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Senator Kennedy’s Proposal to Guarantee Basic Health Benefits for All Americans

David Nexon*

The number of uninsured Americans is shamefully high and has grown rapidly in the last decade. In 1979 slightly less than 30 million people were uninsured; by 1987 the number had climbed to over 37 million. While the rate of increase has slowed in the last three years, the problem remains severe, and the number of the uninsured is likely to continue to increase.

The great bulk of the increase in the number of the uninsured resulted from shifts in the economy which are likely to continue. The 1980s marked a decline in heavy manufacturing, a unionized sector of the economy, which traditionally has had good health plans. Most of the job growth in our society has been in services, retail sales, and small businesses—all areas which traditionally have not had good health insurance. This trend is likely to continue, and the next recession will send the number of the uninsured sharply upward.

Lack of Essential Health Care

The great bulk of the uninsured are working people. Most work hard, 40 hours a week, 52 weeks a year, but they do not have health insurance for their families because their employers do not provide it. About two-thirds of the uninsured are working or are dependents of workers, while the other one-third are out of the labor force or are unemployed.

The problem is not just one of people who lack health insurance. It is also a problem of inadequate health insurance. According to the Department of Health and Human Services (1), approximately 60 million people have health insurance which could prove inadequate in the event of a serious illness. The Department also estimates that about 2.4 million people annually have catastrophic health costs; that is, their costs not covered by insurance exceed $3,000. For most low- and moderate-income Americans, a $3,000 out-of-pocket expense is catastrophic. It cuts to the heart of the family budget and savings. Of course, $3,000 is only the base of the pyramid; it can rise to $10,000, even $100,000 or $150,000, in some cases.

The saddest consequence to people without health insurance and to those with inadequate coverage is the impact on access to essential health care. According to a survey by the Robert Wood Johnson Foundation (2), of 1 million American families, every year some member seeks health care and is turned away because he cannot pay for it. Another 14 million people feel they need health care but do not seek it because they know they cannot pay.

Thus, at least 15 million Americans every year lack needed health care for economic reasons. In addition, people who have no regular source of care often need attention but are not aware of it because they have no symptoms. One result is the increased rate of death from curable cancer reported for minority populations.

A Washington, DC, study (3) reported that about 40% of admission to hospitals were avoidable. This means that while care was probably necessary, hospital admission was avoidable. If these people had accessed the health care system sooner and had a source of regular care, they might not have become so sick as to require hospitalization. This situation has tremendous cost consequences and even greater human consequences for people who suffer needless disability and death. Probably the biggest single reason our people do not get the health care they need is because they are inadequately insured.

Basic Health Benefits Proposal

Our proposal is embodied in S.768, Basic Health Benefits for All Americans (BHB), which has been reported out of the Senate Committee on Labor and Human Resources. The bill requires all employers to provide a basic package of health insurance coverage to employees and their dependents. This part of the proposal would cover about 23 million people, two-thirds of the uninsured. For the remaining one-third, we propose a phased-in, federal/state public program similar to Medicaid. We developed this phased-in proposal because we think that the only way the bill can be enacted in the near future, given the current budget situation, is to have a low first-year cost. After the bill is enacted, two-thirds of the uninsured will receive coverage immediately, and all the remaining uninsured will receive coverage by the year 2000 at the latest.

The employer part of the package requires employers to provide a basic package of health benefits to all full-time employees and their dependents. We defined “full-time” as employees who work at least 17.5 hours per week. Businesses objected to our setting the eligibility standard so low, yet most of the 23 million people needing this coverage would still qualify if the

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eligibility standard were raised to 25 or 30 hours. However, we wanted to be sure that employers have no incentive to scale down working hours in order to avoid the requirement of providing health insurance coverage.

Obviously, for low-wage workers averaging 18 hours a week, health care costs would be a significant percentage of total labor costs. For this reason, for employees working 17.5 to 25 hours per week, the employer would pay a smaller share of the premium than the normal 80%. The proportion would be related to the ratio of the hours the individual worked to 25 hours on a sliding scale.

Adding 2% to 3% to the total national health care cost seems a small price to pay for the benefits given to 37 million people now totally left out of the health insurance system.

This program would cover 23 million of the currently uninsured. The basic required package would include physician and hospital services, diagnostic tests, prenatal and well-baby care, limited mental health benefits, and catastrophic coverage (a stop-loss for out-of-pocket expenses over $3,000). There would be maximum limits on deductibles, copayments, and the employer’s share of the premiums. The deductible limits are $250 for an individual and $500 for a family, copayments are 20%, and the employee could be asked to pay no more than 20% of the premium for a basic plan. No one could be excluded from coverage for reasons of health status or preexisting conditions.

An actuarial equivalency test would allow flexibility in benefit design; that is, an employer might not offer exactly the minimum plan. Most employers, in fact, offer better coverage than this minimum. The actuarial equivalency feature would allow adjustments to reflect the particular needs of the employer and employees as long as basic services are covered. For example, if employers chose to include outpatient drugs, which is not required, a higher deductible or copayment or a higher share of the premium might be picked up by a public program.

This plan is clearly not ideal coverage. In an ideal required insurance plan, the deductible and copayments would be lower and the coverage of services would be broader. However, to get this bill passed we must have something consistent with what most businesses already provide. If we were to require better coverage, we would have to take on not only those businesses that provide no coverage for their workers but also the vast majority of American businesses that already do provide coverage. However, this compromise plan, if enacted, would be a great step forward in the health care of the American people.

We have set up a regional insurer program designed for employee groups of 25 or less. This program would require all insurers who sold in that market to meet minimum standards and to be certified as regional insurers. A firm not certified as a regional insurer could not sell to small businesses. To be certified as a regional insurer, a company would have to offer community-rated coverage, accept any small business that applied for coverage, and not reject any applicant on the basis of health status. The offer of standardized coverage would be required so that people could compare packages from different insurance companies. There could be a choice of different coverages, but the coverage packages would be standardized across insurance companies. In addition, we offer a subsidy to a small business for which the cost of compliance with the bill is excessive.

Under the first phase of the public plan, which goes into effect at the same time as the employer mandate, all uninsured children below 185% of the poverty level and pregnant women between 100% and 185% of the poverty level would be covered. (Pregnant women below 100% of the poverty level are already covered.) These new provisions would cover an additional 4 million people. Therefore, with 23 million covered under the employer plan, a total of 27 million people, including 90% of all currently uninsured children, would be covered in the first phase of the bill. This huge step forward can be made for a relatively low initial federal cost. The second phase, to take effect in 1996, would cover the remaining uninsured, those who are not children or pregnant women, with income between 100% and 185% of the poverty level. This would add 5.7 million people to the program. In the third phase, in 1999, we would assure coverage for every other remaining uninsured American.

As stated previously, there are 2.4 million families with catastrophic costs in excess of $3,000 each year. The first phase of the bill would cover 88% of these families, 2.1 million people, because they are in one of the two categories to be included.

This plan would assure coverage for 12 million currently uninsured children. Prenatal and well-baby care would be covered for 600,000 currently uninsured women and infants. This includes coverage for about 16,500 infants per year who must be admitted to the prenatal intensive care unit with average hospital charges of $35,000.

Guaranteed coverage in new employment for 7 million currently insured but medically uninsurable people is another benefit of the bill. The Department of Health and Human Services (I) estimates that there are currently 7 million insured people who became insured before they developed a health problem or when they began working for a large business that did not require evidence of insurability in providing worker insurance. If they were to lose their job or try to take a job with another employer, particularly in the small business sector, those people would become uninsured. They are essentially locked into their jobs, a situation which is not good for them nor for the economy.
Under the plan, health insurance coverage would be guaranteed for any welfare family accepting employment. Two major barriers keep people from getting off welfare: lack of child care, and lack of medical care. (Welfare recipients get Medicaid.) Our bill eliminates the latter problem because it stipulates that any job taken by a person on welfare must carry with it a basic package of health insurance.

Every American deserves the same insurance protection and access to affordable health care that all of us want for ourselves and our families. The mixed public-private system Senator Kennedy has proposed is a practical, realistic way of meeting this need.

Costs of BHB

The net federal cost of the first phase of our program is $3.1 billion—a not insignificant sum, but one we could probably accommodate through the normal budget process without a specific new tax. A total of $800 million would go for coverage of people who are currently unemployed and without insurance. Under the plan, the federal government would also subsidize copayments and deductibles for workers below the poverty level and subsidize the premium share of the cost of workers who are between 100% to 185% of the poverty level. That cost is calculated to be about $0.9 billion annually.

In addition, the private program will have costs associated with it. Some tax revenue is lost by shifting compensation from currently taxable wages into nontaxable fringe benefits. Furthermore, the subsidy for small businesses would cost about $600 million a year, making a total of about $1.4 billion for the private program.

The gross cost to business for the new coverage is estimated by the Congressional Budget Office to be about $33 billion. A number of offsets reduce that gross cost down to a net of $18 billion. While $18 billion sounds like a lot of money, it is not much in the scale of the total federal budget or that of the total health care system which is $600 billion annually. Adding 2% to 3% to the total national health care cost seems a small price to pay for the benefits given to 37 million people now totally left out of the health insurance system.

Benefits of BHB

BHB will also have benefits for business and the economy. Businesses that do not insure their workers currently have an economic advantage over their competitors who are more socially responsible. However, the bill would reduce the costs of businesses which currently insure their workers. Unreimbursed hospital care charged to businesses that insure their workers adds up to about 15% of total insurance premiums paid to cover hospital costs. Thus, a business that insures its workers must pay to cover people who aren’t insured, often by their own competitors. In addition, the bill is structured to encourage the growth of managed care systems that can reduce the overall cost of health care.

The bill would improve our international competitive position. Around the country the measure has been criticized as imposing additional costs on American business at a time when we’re struggling to compete in world markets. However, this plan would help, not hurt, businesses that are competing in world markets. A total of 97% of all manufacturing workers are employed by businesses which provide them health insurance. Most uninsured workers are employed in retail sales, services, and construction. As none of the latter businesses are in international competition, those who must compete pay more than their fair share.

The plan will reduce welfare dependency and have a minimal impact on employment and inflation. Of the four separate estimates of the impact of the program, all report that the negative economic consequences either in terms of increased inflation or of reduced employment are negligible.

The Problem of Small Business

Concern about the impact of the legislation on small businesses presents our biggest political problem in getting the bill passed. Small businesses with fewer than 25 workers employ 48% of the uninsured and about 30% of the workforce. Many small businesses are afraid of the additional costs that the bill will impose, but the fact is that the small business insurance market is a collapsing system. First, coverage costs too much. Businesses of 25 or fewer employees pay about 20% more than large businesses for identical coverage. In a very small business (ten or fewer employees), the markup can be as much as 35%. Furthermore, the small business, particularly those with ten or fewer people, can seldom buy coverage without a preexisting condition exclusion. If there are employees with serious health problems in the business, coverage usually cannot be obtained.

The small business insurance market is not only too expensive but also premiums are extremely unstable. Many competing health insurers are unwilling to insure any but the healthiest groups. They can give a relatively low initial price based on the fact that the insured are healthy. After a year or two, as more people in the business experience illness, the insurance companies either refuse to renew the coverage or demand a massive price increase. The coverage which was affordable when the business bought it is no longer affordable when the need increases. The problems in the small business market do not arise because insurers are greedy or inefficient. Without federal regulation to restructure the market, competitive pressures force insurers to act in this way. It is a disastrous system.

The bill would help to solve the problems of the small business market because its regional insurer program creates a pool of insured workers. Insurance underwriters would set a fair average rate with guaranteed access to coverage and no exclusions based on preexisting conditions. Community-rated coverage would provide everybody a fair average price, unaffected by whether or not group members have ill-health or include older workers. To the regional insurer, small business coverage appears much like a single large business. It is an efficient way
of providing coverage. We think that the cost to small businesses from this regional insurance system could be reduced by 25% over what they pay in the current market (10% through savings on administrative and sales cost and another 15% through access to managed care systems not available under the current system).

Assuring Health Insurance

The kind of private/public partnership our bill provides is the best approach to assuring health insurance to every American. There are basically three broad alternative ways to solve this problem. One is a full-blown European-Canadian style national health insurance program. The second is to expand Medicaid to include everybody without employment-based insurance in public programs while leaving the employment-based system in place. The third alternative is our proposal, which calls for all workers and their dependents to be covered by their employers and for everybody who is ineligible for employment-based coverage to be picked up by a public program.

The European-Canadian style of national health insurance clearly has some theoretical advantages, but it is a radical shift from our system. It is inconceivable to me that we would adopt a European-Canadian style national health insurance system in the near future, but 37 million Americans should not have to wait for their health coverage. They need it today, and they should not have to wait until we can build a consensus for such a radical change.

The plan to expand Medicaid and place no additional burden on employers is promoted by the insurance industry, by the Chamber of Commerce, and by Republicans opposed to our bill. Such a program is simply not affordable for the federal government and would ultimately eliminate our current employment-based system. About 5.9 million people currently below the poverty level need to be included in a public program under our bill. Another 5 million people, who are poor but working full-time and are uninsured, would receive employment-based coverage under our plan. If employers are not required to provide the insurance, the number of people who must be placed in Medicaid is increased to 10.9 million.

If we had a system in which the taxpayers would bear the cost of coverage, no employers would continue to insure their workers. Employers would be foolish to provide coverage that taxpayers would otherwise pay for, and, instead of having employers insure 5.9 million as under our plan, the number subsidized by the public would increase to 14.7 million people. This is just for people living below the poverty level. To provide for people at 150% of the poverty level, the number increases to 24.7 million. Ultimately, if you make public insurance available, everybody will end up on Medicaid, because no employers will continue to bear the costs necessary to insure their work force.

Every American deserves the same insurance protection and access to affordable health care that all of us want for ourselves and our families. The mixed public-private system Senator Edward Kennedy (D-Mass) has proposed is a practical, realistic way of meeting this need. We are optimistic that the day is not far off when the United States will join every other industrial nation in assuring health care for all its citizens.

References