

Health Care Coverage in America:

Understanding the Issues & Proposed Solutions

CoverThe
Uninsured

ACKNOWLEDGMENTS

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Alliance for Health Reform

www.allhealth.org • (202)789-2300

The Robert Wood Johnson Foundation

www.rwjf.org • (888)631-9989

Cover the Uninsured

www.CoverTheUninsured.org • (202)572-2928

En Español

www.CoverTheUninsured.org/espanol

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The United States has an incredibly complex and convoluted system for financing and delivering health care. Americans get coverage in many ways: through our employers, the federal government, the military, state programs, on our own, and by other means. At the same time, we pay for coverage out of pocket, through state and federal taxes, and through our employers.

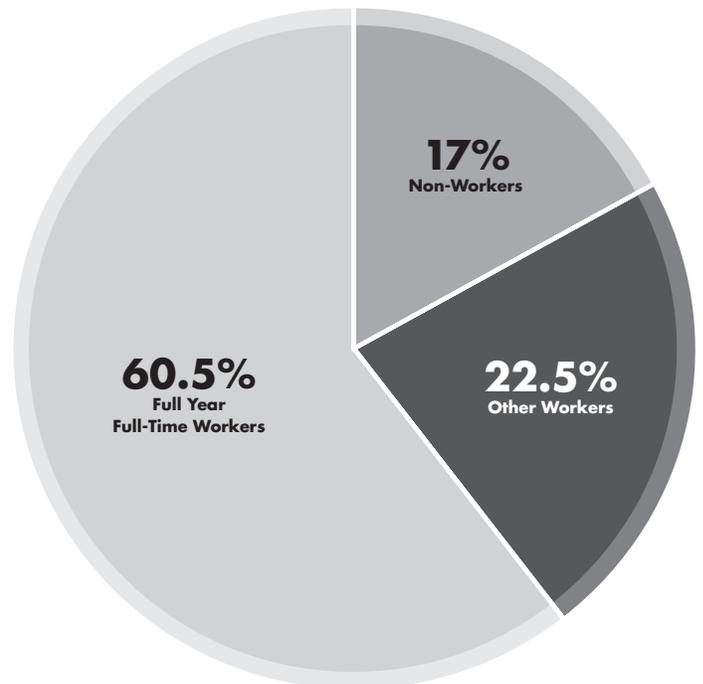
Several times during the past 60 years or so, Americans have engaged in a nationwide discussion asking “How can we get health insurance for those who don’t have it?” And just as important, “How can we help people keep their health insurance if they do have it?”

We are in the midst of another such discussion now. Government officials, political candidates, employers, unions, community leaders and ordinary citizens are expressing a desire for the nation’s piecemeal system of health insurance—employment-based coverage for workers, federally funded Medicare for the elderly, other public programs for certain poor people—to cover the tens of millions of Americans who fall through the cracks each year.

Many say that we can do better and refer to the following facts:

- **Almost one in every six people in the U.S. lacks health insurance—43.6 million in 2002, according to the Census Bureau.¹**
- **The percentage of the U.S. population without health coverage is growing, reaching 15.2 percent in 2002 vs. 14.2 percent in 2000.²**
- **Eight out of 10 of the uninsured are in working families (see Chart 1).³**
- **The uninsured don’t fit any stereotype. They come from every community, every walk of life, every race and ethnic group, every income level.⁴**
- **People who have coverage can’t necessarily count on keeping it. A person could have good coverage**

1. MOST UNINSURED AMERICANS ARE IN WORKING FAMILIES



Source: Employee Benefit Research Institute (2004). Estimates from the March Current Population Survey, 2003 Supplement.

today, none at all six months from now, then regain coverage a few months later. Nearly 85 million people lacked coverage at some point between January 1, 1996 and December 31, 1999.⁵

This publication is designed to help you become an active participant in the national discussion about how we can secure health care coverage—private or public—for all Americans. In the pages to come, you will see evidence that a lack of health coverage has real consequences for a person’s health and financial status. You will learn more about how people get health coverage now, and why so many don’t have it. You will learn more about who is uninsured.

Finally, you will learn about several approaches to reducing the ranks of the uninsured. And you will learn how to make sense of proposals for reducing the number of people who go without health insurance in the U.S.

Why the Renewed Interest in the Uninsured?

Why the renewed interest in making sure all Americans have health care coverage? For one reason, we in the U.S. are growing increasingly concerned about the rising cost of health care and health coverage. We're justifiably afraid that as health coverage becomes more and more expensive, we may not be able to afford our share of coverage offered on the job—if we are offered coverage at all. We know that if we lose a job, we could also lose our access to affordable health coverage and health care (to be discussed in more detail later).

The slow pace of job creation worries many people. The latest recession officially ended at the end of 2001. But the rebound in jobs that normally occurs after a recession has lagged behind expectations, leaving

many formerly employed—and insured—Americans without coverage.

In addition to cost and job worries, the 2004 presidential campaign is focusing on how we might make certain that many more Americans have access to health coverage in our country.

We're justifiably afraid that as health coverage becomes more and more expensive, we may not be able to afford our share of coverage offered on the job—if we are offered coverage at all.

Many Americans are worried about health coverage and health costs. For instance, a Kaiser Family Foundation

poll conducted in January 2004 found that health care ranked second to the economy and jobs among issues respondents said would determine their vote for president this fall.⁶

Even so, many Americans are not convinced that being uninsured is a problem. A majority of Americans polled mistakenly believe the uninsured can receive the care they need through clinics and hospital emergency departments.⁷ Another challenge: Although people tell pollsters they want help for the uninsured, they are less enthusiastic about paying higher taxes for this purpose.⁸ Yet another challenge: Neither the public nor policy-makers have settled on one preferred approach to providing health coverage for the uninsured.⁹

PERSONAL STORIES OF THE UNINSURED

To read personal stories about those who are uninsured, told in their own words, go to the Web site for **Cover the Uninsured Week**, www.CoverTheUninsuredWeek.org/stories.

Uninsured Myths & Facts

1 MYTH: People without health coverage don't work.

FACT: Eight out of 10 people who are uninsured are in working families.¹⁰

2 MYTH: Most uninsured people in the U.S. are minorities.

FACT: Non-Hispanic whites make up three-fourths of the uninsured.¹¹

3 MYTH: Most people without health insurance are poor.

FACT: Almost 29 million of the uninsured in 2002 had household incomes of \$25,000 or more, compared with 14.8 million in households earning less.¹² (*The federal poverty guideline for a family of four in 2002 was \$18,100. As noted, that has increased to \$18,850 for 2004.*)

4 MYTH: It doesn't really matter whether a person has health insurance.

FACT: About 18,000 Americans die each year of treatable diseases because they don't have health coverage, according to the highly respected, nonpartisan Institute of Medicine.¹³

5 MYTH: Virtually everyone who works for a large employer has health coverage.

FACT: More than one out of four of the nation's uninsured in 2001 (nearly 10 million people) either worked for a firm with 500 or more employees or were dependents of someone who worked for a large firm.¹⁴

Why Is Health Coverage So Important?

Why does health coverage make such a big difference in people's everyday lives? Let's look at the evidence.

Effects on Health and Treatment

Not having coverage can be dangerous to your health, according to a wide array of studies conducted by the most respected research institutions in the United States, including the National Academy of Sciences' Institute of Medicine (IOM).

People without health insurance often go without care or delay care. The care they do receive is likely to be of lower quality than the care received by insured people, and they may be charged more for it. An estimated 18,000 adults die each year because they are uninsured and can't get appropriate health care, according to the federally chartered IOM, which produced a series of six reports on the consequences of not having health coverage.¹⁵

The length of time a person goes without health insurance also makes a difference. The Institute of

Medicine noted that people uninsured for at least a year report being in worse health than those uninsured for a shorter period. Some 20 percent of those without coverage for at least a year said their health was poor or fair, compared with 14 percent of those uninsured for less than a year.¹⁶ But even those uninsured for a short period of time experience problems getting access to care.¹⁷

Among the IOM's key findings were:

- Uninsured women with breast cancer are less likely than insured women to receive breast-conserving surgery.
- Hospitalized patients without health insurance receive fewer needed services and worse quality care, and have a greater risk of dying in the hospital or shortly after discharge than patients with insurance.
- The uninsured are less likely to receive care even when they have serious symptoms (see Chart 2).
- Uninsured trauma victims are less likely to be admitted to the hospital or receive the full range of needed

services, and they are 37 percent more likely to die of their injuries.

- Uninsured adults with HIV are less likely to receive highly effective "drug cocktails." When they do get the new drug therapies, their wait to receive them has been an average four months longer than patients who have insurance.¹⁸

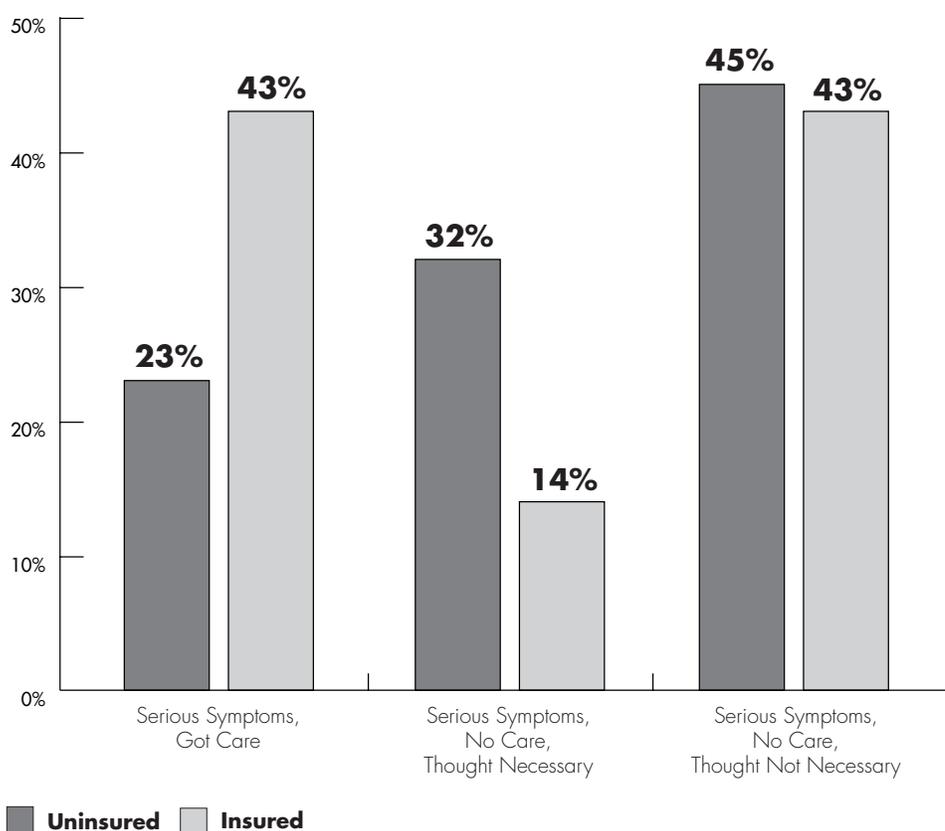
The Institute of Medicine concluded: "Health insurance is associated with better health outcomes for adults and with their receipt of appropriate care across a range of preventive, chronic and acute care services. Adults without health insurance coverage experience greater declines in health status and die sooner than do adults with continuous coverage."¹⁹

Children too suffer health consequences when they lack coverage. Uninsured children are more likely than insured children to lack a usual source of health care, to go without needed care, and to experience worse health outcomes.²⁰

Studies have found that, compared to children with insurance, uninsured children are:

1. Just one-sixth as likely to have a usual site of health care (4 percent vs. 24 percent)
2. More than five times as likely to have an unmet need for medical care each year
3. More than three times as likely not to get a needed prescription drug
4. At least 70 percent more likely to go without care for common childhood conditions such as asthma, ear infections and sore throats²¹

2. UNINSURED LESS LIKELY TO GET CARE, EVEN FOR SERIOUS SYMPTOMS



Note: Respondents were asked whether they had experienced any of 15 symptoms during the previous three months. "Serious" symptoms among the 15 were previously identified by a national sample of physicians. Respondents experiencing symptoms were asked if they had thought it necessary to get care for their symptoms and if they did receive care. Bars show the percentage of uninsured respondents for whom the situation was true, compared to the percentage of insured respondents.

Source: David W. Baker et al., "Health Insurance and Access to Care for Symptomatic Conditions," *Archives of Internal Medicine*, Vol. 160, May 8, 2000, p. 1272.

Effects on Family Finances

Not having insurance threatens the financial security of families. On average, uninsured families pay more than 40 percent of their health care costs out of pocket, according to the Institute of Medicine. Because families with at least one uninsured member tend to have lower incomes than do fully insured families, as well as very few assets, they generally have fewer financial resources to help cope with these higher medical expenses.

This may destabilize a family's financial standing:

- More than half of uninsured working age adults report serious problems paying medical bills, compared with less than a quarter of insured adults.²²
- Of those lacking coverage, 39 percent who also have medical bill problems or accrued medical debt reported that they struggled to pay for expenses such as food, rent or heat. Half (53 percent) said they were forced to use most or all of their savings to pay medical bills. One out of five said they had run up large credit card debts or had to take out a loan against their home to pay medical expenses.²³

Who Is Uninsured?

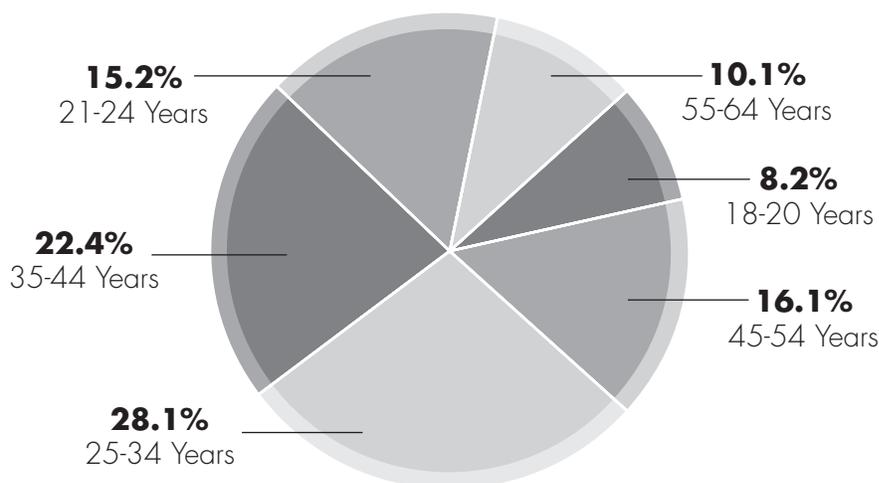
Nearly 44 million people in the U.S. lack health coverage, including nearly 8.5 million children. Almost one in five adults age 18 to 64 was uninsured in 2002; one in 12 children was without coverage.²⁴

The uninsured are members of every race and ethnic group, every age group and every income level. Compared to the general population, however, people who lack health insurance are younger, have lower incomes, have fewer years of schooling, and are more likely to be members of minority groups.²⁵

A common misconception is that those who lack insurance are also out of the job market. In fact, eight of 10 of those who lack insurance are in working families, as noted earlier (see Chart 1).²⁶ Six of 10 had at least one member of the family working full time all year. Jobs held by the working uninsured tend to be in service industries and in smaller firms, where employees are less likely to be offered coverage, rather than in other job settings. The key point, though, is this: the overwhelming majority of the uninsured are from families actively in the labor force.

Americans with incomes below the federal poverty level are most likely to lack coverage—30.4 percent were

3. UNINSURED NON-ELDERLY ADULTS BY AGE, 2002



Source: Employee Benefit Research Institute (2004). Estimates from the March Current Population Survey, 2003 Supplement.

uninsured in 2002 vs. 15.2 percent of the total population. For 2004, the poverty level is \$18,850 for a family of four in every state except Alaska and Hawaii, where the figure is higher (see box, “What Does ‘Federal Poverty Level’ Mean?”).

There are also key differences in insurance coverage among racial and ethnic groups. Hispanics are far more likely than any other ethnic group to be uninsured. In 2002, 32.4 percent of Hispanics were uninsured for the entire year, compared to 20.2 percent of blacks, 18.4 percent of Asian and Pacific Islanders, and 10.7 percent of non-Hispanic whites.²⁷

Also in 2002, 22.7 percent of Hispanic children were uninsured, followed by 13.9 percent of black children, 11.5 percent of Asian American children, and 7.8 percent of non-Hispanic white children.²⁸

The Hispanic community encounters difficulties in securing coverage in part because so many members are recent immigrants who earn modest incomes. Among working-age Hispanic immigrants who have been in the United States for less than five years, 72 percent are uninsured.²⁹ Like other uninsured Americans, uninsured Hispanics are often in low-wage service jobs that don’t offer health coverage. In

WHAT DOES “FEDERAL POVERTY LEVEL” MEAN?

The federal poverty guidelines (also referred to as the “federal poverty level”) are family income figures produced each year by the U.S. Department of Health and Human Services to determine eligibility for certain federal programs, including Head Start, the Food Stamp Program, the National School Lunch Program and the State Children’s Health Insurance Program. Eligibility for certain state assistance programs is also tied to the federal poverty guidelines. For 2004, the guidelines are:

| Size of Family Unit | 48 Contiguous States & D.C. | Alaska | Hawaii |
|---------------------------------|-----------------------------|----------|----------|
| 1 | \$9,310 | \$11,630 | \$10,700 |
| 2 | \$12,490 | \$15,610 | \$14,360 |
| 3 | \$15,670 | \$19,590 | \$18,020 |
| 4 | \$18,850 | \$23,570 | \$21,680 |
| For each additional person, add | \$3,180 | \$3,980 | \$3,660 |

Thus, 100 percent of the FPL for a family of four in most of the U.S. would be \$18,850; 200 percent would be \$37,700, etc.

Source: The 2004 HHS Poverty Guidelines,” U.S. Dept. of Health and Human Services (aspe.hhs.gov/poverty/04poverty.shtml)

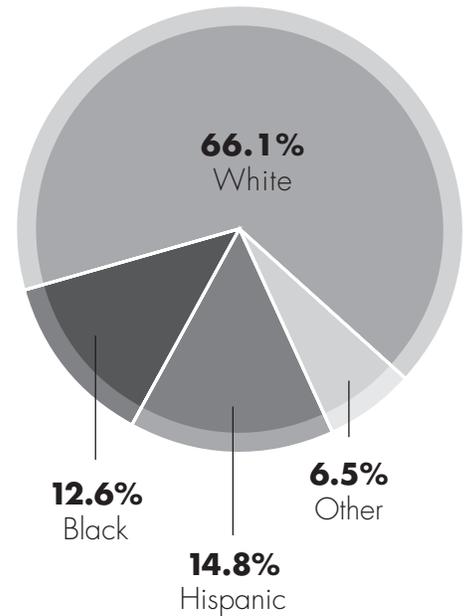
addition, many low-income new immigrants, even when in the U.S. legally, are not eligible for public programs such as Medicaid, although their children are sometimes eligible.

One often-overlooked aspect of the uninsured is that, though the number of uninsured is relatively stable from month to month, it is not the same individuals who are uninsured from month to month and year to year. Hundreds of thousands of Americans lose coverage over the course of a

year, and similar numbers regain it after lacking coverage for relatively short periods of time.

The dynamic nature of the uninsured population has implications for what strategies might be used to deal with the problem. A Commonwealth Fund study found that the number of uninsured, low-income children would decline by nearly 40 percent and the number of uninsured adults would decline by more than 25

4. UNINSURED NON-ELDERLY POPULATION BY RACE AND ETHNICITY, 2002



Note: White = non-Hispanic whites. Black = non-Hispanic blacks. Hispanics can be of any race.

Source: Employee Benefit Research Institute (2004). Estimates from the March Current Population Survey, 2003 Supplement.

percent if every person with public or private insurance at the beginning of a given year retained it through the next 12 months.³⁰

Moreover, barriers prevent people from joining public or private insurance plans. Such barriers include waiting periods before a worker can sign up for an employer plan, and complex enrollment and renewal procedures that discourage people from applying for public insurance and keeping it if they get it.

How Do Americans Get Health Coverage?

Employer-Sponsored Coverage

In the United States, most Americans—175.3 million workers and their dependents—received health coverage through the workplace in 2002 (see Chart 5).³¹ This is far more than the total number of people covered through other means (108.5 million).

Workplace coverage began in the 1930s, developed by the Blue Cross hospital insurance plans. At about

the same time, Henry J. Kaiser started a prepaid group health plan for employees of his construction company in the West, which became the model for today’s health maintenance organizations (HMOs).

These were among the first examples in the U.S. of health insurance “pools,” or groups of people who jointly purchase coverage. The main advantage of insurance pools is that they combine many people who are generally healthy with a few who are likely to need

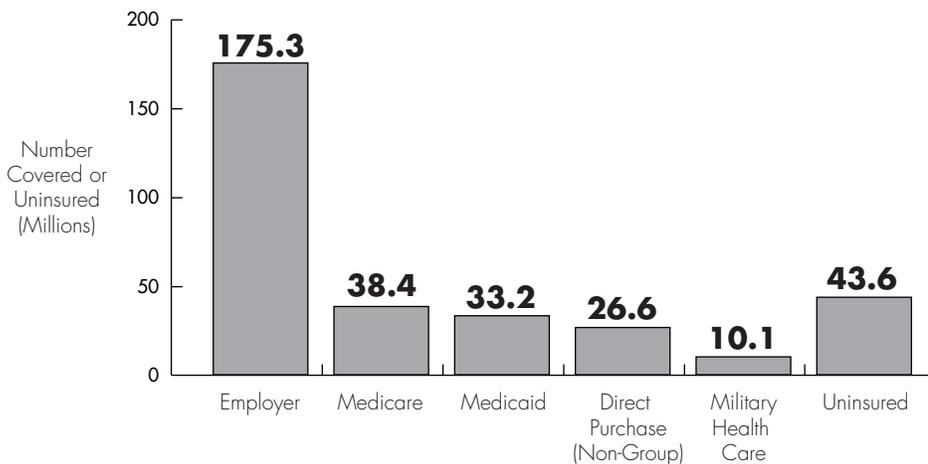
expensive medical care. This spreads risk by offsetting the costs of those with costly medical bills through the premiums of healthier enrollees. Thus, pools help keep coverage affordable.

The practice of getting health coverage through one’s employer got a boost during World War II. The labor market was very tight because so many men and women were serving in the military. The government froze wages to help control inflation, but decided not to consider health benefits as earnings, so they were not frozen. Providing health coverage for employees became a popular tool for recruiting and keeping employees.

After the war, unions in major manufacturing industries, such as the automobile, rubber and steel industries, made the introduction and expansion of health insurance a key demand in their bargaining talks. Employer-sponsored coverage spread rapidly throughout the economy, in union and nonunion companies alike.

Although it has fluctuated with the economy, employer-sponsored health insurance remains an important and popular source of coverage. Health insurance through the workplace has

5. HOW THOSE IN THE U.S. GET HEALTH COVERAGE



Note: A person having more than one type of insurance is counted more than once.

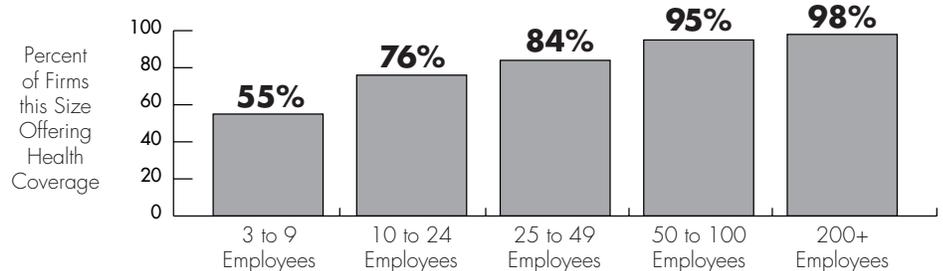
Source: U.S. Census Bureau, September 2003 (www.census.gov/hhes/hlthins/historic/hihist1.html)

remained popular for many reasons. For one, health coverage on the job also carries significant tax advantages for employer and employee. Amounts that employers pay for their employees' coverage are a tax-deductible business expense to the employers. And the money that an employer pays for an employee's insurance is not counted as taxable income to the employee.

Thus, a company's paying \$50 toward an employee's health coverage is more valuable to the employee, dollar-for-dollar, than \$50 per month in pay (for which the employee would have to pay income taxes). Some analysts have estimated that if the cash value of benefits were taxed like income, the value would be close to \$188.5 billion in federal taxes and \$21.4 billion in state taxes for 2004.³² To put that foregone revenue—almost \$210 billion—into perspective, total Medicare spending in 2004 is estimated at \$289 billion.³³

Coverage through an employer, even if the employee pays the full premium, is generally cheaper for the same covered services than if the employee were to shop for coverage on his or her own. An employer, representing many employees, naturally has more clout than any individual employee in negotiating prices with health plans. Insuring a group of employees also represents less overhead cost per person for health plans than insuring an individual. This is reflected in the lower prices charged for group coverage compared to individual coverage.

6. SMALL FIRMS LESS LIKELY TO OFFER COVERAGE THAN LARGE FIRMS



Source: Kaiser Family Foundation and Health Research & Educational Trust, "Employer Health Benefits: 2003" (www.kff.org/insurance/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=21185)

In addition, a group of employees will have many people with minimal medical expenses, balancing the small number who will need expensive care. This mix of people with different levels of risk spreads an insurer's financial risk, another factor that generally leads to lower insurance rates for groups.

Disadvantages of Employer-Sponsored Coverage

Despite its many advantages, employer-sponsored health coverage has a number of disadvantages:

1. Millions of working Americans don't have the opportunity to get it. In 2001, more than 20 percent of "wage and salary" workers in the U.S. were not offered health coverage through their own employers.³⁴ A third of firms in the U.S. did not offer coverage in 2003.³⁵ Two-thirds of uninsured workers in 2001 worked for employers who didn't offer health benefits.³⁶

2. Even if employees are offered coverage on the job, they can't always afford their portion of the premium.
3. Losing a job, or quitting voluntarily, can mean losing affordable coverage—not only for the worker but also for their entire family.
4. A person's link to employer-sponsored coverage can also be cut by a change from full-time to part-time work, or self-employment, retirement or divorce.
5. Most employers offer a small number of health insurance plans for employees to choose from—or only one.

Let's examine these disadvantages in more detail. As mentioned, a third of firms in the U.S. don't offer health insurance at all. Health coverage as a benefit has become widespread among large companies—98 percent of companies with more than 200 workers offer coverage.³⁷ But most new jobs in the economy come from small firms, and these small companies are the least likely to offer health insurance (see Chart 6).

Among small employers who don't offer coverage, three out of four (76 percent) say premiums are too expensive. A third (36 percent) say they believe their employees can get coverage elsewhere.³⁸

Premiums for employer-sponsored coverage are rising much faster than workers' earnings or inflation (see Chart 7). Between spring of 2002 and spring of 2003, premiums for coverage offered by employers across the U.S. increased 13.9 percent—more than six times faster than the growth in the Consumer Price Index. (This includes amounts paid for coverage by both

employer and employee.) Employers with three to 199 workers saw an average increase of 15.5 percent; firms larger than that had an average increase of 13.2 percent.³⁹

Health premiums are expected to rise by an average of 13 to 16 percent in 2004, according to several consulting firms.⁴⁰ In contrast, the Consumer Price Index is expected to grow by 2.2 percent.⁴¹

In response to such double-digit premium hikes, many companies are asking their employees to cover some of the new costs. For instance, workers

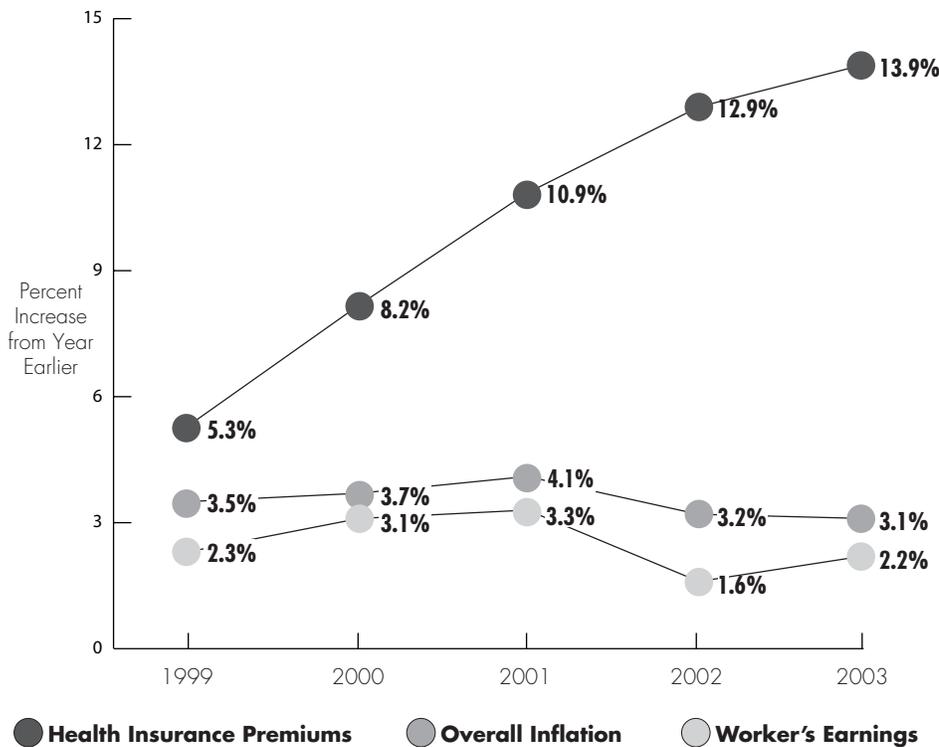
taking single coverage through an employer paid 8 percent more for their coverage in 2003 compared with 2002—\$42 monthly vs. \$39. Family premiums paid by workers increased 13 percent—from \$178 per month to \$201.⁴²

In addition to charging higher premiums, employers are requiring larger copayments, higher deductibles, and restrictions on benefits. As a result of these various cost-sharing measures, many more employees who are offered the chance to buy health insurance on the job may not be able to afford it.

The fact that employers are asking employees to share a higher percentage of the cost of health coverage has been the stated reason for a number of labor disputes in recent months. Almost 60,000 supermarket workers in Southern California were off the job from October 2003 through February 2004, a walkout triggered in part by management demands that workers pay more for health benefits.⁴³ The agreement that ended the strike requires new hires to pay \$450 a year for health benefits while existing employees continue to pay nothing.⁴⁴

At about the same time the Southern California dispute was settled, a strike among 42,000 Stop & Shop grocery workers in New England was averted when the company agreed to continue paying 100 percent of workers' health insurance premiums. Management had proposed that workers pay 20 percent of the premium cost.⁴⁵

7. COST OF HEALTH INSURANCE PREMIUMS IS RISING FASTER THAN EARNINGS OR INFLATION



Source: Kaiser Family Foundation and Health Research & Educational Trust, "Employer Health Benefits: 2003," chartpack p.2. (www.kff.org/insurance/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=21185)

Even in large firms (more than 500 employees) the number of uninsured workers has increased sharply. As of 2001, 26 percent of the nation's uninsured worked for large firms or were dependents of these workers.⁴⁶ Some are not eligible for employer coverage because they work part-time or haven't worked long enough to qualify. Others can't afford their share of the premium, as noted earlier.

Health insurance premiums are rising sharply too for retirees who obtain their coverage through their former employers. In 2003, new retirees under age 65 had to pay 20 percent more for their health coverage than a year earlier. Those retirees age 65 and older had to pay 18 percent more.⁴⁷

The great majority of employers offer no health coverage at all to retirees. Only 28 percent of large employers offered such coverage to early retirees in 2003. An even smaller percentage offered coverage to former employees eligible for Medicare. Both figures have been shrinking over time (see Chart 8), and will likely continue to do so. Some 20 percent of large employers surveyed in mid-2003 said they were likely to end health benefits for future retirees in the next three years.⁴⁸ Noted health economist Uwe Reinhardt of Princeton University believes that "20 years from now, no company will offer retiree health care."⁴⁹

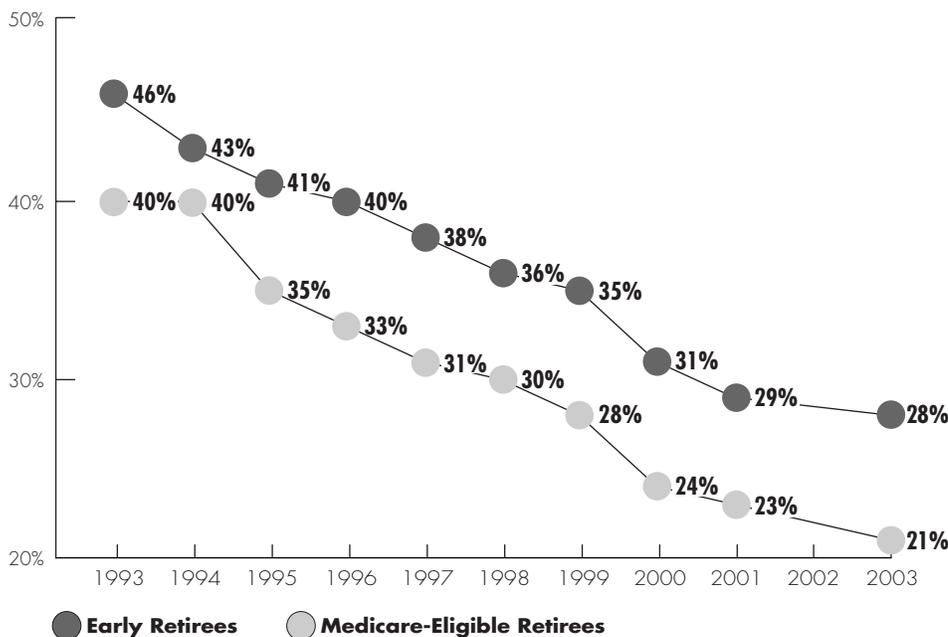
Historically, the highest levels of insurance coverage have been found in manufacturing, the sector of the economy most likely to have labor unions. But union membership is dwindling, dropping in 2003 to the lowest level in two decades—12.9 percent of the workforce.⁵⁰ And the number of manufacturing jobs in the U.S. has declined almost every year since peaking in 1978.⁵¹ Since 2000 alone, manufacturing jobs have shrunk by 12 percent. Many of these jobs are gone forever, as many news stories have pointed out.

Individual Coverage

For those who either have no access to insurance through the workplace, or can't afford their share of the premium, the individual or "non-group" market is one possible alternative. (Though this type of insurance is popularly known as "individual," analysts refer to it as "non-group," since such policies cover both individuals and families.) The Census Bureau says 26.6 million people had non-group coverage in 2002.⁵²

People might seek individual policies if they are self-employed, or if the firm they work for doesn't offer coverage. (As noted earlier, 34 percent of firms didn't offer coverage in 2003.) Layoffs, divorce, the death of a spouse, or a child's growing too old to be on a parent's policy could lead someone to turn to the individual market. One 2001 study concluded that more than one in four working-age adults had sought out coverage in the individual market over a three-year period.⁵³

8. STEADY DECLINE IN NUMBER OF LARGE COMPANIES OFFERING RETIREE COVERAGE



Source: William M. Mercer, 2002.

STATE VS. FEDERAL REGULATION

State and federal regulations profoundly affect health coverage and would likely need to be changed to enact comprehensive coverage reforms. States have primary regulatory authority over all insurance, including health insurance. Some employers, by paying for health services directly rather than by buying insurance, avoid state insurance regulation and are covered under a federal law known by its acronym, ERISA (Employee Retirement Income Security Act). Those who have chosen to be regulated under ERISA account for about 43 percent of all privately insured persons.⁵⁴

Those regulated by states, some 57 percent of all privately insured, find that their policies must by state dictate cover certain health services, such as breast cancer screenings. Businesses complain that the added expense of these mandated benefits drives up the cost of health coverage.

Consumer advocates, on the other hand, say that the mandates are vital for the patients who are guaranteed access to the services covered.

Occasionally, states take giant steps toward trying to make health coverage more affordable. These efforts, like more modest ones, can have unintended consequences.

Washington State, for example, passed a law in 1993 attempting to make individual, or non-group, coverage less restrictive and less expensive. The result: Most insurers stopped writing individual policies in the state.⁵⁵ To keep insurers in the market, the state legislature in 1995 repealed some of the reforms and made big changes to others.⁵⁶

Non-group insurance reform in Kentucky suffered the same fate. In 1994, the Kentucky legislature passed a law creating standard benefits packages

that were to become the only health insurance products sold in the state after July 1995. The law also prohibited insurers from charging more for a policy based on a person's health status, past claims or gender, and restricted insurers' ability to cancel policies. As in Washington State, nearly all insurers exited the market and the legislature had to repeal many of the reforms in 1996.⁵⁷

Those companies that pay for their workers' health benefits directly are under federal supervision and therefore are exempt from state insurance regulations. These "self-insured" companies are thus not bound by laws or regulations governing mandated services.

In order to make substantial changes to the way health insurance works in the U.S., ERISA would likely have to be amended or replaced.

For some, the individual insurance market offers a wider array of health plans to choose from than buying coverage through an employer. And since such insurance is not tied to an employer, it is portable. A person can change jobs, move from full-time to part-time work, or start their own business without losing the coverage.

Some analysts believe that expanding the individual market may offer major benefits to the health care system. They say that coverage chosen and paid for directly by the person covered, rather than by an employer or government, holds the potential for both restraining cost

growth and improving the quality of care. People are more prudent, they assert, when spending what they perceive as their "own" money.⁵⁸

Disadvantages of Individual Insurance

Individual policies usually cost more and may cover less than those obtained through an employer. By definition, insurers and their agents sell individual policies one at a time, rather than as part of a group. This means the insurer's administrative costs for an individual policy are higher than for group policies. These higher costs are reflected in the premiums charged for individual policies.

Also, because people who resort to the individual market tend to have high health care costs, individual market insurers can charge high premiums or deny coverage altogether in most states. This practice is called "medical underwriting."

If they are denied coverage, individuals usually have few places to turn. They can try another company, or turn to their state's high risk insurance pool, if they live in one of the 30 states that have one.⁵⁹ These pools offer health insurance to people who can't get it elsewhere, usually because of a pre-existing medical condition. But the premium cost may

be out of reach. And in a few states, the pool is closed to new people. (For information about your state, go to www.healthinsuranceinfo.net—a Web site maintained by Georgetown University’s Health Policy Institute.)

For all these reasons, a person looking for an individual insurance policy may or may not find one. In the study cited earlier, more than half of those looking said they found it “very difficult or impossible” to find a plan they could afford.⁶⁰

Medicaid

The Medicaid program offers a relatively generous package of benefits covering low-income mothers and children, persons with disabilities and certain seniors. Some 51 million people were covered by Medicaid at some point in 2002, according to the federal Centers for Medicare and Medicaid Services.⁶¹ (This is the number accepted by most health services researchers. The U.S. Census Bureau, however, based on its survey of households, puts the number at 33.3 million.)⁶²

In contrast to employer-sponsored coverage, Medicaid enrollment grew each year during the recession of 2001 and 2002.⁶³ Without this growth, the number of uninsured in those years would have been even higher.

Medicaid is funded by both state and federal dollars. Medicaid spending varies significantly among the groups covered. Children—the healthiest of Medicaid beneficiaries—account for 50 percent of the enrollees but just 18

percent of the spending. Those over 65 and people with disabilities, by contrast, are, as a group, in poorer health and need more services. They comprise only 25 percent of beneficiaries but account for 70 percent of spending (see Chart 9).⁶⁴

Medicaid also pays for nearly half of all long-term care services, including custodial nursing home care. Nearly 70 percent of all nursing home residents receive support from Medicaid.⁶⁵

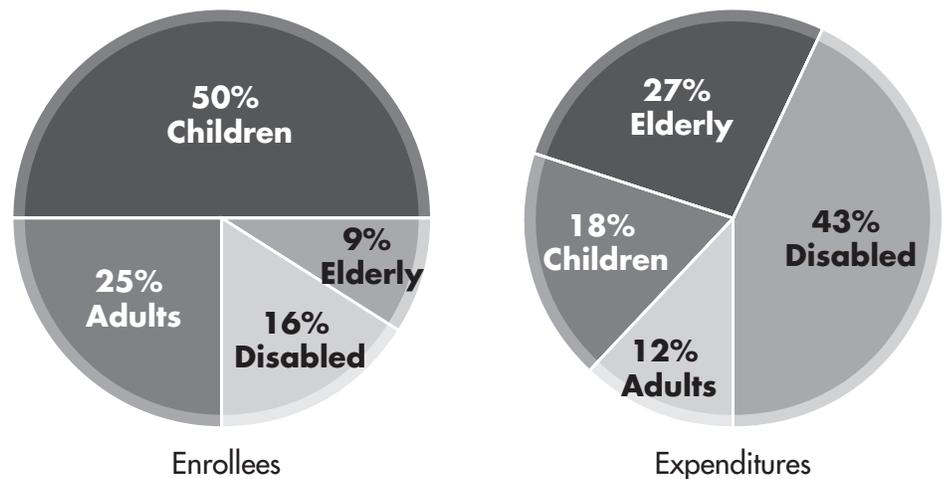
Eligibility rules for Medicaid are complex, reflect a mix of federal requirements and state options, and vary widely from state to state. They are linked to both income and other factors like family makeup and disability status. Federal law makes some people automatically eligible. Major categories of people whom states must cover include:

- Pregnant women and children up to age 6 in families with incomes up to 133 percent of the federal poverty level
- Children ages 6 to 18 in families with incomes up to 100 percent of the poverty level
- People who would have been eligible for welfare according to the criteria in effect before welfare reform in 1996
- People receiving Supplemental Security Income (SSI) due to disability or being elderly

Disadvantages of Medicaid

Medicaid consumes a high proportion of spending by state governments—12 percent of all state-financed spending in fiscal year 2002.⁶⁶ (Connecticut had the highest

9. MEDICAID ENROLLEES & EXPENDITURES



Source: www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=30463

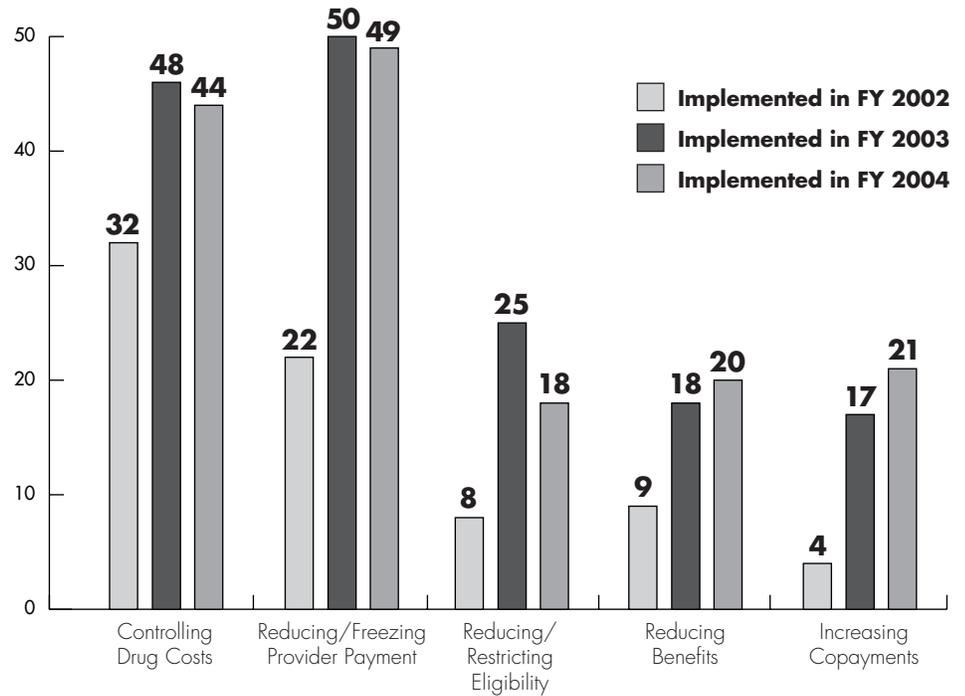
percentage—20.5—and Alaska the lowest—4.4.) That share, after growing fast during the early 1990s, remained fairly stable for several years beginning in 1995.

But the situation changed radically with the economic slowdown in 2001-2002, which forced governors and legislators to cope with large imbalances between declining revenues and increasing spending needs. Although the federal government can incur deficits from one year to the next, states cannot. With the exception of Vermont, all states and the District of Columbia are required by their own constitutions to balance their budgets each year.

Though many states have tried to protect Medicaid, a program that serves such vulnerable populations and brings substantial federal matching funds into the state, its sheer size has forced all states to restrain Medicaid spending growth.

Options for restraining Medicaid spending are few and unattractive: cut payments to providers and plans, restrict benefits, or curtail eligibility. A recent study shows that 50 states reduced or froze Medicaid payments to health care providers in fiscal year 2003, 46 states controlled drug costs, 25 reduced or restricted Medicaid eligibility, 18 reduced benefits, and 17 increased the copayments that beneficiaries must pay for their care (see Chart 10). These moves were on top of cost-cutting measures implemented earlier.

10. STATES UNDERTAKING MEDICAID COST CONTAINMENT STRATEGIES (FY 2002-FY 2004)



Source: Kaiser Commission on Medicaid and the Uninsured (2004). States Respond to Fiscal Pressure: A 50-State Update of State Medicaid Spending Growth and Cost Containment Actions. January 2004 www.kff.org/medicaid/7001.cfm

More cutbacks are planned for fiscal year 2004. The study found that 43 states plan to control Medicaid drug costs, 39 will reduce or freeze provider payments, 21 will increase copayments, 18 will reduce or restrict Medicaid eligibility, and 17 will reduce benefits.⁶⁷ To save even more money, some states have also reduced their efforts to inform the population about the program.

The states' fiscal crunch is not likely to improve anytime soon. The National Association of State Budget Officers reports that 32 states assume that they will have a shortfall in their Medicaid budgets

for fiscal year 2004.⁶⁸ FY 2005 could be even worse.⁶⁹

The Congressional Budget Office estimates that national Medicaid spending will grow by 8.5 percent yearly for the rest of this decade. This rate of growth, although smaller than that seen in fiscal years 2002 and 2003, is faster than tax revenue is expected to grow in the typical state.

Even before the states' recent financial dilemma, Medicaid was criticized by health care providers who say it doesn't pay them enough. As a result, many physicians accept Medicaid patients only rarely, if at all.

Children's Coverage

Some 46 million children—about two-thirds of children under age 18—were covered by a parent's employer-sponsored policy in 2002. Some 17.5 million children were covered by Medicaid or the State Children's Health Insurance Program, the Census Bureau says (see Chart 11).⁷⁰

Congress created SCHIP in 1997. Financed jointly by the federal and state governments, the program is intended for children whose parents earn too much to qualify for Medicaid yet too little to afford private coverage. The federal government has authorized \$48 billion over 10 years for SCHIP. The program must be renewed in 2007, if it is going to continue.

The federal government picks up a larger share of SCHIP costs than Medicaid costs. The federal share ranges from 65 to 84 percent, depending on the state, compared with 50 to 77 percent for Medicaid.

States were given considerable flexibility in the use of SCHIP money. They could create an entirely new program, expand their current Medicaid program to include children eligible under SCHIP, or use a combination of both approaches. Sixteen states established separate state programs, 16 expanded Medicaid, and 19 combined the options. Children applying for a separate state program or a combination program must first be screened to make sure they are not eligible for Medicaid. No one eligible for Medicaid can be enrolled in SCHIP, a rule designed to

discourage states from claiming the richer SCHIP matching dollars for Medicaid-eligible children.

SCHIP eligibility generally extends to children in families with incomes up to 200 percent of the federal poverty level. (Eleven states have a lower income ceiling—Alaska, Colorado, Idaho, Montana, Nebraska, North Dakota, Oklahoma, Oregon, South Carolina, Wisconsin and Wyoming.)⁷¹

Some states have brought children into the program with much higher family incomes. New Jersey's NJ FamilyCare program, for instance, allows children into the program with family incomes as high as 350 percent of the federal poverty level.

Unfortunately, the trend is toward discouraging SCHIP enrollment, rather than encouraging it. As of January 2004, six states had frozen enrollment for an indefinite period—

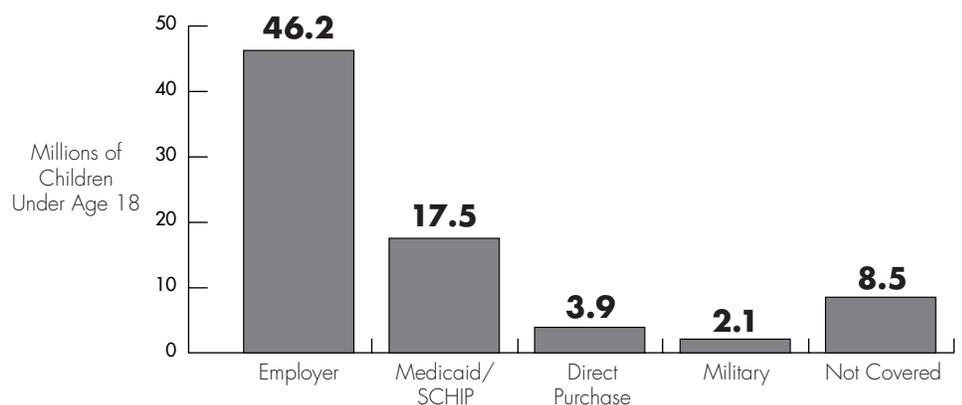
Alabama, Colorado, Florida, Maryland, Montana and Utah.⁷²

Medicare

Virtually everyone over 65 is eligible for Medicare, along with certain individuals who have permanent disabilities and those with end-stage renal disease. Eligibility for Medicare does not depend on a person's income or assets. (This sets it apart from most other government health care financing programs, which are restricted to those with limited finances.) Medicare, which is financed by the federal government and those enrolled in the program, covered 40.5 million people in 2004.⁷³

Medicare is not often part of discussions about the uninsured, so it is not covered in detail in this guide. (General information about Medicare is available at www.medicare.gov.)

11. HOW CHILDREN GET COVERAGE



Note: Children with more than one type of coverage are counted more than once.

Source: U.S. Census Bureau "Historical Health Insurance Tables, Table HI-3 (www.census.gov/hhes/hlthins/historic/hihist3.html)

Approaches to Covering the Uninsured

While the current system of covering Americans has many advantages, clearly its complexity and, more importantly, the fact that tens of millions each year are uninsured suggest that we could be doing a better job in making health care coverage accessible to everyone. Indeed, policy-makers have been trying to do this for more than a half century.

Certainly, there is no shortage of opinion about how to expand coverage; politicians, academics, policy-makers and others have considered a wide range of policies to cover the uninsured. Proposals differ in terms of political philosophy, cost, the number of people who will be insured and many other factors.

As with most complex public policy issues, there is no agreed-upon “best” way to make certain all have health coverage. Proposals differ in whether we should cover only some portion of those who lack coverage now, all Americans whether insured or uninsured, or some variation in between.

In order to better understand the range of policy options available to lawmakers, it’s helpful to look at a series of general approaches to covering the uninsured, ranging from making progress step by step to a wholesale overhaul of our system. It is important to remember that the following isn’t an exhaustive list of options but rather a representative selection of approaches. You can find more information on different approaches to covering the uninsured at the Web site of the Economic and Social Research Institute (ESRI), www.esresearch.org. ESRI analyzed a range of specific proposals from across the political spectrum. The Lewin Group, a prominent consulting firm, estimated the reduction in the number of uninsured that would occur under each of

those proposals, as well as the associated costs or savings for the federal and state governments, employers, and households. Those results are available at www.rwjf.org.

More information on all aspects of the topic of the uninsured is available at the Web site of *Cover the Uninsured*, www.CoverTheUninsured.org.

Employer contribution requirements, better known as employer mandates, would require employers to either provide insurance to their workers or pay a payroll tax that covers all or most of the cost of enrolling their workers under a newly created public plan. Such proposals are also called “pay or play.”

Proponents say that such a requirement would treat all employers fairly; that is, they would have to offer coverage to workers and pay for a portion of that coverage, or else pay the tax. No employer could gain an unfair advantage over its competitors—as it can now—by refusing to cover its workers. Employees and their dependents would have access to health care coverage.

Opponents say that “pay or play” is unfair because it would create an economic burden on employers that don’t now offer insurance to their workers. Employers also generally oppose requirements of any sort, on the grounds that it is up to them to create the appropriate benefit package to attract the types of workers they are looking for. And by adding to the cost of employment, this plan would discourage firms from hiring more workers.

Individual mandates would require everyone to have some basic form of health insurance. Such insurance could

QUESTIONS TO ASK ABOUT ANY HEALTH COVERAGE PROPOSAL

1. How many uninsured people will likely gain coverage?
2. How much new spending of any kind will be necessary to cover each newly insured person?
3. Who will be asked to pay the added costs needed? Government? Employers? Individuals?
4. What is the likelihood that those newly covered will be able to keep their coverage for more than a few months?
5. What is the chance that some people presently insured will lose their coverage as a result of a proposal being implemented? If so, how many?
6. Is funding for the proposal permanent? Can it be sustained over many years?
7. If the proposal is adopted, how might other “players” react, such as physicians, hospitals, insurance companies, employers?
8. What help does the proposal offer to those with special situations, such as unusually high medical expenses?
9. Does the proposal help keep medical expenses in check for those presently paying for coverage, including governments, employers and individuals?

be provided by employers, the public sector or private insurers. An individual mandate is akin to how automobile insurance works—every driver has to buy some sort of coverage, from the legally required minimum amount to a gold-plated policy.

Proponents say that requiring everyone to have insurance would give Americans more “skin in the game” and make them care more about costs and quality. With tens of millions of Americans seeking coverage, insurers would flock to respond, providing a range of policies. Doing so would lower the price of coverage, it is argued, due both to increased competition among carriers and to the addition of so many relatively healthy, low-cost people to the risk-sharing pool.

Opponents say that merely requiring individuals to have coverage wouldn’t necessarily mean that individuals would follow up by getting it. For instance, compliance is far from universal in the automobile insurance market. In fact, 14.5 percent of drivers in states where insurance is compulsory violate the law, according to the Insurance Research Council.

Reasons individuals might not sign up for coverage, despite a mandate, might include cost, fear of being deported (for those who are in the United States illegally) or a lack of concern about the consequences of being uninsured. What’s more, it is argued, government should not stop individuals from deciding how best to spend their own money.

Expansions of existing public programs are another proposed solution for covering the uninsured. Some policy experts suggest that the current structure, with minor adjustments, can help a larger percentage of the uninsured. They argue that public programs such as Medicaid, SCHIP and community clinics can, with additional funds, cover or treat the uninsured. Funding could be provided through a variety of mechanisms, including state, local and federal tax revenue, and tax increases on private insurers.

Proponents say that working within the current framework is the easiest and most efficient way to expand coverage. Federal, state and local officials have already

worked through many of the management changes, and no new bureaucracy is required.

Opponents say that current programs are confusing and inefficient, and have been unable to enroll millions who are already eligible. Moreover, red ink at virtually all levels of government makes it almost certain that additional funds will be difficult to secure.

Tax credits seek to make private health insurance more affordable by allowing individuals and/or employers to deduct the cost of their health insurance premiums directly from the amount they owe in income taxes. The credits can be a fixed amount of money or a percentage of the premium. They can be made refundable (even if the person owes no income taxes, they would get a refund equal to the premium) or advanceable (available at the time when the person is actually paying the premiums instead of having to wait until April 15) or adjusted in other ways. Proponents say that this approach enhances affordability while retaining choice. Because the credit would have some sort of dollar limit, the person would be responsible for the cost beyond the value of the credit. They argue this would make consumers more price conscious when choosing a health plan, and therefore restrain health care inflation. In theory, restraining costs would make it easier to expand coverage.

Opponents say that individuals and employers often don't have the information they need to make good choices, nor the market clout to get good prices. Another problem is that many proposed policies offer tax credits that are too small, relative to the cost of insurance, to induce many uninsured people to buy insurance.

A tax-financed health care system would replace the current mixed financing system in which employers, the government and individuals pay for health care coverage. The most commonly advocated tax-financed system is some form of the "single-payer" approach. Under a completely tax-financed system, providers would remain private, but the government would administer payment for health care—much like the system in Canada. Proponents say that tax-financed systems are the likeliest way to get virtually everyone covered; more efficient, since much of the current complex administrative structure would be eliminated; and more effective at controlling costs, since government would be able to negotiate prices with doctors, hospitals, drug companies and other providers of health care.

Opponents say that such proposals would represent radical change, create too great a role for government, cost the public treasury too much, diminish choice and reduce competition. When government is the sole buyer, they argue, it does not negotiate prices; it sets them. They also claim that the private sector can more efficiently administer health care.

CONCLUSION

The current system of health insurance covers the majority of Americans, but far too many are left without any help at all. Despite efforts stretching over decades, history has shown how hard it has been to solve this persistent problem.

There is no ideal solution to the problem of the uninsured. Most proposals combine coverage expansion with other objectives, such as limiting growth in total national health care spending, limiting the amount of new

federal dollars, targeting new spending to just the previously uninsured or increasing consumer choice. Such goals cannot all be achieved simultaneously. Decision makers must balance these objectives and make trade-offs among them, and citizens need to understand these trade-offs and become involved in public discussions.

It is our hope that this guide will help make those discussions more informed and more focused on finding a consensus for action.

To order or download additional copies of this guide please visit the *Cover the Uninsured* Web site at www.CoverTheUninsured.org/Materials.

GLOSSARY

ADVERSE SELECTION – When a disproportionately high number of individuals who are in poorer than average health enroll in a health plan.

COPAYMENT – A portion of the bill for a medical service that is not covered by the patient’s health insurance policy and, therefore, must be paid out of pocket by the patient. Copayment refers to a flat dollar amount, e.g. \$5 per office visit.

DEDUCTIBLE – A fixed amount, usually expressed in dollars, that the beneficiary of a health insurance plan must pay directly to the health care provider before a health insurance plan begins to pay for any costs associated with the insured medical service.

EMPLOYER CONTRIBUTION REQUIREMENT OR “EMPLOYER MANDATE” – A requirement that employers either provide insurance to their workers or pay a payroll tax that automatically covers their workers under a newly created public plan. Such proposals are also called “pay or play.”

PAY OR PLAY – A requirement that employers either provide insurance to their workers or pay a payroll tax that automatically covers their workers under a newly created public plan.

REFUNDABLE TAX CREDIT – A way of providing a tax

subsidy to an individual or business for a defined purpose, such as health coverage, even if the person owes no taxes. (See “tax credit” below.) If a person doesn’t owe any tax, the government sends the person (or a third party) a check for the amount of the refundable tax credit.

SINGLE PAYER – A health care system in which a government entity finances most health care as the “single payer” for most health care services. Typically, the government takes in taxes for health care purposes. The government then pays health care providers, such as hospitals and physicians, to provide care to those enrolled in the government health care plan. An example is the Canadian health system.

SUPPLEMENTAL SECURITY INCOME (SSI) – A federal program providing cash assistance to low-income individuals who are elderly, blind or disabled.

TAX CREDIT – An amount that can be subtracted from the tax a person or business owes. A tax credit is much more valuable than a tax deduction of the same amount, since the deduction simply reduces the income on which a person or business pays taxes.

TAX EXCLUSION – Excluding the value of an employer-sponsored benefit, such as health coverage premiums paid by an employer, from an employee’s taxable income.

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