



HOW THE SLOWING U.S. ECONOMY THREATENS EMPLOYER-BASED HEALTH INSURANCE

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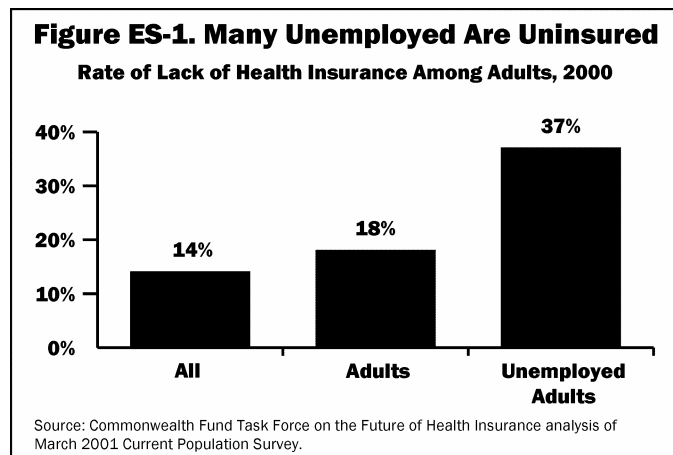
EXECUTIVE SUMMARY

With the slowing of the U.S. economy, the focus of federal health policy has shifted from expanding to protecting health insurance coverage. Rising unemployment and health care costs threaten to erode employer-based health insurance coverage, the major source of health coverage in the nation. State health insurance programs such as Medicaid are under duress as well. This retrenchment occurs against a backdrop of growing federal and state budget problems and unforeseen demands on the health care system because of the September 11 and bioterrorism attacks. This report summarizes recent findings of other reports and provides new analysis of job-based health insurance, unemployment, and the economic consequences of the lack of health coverage. It also discusses policy options and issues. Highlights include:

JOB LOSS AND HEALTH INSURANCE

- **Unemployment is rising.** The unemployment rate rose to 5.4 percent in October 2001, the largest one-month increase in 21 years. Private analysts project that the rate could approach 6.3 to 7.6 percent in 2003.

- **Unemployment leads to loss of health insurance.** About 30 to 40 percent of workers who lose their jobs lose their health insurance as well. The uninsured rate among unemployed adults is nearly three times as high as the uninsured rate in the general population (37% vs. 14%) (Figure ES-1).



SOURCES OF HEALTH COVERAGE FOR THE UNEMPLOYED

- **Although three of four insured workers are eligible for COBRA, few participate, mostly because of cost.** Only about one of five workers eligible for coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) purchases it. Families pay, on average, about \$7,200 for COBRA. In some states (Connecticut and New Jersey), annual premiums can exceed \$8,000. COBRA premiums could consume two-thirds of the typical unemployment benefits check.

- **Low-income workers are twice as likely to be ineligible for COBRA.** Workers in small businesses (fewer than 20 employees) are not eligible for COBRA under federal law. Low-income workers are more likely to work in such firms. Rural states also have a larger percentage of workers in small businesses; Montana, Wyoming, Idaho, and Vermont are among the five states with the highest proportion of workers in small businesses (Florida is also in the top five).
- **Alternative sources of health insurance are unaffordable or inaccessible for most unemployed people.** Over eight times as many unemployed adults are uninsured as are insured through the individual market, reflecting barriers in the individual market (e.g., 37 states allow individual insurers to deny coverage to certain applicants). Medicaid and the State Children's Health Insurance Program (CHIP) cover 15 percent of unemployed women and 53 percent of children with unemployed parents. The median upper income limit for parents is 47 percent of the poverty line (about \$8,500 for a family of four), however, and childless adults can receive Medicaid coverage only in the eight states that have received federal waivers.

UNEMPLOYED ARE NOT THE ONLY ONES AT RISK OF LOSING JOB-BASED HEALTH INSURANCE

- **Private health insurance premium increases have more than doubled since 1999.** Rates rose by an average of 11 percent in 2001, up from 4.8 percent in 1999 and 0.8 percent in 1996. Health care costs may be even higher now because of the September 11 and bioterrorism attacks. Preliminary reports suggest that these attacks have resulted in greater use of mental health care facilities, more heart attacks, and an increased number of visits to doctors and hospitals for flu-like symptoms.
- **More workers may become uninsured.** Given that health insurance premiums are growing at a rate that is three times higher than wage growth, the premium increase alone—without a cost-shift—could consume a significant amount of any wage increase for most American workers.

ECONOMIC CONSEQUENCES OF LOSS OF HEALTH INSURANCE

- **Uninsured people are less capable of paying basic expenses.** According to unpublished data from the 2001 Commonwealth Fund Health Insurance Survey, nearly two of five uninsured could not pay for basic living costs such as food, rent, heating, or electric bills and nearly one of four uninsured was without phone

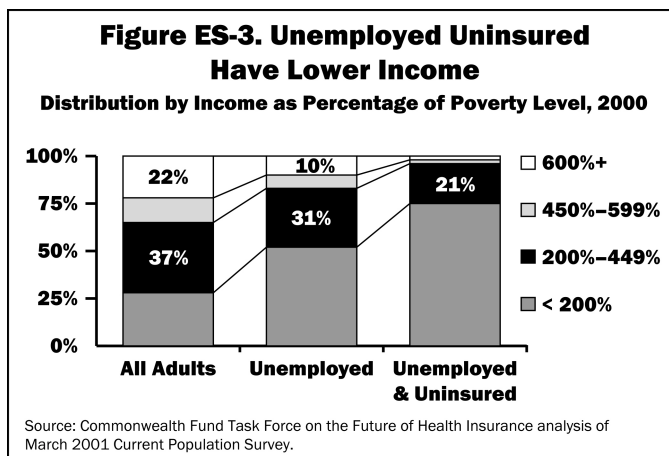
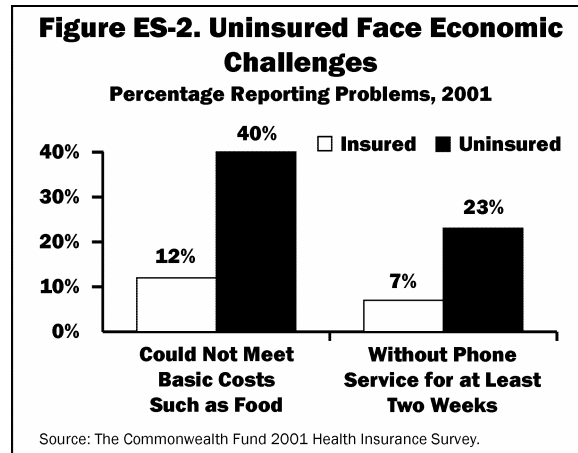
service for at least two weeks (Figure ES-2). About half of all Americans who file for personal bankruptcy protection do so because of health care costs.

- **More uninsured will strain the health care sector.** Growth in the health care sector in 2000 accounted for 30 percent of gross domestic product (GDP) growth.

In addition, health care generated about 45 percent of all new jobs in 2000. Although the health sector is less sensitive to economic downturns than other sectors, an increase in the number of people without insurance could depress the demand for health care workers, especially among safety-net providers.

- **More unemployed, uninsured people will affect state budgets.** A 2 percentage-point increase in unemployment could add about 3.3 million people to Medicaid under current eligibility rules, at a cost of \$5 billion in one year. This comes at a time when state budget officers are reporting that the budget shortfalls for 2002 may be at least \$15 billion.

The report concludes with a discussion of policy options. Several proposals are being considered to assist the unemployed who lose health insurance, including subsidizing COBRA, extending Medicaid eligibility, and providing states with grant money for premium assistance. The relative success of these approaches will depend on their (1) ability to be implemented rapidly, (2) targeting of the unemployed at risk of becoming uninsured, (3) adequacy of funding (at the individual and overall program levels), and (4) consistency with larger reforms. In the Appendix, the report discusses why subsidizing health insurance for the unemployed could result in “economic stimulus.” Specifically, given the cost of COBRA and the income distribution of the unemployed, COBRA subsidies would not only maintain health insurance coverage but also increase consumer spending (Figure ES-3).



HOW THE SLOWING U.S. ECONOMY THREATENS EMPLOYER-BASED HEALTH INSURANCE

INTRODUCTION

In the fall of 2001, health policy took a 180-degree turn, from focusing on expanding health insurance to those who lack it to preserving health coverage for those who have it now. This has been prompted by the slowing economy that has put job-based health insurance at risk for many. Increased unemployment, reduced hours, and soaring health insurance premium costs have led most analysts to fear that job-based insurance, the major source of health insurance in the United States, will decline. Similarly, states face high health care costs and more low-income uninsured people at a time when their budgets, like the federal budget, are severely challenged.^a

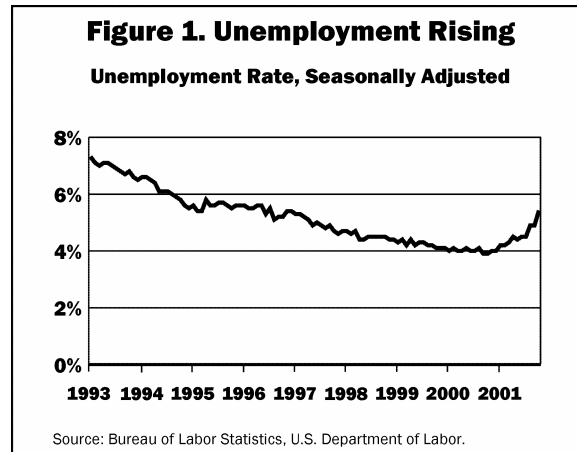
This report gathers the facts and provides new information on the relationship between job loss and health insurance loss. Specifically, it describes the insurance status of unemployed adults, identifies others who may be at risk of becoming uninsured, and reviews the economic impact of lack of health insurance on individuals, the health sector, and states (the Appendix also includes an explanation of why health insurance subsidies can be considered an economic stimulus). Finally, the report discusses the issues that must be addressed by the major policy options aimed at helping the growing number of unemployed, uninsured Americans.

I. ECONOMIC SLOWDOWN AND JOBS

The economy shows signs of entering a recession. During 2001, the U.S. economy took a turn for the worse. Real gross domestic product (GDP) growth declined in the third quarter of 2001 for the first time since 1992.¹ Retail sales fell by 2.4 percent during September; consumer confidence fell between 10 and 15 percent from August to September; and state tax revenues were down.² In its August 2001 assessment of the economy, the Congressional Budget Office (CBO) wrote that the economy “has not experienced such a marked decline in both industrial activity and employment since World War II without going into recession.”³ Since September 11, leading experts agree that the economy shows signs of entering a recession.⁴

^a This report concentrates on the effects of unemployment on employer-based health insurance. The slowing economy also has significant effects on state budgets, Medicaid, and the State Children’s Health Insurance Program. For more information, see the studies posted on the Kaiser Family Foundation website (www.kff.org) under “New Reports on Maintaining Health Coverage and Securing Medicaid in Our Current Economy” and on the Center on Budget and Policy Priorities’ website: www.cbpp.org.

Unemployment has increased dramatically. After a 30-year low of 3.9 percent in October 2000, the unemployment rate climbed to 5.4 percent in October 2001 (Figure 1). The increase between September and October 2001 was the largest one-month increase since the recession in the 1980s. In just one year, an additional 2.2 million became unemployed, for a total of 7.7 million workers. In addition, since August alone, the number of part-time workers whose hours had been cut back or who were unable to find a full-time job increased by 1.1 million.⁵ Although highly uncertain, unemployment rates are projected to continue to rise through 2002. Prior to September 11, the CBO projected that the unemployment rate would rise to 5.2 percent by the end of 2002. Since then, some economists have predicted that the unemployment rate could rise to 6.3 to 7.6 percent by 2003—nearly twice the rate of October 2000.⁶

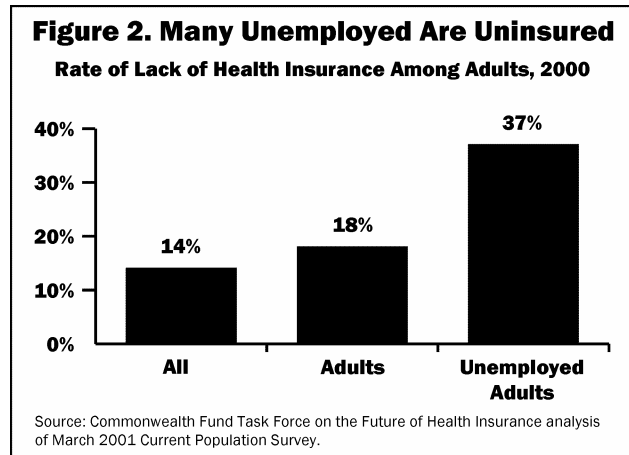


II. JOB LOSS AND HEALTH INSURANCE

Job loss often results in loss of health insurance. About 64 percent of all Americans and nearly 90 percent of privately insured Americans get health coverage on the job.⁷ Employers' purchase of health insurance for a group of employees is, on average, less expensive than individually purchased health insurance because it spreads risk and lowers administrative costs. In addition, employers' health benefits are tax deductible; however, the connection of health insurance to jobs means that job change or loss often results in loss of health coverage. Between 1992 and 1995 (a period that included high unemployment), about 42 percent of workers with one or more job interruptions experienced at least a month without health insurance, compared with 13 percent of full-time workers without a job change.⁸ In 1998, even when the economy was strong, one of three unemployed experienced a loss of health insurance.⁹ Among the uninsured, job loss and change are common as well. One study found that nearly three of five uninsured adults (58%) who were uninsured at any point during the year had lost or changed jobs in the previous 12 months.¹⁰

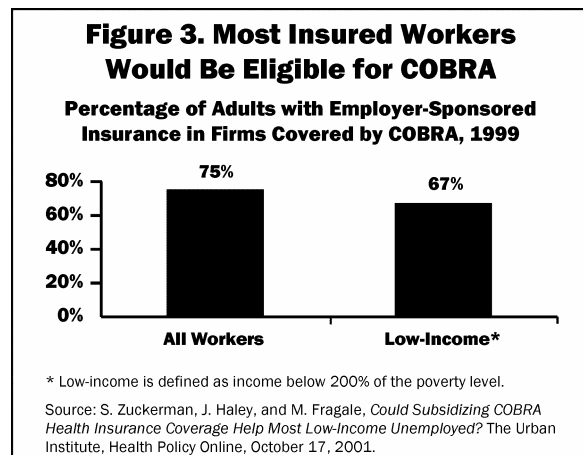
Higher rate of unemployment could increase the number of uninsured. The most recent information on the insurance status of unemployed workers comes from the year 2000. About 37 percent of unemployed adults were uninsured, higher than the proportion with any type of coverage (Appendix Table 1). This rate is over twice the

proportion of uninsured adults in general and nearly three times higher than the rate of lack of insurance in the entire U.S. population (Figure 2). Given the 38 percent increase in the number of unemployed from October 2000 to October 2001, the number of uninsured has probably risen dramatically as well. Unemployed adults are not the only ones at risk of being uninsured. The rate of lack of health insurance among children was 17 percent for those with unemployed parents, compared with 12 percent for all children.



III. SOURCES OF HEALTH COVERAGE FOR THE UNEMPLOYED

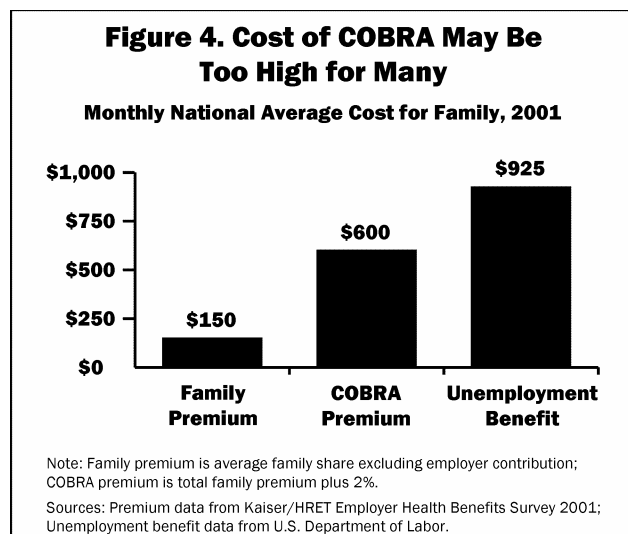
COBRA is an important option for millions of people. To address the loss of health insurance that results from the loss of a job, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) included a provision to provide continuation coverage to certain workers (this coverage is commonly known as COBRA). Under COBRA, employers with 20 or more employees must continue to provide access to their health plans to workers who separate from the firm (except in the case of gross misconduct) or lose coverage because of reduced hours. Individuals and families can purchase this coverage for, at most, 102 percent of the full premium for active employees for up to 18 months in most circumstances. About 38 states extend COBRA either for a longer period of time or for workers in small businesses.¹¹ One recent study found that three of four workers and their adult dependents who are insured through their jobs would qualify for COBRA (Figure 3).¹² Excluding adult dependents, analysis of the 2000 data shows that 86 percent of all workers with employer-sponsored insurance work in firms with at least 25 employees and would thus qualify for COBRA.^b About 5 million people are



^b The March 2001 Current Population Survey collects information on firm size (not establishment size), but does not include a category for 20 or more employees; using 25 or more employees thus underestimates the percentage of insured workers eligible for COBRA.

insured through COBRA¹³ and the average duration of participation is 10.5 months.¹⁴ COBRA has succeeded in preventing workers from becoming uninsured. One study found that unemployed people with access to COBRA were 19 percent more likely to remain insured than people without access to COBRA.¹⁵

Few unemployed workers participate in COBRA, probably because of cost. Only about one of five eligible employees elects COBRA.¹⁶ Some of these eligible people get health coverage through a spouse’s job. For many others, the barrier is cost. Using the average group health insurance premium rates for 2001, COBRA costs \$2,700 per year for an individual and \$7,200 per year for a family.¹⁷ Given the variation in state health insurance premiums, COBRA could cost more than \$8,000 in some states (Connecticut and New Jersey) (Appendix Table 2). This premium is considerably higher than the family share of premiums when employers contribute (about \$1,800 per year, or \$150 per month). The monthly COBRA premium can constitute as much as two-thirds of the average worker’s unemployment check of \$925 per month (Figure 4).¹⁸ Those who do participate in COBRA typically have higher health care needs, which justifies paying the cost of the COBRA premiums. Studies suggest that the COBRA participants’ claims costs are about 50 percent higher than those of active employees.¹⁹



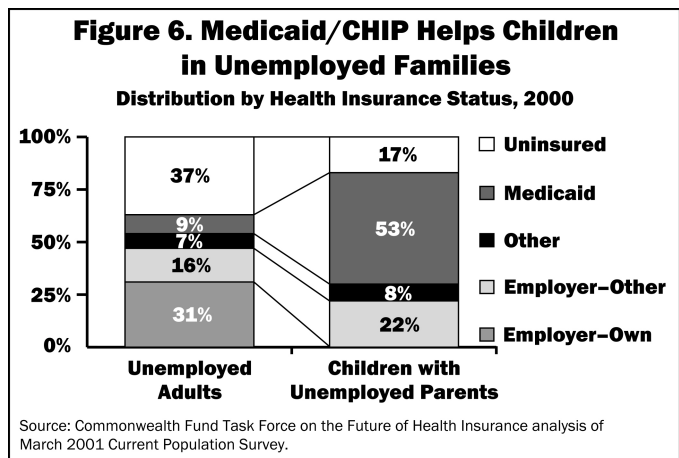
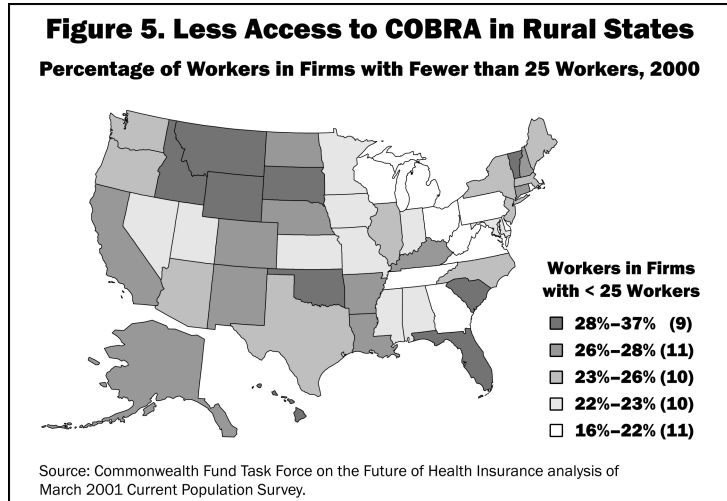
Low-income workers and workers in small businesses are less likely to be eligible for COBRA. About one-third of low-income workers and their adult dependents who have employer-sponsored insurance are not eligible for COBRA because their employers are not obliged to offer it (Figure 3).²⁰ This is because a greater proportion of low-wage workers are employed by firms with fewer than 25 employees: 36 percent of workers with income below 200 percent of the poverty level (about \$35,000 for a family of four) compared with 18 percent of workers with income above 600 percent of the poverty level (about \$105,000). Similarly, compared with urban areas, rural areas tend to have a greater proportion of workers in small businesses who may not be eligible for COBRA (27% vs. 23% work in firms with fewer than 25 employees). Rural states also have a larger percentage of workers in small firms. Montana, Wyoming, Idaho, and

Vermont are among the five states with the highest proportion of workers in small businesses (Florida is also in the top five) (Figure 5; Appendix Table 2).

Individual health insurance is not a viable alternative for the unemployed. Unemployed people could seek coverage in

the individual health insurance market. This market does not link health insurance to work; however, in 37 states, individual market insurers can deny coverage to applicants based on their health status, age, family history, and other factors taken into account in medical underwriting.²¹ Even when offered coverage, individuals' premiums may be high or benefits may be excluded based on their health or demographic characteristics.²² Healthy individuals may find health insurance in this market but, even then, administrative costs may be three times higher than those in the employer market.²³ This helps explain why only 4 percent of unemployed adults were insured in the individual market in 2000. In fact, there were over eight times as many unemployed adults who were uninsured as there were unemployed adults who purchased individual health insurance.

Medicaid helps some unemployed families but access is limited. Medicaid and the State Children's Health Insurance Program (CHIP) offer affordable health insurance coverage to about 40 million Americans. Eligibility for these programs is generally based on income, health status, and family status. There is no federal requirement that Medicaid cover unemployed adults and their dependents, although some qualify for other reasons.^c In 2000, over half of all children with unemployed parents were enrolled in Medicaid or CHIP (Figure 6). This is



^c States have the option to have Medicaid pay COBRA premiums for individuals whose income is below the federal poverty level, who meet an assets test, and for whom the coverage would be cost effective to the program. To be cost effective, the individual would have to be otherwise eligible for Medicaid. Few states have taken this option.

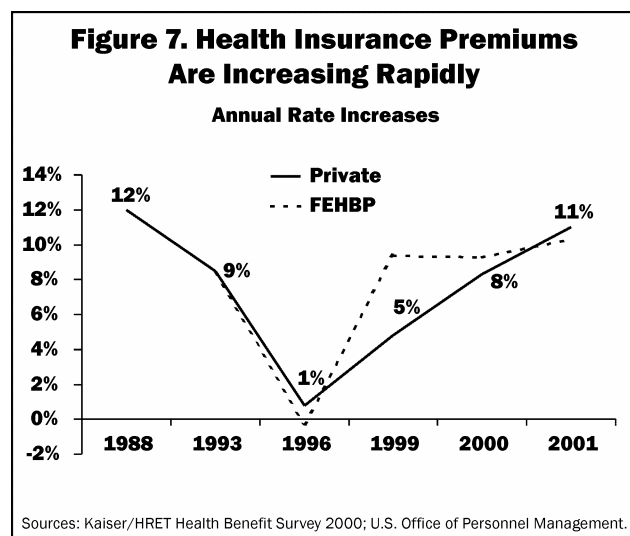
because 95 percent of all children in families with income below 200 percent of the poverty level (about \$35,000 for a family of four) are eligible for these programs.²⁴ Similarly, existing Medicaid eligibility rules help some low-income, unemployed parents. In 2000, Medicaid covered about 9 percent of all unemployed adults. This includes 15 percent of unemployed women and 22 percent of poor, unemployed adults. One study estimated that if the unemployment rate rose to 6.5 percent, Medicaid eligibility would increase by 3.3 million without any changes in current eligibility rules, demonstrating the importance of Medicaid during a recession.²⁵

Although Medicaid and CHIP help some unemployed workers and their families, access depends on the state of residence. The median upper income eligibility limit for low-income parents is 47 percent of the poverty level (about \$8,000 for a family of four). Twenty-two states restrict Medicaid eligibility to parents with income below 50 percent of the poverty line; only 16 states have extended coverage to parents at or above that line.²⁶ Moreover, federal law prohibits coverage of nondisabled, nonelderly, childless adults; only eight states have received Section 1115 waivers for such coverage.²⁷

IV. JOB LOSS NOT THE ONLY REASON FOR LOSS OF HEALTH INSURANCE

Although a large proportion of the unemployed is uninsured, a small proportion of uninsured adults is unemployed (7%). This reflects the complexity of the U.S. health insurance system. A large percentage of workers either lack access to employer-based health insurance or have access to it but cannot afford it. The proportion of uninsured who are employed but cannot afford health insurance may rise along with unemployment in the worsening economy.

After historically low growth, health care costs are rising. Private health insurance premiums rose by 11 percent in 2001, compared with 4.8 percent in 1993 and 0.8 percent in 1996 (Figure 7). The premium rate increase in 2001 for small businesses was even greater (12.5% for firms with 3 to 199 workers and 16.5% for firms with 3 to 9 workers).²⁸ Similar to private insurance premiums, premiums in the Federal Employees Health Benefits Program (FEHBP) are expected to increase by 13 percent for 2002.²⁹ These growth rates are comparable to the premium growth rates of 1991–1993 when the issue of health care reform topped the national agenda.



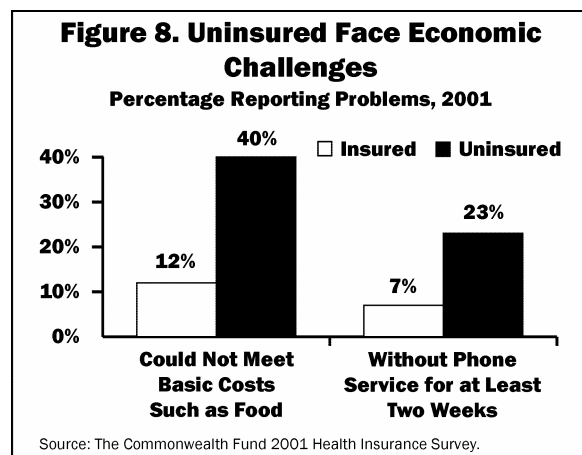
Health care cost inflation has been exacerbated by September 11. Private analysts predict that the attack of September 11 and the subsequent bioterrorism attack could increase health care cost inflation. Ernst & Young LLP estimates that costs will rise by an extra 2.5 to 8 percent in New York, the District of Columbia, and Florida—all hit by anthrax attacks—and by 1 to 3 percent nationally. According to the vice president of Segal Company, if 5 percent of employees filled prescriptions for the anthrax antibiotic Cipro, employers' prescription drug costs could rise by 3 percent on top of the approximately 15 percent increase in drug costs anticipated for 2002 in the absence of the attack.³⁰ Drug costs represent only a fraction of health care costs but have been significantly affecting cost growth in recent years. The terrorist attacks on the World Trade Center and the Pentagon may also result in higher health care spending. The number of prescriptions for antidepressants and anti-anxiety drugs has risen dramatically, as has the overall use of the mental health system. Further, preliminary studies show that there was a significant increase in heart attacks following September 11, also probably triggered by stress.³¹

Higher health care costs are being shifted to workers. Higher health care costs may result in reduced employer profits but, given the weakness of the economy, will most likely result in a cutback in benefits and a cost-shift to workers. One survey found that 56 percent of employers plan to shift a greater proportion of the health insurance premium costs to their workers.³² Even assuming that there is no cost-shift to workers, the family share of the typical group policy could rise to \$2,000 a year. Premium increases could consume a significant proportion of any wage increase for many American workers.

V. ECONOMIC CONSEQUENCES OF LOSS OF HEALTH INSURANCE

Uninsured people are less capable of paying other expenses. Research has found that lacking health insurance not only reduces access to needed care but also is associated with economic stress for working families.

According to unpublished data from the 2001 Commonwealth Fund Health Insurance Survey, nearly two of five uninsured could not pay for basic living costs such as food, rent, heating, or electric bills and nearly one of four uninsured was without phone service for at least two weeks (Figure 8).³³ Although the uninsured use less health care, underutilization often has serious health



and economic consequences. Uninsured people are 50 to 70 percent more likely to be hospitalized for conditions that could be addressed on an outpatient basis, such as diabetes and pneumonia.³⁴ Inadequate insurance and lack of insurance contribute to the fact that about half of all Americans who file for personal bankruptcy protection do so because of health care costs.³⁵

Lack of health insurance limits the ability to find a good job. Overall, studies indicate that COBRA has had a strong, positive effect on reemployment. Because health care coverage protects individuals against catastrophic costs, insurance enables unemployed people to look for work without the concern of bankruptcy caused by illness or injury. On average, COBRA slightly extends the duration of unemployment; however, in its evaluation of a proposal that would heavily subsidize coverage for low-income, unemployed workers, the CBO estimated that it would increase the duration of unemployment by only one week.³⁶ Moreover, one study found that having COBRA significantly increased the reemployment earnings of people losing jobs.³⁷

An increased number of uninsured will strain the health care sector. A recent study found that growth in the health care sector in 2000 accounted for 30 percent of GDP growth. In addition, health care generated about 45 percent of all new jobs in 2000.³⁸ Even in 2001, the health services industry led the nation in job growth, adding nearly 100,000 new jobs from June to October.³⁹ Although the terrorist attacks may increase health care cost inflation and use of care by those with insurance, the economic slowdown will quite likely increase the number of people without health insurance. Since uninsured people typically use fewer health care services, greater numbers of uninsured could depress the demand for health care workers, especially among safety-net providers. Although most health care providers in the United States provide some level of uncompensated care for the uninsured, available resources are currently being taxed by the rise in health care costs and the need to prepare for bioterrorism.

More unemployed, uninsured people will affect state budgets. States often pay for health care through Medicaid, CHIP, and state-funded safety-net programs for those who are no longer insured in the private sector. A recent study found that an increase in unemployment could increase Medicaid costs by \$5 billion per year.⁴⁰ This comes at a time when Medicaid spending growth is already outstripping that of other state programs. In FY 2001, actual Medicaid spending exceeded appropriated amounts in 37 of the 50 states.⁴¹ The states' ability to pay for these higher Medicaid and CHIP costs is limited. State budget officers are reporting that the budget shortfalls for 2002 may be at least \$15 billion, with most states anticipating the need to cut budgets and Medicaid.⁴²

VI. POLICY OPTIONS AND ISSUES

Federal and state policymakers recognize the potential loss of health insurance coverage caused by the economic slowdown and are contemplating options to address it in the context of the economic stimulus bill (see the Appendix, Health Insurance Subsidies as Economic Stimulus). Most proposals build on COBRA by subsidizing premiums for such coverage. Others target those who lose health insurance but are not eligible for COBRA, primarily by extending Medicaid coverage for such individuals. The proposals being considered as of November 8, 2001, are summarized in Appendix Table 3. This section discusses the major issues to be addressed in designing such policies.

Can federal assistance be implemented quickly? Quick implementation of an enacted health insurance policy is a necessity in the current environment. Three policy design features have strong effects on the ability to get the program up and running: which program is used, what benefits are subsidized, and how the subsidies are administered.

Administering new health insurance assistance through existing programs probably results in the shortest period between legislative enactment and operation. Medicaid, which covers as many Americans as Medicare, has the systems available to extend assistance but doing so usually requires state legislative approval or (in the President's proposal) federal approval, which could delay implementation. The challenges of state implementation are greater under proposals to allow health insurance subsidies to flow through the Social Services Block Grant (SSBG) and the National Emergency Grant (NEG) programs. These programs have not previously administered health insurance subsidies and thus would have to both set up a new health insurance program and implement it. The tax code is a third option, since it currently provides significant subsidies for health care. It, too, faces challenges, however, because it has not recently administered refundable tax credits for health care and is implementing numerous changes related to the major tax bill passed in 2001. Therefore, policy options for insuring the unemployed must balance the relative costs of overtaxing existing systems against the benefits of building on programs that have relationships with individuals and insurers and that can rapidly implement a new program.

Additional issues that affect rapid implementation of a new program for insuring unemployed people are the design of the benefits package and delivery of the premium assistance. Some proposals adopt existing benefits packages, such as COBRA (already defined as benefits offered to active employees), Medicaid, or CHIP. Other proposals allow states to design the benefits package. In previous attempts to expand health insurance coverage, the definition of the minimum benefits package has been one of the

most contentious issues, suggesting that including specific, existing benefits standards would facilitate implementation. Similarly, the speed of implementation of any new proposal will be directly linked to the use of existing channels to deliver subsidies to affected families. Medicaid, CHIP, and the tax system have preexisting connections to families, businesses, and insurers that could be the basis of a new premium subsidy. Whether the premium assistance is provided up front (a family pays only the reduced premium) or after the fact (the family pays the full premium and applies for a federal or state refund) matters as well. Generally, studies have found that the uninsured have too little disposable income to pay premiums on a monthly basis, even with the knowledge that they would get a refund.⁴³ Thus, the unemployed would be best helped if they actually paid less in premiums rather than paid the full amount and were reimbursed later.

Is the policy targeted to help unemployed people likely to become uninsured? Like most uninsured, the unemployed uninsured are not a homogeneous group, so that no single policy can address this problem. Policies that focus entirely on those who are eligible for COBRA miss the significant proportion of the unemployed who worked in small businesses and thus lack access to such coverage. Limiting assistance only to states that have been directly affected by the events of September 11 (the NEG programs) would also exclude a significant number of unemployed uninsured because unemployed people live in all states. Building on Medicaid without creating a new option for the unemployed leaves out childless adults because such individuals are not currently eligible for Medicaid. And, although linking subsidies to income does focus resources on those that need them most, it could slow the impact of the policy because the application and income verification processes take time.

Is the funding adequate to protect coverage? Another major question is whether the financing of the policy is sufficient to achieve the goal of maintaining health care coverage. Research shows that the effectiveness of a policy to insure the uninsured depends in large part on the amount of premium assistance: the lower the percentage of income spent on health insurance premiums, the higher the rate of participation. For example, using one set of participation assumptions,⁴⁴ a 50 percent COBRA subsidy would result in a premium of \$3,600, which is about 9 percent of the income of a typical family^d—resulting in a participation rate of around 55 percent. The level of premium assistance varies by proposal but, clearly, more people are helped by higher premium subsidies. In addition to funding at the individual level, funding at the aggregate level needs to be sufficient to meet demand. Block grant programs with inadequate federal funding would lead to waiting lists and rationing of assistance at the state level, and could result in pressure on states to care for those left out of the federal program.

^d According to the Census Bureau, the median family income in 2000 was \$42,100.

Is the health insurance policy consistent with current and future policies?

The final question concerning policies to help the unemployed uninsured is: Does the policy deviate significantly from larger plans addressing how the health insurance system should be structured? Prior to the economic slowdown in mid-2001, both the President and Congress allocated part of the federal budget surplus to an expansion of health insurance coverage. This interest in expanding coverage has been supplanted by proposals to protect existing coverage for people losing their jobs; however, the underlying problem has not gone away and, in fact, is worsening. Interim proposals to help the unemployed could be just that: time-limited, temporary programs that have no bearing on future policy directions. On the other hand, strengthening the employer-based health insurance system, creating new ways to subsidize private health insurance, extending Medicaid and CHIP, and other elements of the current proposals could help lay the groundwork for future efforts to reduce the excessive number of uninsured Americans.

APPENDIX

HEALTH INSURANCE SUBSIDIES AS ECONOMIC STIMULUS

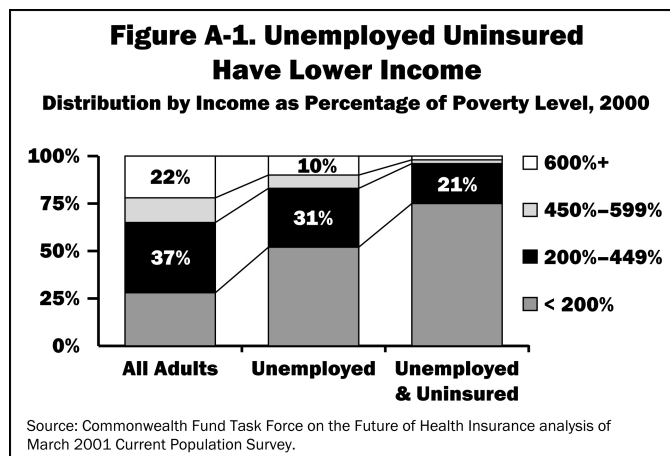
What is economic stimulus? Congress is currently contemplating an “economic stimulus” bill. The objectives of this legislation, according to the chairmen and ranking members of the House and Senate Budget Committees, are to “restore consumer and business confidence, increase employment and investment, and help those most vulnerable in an economic downturn....”⁴⁵ Policies under consideration are measured against these standards and also are expected to be implemented rapidly and to be temporary to avoid long-term drains on the budget. The question has been raised: To what extent can policies to subsidize COBRA be considered economic stimulus?

Health care spending and income. In the last decade, researchers have begun to recognize out-of-pocket health care spending and health insurance spending as critical to defining economic well-being. A report by the National Research Council recommended that household contributions toward the costs of medical care and health insurance premiums be considered a “necessary expense” like income taxes. As such, these expenses should be deducted from gross income to accurately measure a family’s available resources.⁴⁶ Others have suggested that health care is so important that its costs, along with those of clothing and shelter, should be added to the cost of food in the definition of the poverty threshold, the minimum level of resources needed to function in the society.⁴⁷ Irrespective of how health care expenses are treated in calculating income, subsidies for health insurance reduce such expenses and thus increase income (holding revenue sources constant). In 2001, the federal government spent about \$100 billion on tax subsidies for health care, \$139 billion on Medicaid and CHIP, and \$216 billion on Medicare.⁴⁸

Loss of job-based health insurance and income. When individuals lose jobs, they lose more than after-tax wages, some of which is partly compensated for by unemployment insurance. There is, for many, the additional loss of employer-paid health insurance premiums. Individuals purchasing COBRA or individual health insurance thus are not only paying for expensive premiums when they have less income but are also purchasing such coverage out of after-tax income, whereas employer-paid premiums are not taxed and, on average, result in a 27 percent tax subsidy.⁴⁹ Thus, even if unemployed people were able to purchase individual health insurance policies that covered the same benefits for the same premiums as their former employers’ plans, they would experience a loss in income because of the loss of the tax subsidy.

COBRA subsidies as economic stimulus. Policies that subsidize COBRA coverage would, in this framework, increase income for virtually all participants and thus allow for increased consumer spending, which would stimulate the economy. This can be seen by following what would happen to COBRA eligibles if they received subsidies. About 20 percent of people eligible for COBRA today purchase this coverage, while others purchase individual health insurance. Under a proposal to subsidize COBRA, this latter group would receive relief from the premium payments they would otherwise have to make and have extra money to spend on goods and services. Because most COBRA participants have modest incomes—about 58 percent have incomes below 300 percent of the poverty level (about \$50,000 for a family of four)⁵⁰—they have a high propensity to consume any increases in their income.

A second group of people eligible for COBRA consists of those who would have forgone the opportunity to buy into COBRA in the absence of subsidies. Given subsidies, some would buy COBRA rather than become uninsured. If the out-of-pocket premium they would pay after the subsidy is less than what they would have paid for health care if they had been uninsured, this group, too, would have extra money that could be spent on consumption. Three of four adults who are unemployed and uninsured have incomes below 200 percent of the poverty level and would probably use this extra money to pay for daily expenses (Figure A-1). Experience with COBRA shows that people who purchase it tend to have higher than average health care needs, so it can be expected that those who



purchase it, with or without a subsidy, need health care services. If the out-of-pocket premium they would have to pay after the subsidy is more than what they would have paid for health care if they had been uninsured, there would be no stimulative effect of the coverage and these people would have less to spend on consumption.

A third group of COBRA-eligible people consists of those who forgo buying COBRA, even with a subsidy. For them, there is neither a cost nor a stimulative or depressant effect.

Appendix Table 1. Insurance Distribution, 2000

	ALL ADULTS (AGES 18 TO 64)		UNEMPLOYED ADULTS		CHILDREN OF UNEMPLOYED ADULTS	
	Number (thousands)	Distribution	Number (thousands)	Distribution	Number (thousands)	Distribution
Total	166,907	100%	5,567	100%	1,448	100%
Employer: Own	83,385	50%	1,739	31%	6	0%
Employer: Other	31,148	19%	880	16%	313	22%
Individual	9,438	6%	250	4%	79	5%
Medicaid	7,029	4%	496	9%	764	53%
Other	6,646	4%	115	2%	33	2%
Uninsured	29,261	18%	2,087	37%	252	17%

Source: Commonwealth Fund Task Force on the Future of Health Insurance analysis of March 2001 Current Population Survey.

Appendix Table 2. State Information Relevant to the Unemployed and Uninsured

	1. Rate of Uninsured, 1998-2000		2. Annual COBRA Premiums, 2001	3. Monthly Unemployment Benefit, 2000	4. Unemployment Rate, 9/2001	5. Workers in Firms with Fewer Than 25 Workers, 2000	
	Percent	Rank				Percent	Rank
Alabama	14.2%	19	\$6,263	\$823	5.0%	23%	37
Alaska	18.1%	7	\$7,162	\$1282	6.5%	28%	10
Arizona	19.5%	3	\$6,548	\$888	4.6%	24%	27
Arkansas	15.3%	13	\$6,380	\$870	4.9%	26%	20
California	19.2%	5	\$6,939	\$883	5.4%	26%	18
Colorado	14.1%	20	\$6,920	\$1,446	3.7%	28%	11
Connecticut	9.5%	42	\$8,270	\$1,425	3.6%	26%	16
Delaware	11.2%	35	\$7,101	\$1,277	3.2%	21%	47
Dist. of Columbia	14.5%	18	\$7,190	\$1,290	6.6%	16%	51
Florida	17.2%	10	\$7,114	\$961	4.3%	32%	3
Georgia	15.2%	15	\$6,765	\$1,083	3.8%	21%	44
Hawaii	9.8%	41	\$6,584	\$1,269	4.4%	29%	6
Idaho	16.5%	11	\$6,109	\$953	4.9%	30%	4
Illinois	13.3%	24	\$7,673	\$1,485	5.5%	23%	29
Indiana	11.3%	34	\$7,080	\$1,165	4.2%	22%	40
Iowa	8.2%	49	\$6,170	\$1,277	3.2%	23%	34
Kansas	11.0%	36	\$7,024	\$1,117	3.8%	23%	33
Kentucky	13.1%	26	\$6,736	\$1,321	4.6%	27%	14
Louisiana	19.5%	4	\$7,332	\$853	5.5%	28%	12
Maine	11.5%	33	\$7,347	\$1,217	4.3%	26%	21
Maryland	11.9%	32	\$7,904	\$1,212	4.1%	23%	38
Massachusetts	9.2%	45	\$7,781	\$1,438	3.9%	25%	26
Michigan	10.6%	38	\$7,450	\$1,260	5.1%	21%	45
Minnesota	8.2%	50	\$7,390	\$1,243	3.4%	23%	32
Mississippi	15.7%	12	\$6,610	\$823	5.4%	23%	31
Missouri	9.0%	46	\$6,734	\$1,018	4.2%	22%	39
Montana	18.3%	6	\$6,734	\$901	4.6%	37%	1
Nebraska	9.5%	43	\$6,595	\$922	3.0%	27%	15
Nevada	17.5%	9	\$7,194	\$1,044	4.7%	23%	35
New Hampshire	8.6%	47	\$7,351	\$1,169	4.1%	27%	13
New Jersey	12.9%	27	\$8,093	\$1,667	4.5%	23%	30
New Mexico	22.6%	1	\$5,811	\$940	5.7%	26%	17
New York	15.3%	14	\$7,744	\$1,178	4.9%	25%	25
North Carolina	13.7%	22	\$7,018	\$996	5.2%	24%	28
North Dakota	12.1%	30	na	\$714	1.7%	26%	19
Ohio	10.2%	40	\$6,799	\$1,091	4.3%	22%	41
Oklahoma	17.7%	8	\$6,977	\$1,039	3.4%	28%	8
Oregon	13.7%	23	\$6,496	\$1,373	6.4%	26%	22
Pennsylvania	8.3%	48	\$7,259	\$1,147	4.6%	22%	43
Rhode Island	6.9%	51	\$7,439	\$1,507	3.9%	20%	49
South Carolina	13.8%	21	\$6,903	\$1,035	5.3%	28%	9
South Dakota	12.0%	31	na	\$935	3.1%	29%	7
Tennessee	10.8%	37	\$6,739	\$992	4.0%	20%	48
Texas	22.2%	2	\$7,379	\$1,005	5.0%	25%	24
Utah	13.2%	25	\$6,442	\$1,026	4.2%	23%	36
Vermont	10.3%	39	\$7,557	\$1,173	3.2%	29%	5

	1. Rate of Uninsured, 1998–2000		2. Annual COBRA Premiums, 2001	3. Monthly Unemployment Benefit, 2000	4. Unemployment Rate, 9/2001	5. Workers in Firms with Fewer Than 25 Workers, 2000	
	Percent	Rank				Percent	Rank
Virginia	12.9%	28	\$7,065	\$1,160	3.1%	21%	46
Washington	12.8%	29	\$7,045	\$1,217	6.1%	25%	23
West Virginia	15.2%	16	\$6,430	\$1,031	4.9%	22%	42
Wisconsin	9.3%	44	\$7,696	\$1,104	4.0%	20%	50
Wyoming	15.1%	17	\$7,130	\$979	4.0%	34%	2
United States	14.4%	—	\$7,200	~\$900	4.9%	24%	—

Sources: Column 1: U.S. Census Bureau; Column 2: Estimated COBRA costs for 2001 multiplied by the ratio of state-to-national health insurance premium costs for 1999 from Kaiser Family Foundation's State Health Facts Online; Column 3: Economic Policy Institute's estimates of unemployment benefits in communities with median income;⁵¹ Column 4: U.S. Bureau of Labor Statistics—Note: October 2001 unemployment rates by state were to be available on November 20, 2001; Column 5: Commonwealth Fund Task Force on the Future of Health Insurance analysis of March 2001 Current Population Survey.

Appendix Table 3. Major Proposals to Help the Unemployed Keep Health Insurance

	Senate Finance Committee Proposal ⁵²	House Substitute Bill ⁵³	House-Passed Bill ⁵⁴	COBRA Plus Act of 2001 ⁵⁵	President's Proposal ⁵⁶
Spending	\$16 billion	\$24–\$25 billion	\$3 billion	\$9.4 billion	No new funding*
Program	State grants for COBRA eligibles, Medicaid for non-COBRA eligibles**	Treasury credits to employers/insurers for COBRA eligibles, Medicaid for non-COBRA eligibles*	Social Services Block Grant (SSBG) for all unemployed	Refundable tax credits for COBRA eligibles	NEG for COBRA eligibles, Medicaid/CHIP waivers for non-COBRA eligibles
Eligibility	COBRA eligible, unemployed after 9/11/01 for COBRA, state-defined upper income limit for Medicaid	COBRA eligible, unemployed after 7/1/01 for COBRA, state-defined upper income limit for Medicaid	Unemployed, not eligible for public program; states define additional eligibility limits	COBRA eligible, not eligible for public program	COBRA eligible for NEG, states define eligibility limits for waivers
Benefit	COBRA, Medicaid	COBRA, Medicaid	State-defined within broad standards	COBRA	COBRA for NEG, state-defined for waivers
Amount of Assistance	50% for COBRA, 100% for low-income, modest premiums for higher-income in Medicaid***	75% for COBRA, 100% for low-income, modest premiums for higher-income in Medicaid***	Unspecified	50% for COBRA up to a cap: \$1,320 single \$3,480 family	Up to 75% of COBRA in NEG, unspecified for waivers
Duration of Assistance	Up to 12 months (both programs)	Up to 12 months (both programs)	Unspecified	Up to 9 months	Up to 10 months for COBRA in NEG, unspecified for waivers
Duration of Program	CY 2002 with no payments after 3/31/03	One year from enactment	FY 2002	CY 2002–2003	FY 2002 for NEG, unspecified for waivers

* The Administration proposes to allow states to use funding already authorized and appropriated by Congress: \$3 billion from the National Emergency Grant (NEG) programs and \$11 billion from the State Children's Health Insurance Program (CHIP).

** States would receive an enhanced Federal matching rate for electing this option. The Senate Finance Committee proposal would also temporarily increase the Medicaid matching rate to protect existing Medicaid/CHIP coverage.

*** States could charge premiums for higher-income participants consistent with the Medicaid buy-in provision in the Work Incentives Improvement Act of 1999. States could also "wrap around" the COBRA premium or subsidize the family share of the premium for those with low income who would otherwise qualify for this new Medicaid option.

METHODOLOGY

The analysis in this paper used March 2001 Current Population Survey (CPS) data and was produced by Sherry Glied and Danielle Ferry of Columbia University's Joseph L. Mailman School of Public Health for The Commonwealth Fund Task Force on the Future of Health Insurance. The analysis used the CPS's revised methodology for measuring the uninsured. Most statistics concentrated on adults ages 18 to 64. For the purpose of this paper, a family was defined as a health insurance unit—a smaller family unit than that used by the Census Bureau—so less income is counted and thus slightly more low-income, uninsured people are reported here. Health insurance is defined hierarchically, so that each individual is assigned one health insurance category, even when he or she reported more than one source of coverage during the year. People were classified as “unemployed” if they reported receiving unemployment benefits at the time of the survey.

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#472 *Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools* (August 2001). Lori Achman and Deborah Chollet, Mathematica Policy Research, Inc. The authors argue that high premiums, deductibles, and copayments make high-risk pools unaffordable for people with serious medical conditions, and suggest that by lifting the tax exemption granted to self-insured plans, states could provide their high-risk pools with some much-needed financing.

#468 *Market Failure? Individual Insurance Markets for Older Americans* (July/August 2001). Elisabeth Simantov, Cathy Schoen, and Stephanie Bruegman. *Health Affairs*, vol. 20, no. 4. This new study shows that adults ages 50 to 64 who buy individual coverage are likely to pay much more out-of-pocket for a limited package of benefits than their counterparts who are covered via their employers.

#469 *Embraceable You: How Employers Influence Health Plan Enrollment* (July/August 2001). Jon Gabel, Jeremy Pickreign, Heidi Whitmore, and Cathy Schoen. *Health Affairs*, vol. 20, no. 4. In this article, the authors reveal that high employee contributions for health insurance often deter low-income workers from signing up for coverage, even when they are eligible.

#470 *Medicare+Choice: An Interim Report Card* (July/August 2001). Marsha Gold, Mathematica Policy Research, Inc. *Health Affairs*, vol. 20, no. 4. The author explains that the Medicare+Choice options available to beneficiaries have diminished: existing plans have withdrawn from M+C, few new plans have entered the program, greater choice has not developed in areas that lacked it, and the inequities in benefits and offerings between higher- and lower-paid areas of the country have widened rather than narrowed.

#457 *Health Insurance on the Way to Medicare: Is Special Government Assistance Warranted?* (July 2001). Pamela Farley Short, Dennis G. Shea, and M. Paige Powell, The Pennsylvania State University. The authors conclude that the loss of employer insurance should not be used as the primary justification for implementing Medicare buy-in or other reforms for over-55 and over-62 age groups, but instead propose that the better justification for such reforms is the poorer average health status of those nearing age 65.

#449 *How the New Labor Market Is Squeezing Workforce Health Benefits* (June 2001). James L. Medoff, Howard B. Shapiro, Michael Calabrese, and Andrew D. Harless, Center for National Policy. To understand how labor market trends have contributed to the decline in the proportion of private-sector workers receiving benefits from their own employers—and to anticipate future trends—this study examines changes over a 19-year period, 1979 to 1998.

#464 *Health Insurance: A Family Affair—A National Profile and State-by-State Analysis of Uninsured Parents and Their Children* (May 2001). Jeanne M. Lambrew, George Washington University. This report suggests that expanding Medicaid and State Children's Health Insurance Program (CHIP) coverage to parents as well as children may not only decrease the number of uninsured Americans but may be the best way to cover more uninsured children.

#453 *Running in Place: How Job Characteristics, Immigrant Status, and Family Structure Keep Hispanics Uninsured* (May 2001). Claudia L. Schur and Jacob Feldman, Project HOPE Center for Health Affairs. This report looks at factors that influence health insurance coverage for Hispanics, the fastest-growing minority population in the United States. The analysis shows that characteristics of employment account for much, but not all, of the problem. Family structure seems to play some role, as does immigrant status, which affects Hispanic immigrants more than other groups.

Preparing for the Future: A 2020 Vision for American Health Care (April 2001). Karen Davis. *Academic Medicine*, vol. 76, no. 4. Copies are available from Karen Davis, President, The Commonwealth Fund, 1 East 75th Street, New York, NY 10021-2692.

#462 *Expanding Public Programs to Cover the Sick and Poor Uninsured* (March 2001). Karen Davis. In invited testimony before the Senate Finance Committee, the Fund's president presented a compelling case for expanding existing public health insurance programs to provide coverage for the most vulnerable segments of the nation's 42.6 million uninsured. She stressed the importance of expanding Medicaid and the Children's Health Insurance Program (CHIP) to cover parents of covered children.

#441 *Medicare Buy-In Options: Estimating Coverage and Costs* (March 2001). John Sheils and Ying-Jun Chen, The Lewin Group, Inc. This paper examines the need for insurance expansions for Americans approaching retirement age and analyzes the probable impact of Medicare buy-in options on program costs and their effectiveness in reducing the numbers of uninsured.

#445 *Expanding Employment-Based Health Coverage: Lessons from Six State and Local Programs* (February 2001). Sharon Silow-Carroll, Emily K. Waldman, and Jack A. Meyer, Economic and Social Research Institute. As with publication **#424** (see below), this report describes the various ways states and local communities are making coverage more affordable and accessible to the working uninsured, but looks more closely at programs in six of the states discussed in the earlier report.

#415 *Challenges and Options for Increasing the Number of Americans with Health Insurance* (January 2001). Sherry A. Glied, Joseph A. Mailman School of Public Health, Columbia University. This overview paper summarizes the 10 option papers written as part of the series *Strategies to Expand Health Insurance for Working Americans*.

#442 *Incremental Coverage Expansion Options: Detailed Table Summaries to Accompany Option Papers Commissioned by The Commonwealth Fund Task Force on the Future of Health Insurance* (January 2001). Sherry A. Glied and Danielle H. Ferry, Joseph L. Mailman School of Public Health, Columbia University. This paper, a companion to publication **#415**, presents a detailed side-by-side look at the 10 option papers in the series *Strategies to Expand Health Insurance for Working Americans*.

#459 *Betwixt and Between: Targeting Coverage Reforms to Those Approaching Medicare* (January/February 2001). Dennis G. Shea, Pamela Farley Short, and M. Paige Powell. *Health Affairs*, vol. 20, no. 1. The article examines whether eligibility for a Medicare buy-in should be based on age or ability to pay.

#439 *Patterns of Insurance Coverage Within Families with Children* (January/February 2001). Karla L. Hanson. *Health Affairs*, vol. 20, no. 1. Using the 1996 Medical Expenditure Panel Survey, this article examines patterns of health insurance within families with children, determining that 3.2 million families are uninsured and another 4.5 million families are only partially insured.

How a Changing Workforce Affects Employer-Sponsored Health Insurance (January/February 2001). Gregory Acs and Linda J. Blumberg. *Health Affairs*, vol. 20, no. 1. Copies are available from *Health Affairs*, 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#425 *Barriers to Health Coverage for Hispanic Workers: Focus Group Findings* (December 2000). Michael Perry, Susan Kannel, and Enrique Castillo. This report, based on eight focus groups with 81 Hispanic workers of low to moderate income, finds that lack of opportunity and affordability are the chief obstacles to enrollment in employer-based health plans, the dominant source of health insurance for those under age 65.

#438 *A 2020 Vision for American Health Care* (December 11/25, 2000). Karen Davis, Cathy Schoen, and Stephen Schoenbaum. *Archives of Internal Medicine*, vol. 160, no. 22. The problem of nearly 43 million Americans without health insurance could be virtually eliminated in a single generation through a health plan based on universal, automatic coverage that allows choice of plan and provider. The proposal could be paid for, according to Fund President Davis and coauthors, by using the quarter of the federal budget surplus which results from savings in Medicare and Medicaid.

#424 *State and Local Initiatives to Enhance Health Coverage for the Working Uninsured* (November 2000). Sharon Silow-Carroll, Stephanie E. Anthony, and Jack A. Meyer, Economic and Social Research Institute. This report describes the various ways states and local communities are making coverage more affordable and accessible to the working uninsured, with a primary focus on programs that target employers and employees directly, but also on a sample of programs targeting a broader population.

Tracking Health Care Costs: Inflation Returns (November/December 2000). Christopher Hogan, Paul B. Ginsburg, and Jon R. Gabel. *Health Affairs*, vol. 19, no. 6. Copies are available from *Health Affairs*, 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#411 *ERISA and State Health Care Access Initiatives: Opportunities and Obstacles* (October 2000). Patricia A. Butler. This study examines the potential of states to expand health coverage incrementally should the federal government decide to reform the Employee Retirement Income Security Act (ERISA) of 1974, which regulates employee benefit programs such as job-based health plans and contains a broad preemption clause that supersedes state laws that relate to private-sector, employer-sponsored plans.

Customizing Medicaid Managed Care—California Style (September/October 2000). Debra A. Draper and Marsha Gold. *Health Affairs*, vol. 19, no. 5. Copies are available from *Health Affairs*, 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#392 *Disparities in Health Insurance and Access to Care for Residents Across U.S. Cities* (August 2000). E. Richard Brown, Roberta Wyn, and Stephanie Teleki. A new study of health insurance coverage in 85 U.S. metropolitan areas reveals that uninsured rates vary widely, from a low of 7 percent in Akron, Ohio, and Harrisburg, Pennsylvania, to a high of 37 percent in El Paso, Texas. High proportions of immigrants and low rates of employer-based health coverage correlate strongly with high uninsured rates in urban populations.

Inadequate Health Insurance: Costs and Consequences (August 11, 2000). Karen Donelan, Catherine M. DesRoches, and Cathy Schoen. *Medscape General Medicine*. Available online at www.medscape.com/Medscape/GeneralMedicine/journal/public/mgm.journal.html.

#405 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. This summary report, based on *The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70*, reveals that those nearing the age of Medicare eligibility and those who recently enrolled in the program place high value on Medicare. At the same time, many people in this age group are struggling to pay for prescription drugs, which Medicare doesn't cover.

#406 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. This full report of findings from *The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70* reveals that those nearing the age of Medicare eligibility and those who recently enrolled in the program place high value on Medicare. At the same time, many people in this age group are struggling to pay for prescription drugs, which Medicare doesn't cover.

#391 *On Their Own: Young Adults Living Without Health Insurance* (May 2000). Kevin Quinn, Cathy Schoen, and Louisa Buatti. Based on *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* and Task Force analysis of the March 1999 Current Population Survey, this report shows that young adults ages 19–29 are twice as likely to be uninsured as children or older adults.

#370 *Working Without Benefits: The Health Insurance Crisis Confronting Hispanic Americans* (March 2000). Kevin Quinn, Abt Associates, Inc. Using data from the March 1999 *Current Population Survey* and *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance*, this report examines reasons why 9 million of the country's 11 million uninsured Hispanics are in working families, and the effect that lack has on the Hispanic community.

#361 *Listening to Workers: Challenges for Employer-Sponsored Coverage in the 21st Century* (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. Based on *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance*, this short report shows that although most working Americans with employer-sponsored health insurance are satisfied with their plans, too many middle- and low-income workers cannot afford health coverage or are not offered it.

#362 *Listening to Workers: Findings from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. This full-length analysis of the Fund's survey of more than 5,000 working-age Americans finds that half of all respondents would like employers to continue serving as the main source of coverage for the working population. However, sharp disparities exist in the availability of employer-based coverage: one-third of middle- and low-income adults who work full time are uninsured.

#364 *Risks for Midlife Americans: Getting Sick, Becoming Disabled, or Losing a Job and Health Coverage* (January 2000). John Budetti, Cathy Schoen, Elisabeth Simantov, and Janet Shikles. This short report derived from *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* highlights the vulnerability of millions of midlife Americans to losing their job-based coverage in the face of heightened risk for chronic disease, disability, or loss of employment.

#347 *Can't Afford to Get Sick: A Reality for Millions of Working Americans* (September 1999). John Budetti, Lisa Duchon, Cathy Schoen, and Janet Shikles. This report from *The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* finds that millions of working Americans are struggling to get the health care they need because they lack insurance or experience gaps in coverage.