

1990

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### Recommended Citation

Robert E. Eckhardt, Opening Remarks: An Overview of the Problem, Symposium: Ohioans without Health Insurance: How Big a Problem - Are there Solutions, 4 J.L. & Health 151 (1989-1990)

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## V. OPENING REMARKS: AN OVERVIEW OF THE PROBLEM

ROBERT E. ECKARDT

### A. THE ROLE OF THE CONSULTANT

It is a pleasure to be here this morning and to give you some opening comments about what is obviously a very important issue and one that I think does require the involvement of a multitude of different persons from public policy, public health, law and other fields. As I look at the Conference program, however, I feel a little bit uneasy with my assignment since those of us in Foundations are quintessential consultants; we are not really out on the front line doing anything, but are instead providing advice, assistance, counseling, and sometimes money, to those who *are* out there. That description of the role of a consultant reminds me of a story that really tells you what a consultant is.

A number of tomcats were quite active with the lady cats in the neighborhood and one, who was particularly active and was sort of the king tomcat, was always surrounded by the lady cats and so was the object of much envy and jealousy from the other tomcats. One evening when he was particularly active, he unfortunately just did not quite clear a barbed wire fence and some of his, shall we say, more important equipment was left behind. After that, he disappeared from the scene for a number of months, and no one was quite sure what had happened to him. But when he finally reappeared, he took up right where he left off, and there were all the lady cats around him again. This created some consternation among the other tomcats, and they asked each other how he could be doing this. They all knew what happened to him. He didn't have his equipment any more. How could he be attracting all the lady cats? And then one of the more sophisticated tomcats said, "Relax we don't have to worry about him any more. He's become a consultant."

As the story suggests, I think you will hear much more about what it's like to really be "doing it" in regard to health care and insurance from the rest of the speakers today, but I do hope that I can step back and give you a broader perspective to start the conference.

### B. TRADITIONAL METHODS OF OBTAINING COVERAGE FOR MEDICAL CARE

Let me begin by giving you my bottom line: Obviously, there is no easy solution to this problem, and it is going to take a great deal of effort on the part of many people if we are going to have any success. What I would like to do is to begin with some background information. Then, I want to take you quickly over the facts and figures and finally try to put the issue in perspective.

In the United States, there are three traditional ways in which persons receive coverage for medical care. As we all know, these are employment-based insurance coverages under various governmental programs such as Medicaid or Medicare, and self-pay. Substantial changes in all three of these mechanisms have occurred in the past few years and contribute

to the issue we are looking at today: How do we make provision for coverage to both the uninsured and underinsured population, particularly when this is a growing population?

### **C. SUBSTANTIAL CHANGES TO THE TRADITIONAL METHODS**

Although there are many causes for this trend I would like to look at three today. The first is the changing pattern in employment and employee-provided health care coverage. The second is the decreasing coverage by governmental programs. Third, is the failure of existing health care cost controls. All of these, I believe, contribute to the problem.

### **D. CHANGES IN THE AMERICAN ECONOMY**

The past few years have obviously led to major changes in the American economy, several of which have led to similarly major changes in health care coverage provided through employment. Perhaps the two most important changes have been the increasing shift to a service rather than a manufacturing economy and the growing importance of small businesses. In general, health insurance coverage has been an accepted and expected fringe benefit of large industrial firms since it was instituted in response to World War II wage controls. Many people do not realize that health insurance really appeared as a major employee benefit in industry when wages were controlled during World War II and employers were looking for ways other than salary to compensate workers. Given its favorable tax status—it's not treated as income from employment for income tax purposes—the general trend has been toward increasingly richer benefits and broader coverage. However, the sharp decline in high-paying manufacturing jobs has eroded this high level of coverage.

### **E. GROWTH OF SMALL EMPLOYERS**

A related but different change has been the growth of small employers. Providing health insurance to employees in small businesses has certain inherent disadvantages, such as higher per capita administrative expenses and a smaller pool for risk sharing. The net result is that smaller employers generally face higher costs for lower benefits. When this price disadvantage is combined with the lower levels of unionization, one frequently encounters limited or no coverage or coverage of only the employee rather than the entire family. Nationwide, as many as sixty percent of firms with fewer than twenty-five employees provide no health insurance,<sup>1</sup> and those firms that do, provide less generous levels of coverage, or provide coverage only to the employee rather than to the entire family.

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<sup>1</sup> DEPT. OF THE TREASURY, Report to the President and to the Congress. *Financing Health and Long-term Care*, 72 (1990).

In Cleveland, however, we are extremely fortunate to have one of the nationally recognized small employer cooperative programs run through the Council of Smaller Enterprises, COSE, which you may hear about later today. Therefore, our experience, although similar to that found nationally, has generally been better.

## F. DECREASED COVERAGE OF "AT-RISK" POPULATIONS

A second major cause of the problem is decreased coverage of the at-risk population under existing governmental programs. One reason for this is the growing number of poor and low income people in this country. The past few years have seen a fifty percent increase in persons living below the federally-defined poverty level.<sup>2</sup> At the same time, these states have generally been moving in the direction of decreased generosity in their Medicaid programs. This has been played-out by increasing eligibility levels so that fewer people qualify, reducing the level of covered benefits and, frequently, offering lower payments to providers, which may lead to decreased access to care. The net result of these two changes in coverage of the low-income population can be seen in two statistics. Number One: between 1975 and 1986 the proportion of the population below the poverty line covered under Medicaid declined by one-third.<sup>3</sup> Number Two: in more than half the states Medicaid reaches less than one-third of the people in poverty as federally defined.<sup>4</sup> This failure of the safety net to catch persons at risk means of course, that many of them appear elsewhere in the system as "the uninsured."

## G. FAILURE OF HEALTH CARE COST CONTAINMENT

The third trend that I believe is important is the apparent complete failure of health care cost containment today. We seem to be unable to break out of a pattern in which health care cost inflation runs at two to three times the general rate of inflation. Now this means that health cost inflation still moves up or down with the general rate of inflation, so we feel better when health care inflation comes down from twenty to twelve percent.<sup>5</sup> But at the same time, the general inflation rate has come down in approximately the same ratio. Although a discussion of the cause for this is not an appropriate inquiry today, I think it is important to point

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<sup>2</sup> U.S. Dept. of Commerce Statistical Abstract 1990, Table No. 743, at 458.

<sup>3</sup> See Rowland, Lyons & Edwards. *Medicaid: Health Care for the Poor in the Reagan Era*, 9 AM. REV. PUB. HEALTH 427-50 (1988)

<sup>4</sup> *Id.* U.S. DEPT. OF HEALTH AND HUMAN SERVICES, HEALTH CARE FINANCING ADMINISTRATION MEDICARE AND MEDICAID DATA BOOK, 1988 (1989).

<sup>5</sup> For medical costs, see NATIONAL CENTER FOR HEALTH STATISTICS. NATIONAL MEDICAL CARE UTILIZATION AND EXPENDITURE SURVEY Series A-C; see also U. S. Dept. of Commerce Statistical Abstract 1990, Table No. 150, at 99, Table No. 757, at 468. See generally Blumstein, *Financing Uncompensated Care: An Approach to the Issues*, 38 J. OF L. EDUC. 511 (1988); Brown, *Public Hospitals on the Brink: Their Problems and Their Options*, 7 J. HEALTH POL. POL'Y & L. 927-44 (1983).

out that such high levels of inflation have led to major price increases both for self-paid patients and third parties and contribute to the problem of the uninsured. As one might expect, third parties have balked at the substantial premium increases associated with these large and frequent rate increases. They have demanded price discounts and have been unwilling to pay the cost-shifted amounts traditionally included in provider's bills to cover the cost of the uninsured. Large payers demand that this implicit tax, which is what it really is, be rooted out and passed on to someone else. As the number of persons or payers willing to pay this tax decreases, either it will get very large for those willing to pay, or it will become provider bad debt or charity care, or persons likely to produce it — the under- and un-insured — will be kept out of the system. I think we probably would say that all three are occurring.

## **H. HOSPITALS AS PROVIDERS OF UNPAID, UNCOMPENSATED CARE**

Although hospitals, most of which in this region are charitable tax-exempt institutions, provide substantial amounts of charity care, there is a limit to the amount of unpaid care any institution can bear. This becomes particularly difficult when charity care is not equally distributed and providers are being asked, at the same time, to be more businesslike. Although I do not have all the figures, and I think someone else may present them this morning, in Florida, seventy-two percent of all unresolved hospital charges come from patients under sixty-five with no health insurance and an additional sixteen percent from patients under sixty-five with inadequate insurance.

As we look later today at the level of unpaid or uncompensated care that providers provide, it would be useful to look up the figures in this community. Given these trends, for which I see little likelihood of change in the near term, what are some of the facts and figures concerning the un- and under-insured? (I would say that that is a somewhat complicated phrase: "un- and under-insured", but I haven't figured out how to make it shorter and neater.) I must clarify that I am focusing on those under age sixty-five since, in spite of all the problems of Medicare, those over sixty-five have almost universal coverage through the Medicare program. So, I'll be looking at persons under sixty-five without coverage or with limited coverage. I want to leave you with five facts and a belief.

## **I. FIVE "FACTS" AND ONE "BELIEF" REGARDING THE PROBLEMS OF THE UNINSURED AND UNDERINSURED**

### *1. Large Population Represented in the Above Group*

The first fact is that there is a very large population represented in the group we are discussing today. Estimates are that sixty-five million people in the United States under the age of sixty-five, or thirty percent of the

population, may have inadequate health insurance against large medical bills. Of this number, slightly more than half or about 35 million, or 17.5% of the population under the age of sixty-five, are without private or public coverage for all or part of the year. The remainder, 30 million, are underinsured against large medical bills.<sup>6</sup>

## 2. *The Relationship Between Lack of Coverage and Income Status*

The second fact is that lack of coverage is related to, but not solely dependent upon, income status. If one uses the federal poverty level as a way to measure income status, those without coverage tend to fall roughly into thirds. Approximately one-third have incomes of more than 200 percent of the poverty level; thirty-five to forty percent are below the poverty level, while the remainder, just under one-third, are the near-poor — those between the poverty line and 200 percent of the poverty line.<sup>7</sup> In this region, I must note, however, it appears that our distribution is slightly different than that found nationally. Our region has a lower representation from those in the so-called “higher income” group and more in the near-poor group. But, essentially the distribution in this region is still close to one-third in each of those three groups.

## 3. *Uninsured Does not Necessarily Mean Unemployed*

The third fact is that since many of the uninsured work, they are not the same as the unemployed. Solving unemployment problems does not eliminate the problem of uninsured persons. In 1986, 17 million working Americans, or one-sixth of the work force, were uninsured.<sup>8</sup> Using the figure of 35 million I spoke about before, that would mean that just about one-half of the uninsured are working, usually in lower-paying service industry jobs and/or in smaller businesses. A related fact is that many uninsured are dependents of workers with employment-related single coverage. More than two-thirds of those with no health insurance coverage live in homes where the head of the household works full-time and year round and frequently with health insurance coverage only for himself or herself,<sup>9</sup> not the entire household.

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<sup>6</sup> See also Short, Monheit & Beauregard, A PROFILE OF UNINSURED AMERICANS, NATIONAL MEDICAL EXPENDITURE SURVEY, RESEARCH FINDINGS 1. NATIONAL CENTER FOR HEALTH SERVICES RESEARCH AND HEALTH CARE TECHNOLOGY ASSESSMENT (1989) [hereinafter A PROFILE OF UNINSURED AMERICANS]; see generally GENERAL ACCOUNTING OFFICE, HEALTH INSURANCE: AN OVERVIEW OF THE WORKING UNINSURED (1989) [hereinafter GENERAL ACCOUNTING OFFICE].

<sup>7</sup> COMMITTEE ON EDUCATION AND LABOR, 100th Cong., 2nd Sess., HEALTH INSURANCE AND THE UNINSURED: BACKGROUND DATA AND ANALYSIS 94 (Committee Print 1988) [hereinafter COMMITTEE ON EDUCATION AND LABOR].

<sup>8</sup> See generally GENERAL ACCOUNTING OFFICE, *supra* note 6; A PROFILE OF UNINSURED AMERICANS, *supra* note 6.

<sup>9</sup> COMMITTEE ON EDUCATION AND LABOR, *supra* note 7.

#### 4. *Numbers of Uninsured Increasing*

The fourth fact is that, due to the factors that I already mentioned, the numbers of the uninsured are increasing. Between 1977 and 1986, they increased by nine million, from 26 million to 35 million.<sup>10</sup> Although there is some evidence that the growth may have been slower in the years since 1986, the factors that promote this growth remain. Continuing failure to bring health care cost increases under control, for example, will likely again increase this population.

#### 5. *Children-Disproportionately Large Segment of those Numbers*

The fifth fact I want to leave with you is that children are disproportionately represented in the uninsured and underinsured population. Nearly one in five children in the United States has no coverage, and one-third of the uninsured, almost 12 million, are children.<sup>11</sup> Looking at it another way, the chance of being uninsured is thirty-seven percent higher for a child than for an adult. Finally, going back to the employment status issue, more than one-third of all uninsured children, 4.1 million of them, live with a parent or guardian who is insured.

#### 6. *Problems Not a Result of Lack of Funds*

And now the belief. The belief is that this situation is not the result of a lack of money going into health care, since the United States system under any measure is the most expensive in the world. In 1987, the United States spent \$1,987 per capita for health care.<sup>12</sup> This is significantly more than is spent in other industrialized nations. Since per capita figures are sometimes difficult to interpret, another way of looking at this is as a percentage of our Gross National Product (GNP). In round numbers, the United States spends eleven percent of GNP on health care while other comparable nations spend nine percent.<sup>13</sup> Although a two percent difference sounds small, it might be better to say the United States spends twenty percent more, since that represents the spending differential. I suggest that a more effective and efficient use of such funds will allow many of the problems we are discussing today to be dealt with. But little consensus yet exists about what is effective and efficient, except that what is ineffective and inefficient can probably be found in someone else's budget rather than your own.

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<sup>10</sup> *Id.* at 110.

<sup>11</sup> See *U. S. Dept. of Commerce Statistical Abstract 1990*, Table No. 152, at 100.

<sup>12</sup> *Id.* Table No. 134, at 92.

<sup>13</sup> *Id.* Table No. 1444, at 839.

## J. WHAT ARE THE IMPLICATIONS OF THOSE PROBLEMS?

Although I have primarily used national statistics, studies in Ohio and Cleveland suggest that the outlines of the problem here are similar, although they do vary somewhat. Certainly, the driving forces I spoke of earlier—industrial decline, and its replacement by small businesses and service industries, growing numbers of the poor and near poor, and failed health care cost control— are found here. What are some of the implications of these statistics? I have given you some facts and figures about the size and scope of the problem. Before we spend the day discussing possible solutions, perhaps we should stop and ask a more basic question: Why should we care? What makes health care special? Lots of people don't have access to goods and services in our economy, or they have access to lower price, lower quality and lower amenity products. Is there something about health care that makes it different from these other goods? I would like to suggest that our personal and societal lack of clarity around these basic questions underlines much of our difficulty in dealing with the issues of the un- and under-insured. At its heart, this issue is the provision of a good in short supply. We seem to be undecided about the degree to which health care should be rationed by our usual rationing mechanisms: price and ability to pay. Or, since we obviously will never have the ability to provide the entire amount of health care people are likely to desire, should it be rationed in some other way, such as by governmental fiat or by availability, e.g., waiting lists?

I believe that most people see health care as more than a market place good but less than a right. We clearly make some distinctions: purely cosmetic surgery is rarely provided without checking into your ability to pay, but life saving emergency care is rarely postponed until financial coverage is established, even if this life saving treatment is made necessary through the voluntary assumption of risky or unhealthy behaviors. Less clear, perhaps, is the vast majority of medical care where small benefits accrue to individuals and are paid for by a larger group. To what degree does this constitute a right? Does the degree of improvement that is expected play a role? Should the standard be what a reasonable person would be willing to pay? If so, pay on what basis? Out of pocket or with health insurance coverage? That brings you right back to the central dilemma. Perhaps we should be using cost-benefit analysis. However, we do not know what the benefits are; they are difficult to measure or to estimate in any case, and they may vary. How we value them may vary based on who we are.

Decisions around these questions, however, will be necessary if we are to decide what level of service, if any, society should provide or mandate to its citizens regardless of the source of payment for those services. Consideration of these issues is important in deciding whether low cost or low coverage programs are appropriate. Are we willing to define and accept the "blue light special?" Or will every one need access to boutique health care?

## K. SOCIETAL VALUE CLARIFICATION NEEDED

I've tried to indicate what I believe are some of the underlying causes of the problem of the un- and under-insured. By showing you some of the statistics, I have tried to leave you with some particular facts and to indicate how the underlying causes influence the size, shape, and structure of the problem. Finally, I have tried to indicate that much of the issue, I believe, is driven by, and clouded by, what are essentially unresolved moral and philosophical issues concerning health care. The message that I hope you will carry during the day while we discuss possible solutions is that this is less a technical problem, with a technical solution, than a venture into a societal values clarification. One must be aware that these values will be influenced by numerous factors including the self-interest of persons participating in the system. This is to be expected, but it does not turn these into provider questions. They are much deeper than how we view society and the complex role of medical care in it, and its value compared with other societal goods. I would hope today that we would all strive to avoid the solution which so often comes to a difficult problem. That solution which is simple, elegant and wrong. Thank you.