Chapter 1: The Uninsured

Tens of millions of Americans lack health insurance, and obtaining and keeping health care coverage in America has been a persistent problem. While health coverage in most economically developed countries is guaranteed or compulsory, it is a choice for most Americans, though high costs force many to forgo it. Lack of coverage, even for relatively short periods, can have devastating clinical and financial consequences.

Because of factors such as rising health care costs, the impact of shorter job tenure on private coverage and the potential for changes in eligibility requirements for public coverage programs, those who have insurance today may not have it tomorrow. Indeed, the number of non-elderly uninsured grew to 43.9 million during the decade ending in 1998, a trend which temporarily reversed in 1999 and 2000.[1]

Since then, the number of uninsured has again steadily risen. (See chart, "Number of Nonelderly Uninsured Americans, 2000 - 2005.") According to the U.S. Census Bureau, 39.6 million Americans under age 65 lacked insurance for all of 2000, but in 2005, the latest figure available, that number had grown to 46.1 million people.[2,3,4*] (There are several different ways to estimate the number of uninsured. See the box, "Counting the Uninsured – Not As Easy As 1,2,3," for a discussion of the subject).

Slower economic growth played a part in that increase, as companies laid off workers and added fewer to their payrolls. (See chart, "Sources of Health Coverage in the U.S., 2005.") Rising health care costs also contribute to the climbing number of uninsured, in part because employers become less likely to offer insurance as premiums become more expensive.[5]

Public programs such as Medicaid saw enrollment grow as workers lost income and became eligible for benefits. But looming budget deficits forced most states to put a brake on this growth by reducing eligibility or benefits, among other actions.

WHERE DO PEOPLE GET HEALTH INSURANCE?

Employer-sponsored coverage - Almost 63 percent of nonelderly people in the United States – roughly 162 million workers and their dependents in 2005 – get their coverage through employers.[6] (See chart, "Sources of Health Coverage in the U.S., 2005.") Large firms (with 200 or more workers) are

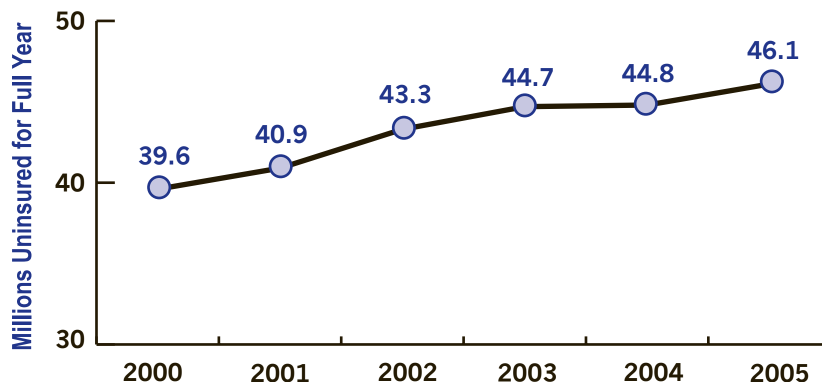
For story ideas on the uninsured, see page 10. A list of experts and websites also begins on page 10.

*Since almost everyone age 65 or older is covered by Medicare (see Chapter 4, "Medicare"), analysts of the uninsured often focus on the under-65 population.

KEY FACTS

- The number of non-elderly uninsured persons in the U.S. continued to grow in 2005 to almost 46.1 million, or 6.6 million more than in the year 2000. [a]
- Overwhelmingly, the uninsured live in working families, but are not offered health benefits through their jobs. Uninsured workers tend to work for small businesses and tend to have limited incomes. [b]
- A decline in job-based coverage fueled growth in the uninsured; safety net public programs such as Medicaid did not keep pace to offset this loss in coverage.[c]
- Lack of coverage and coverage stability is particularly burdensome on the seriously and chronically ill, whose care is often delayed or denied when they cannot pay. [d]
- Another 16 million Americans are under-insured, with coverage that is inadequate to secure them access to needed care or protect against catastrophic medical bills. [e]
- Although the high cost of health insurance is a leading reason why people lack coverage, many inexpensive insurance policies are for sale. However, the uninsured may not be eligible for low premiums if they are older or in poor health, and covered benefits under low-cost policies may be limited. [f]

most likely to offer health coverage. (Only about half of companies with 3 to 9 employees offered any coverage at all in 2006, compared to 98 percent of large firms.[7]) Workers in manufacturing and government jobs are more likely than others to be offered health benefits. Higher wage firms are more likely than low wage firms to offer health coverage. Part-time workers, on the other hand, are less likely to be offered health benefits, and temporary workers are rarely offered health benefits.[8]



Source: U.S. Census Bureau (2006). "Table HI-6. Health Insurance Coverage Status and Type of Coverage by State -- People Under 65: 1987 to 2005." August 31. (www.census.gov/hhes/www/hlthins/historic/hihistt6.html)

Public programs – Some 18 percent of the non-elderly had health insurance through government programs in 2005.[9] Of these, most (almost 35 million according to the Census Bureau) were covered by Medicaid. (This is the number of people covered for the full year. Some 54 million nonelderly people were covered by Medicaid at some point during 2006.)[10] Medicaid is the safety net program for certain low-income populations: children, pregnant women and parents of dependent children, the elderly and people with disabilities. The federal government and states jointly finance Medicaid and set program eligibility standards, which vary by covered population. Unless one falls into a coverage category like those mentioned above, he or she is not eligible for Medicaid, no matter how poor.[11] (For more information on Medicaid, see Chapter 7.)

2006 HHS Poverty Guidelines

Family Size	Annual Income
1	$9,800
2	$13,200
3	$16,600
4	$20,000
5	$23,400
For each additional person, add	$3,400

For 48 contiguous states and D.C.; poverty thresholds for Alaska and Hawaii are somewhat higher.

Source: U.S. Dept. of Health and Human Services (http://aspe.hhs.gov/poverty)

The State Children's Health Insurance Program (SCHIP), like Medicaid, offers states federal matching funds to expand health care coverage for children. Most states have elected to cover children in families with incomes up to 200 percent of the poverty line or higher. (See chart, "2006 HHS Poverty Guidelines.") For parents, however, the income eligibility standards are usually lower, and vary by state.[12] (For more information on SCHIP, see Chapter 4, "Children's Health Coverage.")

Other important public programs that provide health coverage for people under 65 include Medicare, which covers certain eligible persons with disabilities (see Chapter 4 for more information about Medicare); TriCare, which covers members of the U.S. military and their families; veteran's health care administered by the Department of Veterans Affairs; the Indian Health Service, which delivers care to native Americans; and the Federal Employee Health Benefits Program, which provides care to government employees. (See box, "Major Public Coverage Programs at a Glance.")

Counting the Uninsured — Not as Easy as 1, 2, 3

Estimates of the number of uninsured vary from survey to survey in part because of differences in how the surveys are structured and conducted. There are four major surveys researchers use. The Current Population Survey (CPS) and the Survey of Income and Program Participation (SIPP) are both conducted by the Census Bureau. The Agency for Health Care Research conducts the Medical Expenditure Panel Survey (MEPS) and the National Center for Health Statistics conducts the National Health Interview Survey (NHIS).[1] In 2002, for example, the number of individuals estimated to be uninsured for a full year ranged from 22 million by SIPP to 44 million by CPS.[2]

The CPS has the largest sample of the three,[3] reaching roughly 73,000 households.[4] The CPS is a monthly survey primarily designed to generate data on employment. Each year, its March supplement asks participants about their health insurance status.[5] The survey attempts to identify individuals who were uninsured for an entire calendar year. But because a year is a long time to remember, experts believe that the survey likely overcounts the number of individuals who were without insurance for the entire year and, in fact, includes individuals who were insured for part of the year. It also is believed to undercount the number of its respondents who receive Medicaid.[6]

The SIPP interviews the same individuals every four months and asks them about their insurance status over the last four months from the date of the survey. The CPS health insurance survey takes place annually in March and asks respondents whether they had insurance from January to December of the previous year. Because respondents are asked to recall insurance coverage over a shorter period of time that is closer to the time of the interview, SIPP is thought to more accurately reflect participants' insurance status. However, the SIPP surveys roughly half as many households as the CPS and, while it is conducted continuously, data is only released every few years.[7]

The MEPS collects data several times a year and produces point-in-time, monthly, and annual estimates. The MEPS sample is smaller than the CPS.[8]

Unlike SIPP and MEPS, the National Health Interview Survey does not re-interview respondents over time. Participants are asked to report their status as of the time of the interview, yielding what is called a "point-in-time" estimate.[9]

But while different surveys may yield different estimates of actual number of uninsured, taken together the various surveys do indicate overall trends in the number of uninsured.

1 Catherine Hoffman and John Holahan (2005). "What is the Current Population Survey Telling Us About the Number of Uninsured?" Kaiser Family Foundation, August, p. 2 (www.kff.org/uninsured/7384.cfm)

2 Catherine Hoffman and John Holahan (2005). "What is the Current Population Survey Telling Us About the Number of Uninsured?" Kaiser Family Foundation, August, p. 3 (www.kff.org/uninsured/7384.cfm)

3 Catherine Hoffman and John Holahan (2005). "What is the Current Population Survey Telling Us About the Number of Uninsured?" Kaiser Family Foundation, August, p. 2 (www.kff.org/uninsured/7384.cfm)

4 U.S. Census Bureau (2005). "Source and Accuracy of Estimates for Income, Poverty, and Health Insurance Coverage in the United States: 2004." (www.census.gov/hhes/www/income/p60_229sa.pdf) Retrieved Aug. 24, 2006.

5 Understanding Estimates of the Uninsured: Putting the Differences in Context. Office of the Assistant Secretary for Planning and Evaluation, Health and Human Services, 2000. (http://www.aspe.hhs.gov/health/reports/hiestimates.htm) Retrieved Aug. 24, 2006.

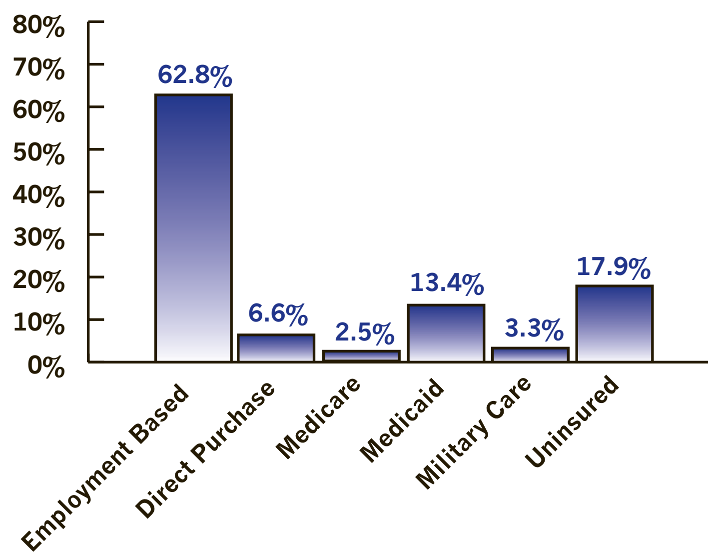
6 Office of the Assistant Secretary for Planning and Evaluation, Health and Human Services (2005). "Understanding Estimates of the Uninsured: Putting the Differences in Context." Updated September 5. (http://aspe.hhs.gov/health/reports/05/uninsured-understanding-ib/#estimates); and U.S. Census Bureau (2006). "Overview of the Survey of Income and Program Participation." Updated May 9. (www.bls.census.gov/sipp/overview.html)

7 Congressional Budget Office (2003). "How Many People Lack Health Insurance and for How Long?" Appendix A, May. (www.cbo.gov/showdoc.cfm?index=4210&sequence=3)

8 Office of the Assistant Secretary for Planning and Evaluation, Health and Human Services. "Understanding Estimates of the Uninsured: Putting the Differences in Context." (www.aspe.hhs.gov/health/reports/hiestimates.htm)

9 Congressional Budget Office (2003). "How Many People Lack Health Insurance and for How Long?" Appendix A, May. (www.cbo.gov/showdoc.cfm?index=4210&sequence=3)

Individual health insurance – The individual (or "non-group") insurance market may be the only alternative for those who do not have access to employer-sponsored coverage, cannot afford their share of the premium for employment-based coverage, or do not qualify for government programs.



Note: Figures total more than 100% because some individuals have coverage from more than on source.

Source: U.S. Census Bureau (2006). "Table HI-6. Health Insurance Coverage Status and Type of Coverage by State --People Under 65: 1987 to 2005." August 31. (www.census.gov/hhes/www/hlthins/historic/hihistt6.html)

Compared to the number of Americans with employment-based coverage, the individual market is small. About 17 million Americans under age 65 – 6.6 percent of that population – had individually purchased health insurance in 2005.[13] One study concluded that more than one in four working-age adults bought or considered buying coverage in the individual market over a three-year period.[14]

Health insurance in the individual market is more expensive than employer-sponsored coverage for several reasons. Almost seven out of 10 people (69 percent) who sought individual coverage in 2001 had difficulty finding a plan they could afford, one survey found.[15] Marketing and administrative costs per insured person are much higher for policies sold one-by-one rather than to groups. In addition, people buying individual coverage must pay the full premium. In contrast, those enrolled in employment-based coverage in 2006 paid an average of 16 percent of the total premium for themselves alone or 27 percent for family coverage, with the remainder covered by the employer.[16]

Individuals with health problems have an additional disadvantage. Insurance companies in most states are allowed to engage in "medical underwriting." This involves setting the premium based on the likelihood that an applicant will need a large amount of health services. Thus, insurance companies usually charge more to those who are older or in ill health, than to younger, healthier people. Also, insurers are typically allowed to deny or delay coverage for particular conditions. For instance, a person with diabetes might be offered a policy covering all medical needs except diabetes and its complications. Or insurers can simply deny coverage altogether.[17]

WHO ARE THE UNINSURED?

The 46.1 million uninsured constituted almost 18 percent of the non-elderly population in 2005.[18] (For statistics on all uninsured persons, including those age 65 and older, go to www.census.gov /hhes/www/hlthins/hlthins.html.) The typical uninsured person is a low-wage adult worker for whom coverage is either unavailable or unaffordable. Certain social and economic characteristics increase the risk of being uninsured.[19] (See chart, "Uninsured Population by Age and Income, 2005.")

Low income – The risk of being uninsured is much greater among low-income people. For example, one-third of workers earning less than $20,000 were uninsured in 2004 versus 5.6 percent of workers earning $50,000 or more.[20] In 2005, 19 percent of children living below the federal poverty level were uninsured, compared to 9.4 percent of children living above the poverty level.[21]

Age – Eleven percent of children were uninsured in 2005, compared to 20.5 percent of non-elderly adults, reflecting the relatively greater availability of public coverage (Medicaid and S-CHIP) for infants and children.[22] Young adults aged 18-24 are most likely to be uninsured (31 percent) of any age group[23] as they lose eligibility under either Medicaid or their parents' health insurance.[24]

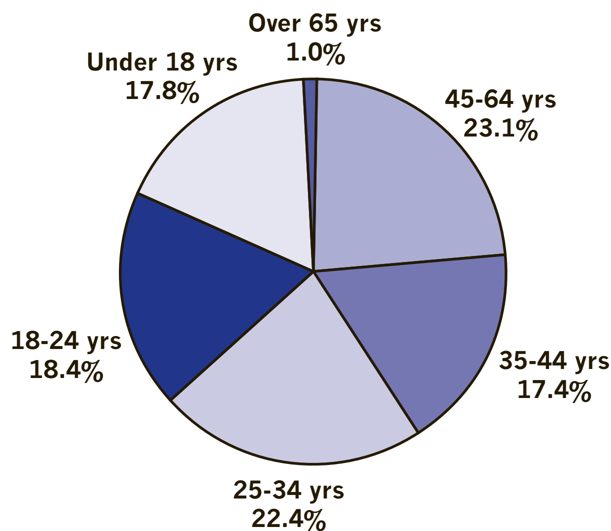
Ethnicity and Citizenship – Eighty-two percent of the non-elderly uninsured in 2005 were U.S. citizens and 48 percent were white. However, the risk of being uninsured is far higher for non-citizens and non-whites. More than one-third of Hispanics and 21 percent of African-Americans were uninsured, compared to 13 percent of whites. Among non-citizens, 40-50 percent lacked health insurance, due to restrictions in eligibility for public coverage and their frequent employment in low wage jobs without health benefits.

Geography – Rates of uninsurance are highest in some southern and southwestern states. For example, non-elderly residents of Texas (27 percent), New Mexico (23 percent), Florida (24 percent), Arizona (23 percent) and Louisiana (21.5 percent) disproportionately lacked coverage. By contrast, coverage rates tend to be higher in New England and Midwestern states, for example, Minnesota (10 percent uninsured), New Hampshire (12 percent) and Vermont (13 percent.)[25]

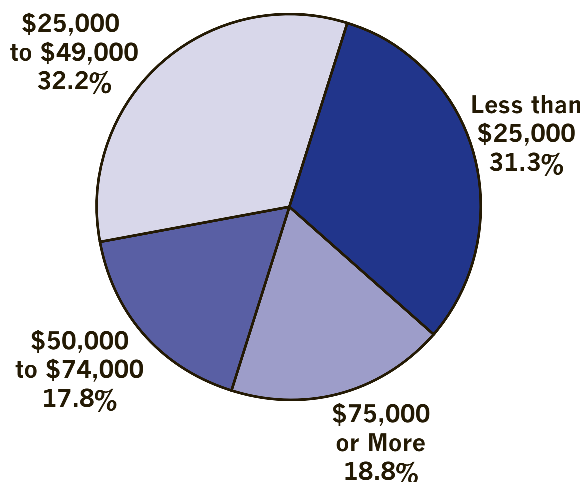
Working families – Although having a job lowers the risk of being uninsured, more than 80 percent of the non-elderly uninsured in 2004 were in working families. Almost 70 percent were in families with one or more full-time worker.[26] The vast majority of uninsured workers are not offered health benefits; only 20 percent of uninsured workers are offered and decline coverage, most frequently because they don't have the money to pay their portion of the insurance premium.[27]

UNINSURED POPULATION BY AGE AND INCOME, 2005

Uninsured Population by Age



Uninsured Population by Income



Source: U.S. Census Bureau (2007). "People With or Without Health Insurance Coverage by Selected Characteristics: 2004 and 2005." (www.census.gov/hhes/www/hlthins/hlthin05/hi05t8.pdf)

GETTING AND KEEPING HEALTH INSURANCE

Many who have health insurance today may lose it tomorrow. One study found 82 million Americans, or 32 percent of the non-elderly population, were uninsured for at least one month over a two-year period from 2002 - 2003.[28] Two-thirds (65.3 percent were uninsured for six months or more during this period).[29]

Relatively minor fluctuations in income can cause low-income individuals to cycle in and out of Medicaid eligibility. Those with incomes above 200 percent of the poverty level may experience lapses in private coverage if job changes lead to employers that don't offer health benefits; or they may encounter waiting periods of several months or

Major Public Coverage Programs at a Glance

Program	Enrollment and Eligibility
Indian Health Service	Covers 1.8 million of the 3.3 million American Indians and Alaskan Natives in the U.S.[1] Members of federally recognized American Indian and Alaskan Native Tribes and their descendants.
Medicaid	Covers about 60 million at some point during the year.[2] To receive Medicaid, a person must be both "categorically eligible" and also meet financial eligibility requirements. Eligible categories include: women, children, parents of dependent children, disabled, pregnant women and the elderly.
Medicare	Covers nearly 42.5 million.[3] All those 65 years or older who are U.S. citizens or legal residents living in the U.S. for five years in a row.[4] Individuals younger than 65 with end stage renal disease or amyotrophic lateral sclerosis (ALS, also known as Lou Gehrig's disease).[5] Most people who qualify for cash benefits under Social Security Disability Insurance can obtain Medicare-covered services after a two-year wait.[6]
SCHIP	Covers 4.2 million children.[7] Children in families with incomes up to 200 percent of FPL (higher in some states).[8]
Tricare	Active duty and retired service members from any of the seven branches (Army, Air Force, Navy, Marine Corps, Coast Guard, Public Health Service, or the National Oceanic & Atmospheric Administration.), their spouses and unmarried children under 21 (including stepchildren).[9]
VA	Veterans, family members, or survivors of veterans.[10]
FEHBP	Covers more than 4 million federal employees, and retirees, and their families.[11]

1 http://info.ihs.gov/Files/IHSFacts-June2006.pdf

2 http://ftp.cbo.gov/ftpdocs/73xx/doc7387/07-13-Medicaid.pdf, p. 4

3 Centers for Medicare and Medicaid Services (2006). "2006 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. Introduction: Highlights, p. 2." May 1. (www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2006.pdf)

4 Medicare Rights Center. "Q&A: Eligibility." (www.medicarerights.org/q&amedicareeligibility.html)

5 Medicare Rights Center. Q&A: Eligibility. (www.medicarerights.org/q&amedicareeligibility.html)

6 Centers for Medicare and Medicaid Services, Medicare Enrollment Reports, National Trends 1966-2005, http://www.cms.hhs.gov/MedicareEnRpts/

7 U.S. Department of Health and Human Services data cited in Alliance for Health Reform (2006). "SCHIP and Medicaid Enrollment: What's Next?" April, p. 2. (www.allhealth.org/Publications/pub_6.pdf)

8 U.S. Department of Health and Human Services data cited in Alliance for Health Reform (2006). "SCHIP and Medicaid Enrollment: What's Next?" April, p. 1. (www.allhealth.org/Publications/pub_6.pdf)

9 http://www.tricare.osd.mil/Factsheets/viewfactsheet.cfm?id=174

10 http://www1.va.gov/opa/fact/docs/vafacts.pdf

11 Office of Personnel Management (www.opm.gov/insure/index.asp)

longer before they are eligible for health benefits.[30]

Although federal law, commonly known as COBRA, guarantees many workers the right to remain covered temporarily under their former employer's health plan if they pay the entire premium, most cannot afford to do so. (For more information about COBRA continuation coverage, see Chapter 2, "Private Health Coverage".)

On average, about 2 million Americans lose health insurance every month.[31] Most remain uninsured for less than one year.[32] However, research shows people in poor health are twice as likely to encounter a lengthy spell without health insurance compared to people in good health.[33] Health problems may make

it more difficult to regain coverage after a person is too sick to work. In addition, people with serious or chronic health conditions can be discouraged from enrolling in new coverage that imposes pre-existing condition exclusions.[34]

WHY COVERAGE IS IMPORTANT

Not having health insurance can contribute to serious adverse health consequences, including death.

- According to the federally chartered Institute of Medicine, about 18,000 deaths among those aged 25 - 64 in 2002 could have been prevented had these individuals had insurance.[35]
- Uninsured people are almost twice as likely as the insured to delay getting needed medical care (15.7 percent vs. 8.6 percent).[36]
- Even when they have serious symptoms they think need attention, 30 percent of the uninsured report getting no care, compared with 14 percent of the insured.[37]
- Cancer patients who don't have coverage die sooner than those with insurance, largely because of delayed diagnosis.[38]
- Twenty-five percent of adult diabetics who were uninsured for a year or more went two years without a checkup, compared to 5 percent of diabetics with insurance.[39]
- Children without coverage often go without medical care for common childhood illnesses. For example, children with insurance are more than twice as likely to get medical help for recurrent ear aches and nearly twice as likely to get asthma treatment as children lacking coverage.[40]

Lack of coverage can result in health consequences that extend beyond those who are uninsured. In 1997, New York experienced a large rubella outbreak which started in an area where several uninsured individuals did not receive rubella vaccinations. Subsequently, surrounding communities also became infected.[41]

In 2002, an article in the journal *Science* predicted that the less frequent use of health services by the uninsured could hinder the detection and containment of a bioterrorist attack. The researchers reasoned that because of concerns about the costs of seeking care, or worries about deportation for doing so (among undocumented aliens), uninsured people would delay seeking treatment after contracting an infectious illness in a bioterror incident. As a result, hospitals and other health care providers would be unaware of the full extent of an outbreak.[42]

The growing number of uninsured also contributes to overcrowding of emergency rooms and increased uncompensated care. The burden on emergency rooms has prompted more than 400 to close over the past decade and increased the time all patients must wait, even for lifesaving care.[43]

Not having insurance also has financial consequences. Many people lacking coverage are living from paycheck to paycheck. When they do go to a doctor, they are asked to pay up front. Some nonprofit hospitals, despite requirements that they provide free or reduced-cost charity care to the indigent, pursue aggressive collection practices against uninsured patients by turning their cases over to bill collectors and demanding full payment.[44]

The uninsured who seek health care may need years to pay off medical expenses, if they can pay at all.[45] A study by The Commonwealth Fund found that almost one in three U.S. adults – an estimated 61 million people – reported having trouble paying medical bills in 2003. Especially vulnerable to such problems were the uninsured, blacks, Hispanics, women, and persons reporting a disability, chronic condition or being in fair or poor health. [46] Families where all members are uninsured are about twice as likely to report medical bill problems as insured families – 23.7 percent for uninsured families compared with 11.4 percent for insured families.[47]

High medical debt can also increase a person's risk of bankruptcy. Anywhere from to 27 percent to almost half of bankruptcies have medical debt as a triggering factor, depending on who is surveyed and how survey questions are framed.[48]

THE UNDERINSURED

Having insurance does not always guarantee health security. One analysis estimates that 16 million Americans are under-insured, with coverage that is inadequate to secure them access to needed care or

protect against catastrophic medical bills.[49] For example, individual health insurance policies often have substantial gaps, imposing high cost sharing and limiting (or not covering) benefits such as prescription drugs, mental health or maternity care.[50]

Coverage under job-based health plans has also eroded somewhat. A growing phenomenon today, for example, are "tiered" copayments, especially for prescription drugs, requiring higher cost sharing for more expensive care. (A copayment is the portion of the person's medical bill that is not covered by insurance, and thus must be paid out-of-pocket.) This trend has been adopted to encourage cost consciousness among consumers.

However, among chronically ill individuals who need ongoing care, even modest cost sharing can hinder access to care. For example, modest copayments can make it difficult for diabetics to access insulin and other medications to manage their diabetes.[51]

Increasingly, medical debt is also a problem for the under-insured, especially those with serious health conditions and limited incomes. Between 2001 and 2003, the proportion of low-income, chronically ill people with private insurance who spent more than 5 percent of their income on out-of-pocket health care costs grew from 28 percent to 42 percent.[52]

State and federal efforts to reduce Medicaid expenses are also adding to the problem of under-insurance. The Deficit Reduction Act allowed states to replace the standard Medicaid benefits package with so-called "benchmark plans" that resemble commercial insurance. This means some Medicaid beneficiaries have lost coverage for certain benefits they had previously, and some beneficiaries new to Medicaid do not have as broad a benefit package as they would have enjoyed in years past. (See Chapter 6, Medicaid, for more information.)

Even before the DRA was passed, states were cutting back on optional acute care benefits to rein in their expanding Medicaid costs. The number of states reducing Medicaid benefits doubled from nine in FY 2002 to 18 in FY 2003, and climbed again to 19 in FY 2004.[53]

HOW MUCH DOES HEALTH INSURANCE COST?

The cost of coverage is a key reason why individuals and families are uninsured. Yet the answer to the question, "What does health insurance cost?" can be difficult to pin down. On average, employer-sponsored health care in the U.S. cost about $4,000 per individual covered in 2005 and almost $11,000 per family covered.[54] Premiums for individual coverage ranged from an annual average of $3,767 for Health Maintenance Organizations (HMOs) to $4,150 for Preferred Provider Organizations (PPOs). Premiums for family coverage range from an annual average of $9,979 for a traditional indemnity plan (this would not include the cost of a deductible) to $11,090.[55] Employer-sponsored coverage tends to be comprehensive in the benefits covered, and it tends to pool both high and low cost individuals together.

Individual insurance policies can be purchased in many areas for much less.[56] But such low premiums apply to policies that limit coverage for key benefits (such as prescription drugs) and impose high deductibles (for example, $5,000). (A deductible is the amount of money a beneficiary must pay directly to a health care provider before costs are covered by the health plan or insurance company.) In addition, lowest premiums are only offered to young adults in excellent health; premiums for older persons with some health conditions can cost many multiples of the lowest-cost plans. And some states regulate insurance rates more strictly than others.[57]

CURRENT POLICY DEBATES AND PROPOSALS

Despite rising numbers of uninsured, Washington has not enacted significant legislation to expand coverage since 1996, when the State Children's Health Insurance Program (SCHIP) was passed. With rising deficits (exacerbated in part by the addition of the expansive new prescription drug benefit to the Medicare program), and public attention focused on war, terrorism and the economy, lawmakers have been reluctant to commit funding to covering the uninsured.

But the uninsured are still on policymakers' "radar screens." A 2003 law, passed as part of the new Medicare drug bill, made it possible for uninsured individuals and families to create health savings

accounts (HSAs) for out-of-pocket health expenses. Those opening HSAs receive tax breaks if they also purchase qualified high-deductible health insurance policies. Proponents argued that such policies would be more affordable for the uninsured, while critics worried that low-income uninsured could not afford to fund such accounts, even with tax subsidies. (See Chapter 2, "Private Health Coverage", for more information.)

For several years President Bush has proposed a refundable tax credit for Americans who don't have insurance. The Treasury Department estimates that the credit would extend insurance to 4.5 million Americans.[58]

Some critics of the Bush tax credits argue that they don't do enough to cover the more than 46 million people without insurance. A Commonwealth Fund study found that for all but the youngest and healthiest Americans, premiums cost significantly more than the amount of tax credits proposed.[59]

The president also supports legislation to enable small employers to form Association Health Plans (AHPs), which would allow firms to create large pools of workers. (For more on AHPs, see Chapter 2, "Private Health Coverage".)

Beyond Washington, some states are taking action. In 2006, Vermont enacted a voluntary program for the uninsured called "Catamount Health," which provides sliding scale subsidies for premiums and cost sharing under commercial health insurance plans. The state estimates as many as 25,000 of 60,000 uninsured Vermont residents may enroll in coverage under this program. If coverage goals are not reached by 2010, the legislature may consider coverage mandates. [60]

The state of Massachusetts enacted legislation in 2006 establishing a mandate for individuals to have health insurance. By mid-2007, the state will require all residents to obtain health insurance or pay a penalty. New, affordable policies and subsidies will be created to enable compliance with the mandate. In addition, employers will be required to make a "fair and reasonable" contribution to the cost of coverage for their employees.[61]

Also in 2006, Maryland enacted legislation that required very large employers to either "pay or play," meaning that they must provide health coverage worth at least eight percent of payroll or pay a tax to the state to help support Medicaid. After the Maryland legislature overrode a gubernatorial veto, a U.S. District Court struck down the law on grounds that it was preempted by federal law. Nonetheless, similar bills were being discussed in several other states as of September 2006.[62]

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. The program 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 persons, as well as dependents of any of those mentioned. Participating employers pay at least 60 percent of the total premium 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.[63,64]

One attempt to have the federal government reinforce state efforts like these was the introduction in May 2006 of legislation to offer federal grants to states that propose new efforts to extend health care to their uninsured residents. The Health Partnership Act of 2006, introduced by Senators Jeff Bingaman (D-N. Mex.) and George Voinovich (R- Ohio), would help states try anything from tax credits like those proposed by President Bush to a single-payer (Canadian-style) plan.[65] A companion bill in the House was introduced by two Republicans and two Democrats - Tom Price (R-Ga.), Bob Beaupez (R-Colo.), Tammy Baldwin (D-Wisc.) and John Tierney (D-Mass.).[66]

CONCLUSION

Since several polls suggest that health coverage for the uninsured is a major concern to voters, policymakers will most likely continue to focus on the issue. A March 2006 Gallup poll found 68 percent of respondents reporting that they worry about this problem a great deal.[67] Asked which one issue would be most important in determining their vote for Congress, respondents in an August 2006 Newsweek poll ranked health care #4, behind Iraq, the economy and terrorism.[68] In the 2006 and 2008

election cycles, it is likely to garner considerable interest as constituents demand help with the rising costs of coverage and feel threatened with the prospect of losing coverage altogether.

STORY IDEAS

- Hospitals across the country have come under attack for charging full prices to people without insurance while offering substantial discounts to large payors, such as insurance companies. More than 4,200 hospitals nationwide have pledged to offer free or reduced-cost care to the uninsured. Are hospitals in your area among them? For a listing, see www.hospitalconnect.com (search for "statement of principles.")

- Despite improving employment conditions, the number of people who are uninsured has grown. Are they still getting needed medical services? How has this affected local community clinics and emergency rooms and their ability to provide services to all residents?

- How do chronically ill individuals navigate health insurance transitions? What do waiting periods, pre-existing condition exclusions, or other coverage lapses mean for people with diabetes, asthma, or hypertension? How does health insurance, or lack thereof, affect their ability to manage their health conditions and avoid more serious complications?

- What efforts have area businesses made to cover workers or reduce health costs? Some large employers have joined an initiative to offer low-cost coverage options to low wage and part time workers, at the workers' expense. What do these low-cost policies cover? Are uninsured workers signing up? How do low-cost coverage options compare to the health benefits of other workers (for example, at your job)?

- As states continue to experience hard times, what changes have they made or are they contemplating to Medicaid? Most states have attempted to cut costs by reducing eligibility or benefits, though some have since reversed the cuts as revenues revived. What has your state been doing and how has it affected those with Medicaid coverage – or needing it

- Companies across the country have increasingly limited retiree medical benefits. What are people between 55-64 doing to get coverage? Talk with employers who may try to help even if they don't offer coverage.

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