State Health Watch

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THOMSON AMERICAN HEALTH CONSULTANTS

Protecting the uninsured involves knowing just exactly who they are

Public policy-makers trying to increase health insurance coverage will be more effective if they design programs that fit the uninsured population, according to Congressional Budget Office director Douglas Holtz-Eakin. The trick, he added, is figuring out the big picture, which often is too big to actually read.

Testifying recently before the Health Subcommittee of the U.S. House Ways and Means Committee, Mr. Holtz-Eakin said that even something as basic as counting the number of uninsured people is tough.

"It has been frequently stated that about 40 million people lack health insurance coverage," he added. "That estimate, by itself, presents an incomplete and potentially misleading picture of the uninsured population. The uninsured population is constantly changing as people gain coverage and lose coverage. Furthermore, people vary greatly in the length of time that they remain uninsured. Some people are uninsured for long periods of time, but more are uninsured for shorter periods."

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Governors say their budgets have improved over last year's, but they still see trouble ahead

Although many governors are feeling more upbeat about their states' economy than they did last year, they still see major problems ahead, particularly in health care. They have asked congressional leaders to not make it worse by including Medicaid cuts in the FY 2005 budget.

Fiscal Fitness: How States Cope

The governors spoke out on Medicaid during the winter meeting of the National Governors Association (NGA) and sent a letter to the chairman and ranking minority member of the Senate Budget Committee asking that Medicaid be spared from any federal cuts.

"States are currently emerging from the most severe budget crisis since World War II, and nearly every state has already enacted difficult cuts to its Medicaid program, including both eligibility levels and provider payments," the letter said. "Federal funding reductions would force states to implement even deeper cuts by restricting eligibility, eliminating or reducing critical

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Uninsured

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Using data from 1998 — the latest available for the measures they wanted to use — Congressional Budget Office staff estimated that between 21 million and 31 million people were uninsured all year; at any point in time during the year, some 40 million people were uninsured; and nearly 60 million people were uninsured at some point during the year.

Mr. Holtz-Eakin testified that more recent analyses by the Agency for Healthcare Research and Quality indicate that the measures his office used to assess the number of uninsured have remained fairly stable in the years from 1998 to 2001.

Nearly 30% of Americans younger than 65 who become uninsured in a given year remain so for more than 12 months, Mr. Holtz-Eakin said, while 45% obtain coverage within four months. People with less education, those with low income, and Hispanics are more likely than others to be uninsured. They also are somewhat more likely to remain uninsured for long periods.

Majority in working families

The vast majority of the uninsured, according to Mr. Holtz-Eakin's analysis, are in working families. Some 43% of those who were uninsured all year in 1998 were in families in which at least one person worked full time all year. And 47% were in families in which at least one person worked part time or for a portion of the year. Studies also have found that 75% of uninsured workers are not offered insurance by their employers. Low-wage workers are less likely to be offered insurance by their employers and less likely to accept it if it is offered.

In trying to solve the problem of the uninsured, he said, policy-makers should be mindful of the dynamic nature of the uninsured population as well as the distinction between the short-term and long-term uninsured.

"For people with short spells of being uninsured," he advised, "policies might have the goal for filling the temporary gap in coverage or of preventing such a gap from occurring. For people with longer periods without insurance, policies might seek to provide or facilitate an ongoing source of coverage."

An issue that complicates designing solutions is what is known as the crowding out of existing coverage — when employees or employers drop existing coverage in favor of a new government initiative. A related issue, according to Mr. Holtz-Eakin, concerns health insurance tax credits or similar subsidy programs. Some proposals would extend credits or subsidies to people who would have been insured even without them. With both crowding out and tax credits/subsidies, federal aid is going to people who otherwise would have been insured. As a result, the federal cost per newly insured person could be substantially greater than the cost for each person who uses the federal programs or receives a tax credit.

Mr. Holtz-Eakin's most important warning is that incremental reforms probably cannot provide insurance for everyone and attempting to achieve 100% coverage would be very expensive. As an alternative, he said, policy-makers could consider policies intended to expand coverage in conjunction with policies to strengthen the system through which the uninsured

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Myths about the uninsured: You didn't know these?

As part of the recent hearing held by the U.S. House of Representatives Ways and Means Committee's Subcommittee on Health on the problems of the uninsured, Len Nichols, vice president of Center for Studying Health System Change in Washington, DC, described 10 myths he said are widely held about the uninsured and then explained why economists say each of the myths is misleading.

1. **It is known how many people are uninsured.** While 44 million uninsured is the latest "official" number from the most recent Current Population Survey, the truth could be and is on either side of that number. Mr. Nichols says the important consideration is the time frame. The longer the period of time, the smaller the number of people who always are without health insurance, and the larger the number of people who are without insurance for some of the relevant time period. "Perhaps," he said, "the most important thing to establish from a policy perspective is not the precise number, as long as we are confident that the number of uninsured for an entire year is in the tens of millions, and researchers are confident of this. The most important analytic measurement may be the time trend is the percentage of nonelderly Americans who are uninsured, which has recently been quite adverse."
2. **The uninsured are all alike.** Mr. Nichols said the uninsured tend to be somewhat lower-income, and in somewhat poorer health, but "because there are so many of them and because they do span various dimensions of American life, there are many who are young and healthy, but there are many who are not; there are many who are reasonably well off, including a sizable fraction above the median income. And then, as is also important to note, there is a sizable fraction below the poverty line who are also sick and in a very bad way." Policy-makers, he added, need to understand this diversity and be careful and clever in making limited funds go as far as they can toward expanding coverage.
3. **Coverage is coverage is coverage.** Insurance differs, according to Mr. Nichols, in terms of the kinds of financial protection it offers, in the potential for improvement in health it offers, and in the humanity of the treatment people receive when they contact the health care system. Also, the kind of insurance people get depends very strongly on where they get it, through a Fortune 500 company, for example, or in the individual market.
4. **Health insurance would improve the health of all the uninsured.** Mr. Nichols said this is one of the more complicated, emotional disputes in health policy analysis. He suggested a high standard of proof that causation is not likely to be appropriately inferred unless there has been an adequate natural experiment or a true experiment in which a representative sample of people are assigned to have or not have insurance for the duration of the experiment. While this standard of proof rarely has been met in the research literature, he pointed out that when it has been met, the bulk of the evidence suggests that health insurance does have positive effects on the health of certain populations — the poor, the elderly, the truly sick, and children. But what has not been proven by this standard is that universal coverage would improve the health of all the uninsured. There also is an ongoing question, he said, of whether universal coverage would eliminate poor health status among vulnerable populations, and he suggested, based on data, that insurance can help the populations and reduce gaps, but eliminating the disparities gap will require multiple policy changes.
5. **Individuals without insurance choose to be so.** Mr. Nichols said this proposition is true in some general sense because no law prohibits people from buying insurance and most people could buy individual policies. But, he said, if we think of realistic or reasonable choices for low-income people or those at high levels of risk, if they don't have insurance now, obtaining insurance voluntarily without further subsidies probably is not a realistic option.
6. **U.S. employers spend $400 billion a year for workers' health care.** This proposition, Mr. Nichols said, demonstrates that economists think differently than other people. Based on theoretical knowledge and some careful empirical work,

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he added, most economists contend that most employers do not pay for health insurance. Rather, economists theorize that, ultimately, most workers end up paying for health insurance in the form of lower wages. "Sooner or later, the bulk of workers will end up paying for the health insurance that policy makers give them with the best of intentions," he explained. "They'll end up paying for it themselves through reduced wages and fewer jobs unless they receive a subsidy. Of course, if they receive a generous subsidy or their employer does, that subsidy will ultimately go to workers."

7. **The decision to remain uninsured has no effect on anyone else.** Mr. Nichols said he chose this myth to highlight the reality that the willingness of some workers to take jobs without health insurance, even if they are a minority of the work force, has important consequences for everyone else. For example, it means that employers have a decision about whether to offer health insurance, and will make that decision based largely on the preferences, expectations, and productivity of the dominant type of workers they need to produce their products and services, as well as on their own unique costs of delivering health insurance to their work force.
8. **Workers used to be afraid to switch jobs because of health insurance, and the Health Insurance Portability and Accountability Act (HIPAA) fixed that.** Economists call "job lock" the phenomenon of workers remaining with less productive jobs than they could get because they fear losing health insurance if they were to switch. HIPAA, adopted in 1996, was designed to make the portability of health insurance more real and reduce job lock. Mr. Nichols cited some studies that found some pre-HIPAA job lock, though the welfare cost from the job lock is impossible to quantify. He said economists can't tell if additional policy intervention is justified.
9. **Economists don't know anything about why people are uninsured.** Mr. Nichols noted that while it may seem that economists always argue among themselves, there are three things that most economists say about the lack of insurance coverage:
   • The single most important reason people are uninsured in this country is that they are not willing to pay what it costs to insure themselves.
   • The prices people are required to pay for health insurance vary widely across different circumstances and insurance markets.
   • Even though price matters a lot, most people and firms have fairly realistic demands for health care and health insurance.
10. **The combined research evidence supports doing nothing to address the problems of the uninsured today.** While economists and health policy analysts can't say with scientific certainty that any specific subsidies or policies should be implemented to reduce the number of uninsured, Mr. Nichols pointed out they are able to articulate the trade-offs involved, but only elected officials entrusted with the power of the people can decide if the opportunity cost is worth it, that is, which competing priorities will and should get less attention and fewer resources.

"Perhaps the best evidence of the value of health insurance is not in statistics or econometrics," Mr. Nichols said, "but rather lies in the fact that all the health policy analysts I know — and I know quite a few around the country — actively seek out and keep health insurance at all times, even when self-employed, and they even buy it for their recalcitrant adult children when the latter emerge from college feeling immortal but also stunned at the retail price of nice apartments in our great cities these days."

The choice, he added, comes down to whether our society is willing to pay to protect the working poor from the risks that others pay to avoid for themselves, and to protect us all from living with their free-rider risk.

"We economists cannot tell you with certainty the best particular way to expand health insurance coverage," Mr. Nichols concluded in his testimony, "but I can say the case for some kind of significant coverage expansion seems strong to many health economists and health policy researchers today. The prudent strategy in the event that you do move in that direction would be to monitor the outcomes quite closely and be prepared to alter details of the program or change course altogether if credible evidence warrants it."

Contact Mr. Nichols at lnichols @hschange.org. ■

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receive care, such as through increased funding for community health centers and public hospitals.

Determining factors

Kaiser Commission on Medicaid and the Uninsured executive director Diane Rowland testified that health coverage in America is very much a patchwork with health insurance dependent on where people live, where they work, and, too often, what they earn.

She also noted the heavy reliance on employer-based coverage and said the cost of health insurance in the workplace "is a substantial financial burden for both the employer and the employee, but remains a key fringe benefit, especially in large or unionized firms." She noted that when health insurance is offered in a workplace, most employees take the coverage even though the share of the premium they must pay often represents a substantial portion of their income.

"If health insurance coverage is not available through a group policy from an employer, families are hard pressed to be able to find and pay for a policy in the individual insurance market," Ms. Rowland testified. "Most directly purchased policies are expensive and have more limited benefits and more out-of-pocket costs than group coverage plans. Moreover, the cost of these policies is based on age and health risk, and any preexisting health conditions are generally excluded from coverage."

While Medicaid and SCHIP help fill the gaps for some of the lowest income people, this coverage is directed primarily at children and pregnant women and varies in availability across the states.

Ms. Rowland said all Americans should be concerned about the number of uninsured because health insurance makes a difference in how people access the health care system and, ultimately, their health. Leaving a substantial share of the population without health insurance affects not only those who are uninsured, but also the health and economic well-being of the country.

"Survey after survey," she said, "finds the uninsured are more likely than those with insurance to postpone seeking care, forgo needed care, and not get needed prescription medications. Many fear that obtaining care will be too costly. More than a third of the uninsured report needing care and not getting it, and nearly half say they have postponed seeking care due to cost.

"More than a third of the uninsured compared to 16% of the insured report having problems paying medical bills, and nearly a quarter report being contacted by a collection agency about medical bills compared to 8% of the insured," Ms. Rowland added.

"The uninsured also are less likely to have a regular source of care than the insured, and when they seek care, they are more likely to use a health clinic or emergency room. Lack of insurance thus takes a toll on both access to care and the financial well-being of the uninsured," she added.

Ms. Rowland also detailed the serious consequences that can await those who forego care.

She said that among the uninsured surveyed, half reported a significant loss of time at important life activities, and more than half reported a painful temporary disability, while 19% reported long-term disability as a result.

Compromising health

Lack of health insurance compromises the health of the uninsured, Ms. Rowland explained, because they receive less preventive care, are diagnosed at more advanced disease stages, and once diagnosed, tend to receive less therapeutic care and have higher mortality rates than the insured.

She reported that uninsured adults are less likely to receive preventive health services such as regular mammograms, clinical breast exams, pap tests, and colorectal screenings. They have higher cancer mortality rates, in part, because their diagnosis often comes late in the disease's progression and survival chances are greatly reduced. Similarly, uninsured people with heart disease are less likely to undergo diagnostic and revascularization procedures, less likely to be admitted to hospitals with cardiac services, more likely to delay care for chest pain, and have a 25% higher in-hospital mortality.

For more information, go to: www.cbo.gov and www.kff.org. ■

Fiscal Fitness

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health benefits, and cutting or freezing provider reimbursement rates. As a result, Medicaid funding cuts could add millions more to the ranks of the uninsured and would harm our nation's health care safety net."

The governors' view of the economy and the problems their states face was included in an NGA summary of 45 state-of-the-state addresses distributed by the association's Center for Best Practices.

Reports more upbeat

Compared to 2003, the summary said, the majority of governors in their addresses for 2004 were much more upbeat about current economic conditions and the state budgetary outlook. While last year some 86% of governors described huge budget gaps that loomed, outlined dire service cutbacks that were needed, or otherwise referred to a severe budget crisis that their states were experiencing, this year, the vast majority of governors described a more optimistic economic climate, including modest job growth that has occurred in the past year.

While saying that economic conditions had improved somewhat, the governors cautioned that their state budgets and economic outlook were far from rosy. Rather, most said their states still are facing spending cuts to eliminate budget gaps.

In the 2004 speeches, 89% of governors said their state's economic picture is improving, while 79% said budget conditions remained very tight and would require difficult spending choices. The governors of California, Connecticut, Iowa, and West Virginia described more dire fiscal circumstances, while the governors of Colorado, North Dakota, and Wyoming said their state budgets were either strong or expecting a surplus.

Even more than last year, governors singled out increased health care costs as a key factor that must be addressed to accomplish these goals:

1. control state spending by limiting Medicaid costs, cover the uninsured, and provide health benefits to government employees and teachers;
2. improve the business climate by limiting the high costs of providing health insurance coverage to employees;
3. improve the well-being of state residents by making prescription drugs and health insurance more affordable.

The report noted that nearly every governor made some reference to health care and many emphasized the twin needs of expanding basic health insurance coverage and bringing down health care costs for individuals, businesses, and states. Comments in the state-of-the-state speeches covered a wide range of issues:

- 42% of governors addressed the need to expand health insurance coverage for the uninsured.
- 40% proposed or supported initiatives related to children's health including immunization, dental care, health insurance coverage, mental illness, and childhood diseases.
- 40% emphasized the need for or discussed plans under way to limit costs of prescription drugs for seniors and others through discount programs (nine states), opportunities to buy prescription drugs from Canada (four states), or other means.
- 36% discussed the importance of long-term care for the elderly and the disabled, particularly the need to increase options for home- and community-based care.
- 33% discussed the need to have an impact on specific health conditions such as mental health, substance abuse, cancer, tobacco use, obesity, hepatitis C, diabetes, and West Nile virus.
- 33% proposed or said they supported efforts to curtail spiraling costs of Medicaid.

Meanwhile, representatives of seven hospital organizations wrote members of Congress urging that Medicaid not be cut in the upcoming budget.

The letter from the American Hospital Association, Association of American Medical Colleges, Catholic Hospital Association of the United States, Federation of American Hospitals, National Association of Children's Hospitals, National Association of Public Hospitals and Health Systems, and VHA Inc. not only called for no cuts to Medicaid, but also asked for an extension of the $10 billion in temporary state fiscal relief provided last year through increases to the federal match. That relief is due to expire June 30.

Download the complete summary of state-of-the-state addresses and find more information at www.nga.org. More information on the hospital position is available from the American Hospital Association at www.aha.org. ■

Study: Blacks and Latinos are more likely to forego prescriptions

As a result of a number of factors, many of them economic, working-age African-Americans and Latinos are considerably more likely than whites not to fill all of their prescriptions because of cost concerns. That's the conclusion drawn by the Center for Studying Health System Change through an analysis of results from its Community Tracking Study 2001 Household Survey.

Overall, according to study co-author J. Lee Hargraves, about 20% of blacks, 16% of Latinos, and 11% of non-Hispanic whites did not fill at least one prescription in 2001 because of cost concerns. Mr. Hargraves tells *State Health Watch* the problem is of particular concern because medicine relies on Rx drugs to treat most chronic conditions. Chronic conditions contribute substantially to racial and ethnic disparities in health status in the United States, according to Mr. Hargraves, and are among the principal reasons why blacks die at a younger age and at a much higher rate than white Americans. Blacks also are more likely to have multiple chronic conditions.

More than 30% of blacks and 25% of Latinos with chronic conditions didn't purchase all of their prescriptions in 2001 because of cost, compared with 17% of whites living with chronic conditions. Working-age Latinos and blacks without chronic conditions also were more likely than whites to face prescription drug affordability problems. In general, however, people without chronic health problems are much less likely to report having problems purchasing prescription drugs.

The study found that uninsured people were more than three times as likely as those with private health coverage to have gone without at least one prescription in 2001 because of cost concerns. But Mr. Hargraves says that earlier research by his organization has shown that drug affordability problems are not limited to the uninsured since some 25% of working-age people with Medicaid or other state coverage did not purchase at least one prescription in 2001 because they could not afford it.

Prescription drug access problems are lowest for the privately insured, regardless of race or ethnicity.

However, Mr. Hargraves says, prescription drug access problems are lowest for the privately insured, regardless of race or ethnicity. However, significant racial and ethnic disparities in access to prescription drugs exist among those with private insurance, with the largest disparities among those with chronic conditions. Working-age privately insured African-Americans with chronic conditions were twice as likely as whites (22% compared with 11%) not to purchase all of their prescription drugs in 2001 because of cost concerns. Privately insured Latinos with chronic conditions (18%) also experienced more problems affording drugs than did whites.

Mr. Hargraves tell *State Health Watch* that not all insurance plans are the same, and those differences in the products offered, copays, deductibles, etc. contribute to the disparities. "We didn't think the differences would be as large as they are," he says.

Several possible explanations

According to the study, there are a number of explanations for the disparities. For example, employed blacks and Latinos generally earn less than whites, and they are less likely to work for employers offering health plans with generous prescription drug benefits. Also, if offered a choice of health plans, those employees may be more likely to select one with lower premiums, which generally would mean fewer benefits and more patient cost-sharing, to increase take-home pay.

Mr. Hargraves says that any solution to this problem will come from the ongoing debate in the country on what the nation should do about health insurance for all people.

"There's a tension between personal responsibility and what we should do as a country," he says. "National health insurance is on the nation's agenda again, at least through the November presidential election. There are likely to be lots of demonstration projects to try to find answers to some of the questions."

Meanwhile, another study shows that Hispanics are less likely to receive or use medications for asthma, cardiovascular disease, HIV/AIDS, mental illness, and pain. The authors say that disparities in drug treatment are substantial and often persist even after adjustments for differences in income, age, insurance coverage, and coexisting medical conditions.

Tailor prescribing to patients

That study, conducted for the National Alliance for Hispanic Health by the National Pharmaceutical Council, encourages doctors to tailor prescribing for Hispanics based on age, coexisting conditions, responsiveness to medications, and cultural perceptions of disease and treatment.

The study shows that differences among racial and ethnic groups in

how medicines are metabolized have been observed and may be due to variation in genes regulating drug metabolism, environmental factors, or their interaction. Such differences, the researchers say, can result in higher or lower levels of drugs in the bloodstream.

Warranting extra attention

Based on preliminary evidence, the study cites several classes of medicines that particularly warrant extra attention. Thus, some Hispanic groups may require lower doses of antidepressants and some antipsychotic medications may be more prone to increased side effects at normal doses.

In one study, the average therapeutic dose for Hispanics was half that commonly given to whites or African-Americans. Likewise, Mexican Americans metabolize drugs regulated by the CYP2D6 gene faster than do whites, which can affect 30% of therapeutically important medications, including many cardiovascular drugs.

The study also found that language barriers and differences in cultural values can have an impact on the quality of care delivered and can negatively influence compliance, self-management, of chronic disease, and overall health outcomes for many Hispanic patients.

Researchers recommendations

The study authors — Carolina Reyes, MD, assistant clinical professor at the UCLA School of Medicine; Adolph P. Falcon, director of policy for the National Alliance for Hispanic Health; and Texas Sen. Leticia Van de Putte, a pharmacist — make the following recommendations:

- Improve access to pharmaceutical therapy by making health care financing and reimbursement practices broad and flexible enough to enable rational choices of drugs, dosages, and formulations for Hispanic patients based on their genetic, medical, and cultural needs.
- Prescribe based on individual needs, so those for Hispanic populations considerations include biological, environmental, and cultural factors that can influence drug effectiveness and patient adherence to treatment regimens.
- Treat coexisting conditions common in the Hispanic population including depression paired with asthma, diabetes, or cardiovascular disease, and diabetes paired with depression.
- Meet quality standards of cultural proficiency and communication, recognizing communication barriers and cultural differences between health care providers and Hispanic patients can reduce treatment adherence and compromise overall disease management.

Legislation introduced

To try to address problems of health disparities for racial and ethnic minorities, three members of the U.S. Senate have introduced comprehensive legislation known as the "Closing the Health Care Gap Act."

Senate majority leader Bill Frist (R-TN), one of the sponsors, described the bill as "the most comprehensive national initiative to address disparities in health care access and quality."

He added there is a gap in health care today, despite strides made in recent years.

Mr. Frist pointed out that his new bill will build on legislation he and others introduced previously, the Minority Health and Health Disparities Research Education Act, which became law in November 2000.

The new bill is intended to improve overall quality of care, expand access to care, enhance research opportunities, and foster innovative outreach programs to address health care disparities. It also is said to strengthen leadership at the local and national level and promote programs to increase diversity in the health care work force.

Contact Mr. Hargraves at (202) 554-7569. To access the National Alliance study, go to: www.hispanichealth.org or www.npcnow.org; or call Sandy Welsh at the National Alliance for Hispanic Health at (202) 312-1096. For more information about the Closing the Health Care Gap Act, go to: thomas.loc.gov. ■

This issue of *State Health Watch* brings you news from these states:

Workers like employer health coverage mandate, but some see problems

While little was said about expansion of employer-based health coverage in recent years, discussion about the prospect has recently resumed, fueled in part by passage of the Health Insurance Act of 2003 in California, the first state-based "play or pay" legislation in almost a decade, and in part by references to employer-based coverage by many of the Democratic presidential candidates during the early primaries.

What CA survey found

A survey commissioned by the California Healthcare Foundation has found that workers both in California and nationally support mandates on employers, while a Commonwealth Fund study indicates employers "strongly support" job-based coverage.

However, a analyst from the Galen Institute in Alexandria, VA, testified before the Health Subcommittee of the House Ways and Means Committee that there are significant negative consequences to relying on employer mandates. The analyst also has questioned the validity of the Commonwealth Fund findings.

In the California Healthcare Foundation survey of workers, researchers found that in both California and the nation as a whole, approximately half of working-age adults indicated they thought all employers should be required to offer health insurance to all employees.

Another 25% opted for a less inclusive mandate that would require employers to offer coverage to certain employees, such as those who are permanent and work full time. Another 10% voiced support for a mandate only for large employers. Just 13% in California and 10% in the country as a whole thought employers should not be required to provide insurance to their employees.

In general, according to the findings published in the March 17 *Health Affairs*, groups traditionally more likely to be disenfranchised in the health care system are more likely to be in favor of a full mandate on employers (covering all employers and all employees). Blacks were particularly strong supporters of a full mandate nationally (79%). The uninsured were somewhat more likely than those not already covered to support a full mandate, but the difference was not as large as for other groups.

Of those who supported a requirement on employers to provide some level of health insurance, 65% of California residents and 70% of U.S. residents said employers should be required to pay for most of the cost of health insurance premiums for their employees.

Include dependents, too

The vast majority of people who supported some type of employer mandate also thought coverage for dependents should be included. The researchers said support for dependent coverage was uniform across all subgroups except the insured, who voiced stronger support for dependent coverage than did the uninsured. Some 80% of those backing dependent coverage wanted to see employers pay for some of the premium cost for dependents.

When asked what might happen to wages and employment if employer-mandated coverage was implemented, 81% of California residents thought there would be some effect, slightly less than the 86% of respondents nationally who expected an effect. Those with the lowest incomes, blacks, the uninsured, and the least educated were least likely to think that there would be an overall employment or wage impact.

Mandate makeup

The researchers conclude that while strong and widespread support for a mandate is evident from the survey, opinion is varied on the specific provisions that should be part of a mandate. Questions about which employers are subject to the mandate and what types of employees are covered are the most fundamental.

"The disconnect between workers' views on how a mandate would affect overall wages and employment and how they perceive that it would affect their own situation is of particular interest," the report explained.

"Across all population subgroups, many more workers think that a mandate is more likely to affect others than to affect their own job or pay. Interestingly, subgroups most likely to be affected by wage reductions or layoffs — including the lowest-paid and least educated workers — are least likely to perceive this potential effect. If an employer mandate is implemented and these workers experience adverse labor market effects, their support for the requirement could erode," the report continued.

Meanwhile, the Commonwealth Fund found while many employers said it is "very important" to provide or help workers pay for health coverage, rising premium costs are forcing them to shift more costs to employees or cut back on benefits.

According to this study, the majority of employers who offer coverage (59%) preferred an employer mandate over public program expansion, while 50% of employers who do not now offer coverage prefer a public program expansion over an employer mandate. While majorities of small (51%) and large (64%) employers preferred an employer mandate, small employers expressed more support for public program expansions than did large employers.

Looking at new paradigms

Based on the survey findings, the Commonwealth Fund researchers said, employers appear willing to consider new public-private policies to increase the availability of affordable coverage, measures that would go a long way toward bridging the divide in the quality of U.S. jobs.

Many employers told the researchers they have cut back on their support for health insurance coverage for workers because of increases in premium costs. Many said they were limiting eligibility, perhaps through a waiting period for coverage to kick in or by restricting coverage to full-time employees.

Employers generally expressed a willingness to cooperate with a number of different policy approaches to expanding coverage including tax credits, COBRA, and increasing enrollment in Medicaid and SCHIP.

The report said a majority of employers (59%) say corporations should be responsible for sharing costs of their employees' health benefits, either by providing coverage or by contributing to a fund that would cover the uninsured.

"The survey findings suggest that many employers are committed to offering health benefits and believe that providing insurance not only helps employees but also yields benefits to companies as a whole," the report said. "Employers who offered health insurance in the survey said that health benefits improve their ability both to recruit and retain employees."

Survey results flawed?

While results of the California Healthcare Foundation and Commonwealth Fund studies might lead policy-makers to conclude that expansion of employer mandates would be a good approach to solving at least some of the problem of the uninsured, Galen Institute Center for Consumer-Driven Health Care director Greg Scandlen advised caution.

Looking at the Commonwealth Fund study, he said the strong showing by employers in favor of workplace coverage comes as a function of the way the question was asked, rather than genuine support for the concept.

"The only way Commonwealth was able to get such a result was by limiting the policy options presented to two," he said, "expand public insurance or require employers to offer benefits or contribute to the cost. No other option was available. This is like giving someone the option of death by hanging or death by drowning and announcing that 50% of all people want to die by drowning."

And in testimony before the House Ways and Means Committee Health Subcommittee he raised the proposition that employer-based coverage is more of a problem than a solution.

He noted that in 1943, the Internal Revenue Service ruled that employer-sponsored benefits would be excluded from income, and Congress codified that ruling in 1954.

At that time, he said, health insurance was not very expensive and relatively few Americans had any coverage at all, so the revenue effect was small.

"The measure was seen as a good way to encourage more coverage," he told the hearing, "and in that, it was very successful. The numbers of Americans with health insurance coverage grew from about 12 million in 1940 to 80 million in 1950 to 132 million by 1960, and the kind of coverage became more generous, moving from basic hospitalization coverage to more comprehensive major medical plans.

But Mr. Scandlen sees two negative consequences to the growth of employer-based coverage:

1. Tax policy advantaged only those with employer-sponsored health coverage, and not people who bought their own or who paid directly for services.
2. The large amount of new money in the system raised prices for everyone, including those with no coverage.

People not associated with an employer, especially the aged and the poor but also the self-employed and people whose employers didn't offer coverage, found it increasingly difficult to pay for health care.

In 1965, Congress addressed part of this problem by creating Medicare for the aged and Medicaid for the poor. But, according to Mr. Scandlen, that infusion of new money into the system led to even greater increases in the cost of care. In 1960, 56% of total national health spending was paid directly out-of-pocket by consumers, and only 21% was paid by state and federal governments.

In just seven years, that had changed to 36% out-of-pocket and 37% from government payers. The total amount of money spent on health care rose dramatically, tripling from 1965 to 1977, and

rising from 5.9% of the gross national product to 8.3%. Mr. Scandlen said these "demand-induced cost increases further disadvantaged people remaining outside of the subsidized system."

Subsidies = higher prices?

Since 1965, he said, we have had a system that subsidizes the elderly, the poor, and people who get coverage on the job.

Federal expenditures alone equaled $250 billion for Medicare in 2003, $160 billion for Medicaid and SCHIP, and $180 billion in 2004 for employer-sponsored coverage. "This subsidized spending clearly results in higher prices for everyone, including those who get no subsidies at all," he said. "Someone getting coverage on the job has to earn $4,000 in compensation to get $4,000 in benefits," Mr. Scandlen explained.

"The same person who does not get coverage from an employer may have to earn $8,000 in wages to have enough left over after taxes to pay for a $4,000 insurance policy. Members of Congress, corporate executives, members of labor unions all are well-subsidized. But someone who is laid off from a job, a waitress in a diner, a stock clerk in a small retail store, people whose employers don't provide coverage get no help with their health premiums at all. Their only choice is to buy individual coverage with after-tax dollars or go uninsured," he added.

Another consequence of the tax subsidy provided solely to employer-sponsored coverage, he said is that anyone who can get an employer-based plan will do so, leaving only those who can't get such plans in the individual market.

These people may be lower-income workers, people too sick to work or semiretired, people who change jobs frequently, and people with seasonal employment. They are older, sicker, and poorer than people with employer-sponsored coverage. Because they tend to be older, sicker, and financially less stable, the cost of the coverage is higher than it would be for an employer-sponsored pool. There are higher claims costs because they are sicker, and there are higher administrative costs because premium collection, marketing, and retention are difficult. Yet these people get no help from their employers and no tax advantage from the government.

Is ERISA getting in the way?

And while some employers might be willing to contribute to the costs of coverage for these employees, the Employee Retirement Income Security Act (ERISA) can get in the way, from Mr. Scandlen's perspective, because employers might be willing to contribute money to the cost of an individual policy chosen and owned by the employee but not commit to purchasing a full-scale benefit plan with all the regulatory reports and responsibilities. But the tax code prohibits them from simply contributing money.

Under ERISA an employer's contribution makes the coverage an "employee welfare benefits plan" subject to the requirements of any other group plan. In addition, he said, ERISA plans that buy coverage from an insurance company indirectly are subject to all the regulations that apply to their insurer. But employers that self-insure their benefits are exempt from state insurance laws. Large employers are able to self-insure and thus are exempt from state law. Smaller employers must buy coverage from insurers and thus are subject to state law.

Mr. Scandlen said this division among employers disrupts state political equilibrium.

Large politically influential employers don't care what the state legislatures do because they are unaffected by it. "That leaves only small, powerless employers to complain when a new mandate is proposed or new restrictions are placed on their coverage," he said. "As a result, advocates of more regulations and more mandates encounter little effective resistance."

Before ERISA was enacted in 1974, there were very few mandated benefits. But since it became law, more than 1,500 laws have been enacted by state legislatures mandating coverage of someone's favorite service. States also have passed limits on underwriting, community rating laws, price controls, and a vast number of other laws and regulations that have destroyed the insurance market in some states, in Mr. Scandlen's view.

"Whatever their seeming merit," he testified, "all of these laws add costs and complications to the process of a small employer providing coverage to its workers," he pointed out.

Mr. Scandlen told the committee that these are the kinds of underlying conditions that make it difficult for the uninsured to access coverage.

But he cautioned that "the American people, the American health care system, and the American economy are entrenched in this system [and] even if we wanted to undo it, it would be enormously disruptive to do it quickly. Change should be made carefully and thoughtfully. Having an understanding of this history and the consequences of well-intentioned policies should make it more feasible to tailor changes that can work."

For more information, go to: www.chcf.org; www.cmwf.org; and www.galen.org. ■

Clip files / Local news from the states

This column features selected short items about state health care policy.

Medicaid exec: Funds will dry up this summer

MONTGOMERY, AL—The Alabama Medicaid Agency will run out of money sometime around midsummer unless state lawmakers approve extra funding, the agency's commissioner has said.

A bill sponsored by Rep. John Knight, D-Montgomery, and backed by Gov. Bob Riley would steer a supplemental $39.8 million to Medicaid this year.

Alabama Medicaid Commissioner Carol Herrmann said she expects the funding to be approved and that it would have dire consequences if the emergency relief were lost in the legislative shuffle.

Also, Alabama's Medicaid program will not meet federal standards for access to care unless agency funding is increased for the next fiscal year, which starts Oct. 1, Herrmann predicted. "We cannot make any more cuts," Ms. Herrmann pointed out.

Alabama's Medicaid program expects to have a $60 million shortfall in its budget for this fiscal year and to fall $182 million short in fiscal 2005 if it does not get more money.

The program is budgeted to receive $230 million from the state General Fund this year, although it also has money coming in from other sources. Because of cash-flow problems, Medicaid regularly has delayed payments to care providers. Without the supplemental appropriation, the agency wouldn't have funds to pay providers during the final few months of the fiscal year, she said. "We would have a pretty dire situation," she said.

—*Birmingham News*, March 23

KidCare insurance will be cut back

TALLAHASSEE, FL—Thousands of children statewide can expect to get kicked out of the Florida KidCare program starting later this year because of a major revamp of the subsidized health insurance plan that legislators approved.

With election-year politics surrounding the debate, the Republican-led Florida House sent Senate Bill 2000 — the most comprehensive measure yet to pass the 2004 Legislature — to the governor's desk on an 80-37 party-line vote.

House Republicans said the future program cutbacks were necessary to keep the program fiscally sound for years to come.

Republican sponsors emphasized the most appealing aspects of their KidCare legislation — most notably that the bill temporarily adds more children to the program.

It does so by authorizing $25 million, most of it one-time federal money, to take 90,000 children off a waiting list for the health coverage.

But the Democratic legislators, who have been pushing for months to get legislative approval to allow more children into the program, were not satisfied.

They argued that the legislation still won't help 20,000 additional children on a waiting list to be served, and the overall changes to the bill will trim the rolls for the health program by placing severe new restrictions on future enrollment and eligibility.

—*Tallahassee Sun-Sentinel*, March 16