

Creating Consensus On Coverage Choices

A proposal for near-universal coverage that makes good coverage both easily available and affordable and that preserves the diversity of benefits and insurance plans in our current system.

by **Karen Davis and Cathy Schoen**

ABSTRACT: The framework for reaching near-universal coverage outlined in this paper combines tax credits for private insurance and public program expansions. It illustrates how a series of incremental steps could be phased in to achieve near-universal coverage. Hallmarks include creation of a Congressional Health Plan; use of the income tax system to provide tax credits and enroll uninsured people; creation of a state Family Health Insurance Program open to everyone below 150 percent of poverty; and creation of a Medicare Part E, open to the disabled and uninsured older adults. The paper provides coverage and cost estimates and identifies potential sources of revenue to finance coverage.

DESPITE THE STALEMATE ON universal health insurance coverage, there are important areas of consensus in the policy debate. Most importantly, there is consensus that the current health care system does not work well, and broad public support exists for covering the uninsured.¹ The characteristics of the uninsured are well defined.² The scientific literature provides convincing documentation that the uninsured do not get needed care, especially preventive services and proper management of chronic conditions.³ Important health and economic benefits accrue to the uninsured from coverage.⁴

The major disagreement is over the role of private insurance in covering the uninsured, whether public programs should be expanded to additional groups, and the commitment of adequate budgetary resources required to assist those who are unable to afford the full cost of health coverage.⁵ There is also the question of whether to focus simply on expanding coverage or to reform the delivery of health care services at the same time, and whether to focus expansion efforts on the uninsured or to replace existing coverage with a new system of insurance for all.⁶ Attempts at radical reform of the health care system or proposals that threatened insured people's current coverage have failed.⁷

This paper outlines a framework that could help bridge differences between those who would expand coverage using private insurance and those who prefer

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public insurance, as well as differences between those supporting an incremental approach and those seeking more fundamental changes. It incorporates features from an individual mandate with tax credits as well as expansion of public programs, and it illustrates how these might work in tandem to improve coverage and enhance choices for both the insured and uninsured. As a framework, it should not be viewed as a “single best plan” but rather as a guide for possible action in the near term and a roadmap for moving toward universal coverage. It constitutes a beginning point for discussions around which parties with differing views could begin to identify areas of common agreement and feasible near-term steps.

The framework also illustrates how incremental steps, if structured as part of a longer-term strategic plan, could move toward more universal coverage. This addresses concerns that moving in increments might otherwise result in more fragmented coverage or that erosion of private coverage might offset reform initiatives with little forward progress.

The framework discussed here focuses primarily on making insurance accessible and affordable. However, it could also contain features that would promote a quality agenda: policies to improve quality of care, promote modern information technology, encourage science-based appropriate services, and involve patients more actively in their care.⁸

In brief, the most serious health insurance problems facing the nation are as follows. Forty-one million people were uninsured in 2001.⁹ One-fourth of people under age sixty-five are uninsured at some point during the year, and one-third of Americans change insurance plans over any given three-year period.¹⁰ Two-fifths of insured people with incomes below \$35,000 still have difficulty obtaining needed care or paying medical bills, despite having coverage.¹¹ Participation in current programs is low: More than half of the nation’s eight million uninsured children are eligible for Medicaid or the State Children’s Health Insurance Program (SCHIP).¹² Only about 20 percent of those eligible for continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) participate.¹³ About one-third of adults seeking coverage in the individual insurance market find it difficult or impossible to find a plan that meets their needs.¹⁴ Small firms with older employees or a few sicker employees are also at risk for paying much higher premiums if they lack an option that pools health risks.

Study Methods

To illustrate the coverage potential and associated costs of a mixed public-private approach, we present estimates provided by the Lewin Group using estimates from Lewin’s Health Benefits Simulation Model. All estimates assume 2002 population initial insurance and cost distributions.¹⁵

■ **A consensus framework.** Several general principles shape the consensus framework: choice of coverage, including retention of current coverage choices; affordability; automatic coverage; and protection from adverse risk selection. We

describe below how each of these could be achieved and the potential of a combined approach for improving coverage and insurance stability, quality, and affordability.

Congressional Health Plan. A central element of the framework is the establishment of a new Congressional Health Plan (CHP), which would make available a choice of any insurance plan participating in the Federal Employees Health Benefits Program (FEHBP). The CHP would be distinct from the FEHBP, although plans participating in one would be required to participate in the other. Members of Congress would switch their own coverage to the CHP to symbolize their commitment to ensuring high-quality coverage and choices. Benefit packages would be the same in the CHP and FEHBP markets and, as they are now, subject to FEHBP approval. Any new carrier would be required to meet the same standards.

Enrollment in the new plan would be open to self-employed people and small businesses with fewer than fifty employees, as well as any person who has been uninsured for six months and lacks access to group coverage. New electronic enrollment processes over the Internet would help to ease administration, making it easy for individuals and small businesses to initiate, change, or terminate coverage and make premium payments.

This new option would set premiums at expected community rates and offer coverage irrespective of the individual's or small firm's anticipated health risks. Expecting that initially this community rate would attract those with higher-than-average health risks, federal funds would finance these risks through reinsurance or other risk-pooling arrangements. The resulting "average" premium rates would likely be particularly attractive to those now insured in the individual or small-group market who have higher-than-average health risks. Furthermore, because the federal government would compensate participating plans for adverse risk selection, the community-rated premium would be less than that now available to many small businesses and individuals purchasing coverage in the individual market. Based on the Blue Cross Blue Shield Standard Plan, the estimated premium in 2002 would be \$2,880 for an individual, \$5,772 for a couple, \$8,328 for a two-parent family, and \$4,716 for a single-parent family.

Insurance verification and tax credits. One of the framework's important new features is a mechanism to assess health insurance coverage annually, automatically enroll uninsured people in coverage, and provide tax credits for premiums in excess of a certain percentage of income. All individual tax filers would need to show evidence of health insurance when they file their personal income taxes.

Any individual or family without coverage would receive tax credits for premiums in excess of 5 percent of adjusted gross income for those with lower incomes and in the lower tax brackets (15 percent or lower, or below \$27,950 for individuals and \$46,700 for families) and 10 percent of adjusted gross income for those with higher incomes. The tax credits would apply to standard-plan premiums for insurance coverage in the CHP effective July 1 following filing of the annual tax return. Enrollment of uninsured people would be automatic. Such coverage could be

required, or people could have the choice of declining participation.

Once insurance verification systems were in place, the federal government could also establish an insurance verification electronic clearinghouse.¹⁶ Any health care provider could query this database to check the source of a patient's insurance coverage. Uninsured people could be informed about insurance options available to them. This would help minimize the numbers of uninsured people surfacing during the income tax filing process and would promote earlier enrollment.

■ **Public program expansions.** *Medicare.* To further reduce adverse risk selection in the CHP and to promote insurance continuity and integrity within families, a new Part E would be added to Medicare (Part D is reserved for a drug program). Three groups would be offered coverage through Medicare: dependents of current Medicare beneficiaries, adults age sixty and older without access to group coverage, and the disabled in the two-year waiting period for Medicare coverage. The disabled would pay the Part B annual premium, while Medicare family members and adults age sixty and older would pay a community-rated annual premium, estimated to be \$4,344.

In costing out this option, it is assumed that all of Medicare includes a prescription drug benefit with a \$250 deductible and \$4,000 out-of-pocket limit enacted through separate legislative action. This new Medicare Part E would be the default option at tax filing time for uninsured adults ages 60–64. Enrollment for this group and tax credits for premiums in excess of 5–10 percent of income would be automatic through tax filing, as above.

Low-income families and individuals. The CHP options are unlikely to work well for families and adults with very low incomes who cannot afford out-of-pocket costs for excluded benefits, cost sharing, or premiums. Their situations are also more unstable than those of other Americans—with fluctuations in income, employment, and residence—and they are more likely to have serious health problems requiring special services. States with experience in administering health care programs for low-income people are probably better able to deal with these circumstances than is a tax system oriented toward annual reporting of income.

To provide an option that is more suitable for low-income people, eligibility under public programs would be expanded to include Americans living below 150 percent of poverty. Any low-income person or family preferring to obtain coverage through the CHP and meeting its eligibility requirements could still do so; in fact, some may well prefer its greater choice of private plans and providers.

This proposal would expand SCHIP to include all families and single people with incomes below 150 percent of poverty (approximately \$13,800 for an individual and \$21,400 for a three-person family in 2001). This program would be renamed FHIP. It would have the same benefits that SCHIP has, and states would administer it as they now administer SCHIP. States would have the option of buying eligible families into employer coverage, or potentially into the CHP. States also would have the option of extending coverage above 150 percent of poverty

through use of federal matching funds and premiums charged on a sliding scale. FHIP would be the default coverage for all uninsured people filing tax returns with incomes below 150 percent of poverty.

Federal matching rates for all families and nonelderly adults for acute care services (excluding long-term care) in Medicaid as well as for the expansion group would be at the enhanced SCHIP rate. This enhanced matching rate for those currently covered would offset the state share of costs for new FHIP enrollment.

■ **Employer group coverage.** Employer-sponsored health insurance is the coverage of choice for most working Americans.¹⁷ It has many advantages: health risk pooling, lower administrative costs and premiums, automatic enrollment and payroll withholding for the employee share of premiums, and experienced health benefit managers who select plans and resolve administrative problems. Importantly, employers now cover 160 million workers and family members and contribute about \$335 billion toward health insurance coverage.¹⁸ Keeping employer coverage as a mainstay of the current health insurance system in a transition to more universal coverage is essential, to minimize disruptions in coverage and the incremental budgetary cost of covering the uninsured. To strengthen the stability of employer benefits for working families, several reforms would modestly expand employer health coverage and help workers and their families retain their insurance.

For workers who are between jobs, a continuation of previous employer coverage for two months would provide a bridge to subsequent coverage in the next job and would eliminate the administrative hassle of signing up for COBRA coverage. For those who are uninsured over a longer term, provision of a subsidy covering 70 percent of COBRA premiums could be expected to increase the number of people participating in the program. A recent study suggests that a subsidy of this magnitude could more than double participation rates.¹⁹

Changing insurance practices to cover dependent young adults up to age twenty-three under their parents' health insurance would further reduce uninsurance rates for this population during a time of transition. Employer plans typically cover full-time college students, but not young adults in similar circumstances who do not attend college or attend part time.²⁰ This practice discriminates against lower-income working families whose children are unable to pursue college studies full time.

There is also a fundamental inequity between employers that help finance coverage for their workers and those that do not. A contribution from all firms would be needed to help generate the revenue to finance coverage, to create a disincentive for firms to drop coverage, and to reduce inequities across firms and in labor markets. Companies not offering coverage to employees would contribute 5 percent of payroll, up to \$1 per hour worked, through the payroll tax system. These funds would be pooled to provide coverage in the CHP. Those offering coverage would be exempt from this "play or pay" contribution. To be exempt, however, they would have to meet general prevailing minimum standards on coverage and

achieve 80 percent participation.

Small firms would be able to join the CHP, under which they realize the administrative economies of community-rated coverage of a larger group and have more insurance plan choices for employees. However, some firms may prefer making the financial contribution and leaving their employees to enroll directly in the CHP or through the personal income tax default mechanism.

Impact On Insurance Coverage: All Features Combined

The features described above could be combined and linked through the tax system to identify and enroll the uninsured automatically. This expansion could either require everyone to participate (individual mandate) or allow opting out.

The numbers of uninsured people would drop under either alternative. Among the forty-one million people who are now uninsured, an estimated thirty-three million would be insured under the opt-out version and thirty-nine million under the individual mandate (some nonfilers or undocumented immigrants are likely to remain uninsured) (Exhibit 1). The individual mandate would be particularly effective in lowering uninsurance rates among those at higher income levels who might not participate under a purely voluntary scheme.

The uninsured would be covered by a balance of private and public coverage (Exhibit 2). About 59 percent of the population would be covered in private plans in the individual-mandate version. Public programs would enroll slightly less than a third of the population under either version.

The mix of private and public coverage for people who are now uninsured would vary by income (Exhibit 1). In the individual-mandate version, the majority of the poor would be covered through public insurance unless they chose private alternatives (63 percent Medicaid/SCHIP/FHIP, 4 percent Medicare compared with 20 percent CHP and employer plans) and those with incomes at more than

EXHIBIT 1
Numbers Of Uninsured People Under Current Law And Distribution Of Coverage Under Individual Mandate, By Income Level

	Total	Percent of poverty			
		Below 100	100-149	150-199	200 or more
Total uninsured under current law (millions)	41.9	11.8	6.9	6.0	17.3
Coverage under individual mandate					
Employer	26%	15%	25%	35%	30%
Congressional Health Plan	30	5	3	33	56
Medicaid/Family Health Insurance Program	35	63	61	23	9
Medicare	3	4	4	3	3
Uninsured	7	14	7	5	2

SOURCE: Lewin Group estimates using the Health Benefits Simulation Model.

EXHIBIT 2
Distribution Of People By Primary Source Of Coverage Under Current Law, Automatic Enrollment With Opt-Out, And Individual Mandate

	Current law	Automatic enrollment with opt-out	Individual mandate
Employer	58%	58%	59%
Congressional Health Plan	– ^a	8	9
Nongroup coverage	4	1	1
CHAMPUS/others	1	1	1
Medicare	12	14	14
Medicaid/SCHIP	10	15	15
Uninsured	15	3	1

SOURCE: Lewin Group estimates using the Health Benefits Simulation Model.

NOTE: CHAMPUS is Civilian Health and Medical Program of the Uniformed Services, now known as Tricare. SCHIP is State Children's Health Insurance Program.

^a Not applicable.

twice the poverty level would be predominantly in either CHP or employer plans (86 percent CHP or employer plans).

The framework is designed to minimize involuntary disruptions in current sources of coverage. Most insured people with coverage from employers, Medicare, or Medicaid/SCHIP would keep that coverage. As a result, the current mix of private and public coverage for the entire population would remain relatively unchanged (Exhibit 2).

Some insured small businesses and individuals in the nongroup market, however, might choose to change coverage. An estimated twenty million people would have improved or lower-cost coverage available to them. About ten million people who now have coverage through a small business would move to the CHP as employers sought out its lower-cost premiums. This amounts to lower premium rates for an estimated one-third of all small-firm employees now receiving health benefits.²¹ An estimated eight million people would switch from nongroup coverage to private or public group coverage as this group also made gains from lower premium costs and improved benefits. About two million people now covered by Medicaid would switch to employer coverage.

■ **Expansion costs.** This gain in coverage is expected to increase the use of health care services by an estimated \$50 billion. This represents about a 3 percent increase in the \$1.5 trillion in national health spending expected in the absence of change. The improved coverage would help correct the underuse of preventive and chronic disease services by the under- and uninsured. Out-of-pocket costs for the under- and uninsured would fall by \$20 billion, reducing the financial burdens and risk of medical bankruptcy that are all too common today.

■ **Efficiency gains.** A number of efficiency gains are possible from this proposal. Most importantly, the economies of group coverage are substituted for those of individual coverage. The new CHP is estimated to have total administrative costs of 19

percent—compared with 30–50 percent in individual plans. The number of people covered through the individual market would drop by eight million. Through this shift to group coverage, people would receive better coverage and greater choice at lower premiums and much lower administrative overhead.

Emphasis on electronic administration would also yield savings. Establishment of an electronic clearinghouse to verify insurance enrollment would reduce providers' administrative costs. Families would tend to be covered under the same plan, rather than under multiple plans for different family members.²² The proposal would also reduce insurance turnover and the administrative costs associated with this turnover, as more people would be able to find a stable source of coverage that did not change over time even as their income or job changes. The reduced turnover would foster greater continuity in physician-patient relationships, which some evidence shows can reduce health care spending.²³

Basing tax credits on standard-plan premiums would give everyone enrolled in the CHP an incentive to seek out plans that offer good benefits and lower premiums. Some people may be willing to join more restricted networks, gaining the advantage of both lower premiums and more comprehensive benefits, or other plans that appeared to offer high value for comparable premiums.

The reinsurance trust fund, meanwhile, could be structured to retain some incentive for insurers to control costs (for example, the government could pick up 90 percent of costs above a given threshold, such as \$30,000 per year). However, it would also be important to incorporate a mechanism for identifying high-cost individuals who could benefit from modern methods of chronic disease management and science-based quality standards. Since 10 percent of the population accounts for 70 percent of all health care outlays, focusing quality improvement efforts on chronic disease treatment should be particularly effective in reducing unnecessary duplication of procedures and other waste.²⁴

Phasing In: Incremental Steps Within A Longer-Term Strategy

The proposal lends itself to being phased in over time and to having elements modified based on experience. Ideally, the CHP component would be established first, perhaps opening coverage to small businesses and uninsured people on a voluntary basis. Insurance verification through the income tax system would require time to be put in place and should be implemented early on. It could start with automatic enrollment with opt-out, perhaps followed by the individual mandate in later phases. Medicaid/FHIP expansions could occur in steps, as could the Medicare coverage expansion for the disabled and for older adults.

One illustrative incremental phasing strategy that uses income to guide each step is shown in Exhibit 3. In the first phase, tax credits and FHIP expansion of coverage would be targeted to people living below 100 percent of poverty. In the second phase, the target population would increase to 150 percent of poverty. In the third phase, tax credits would be available to those with incomes up to 200

EXHIBIT 3
Illustrative Incremental Phasing-In Toward Universal Coverage, Number Of Uninsured People Remaining After Implementation Of Each Phase (Millions), By Age Group

	Total	Under 19	19-24	25-44	45-59	Disabled and 60-64
Baseline uninsured	41.8	9.0	7.4	17.1	6.9	1.4
Phasing—remaining uninsured						
Phase 1: under 100% of poverty	32.5	7.2	5.7	13.5	5.1	1.0
Phase 2: up to 150% of poverty	26.9	6.1	4.7	11.3	4.0	0.8
Phase 3: up to 200% of poverty	22.3	5.2	3.9	9.5	3.1	0.6
Phase 4: all features with opt-out	8.8	2.6	1.4	4.2	0.5	0.1
Phase 5: mandate	2.9	0.6	0.6	1.3	0.4	0.0

SOURCE: Lewin Group estimates using the Health Benefits Simulation Model.

NOTES: See text for description of phases. Table illustrates rough estimates of people covered in each phase, based on poverty and age grouping. Actual coverage would depend on specific features implemented and financed in each phase.

percent of poverty. The opt-out version for all would be adopted in the fourth phase, and the individual mandate, in the final fifth phase.

As shown in Exhibit 3, the number of uninsured Americans would decline by nine million in the first phase, six million in the second phase, five million in the third phase, fourteen million in the fourth phase, and six million in the fifth phase.

Enrollment in the CHP is likely to build gradually to a total of twenty-four million by the final phase. Eventually, if this plan is successful in providing a choice of high-quality, stable coverage at competitive premiums, it could be opened up to larger employers or added as a choice for those covered under public programs.

■ **Costs and revenues.** The plan is designed on balance to impose no net additional cost on employers or state and local governments. Employers that now offer health coverage, however, would save an estimated \$22 billion, while employers that do not would incur additional costs of \$20 billion. This amount would be split about equally between firms purchasing coverage through CHP and those contributing to a pool to fund coverage for uninsured workers.

The enhanced match for current Medicaid non-long term care services plus the expansion groups would offset new costs for public programs. State and local governments would see modest net savings as a result of reduced costs of charity care in public hospitals and reduced costs of public employees' health benefits.

There are five major sources of federal budget costs: CHP reinsurance costs; tax credits for CHP premium assistance; tax credits for Medicare buy-in premiums and COBRA coverage; coverage of disabled and older adults under Medicare Part E; and expansion of Medicaid/SCHIP/FHIP. Offsets to these costs could include contributions from employers not offering coverage and from reduction of \$30 billion in current federal subsidies for uncompensated care.²⁵

Given current economic and budgetary conditions, implementation would most likely be achieved in phases. Actual costs would depend on the specific phase-in scenarios as well as health care spending trends. Possible sources of fi-

nancing include tax savings from repeal of the current income tax deduction for health care expenses; assessment of a one-percentage-point income tax in January 2004 or January 2007, when reductions of one percentage point are now scheduled for all tax brackets; or other budgetary trade-offs.²⁶

The fully implemented federal budgetary costs (based on 2002 health expenditures) would be an estimated \$70 billion (Exhibit 4). Revenues from repeal of the one-percentage-point reduction in the income tax scheduled for January 2004 would yield \$39 billion, and repeal of the current tax deduction for health expenses would yield \$4 billion, leaving a balance of \$27 billion to be financed through other budgetary trade-offs.

■ **Concerns.** Maintaining the existing system of health insurance coverage while adding features to provide affordable choices to the under- and uninsured has its drawbacks. It is admittedly more complex than eliminating the current system and creating one new system for all.

One of the greatest potential weaknesses is that healthier and sicker people will choose different forms of coverage. This risk selection could prove destabilizing. While design features attempt to address this flaw through reinsurance and making public coverage the preferred source of coverage for the poor, elderly, and disabled, private plans might withdraw from participation if they are not adequately protected from adverse risk selection.

Financing is always the most controversial issue. Employers are likely to resist bearing additional costs, whether covering workers who are now uninsured or paying the additional cost of COBRA coverage. Diverting funds that now go for uncompensated care of the uninsured will also meet with resistance from safety-

EXHIBIT 4
Changes In Federal Spending Under The Congressional Health Plan (CHP) Proposal, Billions Of Dollars

	Opt-out	Mandate
Costs		
CHP Reinsurance Trust	\$17	\$12
Tax credits	35	39
Net new Medicare	12	11
Net new Medicaid/SCHIP/FHIP	36	37
Uncompensated care offsets	-30	-30
Total costs	71	69
Revenue		
Income tax assessment	39	39
Elimination of tax deduction for health expenses over 7.5% of adjusted gross income	4	4
Other revenues and budgetary trade-offs	28	26
Total revenues/offsets	71	69

SOURCE: Lewin Group estimates using the Health Benefits Simulation Model.

NOTES: SCHIP is State Children's Health Insurance Program. FHIP is Family Health Insurance Program.

net providers. Substantial new federal revenues would be required, forcing societal trade-offs of tax relief versus improved insurance coverage. But universal coverage is unlikely to be feasible unless all parties—the uninsured, the insured, employers, providers, and government—are willing to share in the cost.

Finally, the ultimate cost of covering the uninsured will depend upon the strength of the economy, trends in health costs, and other health and economic factors. The costs are only an estimate and could be higher or lower. The virtue of a phased-in strategy is that assessments of experience with the plan and economic and budgetary conditions can be weighed as each additional step is taken.

Concluding Comments

The proposed framework introduces the feature of automatic coverage to the health insurance system, addressing the nation's current failure to enroll many people who are technically eligible for public programs or employer coverage. By doing so, it achieves near-universal health coverage, employing a balance of private and public insurance and preserving current sources of coverage where they are working well. It makes coverage affordable for the uninsured and spreads the cost of coverage over multiple parties. It removes the risk of adverse selection from private coverage through reinsurance and stop-loss mechanisms. It builds on the advantages of group coverage where possible and preserves employer contributions to health benefits—without adding, on balance, to employers' costs. It builds on existing administrative structures such as the FEHBP, Medicaid/SCHIP, and Medicare. Finally, it introduces new electronic clearinghouse and health insurance enrollment mechanisms that simplify and increase the efficiency of our current fragmented system.

The framework also provides people with choices as to their source of health coverage. The plan makes good coverage both easily available and affordable. It also preserves the diversity of benefits and insurance plans in our current system: Over time, people could choose the source of coverage and specific plan that best meets their individual or family circumstances. Many of those employed by small businesses would join the new Congressional Health Plan, where their coverage would remain stable even if they moved from job to job.

Most importantly, it ensures that all Americans have access to health care services and removes the fear of burdensome medical bills or bankruptcy from catastrophic medical expenses. It enables the health care system to provide care to all without concern that the financial health of the institution would be put at risk by serving those unable to pay.

We propose a flexible framework that provides a long-term vision within which to make incremental changes. It lends itself to phasing in. Any given element of the plan—such as methods for covering low-income or high-risk people—can be replaced with a better alternative that gains widespread support. It is hoped, however, that setting forth this framework will provide a mechanism for

building consensus for change. It is offered not with the view that it is the best plan, or even the authors' preferred approach, but with the hope that it will stimulate public interest and debate and a better appreciation of the choices, benefits, costs, consequences, and trade-offs involved.

Continuing gridlock on health system reform is unacceptable. The uninsured and underinsured are growing in number and exacting an economic and health toll that the nation can ill afford. Inaction is undermining the financial vitality of the health care system at the very time it needs to be prepared in the event of an attack or natural disaster. The framework described here would help forge a stronger, more cohesive society; a more productive economy; and a nation better prepared to withstand any challenge. It is an investment worthy of the United States in the twenty-first century.

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