



SMALL BUT SIGNIFICANT STEPS TO HELP THE UNINSURED

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EXECUTIVE SUMMARY

The number of uninsured Americans rose by 1.4 million in 2001—a reversal of recent improvements made by public policy and a reflection of the weakened economy. The same economic slowdown that has exacerbated the problem of the uninsured has also diminished the public resources needed to address it. This paper suggests a number of low-cost policies that could improve health coverage in this environment by providing discrete groups of people with access to private health insurance, public coverage, or both.

Generally, the policies outlined below would cost less than \$1 billion per year—a small amount relative to total spending on Medicare and Medicaid (\$260 billion and \$270 billion, respectively). Even if all were enacted, they would neither significantly reduce the number of uninsured nor substitute for comprehensive health system reform. However, they would represent progress, albeit modest, toward helping the nation’s uninsured and underinsured.

WORKERS CHANGING JOBS

People who change jobs are twice as likely to experience a gap in health coverage as those who remain in the same job all year. Studies have found that even short periods without health insurance can reduce access to care. Two options to help people who are changing jobs include:

- **Extending COBRA continuation coverage to all workers who need it.** COBRA would be extended to workers in small businesses, allowing them to buy into their former employer’s health plan for up to 18 months in most circumstances. Such an extension, which some states have already enacted, would lay the groundwork for making COBRA more affordable through tax policy or other forms of subsidies.
- **Adding health insurance assistance to unemployment insurance.** This proposal would give states an enhanced federal matching rate for providing time-limited Medicaid/CHIP coverage to low-income people receiving unemployment benefits. Medicaid/CHIP would subsidize coverage through COBRA when accessible, and participants would pay a premium based on their income.

WORKERS IN SMALL BUSINESSES

Workers in small businesses are more likely to lack health insurance than workers in large businesses. Because they often face higher and more volatile premiums for less generous benefits, small firms, compared with large firms, are less likely to offer coverage. In 2002, the relatively low rate of small firms offering health coverage dropped significantly. Few

public policies have succeeded in increasing the number of small businesses offering coverage. Two alternative ideas are:

- **Testing a Federal Employees Health Benefits Program buy-in through a demonstration.** This demonstration would allow a limited number of small businesses to insure their workers through the Federal Employees Health Benefits Program. Participating employers would pay the same share of the premium as does the federal government, and the federal government would offset any above-average costs of demonstration enrollees to protect the premiums of federal workers. This could be coupled with a tax credit to make this coverage more affordable for lower-wage employees.
- **Testing an individual insurance tax credit through a demonstration.** This demonstration would allow a limited number of self-employed people and workers in small firms who lack access to job-based coverage to receive a refundable, significant (e.g., 65% to 75%) tax credit for premiums for individual health insurance with strong consumer protections (e.g., guaranteed issue, no preexisting condition exclusions, minimum benefits, no insurance underwriting).

LOW-INCOME PEOPLE

One-third of the nation's uninsured are poor. Of the 12.7 million uninsured with incomes below the poverty threshold, 2.8 million are parents and 6.6 million are childless adults. Only 20 states have used existing Medicaid options to extend eligibility to all poor parents, and a handful of states have sought demonstration waivers to cover childless adults. One option to help poor adults is:

- **Gradually phasing in public coverage of poor adults.** This proposal would provide options and incentives for states to phase in Medicaid coverage of all adults with incomes below the poverty threshold. To offset some (or all) state costs of this expansion, the federal government would gradually assume a greater percentage of the Medicaid costs for those enrolled in both Medicaid and Medicare—the so-called dual-eligibles.

YOUNG ADULTS AGING OUT OF CHILDREN'S HEALTH COVERAGE

Young adults have the highest rate of uninsurance. While 12 percent of children are uninsured, 27 percent of young adults lack coverage, suggesting that turning age 19 poses a risk to health insurance coverage. Two policies to address this problem are:

- **Extending private plans’ dependent coverage up to age 21.** This proposal would require all insurers that offer dependent coverage to define a dependent as any unmarried child up to age 21 at a minimum.
- **Extending Medicaid/CHIP options up to age 21.** This policy would create a new state option to extend Medicaid and CHIP coverage to all young adults up to age 21. States could access CHIP’s enhanced federal matching rate for this coverage.

OLDER ADULTS LOSING ACCESS TO JOB-BASED COVERAGE

Older adults are more likely to have health problems and less likely to have access to job-based coverage than younger adults. Older Americans’ attachments to the workforce diminish after age 55—at the same time that their risk of incurring health problems increases. Older women are particularly vulnerable, since their coverage as dependents is more likely to change at this age (because of the retirement of husbands or a change in marital status). The number of uninsured older adults will increase in the next decade as the baby boom generation moves through this age bracket. Two options to improve access to coverage for this group include:

- **Extending COBRA continuation coverage for early retirees.** This proposal would allow workers age 60 and older who retire without retiree health insurance to purchase COBRA continuation coverage until they enroll in Medicare. The COBRA premiums during this extended period could be set at higher rates than current COBRA premiums to offset this group’s higher costs. A tax credit could be added to make this coverage more affordable.
- **Creating a Medicare buy-in for younger spouses of Medicare beneficiaries.** This proposal would create a Medicare option for those people ages 60 to 64 who lose access to job-based health insurance because their older spouses have retired. Participants would pay a base premium for this coverage, along with a risk premium that would be added to their Part B premium when they turn 65, to offset the above-average costs of participants.

PEOPLE WITH HEALTH PROBLEMS FACING LIMITED ACCESS TO PRIVATE COVERAGE

A significant number of Americans have health problems that could prevent them from accessing affordable private insurance. According to recent research, nearly 40 percent of nonelderly adults have at least one chronic health condition, as do one-fourth of all uninsured adults. Insurers, by design, benefit from having fewer sick enrollees, yet public policy has not systematically put in place private insurance regulations or public program options to prevent these individuals from becoming and remaining uninsured. Two options to fill these gaps include:

- **Allowing Medicaid to act as a high-risk pool.** This policy would allow states to extend Medicaid eligibility to high-risk people who do not meet the strict definition of disability used for program eligibility today. It would allow states to fund this coverage through an assessment of private insurers, who would benefit from public coverage of these costly individuals.
- **Gradually phasing out Medicare’s 24-month waiting period.** This proposal would shorten, by one or more months per year, the 24-month waiting period for Medicare coverage that is now required for individuals receiving Social Security Disability Insurance (SSDI).

INSURED PEOPLE AT RISK OF BECOMING “UNDERINSURED”

A growing number of insured people lack adequate health and financial protections. The current period of rising health care costs is not only threatening coverage but resulting in scaled-back coverage for those remaining insured. In 2002 alone, deductibles for preferred provider organizations increased by 37 percent. Reduction of coverage for medically appropriate services may also occur in this environment. One policy to address this emerging problem is:

- **Creating a national health coverage advisory commission.** This proposal would create a commission to promote coverage of evidence-based medicine along with standards for cost-sharing for public and private health insurance. This would strengthen insured individuals’ financial protection and ability to access clinically sound services.

Although similar in scope, these options differ in the aspect of the insurance problem they address, the type of people they help, and their relative advantages and disadvantages. Some would assist people in transitions (e.g., extending COBRA, helping younger and older adults); others would particularly benefit women (e.g., Medicare buy-ins for younger spouses of Medicare beneficiaries); and some would improve equity (e.g., removing family status, firm size, and education from eligibility criteria for certain policies). Although designed to minimize controversy, each idea would likely generate some level of resistance, such as concerns about costs, policy mandates, or crowd-out (the replacement of private insurance with public coverage). In addition, even if all were enacted, they would neither significantly reduce the number of uninsured nor substitute for comprehensive reform in the U.S. health system. The options in this paper are intended to illustrate the numerous ways that some progress—albeit minor—can be made in helping the nation’s uninsured and underinsured.

SMALL BUT SIGNIFICANT STEPS TO HELP THE UNINSURED

INTRODUCTION

The number of uninsured Americans rose by 1.4 million in 2001—a reversal of recent improvements and a reflection of the weak economy. Health care costs, after record-low growth rates in the 1990s, have rebounded; private group health insurance premium growth in 2002 was higher than it had been in the early 1990s. Because no clear cost-containment solution is on the horizon (like the promise of managed care in the last decade), employers and insurers are increasingly shifting some of these rapid cost increases to insured individuals. As a result, a growing number of Americans are both uninsured and underinsured as benefits decline. Yet the same economic slowdown that has exacerbated these problems has also diminished the public resources needed to address them.

This report suggests a number of low-cost policies that could provide relief in this environment. These policies would provide discrete groups of people with access to private insurance, public coverage, or both. The policies are each designed to cost no more than about \$1 billion per year and, in most cases, much less. This represents less than 1 percent of the costs of Medicare, Medicaid, and/or the new costs of extending coverage to all Americans. As such, even if all were enacted, they would neither significantly reduce the number of uninsured nor substitute for comprehensive reform of the U.S. health system. The report's goal is to suggest that there are numerous small but significant steps that can be taken to break the recent policy impasse and help the nation's uninsured.

I. UNINSURED IN AMERICA: A DEEPENING PROBLEM

Serious Health and Economic Consequences of Lacking Insurance

In a nation with, arguably, the best-quality medical care in the world, there is no system to ensure that all Americans have health insurance. Contrary to popular belief, even those who are poor or sick are not guaranteed access to affordable health care. Because of the expense of health care, those without health insurance often skip or delay needed care due to cost. One recent study found that more than 50 percent of adults without health insurance did not see a doctor when sick, did not fill a prescription, skipped recommended medical tests, or did not see a specialist due to cost.¹ This lack of access has real health consequences. For example, uninsured people with heart attacks are less likely to receive state-of-the-art treatment and are more likely to die while hospitalized or shortly thereafter.² Lack of access also has financial consequences. About half of the uninsured reported struggling to pay for expenses such as food and rent, and the vast majority (70%) were forced to deplete their savings to pay medical bills.³ Health costs are a major factor in personal bankruptcy, accounting for 40 percent of filings in 1999.⁴ The consequences of

this fragmented health coverage system are felt by those who are insured as well, since health providers often shift the costs of uncompensated care to them through higher quotes and premiums.

Profile and Prevalence of the Uninsured

About 41 million Americans (14.6%) were uninsured in 2001—more than the number of people enrolled in either Medicare or Medicaid.⁵ This figure masks the much larger number of people who gain and lose health insurance throughout the year. In 1996, 62 million Americans (27%) were uninsured for at least one month during the year.⁶ A different survey found that, in 2001, fully half of adults with annual income below \$20,000 were uninsured for all or part of the year.⁷ Although the uninsured lack coverage for a variety of reasons, several characteristics distinguish them. More than 60 percent of the uninsured are in the low-income population, with incomes below 200 percent of the federal poverty threshold, or \$36,200 for a family of four. More than 80 percent of uninsured workers are employed by businesses with fewer than 500 employees.⁸ Hispanics (33%), African Americans (19%), and non-citizens (43%) are much more likely to lack health coverage than whites (14%) and U.S. natives (12%).⁹ Young adults are the most likely of all age groups to lack coverage, although the number and rate of uninsured among people ages 55 to 65 are increasing rapidly.

Recent Progress

Recent experience demonstrated that the problem of the uninsured is not insoluble and can be influenced by public policy. In 1999 and 2000, the rate of uninsured Americans dropped after 12 straight years of increases. Studies suggest that this decline can be attributed to an increase in public coverage, specifically among children.¹⁰ The State Children's Health Insurance Program (CHIP) was created in 1997 to build on Medicaid's coverage of low-income children. Between 1997 and 2001, the National Center for Health Statistics reported that the number of uninsured children dropped by 2 million and the rate fell by more than 20 percent.¹¹ Some states expanded coverage to low-income working parents with similar results. For example, Massachusetts implemented a demonstration program called MassHealth in 1997 that extended coverage to parents and some childless adults as well as children. This helped reduce the percent of uninsured young adults (ages 25 to 34) by a third (from 15.4% to 10.5%) and the percent of uninsured among the near-poor (those at 134% to 150% of the poverty level) by more than half (from 26.5% to 11.9%).¹²

Poor Prognosis

Few expect the recent progress to continue. An economic slowdown set in during the spring of 2001, leading to a spike in the unemployment rate. The unemployment rate,

which was at a 10-year low in October 2000 (3.9%), has risen by about 50 percent (reaching 6 percent in November 2002).¹³ In 2001, the poverty rate in the United States increased for the first time since 1992.¹⁴ This was accompanied by the return of high health care cost growth. Employer-sponsored health insurance premiums increased by an average of 12.7 percent in 2002—more than twice the increase from 1998 to 1999 (4.8%).¹⁵ In fact, some analysts predict that private insurance premium growth will be even higher in 2003.¹⁶ The dual problems of a weak economy and high health costs have also created state budget problems. Eighteen states anticipate cutting eligibility for Medicaid or CHIP, and 15 states are planning benefit reductions for 2003.¹⁷ These trends have combined to increase the number of uninsured Americans in 2001 and suggest even greater increases in 2002 and beyond. Analyses of the link between unemployment and insurance suggest that the increase in unemployment could potentially add 2 to 3.4 million more to the ranks of the uninsured.¹⁸ A study that looked at recent trends and future projections estimates that the number of uninsured could increase by 12.8 million between 1999 and 2009.¹⁹

II. RECENT PROPOSALS TO HELP THE UNINSURED

Major Initiatives to Expand Coverage

In 2001, both the new 107th Congress and the new Administration proposed significant investments in health coverage expansion initiatives. The president's fiscal year 2003 budget included a refundable tax credit of \$1,000 for individuals and \$2,000 for families to purchase individual health insurance.²⁰ Members of Congress from both parties introduced the FamilyCare bill, which, among other provisions, added funding to CHIP to cover uninsured parents of eligible children.²¹ Although similar in terms of the size of investment, these two initiatives differed in terms of the uninsured group targeted and means of insuring them. The tax credit proposal would primarily help younger, healthier people through the relatively unregulated individual health insurance market.²² The FamilyCare bill primarily would help low-income parents and other targeted groups of uninsured through government program expansions.²³ Neither proposal passed in 2001, but both the president and the Senate Budget Committee allocated about \$100 billion over 10 years for coverage expansions in their budget plans, introduced in early 2002.²⁴

Minor Initiatives to Expand Coverage

The emphasis on major initiatives for the uninsured diminished in 2002. This resulted from an increasingly bleak budget outlook, the emergence of national security issues and, on the health policy agenda, a debate over a Medicare prescription drug benefit. In its wake, a number of smaller health coverage proposals emerged (see Appendix for descriptions of major coverage policies in the 107th Congress). They consisted primarily

of targeted public program expansions (e.g., allowing states to cover legal immigrant children or children with disabilities) and tax policies (e.g., creating tax credits for COBRA, permanently extending Medical Savings Accounts). Although no coverage expansion policies were enacted, several policies aimed at protecting existing health coverage were signed into law as part of the Trade Act of 2002. This law included a tax credit for COBRA continuation coverage and other specified health insurance for individuals losing jobs due to trade or receiving benefits from the Pension Benefit Guarantee Corporation. It also included funding for state high-risk pools. In addition, Congress passed a temporary extension of transitional medical assistance (TMA).²⁵ This policy extends Medicaid coverage for one year to people losing eligibility due to increased earnings. These policies were designed to maintain coverage for those who would otherwise lose it because of changes in economic circumstances. Neither policy will expand coverage.

Prospects for 2003

From the vantage point of October 2002, it looks unlikely that health coverage expansions will be a top policy priority in 2003. The August 2002 budget outlook, which projected deficits through fiscal year 2005, will likely be worse in January.^{26,27} What resources remain could, if agreement is reached, be devoted to the unfinished business of adding a prescription drug benefit to Medicare. However, renewed concern about health coverage and costs among average Americans and employers may elevate this issue. Not only are the ranks of the uninsured increasing, but the number of dissatisfied, already-insured people is likely to rise. Health care cost pressures are resulting in higher copayments for prescriptions, greater out-of-pocket spending for uncovered services, and higher premiums. The majority of employers report that health insurance, relative to other types of benefits, is their greatest concern. About 60 percent report worrying that health insurance costs will increase faster than the firm can afford.²⁸ Indeed, when comprehensive health reform was debated in 1993, the budget outlook was worse and unemployment was higher than it is today.²⁹ Thus, the issue of access to affordable health insurance may, in 2003, become impossible to ignore.

III. CRITERIA FOR SELECTING POLICIES

The goal of this paper is to provide policymakers with a list of relatively low-cost policies that could break the policy impasse over help for the uninsured. Twelve such ideas are outlined below. They are categorized according to the specific problem or uninsured group that they aim to address. They were chosen for discussion because they met certain criteria intended to make them appealing on both policy and political grounds. These ideas are intended to:

- **Target small but clearly identifiable uninsured groups.** These options focus on relatively small groups of uninsured that lack access to affordable health insurance due to job or family transitions, age, or illness. In addition, these groups are relatively distinct from those who are already insured. This helps limit the potential for “crowd-out,” or displacement of existing coverage with coverage under the new options.
- **Incur relatively low costs.** Although no cost estimates are provided on the ideas outlined below, they are designed to incur relatively low federal budget costs. Generally, they would likely cost below \$1 billion per year, according to the authors’ best guesses. Many would be much lower in cost. Even \$1 billion per year is a small amount relative to what is spent today on Medicare (\$260 billion gross in 2003) and Medicaid (\$270 billion in 2003, including state spending).
- **Cause no harm.** The proposed policies aim to reduce the number of uninsured without eroding coverage or causing other problems in the health system.
- **Build on both public and private insurance systems.** The paper presents a balance of public and private delivery system and financing approaches to coverage expansion.

Since the paper’s goal is to generate additional options and momentum, the policies outlined below are relatively new or are variants of existing ideas. Major policies that have been introduced by members of Congress or the president are described in the Appendix. Policies to improve access rather than insurance coverage (e.g., a tax credit for physicians to treat the uninsured) are not included in the paper to limit its scope. The proposals are geared toward federal health policy but could be adapted to the state level (e.g., substituting the state for the federal employee plan in the buy-in demonstration). Finally, most of the proposals build on the existing insurance infrastructure, compensating for their limited scope by their ability to be implemented quickly.

Rather than providing detailed specifications, the paper includes short sketches of each proposal followed by a discussion of their advantages and disadvantages. Each is prefaced by a description of the aspect of the insurance problem it aims to address as well as existing public policy responses. Information on who may be eligible and approximate costs is provided when possible. The information shown in the figures and tables represents new analysis done for this paper, based primarily on the March 2001 Current Population Survey and 1998 Medical Expenditures Panel Survey.³⁰

IV. OPTIONS

Workers Changing Jobs

Since most Americans get their insurance through their jobs, job change is a major reason why people lose health insurance and become uninsured. In 2001, job loss was the primary reason why most adults were uninsured at some point during the year.³¹

Unemployed adults are uninsured at rates twice that of all adults (37% vs. 18%), yet even those who go straight from one job to the next, without unemployment, are at risk.³²

About 70 percent of workers who were with their current employer for less than six months were not eligible

for job-based health

coverage.³³ Only 8 percent

of adults with the same job throughout the year were

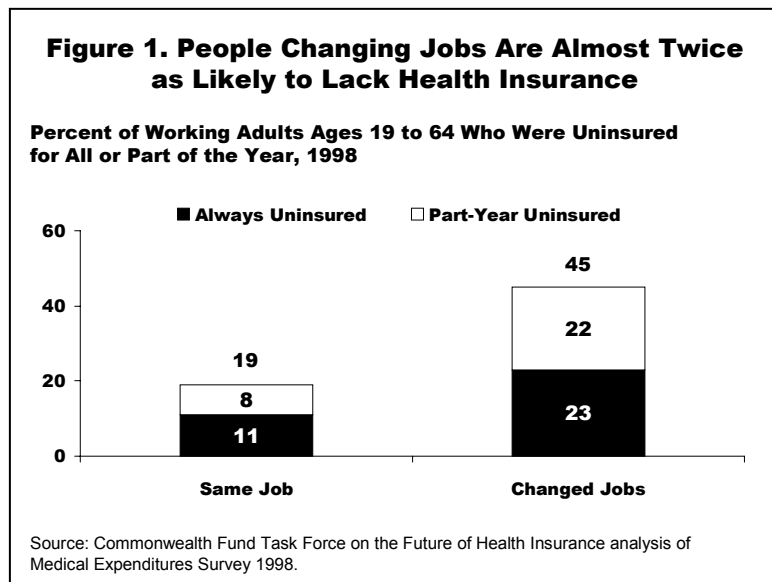
uninsured for part of the year, compared with 22

percent of those changing jobs (Figure 1). Gaps in

health coverage are an important policy issue,

since being uninsured even

for a short period of time can impede access to care.³⁴



Because of this strong link between job loss and health insurance, both federal and state laws have created health options for people between jobs. The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 requires employers with 20 or more employees to provide continued access to health coverage to most workers leaving their jobs. Eligible individuals can purchase this coverage for 102 percent of the premium paid for active employees for up to 18 months in most circumstances. About 38 states have extended COBRA either for a longer period of time or to workers in small businesses.³⁵ In addition, the Health Insurance Portability and Accountability Act (HIPAA) of 1996, among other provisions, guarantees certain people losing group coverage access to individual insurance (or a state-defined alternative) without preexisting condition exclusions.³⁶ As they have with COBRA, several states have gone beyond HIPAA to ensure greater access to health insurance for workers changing jobs.³⁷ One study found that unemployed people with access to COBRA were 19 percent more likely to remain insured than people without access to COBRA.³⁸ However, about one-fourth of workers and their adult dependents who are insured through their jobs do not qualify for COBRA.³⁹

Even if access were improved, the affordability of COBRA and HIPAA coverage remains a problem.⁴⁰ The policies described below aim to fill the gaps in COBRA and make coverage more affordable for certain workers between jobs who are unemployed.

1. Extending access to COBRA continuation coverage to all workers.

One way to improve access to health insurance for workers between jobs is to extend COBRA continuation coverage to all workers losing job-based health coverage. This proposal would ensure that all insured workers, regardless of firm size or location, could purchase health insurance from their previous employer for up to 18 months. It would build on existing “mini-COBRA” laws in most states and have negligible federal costs.

Claims experience suggests that COBRA participants are more expensive for employers to cover than are average workers, and thus small businesses may, under this policy, see their overall premiums rise.⁴¹ This could cause concern at a time of generally high health care costs and a declining rate of small firms’ offering health coverage. However, these concerns have been overcome in most states with no appreciable effect on access to group coverage for active workers. Additionally, filling this gap in access to continuation coverage facilitates the passage of larger policies to make such coverage affordable (e.g., a COBRA tax credit).

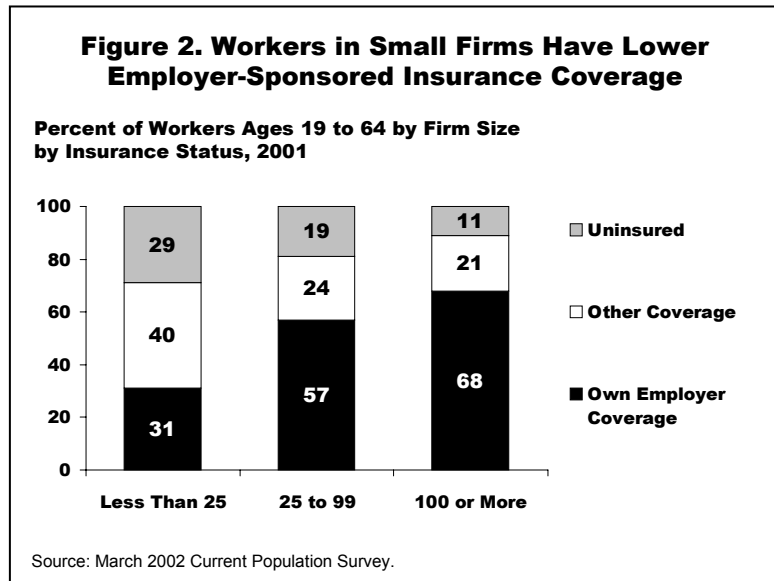
2. Adding health insurance assistance to unemployment insurance. This proposal would give states an enhanced federal matching rate for providing time-limited Medicaid/CHIP coverage to low-income people receiving unemployment benefits. Under this option, individuals receiving unemployment insurance would automatically receive a mail-in application to determine their annualized family income. Eligible individuals would be enrolled in Medicaid or CHIP (depending on their income). States would, when feasible, pay for COBRA premiums for those workers eligible for such coverage. Participants with higher income (e.g., 150% of poverty) would pay a premium based on a sliding scale, similar to CHIP. Coverage would last for six months and could be renewed for an additional six months if the individual remains unemployed. Massachusetts provides similar assistance through its Medical Security Program, and a broader option was included in an economic stimulus bill passed by the Senate Finance Committee in 2001.⁴² According to the Congressional Budget Office, the Senate plan would help about 1 million people at a federal cost of \$1.8 billion for fiscal year 2002.⁴³ The proposed option would likely cost less because, among other differences, it would provide six rather than 12 months of coverage.

Extending Medicaid to unemployed individuals faced opposition in the context of the economic stimulus debate due to its reliance on a public program (rather than on

private insurance, as advocated by some) and its federal and state costs.⁴⁴ However, the proposed policy is narrower and the need for it has grown since high unemployment has persisted. It would use existing eligibility and delivery systems to make health coverage affordable as well as accessible. It also would have lower costs than a COBRA subsidy or a broad-based Medicaid expansion to all low-income adults.

Workers in Small Businesses

Small employers typically pay higher and more volatile premiums for less generous health insurance than do employers in large firms. This is because their leverage is lower, administrative costs higher, and employee turnover greater. As a result, the majority of uninsured workers are employed by small firms. In 2001, workers in small firms (less than 25 workers) were nearly three times as likely to be uninsured as workers in firms with 100 or more workers (29% vs. 11%) (Figure 2).⁴⁵ Workers in small businesses have been disproportionately affected by the slow economy and the return of high health costs. Fewer small firms are offering coverage and fewer workers in small businesses are getting coverage through their jobs.^{46,47}



Public policy has attempted to make health insurance more affordable for small businesses, but few ideas have worked to date. Some policy options have provided subsidies to small businesses or their workers to increase coverage. Others have promoted collective purchasing by small firms in an effort to reduce costs. Analyses of such efforts suggest that they may increase the choice of plans for small businesses, but they do not necessarily increase coverage.⁴⁸ Rather than encouraging small businesses to offer coverage themselves, the ideas below test two alternatives. The first allows small businesses to enroll their workers in health plans contracting with a much larger employer—the federal government. The second eliminates the role of small businesses altogether and allows workers to access subsidized coverage through the individual market. Because these ideas target a large group of uninsured people and could potentially increase premiums for people already insured, they are proposed as demonstrations.

3. Testing a Federal Employees Health Benefits Program buy-in through a demonstration. This proposal would create a demonstration project that allows small businesses to enroll their workers in the Federal Employees Health Benefits Program (FEHBP). FEHBP currently provides health insurance to 9 million people, through more than 180 health plans.⁴⁹ Like other employers, the federal government negotiates rates and benefits for its employees on an annual basis. This proposal would allow a select number of small businesses that did not previously offer health coverage to access local plans at the same rates as federal workers. To participate in this voluntary program, small businesses would make the same minimum contribution towards this coverage as does the federal government. This could be coupled with a tax credit, like that enacted in the Trade Act, to make this coverage more affordable. These workers could be added to the same risk pools as federal employees or insured through a separate risk pool. In either case, federal funding would compensate insurers if the actual costs of new participants exceed the average premium for federal workers. Federal funding would also be needed for the administration of this demonstration and an evaluation. To assess whether the buy-in increases access to coverage for small business workers, coverage levels would be compared with coverage in similar communities without the option. Also, the claims experience of these participants would be compared with that of federal employees to assess the effects of broadening access to this coverage. The federal costs of this demonstration would depend on its scope, duration, and the extent of its use of tax credits.

Probably the greatest potential concern about this demonstration would be that, despite its safeguards, it would result in higher premiums for federal workers. This effect could be avoided altogether by creating a separate risk pool for demonstration participants. As with any demonstration, local issues may arise (e.g., local small business insurers and agents may object to it).⁵⁰ On the other hand, this proposal would test an idea—expanding FEHBP—that has been suggested for years as a way to extend coverage to uninsured Americans.⁵¹ It would also allow for a comparison of two equally subsidized but different delivery system options if combined with the individual insurance tax credit demonstration described below.

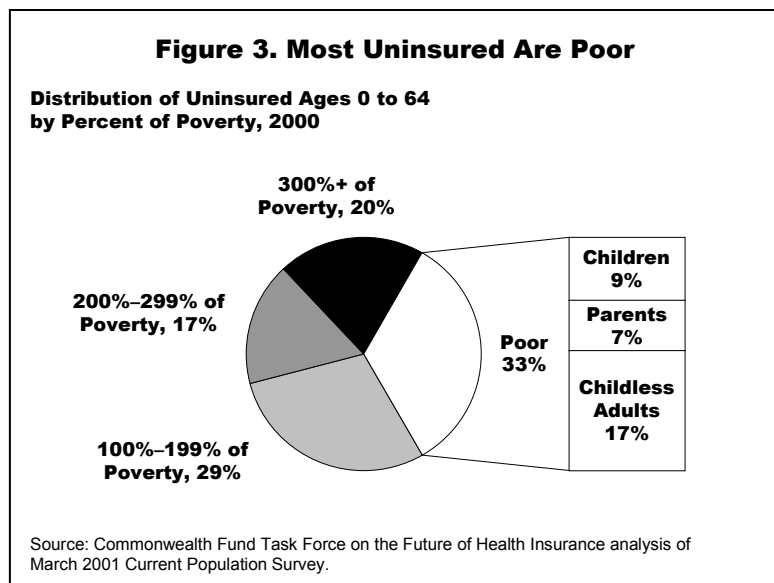
4. Testing an individual insurance tax credit through a demonstration. The president, among others, has proposed to subsidize individual health insurance for workers without access to employer-sponsored coverage. This proposal would create a demonstration project to assess whether this policy achieves its goal without causing unintended consequences: namely, the erosion of employer-based or public coverage. A competitive process would be established to allow states or large cities in areas with different markets to participate in this time-limited option. A specified number of self-employed individuals and workers in small businesses not offering coverage would qualify

for a tax credit that is refundable, available when needed, and a significant, fixed percent (e.g., 65% to 75%) of premiums. Its value would be phased out using the same schedule as the president’s plan (so that it is fully phased out at \$30,000 for individuals and \$60,000 for couples), and it would apply to insurance with a minimum benefit package and meaningful consumer protections (e.g., guaranteed issue, no preexisting condition exclusions, no underwriting). To evaluate its results, surveys of workers and small business owners would be conducted before and after the demonstration. The study would, at least, document the number, proportion, and type of participants, the insurance options available to participants, and employer behavior (e.g., whether new and existing small business owners scaled back their insurance coverage). Because it is a demonstration, federal costs and enrollment would be determined by its design parameters.

In addition to the local concerns caused by demonstrations (as in the federal employees’ plan demonstration), an individual tax credit demonstration would be perceived by some as a backdoor way of creating a national policy. This concern stems from the experience with the Medical Savings Accounts (MSAs) demonstration. Despite its low participation and limited evidence of success, proponents are seeking to expand and extend MSAs (see Appendix for details). However, the disagreement over the effects of an individual tax credit has been largely responsible for the impasse over policy for the uninsured. A well-designed and evaluated demonstration could provide evidence that supports or disproves the claims and criticisms of the individual insurance tax credit. In addition, the demonstration could provide valuable lessons on structuring any tax-based proposal to help the uninsured.

Low-Income People

Although a growing number of uninsured have middle-class incomes, a significant proportion of the uninsured are poor.⁵² Fully one-third of the uninsured have incomes below the poverty threshold and another 29 percent have incomes between 100 and 200 percent of the poverty level (Figure 3). Of these 12.7 million uninsured poor people, 3.4 million are children, 2.8 million are their parents, and



6.6 million are childless adults. Lack of health coverage for people in poverty has potentially severe consequences. Research has linked the lack of insurance to poor health and, in turn, has linked poor health to lower earnings and educational attainment.⁵³

In the United States, only children are guaranteed access to health coverage when they are poor. Medicaid covers children under age 6 with family income below 133 percent of poverty and children ages 6 to 18 with family income below 100 percent of poverty. Low-income parents may be covered through a Medicaid option, but only about 20 states have extended eligibility to all poor parents.⁵⁴ Childless adults can only be covered in Medicaid or CHIP through demonstration waivers. Such demonstrations have traditionally been budget-neutral, constraining the ability of states to significantly expand coverage using this approach.⁵⁵ The option below represents a broad approach to helping low-income people; an alternative approach would be to target specific subsets of low-income people for coverage (e.g., Native Americans, people with certain illnesses, such as cancer or HIV/AIDS).

5. Gradually phasing in public coverage for poor adults. This proposal would provide options and incentives for states to raise the income eligibility limits in Medicaid for adults with incomes below the poverty threshold. To create an incentive for states to expand coverage, the federal government would gradually assume a greater percentage of the Medicaid costs for people dually eligible for Medicare and Medicaid. In return, states would commit to a phase-in schedule for expanding eligibility to poor adults. This phase-in could be structured in a number of ways. For example, it could raise the existing income eligibility limits for parents by a fixed amount annually (e.g., adding 5 percentage points to states' current upper-income eligibility limits) and, once all poor parents are covered, phase in eligibility for childless adults. Alternatively, it could start with childless adults, first raising their eligibility up to the levels of low-income parents and then raising the eligibility limits for all adults simultaneously. Under a third approach, each state would have a different phase-in schedule, so that the percentage increase is calibrated to increase costs by no more than a certain amount (e.g., 5 percent of existing Medicaid costs). As with the individual tax credit demonstration, this proposal provides subsidies for coverage and thus has costs. The federal government's cost would include both the federal share of poor adults' coverage as well as the increased federal share of dual eligibles' coverage. The state costs of this expansion would be partly or, if so designed, fully offset by the increased federal share of dual eligibles' costs. Federal and state costs would depend on the phase-in schedule and could be designed to be relatively low.⁵⁶

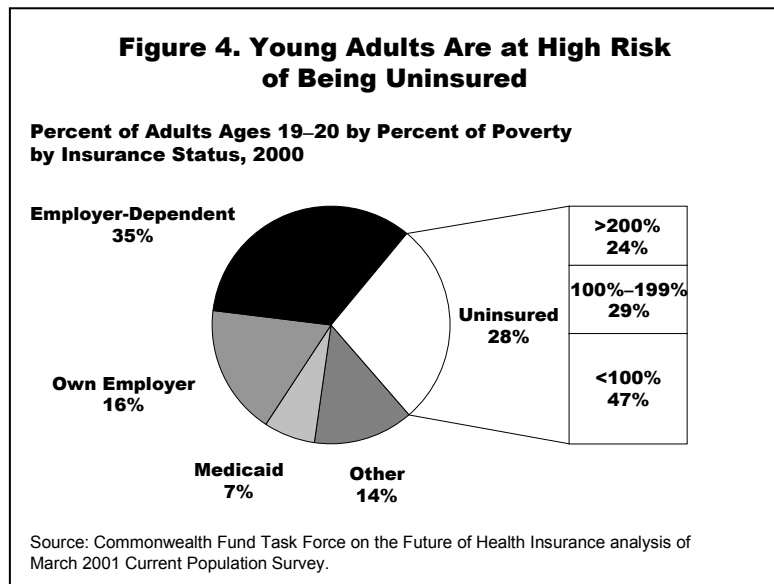
Even as an option with additional funding, some states would likely object to this proposal for fear of its cost liability. Other policymakers may argue that poor adults should be insured through different delivery systems (e.g., individual health insurance with tax credits). That said, extending Medicaid for people in poverty is among the most efficient proposals for insurance expansion since it uses an existing program to cover a group with a high rate of lack of insurance and low access to other types of coverage. Even some advocates of the individual insurance tax credits suggest that Medicaid should be primarily responsible for people with income below the poverty threshold, since their low tax liability poses challenges to administering tax credits.⁵⁷ This option also would move toward a system of increased federal financial responsibility for Medicare beneficiaries, rather than perpetuating the current, bifurcated financing system that relies on Medicaid and states to fill Medicare’s benefit gaps.

Young Adults Aging Out of Children’s Health Coverage

Young adults are in the age group most at risk for lacking health insurance. About 28 percent of 19-to-20-year-olds were uninsured in 2001—over twice the rate of children (12%).⁵⁸ Of those uninsured, nearly half have incomes below the poverty threshold (Figure 4). Entry-level, low-wage jobs often do not offer health insurance.⁵⁹ With a median income that is 40 percent less than that of full-time, full-year workers ages 25 to 44, young adults may also

have greater difficulty affording health coverage.⁶⁰

Yet, young adults are not without health risks. One study found that half of low-income, uninsured adults ages 19 to 29 reported that they went without needed health care, and two-thirds reported not being able to pay a medical bill or being contacted by a collection agency.⁶¹



Both public and private health insurance policies contribute to this problem. Many children lose coverage through their parents’ employer plan when they turn age 19. Most insurers allow older children to be considered dependents on their workers’ policies—but only if they are attending college on a full-time basis. Only about one-third of people ages

19 to 23 attend school full time.⁶² In addition, Medicaid and CHIP do not currently include the state option to cover low-income, young adults unless they are eligible through some other category (e.g., as pregnant women, people with disabilities).⁶³ As a consequence, the proportion of 19-to-20-year-olds covered by Medicaid is 7 percent—well below the rate for those under age 18 (17%).⁶⁴ The two policies described below aim to extend the eligibility limits of programs that cover children to reduce the high rate of young adults who are uninsured.

6. Extending private plans' dependent coverage up to age 21. This proposal would require issuers of health insurance to define dependent coverage to include all unmarried children under age 21 at a minimum. Employers would not have to contribute to this coverage (there are no minimum employer contribution requirements today) and it could be structured like a rider to prevent the family coverage premiums from reflecting this new cost. Allowing older dependents to remain on their parents' policies is not without precedent; all members of Congress and federal employees have that option today. This would have negligible federal costs.

This proposal could have the effect of increasing the cost of family coverage. Although in general young adults have low health care costs, some participants may have health problems that prevent them from finding affordable, underwritten policies in the individual insurance market and would likely take this option. However, the weak job market coupled with a growing number of young adults living at home suggest that this proposal could help a larger than expected number of people. In 2000, over half of men ages 18 to 24 and 43 percent of women in this age group lived with their parents; only a small fraction of these young adults were married.⁶⁵

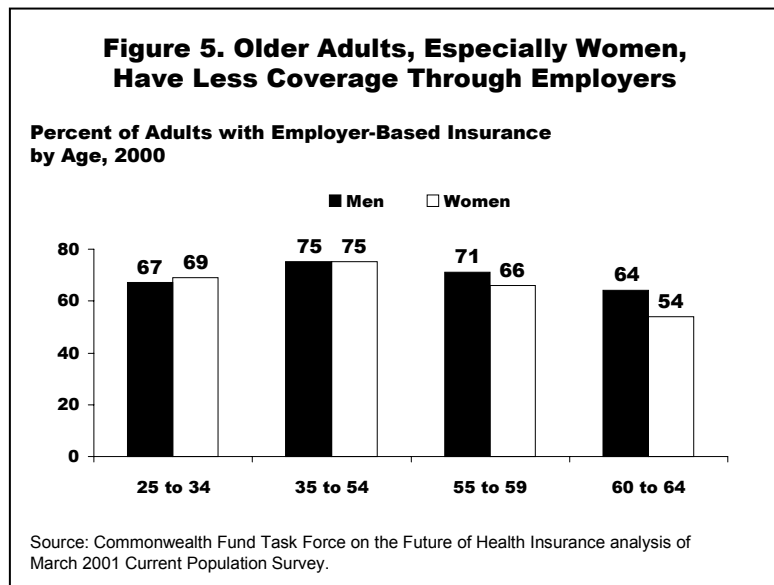
7. Extending Medicaid/CHIP options up to age 21. In the same way that Medicaid extends coverage to those losing eligibility due to increased earnings through transitional medical assistance, Congress could allow states to extend coverage to those losing eligibility due to increased age. A new option could be created in Medicaid and CHIP to allow children already in these programs to maintain that coverage until they become age 21. Alternatively, this coverage could be extended as a requirement, like transitional medical assistance. To mitigate against sudden cost increases, this coverage could be phased in using the same formula used to phase in coverage of children: extending age eligibility one year at a time. A similar proposal was estimated by the Congressional Budget Office to cost about \$100 million per year and increase enrollment by about 10,000.⁶⁶

Given the high percent of uninsured young adults with low incomes, this policy would be an efficient way to reduce the extremely high rate of lack of coverage among this age group. In addition, it could be a valuable option for states that have excess to CHIP allotments. Rather than returning funds to the federal government for redistribution, states could use them to continue health insurance coverage for these young adults.

Older People Losing Access to Job-Based Coverage

Although older Americans’ rate of lack of health insurance is relatively low, it has been gradually rising and will likely accelerate in the near future.⁶⁷ Beginning last year, the baby boom generation started turning age 55, which will swell the number of uninsured in this age bracket. In addition, access to employer-based coverage has been declining. In 2002, only about one-third of firms offered retiree coverage, down from 66 percent of firms in 1988.⁶⁸ Older Americans’ lower access to retiree health coverage, coupled with their weaker attachment to the labor force, has resulted in a significantly lower rate of employer-based coverage

among adults ages 60 to 64 (Figure 5). Older women are particularly vulnerable because of their frequent reliance on their spouses for coverage. One study found that one of 10 married women ages 50 to 70 became uninsured when their husbands turned age 65, retired, and gained Medicare coverage.⁶⁹ In fact, older women are



20 percent more likely to be uninsured than older men.⁷⁰ These challenges in maintaining coverage coincide with an increased risk of health problems and greater incidence of health costs. One study found that nearly half of older uninsured individuals (46%) either could not pay a medical bill or were contacted by a collection agency due to medical bills.⁷¹ Another study found that uninsured, older adults were nearly twice as likely to experience a major decline in overall health as were continuously insured older adults.⁷²

Few public policies have specifically addressed the access problems of the near-elderly. COBRA continuation coverage is extended from 18 months to three years for certain younger spouses of Medicare beneficiaries. The District of Columbia recently

amended its Medicaid demonstration waiver to make uninsured people ages 55 to 65 eligible for coverage. Less directly, states have regulated the individual insurance market to make it more accessible and affordable to older adults, who disproportionately rely on it.⁷³ Similarly, state high-risk pools likely serve older individuals with low access to group or public coverage. The options outlined below would build on private and public options to improve access for certain older Americans who are particularly vulnerable to becoming uninsured.

8. Extending COBRA continuation coverage for early retirees. This policy would allow early retirees who lack access to retiree health coverage to use COBRA as a bridge to Medicare coverage. Specifically, retired individuals age 60 to 64 and their dependents could purchase COBRA continuation coverage until the retiree turns age 65 and enrolls in Medicare, rather than for the 18 months now provided. To compensate for the higher cost of covering older individuals, COBRA premiums would be set at a higher percent of the average costs for active workers during the extended period (e.g., 125% of average premiums). Because these premiums may be unaffordable for some retirees, a refundable, income-based tax credit could be added to this policy. Without the tax credit, this policy would have negligible federal costs; the cost of the tax credit would depend on its value and income eligibility limits (if any).

In addition to the potential that extending COBRA could raise employer health costs, this policy could be viewed as a substitute for employer-sponsored retiree coverage and thus accelerate the decline in this coverage. Yet, this coverage is already inaccessible to most early retirees, causing them to turn to the individual health insurance market. COBRA premiums would be, for many, more affordable than premiums in the individual insurance market, especially if accompanied by a tax credit for lower-income retirees.

9. Creating a Medicare buy-in for younger spouses of Medicare beneficiaries. This proposal would allow younger spouses of Medicare beneficiaries to buy into the program. Eligibility would be extended to people ages 60 to 64 that lose employer-sponsored dependent coverage because their older spouses have retired and enrolled in Medicare. Similar to other Medicare buy-in proposals, individuals would pay a premium that equals the average health costs of people in their age group; a risk premium to offset any above-average costs of buy-in participants would be added to their Medicare premium once they turn age 65. The Medicare buy-in for spouses would have low federal costs since it is essentially self-financed through enrollees' premiums.⁷⁴

Previous Medicare buy-in proposals generated concerns that there could be inevitable pressure to heavily subsidize the option and that it could induce early retirement, creating an added draw on Social Security and reducing income taxes.⁷⁵ This specific plan could be criticized as discriminatory since it helps only married people. However, because married couples are often insured through the work of one spouse, the retirement of that spouse could cause the other to become uninsured—a situation not faced by single adults.⁷⁶ In addition, studies have found that fully insured families are more likely to use appropriate health care.⁷⁷ The same effect could hold true for older adults under a policy that keeps the older couple's insurance intact, especially since women tend to manage the health care for the family.

People with Health Problems Limiting Access to Private Coverage

People with some type of accident or illness, a history of illness, or a chronic health problem need health care services the most and consequently are the most costly and least desirable to insurers. According to one study, 60 million nonelderly adults had at least one chronic condition and, of that group, over 7 million were uninsured in 1999.⁷⁸ This is roughly one-fourth of uninsured adults. One of eight women in the United States is likely to develop breast cancer at some point in her lifetime.⁷⁹ Many other Americans have some type of health problem or behavior that could limit access to private insurance. The Surgeon General recently reported that more than half of American adults are overweight, and nearly one of four adults smoke—risk factors for worse health outcomes.^{80,81}

A patchwork of insurance options exists for people who have some type of health problem. In the private market, HIPAA allows certain people losing job-based insurance to maintain access to health coverage without preexisting condition exclusions. However, for people with serious health conditions, this access may be undermined by unaffordable premiums, since HIPAA does not regulate premiums.⁸² Some states have gone beyond HIPAA to provide greater protections for people with preexisting conditions, including rate regulation.⁸³ Public programs also provide assistance to those with chronic or other illnesses, but these protections have gaps as well. Medicaid typically only covers adults with an illness or disability so severe that it impoverishes them or prevents them from working.⁸⁴ Recent legislation broadened eligibility to people with disabilities who are working and certain uninsured women with breast or cervical cancer.⁸⁵ However, there is no general Medicaid option for individuals who have difficulties accessing private coverage (e.g., those with cancer, multiple sclerosis, or diabetes). Medicare provides coverage to people receiving Social Security Disability Insurance (SSDI), but only after a 24-month waiting period.⁸⁶ In addition, some 30 states have high-risk pools, but they enroll only about 110,000 people—a small fraction of those in the individual market.⁸⁷

Many high-risk pools have waiting lists, limited benefits, high deductibles, and high premiums.⁸⁸ The two policies below extend public programs' reach to help additional high-risk individuals.

10. Allowing Medicaid to act as a high-risk pool. This proposal would create a new Medicaid option for high-risk, low-income people. States would develop their own definition of illness or disability for the purposes of Medicaid eligibility. To gain access to federal funding, this definition would be approved by an independent committee, nominated by administration, congressional, and state officials, to ensure that it is neither too broad and thus costly nor easily gamed by insurers or individuals (e.g., individuals who pay insurers to be deemed “uninsurable” in order to access this coverage). Eligible individuals would receive the states' Medicaid benefits and could, if their income is above a certain level, be charged a premium consistent with other Medicaid and CHIP options. To facilitate funding for this coverage, federal law would be clarified to allow states to use revenue from private insurance assessments as the state contribution to coverage. This type of funding is common for high-risk pools since private insurers benefit when the government pays for care for these individuals.⁸⁹ The proposal could also, for the purposes of funding for this option, allow states to assess Employment Retirement Income Security Act (ERISA) plans as well as other insurers. Using Medicaid as a high-risk pool is not unprecedented; Tennessee rolled its high-risk pool into its Medicaid demonstration program. Prior to recent changes, individuals who were denied private health insurance were eligible to buy into Medicaid.^{90,91} In 2001, about 94,000 “uninsurable” individuals were enrolled in TennCare—nearly as many people enrolled in all other risk pools nationwide.⁹² Using Medicaid rather than a high-risk pool would ensure enrollees an adequate benefits package, no waiting list, and affordable premiums and cost-sharing. From a state perspective, it would secure federal financing of at least half of program costs.

Although Medicaid already covers some of the sickest Americans, extending its reach to more people with health problems could worsen the program's financing problems. Some could argue that this option would create a cost shift to taxpayers from private insurers who should be shouldering their fair share of the costs of people with health problems. In addition, this option could exacerbate the tensions over Medicaid's identity: is it intended to be a safety net for low-income people or a high-risk pool for sick people? However, this option would prevent people with health problems from remaining uninsured until they are so sick and poor that they may qualify for Medicaid. It also provides a more flexible source of financing for a group of people who have or are at great risk of catastrophic health care costs.

11. Gradually phasing down Medicare’s 24-month waiting period.

Medicare covers people whose disability qualifies them for Social Security Disability Insurance (SSDI)—but only after they have received SSDI for 24 months. This waiting period was imposed in 1972, when this coverage class was created, to reduce costs. This proposal would eliminate the arbitrary waiting period by gradually reducing it one or several months at a time. The amount of Medicare costs associated with this policy would depend on the speed with which the waiting period is eliminated. It would have some offsetting federal and state Medicaid savings since some eligible individuals are also eligible for Supplemental Security Income (SSI) and thus Medicaid.⁹³ An alternative approach to this uniform, gradual reduction of the waiting period would be to eliminate it immediately for subgroups of beneficiaries (e.g., those with multiple sclerosis, Alzheimer’s disease, or other degenerative diseases).⁹⁴

In addition to its cost, this policy could raise questions about its goal, since most of those qualifying for SSDI already have health insurance.⁹⁵ Increasing access to Medicare could also be viewed, by some, as an additional incentive for enrollment in SSDI—a program whose rolls have been rising rapidly in the absence of this change.⁹⁶ However, the waiting period is nothing more than a historical artifact that has the potential to cause some individuals to remain uninsured even though they are deemed too ill to work.

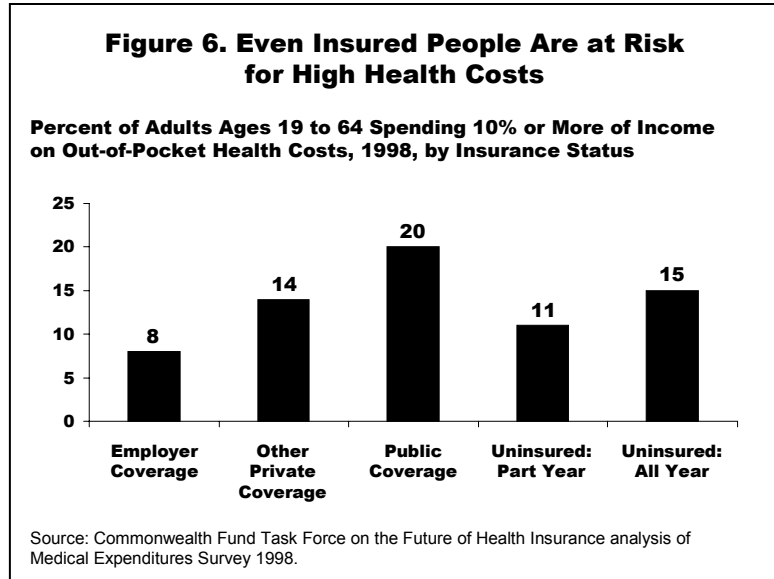
Insured People Who Are at Risk of Becoming “Underinsured”

The current period of high health care costs has led to concern about “underinsurance” in addition to lack of insurance. Many employers and insurers, rather than maintaining current benefits and shouldering higher premiums, are moderating their own premium costs through higher cost-sharing and reduced benefits. A recent survey found that, in 2001, one-third of working adults with employer-sponsored insurance faced higher deductibles or copayments or had reduced benefits compared with the previous year.⁹⁷ A survey of employers found that the average deductible for preferred provider organizations increased by 37 percent between 2001 and 2002 alone.⁹⁸ Although some argue that these changes are intended to encourage people to use fewer services and more cost-effective care, others contend that they could impede access to appropriate health care. For example, a simple, high-deductible, catastrophic coverage plan may limit use of valuable primary care that could improve health and reduce costs in the long run, while permitting waste by covering any service—regardless of its merits—after the deductible is met. These changes also have economic consequences. Among people continuously insured in 2001, 28 percent of middle-income people and 47 percent of low-income people reported having some problems paying medical bills or an access problem due to the cost of care.⁹⁹

Nearly one of 10 individuals with employer-sponsored health insurance still spent at least 10 percent of their income on out-of-pocket health care costs (Figure 6).

Public policy has had to address, in various venues, the challenge of developing standards for health coverage. Private health benefit mandates,

at the federal and state level, have accumulated to ensure coverage of specific services. In public programs, there have been different but equally challenging issues. Medicare's benefit package still looks more like private insurance in 1965 than in 2002. Major policy debates have resulted over attempts both to increase coverage of medically appropriate services (e.g., prescription drugs, certain technologies) and reduce beneficiaries' excessive cost-sharing liability (e.g., Medicare's \$840 hospital deductible). Similarly, elements of Medicaid's benefit package have been controversial. For example, states have objected to the requirement that they cover all medically necessary services for eligible children.¹⁰⁰ The Administration has waived Medicaid's cost-sharing limits and reduced its benefits in state demonstration projects, raising concerns among advocates about access to care.¹⁰¹ In addition, it is arguable that developing CHIP's benefit standards was the most difficult issue in the creation of this program.¹⁰² Practice guidelines—evidence-based standards for what should, and should not, be practiced—have not been widely used to determine public policy related to health benefits.



12. Creating a national health coverage advisory commission. This proposal aims to reduce underinsurance by creating a commission to promote medically and financially sound guidelines for health insurance. Congress would create a national health coverage advisory commission that has two panels. The first panel would be composed of economists, health services researchers, insurance experts, consumers, and others with the specific goal of assessing ways of defining the minimum value of health insurance and, conversely, limits on what individuals should pay in premiums and cost-sharing to prevent underinsurance. The second panel would include health care providers, health services researchers, experts from the National Institutes on Health, consumers, and

others who would create a process for identifying and incorporating sound practice guidelines into coverage recommendations. Both panels would develop joint recommendations and report to Congress on an annual basis on guidelines for coverage. The commission would also recommend specific steps that could be taken to integrate recommendations into public and private insurance policies. This commission would have negligible federal costs.

Developing guidelines for insurance is inherently controversial. The science of both medicine and economics leaves room for disagreement about what is the most appropriate type of treatment and amount of cost exposure. Moreover, recommendations by this commission would have major implications for all payers and providers of care, especially when a particular service or type of cost-sharing is not recommended. That said, decisions about the scope of health insurance coverage are often made on a more or less arbitrary basis. Having a commission would likely improve the quality of the research since practice guidelines would serve as more than an educational tool for providers. Moreover, improving the definition of health coverage also would allow for a better assessment of the adequacy of coverage in the United States. It is possible that many people who report that they are “insured” may have neither the cost protection nor the access to recommended services that is needed to ensure good physical, mental, and financial health.

V. DISCUSSION

The breadth of choices for addressing the problem of the uninsured is considerable. Some options are outlined above, others are listed in the Appendix, and still others have been proposed over the years by state and federal policymakers, health policy experts, researchers, providers, and consumers. Rather than providing an exhaustive list, this paper describes a set of incremental health insurance expansion proposals that have the potential to cross the chasm between ideas and action. They are similar in that they all are “small”—meaning targeted and low cost. The set of options includes a balance of approaches: five build on public programs, five on private insurance systems, and two on both public and private insurance (Table 1). They differ in the aspect of the coverage problem addressed, the groups targeted, and their primary objectives, among other characteristics. To give a sense of these differences, the policies are characterized below by how well they respond to questions typically asked by policymakers evaluating their support for policies.

Table 1. Structure of Options

	Problem Addresses				Approach
	Access to Job-Based Coverage	Job & Life Transitions	Access Due to Health	Affordability	Private Insurance System
PROPOSALS					
Workers changing jobs					
1. Extending access to COBRA continuation coverage to all workers	✓	✓			✓
2. Adding health insurance assistance to unemployment insurance		✓			Both Public & Private
Workers in small businesses					
3. Testing a Federal Employee Health Benefit Plan buy-in through a demonstration	✓			✓	✓
4. Testing an individual insurance tax credit through a demonstration				✓	✓
Low-income people					
5. Gradually phasing in public coverage for poor adults				✓	
Young adults aging out of children's coverage					
6. Extending private plans' dependent coverage up to age 21	✓	✓			✓
7. Extending Medicaid/CHIP options up to age 21		✓		✓	
Older people losing access to job-based coverage					
8. Extending COBRA continuation coverage for early retirees	✓	✓	✓		✓
9. Creating Medicare buy-in for younger spouses of Medicare beneficiaries		✓	✓		
People with health problems limiting access to private coverage					
10. Allowing Medicaid to act as a high-risk pool			✓	✓	
11. Gradually phasing down Medicare's 24-month waiting period		✓	✓	✓	
Insured people at risk of becoming "underinsured"					
12. Creating a national health coverage advisory commission			✓		Both Public & Private

Source: Authors' analysis.

What Problems Do They Address?

Since the policy options presented in this paper are designed to have low costs, they generally address the issue of access to insurance, although a few provide financial assistance for coverage. The problems they address can be classed into four groups:

- **Access to job-based coverage.** The federal employee health plan demonstration would provide certain small firms with access to the same health insurance that workers for the federal government receive. Extending COBRA and dependent coverage would maintain access to the same job-based health insurance that these workers in small firms, early retirees, and young adults had prior to losing their eligibility.
- **Job and life transitions.** Extending COBRA and providing a Medicaid/CHIP option for unemployed people would help reduce the large number of Americans who have some gap in coverage due to job change. In addition, aging—both from childhood to adulthood and from adulthood into old age—creates problems accessing affordable group health coverage. Extending private plans' dependent coverage, Medicaid/CHIP for young adults, and COBRA for early retirees, as well as providing a Medicare buy-in for younger spouses, would help those with age-related access problems. In addition, gradually phasing down the 24-month waiting period for Medicare would eliminate a transition problem created by public policy itself.
- **Health problems limiting access to private coverage.** A different type of access problem results when individuals' health status or risk makes them unattractive to private health insurers. Reducing Medicare's 24-month waiting period, creating a Medicaid high-risk pool, and improving coverage options for older Americans who are at particular risk for developing health problems could ameliorate this problem. In addition, developing a strong medical and financial basis for health insurance coverage would prevent less healthy but already-insured people from experiencing significant uncovered cost liabilities and reduced access to appropriate care.
- **Affordability of coverage.** Several of the policies would make health coverage more affordable. In particular, phasing in poverty-related coverage in Medicaid would provide subsidized health coverage for those who can least afford it. Similarly, the incremental proposals to extend Medicaid/CHIP to young adults, people with high health costs, and the unemployed all address both access and affordability, as does phasing down the Medicare waiting period for people with disabilities. The small business demonstrations would both provide tax credits to improve affordability.

Which Groups Will Be Helped?

Aside from the individuals explicitly targeted by the proposals, policymakers may be interested in how each policy affects specific groups (Table 2). Groups of people often of interest to policymakers include:

- **Middle-class Americans.** Some of these options would help the growing number of middle-class people with health insurance problems. Specifically, the federal employee health plan buy-in demonstration for workers in small businesses and policies for older workers would target groups of uninsured that have higher incomes.¹⁰³ Moreover, since the premiums for these policies are not heavily subsidized, most participants would likely be in the middle class. In addition, the national coverage commission would appeal to already-insured people who are concerned about the stability and adequacy of their health coverage.
- **Women.** The policies to help older adults—the Medicare buy-in for spouses and the extension of COBRA for early retirees—could disproportionately help women who represent nearly three out of five older, uninsured people. In addition, the policy to phase in poverty-related Medicaid coverage would benefit women who represent a slightly larger share of uninsured people with income below the poverty threshold. The national health coverage advisory commission might have a particularly large impact on women, who tend to need and use more health care services than men.¹⁰⁴
- **Racial and ethnic minorities.** Generally, racial and ethnic minorities comprise 24 percent of all uninsured Americans, so that most policies to reduce the number of uninsured would help them.¹⁰⁵ In particular, policies to extend coverage to unemployed and low-income adults are likely to help racial and ethnic minorities given their economic status.
- **Rural residents.** Rural uninsured people tend to be older, to work in small businesses, or to be unemployed. As such, they would benefit from the Medicare buy-in for younger spouses, extended COBRA options, the Medicaid/CHIP option for those temporarily unemployed, and the demonstration ideas for workers in small businesses.

Table 2. Who Is Potentially Helped by the Options

PROPOSALS	Percent of All Nonelderly Uninsured	Among Uninsured in Group (Percent Distribution)*			
		Middle Income**	Women	Minority	Rural
Unemployed adults	5%	25%	38%	32%	21%
– COBRA continuation coverage for all workers					
– Medicaid option for temporarily unemployed					
Workers in small businesses	28%	47%	37%	17%	20%
– Federal employees’ plan demonstration					
– Individual insurance tax credit demonstration					
Adults with income below the poverty threshold	33%	N/A	52%	29%	17%
– Gradually phasing in coverage of poor adults					
Young adults ages 19–20	6%	22%	49%	26%	16%
– Extending dependent coverage up to age 21					
– Extending Medicaid/CHIP up to age 21					
Older adults ages 60–64	4%	45%	59%	20%	22%
– COBRA continuation coverage for early retirees					
– Medicare buy-in for younger spouses of retirees					

* For reference, among all nonelderly Americans, 50% are women, 68% are middle income, 19% are minorities, and 18% are rural residents.

** “Middle income” is defined as having family income above 200% of the federal poverty level (\$36,200 for a family of four in 2002).

Source: Columbia University analysis of the March 2001 Current Population Survey.

How Does the Policy Balance Issues of Efficacy, Efficiency, and Equity?

Policymakers have long been concerned with the trade-offs inherent in different options to cover the uninsured. Recently, policy analysts have characterized some of these trade-offs as the balance between a policy’s effectiveness, efficiency, and equity.¹⁰⁶

- **Effectiveness.** The policies in this paper that may be most effective at covering the uninsured include those that improve both access to and affordability of health coverage. Generally, the Medicaid/CHIP expansions meet this criterion. However, since they are all structured as state options, they are only as effective as states’ willingness to adopt them.

- **Efficiency.** The most efficient policies (defined as those with a high percent of participants who were previously uninsured) would likely be the Medicaid/CHIP option for young adults and the phase-in for poor adults, since these options target groups least likely to have alternative forms of coverage. In addition, the tight eligibility rules for the Medicare buy-in for spouses and small business demonstrations may lead to efficiency.
- **Equity.** The term “equity” suggests that the policy treats people within a particular group similarly. Extending COBRA would provide all workers with the opportunity for continuation coverage, regardless of firm size. Phasing in Medicaid coverage for poor adults would result in eligibility based solely on income, rather than age or marital status. In addition, extending dependent coverage to all young adults to age 21 at a minimum would remove the current preference given to those attending college on a full-time basis.

Conclusion

Small policies cannot cure the myriad problems in the health insurance system in the United States. Solutions will require both significant new funding, since affordability is a major problem, and insurance and delivery system reform, to remove the structural barriers to coverage. The ideas presented in this paper represent a sample of ideas that could be considered in addition to those that have been proposed in Congress and by state officials, researchers, providers, and consumers. They are not incompatible with larger visions for the health system, nor are they intended to substitute or delay action on major reforms. Instead, they aim to break the recent impasse on policy for the uninsured and to make some, albeit limited, progress on reducing the number of uninsured Americans. Success in passing and implementing incremental health policies may, rather than diverting attention away from systemic reform, instill confidence in public policy’s ability to take on the larger challenges in improving health insurance coverage in the United States.

APPENDIX. POLICIES TO ADDRESS THE UNINSURED IN THE 107TH CONGRESS

Proposals Enacted into Law

1. Trade Act of 2002 (H.R. 3009, P.L. 107-210). The Trade Act of 2002 included several health coverage provisions. It provides a 65 percent refundable tax credit available in advance of the annual tax refund for qualified health insurance for workers displaced by the effects of trade laws. Qualified health insurance includes COBRA continuation coverage, various state-based coverage options (e.g., state employee coverage), and, under limited circumstances, individual health insurance. The same tax credit was also extended to individuals ages 55 to 64 who are receiving Pension Benefit Guarantee Corporation (PBGC). This tax credit will cost an estimated \$4.6 billion over 10 years and help approximately 140,000 people.¹⁰⁷ The law also includes \$100 million for the creation and subsidization of state high-risk pools, and \$60 million for other health insurance assistance.

Proposals Passed in a Committee or Floor Vote

2. Tax credits for COBRA (Versions were included in the 2001 and 2002 versions of the Economic Security and Workers Assistance Acts, H.R. 622, 3090). Several bills that were proposed after September 11 to stimulate the economy included temporary, refundable tax credits for workers losing their jobs and health insurance. The proposals differed on the amount of the credit (from 60 to 75 percent) and the type of insurance to which the tax credit could be applied (COBRA only or COBRA plus individual health insurance). A 75 percent COBRA subsidy (accompanied by a Medicaid option to wrap around the tax credit for low-income unemployed people) would cost an estimated \$7 billion and help about 5.1 million people according to the Congressional Budget Office (CBO).¹⁰⁸ The version that has a 65 percent credit but allows a much broader use of the credit would result in \$15.8 billion in revenue loss, according to the Joint Committee on Taxation.¹⁰⁹

3. Medicaid/CHIP options for legal immigrant children and pregnant women (Immigrant Children's Health Improvement Act, in H.R. 4737). Immigrants to the United States are a group with high rates of lack of insurance. According to one study, nearly half of all recently arrived immigrants are uninsured.¹¹⁰ The welfare reform bill of 1996 prohibited states from extending Medicaid (and subsequently) CHIP to certain legal immigrants. The Senate Finance Committee passed in June 2002 a reauthorization bill for the welfare law (Temporary Assistance to Needy Families [TANF]) that would restore the state option to cover pregnant women and children who are legal immigrants through

Medicaid and CHIP. CBO estimates that this provision would cost \$2.2 billion from 2003 to 2012, and would help 155,000 children and 60,000 pregnant women in 2003.¹¹¹ No such provision was in the House version of welfare reform and the Administration has remained silent on this issue.

4. Transitional Medical Assistance extension and simplification (in H.R. 4737).

For many people, returning to work can mean a loss of health coverage through Medicaid. About half of people leaving welfare for work lose Medicaid coverage, and many become uninsured.¹¹² Entry-level jobs are less likely than higher-level positions to offer health insurance; when they do offer insurance, they are more likely to have waiting periods for coverage.¹¹³ In the late 1980s, Congress tackled this problem by creating transitional medical assistance (TMA), which basically requires states to extend coverage to people losing Medicaid eligibility due to increased earnings for up to one year. This provision expired on October 1, 2002, but was temporarily extended through January 2003. The House version of the TANF reauthorization, passed in May 2002, included a one-year extension of TMA. The Senate Finance Committee version, passed in June 2002, included a five-year extension, a state option to extend TMA for a second 12 months, and a simplification of the program to increase participation. The CBO estimates that the House version would cost \$355 million.¹¹⁴ The Senate version would cost \$2.4 billion over 10 years, and would help an estimated 115,000 in 2003 and 260,000 people (full-year equivalents) in 2004.¹¹⁵ The Administration supports a one-year extension.

5. Medicaid buy-in for children with disabilities (Family Opportunity Act, H.R. 600, S. 321). Currently, parents with children with disabilities often have trouble accessing private health insurance. Their children's health care costs typically raise premiums for all workers, especially in small firms, and even with that coverage, needed benefits such as home care, medical equipment, and extensive mental health care may not be covered. In 1999, a law was enacted that allows adults with disabilities to buy into Medicaid when they return to work, but the same policy was not extended to parents of children with disabilities. The Family Opportunity Act allows such families with income below 250 percent of poverty to buy into Medicaid, paying premiums that do not exceed 5 percent of family income. According to the CBO, it would cost \$5.8 billion over 10 years and would help 100,000 children if all states participate.¹¹⁶ It passed the Senate Finance Committee in July 2002 but was not acted on by the full Senate or House of Representatives. The Administration has remained silent on this legislation.

6. CHIP option for pregnant women (Mothers and Newborns Health Insurance Act, S. 724). Although Medicaid covers a significant proportion of births, access to prenatal

care remains a problem for some low-income women. An estimated 13 percent of pregnant women were uninsured in 1999, and uninsured pregnant women are more than twice as likely as insured women to fail to get needed prenatal care.¹¹⁷ To address this, legislation has been introduced to allow states to access CHIP funds for pregnant women if those states have already covered pregnant women through Medicaid to 185 percent of poverty. In addition, the legislation would allow states to extend automatically Medicaid or CHIP to the babies born to mothers on these programs. Preliminary estimates suggested that the bill would cost about \$1.9 billion over 10 years. This proposal passed the Senate Finance Committee in July 2002. An attempt to bring this legislation to the Senate floor was blocked and there was no House action on this bill. The Administration opposed this bill, stating that its fetal coverage regulation for CHIP accomplishes the same goal.¹¹⁸

7. Medical Savings Accounts (MSAs) (permanent extension in House-passed version of Patients Bill of Rights, H.R. 2563).¹¹⁹ MSAs are personal savings accounts dedicated to paying for health costs not covered by high-deductible health insurance policies. An MSA demonstration was authorized in 1996 to allow up to 750,000 individuals who are self-employed or work in firms with 50 or fewer employees to receive tax advantages if they enrolled in certain types of MSAs.¹²⁰ Originally set to expire in 2001, the demonstration has been extended, most recently in the Job Creation and Worker Assistance Act of 2002 (P.L. 107-147) to 2003. The General Accounting Office was charged with studying whether this demonstration helps the uninsured through its lower premiums or, as some critics fear, results in adverse selection. Although enrollment has been so low that an effective evaluation cannot be completed, the House-passed version of the Patients' Bill of Rights legislation included a provision that would, among other changes, make MSAs a permanent, unlimited option and increase the amount that could be put into these accounts.¹²¹ The Administration's fiscal years 2002 and 2003 budgets included similar, permanent expansions and extensions of MSAs. The Joint Committee on Taxation estimated that the president's proposal would cost \$5.1 billion over 10 years.¹²² The version in the Patients' Bill of Rights legislation passed the House in August 2001; no further action was taken on this bill in the 107th Congress.

8. Association Health Plans (AHPs) (included in House-passed version of Patients' Bill of Rights, H.R. 2563; also see H.R. 1774; S. 858). Several proposals would establish AHPs, which are essentially group health plans sponsored by trade, professional, or other business associations that are exempt from certain federal and state insurance regulations. Their goal is to make health insurance more affordable for small businesses. An analysis by the CBO found that premiums would be lower in AHPs, but primarily due to their exemption from state and federal benefit mandates. Moreover, premiums for small businesses outside of AHPs would rise (2%).¹²³ The Administration supports this policy.¹²⁴

Other Major Proposals

9. CHIP option for parents (FamilyCare Act, H.R. 2630, S. 1244). This proposal would increase the annual CHIP allotments and allow states the option of accessing the CHIP matching rate for coverage of the parents of children already eligible for Medicaid/CHIP. Parents would be enrolled in the same program as their children. Under some versions, if states have not achieved coverage of all poor parents by a certain date, a trigger requires them to do so. A similar proposal was scored by the CBO as costing \$56 billion over 10 years.¹²⁵

10. Medicare buy-in (Medicare Early Access and Tax Credit Act of 2001, S. 623; see also S. 2679). This proposal would allow certain people ages 55 to 64 to buy into Medicare. Participants ages 62 to 64 would pay a premium that equals the average cost of people in their age group; a risk premium to offset any above-average costs of buy-in participants would be added to their Medicare premium once they turn age 65. As such, it is self-funded in the long run. Some Medicare buy-in proposals also include a tax credit to make the buy-in premiums more affordable. The CBO estimated that a buy-in proposal with a 25 percent tax credit would help about 650,000 people in the first year and would result in 10-year costs of \$0.2 billion for Medicare, \$1.4 billion in Social Security costs if 1 percent of people ages 62 to 64 retired early due to eligibility for this program. The tax credit would cost an estimated \$7.7 billion in lost revenue.¹²⁶

11. Refundable tax credits for individual health insurance (president's proposal: note: not introduced as a bill). This proposal would provide a refundable tax credit that could be advanced to individuals for 90 percent of premiums up to a cap of \$1,000 for individuals and \$3,000 for families. The full credit would be available to those with income up to \$15,000 for individuals and \$25,000 for couples or families, to be phased out by \$30,000 for individuals and \$60,000 for families. The tax credit could be used for individual health insurance or private purchasing groups, state-sponsored insurance, and state high-risk pools. States may also opt to combine this tax subsidy with Medicaid or CHIP subsidies.¹²⁷ The Congressional Joint Committee on Taxation estimated that this proposal would cost \$92 billion over 10 years.¹²⁸

12. Nonrefundable tax credits for uninsured individuals (Health Insurance Affordability and Equity Act of 2001, H.R. 1181). This proposal would provide a nonrefundable tax credit for health insurance of up to \$1,500 for individuals and \$3,000 for families if those individuals were uninsured for at least one year. The credit would be income-related, with the full credit available for those with income up to \$30,000 for

individuals and \$60,000 for couples or families, to be phased out by \$40,000 for individuals and \$70,000 for families.

13. Small business purchasing coalitions (see Health Plan Purchasing Alliance Act of 2002, S. 2035; also S. 2679). This proposal would establish a grant program to create state-based or direct purchasing groups, known as alliances or coalitions, for small businesses. Like AHPs, the goal of these coalitions would be to provide small firms with the purchasing power of large firms. However, these coalitions would have different rules of construction and operation compared with AHPs. Specifically, all small businesses in an area, regardless of whether they are members of the particular association, could participate. In addition, fewer state health insurance regulations would be waived for these alliances.

14. Tax credits for small businesses (part of Health Insurance Access Act of 2002, S. 2679, Bipartisan Patient Protection Act of 2001, S. 284). Several proposals would create a tax credit of 30 to 50 percent for health insurance for small firms with low-wage workers to provide them with an incentive to offer health insurance.

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¹⁰⁰ National Governors Association, Medicaid Policy (HR 16.3.5) (Washington, D.C.: National Governors Association, 2002). http://www.nga.org/nga/legislativeUpdate/1,1169,C_policy_position^D_533,00.html.

¹⁰¹ C. Mann, *The New Medicaid and CHIP Waiver Initiatives* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, February 2002).

¹⁰² Note that CHIP, created in 1997, has three different types of coverage requirements for children’s benefits packages: (1) *value*: each plan must have a minimum actuarial value, (2) *covered benefits*: each must include key benefits for children such as well-child visits; and (3) *premium and cost-sharing limits*: family costs for premiums and cost-sharing must be nominal for children with family income below 150 percent of poverty and not exceed 5 percent of family income for those above this threshold. These standards have been criticized recently as too stringent, as have Medicaid’s standards.

¹⁰³ Note that the upper-income thresholds for the full individual health insurance tax credit fall between 101 percent (for a family of 6) and 206 percent (for a childless couple) of the federal poverty threshold (trending the 2002 HHS poverty guidelines to 2003 using CBO’s August 2002 projection of 2002 CPI-U); as such, it would not provide much assistance for middle-income taxpayers, defined in this paper as those with income above 200 percent of the poverty threshold.

¹⁰⁴ J. M. Lambrew, August 2001.

¹⁰⁵ Analysis of the March 2001 Current Population Survey by S. Glied and K. Jack, Columbia University, for the Commonwealth Fund Task Force on the Future of Health Insurance.

¹⁰⁶ D. H. Ferry, B. Garrett, S. Glied, E. K. Greenman, and L. M. Nichols, “Health Insurance Expansions for Working Families: A Comparison of Targeting Strategies,” *Health Affairs* 21 (July/August 2002): 246–54.

¹⁰⁷ Congressional Budget Office, *H.R. 3009: Trade Act of 2002* (Washington, D.C.: CBO, August 21, 2002).

¹⁰⁸ Congressional Budget Office, *H.R. 3090 Economic Security and Assistance for American Workers Act of 2001, as reported by the Senate Committee on Finance on November 9, 2001* (Washington, D.C.: CBO, November 15, 2002).

¹⁰⁹ Joint Committee on Taxation, *Estimated Budget Effects of the Revenue Provisions of the “Economic Security and Workers Assistance Act of 2002”* (Washington, D.C.: U.S. Congress, JCT, JCX-070-2, February 14, 2002).

¹¹⁰ O. Carrasquillo, A. Carrasquillo, and S. Shea, “Health Insurance Coverage of Immigrants Living in the United States: Differences by Citizenship Status and Country of Origin,” *American Journal of Public Health* 90 (June 2000): 917–23.

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¹¹³ J. R. Gabel et al., “Embraceable You: How Employers Influence Health Plan Enrollment,” *Health Affairs* 20 (July/August 2001): 196–208.

¹¹⁴ Congressional Budget Office, *H.R. 4584: A bill to amend title XIX of the Social Security Act to extend the authorization of transitional medical assistance for one year, as ordered reported by the House Committee on Energy and Commerce on April 24, 2002* (Washington, D.C.: CBO, May 10, 2002).

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¹¹⁶ Congressional Budget Office, *S. 321: The Family Opportunity Act of 2002, as reported by the Senate Committee on Finance on July 11, 2002* (Washington, D.C.: CBO, August 21, 2002).

¹¹⁷ K. Thorpe, *The Distribution of Health Insurance Coverage Among Pregnant Women* (Washington, D.C.: March of Dimes, 2001).

¹¹⁸ T. Thompson, Letter to Senator Nickles, October 8, 2002.

¹¹⁹ Note that the House passed several versions of the economic stimulus/displaced workers bills, which included a one-year extension of MSAs (e.g., H.R. 3528). In addition, the Patients Bill of Rights (H.R. 2990) included a one-year extension.

¹²⁰ Specifically, these MSAs must be linked to insurance plans that in 2002, for individuals, have deductibles from \$1,650 to \$2,500 and an annual out-of-pocket limit of \$3,300; for families, deductibles from \$3,300 to \$4,950 and an annual out-of-pocket limit of \$6,050. These values are indexed to inflation, rounded to the nearest \$50. Individuals can contribute up to 65 percent of the deductible and families up to 75 percent of the deductible; the accounts are tax-deductible.

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¹²⁶ *Ibid.*

¹²⁷ Office of Management and Budget, *Budget of the United States Government, Fiscal Year 2003* (Washington, D.C.: U.S. Executive Office of the President, OMB, 2002).

¹²⁸ Joint Committee on Taxation, *Estimated Budget Effects of the Revenue Provisions Contained in the President’s Fiscal Year 2003 Budget Proposal* (Washington, D.C.: U.S. Congress, JCT, March 15, 2002).

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#597 *State Health Insurance Expansions: Case Studies of Six States* (January 2003). Sharon Silow-Carroll. The author discusses, in detail, initiatives undertaken to maximize health insurance coverage in Arkansas, Michigan, New Mexico, New York, Utah, and Vermont.

#587 *Assessing State Strategies for Health Coverage Expansion: Summary of Case Studies of Oregon, Rhode Island, New Jersey, and Georgia* (November 2002). Sharon Silow-Carroll, Emily K. Waldman, Jack A. Meyer, Claudia Williams, Kimberley Fox, and Joel C. Cantor. These case study summaries examine the experiences of four states that have attempted health insurance expansions, detailing their relative strengths and weaknesses and highlighting what appear to be the key factors for success. (For the complete case studies, refer to publication #565.)

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#577 *Toward Comprehensive Health Coverage for All: Summaries of 20 State Planning Grants from the U.S. Health Resources and Services Administration* (November 2002). Heather Sacks, Todd Kutyla, and

Sharon Silow-Carroll, Economic and Social Research Institute. In 2000, the federal Health Resources and Services Administration awarded grants to 20 states to create comprehensive health coverage plans for all residents. This publication summarizes the progress these states have made in expanding coverage, detailing the history of reform, providing data on uninsured populations, and describing actions taken and goals for future efforts. Available at www.cmwf.org.

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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.

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