PROSPECTS FOR EXPANDING HEALTH INSURANCE COVERAGE

It should be a no-brainer. Every citizen of the most prosperous nation in the world should have basic health insurance. Yet lack of health insurance remains one of the most glaring examples of how the United States differs from other countries. Despite a robust economy, the number of uninsured nonelderly persons increased steadily in the 1990s, reaching 43.9 million in 1998 before dropping slightly in 1999, to 42.1 million (Fig. 1). This welcome decline in the number of uninsured persons, however, offers no guarantee that the overall trend has changed. Health care costs and insurance premiums are once again increasing rapidly, just as the economy is slowing. If these trends persist, the number of uninsured persons in the United States is likely to grow.

What are the prospects for expanding health insurance coverage? If the recent presidential campaign is any indication, the chances of a swift move toward universal coverage are slim. The debate now centers on whether incremental progress can be made, and if so, in what form. Since proposed increments often need to be implemented state by state, any progress — when it comes — will probably vary according to region.

WHO ARE THE UNINSURED?
The uninsured are invisible to most Americans, yet they are all around us. More than 80 percent of uninsured persons are from families in which at least one member is employed. They care for children, build homes, mow lawns, drive taxis, and work in low-wage jobs in restaurants, bookstores, and gas stations. Almost two thirds of uninsured persons are under the age of 35 years, and more than half are in families with incomes below 200 percent of the federal poverty level, or less than $34,100 for a family of four. Hispanics represent only 13 percent of the overall population in the United States but account for more than one quarter of uninsured persons.

WHAT DIFFERENCE DOES HEALTH INSURANCE MAKE?
Not having health insurance does make a difference. Those who have it are likely to receive more and better health care. Those who do not have it are more likely to delay obtaining necessary, even lifesaving care. According to a recent report by the American College of Physicians and the American Society of Internal Medicine, uninsured persons are much more likely than insured persons to refrain from seeking needed care and to suffer the consequences of delayed or forgone care. For example, those without health insurance are more likely to have had hospitalizations that could have been prevented and to have received a diagnosis of cancer at an advanced stage. Although many of the studies summarized in this report did not control for selection bias, other research confirms that these discrepancies persist after adjustment for demographic, clinical, and socioeconomic factors. Lack of health insurance has financial consequences as well; medical expenses are a leading cause of family debt and bankruptcy.

WHERE DO THE UNINSURED GET MEDICAL CARE?
The uninsured obtain most of their care from private physicians, but they also receive care from government-funded and private clinics and hospitals. Despite the availability of charity and emergency care, uninsured persons are substantially less likely than those with insurance to have a usual source of care.

Private hospitals bear over 60 percent of the costs of uncompensated care, and private, office-based physicians provide more than 75 percent of ambulatory care for uninsured patients and those with Medicaid coverage. Furthermore, over 75 percent of doctors report that they provide at least some charity care — on average, more than 10 hours a month.

Government-sponsored clinics and hospitals are another important source of care for uninsured patients. However, recent fiscal strains caused by declining private and public reimbursement rates have limited the capacity of these institutions to act as a safety net.

In addition, financial pressures may be eroding charity care in the private sector by reducing the time physicians spend providing such care. Physicians practicing in communities with high proportions of people enrolled in managed care (high market penetration) give 25 percent less charity care than their counterparts in low-penetration areas. Physicians who derive most of their practice revenue from managed-care plans provide less charity care than those who receive little revenue from such plans. Uninsured patients in areas with high managed-care penetration are less likely to visit physicians or to have a usual source of medical care and are more likely to have unmet health care needs than are patients in low-penetration areas.

OBSTACLES TO THE EXPANSION OF HEALTH INSURANCE COVERAGE

Public opinion about the uninsured does not always reflect the facts, and this is a major impediment to the expansion of coverage. Despite the evidence that health insurance matters, many people believe the uninsured get all the care they need from emergency rooms, public clinics, private physicians, and other sources. In October 2000, 57 percent of the public...
believed this to be true, as compared with 43 percent in 1993. Yet most physicians know how difficult it is for people without health insurance to obtain primary and specialty care, radiologic and laboratory tests, and prescription medications. In addition, many people do not realize that more than 80 percent of uninsured persons are from families that have one or more employed members but that just scrape by and cannot afford to pay for premiums or large copayments with after-tax dollars. Given the average monthly premium for an employer-sponsored family policy, which was $529 in 2000, it is not surprising that many low-wage workers are either not offered coverage by their employers or cannot afford to pay their share of the premium.

Strong political constituencies move issues through Congress, and the uninsured are not a strong constituency. Compare the level of congressional interest in a Medicare drug benefit, patients’ rights, or women’s health with the degree of concern about the uninsured. Issues involving the elderly, members of health maintenance organizations (HMOs), and women trump those involving the uninsured, who have lower voting rates, are less likely to contribute to political campaigns, and lack an organized group to represent their interests.

Expanding health insurance coverage costs money. Exactly how much depends on the number of uninsured persons who would be covered, the benefits they would receive, and the extent to which those already insured could take advantage of the new subsidies. Also important are the savings from charity care that would no longer be required, as well as savings from avoidable hospitalizations. According to recent estimates, the net annual costs to the public sector could range from $20 billion to $40 billion, for a program that would reduce the number of uninsured persons by up to 25 percent, to over $300 billion, for universal coverage. Although the current federal budget surplus would cover the costs, there are competing claims on these dollars, including proposals for cutting taxes, reducing the national debt, increasing military spending, improving education, and protecting the environment. There are also competing priorities for health care: pharmaceutical benefits for elderly persons, long-term care insurance, and increased reimbursements for teaching hospitals, HMOs, nursing homes, and home health care providers.

Another obstacle to the expansion of health insurance coverage is the level of public confidence in the federal government, which has declined steadily over the past three decades. In 2000, only 30 percent of the general public believed that the “government can be trusted to do the right thing,” as compared with 76 percent in 1964. This lack of confidence inhibits congressional discussions about expanding health care coverage. Yet it is impossible to envision a major expansion without some federal role. Moreover, in the past, members of Congress who supported an expansion of health insurance coverage were split between those who wanted universal coverage and those who favored incremental expansion. Today, fewer hard-core supporters of universal coverage remain in Congress, and there is little consensus among the incrementalists, except on the issue of expanding coverage for children.

A final impediment to the expansion of health insurance coverage is the fact that the proportion of the population that is uninsured varies widely among the states and depends mainly on the numbers of employers that provide health insurance (Fig. 2). During the recent presidential campaign, much was made of the large number of uninsured persons in Texas (25 percent of the nonelderly population). However, only 67 percent of persons in Texas have employer-sponsored or other private coverage, as compared with 86 percent in Minnesota. Thus, for
everyone to have coverage, the proportion of the state population enrolled in public programs would be much higher in Texas than in Minnesota. There are also large variations in the percentage of uninsured persons among communities. For example, 32 percent of children in Los Angeles are uninsured, 17 percent in Miami, 4 percent in Syracuse, and 3 percent in Boston. 20-21

EXPANSION OF COVERAGE FOR CHILDREN

The 1997 Balanced Budget Act included a bipartisan provision for substantial expansion of health insurance coverage for children from low-income families. Although the act was designed primarily to reduce the federal deficit, it also provided $48 billion over a period of 10 years to help the states expand their Medicaid programs for children, implement a separate State Children's Health Insurance Program, or use a combination of these two approaches. The funds available for those state initiatives would provide coverage for up to half the estimated 10 million uninsured children.

This unexpected expansion was politically palatable for two reasons. First, children are thought to deserve health insurance coverage, regardless of their family circumstances. Second, coverage for most children is relatively inexpensive, since they tend to have lower medical expenses than adults and since many poor, seriously ill children are already covered by Medicaid.

The states, however, faced considerable challenges in implementing these programs, and progress has been slow. First, designing and executing the program in each state took longer than expected. Second, the states had to implement two national initiatives — the State Children's Health Insurance Program and Medicaid initially had virtually no net effect. At the same time that children were being enrolled in these new programs, children formerly covered by Medicaid were being dropped as their mothers entered the workforce. 22 It was like bailing with a leaky bucket. Nonetheless, all 50 states and the District of Columbia created programs: 16 established State Children's Health Insurance Programs, 17 expanded Medicaid, and 18 combined the two approaches. In June 2000, 2.3 million children were enrolled in these programs, a 74 percent increase from the June 1999 enrollment. 23

The scope of these programs varies considerably from state to state. Some states have expanded eligibility to include children in middle-income families and adults in low-income families. New Jersey Family Care — one of the most far-reaching programs — has raised the family-income criterion for eligibility to 350 percent of the federal poverty level, or approximately $59,675 per year for a family of four. Parents of children and caregivers in families that earn 200 percent of the federal poverty level, as well as adults who earn up to 100 percent of the federal poverty level, can also enroll in the program. Other
state programs have much stricter eligibility criteria, and a few still impose bureaucratic hurdles that inhibit the enrollment of eligible children. Most State Children's Health Insurance Programs still face the challenge of simplifying the renewal process to sustain the increased levels of enrollment.

These new public programs have fundamentally changed the attitudes of state officials toward their implementation. Many are simplifying enrollment procedures and implementing aggressive measures to reach eligible families. These include establishing private–public partnerships with companies such as Wal-Mart and organizations such as the March of Dimes in order to increase the number of sites where children and adults can enroll in the programs.

STRATEGIES UNDER DISCUSSION

IN CONGRESS

Three different strategies were discussed in the 106th Congress and are likely to be reconsidered in the 107th: changing the tax policy with respect to health insurance; expanding public programs such as the State Children's Health Insurance Program, Medicaid, and Medicare; and instituting market reforms to lower the cost of health insurance for small employers.

Tax Policy

Under current law, employer-sponsored health insurance coverage is heavily subsidized through the tax system. Employers' contributions toward health benefits are exempt from both income and payroll taxes, reducing federal revenues by as much as $115 billion in the year 2000.24 These subsidies benefit high-income taxpayers the most.

Several recent proposals would use the tax code to subsidize an expansion of health insurance coverage.24-26 Most of these proposals build on the existing system of tax subsidies, although at least one would revamp the entire tax-subsidy structure, redistributing subsidies to low- and moderate-income people. These revisions of the tax code would require complex administrative procedures for accounting purposes, to ensure equity, and to prevent fraud.

Most of the proposals would provide tax credits to taxpayers, allowing them to reduce their federal tax payments by some or all of the amount spent for health insurance. Generally, such credits would be refundable, enabling low-income families to claim the credit even if they owed no taxes. Refundable tax credits would essentially be the equivalent of vouchers for the purchase of health insurance.

An alternative approach is to expand existing tax deductions for purchasing health insurance. Currently, self-employed taxpayers can claim "above-the-line" deductions for part of their health insurance costs (i.e., the deduction is available to those who take the standard deduction as well as to those who itemize deductions). The deduction is not available, however, to people who are not self-employed but who purchase nongroup (i.e., individual) coverage. Some proposals would allow people who did not have access to employer-sponsored coverage and who purchased coverage themselves to claim the deduction as well. Of course, tax deductions benefit only those who pay taxes and therefore do not help the poorest families. And the deductions provide greatest relief to those with the highest incomes.

Supporters of tax-based subsidies argue that they separate health insurance from employment and thus give consumers a greater choice of plans.27 Critics counter that subsidizing the purchase of individual coverage could erode the existing employment-based system, since employers might drop coverage or workers might purchase individual coverage and then bargain with their employers for higher wages. In addition, actually achieving substantial gains in coverage would be costly for the federal government. Subsidies would have to be large to encourage participation by the uninsured, and many of those eligible for subsidies would already have coverage.28,29 Moreover, critics argue that regulation of the individual-insurance market varies widely from state to state. Therefore, some people might have to pay considerably more for individual coverage than they do now for similar coverage under an employer-sponsored plan. However, supporters claim that a large increase in the number of people with individual policies could help stabilize the individual-insurance market.

Establishing tax credits also raises complex questions about implementation. Would credits be available only to persons without access to employer-sponsored coverage? If so, how would their eligibility be verified? Would the credit be a flat amount or would it vary according to income or the amount spent for coverage? Would it be made available before coverage was purchased? If so, would some type of tax adjustment be required if a person's income changed during the year? The administrative feasibility of specific tax proposals will be determined by how they address such questions.

Another tax-based strategy for expanding coverage is to provide tax credits to small employers. Proponents of this approach believe that it would encourage small employers to offer coverage to employees. In the past, however, subsidizing small employers resulted in disappointingly low percentages of workers who signed up for subsidized coverage.28 Moreover, just as it would be difficult to provide individual tax credits only to persons who would otherwise be uninsured, it would also be a major challenge to offer tax credits only to employers who would otherwise not provide insurance coverage (or who would only a small percentage of the premium). Quite apart from the issue of equity, this restriction on eligibility would be difficult to enforce, especially given the turnover of employers in the small-business mar-
Medical savings accounts, in conjunction with high-deductible plans that provide coverage for catastrophic costs, have long been favored by some economists and conservative politicians. Persons with high-deductible plans can use these accounts, which are tax-preferred personal savings accounts, to pay for deductibles, coinsurance, and other uncovered medical expenses. Those who support this approach argue that it gives people the flexibility to decide how to use their health insurance dollars and encourages them to be more cost-conscious. Critics claim that medical savings accounts contribute to adverse risk selection by selectively appealing to people who are healthy and wealthy. Medical savings accounts are also faulted for requiring complex accounting procedures, and they have not proved popular in the recent national demonstration.29

Expansion of Existing Public Programs

Another proposal for increasing health care coverage is to expand the scope of existing public programs for the uninsured. Prominent options include raising the maximal income level for enrollment in Medicaid and the State Children’s Health Insurance Program, extending the latter program to include low-income adults, and opening up Medicare to early retirees.

Supporters of this approach argue that it makes sense to expand existing public programs.30 But some critics view Medicaid and the State Children’s Health Insurance Program as overly complex and in need of simplification. Others fear that an increased federal role in health care will lead to increased taxes and burgeoning government bureaucracies.

Market Reforms

Almost one third of small firms (those with fewer than 50 employees) that offer health insurance coverage purchase it through a pooled arrangement.31 Some members of Congress are interested in creating new forms of pooled purchasing that would be exempt from certain state insurance regulations, as a way of reducing the costs associated with state-mandated benefits as well as administrative costs, spreading risks of unequal use of medical resources among larger groups, and expanding the choice of health plans. However, the Congressional Budget Office has estimated that these proposed changes would result in a minimal expansion of health insurance coverage, since most of the participants would be insured in any case.32

CONCLUSIONS

Lack of insurance coverage is a complex problem, and the obstacles to its solution are formidable. Skeptics might conclude that this is not a promising time to expand health insurance coverage. However, there are reasons for optimism. The fact that Congress is split evenly between the two parties could force partisans to seek common ground. In fact, President George W. Bush indicated in his acceptance speech that health care security would be one of his priorities. Both candidates for president said that they would allocate at least $120 billion for the expansion of health insurance coverage over the next 10 years — an amount two and a half times as large as the current federal contribution to the State Children’s Health Insurance Program. This potential fiscal commitment, combined with a renewed sense of urgency on the part of key interest groups, such as the Health Insurance Association of America and Families USA, may spark the first concerted effort to address the problem since the demise of comprehensive health reform in 1994.33

STEVEN A. SCHROEDER, M.D.
Robert Wood Johnson Foundation
Princeton, NJ 08543-2316

I am indebted to my colleagues Linda Bilheimer, David Colby, Barbara Mataraza-Barr, Maureen Lane Michael, Stuart Schear, and Judy Whang for their assistance.

REFERENCES

16. Shell JS. Health coverage 2000: cost and coverage analysis of 8 proposals to expand health insurance coverage. (See http://www.lewin.com/library/ShowLibraryItem.cfm?LibraryId=173.)
24. Sheils J. Health coverage 2000 cost and coverage analysis of 8 proposals to expand health insurance coverage. (See http://104.109.40.27/rw_news_and_events/eventshec.2000/hc-report-00/caveat.htm.)

Copyright © 2001 Massachusetts Medical Society.