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Issue Brief

Universal Coverage in the United States: Lessons from Experience of the 20th Century

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The absence of universal health insurance coverage is one of the great, unsolved problems facing the United States at the onset of the 21st century. Proposals to expand health insurance coverage were frequently considered but infrequently enacted during the 20th century, and the goal of creating a universal health insurance system remained elusive. As a result, today the American health care system relies on a patchwork of insurance coverage, including employer-sponsored health insurance for the majority of working-age adults, the Medicare program for the elderly and disabled, and Medicaid and the State Children's Health Insurance Program (CHIP) for low-income adults and children. This system has serious consequences for the approximately 39 million Americans who are left without insurance—consequences for their health, access to care, preventive care, and quality of care—as well as for those with inadequate health insurance.¹

Yet, the remaining goal is not unattainable. Eighty-five percent of Americans have health coverage and most insured Americans are satisfied with their coverage. This is a strong base on which to build. By understanding how the current health care system developed, how the various proposals for universal health coverage gained and lost political and public support, and the pros and cons of the various alternatives available to expand coverage, we can create a viable strategy to solve the problem of the uninsured in the 21st century.

Efforts to Achieve Universal Coverage in the 20th Century

Although Americans saw a wide variety of proposals put forth to achieve universal health insurance coverage during the 20th century, only coverage for the elderly and disabled, low-income children, and selected low-income adults was enacted. Theodore Roosevelt endorsed health insurance modeled on workmen's compensation in

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his 1912 bid for the presidency.² (Figure 1) President Harry Truman delivered a stirring presidential message on November 19, 1945, calling for the addition of universal health insurance to Social Security;³ his plan was the core of various Wagner–Murray–Dingell bills introduced but not enacted in the late 1940s. President Eisenhower proposed small business risk pools and other market reforms in 1956.

President John F. Kennedy made Medicare a major election issue in 1960, and President Lyndon B. Johnson signed Medicare and Medicaid into law on July 30, 1965.⁴ The United Auto Workers reopened the debate for universal coverage in 1970 by promoting the Kennedy–Griffiths single-payer bill. President Richard Nixon proposed a Comprehensive Health Insurance Plan that received serious legislative consideration in 1974.⁵ The central features were employer-mandated private insurance coverage for workers (and their families) in firms with 25 or more employees, a plan for low-income families that would replace and improve Medicaid, and a federal health insurance plan that would replace and improve Medicare.

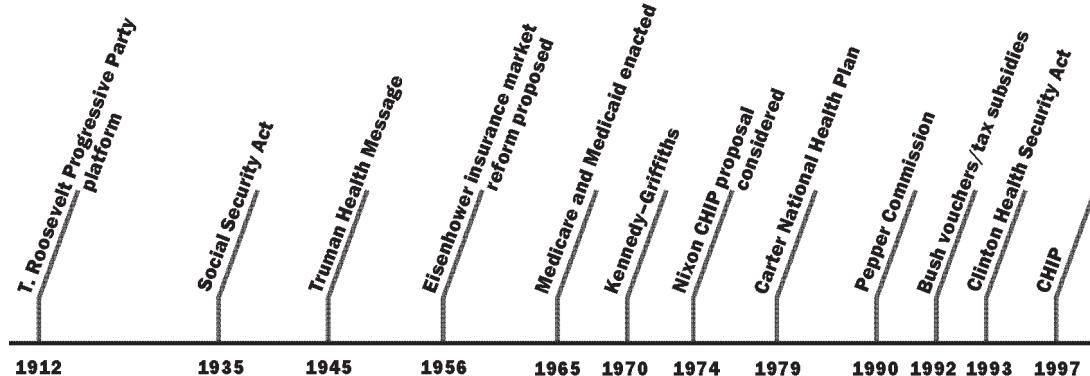
President Jimmy Carter's National Health Plan represented an incremental approach to phased-in health insurance coverage. It included an employer-mandated set of minimum standards on benefits and employer contributions as well as a new federal HealthCare program to replace Medicaid and Medicare and cover all low-income individuals in addition to the elderly and disabled.⁶

The 1990 Pepper Commission chaired by Senator Jay Rockefeller narrowly approved a “pay or play” approach to employer coverage; employers could either “play” by providing health insurance to workers voluntarily or “pay” a payroll tax to have their workers and dependents covered under a public plan.⁸ This was translated into the HealthAmerica legislative proposal introduced by Senator George Mitchell with bipartisan support. Employers were required to pay 80 percent of premiums for full-time workers and 50 percent of premiums for part-time workers. The state-administered public AmeriCare plan provided comprehensive coverage for everyone below the poverty level with no cost-sharing.

President George Bush advanced a health insurance proposal in February 1992 including vouchers for the poor to purchase private health insurance and tax credits or deductions for families with incomes up to \$80,000, as well as the creation of small business pools and health insurance networks.⁷

A Democratically controlled Congress and the newly elected president Bill Clinton committed themselves to enacting national health insurance legislation in 1993–94. The Clinton Health Security Act included an employer mandate requiring employers to pay 80 percent of the premium (up to a maximum of 7.9 percent of payroll), with the family share of premiums not to exceed 3.9 percent of income.⁹ The plan was to be financed by substantial Medicare and Medicaid savings, an increase in the tobacco

Figure 1. Milestones in National Health Insurance Proposals, 1912–1997



tax, and cross-subsidies among employers within risk pools.

Because of the failure to enact these proposals, health policy has shifted focus to incremental approaches to health insurance coverage. The Kassebaum–Kennedy Health Insurance Portability and Accountability Act of 1996 prohibited pre-existing condition clauses for employees changing their employer coverage. It also included a small-scale demonstration of medical savings accounts.

In 1997, the Balanced Budget Act included CHIP, which provided federal matching funds to expand coverage to children in families with incomes up to 200 percent of the federal poverty level. The expanded coverage was financed by an increase in the tobacco tax. An estimated 3.3 million uninsured children are currently covered by CHIP.

Lessons for the 21st Century

Throughout the 20th century, health insurance coverage surfaced as a major public policy issue—only to encounter significant dissension among advocates about the best approaches for expanding coverage and stiff opposition from interests threatened by the prospect of change. The political reality is that the poor, minorities, and the uninsured are the groups most disadvantaged by the health care system and the least able to advocate for change. At the same time, providing universal coverage also requires a redistribution of resources away from those who are better off and have little to gain from expanded coverage.

Although health care was high on the national agenda throughout the last century, the underlying reasons changed over time. Early in the 20th century, leaders of the newly industrialized nation were concerned about lost labor productivity when illness or injury undermined a citizen's ability to work. In the aftermath of the Great Depression, the economic ruin that major health care expenses could bring to uninsured families was a paramount concern. Following World War II, the mortality from preventable disease, as well as recent breakthroughs in medical research, prompted a greater awareness among Americans of the benefits that could be gained from a greater investment in health.

The growth of employer-based private health insurance and the breakdown of private coverage for those who retired or were chronically ill set the stage for Medicare. Republican and Democratic presidents—Nixon and Carter—focused on national health insurance as a mechanism for ensuring equitable access to health care services while at the same time containing health care costs.

More recently, health reform proposals have shifted emphasis from a concern with equity and access to care to a focus on economic incentives in the health care system and how to produce greater efficiency. President Clinton tried to provide a legislative framework for the evolution of managed care that would ensure choice, quality, access, and cost control through managed competition and purchasing coalitions.

In each era, political obstacles to the enactment of universal coverage blocked progress. Major reform efforts sometimes faltered because providers of health services and health insurers felt threatened economically. At other times, proposals foundered because of events external to health care—the outbreak of war, budgetary deficits, or political division. As employers became the main source of health insurance, the nation also became increasingly divided between those with coverage and those without, requiring new taxes or a redistribution of income to finance coverage for low-income uninsured individuals paid for by those who did not stand to benefit.

Important incremental changes did occur, however, namely Medicare and Medicaid in 1965 and children's health insurance in 1997. The private sector also has evolved. Employer-based health insurance expanded dramatically following World War II and managed care came to dominate employer coverage in the 1990s.

Although concern about health insurance has heightened in periods of economic downturn, progress has come in relatively good economic times. From 1974 to 1996, when unemployment exceeded 5 percent, the number of uninsured rose and universal health insurance proposals advanced by Presidents Nixon, Ford, Carter, Bush, and Clinton all failed. This experience suggests that forces conducive to change include economic prosperity. Furthermore,

incremental changes that expand coverage but do not change the organization and delivery of services have fared better than more sweeping health care reform proposals that would have a substantial impact on the economic interests of health care providers and insurers.

Where Are We Headed Now?

The absence of universal health insurance coverage is a serious and growing problem. In 2000, 38.7 million Americans were uninsured.¹⁰ About one-fourth of Americans receive coverage under Medicare and Medicaid. Health insurance coverage voluntarily provided by employers, however, is the mainstay of the American health care system. About 60 percent of all Americans, 158 million people, obtain health insurance through employer-sponsored coverage.

From the middle of the 20th century until the mid-1970s, the number of uninsured Americans declined steadily. From 1953 to 1976, the total dropped from 71 million people to 23 million people—or from 44 percent of the population to 11 percent. (Figure 2) The growth of employer-provided health insurance was the major factor driving down the number of uninsured in the 1950s and early 1960s. The enactment of Medicare and Medicaid in 1965 was the major reason for the rapid decline from the mid-1960s to mid-1970s.

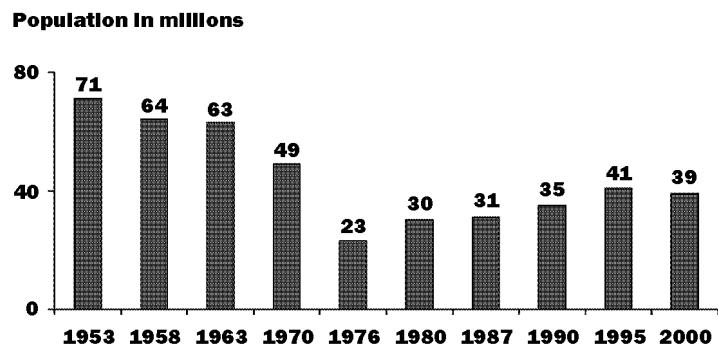
Since the mid-1970s, the number of uninsured has risen, with a downward tick in 1999 in the midst of a strong economy. The reasons for

the increase in the number of uninsured over the last 25 years of the 20th century are less well understood. The most commonly cited reason is the rise in health insurance premiums that has made coverage less affordable for employers and for individuals. This has undoubtedly contributed to the increase in the number of uninsured, but health insurance premiums were also increasing in the 1950s and 1960s when health insurance coverage expanded. Private health insurance premiums were also quite stable in the early 1990s, even declining in real terms, yet the number of uninsured continued to climb steadily by one million people a year. Over a longer period, therefore, no systematic relationship can be found between increases in premiums and the number of uninsured.

When examining the recent history of different types of coverage, it is clear that the growth in the number of uninsured from the mid-1970s to the mid-1990s was a result of the erosion of employer-based health insurance coverage. One contributing factor was the restructuring of American industry over this period—manufacturing jobs declined and service sector jobs expanded, which meant a shift away from firms with good health insurance coverage to those with poor coverage. Employers also took a number of cost-reducing steps such as increasing employee premium shares and reducing or eliminating financial support for coverage of spouses and children. In 1998 dollars, the cost of job-based insurance increased 2.6-fold and employees' contributions for coverage increased

3.5-fold (Figure 3), contributing to a decline in the percentage of non-elderly Americans covered by job-based insurance from 71 percent to 64 percent.¹¹ This increased premium cost for workers has led an increasing number of low-wage workers to decline employer coverage even when it is offered.¹² The rise in the number of uninsured workers from 1977 to 1998 was almost entirely among workers with a high school education or less.¹³ Rates of own-employer coverage among workers with wages in the bottom fifth of all wage earners—

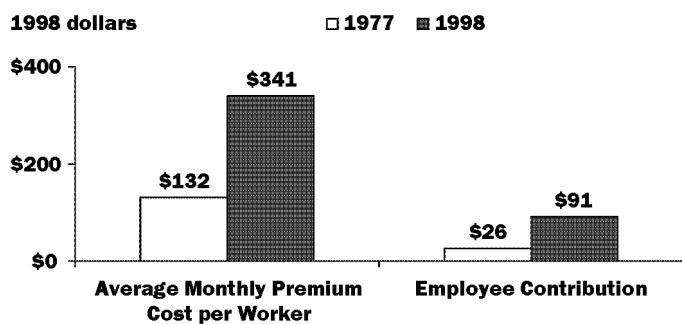
Figure 2. Growth in the Number of Uninsured, 1953–2000



Source: 1953–1976, National Health Interview Survey; 1980, EBRI; 1987–2000, U.S. Census Bureau, *Health Insurance Coverage: 2000*, September 2001.

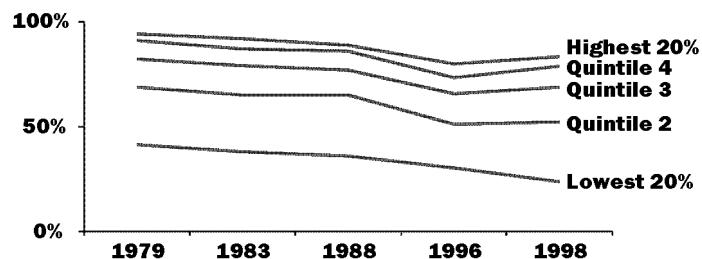
those earning less than \$7.21 per hour—fell from 42 percent in 1979 to 26 percent in 1998.¹⁴ (Figure 4)

Figure 3. Growth in Plan Cost and Employee Contributions of Employer-Sponsored Insurance



Source: Jon R. Gabel, "Job-Based Health Insurance, 1977–1998: The Accidental System Under Scrutiny," *Health Affairs* 18 (November/December 1999): 62–88.

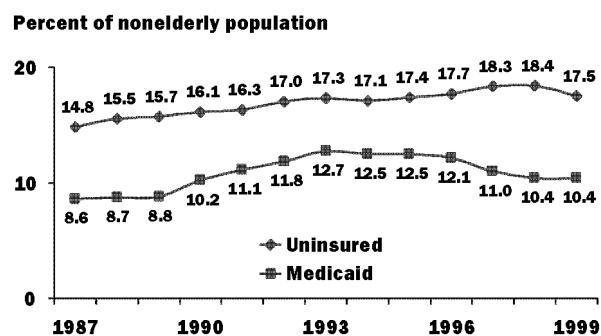
Figure 4. Percent of Private Sector Employees Receiving Own-Employer Health Coverage, by Hourly Wage Quintile, 1979–1998



Note: In 1998, the lowest 20% earned less than \$7.21 per hour and the highest 20% earned more than \$21.15 per hour.

Source: James L. Medoff, Howard B. Shapiro, Michael Calabrese, and Andrew D. Harless, *How the New Labor Market Is Squeezing Workforce Health Benefits*, The Commonwealth Fund, June 2001.

Figure 5. Growth in Uninsured Americans and Medicaid Beneficiaries, 1987–1999



Source: Employee Benefits Research Institute estimates of the March 1998–2000 Current Population Survey.

Medicaid coverage expanded in the late 1980s and early 1990s when legislative changes extended the program to more low-income pregnant women and to children. This expansion of Medicaid offset the erosion of employer-based coverage to some extent, but not sufficiently to stem the rise in the number of uninsured (Figure 5).

The trend since the mid-1990s has been somewhat different. The percentage of the population with employer coverage increased modestly in the late 1990s. This occurred primarily because more people were working and coverage from a spouse's employer increased because more families consisted of two wage earners, but also to some extent because more higher-wage workers were covered by their own employer.¹⁵ Medicaid reversed course, however, and covered a smaller percentage of the population. From 1997 to 1999, for example, the number of people covered by Medicaid dropped by 1 million. Thus, the rise in the number of uninsured over the last five years is mostly accounted for by the decrease in the number of people covered by Medicaid. Part of this trend may be the result of a better economy, movement from welfare to work, or moving from being unemployed to working—although many of the jobs offer no health benefits. Unfortunately, record low unemployment and reduced welfare rolls do not appear to be leading to increased job-based coverage for low-wage workers. Women leaving welfare also may be unaware of their continued eligibility for Medicaid coverage or of coverage options for their children under Medicaid and CHIP.

Working is certainly no guarantee of having adequate health insurance coverage.¹⁶ The vast majority of the uninsured work or are dependents of workers. About 60 percent of these Americans are in families in which someone works full time, all year, and another 24 percent

are in families with a part-time or part-year worker. Only 16 percent of the uninsured are in families without a working adult.

In fact, those working part time or who are self-employed are no more likely to be insured than those not currently working. According to The Commonwealth Fund 2001 Health Insurance Survey, about one-fourth of part-time workers, one-third of those who are self-employed, and 30 percent of those not currently working are uninsured, compared with 21 percent of full-time workers. (Figure 6) Without employers contributing to coverage, health insurance is unaffordable for many workers.¹⁷

Even among full-time workers, however, those earning lower wages are much less likely to be insured. Forty-nine percent of adults working full time with a family income of less than \$20,000 are uninsured, compared with

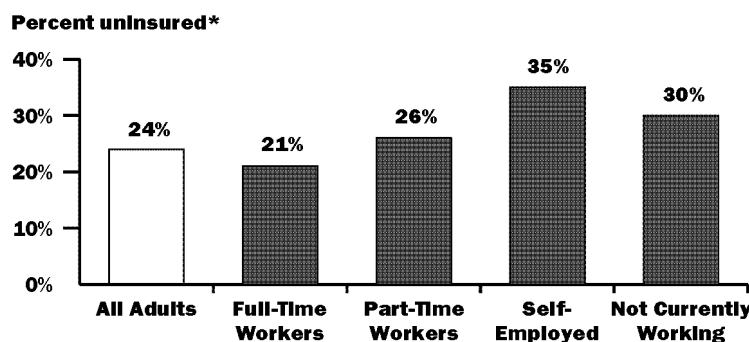
28 percent of those with incomes from \$20,000 to \$34,999 and only 4 percent of those with incomes of \$60,000 or more.¹⁸ (Figure 7)

Options for Providing Coverage to the Uninsured

Given that the uninsured are unable to afford coverage on their own, viable options for expanding coverage will require financial contributions toward premiums from government or from employers. There are four general strategies for providing and financing coverage for the uninsured: federal tax subsidies, federal health insurance programs, federal/state health insurance programs, and expanded employer coverage.

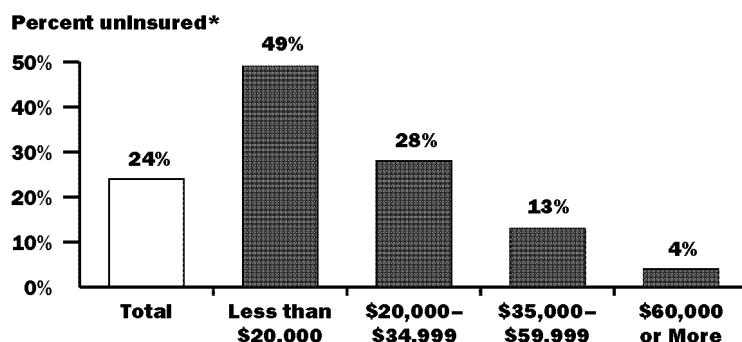
- Tax credits have been proposed by President Bush to enable people to purchase individual health insurance, but such credits alternatively could be used to purchase coverage under employer plans, Medicare, Medicaid, or CHIP.¹⁹
- Older adults could be given the option of purchasing Medicare, and more disabled people could be covered by broadening the eligibility criteria or removing the two-year waiting period for coverage.²⁰
- Low-income parents could be covered along with their children under Medicaid and CHIP. Medicaid coverage also could be expanded to low-income single people and childless couples.²¹
- Employer coverage could be expanded by making coverage automatic upon employment, rather than after a waiting period, and by covering part-time workers. Federal assistance would ensure that the employee share of premiums is affordable. Similarly, COBRA coverage for those employees leaving jobs could be increased through automatic enrollment mechanisms coupled with federal premium

Figure 6. Part-Time Workers and the Self-Employed Are as Likely as the Unemployed to Be Uninsured



* Uninsured when surveyed or had a time uninsured during the year.
Source: The Commonwealth Fund 2001 Health Insurance Survey.

Figure 7. Working-Age Adults Below Median Income Are at High Risk of Being Uninsured



* Uninsured when surveyed or had a time uninsured during the year.
Source: The Commonwealth Fund 2001 Health Insurance Survey.

assistance for those unable to afford even employer group premiums. Opening up public purchasing pools similar to the Federal Employees Health Benefits Program and state public employee benefits plans could induce employers to provide coverage. Subsidies for employers or stop-loss protection are also strategies for expanding employer coverage.²²

Each of these options has advantages and disadvantages relating to the equity of the financing burden, the degree to which expanded coverage is targeted on the uninsured as opposed to substituting for existing coverage, administrative ease, and public support. Depending on the specific proposal, other variables to consider include adequacy of coverage, quality of care, portability and stability of coverage, choice, and continuity in physician–patient relationships.

There is strong public support for having government help low-income workers get health insurance: letting uninsured adults participate in government insurance programs such as Medicare, Medicaid, and CHIP is favored by 81 percent of Americans.²³ Somewhat fewer, although still a large majority, favor offering tax credits or other financial assistance to help people buy health insurance on their own (79%) or requiring all businesses to contribute to the cost of health insurance for their employees (76%). (Figure 8)

Although the recently enacted tax cut has eliminated the federal budget surplus that would

have made it feasible to provide premium assistance under a variety of mechanisms, the tax cut is phased in over time and could be rethought to free budgetary resources to invest in a healthier population, a more productive labor force, and a stronger economy.

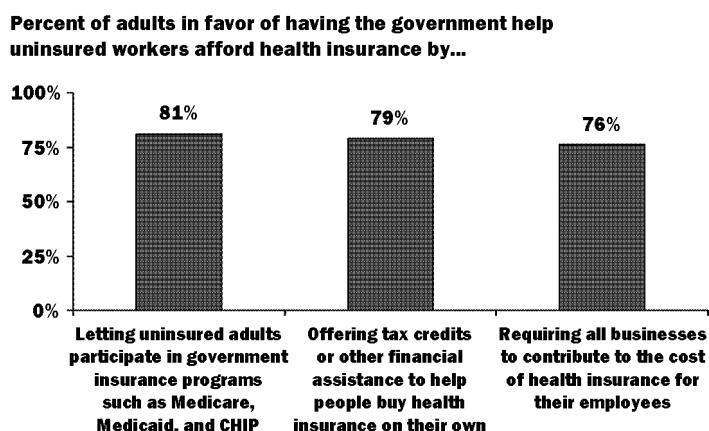
Conclusion

Despite heightened national security concerns and the recent economic slowdown, the United States enters the new century on the heels of a period of relative peace and prosperity, and the foundations of our economy are still strong. Although there has been a recent modest increase in unemployment, the long-term trend is toward a tight labor market (a consequence of lower birth rates beginning in the late 1960s). This should result in a high value being placed on ensuring that children are healthy and able to learn, young adults are healthy and able to work, and chronic conditions in older adults are well managed, thus enabling them to continue working longer. A tight labor market also is likely to attract a growing immigrant population, whose health is essential to productivity. Gaps in the current health insurance system, particularly for those with low incomes, immigrant status, or high health risks, undermine these aims.

In times of external threat to the nation, a policy aimed at expanding health coverage is especially important for practical and moral reasons: after all, everyone needs to feel they have a stake in the welfare of the country, and more than ever, the country needs a healthy and productive workforce. We simply cannot continue with a health care system that excludes some of our people because they lack health insurance or because of their race, ethnicity, or income. Nor can we afford to waste the human resources that are the key to our future strength and prosperity.

With the will and the right resources, the United States can attain the goal of universal health coverage early in this century. Indeed, to be strong, just, and prosperous in the 21st century, our nation depends on it.

Figure 8. Support for Proposals to Expand Health Insurance Coverage for Uninsured Workers



Source: The Commonwealth Fund 2001 Health Insurance Survey.

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