

Alliance for Health Reform
Updated March 2008

Health Care Coverage in America: Understanding the Issues and Proposed Solutions

This publication is designed to help you become an active participant in discussions nationally and in your state about how we can secure health care coverage—private or public—for more Americans and help insured Americans keep the coverage they have.

Health coverage for children was at the top of the health care agenda on Capitol Hill and elsewhere in 2007. While a longer-term reauthorization failed, current funding levels for the successful State Children's Health Insurance Program were extended until March 2009.

The following guide shows how a lack of health coverage has real consequences for a person's health and financial status. You will learn more about how people get health coverage, why so many don't have it and who these people are.

Finally, you will learn about several approaches to reducing the ranks of the uninsured and how to make sense of these proposals.

CoverThe
Uninsured



3	INTRODUCTION
4	WHY THE STRONG INTEREST IN THE UNINSURED?
4	WHY IS HEALTH COVERAGE SO IMPORTANT?
6	WHO IS UNINSURED?
7	HOW DO AMERICANS GET COVERED?
13	APPROACHES TO COVERING THE UNINSURED
17	QUESTIONS TO ASK ABOUT ANY HEALTH COVERAGE PROPOSAL
17	GLOSSARY
17	SOME SPECIFIC PROPOSALS
19	END NOTES

Prepared for *Cover the Uninsured* by the Alliance for Health Reform, Washington, DC with assistance from the Employee Benefit Research Institute.

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Introduction

Like other things we value, health insurance is appreciated most when we don't have it.

That's the situation faced by the nearly 47 million people in the United States who do not have health care coverage.¹ They come from every age group and every income level. And 8.7 million of them are children.

The United States has an incredibly complex and convoluted system for financing and delivering health care. Americans get coverage through their jobs, the federal government, the military, state programs or on their own. At the same time, they pay for coverage through their employers, through state and federal taxes, and out of their own pocket.

Several times since the 1940s, Americans have engaged in nationwide discussions about how to provide health insurance to those who don't have it and how to help people keep their health insurance.

We are in the midst of another such discussion now. Government officials, political candidates, employers, unions, community leaders and ordinary citizens are saying the nation's health care system should be improved and its benefits should be made more widely available. The search goes on for ways to cover the tens of millions of Americans who fall through the system's cracks each year.

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

- About one in six people in the United States—nearly 47 million—lacked insurance for all of 2006, according to the U.S. Census Bureau.² That's an increase of 8.5 million since 2000.³
- In 2006, 8.7 million children were

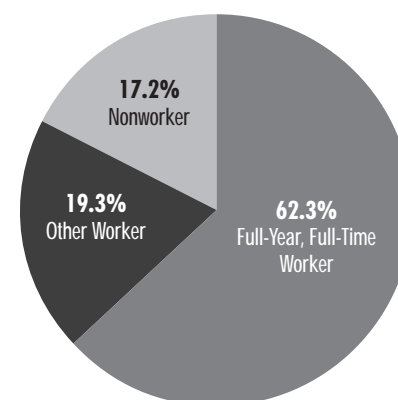
uninsured, up from 8 million in 2005.⁴ This was the third year in a row that the number of uninsured children had risen.

- The percentage of the U.S. population without health coverage has also grown, up from 13.7 percent in 2000 to 15.8 percent in 2006.⁵
- More than eight out of 10 of the uninsured are in working families. (See Chart 1.)⁶
- The uninsured don't fit any stereotype. They come from every community, every walk of life, every race and ethnic group, and every income level. (See Chart 2.)⁷
- People who have coverage can't necessarily count on keeping it. A person could have good coverage today, none at all six months from now and then regain coverage a few months later. Some 65.8 million people—more than 26.1 percent of

the population under age 65—lacked coverage at some point in 2005.⁸

CHART 1: MOST UNINSURED AMERICANS ARE IN WORKING FAMILIES

Uninsured Nonelderly Population by Work Status of Family Head, 2006



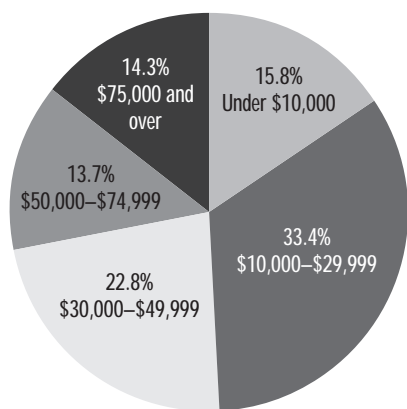
SOURCE: EBRI estimates from the March 2007 Current Population Survey

A NOTE ON UNINSURED NUMBERS

We count the number of uninsured children at 8.7 million for 2006, the latest figure available from the Census Bureau. This applies to children under age 18. There were slightly more than 9 million uninsured children under age 19 in 2006. Other analysts, also using Census data, estimate more than 9 million children are without coverage. Regardless of the counting method used, the United States has far too many uninsured children and action is required soon at the federal and state levels to help them gain health coverage.

CHART 2: UNINSURED COME FROM ALL INCOME LEVELS

Uninsured Nonelderly by Family Income, 2006



SOURCE: EBRI estimates from the March 2007 Current Population Survey

Why the Strong Interest in the Uninsured?

There are several reasons for the strong interest in making sure all Americans have health care coverage. For one, individuals and employers are growing increasingly concerned about the rising cost of health care and health insurance. Employees in particular are justifiably concerned that as health coverage gets more expensive, they may not be able to afford their share of the cost of coverage offered on the job—if they are offered coverage at all. They know that if they lose their job, they might also lose access to affordable health coverage and health care—a prospect discussed in more detail later.

Many Americans are worried about health coverage and health costs. For instance, 44 percent of those polled by the Pew Research Center for the People and the Press in 2008 said that affording health insurance is difficult or very difficult.⁹ Uninsured Americans are more than twice as likely as insured Americans to report a medical need that went unmet because of cost. (See Chart 3.)¹⁰ The uninsured are almost four times more likely than the insured to have an unmet need for prescription drugs.¹¹

Reducing health care costs and expanding coverage are top concerns of Americans. A poll conducted by the Pew Research Center for People and the Press in January 2008 found that 69 percent of respondents felt reducing health care costs should be a top priority for the president and Congress, while 54 percent believed that providing insurance to the uninsured is a top priority.¹²

Even so, many Americans are not convinced that being uninsured is a problem. Forty-five percent of Americans polled in 2007 mistakenly believed the uninsured can receive the care they need from doctors and hospitals.¹³

One important question is: Would Americans be willing to pay more for their health coverage or in taxes to guarantee coverage for all? In a February 2008 poll by the *Los Angeles Times* and Bloomberg, 44 percent said they were willing to pay more in taxes, while 41 percent said they were not.¹⁴

Asked if the federal government should guarantee health insurance for all Americans even if the respondent’s own health insurance costs would go up, 48 percent answered “yes” in a *New York Times*/CBS News 2007 survey.¹⁵

Yet another challenge is this: Neither the public nor policy-makers have settled on one preferred approach to providing health coverage for the uninsured.

Why is Health Coverage So Important?

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

EFFECTS ON HEALTH AND TREATMENT

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

People without health insurance often go without care or delay care. The care

they do receive is likely to be of lower quality than the care received by insured people, and they may be charged more for it. An estimated 18,000 to 22,000 Americans die each year because they don’t have health coverage, according to studies conducted by the nonpartisan Institute of Medicine and the Urban Institute.¹⁷

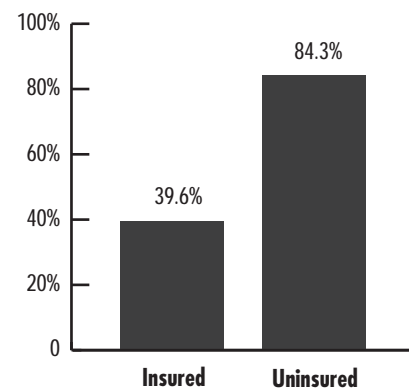
The length of time a person goes without health insurance also makes a difference. The Institute of Medicine noted that people who are uninsured for at least a year report being in worse health than those uninsured for a shorter period of time. Some 12 percent of those in poor health had been uninsured for a year or longer, compared to 5 percent who were uninsured for less than a year.¹⁸ But even among those uninsured for less than a year, it’s not unusual to skip needed medical care or pass up filling a prescription.¹⁹

In its landmark six-part series, the IOM found serious consequences for Americans living without health insurance, including:

- Uninsured women with breast cancer are less likely than insured women to receive breast-conserving surgery.²⁰

CHART 3: AMERICANS WITH UNMET HEALTH CARE NEED BECAUSE OF COST

Percentage of Americans Citing a Health Care Need in Last 12 Months That Went Unmet Because of Cost, 2002–2003



SOURCE: Sanmartin, Claudia et. al. (2006). “Comparing Health and Health Care Use in Canada and the United States.” *Health Affairs* 25, no. 4, p. 1139. (www.healthaffairs.org)

- Hospitalized patients without health insurance receive fewer needed services and lower-quality care and have a greater risk of dying in the hospital or shortly after discharge than patients with insurance.²¹
- The uninsured are less likely to receive care even when they have serious symptoms.²²
- Uninsured trauma victims are less likely to be admitted to the hospital or receive the full range of needed services. Uninsured victims with trauma due to an auto crash are 37 percent more likely to die of their injuries.²³
- Uninsured adults with HIV wait to receive new, highly effective drug therapies an average of four months longer than patients who have insurance. Among adults infected with HIV, having insurance reduces mortality by 71 percent to 85 percent over a six-month period.²⁴

The Institute of Medicine concluded: “Health insurance is associated with better health outcomes for adults and with their receipt of appropriate care across a range of preventive, chronic and acute care services. Adults without health insurance coverage experience greater declines in health status and die sooner than do adults with continuous coverage.”²⁵

Children without health coverage also suffer health consequences. Uninsured children are more likely than insured children not to have a usual source of health care and go without needed care. (See Chart 4.)²⁶

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

- Half as likely to have a “medical home”²⁷
- About half as likely to get needed mental health care or counseling²⁸
- Five times more likely to have an unmet dental need²⁹

- More than eight times more likely to delay care because of cost³⁰

When compared to children with health coverage from any source, uninsured children are:

- Less likely to have had a preventive health visit with a doctor in the past year³¹

The uninsured come from every race and ethnic group, every age group, and every income level.

- Ten times more likely to miss out on at least some needed medical care³²
- A third less likely to have someone they consider a personal doctor or nurse³³
- Almost three times as likely to receive no medical care at all in the course of a year³⁴

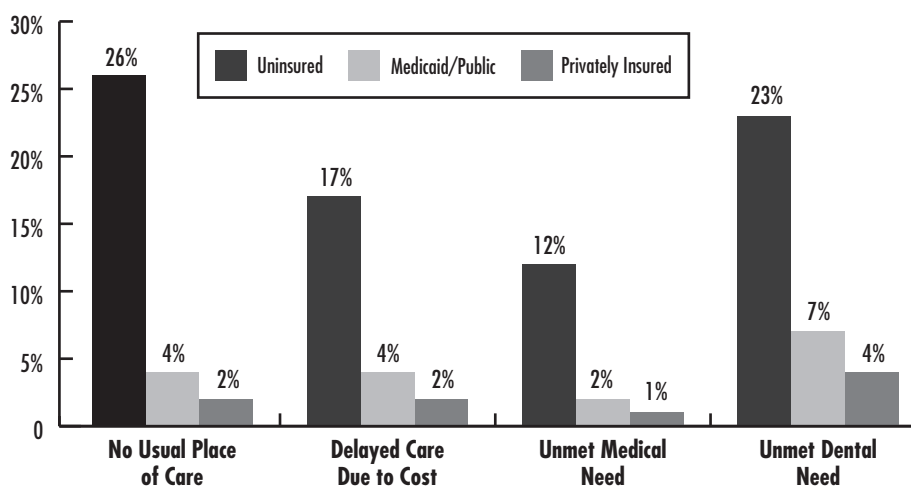
EFFECTS ON FAMILY FINANCES

Not having insurance may threaten the financial security of families. More than a third (35 percent) of the care received by the uninsured is paid for out of their own pockets.³⁵ Because families with at least one uninsured member tend to have lower incomes than fully insured families, as well as very few assets, they generally have fewer financial resources to help cope with these higher medical expenses. This may destabilize an entire family’s financial standing:

- Six out of 10 uninsured working-age adults report problems paying medical bills, compared with 35 percent of insured adults.³⁶
- Of those lacking coverage who also have medical bill problems or accrued medical debt, 27 percent reported that they struggled to pay for expenses such as food, rent and heat. Almost half (44 percent) said they were forced to use most or all of their savings to pay medical bills. One out of five said they had run up large credit card debts or had to take out a loan against their home to pay medical expenses.³⁷

CHART 4: UNINSURED CHILDREN MORE LIKELY TO DELAY OR FOREGO NEEDED CARE

Percent of Children with Selected Access Problems, by Insurance Status, 2006



SOURCE: National Center for Health Statistics, CDC (2006). Cited in Kaiser Commission on Medicaid and the Uninsured (2007). “The Uninsured: A Primer.” Figure 7, p. 8. October (www.kff.org/uninsured/upload/7451-03.pdf)

Who is Uninsured?

The number of people in the United States who lack health insurance has been rising slowly over time. In 2006, nearly 47 million people in the United States lacked health coverage, including 8.7 million children. Adults are uninsured more frequently than children: One in five adults age 18 to 64 was uninsured in 2006. By comparison, one in nine children was without coverage that year.³⁸

The uninsured come from every race and ethnic group, every age group, and every income level. Compared to the general population, however, people who lack health insurance are younger, have lower incomes, and are more likely to be a member of a minority group.³⁹

Nonelderly adults who lack insurance are also concentrated in certain states. According to the Kaiser Family Foundation, the largest percentages of uninsured can be found in Texas (30 percent) and Florida (27 percent), two of the 20 states in which at least 20 percent of the population between the ages of 19 and 64 are uninsured. Another 14 states have uninsured populations between 16 and 20 percent. Only 17 states have uninsured populations of 15 percent or less. The lowest percentage can be found in Minnesota (11 percent).

A common misconception is that those who are uninsured are also out of the job market. In fact, more than eight of 10 of those who lack insurance are in working families. (See Chart 1.)⁴¹ More than six of 10 were in families where the household head worked full time all year.⁴² The majority of uninsured workers (62 percent) are in service occupations and wholesale and retail trade jobs, according to the Employee Benefit Research Institute.⁴³ The key point is this: The overwhelming majority of uninsured Americans are from families actively in the labor force.

Americans living in households with annual incomes below \$25,000 have a higher incidence of uninsurance—24.9 percent being uninsured in 2006 compared to 15.8 percent of the total population.⁴⁴ For 2008, the poverty level is \$21,200 for a family of four in every state except Alaska and Hawaii. (See box, “What Does ‘Federal Poverty Level’ Mean?”)⁴⁵ According to the Census Bureau, 19.3 percent of children living below the poverty line in 2005 were uninsured.⁴⁶

There are also key differences in insurance coverage among racial and ethnic groups. Hispanics are far more likely than any other ethnic group to be uninsured. In 2006, 34.1 percent of Hispanics were uninsured for the entire year, compared to 20.5 percent of blacks, 15.5 percent of Asian and Pacific Islanders, and 10.8 percent of non-Hispanic whites.⁴⁷

In addition, 22.1 percent of Hispanic children were uninsured in 2006, compared to 14.1 percent of black

children, 11.4 percent of Asian American children, and 7.3 percent of non-Hispanic white children.⁴⁸

The Hispanic community encounters difficulties in securing coverage in part because so many members are recent immigrants who earn modest incomes. In 2006, 66.6 percent of foreign-born, non-citizen Hispanics with less than 10 years of U.S. residency were uninsured. Among Hispanics who are naturalized citizens and in the United States for the same length of time, 39 percent lacked coverage.⁴⁹

Like other uninsured Americans, uninsured Hispanics are often in low-wage service jobs that don’t offer health coverage. In addition, many low-income new immigrants, even when in the United States legally, are not eligible for public programs such as Medicaid, although their children are sometimes eligible.

One often-overlooked aspect of the uninsured population is that while the number of uninsured is relatively stable

WHAT DOES “FEDERAL POVERTY LEVEL” MEAN?

The federal poverty guidelines, also referred to as the federal poverty level, are family income figures produced each year by the U.S. Department of Health and Human Services to determine eligibility for certain federal programs, including Head Start, the Food Stamp Program, the National School Lunch Program and the State Children’s Health Insurance Program. Eligibility for certain state assistance programs is also tied to the federal poverty guidelines. For 2008, the guidelines are:

	48 Contiguous States and D.C.		
Size of Family Unit	Alaska	Hawaii	
1	\$10,400	\$13,000	\$11,960
2	\$14,000	\$17,500	\$16,100
3	\$17,600	\$22,000	\$20,240
4	\$21,200	\$26,500	\$24,380

For each additional person, add: \$3,600 (Alaska), \$4,500 (Hawaii), \$4,140

Source: “The 2008 HHS Poverty Guidelines,” U.S. Department of Health and Human Services. <http://aspe.hhs.gov/poverty/08poverty.shtml>

from month to month, it is not the same individuals who are uninsured from month to month and year to year. Hundreds of thousands of Americans lose coverage over the course of a year, and similar numbers regain it after lacking coverage for relatively short periods of time.

The dynamic nature of the uninsured population has implications for what strategies might be used to deal with the problem. A Commonwealth Fund study found that if every person with public or private insurance at the beginning of a given year retained it through the next 12 months, the number of uninsured, low-income children would decline by nearly 40 percent and the number of uninsured adults would decline by more than 25 percent.⁵⁰

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

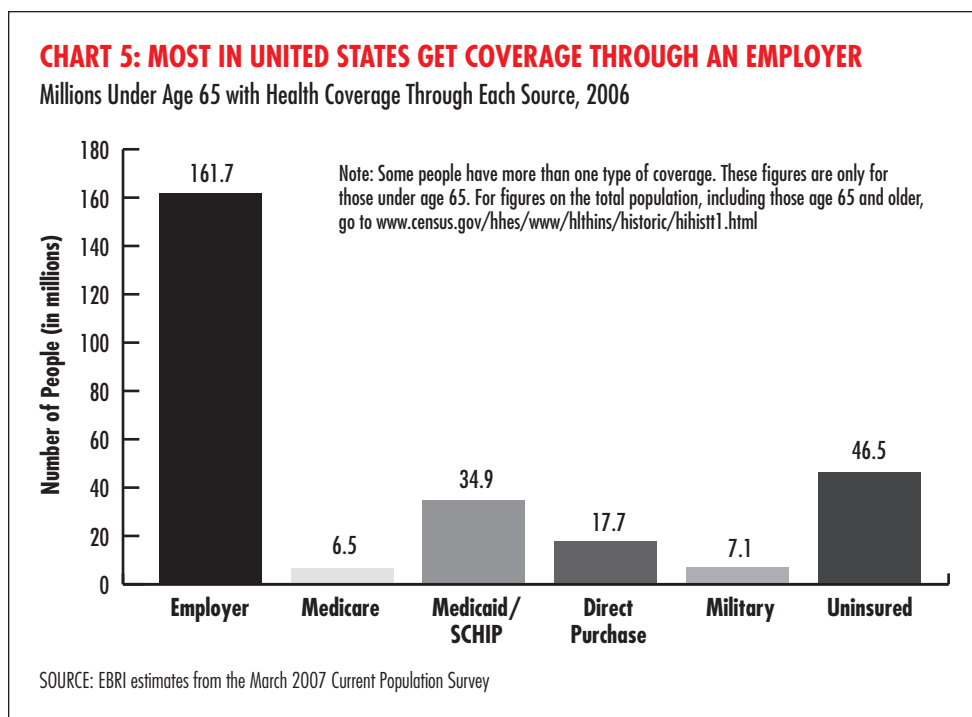
How Do Americans Get Covered?

EMPLOYER-SPONSORED COVERAGE

In the United States, most Americans—161.7 million nonelderly workers and their dependents—received health coverage through the workplace in 2006. This is far more than the 61.8 million nonelderly people covered through other means. (See Chart 5.)⁵¹

Workplace coverage was developed during the 1930s, pioneered by groups such as the Blue Cross hospital insurance plans⁵² and employers like Henry J. Kaiser, who started a prepaid group health plan for employees of his construction company.⁵³

Both of these examples were early



versions of health insurance “pools,” or groups of people who jointly purchase coverage. The main advantage of insurance pools is that they combine many people who are generally healthy with a few who are likely to need expensive medical care. This spreads risk by offsetting the costs of those with high medical bills through premiums of healthier enrollees. Thus, pools help keep coverage affordable.

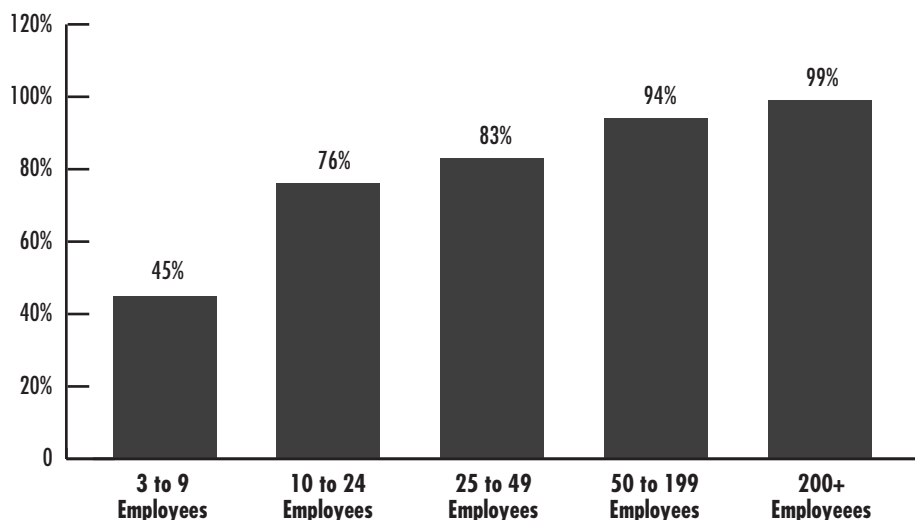
While the percentage of people obtaining health coverage through employers has been steadily shrinking in recent years, this remains by far the most dominant source of coverage. Health insurance through the workplace has remained popular for many reasons. For one, health coverage on the job carries significant tax advantages for employer and employee. Amounts that employers pay for their employees’ coverage are a tax-deductible business expense. In addition, this money is not counted as taxable income to the employee. This would end under a proposal by President Bush, announced in his 2007 State of the Union address, which would instead provide every

taxpayer with a tax deduction for health insurance expenses up to a certain amount.⁵⁴

Thus, at present, the \$50 a company pays toward an employee’s health coverage is more valuable to the employee, dollar for dollar, than \$50 per month in pay, since the employee has to pay income and payroll taxes on salary and wages. Some analysts have estimated that if the cash value of benefits were taxed like income, the increase in state tax revenue alone would have been \$21.4 billion in 2004.⁵⁵ More recently, the projected 2007 value of foregone federal taxes has been estimated at between \$200 billion and \$220 billion.⁵⁶ To put that into perspective, total Medicare spending in 2007 is estimated at \$428 billion.⁵⁷

Employer-sponsored coverage is also important because it is a natural mechanism for spreading the risk of high health care expenses among both healthy and unhealthy people. The many people with modest health care costs help subsidize the few with very high costs.

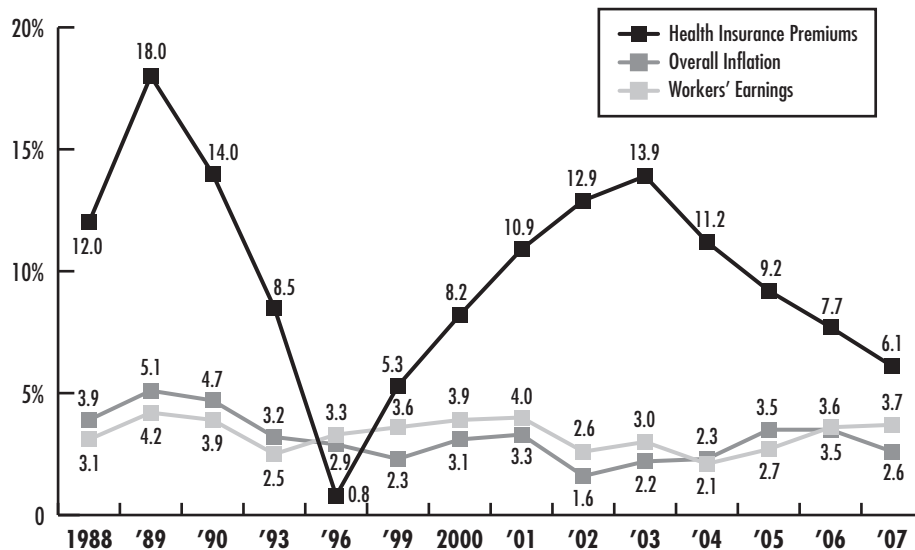
CHART 6: PERCENTAGE OF FIRMS OFFERING HEALTH BENEFITS, BY FIRM SIZE, 2007



SOURCE: Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits: 2007," www.kff.org/insurance/7672/sections/ehbs07-2-2.cfm

- Even if employees are offered coverage on the job, they can't always afford their portion of the premiums. Almost three out of four uninsured workers who chose not to participate in their employer's health plan in 2002 said the plan was too costly.⁵⁹
- Losing a job or quitting voluntarily can mean losing affordable coverage—not only for the worker but also for their entire family.
- A person's link to employer-sponsored coverage can also be cut by a change from full-time to part-time work or self-employment, retirement or divorce.
- Most employers offer a small number of health insurance plans for employees to choose from, and sometimes only one.

CHART 7: INCREASES IN HEALTH INSURANCE PREMIUMS COMPARED TO WAGE GROWTH AND GENERAL INFLATION, 1988–2007



SOURCE: Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits, 2007" www.kff.org/insurance/7672/sections/ehbs07-1-1.cfm

Forty percent of firms in the United States didn't offer health insurance at all in 2007.⁶⁰ Health coverage as a benefit remains widespread among large companies, with 99 percent of companies with more than 200 workers offering coverage.⁶¹ But most new jobs in the economy come from small firms,⁶² which are the least likely to offer health insurance. (See Chart 6.)⁶³

In part, that's because small firms have to pay more for the same level of coverage. Larger pools usually have greater risk-spreading capacity. In addition, an employer that represents many workers naturally has more clout negotiating prices with health plans than a smaller firm. Insuring a larger group of employees also carries a lower overhead cost per person for insurers. This is the reasoning behind proposals to combine employees of small firms into larger groups for insurance purposes.

Among employers who don't offer coverage, almost three out of four say premiums are too expensive. Forty percent say they believe their employees can get coverage elsewhere.⁶⁴

Premiums for employer-sponsored

EMPLOYER-SPONSORED COVERAGE HAS SOME DOWNSIDES TOO

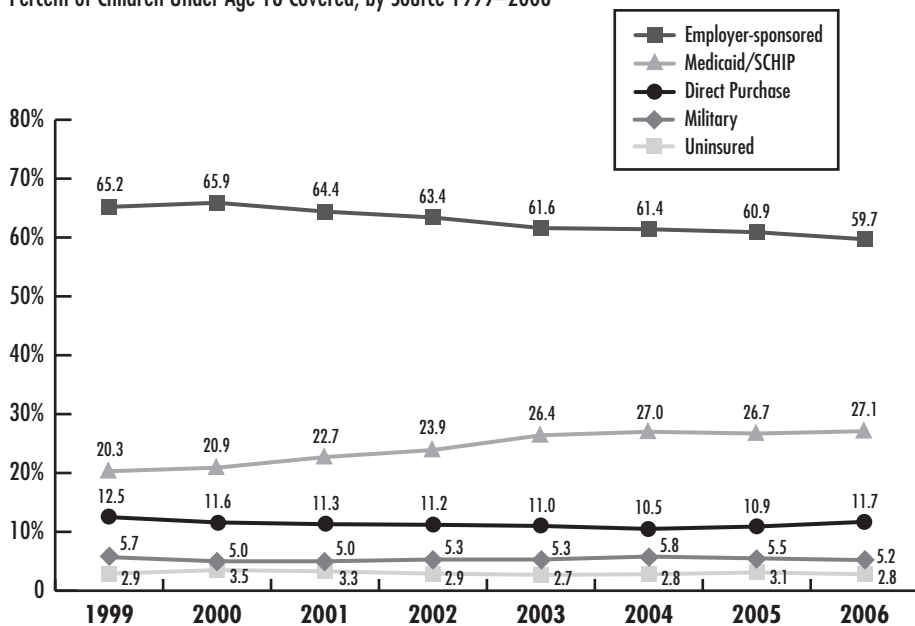
Despite its advantages, employer-sponsored health coverage has a number of disadvantages:

- Millions of working Americans don't have the opportunity to get it. In

2005, 20.1 percent of "wage and salary" workers aged 18-64 worked for an employer that did not offer coverage to any workers, and 17.9 percent were not eligible for the health plan that was offered by their own employer.⁵⁸

CHART 8: MEDICAID, SCHIP CHILDREN'S COVERAGE GROWING IN IMPORTANCE

Percent of Children Under Age 18 Covered, by Source 1999–2006



SOURCE: Table C-3 in DeNavas-Walt, Carmen, Bernadette D. Proctor, and Jessica Smith. "Income, Poverty, and Health Insurance Coverage in the United States: 2006." Current Population Reports. P60-233. Washington, DC: U.S. Department of Commerce, Economics and Statistics Administration, August 2007. (www.census.gov/prod/2007pubs/p60-233.pdf)

health coverage are rising much faster than workers' earnings and inflation. (See Chart 7.) Between spring 2006 and spring 2007, premiums for coverage offered by employers across the United States increased by 6.1 percent—more than twice the growth in the Consumer Price Index (CPI). This includes amounts paid for coverage by both employer and employee.⁶⁵ Employers with three to 199 workers saw an average increase of 5.5 percent; firms larger than that had an average increase of 6.4 percent.⁶⁶

Employers expect health premiums to rise an average of 5.7 percent in 2008, according to a survey by Mercer Human Resources Consulting.⁶⁷ In contrast, the CPI is expected to grow by 2.9 percent.⁶⁸

In response to these steady premium hikes, many companies are asking their employees to cover some of the new costs. For instance, workers taking single coverage through an employer paid 11.5 percent more for their

coverage in 2007 than in 2006—\$58 monthly vs. \$52. Premiums for a family of four paid by workers increased by 10 percent from 2006 to 2007—from \$248 per month to \$273.⁶⁹

But in a counter trend, some employers are giving employees free prescription drugs to help them manage conditions such as diabetes, high blood pressure, asthma and depression.⁷⁰

For children, employer-sponsored coverage is shrinking in importance as Medicaid and SCHIP coverage grows. (See Chart 8.) Between 2000 and 2006, the portion of children covered through job-based insurance decreased from 65.9 percent to 59.7 percent.⁷¹

The health coverage picture for retirees is similar. Overall, 33 percent of firms with 200 or more workers offered retiree health benefits in 2007. This is down substantially from 66 percent in 1988.⁷²

The situation is even less optimistic for future retirees. In 2006, 9 percent of employers offering retiree health

benefits reported that they had terminated subsidized coverage for future Medicare-eligible retirees, and another 10 percent were likely to do so in 2007.⁷³

Even among large firms, there are many uninsured workers. In 2006, 22.4 percent of the nation's uninsured workers age 18-64 were in firms employing more than 500 people.⁷⁴ In part, this reflects the fact that firms vary on whom they classify as eligible for coverage. For example, some firms don't offer part-time employees health benefits, and some don't offer coverage to workers who have been employed for less than a certain amount of time. Some workers decline coverage because they can't afford their share of the premium.

Historically, high levels of insurance coverage have been tied to union jobs. According to the federal Bureau of Labor Statistics, 80 percent of union workers in the private sector had jobs with employer-sponsored health coverage in 2006, compared to 49 percent of nonunion workers.⁷⁵ But union membership has dwindled: In 2007, union members comprised just 12.1 percent of the workforce.⁷⁶ When a union job disappears, health coverage for the union worker may disappear with it.

INDIVIDUAL COVERAGE: PROS AND CONS

For those who have no access to insurance through the workplace or can't afford their share of the premium, the individual or "nongroup" market is one possible alternative. (Though insurance sold in the individual insurance market is often referred to as "individual" coverage, most analysts refer to it as "nongroup," since such policies can cover individuals only, or individuals and families.) In 2006, 6.8 percent of the nonelderly U.S. population, or 17.7 million people, were covered by a nongroup policy.⁷⁷

People might seek individual policies if they are self-employed or if the firm they work for doesn't offer coverage.

(As noted, 40 percent of firms didn't offer coverage in 2007.) Layoffs, divorce, the death of a spouse or a child's growing too old to be on a parent's policy could lead someone to turn to the individual market. One 2004 study estimated that the 20 percent of Americans not eligible for group or public insurance find their only coverage options in the individual market.⁷⁸

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

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

These higher costs are reflected in the premiums charged for individual policies. More than half of adults with coverage through the individual market pay \$3,000 or more in premiums each year, compared with one in five adults covered by employer-sponsored plans.⁷⁹

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

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

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

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For all these reasons, a person looking for an individual insurance policy may or may not find one. In one 2004 study, high prices were recognized as the dominant factor for low participation in the individual market.⁸⁰

HSAs AND HIGH-DEDUCTIBLE HEALTH PLANS

Health savings accounts (HSAs) are a relatively new model of health insurance coverage. Individuals can only contribute to an HSA if they are also covered by a qualified high-deductible health plan. In 2008, these plans must have an annual deductible of at least \$1,100 for self-only coverage and \$2,200 for family coverage, and a maximum out-of-pocket limit of \$5,600 for self-only coverage and \$11,200 for family coverage.⁸¹ According to America's Health Insurance Plans, a trade association representing many types of health plans, 4.5 million people were covered by an HSA-qualified high-deductible health plan as of January 2007.⁸²

HSAs are a trustee account holding pre-tax dollars from workers and employers that individuals can draw from to purchase health services. They were established by the Medicare Modernization Act of 2003. In 2008, the maximum amount that can be contributed to an HSA is \$2,900 for self-only coverage and \$5,800 for family coverage.⁸³ HSA contributions can be made by individuals, their employers or both.

This coverage carries with it certain preferences in tax treatment. Contributions to an HSA are tax deductible for individuals who purchase their own coverage, but do not reduce income subject to payroll tax. Earnings on the funds kept in HSA accounts accumulate tax free, balances can be rolled over year to year and withdrawals from the accounts are tax-free if made for qualified medical expenses.⁸⁴

Analysts and policy-makers are actively debating many questions about HSAs: What impact will they have on the individual and group health insurance markets? Will they concentrate or spread the health risks of the population receiving coverage in the private market? How might HSAs affect overall health spending over time? What impact are HSAs likely to have on the number of uninsured Americans during the next several years?

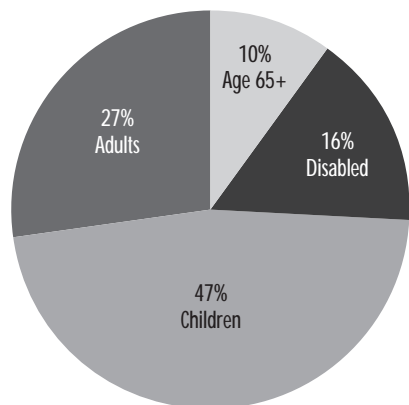
President Bush has long been a proponent of HSAs. He signed the original legislation creating HSAs in 2003, then signed another bill in late 2006 encouraging the use of this model.⁸⁵ In his 2007 State of the Union address, the president called for further expansion of HSAs.⁸⁶

HSA proponents argue that expanding the role of the consumer and providing equivalent tax preferences in the individual market will improve the overall health care system. They note that a high-deductible policy paired with an HSA allows individuals to assume responsibility for paying for many of their own services rather than having them paid by an insurer or a government program. They argue that this has the potential for both restraining the cost growth in those plans and making individuals more aware of the quality of care they are receiving. People are more prudent, they assert, when spending what they perceive as their "own" money.⁸⁷

However, some analysts doubt that HSAs will do much to lower the number of uninsured in the United States.⁸⁸

CHART 9: MEDICAID ENROLLEES

Unduplicated Annual Enrollment for Fiscal Year 2007



SOURCE: U.S. Department of Health and Human Services "2007 CMS Statistics." (www.cms.hhs.gov/CapMarketUpdates/Downloads/2007CMSstat.pdf)

They argue that HSAs will mainly serve to concentrate healthy people with more disposable income in high-deductible health plans, causing them to drop out of the conventional group market. This, they say, could cause adverse selection—the concentration of sicker people with more modest incomes—in traditional low-deductible health plans that have long been the cornerstone of the group market, and cause sharp premium increases that make such coverage unaffordable over time for many people.

In a February 2007 report, the federal National Health Statistics Group said that estimates of health spending reductions resulting from HSAs coupled with high-deductible health plans are “fairly modest.”⁸⁹

Time will tell how popular HSAs will become and how they will evolve. For instance, America’s Health Insurance Plans has called on Congress to allow more generous contributions into HSAs if someone in the family is enrolled in a disease management or care coordination program for a chronic condition. The organization also suggests that early retirees could be allowed to use HSA funds to buy retiree health coverage.⁹⁰

MEDICAID

The Medicaid program offers a relatively generous package of benefits for low-income mothers and children, people with disabilities, and certain seniors. Some 60.9 million people were covered by Medicaid at some point during fiscal year 2007, according to the Department of Health and Human Services.⁹¹ This is the number accepted by most health services researchers. The U.S. Census Bureau, based on its survey of households, puts the number at 38.3 million covered for the non-institutionalized population in 2006.⁹²

Medicaid enrollment has grown each year since 1998.⁹³ Without this growth, the number of uninsured in those years would have been even higher.

Medicaid is funded by both state and federal dollars. Medicaid spending per person varies significantly among the groups covered. Children, the healthiest of Medicaid beneficiaries, accounted for 47 percent of the enrollees but just 17 percent of the spending in 2005.⁹⁴ Those over 65 and people with disabilities, by contrast, are as a group in poorer health and in need of more services. They comprised only 26 percent of beneficiaries but accounted for 75 percent of spending. (See Chart 9.)⁹⁵

Medicaid also pays for nearly half (49 percent) of all long-term care services, including custodial nursing home care.⁹⁶ Nearly 60 percent of all nursing home residents receive support from Medicaid.⁹⁷

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

- Pregnant women and children up to age 6 in families with incomes up to

133 percent of the federal poverty level

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

THE UNEASY RELATIONSHIP BETWEEN STATE BUDGETS AND MEDICAID COSTS

Medicaid consumes a high proportion of spending by state governments. It is the second largest item for state government general fund spending, after elementary and secondary education. In fiscal year 2007, Medicaid accounted for 21.5 percent of general fund spending by the states.⁹⁸ Looking at total state spending, including federal funds spent by the states in 2006, Medicaid made up 21.1 percent of expenditures. Maine had the highest percentage (34.1 percent of total state spending) and Wyoming had the lowest (8 percent).⁹⁹

The economic slowdown in 2001-2002 forced governors and legislators to cope with large imbalances between revenues and increased spending needs. While the federal government can incur deficits from one year to the next, all states, with the exception of Vermont, must balance their budgets each year. More recently, most state economies have recovered, and many states have taken legislative action to gain greater control over their budgets. For fiscal year 2007, 18 states enacted tax and fee increases, while 24 enacted net decreases.¹⁰⁰

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

Some of the options for restraining Medicaid spending are politically painful. For example, states can cut payments to providers and plans, restrict benefits, and curtail eligibility. To save even more money, some states have also reduced their outreach and enrollment campaigns that inform the public about who is eligible and how to sign up for Medicaid benefits.

States were projected to get a short respite in the steep upward trend of Medicaid spending. In fact, Medicaid spending growth declined for the first time in the program’s 40-plus year history in 2006.¹⁰¹ This is largely because beginning in January 2006, states were no longer liable for the prescription drug expenses of “dual eligibles”—those who are eligible for both Medicare and Medicaid. Instead, states now make payments equal to about 5 percent of state Medicaid expenses to the federal government,

which is paying these drug expenses through Medicare.

But the Medicaid spending “breather” will be short lived. Recent projections suggest that health care spending will continue to rise at an average annual rate of 8 percent through fiscal year 2017.¹⁰² Medicaid accounts for 22 percent of state budgets, so rising costs will continue to put pressure on states.¹⁰³

STATE CHILDREN’S HEALTH INSURANCE PROGRAM

More than 20 million children under age 18 were covered by Medicaid or the State Children’s Health Insurance Program (SCHIP) in 2006, according to the Census Bureau.¹⁰⁴

Congress created SCHIP in 1997. Financed jointly by the federal and state governments, the program is intended for children whose parents earn too much to qualify for Medicaid yet too little to afford private

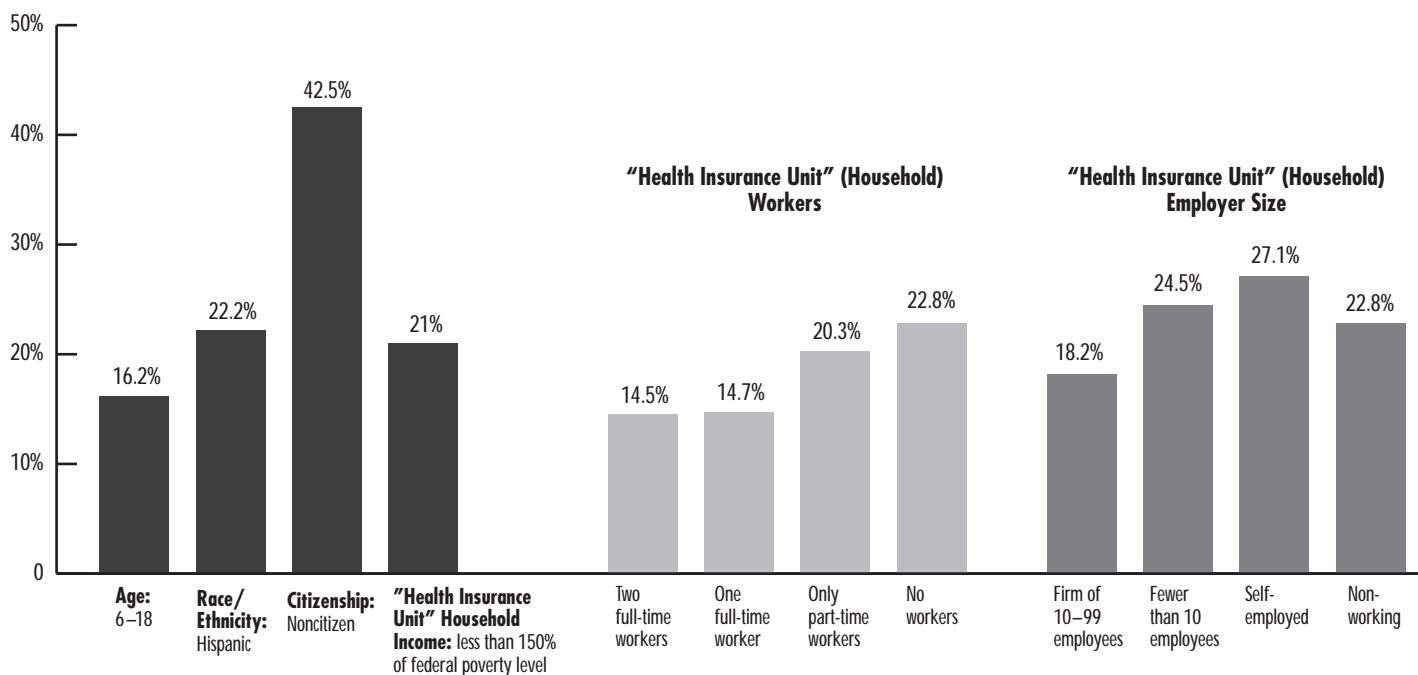
coverage. SCHIP has been remarkably successful. Almost 70 percent of eligible children have been enrolled, according to the Urban Institute. Among eligible children in fair or poor health, 80 percent are signed up. But 1.8 million eligible children are still not enrolled in the program. (See Chart 10 for characteristics of eligible but unenrolled children.)¹⁰⁵

SCHIP eligibility is generally focused on children in families with incomes up to 200 percent of the federal poverty level. In 1997, only nine states covered children up to this income level. Today, only eight states have not yet reached this level, while 15 states now cover children in families with incomes greater than 200 percent of the poverty level.

Some states have brought children with much higher family incomes into the program. For instance, New Jersey’s *NJ FamilyCare* program accepts children

CHART 10: SELECTED CHARACTERISTICS OF CHILDREN WHO QUALIFY FOR SCHIP BASED ON INCOME, BUT AREN’T ENROLLED, 2005

For comparison, 11.2% of all children were uninsured in 2005 (U.S. Census Bureau)



SOURCE: Kenny, Genevieve and Allison Cook (2007). “Coverage Patterns among SCHIP-Eligible Children and Their Parents.” Urban Institute, February. www.urban.org/UploadedPDF/311420_Coverage_Patterns.pdf

with family incomes as high as 350 percent of the federal poverty level, which in 2007 amounts to more than \$72,000 for a family of four.

The federal government authorized \$48 billion over 10 years for SCHIP. The financing of SCHIP during the last 10 years has provided states with a powerful inducement to cover more children because they can use federal funds, while putting up fewer of their own dollars than is required under Medicaid.

Across all states, the average federal matching rate for SCHIP in 2007 was 70 percent, meaning that for every 30 cents in revenue raised by states for the program, the federal government provided 70 cents. By comparison, the average federal matching rate for Medicaid was 60 percent.¹⁰⁶

States have considerable flexibility in the use of SCHIP money. Some states have established an independent Children's Health Insurance Program (CHIP), while others have chosen to expand their Medicaid program to include children in families with higher household incomes. Still other states have adopted a combination of both approaches. Currently, 16 states have a separate program for children, 16 have expanded their Medicaid program and 19 have combination programs. Children applying for a separate state program or a combination program must first be screened to make sure they are not eligible for Medicaid. This is because no child who is eligible for Medicaid can be enrolled in SCHIP—a rule that is designed to discourage states from claiming the more generous SCHIP matching dollars for Medicaid-eligible children.

The federal legislation that created SCHIP in 1997 was scheduled to expire in September 2007. When considering how to extend the program, lawmakers needed to decide how much money the federal government would provide. Keeping the current level of federal funding, roughly \$5 billion per year,

would result in 1.6 million to 1.9 million children losing coverage between 2006 and 2012.¹⁰⁷ To keep enrollment at current levels would require adding anywhere from \$8 billion to \$15 billion over the next five years. Reaching the almost 2 million children who are eligible but not enrolled would cost an estimated \$40 billion to \$60 billion over five years.¹⁰⁸

More recently, we have seen
a flurry of interest among
state legislatures and
governors' offices.

Some advocates proposed extending the program to additional groups, including parents of eligible children. Such an expansion would further increase projected costs. Under special permission from the federal government, eight states already cover some parents. Four states cover some childless adults, and 11 states use SCHIP funds to cover some pregnant women.¹⁰⁹

Last fall, two separate versions of a new SCHIP bill were passed by the House and Senate but President Bush vetoed both of them. In December 2007, Congress passed legislation that extended the program through March 31, 2009, with enough funding for states to maintain their current enrollment through that date. President Bush signed the bill on December 29, 2007.

Many people wonder if the SCHIP debate provided a preview of broader conversations about ways to reconfigure the nation's public-private health system in order to extend regular medical care to tens of millions of uninsured adults, whose primary source of health services may be an emergency room or a public health clinic.

MEDICARE

Virtually everyone over 65 is eligible for Medicare, along with certain individuals who have permanent disabilities and

those with end-stage renal disease (ESRD). Eligibility for Medicare does not depend on a person's income or assets. This sets it apart from many other government health care financing programs, which are restricted to those with limited finances.

Medicare, which is financed by the federal government and beneficiaries, had an average monthly enrollment of 43.9 million people in 2007, about 16 percent of whom are under the age of 65 and qualified for the program on the basis of permanent disability.¹¹⁰ Individuals of any age who have ESRD also qualify for Medicare coverage¹¹¹ and account for less than 1 percent of Medicare enrollment.¹¹²

Medicare has occasionally been part of discussions about the uninsured. For example, it has been recommended as a platform for providing coverage to early retirees between the ages of 55 and 64. (See the section on public program expansions below.) Because it has only sporadically been part of the debate, it is not covered in detail in this guide. General information about Medicare is available at www.medicare.gov.

Approaches to Covering the Uninsured

While the current system of covering Americans has many advantages, the fact that tens of millions of people each year are uninsured suggests that we could be doing a better job in making health care coverage accessible to everyone. Indeed, policy-makers in Washington have been trying to do this for more than a half century. More recently, we have seen a flurry of interest among state legislatures and governors' offices.

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

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

In order to better understand the range of policy options available to lawmakers, it’s helpful to look at a series of general approaches to covering the uninsured, ranging from making progress step by step to a wholesale overhaul of our system. It is important to remember that the following isn’t an exhaustive list of options but rather a representative selection of approaches.

You can find more helpful information at the *Cover the Uninsured* Web site, www.CoverTheUninsured.org.

Below is a summary of some of the major approaches that have been discussed and debated by researchers, legislators, health industry stakeholders and advocates. This section is based principally on the *Covering America* project of the former Economic and Social Research Institute, supported by the Robert Wood Johnson Foundation.¹¹³

EXPANSION OF EXISTING EMPLOYER-BASED POOLS AND CREATION OF NEW POOLS

During the 1990s and continuing today, Congress has taken an active interest in debating proposals designed to improve access and affordability in the small group insurance market (for employers with 50 or fewer workers) and the individual insurance market. As discussed above, this interest has taken the form of legislation that created health savings accounts (HSAs) and legislation that proposes to create association health plans (AHPs) and similar entities.

The 1996 Health Insurance Portability and Accountability Act created new federal requirements to temper the effect of medical underwriting (e.g., exclusions for individuals with certain costly pre-existing medical conditions) in the small group and individual

markets. But these reforms are now widely acknowledged to have had limited impact on the affordability of and access to coverage for many companies and individuals in these markets, where monthly premiums and annual deductibles have remained high.

One idea that has been carefully considered by experts and policy-makers of diverse viewpoints is the possibility of allowing individuals and employers to buy into an existing large pool. This would spread risk and lower premiums.

One such pool is the Federal Employees Health Benefits Program (FEHBP), which is for federal employees and their dependents. FEHBP is community rated, meaning that federal workers who have a medical history of illness cannot be charged more than those who do not.

Advocates of this approach point out that it takes advantage of existing economies of scale and risk pooling. Opponents claim that costs for FEHBP would rise if a large number of individuals in poor health were allowed to join.

Another pooling approach is association health plans. Passed several times in the U.S. House of Representatives, legislation to create AHPs has always faltered in the Senate. Such plans would help small employers purchase health coverage through trade associations. Proponents note that by grouping together their employees in such plans, small employers could gain the economies of scale—and the lower per-person premiums—enjoyed by larger employers. Critics object to the fact that AHPs would be exempt from state mandates that require health insurers to cover specific diseases or treatments and forbid them from refusing to cover older or sicker individuals or charge them higher premiums.

EMPLOYER CONTRIBUTION REQUIREMENTS

Employer contribution requirements, better known as employer mandates,

would require employers to either provide insurance to their workers or finance coverage through a tax covering all or most of the cost of providing insurance to their workers under newly created public plans, or insurance pools. Such proposals are often referred to as pay or play.

Proponents argue that such a requirement would treat all employers fairly, since employers could not gain a competitive advantage by refusing to cover their workers, as they can now. All employees and their dependents would be guaranteed access to health coverage.

Opponents counter that pay or play is unwise because it would create a new economic burden for lower-wage firms that don’t currently offer health insurance to their workers. These employers often oppose legislation that would require providing health coverage, arguing that it is most appropriate for them to make decisions about the benefits packages they offer in order to attract the most suitable workers. By adding to the cost of employment, they say, this approach would discourage businesses from hiring more workers.

INDIVIDUAL MANDATES

Individual mandates would require everyone to have some basic form of health insurance. Such insurance could be provided by employers, the public sector or private insurers. The individual mandate is akin to automobile insurance—every driver has to buy at least the legally required minimum amount of coverage.

Proponents say that if everyone is required to have insurance, insurers would provide a range of policies with varying benefits in order to attract new business. Doing so would lower the price of coverage, they contend, due to increased competition among carriers and the addition of millions of relatively healthy, low-cost people to the health insurance market.

Opponents believe that requiring individuals to have coverage wouldn’t necessarily mean that everyone would

get it. Compliance is far from universal in the automobile insurance market. In fact, 14.5 percent of drivers in states where insurance is compulsory violate the law, according to the Insurance Research Council.

The primary reason that some individuals might not sign up for health coverage is that doing so could create financial hardships. This is why some experts argue that to make an individual mandate effective, substantial public subsidies would be needed to offset costs for lower-wage workers. In addition, fear of being deported among the immigrant population could mean that some of these individuals would not purchase coverage.

STATE AND LOCAL COVERAGE INITIATIVES

State and local coverage initiatives have shaped highly diverse policy approaches that attempt to provide health insurance for populations that typically find it difficult to access affordable health insurance. In doing so, they borrow concepts and models from both the public and private sectors.

In October 2006, the Pennsylvania Legislature approved funding for Cover All Kids, a program allowing families with incomes above the SCHIP eligibility level to purchase health insurance for their children on a sliding scale based on income. In early 2007, Pennsylvania Governor Ed Rendell unveiled his Prescription for Pennsylvania plan to assist uninsured adults and small businesses in obtaining basic coverage through private insurers. Costs of premiums are shared between businesses that join the program and their employees and are subsidized with state and federal monies that pay the balance of the premium. However, in early March of this year the state House of Representatives passed a bill meant to replace the Governor's proposal that would instead expand eligibility in the state's adultBasic program. The state Senate has yet to vote on the bill but is also crafting their own measure that would help adults obtain affordable coverage from a private insurer.

At the end of October last year, New Mexico Governor Bill Richardson unveiled his HealthSOLUTIONS New Mexico proposal, in which state residents would be required to purchase coverage. Residents with lower incomes would be eligible for subsidies from the state to offset their costs. The plan would require employers to contribute to a fund to help pay for the proposal, with employers receiving a credit for their current contributions toward their employees' health coverage.

State and local coverage initiatives have shaped highly diverse policy approaches.

Also in 2006, Vermont passed legislation that created a new health coverage program for the uninsured called Catamount Health, which provides assistance with paying premiums based on a sliding scale, as well as cost sharing under private health insurance plans. The state estimates that as many as 25,000 of the 60,000 uninsured Vermont residents may enroll in this program. If coverage goals are not reached by 2010, the Legislature may consider coverage mandates.

The state of Massachusetts enacted legislation in 2006 establishing a mandate for individuals to have health insurance. On July 1, 2007, the state began enforcing the law to require all residents to obtain health insurance or pay a penalty. Massachusetts also established a premium subsidy program that offers subsidized insurance to adults who otherwise lack access to health care coverage through an employer, Medicaid, Medicare or the Veterans Administration. In addition, employers are required to make a "fair and reasonable" contribution to the cost of coverage for their employees. As of December 2007, the program covered close to 160,000 previously uninsured individuals.

In California, Governor Arnold Schwarzenegger had proposed a similar plan that failed to gain enough support in the State Senate to get on the 2008 ballot. Everyone in the state would be required to have coverage, with the state offering premium subsidies for people with low incomes. Employers would have to provide coverage to their employees or pay a fee to the state equal to 4 percent of employee earnings, which would be used to subsidize coverage.

Maine began a new health care initiative called Dirigo Health in 2005. The voluntary program seeks to ensure access to health care for all of the state's 1.3 million residents over a five-year period. It offers health coverage through private insurers to those without access to employer-sponsored coverage, employees of small businesses who work 15 or more hours per week, and self-employed people, as well as their dependents. Participating employers pay at least 60 percent of the total premiums for their participating workers. For those making less than 300 percent of the federal poverty level, premium charges are on a sliding scale based on ability to pay.

A county- and city-based approach was undertaken by San Francisco, which established the San Francisco Health Access Program (SFHAP) in 2006 to provide accessible and affordable health care services for all uninsured residents of San Francisco, regardless of income, immigration status or medical condition. While the program does not provide health coverage, it provides access to affordable medical services that the uninsured would not get otherwise. Enrollment is voluntary and premium costs are based on income. Paid for in part with city funds, the plan is supplemented with an employer health contribution mandate—the Worker Health Care Security Ordinance (WHCSO). WHCSO, which went into effect in January, requires local businesses with more than 20 employees to either provide health care for their workers or make an annual contribution

to SFHAP. However, some small businesses in the city do not like the financial burden it has placed on them. The Golden Gate Restaurant Association has filed suit against the city to end the requirement and is scheduled to present its case in court in April.

EXPANSION OF MEDICAID, SCHIP AND OTHER PUBLIC PROGRAMS

Expanding public programs is yet another approach to covering the uninsured. Some policy experts suggest that these programs, with appropriate adjustments, can be readily expanded to cover a larger percentage of the uninsured. They also argue that public programs would more easily be able to provide services for lower-income people, whose connection to the job market and stable income may be more tenuous.

Such expansions, they note, can be financed through a variety of mechanisms, including state, local and federal tax revenue, as well as tax increases on private insurers. They can also be tailored to require participants to pick up a significant share of the costs. For example, a proposal advanced during the late 1990s that was popularly known as the Medicare “buy-in” bill would have allowed retired workers under age 65 with no other source of health insurance to join Medicare by paying a monthly premium.¹¹⁴

Opponents of public-sector expansions argue that current programs are poorly organized and frequently fail to enroll millions who are eligible. Moreover, they say, large annual federal deficits are likely to make securing funds for expansions politically difficult. In the case of public programs that are financed with matching contributions, such as Medicaid and SCHIP, it is believed that some states would resist large-scale expansions based on budgetary concerns.

TAX PROPOSALS

Tax proposals seek to make private health insurance more affordable by

allowing individuals and employers to use pre-tax dollars to pay for insurance premiums, usually through a credit on the amount they owe in income taxes or by granting a tax deduction for premium expenses. The credits could be designed as a fixed dollar amount or as a percentage of the premium. They can be made refundable for those who owe no income taxes and advanceable at the time the person is actually paying the premiums instead of having to wait until April 15.

Granting a tax deduction for premium expenses while treating employer-sponsored coverage as taxable income would erase the tax disadvantage people face when they buy nongroup coverage.

Proponents of tax incentives argue that this approach enhances affordability while retaining choice of various plans in the private market and encourages people to take responsibility for their health care costs. They argue this would make consumers more price-conscious when choosing a health plan and, therefore, restrain health care inflation. In theory, restraining costs would make it easier to expand coverage.

Opponents say that individuals and employers often don’t have the information they need to make “best value” choices of quality providers, services and treatments nor the purchasing clout to get good prices. Another problem cited is that many proposals offer tax credits that are too modest—when compared to the actual cost of insurance—to persuade a significant number of uninsured people to buy coverage.

A FULLY TAX-FINANCED HEALTH CARE SYSTEM

The current public-private health care system in the United States could be replaced with one where employers, individuals and other private entities would all be responsible for paying for health care coverage through taxes paid to the government. The most commonly advocated tax-financed system is the single-payer approach.

Under such a system, health care providers would remain private, but the government would administer payments for health care services—similar to the Canadian model. Proponents argue that a tax-financed system is the likeliest way to get virtually everyone covered and would be more efficient, since administrative costs could be significantly reduced. In addition, the potential exists for more effective control of costs, if the government uses its full clout in negotiating prices with doctors, hospitals, drug companies and other health care providers.

Opponents of this approach contend that a government-organized health care system would radically change the way Americans receive health care and create too great a role for government vis-à-vis the private sector. They also say the cost to the public treasury would be unacceptably high, choices of health care providers and services could diminish, and development of new health technology and treatments would suffer. What’s more, they argue that when government is the sole buyer, it does not negotiate prices; it sets them.

CONCLUSION

Our current system of health insurance—a patchwork of public programs, employer-based coverage and individual policies sold in the nongroup market—covers the majority of Americans. But far too many are left without the resources necessary to purchase and keep dependable coverage. Despite congressional efforts that span much of the 20th century and the start of the 21st, history shows it has been difficult to agree on large-scale solutions that can solve the persistent problem of uninsurance.

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

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

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

PERSONAL STORIES OF THE UNINSURED

To read personal stories about those who are uninsured, told in their own words, visit www.CoverTheUninsured.org/stories.

Questions to Ask About Any Health Coverage Proposal

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

GLOSSARY

For a glossary of health insurance terms, go to the *Cover the Uninsured* Web site www.CoverTheUninsured.org/glossary or the Alliance for Health Reform site www.allhealth.org/sourcebookcontent.asp?CHID=25.

SOME SPECIFIC PROPOSALS

Private-sector coalitions, members of Congress and President Bush have weighed in with proposals to help the uninsured. For more information on and comparisons of proposed legislative solutions, visit www.CoverTheUninsured.org/legislation. Here is a representative selection:

White House Proposal – In his 2007 State of the Union address, President Bush proposed tax breaks to make private health coverage more affordable to those who lack it. The president's plan would allow families to deduct \$15,000 from their taxable income and use the resulting tax savings to help pay for coverage. Those filing as individuals could deduct \$7,500. The tax break would be paid for by counting the value of employer-sponsored coverage exceeding the deduction as regular income. For more, go to www.whitehouse.gov/stateoftheunion/2007/initiatives/healthcare.html.

Citizens' Health Care Working Group – This congressionally mandated group held town meetings around the country for 15 months, conducted surveys, and solicited

KEY FACTS ABOUT THE UNINSURED

- > Nearly 47 million people in the United States—in every age group and at every income level—were uninsured for all of 2006.¹¹⁵
- > More than eight out of 10 of the uninsured are in working families.¹¹⁶
- > During all of 2006, 8.7 million children were uninsured, up from 7.7 million in 2004.¹¹⁷
- > Uninsured children are much more likely than children with insurance to lack a usual source of care, delay care or have unmet medical needs.¹¹⁸
- > Almost 70 percent of children eligible for the State Children's Health Insurance Program are enrolled. However, 1.8 million eligible children are not enrolled.¹¹⁹
- > An estimated 18,000 to 22,000 adults die each year because they are uninsured and can't get appropriate health care.¹²⁰
- > The majority of those polled in February 2008 by the *Los Angeles Times* and Bloomberg News said they would be willing to pay more in taxes to provide health insurance for every American.¹²¹

comments from individual citizens and organizations. The recommendations it submitted to Congress and President Bush would provide affordable core health benefits to all Americans, guarantee financial protection against very high health care costs, and improve the quality and efficiency of care, among other goals. To learn more, go to www.citizenshealthcare.gov.

Health Coverage Coalition for the Uninsured – The proposal from this group, which represents health care providers, insurers and consumers, focuses first on getting coverage for the nation’s uninsured children through expanded public programs, a family tax credit for the purchase of children’s coverage and grants to allow states to experiment with new approaches to expanding coverage. Phase two will aim at expanded public- and private-sector coverage for uninsured adults. For details, go to www.coalitionfortheuninsured.org.

Divided We Fail – This coalition announced that it will be working “to find broad-based, bi-partisan solutions to the most compelling domestic issues facing the nation—health care and the long-term financial security of Americans.” Comprised of AARP, Business Roundtable, The National Federation of Independent Business and Service Employees International Union, the coalition represents 50 million members. (AARP is also part of the Health Coverage Coalition for the Uninsured.) To learn more, go to www.dividedwefail.org.

America’s Health Insurance Plans (AHIP) – AHIP’s proposal aims to cover 40 million uninsured Americans by expanding eligibility for public programs, enabling all consumers to purchase health insurance with pre-tax dollars, providing financial assistance to help working families afford coverage, and encouraging states to develop and implement access proposals. For details, go to www.ahipbelieves.com.

Federation of American Hospitals – The federation’s Health Care Passport plan aims to insure 98 percent of Americans, primarily through an expansion of private-sector coverage. Everyone in the United States would be required to have coverage either on the job or through direct purchase. Subsidies would be provided for lower-income uninsured people. Medicaid would be expanded to cover all uninsured adults below the federal poverty level. For more, go to www.fahs.org/passport.

Healthy Americans Act – Introduced by U.S. Senator Ron Wyden (D-Oregon) and Senator Bob Bennett (R-Utah), this bill is designed to “ensure every American can afford a high-quality, private health plan that is comparable to what Members of Congress enjoy now.” After two years, all employers would be required to gradually raise employees’ pay to help them buy private coverage. All individuals would be required to buy coverage for themselves and any dependent children. Insurers would be required to cover anyone who applies, regardless of health circumstances, without raising prices because of an enrollee’s preconditions. To learn more, go to www.wyden.senate.gov.

State Grants – A bipartisan group of lawmakers has introduced legislation in both the House and Senate to create experimental grants to states to test health reform strategies. The grants could be used for tax credits, expanding Medicaid or the State Children’s Health Insurance Program, or health savings accounts. Program proposals would be submitted to a bipartisan State Health Innovation Commission, which then would present the proposals to Congress for review and funding. To access a news story about this proposal in the KaiserNetwork Daily Health Policy Report, go to www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=42324.

End Notes

- ¹ DeNavas-Walt C, Proctor BD and Smith J. "Income, Poverty, and Health Insurance Coverage in the United States: 2006." Current Population Reports. P60-233. Washington, DC: U.S. Department of Commerce, Economics and Statistics Administration, August 2007. (www.census.gov/prod/2007pubs/p60-233.pdf)
- ² DeNavas-Walt et al.
- ³ DeNavas-Walt et al.
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