area to the HMO in return for services at least equivalent to the Medicare package. Medicaid programs also have attempted to institute managed care for various parts of their uninsured or Medicaid populations. States such as Arizona, Wisconsin, and California have experimented with expanding coverage within the context of capitated programs that control use. While providing access to
or requiring participation in cost-effective health care will expand the amount of coverage that can be provided for a given expenditure, more money will need to be spent on Medicaid if it is to be expanded to include many of the poor nonworking populations currently not eligible.

The medically uninsurable. Many states have responded to the problems of the medically uninsurable by developing risk pools to subsidize coverage for individuals unable to purchase insurance because of pre-existing medical conditions. The medically uninsurable represent a small group of individuals, sometimes estimated at one to two million, who despite their size can account for substantial expenditures on health care. Most of what is spent for this group probably will be uncompensated care and will cause substantial financial distress to them and their families, as well as to their providers of care.

Subsidized insurance pools are appropriate mechanisms for dealing with this group. Many existing programs, however, have left these individuals with high deductibles and copayments or with high premiums because of states’ unwillingness to be explicit about the need to subsidize insurance for this highly vulnerable group. Some, but not all, states define eligibility in terms of either specified medical conditions or insurance denial by one or more insurance companies. Although determining an inability to obtain insurance in the private market is sometimes 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 large numbers of low-income uninsured, for whom there is a market—albeit a difficult one for them to enter. States that prefer not to use sliding-scale premiums could consider the use of a Medicaid buy-in program for medically uninsurable people near the poverty line.

Difficulties in explicitly recognizing the need for a subsidy to finance the difference between the rate charged the medically uninsurable person and the cost of providing the coverage have led to the use of indirect financing mechanisms. The most common is to require commercial insurers to participate in the risk pool, which means that the costs are financed only by the people who purchase their insurance individually or collectively through their employer. It also means that most of the large employers, who self-insure, do not participate in the financing of these pools. I discuss the adverse impact on competition that may result from excluding the self-insured from the financing of the medically uninsurable in a later section. Although the Employment Retirement Income Security Act (ERISA) presents some problems in including these employers, there are other ways to provide for broadly based financing, including
an excise tax on employers who refuse to participate in the pool.

The working uninsured. Since at least 75 percent of the uninsured are workers or their dependents, some form of employer-based or worker-oriented strategy will be central to reducing the total number of uninsured. These strategies include the following: (1) purely employer-based, such as changes in the tax subsidies for the self-employed; (2) tax incentives for small employers; (3) improved access to pooling and other arrangements for reducing the cost of insurance to small employers; and (4) mandating the offering or provision of benefits by all employers. However, strategies for insuring the working poor, and perhaps some low-income workers as well, may require a combination of public and private approaches. These might include subsidies for employer coverage of below-poverty-income workers, subsidies for low-income purchasers of insurance, Medicaid buy-in strategies, and a proportionally determined assessment of premiums on mandated coverage.

The most basic decision is whether to rely on an incentive-based strategy or a mandatory strategy. Incentive-based strategies include the extension of the tax subsidy to the self-employed, the use of subsidized insurance pools, and the facilitation of industry pooling mechanisms designed to encourage the formation of multiple employer pools. Mandatory strategies can include the offering of health insurance and the payment for all or most of the health insurance premium by the employer. A mandatory component was included in the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, which requires that employers offer continuation and conversion of coverage for dependents for whom death, divorce, or termination results in a loss of coverage.

The most obvious way to ensure coverage to the employed population 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 effect on employment and prices will vary substantially, depending on the level of insurance offered, the share the employer is required to pay, the wage level of the employee, and technical conditions about the nature of production. In general, increasing the size of the employer contribution 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 probably will see higher product prices. Some firms, especially new or marginal firms, may not be able to withstand the transition to higher consumer prices, and some firms whose markets are very competitive may not be able to survive.

There are a variety of ways to minimize some of the adverse effects of
mandatory coverage: lower levels of coverage, smaller employer shares, or exempting new and small firms or part-time workers. At the same time, however, these exemptions mean that some populations or some types of coverage will be excluded, thus mitigating the primary attraction of mandatory coverage. The most minimum type of mandatory insurance would be to require that employers offer but not finance a health insurance package. This type of mandate would ensure that all employees have the opportunity to purchase insurance. Since, historically, almost all employees who have been offered health insurance purchase it, it is possible that such a requirement could reduce substantially the numbers of working uninsured.

Legislation mandating that employers provide their employees with health insurance coverage was recently introduced by Sen. Edward Kennedy (D-MA) (S. 1265, The Minimum Health Benefits for All Workers Act of 1987). The fate of this proposed legislation is unclear, but it is certain to be given serious consideration. Massachusetts also has passed legislation recently requiring employers with five or more employees to provide coverage for their workers or to pay a substantial sum into a state insurance pool.

The primary alternative to mandating insurance is to provide 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 several ways to incorporate additional incentives into the system, particularly for small firms. Until recently there was no tax exemption for the health insurance premium of the self-employed or unincorporated business. Therefore, they had little incentive to provide coverage for their workers. The 1986 Tax Reform Act allows self-employed workers and unincorporated businesses to deduct 25 percent of their health insurance cost if they offer similar coverage to their workers. Whether there will be much response to this provision is unclear; it is very limited, the provision is scheduled to end in 1989, and it does not address any of the operational details or administrative costs of finding and setting up employee coverage.

Finding ways to assist small employers and particularly new businesses is a must if we are to improve insurance. Small employers generally must pay higher premiums than large group plans or self-insuring firms. The use of multiple employer trusts (METs) or other industry pooling ar-
rangements might be able to 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 with only modest amounts of success. METs have reported a lack of interest on the part of the insurance community and also problems of adverse selection. Whether the lack of interest from insurance companies is real or just perceived is unclear. Problems of adverse selection could be assisted by a risk pool for the medically uninsurable, particularly one in which employers below a certain size could enroll their high-risk employees.

Another possible pooling mechanism would involve the development of administrative mechanisms, similar to the Taft-Hartley Trusts, that serve as the holder of insurance for high-turnover employees. The Taft-Hartley Trusts were developed for unionized workers of industries with high labor turnover. They provide a mechanism for employees to maintain health and pension benefits while moving from employer to employer. Employers pay into the trust based on the number of hours employees have worked. 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 for the worker. Pooling mechanisms such as METs or Taft-Hartley-like trusts may require some assistance in their formation. Subsidies to initiate these activities may be extremely worthwhile investments for the government to pursue. Several of the projects funded by The Robert Wood Johnson Foundation as part of their program for the uninsured include METs.

Even with similar tax treatments and improved access to lower-priced products, some small employers still may be reluctant to provide coverage for their workers. While health insurance may be regarded as a necessary incentive to attract and retain employees in highly skilled jobs or competitive market areas, it may not be regarded as similarly attractive in industries dominated by low-paying or high-turnover jobs. To the extent this is true, improved access to good rates and tax advantages will not be sufficient to induce an offering of insurance, and we will need to turn either to mandatory provisions or to increased levels of subsidy.

The sharing of responsibility for the coverage of low-salaried workers between employers, employees, and government is a particularly thorny problem. This could be done through direct subsidies to such employers or by making a subsidized insurance pool available to their employees. Where public programs and private funding overlap to provide coverage, there may be a substantial temptation to lower existing levels of employer-provided coverage. This is not a small problem. Estimates indicate that as many as 70 percent of low-income workers and almost 50 percent of poverty-level workers are currently covered by health insurance.
However, even if there is some spillover into the currently insured population, it may be a cost we are willing to bear if the alternative is mandatory employer-provided insurance.

**Impact Of Gap-Filling Strategies On Competition**

Just as introducing market elements and competitive forces into the health care environment has exacerbated the plight of the uninsured, the types of strategies introduced to extend insurance coverage to the uninsured will have an impact on the level of competition in the health care environment. To the extent that increasing competition is an explicit aim of the public and private sector, there are a variety of steps that providers of health insurance or health care can undertake to enhance competitive forces. (See Alain Enthoven, in this issue.) Enthoven believes that the “sponsors” of health insurance, generally employers or government, should structure coverage decisions in ways which lower the likelihood of risk selection and market segmentation by the insurance companies, both of which represent serious threats to continued competition.

In addition to assessing the impacts of the various strategies on competition, this next section also assesses whether the strategies are consistent with incentives in the changed health care environment. As Victor Fuchs notes in his article here, many of the changes introduced in the 1980s have been directed more toward changing incentives rather than increasing competition per se, in the economist’s narrow sense of the word. These changes have included a movement away from cost-based reimbursement to prospective pricing, the increased use of countervailing power between buying and selling groups, and the adoption of a prudent buyer approach by the major purchasers of health care.

**Medicaid.** The primary impact of Medicaid expansion is to provide market access to a group who otherwise has very limited access to health care. In addition, the largest potential impact of expanding Medicaid would be associated with the use of increased competitive bidding arrangements, expansions of managed care settings, and other attempts by the government to induce lower-cost behavior on the part of providers and, to a much lesser extent, on the consumers of health care. To the extent that the managed care settings include those both eligible and not eligible for Medicaid, the expansion of Medicaid also may help to increase competitive behavior between different providers of health care.

As Enthoven notes, it is important for the government to provide coverage in a way that promotes competition because of the leadership role it provides. This is less an issue for Medicaid than for Medicare, where the way in which capitation is encouraged and financed can have
important implications for market segmentation and risk selection. It is important, however, for Medicaid to provide the necessary level of funding to care for the Medicaid population and not to force providers to rely on cross-subsidization for any differentials.

Insurance pools. The impact of subsidized insurance pools as a strategy either for uninsurables or for all working uninsured is more difficult to assess and will depend in part on the make-up and financing of the pool. With regard to the subsidy financing, it is important to reiterate that taxing health insurance premiums or carriers who write health benefits and thereby exempting all firms who self-insure is not only an inequitable way to finance the subsidy but may lead to a further breakdown in competition among health benefit plans by inducing a greater number of firms to self-insure. The self-insured are a problem because ERISA exempts employer benefit and welfare plans covered by ERISA from state regulation (which includes taxation), and it means that other revenue sources will be needed to finance the subsidy unless the ERISA preemption provision is amended. An alternative strategy is to subject all employers who do not participate in the pool to an excise tax, as suggested in the “Improved Access to Health Care” legislation introduced by Congressmen Pete Stark (D-CA) and Bill Gradison (R-OH) in 1986, or to use any other broadly based tax.

To the extent that the insurance pool is targeted to the medically uninsurable, it should have little impact on the insurance industry and will serve primarily to increase access to insurance for this high-user group. The primary way competition within the industry will be affected is if high-risk pools provide safety valves for plans that otherwise would have unusually high numbers of very high users. This could be particularly important for areas with disproportionate numbers of people with acquired immunodeficiency syndrome (AIDS). Without such protection, local benefit plans would find themselves at a competitive disadvantage relative to national carriers. If risk pools are available to small employers who are purchasing insurance for their high-risk employees, subsidized risk pools could increase the ability of small employers to offer health insurance coverage, either singly or in groups, without experiencing adverse selection. In this case, the incentives facing the employer are affected, not competition itself. If the subsidized insurance pool is opened up to all uninsured individuals or all low-income uninsured individuals, it is likely to have an impact both on the insurance industry and on employers currently offering health insurance to similar populations.

Industry pooling mechanisms should allow small employers to become larger purchasing forces in the market, thus promoting countervailing power as opposed to increasing competition per se. Since the pooling
mechanisms are primarily designed to attract small employers who have little bargaining power, in some ways they are anticompetitive in their nature. Health and welfare trusts also will allow small groups or uncovered individuals to become more powerful purchasing units and thus increase countervailing power although not increase competition per se.

**Mandated insurance.** The effects of mandated insurance on health care competition will depend on the structure of the mandate. If a provision is included to require a fixed contribution to all health plans irrespective of benefits covered, competition between health plans should increase, although the equal contribution provision could be introduced independently from mandated benefits. If additional employers are put in the position of looking for low-cost insurance coverage, competition may increase among insurance plans. However, if insurers/providers regard employers as a “captive audience,” the mandate could result in effectively less competition among insurance carriers.

The effect of mandated benefits on competition will also depend on how insurance is to be offered. The use of five to eight regional carriers, as is suggested in the Kennedy-Waxman legislation, could give an advantage to indemnity insurers with multiple products and tend to concentrate market shares to the disadvantage of local health benefit programs such as HMOs and PPOs.

**Conclusion**

The number of uninsured has clearly increased. At best, the number has increased from 26 million in 1977 to 31 million in late 1985, and it is possible that the number is closer to 37 million. A critical issue is whether the uninsured population has stabilized at about 31 million, with some declines likely as we inch our way below 6 percent unemployment, or whether the uninsured population has continued to grow despite the substantial reductions in unemployment since early 1983.

Those that believe the estimate of 37 million argue that the increase is continuing because of the increased growth in service-sector jobs, particularly those characterized by low wages and benefits. Those who believe the 31 million estimate, myself included, argue that the growth in professional and business service jobs during 1984-1986 reversed the trend observed for 1979-1984. This debate will only be settled as better data become available, and it clearly warrants close monitoring.

Even if the lower estimate is correct, it is still a serious problem. The change in the financial environment of the health care sector and, in particular, the adoption of a prudent buyer mentality by all of the major purchasers of health care has meant that the traditional way of financing
Devising appropriate strategies for the uninsured requires either a complete restructuring of the health care system, which I think is unlikely, or a series of policies that reflect the heterogeneous nature of the uninsured. These include strategies for the poor, nonworking uninsured, the medically uninsurable, and the working uninsured. The strategies I have discussed—expanding Medicaid, subsidized risk pools, tax incentives, industry pooling mechanisms, and mandating employer-provided insurance—involves both the public and private sectors in addressing the problems that continue to affect access to care for all Americans. The primary effect of these strategies is to increase access to insurance coverage for groups that otherwise have minimal access.

Just as competition exacerbates these problems, strategies that are directed toward their solution will have an impact on competition. These strategies also can promote or diminish the changed incentives introduced during this decade. Government should lead the way by encouraging consumers and providers to be cost-conscious, by not requiring providers to cross-subsidize because of underpayment, and also by discouraging market segmentation or increased market share of national carriers at the expense of local health plans.

Competition and the changed incentives of the 1980s have made it imperative that we address the problems of the uninsured. But it is equally important to be sure that the strategies we introduce to solve these problems do not introduce a new set of problems all their own.

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