

Chapter 1. The Uninsured: A Growing Challenge

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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 new 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. The U.S. spends more on health care than any other nation, and costs continue to grow. Demographic changes place growing demands on our systems of care, including long-term care. The U.S. still faces significant public health challenges such as obesity, HIV/AIDS, and tobacco use and our public health infrastructure is inadequate to meeting the tasks at hand.

While all of these issues are serious and need attention, 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 2001, 41 million Americans under age 65 (16.5 percent of all people in this age group) 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 remaining uninsured individuals have, for the most part, been able to get by on their relatively good health and the availability of charity care at critical times.¹ Despite this, it is still the case that many of the uninsured are at significant financial and health risk, and the growth in the uninsured places growing pressures on our methods of financing health care.

It is not clear that our current system of health insurance can—or should—be sustained in its current form, and there is growing interest among many policymakers to take major steps to address this issue. But no option is free, and none are without significant trade-offs. As a result, policymakers face a difficult set of choices regarding the future of health insurance in America.

This book contains description, analysis, and debate on a number of federal policy options for increasing access to health insurance in the United States. It is based in part on a conference held in April 2003 in Austin, Texas, at the LBJ Presidential Library and the Center for Health and Social Policy at the LBJ School of Public Affairs entitled *Big Choices: The Future of Health Insurance for America's Families*.

To provide context for the policy options, this chapter describes the historical development of the American system of health insurance and provides background on the growth in health care costs in the U.S. The chapter also includes a description of who is covered and why some people remain uninsured, as well as the challenges to increasing access to health insurance.

Historical Development of Health Insurance in the United States

Early 20th Century Advances

In the early part of the 20th century, few Americans had any form of health insurance. In the early 1900s, the primary objective of insurance-like initiatives was to protect against the loss of income due to illness or injury, not to provide reimbursement for medical expenses. This lack of emphasis on medical expenses was due in part to the fact that truly effective services were limited, with hospitals serving mainly as sick houses for the poor and those infected with contagious diseases.²

Fraternal orders and benefit societies at the time were extensively involved in providing life insurance and aiding the sick and disabled. By 1914, there were 179 fraternal associations nationally with nearly eight million members affecting 25 to 30 percent of American families. However, only about one percent of the \$97 million they paid out in benefits that year went for medical care.³

Employer-sponsored health benefits for American workers were quite limited well into the early 20th century. The railroad, mining, and lumber industries were exceptions, with geographical isolation and legal liability issues being the principal reasons for extensive company involvement in medical care. Other employers generally avoided taking on any significant responsibility in this area.⁴

Over time, advances in science, technology, and hygiene (including the use of trained nurses, antiseptic techniques, and surgical anesthesia) created more effective means of medical intervention, allowing hospitals to evolve into physician “workshops” for all types and classes of patients. As medical care became more complex and physicians became increasingly dependent on special equipment and consultation with other medical specialists, the number of U.S. hospitals increased from 178 to more than 4,300 over the period 1870 to 1910.⁵ Still, while hospital costs were on the verge of becoming an important cost concern, protection against lost income due to illness and injury rather than protection against excessive medical expenses remained the significant objective in the pre-World War I era.⁶

In the late 1920s, mounting concerns about the cost and distribution of medical care prompted the formation of the Committee on the Costs of Medical Care (CCMC), a commission funded by six major foundations. With the cooperation of organizations that ranged from insurance companies to the American Medical Association, the CCMC issued nearly 30 field studies and reports between 1928 and 1932. A majority of committee members endorsed the concept of voluntary insurance, arguing that compulsory coverage would be too costly for taxpayers and employers.⁷

Around the time of the CCMC's tenure, payments for medical expenses amounted to only about 10 percent of benefits paid under health insurance for the few who had it. However, the concept of group coverage for hospitalization and physician expenses was beginning to gain popularity. The first Blue Cross plan began in Dallas in 1929, when the Baylor University Hospital agreed to provide 1,500 school teachers with up to 21 days of hospital care a year for \$6 per person. In 1934, commercial insurers followed suit and began offering coverage for hospital care on a group basis.⁸ The first Blue Shield plan designed for coverage of physician services began in 1939, with commercial insurers and groups of physicians offering their own versions of coverage as well.⁹

During and after World War II, the growth of employer-based health insurance was fueled by a number of factors, including federal actions. For instance, a 1943 ruling by the War Labor Board, which had one year earlier introduced wage and price controls, ruled that contributions to insurance and pension funds did not count as wages, a move that prompted employers to use these benefits as a means to attract scarce workers. The right of unions to bargain collectively over health insurance benefits was affirmed by the Supreme Court in 1949, and in 1954, the Internal Revenue Code made it clear that contributions for health insurance were tax deductible as a business expense for employers and were to be excluded from employees' taxable income.¹⁰ As a result, while 12 million people were covered by private health insurance in 1940 (less than 10 percent of the population), that figure rose to 32 million by 1945. Seventy-seven million were covered by 1950.¹¹

Public Program Expansions

While the idea of voluntary private insurance was gaining ground, numerous initiatives to introduce compulsory or public health insurance were largely unsuccessful. Legislation to study and plan for national employment, old age, and sickness insurance was introduced but not passed by Congress in 1916 and 1917, and efforts to establish compulsory health insurance plans failed in 16 states from 1915 to 1920. The Social Security Act passed in 1935 with no provisions for health insurance, in part due to strong opposition by the medical profession and the hospital industry. Although President Truman was in favor of national health insurance, Congress never brought a bill out of committee during his administration. The Eisenhower administration's efforts to subsidize private insurance coverage for poor, elderly, and high-risk individuals were also unsuccessful.¹²

By the late 1950s and early 1960s, a number of factors led to the passage of limited government-sponsored health insurance, including the growth of medical schools, hospitals, and other institutions with an interest in adding dollars to the health care financing pool, labor's continued support for compulsory health insurance, and pressure from older Americans who gathered for hearings held around the country by a new Senate subcommittee on aging. The Kerr-Mills Act extended federal support for state programs to benefit the aged poor in 1960, but dramatic changes did not take place until 1965 with the passage of Medicare and Medicaid, an integral part of President Johnson's Great Society and the War on Poverty.¹³

As noted by longtime advisor Wilbur Cohen, President Johnson saw lack of education and ill health as two of the greatest elements in producing poverty and disadvantage in the United States.¹⁴ Fortunately, the economic and political situation of the country in the mid-1960s provided “one of those rare moments when a government ha[d] real freedom to compose a national agenda, with some assurance that it would be able to do most of the things it chose to do,” and Johnson knew this.¹⁵ Medicare and Medicaid were just two of the policy initiatives undertaken during his administration that would contribute to improvements in the health and well-being of the population, as well as to a dramatic decline in poverty over the next two decades.

The Medicaid program provided health insurance for some of the poor, although coverage was fairly limited in most states. Medicare provided coverage for the elderly, who particularly benefited from expansions in public health insurance coverage. In the early 1960s, only 54 percent of Americans age 65 and older had private hospital insurance.¹⁶ By 1976, 87 percent of the elderly population had coverage through the Medicare program, and only 2 percent were uninsured.¹⁷ Today, the Johnson legacy lives on in part because 96 percent of the elderly population is covered by Medicare, and less than 1 percent is uninsured.¹⁸

While both Medicare and Medicaid are important sources of coverage for those who would otherwise go without, Medicare was designed as universal social insurance program with uniform national standards for eligibility. In contrast, Medicaid was left as an open-ended federal-state funded means-tested program to be administered by the states within broad federal guidelines.¹⁹ As a result, while nearly all elderly individuals had Medicare coverage in 2001, Medicaid coverage has been very uneven among the states, and less than half of people under age 65 who lack other health insurance are covered by the Medicaid program.^{20, 21}

Both Medicare and Medicaid have seen very important incremental expansions over time, but Congress would not enact another major public health insurance program for more than 30 years. Numerous national health insurance and universal coverage proposals were rejected in the 1970s, and again in the 1990s. One such proposal was President Clinton’s Health Security plan, which called for universal health coverage through employer and individual mandates. In 1993, millions listened as he gave a speech to the nation calling for “America to fix a health care system that is badly broken” and advocated providing every American “health care that’s always there, health care that can never be taken away.” Although the plan—described as “courageous” by one commentator—was initially well-received, it ultimately collapsed under the weight of heavy opposition.²²

It was not until 1997 that Congress would enact a significant new public health insurance initiative, the State Children’s Health Insurance Program (SCHIP). SCHIP was created to provide coverage for children whose family incomes are too high to qualify them for Medicaid, but too low for them to easily afford private coverage. Rather than establishing a social insurance mechanism such as Medicare or an open-ended federal-state entitlement such as Medicaid, SCHIP used a block grant model that capped federal

contributions and therefore the number of individuals who would be served by the program. In the early years of SCHIP, to reach as many children as quickly as possible, many states made a concerted effort to streamline their SCHIP eligibility and enrollment processes. Recently, some of these efforts have been cut back as state budget pressures mount and federal spending caps are reached. In 2001, total program enrollment was nearly 5,000,000.²³

Government Regulatory Role in Private Insurance

While state and federal roles in the operation of public programs such as Medicare, Medicaid, and SCHIP are fairly unambiguous, government regulation of private health insurance has traditionally been far more complex. In 1945, Congress enacted the McCarran-Ferguson Act to clarify that states have the primary role in regulating the business of insurance. States license insurers and establish laws that govern insurers' legal structure, finances, and obligations to insured individuals.²⁴ However, a number of federal laws also regulate private health insurance. Enacted in 1974, the Employee Retirement Income Security Act (ERISA) was passed to protect workers from the loss of benefits provided through the workplace. It also had the effect of allowing many employers—specifically, those that finance their employees' medical care expenses internally, rather than through an outside insurer—to escape regulation under state insurance laws (including those governing payment of taxes on premiums, benefit mandates, limits on contracting arrangements, funding requirements, and claims settlement procedures).²⁵

While not a mandate on insurers, the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 required employers with 20 or more employees to offer continued coverage for workers who leave their job or who risk losing coverage. Employers may charge COBRA enrollees no more than 102 percent of their average premium cost, and they must provide coverage to individuals and their dependents for up to 18 months in most circumstances. Today it is estimated that at least three out of four insured workers are eligible for COBRA coverage, but only about one in five eligible employees elect to participate.²⁶

Passed by Congress in 1996, the Health Insurance Portability and Accountability Act (HIPAA) was considered at the time to be perhaps the most significant federal health care reform in a generation. It created the first national standards for the availability and portability of group and individual health insurance coverage, provided tax incentives to purchase long-term care insurance, increased the tax deductibility of health insurance premiums paid by self-employed persons, permitted terminally and chronically ill persons to receive life insurance benefits tax-free, and strengthened federal authority to regulate health care fraud and abuse.²⁷ One study of the early years of HIPAA implementation found that while it has somewhat improved protections for group health insurance coverage, it has not significantly improved access to individual coverage. In addition, although HIPAA provides the basis for federal-state partnerships to strengthen insurance regulation, many analysts have concluded that greater resources for

enforcement, oversight, and public education may be needed for the reforms to create more significant change.²⁸

What is Health Insurance?

Health insurance is a mechanism for protecting against financial loss.²⁹ Although many health care needs are fairly routine and predictable (e.g., vaccinations, annual checkups, occasional doctor visits for minor illnesses that require prescription medications), insurance helps to shield individuals from the high cost of medical care in case of an accident or a severe illness. Under most insurance policies, individuals pay only a portion of their health care costs for covered services, and the insurer picks up the remainder.

Private insurers are able to provide this kind of financial protection by “pooling” the risk of high health care costs across a large number of people. In any given year, some of an insurer’s customers will experience high costs, while others will not. Based on past experience and a number of other factors, insurers charge a policy premium that reflects their anticipated costs for a particular group of customers. In the end, healthy customers with low health care costs end up subsidizing sick customers with high costs. Presumably, healthy customers agree to this arrangement because they too could become sick as the result of an unexpected accident or illness.

Although public health insurance (including Medicare, Medicaid, and SCHIP) may also protect against financial loss, these programs are different than private health insurance in that participants may or may not be responsible for paying premiums or costs related to covered care, and public dollars provide the main source of program funding.

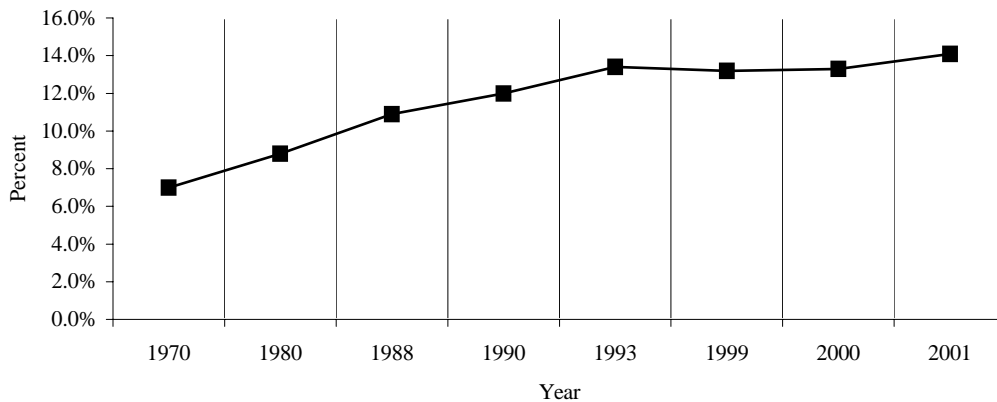
In addition to protecting against financial loss, another function of health insurance may be to facilitate timely access to care.³⁰ Health care providers know that they are likely to receive reimbursement when they treat an individual with insurance, and as a result, they may be more likely to take on insured individuals as patients. However, for number of reasons, some providers may not eligible for reimbursement from certain insurers. Providers may also refuse to take on patients whose insurers offer low reimbursement rates (this is an issue for public insurance programs in particular).

Cost of Health Care

Despite the large population of persons without health insurance, the system of health care that has evolved over time in the United States is the most expensive in the world. Overall spending in this area continues to increase, and health care is one of the fastest

growing segments of the U.S. economy. Since 1970, national health expenditures have increased dramatically, from \$73.1 billion to \$1.4 trillion in 2001.³¹ Adjusting for inflation, national health expenditures grew five-fold during this time period.³² As a percentage of gross domestic product (GDP), national health expenditures increased from 7 percent to 14 percent between 1970 and 2001 (see Figure 1.1).³³

Figure 1.1
National Health Expenditures as Percent of GDP, 1970-2001



Source: Katherine Levit, Cynthia Smith, Cathy Cowan, Helen Lazenby, Art Sensenig, and Aaron Catlin, "Trends in U.S. Health Care Spending, 2001," *Health Affairs*, vol. 22, no. 1, January/February 2003, p. 155.

Over the past few years, the annual rate of growth in health care spending has also increased. In 2001, inflation-adjusted health care spending grew by 6.2 percent, which is the fastest rate of growth in a decade. There is widespread consensus that spending growth will continue in the future.

Though some policymakers consider health care's increasing share of the economy as a sign that the health system is out of control, others argue that the increase in health spending is a reflection of the increased value of health care purchased. Some point to advances in medical technology, which have contributed to the increased costs of health care, but which may also contribute to improved health outcomes and life expectancy.³⁴ Whatever one's point of view on this debate, almost all analysts agree that the increasing cost of health care is a key reason why more persons are uninsured. In addition, cost increases make it increasingly difficult to expand health insurance coverage to the uninsured.

A Comparative Snapshot of Health Expenditures

Since 1990, health care expenditures in Organization for Economic Cooperation and Development (OECD) countries have risen significantly across the board, although the United States, Switzerland, and Germany stand out as the highest spenders per GDP. These same three countries have experienced the greatest increases as well over the past decade, rising 2 or more percentage points (see Table 1.1). Total health expenditures in all OECD countries are at an historical high, averaging 8.4 percent of GDP in 2001. In fact, health care spending has grown 1 percent faster than their economies over the past decade.

The U.S. not only tops the list as the highest per capita spender (an average of \$4,900, more than double the OECD average), but the U.S. also spends the most as a percentage of GDP, at 13.9 percent, up from 13.1 percent in 2000. While more than half of the U.S. health care expenditures are private, public spending is still relatively significant, at 5.8 percent of GDP in 2001. However, public spending in the U.S. as a percentage of total health expenditures is the lowest of all OECD countries (44 percent, compared with an average of 72 percent, with Nordic countries' government spending accounting for over 80 percent of their totals). The proportionally low public spending in the U.S. relates to the fact that a much smaller share of the population in the U.S. is insured through public programs compared to other OECD countries.³⁵

Table 1.1
Total Expenditures on Health (Percent GDP)

Source: Organisation for Economic Co-operation and Development, "OECD Health Data 2003, 2nd ed.," database on CD-ROM, 2003.

Note: Data not available for all countries in all years.

When U.S. government estimates of spending are adjusted to account for the fact that (1) public employee benefit costs are actually a government expense (although part of the premiums are paid with public funds, these amounts are not counted as such because a private insurer ultimately pays the claims), and (2) the government "spends" money (in the form of forgone revenue) by exempting the cost of employer-paid health insurance from income and payroll taxes, the current government-financed share of U.S. health spending may actually be closer to 60 percent. Incorporating these adjustments, government per capita health expenditures in the United States exceeded total public and private per capita health expenditures in every other nation except Switzerland. As a result, Americans paid higher taxes per capita for financing health care than did any other nation's citizens. Despite this fact, the U.S. has not been able to provide the nearly universal coverage available in most other OECD countries.³⁶

Factors Contributing to U.S. Health Care Spending Growth

A number of factors have contributed to the increase in health care spending over time, including greater consumer demand for health services, increased prevalence of chronic disease, the aging of the population, the introduction of new and expensive technologies, increased spending on prescription drugs, wage increases in the health care labor market and changes in the insurance marketplace.³⁷ Many of these factors are interrelated and the extent to which they drive health care spending varies with changes in the health care

marketplace and the population. A discussion of these factors and how they affect health care costs follows.

Advances in Medical Technology

Though relatively little is known about how the introduction of new technologies affects health care costs,³⁸ it is considered by many economists to be one of the most consistent and significant drivers of health spending growth over the past several decades.^{39, 40, 41} A Project Hope review of the various studies that assessed the impact of technology on health spending found that the percentage of health spending attributable to technology ranges between 5 percent to 60 percent, depending on the methodology of the study and the time period examined.⁴² Given the current state of medical science, it seems likely that medical technology will continue to advance rapidly and that these advances will continue to contribute to overall spending growth.

Prescription Drugs

In the past ten years, prescription drug spending has grown at almost twice the pace of all other health services. In 1990, prescription drugs accounted for 6 percent of total national health expenditures and by 2001, that figure had nearly doubled to 10 percent.⁴³ This is partly attributed to the introduction of “blockbuster” drugs in the late 1990s. Over the past three years, growth in prescription drug spending has slowed from 19.7 percent in 1999 to 15.7 percent in 2001. This is due in part to the introduction of fewer new drugs and the implementation of several cost control methods, including generic incentive programs, prior authorization, higher co-payments, and drug utilization review.⁴⁴ The U.S. Centers for Medicare and Medicaid Services projects that in 2010, prescription drugs will account for 14.2 percent of national health expenditures.⁴⁵

Chronic Illness

In 2000, 125 million Americans were living with a chronic condition, representing 45.4 percent of the population.⁴⁶ Projections by the RAND Corporation indicate that this number will increase to 171 million people by 2030, representing 49.2 percent of the population.⁴⁷ As health care spending for persons with chronic conditions is twice as high as that for persons without chronic conditions, this trend has significant implications for health costs.⁴⁸ People suffering from chronic illness account for 76 percent of all hospital admissions, 88 percent of all prescriptions, 72 percent of all physician visits, and 78 percent of all health care spending in the U.S.⁴⁹

Aging Population

The aging of the U.S. population has been a significant contributor to rising health care costs, and in the next few decades it is projected to become a more significant factor. Older Americans have more medical needs than people under age 65, and they have higher per capita health care costs. According to the Centers for Disease Control and Prevention (CDC), health care expenditures for individuals over the age of 65 are four times higher on average than those of persons aged 40.⁵⁰

The high cost of treating the elderly will become a more significant factor in health care spending growth as the percentage of the elderly population increases over the next 30 years. The percentage of the population that is over 65 is projected to grow by 102 percent between 2000 and 2030.⁵¹ In 2000, there were 35 million Americans over the age of 65, and as baby boomers age, that number is projected to grow to 53.7 million by 2020 and to 70 million by 2030.

The CDC estimates that by 2030, the aging of the population alone will contribute to a 25 percent increase in health care spending, even when controlling for inflation and new technologies.⁵² This trend is particularly significant for Medicare, the primary insurer of Americans over the age of 65. It is also a cost consideration for the Medicaid program, which now covers a large portion of nursing home and long-term care costs for the elderly.

Third-Party Reimbursement

Another factor that has contributed to growth in health care spending is the use of insurance to pay for health care. The purpose of health insurance is to pool risks and premiums in order to provide reimbursements for health expenses when they are incurred. Insurance tends to shield people from the full costs of health expenses, and therefore provides an incentive to use more health services. Without aggressive regulatory or market controls, people may “consume” more health care than is necessary or desirable. A number of complex regulatory and public sector control mechanisms have been put in place over the years to reduce the incentive by consumers and providers of care to lower the consumption of health services. But these mechanisms have been less than satisfactory in controlling utilization of health care. The trend towards the use of managed care may have slowed these growth trends, but while managed care is still one of the primary forms of insurance, the public has resisted many of its strictest cost containment strategies.

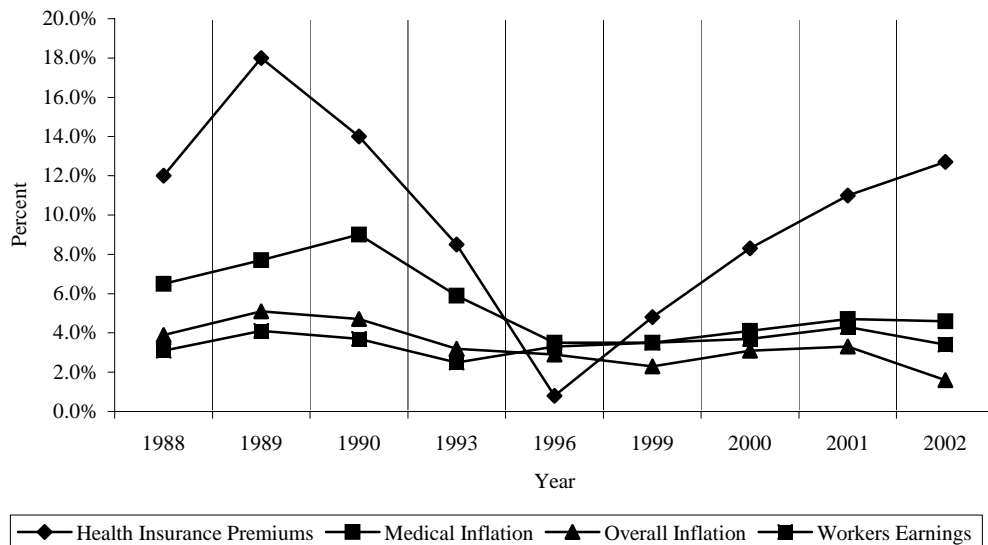
One of the effects of the recent movement away from a tightly controlled system of managed care is believed to be an increase in hospital inpatient and outpatient spending. Hospital care is the largest area of health expenditures accounting for 31 percent of total national health expenditures in 2001.⁵³ Managed care is credited with decreasing the growth in utilization of inpatient services during the 1990s, though the cost savings were partially offset by an increase in outpatient services. Since 2000 spending on inpatient hospital care began to increase again while outpatient spending growth also accelerated.

In the past two years, the increasing cost of hospital care has been the most significant factor contributing to overall health care spending. Between 2000 and 2001, hospital spending increased by 8.3 percent—this is the fastest increase in a decade and accounted for 30 percent of total increases in national health expenditures.⁵⁴ Of the two factors that have contributed directly to an increase in hospital spending—higher utilization and higher prices—higher utilization is a more significant factor.^{55, 56} The higher prices for hospital services is due in part to increased wages resulting from labor shortages and the greater negotiating power of providers.⁵⁷

Rising Cost of Insurance Premiums

The Kaiser Family Foundation and the Health Research Educational Trust produce an annual report on trends in employer health benefits. According to their 2002 report, the rate of growth in the cost of health insurance premiums has outpaced inflation, medical inflation, and workers earnings since 1996 (see Figure 1.2).⁵⁸ In 2001, the annual percentage increase in the price of job-based health insurance premiums reached the double digits for the first time in a decade. Between 2001 and 2002, the cost to employers of providing health insurance to families increased by 12.7 percent and the cost of providing health insurance to individuals increased by 15.4 percent.⁵⁹ In 2002, the average job-based annual premium (including employee and employee share) for a family of four was \$7,954 (up from \$7,053 in 2001), and the average annual premium for an individual was \$3,060 (up from \$2,650 in 2001).

Figure 1.2
Increase in Health Insurance Premiums Compared to Other Indicators, 1988-2002



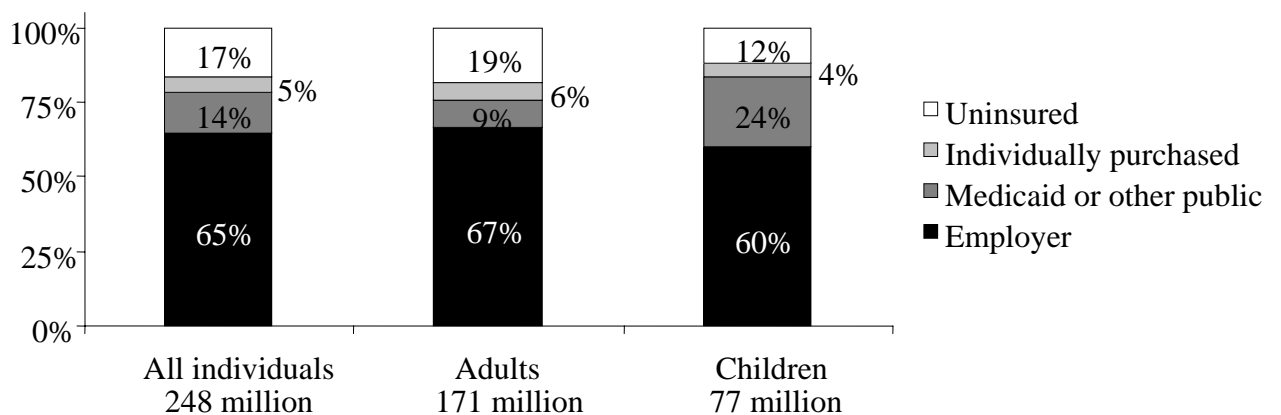
Source: "Employer Health Benefits 2002 Annual Survey" (#3251), The Henry J. Kaiser Family Foundation and Health Research and Educational Trust, September 2002, p. 15. [This information was reprinted with permission of the Henry J. Kaiser Family Foundation. The Kaiser Family Foundation, based in Menlo Park, California, is a nonprofit, independent national health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries.]

The cost of all types of health plans increased in the double digits in 2002. Health maintenance organization premiums grew by 13.3 percent, indemnity insurance, and preferred provider organization premiums rose by 12.7 percent, and point of service premiums rose by 11.9 percent.⁶⁰ Premiums for self-funded plans and insured plans grew at approximately the same rate, indicating that increased expenditures, not an adjustment in the medical underwriting cycle, may have driven the premium increases in 2002.⁶¹

Overview of Recent Trends in Health Insurance Coverage

Among the 248 million nonelderly 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 5 percent purchased private insurance on their own. The remaining 16.5 percent (41 million individuals) 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 (see Figure 1.3).^{62, 63}

Figure 1.3
Health Insurance Coverage of the Nonelderly by Age, 2001



Source: Catherine Hoffman and Marie Wang, *Health Insurance Coverage in America: 2001 Data Update*, Kaiser Commission on Medicaid and the Uninsured (Washington, D.C.: Henry J. Kaiser Family

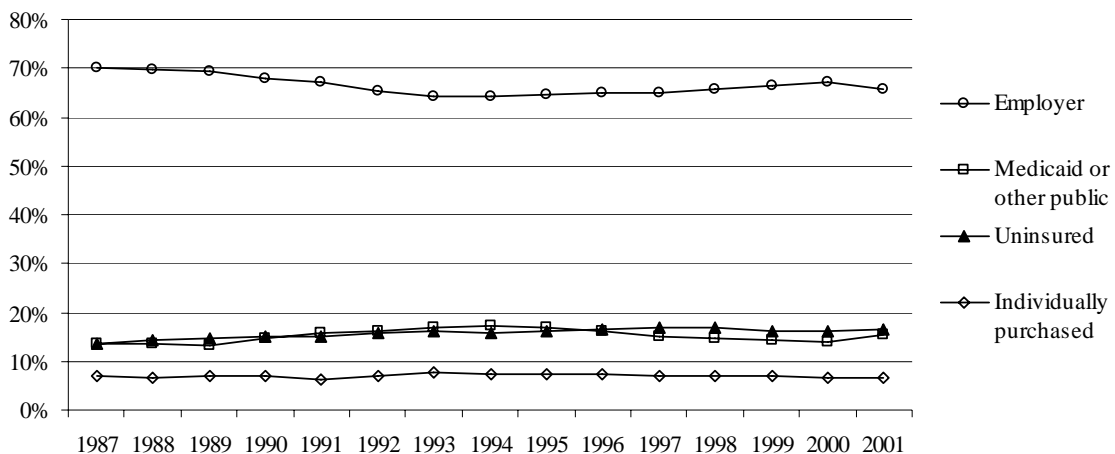
Foundation, January 2003), p. 21.

Note: Individuals reporting more than one source of coverage were assigned to a single category in the following order: Medicaid, employer, and other public (percentage totals may not equal 100 due to rounding). For example, those reporting both Medicaid and employer coverage were assigned to the Medicaid category.

In recent decades, the percentages of people with and without health coverage have fluctuated for different reasons at different points in time (see Figure 1.4). 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.⁶⁴

From 1998 to 2000, while employer-sponsored coverage continued to grow, rates of public and individually-purchased coverage stabilized. As a result, the percentage of uninsured individuals decreased slightly. In 2001, this brief trend was reversed, and the percentage of Americans without health insurance increased from 16.1 percent to 16.5 percent. 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.⁶⁵

Figure 1.4
Sources of Health Insurance among the Nonelderly, 1987-2001



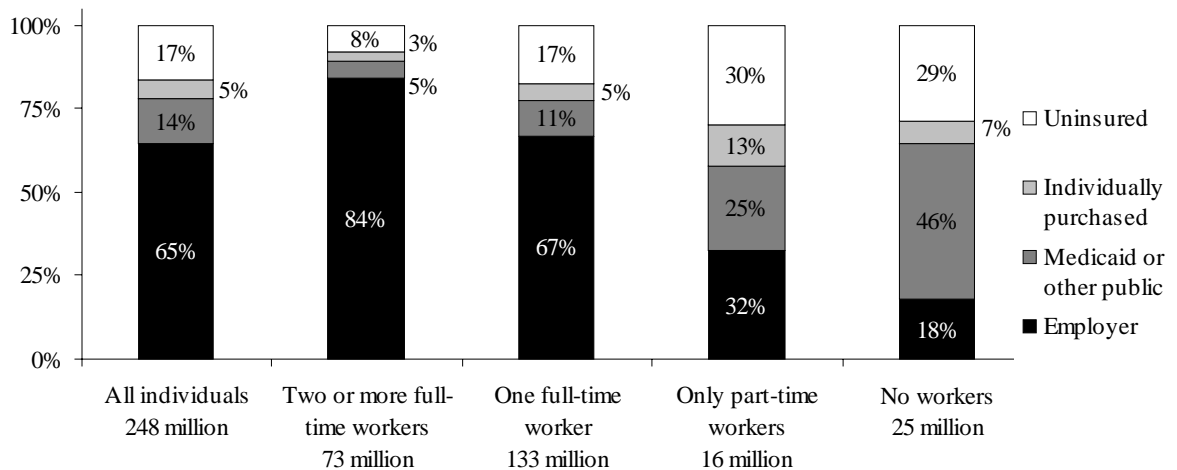
Source: Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2002 Current Population Survey*, Issue Brief no. 252 (Washington, D.C.: Employee Benefit Research Institute, December 2002), p. 4.

Notes: Individuals may report more than one type of coverage, so percentage totals in each year may be greater than 100. Due to a CPS questionnaire change that resulted in fewer persons counted as uninsured in 1999 and years following, percentages for 1987-1998 have been adjusted to provide roughly comparable estimates over time.

Employer-Based Coverage

Most Americans under the age of 65 obtain health insurance through their employers or a family member with employer-based insurance. However, work does not guarantee access to this type of coverage. Among people in families with two full-time workers and a total income of less than 200 percent FPL, less than half (45 percent) had job-based coverage in 2001 and more than a quarter were uninsured. In contrast, among individuals in higher income (i.e., 200 percent FPL or more) families with two full-time workers, almost 90 percent had job-based coverage and only 6 percent were uninsured.⁶⁶

Figure 1.5
Health Insurance Coverage of the Nonelderly by Family Work Status, 2001



Source: Catherine Hoffman and Marie Wang, *Health Insurance Coverage in America: 2001 Data Update*,

Kaiser Commission on Medicaid and the Uninsured (Washington, D.C.: Henry J. Kaiser Family Foundation, January 2003), p. 21.

Note: Individuals reporting more than one source of coverage were assigned to a single category in the following order: Medicaid, employer, and other public (percentage totals may not equal 100 due to rounding). For example, those reporting both Medicaid and employer coverage were assigned to the Medicaid category.

While the percentage of individuals insured through their own employer has remained steady in recent years, the percentage with dependent coverage has declined. For example, in 1987, 34.3 percent of nonelderly individuals obtained health insurance through their own employer and 35.9 percent were covered as the dependent of a family member with employer-based insurance. In 2001, a similar 34 percent obtained health insurance through their own employer, but only 31.6 percent were covered as dependents.⁶⁷

Who Is Offered Coverage and Who Enrolls?

To date, the rising cost of health insurance has not led a large number of employers to drop health insurance as an employee benefit, but the percentage of smaller firms offering health insurance benefits has declined. Between 1996 and 2002, the percentage of large firms (those with more than 200 employees) offering health insurance remained stable at about 99 percent. For firms with between three and 199 employees, the percentage of firms offering health benefits increased from 59 percent to 67 percent between 1996 and 2000 and then declined to 61 percent in 2002. Sixty-eight percent of small employers that do not offer health benefits report that the high cost of premiums is a very important reason that they do not do so.⁶⁸

According to data from the Medical Expenditure Panel Survey conducted by the Agency for Healthcare Research and Quality, while the percentage of private-sector employees who worked in establishments that offered health insurance increased from 86.5 percent in 1996 to 89.1 percent in 1999, the percentage of workers who were actually eligible for coverage in those establishments fell from 81.3 percent to 78.5 percent. As a result, the overall proportion of U.S. private-sector workers eligible for health insurance remained steady at about 70 percent over this period (see Figure 1.6). Among those who were eligible, the percentage of workers who actually enrolled in their employer's plan fell from 85.5 percent in 1996 to 82.3 percent in 1999. Overall, the percentage of private-sector workers enrolled in health coverage through their employer fell from 60.1 percent to 57.5 percent over this period.⁶⁹

Figure 1.6
Percentage of U.S. Private-Sector Workers Eligible for and Enrolled in Employer-Based Health Coverage, 1996 and 1999



Source: James M. Branscome and Beth Levin Crimmel, *Changes in Job-Related Health Insurance, 1996-99*, MEPS Chartbook no. 10 (Rockville, MD: Agency for Healthcare Research and Quality, 2002), pp. 7-9.

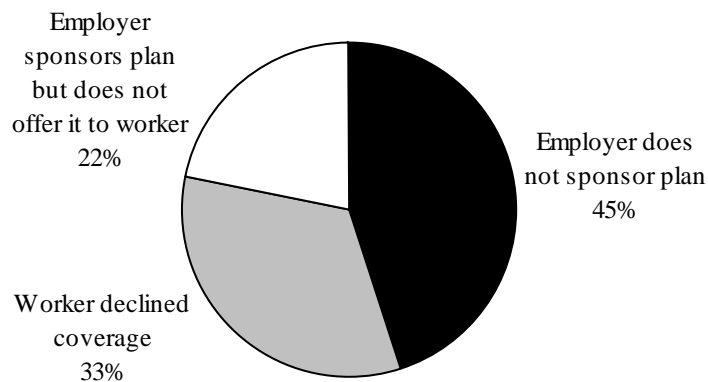
It is important to note that these figures can vary substantially by job characteristics and worker demographics. In general, workers employed in small firms are less likely to be offered coverage than those in large firms. Health insurance also varies by industry of employment. While about 88 percent of public sector and manufacturing employees were offered coverage in 1997, only 65.8 percent of wholesale and retail trade workers and 55.3 percent of agriculture, forestry, fishing, mining, and construction workers received offers. Union employees and full-time workers are much more likely to be offered health insurance than their non-union and part-time counterparts, and older workers are more likely to be offered coverage than those under age 25. Women are somewhat less likely than men to be offered health insurance by their employer, and Hispanics are less likely to be offered coverage than workers of other races.⁷⁰

Among those who are offered health insurance by their employers, take-up rates vary as well. In general, workers who are more likely to be offered coverage are more likely to accept it, and vice versa. For example, while 85.5 percent of workers in large firms (100 employees or more) were offered coverage in 1997 and 86 percent of those workers enrolled, 56.6 percent of workers in small firms were offered coverage and only 75 percent enrolled.⁷¹

Why Are Some Workers Not Covered?

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 (see Figure 1.7).

Figure 1.7
Nonelderly Adult Workers without Health Insurance through Own Employer by Reason Not Covered, 1997



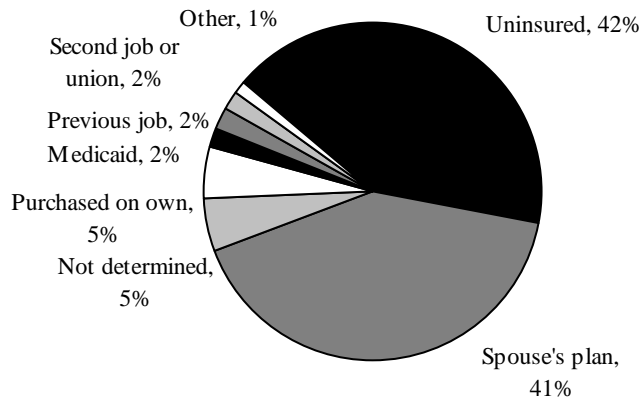
Total = 41 million

Source: Paul Fronstin, *Employment-Based Health Benefits: Who Is Offered Coverage vs. Who Takes It*, Issue Brief no. 213 (Washington, D.C.: Employee Benefit Research Institute, September 1999), p. 13.

Among the one-third of workers who declined coverage, 61 percent did so because they were covered by another plan. Another 20 percent said the coverage was too expensive, and only 2 percent reported that they did not need or want health insurance. Among those whose employer sponsored a health plan but were not offered coverage, 53 percent reported that they did not work enough hours per week or weeks per year to qualify. Another 22 percent had not completed the waiting period required by their employer for eligibility, and only 1 percent reported that they were not eligible due to a pre-existing condition.⁷²

Among all workers without health insurance through their own job, 41 percent were covered by their spouse's plan, 12 percent obtained coverage from some other source, and 42 percent remained uninsured (see Figure 1.8).⁷³ Most workers who remain uninsured (80 percent) are either employed by a firm that does not offer coverage or not eligible for the coverage their employer provides. Only 20 percent of uninsured workers go without coverage as the result of declining an offer from their employer.⁷⁴

Figure 1.8
Insurance Status of Nonelderly Adult Workers without Coverage
through Own Employer, 1997



Total = 41 million

Source: Paul Fronstin, *Employment-Based Health Benefits: Who Is Offered Coverage vs. Who Takes It*, Issue Brief no. 213 (Washington, D.C.: Employee Benefit Research Institute, September 1999), p. 14.

Among the more than two-thirds of nonelderly individuals with access to employer-sponsored insurance (i.e., workers offered coverage and their dependents), data from a 1996-1997 household survey conducted by the Center for Studying Health System Change found that 86 percent were enrolled. An additional 9 percent had some other type of coverage (individually-purchased insurance, Medicaid, etc.), and the remaining 5 percent (7.3 million individuals) were uninsured. When asked why they did not enroll in an employer-sponsored plan when it was offered, two-thirds of all uninsured workers and three-fourths of low-income uninsured workers cited cost as the main reason for declining coverage. In fact, cost may be a barrier to enrollment for low-income workers not only because health insurance premiums consume a larger percentage of their income (relative to higher-income workers), but also because their required out-of-pocket contribution may be higher. As shown in Table 1.2, employee contributions (even for the least expensive plan offered) tend to be higher in firms that primarily employ low-wage workers.⁷⁵

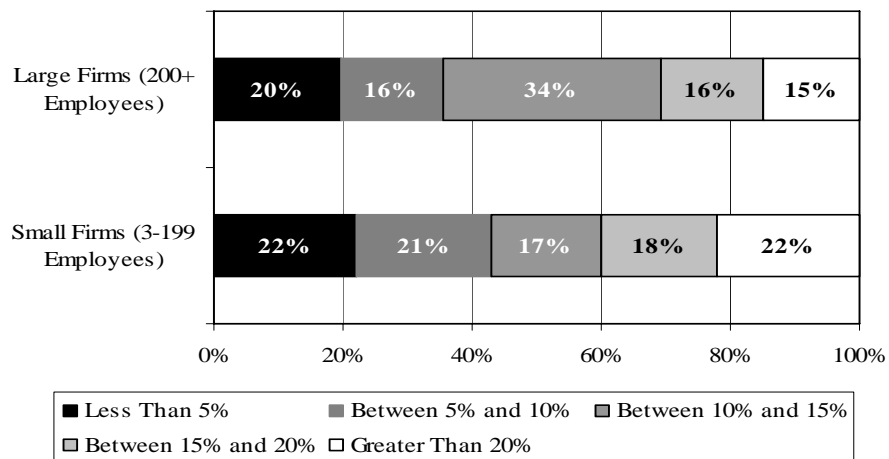
Table 1.2
Employee Cost of Health Insurance and Take-Up Rate by Typical Wage
in Firm, 1996-1997

Source: Peter J. Cunningham, Elizabeth Schaefer, and Christopher Hogan, *Who Declines Employer-Sponsored Insurance and Is Uninsured?* Issue Brief no. 22 (Washington, D.C.: Center for Studying Health System Change, October 1999), p. 2. [Reprinted with permission of the Center for Studying Health System Change, Washington, D.C., <http://www.hschange.org>.]

Premium Increases and Employers

In 2002, small firms experienced a higher average increase in premiums (13.2 percent) than larger firms (12.5 percent). Many firms, both large and small, experienced significant premium increases of greater than 15 percent, but as the Figure 1.9 reflects, small firms were more likely to experience increases of that level.⁷⁶

Figure 1.9
Distribution of Premium Increases by Firm Size, 2002



Adapted from: “Employer Health Benefits 2002 Annual Survey” (#3251), The Henry J. Kaiser Family Foundation and Health Research and Educational Trust, September 2002, p. 17. [This information was reprinted with permission of the Henry J. Kaiser Family Foundation. The Kaiser Family Foundation, based in Menlo Park, California, is a nonprofit, independent national health care philanthropy and is not

associated with Kaiser Permanente or Kaiser Industries.]

To cope with the increased cost of health insurance premiums, employers may pass on more of the costs to their employees, offer less expensive plans with less generous benefit packages, or drop coverage for some or all of their employees. As health insurance is a highly valued benefit among workers, employers are less likely to use these strategies in tight labor markets in which they must compete for employees. In fact, in comparison with 2001, more employers in 2002 reported that they can attract good employees without offering health insurance.⁷⁷

Though the rising cost of health insurance premiums has not resulted in a collapse of employer-based health insurance, there are signals of some erosion in this area, particularly with small employers.

Trends in Changes to Benefits Packages

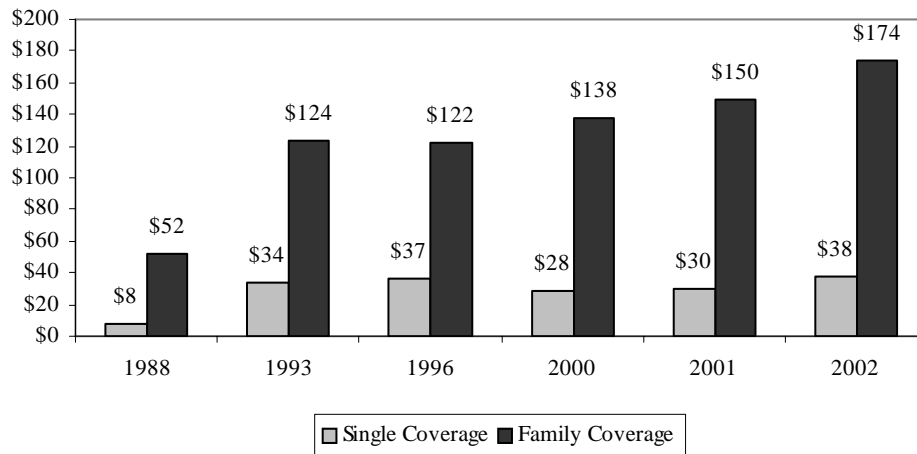
One concern about the increase in the cost of health insurance is that in order to afford higher premiums, employers will reduce benefits packages. Over the last 20 years, job-based health insurance benefits packages have expanded, a trend that is attributed largely to managed care, which emphasizes a wide range of preventive services. Today, most health plans offer a standard package of benefits, which includes annual physicals, visits with the obstetrician/gynecologist, inpatient and outpatient services, prenatal care, prescription drugs, and mental health services. In the last three years, however, 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 and 7 percent of workers experienced an increase in their health benefits.⁷⁸

Trends in Employee Contributions and Cost Sharing

As the cost of health insurance rises, employers are passing on more of the cost of that insurance to their employees. They do this in two ways: 1) by increasing the share of the monthly or annual premium that employees contribute, and 2) by offering plans that require employees to pay higher out-of-pocket expenses for health care services. Total employee contributions to insurance premiums have increased significantly over the past 15 years from \$41.3 billion in 1987 to \$126.4 billion in 2002. However, over that time the percentage of total premiums paid by employees has not changed significantly. In 1988, employees contributed 11 percent of the cost of single premiums and 29 percent of the cost of family premiums. In 2002, employee contributions accounted for 16 percent of single premiums and 27 percent of family premiums.

In 2002, employers passed on a larger share of premiums to their employees. Between 2001 and 2002, the average monthly employee contributions to single health insurance increased from \$30 to \$38 and the average monthly employee contributions to family health insurance increased from \$150 to \$174 (see Figure 1.10).

Figure 1.10
Average Monthly Worker Contribution for Single and Family Coverage, 1988-2002



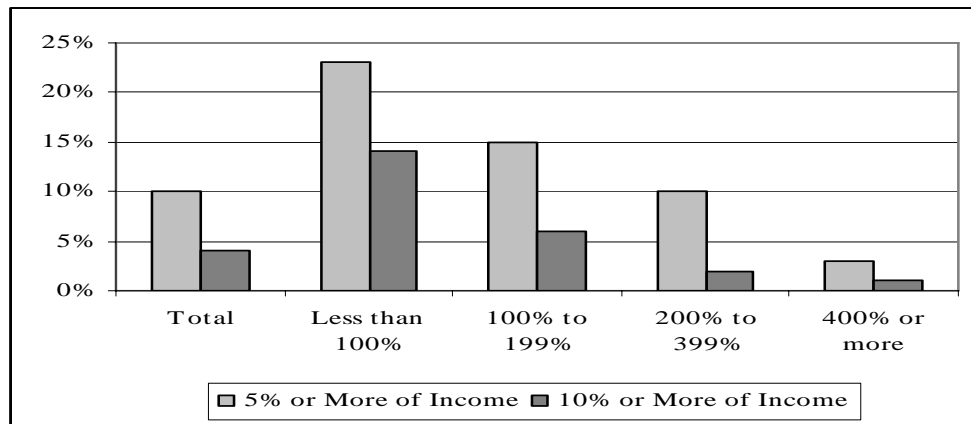
Adapted from: “Employer Health Benefits 2002 Annual Survey” (#3251), The Henry J. Kaiser Family Foundation and Health Research and Educational Trust, September 2002, p. 76. [This information was reprinted with permission of the Henry J. Kaiser Family Foundation. The Kaiser Family Foundation, based in Menlo Park, California, is a nonprofit, independent national health care philanthropy and is not associated with Kaiser Permanente or Kaiser Industries.]

The recent increase in employee contributions for health insurance premiums may be a reflection of employers’ willingness to pass on higher costs for health insurance to employees in a less competitive labor market. Employer-sponsored coverage generally shields individuals from out-of-pocket payments more than other types of coverage, but employees are now paying higher out-of-pocket payments for health services in the form of higher deductibles, co-payments, or co-insurance rates.⁷⁹ In the 2002 annual employer survey on health benefits conducted by the Kaiser Family Foundation and the Health Research and Educational Trust, 29 percent of employers indicated that they had increased the amount that employees pay for health insurance, 28 percent had increased the amount employees pay for prescription drugs, 22 percent had increased the amount that employees pay for deductibles, and 20 percent had increase the amount of employee co-pays and co-insurance.⁸⁰ In general, large firms were more likely than small firms to have made these changes in their policies. According to another study, only 12 percent of small firms increased workers’ co-payments or deductibles.⁸¹ Many employers anticipated increases in the amount employees pay for health benefits in 2003, particularly for health insurance premiums.

Impact of Cost-Sharing on Families

The financial impact of cost-sharing is most significant for people with lower incomes. A recent analysis of 1996 MEPS data found that nearly one-third of nonelderly families spend at least 5 percent of their household spending on health care when their contributions to health insurance premiums and out-of-pocket expenses are taken into account. Health care accounts for a substantial portion (more than 10 percent) of household spending for 11 percent of families, many of whom tend to have lower incomes and higher health care needs.⁸² As depicted in Figure 1.11, families below 100 percent of the poverty level are more likely to spend a greater portion of their income on out-of-pocket expenses than those with higher incomes.

Figure 1.11
Percent of Family Income Paid in Out-of-Pocket Payments



Source: Mark Merlis, "Family Out-of-Pocket Spending for Health Services: A Continuing Source of Financial Insecurity" (New York: The Commonwealth Fund, June 2002), p. ix.

Of families spending more than 10 percent of their income on direct health care expenses, 17 percent report that they forego needed care and 20 percent report difficulty in obtaining services for financial reasons.⁸³

The Individual Market

While most nonelderly Americans obtain health insurance through their employer, in 2001, 6.6 percent (16.4 million) were covered by a policy they or a family member purchased on their own.⁸⁴ Unlike coverage in the group market (e.g., insurance obtained through employers, trade associations, and unions), the availability, comprehensiveness, and cost of insurance in the individual market depends largely on a person's health status, age, place of residence, coverage history, and other factors.⁸⁵ While 30 to 40 percent of

those with individual coverage are enrolled for less than a year to fill gaps created by a change in economic or other life circumstances, more than half of those who purchase individual policies do so as a more permanent source of coverage.⁸⁶

Who Enrolls?

Individuals commonly seeking this type of coverage include the self-employed (this may include people who, while technically self-employed, are working under contract for an employer), those who retire before becoming eligible for Medicare, part-time or contingent workers, those who lose coverage through a spouse, young adults who grow too old to be covered by a parent's health plan, and those who do not otherwise have access to an employer-sponsored or public coverage.⁸⁷

While 18.9 percent of self-employed workers were covered by an individual policy in 2001, only 4.5 percent of those employed by a firm had individual coverage. Only 5.3 percent of people in families headed by a full-time, full-year worker had individual coverage in 2001, compared with 11.3 percent of those in families headed by a part-time or part-year worker. While 12.5 percent of young adults ages 18-20 and 11.5 percent of those ages 21-24 were covered by an individually-purchased plan in 2001, 7.5 percent of children, 4.2 percent of those ages 25-34, and 8 percent of adults ages 55-64 had individual coverage.⁸⁸

How Is Coverage Obtained?

Applying for individual health insurance can take anywhere from two to six weeks, and consumers are typically asked to provide a deposit with their application to help cover the first month's premium. An underwriting process (i.e., review of an individual's health status, history, and other considerations) determines how much a policy will cost, what will be covered, or whether coverage will be offered at all. In addition to the information provided on an application form, insurers may request copies of medical records or other information from an applicant's physician, a physical exam, or lab tests. They may also consult a database maintained by the insurance industry to obtain information on an individual's history with other insurers.⁸⁹

How Much Does Coverage Cost?

A recent study released by the Kaiser Family Foundation tested access to coverage in the individual health insurance market by constructing seven hypothetical applicants (of varying ages and health statuses) and asking insurers in eight markets across the country to consider them as if they were real consumers seeking a policy with a \$500 deductible and \$20 co-payment per physician office visit. The seven hypothetical consumers made a total of 420 applications (60 each), and 154 (37 percent) were rejected (an HIV-positive applicant accounted for 60 of the rejections). Fifty-three percent of accepted applications included benefit restrictions, premium surcharges, or both. Among the five single applicants who received any offer of coverage, the average premium quoted was \$333 per month (\$3,996 per year). If the five applicants had been in perfect health, the average standard rate available to them would have been \$249 per month (\$2,988 per year).⁹⁰

However, averages mask the high degree of variability in the individual insurance market. Health status, age, gender, and other personal characteristics may play an important role in determining the cost and terms of coverage. Place of residence is also an important factor, since states vary in their degree of individual health market regulation. Some states prohibit insurers from placing exclusions on policies, and others require insurers to sell standardized policies at standardized rates within certain guidelines. States have also created “high risk pools” for those who cannot obtain adequate insurance elsewhere, but relatively few people are enrolled in such programs and their costs and covered benefits vary.⁹¹

Medicaid, Medicare, and Other Public Programs

While nearly all Americans are eligible for health coverage through the Medicare program when they reach age 65, most nonelderly 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.⁹² In contrast, only 15.3 percent of the nonelderly population had public coverage (mostly through Medicaid and SCHIP) at some point during the year, and 16.5 percent were uninsured for the entire year.⁹³

Medicaid and SCHIP

Two joint federal-state programs, Medicaid and the State Children’s Health Insurance Program (SCHIP), are the main sources of public coverage among those under age 65, serving more than 28.3 million nonelderly people (mostly disabled individuals and people in families with children) in 2001.⁹⁴ Because they are both means-tested programs, an applicant’s income and resources (e.g., the value of a car) must fall below certain minimum levels in order to qualify.

Under federal law, states are required to provide Medicaid coverage for all children under age 6 with incomes below 133 percent of the federal poverty line (FPL), and all children under age 19 with incomes below 100 percent FPL. Beyond these minimums, income eligibility varies by state and age group, with standards for younger children tending to be more generous. For those with family incomes too high to qualify for Medicaid, all but 11 states currently cover children to at least 200 percent FPL under SCHIP.⁹⁵

As of June 2001, income thresholds for a parent with two children applying for Medicaid ranged from 22 percent of the federal poverty line (\$259 per month for a family of three) in Arkansas and Louisiana to 200 percent FPL (\$2,358 per month) in the District of Columbia. Overall, 14 states required monthly earnings below 50 percent of the federal poverty line, 25 allowed earnings from 50 to 100 percent FPL, and 11 states and the District of Columbia allowed earnings of 100 percent FPL or greater.⁹⁶

Rates of private insurance coverage among the nonelderly vary considerably from state to state, ranging from a low of 59.2 percent in New Mexico to a high of 81.4 percent Wisconsin during 1996-1998. This coverage variability directly affects the size of the population at risk of being uninsured, or what some call the “insurance gap.” For those

who fall into this category, Medicaid is by far the largest source of coverage in every state. However, the proportion of at-risk individuals (i.e., low-income individuals without private insurance) covered by Medicaid also varies substantially, ranging from 26.8 percent in Nevada to 74.7 percent in Vermont during 1996-1998.⁹⁷

Medicaid Enrollment and Spending Issues

Over the past few years, a significant challenge to increasing access to care in the United States has been the sensitivity of the health insurance system to the state of the economy. The United States has been in a period of economic slow-down during the early part of this decade. With rising rates of unemployment, fewer people have employment-based health coverage. Some may be able to continue their employer-based coverage under COBRA, but most find that an unaffordable option. Others may purchase individual or family plans in the individual health insurance market to temporarily fill the gap in coverage. Others will either qualify for public programs or join the ranks of the uninsured.

During the recent economic decline, enrollment in Medicaid has grown substantially. As enrollment in Medicaid and other public programs grows, the amount of money that governments at the federal, state, and local levels spend to support the programs also increases. At the same time, governments' tax revenues decline because of the decline in the economy. Facing a fiscal squeeze, many states have implemented restrictions on Medicaid eligibility in order to stop or slow the growth in enrollment and to contain costs. As a result, more low-income Americans lose their health insurance. The growing number of uninsured is an increased burden on public safety net providers. Consequently, during periods of economic decline, at the same time that people are losing employer-sponsored coverage, governments at the federal, state, and local levels are struggling to maintain coverage under public programs and may not have the resources to expand coverage to health care for the uninsured.

The recent economic decline has contributed to a substantial growth in the number of people enrolled in Medicaid. Between December 2000 and December 2001, enrollment in the program grew by 9.8 percent, from 33.3 million individuals to 36.6 million individuals.⁹⁸ By 2003, the number of people on Medicaid reached 42 million.⁹⁹ Other factors contributing to the growth in Medicaid enrollment over this time period were loosening of eligibility requirements and administrative simplifications.¹⁰⁰

The growing number of individuals enrolled in Medicaid has contributed to an increase in the cost of operating the program. In fiscal year 2002, the average annual rate of growth in Medicaid spending was 12.8 percent. This was the highest annual growth rate in a decade and it followed a 9 percent growth rate in the previous fiscal year.¹⁰¹ In addition to enrollment growth, these changes have also been attributed in part to increasing expenditures on prescription drugs.¹⁰²

The combination of increasing Medicaid expenditures and declining tax revenues has contributed to a substantial fiscal squeeze in most states. In order to balance their budgets in fiscal year 2003, 37 states were forced to cut spending in the middle of the

year by a combined \$14.5 billion.¹⁰³ According to the National Governors Association and the National Association of State Budget Officers, this is the largest spending cut in the 27 years that the survey has conducted. It is projected that in fiscal year 2004, states will again face budget deficits, which will increase pressure on Medicaid coverage. The extent to which Medicaid has contributed to states' fiscal problems depends on the percentage of the state's budget accounted for by Medicaid spending. As a percentage of their budgets, the amount that states spend on Medicaid varies significantly from 8.7 percent to 30 percent. On average, states spend approximately 20 percent of their budgets on Medicaid.¹⁰⁴

The federal government acted to provide some relief to states on Medicaid spending in 2003 and 2004. The Jobs and Growth Tax Relief and Reconciliation Act of 2003, which was enacted earlier this year, temporarily raises the federal matching rate for Medicaid funds, thus decreasing state's share of Medicaid spending.¹⁰⁵ The legislation also included grants to the states for additional fiscal relief.

Despite this, many states have responded to the federal squeeze by cutting spending in their Medicaid programs. 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).¹⁰⁶ For example, Tennessee dropped 200,000 beneficiaries, Michigan eliminated 38,000 beneficiaries, and Massachusetts cut 36,000 childless adult beneficiaries.¹⁰⁷

Medicare and Military Coverage

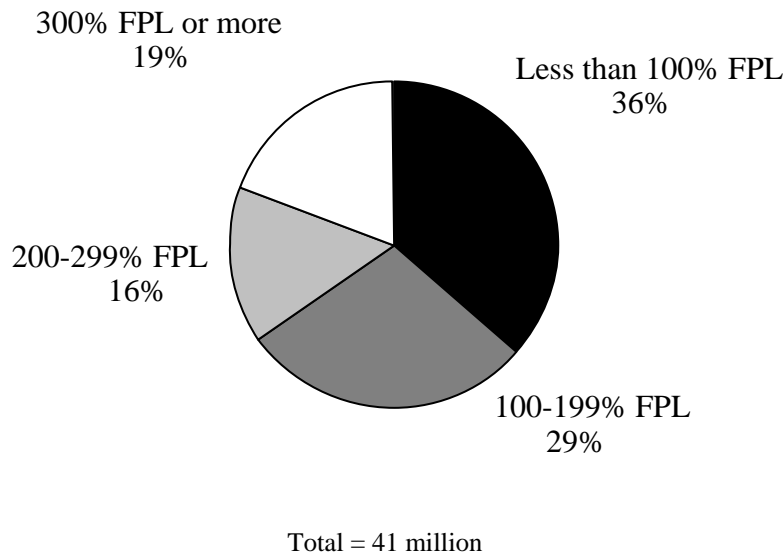
While Medicaid supplies the vast majority of public health insurance coverage for people under age 65, a relatively small number of nonelderly individuals obtained Medicare (5.6 million) or military coverage (6.6 million) in 2001. The proportion of nonelderly individuals with Medicare coverage has increased slightly over the past 15 years, from 1.5 percent in 1987 to 2.3 percent in 2001. However, the proportion with military coverage declined from 4 percent to 2.7 percent over the same period, in large part due to downsizing in the armed forces.¹⁰⁸

The Uninsured

In general, the likelihood of being uninsured or being covered by various sources of health insurance depends on a number of factors. These include income, job and employer characteristics, education, health status, age, gender, race and ethnicity, citizenship status, and geography. In 2001, 41 million Americans under age 65 (16.5 percent) went without health insurance for the entire year. While low-income individuals (i.e., those with incomes below 200 percent FPL) represented only one-third of the total nonelderly population, they accounted for almost two-thirds of those who were uninsured in 2001 (see Figure 1.12). Adults are also overrepresented in the uninsured population, in part due to the fact that they are less likely than children to qualify for public coverage.

While they accounted for 69 percent of all nonelderly individuals, adults represented 77 percent of the uninsured in 2001.¹⁰⁹

Figure 1.12
Nonelderly Uninsured by Family Income, 2001

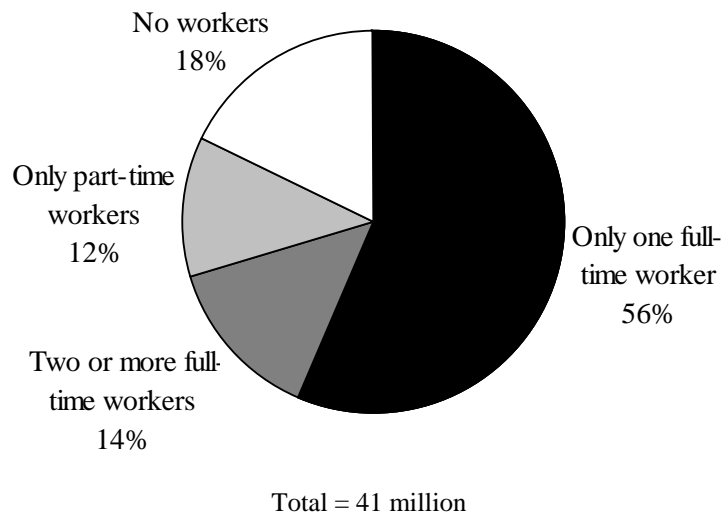


Source: Catherine Hoffman and Marie Wang, *Health Insurance Coverage in America: 2001 Data Update*, Kaiser Commission on Medicaid and the Uninsured (Washington, D.C.: Henry J. Kaiser Family Foundation, January 2003), p. 28.

Note: FPL means Federal Poverty Level.

As discussed earlier, the availability of employer-based health insurance varies by firm size, industry of employment, and other job characteristics. For example, within three industry groups that account for 60 percent of all jobs in America, health insurance coverage is quite different for those in service/labor versus professional/technical positions. While 33 percent of wholesale, retail, and trade workers in service/labor jobs were uninsured in 2001, only 18 percent of the professional/technical workers in that industry were uninsured. The breakdown for the professional services industry was 20 percent versus 8 percent, and 15 percent versus 6 percent in the mining and manufacturing industry.¹¹⁰ In 2001, more than two-thirds of the nonelderly uninsured lived in families that had at least one full-time worker (see Figure 1.13). Only 18 percent of uninsured individuals lived in a family with no workers.¹¹¹

Figure 1.13
Nonelderly Uninsured by Family Work Status, 2001



Source: Catherine Hoffman and Marie Wang, *Health Insurance Coverage in America: 2001 Data Update*, Kaiser Commission on Medicaid and the Uninsured (Washington, D.C.: Henry J. Kaiser Family Foundation, January 2003), p. 28.

Among young adults (many of whom have “aged off” a parent’s insurance plan and do not have jobs that offer coverage), the probability of being uninsured is particularly high. In 2001, 29.9 percent of adults ages 19-24 were uninsured. In contrast, only 16.2 percent of those ages 35-44 were uninsured. Hispanics are another group with a high proportion of uninsured individuals. While 11.6 percent of whites and 20.1 percent of blacks went without coverage in 2001, 34.8 percent of Hispanics were uninsured.¹¹²

Without using more sophisticated statistical methods, it is difficult to say how much of the difference between the uninsured rates of various groups can be attributed solely to particular social or economic characteristics or to differences in immigrant status or race and ethnicity. While most published analyses examine each factor separately (such as percentage of uninsured individuals by income, by employment status, etc.) to provide a general picture of how coverage varies among different groups, it should be noted that these types of comparisons do not allow us to evaluate the relative importance of each factor in determining an individual’s insurance status. For example, while both young adults and never married individuals have higher-than-average probabilities of being uninsured, it is difficult to isolate the effect of being young from that of being never married without using more sophisticated (multivariate) statistical methods.¹¹³

One recent analysis that attempts to examine many of these factors together found that, for example, about two-thirds of the difference in uninsured rates between non-Hispanic whites and Hispanics can be accounted for by measured differences in each group's socioeconomic and demographic (including nativity) characteristics. In other words, much of the difference in uninsured rates between these two groups is due to the fact that they are also different with respect to other characteristics (besides race/ethnicity) that affect the probability of being uninsured.¹¹⁴

Finally, although lack of health insurance is a major problem throughout the nation, differences in employment patterns, population characteristics, and public program eligibility standards mean that some states have larger numbers of uninsured individuals than others. In 2001, nonelderly uninsured rates ranged from 8.6 percent in Wisconsin to 25.7 percent in Texas. In general, western and southern states have higher proportions of uninsured residents than states in other parts of the country.¹¹⁵

How Long Do People Stay Uninsured?

While figures on the uninsured cited in this chapter have thus far referred only to those who were without health insurance for an entire calendar year according to the Census Bureau's Current Population Survey (which does not ask respondents for insurance start and end dates), it should be noted that the lengths of spells without coverage do vary.¹¹⁶ Using data from the Census Bureau's Survey of Income and Program Participation for the period October 1994 to September 1995, one study found that two-thirds of spells without health insurance lasted for less than one year, and approximately one-third lasted the entire year.¹¹⁷

Using data from the 1996 Medical Expenditures Panel Survey, another study showed that one-third of nonelderly individuals were uninsured at least once during a two year follow-up period. Among those who had an uninsured spell, 25 percent were chronically uninsured, going without coverage for the entire two years. Individuals with higher socioeconomic status have shorter periods without coverage; and while young adults are more likely to be uninsured than other age groups, they have shorter uninsured spells. Non-workers, Hispanics, and high school dropouts have longer uninsured spells, and there is evidence to suggest that the likelihood of regaining coverage declines as people remain uninsured for longer and longer periods of time.¹¹⁸

Consequences of Being Uninsured

Research showing that health insurance positively affects the use of health services is widely accepted, and it is clear that accessing medical care is a bigger problem for people without health coverage. For example, according to data from a household survey conducted by the Center for Studying Health System Change, 15 percent of uninsured people reported an unmet need for medical care in 2001, while only 4.4 percent of insured people reported this problem. Similarly, uninsured people were almost twice as likely to delay needed medical care as insured people (15.7 percent versus 8.6 percent). Among those who had an unmet need or delayed care, cost was the most frequently cited

reason. In addition, while 52.3 percent of those with insurance worried about the cost of care, 93.1 percent of those without insurance reported cost as a concern.¹¹⁹

Although the link between insurance and access to care is well-established, the relationship between health insurance and individuals' health outcomes is more ambiguous. As noted in a recent study from the Joint Center for Poverty Research that reviewed the research literature in this area, establishing a causal relationship between insurance status and health is difficult for two main reasons. First, while people who have health insurance and people who do not are different from each other in ways that can be measured (e.g., age, race, educational attainment), they may also be different in ways that cannot be measured easily or at all (e.g., environment, attitudes, preferences). As a result, statistical analyses may be problematic. Second, the relationship between health insurance and health can be interrelated. For example, health insurance may lead to better health through increased access to care, but at the same time, access to health insurance may be affected by one's health status (e.g., an individual who cannot obtain coverage due to a pre-existing condition or someone who "spends down" their income on medical expenses to qualify for public coverage). As a result, it may be difficult to determine the "real" cause of health outcomes.¹²⁰

To avoid these potential difficulties, the authors' literature review focused on quasi-experimental and experimental studies whose research designs provided a basis for establishing a causal relationship between health and health insurance in specific situations. Overall, the conclusion was that policies to expand insurance can also promote health. However, the authors noted that based on the available evidence, they were unable to say exactly which interventions related to health insurance would be most effective for improving health in the future.¹²¹ As discussed in this chapter and those that follow, this uncertainty is a key reason why so much disagreement exists about the best way to ensure access to quality health care for all Americans.

Another recent review of the research literature from the Kaiser Commission on Medicaid and the Uninsured also concludes that health insurance positively affects health outcomes, including mortality rates. Since extra years of life and more healthy years of life could add to individuals' and families' earnings, as well as to our national wealth, the authors argue that the next step for research should be to estimate the size of these and other potential benefits. Ultimately, such estimates could be used to inform the policy debate over expanding health insurance coverage.¹²²

Where Do the Uninsured Go for Care, and Who Pays?

In what is often referred to as the health care "safety net," individuals without insurance must navigate a fragmented, patchwork system of providers and services. Hospitals, health clinics, and physicians all provide care for the uninsured, but the delivery and financing of safety-net care varies substantially across communities. For example, in some areas, a sole public hospital is the core of the local safety net. In others, a network of community health centers serves as the main source of care. The mix of financial resources used to support safety-net care varies as well. While some states rely more heavily on direct state and local funding for the uninsured (in addition to federal dollars),

others largely depend on the ability of providers to pass costs along to third-party payers.¹²³

In the aggregate, a recent study published in *Health Affairs* estimated that uninsured individuals received \$35 billion in uncompensated care (defined as the difference between the cost of care provided and the amount actually paid by the uninsured) in 2001, or about 2.8 percent of total personal health care spending in the United States. Most of this uncompensated care (\$30.6 billion) was financed by governments through a variety of mechanisms including grants, direct provision programs, tax appropriations, and Medicare and Medicaid payment add-ons. The federal government financed the largest share of these costs, and most of the money went to hospitals (which deliver about two-thirds of uncompensated care).¹²⁴

Future Projections of the Uninsured

Absent any major changes in policy, the number of Americans without health insurance is likely to grow in the future. However, attempts to predict future patterns of health insurance coverage are complicated by a number of factors.

To the extent that we wish to determine how changes in the U.S. population (e.g., an increase in the percentage of near-elderly coupled with an increase in the percentage of part-time workers) might affect the number of individuals with various types of insurance, predictions are complicated by the fact that future economic conditions that will also affect health coverage (including health care cost inflation, wage growth, and the rate of unemployment) are highly uncertain. For instance, states faced with a budget shortfall might react to rapid health care cost inflation by tightening the eligibility criteria for public insurance programs. Similarly, some employers might pass on the cost of rising premiums to their employees (possibly leading to decreased participation), while others might stop offering health insurance altogether. At the same time, rising unemployment could lead to growth in the uninsured population if those who lose their jobs do not qualify for or cannot afford COBRA or some other type of coverage.¹²⁵

As a result of these uncertainties, researchers must make assumptions based on trends and past experience when projecting the number of individuals with health insurance into the future. Inevitably, different assumptions will lead to different projections. For example, a 2001 study published in *Health Affairs* found that the nonelderly 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.¹²⁶ Using various scenarios of economic growth and health care cost inflation, a 2000 study commissioned by the Health Insurance Association of America estimated that the number of nonelderly uninsured could range from 48 million to 61 million in 2009.¹²⁷ Similarly, a 1999 study by the National Coalition on Health Care estimated that the nonelderly uninsured population could constitute between 52.2 million and 61.4 million individuals in 2009.¹²⁸

Policy Alternatives and Key Questions to Consider

It is fair to conclude that the number of persons in the U.S. without health insurance will likely increase unless current policies are substantially revised. As interest has grown in addressing this problem, so have the policy solutions. 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 in the approach to achieving that goal, which segment of the uninsured population they would target, and how many Americans they would affect.

The wide range of proposals to increase access to health insurance can be grouped into four broad categories: 1) proposals to assist individuals to purchase insurance, 2) proposals to expand the public programs, 3) proposals to strengthen the employer-based system of health insurance, and 4) proposals to replace most of the current health insurance system with a single-payer national health insurance system. The remainder of this book provides examples of proposals in each of these categories as well as analysis and discussion of the various approaches.

1) Individual Tax Incentives

One approach to increasing access to insurance is to expand options for obtaining insurance through the individual market. As noted earlier in this chapter, approximately 6.6 percent (16.4 million) of Americans purchase health coverage on their own.¹²⁹ 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.¹³⁰ 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 may be prohibitive.

In Chapter 2, Mark Pauly and Ruben King-Shaw discuss options for expanding health insurance coverage through refundable tax credits. In Chapter 8, Mark Pauly's and Bradley Herring's paper entitled "Expanding Coverage via Tax Credits: Trade-Offs and Outcomes" examines how tax credits of different designs would reduce the number of uninsured. They conclude that small credits (25 percent or less of the cost of a premium) would not draw substantial numbers of the uninsured into the individual insurance market. Credits covering approximately half the cost of an individual health insurance premium might make it possible for a significant number of uninsured Americans to buy insurance in the individual market.

In 2002, President Bush proposed a tax credit of up to \$1,000 for individuals purchasing their own insurance, and up to \$3,000 for families, targeted to individuals and families with incomes below about 300 percent of the poverty level.¹³¹ According to the Bush Administration, the credit would cost about \$10 billion a year and would provide coverage to 6 million of the uninsured—about 15 percent of the uninsured population.¹³² Other participation estimates of the Bush proposal are considerably smaller. The U.S. Joint Tax Committee assumes costs and participation rates about 30 percent lower,¹³³ and a recent estimate provided in congressional testimony assumed participation rates of

about 65 percent lower than administration estimates, thereby leading to a reduction of about 2 million uninsured persons—a 4 percent 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.¹³⁴

2) Public Program Expansion

A second category of proposals to increase access to insurance is public program expansion. The most common sources of health insurance coverage for the nonelderly are the Medicaid and SCHIP programs, which together insured more than 28.3 million nonelderly individuals (mostly women, children, and disabled adults) in 2001.¹³⁵

The Medicaid program was expanded significantly in the 1980s and 1990s. Legislation was enacted extending eligibility to certain population groups (pregnant women and children up to the age of six with incomes below 133 percent of FPL and children ages 6 to 18 with incomes below poverty) and federal Section 1115 waivers were established to expand the scope of coverage under Medicaid.¹³⁶ Many states have also attempted to increase enrollment in the program by simplifying the eligibility determination and enrollment processes.

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 everyone with incomes below 185 percent 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. Senator John Kerry proposed that nearly all uninsured children be covered by SCHIP and that parents up to 200 percent of the poverty level be covered by Medicaid.

In Chapter 3, Judith Feder discusses public program expansion. In the corresponding paper in Chapter 9, “Covering the Low-Income Uninsured: The Case for Expanding Public Programs,” Judith Feder, Larry Levitt, Ellen O’Brien, and Diane Rowland discuss the potential for increasing access to the uninsured through an expansion of the Medicaid

program. They propose raising income eligibility requirements and allowing all individuals who are income-eligible to enroll in the program.

The strongest argument for expanding public programs is the capacity to target limited additional resources to persons most in financial need. About 64 percent of uninsured nonelderly Americans (27.7 million) are in families with incomes below 200 of the poverty line, and 36 percent (15.6 million) live below the poverty level.¹³⁷ Public programs such as Medicaid and SCHIP can effectively target support to these families and individuals. 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.

3) Expanding Employer-Based Coverage

Employer-based health insurance is currently the foundation of insurance coverage for nonelderly 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), which may be combined with employer tax subsidies, purchasing pools for small employers, and/or health savings accounts. 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 percent refundable tax credit to employers, coupled with an additional 25 percent 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.¹³⁸

In Chapter 4, Cathy Schoen discusses the employer-based approach. In the corresponding paper in Chapter 10, "Creating Consensus on Coverage Choices," Karen Davis and Cathy Schoen propose a major expansion in employer-based coverage as part of a multi-tiered approach to expanding access to care, which includes strategies for the employer system, the public sector, and the individual insurance market. Among the employer-based strategies contained in their proposal are a continuation of coverage for two months after an employee leaves a job, subsidies for COBRA coverage for the uninsured who are between jobs for extended periods of time, and extending private insurance coverage of dependent youth up to the age of 23 regardless of whether they are in school. To reduce the inequities between firms that provide health insurance and those that do not, employers that do not provide health insurance would be required to contribute funds to a public health insurance program. In addition, to give small firms

the economic advantage of a large purchasing pool, small firms would be allowed to join a large publicly-funded health insurance program.

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.

4) National Health Insurance

The most ambitious proposal to address the uninsured would be to create 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. Risk would be held by the taxpayers through the government, which would have primary responsibility for overseeing care and controlling costs.

Former Senator Carol Mosley Braun 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 percent employer tax.

In Chapter 5, James A. Morone discusses universal health care. Chapter 11 contains his corresponding paper entitled “Medicare for All,” as well as a paper entitled “A National Health Program for the United States: A Physicians’ Proposal.” In this paper, Steffie Woolhandler and David Himmelstein present a proposal for replacing the current health care system with a national health insurance system. 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, Choices, and Actions

While the options described above all deal with the same issue, the approaches are profoundly different, and raise a number of enormously important and complex issues.

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?

A second key issue is that different 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, while individually purchased policies have been the least comprehensive in nature. These differences have implications for who would most likely benefit under different reforms. A move toward 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. On the other hand, less comprehensive coverage might make the public more prudent in their daily health care decisions, thereby potentially lowering health care inflation.

A final key issue that is perhaps most important relates to 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 the United States faces major choices in this area—choices that will lead to very different outcomes. Will we see 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 to 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 present, coupled with a strong governing coalition that was in general agreement with the direction of reform proposed by the president.

Do these Conditions Exist Now?

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 cutbacks. 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? 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.

And what about the role of 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. Given the absence of national consensus, the polarization of the electorate and a deeply divided Congress, presidents face real challenges making substantial progress on this issue.

In April 2003 the LBJ Presidential Library and the Center for Health and Social Policy at the LBJ School of Public Affairs held a conference with national policy experts to discuss policy alternatives and grapple with these questions. As this book makes clear, there is no consensus on the best approach. This book attempts to frame these choices to help the reader come to a greater understanding of the choices we face and the implications of the alternatives for change.

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