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Issue Brief

Covering the Uninsured: Prospects and Problems

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Introduction: The Current Status of Health Insurance Coverage

Increasing the number of Americans with health insurance has been a recurrent focus of federal and state policymaking, and recent trends suggest that the issue continues to warrant legislative attention. The number of people without health insurance coverage in the United States increased in 2001, a reversal of two years of falling rates of uninsurance. According to the Census Bureau, an estimated 14.5 percent of the total population (41.2 million people) lacked health insurance for the entire year in 2001, up from 14.2 percent in 2000—an increase of 1.4 million people.[1] Insurance coverage varies by state of residence, with New Mexico and Texas having the highest average uninsured rates from 1999 to 2001 (23 percent) and Rhode Island and Minnesota the lowest (7.8 percent). Private employment-based insurance remains the primary source of insurance coverage for most Americans, but public programs such as Medicare, Medicaid, and the state Children's Health Insurance Program (CHIP) are an important source of coverage for millions of elderly and disabled individuals and low-income children and adults.

Gaps in private and public coverage leave many Americans without access to health insurance or with only limited coverage. Many workers do not have access to employment-based insurance because they cannot afford it or their employer does not offer it.[2] Coverage in the private, non-group insurance market has been limited because premiums are based on an individual's age and health status, and are substantially more expensive than group plans purchased by employers.[3,4] Medicaid and CHIP cover many low-

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income Americans, primarily children, but eligibility criteria and covered services for these programs vary across states, resulting in coverage disparities. In addition to gaps that leave millions without insurance, researchers estimate that about one-fifth of insured individuals are underinsured, meaning that they face limits on coverage or substantial financial barriers to receiving treatment if they become ill.[5] Overall, these limitations in public and private coverage are not new. Yet recent trends—such as rising health care costs that fuel growth in health insurance premiums, and higher unemployment rates linked to a weakened economy—could lead to an erosion of the modest coverage improvements seen at the end of the 1990s.

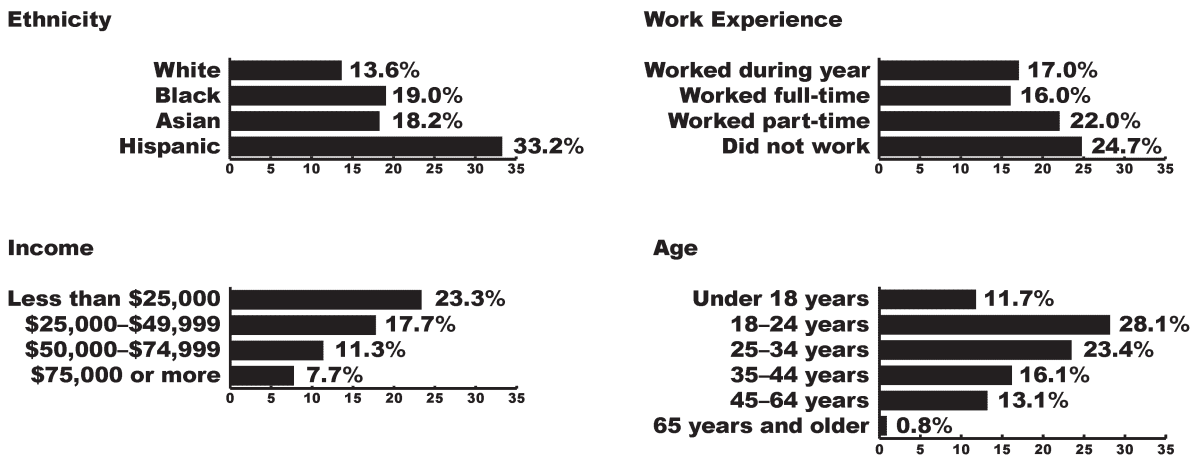
Who Are the Uninsured?

People without insurance cannot easily be categorized. Demographic factors such as age, race, and ethnicity, as well as socioeconomic and employment status, affect health insurance coverage rates. The poor and near-poor have the greatest risk of being uninsured, but the large majority of uninsured also come from working families.[6] Exhibit 1 presents rates of the uninsured in 2001 by selected characteristics.

Trends in Public and Private Coverage

In 2001, almost 200 million people had private health insurance coverage. The vast majority, 176.5 million people, had employer-sponsored coverage. Public programs covered 71.3 million people, including 38 million enrolled in Medicare, 31.6 million covered by Medicaid, 9.5 million with military health care (including care provided by the Veterans Administration), and 2.3 million covered by CHIP. (Coverage estimates by type of plan are not mutually exclusive, since people can have both public and private coverage as well as both Medicare and Medicaid.) Rates of employment-based coverage gradually increased in the mid- to late-1990s, fueled by a good economy, low unemployment, and slower growth in insurance premiums.[7] Enrollment in Medicaid declined following welfare reform in 1996, but state efforts to increase outreach and expand eligibility helped to stabilize Medicaid coverage. The CHIP program, begun in 1997, increased insurance coverage among low-income children. In 1999 and 2000, these coverage trends resulted in a decrease in the total number of uninsured. However, recent trends in coverage and rising health care costs may threaten coverage improvements. As described below, premiums for employer-sponsored coverage are increasing and many employers pass on these rising costs to their employees. States are facing budget constraints that may lead to cuts in eligibility and benefits in public programs such as Medicaid and CHIP. Reflecting these trends, half of insured individuals are worried about not being able to

Exhibit 1. Rates of the Uninsured in 2001 by Selected Characteristics



Source: U.S. Census Bureau, Current Population Survey, 2002 Annual Demographic Supplement.

afford insurance or having benefits cut back in the coming year.[8]

Employer-Sponsored Insurance Trends

The percent of people covered by employer-sponsored insurance decreased in 2001, from 63.6 to 62.6 percent.[9] The declining rate of employer coverage has been accompanied by increasing premiums. Between spring 2001 and spring 2002, monthly premiums for employment-based coverage rose 12.7 percent, significantly faster than wage gains for non-supervisory workers (3.4 percent).[10] Between 2001 and 2002, the worker's share of the overall premium rose by 27 percent for single coverage (an average of $454 per year in total) and 16 percent more for family coverage (an average of $2,084 per year in total).[11] In 2001, the average annual cost to an employer was $3,060 for individual coverage and $7,954 for family coverage.[12]

With a 15 percent average increase in health care premiums projected for 2003, additional increases in employee contributions are likely to occur in the future.[13] A variety of surveys find that employers plan to deal with rising health care costs by increasing employees' share of premiums as well as other cost-sharing measures. An employer survey found that 78 percent of large firms (200 or more workers) plan to increase employee premium contributions in the future, up from 44 percent in 2000.[14] Forty percent of workers in January 2002 reported that they paid more for employer-sponsored coverage in 2001 than in the previous year.[15] Along with increasing the employee contribution for premiums, employers are adopting cost-sharing methods that increase employees' responsibility for decisions about care. These include raising costs for care received out-of-network and copayments for physician and hospital services and prescription drugs. One-third of working adults report higher deductibles or copayments or benefit reductions in 2001 compared with the previous year.[16]

Employers are also evaluating new health plan benefit designs, such as defined contribution and consumer-driven or consumer-directed plans. These insurance arrangements are designed to give workers more choice, flexibility, and control in making health care decisions.[17] In defined contribution plans, employers offer employees a fixed sum to pay for coverage on their own. The employee pays any insurance costs that exceed the employer's contribution. Approximately one-quarter of firms say it is likely they will adopt this approach in the next few years.[18] Consumer-driven plans combine a high-deductible, catastrophic insurance policy (i.e., a major medical plan) with a health reimbursement account (HRA). In this arrangement, a portion of the employer's insurance contribution is placed in a personal health account from which employees can draw to purchase health care services with tax-exempt dollars.[18,19] In June 2002, the Department of Treasury issued a ruling that clarifies that HRAs must be funded solely by the employer and cannot be funded by salary reductions, defines HRAs as group health plans subject to the COBRA continuation requirements, and allows unused balances in HRAs to carry over from one year to the next.[20] These features could increase the appeal of consumer-driven plans. According to a recent survey, about 30 percent of large employers say they will offer a consumer-driven plan by 2003.[21]

Requiring workers to pay higher cost-sharing amounts at the time of use reverses the trend toward lower cost-sharing amounts that accompanied the shift from indemnity insurance to managed care (e.g., a shift from a $100 deductible and 20 percent coinsurance to $10 per visit copayments). Some might argue that such a shift is overdue, since insurance arrangements have tended to insulate consumers from the actual cost of care, which may increase consumption of marginally beneficial services. Some might also argue that this shift is timely because managed care restrictions on use, which accompanied the lower cost-sharing, have been relaxed in recent years—giving rise to the term "managed care lite." Giving employees more control over their health spending through the use of consumer-driven plans could make basic coverage more available and affordable, thereby increasing coverage and relieving employers of increasing cost pressures, but it could also mean that some workers will pay more in costs at the time of use than under their old policies. The

degree to which this ultimately will shift costs to workers will depend to a great extent on the amount the employer contributes as the lump sum and the correlation of high spending across years; i.e., whether high spending in one year is offset by low spending in another, so that in the low-spending year the worker comes out ahead. Requiring workers to pay higher premiums for the same coverage may lead some employees to drop coverage and thus exacerbate the problem of the uninsured.

Trends in Public Coverage: Medicaid and CHIP

Among the entire population, the percent covered by government insurance programs rose in 2001, from 24.7 to 25.3 percent. This increase was largely due to an increase in the rate of Medicaid coverage, from 10.6 percent in 2000 to 11.2 percent in 2001.[22] According to the Census Bureau, Medicaid covered 31.6 million people in 2001. Beneficiaries include low-income mothers and children, and elderly and disabled individuals. Congress enacted CHIP as part of the Balanced Budget Act of 1997, providing $20.3 billion in federal funds over five years for states to expand coverage to low-income uninsured children. Enrollment in CHIP grew slowly during the initial years, but as of the end of 2001, total enrollment exceeded three million children. If the downward trend in private employer-sponsored insurance coverage continues beyond 2001, further increases in public program enrollment are likely to occur, absent changes at the state level to limit coverage expansions in order to reduce expenditures.

Prospects for Coverage Expansions

Recent policy debates have emphasized targeted approaches to expanding coverage. Current proposals include increasing enrollment in existing public programs, establishing tax benefits for purchasing health insurance, and expanding coverage through public–private linkages.

Public Program Creation and Expansion

Some policymakers support expanding coverage by building on existing public programs or creating new state-based programs. Proponents of these strategies argue that increasing coverage can be most easily accomplished by expanding eligibility for existing programs. Opponents are concerned about the substitution of public coverage for private coverage, and concerned that such expansions create a larger and less desirable role for government given that the private market is the predominant source of coverage.

Despite these concerns, a number of states have increased enrollment in existing programs by raising income or age eligibility levels for Medicaid and CHIP beyond federal minimums, and opening enrollment to parents of children eligible for these programs. Section 1115 of the Social Security Act provides authority to the secretary of the Department of Health and Human Services (HHS) to waive statutory provisions of the federal law to permit demonstration programs that further Medicaid program goals. As of May 2002, 8.2 million individuals received coverage under Section 1115 waivers, accounting for nearly one-fifth of all Medicaid spending.[23] The Bush administration has also enhanced the flexibility of states to increase coverage in Medicaid and CHIP through the Health Insurance Flexibility and Accountability (HIFA) waiver initiative. Announced in August 2001, HIFA is targeted at populations with incomes below 200 percent of the federal poverty level ($17,720 for an individual in 2002). HIFA allows states to finance coverage expansions by reducing the cost of public coverage in ways not otherwise permitted, such as reducing benefits and increasing cost-sharing for certain groups.[24] Such flexibility is viewed as essential by some states facing budget shortfalls that nevertheless want to implement public program expansions.

Using waiver authority, a few states have taken steps to extend Medicaid or CHIP coverage to low-income parents whose children are eligible for these programs. Research suggests that by covering parents, states can also increase the extent to which uninsured children are enrolled in Medicaid and CHIP.[25,26] In 1999, 11 states and the District of Columbia expanded coverage to parents through either Medicaid or a separate state-funded program.[27] As of October 2002, HHS had approved waivers to cover parents using Medicaid or CHIP funds in six states

(three of which also implemented expansions in 1999).[28, 29]

Some states have created programs that target uninsured adults, financed solely through non-federal sources. For example, Pennsylvania's adultBasic program uses $76 million from the state's share of the national tobacco settlement to provide low-cost health insurance for uninsured individuals ages 19 to 64 with low incomes (below 200 percent of the federal poverty level). However, current economic conditions have reduced state tax revenues nationwide and placed competing demands on limited state funds. Thus, the prospects for covering a large number of uninsured people through such state-based programs may be limited in the foreseeable future.

Establishing Tax Benefits for Health Insurance

Many policymakers favor expanding coverage by creating tax benefits that provide financial incentives for individuals or employers to purchase health insurance. Options include creating a refundable tax credit for all workers, expanding and permanently extending Archer medical savings accounts (MSAs), creating tax credits for small employers, and expanding tax benefits for the self-employed.[30] Proponents of tax benefit approaches argue that they give consumers greater choice and control over their health insurance arrangements, and that they address equity and efficiency problems in current law regarding tax benefits. Opponents argue that these approaches are unlikely to make much difference for people who do not now purchase insurance. A primary concern with the tax credit approach is that depending on the size of the credit, it might not benefit lower-income families who cannot afford to purchase insurance before the subsidy kicks in. Opponents also argue that tax benefit approaches could erode the employment-based system but leave consumers with inadequate and more costly alternatives.

The 107th Congress considered various tax benefit proposals. Proposals were made to expand and permanently extend the authorization for MSAs (set to expire December 31, 2003); to allow self-employed taxpayers to deduct 100 percent of the cost of their insurance beginning in 2002; to allow individuals to deduct 100 percent of their insurance premiums, regardless of whether they itemize; and to authorize a tax credit for small employers (2 to 50 employees). In his Fiscal Year 2003 budget, President Bush allocated $89 billion over 10 years to establish a refundable tax credit for individuals under age 65. Under this approach, people who purchase coverage in the individual market could reduce their federal tax payments by some or all of the amount spent for insurance. A refundable tax credit would enable low-income people to claim the credit even if they owed no taxes.

While most of these proposals were not enacted in the 107th Congress, a tax credit provision was included in trade legislation signed into law in August 2002. The Trade Act of 2002 (P.L. 107-210) provides $12 billion over 10 years for benefits to trade-displaced workers, including a refundable tax credit to cover 65 percent of the cost of health insurance premiums. Uninsured workers who lose their jobs due to increased importation could use the tax credit to purchase insurance through employer-sponsored coverage offered by their former employers (i.e., COBRA coverage), or through state-sponsored insurance purchasing pools and high-risk pools.

Expanding Coverage Through Public–Private Linkages

Some policymakers have proposed to expand coverage by using public funds to subsidize the purchase of employer-sponsored insurance. Such an approach could assist low-income people who are offered coverage by their employer, but who cannot afford the employee share of the premium. Proponents of premium assistance, or "buy-in," programs argue that the combination of public funds with employer contributions lessens the strain on both public and private payers and potentially allows funds to cover more people. Building on employer coverage could also help increase coverage by avoiding the stigma associated with enrollment in public programs.

Under current law, states can create premium assistance programs through the Medicaid Health Insurance Premium Payment (HIPP)

program or through CHIP.[31] The cost of the buy-in must be no higher than what the state would have paid to enroll the individual in the public program (the cost-effectiveness test). Establishment of premium assistance programs to date has been limited because states have found the cost-effectiveness test difficult to demonstrate and have had trouble identifying eligible people—those who are enrolled in public programs but who could access employer-sponsored coverage.[32] HIPP enrollment represents only 1 percent of states' total Medicaid program enrollment.[33] To date, seven states have received approval from HHS to develop premium assistance programs using CHIP funds.[34] Despite limited experience with premium assistance, the use of this strategy is likely to increase. The HIFA initiative strongly encourages states to integrate Medicaid and CHIP funds with funds for private health insurance, and relaxes the cost-effectiveness guidelines to facilitate this activity. According to HIFA guidelines, states are not required to adhere to the cost-effectiveness test, but must monitor total costs and ensure that they are not significantly higher than if "buy-in" participants were enrolled in public programs. With this flexibility, states have opportunities to use public funds to subsidize private coverage among the low-income uninsured, while keeping within budget limits.

Potential Barriers to Coverage Expansions

Policymakers face difficult challenges in dealing with the uninsured problem, some of which are due to the design of the insurance system and the nature of public and private coverage. For instance, loss of employment can lead to loss of insurance, but the unemployed are not automatically covered elsewhere.[35] For those who lack a source of employment-based or public coverage, the individual market is the only option. Yet, coverage in this market is unstable and often unobtainable, the result of high prices, medical underwriting practices, and a small risk pool.[36] Also, many uninsured people may be eligible for public programs but do not participate because of enrollment barriers, lack of awareness, or concerns about stigma.

As states implement eligibility expansions through Medicaid and CHIP that target people at higher income levels, policymakers are concerned about minimizing the extent to which public coverage substitutes for existing private coverage. Estimates of the magnitude of this substitution effect, known as "crowd out," vary.[37] A primary concern is that employers might reduce or drop benefits for employees because of the availability of public coverage. In their public program expansions, states have implemented measures to minimize crowd out, such as imposing premiums and establishing waiting periods after losing private coverage. Such policies may prevent crowd out but also may result in more limited enrollment among the uninsured.

Other barriers to expanding coverage stem from more recent trends in health care. For the first time in more than a decade, per capita health care spending rose at a double-digit rate in 2001, increasing by 10 percent.[38] National health spending is expected to grow faster than the gross domestic product (GDP) for the rest of the decade, with the health share of GDP projected to rise from 13.2 percent in 2000 to 17.0 percent by 2011.[39] Thus, even if the uninsured rate does not increase significantly in the near future, health care cost growth makes any measures that would reduce the current uninsured population more expensive.

Conclusion

Incomplete insurance coverage has been a formidable problem for policymakers. Solutions, whether incremental or broader in scope, involve decisions about how to invest public funds. Reaching out to a broad spectrum of uninsured individuals could require a substantial investment of public and private dollars. Conversely, minimizing costs in the current constrained budget environment may mean restricting or limiting the target population for coverage expansions. The factors that currently exist—higher health care costs, increasing insurance premiums and cost-sharing amounts, unemployment growth, and state budget restrictions—suggest that making significant inroads in the uninsured population may be difficult in the foreseeable future.

Exhibit 2. Percent of People Without Health Insurance for the Entire Year by State: 3-Year Average, 1999–2001

State	Percent
United States–Total	14.5
Alabama	13.2
Alaska	17.7
Arizona	18.4
Arkansas	15.0
California	19.2
Colorado	15.1
Connecticut	9.7
Delaware	9.5
District of Columbia	13.6
Florida	17.8
Georgia	15.3
Hawaii	9.7
Idaho	16.5
Illinois	13.6
Indiana	10.8
Iowa	8.0
Kansas	11.4
Kentucky	13.0
Louisiana	19.7
Maine	10.7
Maryland	11.3
Massachusetts	8.7
Michigan	9.9
Minnesota	7.8
Mississippi	15.2
Missouri	8.8
Montana	16.0
Nebraska	9.6
Nevada	17.2
New Hampshire	9.0
New Jersey	12.5
New Mexico	23.2
New York	15.8
North Carolina	14.2
North Dakota	10.9
Ohio	10.8
Oklahoma	17.9
Oregon	13.1
Pennsylvania	8.7
Rhode Island	7.2
South Carolina	13.3
South Dakota	10.4
Tennessee	10.8
Texas	23.0
Utah	13.6
Vermont	9.7
Virginia	11.9
Washington	13.5
West Virginia	14.2
Wisconsin	8.5
Wyoming	15.6

Source: U.S. Census Bureau, Current Population Survey, 2002 Annual Demographic Supplement.

REFERENCES

1 Robert J. Mills. *Health Insurance Coverage: 2001.* Current Population Reports P60–220. U.S. Census Bureau, September 2002.

2 Jeanne M. Lambrew. *How the Slowing U.S. Economy Threatens Employer-Based Health Insurance.* The Commonwealth Fund, November 2001.

3 Kaiser Commission on Medicaid and the Uninsured. *The Uninsured: A Primer.* Henry J. Kaiser Family Foundation, March 2002.

4 Jon Gabel, Kelley Dhont, and Jeremy Pickreign. *Are Tax Credits Alone the Solution to Affordable Health Insurance? Comparing Individual and Group Insurance Costs in 17 U.S. Markets.* The Commonwealth Fund, May 2002.

5 Kaiser Commission on Medicaid and the Uninsured. *Underinsured in America: Is Health Coverage Adequate?* Henry J. Kaiser Family Foundation, July 2002.

6 Kaiser Commission, *The Uninsured: A Primer,* March 2002.

7 John K Iglehart, "Changing Health Insurance Trends," *New England Journal of Medicine* 347 (September 19, 2002): 956–62.

8 Kaiser Commission, *Underinsured in America,* July 2002.

9 Mills, *Health Insurance Coverage: 2001,* September 2002.

10 Iglehart, "Changing Health Insurance Trends," September 19, 2002.

11 Kaiser Family Foundation/Health Research and Educational Trust. *Employer Health Benefits: 2002 Summary of Findings.* Kaiser Family Foundation, September 2002.

12 Ibid.

13 Hewitt Associates. "Health Care Cost Increases Expected to Continue Double-Digit Pace in 2003." Press Release, October 14, 2002. Accessible at http://was.hewitt.com/hewitt/resource/newsroom/pressrel/2002/10-14-02.htm/, accessed October 21, 2002.

14 Kaiser/HRET. *Employer Health Benefits,* September 2002.

15 Jennifer Edwards et al. *The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care.* The Commonwealth Fund Issue Brief, August 2002.

16 Ibid.

17 Hewitt Associates. "Health Care Cost Increases," October 14, 2002.

18 Kaiser/HRET. *Employer Health Benefits,* September 2002.

19 Iglehart, "Changing Health Insurance Trends," September 19, 2002.

[20] The ruling specifies that maximum reimbursement amounts deposited by an employer in an employee's HRA in one year would be increased by any unused reimbursement amounts from previous years. The ruling is accessible at http://www.ustreas.gov/press/releases/docs/rev.rul.pdf/, accessed November 22, 2002.

[21] Kathy Kristof, "New Health Care Plans May Not Be a Panacea." *Los Angeles Times*, August 25, 2002.

[22] Mills, *Health Insurance Coverage: 2001,* September 2002.

[23] Jennifer Ryan. *1115 Ways to Waive Medicaid and CHIP Rules*. National Health Policy Forum, Issue Brief No. 777, June 2002.

[24] Jennifer Ryan. *Health Insurance Family Style: Public Approaches to Reaching the Uninsured*. National Health Policy Forum, Issue Brief No. 767, September 24, 2001.

[25] Lisa Dubay and Genevieve Kenney. *Covering Parents Through Medicaid and CHIP: Potential Benefits to Low-Income Parents and Children*. Kaiser Commission on Medicaid and the Uninsured, October 2001.

[26] Institute of Medicine. *Health Insurance Is a Family Matter*. Washington, D.C.: National Academies Press, 2002.

[27] Dubay and Kenney, *Covering Parents,* October 2001.

[28] Ryan, *Health Insurance Family Style,* September 24, 2001.

[29] Centers for Medicare and Medicaid Services. State Children's Health Insurance Program (CHIP) Approved Section 1115 Demonstration Projects, October 7, 2002. Accessible at http://www.cms.gov/CHIP/1115waiv.pdf/, accessed November 4, 2002.

[30] Medical savings accounts are personal savings accounts for unreimbursed medical expenses. They are used to pay for health care not covered by insurance, including deductibles and copayments. The formal name of MSAs is now Archer MSAs. The original MSA legislation (the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191) authorized a limited number of MSAs under a demonstration beginning in 1997.

[31] Ryan, *Health Insurance Family Style,* September 24, 2001.

[32] Leslie Conwell and Ashley Short. *Premium Subsidies for Employer-Sponsored Health Coverage: An Emerging State and Local Strategy to Reach the Uninsured*. Center for Studying Health System Change, Issue Brief No. 47, December 2001.

[33] Ryan, *Health Insurance Family Style,* September 24, 2001.

[34] Ibid.

[35] Lambrew, *How the Slowing U.S. Economy,* November 2001.

[36] Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services. *Assessing the Individual Health Insurance Market in the Post-HIPAA Era: A Review of the Literature,* June 2001.

[37] See, for instance, Richard Kronick and Todd Gilmer, "Insuring Low-Income Adults: Does Public Coverage Crowd Out Private?" *Health Affairs* 21 (January/February 2002): 225–37; David Cutler and John Gruber, "Does Public Insurance Crowd-Out Private Insurance?" *Quarterly Journal of Economics* 111 (2): 391–430; Linda Blumberg et al. "Did the Medicaid Expansions for Children Displace Private Insurance? An Analysis Using the SIPP," *Journal of Health Economics* 19 (1): 33–60.

[38] Bradley Struck et al., "Tracking Health Care Costs: Growth Accelerates Again in 2001," *Health Affairs* Web Exclusive, September 25, 2002. W299–W310.

[39] Alliance for Health Reform. *Health Care Costs & Health Coverage,* August 2002.