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Health Care
Coverage in America:
**Understanding the Issues
and Proposed Solutions**

CoverThe
Uninsured

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Introduction

Health insurance is one of the most important—and most misunderstood—subjects any of us faces in everyday life. In its simplest form, the concept of health insurance is based on mutual need: the need of individuals to pay for their medical services, and the need of health care providers to have a secure source of income.

One of the earliest arrangements illustrating this concept—a precursor to the Blue Cross plans that were formed to finance hospital care—was an agreement made in 1929 between Baylor Hospital and teachers in Dallas.

The so-called Baylor Plan allowed teachers to pay 50 cents per month into a fund that guaranteed up to 21 days of care at the hospital.¹ Participating teachers gained peace of mind; the hospital reduced its unpaid bills. This concept developed into a nonprofit model that spread rapidly during the 1930s and then expanded to physicians, who formed Blue Shield.

At about the same time, Henry J. Kaiser started a prepaid group health plan for employees of his construction company in the West, which was the initial model for today's health maintenance organizations (HMOs).² Gradually, commercial insurance companies entered the market. After World War II, when government policies encouraged health insurance as a form of employee compensation, enrollment in health plans exploded—from 20 million in 1940, to 142 million in 1950.³

But millions of people remained without coverage. Congress made a major attempt to address this problem in 1965. After years of contentious debate, the two great publicly financed programs, Medicare and Medicaid, were signed into law. These programs provided a new source of funding for the care of people who were then of

little interest to commercial insurers—retirees living on low fixed incomes, individuals with disabilities, frail elders, and poor women and children.

Health Insurance Today

This basic mix of private and public coverage continues today, although it has gone through many changes and has become far more complex. Coverage comes in myriad ways: through our jobs, the federal government, the military, state programs, or on our own without help from any of these other programs. We pay for coverage out of our own pockets, through state and federal taxes, and through arrangements with our employers.

Still, close to 46 million people in the United States, in every age group and at every income level, are uninsured—a fact that remains a major national concern.

This is not a new concern. Several times since the 1940s, Americans have engaged in a nationwide discussion asking, “How can we provide health insurance to those who don’t have it?” and just as important, “How can we help people keep their health insurance?” These discussions have produced new programs and new tax incentives. We have seen solutions that attempt to meet the special needs of individuals with certain health conditions. In an effort to reduce costs and improve quality, we’ve also seen

cut-backs on delivery and payment systems that are considered wasteful. The quest for “best value” in health care has become a popular theme.

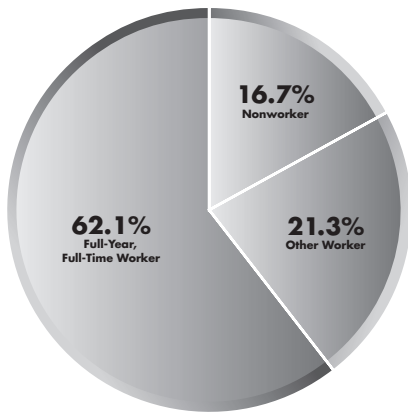
We are in the midst of another broad-ranging discussion about where our health care system should go. Government officials, political candidates, employers, unions, community leaders and ordinary citizens are saying the nation’s health care system should be improved and made more equitable. The search goes on for ways to cover the tens of millions of Americans who fall through the cracks each year.

Referring to the following facts, many say that we can do better:

- 45.8 million people in the U.S.—almost one in seven Americans—lacked insurance for all of 2004, according to the Census Bureau,⁴ an increase of 6 million since 2000.⁵
- The percentage of the U.S. population without health coverage has also grown, from 14.2 percent in 2000 to 15.7 percent in 2004.⁶
- More than eight out of 10 of the uninsured are in working families (see Chart 1).⁷
- The uninsured don’t fit any stereotype. They come from every community, every walk of life, every race and ethnic group, and every income level.⁸
- People who have coverage can’t

1. MOST UNINSURED AMERICANS ARE IN WORKING FAMILIES

Uninsured Nonelderly Population by Work Status of Family Head, 2004



Source: EBRI estimates from the March 2005 Current Population Survey

necessarily count on keeping it. A person could have good coverage today, none at all six months from now, and then regain coverage a few months later. More than 25 percent of the population under 65—62.9 million people—lacked coverage at some point in 2003.⁹

This publication is designed to help you become an active participant in the national discussion about how we can secure health care coverage—private or public—for all Americans. In the pages to come, you will see the evidence that a lack of health coverage has real consequences for a person’s health and financial status. You will learn more about how people get health coverage now, why so many don’t have it, who is uninsured and several approaches to reducing the number of people who go without health insurance in the United States.

Why the Renewed Interest in the Uninsured?

Why is there a renewed interest in ensuring that all Americans have health care coverage? Individuals and employers are growing increasingly concerned about the rising cost of health care and health insurance. We’re justifiably concerned that as health

coverage becomes more and more expensive, we may not be able to afford our share of the cost of coverage offered on the job—if we are offered coverage at all. We know that if we lose a job, we might also lose access to affordable health coverage and health care (a prospect discussed in more detail later).

Many Americans are worried about health coverage and health costs. For instance, a Kaiser Family Foundation poll conducted in December 2005 found that 76 percent of respondents considered increasing health insurance coverage for Americans a very important priority for the president and Congress.¹⁰

Even so, many Americans are not convinced that being uninsured is a problem. A majority of Americans polled in 2004 mistakenly believed that the uninsured can receive the care they need through clinics and hospital emergency departments.¹¹ In addition, although most people tell pollsters that they are willing to pay more in taxes to assure coverage for all Americans, many are undecided about just how much they are willing to pay.¹² Yet another challenge is that neither the public nor policy-makers have settled on one agreed-upon approach to providing health coverage for the uninsured.¹³

Why is Health Coverage So Important?

Why does health coverage make such a big difference in people’s everyday lives? Let’s look at the evidence.

EFFECTS ON HEALTH AND TREATMENT

Not having coverage can be dangerous to your health, according to a wide array of studies conducted by one of the most respected research institutions in the United States, the National Academy of Sciences’ Institute of Medicine (IOM).

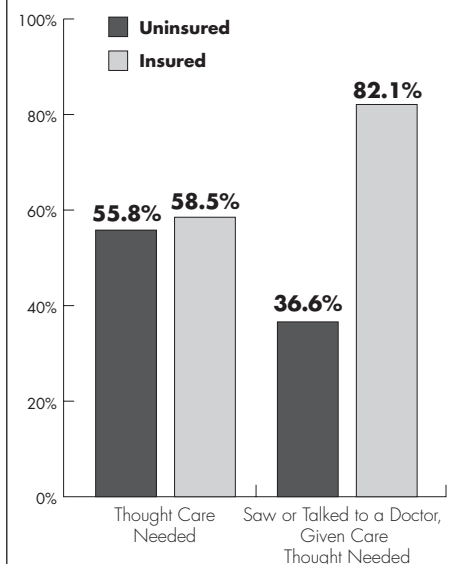
People without health insurance often go without care or delay care. The care they do receive is likely to be of lower quality than the care received by insured people. An estimated 18,000

adults die each year because they are uninsured and can’t get appropriate health care, according to the federally chartered IOM, which produced a series of six reports on the lack of health coverage in America.¹⁴

The length of time a person goes without health insurance also makes a difference. The IOM noted that people who are uninsured for at least a year report being in worse health than those who are uninsured for a shorter period of time. About 20 percent of those without coverage for one year or longer said their health was poor or fair, compared with 14 percent of those who were uninsured for less than a year.¹⁵ But even those who are uninsured for a short period of time experience problems obtaining access to care.¹⁶

2. UNINSURED LESS LIKELY TO GET CARE

Percentage of Nonelderly Adults Who Thought Care Was Needed and Who Saw or Talked to a Doctor, by Insurance Status



Source: Jack Hadley and Peter J. Cunningham. “Uninsured as Likely to Perceive Need for Care but Half as Likely to Get Care.” Center for Studying Health System Change, Issue Brief No. 100, October 2005.

Among the IOM's key findings were:

- Uninsured women with breast cancer are less likely than insured women to receive breast-conserving surgery.
- Hospitalized patients without health insurance receive fewer needed services and worse quality care, and have a greater risk of dying in the hospital or shortly after discharge than patients with insurance.
- The uninsured are less likely to receive care even when they have serious symptoms.
- Uninsured trauma victims are less likely to be admitted to the hospital or to receive the full range of needed services. Uninsured victims with trauma due to an auto crash are 37 percent more likely to die of their injuries.
- Uninsured adults with HIV wait to receive new, highly effective drug therapies an average of four months longer than patients who have insurance. Among adults infected with HIV, having insurance reduces mortality by 71 percent to 85 percent over a six-month period.¹⁷

The IOM concluded: "Health insurance is associated with better health outcomes for adults and with their receipt of appropriate care across a range of preventive, chronic and acute care services. Adults without health insurance coverage experience greater declines in health status and die sooner than do adults with continuous coverage."¹⁸

The 8.3 million children without health coverage also suffer health consequences. Uninsured children are more likely than insured children not to have a usual source of health care, go without needed care and experience worse health outcomes.¹⁹

Studies have found that compared to children with either public or private insurance, uninsured children are:

- Just one-third as likely to have a usual source of health care²⁰

- 10 times more likely to miss out on needed medical care²¹
- Five times more likely not to get a needed prescription drug²²
- Almost twice as likely to be in fair or poor health²³
- At least 70 percent more likely to go without care for common childhood conditions such as asthma, ear infections and sore throats²⁴
- More than twice as likely to receive no medical care at all in the course of a year²⁵

The uninsured are less likely to receive care even when they have serious symptoms.

IMPACT ON FINANCIAL SECURITY

Not having insurance may threaten the financial security of families. More than a third (35%) of the care received by the uninsured is paid for out of their own pockets.²⁶ Because families with at least one uninsured member tend to have lower incomes and fewer assets than fully insured families, uninsured families generally have fewer financial resources to help cope with these higher medical expenses.

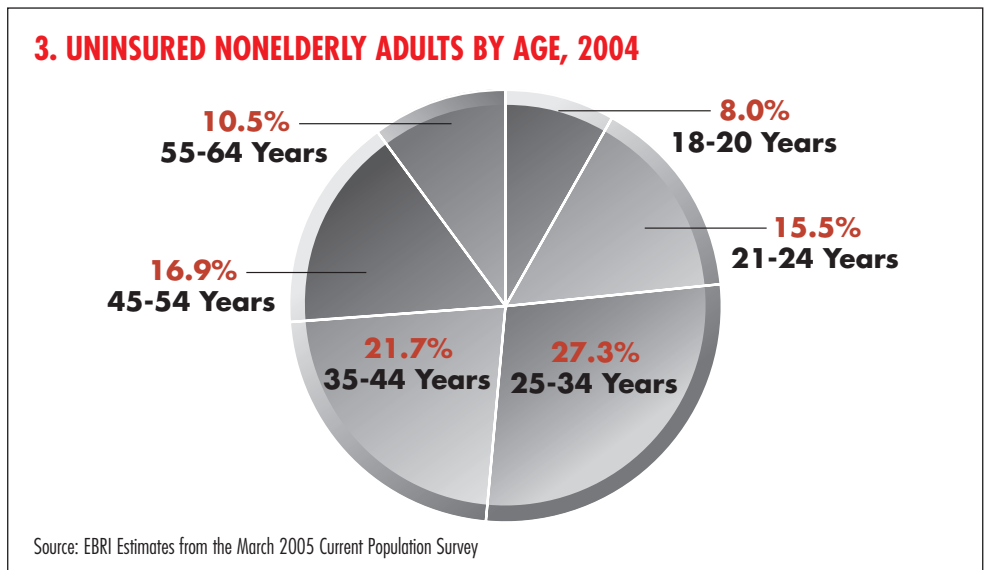
Lack of health coverage may destabilize an entire family's financial standing:

- Six out of 10 uninsured working age adults report problems paying medical bills, compared with 35 percent of insured adults.²⁷
- Of those lacking coverage who have medical bill problems or have accrued medical debt, 27 percent reported that they struggled to pay for expenses such as food, rent or heat. Almost half (44%) said that they were forced to use most or all of their savings to pay medical bills. One out of five said that they had run up large credit card debts or had to take out a loan against their homes to pay medical expenses.²⁸

Who are the Uninsured?

The number of people in the United States who lack health insurance has been increasing over time. In 2004, 45.8 million people in the United States lacked health coverage, including 8.3 million children. Adults are uninsured more frequently than children: one in five adults aged 18 to 64 was uninsured in 2004. By comparison, one in nine children was without coverage that year.²⁹

The uninsured come from every race and ethnic group, every age group and every income level. Compared to the



general population, however, people who lack health insurance are younger, have lower incomes, and are more likely to be members of minority groups.³⁰

Nonelderly adults who lack insurance are also concentrated in certain states. According to the Kaiser Family Foundation, the largest percentages of

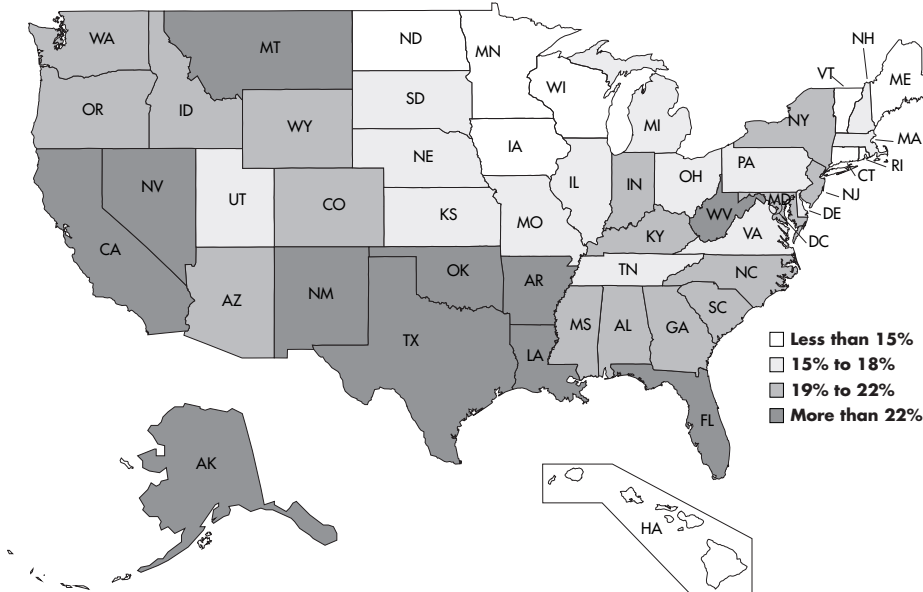
uninsured people can be found in Texas (30%) and New Mexico (29%), two of the 18 states in which more than 20 percent of the population between the ages of 19 and 64 is uninsured. Another 18 states have uninsured rates between 16 percent and 20 percent. In only 14 states do the uninsured make up 15 percent or less of the population. The lowest percentage of uninsured is in Minnesota (11%).³¹

A common misconception is that those who lack health insurance are out of the job market. In fact, eight out of 10 of those who lack insurance are in working families, as noted earlier (see Chart 1).³² Six out of 10 had at least one family member working full time year round.³³ The working uninsured tend to have jobs in the service industries and in smaller firms with lower wages where employees are less likely to be offered coverage. The key point is that the overwhelming majority of the uninsured are from families actively in the labor force.

Americans living in households (family and non-family) with annual incomes below \$25,000 have a higher incidence of uninsurance: 24.3 percent were uninsured in 2004 compared to 15.7 percent of the total population.³⁴ For 2006, the federal poverty level is \$20,000 for a family of four in every state except Alaska and Hawaii, where the figure is higher (see box, What Does “Federal Poverty Level” Mean?). More than 54 percent of the uninsured are in families making 200 percent or less of the federal poverty level annually.³⁵

Members of the Hispanic community encounter difficulties in securing coverage in part because many are recent immigrants who earn modest incomes. In 2004, among foreign-born Hispanics with less than 10 years of U.S. residency, 61.4 percent were uninsured.³⁸ Like other uninsured Americans, uninsured Hispanics are often in low-wage service jobs that do not offer health coverage. In addition, many low-income new immigrants, even when in the United States legally, are not eligible for public

4. PERCENTAGE OF UNINSURED ADULTS AGED 19-64 BY STATE, 2003-2004



NOTE: In this chart only, “nonelderly adults” include only those aged 19-64. In all other cases in this document, “nonelderly adults” includes those aged 18-64.

Source: Kaiser’s Statehealthfacts.org.

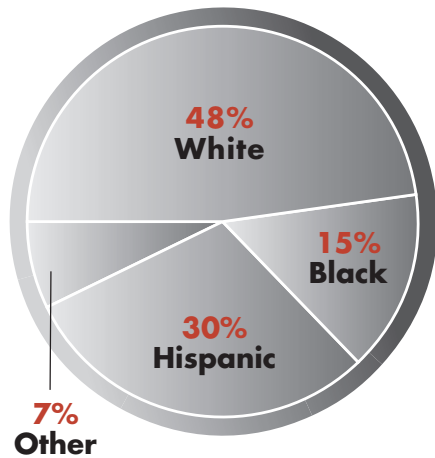
WHAT DOES “FEDERAL POVERTY LEVEL” MEAN?

The federal poverty guidelines (also referred to as the “federal poverty level”) are family income figures produced each year by the U.S. Department of Health and Human Services (HHS) to determine eligibility for certain federal programs, including Head Start, the Food Stamp Program, the National School Lunch Program and the State Children’s Health Insurance Program. Eligibility for certain state assistance programs is also tied to the federal poverty guidelines. For 2006, the guidelines are:

Size of Family Unit	48 Contiguous States and D.C.			Alaska	Hawaii
1	\$9,800			\$12,250	\$11,270
2	\$13,200			\$16,500	\$15,180
3	\$16,600			\$20,750	\$19,090
4	\$20,000			\$25,000	\$23,000
For each additional person, add:	\$3,400			\$4,250	\$3,910

Source: “The 2006 HHS Poverty Guidelines,” U.S. Department of Health and Human Services. <http://aspe.hhs.gov/poverty/06poverty.shtml>

5. UNINSURED NONELDERLY POPULATION BY RACE AND ETHNICITY, 2004



Note: "White" includes non-Hispanic whites, "black" includes non-Hispanic blacks, and "Hispanic" can be of any race.

Source: EBRI estimates from March 2005 Current Population Survey

programs such as Medicaid, although their children are sometimes eligible.

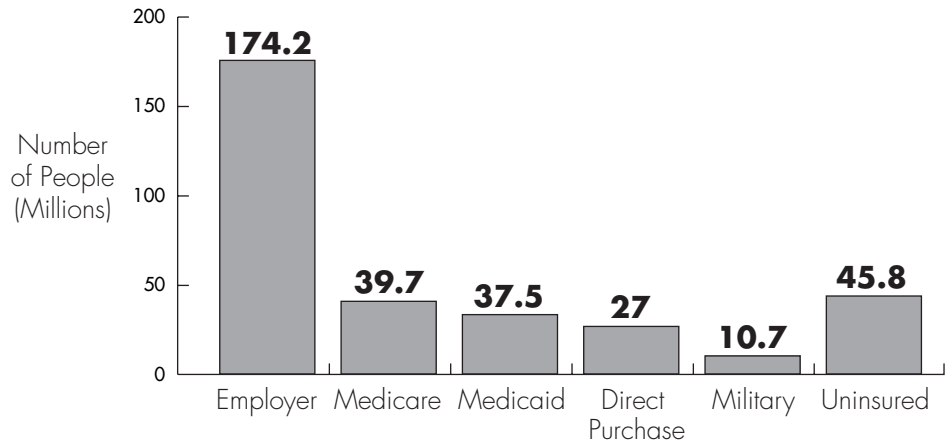
One overlooked aspect of the uninsured problem is that while the number of uninsured is relatively stable from month to month, it is not the same individuals who are uninsured from month to month and year to year. Hundreds of thousands of Americans lose coverage over the course of a year, and similar numbers regain it after lacking coverage for relatively short periods of time.

The dynamic nature of the uninsured population has implications for different strategies that might be used to deal with the problem. A Commonwealth Fund study found that the number of uninsured, low-income children would decline by nearly 40 percent and the number of uninsured adults would decline by more than 25 percent if every person with public or private insurance at the beginning of a given year retained it through the next 12 months.³⁹

There are also key differences in insurance coverage among racial and

6. HOW PEOPLE IN THE UNITED STATES GET COVERAGE

Sources of Health Coverage, 2004



Note: Some people have more than one source of health coverage.

Source: U.S. Census Bureau, <http://www.census.gov/hhes/www/hlthins/historic/hlhist1.html>

ethnic groups. Hispanics are far more likely than members of any other ethnic group to be uninsured. In 2004, 32.7 percent of Hispanics were uninsured for the entire year, compared to 19.7 percent of blacks, 16.8 percent of Asians and Pacific Islanders, and 11.3 percent of non-Hispanic whites.³⁶

Also in 2004, 21.1 percent of Hispanic children were uninsured, compared to 13.0 percent of black children, 9.4 percent of Asian American children, and 7.6 percent of non-Hispanic white children.³⁷

Moreover, barriers prevent people from joining public or private insurance plans. Such barriers include waiting periods before a worker can sign up for an employer plan and complex enrollment and renewal procedures that discourage people from applying for public insurance and retaining it.

Sources of Health Coverage

EMPLOYER-SPONSORED COVERAGE

Most Americans—174.2 million workers and their dependents—received health coverage through the workplace in 2004. This is far more than the total number of people covered through other

means (see Chart 6).⁴⁰

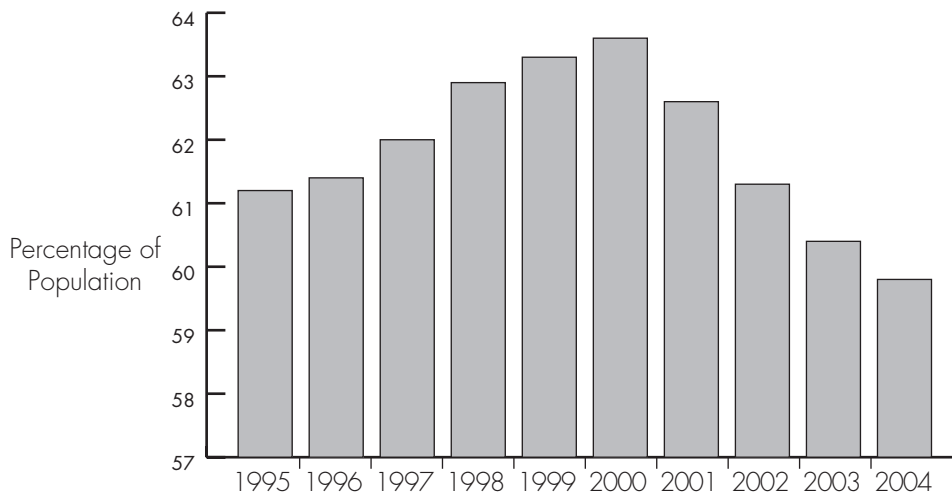
As previously discussed, workplace coverage was developed during the 1930s, pioneered by Blue Cross hospital insurance plans⁴¹ and employers like Henry J. Kaiser, who started a prepaid group health plan for employees of his construction company.⁴²

Both of these examples were early versions of health insurance "pools," or groups of people who jointly purchase coverage. The main advantage of insurance pools is that they combine many people who are generally healthy with a few who are likely to need expensive medical care. This spreads risk by using the premiums of healthier enrollees to offset the cost of those with high medical bills. Thus, pools help keep coverage affordable.

Although it fluctuates with the economy, employer-sponsored health insurance remains an important and popular source of coverage. Health insurance through the workplace has remained popular partly because it carries significant tax advantages for the employer and the employee. The amount that an employer pays for its employees' coverage is a tax-deductible business expense and is not counted as taxable income to the employee.

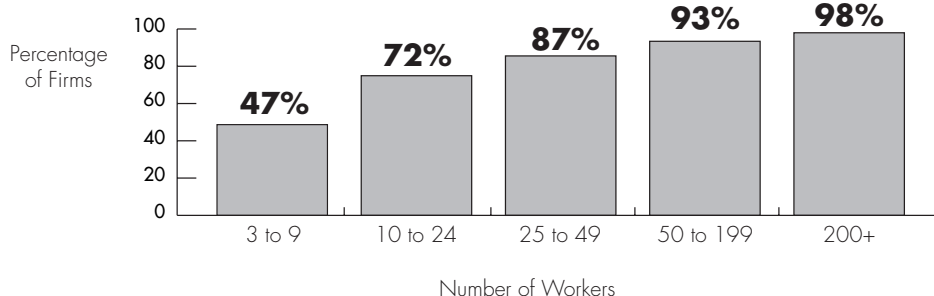
7. EMPLOYER-SPONSORED COVERAGE, 1996-2004

Population Covered by Employer-Sponsored Health Insurance



Source: U.S. Census Bureau, March 2005 Current Population Survey

8. PERCENTAGE OF FIRMS OFFERING HEALTH BENEFITS, BY FIRM SIZE, 2005



Source: Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits: 2005," <http://www.kff.org/insurance/7315/upload/7315.pdf>

Thus, the \$50 that a company pays towards an employee's health coverage is more valuable to the employee, dollar for dollar, than \$50 per month in wages on which the employee would have to pay income and payroll taxes. Some analysts have estimated that if the cash value of benefits were taxed like income, the increase in state tax revenue alone would be \$21.4 billion in 2004.⁴³ More recently, the projected 2007 value of foregone federal taxes has been estimated to be between \$153 billion and \$223 billion.⁴⁴ To put this into perspective, total Medicare spending in 2007 is estimated at \$445 billion.⁴⁵

DISADVANTAGES OF EMPLOYER-SPONSORED COVERAGE

Despite its many advantages, employer-sponsored health coverage has a number of disadvantages:

- Millions of working Americans don't have the opportunity to obtain employer-sponsored coverage.
- In 2002, 41.9 percent of "wage and salary" workers aged 18-64 were not offered health coverage through their own employers.⁴⁶
- Forty percent of firms of all sizes in the United States did not offer coverage in 2005.⁴⁷

➤ Fifty-four percent of uninsured workers in 2002 worked for employers who didn't offer health benefits.⁴⁸

➤ Even if employees are offered coverage on the job, they can't always afford their portion of the premium.

➤ Losing a job, or quitting voluntarily, can mean losing affordable coverage—not only for the worker but also for their family.

➤ A person's link to employer-sponsored coverage can also be cut by a change from full-time to part-time status, self-employment, retirement or divorce.

➤ Most employers offer a small number of health insurance plans for employees to choose from, which may not fit the needs of the employee and their family.

Health coverage as a benefit has become widespread among large companies—98 percent of companies with more than 200 workers offered coverage in 2005.⁴⁹ However most new jobs today come from small firms, and these small companies are the least likely to offer health insurance because they have to pay more for the same level of coverage (see Chart 8).⁵⁰ Larger pools usually have greater risk-spreading capacity, so larger employers are often able to provide coverage with lower premiums. In addition, an employer that represents many workers has more leverage than a smaller firm in negotiating prices with health plans.

Among small and medium size employers (three-199 workers) that don't offer coverage, three out of four say premiums are too expensive. A third (33%) say they believe their employees can get coverage elsewhere.⁵¹

Premiums for employer-sponsored coverage are rising much faster than workers' earnings or inflation (see Chart 9). Between spring 2004 and spring 2005, premiums for coverage offered by employers across the United States increased by 9.2 percent—more than two and a half times faster than

the growth in the Consumer Price Index (CPI) which includes amounts paid for coverage by both employer and employee. Employers with three to 199 workers saw an average 9.8 percent increase; firms larger than that had an average increase of 8.9 percent.⁵²

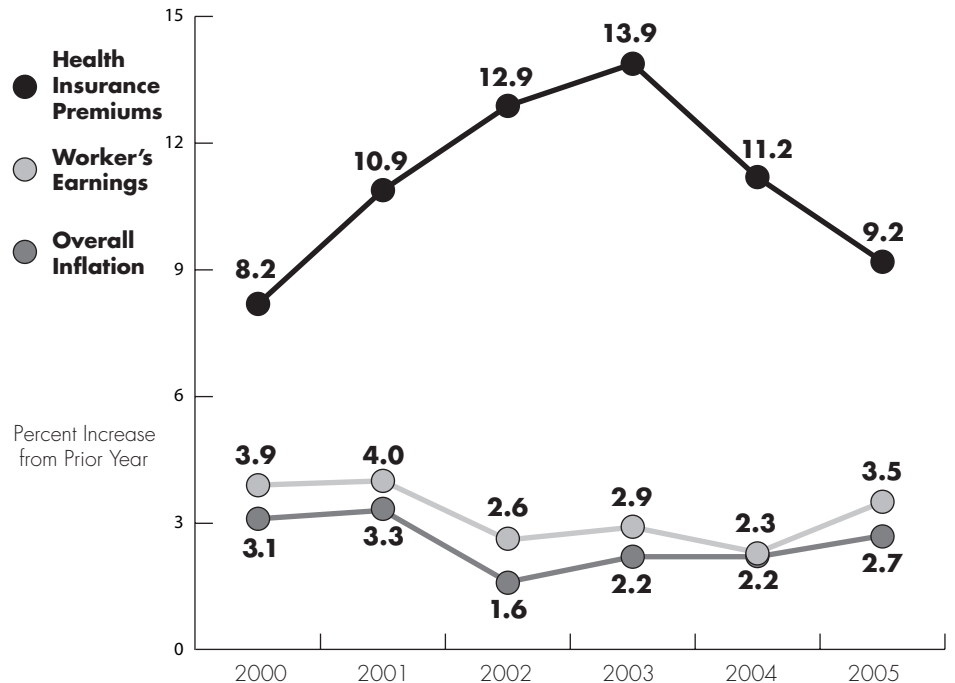
Health premiums are expected to rise between 6.7 percent and 9.9 percent in 2006, according to several consulting firms.⁵³ In contrast, the CPI is expected to grow by 2.8 percent.⁵⁴

In response to the double-digit premium increases, many companies are asking their employees to cover some of the new costs. For instance, workers with individual coverage through an employer paid 8.5 percent more for their coverage in 2005 than in 2004—\$51 vs. \$47 monthly. Premiums for a family of four paid by workers increased 2 percent—from \$222 to \$226 per month.⁵⁵ Chart 9 illustrates recent trends in health insurance premium increases as compared to annual increases in general inflation and workers' earnings.

In addition to charging higher premiums, employers are requiring larger copayments, higher deductibles and restrictions on benefits. As a result of these various cost-sharing measures, many more employees who are offered the chance to buy health insurance on the job may not be able to afford it.

In the case of retirees, large companies and labor unions in some sectors, notably in the automotive industry, have been making changes in retiree benefits. General Motors and the United Auto Workers (UAW), for example, announced in late 2005 that retired workers would be required to pay premiums and annual deductibles for the first time ever starting in April 2006.⁵⁶ Two months later, Ford Motor Co. employees represented by the UAW ratified an agreement to cut health costs by an estimated \$850 million per year. The agreement includes diversion of a portion of pay increases for active workers into a health care fund to

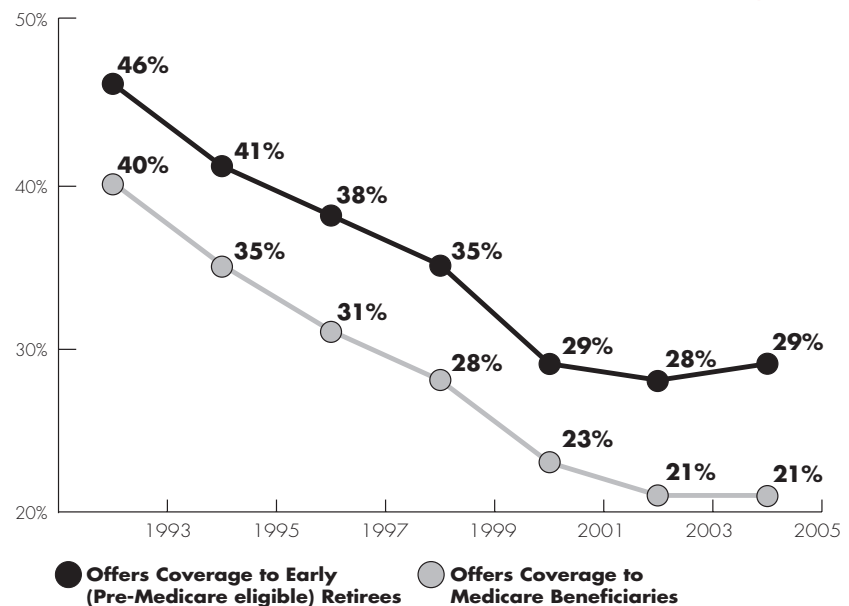
9. INCREASES IN HEALTH INSURANCE PREMIUMS COMPARED TO WAGE GROWTH AND GENERAL INFLATION, 2000-2005



Source: Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits: 2005," p. 13. www.kff.org/insurance/7315/upload/7315.pdf

10. FEWER LARGE COMPANIES ARE OFFERING RETIREE COVERAGE

Coverage for Retirees Who Are Medicare Beneficiaries and Early Retirees



Source: Mercer Human Resource Consulting, "National Survey of Employer-Sponsored Health Plans 2005"

offset health spending. Higher out-of-pocket costs will accrue over time for Ford retirees, whose benefits are now effectively capped at the average level of spending in 2006.⁵⁷ Other companies that have implemented or are considering implementing reductions to or the elimination of retiree health coverage include Sears, Lucent, Delta and U.S. Airways.⁵⁸ Overall, only 33 percent of firms with 200 or more workers offered retiree benefits in 2005, down from 66 percent in 1988.⁵⁹

A survey of large firms (more than 1,000 workers) that are continuing to offer new retirees coverage found that in 2004, monthly premiums averaged \$262, with the retiree's share being \$101 a month. Early retirees—those under the age of 65—paid more, contributing on average \$187 toward a \$487 monthly premium.⁶⁰ A recent General Accounting Office (GAO) study of retiree benefits concluded that although the decline in offers of coverage has shown signs of leveling off, there is also evidence that retirees are paying a greater portion of that coverage.⁶¹

But the great majority of employers offer no health coverage at all to Medicare-eligible retirees. Only 21 percent of employers with more than 500 employees offered coverage to retirees who were Medicare beneficiaries in 2005, while 29 percent of these firms offered coverage to early retirees who would be eligible for Medicare in the future (see Chart 10).⁶²

For a growing number of companies, eliminating health coverage altogether is an option, meaning that more workers are uninsured today than ever. Even among employees of large firms, the number of uninsured workers has increased sharply. As of 2004, 23.1 percent of the nation's non-elderly uninsured adult workers were in firms employing more than 500 people.⁶³ This reflects the fact that firms vary on who they classify as eligible for coverage. For example, some firms don't offer part-time employees health benefits, and some

STATE VS. FEDERAL REGULATION

Individual Coverage: Pros and Cons

For those who do not have access to insurance through the workplace or cannot afford their share of the premiums, the "individual" or "nongroup" market is one possible alternative. Insurance sold in the individual insurance market is often referred to as "individual" coverage, but most analysts refer to it as "nongroup," since such policies can cover individuals or families. Of the nonelderly population with health insurance, 5.4 percent (13.8 million people) were covered in the nongroup market in 2004.⁶⁷

People might seek individual policies if they are self-employed or if the firm they work for does not offer coverage. (As noted earlier, 40 percent of firms didn't offer coverage in 2005.) Layoffs, divorce, the death of a spouse, or children becoming too old to be on a parent's policy are possible reasons to turn to the individual market. One 2004 study estimated that the 20 percent of Americans not eligible for group or public insurance found their only coverage options in the individual market.⁶⁸

For some, the individual insurance market offers a wider array of health plans to choose from than what is offered through their employer. And since such insurance is not tied to an employer, it is portable. A person can change jobs, move from full-time to part-time work, or start their own business without losing their coverage. However, individual policies usually cost more and may cover less than those obtained through an employer. Insurers and their agents sell individual policies one at a time, rather than as part of a group. This means that the insurer's administrative costs for an individual policy are higher than for group policies. These higher costs are reflected in the premiums charged for individual policies.

Also, because people who resort to the individual market tend to have high health care costs, individual market insurers can charge high premiums or deny coverage altogether in some states. This practice is called "medical underwriting."

If individuals are denied coverage, they usually have few places to turn. They can try another company, or turn to their state's high-risk insurance pool, if they live in one of the 35 states that have one.⁶⁹ These pools offer health insurance to people who can't get it elsewhere, usually because of a pre-existing medical condition. But the premium may be out of reach for the individual. And in a few states, the pool is closed to new people. (For information about your state, go to www.healthinsuranceinfo.net, a Web site maintained by Georgetown University's Health Policy Institute).

For these reasons, a person looking for an individual insurance policy may or may not find one. In the study cited earlier, high prices were the dominant factor for low participation in the individual market.⁷⁰

don't offer coverage to workers who have been employed for less than a certain amount of time. In addition, some workers decline coverage because they can't afford their share of the premiums.

Historically, the highest levels of insurance coverage have been found in manufacturing, the sector of the economy most likely to have labor unions. But as noted earlier, some unions are negotiating deals with companies to trim health coverage or to make it more expensive for workers. Also, union membership is dwindling: in 2005, union members comprised just 12.5 percent of the workforce.⁶⁴ Finally, the number of manufacturing jobs in the United States has declined almost every year since peaking in 1978.⁶⁵ This is strikingly evident in the years between 2000 and 2004, when manufacturing jobs shrunk by 17 percent.⁶⁶ Many of these jobs are gone forever.

HSA's AND THE "OWNERSHIP SOCIETY"

Health savings accounts (HSAs) are a relatively new model of health insurance coverage. They can only be offered in conjunction with high-deductible health plans—those with annual deductibles of at least \$1,050 for individuals and \$2,100 for families. This type of coverage offers certain preferences in tax treatment. Some analysts believe HSAs will become widespread. According to America's Health Insurance Plans, a trade association representing a wide range of managed care and other types of health plans, 3.2 million people have purchased HSA/high-deductible health plans from its member companies as of January 2006.⁷¹

HSAs are a kind of bank account holding pre-tax dollars from workers and employers, from which individuals can draw from to purchase health services. They were established by the Medicare Modernization Act of 2003. The maximum amount that can be contributed to an HSA in a given year is the amount of the deductible. In

2006 it was \$2,700 for individuals and \$5,450 for family accounts—whichever is less. HSA contributions can be made by individuals, their employer or both. These contributions are deductible for individuals who purchase their own coverage, but do not reduce income subject to payroll tax. Interest on the funds kept in HSA accounts is tax-exempt, balances can be rolled over year to year, and withdrawals from the accounts are tax-free if they are made for qualified medical expenses.⁷²

The Bush administration recently proposed changes to make HSAs even more attractive to consumers, including those purchasing policies in the nongroup market. One proposal would give individuals a new tax credit to offset the payroll tax that they would otherwise pay on their HSA contributions. Another would raise HSA contribution limits to the level of the plan's out-of-pocket maximum—typically at least three times as high as the deductible. A third would allow individuals to exclude premium costs of individual HSA-related policies from taxable income.⁷³ Analysts and policymakers are actively debating many questions about HSAs, including: What impact they will have on the individual and group health insurance markets? Will they concentrate or spread the health risks of the population receiving coverage in the private market? How might HSAs affect overall health spending over time? What impact are HSAs likely to have on the number of uninsured Americans during the next several years?

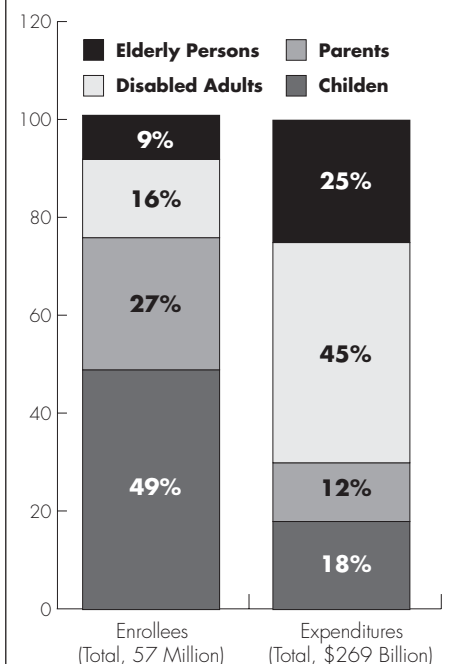
Some analysts argue that expanding the role of the consumer and providing equivalent tax preferences in the individual market will improve the overall health care system. HSA proponents note that a high-deductible policy paired with an HSA allows individuals to assume responsibility for paying for many of their own services—rather than having them paid by an insurer or a government program. They

argue that this has the potential for both restraining the cost growth in those plans and making individuals more aware of the quality of care they receive. People are more prudent, they assert, when spending what they perceive as their "own" money.⁷⁴

However, other analysts argue that HSAs will mainly serve to concentrate healthy people with more disposable income in high-deductible health plans, and those people will drop out of the conventional group market. This, they say, could cause adverse selection—the concentration of sicker people with more modest incomes—in traditional low-deductible health plans that have long been the cornerstone of the group

11. MEDICAID ENROLLEES AND EXPENDITURES

This graph shows values estimated by the Kaiser Commission on Medicaid and the Uninsured based on data from the Congressional Budget Office and the Centers for Medicare and Medicaid Services, 2005. Totals may not add to 100 percent because of rounding.



Source: Kaiser Commission on Medicaid and the Uninsured. "The Medicaid Program at a Glance."

market, and could cause sharp premium increases that make such coverage unaffordable over time for many people.

MEDICAID

The Medicaid program offers a package of benefits covering low-income mothers and children, persons with disabilities, and certain senior citizens. About 57.3 million people were covered by Medicaid at some point in 2005, according to the Department of Health and Human Services.⁷⁵ (This is the number accepted by most health services researchers. The U.S. Census Bureau, based on its survey of households, puts the number at 37.5 million in 2004⁷⁶).

In contrast to employer-sponsored coverage, Medicaid enrollment has grown each year since 1998.⁷⁷ Without this growth, the number of uninsured in those years would have been even higher.

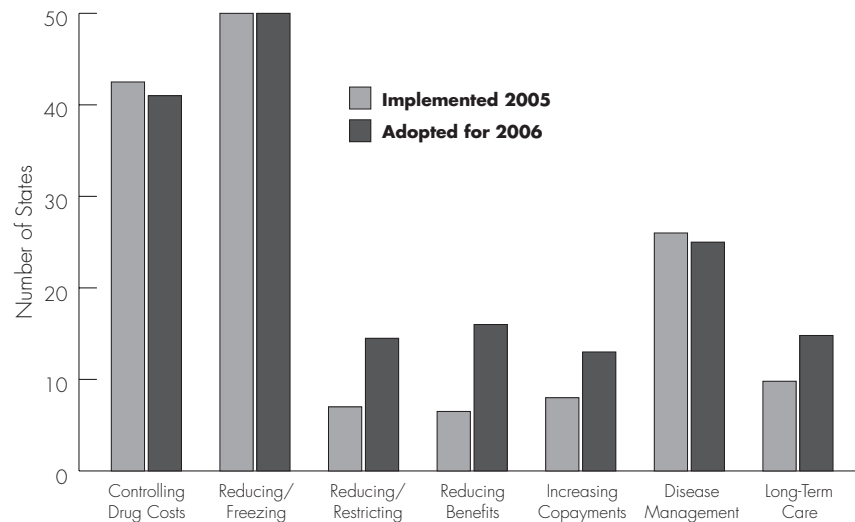
Medicaid is funded by both state and federal dollars. Medicaid spending varies significantly among the groups covered. Children—the healthiest of Medicaid beneficiaries—account for 49 percent of enrollees, but just 18 percent of spending. Those over 65 years of age and people with disabilities, by contrast, are as a group in poorer health and in need of more services. While they comprise only 25 percent of beneficiaries, they account for 70 percent of spending (see Chart 11).⁷⁸

Medicaid also pays for 43 percent of all long-term care services, including custodial nursing home care. Nearly 60 percent of all nursing home residents receive support from Medicaid.⁷⁹

Eligibility rules for Medicaid are complex, reflect a mix of federal requirements and state options, and vary widely from state to state. They are linked to both income and other factors, such as family makeup and disability status. Federal law makes some people automatically eligible. The major categories of people whom states

12. STATE COST-CONTAINMENT STRATEGIES: ADOPTED VS. IMPLEMENTED FOR FYs 2005-2006

States Undertaking New Medicaid Cost Containment Strategies, 2005-2006



Source: Kaiser Commission on Medicaid and the Uninsured, Medicaid Budgets, Spending and Policy Initiatives in State Fiscal Years 2005-2006. October 2005.

must cover include:

- Pregnant women and children up to age 6 in families with incomes up to 133 percent of the federal poverty level
- Children ages 6 to 18 in families with incomes up to 100 percent of the federal poverty level
- People who would have been eligible for welfare according to the criteria in effect before welfare reform in 1996
- People receiving Supplemental Security Income (SSI) due to disability or being elderly

THE RELATIONSHIP BETWEEN STATE BUDGETS AND MEDICAID COSTS

Medicaid consumes a high proportion of spending by state governments—about 17 percent of states’ general fund spending in fiscal year 2004.⁸⁰ New Hampshire had the highest percentage (29.6%) and Wyoming the lowest (4.8%).⁸¹

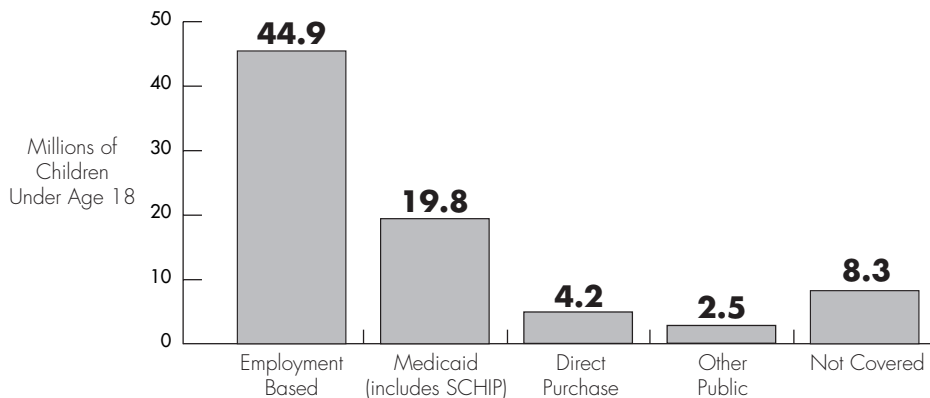
The economic slowdown in 2001-2002 forced governors and legislators to cope with large imbalances between

revenues and increased spending needs. (Although the federal government can incur deficits from one year to the next, all states, with the exception of Vermont, must balance their budgets each year). Most state economies have since recovered, and many states have taken legislative action to gain greater control over their budgets. For fiscal year 2006, 25 states enacted tax and fee increases, while 14 enacted net decreases.⁸²

Though many states have tried to protect Medicaid, a program that serves such vulnerable populations and brings substantial federal matching funds into the state, its sheer size has forced all states to try to hold down Medicaid spending growth.

Some of the options for restraining Medicaid spending are politically painful. For example, states can cut payments to providers and plans, restrict benefits, and curtail eligibility. The number of states pursuing various cost-containment strategies in 2005 and 2006 are depicted in Chart 12 (see above). In 2006, more states plan to

13. HOW CHILDREN GET HEALTH COVERAGE, 2004



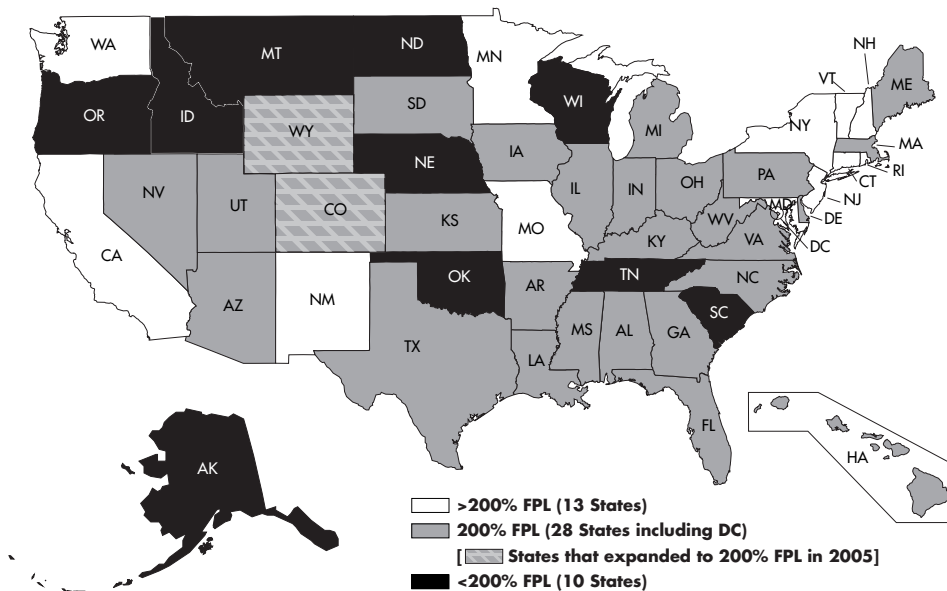
Source: U.S. Census Bureau. "Income, Poverty, and Health Insurance Coverage in the United States: 2004." www.census.gov/prod/2005pubs/p60-229.pdf

CHILDREN'S COVERAGE

In 2004, about 45 million children—roughly two-thirds of children under age 18—were covered by a parent's employer-sponsored policy. Almost 20 million children were covered by Medicaid or the State Children's Health Insurance Program (SCHIP), according to the Census Bureau (see Chart 13).⁸⁵

SCHIP, authorized in 1997 and financed jointly by the federal and state governments, is intended for children whose parents earn too much to qualify for Medicaid, yet too little to afford private coverage. Congress has authorized \$48 billion over 10 years for SCHIP and the program must be renewed in 2007 in order to continue.

14. CHILDREN'S ELIGIBILITY FOR MEDICAID/SCHIP BY INCOME, JULY 2005



NOTE: The Federal Poverty Line (FPL) for a family of three in 2005 was \$16,090 per year.

Source: Kaiser Commission on Medicaid and the Uninsured. "In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families."

The federal government picks up a larger share of SCHIP costs than Medicaid costs. The federal share for SCHIP ranges from 65 percent to 84 percent, depending on the state, compared with 50 percent to 77 percent for Medicaid. In addition, states have considerable flexibility in the use of SCHIP money. In the early years of the program, some states established an independent SCHIP, while others chose to expand their Medicaid program to include children in families with higher household incomes. Still other states adopted a combination of both approaches. Currently, 16 states have a separate Children's Health Insurance Program, 16 have programs that are an expansion of Medicaid, and 19 have combination programs. Children applying for a separate state program or a combination program must first be screened to make sure they are not eligible for Medicaid. This is because no child who is eligible for Medicaid can be enrolled in SCHIP—a rule that is designed to discourage states from claiming the more generous SCHIP matching dollars for Medicaid-eligible children.

SCHIP eligibility is generally focused on children in families with incomes up to 200 percent of the federal poverty

take measures to reduce eligibility, increase copayments and reduce long-term care costs as compared to 2005.⁸³ To save even more money, some states have also reduced their outreach and enrollment campaigns that inform the public about who is eligible and how to sign up for Medicaid benefits.

States' fiscal dilemmas with regard to Medicaid spending are not likely to improve dramatically. The National Association of State Budget Officers reports that 22 states experienced shortfalls in their Medicaid budgets in fiscal year 2004, and 26 states anticipated a shortfall for fiscal year 2005.⁸⁴

level. Although most states maintain SCHIP eligibility at this level, 10 states have set an income ceiling below 200 percent of the poverty level, while 13 states have set their limit above 200 percent.⁸⁶ (see Chart 14)

Some states have brought children into the program with much higher family incomes. New Jersey's NJ FamilyCare program, for instance, accepts children with family incomes as high as 350 percent of the federal poverty level. However, between July 2004 and July 2005, 14 states took steps that made it more difficult for families to obtain coverage through SCHIP, while 20 made simplifications designed to ease enrollment.⁸⁷

MEDICARE

Almost everyone over 65 is eligible for Medicare, along with certain individuals who have permanent disabilities and those with end-stage renal disease. Eligibility for Medicare does not depend on a person's income or assets, which sets it apart from many other government health care financing programs. Medicare, which is financed by the federal government and beneficiaries, had an enrollment of 42.1 million people in 2005,⁸⁸ about 15 percent of whom qualify for the program on the basis of permanent disability and are under the age of 65.⁸⁹ Individuals of any age who have end-stage renal disease also qualify for Medicare coverage⁹⁰ and account for less than 1 percent of Medicare enrollment.⁹¹

Medicare has occasionally been part of discussions about the uninsured, as a platform for providing coverage to early retirees between the ages of 55 and 64 (see section on public program expansions). But because it has been part of the debate only sporadically, it is not covered in detail in this guide. General information about Medicare is available at www.medicare.gov.

Approaches to Covering the Uninsured

While the current system of providing Americans with health care coverage

has many advantages, clearly its complexity—and, more importantly, the fact that tens of millions of people each year are uninsured—suggest that we could be doing a better job in making health care coverage accessible to everyone. Indeed, policy-makers have been trying to do this for more than a half century.

Certainly, there is no shortage of opinions about how to expand coverage. Politicians, academics, policy-makers and others have considered a wide range of policies to cover the uninsured. Proposals differ in terms of political philosophy, cost, the number of people who will be insured and many other factors.

As with most complex public policy issues, there is no agreed-upon “best” way to make certain all have health coverage. Proposals differ in whether we should cover only some portion of those who lack coverage now, all Americans, or some variation in between.

As with most complex public policy issues, there is no agreed-upon “best” way to make certain all have health coverage.

In order to better understand the range of policy options available to lawmakers, it's helpful to look at a series of general approaches to covering the uninsured, ranging from incremental progress to a complete overhaul of our system. It is important to remember that the following is not an exhaustive list of options but rather a representative selection of approaches.

More information can be found at the *Cover the Uninsured Week* Web site, www.CoverTheUninsured.org. Specific information on different approaches to covering the uninsured is also available at the Economic and Social Research Institute (ESRI) Web site, www.esresearch.org. ESRI's

Covering America project keeps track of policy developments and analyzes and compares proposals to cover the uninsured.

Families USA and the Commonwealth Fund also regularly publish analyses of government proposals to cover the uninsured, which can be found at www.familiesusa.org and www.cmwf.org. More information on all aspects of the topic of the uninsured is available from the Kaiser Family Foundation, www.kff.org.

Below is a summary, based principally on ESRI's work, of some of the major approaches that have been discussed and debated by researchers, legislators, health industry stakeholders and advocates.

EXPANSION OF EXISTING EMPLOYER-BASED POOLS AND CREATION OF NEW POOLS

During the 1990s and continuing today, Congress has taken an active interest in debating proposals designed to improve access and affordability in the small group insurance market (for employers with 50 or fewer workers) and the individual insurance market. As discussed above, this interest has taken the form of legislation that created HSAs and that proposes to create association health plans (AHPs) and similar entities. The 1996 Health Insurance Portability and Accountability Act (HIPAA) created new federal requirements to temper the effect of medical underwriting (e.g., exclusions for individuals with certain costly pre-existing medical conditions) in the small group and individual markets. But these reforms are now widely acknowledged to have had limited impact on the affordability and access to coverage for many companies and individuals in these markets, where monthly premiums and annual deductibles have remained high.

One idea that has been carefully considered by experts and policy-makers of diverse viewpoints is the possibility of allowing individuals and employers to “buy into” an existing large pool that is characterized by the

spreading of risk and lower premiums. One such pool is the Federal Employees Health Benefits Program (FEHBP), which is for federal employees and their dependents. The FEHBP is community-rated, meaning that federal workers who have a medical history of illness cannot be charged more than those who do not. Advocates of this approach point out that it takes advantage of existing economies of scale and risk pooling. Opponents claim that costs for the FEHBP would rise if a large number of individuals in poor health were allowed to join.

EMPLOYER CONTRIBUTION REQUIREMENTS

Employer contribution requirements, or employer mandates, would require employers to either provide insurance to their workers or finance coverage through a payroll tax that covers all or most of the cost of providing insurance to their workers under newly created public plans, or insurance pools. Such proposals are often referred to as “pay or play.”

Proponents argue that such a requirement would treat all employers fairly. Meaning that employers could no longer gain a competitive advantage by refusing to cover their workers. All employees and their dependents would be guaranteed access to health coverage.

Opponents counter that pay or play is unwise because it would create a new economic burden for lower-wage firms that do not now offer health insurance to their workers. These employers often oppose legislation that would require coverage, arguing that they should make decisions about the benefits packages they offer in order to attract the most suitable workers. By adding to the cost of employment, they say, this approach would discourage businesses from hiring more workers.

INDIVIDUAL MANDATES

Individual mandates would require everyone to have some basic form of health insurance. Such insurance could

be provided by employers, the public sector or from private insurers. The theory behind the individual mandate is akin to how automobile insurance works: every driver has to buy at least the legally required minimum amount of coverage.

Proponents say that if everyone is required to have insurance, insurers would provide a range of policies with varying benefits in order to attract new business. Doing so would lower the price of coverage, they contend, due to increased competition among carriers and the addition of millions of relatively healthy, low-cost people to the health insurance market.

Opponents believe that requiring individuals to have coverage wouldn’t necessarily mean that everyone would get it. Compliance is far from universal in the automobile insurance market. In fact, 14.5 percent of drivers in states where insurance is compulsory violate the law, according to the Insurance Research Council.

The primary reason that some individuals might not sign up for health coverage is because it could create financial hardships for lower-wage individuals who feel that they cannot afford it. Therefore, experts argue that to make an individual mandate effective, substantial public subsidies would be needed to offset costs for lower-wage workers.

STATE AND LOCAL COVERAGE INITIATIVES

State and local coverage initiatives have shaped highly diverse policy approaches that attempt to provide health insurance for populations that typically find it difficult to access affordable coverage. In doing so, they borrow concepts and models from both the public and private sectors.

For example, Muskegon County in Michigan developed a community health project with grant funds starting in 1993. The start-up funds were used to establish a community-owned plan called Access Health which focuses on small and mid-size employers, such as

day care centers and restaurants. The plan’s financing combines funds from three sources: employers and employees, who pay 30 percent each of the total premium cost, and Access Health, which pays the remaining 40 percent. This community share is derived from a novel combination of local government, community and foundation funds, as well as federal “disproportionate share hospital” funds. Today, the plan serves more than 400 employers.⁹²

Medicaid, SCHIP and
Medicare expansions are
yet another approach to
covering the uninsured.

Another, more controversial approach is embodied by Maryland’s recently enacted law requiring large employers with more than 10,000 workers to spend at least 8 percent of their payroll on health care or contribute to a state fund designed to assist individuals in obtaining affordable health insurance. Wal-Mart, which would be affected by the Maryland law, is vigorously opposing efforts to pass similar legislation in several other states.⁹³

A county- and city-based approach is being undertaken by San Francisco, which established a health plan under the auspices of the local health authority in the mid-1990s. Known as the “San Francisco Health Plan,” the program enrolls low- and moderate-income families and offers several health insurance options, including Healthy Kids and Young Adults and Healthy Workers, the latter a program aimed at providing health coverage for home health workers. Healthy Kids-San Francisco expands on the state’s Children’s Health Insurance Program, and provides extensive outreach to enroll uninsured children who are already accessing safety net facilities, such as public hospitals and

community health centers. The goal of Healthy Kids-San Francisco is to provide coverage to all uninsured children in San Francisco County.⁹⁴

MEDICAID, SCHIP AND MEDICARE EXPANSIONS

Medicaid, SCHIP and Medicare expansions are yet another approach to covering the uninsured. Some policy experts suggest that these programs, with appropriate adjustments, can be readily expanded to cover a larger percentage of the uninsured. They also argue that public programs would be better able to provide services for lower-income people, whose connection to the job market and stable income may be more tenuous. Such expansions, they note, can be financed through a variety of mechanisms, including state, local and federal tax revenue, as well as tax increases on private insurers. They can also be tailored to require participants to pick up a significant share of the costs. For example, a proposal advanced during the late 1990s that was popularly known as the Medicare “buy-in” bill would have allowed retired workers under age 65 with no other source of health insurance to be covered under the program for a monthly premium of about \$300-\$400.⁹⁵

Opponents of public sector expansions argue that current programs are poorly organized and frequently fail to enroll millions who are eligible. Moreover, they say, large annual federal deficits are likely to make securing funds for expansions politically difficult. In the case of public programs that are financed with matching contributions, such as Medicaid and SCHIP, it is believed that some states would resist large-scale expansions based on budgetary concerns.

TAX PROPOSALS

Tax credits seek to make private health insurance more affordable by allowing individuals and/or employers to use pre-tax dollars to pay for insurance

premiums, usually through a credit on the amount they owe in income taxes. The credits can be designed as a fixed dollar amount, or as a percentage of the premium. They can be made refundable for persons who owe no income taxes or advanceable at the time the person is actually paying the premiums (instead of having to wait until April 15). Proponents say that this approach enhances affordability while retaining choice of various plans in the private market, and would encourage persons to take responsibility for health care costs that exceed the value of the credit. They argue this would make consumers more price-conscious when choosing a health plan, and therefore restrain health care inflation. In theory, restraining costs would make it easier to expand coverage.

Opponents say that individuals and employers often don't have the information they need to make “best value” choices of quality providers, services and treatments, or the purchasing clout to get good prices. Another problem cited is that many proposals offer tax credits that are too modest—when compared to the actual cost of insurance—to persuade a significant number of uninsured people to buy coverage.

TAX-FINANCED HEALTH CARE SYSTEM

A fully tax-financed health care system would replace the current public-private mixed model in the United States with one where employers, individuals and other private entities would all be responsible for paying for health care coverage, through taxes paid to government. The most commonly advocated tax-financed system is some form of a “single-payer” approach. Under such a system, providers would remain private, but the government would administer payments for health care services—similar to the Canadian model. Proponents argue that a tax-financed system is the most promising approach because it is most likely to get virtually everyone covered and would be more efficient, since

administrative costs could be significantly reduced. The potential exists for more effective control of costs if government used its full authority in negotiating prices with doctors, hospitals, drug companies and other providers of health care.

Opponents of this approach contend that a government-organized health care system would radically change the way Americans receive health care and create too great a role for government with regard to the private sector. They also say the cost to the public treasury would be high, the choices of health care providers and services could diminish, and the development of new health technology and treatments would suffer. When government is the sole buyer, they argue, it does not negotiate prices, it sets them.

CONCLUSION

Our current system of health insurance—a patchwork of public programs, coverage offered by employers and individual policies sold in the nongroup market—covers the majority of Americans. But far too many do not have the resources necessary to purchase and keep dependable coverage. Despite congressional efforts that span much of the 20th century and the start of the 21st, history shows it has been difficult to agree on large-scale solutions that can solve the persistent problem of uninsurance. There is no ideal or easy solution to the problem of the uninsured. Most proposals combine coverage expansion with other objectives, such as limiting growth in total national health care spending, limiting the amount of new federal dollars spent, targeting new spending to the previously uninsured only or increasing consumer choice. Such goals cannot all be achieved simultaneously. Decision makers must balance these objectives and make trade-offs among them, and citizens need to understand these trade-offs and become involved in public discussions.

It is our hope that this guide will help make those discussions more informed and more focused on finding a consensus for action.

PERSONAL STORIES OF THE UNINSURED

To read personal stories about those who are uninsured, told in their own words, go to www.CoverTheUninsured.org/stories.

Questions to Ask About Any Health Coverage Proposal

- ❶ How many uninsured people will likely gain coverage?
- ❷ How much new spending of any kind will be necessary to cover each newly insured person?
- ❸ Who will be asked to pay the added costs needed? Government? Employers? Individuals?
- ❹ What is the likelihood that those who are newly covered will be able to keep their coverage for more than a few months?
- ❺ Will some people who are presently insured lose their coverage as a result of a proposal being implemented? If so, how many?
- ❻ Is funding for the proposal permanent? Can it be sustained over many years?
- ❼ If the proposal is adopted, how might other “players” react, such as physicians, hospitals, insurance companies and employers?
- ❽ What help does the proposal offer to those with special situations, such as unusually high medical expenses?
- ❾ Does the proposal help keep medical expenses in check for those presently paying for coverage, including governments, employers and individuals?

A PowerPoint presentation to accompany this guide is available at www.CoverTheUninsured.org/materials.

STATE vs. FEDERAL REGULATION

State and federal regulations profoundly affect health coverage and would likely need to be changed to enact comprehensive coverage reforms. States have primary regulatory authority over all insurance, including health insurance. Some employers, by paying for health services directly rather than by buying insurance, avoid state insurance regulation and are covered under a federal law called ERISA (Employee Retirement Income Security Act). Those employers that have chosen to be completely or partially self-insured and regulated under ERISA cover about 54 percent of all privately insured individuals.¹⁰⁰

The insurance companies that cover the other 46 percent of all privately insured individuals are regulated by the states. State law requires their policies to cover certain health services, such as breast cancer screenings. Businesses complain that the added expense of these mandated benefits drives up the cost of health coverage. Consumer advocates, on the other hand, say that the mandates are vital for the patients who are guaranteed access to the services covered.

Those companies that pay for their workers’ health benefits directly are under federal supervision and are therefore exempt from state insurance regulations. These “self-insured” companies are thus not bound by laws or regulations governing mandated services.

In order to make substantial changes to the way health insurance works in the United States, ERISA would likely have to be amended or replaced. Congress is currently considering several proposals that would amend ERISA to allow small businesses to band together and purchase health insurance with some of the same advantages as large employers.

Under one version of these proposals, small businesses could group into an association health plan through their trade, industry, professional or similar business association. AHPs would be permitted to self-insure under federal law as ERISA-certified plans, and would thus be exempt from state benefit mandates and other consumer protection requirements.¹⁰¹ AHP supporters contend that this would reduce coverage costs for many small employers, allowing them to offer insurance to more of their employees.¹⁰² But some experts say that AHPs could actually increase the number of uninsured people, arguing that many small firms buying insurance outside of AHPs in traditional state-regulated insurance markets would see their coverage costs soar—with premium increases as high as 23 percent.¹⁰³

Along with AHP legislation, Congress is also considering a separate proposal that would create small business health plans (SBHPs). As proposed, these plans are conceptually similar to AHPs, but SBHPs would not be permitted to self-insure, and would be subject to some state oversight. Under the original version of the bill, SBHPs would be required to comply with those benefit mandates that are in place in at least 45 states. A later version would allow insurers to bypass state laws only if they offered a plan that was based on a state government employee health plan of one the five most populous states.¹⁰⁴

UNINSURED MYTHS AND FACTS

Myth: People without health coverage don't work.

Fact: Eight out of 10 people who are uninsured are in working families.⁹⁶

Myth: Most people without health insurance are poor.

Fact: Almost 31 million of the uninsured in 2004 had household incomes of \$25,000 or more, compared with 15.1 million in households earning less.⁹⁷ The federal poverty level for a family of four in 2004 was \$18,850 (\$20,000 for 2006).

Myth: It doesn't really matter whether a person has health insurance.

Fact: About 18,000 Americans die each year of treatable diseases because they don't have health coverage, according to the highly respected, nonpartisan Institute of Medicine.⁹⁸

Myth: Virtually everyone who works for a large employer has health coverage.

Fact: Of all uninsured non-elderly adult workers, nearly one quarter (23.1%) worked in private firms of 500 or more employees in 2004.⁹⁹

GLOSSARY

ADVERSE SELECTION

When a disproportionately high number of individuals who are in poorer than average health enroll in a health plan.

COPAYMENT

A portion of the bill for a medical service that is not covered by the patient's health insurance policy and therefore must be paid out of pocket by the patient. Co-payment refers to a flat dollar amount, e.g., \$5 per office visit.

DEDUCTIBLE

A fixed amount, usually expressed in dollars, that the beneficiary of a health insurance plan must pay directly to the health care provider before a health insurance plan begins to pay for any costs associated with the insured medical service.

EMPLOYER CONTRIBUTION REQUIREMENT OR EMPLOYER MANDATE

A requirement that employers either provide insurance to their workers or pay a payroll tax that automatically covers their workers under a newly created public plan. Such proposals are also called pay or play.

PAY OR PLAY

A requirement that employers either provide insurance to their workers or pay a payroll tax that automatically covers their workers under a newly created public plan.

REFUNDABLE TAX CREDIT

A way of providing a tax subsidy to an individual or business for a defined purpose, such as health coverage, even if the person owes no taxes. (See "tax

credit" below.) If a person doesn't owe any tax, the government sends the person (or a third party) a check for the amount of the refundable tax credit.

SINGLE PAYER

A health care system in which a government entity finances most health care as the "single payer" for most health care services. Typically, the government takes in taxes for health care purposes. The government then pays health care providers, such as hospitals and physicians, to provide care to those enrolled in the government health care plan. An example is the Canadian health system.

SUPPLEMENTAL SECURITY INCOME (SSI)

A federal program providing cash assistance to low-income individuals who are elderly, blind or disabled.

TAX CREDIT

An amount that can be subtracted from the tax a person or business owes. A tax credit is much more valuable than a tax deduction of the same amount, since the deduction simply reduces the income on which a person or business pays taxes.

TAX EXCLUSION

Excluding the value of an employer-sponsored benefit, such as health coverage premiums paid by an employer, from an employee's taxable income.

For a more complete glossary, go to the *Cover the Uninsured Week* Web site at www.CoverTheUninsured.org/glossary or the Alliance for Health Reform www.allhealth.org/sourcebook2004/pdfs/glossary.pdf.

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