

Alliance for Health Reform
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www.allhealth.org/publications/Uninsured/Health_Care_Coverage_in_America_2008_82.pdf

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

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

Health coverage for children will be at the top of the health care agenda on Capitol Hill and elsewhere in 2007. The successful State Children's Health Insurance Program (SCHIP) comes up for renewal in September. But states are concerned that they won't have enough money to serve the children already in the program, not to mention the nearly 2 million who are eligible but not yet enrolled.

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

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

**CoverThe
Uninsured**

CoverThe Uninsured

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Introduction

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

That's the situation faced by more than 46 million people in the United States—in every age group and at every income level.¹ Among them are the 8.3 million children who are uninsured, a group that will get special attention on Capitol Hill in 2007.

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

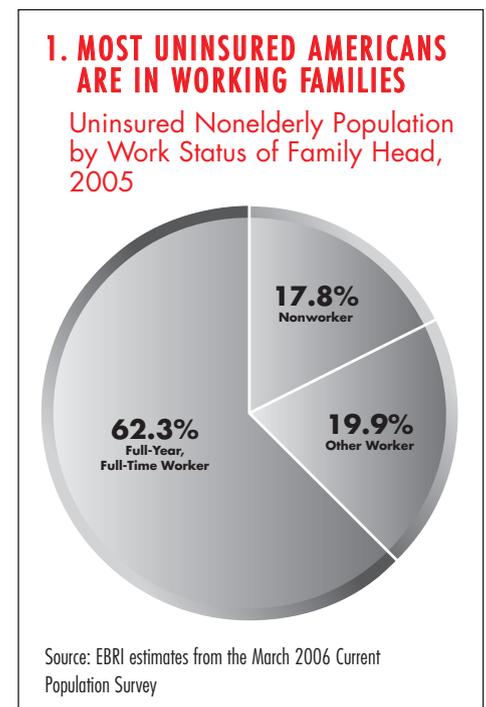
Several times since the 1940s, Americans have engaged in nationwide discussions about how to provide health insurance to those who don't have it, and how to help people keep their health insurance.

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

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

- About one in six people in the United States—46.6 million—lacked insurance for all of 2005, according to the U.S. Census Bureau.² That's an increase of 6.8 million since 2000.³

- In 2005, 8.3 million children were uninsured, up from 8 million in 2004.⁴
- The percentage of the U.S. population without health coverage has also grown, up from 14.2 percent in 2000 to 15.9 percent in 2005.⁵
- More than eight out of 10 of the uninsured are in working families (see Chart 1).⁶
- The uninsured don't fit any stereotype. They come from every community, every walk of life, every race and ethnic group, and every income level (see Chart 2).⁷
- People who have coverage can't necessarily count on keeping it. A person could have good coverage today, none at all six months from now, and then regain coverage a few months later. Some 63.9 million people—more than 25 percent of the population under age 65—lacked coverage at some point in 2004.⁸



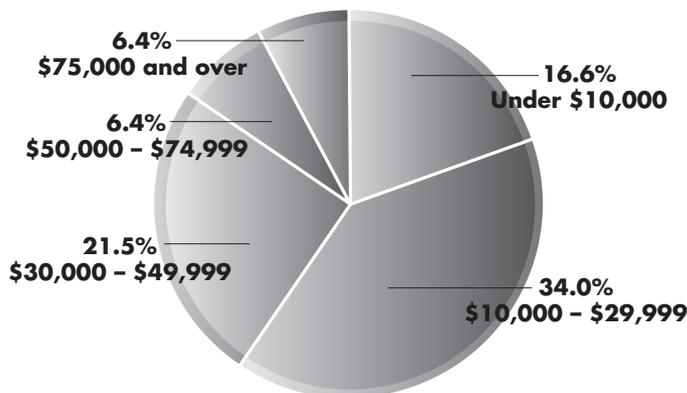
A NOTE ON UNINSURED NUMBERS

Throughout this publication, you will see 46.6 million as the total number of uninsured in the United States for all of 2005. On March 23, 2007, the U.S. Census Bureau released a revised figure of 44.8 million uninsured for 2005, based on a more accurate methodology. All other uninsured figures will eventually be revised as well, going back to 1995, but trends will not change. For more information, go to the Census Bureau's website at www.census.gov and click on "Health Insurance."

We count the number of number of uninsured children at 8.3 million for 2005, the latest figure available from the Census Bureau. This applies to children under age 18. There were slightly more than 9 million uninsured children under age 19 in 2005. Other analysts, also using Census data, estimate more than 9 million children are without coverage. Regardless of the counting method used, the United States has far too many uninsured children and action is required soon at the federal and state levels to help them gain health coverage.

2. UNINSURED COME FROM ALL INCOME LEVELS

Uninsured Nonelderly by Family Income, 2005



Source: EBRI estimates from the March 2006 Current Population Survey

Why the Renewed Interest in the Uninsured?

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

Many Americans are worried about health coverage and health care costs. For instance, 54 percent of those polled by the Pew Research Center for the People and the Press in 2006 said that paying for the cost of a major illness is a major problem. Some 44 percent said paying for prescription drugs is a major problem.⁹ Uninsured Americans are more than twice as likely as insured Americans to report a medical need that went unmet because of cost (see Chart 3.)¹⁰ The uninsured are almost four times more likely than the insured to have an unmet need for prescription drugs.¹¹

A poll conducted for the Federation of American Hospitals in February 2007 suggests that expanding coverage may

well be an issue leading up to the presidential election of 2008. Among other questions, the poll of registered voters asked how important a presidential candidate's position on coverage for the uninsured will be in deciding how to vote in 2008. Some 35 percent answered "extremely important," and another 44 percent said "somewhat important."¹²

Even so, many Americans are not convinced that being uninsured is a problem. A majority of Americans polled in 2004 mistakenly believed the uninsured can receive the care they need through clinics and hospital emergency departments.¹³

One important question is: Would Americans be willing to pay more for their health coverage or in taxes to guarantee coverage for all? In a January 2007 poll by NBC News and the Wall Street Journal, 40 percent said they were not willing to pay more in taxes.¹⁴ This number shrunk to 34 percent in a similar February poll by the *New York Times* and CBS News.¹⁵

Asked if the federal government should guarantee health insurance for all Americans, even if the respondent's own health insurance costs would go up, 48 percent answered "yes" in the *New York Times*/CBS News survey.¹⁶

Yet another challenge is this: Neither the public nor policy-makers have

settled on one preferred approach to providing health coverage for the uninsured.¹⁷

Why is Health Coverage So Important?

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

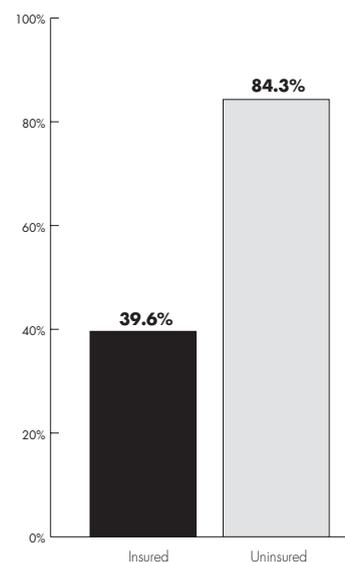
EFFECTS ON HEALTH AND TREATMENT

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

People without health insurance often go without care or delay care. The care they do receive is likely to be of lower quality than the care received by insured people, and they may be

3. AMERICANS WITH UNMET HEALTH CARE NEED BECAUSE OF COST

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



Source: Sanmartin, Claudia et al. (2006). "Comparing Health And Health Care Use In Canada And The United States." *Health Affairs* 25, no. 4, p. 1139. (www.healthaffairs.org)

charged more for it. An estimated 18,000 adults die each year because they are uninsured and can't get appropriate health care, according to the federally chartered IOM, which produced a series of six reports on the lack of health coverage in America.¹⁸

The length of time a person goes without health insurance also makes a difference. The Institute of Medicine noted that people who are uninsured for at least a year report being in worse health than those uninsured for a shorter period of time. Some 12 percent of those in poor health had been uninsured for a year or longer, compared to 5 percent who were uninsured for less than a year.¹⁹ But even among those uninsured for less than a year, it's not unusual to skip needed medical care or pass up filling a prescription.²⁰

Among the IOM's key findings were the following:

- Uninsured women with breast cancer are less likely than insured women to receive breast-conserving surgery.²¹
- Hospitalized patients without health insurance receive fewer needed services and lower-quality care, and have a greater risk of dying in the hospital or shortly after discharge than patients with insurance.²²
- The uninsured are less likely to receive care even when they have serious symptoms.²³
- Uninsured trauma victims are less likely to be admitted to the hospital or receive the full range of needed services. Uninsured victims with trauma due to an auto crash are 37 percent more likely to die of their injuries.²⁴
- Uninsured adults with HIV wait to receive new, highly effective drug therapies an average of four months longer than patients who have insurance. Among adults infected with HIV, having insurance reduces mortality by 71 percent to 85 percent over a six-month period.²⁵

The Institute of Medicine concluded:

“Health insurance is associated with better health outcomes for adults and with their receipt of appropriate care across a range of preventive, chronic and acute care services. Adults without health insurance coverage experience greater declines in health status and die sooner than do adults with continuous coverage.”²⁶

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

Children without health coverage also suffer health consequences because of that lack. Uninsured children are more likely than insured children not to have a usual source of health care and go without needed care (see Chart 4).²⁷

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

- Half as likely to have a “medical home”²⁸
- About half as likely to get needed mental health care or counseling²⁹
- Five times more likely to have an unmet dental need³⁰

- More than eight times more likely to delay care because of cost³¹

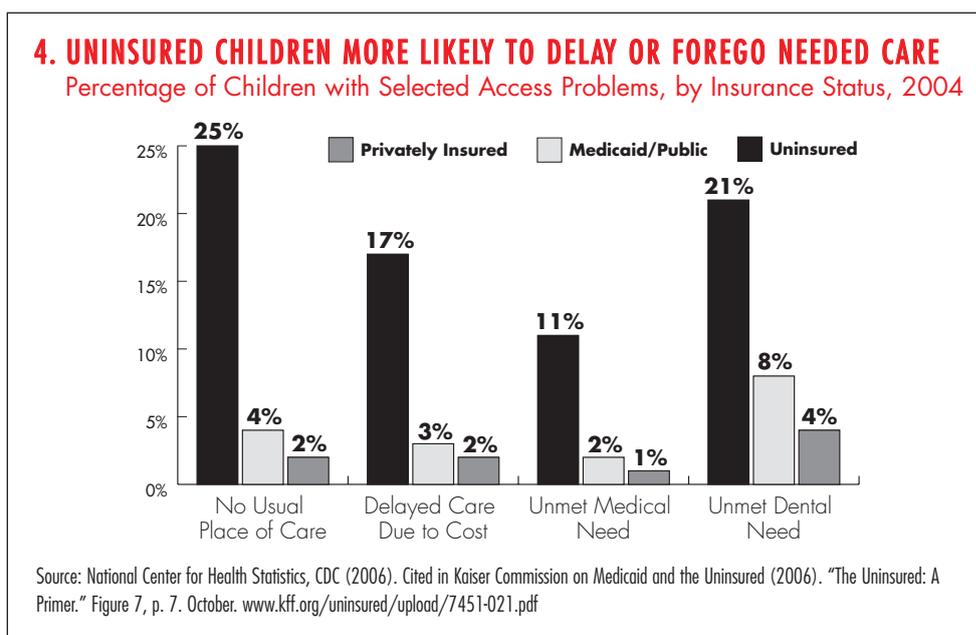
When compared to children with health coverage from any source, uninsured children are:

- Less likely to have had a preventive health visit with a doctor in the past year³²
- Ten times more likely to miss out on at least some needed medical care³³
- A third less likely to have someone they consider a personal doctor or nurse³⁴
- Almost times more likely to receive no medical care at all in the course of a year³⁵

EFFECTS ON FAMILY FINANCES

Not having insurance may threaten the financial security of families. Over a third (35 percent) of the care received by the uninsured is paid for out of their own pockets.³⁶ Because families with at least one uninsured member tend to have lower incomes than fully insured families, as well as very few assets, they generally have fewer financial resources to help cope with these higher medical expenses.

This may destabilize an entire family's financial standing:



> Six out of 10 uninsured working-age adults report problems paying medical bills, compared with 35 percent of insured adults.³⁷

> Of those lacking coverage who also have medical bill problems or accrued medical debt, 27 percent reported that they struggled to pay for expenses such as food, rent and heat. Almost half (44 percent) said they were forced to use most or all of their savings to pay medical bills. One out of five said they had run up large credit card debts or had to take out a loan against their home to pay medical expenses.³⁸

Who is Uninsured?

The number of people in the United States who lack health insurance has been rising slowly over time. In 2005, 46.6 million people in the United States lacked health coverage,³⁹ including 8.3 million children. Adults are uninsured more frequently than children: One in five adults age 18 to 64 was uninsured in 2005. By comparison, one in nine children was without coverage that year.⁴⁰

The uninsured come from every race and ethnic group, every age group, and every income level. Compared to the general population, however, people who lack health insurance are younger, have lower incomes, and are more likely to be a member of a minority group.⁴¹

Nonelderly adults who lack insurance are also concentrated in certain states. According to the Kaiser Family Foundation, the largest percentages of uninsured can be found in Texas (31 percent) and Florida (27 percent)—two of the 20 states in which at least 20 percent of the population between the ages of 19 and 64 are uninsured. Another 17 states and D.C. have uninsured populations between 16 percent and 20 percent. Only 13 states have uninsured populations of 15 percent or less. The

lowest percentage can be found in Minnesota (11 percent).⁴²

A common misconception is that those who lack health insurance are also out of the job market. In fact, more than eight of 10 of those who lack insurance are in working families (see Chart 1).⁴³ More than six of 10 were in families where the household head worked full time all year.⁴⁴ The majority of uninsured workers (62 percent) are in service occupations and wholesale and retail trade jobs, according to the Employee Benefit Research Institute.⁴⁵ The key point is this: The overwhelming majority of uninsured Americans are from families actively in the labor force.

Americans living in households with annual incomes below \$25,000 have a higher incidence of uninsurance, with 24.4 percent being uninsured in 2005, compared to 15.9 percent of the total population.⁴⁶ For 2007, the poverty level is \$20,650 for a family of four in every

state except Alaska and Hawaii. (See box, “What Does ‘Federal Poverty Level’ Mean?”)⁴⁷ According to the Census Bureau, 19 percent of children living below the poverty line in 2005 were uninsured.⁴⁸

There are also key differences in insurance coverage among racial and ethnic groups. Hispanics are far more likely than any other ethnic group to be uninsured. In 2005, 32.7 percent of Hispanics were uninsured for the entire year, compared to 19.6 percent of blacks, 17.9 percent of Asians and Pacific Islanders, and 11.3 percent of non-Hispanic whites.⁴⁹

In addition, 21.9 percent of Hispanic children were uninsured in 2005, compared to 12.5 percent of black children, 12.2 percent of Asian American children, and 7.2 percent of non-Hispanic white children.⁵⁰

The Hispanic community encounters difficulties in securing coverage in part because so many members are recent

WHAT DOES “FEDERAL POVERTY LEVEL” MEAN?

The federal poverty guidelines, also referred to as the federal poverty level, are family income figures produced each year by the U.S. Department of Health and Human Services to determine eligibility for certain federal programs, including Head Start, the Food Stamp Program, the National School Lunch Program and the State Children’s Health Insurance Program. Eligibility for certain state assistance programs is also tied to the federal poverty guidelines. For 2007, the guidelines are:

Size of Family Unit	48 Contiguous States and D.C.		
	Alaska	Hawaii	
1	\$10,210	\$12,770	\$11,750
2	\$13,690	\$17,120	\$15,750
3	\$17,170	\$21,470	\$19,750
4	\$20,650	\$25,820	\$23,750
For each additional person, add:	\$3,480	\$4,350	\$4,000

Source: “The 2007 HHS Poverty Guidelines,” U.S. Department of Health and Human Services. <http://aspe.hhs.gov/poverty/07poverty.shtml>

immigrants who earn modest incomes. In 2005, 64 percent of foreign-born, non-citizen Hispanics with less than 10 years of U.S. residency were uninsured. Among Hispanics who are naturalized citizens and in the United States for the same length of time, 37 percent lacked coverage.⁵¹

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

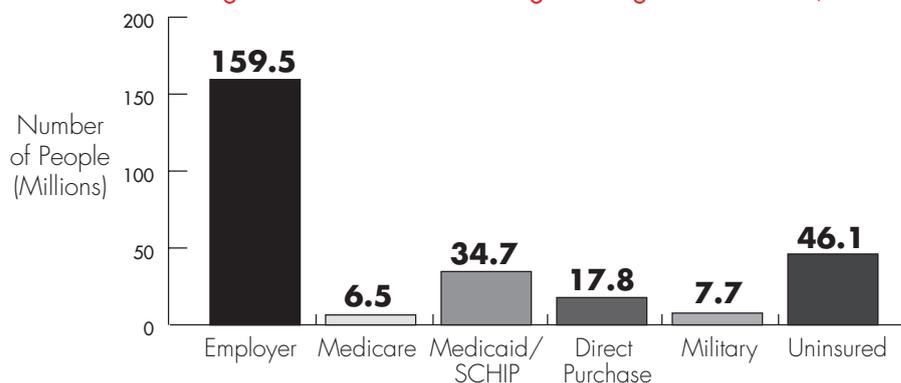
One often-overlooked aspect of the uninsured population is that although the number of uninsured is relatively stable from month to month, it is not the same individuals who are uninsured from month to month and year to year. Hundreds of thousands of Americans lose coverage over the course of a year, and similar numbers regain it after lacking coverage for relatively short periods of time.

The dynamic nature of the uninsured population has implications for what strategies might be used to deal with the problem. A Commonwealth Fund study found that if every person with public or private insurance at the beginning of a given year retained it through the next 12 months, the number of uninsured, low-income children would decline by nearly 40 percent and the number of uninsured adults would decline by more than 25 percent.⁵²

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

5. MOST IN UNITED STATES GET COVERAGE THROUGH AN EMPLOYER

Millions Under Age 65 with Health Coverage Through Each Source, 2005



Note: Some people have more than one type of coverage. These figures are only for those under age 65. For figures on the total population, including those age 65 and older, go to www.census.gov/hhes/www/hlthins/historic/hihist1.htm

Source: EBRI estimates from the March 2006 Current Population Survey

How Do Americans Get Covered?

EMPLOYER-SPONSORED COVERAGE

In the United States, most Americans—159.5 million nonelderly workers and their dependents—received health coverage through the workplace in 2005. This is far more than the 63.3 million nonelderly people covered through other means (see Chart 5).⁵³

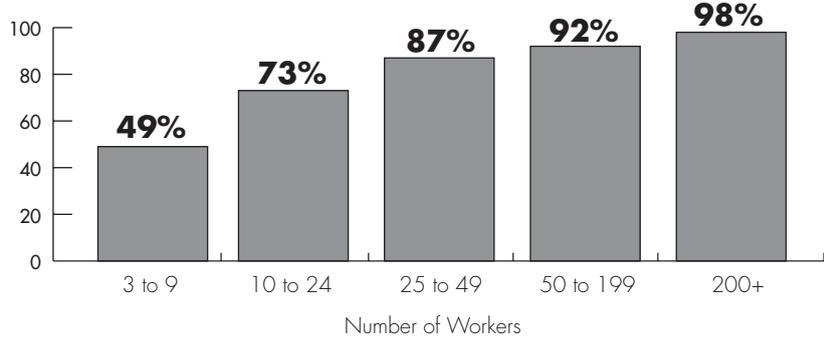
Workplace coverage was developed during the 1930s, pioneered by groups such as the Blue Cross hospital insurance plans⁵⁴ and employers like Henry J. Kaiser, who started a prepaid group health plan for employees of his construction company.⁵⁵

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

While the percentage of people obtaining health coverage through employers has been steadily shrinking in recent years, this remains an important and popular source of coverage. Health insurance through the workplace has remained popular for many reasons. For one, health coverage on the job carries significant tax advantages for the employer and employee. Amounts that employers pay for their employees' coverage are a tax-deductible business expense. In addition, this money is not counted as taxable income to the employee. This would end under a proposal by President Bush, announced in his 2007 State of the Union address, which would instead provide every taxpayer with a tax deduction for health insurance expenses up to a certain amount.⁵⁶

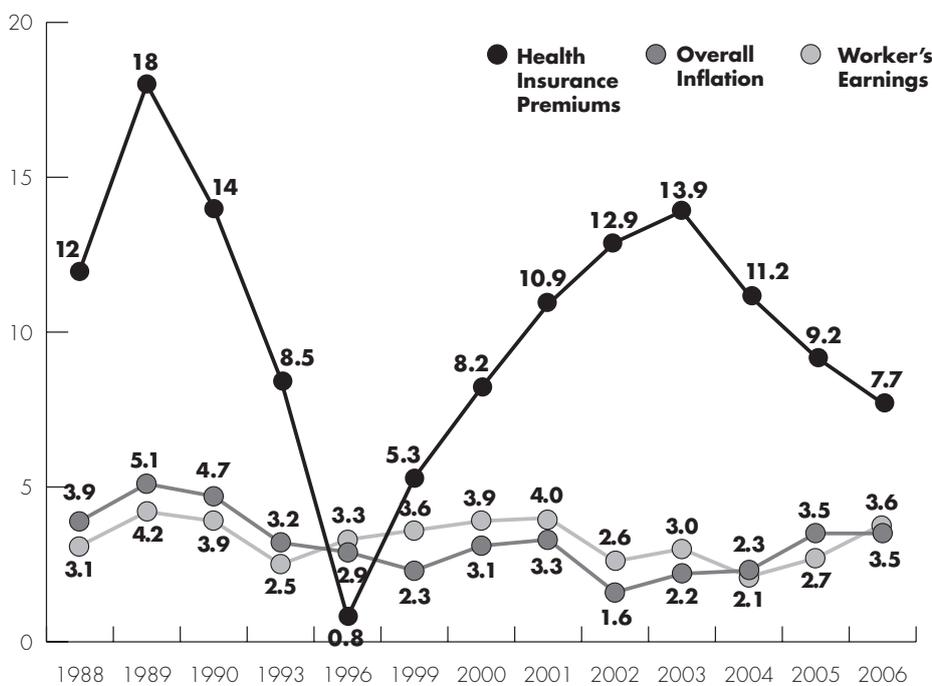
Thus, at present, the \$50 a company pays toward an employee's health coverage is more valuable to the employee, dollar for dollar, than \$50 in pay, since the employee has to pay income and payroll taxes on salary and wages. Some analysts have estimated that if the cash value of benefits were

6. PERCENTAGE OF FIRMS OFFERING HEALTH BENEFITS, BY FIRM SIZE, 2006



Source: Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits: 2006," <http://www.kff.org/insurance/7527/sections/ehbs06-2-2.cfm>

7. INCREASES IN HEALTH INSURANCE PREMIUMS COMPARED TO WAGE GROWTH AND GENERAL INFLATION, 1999-2006



Source: Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits: 2006" www.kff.org/insurance/7527/sections/ehbs06-1-1.cfm

DISADVANTAGES OF EMPLOYER-SPONSORED COVERAGE

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

> Millions of working Americans don't have the opportunity to get it. In 2002, 41.9 percent of "wage and salary" workers aged 18–64 were not offered health coverage through their own employers.⁶⁰ In 2002, 54 percent of uninsured workers worked for employers who didn't offer health benefits.⁶¹

> Even if employees are offered coverage on the job, they can't always afford their portion of the premiums. Almost two out of three uninsured workers who chose not to participate in their employer's health plan in 2002 said the plan was too costly.⁶²

> Losing a job or quitting voluntarily can mean losing affordable coverage—not only for the worker but also for their entire family.

> A person's link to employer-sponsored coverage can also be cut by a change from full-time to part-time work or self-employment, retirement or divorce.

> Most employers offer a small number of health insurance plans for employees to choose from, and sometimes only one.

Thirty-nine percent of firms in the United States didn't offer health insurance at all in 2006.⁶³ Health coverage as a benefit remains widespread among large companies, with 98 percent of companies with more than 200 workers offering coverage.⁶⁴ But most new jobs in the economy come from small firms,⁶⁵ which are the least likely to offer health insurance (see Chart 6).⁶⁶

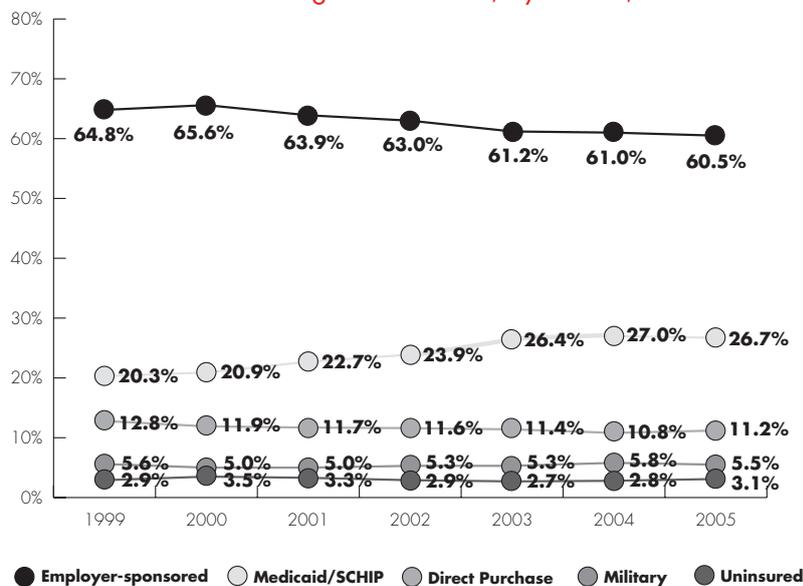
In part, that's because small firms have to pay more for the same level of coverage. Larger pools usually have greater risk-spreading capacity. In addition, an employer that represents

taxed like income, the increase in state tax revenue alone would have been \$21.4 billion in 2004.⁵⁷ More recently, the projected 2007 value of foregone federal taxes has been estimated at between \$200 billion and \$220 billion.⁵⁸ To put that into perspective, total Medicare spending in 2007 is

estimated at \$428 billion.⁵⁹

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

8. MEDICAID, SCHIP CHILDREN'S COVERAGE GROWING IN IMPORTANCE
Percent of Children Under Age 18 Covered, by Source, 1999-2005



Source: U.S. Census Bureau (2006). "Table HI-5. Health Insurance Coverage Status and Type of Coverage by State – Children Under 18: 1987 to 2005." August 29. www.census.gov/hhes/www/hlthins/historic/hilhist5.html

many workers naturally has more clout in negotiating prices with health plans than a smaller firm. Insuring a larger group of employees also carries a lower overhead cost per person for insurers. This is the reasoning behind proposals to combine employees of small firms into larger groups for insurance purposes.

Among employers who don't offer coverage, almost three out of four say premiums are too expensive. A third say they believe their employees can get coverage elsewhere.⁶⁷

Premiums for employer-sponsored health coverage are rising much faster than workers' earnings and inflation (see Chart 7). Between spring 2005 and spring 2006, premiums for coverage offered by employers across the United States increased 7.7 percent—more than twice the growth in the Consumer Price Index (CPI). This includes amounts paid for coverage by both the employer and employee.⁶⁸ Employers with three to 199 workers saw an average increase of 8.8 percent; firms larger than that had an average increase of 7 percent.⁶⁹

Employers expect health premiums to rise an average of 6.1 percent in 2007, according to a large survey by Mercer Human Resources Consulting.⁷⁰ In contrast, the CPI is expected to grow by 1.9 percent.⁷¹

In response to these steady premium hikes, many companies are asking their employees to cover some of the new costs. For instance, workers taking single coverage through an employer paid 10.6 percent more for their coverage in 2006 than in 2004—\$52 monthly vs. \$47. Premiums for a family of four paid by workers increased almost 12 percent from 2004 to 2006—from \$222 per month to \$248.⁷²

But in a counter trend, some employers are giving employees free prescription drugs to help them manage conditions such as diabetes, high blood pressure, asthma and depression.⁷³

For children, employer-sponsored coverage is shrinking in importance as Medicaid and SCHIP coverage grow (see Chart 8). Between 2000 and 2005,

the portion of children covered through job-based insurance decreased from 65.6 percent to 60.5 percent.⁷⁴

The health coverage picture for retirees is looking somewhat brighter. Overall, 35 percent of firms with 200 or more workers offered retiree health benefits in 2006. This is up slightly from the 33 percent offering such benefits in 2005 but down substantially from 66 percent in 1988.⁷⁵

The situation is less optimistic for older retirees and new hires. Some 10 percent of employers provide coverage to current and future retirees already on the employment rolls, but not to new hires.⁷⁶ Twenty-two percent of employers that offered a retiree health plan to new hires in 2006 expect to stop doing so by 2011.⁷⁷ In addition, the percentage of employers offering coverage to Medicare-eligible retirees dropped from 21 percent to 19 percent between 2005 and 2006.

Even among large firms, the number of uninsured workers has increased sharply. In 2005, 23.1 percent of the nation's uninsured workers age 18–64 were in firms employing more than 500 people.⁷⁸ In part, this reflects the fact that firms vary on whom they classify as eligible for coverage. For example, some firms don't offer part-time employees health benefits, and some don't offer coverage to workers who have been employed for less than a certain amount of time. Some workers decline coverage because they can't afford their share of the premium.

Historically, high levels of insurance coverage have been tied to union jobs. According to the federal Bureau of Labor Statistics, 80 percent of union workers in the private sector had jobs with employer-sponsored health coverage in 2006, compared to 49 percent of nonunion workers.⁷⁹ But union membership is dwindling: In 2006, union members comprised just 12

percent of the workforce.⁸⁰ When a union job disappears, health coverage for the union worker may disappear with it.

INDIVIDUAL COVERAGE: PROS AND CONS

For those who have no access to insurance through the workplace or can't afford their share of the premium, the individual or "non-group" market is one possible alternative. (Though insurance sold in the individual insurance market is often referred to as "individual" coverage, most analysts refer to it as "non-group," since such policies can cover individuals only or individuals and families.) In 2005, 6.9 percent of the nonelderly U.S. population—17.8 million people—were covered by a non-group policy.⁸¹

People might seek individual policies if they are self-employed or if the firm they work for doesn't offer coverage. (As noted, 39 percent of firms didn't offer coverage in 2006.) Layoffs, divorce, the death of a spouse or a child's growing too old to be on a parent's policy could lead someone to turn to the individual market. One 2004 study estimated that the 20 percent of Americans not eligible for group or public insurance find their only coverage options in the individual market.⁸²

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

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

individual policy are higher than for group policies.

These higher costs are reflected in the premiums charged for individual policies. More than half of adults with coverage through the individual market pay \$3,000 or more in premiums each year, compared with one in five adults covered by employer-sponsored plans.⁸³

If they are denied coverage,
individuals usually have few
places to turn.

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

If they are denied coverage, individuals usually have few places to turn. They can try another company or turn to their state's high-risk insurance pool if they live in a state that has one. These pools offer health insurance to people who can't get it elsewhere, usually because of a pre-existing medical condition. But the premium cost may be out of reach, and in a few states the pool is closed to new people. (For information about your state, go to www.healthinsuranceinfo.net, a Web site maintained by Georgetown University's Health Policy Institute.)

For all these reasons, a person looking for an individual insurance policy may or may not find one. In one 2004 study, high prices were recognized as the dominant factor for low participation in the individual market.⁸⁴

HSAs AND HIGH-DEDUCTIBLE HEALTH PLANS

Health savings accounts (HSAs) are a

relatively new model of health insurance coverage. They can only be offered in conjunction with high-deductible health plans, which are defined in 2007 as plans with annual deductibles of at least \$1,010 for self-only coverage and \$2,200 for family coverage.⁸⁵ According to America's Health Insurance Plans, a trade association representing many types of health plans, 3.2 million people had purchased HSA/high-deductible health plans from their member companies as of January 2006.⁸⁶

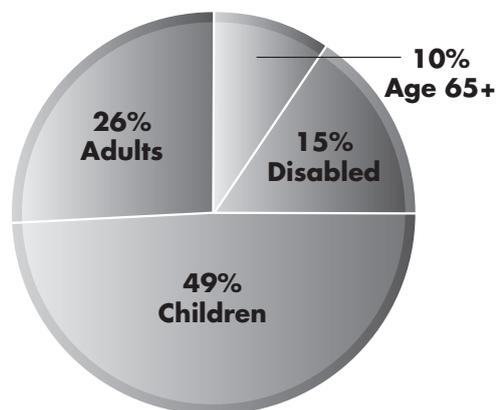
HSAs are a kind of bank account holding pre-tax dollars from workers and employers, which individuals can draw from to purchase health services. They were established by the Medicare Modernization Act of 2003. In 2007, the maximum amount that can be contributed to an HSA is \$2,850 for self-only coverage and \$5,650 for family coverage.⁸⁷ HSA contributions can be made by individuals, their employer or both.

This coverage carries with it certain preferences in tax treatment. Contributions to an HSA are tax deductible for individuals who purchase their own coverage, but do not reduce income subject to payroll tax. Interest on the funds kept in HSA accounts is tax-exempt, balances can be rolled over year to year, and withdrawals from the accounts are tax-free if made for qualified medical expenses.⁸⁸

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

9. MEDICAID ENROLLEES

Unduplicated Annual Enrollment for Fiscal Year 2006



Source: U.S. Department of Health and Human Services "2006 CMS Statistics." www.cms.hhs.gov/CapMarketUpdates/Downloads/2006CMSstat.pdf

President Bush has long been a proponent of HSAs. He signed the original legislation creating HSAs in 2003, then signed another bill in late 2006 encouraging the use of this model.⁸⁹ In his 2007 State of the Union address, the president called for further expansion of HSAs.⁹⁰

HSA proponents argue that expanding the role of the consumer and providing equivalent tax preferences in the individual market will improve the overall health care system. They note that a high-deductible policy paired with an HSA allows individuals to assume responsibility for paying for many of their own services, rather than having them paid by an insurer or a government program. They argue that this has the potential for both restraining the cost growth in those plans and making individuals more aware of the quality of care they are receiving. People are more prudent, they assert, when spending what they perceive as their "own" money.⁹¹

However, some analysts doubt that HSAs will do much to lower the number of uninsured in the United States.⁹² They argue that HSAs will mainly serve to concentrate healthy

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

In a February 2007 report, the federal National Health Statistics Group said that estimates of health spending reductions resulting from HSAs coupled with high-deductible health plans are "fairly modest."⁹³

Time will tell how popular HSAs will become and how they will evolve. For instance, America's Health Insurance Plans, the trade association, has called on Congress to allow more generous contributions into HSAs if someone in the family is enrolled in a disease management or care coordination program for a chronic condition. The organization also suggests that early retirees could be allowed to use HSA funds to buy retiree health coverage.⁹⁴

MEDICAID

The Medicaid program offers a relatively generous package of benefits covering low-income mothers and children, people with disabilities, and certain seniors. Some 56.3 million people were covered by Medicaid at some point during fiscal year 2006, according to the Department of Health and Human Services.⁹⁵ This is the number accepted by most health services researchers. The U.S. Census Bureau, based on its survey of households, puts the number at 38.1 million covered for the full calendar year 2005.⁹⁶

Medicaid enrollment has grown each year since 1998.⁹⁷ Without this growth, the number of uninsured in those years would have been even higher.

Medicaid is funded by both state and federal dollars. Medicaid spending per person varies significantly among the groups covered. Children—the healthiest of Medicaid beneficiaries—accounted for 49 percent of the enrollees but just 18 percent of the spending in 2004. Those over 65 and people with disabilities, by contrast, are as a group in poorer health and in need of more services. They comprised only 25 percent of beneficiaries but accounted for 70 percent of spending (see Chart 9).⁹⁸

Medicaid also pays for nearly half (49 percent) of all long-term care services, including custodial nursing home care.⁹⁹ Nearly 60 percent of all nursing home residents receive support from Medicaid.¹⁰⁰

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

of people whom states must cover include:

- Pregnant women and children up to age 6 in families with incomes up to 133 percent of the federal poverty level
- Children ages 6 to 18 in families with incomes up to 100 percent of the poverty level
- People who would have been eligible for welfare according to the criteria in effect before welfare reform in 1996
- People receiving Supplemental Security Income (SSI) due to disability or being elderly

THE UNEASY RELATIONSHIP BETWEEN STATE BUDGETS AND MEDICAID COSTS

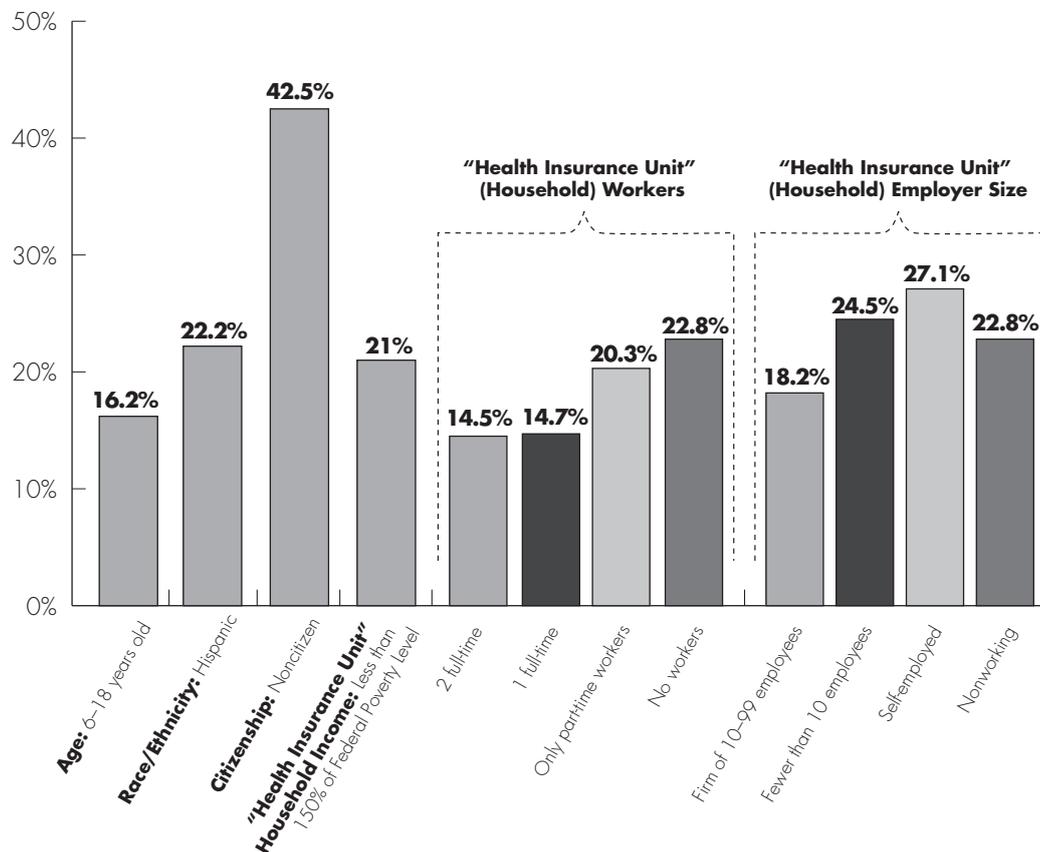
Medicaid consumes a high proportion of spending by state governments. It is the second largest item for state government general fund spending, after elementary and secondary education. In fiscal year 2006, Medicaid accounted for 18.1 percent of general fund spending by the states.¹⁰¹ Looking at total state spending, including federal funds spent by the states, Medicaid made up 22.2 percent of expenditures. Maine had the highest percentage (34.7 percent of total state spending) and Wyoming had the lowest (7.4 percent).¹⁰²

The economic slowdown in 2001–2002 forced governors and legislators to cope with large imbalances between revenues and increased spending needs. While the federal government can incur deficits from one year to the next, all states, with the exception of Vermont, must balance their budgets each year. More recently, most state economies have recovered, and many states have taken legislative action to gain greater control over their budgets. For fiscal year 2006, 25 states enacted tax and fee increases, while 14 enacted net decreases.¹⁰³

Though many states have tried to protect Medicaid, a program that

10. SELECTED CHARACTERISTICS OF CHILDREN WHO QUALIFY FOR SCHIP BASED ON INCOME, BUT AREN'T ENROLLED, 2005

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



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

serves vulnerable populations and brings substantial federal matching funds into states, its sheer size has forced all states to try to hold down Medicaid spending growth.

Some of the options for restraining Medicaid spending are politically painful. For example, states can cut payments to providers and plans, restrict benefits, and curtail eligibility. In 2006, more states planned to take measures to reduce eligibility, increase co-payments and reduce long-term care costs as compared to 2005.¹⁰⁴ To save even more money, some states have reduced their outreach and enrollment campaigns that inform the public about who is eligible and how to sign up for Medicaid benefits.

States were projected to get a short respite in the steep upward trend of Medicaid spending. The federal National Health Statistics Group foresaw an increase of less than 1 percent in state and local Medicaid expenditures for 2006, compared to a 12 percent rise the year before.¹⁰⁵ This is largely because beginning in January 2006, states are no longer liable for the prescription drug expenses of “dual eligibles”—those who are eligible for both Medicare and Medicaid. Instead, states now make payments equal to about 5 percent of state Medicaid expenses to the federal government, which is paying these drug expenses through Medicare.

But this Medicaid spending “breather” will be short-lived. State and local Medicaid expenses are projected to rise 7.8 percent in 2007, while federal Medicaid spending is projected to grow by 7 percent.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Almost 20 million children under age 18 were covered by Medicaid or the State Children's Health Insurance Program in 2005, according to the

Census Bureau.¹⁰⁶ But if SCHIP is going to continue, Congress must renew the program in 2007.

Congress created SCHIP in 1997. Financed jointly by the federal and state governments, the program is intended for children whose parents earn too much to qualify for Medicaid yet too little to afford private coverage. SCHIP has been remarkably successful. Almost 70 percent of eligible children have been enrolled, according to the Urban Institute. Among eligible children in fair or poor health, 80 percent are signed up. But 1.8 million eligible children are still not enrolled in the program. (See Chart 10 for characteristics of eligible but unenrolled children.)¹⁰⁷

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

Some states have brought children with much higher family incomes into the program. For instance, New Jersey's *NJ FamilyCare* program allows children with family incomes as high as 350 percent of the federal poverty level, which in 2007 amounts to more than \$72,000 for a family of four.

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

Across all states, the average federal matching rate for SCHIP in 2007 is 70 percent (meaning that for every 30 cents in revenue raised by states for the

program, the federal government provides 70 cents. By comparison, the average federal matching rate is 57 percent.¹⁰⁸

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

As lawmakers move toward extending the program, they will also need to decide how much money the federal government will provide. Keeping the current level of federal funding—roughly \$5 billion per year—would result in 1.6 million to 1.9 million children losing coverage between 2006 and 2012.¹⁰⁹ To keep enrollment at current levels would require adding anywhere from \$8 billion to \$15 billion over five years. To reach the almost 2 million children who are eligible but not enrolled, estimates range from \$40 to \$60 billion over five years.¹¹⁰

Some advocates have proposed extending the program to additional groups, including parents of eligible children. Such an expansion would further increase projected costs. Eight states already cover some parents, under special permission from the federal government. Four states cover some childless adults,

and 11 states use SCHIP funds to cover some pregnant women.¹¹¹

President Bush's 2007 budget calls for current spending levels to be increased by \$5 billion over five years, or about \$1 billion a year beyond current spending.

While the “endgame” on SCHIP reauthorization has yet to play out, it seems clear that with broad bipartisan support for the program, there will be no lack of attention given to proposals that are now being shaped in the House and Senate. Many state officials who have ambitions to extend coverage to many more of their low-income children are watching carefully. Many more people are wondering if the SCHIP debate provides a preview of broader conversations about ways to reconfigure the nation's public-private health system, in order to extend regular medical care to tens of millions of uninsured adults whose primary source of health services now may be an emergency room or a public health clinic.

MEDICARE

Virtually everyone over 65 is eligible for Medicare, along with certain individuals who have permanent disabilities and those with end-stage renal disease (ESRD). Eligibility for Medicare does not depend on a person's income or assets. This sets it apart from many other government health care financing programs, which are restricted to those with limited finances.

Medicare, which is financed by the federal government and beneficiaries, had an average monthly enrollment of 43.1 million people in 2006, about 16 percent of whom qualified for the program on the basis of permanent disability and are under the age of 65.¹¹² Individuals of any age who have ESRD also qualify for Medicare coverage¹¹³ and account for less than 1 percent of Medicare enrollment.¹¹⁴

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

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

Approaches to Covering the Uninsured

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

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

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

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

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

Below is a summary of some of the major approaches that have been discussed and debated by researchers, legislators, health industry stakeholders and advocates. This section is based principally on the Covering America project of the former Economic and Social Research Institute, supported by the Robert Wood Johnson Foundation.¹¹⁵

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

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

The 1996 Health Insurance Portability and Accountability Act created new federal requirements to temper the effect of medical underwriting (e.g., exclusions for individuals with certain costly pre-existing medical conditions) in the small group and individual markets. But these reforms are now widely acknowledged to have had limited impact on the affordability of and access to coverage for many companies and individuals in these markets, where monthly premiums and

annual deductibles have remained high.

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

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

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

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

EMPLOYER CONTRIBUTION REQUIREMENTS

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

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

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

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

INDIVIDUAL MANDATES

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

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

Opponents believe that requiring individuals to have coverage wouldn’t necessarily mean that everyone would get it. Compliance is far from universal in the automobile insurance market. In fact, 14.5 percent of drivers in states where insurance is compulsory violate the law, according to the Insurance Research Council.

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

STATE AND LOCAL COVERAGE INITIATIVES

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

In 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 the 60,000 uninsured Vermont residents may enroll in this program. If coverage goals are not reached by 2010, the Legislature may consider coverage mandates.

The state of Massachusetts enacted legislation in 2006 establishing a mandate for individuals to have health insurance. 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.

In California, Governor Arnold Schwarzenegger has proposed a similar plan. Everyone in the state would be required to have coverage, with the state offering premium subsidies for people with low incomes. Employers would have to provide coverage to their employees or pay a fee to the state equal to 4 percent of employee earnings, which would be used to subsidize coverage.

Maine began a new health care initiative called Dirigo Health in 2005. The voluntary program seeks to ensure access to health care for all of the state’s 1.3 million residents over a five-year period. It offers health coverage through private insurers to those without access to employer-sponsored coverage, employees of small businesses who work 15 or more hours per week and self-employed persons, as well as their dependents. 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.

A county- and city-based approach is being undertaken by San Francisco, which established a health plan under the auspices of the local health authority in the mid-1990s. Known as the San Francisco Health Plan, the program enrolls low- and moderate-income families and offers several health insurance options, including Healthy Workers, which is aimed at providing health coverage for home health workers, and Healthy Kids and Young Adults, whose goal is to provide coverage to all uninsured children in San Francisco County.¹¹⁶ This program expands on California’s CHIP and does extensive outreach to enroll uninsured children who are already accessing safety-net facilities, such as public hospitals and community health centers.

EXPANSION OF MEDICAID, SCHIP AND OTHER PUBLIC PROGRAMS

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

Such expansions, they note, can be financed through a variety of mechanisms, including state, local and federal tax revenue, as well as tax increases on private insurers. They can also be tailored to require participants to pick up a significant share of the costs. For example, a proposal advanced during the late 1990s that was popularly known as the Medicare “buy-in” bill would have allowed retired workers under age 65 with no other source of health insurance to join Medicare by paying a monthly premium.¹¹⁷

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

TAX PROPOSALS

Tax proposals seek to make private health insurance more affordable by allowing individuals and employers to use pre-tax dollars to pay for insurance premiums, usually through a credit on the amount they owe in income taxes or by granting a tax deduction for premium expenses, as President Bush proposed in his 2007 State of the Union address. The credits could be

designed as a fixed dollar amount or as a percentage of the premium. They can be made refundable for persons who owe no income taxes and advanceable at the time the person is actually paying the premiums instead of having to wait until April 15.

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

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

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

A FULLY TAX-FINANCED HEALTH CARE SYSTEM

The current public-private health care system in the United States could be replaced with one where employers, individuals and other private entities are all responsible for paying for health care coverage through taxes paid to government. The most commonly advocated tax-financed system is the “single-payer” approach. Under such a system, health care providers would remain private, but the government would administer payments for health care services—similar to the Canadian model.

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

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

CONCLUSION

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

There is no ideal or easy solution to the problem of the uninsured. Most proposals combine coverage expansion with other objectives, such as limiting growth in total national health care spending, limiting the amount of new federal dollars spent, targeting new spending to the previously uninsured only or increasing consumer choice. Such goals cannot all be achieved simultaneously. Decision makers must balance these objectives and make trade-offs among them, and citizens

need to understand these trade-offs and become involved in public discussions.

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

PERSONAL STORIES OF THE UNINSURED

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

Questions to Ask About Any Health Coverage Proposal

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

KEY FACTS ABOUT THE UNINSURED

- > More than 46 million people in the United States—in every age group and at every income level—were uninsured for all of 2005.¹¹⁸
- > More than eight out of 10 of the uninsured are in working families.¹¹⁹
- > During all of 2005, 8.3 million children were uninsured, up from 8 million in 2004.¹²⁰
- > Uninsured children are much more likely than children with insurance to lack a usual source of care, delay care or have unmet medical needs.¹²¹
- > Almost 70 percent of children eligible for the State Children’s Health Insurance Program are enrolled. However, 1.8 million eligible children are not enrolled.¹²²
- > An estimated 18,000 adults die each year because they are uninsured and can't get appropriate health care.¹²³
- > Nearly half of those polled in February 2007 by the New York Times and CBS News said they would be willing to pay more for health coverage or \$500 more a year in taxes if all Americans could have health insurance.¹²⁴

GLOSSARY

For a glossary of health insurance terms, go to the *Cover the Uninsured Week* Web site

www.CoverTheUninsured.org/glossary or the Alliance for Health Reform site www.allhealth.org/sourcebookcontent.asp?CHID=25.

SOME SPECIFIC PROPOSALS

Private-sector coalitions, members of Congress and President Bush have weighed in with proposals to help the uninsured. Here is a representative selection:

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

Citizens' Health Care Working Group – This congressionally mandated group conducted town meetings around the country for 15 months, conducted surveys, and solicited comments from individual citizens and organizations. The recommendations it submitted to Congress and President Bush would provide affordable core health benefits to all Americans, guarantee financial protection against very high health care costs, and improve the quality and efficiency of care, among other goals. To learn more, go to www.citizenshealthcare.gov.

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

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

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

Federation of American Hospitals – The federation's Health Care Passport plan aims to insure 98 percent of Americans, primarily through an expansion of private-sector coverage. Everyone in the United States would be required to have coverage either on the job or through direct purchase.

Subsidies would be provided for lower-income uninsured people. Medicaid would be expanded to cover all uninsured adults below the federal poverty level. For more, go to www.fahs.com/passport/index.html.

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

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

End Notes

- ¹ “People With or Without Health Insurance Coverage by Selected Characteristics: 2004 and 2005.” U.S. Census Bureau, August 29, 2006. (www.census.gov/hhes/www/hlthins/hlthin05/hi05t8.pdf) On March 23, 2007 the Census Bureau released a revised estimate of 44.8 million uninsured for 2005. For more information, go to www.census.gov/Press-Release/www/releases/archives/health_care_insurance/009789.html. Revised estimates will be available for 1995 to 2004 as well at www.census.gov/hhes/www/hlthins/hlthins.html.
- ² “Table HI-1. Health Insurance Coverage Status and Type of Coverage by Sex, Race and Hispanic Origin: 1987 to 2005.” U.S. Census Bureau, August 29, 2006. (www.census.gov/hhes/www/hlthins/historic/hihistt1.html)
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