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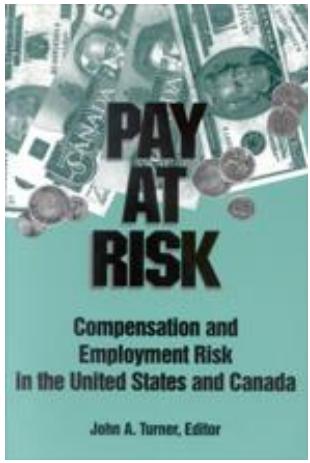
Health and Coverage at Risk



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INTRODUCTION

Over the past two decades, the financing and delivery of health care in the United States has undergone a dramatic transformation. The Canadian health care system is also changing and may, in the end, look more like the U.S. system than it does now. This chapter explains and compares the health care coverage risks for employees in the United States and Canada and examines policy options facing the health care systems in the two countries.

OVERVIEW OF THE U.S. HEALTH CARE SYSTEM

The transformation of the U.S. health care system has been primarily motivated by rising health care costs. Between 1988 and 1993 alone, for example, employers were faced with average annual premium increases of 12 percent (KPMG Peat Marwick LLP 1997). In response, employers attempted to control costs by making changes in benefits. Most workers now have an expanded role in the financing and delivery of their health care. The transformation of the health care system has also spurred federal and state legislative efforts to "protect the rights of patients."

Unlike the case in most industrialized nations, the U.S. health care system does not explicitly seek to provide health care coverage to everyone. There are a number of different sources of coverage and few national standards regarding coverage. People are not required to have

coverage, nor are employers obligated to offer it. While private coverage is available to individuals, the relatively small individual private health insurance market covers only 5 percent of the population under the age of 65. Public health care coverage is limited to particular populations. As a consequence, not everyone has health care coverage, coverage is not uniform, and different systems for financing and delivering health care operate at the same time.

Employer Coverage

Most Americans—nearly 82 percent of the non-elderly population—have health care coverage, but over 18 percent or 43.1 million people do not (Employee Benefit Research Institute 1997a). Employers are the primary source of this coverage, providing coverage to 64 percent of the non-elderly population either directly or as a family member of a covered worker. In 1995, private health care coverage paid for 32 percent ($281.2 billion) of the nation's health care expenditures, which totaled $878.8 billion, on behalf of 70 percent of the population (U.S. Bureau of the Census 1997a, table 120; U.S. Department of Health and Human Services 1997a, table 1).

Employers take on differing roles for very different reasons. Some offer comprehensive coverage in an effort to attract and retain employees while others remain competitive even without offering health benefits. Some employers are not very involved with the design and administration of the health care coverage and essentially choose health plan options packaged by health plans or health insurers. Other employers operate their own plans and are in a position to make decisions about all aspects of the plan. Employers operate in different health care coverage markets and hence their ability to obtain and negotiate favorable coverage varies by the overall size of the employers and their size relative to the market in particular. Variation in employer involvement, flexibility, and options adds to the variation in financing that fragments and complicates health care delivery.

The Medicare Program

About 12 percent of the non-elderly population and 15 percent of the total population have public coverage, with Medicare and Medicaid

being the two principal sources of public coverage (U.S. Department of Health and Human Services 1997b, table 1). Medicare is a federal program established in 1965 to help persons age 65 and older obtain and pay for medical care. Before Medicare, less than one-half of the elderly had hospital insurance and an even smaller proportion had coverage for outpatient care. In 1972, the program was extended to certain people under age 65: those with kidney failure and those receiving Social Security Disability Insurance (DI) benefits for at least two years. Currently, Medicare insures virtually all of the elderly in the United States. The program covers about 38 million people (33 million 65 and older and 5 million disabled) (U.S. Department of Health and Human Services 1997a, table 1).

The Medicare program has two parts. Part A covers inpatient hospital services, skilled nursing facility benefits, home health care, and hospice care. Part B covers physician and outpatient hospital services, clinical, diagnostic, and laboratory tests, durable medical equipment, and some additional supplies and services not covered under Part A.

Medicare is a major payer in the U.S. health care system. In 1996, Medicare expenditures were $203.1 billion or 20 percent of all health care expenditures (Levit et al. 1998). Medicare expenditures account for 22 percent of all inpatient hospital payments and 21 percent of all physician payments (U.S. Department of Health and Human Services 1997a, table 1). Medicare covers 44 percent of health care spending for the elderly overall, but a smaller share for the very old, who require more long-term outpatient prescription drugs, which Medicare does not cover (U.S. Bureau of the Census 1997a, table 153).

The Medicaid Program

Medicaid covers largely the very poor and the very sick. Other than low-income (but not poor) pregnant women and children, this program is not available to the vast majority of the working age population.[1]

The Medicaid program provides health and long-term care coverage to low-income individuals who meet certain eligibility requirements. The program is financed jointly by states and the federal government and administered by states. Broad federal guidelines are established for the program, but states have considerable discretion in establishing eligibility rules, determining the scope and depth of cover-

age, and setting payment rates for providers. While certain groups of individuals must be covered and a set of fairly comprehensive services must be provided, states have the option to expand eligibility to other groups and to provide a broader range of services. Consequently, the program is implemented differently in each state, and local health care markets are affected differently.

Medicaid was established in 1965 to cover participants in federally funded income maintenance programs for the poor (primarily dependent children and their mothers), the aged, and the disabled. Over time, program expansions have extended coverage to millions of people who are not in the welfare system and with the implementation of the new welfare program, Temporary Aid to Needy Families, enrollment in Medicaid is no longer automatic for families who receive cash assistance. In 1995, Medicaid covered 36.3 million people: 17.1 million children, 7.6 million adults in families, 4.1 million elderly persons, and 5.8 million blind and disabled persons (U.S. Department of Health and Human Services 1997a, table 72).

The federal government shares in the financing of Medicaid by matching state expenditures at varying rates. For health care benefits, the matching rate varies—from 50 percent to 83 percent—inversely with a state's per capita income. These federal matches are quite attractive and, over the years, states have effectively and creatively used the program to finance services that at one time were not a part of Medicaid. Despite state opposition to federal mandates, most states have voluntarily decided to provide most, if not all, the optional benefits covered under Medicaid.

With the program expansions, Medicaid has become a significant payer in the health care system. In 1996, Medicaid outlays were $131.1 billion or 14 percent of all health care expenditures (Levit et al. 1998). About 43 percent of the cost was financed by the federal government, the balance by states (Liska et al. 1997, table B-2). Medicaid accounts for 32 percent of all hospital and 20 percent of all physician payments (U.S. Department of Health and Human Services 1997a, tables 2–3). About 39 percent of all births are covered by Medicaid, as is health care for nearly 25 percent of children (Liska et al. 1997; Rowland 1995). Medicaid finances 47 percent of all nursing home care, provides health care coverage to 13 percent of the non-elderly population, and supplements Medicare for 3 percent of the elderly. Overall,

half of all people living in poverty are assisted directly by Medicaid (Liska et al. 1997; Employee Benefit Research Institute 1997a).

HEALTH CARE COVERAGE IN THE UNITED STATES

The fragmented system of financing health care in the United States leaves many people uninsured or underinsured. The percentage of the non-elderly population without health care coverage has increased from 15 percent in 1987 to 18 percent in 1996 (Employee Benefit Research Institute 1997a,b). This change is due, in part, to a decline in employer-provided coverage, although that decline has been offset somewhat by an increase in the proportion of the population with publicly funded coverage.

Some Groups are More Likely to Have Health Care Coverage

Coverage rates vary widely across demographic groups. Children are more likely than non-elderly adults to be insured. Expansions in the Medicaid program have played a significant role in increasing the proportion of children with health care coverage. The age group least likely to have care coverage is young adults, ages 19–24 (U.S. Department of Health and Human Services 1997b, table 1).

There are significant differences in coverage patterns for racial and ethnic groups. Among the non-elderly, Hispanics are most likely to be uninsured (34 percent), followed by blacks (23 percent). A much smaller proportion of whites (13 percent) is uninsured (U.S. Department of Health and Human Services 1997b, table 2). Income is another factor that affects coverage. Despite the existence of Medicaid, about 34 percent of the non-elderly poor have no health care coverage compared with 18 percent of the non-elderly population as a whole (U.S. Bureau of the Census 1997b).

Married individuals are more likely to be insured than individuals who have never been married or who are no longer married (U.S. Department of Health and Human Services 1997b, table 2). It appears that education has an impact on coverage status; among adults, the

likelihood of being uninsured declines as the level of education rises (Bennefield 1997).

Coverage is higher in metropolitan areas and in the Northeast and Midwest regions of the country. Coverage is lower outside metropolitan areas, in the West, and in the South (U.S. Department of Health and Human Services 1997b, table 2).

The coverage status of workers

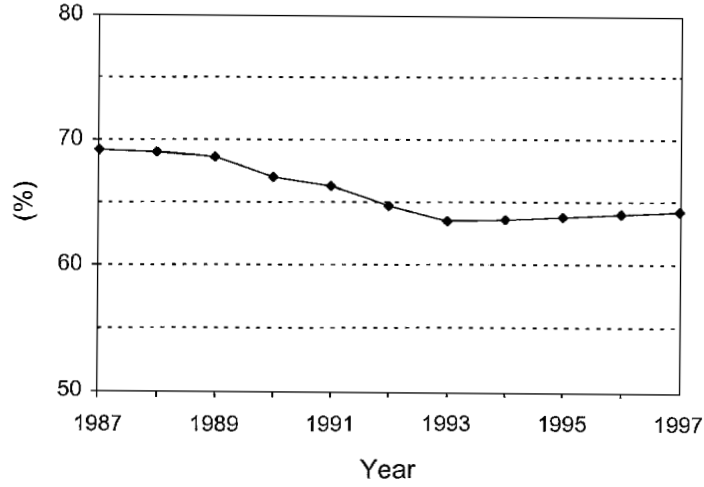
Employment status remains the most important factor related to health care coverage. Some 82 percent of employed individuals have coverage, compared with 74 percent of unemployed individuals (U.S. Department of Health and Human Services 1997b, table 2). The health care coverage status of workers is discussed in more detail below.

Almost one-fifth (18.4 percent) of working adults are uninsured and a similar percentage of all persons in families with working adults (18.5 percent) have no coverage (U.S. Department of Health and Human Services 1997b, table 2). Working adults account for half (50.4 percent) of all the uninsured in the United States and almost 87 percent of the uninsured population lives in households with a working adult.

Employment grew by 15 percent and unemployment rates declined by 20 percent between 1987 and 1997 (Executive Office of the President 1999), yet employment-related health care coverage decreased from 69 percent of the non-elderly population in 1987 to 64 percent in 1997 (Figure 4.1). Over the same period, the percentage of full-time workers without coverage increased from 13 percent to nearly 15 percent (Figure 4.1; Employee Benefit Research Institute 1997a, figure 6). Yet, despite the rise in costs and decline in coverage, the number of employers offering coverage has increased. These seemingly inconsistent trends indicate that the employer-based coverage system is not simple.

Age. Younger workers are most likely to lack health care coverage. More than one-third (36 percent) of young adults aged 19–24 have no coverage. Workers aged 19–24 account for 12 percent of the workforce but 23 percent of uninsured workers. The 25- to-29-year-old group also has low coverage rates—nearly one in four (23 percent) lacks coverage.

Figure 4.1 Employment-Based Health Care Coverage



In general, coverage rates increase with age, and the increase is due to increases in employment-related coverage. Just over half of all 19- to 24-year-olds (53 percent) have employment-related coverage, that is, they are covered through their own or a relative's job. By contrast, more than three-quarters of 45- to 54-year-olds (79 percent) have coverage. After age 55, employment-related coverage decreases slightly, but more than three-quarters (76 percent) of adults aged 55–64 still have employment-related coverage (U.S. Department of Health and Human Services 1997c, table 2).

Gender. Working women have higher levels of employment-related coverage (84 percent) than working men (79 percent) (U.S. Department of Health and Human Services 1997c, table 2). It is interesting to note, however, that working women are less likely to have employment-related health care coverage in their own names (40 percent) than are working men (55 percent) (U.S. Department of Health and Human Services 1997c, p. 2). In addition to receiving coverage from their own employers, some working women are covered as dependents of working men. The proportion of non-elderly men with employment-based coverage in their own name decreased from 59 per-

cent in 1987 to 55 percent in 1995. Among women, the percentage increased from 37 percent to 40 percent during the same period, but direct coverage for women still lags behind direct coverage for men (Employee Benefit Research Institute 1997a, figure 18).

Ethnic group. Coverage rates are much higher for white workers than they are for minority workers. Hispanics have the lowest rates, with just 55 percent of the population covered. Among blacks, coverage is 66 percent, compared with 77 percent of whites. Within racial and ethnic groups, women are more likely to have employment-related coverage than men. The group with the lowest rate of coverage is Hispanic males; more than two in five (44 percent) lack coverage. By comparison, 30 percent of black male workers and 17 percent of white male workers are uninsured. While Hispanic males account for just 6 percent of workers aged 16–64, they account for 13 percent of uninsured workers (table 2 in U.S. Department of Health and Human Services 1997c).

Hours worked. Part-time workers are less likely than full-time workers to have employment-related coverage. In 1995, some 63 percent of full-time workers aged 18–64 had employment-based coverage in their own name, more than three times the coverage rate for part-time workers (20 percent) (U.S. Department of Health and Human Services 1997c, figure 4). Part-time workers are also more likely than their full-time colleagues to be uninsured. One in four part-time workers and 17 percent of full-time workers are uninsured (U.S. Department of Health and Human Services 1997c, figure 6).

Overall, 58 percent of part-time workers aged 16 and older have employment-related coverage. Older workers, aged 55–64,have the highest rates of coverage. Some 64 percent of older part-time workers are covered either as workers or as dependents of workers (Employee Benefit Research Institute 1997c, table 1).

Male part-time workers are less likely to have employment-related coverage than female part-time workers (52 percent vs. 61 percent). There is little difference between the genders in terms of coverage under their own name, but female part-time workers are more likely to be covered as dependents (Employee Benefit Research Institute 1997c, table 1).

Coverage for part-time workers increased from 17 percent to 20 percent between 1987 and 1995. The percentage of part-time workers without coverage was higher (22.4 percent) in 1995 than it was in 1987 (19.7 percent), but the 1995 rate was lower than the highest rate of uninsured part-time workers (23.7 percent) reported in 1992 (Employee Benefit Research Institute 1997a, figure 6).

Self-employment. Only half of self-employed workers have employment-related coverage, while more than three quarters (77.1 percent) of workers who are not self-employed have insurance (U.S. Department of Health and Human Services 1997, table 3). This difference may reflect U.S. tax policy, which allows self-employed workers to deduct only 30 percent of what they spend on health care coverage, while employer contributions to coverage made on behalf of wage earners are fully deductible from taxable income.

Lower rates of insurance for the self-employed, however, may also be related to the fact that the self-employed are more likely to work in small firms and therefore may face higher premiums. Fewer than half of the self-employed who work alone (45.4 percent) have employment-related coverage, compared with 72.7 percent in businesses with 10 or more workers.

As with all workers, coverage rates for self-employed workers aged 18–64 decreased from 27.9 percent in 1987 to 25.4 in 1995, although there was some fluctuation over the years (Employee Benefit Research Institute 1997a, table 4).

Employer size. Workers and their dependents without coverage are more likely to work for smaller firms in industries that have not traditionally needed to offer coverage. The proportion of workers with employment-related coverage increases with the size of the firm. In firms with fewer than 10 workers, 58.8 percent of wage earners had employment-related coverage. In firms with 500 or more workers, 91 percent of wage earners had employment-related coverage. Conversely, the proportion of uninsured wage earners decreases as firm size increases. Almost one-third of wage earners (30.4 percent) in firms with fewer than 10 workers were uninsured compared with just 6.7 percent in the largest firms, those with 500 or more workers (U.S. Department of Health and Human Services 1997c, table 3). About

15.4 percent of workers are employed in firms with fewer than 10 workers, but they account for 25.4 percent of uninsured workers (U.S. Department of Health and Human Services 1997c, table 5).

In the 1990s, it became more common for small firms to offer coverage. Among all firms with fewer than 200 employees, coverage was offered by 46 percent in 1989 and 49 percent in 1996. The percentage of employees enrolled in plans offered by small firms declined, however, during the same period from 72 percent in 1989 to 66 percent in 1996. The likely reason for the decline is that workers cannot afford to pay for coverage. The average monthly contribution for workers in small firms increased from $34 in 1988 to $175 in 1996 (Ginsburg, Gabel, and Hunt 1998).

Workers in all firms were more likely to be uninsured in 1995 than in 1987. Over time, there has been a decrease in the proportion of workers in large firms who have coverage. Some 73.3 percent of workers in firms with 500 or more workers had coverage in 1987, compared with 68.1 percent in 1995. The coverage rate for smaller firms remained about the same from 1987 to 1995 (Employee Benefit Research Institute 1997a, figure 7).

Wages. As they compete to attract and retain skilled workers, firms must offer attractive benefit packages. Workers who earn more money are therefore more likely than workers at the lower end of the wage scale to have coverage. Fewer than half of the lowest wage earners (43.3 percent) have employment-related coverage, but 95.5 percent of wage earners at the highest end of the scale have employment-related coverage. It is not surprising, then, that more than one-third of the lowest wage workers (37.8 percent) have no coverage, compared with just 2.9 percent of the highest wage workers. Even so, between 1987 and 1995, the highest income group had the largest decrease in the percentage of employment-related coverage. Some 86.5 percent of workers with earnings of $40,000 or more had coverage in 1987, compared with 81.6 percent in 1995 (Employee Benefit Research Institute 1997a, figure 9).

Industry. Some industries—agriculture, personal services, construction, retail, business repair services, and recreation—are substantially less likely to provide coverage. Some of these categories

represent the sectors of the economy in which employment opportunities are growing the fastest. Coverage is more likely to be provided in sectors in which employment opportunities have been growing slowly and even declining. These include mining, manufacturing, government, finance, insurance, and real estate, as well as transportation, utilities, and the communications industry. Some of those trends may be tied to the past. For example, 92.8 percent of unionized workers but 71 percent of nonunionized workers are covered by employment-related insurance.

A Lack of Coverage Limits Access to Care

Coverage matters; access to health care services is severely limited for the uninsured. More than one-quarter of people without any coverage (27 percent) report that they had difficulties or delays in obtaining health care when they needed it. The rate is more than twice as high as for those with public coverage (12 percent) and almost four times as high as people with private coverage (7 percent).

The cost of health care prevents some families from getting the services they need. More than one-third of privately insured families (37 percent) and close to half of publicly insured families (46 percent) say they have difficulties obtaining health care services because they cannot afford the care despite having coverage. The problem is greatest for uninsured families, however, with 87 percent reporting that they cannot afford care (U.S. Department of Health and Human Services 1997d, table 1).

Another measure of access to care is whether people have a usual source of health care. The uninsured are much more likely to lack such a source than those with coverage. Some 38 percent of uninsured people say they do not have a usual source of health care compared with 15 percent of those with private coverage and 13 percent of those with public insurance (U.S. Department of Health and Human Services 1997d, table 1). A national survey of coverage conducted in 1997 found that uninsured adults were four times as likely as those who were continuously insured not to have received needed medical care or to have not filled a prescription in the past year (Kaiser Family Foundation and The Commonwealth Fund 1997).

Ratings related to the quality of care also vary by coverage status. In a recent survey of low-income adults in five states, almost one-third of the uninsured reported that the services they received had been fair or poor, compared with 18 percent of those with Medicaid and 17 percent of those with private insurance (Schoen et al. 1997).

The gulf in access to care is certainly greatest between those with coverage and those without, but having an insurance card is not necessarily sufficient to ensure access to health care since coverage varies dramatically in its scope and depth. Health insurance policies range from those that provide comprehensive coverage for all health care services related to illness and preventive care to those that only provide coverage for catastrophic care. Most policies limit coverage by excluding some services and limiting the amount of certain services that will be covered. Also, large deductibles or copayments may serve to limit the amount of care that people seek.

While Medicare provides good coverage for the elderly, it appears that people who supplement their Medicare coverage, and therefore have more comprehensive coverage, have better access to care. Among the elderly, some 11.9 percent of those covered only by Medicare lack a usual source of health care compared with 7.7 percent of elderly people covered by other public or private insurance in addition to Medicare (U.S. Department of Health and Human Services 1997d, table 1).

Increasing Risk in the Coverage Market

The coverage most employers offer today is different from what was available in the past.

Coverage pays less

For those who still have coverage, the coverage is less comprehensive than it has been in the past. Conventional plans used to pay the full cost or close to the full cost of health care. Throughout the 1980s, however, employers moved away from health insurance policies that offer first-dollar coverage for any provider. Instead, employers are frequently required to meet certain deductibles before insurers will pay for care. In addition, requirements for copayments for certain services have become much more common. Also, health insurance policies with limits on the maximum amount that will be paid over the course

of a person's life have become more common (Employee Benefit Research Institute 1997d, tables 30.5 and 30.8).

Employers pay less

Employers have moved away from full coverage of premiums, leaving to some employees a clearer choice between more direct compensation or more benefits. In 1983, almost all full-time employees in medium and large firms (96 percent) participated in health insurance plans. By 1993, participation had dropped to 82 percent. At the same time, the percentage of medium and large employers that fully financed health insurance for individual employees decreased substantially from 73 percent in 1981 to 37 percent in 1993. Similarly, the percentage that fully financed family coverage dropped from 51 percent in 1981 to 21 percent in 1993 (Employee Benefit Research Institute 1997d, tables 30.5 and 30.8).

The proportion of premiums paid by employees has also increased. In 1988, employees in small and large firms paid 34 percent and 29 percent, respectively, of premiums for family coverage. By 1996, payments for premiums had increased to 44 percent for employees in small firms and 30 percent for employees in large firms (Figures 4.2A and 4.2B).

It is likely that the financial burdens for individuals and families associated with health insurance coverage have led to an increase in the percentage of employees who turn down coverage. The high cost of health insurance premiums and deductibles may cause some employees to decline coverage even when it is available from employers. In firms that offer health insurance benefits, the percentage of employees enrolled has declined from 72 percent in 1989 to 66 percent in 1996 for small firms and from 73 percent in 1989 to 67 percent in 1996 for large firms (Ginsburg, Gabel, and Hunt 1998).

Firms of all sizes increasingly have made an effort to control health care costs by self-insuring. Rather than buying coverage, employers set money aside and then use the funds to pay benefits. The percentage of employers self-funding indemnity plans grew from 19 percent in 1993 to 30 percent in 1996, and the percentage of self-funding preferred-provider plans grew from 6 percent in 1993 to 26 percent in 1996 (tables 28.1 and 28.2 in Employee Benefit Research Institute 1997d). Self-insurance can reduce employer health care costs by bypassing state mandates to cover certain providers or services. But, to

Figure 4.2A Premium Shares by Type of Coverage in Smaller Firms, 1988 and 1996

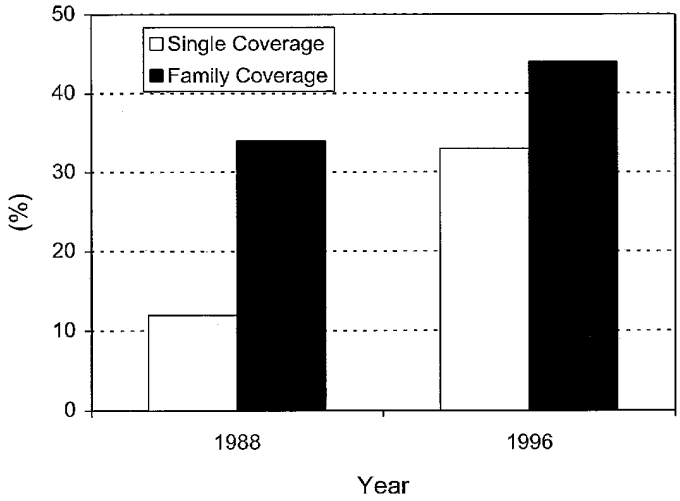
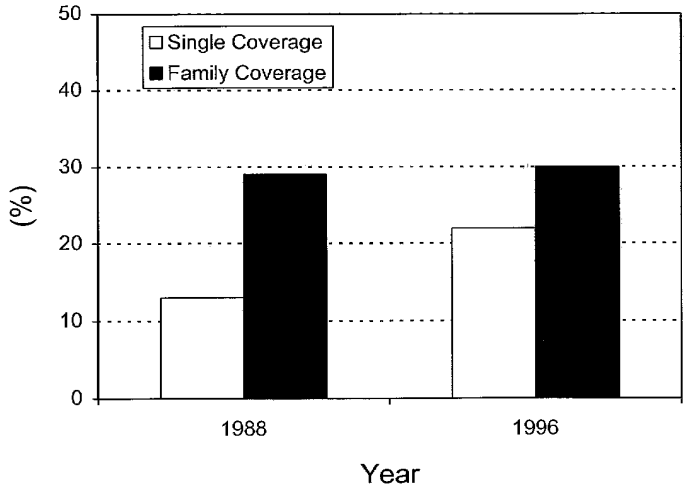


Figure 4.2B Premium Shares by Type of Coverage in Larger Firms, 1988 and 1996



the extent that employers turn to self-insurance for this purpose, the value of health care coverage to employees can decline.

Family coverage is less common

The decline in family coverage certainly is consistent with employer efforts to limit health care expenditures, but it also reflects the fact that it is more likely that both spouses are working, increasing a couple's potential coverage sources. Between 1980 and 1996, the labor force participation rate for married women increased from 50 percent to 61 percent (U.S. Bureau of the Census 1997a, table 630).

Employers are shifting costs to both employees and other employers by encouraging employees to obtain coverage through a working spouse's health plan. However, according to interviews by Silow-Carroll et al. (1995), employers do not want to subsidize health insurance premiums of employees of other firms. Others noted that under the current system, it makes the most sense to ask business to continue covering families even if some businesses are carrying a disproportionate share of the burden. Only one respondent favored paying an extra amount to regional alliances for family coverage cases, and some small employers said the uninsured should be "made to go out and work for health benefits like the rest of us."

Employers are more likely to offer managed care plans

During the 1990s, employers have moved more aggressively into managed care plans in an effort to control costs. Managed care plans include health maintenance organizations as well as less restrictive arrangements, such as preferred-provider organizations and point of service plans. All require or encourage enrollees to use specific groups or networks of health care providers.

In 1997, managed care plans comprised 81 percent of the health insurance market, up from 29 percent in 1988. One reason for this large shift is that fewer employers provide the option of a conventional plan. In 1997, only 51 percent of workers could choose a conventional plan, compared with 89 percent in 1988 (KPMG Peat Marwick LLP 1997).

Initially, managed care was a large-employer movement, but recent growth in managed care enrollment reflects a shift among small firms as well. Some employers have made the change because costs are

lower in managed care plans, and some have been forced to change because indemnity plans are not available.

From a consumer's perspective, the movement towards managed care plans can be advantageous because it eliminates some requirements for deductibles and/or copayments. Coordination among providers may also be easier in managed care plans, improving patients' health outcomes, but managed care may pose other dilemmas due to stricter limits on benefits and rules related to available services, provider choice, and prescription drugs. Recent interest on the part of policymakers in the extent to which managed care plans restrict services indicates that the manner in which the plans operate will continue to evolve.

Risks Associated with Employer-provided Coverage

As the health insurance system in the United States has evolved, and particularly as more firms have adopted managed care plans, the risks associated with providing and using health insurance have increased.

Risks for employers

The anticipation and reaction of both real and perceived risks by employers affect the health insurance risks faced by employees. Employers face both financial and administrative risks.

The cost of coverage poses financial risks. Employer-financed health care expenditures are increasing. As a percentage of total compensation, employer-financed health insurance has increased relatively steadily from 1.1 percent in 1960, to 4.4 percent in 1980, to 7.6 percent in 1994 (Employee Benefit Research Institute 1997d, table 34.1). In 1960, health benefits accounted for 14.3 percent of all employer benefit spending. By 1994, 40.8 percent of benefit spending was for health benefits (Employee Benefit Research Institute 1997d, table 2.2).

In the late 1990s, increases in health plan premiums were quite low relative to previous years. The increase from spring 1996 to spring 1997 was just 2.1 percent (KPMG Peat Marwick LLP 1997). Based on these figures, many employers believed they had effectively contained health care costs. There are indications, however, that this may not be

the case. While the shift to managed care can achieve savings, most of the savings so far has come from one-time changes. Health care inflation both within health plans and outside of health plans has been essentially the same, although there is some evidence to suggest that the overall cost increases in communities with substantially larger managed care penetration are less (Price Waterhouse LLP 1995).

While the more aggressive firms may succeed in lowering their own costs, they do not necessarily lower the overall cost of health care, just the distribution of those costs among payers. As a result, even if some firms make every effort to keep their own costs low, they may still see their health care costs rise because they cannot control the broader market.

The level of risk posed by health care costs varies for employers. For firms that do not already offer health insurance—generally smaller or newer firms—the transition costs associated with providing coverage represent a major expense. If they decide to offer insurance, they might have to forego other opportunities. However, if they need to offer health benefits to attract or retain specific employees, the cost may seem less onerous.

For most established businesses, it is not the cost of health care per se that is problematic. It is routinely viewed as part of the cost of labor. Unanticipated increases in health care costs pose risks, however. Unlike other inputs into the cost of business, this component of labor costs is not very predictable and there is no futures market to help stabilize unanticipated costs. When health care costs exceed budgets, employers must cut other costs, delay hiring new employees, or delay making capital improvements.

There is some disagreement about how much of the increased health care costs employers absorb and how much is passed on to employees, passed forward to consumers, or passed back to stockholders. In the short-term, employers must pay the cost. Yet, many employers argue that product prices are higher than those of their international competitors because of the higher cost of health care. However, there is evidence that over time, employers adjust wages to compensate for increases in the cost of health care (Silow-Carroll et al. 1995). In all likelihood, cost increases are passed in every direction, but the degree and speed to which the unexpected cost increases are

absorbed will depend on the market conditions in which an employer incurs them.

Employers have new responsibilities associated with administering plans. In addition to paying for health insurance, employers must learn about various plans to determine which plans best fit their needs and the needs of their employees. If they offer more than one plan—as most large firms do—they must provide information to help employees choose plans. With the advent of managed care, employers are expected to help their employees understand various rules associated with the plans, such as the fact that coverage may only be available for certain health care providers and that prior authorization may be required for certain services. Employers may also intervene in certain disputes between the insurer and the employee. Under this system, choices employers make about which plans to offer may result in dissatisfaction among workers who find that certain treatments are no longer covered or that they must change health care providers.

Risks for employees

As the cost and risks to employers has increased, so too have the risks to employees.

Financial risks. As noted earlier, employees are expected to bear a greater portion of health care costs now than in the past. As a result, more employees are declining to enroll in health insurance plans even when employers offer the plans. Between 1989 and 1996, 76.4 percent of the decline in employer health coverage was the result of growth in the required employee premium contribution (AFL-CIO 1996). In addition, even employees with health care coverage may face problems obtaining and paying for care.

Coverage risks. In the past decade, choosing a plan has increasingly meant choosing a specific set of physicians, hospitals, laboratories, and a specific drug formulary. Thus, the choices made by employers determine the type of health care employees will receive and who will provide the care. When employers change the coverage they offer, employees may discover that physicians associated with their former plan or services covered by their old plan are no longer covered.

For most working-age people and their dependents, these restrictions may be simply a matter of convenience; but, for a few chronically ill or disabled persons and for some uniquely acute illnesses, these differences may have a direct bearing on the course of their care. A change in plans can be devastating if people are forced to rebuild the network of providers who understand their condition. This may be the largest single risk an individual with a health condition faces—that their particular ailment might be better served under a particular health plan that their employer no longer offers or by a provider whose services are no longer covered by the plan.[2]

Changes in the source of care may interrupt the continuity of health care and have an impact on the quality of care received, but people in approximately 12 percent of American families changed their usual source of health care within a one year period in 1996. Among those people, 25 percent of the families with members who changed their usual source of care made the change for reasons related to their insurance coverage. For example, they changed health insurance plans or they were forced to change doctors because the insurance plan changed the doctors with whom they contract (U.S. Department of Health and Human Services 1997d, figure 1). In a 1997 national survey of health insurance, one-third of adults aged 18–64 reported that they had been in their current health plan for less than two years (Kaiser Family Foundation and The Commonwealth Fund 1997).

Employees must learn to navigate the system. Each health plan has its own unique set of administrative procedures, and changes in these procedures happen frequently. Employees are expected not only to understand the plan rules when they enroll but also to be aware of and adapt to changes as they occur.

Is the System at Risk?

The pressures to control costs that have been brought about by health care payers, the active interventions of employers, the movement towards managed care, and the tremendous consolidation of resources in those plans could dramatically alter the delivery of health care. There is real potential for the organization of health care services to become more efficient for the patient and actually improve the qual-

ity of care for those who need considerable health care services. There is no guarantee that the net result will improve the delivery of care, however. It could just as easily result in greater variation in access to care and even larger variations in the quality of care and not necessarily at a lower relative price. Some of the current influences on the health insurance system are discussed below.

Market segmentation

The system of voluntary, employer-based coverage has certain advantages. The large employer offers a logical grouping of people that facilitates the easy pooling of risk and dissemination of information. An employer-based group offers economies of scale for administration and communication. Large employers are able to negotiate favorable terms and have the market power to smooth disputes between employees and health plans. Some large employers have worked with insurers to develop new health insurance products and some have developed their own insurance plans. Lower administrative and marketing costs and a lower risk premium all combine to make the average cost per insured person in a larger group less than the cost in a smaller group for the same amount of coverage.

The relative success of larger employers has, however, accelerated the natural tendency of the market to segment into smaller risk pools. It is quite natural for health insurers to seek larger groups with smaller proportions of higher risk individuals and avoid smaller groups, particularly those with large proportions of higher risk individuals. Many of the decisions insurers make about prices, benefits, providers, and sales approaches are designed to avoid high-risk groups and to attract lower risk groups. Market segmentation thus increases risks for smaller employers or those with higher cost workers.

The move to managed care

The use of managed care plans has been cited as an effective method for controlling health care costs. There is some question, however, about the level of future savings that can be achieved. Most managed care savings stem from the economies of scale of integrating providers and volume discounts to a large purchaser. Additional savings will require more effective and efficient management of care itself. Far too many health plans, however, have devoted their resources to the

integration of providers and attaining market shares. Fewer plans have invested in the management information systems necessary to more effectively manage health care. In addition, premiums could rise if proposals to increase flexibility for consumers in managed care plans are enacted.

Another trend related to managed care is that, in just the last few years, very large, publicly held managed care companies have been purchasing and consolidating providers. This integration could dramatically alter the supply side of the market and could have a real impact on the costs of health care in the future. What is less clear about this movement is how pervasive this trend will be and whether certain populations will have less access to health care because of the changing distribution of providers. It is also less clear whether these organizations will be able to sustain the growth achieved by merging and consolidating.

Political responses

Political responses to an unstable insurance market will also have consequences for the health insurance system. Inadequacies in the employer-provided health insurance market have been the basis for proposals for a national public program that all employers would be required to help finance. This seems less likely in the current political climate than public actions to make incremental changes in the health care system, particularly actions to stabilize the market, subsidize some of the uninsured to help them into the market, and segment the market in a rational way. Most states have undertaken each of these activities, although they have done so differently and with different emphasis. In addition, the federal government has based new federal standards on ongoing activities in states.

In an effort to stabilize the market, for example, most states have worked towards limiting medical underwriting and guaranteeing that anyone willing and able to purchase insurance will be able to do so. More recently, on the federal level, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) supports state efforts and makes changes in the tax code that would subject self-insured plans to many of the same provisions applied to state regulated plans. This act was recently implemented and many of the state insurance reforms are also recent so it is too soon to know how the market will change. It is

not likely, however, that the reforms will lower the cost of health insurance. In fact, it is more likely that prices will rise. If health insurance companies are forced to broaden risk pools and take on more risk, they may raise premiums. As a consequence, firms that do not yet offer health insurance but are planning to do so may delay implementing their plans for financial reasons. It is more likely, however, that these firms will have access to health insurance when they decide to make the purchase.

Efforts to provide health insurance to those without coverage have also occurred on the state and federal levels. In the last several years, the number of state-sponsored health insurance programs for the uninsured has increased. Beginning in 1987, Congress passed a series of laws to expand eligibility for pregnant women and children in the Medicaid program and gave states the flexibility to further expand program eligibility. The State Children's Health Insurance Program provides states with funds to provide coverage for low-income uninsured children who do not qualify for Medicaid. States have aggressive outreach campaigns to find and enroll uninsured children. There is some concern that employers may not feel compelled to offer health insurance if publicly subsidized insurance is available. Policymakers note, however, that many low-wage workers are employed at firms that have not offered insurance in the past because it is either unavailable or unaffordable.

OVERVIEW OF THE CANADIAN HEALTH CARE SYSTEM

This section begins with a brief description of the system of health care in Canada. The compelling demographic change and its implications for public finance of pay-as-you-go programs, including health care, are then presented.

Universal Coverage

A fundamental difference between the U.S. and Canadian health care systems is that decisions that Canadian employers make do not

have an impact on employee's access to most health care. Access to health care in Canada is universal. For the most part, access to care in Canada is unrelated to employment status or to the type of compensation offered by employers. Therefore, health care coverage is not a factor that people must consider when they think about changing jobs.

The Canadian constitution gives jurisdiction over health care to the provinces and territories. Thus, what is commonly referred to as "Canada's system of public health care" is really 10 provincial and 2 territorial health care systems, bound by a set of common principles enunciated in the Canada Health Act. The five key principles of the system are public administration (nonprofit delivery by public authorities accountable to the provincial government), comprehensiveness (provision of all medically necessary service), universality (coverage of the entire population), accessibility (reasonable access to services without barriers), and portability of health care coverage across jurisdictions.

"Socialized Medicine"?

While Canada's system of health care is often referred to as "socialized medicine," there are at least two aberrations from a pure socialized medicine model. First, most physicians are not employees of the state. Physicians, in private or group practice, bill the provincial health care authority on a fee-for-service basis, although the fees that physicians can charge are negotiated, usually between the provincial government and representatives of physicians. Physicians cannot bill patients directly for services, nor can they ask patients to pay an amount above that paid by the provincial health authority.

Second, a considerable and growing proportion of Canadian health care financing is private, including expenditures by health insurance companies, out-of-pocket expenditures by individuals, and patient services paid by individuals or insurance companies (e.g., for nonmedically essential services, private hospital rooms, etc.). While real public sector health expenditures have been falling since 1994, private expenditures have been growing at 4 percent per year (Table 4.1). Indeed, private health expenditures became an increasingly important component of total public and private health expenditures during the 1990s and grew faster than public sector expenditures in every year since

1991. In 1996, the proportion of public to total financing had fallen to 69.9 percent, while the private sector contribution increased to 30.1 percent, compared with 74.6 percent and 25.4 percent, respectively, in 1991. For additional perspective, the percentages were 76.4 percent public and 23.6 percent private in 1975. It should also be noted that, due to changes in the funding formula, the proportion of provincial health expenditures financed by the federal government fell from 41 percent to 32 percent between 1977 and 1995.

Rising Costs

Total health care costs were slightly over $75 billion in 1996, or 9.5 percent of Gross Domestic Product. While real expenditures have been increasing through the 1990s, the 1996 share was down from a high of 10.2 percent in 1992, but up considerably from 7 percent in the 1970s (Health Canada 1997).

The public health care system is financed through taxation of individuals, businesses, and corporations in addition to borrowing by the federal and provincial governments. In two provinces, Alberta and British Columbia, health care premiums are assessed, but nonpayment of the premium has no impact on eligibility for health services. Both the federal and provincial governments share the costs of financing health care costs, but the cost-sharing formula has evolved over time. Initially, the federal government financed approximately 50 percent of each province's health care expenditures. From 1977 to 1996, the federal government provided transfers to the provinces (which covered federal contributions to both health care and postsecondary education) based on the notion that per capita expenditures on essential government services should be approximately equal and not vary substantially from province to province. Since 1996, the federal contribution has been lump-sum transfers in the form of money and relinquishing "tax room" (i.e., the federal government lowers personal and/or corporate tax rates, allowing the provinces to increase tax rates with no net impact on the tax burden to individuals or corporations).

In common with the United States, Canadian governments have been concerned about the growing costs of health care. Health care costs are the single largest line item of provincial government budgets and, as such, have been a source of careful scrutiny by politicians seek-

Table 4.1 Public and Private Health Expenditures in Canada, 1990–1996[a]

Category	1990	1991	1992	1993	1994	1995	1996
Total ($, billions)	61.2	66.4	70.1	71.8	73.0	74.3	75.2
Real change (%)	2.97	3.84	2.47	1.08	0.71	0.66	0.56
Per capita ($)	2,201	2,362	2,456	2,480	2,496	2,509	2,511
Public sector ($, billions)	45.6	49.6	52.0	52.5	52.6	52.8	52.6
Real change (%)	2.85	4.06	1.99	0.26	–0.38	–0.57	–0.74
Per capita	1,643	1,763	1,820	1,812	1,800	1,783	1,754
Private sector ($, billions)	15.5	16.8	18.2	19.3	20.4	21.5	22.7
Real change (%)	3.35	3.17	3.96	3.58	3.95	4.16	4.08
Per capita ($)	558	599	636	668	696	726	757

SOURCE: Health Canada (1997).

[a] Total, public sector, private sector, and all per capita expenditures are in current Canadian dollars.

ing to control and eliminate budget deficits. In addition, Canada's demographic structure is changing in ways that put at risk the sustainability of all manner of pay-as-you-go financed programs, especially those geared toward the elderly population.

Fiscal pressures have caused all levels of government to reevaluate their expenditures. Since health expenditures account for about one-third of total provincial expenditures, they are an obvious target for retrenchment. Combined with substantial reductions in federal transfers to the provinces, the health care system has come under considerable restraint in virtually all jurisdictions in Canada. The recent decline in public health expenditures and the growing proportion of health care financing from private sources reflect public sector retrenchment in health services financing in Canada. Recent efforts to restructure the delivery of services have been aimed at containing public health care costs, although it is a source of considerable debate as to whether these reforms are harming or improving health services for Canadians.

Demographic Changes and Their Implications for Pay-As-You-Go Financing

Canada's system of health care is financed on a pay-as-you-go basis. That is, health expenses are financed in the year in which they are incurred. The federal government and most provincial governments have experienced extended periods of budget deficits resulting in considerable accumulation of public debt, relative to the size of the economy. Finding ways to respond to budget deficits, public debt, and debt-servicing costs has become a preoccupation for governments. Concurrent with the period of public debt accumulation, the demographic profile of Canada has been evolving. In response, policymakers have begun to evaluate the costs of public programs on broader terms than annual changes in the budget balance, considering also their intergenerational implications (Auditor General of Canada 1998).

This new intergenerational perspective creates challenges because it opens a debate that Canadians have been largely able to avoid. Passing the costs of current programs on to future generations of Canadians has been expedient, largely because the generations to whom the costs were passed were not yet born, and therefore not heard, when these funding decisions were made. As Canada's demographic structure has changed, so has the need to carefully consider expanded funding of pay-as-you-go programs and to make difficult reforms to ensure the economic sustainability and political viability of cherished programs like public health care.

Pay-as-you-go financing of programs can be a reasonable approach to providing generous benefits when the size of the working age population, relative to the size of the population receiving benefits is large and stable over time. Until recently, this had been the situation in Canada. However, this situation is changing dramatically for three fundamental reasons: 1) an aging population, 2) a continuing increase in life expectancies, and 3) a decline in fertility.

The combination of these factors with the reliance on pay-as-you-go financing has led to concern about the long-run viability of Canada's health care system. Public policy concern with the issue of intergenerational equity is heightened by the fact that the aging of the Canadian population not only places upward pressure on the cost of

Canada's health care programs, but also on the cost of Canada's public pension programs, which are also financed on a pay-as-you-go basis.

The aging of the population will also affect system costs. Older Canadians are the largest per capita consumers of publicly financed health care services. Per capita spending on health care increases substantially with age. For perspective, in 1994, public health expenditures averaged $7,040 for Canadians age 65 and older. In contrast, per capita public sector health expenditures were $647 for those aged 0–14, $846 for those aged 15–44, and $1,563 for those aged 45–64.

It should be noted that health care is only one of a number of larger public programs financed on a pay-as-you-go basis. For example, federal government income support for elderly Canadians is provided through three programs: Old Age Security (OAS), the Guaranteed Income Supplement (GIS), and the Canada Pension Plan (CPP). The Canada Pension Plan provides a timely example of the pressures facing pay-as-you-go government programs from which net benefits (benefits received less contributions) are heavily weighted toward the elderly population and the policy responses to these pressures.

Like the Social Security system in the United States, CPP has undergone a number of reforms. Among these was a sharp rise in the actual contribution rate, from the current level of 5.85 percent to 9.9 percent in 2003. The latter is estimated to be the "steady-state" rate—that is, the contribution rate necessary to fully fund new benefits and to service the existing unfunded liability. The purpose of the sharp and rapid increase in contribution rates was twofold: 1) to forestall the larger increase in contribution rates that would otherwise be required and 2) to increase the degree of funding, thereby lessening the extent to which the CPP is financed on a pay-as-you-go basis. In the absence of this reform, the (pay-as-you-go) contribution rate would have risen from the current pay-as-you-go contribution rate of 8.00 percent in 1997 to 14.22 percent in 2030, an increase of 77.8 percent. As emphasized earlier, the purpose of these reforms was to promote intergenerational equity by reducing (but not eliminating) the extent to which younger workers will pay higher contributions for the same (or lower) level of benefits.

There are no official projections of the pay-as-you-go tax rates necessary to finance Canada's health care system. However, the Auditor General of Canada has released projections of the ratio of government

spending on Canada's public pension programs (CPP/QPP, OAS [including SPA and WSPA], GIS) and on health care to gross domestic product (GDP) from the present to the year 2031 (Auditor General of Canada1998). These figures demonstrate the projected costs of these programs as a proportion of the entire economy, not just employment earnings. These projections show that demographically driven increases in public spending on pensions and on health care represent a major challenge to fiscal planning in the years ahead. Under the median scenario for health care costs, government spending on these items will rise from 11.6 percent of GDP in 1996 to 17.2 percent (a 48 percent increase) by 2031. Health care costs are, by far, the largest single component of these costs and are projected to rise from 6.4 percent of GDP to 9.0 percent.

POLICY OPTIONS FOR THE UNITED STATES AND CANADA

Few Canadians would see the U.S. health care system as ideal, and few Americans think the Canadian system is flawless. Yet, policy options under consideration in each country could make the systems far more alike than they have been in the past.

United States

The Canadian system has universal coverage and is plagued by costs. In contrast, coverage is the U.S. system's most important problem, although costs are certainly a close second.

Most U.S. policymakers have abandoned, at least for now, the goal of achieving universal coverage by means of a single, sweeping reform. The wave of the future seems to be specialized remedies such as those already passed on behalf of people leaving or changing jobs or abandoning welfare for the work place, but the incremental road to universal health care coverage (most people's ultimate goal) may not be direct. Most of the easy coverage fixes—and probably some that are not so easy—have been enacted. Yet, growing numbers of Ameri-

cans—many of them full-time, full-year workers or their families—remain without coverage or the near-term prospect of obtaining it.

Those with coverage, in turn, can expect incremental efforts to improve their negotiating power against insurance companies and health care plans that take a narrow view (at least in the patient's eyes) of what constitutes medically necessary health care. While "patient rights" is the new watchword for health system reformers, "patient responsibility" is the unspoken but necessary corollary. Patients have more medical choices than ever before, but plans have more reasons and ways to limit them. Only the determined and informed patient will be able to protect and exercise all rights the states or the federal government may declare.

Canada

Some years ago, Mike Myers, a Canada-born comedian, said the Canadian health insurance system is one of the top five things Canadians like best about their country (another of the five was Florida). While Canadians probably still like Florida, it would be interesting to know whether the health care coverage system would make the top-five list today. Fiscal pressures have led to major changes in the system, including reductions in inpatient care, expanded community services, and consolidation of hospitals under regional authorities (Naylor 1999). These changes have shaken public confidence in the system. Ongoing challenges include integrating services across the continuum of care, standardizing prescription drug coverage, reforming physician payment practices, and measuring and managing the quality of care. This incremental agenda is seen as the best way for Canada to sustain and improve its single-payer system.

What are the real and perceived implications of government restraint in health care expenditures for Canadian workers? First, if it is true that reduced government expenditures are truly harmful, then an obvious implication could be compromised health. There is considerable debate about whether recent reductions in health expenditures have been harmful (see, for example, Drache and Sullivan 1999; Evans 1999). The Canadian health care system has been heavily reliant on the hospital as the key center for providing health care. Recent reforms have focused on restructuring health care, such that less is provided in

hospitals, the most costly mode, and more through community and home-based services. Nonetheless, a reduction in hospital resources can lead to a general perception that the public health care system is failing and that more drastic alternatives need be found.

Pressure to contain direct government expenditures may lead to the introduction of user fees for some services, the de-listing (or non-listing) of services that are "medically necessary" and therefore financed by provincial health authorities, or the "under-provision" of services resulting in queues for even some medically necessary services. To varying degrees, all of these have begun to appear in Canada.

Taken together, a loss of confidence in the public health care system, real or perceived, could result in the deeper participation of private care providers and insurers into the Canadian health care system. There is clearly an open debate about the extent to which private versus public provision of health care services, or some combination, is optimal. This debate is clearly beyond the purview of this chapter. However, there is no evidence that private provision of health care results in better health outcomes, or superior cost containment, relative to public provision. Further movement of the Canadian system in this direction could be expected to introduce the same types of issues discussed in the U.S. context previously in this chapter.

CONCLUSIONS

Canadian and U.S. workers face health care risks very differently. Most Americans under age 65 depend on their employers for health care coverage. Employers, in turn, are shifting more of the cost and risk of health care coverage to their employees. To the extent that policymakers address these risks, it will probably be to shift more of these risks back to employers and health care plans.

For Canadians, health care risks are pooled in the political marketplace, not the labor market. But, to the extent that Canadians see themselves as being harmed by the ongoing restructuring of their health care system, they are bound to consider other approaches to delivering health care, including a greater role for private provision. Given the

U.S. experience, it is an open question whether this will result in Canadian workers leaping from the frying pan into the fire.

Notes

1. Beginning in 1987, Congress passed a series of laws to expand eligibility for pregnant women and children in the Medicaid program and gave states the flexibility to further expand program eligibility. The recently established State Children's Health Insurance Program provides states with funds to provide coverage for low-income uninsured children who do not qualify for Medicaid.
2. Until recently, employers were also at risk if they had to sign with a new insurer and there was a requirement for a waiting period before treatment for pre-existing conditions would be covered. With the passage of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the risk to employees has substantially been reduced. HIPAA does protect employees when they change to new health plans by transferring existing credit under the old plan to the new plan. Furthermore, the waiting period before treatment for preexisting conditions would be covered has been limited to 12 months. Nevertheless, the exceptions involved that still make it difficult for employers to completely transfer their credit to the new plan.

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