



JULY 2005

Issue Brief

Options for Federal Coverage of the Uninsured in 2005

ERIN C. STRUMPF AND JULIETTE CUBANSKI

For more information about this study, please contact:

Mary Mahon
Public Information Officer
The Commonwealth Fund
1 East 75th Street
New York, NY 10021-2692
Tel 212.606.3853
Fax 212.606.3500
E-mail mm@cmwf.org

ABSTRACT: Current approaches to reducing the number of uninsured include insurance tax credits for individuals and employers, expanding private group coverage, expanding eligibility for public programs, creating new public programs, and reforming insurance markets. Proposals vary in how they would expand coverage, how many uninsured would be covered, and how much they would cost. Although the costs of expanding coverage are significant, so are the costs of high uninsured rates. Moreover, expanding coverage would likely lead to substantial gains in health and productivity.

★ ★ ★ ★ ★

Introduction

The number of uninsured Americans increased again in 2003, resulting in the highest uninsured rate since 1998.¹ Uninsurance significantly impacts the lives of Americans across the income spectrum, mostly poor and middle-class working Americans.² The health and financial costs to individuals and to the nation as a whole have been well documented.³ A range of options to deal with this issue are under discussion.

Current approaches to reducing the number of uninsured generally build on the existing system of public and private coverage. Approaches include establishing tax credits for individuals and employers to defray the cost of health insurance, expanding private group coverage through employers or other group-purchasing arrangements, expanding eligibility for federal and state public programs, creating new public programs, and reforming the health insurance market. Some proposals combine various approaches to expanding coverage, while others aim to insure all Americans using a single system, such as a national government-run program or mandatory employment-based or individual coverage within the private insurance market.

Additional copies of this and other Commonwealth Fund publications are available online at www.cmwf.org.

To learn about new Fund publications when they appear, visit the Fund's Web site and [register to receive e-mail alerts](#).

Commonwealth Fund pub. #831

This issue brief was prepared for The Commonwealth Fund/John F. Kennedy School of Government Bipartisan Congressional Health Policy Conference, January 13–15, 2005.

Approaches to expanding insurance can be categorized according to:

- the vehicle for coverage—the private individual market or group-based plans, existing public sector programs or new public options, or both;
- the sources of payment for coverage—federal or state governments, employers, or individuals;
- the populations that would be covered—all Americans or specific subgroups of uninsured individuals;
- the number of uninsured who would be reached; and
- the economic impact, including the total cost of additional coverage and how it would be financed.

The Uninsured: A Profile

An estimated 45 million people, 15.6 percent of the population, lacked health insurance in 2003, up from 14.2 percent in 2000. This represented an increase of 1.4 million people in one year and 5.2 million more uninsured (an increase of nearly 13 percent) over four years.⁴ This recent increase in uninsured rates is driven by continuing declines in employer-sponsored insurance coverage. Declines in employer coverage among children have been offset by increases in enrollment by Medicaid and the State Children's Health Insurance Program (SCHIP).⁵ The Census Bureau's estimate of the number of uninsured measures the number uninsured at a particular point in time. Counting those who are uninsured for the entire year or at any point during the year yields much lower or higher numbers, respectively.⁶ Using Census Bureau and other federal surveys, the Congressional Budget Office (CBO) estimates that 21 million to 31 million were uninsured for the entire year and 60 million were uninsured at some point during the year.⁷ Recent studies also find high rates of churning in insurance markets over time, with people gaining and losing coverage repeatedly over several years.⁸

Uninsured Americans comprise a diverse population. Determinants of coverage include age and race and ethnicity as well as socioeconomic and employment status.⁹ The poor and near-poor have the greatest risk of being uninsured, but the large majority of uninsured work or are members of working families.¹⁰ Being middle class isn't sufficient protection against uninsurance, as 30 percent of the uninsured have family incomes above the annual median of \$43,400.¹¹ Young people between the ages of 19 and 29 are at increased risk of uninsurance because they tend to have low-wage jobs, lose access to coverage through their parents when they graduate from high school or leave college, or lose public coverage when they reach age 19.¹² Hispanics are less likely than all other racial or ethnic groups to be insured and have the highest uninsured rates across all wage, income, and job categories.¹³ Men historically have been somewhat more likely to be uninsured than women, but this gap has been closing.¹⁴ For some individuals, lack of coverage is a short-term problem, while for others the problem persists for a year or longer.¹⁵

Sources of Coverage

Approximately 60 percent of Americans have employer-sponsored health insurance coverage and 14 and 12 percent have coverage through Medicare and Medicaid/SCHIP, respectively.¹⁶ While they provide coverage to a large number of people, employers and the federal and state governments show signs of strain as a result of recent downward economic trends. Unstable labor market conditions have reduced rates of employment-based coverage. Escalating health care costs and premiums have affected both private and public payers. The percentage of people covered by employer-sponsored insurance decreased significantly since 2000, from 63.6 to 60.4 percent.¹⁷ The shift away from manufacturing and toward service-sector jobs—a move from industries with high rates of employer-sponsored coverage to industries

with lower rates—contributed to this decline. Most employers, especially large firms, continue to offer coverage, but some are scaling back coverage or requiring more cost sharing for current workers and retirees.¹⁸ In addition, the share of employees in large firms who participate in employer-sponsored plans is declining, especially among low-wage workers.¹⁹ Small employers, facing higher premiums for group coverage, are less likely than large firms to offer coverage and face more rapid increases in premiums.²⁰ Between spring 2003 and spring 2004, monthly premiums for employment-based coverage rose 11.2 percent, significantly faster than wage gains for nonsupervisory workers (2.2 percent).²¹ This was the fourth consecutive year that employers have faced double-digit rates of premium inflation.

Among the entire population, the percentage covered by government insurance programs, such as Medicaid, Medicare, and SCHIP, rose to 26.6 percent in 2003, from 24.7 percent in 2000. This rise was largely due to an increase in the rate of Medicaid coverage, from 10.6 percent to 12.4 percent.²² While the uninsurance rate for adults increased over this period, there was no increase among children due to expanded coverage under Medicaid and SCHIP offsetting losses in private coverage. According to the Department of Health and Human Services (HHS), 5.8 million children were enrolled in SCHIP in 2003, a 75 percent increase since 2000.²³ While Medicaid and SCHIP play a crucial role in providing health insurance coverage for low-income populations, every state in the nation responded to rising health care costs and limited state budgets by implementing cost-control measures for their Medicaid programs in 2004 and plan to do the same in 2005.²⁴ While federal fiscal relief helped many states meet budget shortfalls and maintain or expand Medicaid coverage in 2004, the expected loss of federal support in 2005 will require a significant increase in state Medicaid spending to maintain current eligibility levels.

The impact of uninsurance can be measured both in terms of poorer health status among the uninsured and in financial costs to the uninsured, to employers, and to the health system overall.²⁵ While few studies have been designed to test a causal relationship between health insurance and health status, many studies have demonstrated that a correlation exists between the two.²⁶ Some research suggests that insurance coverage is related to better health, which leads to higher labor force participation and higher income. Those without coverage receive fewer preventive services and tend to seek medical care when their illnesses are at more advanced stages, resulting in higher treatment costs, lengthier illnesses, and worse health outcomes. The financial impact of uninsurance can be measured in terms of lower earnings, lost productivity, and premature death and disability. The Institute of Medicine (IOM) reports that the aggregate cost of increased morbidity and mortality due to uninsurance in the U.S. is between \$65 billion and \$130 billion per year and, with an estimated 18,000 deaths per year, ranks lack of health insurance as the sixth leading cause of death for adults ages 25 to 64.²⁷ Costs to the health system can be measured in terms of the value of uncompensated care provided to the uninsured, estimated at almost \$35 billion in 2001, of which \$24 billion was provided by hospitals.²⁸ Of this amount, employers and managed care companies helped fund \$1.5 billion to \$3 billion through higher premium rates.²⁹

An Overview of Federal Approaches to Expanding Coverage

There are a range of federal approaches to increase the rate of insurance coverage. While tax credits enjoy bipartisan support and are a prominent feature of many current proposals, disagreement remains regarding how they can be most effective. Federal action to enhance the private, nongroup insurance market is an approach to improving accessibility and affordability. Another major route

to increasing coverage is by expanding public insurance programs, including Medicare, Medicaid, and SCHIP. The federal government can provide opportunities for states, local governments, and employers to expand coverage.

Tax credits

The tax-preferred status of employer-sponsored health insurance benefits provides a strong financial incentive for workers to obtain coverage through their employers. Many policymakers support additional tax-based subsidies for the uninsured to equalize this incentive and to expand coverage by making it more affordable. Tax credits have been proposed for both individuals and employers to reduce the costs of coverage in the individual market, the employer-based system, new group insurance pools, and public programs. Proposed tax credits for individuals generally target people with low to moderate incomes, phase out as income rises, and are refundable (allowing individuals who pay little or no income tax to qualify) and advanceable (providing immediate purchasing power).³⁰

A number of factors determine the reach and cost of tax credits:

- eligibility for the credit (all individuals, individuals without access to public or private group coverage, or small businesses);
- the amount and type of the credit (fixed-dollar or a proportional amount or varying with income); and
- the nature of insurance coverage for which the credit can be used.³¹

The use of individual tax credits to expand coverage would target those who are not linked to the system of group coverage through their workplace. Tax credits may help many relatively young, healthy individuals and families, but without a relatively large credit they may not help older individuals or uninsured people with preexisting

conditions. For these groups, individual policies might be prohibitively expensive, might exclude certain health conditions from coverage, or might not be available at all. Proponents of tax credits for individuals argue that they give consumers greater choice and control, and that they address equity and efficiency problems in the current tax code. Opponents argue that tax credits alone, without a new source of group coverage or market regulations, may erode the employment-based system but leave consumers with inadequate and more costly alternatives.

Experts have estimated the cost and coverage impacts of a new individual tax credit to purchase nongroup coverage and a new tax deduction for premiums for high-deductible, nongroup health insurance policies.³² Approximately 10 million people would use a tax credit similar to the one President Bush proposed in the 2005 revenue proposals³³ and the number of uninsured would be reduced by 1.8 million. The tax credit policy would cost about \$2,570 per newly insured person. The tax credit and tax deduction combined, while leveling the field between employer-based and nongroup coverage, would result in fewer newly insured people than the tax credit policy alone.

The Trade Act of 2002 (P.L. 107-210) provides \$12 billion over 10 years in Trade Adjustment Assistance (TAA) to workers who lose their jobs due to foreign competition. The law created the Health Coverage Tax Credit, a refundable and advanceable tax credit to cover 65 percent of health insurance premiums. Eligible uninsured workers can use the tax credit to purchase employer-sponsored coverage offered by their former employers (i.e., COBRA³⁴ coverage), a spouse's employer health plan, a previously purchased individual policy, or state-based group insurance, such as a state's purchasing pool for employees or for high-risk individuals. The law also established a tax credit for retirees age 55 or older who receive pensions from the Pension Benefit Guarantee Corporation. Some 200,000 to 300,000

workers and their families are estimated to be eligible for the tax credit and both federal and state officials have made significant progress in developing the necessary infrastructure to implement the program.³⁵ Challenges still remain however, including obstacles to enrollment such as the affordability of the worker's premium share, the timing of advance payment, complicated outreach materials, and the limited appeal of the available coverage options. The latest enrollment figures indicate that less than 6 percent of workers identified as eligible were enrolled as of December 2003.³⁶

Tax credits can also be provided to employers to help finance employer-sponsored coverage. This approach is viewed as especially helpful for small businesses. Supporters note that tax credits to employers build on the existing employer-based system and take advantage of the savings that come from pooling risk and lower administrative costs. Opponents criticize them for maintaining the imbalance in tax treatment between insurance purchased by the employer and insurance purchased by individuals. In general, tax credits may not be generous enough to induce many employers to offer coverage to their workers.

Reforming the Private Insurance Market

Purchasing coverage in the private nongroup insurance market has been suggested as a way to increase consumer choice and rates of insurance coverage. However, experts also note that this insurance market does not always work well since insurance companies often compete to avoid costly or high-risk individuals rather than to provide the most cost-effective treatment.³⁷ Providing individuals with money to purchase insurance in the private market (via tax credits, Health Savings Accounts, etc.) does not mitigate the incentives for insurance companies to avoid those they think will be costly by charging high premiums or using other selection mechanisms. Assuring insurance companies that they would not be responsible for the costs of very high-cost patients will lessen this

incentive.³⁸ These highest-cost patients usually suffer from very serious diseases that are often unpredictable. This approach, known as reinsurance, has been suggested as a way to reduce insurance premiums, to stabilize the provision of health insurance by employers, and to make health insurance accessible and affordable to middle-class families who do not get insurance through their employer. It can also spread the risk of very high expenditures associated with severe illnesses among the entire population. Reinsurance is often described as a necessary step in order for free-market approaches to increasing insurance coverage to be successful.

In the 1990s, many states took action to increase the availability of private nongroup coverage by requiring that insurers accept all applicants without regard to health status (guaranteed issue), that insurers renew existing policies, or by restricting the use of preexisting condition exclusions. Rating bands and community rating were used to improve affordability and minimum benefits mandated to protect consumers from policies that provided little to no protection from financial loss. Evidence from these states' experiences indicates that some forms of regulation increase access for high-risk individuals. However, premiums are rarely reduced enough to significantly increase affordability and regulation may increase costs for low-risk individuals seeking basic coverage. Some experts note that nongroup insurance market regulation at the state or federal level (as in the Health Insurance Portability and Accountability Act of 1996 [HIPAA, P.L. 104-191]) could enhance the effectiveness of tax credits in increasing access to health insurance coverage.³⁹

Medicare Expansions and the Federal Employees Health Benefit Program

Medicare currently covers 6 million disabled adults under age 65, nearly all of whom had to wait more than two years after qualifying before they received benefits. Disabled beneficiaries tend to be

older, more than 75 percent have incomes below 200 percent of poverty,⁴⁰ and nine in 10 suffer from one or more chronic illnesses.⁴¹ Purchasing nongroup insurance coverage is difficult and costly for many disabled adults. Many who wait for Medicare benefits rely on the partial safety net that Medicaid provides. The cost to states and the federal government for this coverage was estimated at \$7.6 billion in 2002.

Eliminating the waiting period and making disabled adults eligible for Medicare coverage when they qualify for cash benefits under the Social Security Disability Insurance (SSDI) program could improve access to health insurance for as many as 400,000 uninsured disabled adults. The total annual net cost to the federal budget is estimated at \$6.2 billion after taking federal Medicaid savings into account.⁴² While Medicare coverage would replace some private insurance coverage, paying for this insurance currently imposes significant financial burdens on both private employers and SSDI beneficiaries who pay high premiums to maintain private coverage.⁴³

In 2003, nearly one in four adults age 55 to 64 were uninsured or had private nongroup insurance.⁴⁴ As rates of employer-sponsored retiree coverage decline and nongroup insurance remains difficult to afford or purchase by older adults with chronic health conditions or low incomes, some have recommended expanding the Medicare program by allowing older adults to buy into the program.⁴⁵ Advocates note that this would enable a smooth transition to Medicare after age 65 and would allow spouses of different ages to have the same insurance. Opponents, however, cite the subsidies that would be necessary to achieve a high participation rate.

Another approach to increasing rates of insurance coverage would be to allow uninsured Americans to buy into the Federal Employees Health Benefits Program (FEHBP). This program offers many different insurance plans and combines risk pooling, competition among health plans,

comprehensive benefits and consumer choice. While there is some concern that only those with health problems would purchase this coverage without an individual mandate in place, continued use of community-rated premiums for new enrollees or premium subsidies for those with low incomes could mitigate this problem.⁴⁶

Employer Pools and Group Purchasing Arrangements

While group purchasing arrangements such as association health plans (AHPs) and employer pools are often organized at a state or local level, the federal government plays an important role in encouraging these approaches to reduce the cost of insurance and to increase coverage. Grouping individuals and small businesses together to purchase health insurance can maximize affordability and consumer choice. Less stringent licensing requirements, which can aid in controlling costs, can also result in increased financial instability and insolvency.⁴⁷ Voluntary associations are also more likely to be attractive to firms with older or sicker workers, which can result in relatively high premiums.

Many states coordinate public and private sources of insurance coverage by assisting Medicaid and SCHIP beneficiaries to buy into their employer-based coverage. The Employee Retirement Income Security Act (ERISA) however, exempts self-insured employers from state regulation, making it difficult for states to ensure that their public program participants are receiving benefits as generous as those provided under the public programs. Addressing the interaction of federal regulation and state programs can be an important component of approaches to expanding coverage.

Medicaid and SCHIP

Public programs such as Medicaid and SCHIP are important sources of coverage for millions of low-income children and adults and disabled individuals. Expanding eligibility for existing public programs or creating new state-based programs would target many uninsured people who have no

reliable or affordable link to employment-based coverage, such as low-income adults, children in low-income families, and people with disabilities or chronic health conditions that limit access to private coverage. The federal government allows states to experiment with different approaches to covering their uninsured population with Section 1115 and Health Insurance Flexibility and Accountability Initiative (HIFA) waivers and provides matching funds for state expenditures under Medicaid and SCHIP and for establishing and operating high-risk pools.

Current Proposals to Increase Coverage

Members of Congress, President Bush, and Senator John Kerry during his campaign for President introduced proposals to reduce the number of uninsured.⁴⁸ The Bush Administration's plan consists of a tax credit for low-income individuals to purchase insurance in the individual market and a tax deduction for the purchase of high-deductible, nongroup coverage in combination with a Health Savings Account. Democratic proposals focus on expansions of existing public-private group insurance programs while also supporting the employer-based system and providing tax credits to improve affordability. In the 108th Congress, these approaches to coverage were the subject of dozens of bills introduced in both chambers.

The Bush Administration's proposal to expand health insurance coverage includes tax credits for individuals and families, expansion of low-premium, high-deductible insurance plans with Health Savings Accounts (HSAs), and encouraging the formation of Association Health Plans.⁴⁹ Tax credits of up to \$1,000 for low-income individuals and \$3,000 for low-income families (up to \$25,000 for a family of four) would help pay premium and deductible costs. President Bush also plans to propose a tax credit for small businesses and their employees who set up and contribute to an HSA as well as to allow individuals who purchase low-premium, high-deductible

insurance policies to deduct the premiums from their taxable income. The president supports allowing small businesses to combine their purchasing power when buying health insurance on behalf of their employees as well as expanding AHPs to civic and charitable groups, churches, and other organizations. President Bush also has discussed a "Cover the Kids" campaign, with the goal of covering all SCHIP-eligible children within the next two years. Bush's plan is estimated to cost the federal government between \$91 billion and \$195 billion over 10 years (2005–2014) and provide coverage for approximately two to eight million people who were previously uninsured.⁵⁰

During his presidential campaign, Senator Kerry's proposal for increasing health insurance coverage included expansions of public programs with fiscal relief for states, reinsurance against catastrophic costs for health insurance plans provided by the federal government, and the option for individuals and employers to buy into the Federal Employees Health Benefits Program (FEHBP).⁵¹ More than 18 million uninsured children and adults would be covered under Medicaid and SCHIP expansions. FEHBP would be changed by adding a new pool for small and large businesses, individuals, and families and by providing refundable tax credits for part of the cost of coverage for small businesses, their employees, and workers who are laid off. A "premium rebate pool" would be created to reimburse employee health plans for 75 percent of the catastrophic costs they incur above \$50,000, as long as they guarantee the savings are used to reduce the cost of workers' premiums. Kerry's plan is estimated to cost the federal government between \$653 billion and \$1,305 billion over 10 years (2005–2014) and to cover 25 to 27 million uninsured Americans.⁵²

Establish tax credits

A refundable tax credit to help make insurance more affordable for certain individuals and employers is a component of health care reform

proposals supported by members of both parties. Tax credit legislation in the 108th Congress included:

- Expanding the Trade Adjustment Assistance tax credit to all unemployed workers, not only trade-displaced workers
- Expanding the tax deduction up to 100 percent of the health insurance premium for all taxpayers
- Providing a tax credit to small employers for coverage offered to low-wage workers
- Providing a tax credit to low-wage workers for their premium contribution for employer-sponsored coverage or for buying into the FEHBP
- Providing a tax credit to assist unemployed workers with premiums for COBRA coverage
- Allowing tax deductions for federal civilian and military retirees for Federal Employees Health Benefits Program (FEHBP) and TRICARE health insurance premium payments

Reform the private insurance market

Proposals in the 108th Congress to make insurance more accessible and affordable through private market reforms included:

- Establishing standards for state-based reinsurance programs and award grants to states to cover the costs of such programs
- Establishing a reinsurance fund for carriers that experience a catastrophic claim (over \$50,000) for benefits provided to individuals who are self-employed or work for a business with fewer than 100 workers
- Awarding demonstration grants to states to demonstrate the effectiveness of innovative market reforms for increasing access to health insurance, such as purchasing cooperatives for small businesses, reinsurance pools, and high-risk pools

Expand group coverage

Proposals to expand group coverage by building on the employer system and creating new opportunities for pooled purchasing have received bipartisan support. Legislation in the 108th Congress to expand access to employment-based or other sources of group coverage included:

- Establishing regulations for new group purchasing pools for small employers or self-employed individuals
- Allowing small businesses or the self-employed to buy into publicly sponsored programs, such as the FEHBP, state-run pools, or private group purchasing alliances
- Promoting the formation of small employer association health plans (AHPs).

Expand federal public programs

Proposals in the 108th Congress to increase the number of uninsured people covered by federal programs included:

- Allowing uninsured people 55–64 years of age to purchase insurance through Medicare before they reach the official eligibility age of 65
- Eliminating the two-year waiting period for Medicare eligibility for disabled individuals
- Expanding Medicare eligibility to all uninsured individuals

Conclusion

Proposals to cover the uninsured vary in how they would expand coverage, how many uninsured they would cover, and how much they would cost. Though all expansion efforts require additional funding to pay for increased coverage, the costs of our current system must also be acknowledged. In 2004, uncompensated care for the full- and part-year uninsured totaled approximately \$41 billion, more than two-thirds of it is funded by federal dollars.⁵³ Comprehensive coverage is estimated to

increase health spending by \$48 billion per year but is also likely to result in health and productivity improvements totaling \$103 billion annually. While the costs of expanding coverage are significant, so are the costs of high and increasing rates of uninsurance.

NOTES

¹ U.S. Census Bureau, Historical Health Insurance Tables, 1987–2003, retrieved from: <http://www.census.gov/hhes/hlthins/historic/index.html>.

² K. Swartz. Reinsuring Health, forthcoming.

³ Institute of Medicine Committee on the Consequences of Uninsurance. 2003. *Hidden Costs, Value Lost: Uninsurance in America*. National Academy of Sciences; June 2003.

⁴ C. DeNavas-Walt et al. 2004. U.S. Census Bureau, Current Population Reports, P60-226, *Income, Poverty, and Health Insurance Coverage in the United States: 2003*, U.S. Government Printing Office, Washington, D.C.

⁵ J. Holahan and A. Ghosh. 2004. *The Economic Downturn and Changes in Health Insurance Coverage, 2000–2003*. Kaiser Commission on Medicaid and the Uninsured, September 2004.

⁶ Congressional Budget Office. 2003. *How Many People Lack Health Insurance and for How Long?* May 2003; J. Rhoades and J. Cohen. 2003. Statistical Brief #24: *The Uninsured in America—1996–2002: Estimates for the Civilian Noninstitutionalized Population Under Age 65*. Agency for Healthcare Research and Quality; September 2003. Retrieved from: <http://www.meps.ahrq.gov/papers/st24/stat24.htm>.

⁷ Congressional Budget Office, 2003, op. cit.

⁸ P.F. Short and D. Graefe. 2003. [Battery-Powered Health Insurance: Stability in Coverage of the Uninsured](#). *Health Affairs* 22 (6): 244–255;

November/December 2003; P.F. Short D. Graefe, and C. Schoen. 2003. [Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem](#). The Commonwealth Fund; November 2003.

⁹ C. DeNavas-Walt, op. cit.

¹⁰ Ibid.

¹¹ K. Swartz, op. cit.

¹² S.R. Collins, C. Schoen, and K. Tenney. 2003. [Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help](#). Task Force on the Future of Health Insurance Issue Brief. The Commonwealth Fund; May 2003.

¹³ M.M. Doty. 2003. [Insurance, Access, and Quality of Care Among Hispanic Populations](#). 2003 Chartpack. The Commonwealth Fund; October 2003.

¹⁴ C. DeNavas-Walt, op. cit.; J. Lambrew. 2001. [Diagnosing Disparities in Health Insurance for Women: A Prescription for Change](#). The Commonwealth Fund; August 2001.

¹⁵ J. Haley and S. Zuckerman. 2003. *Is Lack of Coverage a Short- or Long-Term Condition?* Kaiser Commission on Medicaid and the Uninsured; June 2003; Economic Research Initiative on the Uninsured (ERIU). 2002. *A Revolving Door: How Individuals Move In and Out of Health Insurance Coverage*. ERIU Research Highlight Number 1; October 2002. Retrieved from: http://www.umich.edu/~eriu/pdf/highlight_1.pdf.

¹⁶ C. DeNavas-Walt, op. cit.

¹⁷ Ibid.

¹⁸ Kaiser Family Foundation/Health Research and Educational Trust. 2004. *Employer Health Benefits: 2004 Summary of Findings*. Kaiser Family Foundation, September 2004.

¹⁹ S. Glied and J. Lambrew. 2003. [The Growing Share of Uninsured Workers Employed by Large Firms](#). The Commonwealth Fund; October 2003.

²⁰ P. Fronstin. 2003. *Small Employers and Health Benefits: Findings from the 2002 Small Employer Health Benefits Survey*. Testimony Submitted for the Hearing on Small Business and Health Insurance, Committee on Small Business, United States Senate. Employee Benefits Research Institute; February 5, 2003.

- ²¹ Kaiser Family Foundation/Health Research and Educational Trust, 2004, op. cit.
- ²² C. DeNavas-Walt, op. cit.
- ²³ Center for Medicare and Medicaid Services, FY 2003 Number of Children Ever Enrolled in SCHIP by Program Type. Retrieved from: <http://www.cms.hhs.gov/schip/enrollment/fy2000.pdf> and <http://www.cms.hhs.gov/schip/enrollment/schip03.pdf>.
- ²⁴ V. Smith et al. 2004. The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005, Results from a 50-State Survey. Kaiser Family Foundation, October 2004.
- ²⁵ K. Davis. 2003. [Commentary: The Costs and Consequences of Being Uninsured](#). *Medical Care Research and Review* 60 (2): 89S–99S. Supplement to June 2003; Institute of Medicine Committee on the Consequences of Uninsurance, op. cit.
- ²⁶ Economic Research Initiative on the Uninsured (ERIU). 2003. *Jumping to Conclusions: Will Expanding Health Care Insurance Improve the Health of the Uninsured?* ERIU Research Highlight Number 2; March 2003. Retrieved from: <http://www.umich.edu/~eriu/pdf/research-highlight-mar.pdf>; J. Hadley. 2003. Sicker and Poorer—The Consequences of Being Uninsured: A Review of the Research on Relationship Between Health Insurance, Medical Care Use, Health, Work, and Income. *Medical Care Research and Review* 60 (2): 3S–75S. Supplement to June 2003.
- ²⁷ According to the IOM, “These are the benefits that could be realized if extension of coverage reduced the morbidity and mortality of uninsured Americans to the levels for individuals who are comparable on measured characteristics and who have private health insurance.” Institute of Medicine Committee on the Consequences of Uninsurance. 2003. *Hidden Costs, Value Lost: Uninsurance in America*. National Academy of Sciences; June 2003.
- ²⁸ J. Hadley and J. Holahan. 2003. How Much Medical Care Do the Uninsured Use, and Who Pays for It? *Health Affairs* Web Exclusive: W3–66–W3–81; February 12, 2003.
- ²⁹ Ibid.
- ³⁰ B. Fuchs, M. Merlis, and J. James. 2002. *Expanding Health Coverage for the Uninsured: Fundamentals of the Tax Credit Option*. National Health Policy Forum Background Paper; August 28, 2002; Lyke, B. 2003. *Tax Benefits for Health Insurance: Current Legislation*. Congressional Research Service Issue Brief; May 7, 2004.
- ³¹ B. Fuchs et al., 2002, op. cit.
- ³² J. Gruber. 2004. Coverage and Cost Impacts of the President’s Health Insurance Tax Credit and Tax Deduction Proposals. The Henry J. Kaiser Family Foundation. March.
- ³³ The Administration proposes a refundable tax credit of up to 90 percent of the premium for nongroup health insurance, with a maximum of \$1,000 per adult and \$500 per child for up to 2 children in a family. Those with low incomes (below \$15,000 for individuals and \$25,000 for families) would receive the 90 percent credit and the subsidy percentages would then decline with income, phasing out at \$30,000 for individuals, \$40,000 for single adults with dependents, and \$60,000 for two-adult families. The maximum premium eligible for the credit would be \$1,111 for adults and \$556 for children in 2005. Individuals may also take a deduction from adjusted gross income for 100 percent of the premiums that they pay for high-deductible, nongroup health insurance purchased in combination with a Health Savings Account.
- ³⁴ COBRA allows unemployed workers to continue coverage offered by a former employer if they pay 102 percent payment of the cost of the policy.
- ³⁵ S. Dorn and T. Kutyla. 2004. [Health Coverage Tax Credits Under the Trade Act of 2002](#). The Commonwealth Fund Task Force on the Future of Health Insurance Issue Brief; April; Internal Revenue Service, U.S. Department of the Treasury. Health Care Tax Credit General Information. Undated. Retrieved from: http://www.irs.gov/pub/irs-utl/general_info_state_toolkit.pdf.
- ³⁶ U.S. Government Accountability Office. 2004. *Health Coverage Tax Credit: Simplified and More Timely Enrollment Process Could Increase Participation*. September 2004, retrieved from: <http://www.gao.gov/new.items/d041029.pdf>.

- ³⁷ K. Swartz, op. cit.
- ³⁸ Ibid.; J.P. Newhouse. 2002. *Pricing the Priceless: A Health Care Conundrum*. MIT Press, Cambridge, MA.
- ³⁹ B.C. Fuchs. 2004. *Expanding the Individual Health Insurance Market: Lessons from State Reforms of the 1990s*. The Robert Wood Johnson Foundation's Synthesis Project, report no. 4, June 2004.
- ⁴⁰ The federal poverty level was \$12,015 for a family of two and \$18,810 for a family of four in 2003.
- ⁴¹ S.B. Dale and J.M. Verdier. 2003. *Elimination of Medicare's Waiting Period for Seriously Disabled Adults: Impact on Coverage and Costs*. The Commonwealth Fund Task Force on the Future of Health Insurance Issue Brief; July.
- ⁴² Ibid.
- ⁴³ Ibid.
- ⁴⁴ C. DeNavas-Walt, op. cit.
- ⁴⁵ K. Davis and C. Schoen. 2003. *Creating Consensus on Coverage Choices*. *Health Affairs* Web Exclusive. April 23, pp. 199–211; Medicare Early Access Act of 2004 (H.R.4357), introduced by Representative Stark [CA-13], 5/12/2004. Retrieved from: <http://thomas.loc.gov/cgi-bin/bdquery/z?d108:h.r.04357>.
- ⁴⁶ K. Davis and C. Schoen, 2003, op. cit.
- ⁴⁷ M. Kofman et al. 2004. *MEWAs: The Threat of Plan Insolvency and Other Challenges*. The Commonwealth Fund Task Force on the Future of Health Insurance Issue Brief; March.
- ⁴⁸ S.R. Collins, K. Davis, and J. Lambrew. 2004. *Health Care Reform Returns to the National Agenda: 2004 Presidential Candidates' Proposals*. The Commonwealth Fund; October.
- ⁴⁹ Bush-Cheney '04, Inc. A Plan for Helping American Families in a Changing World. Retrieved from: <http://www.georgewbush.com/agenda/chapter.aspx?ID=2>.
- ⁵⁰ K.E. Thorpe. 2004. *Federal Costs and Newly Insured Under President Bush's Health Insurance Proposals*. August 2004, retrieved from: <http://www.sph.emory.edu/hpm/thorpe.html>; J. Sheils. 2004. *Bush and Kerry Health Care Proposals: Cost and Coverage Compared*. September 2004, retrieved from: http://www.lewin.com/Spotlights/Features/Lewin_Candidates_Health_Plan_Analysis.htm; J. Antos et al. 2004. *Analyzing the Kerry and Bush Health Proposals: Estimates of Cost and Impact*. The American Enterprise Institute (AEI), September 2004, retrieved from: http://www.aei.org/publications/pubID.21166/pub_detail.asp.
- ⁵¹ John Kerry for President, Inc. *John Kerry's Plan to Make Health Care Affordable to Every American*. Retrieved from: http://www.johnkerry.com/issues/health_care/health_care.html.
- ⁵² K.E. Thorpe, 2004, op. cit.; J. Sheils, 2004, op. cit.; J. Antos et al, 2004, op. cit.
- ⁵³ J. Hadley and J. Holahan, 2004. *The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?* The Kaiser Commission on Medicaid and the Uninsured. May 2004, retrieved from: <http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=35965>.

Other issue briefs produced for The Commonwealth Fund/John F. Kennedy School of Government 2005 Bipartisan Congressional Health Policy Conference

[Alzheimer's Disease: Research Advances and Medical Reality](#), Erica Seiguer

[State Preparedness for Bioterrorism and Public Health Emergencies](#), Rachel Garfield

[Medical Errors: Five Years After the IOM Report](#), Sara Bleich

[Protecting the Nation's Health: Ensuring a Stable Supply of Influenza Vaccine](#), Erica Seiguer

[International Innovations in Health Care: Quality Improvements in the United Kingdom](#), Gillian K. SteelFisher

[Medicare: Making It a Force for Innovation and Efficiency](#), Jessica Mittler

[Issues Related to State and Employer Innovations in Insurance Coverage](#), Erin C. Strumpf

[The Commonwealth Fund](#) is a private foundation supporting independent research on health and social issues. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

