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Issue Brief

Is Incremental Change Working? Or Is It Time to Reconsider Universal Coverage?

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Introduction

Addressing the limitations of health insurance coverage in the U.S. is resurfacing as a legislative priority and has emerged as an issue in the 2004 presidential election campaign. Reaching consensus on a comprehensive solution, however, has proved difficult. The history of attempts to establish universal health insurance coverage spans the 20th century, from efforts in the 1910s promoted by Theodore Roosevelt in his presidential campaign through the early 1990s.¹

Current and proposed approaches to reducing the uninsured population generally build on the existing system of public and private coverage. Approaches include establishing new tax credits for individuals and employers to defray the cost of health insurance, expanding private group coverage through employers or other group-purchasing arrangements, expanding eligibility for federal and state public programs, and creating new public programs. Some proposals combine various approaches to expanding coverage, while others aim to insure all Americans using a single approach, such as a national government-run system or mandatory employment-based or individual coverage within the private insurance market. Approaches to expanding insurance can be categorized according to:

- the vehicle for coverage—the private individual market or group-based plans, existing public sector programs or new public options, or both;
- the sources of payment for coverage—federal or state governments, employers, or individuals;
- the populations that would be covered—all Americans or specific subgroups of uninsured individuals;
- the number of uninsured that would be reached; and
- the economic impact, including the total cost of additional coverage and how it would be financed.

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The Uninsured: A Profile

An estimated 43.6 million people, 15.2 percent of the population, lacked health insurance in 2002, up from 14.6 percent in 2001. This represents an increase of 2.4 million people in one year and 4 million more uninsured (an increase of 10%) over two years.² While the Census Bureau estimate of the number of Americans without health insurance measures annual rates of coverage, the number uninsured depends on whether one measures rates of coverage as those uninsured for the entire year, at a single point in time, or at any point during the year.^{3,4} Using different surveys sponsored by the Census Bureau and other federal agencies, the Congressional Budget Office (CBO) estimates that 21 million to 31 million were uninsured for the entire year and roughly 60 million were uninsured at any time during the year in 1998.⁵ Recent studies also find high rates of churning in insurance markets over time, with people gaining and losing coverage repeatedly over the course of several years.^{6,7}

Uninsured Americans comprise a diverse population. Determinants of coverage include demographic factors such as age and race and ethnicity, as well as socioeconomic and employment status.⁸ The poor and near-poor have the greatest risk of being uninsured, but not as a result of unemployment, since the large majority of uninsured work or are members of working families.⁹ Young people between the ages of 19 and 29 are at increased risk of uninsurance because they tend to occupy low-wage positions, or lose access to coverage through their parents when they graduate from high school or leave college or to public coverage when they reach age 19.¹⁰ Hispanics are less likely than all other racial or ethnic groups to be insured, and have the highest uninsured rates across wage, income, and job categories.¹¹ Men historically have been somewhat more likely to be uninsured than women, but this gap has been closing over time.^{12,13} For some individuals, lack of coverage is a short-term problem, lasting only a few months, while for others the problem persists for one year or more.^{14,15}

Sources of Coverage

Employers and the federal and state governments, the major sources of insurance coverage, show signs of strain as a result of recent downward economic trends. Unstable labor market conditions have led to reductions in employment-based coverage, and escalating health care costs and premiums have affected both private and public payers. The percentage of people covered by employer-sponsored insurance decreased in 2002, from 62.6 to 61.3 percent.¹⁶ Most employers, especially large firms, continue to offer coverage, but some are scaling back coverage for current and former workers or retirees.¹⁷ In addition, the share of employees in large

firms who participate in employer-sponsored plans is declining, especially among low-wage workers.¹⁸ Small employers, facing higher premiums for group coverage due to less risk spreading and higher administrative costs, are less likely than large firms to offer coverage and face more rapid increases in premiums despite cutting back on benefits.¹⁹ The declining rate of employer coverage has been accompanied by rising premiums. Between spring 2002 and spring 2003, monthly premiums for employment-based coverage rose 13.9 percent, significantly faster than wage gains for nonsupervisory workers (3.1 percent).²⁰ Among the entire population, the percentage covered by government insurance programs, such as Medicaid, Medicare, and the State Children's Health Insurance Program (SCHIP), rose in 2002, from 25.3 percent to 25.7 percent. This rise was largely due to an increase in the rate of Medicaid coverage, from 11.2 percent in 2001 to 11.6 percent in 2002.²¹ According to the Department of Health and Human Services (HHS), 5.3 million children were enrolled in SCHIP in 2002, a 15-percent increase over the 2001 enrollment. Many states face budget constraints that could prevent additional expansions in public programs. Recent gains in public coverage have not offset the losses in private coverage, resulting in a net reduction.

The impact of uninsurance can be measured both in terms of poorer health status among those without insurance and in financial costs to the uninsured, to employers, and to the health system overall.^{22,23} While few studies have been designed to test a causative relationship between health insurance and health status, many studies have demonstrated that a correlation exists between the two.^{24,25} Some research suggests that insurance coverage is related to better health, which leads to higher labor force participation and higher income. Those without coverage receive fewer preventive services and tend to seek medical care when their illnesses are at more advanced stages, resulting in higher treatment costs, lengthier illnesses, and worse health outcomes. The financial impact of uninsurance on employers and workers can be measured in terms of lower earnings, lost productivity, and premature death and disability. The Institute of Medicine (IOM) reports that the aggregate cost of increased morbidity and mortality due to uninsurance in the U.S. is between \$65 billion and \$130 billion per year and, with an estimated 18,000 deaths per year, ranks lack of health insurance as the sixth leading cause of death for adults ages 25 to 64.²⁶ Costs to the health system can be measured in terms of the value of uncompensated care provided to the uninsured, estimated at almost \$35 billion in 2001, of which \$24 billion was provided by hospitals.²⁷ Of this amount, employers and managed care companies helped fund \$1.5 billion to \$3 billion through higher premium rates.²⁸

An Overview of Approaches to Expanding Coverage

Following unsuccessful efforts at major health care reform in the early 1990s, policies to expand coverage have been incremental rather than comprehensive. Policies have been implemented to establish tax credits for health insurance premiums, expand private group coverage, and expand federal and state public programs.

Tax Credits

Tax exemption of the value of employer-sponsored health insurance benefits provides a strong financial incentive for workers to obtain coverage through their employers. Many policymakers support additional tax-based subsidies for the uninsured as a vehicle for coverage expansions. Tax credits have been proposed to reduce the costs of coverage in the individual market, the employer-based system, new group insurance pools, and public programs. They have been targeted to both individuals and employers. Proposed tax credits for individuals generally target people with low to moderate incomes, phase out as income rises, and are refundable (allowing individuals who pay little or no income tax to qualify) and advanceable (providing immediate purchasing power).^{29,30}

A number of factors determine the reach and cost of tax credits:

- eligibility for the credit (all individuals, individuals without access to public or private group coverage, small businesses);
- the amount and type of the credit (fixed-dollar or proportional amount or varying with income); and
- the nature of insurance coverage for which the credit can be used.³¹

The use of individual tax credits to expand coverage would target those who are not linked to the private system of employment-based group coverage, are not offered coverage through their workplace, or cannot afford coverage offered by their employers. Tax credits proposed for use in the individual market, such as those in the Bush Administration's FY 2004 budget targeted to people with low incomes, could help many relatively young, healthy individuals and families. Depending on the size of the credit, however, tax credits might not help uninsured people with pre-existing conditions or who are older. For these groups, individual policies might be prohibitively expensive, exclude certain health conditions from coverage, or not be available at all. Proponents of tax credits for the individual market argue that they give consumers greater choice and control over their insur-

ance arrangements, and that they address equity and efficiency problems in the current tax code. Opponents argue that tax credits alone, without a new source of group coverage or market regulations, are unlikely to make much difference for many people who do not now purchase insurance. Opponents also argue that tax credits could erode the employment-based system but leave consumers with inadequate and more costly alternatives.

In the 107th Congress, a health insurance tax credit provision was included in the Trade Act of 2002 (P.L. 107-210). This law provides \$12 billion over 10 years in Trade Adjustment Assistance (TAA) to workers who lose their jobs due to foreign competition, including the Health Coverage Tax Credit, a refundable and advanceable tax credit to cover 65 percent of health insurance premiums. Eligible uninsured workers can use the tax credit to purchase employer-sponsored coverage offered by their former employers (i.e., COBRA³² coverage), a spouse's employer health plan, a previously purchased individual policy, or state-based group insurance, such as a state's purchasing pool for employees or for high-risk individuals. The law also establishes a tax credit for retirees age 55 or older who receive pensions from the Pension Benefit Guarantee Corporation. Initial eligibility for the tax credit began in December 2002 for individuals filing for the credit on their tax return. Estimates of eligibility range from approximately 200,000 workers and their families³³ to over half a million,³⁴ but by the end of December 2003, the federal government reported that only 8,374 workers were receiving tax credits for health insurance under the program.³⁵

Group Coverage

Private, employment-based group coverage remains the primary source of insurance for most Americans. The majority of uninsured Americans belong to families headed by at least one full-time worker.³⁶ Small employers face particular challenges in offering coverage, however. Many policymakers support expanding employment-based coverage by providing small employers with new group options to pool risk and purchasing power, strategies to lower premium costs with reinsurance, or tax subsidies for employers or for employees' premium payments for employer coverage. Mandating that all employers provide insurance is another approach to expanding group coverage among the working population. Group purchasing arrangements³⁷ for individuals and small firms also have been created with public and private sponsors. Many states also have established insurance pools for high-risk individuals, who for medical reasons have not been able to obtain coverage on their own.

Expanded group coverage could reach the majority of uninsured individuals who have a link to employment, but might exclude many vulnerable populations, such as the disabled and retirees younger than 65. Enhancing options for group coverage could help workers in small firms that currently do not offer coverage, low-income workers who cannot afford coverage offered by their employers, workers who are changing jobs or temporarily unemployed, or uninsured individuals who are affiliated with membership associations. Proponents argue that building on employer coverage takes advantage of the well-established link between employment and insurance, and could take advantage of payroll deductions for more automatic enrollment and collection of premiums to pay for coverage. Pooled purchasing power could result in lower costs and increased access to coverage for individuals and small groups, which typically have greater difficulty obtaining affordable private coverage. Few objections have been raised against proposals to expand voluntary employment-based group coverage. Many object to employer mandates, however, on the basis of the costs imposed on businesses who do not currently provide insurance, many of which are small firms that employ low-wage workers and cannot obtain affordable coverage. Also, there is concern about establishing association health plans without ensuring minimum standards for consumer protections, risk pooling, non-discrimination, and access.

As of mid-2003, 22 states had enacted legislation to establish or allow purchasing pools for small groups (including employers and associations) and individuals.³⁸ Research suggests that these purchasing pools have had limited success to date in covering previously uninsured people, and have not generated significant savings for participants, although they have broadened health plan choice.³⁹ High-risk pools, currently operating in 29 states, enrolled about 153,000 individuals in 2002.⁴⁰ The Trade Act of 2002 established a \$100 million grant program to encourage states to create or expand high-risk pools, and to offset operating losses that states experience.

States have also enacted insurance mandates as a way to expand group coverage. Hawaii enacted a mandate in the early 1970s that pre-dated (and thus received a waiver from) the Employee Retirement Income Security Act of 1974 (ERISA), a federal law that restricts how states regulate employer-sponsored health benefits. Washington and Massachusetts both included mandates as part of insurance coverage legislation in the early 1990s but the mandates were not implemented. Most recently, California enacted a law (Senate Bill 2) to mandate employment-based coverage.⁴¹ The law requires businesses to provide health insurance directly to employees or pay for coverage through a newly created

State Health Purchasing Program. Small employers with fewer than 20 employees are exempt, as are businesses with 20 employees to 49 employees unless the state implements a tax credit that covers 20 percent of the employer cost. Coverage under California's plan is scheduled to phase in starting in 2006 and is estimated to cover 1 million of the state's 6.3 million uninsured residents. Estimated costs vary widely, from \$1.4 billion to \$11 billion. Since most large employers in the state currently offer coverage, the cost burden would fall primarily on small firms. The law faces legal challenges, including a challenge that it possibly violates ERISA.

Federal and State Public Programs

Public programs such as Medicare, Medicaid, and SCHIP are important sources of coverage for millions of elderly and disabled individuals and low-income children and adults. Many policymakers support increasing coverage by expanding eligibility for existing public programs or creating new state-based programs. A more comprehensive approach is to cover all Americans under one program run by federal or state governments, known as a single-payer system.

Expanding public programs would target many uninsured people who have no reliable, stable, or affordable link to employment-based coverage, such as low-income adults, children in low-income families, and people with disabilities or chronic health conditions that limit access to private coverage. In most states, eligibility for public programs remains tied to welfare cash assistance categories, including families with children, the elderly, and the disabled. As a result, most childless adults, with the exception of those with disabilities, are ineligible for public health insurance regardless of their income or medical need. Supporters of expanded eligibility for public programs argue that these programs have the administrative capacity to provide group coverage and thus offer ready vehicles for increasing coverage among vulnerable low-income populations. Public programs also could offer a stable source of coverage for those without access to job-based coverage or with less stable links to any one employer or other sources of private group insurance. Opponents are concerned about the substitution of public coverage for private coverage and also about the stress on state capacity to finance expansions without new federal matching arrangements. Proponents of a single-payer system argue that a standardized, national health insurance system is an equitable way to ensure coverage for the entire population and would lower the administrative, underwriting, marketing, and other insurance costs associated with a fragmented insurance system. Opponents are concerned that a single insurance system could prove less flexible and less able to adapt to different regional and market conditions.

With the approval of the federal government, states have used the waiver process to increase public coverage by raising income or age eligibility levels for Medicaid and SCHIP beyond federal minimums, and by opening enrollment to parents of children eligible for these programs. Since January 2001, HHS has approved more than 2,500 SCHIP and Medicaid waivers and state plan amendments that have expanded eligibility to approximately 2.4 million people and enhanced benefits for roughly 6.5 million people.⁴² In 2003, at least six states, including Illinois, Massachusetts, Minnesota, New Jersey, Utah, and Washington, received HHS approval for coverage expansion waivers. States could face difficulty implementing these or additional expansion plans, however, in light of state budget shortfalls that are expected to exceed \$70 billion in the 2004 fiscal year.⁴³

While most action at the state level has consisted of expansions to existing public programs, new sources of public coverage also have been established. For example, Maine recently enacted a law to provide health insurance for all state residents by 2009, in part through a new statewide program.⁴⁴ The program, called Dirigo Health, expands the state's Medicaid program to cover more low-income individuals and sets up a new program to provide coverage through private insurance plans to uninsured individuals, small businesses with fewer than 50 employees, and the self-employed. The state also will provide subsidies on a sliding scale to people whose income is below 300 percent of the federal poverty level (FPL). Coverage starts in July 2004. The cost will be covered using funds from enrollees, employers, bad debt and charity care pools, a surcharge on health insurance premiums, and federal matching funds. In the first year, there are new state funds to support premium subsidies.

Current Proposals to Increase Coverage

Proposals to reduce the number of uninsured people have been introduced by many members of Congress, the Bush administration, and the Democratic presidential candidates. The Bush Administration's primary plan to date consists of a tax credit for low-income individuals to purchase insurance in the individual market, whereas most of the Democratic proposals combine employer group options, tax credits, and expansions of existing public-private insurance group insurance programs. In the 108th Congress, these varying approaches to coverage are the subject of dozens of bills introduced in both chambers. While advocates tend to emphasize specific proposals (e.g., tax credits, public program expansions), in the search for consensus there is generally an openness to combinations of approaches.

Establish Tax Credits

An individual tax credit is the centerpiece of the Bush Administration's current coverage proposal. The plan would provide low-income uninsured people with a refundable tax credit for 90 percent of health insurance premiums for a qualified policy, up to \$1,000 for an individual or \$3,000 for a family. The full credit amount would be available to individuals with income below \$15,000 and families with income of \$25,000 or less, phasing down as income increased. Generally, the proposal would rely on the individual insurance market and would follow existing state regulations governing this market. Also the proposal would, at state option, allow individuals not otherwise eligible for public programs to use the credit to purchase coverage through private plans that participate in states' Medicaid or SCHIP programs, or through purchasing pools for state employees or high-risk individuals.

A refundable tax credit to help make insurance more affordable for certain individuals and/or employers is a component of health care reform proposals supported by several Democratic presidential candidates and a range of congressional proposals. Provisions of current tax credit legislation in the 108th Congress include:

- Expanding the TAA tax credit to all unemployed workers, not only trade-displaced workers
- Expanding the tax deduction up to 100 percent of the health insurance premium for all taxpayers
- Providing a tax credit to small employers for coverage offered to low-wage workers
- Providing a tax credit to low-wage workers for their premium contribution for employer-sponsored coverage
- Providing a tax credit to assist unemployed workers with premiums for COBRA coverage
- Allowing tax deductions for federal civilian and military retirees for Federal Employees Health Benefits Program (FEHBP) and TRICARE health insurance premium payments

Expand Group Coverage

Proposals to expand group coverage by building on the employer system and creating new opportunities for pooled purchasing have received bipartisan support. Legislation in the 108th Congress to expand access to employment-based or other sources of group coverage includes:

- Establishing regulations for new group purchasing pools for small employers or self-employed individuals

- Allowing small businesses or the self-employed to buy into existing publicly-sponsored programs such as the FEHBP, state-run pools, or private group purchasing alliances
- Providing funds for new state-run high-risk insurance pools for uninsured individuals
- Proposals, including House Passed H.R. 660, that would promote the formation of small employer association health plans (AHPs). H.R. 660, the Small Business Health Fairness Act of 2003, would permit AHPs to operate nationwide and exempt them from state regulations such as mandates, small group market reforms, and consumer protections. This bill passed the House on June 19, 2003. No action has been taken yet in the Senate on this legislation or its companion bill (S. 545).

Expand Federal and State Public Programs

A variety of approaches would expand eligibility for public programs. These proposals include expanding income eligibility levels for SCHIP, making poor and near-poor parents and childless adults eligible for Medicaid and SCHIP enrollment, and expanding Medicare eligibility. At least one presidential candidate and several existing congressional proposals would also seek to create a new national health insurance program for all Americans. Provisions in current legislation in the 108th Congress to increase the number of uninsured people covered by public programs include:

- Increasing the income eligibility level in Medicaid and SCHIP for currently eligible population groups
- Making parents of children eligible at existing income levels for children, expanding coverage to childless adults, allowing young adults to stay on Medicaid/SCHIP beyond their 19th birthday as long as incomes continue to meet program thresholds, and covering legal immigrant women and children who meet existing state program income criteria.
- Establishing Medicaid eligibility for all disabled children
- Establishing temporary Medicaid eligibility for the unemployed
- Allowing uninsured people 55–64 years of age to purchase insurance through Medicare before they reach the official eligibility age of 65
- Eliminating the two-year waiting period for Medicare eligibility for disabled individuals⁴⁵
- Expanding Medicare eligibility to all uninsured individuals

Conclusion

The growing number of uninsured Americans has prompted policymakers to propose a range of solutions. Proposals vary in how they would expand coverage, how many uninsured they would cover, and how much they would cost. All expansion efforts, even those that build on the current system, require additional funding to pay for increased coverage. Estimates suggest that the uninsured would use between \$34 billion and \$68 billion annually in additional medical care if they were fully insured—at most a very small increase in total national medical expenditures.⁴⁶ Proposals to expand coverage for those currently uninsured, however, would also tend to shift some of the responsibility for financing to the federal budget, and, if applied equitably, would help make insurance more affordable for some adults and families with insurance. As a result, any more comprehensive policy that would reach a substantial share of the 43.6 million currently uninsured would tend to increase total federal spending by more than the increase in total national medical expenditures. Congress allocated \$50 billion over 10 years in the 2004 Budget Resolution for this purpose. Estimated costs of more comprehensive proposals that would insure at least 30 million of those currently uninsured range upward from \$70 billion a year or more.⁴⁷

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