

Covering America

REAL REMEDIES
FOR THE UNINSURED

Economic and Social Research Institute

OCCASIONAL PAPER

December 2001

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The *Covering America*
project is made
possible by a grant
from the Robert Wood
Johnson Foundation

Prospects for a Reduction in the Number of Uninsured Americans

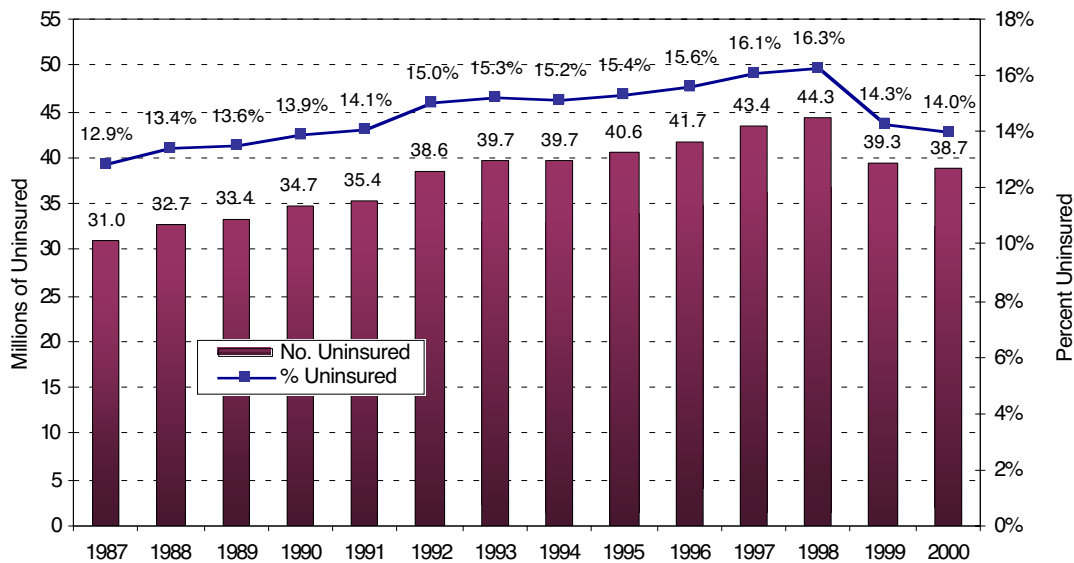
Nearly 40 million Americans have no health insurance. They are not covered by employer-sponsored health plans or other forms of private insurance, nor are they protected by public programs like Medicaid, the State Children's Health Insurance Program (S-CHIP), or Medicare. Lack of coverage creates a number of problems. People without insurance are less likely to seek preventive care and more likely to put off going for medical care when they are sick, and are then forced to seek more intensive, expensive medical intervention when the condition becomes acute. They are more likely to use medical resources inefficiently, seeking care in hospital emergency rooms rather than from doctors in their offices. They are, of course, more likely to incur large unpaid medical bills that become a financial hardship for them and their families or become unpaid provider expenses. And, perhaps most important, they are more likely to experience bad health consequences. They may be up to three times more likely than privately insured individuals to experience adverse health outcomes. They have both higher mortality rates and higher morbidity rates.¹

Recent news accounts about the number of Americans who lack health insurance coverage have undoubtedly created confusion about the seriousness and persistence of this problem. Because the most recent figures show a decline in the number of Americans who are uninsured, some people may be led to believe that the problem is diminishing and that we can look forward to continued progress. A major purpose of this paper is to look at the evidence to try to determine whether the problem of the uninsured is correcting itself and is likely to be solved through the normal operations of the economy, or whether a solution requires significant policy changes.

Trends

The first thing to note is that the country's experience of having substantial numbers of people without the protection of health insurance is a longstanding problem. As shown in Figure 1 (based on data from the Current Population Survey), the number of people without health coverage edged up steadily between 1987 and 1998, followed by a decline in 1999

Figure 1: Number and percent of total population without health coverage for 12 months, 1987-2000



Source: Current Population Survey: Robert J. Mills, "Health Insurance Coverage: 2000," *Current Population Reports*, U.S. Census Bureau, U.S. Department of Commerce, September 2001.

and 2000. In every year since 1991, at least 14 percent of the population (including the elderly) has lacked health insurance for at least a full year. The number and proportion of people without coverage grew between 1994 and 1998 even though this was a period of unbroken prosperity and economic growth.

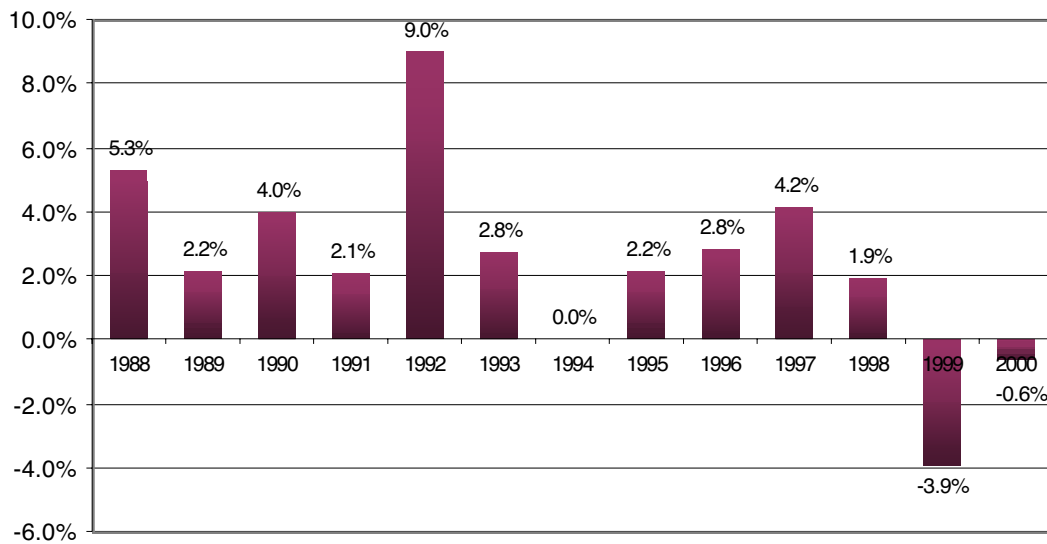
Although the situation shows improvement in the last two years, the substantial reduction in the number and proportion of people without insurance between 1998 and 1999 is misleading. Beginning in 1999, the Current Population Survey (CPS) used a revised estimating methodology to correct an estimating problem that was reflected in all the previous years' estimates. In the two most recent surveys, the researchers added a question to verify the reliability of answers to other questions about the kind of coverage people have.² The verification question, as expected, showed that the number of people who have coverage is higher than the answers to the other questions suggest. Had the same methodology been used in previous years, the estimates of the number of uninsured in those previous years presumably would have also been lower. Had the older methodology been continued, the number of uninsured would have been 42.6 million in 1999 and 42.3 million in 1998. Thus

the actual reduction in the number of uninsured is less than the new numbers suggest.

To provide a more accurate picture of the trend, Figure 2 shows the year-to-year percentage change in the number of uninsured using a consistent (that is, the old) methodology for the whole period. Clearly, there was a significant decline between 1998 and 2000; the high employment rates, tight labor markets, and prosperous economic conditions surely did cause more people to be insured. The surprising fact, however, is that the number of uninsured *grew* rather than declined in the preceding years, given that the period of sustained economic growth began several years earlier.

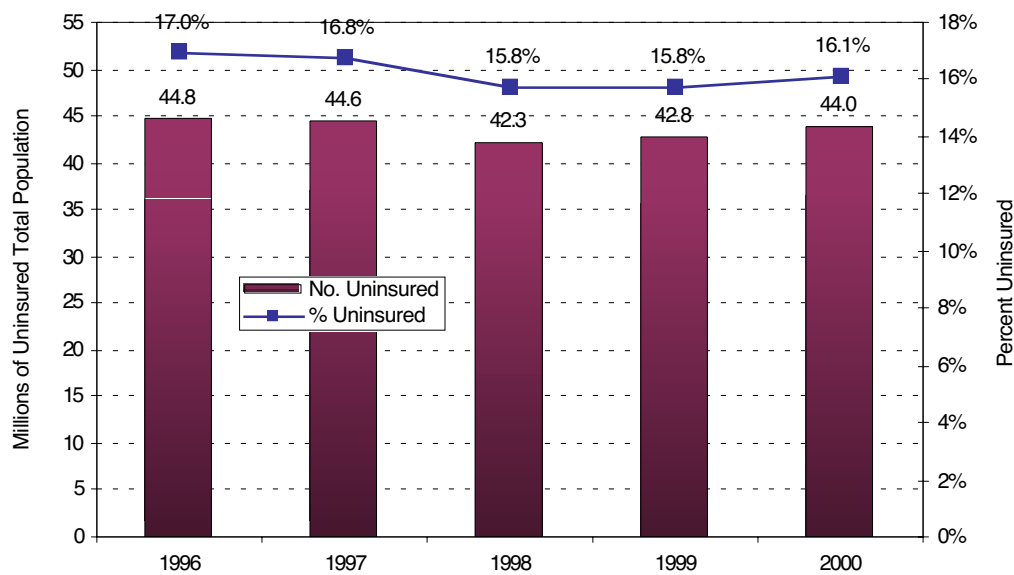
To get a fuller picture of the extent of the problem, it is useful to look at another data source. Figure 3 shows the number and proportion of all Americans without health insurance as estimated from the Medical Expenditure Panel Survey. This survey differs from the CPS in that it reports the number of people (including the elderly) who are without health insurance during a period that averages somewhat less than six months.³ This approach produces an estimate of more uninsured people, since the number of people who

Figure 2: Percent change in the number of uninsured from year to year (using the “old” methodology for all years)



Source: Current Population Survey: Robert J. Mills, “Health Insurance Coverage: 2000,” *Current Population Reports*, U.S. Census Bureau, U.S. Department of Commerce, September 2001.

Figure 3: Number and percent uninsured for six-month period or less, 1996-2000



Source: Medical Expenditure Panel Survey, U.S. Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research.

have no coverage for an entire year is less than the number who are without coverage for six months or less. Although the data are available for fewer years, the experience of the last five years does not provide any evidence of a significant diminution of the problem. In the most recent four years, nearly one out of every six Americans had no health insurance from either public or private sources for a six-month period.

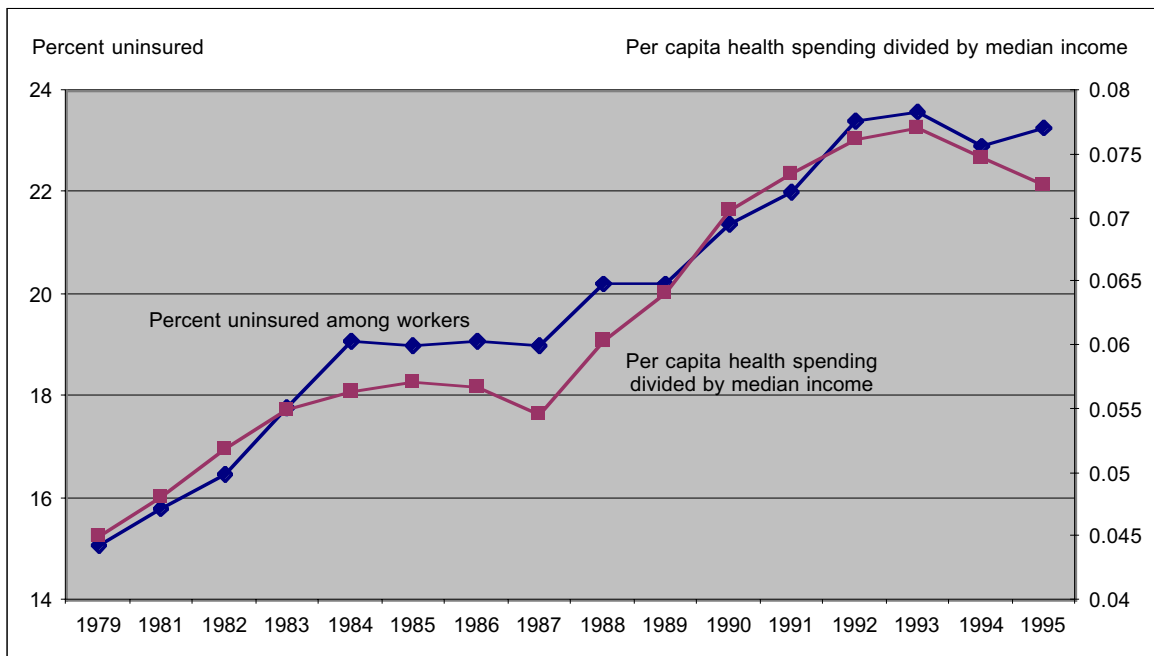
Crucial Factors Explaining Change in Coverage Levels

To assess likely future trends in the rate of insurance coverage, it is important to know which factors strongly influence that rate. Several researchers have investigated this issue.

Richard Kronick and Todd Gilmer have made a convincing case that the most important determinant of insurance coverage is affordability. They believe that the most accurate measure of affordability

is the relationship between health care spending and income. They argue that coverage rates for health insurance declined over the last two decades because health care premiums increased more rapidly than income—that is, because health care coverage became less affordable. They examined the data on health care premiums relative to personal income for the period 1979 through 1995. They found that an increasing proportion of people was spending more for health care coverage as a percentage of income, and so the ratio of health care spending to income rose during most of this period. The close relationship between the ratio of health care spending to income and the number of uninsured workers is illustrated in Figure 4 below. The authors consider the influence of other factors but draw the conclusion that “the sharp declines in insurance coverage among workers from 1979 to 1995 can be accounted for almost entirely by the fact that per-capita health care spending increased much more rapidly than income over this period. . . . More workers were uninsured in 1995 than in 1979 be-

Figure 4: Percentage uninsured among workers and per capita health spending divided by median income, 1979-1995



SOURCE: Richard Kronick and Todd Gilmer, "Explaining the Decline in Health Insurance Coverage, 1979-1995," *Health Affairs*, Mar/April 1999, Vol. 18, No. 2, p. 45.

TABLE 1: Increases in health insurance premiums compared to workers' earnings, 1988-2001

	1988	1993	1996	1999	2000	2001
Premiums	12.0%	8.5%	0.8%	4.8%	8.3%	11.0%
Workers' Earnings	3.5%	2.3%	2.7%	3.8%	3.7%	4.3%

Source: Larry Levitt et al., *Employer Health Benefits, 2001, Annual Survey*, The Kaiser Family Foundation and Health Research and Educational Trust, 2001, Exhibit 2.2.

cause rising health-care expenditures made insurance unaffordable for a growing number of workers.”⁴

More recent research by the same authors confirms the findings that the rate of uninsurance is strongly influenced by the relationship between insurance premium price and worker income.⁵ Based on this research, Kronick and Gilmer believe that the number of uninsured is likely to increase in the next several years as health coverage premium increases continue to outpace workers' earnings. After a brief respite in the mid- to late-1990's, health care cost escalation has accelerated sharply in 2000 and 2001 (see Table 1). The economy is in a substantial slowdown, and that is likely to have a negative effect on earnings. The combination of accelerating premiums and stagnant earnings makes insurance coverage less affordable. This can be expected to cause an increase in the number of uninsured.

Other researchers provide evidence that appears, at least at first, to be inconsistent with the Kronick and Gilmore analysis. Holahan and Kim found that in the period of rapid economic growth between 1984 and 1988, although the number of non-elderly uninsured increased overall by 4.2 million, the number of people with employer-sponsored coverage grew by 9.4 million people.⁶ But this growth was not attributable to more frequent offering of coverage by employers. It was due to the movement of large numbers of people from lower-income groups to higher-income groups, whose employers more frequently offer coverage. Even for the higher-income groups, the proportion of people with employer-sponsored coverage declined, so that the number of people without coverage in this group actually increased (but not by enough to offset the favorable effect of large numbers of workers moving into higher-wage jobs).

The researchers conclude that the number of uninsured would have increased even more rapidly between 1984 and 1988 had the growth of the economy not pushed people into higher income brackets.

In a follow-up analysis of the period 1998-1999, Holahan found that employer-sponsored coverage finally began to increase for low-income Americans. This growth, combined with stability in the rate of Medicaid coverage and continuous movement of people into higher-income categories, caused the total rate of uninsurance to decline.⁷

Paul Fronstin shows that the proportion of non-elderly Americans with *employer-based* insurance increased from 1994 to 1999.⁸ He attributes the greater insurance coverage primarily to greater coverage of children who were covered under their parents' employer plans. This increase reflects, according to Fronstin, a combination of welfare reform and the strong economy, both of which resulted in more young mothers being employed, and in jobs with health coverage. Fewer women were on welfare and more were working. Another contributing element, according to Fronstin, was a change in the labor force composition: fewer workers in part-time or part-year work, fewer self-employed workers, and more workers in large firms. The proportion of small employers offering coverage increased, and overall offer rates went up in the 1997-1999 period. Thus the strong economy seemed to be the main determinant of greater proportions of people getting employer-based coverage.

But this increase in employer-sponsored insurance coverage was partially offset, Fronstin notes, by declines in publicly funded coverage, especially Medicaid. The Medicaid numbers declined because welfare reform was associated with falling

Medicaid enrollment.⁹

Ultimately, Fronstin agrees that it would be overly optimistic to expect the number of uninsured to decline significantly. “As long as the economy is strong and unemployment is low, employment-based health insurance coverage will expand and the uninsured will gradually decline. . . . In contrast, if the economy continues to weaken and health benefit costs continue to increase, the uninsured would quickly start to increase again. Even for those who keep their jobs, small employers would likely drop health benefits, and large employers would likely shift the cost of coverage onto workers, resulting in fewer workers accepting coverage.”¹⁰

And finally, in the absence of major public policy to extend coverage, there is virtually no chance in the foreseeable future that the problem of the uninsured would be “solved” even if the number of uninsured were to drop much faster than anyone would expect. Even a drop to 50 percent of the current level would still leave 20 million Americans without the protection of health insurance. No imaginable change in economic conditions without a major change in the affordability of coverage could cause the number of uninsured to decline to just a residual few. Currently, both factors that determine affordability—medical costs and worker income—are moving in the wrong direction. While economic conditions are likely to improve in the long run, almost no one expects health care costs to remain stable over the long haul.

Barriers to Improvement

Three types of barriers impede improvement of the problem. Unless these barriers are overcome through a set of fundamental policy changes, a substantial reduction in the number of uninsured is very unlikely.

1. Lack of affordability.

Health coverage is viewed as unaffordable by many workers and by many employers, particularly smaller firms. Health coverage is expensive, averaging more than \$7,000 for family coverage;¹¹ and marginal employers, struggling to stay afloat, cannot afford to add the cost of paying premiums to their compensation bill. Even when coverage is available from their employers, many low-wage

workers decline it because they cannot afford their share of the premium. Buying individual coverage—the only option if employer-sponsored coverage is unavailable—is even more expensive. For those who are unemployed or out of the labor force, the cost of individual coverage is frequently prohibitive.

2. Low take-up rates in public programs.

Enrollment in Medicaid and S-CHIP has fallen considerably short of potential eligibility. About 5.6 million children in families with incomes below 200 percent of the federal poverty level, who are thus eligible for Medicaid or S-CHIP, do not have any form of coverage.¹² The Center for Studying Health System Change found that the percentage of low-income children eligible for public coverage rose sharply from 63 percent in 1996-1997 to 92 percent in 1998-1999 after S-CHIP became law (98 percent are eligible for either public coverage or employer-sponsored coverage). Yet, the proportion of eligible low-income children enrolling in public programs—the “take-up rate”—was only 42 percent in 1998-99. In “high-uninsurance” communities—those with more than 16 percent of children uninsured—the take-up rate was only 38 percent.¹³ Expanding eligibility for public programs even further would undoubtedly increase coverage, but this experience suggests that significant numbers of people would not take advantage of the expansion.

In addition to public coverage programs, federal legislation tries to ensure availability of coverage to vulnerable groups through other mechanisms, such as COBRA, which is designed to allow those who leave a job and have no other coverage to buy into their prior employer-sponsored coverage. But the COBRA protection, which guarantees the right to continued coverage, is little real help for low-wage workers, who typically cannot afford to pay the premium. Again, the low take-up rate diminishes the effectiveness of the program. Only 7 percent of unemployed adults were covered by COBRA in 1999.¹⁴

3. Free riders.

A significant number of uninsured people can afford coverage but choose not to take it. This includes many self-employed people and young adults. If, when they need care, they rely on charity care or become “bad debts” for their providers, they are getting a free ride at others’ expense. Of

course, if these people pay for their care out-of-pocket, as higher-income uninsured people probably do, or if they need little medical care, as is often true of young adults, these people do not represent the same social problem as the uninsured who cannot afford coverage or care. Low-income people who are deterred by the expense and thus use little care even when needed should be cause for concern.

The Challenge of Affordability

The belief that health coverage is too expensive deters many employers from offering it and prevents many workers from participating when their employers do offer coverage or from buying coverage on their own.

Only 58 percent of firms with three to nine workers offered coverage in 2001, compared to nearly all firms (96 percent) with 50 or more workers.¹⁵ Moreover, among many companies offering health coverage, including large firms, a sizeable number of workers are ineligible for an employers' offer because they fail to meet a requirement related to minimum hours worked per year. And a large and growing number of workers turn down their employers' offer of health insurance, usually citing affordability. In fact, the employee monthly insurance contribution to family coverage averages \$150 in 2001.¹⁶

Both government and the business sector have undertaken a number of initiatives to improve the problem of affordability facing workers and firms. All have met with only very limited success so far. For example, a number of states and several coalitions of large employers have sponsored purchasing cooperatives for small companies. These co-ops were designed to lower administrative costs and premiums, draw in small firms not previously offering coverage, and increase choice of health plans (employees of small firms are far less likely to have a choice of plans than those in larger companies). Assessments of these initiatives nationwide show that they have generally not lowered health costs, and about 8 of 10 firms joining were already offering coverage. Choice, however, was substantially increased.¹⁷ State initiatives to provide tax credits for small companies have likewise had little success to date.¹⁸ These credits were usually small, temporary, and poorly marketed, yielding a predictably low take-up rate by employers.

More recently, states are engaging in a number of premium-subsidy innovations designed to assist workers with their share of the cost under employer-sponsored coverage. For example, Health Insurance Premium Payment (HIPP) programs use Section 1906 of the Medicaid statute to pay the contribution necessary to enroll Medicaid-eligible workers in employer-sponsored health coverage, provided that this is cost-effective compared to regular Medicaid coverage. Enrollment in HIPP programs has been very limited. For example, Iowa's program, among the largest, covers about 9,600 people. In addition, seven states have received permission from the federal government to use S-CHIP funds to subsidize employer-sponsored coverage for eligible children, and in some cases, their parents. Initial experience under this program was discouraging, as states were faced with rigid requirements related to minimum employer contributions, cost-effectiveness tests, and the prevention of substituting public for private coverage.¹⁹

Just recently, however, the Health Insurance Flexibility and Accountability Demonstration Initiative (HIFA) opened up greater flexibility in using waivers under Medicaid and S-CHIP to wrap around employer coverage. HIFA allows states to bring in higher-income people, modify the benefit, impose more cost-sharing, waive some of the restrictive cost-effectiveness tests, and even cover childless adults under some circumstances. While many states now find themselves in fiscal situations that may preclude immediate expansions even with the federal match, these changes have the long-run potential to bolster premium assistance. But helping workers afford coverage is proving just as challenging as helping employers. So, in the near future, it would be unrealistic to expect a large reduction in the number of uninsured as a result of activities undertaken by states.

Barriers to Enrollment in Public Programs

There is a striking difference between the treatment of health coverage for the elderly and disabled under Medicare, and coverage for low-income Americans who do not fall into one of these categories. The U.S. has what is essentially universal hospital coverage for the elderly and disabled, financed by a legally mandated tax on employers and employees. Enrollment of seniors is virtually automatic when people reach 65, assuming they meet the requirement for a minimum

amount of time working.²⁰ Medicare covers 40 million Americans.²¹

In contrast, enrollment in Medicaid and S-CHIP is voluntary, and subject to a number of serious impediments. First, some low-income people avoid these programs, associating them with a welfare stigma or government interference in their choices. Second, despite a number of reforms undertaken by the states, the application process is frequently burdensome. Third, many people who could enroll in these programs do not realize they are eligible. States have been working on these problems for years. They have tried to be more vigorous in conducting “outreach” programs. But there may be limits to the success of these efforts, both because states may be reluctant to spend the resources to do this—especially since increased enrollment requires additional state matching funds—and because it may be difficult to overcome the resistance of potential enrollees.

Another important source of public “coverage” in the U.S. health care system is the uncompensated care provided by safety net hospitals, community health centers, and many physicians. These providers, most of which depend heavily on public funding, offer a wide range of health care services to indigent people. For many people, such as poor single adults without dependent children, migrant workers, the homeless, and undocumented immigrants, safety net providers are the only source of care. But it is probably unrealistic to expect an expansion of this source of care sufficient to cover a large proportion of the uninsured. Even if there were such an expansion, most people would not see this as being a fully adequate substitute for having ongoing health insurance.

Free Riders and “Immortal” Young Adults

A substantial number of people are uninsured because they appear to lack the motivation, rather than the resources, to participate in the mixed public/private U.S. insurance system. For example, 17 percent of the uninsured are in households that have annual incomes between \$50,000 and \$75,000 and another 14 percent have incomes above \$75,000 a year (see Figure 5).

Young adults have much higher rates of uninsurance than children or older adults—27.3 percent of 18 to 24 year-olds and 21.2 percent of 25 to 34 year-olds are uninsured (see Figure 6). The low

rates of insurance reflect, to some degree, the perception of many young people that they do not need coverage because they are healthy and face a low probability of needing expensive care. The risk of “going bare” is not seen as high enough to offset the cost of buying coverage. The self-employed have higher rates of uninsurance than workers (29 percent for the self-employed versus 19 percent for private sector workers),²² and many could afford some type of coverage.

In the absence of some strong incentives or a requirement for individuals to have private coverage, we should not expect any appreciable reduction in the number of people who can afford but choose not to buy health coverage.

Implications

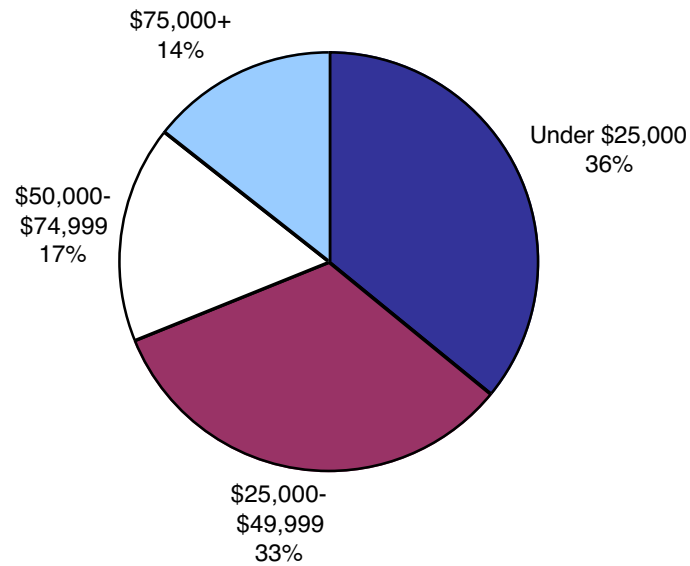
The evidence suggests that we should not expect any large reduction in the number of uninsured. If anything, the current major downturn in the economy (not reflected in the estimates of uninsurance reported in this paper) and the upswing in health insurance premiums indicates that we should be prepared for some increase in the number of uninsured in the next several years. Even if that proves not to be the case, it seems clear that no major improvement is likely unless we take bold actions.

The problem of the uninsured *is* serious. Solving it will require resources and policy reforms. In this section we discuss some of the key decisions and outline some of the main options.

In order to insure those now lacking coverage, we do not have to completely overturn the health coverage system that most Americans enjoy. There are a number of rational, workable approaches to solving the problem. (For a set of 10 major reform proposals that cover a broad philosophical spectrum, prepared by noted health analysts and researchers, see *Covering America: Real Remedies for the Uninsured*, Economic and Social Research Institute, June 2001.)

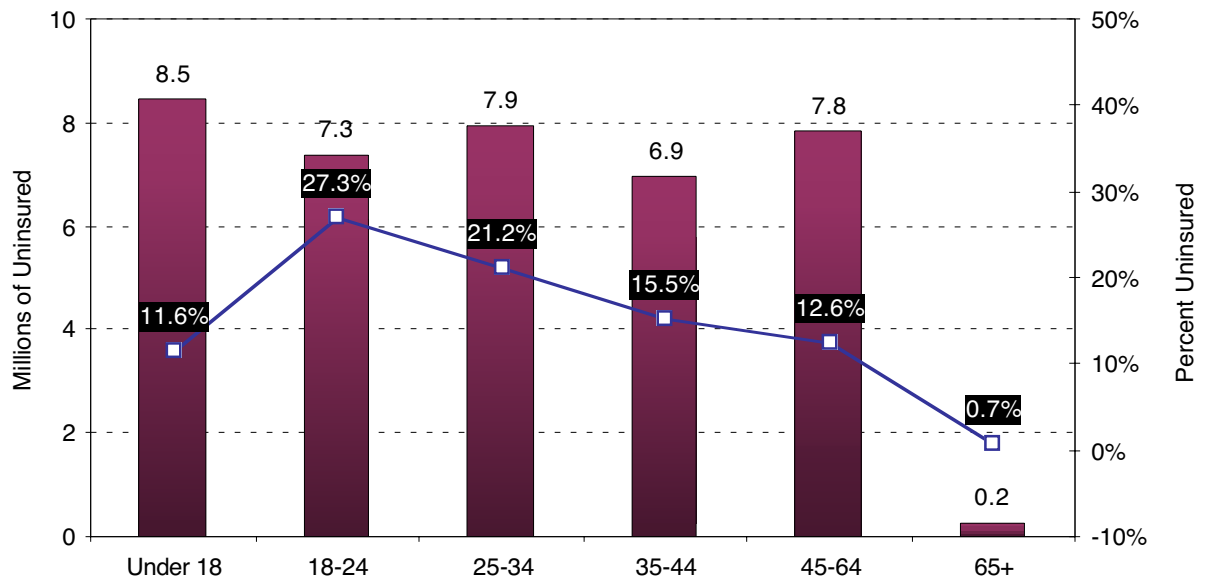
One major barrier is finding sources of funds. Although some of the cost could be offset by redirecting poorly targeted existing subsidies, there is no question that substantial new funding is necessary to pay for the extra health care costs that the uninsured will generate after they become covered. A person newly insured will spend more on

Figure 5: Distribution of uninsured people by household income



Source: Current Population Survey: Robert J. Mills, "Health Insurance Coverage: 2000," *Current Population Reports*, U.S. Census Bureau, U.S. Department of Commerce, September 2001.

Figure 6: Number and percent uninsured by age group



Source: Current Population Survey: Robert J. Mills, "Health Insurance Coverage: 2000," *Current Population Reports*, U.S. Census Bureau, U.S. Department of Commerce, September 2001.

certain health services (for example, primary and preventive care in a doctor's office or a clinic) and less on other services (for example, an emergency room walk-in visit for non-emergent care). To some extent, a pattern of care placing greater emphasis on early detection and preventive care will save some resources down the road, including some avoidable hospital admissions. But moving toward universal coverage will require a substantial commitment of new resources.

Another major barrier is that a large coverage expansion will inevitably produce winners and losers. Resources will be shifted from some actors to others. For example, a reform that provides everyone with the means to buy coverage in private markets might eliminate the need for "safety net" providers, who provide free and subsidized coverage. Disproportionate share hospital payments would be eliminated. Similarly, such an approach could make state Medicaid staff unnecessary. On the other hand, a large expansion of the public system, especially something along the lines of a single-payer system, could hurt private insurers and perhaps put additional pressures on providers that could reduce their income. And, of course, financing the expansion would require significant new tax revenues, which involves difficult questions about which taxpayers should bear the tax burden.

A key choice is whether this extra spending should be paid for by government directly or whether government should require new spending by employers or consumers by mandating that they buy coverage. If it is the former, the public sector would subsidize those who cannot afford coverage. But that raises another fundamental question. Should the subsidy take the form of an expansion of public programs, like Medicaid and S-CHIP? Or should the public subsidies instead provide needy people with the financial wherewithal to purchase coverage on their own through private markets, as would be the case if the tax credit approach were chosen? Making this key choice between expansion of public programs or private markets involves both philosophical and practical considerations. An additional aspect of the choice is that public program expansion requires an appropriation, whereas tax credits do not appear on public budgets, though they obviously require additional tax revenues to finance the tax loss.

Instead of using tax funds to support additional coverage, government could mandate that employers offer coverage and/or that people take it. This can be viewed as a kind of "head tax." This approach requires workers to take a certain proportion of their compensation in the form of health coverage whether they want to or not. We do this now with Social Security and with Unemployment Compensation. Workers and their employers cannot choose whether they want to contribute to their old-age pensions through Social Security—they are legally mandated to do so. Firms cannot opt in or out of unemployment insurance taxes—they are required by law to pay. There are consequences of these requirements. Some believe that Social Security reduces private saving or that unemployment insurance lengthens spells of unemployment. Similarly, a mandate on employers to provide health coverage could lead to some loss of jobs and the failure of some marginal businesses. The issue is whether our society is prepared to pay these prices to guarantee protection for all, as we have done with Social Security and Medicare.

Some approaches would combine government subsidies and structural reforms in the health care system to broaden coverage. One such structural reform would be the development of insurance exchanges or purchasing cooperatives. These could be organized at state or regional levels as a way to provide an efficient source of health insurance for people who are eligible for subsidies but still would have trouble obtaining affordable coverage because of the inefficiencies of the individual and small-group insurance markets. Potential beneficiaries would include the unemployed, those out of the labor force who do not qualify for government assistance, and workers who cannot afford, or who do not qualify for, job-based insurance. These organizations would attempt to negotiate lower premiums than people not part of government programs or large employer groups could obtain on their own. Experience shows that their potential for success in getting good deals would depend in large part on how much business they could offer insurers. While such organizations may provide some cost savings and more efficiently organize the purchase of insurance, any cost reductions will not be enough to make coverage affordable for most people for whom cost is the deterrent to buying coverage. Most of these people will need subsidies in addition, but the

subsidies could be smaller than would otherwise be the case. If receipt of the subsidy were made conditional on using the insurance exchange as the source of coverage, the exchange's volume of business and thus its purchasing clout would be significantly enhanced.

Whatever the choice for expanding coverage, the American public will have to pay. We will pay through our taxes if a government subsidy is used. Alternatively, if a legally mandated requirement is used, we will pay through foregone wages and benefits, as well as some job losses (for example, where money wages cannot be lowered because of the minimum wage).

But it is important to remember the distinction between resource costs and budgetary costs. A reform that involves a large expansion of public programs may produce a large budgetary cost, but some of this simply represents a shift in who pays rather than an increase in the total resource costs. If public program expansions cause some people to drop private coverage and shift to public coverage—the “crowd out” phenomenon—the budgetary cost rises but the medical system does not necessarily use up any more real resources. If new public coverage makes it unnecessary for providers to shift uncompensated care costs to paying customers, this is more a shift in how the care is paid for than a commitment of new resources. Clearly, covering people who are now uninsured will result in new demand for care and the need to

allocate more real resources to health care. That, of course, is the point: to provide people with better care. But the additional resource cost is likely to be substantially less than the budgetary cost, and it is the former that is more important from an economic standpoint (though perhaps not from a political standpoint). If we use more real resources to produce medical care, those resources cannot be used to produce other goods and services.

Some observers believe that the magnitude of the problem requires a complete overhaul of the U.S. system along the lines of a single-payer system. Alternative approaches would build on the existing mixed public/private, multi-payer system in this country. These strategies would alter a number of key features of our health care system while building on others. The choice among these options will be driven by important differences in opinions about what works as well as in philosophical preferences about the roles of government, business, and individuals. But one thing seems clear: Minor tinkering with the current set of programs and practices, without filling the gaps and correcting the major flaws in our current system, is unlikely to make a significant contribution to solving the problem. Such incrementalism might keep matters from getting worse but will probably not lead to a breakthrough. Only major public policies to make coverage more affordable, lower barriers to participation in public programs, and address the “free-rider” situation can solve the problem of uninsured Americans.

Notes

¹ American College of Physicians—American Society of Internal Medicine, “No Health Insurance? It’s Enough to Make You Sick - Scientific Research Linking the Lack of Health Coverage to Poor Health,” www.acponline.org/uninsured/lack-exec.htm.

² In previous years, the people counted as uninsured were a residual: those who did not say that they were covered when asked about particular kinds of coverage were counted as uninsured. Under the new methodology, those people are asked to verify that they were not covered by any health plan. If they say that is not correct, they are then asked to identify the type of insurance that covers them.

³ People are asked about their insurance status between the beginning of the interview year and the time of the interview, and the interviews take place during the first six months of the year.

⁴ Richard Kronick and Todd Gilmer, “Explaining the Decline in Health Insurance Coverage, 1979-1995,” *Health Affairs*, Mar/April 1999, Vol. 18, No. 2, p. 45.

⁵ Richard Kronick and Todd Gilmer, “Evaluating the Decline in Health Insurance Coverage, 1996-1999,” submitted for publication.

⁶ The overall decline in the number of uninsured is explained by reductions in Medicaid coverage and private non-group coverage. John Holahan and Johnny Kim, "Why Does the Number of Uninsured Americans Grow?," *Health Affairs*, Vol. 19, No. 4, July/August 2000, pp. 188-196.

⁷ John Holahan, "Why Did the Number of Uninsured Fall in 1999?," Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, Jan. 2001.

⁸ Paul Fronstin, *Employment-Based Health Benefits: Trends and Outlook*, EBRI Issue Brief Number 233, May 2001.

⁹ Fronstin, p. 9.

¹⁰ Paul Fronstin, testimony before the Committee on Ways and Means, Subcommittee on Health, U.S. House of Representatives, Hearing on Health Insurance Coverage and Uninsured Americans, April 4, 2001.

¹¹ Larry Levitt et al., *Employer Health Benefits, 2001, Annual Survey*, The Kaiser Family Foundation and Health Research and Educational Trust, 2001, Exhibit 2.16.

¹² U.S. Census Bureau, Current Population Survey, 2001, http://ferret.bls.census.gov/macro/032001/health/h10_000.htm.

¹³ Peter J. Cunningham, "Targeting Communities with High Rates of Uninsured Children," *Health Affairs* Web Exclusive, July 25, 2001, http://www.healthaffairs.org/archives_library.htm

¹⁴ Stephen Zuckerman, Jennifer Haley, and Matthew Fragale, "Could Subsidizing COBRA Health Insurance Coverage Help Most Low-income Unemployed?," *Health Policy Online*, Urban Institute, October 17, 2001, www.urban.org/authors/zuckerman.html.

¹⁵ Levitt, Exhibit 3.1.

¹⁶ Levitt, Exhibit 7.1

¹⁷ Elliot K. Wicks, Mark A. Hall, and Jack A. Meyer, *Purchasing Health Coverage for Small Employers: Barriers to Small-Group Purchasing Cooperatives*, Economic and Social Research Institute, March 2000.

¹⁸ Sharon Silow-Carroll, "Employer Tax Credits to Expand Health Coverage: Lessons Learned," prepared for The Commonwealth Fund, Economic and Social Research Institute, 2000.

¹⁹ Jennifer M. Ryan, "Health Insurance Family Style: Public Approaches to Reaching the Uninsured," Issue Brief No. 767, National Health Policy Forum, George Washington University, Sept. 24, 2001, pp. 4-5.

²⁰ Part B of Medicare, covering physician services, lab, and diagnostic tests, is "optional," but well over 90 percent of the eligible population enrolls.

²¹ Office of Strategic Planning, Health Care Financing Administration, U.S. Department of Health and Human Services, *Health Care Financing Review*, Fall 2000, Vol. 22., No. 1, p. 88. This number is based on actual enrollment. It differs from the 37 million reported from the survey data from the Current Population Survey: Robert J. Mills, "Health Insurance Coverage: 2000," *Current Population Reports*, U.S. Census Bureau, U.S. Department of Commerce, September 2001.

²² Self-employed people do not get as large a tax advantage as that available to employed workers whose employer pays for coverage. Moreover, the self-employed are more likely to purchase insurance than other workers who are not offered coverage by their employers. Jonathan Gruber and James M. Poterba, "Tax Incentives and the Decision to Purchase Health Insurance: Evidence from the Self-Employed," *NBER Reprints* 2029 (also Working Paper 4435), National Bureau of Economic Research, Inc., 1996.

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