



# REDUCING THE NUMBER OF UNINSURED

**T**he U.S. Census Bureau reports that, on a single day, there are 44.3 million people in the United States who do not have health coverage. This number is up 10 million over the last decade.<sup>1</sup> Perhaps more indicative of our vulnerability is the fact that 81 million people, or three out of 10 Americans, will go without health insurance for at least one month over a three-year period. The uninsured are a pluralistic group, yet they tend to be working individuals with low or moderate income. Some can't buy insurance because they are too sick, while others are young and healthy and choose not to. Most, however, simply cannot afford the premiums because their incomes are too low and their employers do not contribute adequately or at all toward the cost of coverage.

Underlying these numbers is both good news and bad. Regarding private insurance, the good news is that more employers are offering health insurance to their workers and that employees highly value these benefits. The bad news is that fewer workers are taking this coverage because of rising premium costs. Regarding public programs, the good news is that throughout the early and mid-1990s the federal government and the states expanded Medicaid and created the new Children's Health Insurance Program (CHIP), making millions of uninsured people eligible for coverage. In fact, 2 million children were covered through CHIP in 1999.<sup>2</sup> The bad

## *Policymakers Need the Will to Find A Way*

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news is that since 1996 Medicaid enrollment has dropped substantially due to administrative difficulties as a result of welfare reform, and it has been a real challenge to enroll low-income children for Medicaid and CHIP. Currently more than 4 million uninsured children are eligible for one of these two programs but are not enrolled.

Fortunately, policymakers and the public seem increasingly willing to talk about and take steps toward reducing the number of uninsured. In January President Clinton put forward a proposal to expand coverage to one-fourth of the uninsured, and Republican leaders such as House Majority Leader Richard Armey, R-TX, have championed bills that offer tax credits for the purchase of insurance. Diverse organizations such as the Health Insurance Association of America, Catholic Health Association of the United States, American Medical Association, American Hospital Association, and Families USA recently presented their plans for expanding coverage (CHA's working proposal, "Building an Infrastructure for Universal Coverage," is discussed below).

When the public was asked what government should do about the uninsured, 81 percent of Americans said that government should make an effort to address the problem.<sup>3</sup> Forty-nine percent said that government should make a major effort. Perhaps more important, 55 percent of Americans said they would be willing to pay higher taxes to finance coverage for the uninsured.

The booming U.S. economy, while unsuccessful in expanding coverage on its own, is largely responsible for a federal surplus that is projected to be about \$800 billion over the next 10 years.<sup>4</sup> This new funding source presents an excellent opportunity for federal action on the uninsured.

The talk about expanding coverage in 2000 is certainly less sweeping than the healthcare reform



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debate of 1993 and 1994. These days the phrases “biting off only what you can chew” and “not letting the perfect be the enemy of the good” are repeated with nodding agreement throughout Washington. Few policymakers from the Left or the Right are talking about a complete overhaul of the healthcare system. Rather, they are putting forward plans to expand coverage on a step-by-step basis, working largely within the existing structure and making changes only as needed. CHA’s approach is both long-term and short-term, with the goal of accessible and affordable healthcare for all in a just and compassionate healthcare system. Achieving this goal will take time and hard work, but progress can be made now.

Proposals under discussion in Washington tend to fall into two categories: an expansion of existing public programs, and using a system of premium subsidies, vouchers, and tax credits.

#### EXPANSION OF EXISTING PUBLIC PROGRAMS

One approach to reducing the number of uninsured is to expand existing public programs. President Clinton and others have proposed allowing certain 55- to 65-year-olds to “buy into” Medicare, and others have suggested that Medicare serve as a model for universal coverage for children. However, Medicare comes with its own baggage; it is perceived as costly and difficult to change to reflect innovations in the private insurance system. There is also resistance on Capitol Hill to a federal-only solution and the burden it might place on the underlying, highly popular Medicare program.

More appropriate for an expansion, many argue, are the federal-state programs serving low-income groups—namely Medicaid and CHIP. Low- and moderate-income individuals are much more likely to be uninsured than those with higher incomes, and the federal-state partnership is an approach consistent with the U.S. tradition. States already play an important role in regulating healthcare delivery and insurance markets, and they administer and pay for about 40 percent of Medicaid and CHIP combined. Several states, such as Washington and Tennessee, already use these programs to guarantee insurance to low- and moderate-income families.

A third public program held up as a model is the Federal Employees Health Benefits Program (FEHBP), which provides health coverage to 9 million federal workers, including the president and members of Congress. The FEHBP program

allows federal workers to choose among several health insurance plans in an area based on the benefits, premium amount, and restrictiveness of the plan. Typically, individuals can choose between fee-for-service and managed care plans, paying the difference for higher-cost coverage. On average, the federal government pays 73 percent of the premium. Plans must offer a minimum set of benefits at a community-rated premium. The FEHBP model is appealing because it offers a regulated marketplace for the selection of private insurance with built-in incentives for cost containment. The administrative costs are very low, and the program is popular.

#### PREMIUM SUBSIDIES, VOUCHERS, AND TAX CREDITS

The approach to reducing the number of uninsured that by far has the most support—at least at the surface level—is for the federal government to offer premium subsidies to individuals and families for the purchase of private insurance. Tax credits are the most popular form for these subsidies, as evidenced by a spate of proposals in Congress and on the presidential campaign trail. For Republicans and some Democrats, tax credits are a “twofer.” They can address the problem of the uninsured and at the same time lower taxes and reduce the revenues available for additional federal spending. Tax credits can also be targeted to low- and moderate-income Americans and administered through the existing federal system for verifying income. But tax credit proposals differ in many ways, and the areas of disagreement could overwhelm those of agreement. In fact, some use the term “tax credit” to refer to direct federal payments on behalf of an individual or family to cover all or a portion of health insurance premiums. The term “voucher” could be used as well; however, it has a negative connotation left over from its use in Reagan administration efforts to scale back and privatize many federal programs.

Regardless of what one calls the premium subsidy, most health policy experts agree on several characteristics that must be in place for it to work. First, low- and moderate-income groups must receive the full benefit of the subsidy; in other words, a tax credit must be “refundable.” This means that those who have incomes so low that they do not pay federal income tax should still receive the credit. Second, the subsidy must be available when premium payments are due. Third, the subsidy must be large enough to cover most if not all of the premium of a reasonable

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cost plan. And finally, those receiving the subsidy must be given a source for purchasing insurance coverage. Putting money on the stump without facilitating the purchase of adequate health insurance does not help individuals and does not serve the overall system well either.

### CHA'S WORKING PROPOSAL FOR EXPANDING COVERAGE

In January CHA put forward a working proposal that would reduce the number of uninsured in the United States by 15.6 million persons as a step toward universal coverage. By design, this proposal would establish much of the infrastructure required to achieve universal coverage in the future, such as a program of subsidies for the purchase of insurance by low-income people and the creation of insurance pools for people who do not have employer-sponsored coverage.

Our proposal has several goals:

- Place a special emphasis on securing coverage for low-income families and strengthen the healthcare safety net for vulnerable populations such as the homeless
- Ensure that individuals gaining coverage have an adequate benefits package that is not a "bare bones" policy, such as catastrophic coverage or Medical Savings Accounts (MSAs), and ensure that premium contributions and cost sharing are affordable
- Significantly reduce fragmentation in health insurance markets, making premiums less dependent on an individual's health status
- Encourage consistency and continuity of coverage and healthcare for families, with a strong preference that all members of a family be on the same health plan
- Leverage existing arrangements for health insurance offered by federal and state government and businesses and build on the successes of these efforts
- Recognize the difficulty in getting some uninsured individuals and families to enroll in government-subsidized insurance programs (because of costs, administrative hassle, and social stigma) and therefore take a multifaceted approach to reducing the number of uninsured, with an emphasis on outreach

Our proposal includes five main elements:

- **Medicaid/CHIP Expansion** Expand eligibility under Medicaid and/or CHIP for all persons below 150 percent of the federal poverty level, including non-U.S. citizens who are legally in the United States
- **Premium Subsidies** Create a program to

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provide premium subsidies for the purchase of private insurance equal to two-thirds of the premium for income below \$35,000 for single individuals and \$50,000 for families

- **Expansion of FEHBP** Permit individuals without access to employer-sponsored coverage to obtain coverage through FEHBP

- **Outreach and Enrollment for Medicaid/CHIP Coverage** Remove barriers to enrollment in Medicaid and CHIP and expand outreach to special populations

- **Funding to Strengthen the Healthcare Safety Net** Provide grants to local communities to enhance collaboration and cooperation among safety-net hospitals and clinics

### CRITERIA FOR COMPARING PROPOSALS AND DETERMINING SUCCESS

The major goal of efforts to expand health coverage is self-evident: reducing the number of uninsured. But policymakers must deal with a myriad of issues as they seek changes in a \$1.3 trillion diverse healthcare system.<sup>5</sup> Adjustments in incentives for the purchase of health insurance can have unintended effects, and unless they are targeted appropriately these public policies may end up as inefficient and ineffective ways to expand coverage.

In the search for good public policy in this area, a few questions stand out:

- **What populations should the government target for coverage expansions?** For many years policymakers have agreed that government efforts should first target low- and moderate-income individuals, particularly children. Children cannot secure coverage on their own and their premium costs are relatively inexpensive, allowing federal dollars to stretch farther. The uninsured rate is actually highest for the 18 to 25 age group. Their healthcare is inexpensive as well, but there is much less consensus as to how best to address the problem for these young adults. Another targeted group, based on vulnerability, is 55- to 65-year-olds, who may be less connected to the workforce and may have health problems that prevent them from finding affordable coverage. However, because older adults' coverage is expensive, federal assistance would not stretch as far. Another target group is unemployed individuals between jobs, because assistance for them tends to be temporary until they find new jobs, most with employer health benefits. Yet another



target group is uninsured parents of children already eligible for Medicaid or CHIP. Proposals such as the president's build on the existing system and benefit families by allowing all family members to be on the same health plan.

• **What role should federal and state government programs play? Should there be a strong preference for private insurance?** The debate over the role of government in addressing social problems is as old as the Constitution. A large majority of Americans have private health insurance, and they are generally satisfied with that coverage. Over the past 50 years, while public insurance has expanded with Medicare, Medicaid, and CHIP, so has employer-based insurance. There is great reluctance in Washington to establish new categories of "entitlements" or promises of public coverage. Not only would it be costly to the federal budget, but it goes against the grain of those in Congress who wish to downsize the government. Many feel that private coverage fits the American system better, allowing families to choose a health insurance plan suited to their needs and allowing plans to structure and pay for healthcare delivery in a more cost-effective way. The success of the private insurance system falls far short of this rhetoric, but for now there is a preference in Washington for supporting this system whenever possible and only expanding public programs when private coverage clearly is not feasible.

• **What type and quality of insurance do we want individuals to have?** Having an insurance card, of course, is only as good as the benefit package behind it. Many of the tax credit proposals under consideration take a "hands off" approach to the type of coverage an individual could purchase with the subsidy. Some continue to push for the use of MSAs as an acceptable option despite their inadequacy and the lack of interest to date on the part of consumers. Other tax credit proposals say that the benefit package purchased must include basic services such as inpatient hospitalization; however, the lack of specifics in these proposals allows individuals to purchase "bare bones" coverage. One of the attractions of expanding public programs to assist the uninsured is that these programs already have a set of benefits sufficiently extensive to meet individuals' healthcare needs. Federal minimum benefit standards for the purchase of subsidized private insurance would work as well.

• **What level of premium subsidy is needed to encourage the purchase of insurance?** The

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average annual cost of health insurance for an individual without access to employer-based coverage is \$2,370.<sup>6</sup> Recent studies have shown that low- and moderate-income uninsured individuals, the bulk of the total uninsured, are willing and/or able to pay only small amounts toward their health insurance premiums. As a result, substantial government subsidies are needed to pay the remaining share. Proposals that offer a \$1,000 per year voucher or tax credit are unlikely to result in greatly expanded coverage. A government subsidy closer to two-thirds or more of the premium could, however, encourage millions of the uninsured to purchase coverage. As the subsidy goes up, of course, the cost to the government escalates; giving \$2,000 to 20 million people would cost \$40 billion each year. In addition, as the real cost of insurance for low- and moderate-income individuals goes down, businesses that offer health coverage and workers who take it may decide to drop employer-based coverage and shift to a government-subsidized system. This phenomenon, called "crowd out," could happen in a Medicaid/CHIP expansion or premium subsidy program. This possibility needs to be addressed if scarce federal and state dollars are to be used most efficiently.

• **How can we prevent employers from dropping coverage for their workers?** Crowd out apparently is not a problem for uninsured groups below the poverty level because they tend not to have access to employer-based insurance. Yet for millions of the uninsured who have moderate incomes—for example, a family of four with an income of \$25,000—an employer may offer coverage but pay only a small portion of the premium. One way to avoid crowd out in such cases is to make government premium subsidies available for employer-based insurance as well. This approach avoids an "all or nothing" dilemma for both businesses and workers. The subsidy for employer-based coverage could be a smaller dollar amount than for others, but workers would still be better off to purchase coverage through their employer. Another protection against crowd out is to limit government subsidies or public program expansions to certain income levels. An employer with only one-third or one-half its workforce eligible for the subsidy/program would be reluctant to eliminate health coverage entirely for all workers.

• **What are the administrative challenges in establishing new health coverage programs?** An important issue, of course, is the ease of administration of any new program for expanded



health coverage. Federal and state governments have already shown that they can administer Medicare, Medicaid, and CHIP, even though there have been some problems along the way. Administering premium subsidies for private insurance may be a trickier enterprise, and there is very little experience so far. Since the subsidy amount is likely to be based on a person's income, many have suggested administering it through the tax system. Advance payments could be arranged through payroll withholding, or, for workers with little or no tax liability, the subsidy could appear as an addition to the worker's take-home pay. Nonworking individuals could apply for advance payments of the premium subsidy through public assistance agencies specified by the state, and the federal government would reimburse states for the full cost of these subsidies, including administrative costs.

• **What changes to insurance markets are needed?** Individuals trying to purchase health insurance on their own often face an insurance market that requires pre-existing condition exclusions and sets premiums based on age, gender, and health status. Clearly, millions of the uninsured could not effectively enter this market even if they received a government subsidy. States traditionally have played the role of insurance regulator, and several states have moved closer to community rating. The federal government waded into this area with the Health Insurance Portability and Accountability Act of 1996, which protects health insurance coverage for workers and their families when they change or lose their jobs. A federally mandated community rating is unlikely because of uncertainty about the impact on premiums for those who already have health coverage, but there are ways to move closer to this goal. The CHA working proposal would establish an insurance "pool" (based on the FEHBP model) which would include millions of individuals. With limitations on differential premiums combined with risk-adjusted government subsidies, it could draw in even more of the uninsured or serve as a model for other state-based insurance pools. One way or another, policymakers need to address the persistent problems in the health insurance market. Fortunately, there is some evidence from the states about what has worked and what has not.

• **How much are the federal government and state governments willing to spend to expand coverage?** Meaningful coverage expansions will not come cheap. While some argue that

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steps.

the healthcare system already contains adequate dollars to pay these costs, there are no magic wands to wave to capture these savings. The last effort to squeeze out so-called inefficiencies in Medicare and Medicaid resulted in the Balanced Budget Act of 1997, legislation which left healthcare providers reeling. Beyond cuts such as these, policymakers will need to consider new sources of federal revenue. While the budget surplus presents an opportunity, reducing the number of uninsured will have to compete with tax cuts, military spending, Medicare prescription drugs, highways, and health research for funding. New broad-based taxes are not being considered at this time, although tobacco and other sin taxes are always a possibility.

#### NEXT STEPS ON THE JOURNEY

If the healthcare reform debate in 1993 and 1994 taught policymakers anything, it is that legislative efforts to address problems in the current system will only come in measured steps. Reducing the number of uninsured is a daunting, yet an achievable, goal. There may be a window of opportunity in the next year for Congress and the president to take important steps toward that goal. While no coverage expansion proposal on the table so far is without complications, many of them represent a good place for policymakers to start crafting a significant, bipartisan initiative. CHA's working proposal to reduce the uninsured by 15.6 million people is one way to go, and it has much in common with other approaches put forward in Washington. What we need now is a serious commitment by policymakers to begin work on solutions that will eventually lead to accessible and affordable healthcare for all. □

#### NOTES

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