INFORMATION BRIEF
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Universal Health Coverage: An Economist's Perspective

The state can provide universal health care in a number of ways, but there are costs and benefits to doing so. This policy brief reviews the costs and benefits of adopting a statewide universal health care system from an economist's perspective. The concepts set forth here are drawn from fundamental economic principles and studies related to universal health care.

Definitions of Universal Health Care

For purposes of this brief, universal health care is defined as health care provided to all individuals regardless of gender, race, region, age, health status, income, or wealth. The state can provide universal health care in many ways, including the following:

- Paying health care providers from a single organization (single payer)
- Subsidizing coverage through the private sector
- Providing vouchers or refundable tax credits to obtain health care in the private sector
- Mandating all persons to have health care coverage

Also, universal health care coverage may not imply actual universal health care. Universal health care coverage means that everyone is allowed treatment, but does not mean everyone receives health care because some may choose not to receive treatment or may not know it is available. This paper is meant to be general in the sense that concepts discussed here may be relevant in the discussion to adopt almost any health care system, not only single-payer plans.

The Problem from an Economist's Perspective

An incomplete market exists when consumers desire a product, but none is provided by a private business. The case of the uninsured is an example—individuals may desire health insurance, but none is available at the price they are willing or able to pay. The price of health insurance is key here, and that is a product of group interactions between insurance providers, consumers, and employers.

The price of insurance is too high of a price for some consumers. Insurance is available for individuals and businesses who can afford it, but some may find it unaffordable.

- Many of the uninsured may be more costly to cover (e.g., because of their health conditions or history) than the general population.

- Insurers provide services to the lower cost part of the population, which allows them to lower their rates, albeit not low enough to make it affordable to all.

Individuals choose not to purchase private insurance. Individuals purchase private health insurance if the perceived benefits to them outweigh its costs. Three common reasons for not purchasing insurance are the cost, perceived need, and lack of information:

- **Some may simply find insurance too expensive.** These individuals may have too much income and assets to qualify for Medicaid and are ineligible for or otherwise find MinnesotaCare too expensive. For example, individuals who become unemployed lose their insurance and may have to spend down their assets until they become eligible for either MinnesotaCare or Medical Assistance. High insurance costs can be a contributor to individuals filing for bankruptcy.[1] However, bankruptcy may be less of a problem in Minnesota since individuals can qualify for MinnesotaCare with less than $10,000 in assets and households of two can qualify with less than $20,000 in assets.

- **People are betting they will not need health insurance.** Although some may correctly assess their risk and would normally not expect to incur much in health care costs, they may go without health insurance, finding it too costly compared to their expected risk of illness. However, without more information about their susceptibility and exposure to illnesses, risk of accident, need for preventative care, or other health care treatments, some may be poor judges of their own susceptibility to illnesses. They may wrongly think that they are in the group of the healthy with little chance of incurring significant health costs.

- **Imperfect information makes it difficult to decide.** The complexity of insurance plans and assessing one's risk to illnesses make it difficult for even intelligent and careful consumers to make adequately informed decisions. Some consumers may

[1] See David U. Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler, "MarketWatch: Illness and Injury As Contributors to Bankruptcy," *Health Affairs* (January 2005).

choose to go without health insurance, even though it is not in their best interest, because they lack information or because it is too difficult to assess all the information and details.

Employers may find it too costly and unprofitable to provide health insurance to their employees. Employers may have too little in earnings for them to want to pay for health insurance costs. One concern is for small employers who may face higher coverage costs in comparison to larger employers.[2] Part of the reason for lower costs to smaller employers is that there are per-person cost savings for large employers who may develop their own insurance plan without purchasing from a retail insurance provider.

Economists Often Weigh the Benefits of Adopting a Policy with Its Costs

Incomplete Markets Are Common; Are They Worth Fixing?

There are many things people desire, but which are unavailable at a price they are willing to pay. The question for the public provision of health care is whether the benefits outweigh the costs.

If the benefits outweigh the costs, then there may be justification for adopting a public policy providing universal coverage. The costs and benefits are often divided into two types: (1) the effect on individuals, based upon notions of fairness, known as equity; and (2) the effect on aggregate income, or otherwise referred to as "efficiency" by economists. In inefficient markets, there is a barrier that prevents trade from allowing consumers to choose the allocation that makes them happiest, given their income, and allows businesses to maximize their profits (otherwise known as market failure). In the debate regarding universal health care, economists suggest both efficiency and equity are relevant considerations.

The Benefits of Universal Health Care

Reasons Based Upon Fairness

One commonly cited reason for providing health care for all is to preserve the life and dignity of others. Some members of the population may feel that treating others fairly includes providing health care. In a way, everyone has access to health care through Medicare, Medical Assistance, MinnesotaCare, or hospital emergency rooms. But fairness can be viewed as more about the quality and level of care.

To implement universal coverage, there has to be at least one organization that collects money to pay for it. In order to pay for such a public benefit, a central organization willing to cover the costs of collection, like a state government, may be needed. However, who should pay and how much is an issue. For example, the state government could pay for at least part of the uninsured's health care cost through subsidies to insurers. Or, it may choose to pay for it

[2] See Alpha Center, *Risk Adjustment:A Key to Changing Incentives in the Health Insurance Market*, prepared for the Robert Wood Johnson Foundation (March 1997).

through vouchers to consumers. Ideally, the amount paid would equal the benefit each individual receives in knowing that there is a fair system for the provision of health care.

These matters are complicated by notions of what constitutes fairness, and there is imperfect information about how many may be able to pay for their own health care. Some may feel that it is appropriate that families work harder or invest in developing their skills. Others may recognize that some families may face significant physical or other barriers that make it difficult to increase their earnings. The border between appropriate and inappropriate intervention may be difficult to determine because of insufficient information and because it is subject to the values of the community.

Reasons Relating to Higher Aggregate Income

Large insurance companies provide the potential for imperfect competition, and universal health care may counter the problem with bilateral bargaining.[3] Adam Smith's notion of perfect competition has to do with many small businesses competing for dollars from many consumers so that no single business or person can unilaterally affect prices. However, the health care sector might be characterized as having several large providers in the health insurance market, thereby creating the potential for these businesses to unintentionally or intentionally collude, resulting in higher prices. Some may suggest that health insurance prices are lower because of cost savings associated with larger insurance companies. However, one must also consider that the larger companies are not providing insurance to the more costly group of uninsured. In the end, there still maybe potential for prices that exceed their minimum costs.

One way to potentially lower the price is to reduce the number of health insurance purchasers and thereby reduce administrative costs. Universal health care might include the creation of a bargaining unit that can negotiate lower health care payments to more adequately reflect costs.

Individuals may hold back their careers because job changes or increases in income will increase their health care costs. In some cases, health care costs may prevent some individuals from working or seeking higher earnings. Working harder to increase earnings may result in losing their subsidized coverage or having to pay more in premiums. Researchers found evidence of this in the 1980s before expansions to Medicaid.

MinnesotaCare may extend coverage to working parents, but there may still be situations where parents are made worse off by earning more. Some research has found that higher MinnesotaCare premiums and becoming ineligible for the program may result in lower net income even with an increase in earnings.[4] However, the evidence on whether such occurrences affect behavior is mixed. This may be because knowing how public benefits, taxes, child care subsidy payments, and subsidized MinnesotaCare premiums would change with more earnings

[3] See Rhema Vaithianathan, "Health Insurance and Imperfect Competition in the Health Care Market," *Journal of Health Economics*, 25, issue 6 (2006): 1193-1202.

[4] See Donald Hirasuna and Paul Wilson, *The Gain to Work for Low- and Moderate-Income Workers: Changes in Effective Tax Rates 1998-2004*, House Research Department Information Brief (October 2006).

can be very complex and opaque to most individuals. Some suggest that this may be more of a question of fairness.

As noted earlier, **small businesses often face higher health insurance costs and are less likely to provide coverage for their employees.** Providing universal coverage may contribute to the profitability of small businesses and may add to their growth.

Universal health care coverage may increase profitability among hospitals that must pay for the treatment of uninsured. Choosing to go without insurance violates the principles of a well-functioning economy when hospitals must treat these individuals as required by federal or state law. Hospitals are required to provide emergency care to the uninsured and others, regardless of their ability to pay. Hospitals must shift these costs by either charging higher prices for services or lowering expenditures on other items. Although it is very uncertain, more profitability for hospitals through universal coverage may result in higher aggregate income.

Universal health care might lower administrative costs. Single-payer plans where there is one coverage for all individuals may lower administrative health care costs by having only to apply the rules of one plan to each person's coverage.[5]

Publicly Provided Health Care

Designing and implementing a universal health care that improves the current system is a daunting task. Below are a few of the challenges and risks involved.

Getting prices right may be more difficult than it looks. Whether universal health care is a good decision depends upon the costs and the benefits. Keeping costs at a level that avoids excessive profits to providers, but also avoids sacrifices in the quality of care and innovation in new medical treatments that people are willing to pay for is no easy task. A statewide initiative, as opposed to a national initiative, may have some advantages since states may be able to look to other U.S. domestic private health care markets to assess of private sector costs.

- **If reimbursements for costs are too low, providers may sacrifice the quality of services** or may provide only a limited number of services, creating waiting lists for some treatments.

- **On the other hand, providers may become inefficient, overstating their costs to government.** Economists often question whether government services like schools, utilities, and government agencies provide their services at the lowest cost levels. They suggest that sometimes, these services may overstate their costs and lead to higher government expenses than a competitive system.

- **Without competition, it is difficult to determine the lowest cost of providing medical care.** Providing for competition allows organizations to constantly search

[5] David U. Himmelstein, Steffie Woolhandler, and Sidney M. Wolfe, *Administrative Waste in the U.S. Health Care System in 2003: The Cost to the Nation, the States and the District of Columbia, With State-Specific Estimates of Potential Savings*, Public Citizen Health Research Group, Washington, D.C. (August 27, 2003).

for less expensive ways of providing services. However, in the case of cost savings with increasingly larger organizations, sometimes the least-cost way of delivering a service may be a single monopoly provider.

- **Prices set without competition may impact innovation.** Traditional economic models suggest that businesses interested in the long term will charge higher prices to finance research, and consumers are willing to pay higher prices for research that results in treatments with better health outcomes. Setting prices for individual treatments or insurance coverage may affect the incentives for businesses and consumers. Changing incentives in a well-functioning market, or what may be deemed as the best attainable market, may affect cost-savings measures and new innovative treatments in ways different than what would maximize the region's income and from what many consumers would want.

One plan that fits all may result in concerns about a lack of consumer choice.

- **One advantage of privately provided health insurance plans is that consumers may choose among several different plans**. Under universal coverage, a likely issue is that some may want additional coverage. Some more restrictive approaches, such as a single-payer plan, may restrict choice. In a less obvious way, choice may be limited in that persons cannot purchase their desired coverage at subsidized prices and may find it unaffordable regardless of whether health care is financed through subsidies to the provider or to the consumer, so in some sense, choice may be limited in many different types of plans.

- **Depending on the type of universal coverage** there may be significant adjustments as insurance companies either shut down operations in Minnesota, or cut back in employment. This may impose adjustment costs as some employees get laid off, receive unemployment insurance benefits, and search for new jobs. Some forms of universal or almost-universal coverage may avoid large employment shifts, such as subsidizing coverage through the private sector.

With universal coverage, some individuals may still not be covered by health insurance.

An issue is going to be **who to include within the universal health care system**. Including all individuals regardless of residency might raise issues regarding the treatment of transients, persons who are residents of other states who cross Minnesota's border for treatment, and noncitizens or other in-migrants who may wish to take advantage of Minnesota's health care system.

- At least for in-migration for welfare benefits, the evidence is mixed on how much of this occurs if any, but there is still the potential for added costs depending upon who is eligible.

- Once eligibility is determined, the state might use an insurance card to help reduce the administrative costs of determining who is covered.

Regardless, there will likely always be some who are eligible for coverage, but do not receive it. Even under universal coverage, some may decline coverage because their costs are too high. These costs include out-of-pocket costs for premiums, time spent filling out forms, and the availability of information about health care coverage.[6] For example, even some individuals who are eligible for Medicaid still do not enroll.

Finally, monitoring and evaluating the system will entail some costs as well, which may be less significant, but may be worth considering.

For more information about health care, visit the health and human services area of our web site, www.house.mn/hrd/issinfo/hlt_hum.htm.

[6] See Janet Currie, "Take up of Social Benefits" in *Poverty, the Distribution of Income, and Public Policy*, eds. Alan Auerbach, David Card, and John Quigley (New York: Russell Sage Foundation, forthcoming).