

Health Insurance for the Uninsured: Time for Action?

Americans can be proud of the many accomplishments of our health care system. The United States is the world leader in basic medical research and technology. Life expectancies continue to increase, in part due to medical advances. Most Americans have access to some of the most sophisticated medical care available in the world, and almost all Americans have access to some form of health care. For most Americans, a major illness no longer translates into a catastrophic financial setback for the family.

While the United States has much to be proud of in the health care area, it also faces real challenges. Health costs continue to sky-rocket, and our public health infrastructure is inadequate in many areas. Perhaps the most daunting challenge that the U.S. faces is the growing number of persons with little or no health insurance. Without access to insurance, individuals face major financial risks and limited access to care.

In 2002, almost 44 million Americans—15 percent of the population—went without health insurance for the entire year, and millions more were underinsured or had lengthy gaps in coverage. While a majority of American families have been adequately and often generously covered by their employers, and most elderly and very low-income people have been covered by Medicare and Medicaid, the uninsured, for the most part, have paid for health care out of their own pockets or at critical times through available charity care. Many of the uninsured are at significant financial and health risk, and the growth in the number of uninsured places growing pressures on our methods of financing health care.

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About a half dozen times in the 20th century, the federal government considered major legislative action to provide coverage for the uninsured. Several modest expansions have been adopted over the years, but only once—in 1965—did the U.S. take a dramatic step in addressing this issue. LBJ's Great Society provided health insurance for the elderly, the disabled and some of the nation's poor. Since 1965, only a few incremental steps have been taken to address this problem.

Are we getting closer to real reform in this area? It is likely that the issue will receive considerable attention in the upcoming Presidential elections, and public interest is growing as the number of persons without health insurance continues to grow. Most of the major candidates have staked out positions on the issues, and no candidate in either party calls for a continuation of the status quo. The options differ sharply in approach and outcomes, and no plan is without significant trade-offs. The hard reality is that the U.S. faces a difficult set of choices regarding the future of health insurance in America.

RECENT TRENDS IN HEALTH INSURANCE COVERAGE

Among the 248 million non-elderly individuals in the United States in 2001, 65 percent obtained health insurance through an employer, 14 percent were covered by Medicaid or another public program, and 6 percent purchased private insurance on their own. The remaining 15 percent were uninsured. Although fewer children than adults were covered by private insurance, Medicaid and other public programs more than offset this difference. As a result, while 19 percent of adults went without coverage in 2001, only 12 percent of children were uninsured.¹

The percentages of people with and without health coverage have fluctuated for different reasons at different points in time (see Figure 1). For example, between 1987 and 1993, growth in the number of uninsured individuals can be attributed to the erosion of employer-based health benefits. Although public programs were covering an increasing percentage of Americans during this period, their growth was not enough to offset declines in employer coverage. In contrast, from 1994 to 1998, while the percentage of Americans with employer-based health insurance increased, so did the percentage of uninsured individuals. During this period, declines in public and individually-purchased coverage were large enough to offset gains

in employer sponsored insurance.² Since 2001, the percentage of Americans without health insurance has increased. Public coverage increased from 14.1 percent to 15.3 percent, but this growth was not enough to offset the decline seen in employer-sponsored insurance.³

1. EMPLOYER-BASED INSURANCE COVERAGE

Employer-based health insurance has been the cornerstone of the U.S. system for the past half century. Most Americans under the age of 65 obtain health insurance through their employer or a family member with employer-based insurance. However, work does not guarantee access to this type of coverage.

Overall, nearly 40 percent of America's 108 million workers (excluding the self-employed) did not have health insurance through their own job in 1997. Among these individuals, 45 percent were employed at a firm that did not provide health insurance to any of its workers, 33 percent were offered coverage but declined it, and 22 percent were employed at a firm that sponsored a health plan but did not offer it to the worker.⁴

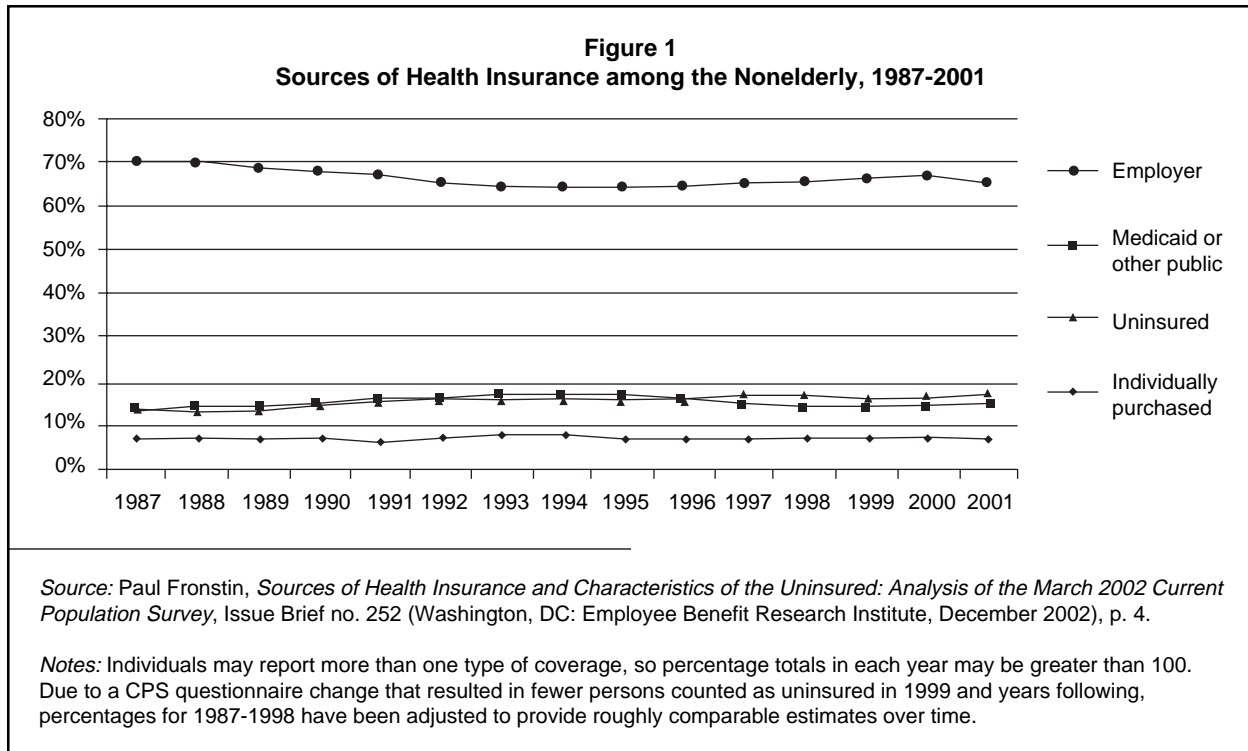
There have been recent signs of erosion in employer-provided health insurance coverage, particularly among small firms. For firms with between 3-199 employees, the percentage offering health benefits declined from 67% in 2000 to 61% in 2002.⁵ And in the last three years more firms are reporting that they have reduced their health benefits packages. Though most workers experienced no change in their employee benefits in 2002, 17 percent reported a reduction in their benefits in comparison with seven percent of workers who experienced an increase in their health benefits.⁶

2. INDIVIDUAL-BASED INSURANCE COVERAGE

In 2001, 16 million non-elderly Americans (6.6% of this population) were covered by an insurance policy they or a family member purchased on their own. Unlike employer-provided insurance, the cost, availability and comprehensiveness of insurance purchased in the individual market depends on a person's age, health status and coverage history. A lengthy underwriting process (i.e. a review of all of the factors above) determines how much the policy will cost, what will and will not be covered or whether coverage will be offered at all. Younger and healthier workers are clearly advantaged in this market, compared to older persons or individuals with significant health risks.⁷

3. PUBLIC INSURANCE COVERAGE

While nearly all Americans are eligible for health



coverage through the Medicare program when they reach age 65, most non-elderly individuals qualify for public coverage on the basis of income, disability, or military service. In 2001, 96.6 percent of people age 65 and older obtained coverage from Medicare or another government program, and less than 1 percent were uninsured.⁸ In contrast, *only about half of the non-elderly uninsured population is covered by public programs.*⁹

Two joint federal-state programs, Medicaid and the State Children's Health Insurance Program (SCHIP), are the sources of public coverage among those under age 65, serving more than 28.3 million non-elderly people (mostly disabled individuals and people in families with children) in 2001.¹⁰ Rates of private insurance coverage among the non-elderly vary considerably from state to state.

There are also recent signs of erosion in public program benefits. In the past two years, at least a dozen states have enacted legislation or obtained permission from the federal government to drop Medicaid coverage for hundreds of thousands of optional beneficiaries (individuals who are eligible under the states' Medicaid plans, but who the federal government does not require states to cover).¹¹ For example, Tennessee dropped 200,000 beneficiaries, Michigan eliminated 38,000 beneficiaries, and Massachusetts cut 36,000 childless adult beneficiaries.¹² In Texas, recent legislative changes will

mean that SCHIP will enroll 169,000 fewer children and Medicaid will enroll about 300,000 fewer beneficiaries by 2005.¹³ If state budget pressures continue in the future, cut-backs in public programs will likely continue.

FUTURE PROJECTIONS OF HEALTH INSURANCE COVERAGE

The number of Americans without health insurance is likely to grow in the future, absent major changes in policy. A 2001 study published in *Health Affairs* found that the non-elderly uninsured population could decrease slightly by 2009 under "extremely optimistic" assumptions, increase to about 44 million under moderate assumptions, or increase to about 52 million under pessimistic assumptions.¹⁴ A 2000 study commissioned by the Health Insurance Association of America estimated that the number of non-elderly uninsured could range from 48 million to 61 million in 2009.¹⁵ Similarly, a 1999 study by the National Coalition on Health Care estimated that the non-elderly uninsured population could constitute between 52 million and 61 million individuals in 2009.¹⁶

POLICY ALTERNATIVES

As the number of persons without health insurance continues to grow, so has interest in addressing the issue. There is a very wide range of proposals to provide access to health insurance to the millions of Americans who are uninsured. Though the proposals share a common goal of increasing access to health insurance, they vary significantly in approach and scope.

The range of proposals to increase access to health insurance can be grouped into three broad categories: 1) proposals to assist individuals to purchase individual insurance; 2) proposals to strengthen the employer-based system of health insurance; 3) proposals to expand public programs or even replace most of the current health insurance system with a national health insurance system.

1. INCENTIVES TO ASSIST INDIVIDUALS TO PURCHASE INSURANCE

One approach to increasing access to insurance is to help individuals to obtain insurance through the individual health insurance market. Approximately 6.6 percent of Americans now purchase health coverage on their own.¹⁷ The affordability and availability of coverage in the individual market depends greatly on the person's age, health status, place of residence, and other factors.¹⁸ For young and healthy individuals, purchasing health insurance in the individual market can be a viable option for obtaining temporary or long-term coverage. However, for older and sicker individuals, the cost of such coverage is often prohibitive.

For those purchasing their own insurance, President Bush has proposed a tax credit of up to \$1,000 for individuals and up to \$3,000 for families, targeted to individuals and families with incomes below about 300% of the poverty level.¹⁹ According to the Administration, the credit would cost about \$10 billion a year and would provide coverage to 6 million of the uninsured—about 15% of the uninsured population.²⁰ Other participation estimates of the Bush proposal are considerably smaller. The US Joint Tax Committee assumes costs and participation rates about 30% lower,²¹ and a recent estimate provided in Congressional testimony assumed participation rates of about 65% lower than Administration estimates, thereby leading to a reduction of about 2 million uninsured persons—a 4% reduction in the total number on the uninsured. While the numbers of individuals affected are modest relative to the options discussed below, it is important to

point out that larger individual tax credits would certainly benefit more people.

There is serious debate over the long term impact of such a change. Proponents argue that the individual tax credit approach helps individuals to purchase individual insurance and thus will make up for some of the continued erosion of employer-based and public health insurance. In addition, tax credits may promote individual choice and help to control health care costs by empowering people to make cost-conscious decisions about their own health care. Opponents argue that the credits would not be large enough for most low and moderate income individuals to purchase health insurance and that insurance policies would provide only very limited benefits to low and moderate income people. In addition, opponents argue that individual tax credits would further weaken the employer-based insurance system, because younger and healthier workers would opt out of employer coverage, leaving older and less healthy workers in employer plans, thereby driving up costs and encouraging more employers to drop health insurance coverage.²²

2. EXPANDING EMPLOYER-BASED COVERAGE

Employer-based health insurance is currently the foundation of coverage for non-elderly Americans. While some point to signals of decline in employer-based coverage as a sign of the eventual erosion of job-based health insurance, others believe that the best way to expand access to insurance is by strengthening and expanding this form of insurance. A number of health policy reform proposals are designed to increase access to the employer-based system of coverage. Proposals in this category include employer mandates (requiring employers to offer health insurance to their employees), and/or expanded employer tax subsidies for health insurance. The most notable proposal in this area in recent years was the Clinton health care proposal, which coupled employer mandates with new employer subsidies.

Recently, Representative Dick Gephardt unveiled a proposal that provides a 60% refundable tax credit to employers, coupled with an additional 25% credit to lower wage workers to pay for insurance. The proposal, which more than doubles the relative value of current law tax incentives for the purchase of employer-provided insurance, would likely ensure coverage for the vast majority of the working uninsured. The costs of such an approach are considerable; according to one analysis, the annual costs after full implementation would be about \$100 billion a year.²³

Moving toward universal coverage by requiring or greatly expanding employer-based health insurance is also very contentious. Some proponents argue that the provision of health insurance should be part of the social contract for employers, with health insurance as a legally mandated employee benefit, similar to Social Security or unemployment insurance. Opponents argue that significant expansions in this area would lead to cuts in wages, non-health benefits and overall employment levels, particularly for low wage workers. Supporters counter that expanded tax incentives would ameliorate these concerns, but opponents argue that major new tax subsidies would be very expensive and lead to significantly higher levels of health care inflation.

3. PUBLIC PROGRAM EXPANSION

A third category of proposals to increase access to insurance is public program expansion. The most common sources of public health insurance coverage for the non-elderly are the Medicaid and CHIP programs, which together insured more than 28 million non-elderly individuals (mostly women, children, and disabled adults) in 2001.²⁴ A variety of options have been discussed to greatly expand these programs to cover more of the uninsured. In addition, there are proposals to expand public insurance by establishing a national health insurance program. Under most national health insurance plans, health care would be financed by taxpayers and administered by government at the federal, regional, or state levels. All Americans would be eligible for the program—insurance would no longer be tied to jobs—and private insurance would be eliminated or significantly scaled back.

A number of Presidential candidates have proposed expansions in public programs to reduce the number of uninsured. For example, former Governor Howard Dean has proposed to extend health coverage to all children and young adults and other adults with incomes below 185% of the poverty level through expansions in Medicaid and SCHIP, which would expand coverage to roughly 12 million of the uninsured. Senator Joe Lieberman has proposed a similar plan, but with more expansive Medicaid changes to cover more families. Former Senator Carole Mosley Brown and Representative Dennis Kucinich have both proposed variants of the single-payer national health insurance plan. For example the Kucinich plan calls for “Medicare for All”, a single payer system that over time would remove private insurance companies from the system, to be financed by a 7.7% employer tax.

The strongest argument for expanding public pro-

grams is the capacity to target limited additional resources to persons most in financial need. More than half of uninsured non-elderly Americans (23 million) are in families with incomes below 200% of the poverty line, and 12 million live below the poverty level. Public programs such as Medicaid and SCHIP can effectively target support to these families and individuals.²⁵ Opponents counter that dramatic expansions of public programs would be prohibitively expensive and that the employer-based system will be further eroded if public programs are expanded to take in more working families.

The key advantage of a national health insurance system is that it would guarantee health insurance to all Americans. It could potentially reduce the overall costs of the American health insurance system because it would reduce system complexity. But national health insurance is strongly opposed by many due to the magnitude of the disruption to the current system and whether such a drastic change would be acceptable to many Americans. Most Americans support few if any limits on the use of health services or choice of providers. There are serious questions regarding quality of care as well as the form, nature and effect of regulatory cost containment mechanisms.

ISSUES AND CHOICES

The options described above may all deal with the same issue, but the approaches are profoundly different, and raise a number of enormously important and complex questions. One key issue relates to the relationship of the reform to the existing system. Any major reform to substantially reduce the number of uninsured will have implications for how the overall system is structured. Strengthening one part of the system—individual insurance, employer coverage or public programs—could potentially reduce the role now played by the other parts of our insurance system. What part of our current system do we wish to build on in the future?

In addition, the various options likely lead to very different outcomes for the uninsured population. For example, should policies provide comprehensive health insurance benefits and/or minimum cost-sharing or should they have limited benefits and/or require substantial contributions from the individual? Public programs historically have provided the most comprehensive set of benefits, with individually purchased policies the least comprehensive in nature. The comprehensiveness of insurance and the level of cost-sharing have implications

for who would most likely benefit. Less comprehensive insurance plans or plans that have substantial cost-sharing may benefit people who are young and healthy because their need for health services is relatively low, but they may not be as beneficial to heavier users of the system. And less comprehensive coverage might make the public more prudent in their daily health care decisions, thereby potentially lowering health care inflation.

Perhaps most important, what are the values and principles underlying the various reform proposals and where they would lead us as a society in the future? The core values question underlying this overall issue seems clear: who ultimately should have primary responsibility for Americans' access to health insurance—the public, employers or individuals? What do we want our society to provide to its citizens in this area, and what are the values inherent in those choices?

It is clear that we face major choices in this area—choices that will lead to very different outcomes. How close are we to actually making these choices?

WILL WE TAKE ACTION SOON?

Over the course of its history, the United States has taken several dramatic steps to address important social policy issues. Two such examples in the 20th century were the creation of Social Security and the enactment of sweeping civil rights protections. What were the conditions that existed at the time that enabled the nation to tackle those longstanding issues? And to what extent do these conditions exist today?

At a very basic level, two key elements had been present in the 1930s and the 1960s that provided sufficient alignment for major reforms to be adopted. First, there was a deep and growing public concern that something major had to be done, even if it necessitated real sacrifice. And second, assertive Presidential leadership was needed, coupled with a strong governing coalition that was in general agreement with the direction of reform proposed by the President.

Will these conditions exist in 2004?

It is clear that public pressures continue to mount on the issue of health insurance for the uninsured. The number of persons without health insurance continues to grow. Many middle class families are without coverage or are concerned about insurance coverage cut-backs. Health care providers have growing concerns about their capacity to provide quality care. Health care costs continue to grow

unabated, and employers and states are increasingly reluctant to maintain current levels of insurance coverage.

But real questions remain. Are the uninsured in a position to place sufficient political pressure on the system to force action? And for the average voter, are there other concerns that have higher priority? And in an area as complex as health care, is there anything approaching a public consensus on the public versus private role in the provision of health insurance? To some extent, it is not surprising that there are profoundly different approaches to address this issue, because today's public is not united on how to proceed.

What about Presidential leadership? The role of presidents is not simply to ride an emerging public consensus; presidents lead efforts to bring about public consensus as well as consensus in Congress. Would a President Bush or a President Gephardt or a President Dean be in a position to lead efforts to secure passage of major reforms? Given the absence of national consensus, the polarization of the electorate and a deeply divided Congress, any President faces an uphill climb on this issue. Absent stronger public pressure or a major political realignment that gives one national party strong control of government, major action in the short term appears unlikely.

So what is the likely outcome in the short term? We will likely see modest and incremental changes to the public, employer *and* individual insurance systems, with continued high numbers of persons without health insurance and continued public unease. Only when public unease turns to real pressure on our elected officials to act—and our leaders are willing to lead—will we see real action. And any major action on this issue will necessitate real sacrifices from the American people.

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NOTES

1. Unless otherwise noted, the estimates cited in this chapter are based on various analyses of the Census Bureau's Current Population Survey (CPS).
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