

Expanding Coverage: Reflections On Recent Efforts

The themes are not new, but the sense of urgency may be, if a weaker economy causes employer coverage rates to drop.

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ABSTRACT: This paper focuses on the major health care initiatives and proposals that policymakers have enacted or considered since 1980 and describes what we can learn from these efforts to expand coverage. Most proposals have focused on incremental strategies, through expansion of public programs or tax incentives for the purchase of private coverage, although universal proposals have also emerged. Incremental approaches, which seem more politically feasible, still involve complex policy trade-offs. Efforts to improve take-up rates of public and private insurance could greatly expand coverage as well.

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INSURANCE COVERAGE IN THE UNITED STATES has developed incrementally along three separate pathways: employer-sponsored insurance, Medicare, and Medicaid plus the State Children's Health Insurance Program (SCHIP). This fragmented system has left many without health insurance. Indeed, 17.5 percent of nonelderly Americans were uninsured in 1999, a number that was much higher than was true a decade earlier.

Several times since World War II—most recently in 1993—federal policymakers have considered and rejected proposals to provide universal coverage, although incremental expansions have been enacted. The issue of the uninsured endures on the agenda, especially given the growing body of evidence attesting to the impact of health insurance on health status. Persons who lack coverage are more likely to delay or forgo care, to have fewer services ordered by providers on their behalf (with deleterious effects on their health), and to have higher mortality rates.

Today, a variety of federal and state policymakers and interest groups are once again considering options for expanding coverage, but generally on an incremental basis. Those promoting further expansions see new opportunities to do so in the favorable fiscal environment produced by federal budget surpluses and tobacco settle-

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ment funds. In this paper we review the major initiatives and proposals that policymakers have enacted or considered since 1980 and reflect on what the nation can learn from those experiences.

Expansions Of Medicaid Eligibility In The 1980s And Early 1990s

National health insurance was not a major part of the policy agenda for most of the 1980s, a decade in which growing budget deficits dominated federal policy. Beginning in 1984, however, Congress enacted a series of measures to expand eligibility for Medicaid, focusing primarily on infants, children, and pregnant women—population groups for whom one could generate political support.

With the options granted to states in the Omnibus Budget Reconciliation Act (OBRA) of 1986, Medicaid eligibility criteria changed in important ways. By granting the states authority to provide Medicaid coverage to all pregnant women, infants, and children up to age five with family incomes below the poverty level, OBRA took the first steps to sever the link between Medicaid and welfare eligibility. A rapid succession of mandates and options for covering these three groups followed, with dramatic effects on enrollment. Between 1975 and 1986 the number of children in Medicaid grew only slightly, from 9.6 million to 10.0 million. By 1993 this number had risen to 16.3 million.¹

Despite that growth, the proportion of children who were uninsured actually increased slightly, from 13.1 percent in 1987 to 13.7 percent in 1993, as the proportion with private coverage declined. Researchers disagree on the extent to which that shift in source of coverage was the result of a decline in employer coverage over time or reflected the displacement of private by public coverage.²

Notably, however, the majority of poor adults remained ineligible for Medicaid (as they do to this day). The major reductions in private coverage of nonelderly adults that also occurred during this period were offset only slightly by increases in Medicaid coverage. Consequently, the proportion of uninsured nonelderly adults rose from 15.6 percent in 1987 to 18.8 percent in 1993.

Changing Dynamics In The Late 1980s And Early 1990s

Momentum for universal coverage picked up steam by the end of the 1980s, in response to a variety of concerns. The number of uninsured persons had increased steadily throughout the decade, providers worried about growing amounts of uncompensated care, and the public had become more supportive of government action in the health care arena.³ The 1990–1991 recession aggravated the situation,

causing consumers to worry about their risks of losing coverage. Health care costs were rising sharply, much to the concern of employers, and health benefits were becoming a factor in labor unrest.

■ **Pressure for mandates on employers.** By the end of the 1980s some business leaders—despite their concerns about big government—were calling for universal health insurance as a means to control rising health care costs. Moreover, some large employers that offered insurance were willing to support an employer mandate to prevent cost shifting from those that provided no coverage or offered only meager benefits.⁴ Leading congressional Democrats, two national commissions, several provider organizations, and some states also endorsed employer mandates, generally in the form of a “play-or-pay” approach.⁵ Many small businesses, however, and larger ones that did not offer coverage were unalterably opposed to mandates. That opposition was to prove a major barrier to President Bill Clinton’s health care reform proposal.

Also supporting an employer mandate, at least initially, was the Jackson Hole group—a gathering of influential, market-oriented health policy experts. In the early 1990s the group produced its own blueprint for health care reform, based on the concept of “managed competition,” which was to have an important influence on the health care proposals developed by the Clinton administration and others. According to that blueprint, market forces and consumer choice would expand coverage and contain costs, with government regulation to ensure competitive markets. (The group modified its plan in 1994, dropping the employer mandate unless other health care reforms failed.)⁶

■ **A tax credit experiment.** During this period of hot debate over employer mandates, Congress continued to develop incremental proposals to expand coverage. In contrast to Medicaid expansions, at least one initiative attempted to increase the enrollment of low-income families in private plans. Specifically, OBRA 1990 included tax incentives for low-income parents receiving the Earned Income Tax Credit (EITC) to provide health coverage for their children. The program was flawed in both design and implementation, however, which limited its effectiveness.⁷

First, the financial incentives were not strong enough to encourage much participation. The credit was small, even for extremely low-income families, on average covering less than one-quarter of the taxpayer’s share of a family premium. Moreover, although eligible workers could claim their credit in advance through their employer, few did so. Consequently, cash-flow problems remained.

Second, information about the program was limited and sometimes misleading, and many people did not know that they were

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eligible. Those taxpayers who did claim the credit tended to be among the higher-income recipients of the EITC, with most of the benefits of the credit going to those who were already insured.

Finally, insufficient regulation of insurance products and the individual insurance market resulted in widespread abuses by unscrupulous insurers. As one might have predicted, the health insurance tax credit had little impact on insurance coverage, and Congress repealed the legislation in 1993.

■ **President Bush’s proposal.** The push for universal coverage gained more political strength in 1991, when Democrat Harris Wofford defeated Republican Richard Thornburg in the U.S. Senate race in Pennsylvania by focusing on the right to access to health care. Democrats used the momentum to push national health insurance onto the agenda for the 1992 presidential race.

In 1992 the mounting political pressure prompted the George Bush administration to produce its own coverage proposal, based on tax credits and insurance market reforms.⁸ Tax provisions included refundable, income-related tax credits for poor and near-poor persons and families, with a choice of a tax credit or a deduction for other low- and moderate-income persons. States were to define a basic benefit package for the amount of the credit. The proposal also allowed full deductibility of premiums for the self-employed.

Insurance market reforms required insurers to guarantee availability and renewability, and to limit exclusions for preexisting conditions. Other measures to make insurance more available and affordable included the establishment of federally certified networks through which small employers could purchase coverage, and measures to pool risks in the individual and small-group markets. Many health insurance proposals that are under discussion today include elements of President Bush’s plan. One feature that has not been widely replicated, however, deserves particular attention: the mandate for states to define a basic benefit package, with the authority to require two plans to offer it. That mandate was a response to a dilemma faced by all proposals to expand coverage through tax credits (or other individual subsidies): how to contain costs and yet provide a subsidy that is large enough to affect coverage. President Bush’s proposal required the states to establish plans with actuarial values to match the amount of the subsidy. Such an approach ensured that low-income persons would be able to purchase coverage

with little out-of-pocket spending, which could have greatly expanded coverage. But because the tax credit amount was less than the average cost of a typical policy, the covered benefits in plans established by the states would have been much less generous than those in a typical employer-sponsored plan.⁹

The Clinton Plan, 1992–1994

Bill Clinton campaigned on the issue of universal coverage in 1992, initially advocating a play-or-pay approach. He eventually adopted a managed competition strategy, based on the Jackson Hole model, which used a combination of mandates and subsidies to achieve universal coverage.

The managed competition provisions in his proposal included a requirement for all employers to contribute to the cost of their workers' premiums and for all individuals and families—with the exception of the elderly and the poor—to pay the remainder. Most consumers would have gained access to a choice of health plans through a nationwide system of regional purchasing alliances, with premium contribution requirements varying according to the cost of the plan they chose. Firms of 5,000 or more, however, would have had the option to sponsor their own corporate alliances. The proposal also included subsidies for small low-wage firms and for low-income individuals and families.¹⁰

In one important respect, however, the Clinton proposal diverged markedly from the Jackson Hole blueprint. The Clinton administration did not want to rely exclusively on a reinvigorated marketplace to contain costs and proposed to buttress market forces with spending controls. Imposing such controls on top of a new market-based system compounded the complexity of the proposal.

Journalists and political scientists have speculated about why the Clinton health plan failed.¹¹ While the potential reasons are manifold, we highlight two aspects. First, universal coverage was politically feasible only if the rate of growth of health care spending could be slowed. That constraint arose from the expectations of employers and unions, as well as the budgetary scoring requirements of the Congressional Budget Office. Slower spending growth—whether through market forces, spending controls imposed by government, or both—meant that the proposal would produce losers as well as winners. Potential losers included those consumers who would receive less health care or have to pay more than previously, providers whose payments would grow more slowly, and insurers who would be subject to premium caps. The possibility of losing out provided fertile ground for various interest groups to play on people's fears and uncertainties about the proposal.

More generally, the demise of the Clinton proposal illustrates the quandary that would-be health care reformers face. To avoid disrupting the health care system, the Clinton proposal, radical though it seemed, built on the existing employment-based structure, with all of its complexities and multiple public-sector components. Under such circumstances, health care proposals can be relatively broad and general, and face the charge that they leave too many questions unanswered. Or, like the Clinton proposal, they can attempt to provide a detailed explanation of how every sector of the health care industry would change and end up with a scheme that few can comprehend but in which everyone can find a feature to dislike. With hindsight, one might argue that the first approach has a better chance of succeeding politically. Policymakers can avoid much organized opposition by spelling out few details, proposing broad general legislation, and allowing the details to be worked out in regulation. But that strategy may also backfire; subsequent opposition can derail enacted legislation, as we discovered following the enactment of the Medicare Catastrophic Coverage Act in 1988.

Back To The States

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With the demise of health care reform at the national level in the mid-1990s, the action shifted once more to the states, several of which were looking to Medicaid as a tool to expand coverage. Certain provisions in the welfare reform act of 1996 and the enactment of SCHIP in 1997 have given additional impetus to state coverage initiatives. As states pursue their separate strategies, the coverage picture across the country becomes more diverse and complex.

■ **Extending Medicaid eligibility to new populations.** In the mid-1990s the states had two mechanisms for expanding coverage under Medicaid. They could raise the effective income eligibility standards for their traditional Medicaid populations. Alternatively, they could obtain a waiver from federal Medicaid rules enabling them to expand coverage beyond the traditional populations to other low-income individuals and families. In response to those opportunities, several states raised their income eligibility standards for traditional populations, and some used the waiver authority to expand coverage to adults who otherwise would be ineligible.

Welfare reform in 1996 continued the process of delinking Medicaid eligibility from cash assistance. The act, plus subsequent regulations issued by the U.S. Department of Health and Human Services, allows states to expand Medicaid coverage to low-income working families without having to go through the waiver process. A few states have used this mechanism to expand Medicaid coverage for adults, sometimes in combination with waivers.

By February 2000 fourteen states and the District of Columbia had used one or more of these flexibility options, or their own state funds, to enable them to offer Medicaid coverage to adults.¹² As with previous expansions of Medicaid, these more recent initiatives range broadly in scope among the states, according to whom they cover and to what income level.

Even as states have developed new programs to expand coverage to families at higher income levels and broaden the scope of eligibility beyond the traditional populations, however, many have faced declining Medicaid participation by low-income families. That decline has resulted in part from the implementation of welfare reform, which has caused many eligible persons to be dropped from Medicaid. A recent report found, for example, that Medicaid enrollment of parents in the fifteen states with the most low-income uninsured adults fell by 27 percent between January 1996 and December 1999, from 3.5 million to 2.6 million.¹³ Contributing factors include the inadequacies of states' information systems for tracking eligibility, lack of knowledge among low-income families leaving welfare of their continuing eligibility for Medicaid, and the complexities of states' processes for eligibility determination, enrollment, and recertification. Many states are now looking for ways to simplify their administrative processes in the hope of preventing low-income families from falling through the cracks.

■ **Covering kids through SCHIP.** In 1997 federal policymakers turned their attention to the issue of uninsured children. As in the 1980s, it was easier to generate bipartisan support for expanding public programs to cover low-income children than to cover other uninsured groups. Also, the coverage estimates were disturbing. According to the most recent national data available at the time, of the forty million uninsured persons in 1995, almost ten million were children, of whom almost seven million were in families with incomes below 200 percent of the poverty level.¹⁴

Through the enactment of SCHIP, Congress provided federal matching funds at an enhanced rate for states to expand coverage to children up to 200 percent of poverty (or to higher percentages in those states that had already expanded coverage to children at higher income levels than those required by Medicaid). All states are now participating in the program.

Implementation of SCHIP has been a learning experience for both state and federal policymakers. Among the more difficult problems that states have faced are how to inform families that have always been outside the traditional welfare system that their children are eligible for coverage under this new public program, and how to simplify the enrollment process to make it easy for families to par-

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participate. While some states have been quite successful in enrolling uninsured children in the program, others have started more slowly. Consequently, many states are facing the prospect of returning some of their SCHIP allocations because they have been unable to use the initial allotment within the required three-year period.¹⁵

SCHIP also raises some ethical questions that policymakers should address as they consider whether to use the program as a model for further expansions of public coverage. Because of concerns that states would not participate without strong financial incentives to do so, the program reimburses states at a higher rate for higher-income children than it does for those who are eligible for Medicaid. Consequently, in some states we are seeing the emergence of two classes of care for low-income children, as SCHIP can afford to pay higher rates than Medicaid to providers and health plans.¹⁶ That unintended outcome raises troubling questions about the trade-off that may be necessary when designing state-based policies to expand coverage.

Insurance Market Reforms

Over the past decade, in addition to their attempts to expand public coverage, both federal and state governments have taken steps to improve the functioning of private health insurance markets. States have focused on reforming the individual and small-group markets through such requirements as guaranteed issue and renewal, portability, limits on preexisting condition exclusions, and restrictions on premium rates. At the federal level, the enactment of the Health Insurance Portability and Accountability Act (HIPAA) in 1996 represented an incremental step to make insurance more accessible and portable through limiting restrictions on the coverage of preexisting conditions for people who had maintained qualified coverage. Although those reforms may have made insurance more accessible to certain groups and stabilized markets, they have not increased coverage much, since they do not generally address affordability.¹⁷

In addition, some states have attempted to establish health insurance purchasing cooperatives (HIPCs) to reduce the cost of coverage for small employers. Those initiatives too have had little impact on coverage, as HIPCs have generally been unsuccessful in attracting enough members to produce significant cost savings.¹⁸

Despite their lack of impact on coverage, initiatives to reform

health insurance markets should not be dismissed as wasted effort. As policymakers turn to consider alternative approaches for subsidizing private coverage, effectively functioning insurance markets will be essential for the success of such initiatives.

Challenges Ahead

Despite recent efforts, challenges remain for the next steps in expanding coverage. Those steps may include new coverage initiatives, through the development of new programs or the extension of old ones, as well as efforts to encourage people to take advantage of existing coverage opportunities. Any new coverage initiatives will involve complex policy trade-offs. Moreover, rising health care costs may temper the nation's enthusiasm for further expansions.

■ **New coverage initiatives.** Expanding health insurance coverage is once again on the political agenda, reflecting both the favorable fiscal climate and concern that the booming economy has, until recently, done little to stem the growth in the number of uninsured.¹⁹ Proposals under discussion include further expansions of public programs and a variety of tax credit and subsidy initiatives. While some organizations continue to push for universal coverage through social insurance or mandates on states and employers, those options do not seem feasible in the current political environment. Recent experiences point to several issues that policymakers should take into account as they consider coverage options.

Further expansions of public programs. Any expansion of public programs such as Medicaid and SCHIP must occur in partnership with the states, which now exercise considerable discretion over those programs. Greater state discretion has resulted in wide variations in the populations covered by Medicaid and SCHIP, the services provided by those programs, and per capita spending. Those variations are primarily attributable to differences among the states in wealth, industrial structures, labor markets, and, to some extent, politics.

Relative needs also vary widely. Thus, if policymakers continue to use state-based programs to expand coverage, they must recognize that states face problems of relatively different magnitudes, and "one size fits all" solutions may not be appropriate. States such as Mississippi and Texas, for example, with low proportions of their populations covered by employer insurance, have much more ground to make up through public programs than do states with higher prevalence of employer coverage, such as Wisconsin and Minnesota.

Given the differences in both relative need and the design of public programs, state-based approaches to expanding coverage raise serious equity concerns: Persons in like circumstances are treated differently, depending on where they live. Short of a univer-

sal coverage initiative, reducing the variability among the states in the proportion of the population that is uninsured can probably be achieved only by requiring states to cover all uninsured persons below a certain income level. Such an approach would probably be infeasible without major federal financial assistance. But there are political downsides to subsidizing the states on the basis of need. Specifically, the more federal programs distinguish among the states according to need, the more heated are the political battles over funding allocations. Some states, for example, have questioned the fairness of the initial approach for allocating funds for SCHIP, as well as the redistribution of unused SCHIP allocations.²⁰

Tax credits and subsidies. The current bipartisan support in Congress for health insurance tax credits suggests that many policymakers would prefer to use subsidies to encourage the purchase of private coverage, rather than to expand public programs. A lesson from previous policy changes, including state insurance market reforms, HIPAA, and the limited experience with the health insurance tax credit, is that unless those subsidies covered a major portion of the premium, efforts to expand coverage would be largely unsuccessful.

The tax credit experience also suggests that policymakers should address the implementation of a tax credit program. Effective communications strategies would be essential (targeting nonfilers in particular), explaining eligibility for the credits and how to obtain them. Advance payment options should be considered to reduce cash-flow problems for low-income persons. Also, stronger regulation of the individual insurance market, in which many people would spend their credits, would be necessary.

Policy trade-offs. Regardless of the approach they adopt, those seeking to expand coverage will face difficult policy trade-offs. Some displacement of private financing by public financing is inevitable, for example, and policymakers must decide how much is acceptable. Expansions of public programs to cover persons at higher income levels, and attempts to provide more stable coverage through minimum periods of eligibility, will erode employer-sponsored coverage. Likewise, tax credit and voucher initiatives will displace private financing, as those who are already insured take advantage of the new subsidies for which they are now eligible.

Another difficult trade-off is between the number of persons covered and the generosity of benefits they receive. That is, given a budget constraint, should one attempt to cover as many people as possible with relatively meager benefits, or ensure that high-priority target populations receive comprehensive benefits with minimal cost-sharing requirements? President Bush addressed that issue head-on in his 1992 proposal, opting for more coverage with scantier

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benefits. Medicaid, by contrast, reflects a policy of providing rich benefits to a select group of eligible persons.

A third perplexing choice is between costs and marginal tax rates. The more rapidly an income-related subsidy phases out as income rises, the higher is the marginal tax rate that a low-income family faces (and, hence, the greater are work disincentives). A gradual phase-out reduces the problem but raises program costs.

■ **Encouraging take-up of existing options.** In addition to developing new coverage options, policymakers can develop strategies to encourage uninsured persons to take advantage of health insurance options for which they are already eligible. If, for example, everyone who is offered employer coverage enrolled in their employer’s plan, the uninsured population would decline by 20 percent, or about seven million people.²¹ If every child who is eligible for SCHIP or Medicaid were enrolled, the number of uninsured would decline by an additional five million. Enrolling all adults eligible for Medicaid could reduce the uninsured by more than 1.6 million.²²

Strategies to enroll and retain people in programs for which they are already eligible include advertising the availability of public programs, simplifying the enrollment and recertification requirements for those programs, coordinating enrollment efforts among programs, extending subsidies to those offered private insurance who cannot afford it, and instilling awareness of the value of insurance.

■ **Effects of rising health care costs.** Health insurance premiums, which stabilized in the mid-1990s, are now rising again. Employee benefits experts anticipate hefty increases in premiums in 2001 and, possibly, for several years to come. The Federal Employee Health Benefits Program (FEHBP), for example, recently announced that average premiums would rise by 10.5 percent in 2001, following increases of more than 9 percent in both 1999 and 2000.²³

Thus far, however, rising premiums have not reduced employer-sponsored insurance. In today’s tight labor market, employers are not passing on premium increases to their employees. Average premium contributions were lower in 2000 than in 1999, and employees contribute a smaller share of premiums now than they did in 1993.²⁴

Nonetheless, although the economy is about as strong as it is ever going to be, a major expansion of employer-sponsored insurance has not occurred. The percentage of the nonelderly population that was uninsured fell in 1999 to 17.5 percent (with most of the reduction

resulting from expansions in employer-sponsored coverage), but that rate was still higher than during the last recession in 1990–1991, and much higher than the rate of 15.7 percent ten years ago.

Because costs are the primary factor affecting employers' decisions to offer coverage and employees' decisions to accept it, policymakers have every reason to be concerned about the permanence of recent gains in private coverage as premiums begin to rise again. The last time employer-sponsored coverage declined significantly was between 1989 and 1993, a period of rapid premium growth in which the economy experienced a mild recession. The economy is now tempering the effects of rising health care costs on coverage, but labor markets are unlikely to stay this tight indefinitely. Any weakening of the economy would almost certainly result in reductions in private coverage—especially if premiums continue to rise rapidly—and increased demand for Medicaid and SCHIP. If history is any guide, however, declines in private coverage combined with rising costs could generate new enthusiasm for universal coverage.

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The authors thank Steven Schroeder, Jack Ebeler, Stuart Altman, and Larry Levitt for their helpful comments on this paper. This views expressed here are those of the authors and do not necessarily represent the views of the Robert Wood Johnson Foundation.

NOTES

1. *Health Care Financing Review: Medicare and Medicaid Statistical Supplement, 1999* (Baltimore: HCFA, 1999), 278.
2. See, for example, L. Dubay and G. Kenney, "Revisiting the Issues: The Effects of Medicaid Expansions on Insurance Coverage of Children" (Unpublished paper, Urban Institute, October 1995).
3. M. Schlesinger and T. Lee, "Is Health Care Different? Popular Support of Federal Health and Social Policies," *Journal of Health Politics, Policy and Law* 18, no. 3 (1993): 551–628.
4. J.B. Judis, "Abandoned Surgery: Business and the Failure of Health Care Reform," *American Prospect* (Spring 1995): 65.
5. P. Houston, "Panel Proposed Health Plan to Aid Uninsured," *Los Angeles Times*, 31 January 1989, 1.
6. "Jackson Hole Group: Managed Competition II Emerges," *American Health Line*, 1 March 1994.
7. U.S. General Accounting Office, *Health Insurance Tax Credit Participation Rate Was Low* (Washington: U.S. Government Printing Office, 1994); and House Ways and Means Subcommittee on Oversight, *Report on Marketing Abuse and Administrative Problems Involving the Health Insurance Component of the Earned Income Tax Credit* (Washington: U.S. GPO, 1993).
8. Executive Office of the President, *The President's Comprehensive Health Reform Proposal* (Washington: The White House, 6 February 1992).
9. Statement of Robert D. Reischauer, director, Congressional Budget Office, before the House Committee on Ways and Means, 4 March 1992.
10. CBO, *An Analysis of the Administration's Health Proposal* (Washington: CBO, February 1994).

11. For example, see H. Johnson and D.S. Broder, *The System* (Boston: Little, Brown and Company, 1996); and L.R. Jacobs and R.Y. Shapiro, *Politicians Don't Pander* (Chicago: University of Chicago Press, 2000).
12. M. Krebs-Carter and J. Holahan, *State Strategies for Covering Uninsured Adults* (Washington: Urban Institute, February 2000).
13. Families USA, *Go Directly to Work, Do Not Collect Health Insurance: Low-Income Parents Lose Medicaid* (Washington: Families USA Foundation, 2000).
14. Employee Benefit Research Institute, *Sources of Health Insurance and the Characteristics of the Uninsured: Analysis of the March 1996 Current Population Survey*, EBRI Issue Brief no. 179 (Washington: EBRI, November 1996).
15. J. Guyer, "Maximizing Child Health Coverage Depends on Establishing an Effective System for Reallocating Unspent SCHIP Funds" (Washington: Center on Budget and Policy Priorities, October 2000).
16. See, for example, C. Lee, "Medicaid May Lose Dentists to Other Plan; Higher Fees Paid for Same Work," *Dallas Morning News*, 4 October 2000, 23A.
17. S. Zuckerman and S. Rajan, "An Alternative Approach to Measuring the Effects of Insurance Market Reforms," *Inquiry* 36, no. 1 (1999): 44-56.
18. E.K. Wicks, M.A. Hall, and J. Meyer, *Barriers to Small Group Purchasing Cooperatives* (Washington: Economic and Social Research Institute, 2000).
19. See, for example, Robert Wood Johnson Foundation, "Health Coverage 2000: Meeting the Challenge of the Uninsured," <www.rwjf.org/main.html> (30 October 2000).
20. Newsbytes News Network, "Handful of States Raise Questions about Viability, Fairness of CHIP," *Newsbytes PM* (25 September 1998); and J. Reichard, "State Squabble Likely over Unspent SCHIP Money," *Medicine and Health* (24 April 2000): 1.
21. P.J. Cunningham, E. Schaefer, and C. Hogan, *Who Declines Employer-Sponsored Health Insurance and Is Uninsured?* Issue Brief (Washington: Center for Studying Health System Change, 1999), 22.
22. Urban Institute, unpublished estimates for 1998, derived from the Current Population Survey (CPS).
23. "FEHBP Premiums to Rise 10.5 percent; Drug Prices Called Main Culprit in Increase," *BNA's Health Care Daily Report* (19 September 2000).
24. Henry J. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2000 Annual Survey* (Menlo Park, Calif.: Kaiser Family Foundation/HRET, 2000), 74.