

A Systematic Approach to Expanding Health Insurance Coverage

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Mr. Chairman and members of the Subcommittee, my name is Michael J. O'Grady and I am a Senior Fellow at the National Opinion Research Center at the University of Chicago. Previously I was the Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services (HHS). I have also served on the professional staff of the Senate Finance Committee, the Joint Economic Committee and the Congressional Research Service. In those various roles I have had a chance to extensively study the problem of the uninsured and a number of different approaches to reducing the number of uninsured. Thank you for giving me an opportunity to speak with you about this critical subject today.

Background:

The United States faces a serious problem: between 10 percent and 15 percent of the population lacks access to health care, except for limited emergency services. Those without health insurance are significantly restricted to routine health care, screenings, immunizations and preventive services. Providing health insurance to those who do not have it is a vital goal.

This testimony examines who the uninsured really are, provides three policy dimensions to help prioritize government efforts to reduce the number of uninsured, and then reviews the mix of tools that can be used to make insurance available to as many people as possible.

A few key points upfront.

First, the uninsured are not one population -- they are employed and unemployed, poor and middle class, young and middle age, citizens and non-citizens.

Second, there are several policy dimensions for triaging government efforts to help the uninsured. These include desire and affordability of insurance, length of time without insurance, and citizenship status.

Third, there are different ways to make health care more accessible to the uninsured. These include tax credits and/or tax deductions; government subsidies for needy populations; employer and/or individual mandates; as well as the availability of free or subsidized clinics.

1. Who Are the Uninsured?

The key point to understand here is that the uninsured are not one population.

- ◆ More than half of the uninsured who are of working age are full-time workers.

- ◆ Those who work in small firms are far less likely to have coverage than those in large firms.
- ◆ The uninsured are found at all income levels, but most notably the poor and near-poor.
- ◆ The uninsured are found at all ages, except seniors because of Medicare.
- ◆ Hispanics are the least likely to be insured, followed by Blacks, Asians and Whites.
- ◆ About 20 percent of the uninsured live in the U.S. but are not U.S. citizens.

Let me provide statistics on each of these areas.

Employment Status: Most of the population obtains its health insurance through a current or former employer. Employment-based health insurance is somewhat unique to the United State, having developed as a response to wage controls during World War II.¹ The Census Bureau estimates that 60 percent of the population is covered through employment-based health insurance.²

Somewhat surprisingly, however, a large percentage of the uninsured also are involved in the workplace, either as full-time or part-time workers.

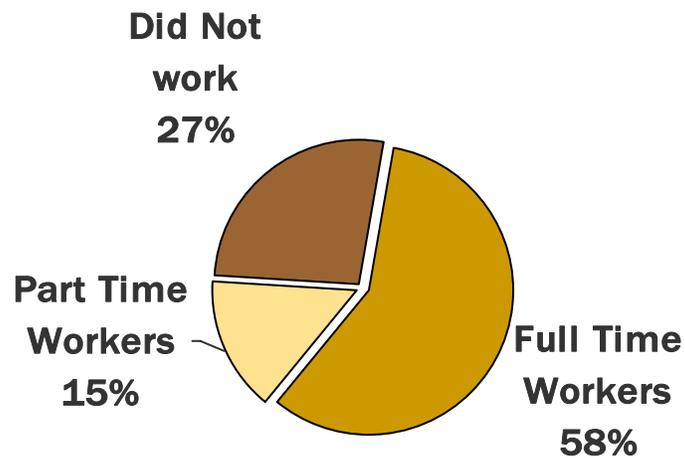
Chart 1 illustrates that the majority of the uninsured has a significant attachment to the labor force. Although part-time and part-year workers have had difficulties obtaining coverage for much of the post-war period, in recent years full-time, full-year workers increasingly have faced a lack of health insurance. This is due in part by the trend in which insurance costs are growing faster than employers' ability to pay.³

¹Employers trying to attract scarce skill labor were not allowed to offer higher wages, so they added extra benefits, such as hospitalization and other health care benefits. Offering health insurance became a regular tool by employers to recruit and retain the best workers. In Europe after the war much of the infrastructure was destroyed and the government was the only effective means of offering coverage. The differences between the American and European approaches are sometimes argued on ideological grounds today, but their inception was driven more by practical necessity.

² http://pubdb3.census.gov/macro/032007/health/h09_000.htm.

³ Health insurance is just one component of the total compensation package an employer offers. Depending on the needs and preferences of the workers they are trying to attract, other components, in particular wages, may be more effective at attracting talent. As the new jobs in the American economy are more likely to be in the service sector than in the manufacturing sector, employers have not had to offer the same mix of benefits to attract and keep the workers they need.

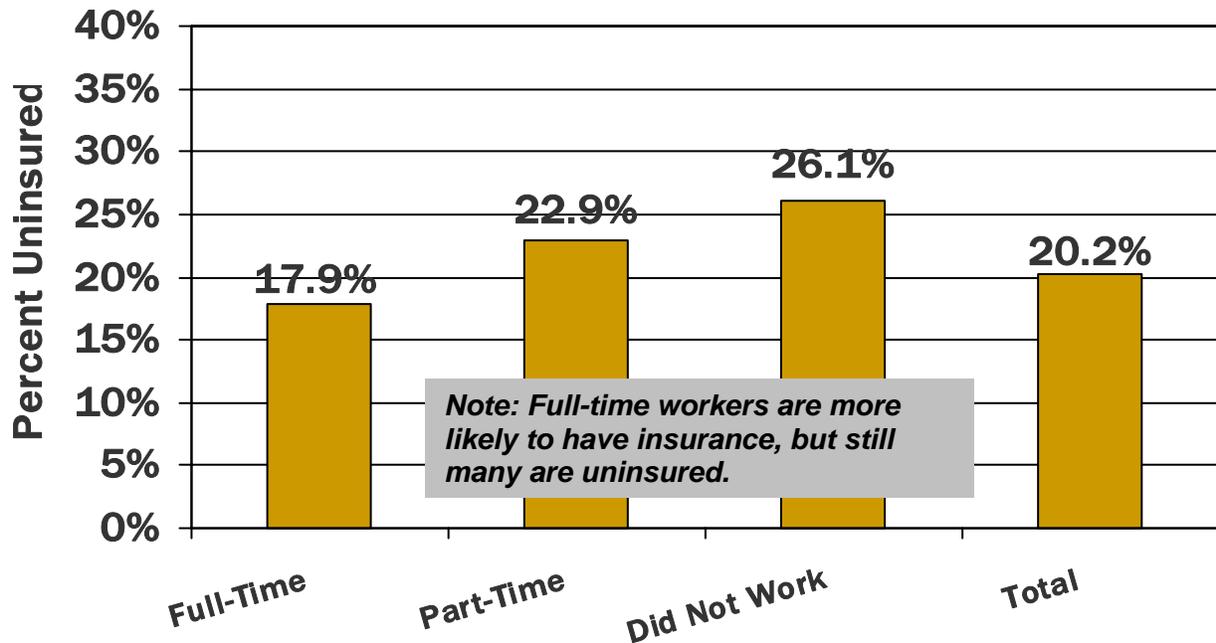
Chart 1
The Percent Of Uninsured by Attachment To The Labor Force,
Ages 18 To 64, 2006
(e.g., 58% of working age uninsured are full-time workers)



Source: U.S. Census Bureau, Current Population Survey, 2007 Annual Social and Economic Supplement. Table HI02. U.S. Bureau of the Census.

Chart 2 provides further evidence of the relationship between work and health insurance coverage. It shows that full time workers are much less likely to be uninsured than either part time worker or people out of the labor force. For this overall group of working age adults 20.2 percent report no health insurance during 2006. Full time workers fare better with 17.9 percent reporting no health insurance, but not substantially better and not as well as many observers might have expected.

Chart 2
The Percentage Without Health Insurance by Attachment To The
Labor Force, Ages 18 to 64, 2006
 (e.g., 17.9% of full time workers are uninsured)

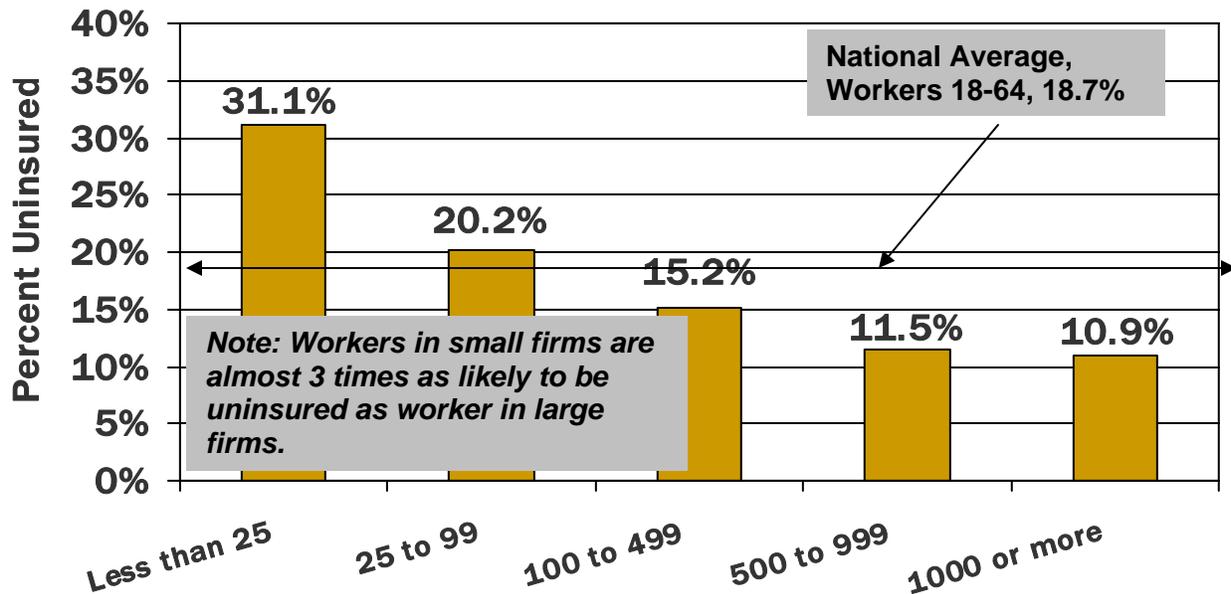


Source: U.S. Census Bureau, Current Population Survey, 2007 Annual Social and Economic Supplement. Table HI02. U.S. Bureau of the Census.

Chart 3 illustrates the relationship between firm size and insurance coverage. Larger firms are much more likely to offer their workers and retirees coverage. They are in a much stronger position to negotiate lower premiums, and almost all are self-insured. Also, once they have enough workers, retirees and dependents, they can in effect create their own insurance pool. These result in lower costs in two ways:

1. The firm only pays the insurance company to administer benefits, rather than hold insurance risk. Insurance companies can calculate the dollar value of the risk they are asked to take and add that amount to the price of the premium.
2. They avoid state benefit mandates and state premium taxes. Self-insured employers are regulated by the U.S. Labor Department and state mandates and taxes are preempted.

Chart 3
The Percentage Of Workers Without Health Insurance Based On
Different Firm Sizes, 2006
 (e.g., 31.1% of workers in firms less than 25 are uninsured)

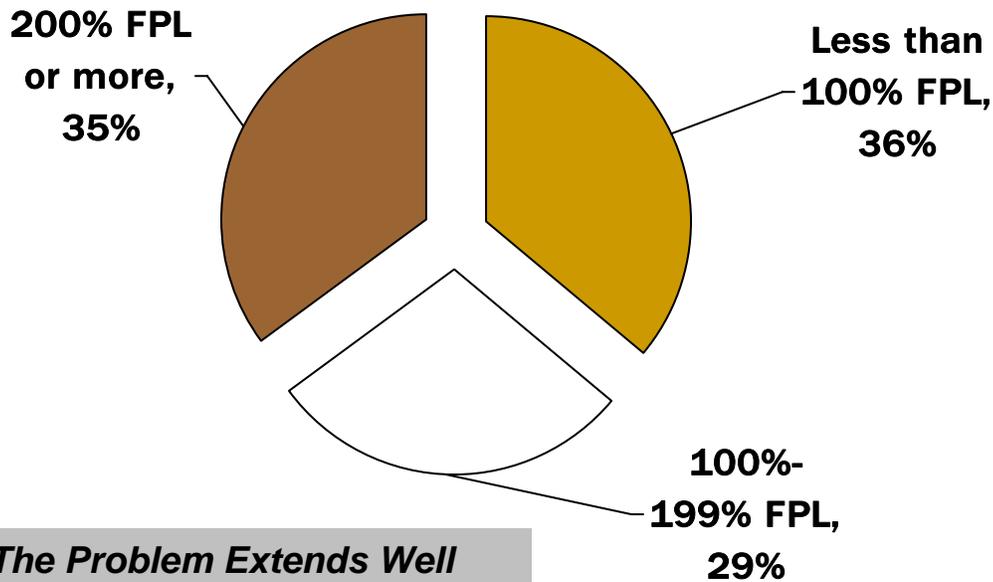


Source: U.S. Census Bureau, Current Population Survey, 2007 Annual Social and Economic Supplement. Table HI02. U.S. Bureau of the Census.

The size of the firm is an important predictor of whether a worker or retiree will have health insurance coverage and how affordable that coverage will be. Large firms (those with at least 500 workers) almost undoubtedly offer coverage and have negotiated the lowest premiums. Still, as Chart 3 shows, about one in 10 workers in large firms have no coverage - either these workers do not believe that they need the coverage or that they cannot afford the premiums. The former view is sometimes held by single, healthy, young workers; the latter held by those at the lower income brackets.

Income and Coverage: Being uninsured is not limited to the poor or the near-poor. Chart 4 illustrates the income distribution of the uninsured. People with 200 percent of more of the federal poverty level made up 35 percent of the uninsured in 2006. The federal poverty line was \$20,614 for a family of four in 2006, so these could be families making \$41,228 or more. It is unclear whether this is a problem in which coverage is offered and is still unaffordable even for people at this income level or if it is a problem of access to coverage for small businesses or the self-employed or any number of other possibilities.

Chart 4
The Percent of the Uninsured by Family Income in 2006
(e.g., 35% of the uninsured have incomes 200% or above the federal poverty line)



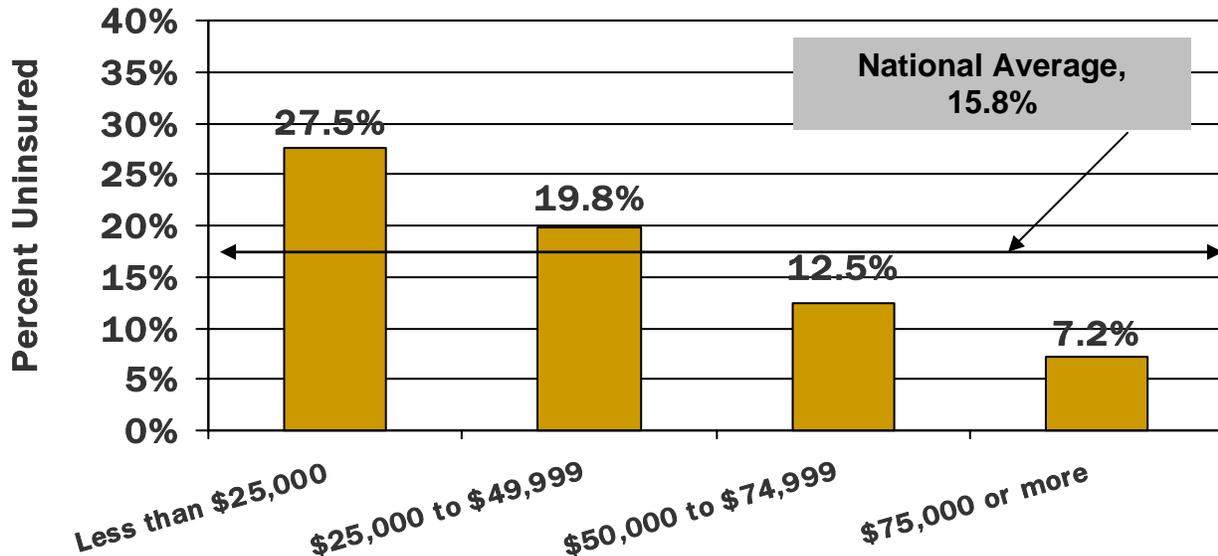
Note: The Problem Extends Well Beyond the Poor and Near-Poor.

The federal poverty level (FPL) was \$20,614 for a family of four in 2006.
Source: KCMU/Urban Institute analysis of March 2007 CPS.

Chart 5 below illustrates what percentage of each income group went without coverage in 2006. The previous chart showed that more than a third of the uninsured can be considered moderate to high income. Chart 5 also shows that while the lack of insurance extends beyond the poor and near-poor, the rate of those without insurance is highly correlated with income. More than one in four of those who make less than \$25,000 do not have insurance compared with about one in 14 who make \$75,000 or more.

Chart 5
 The Percentage without Health Insurance by
 Family Income, 2006

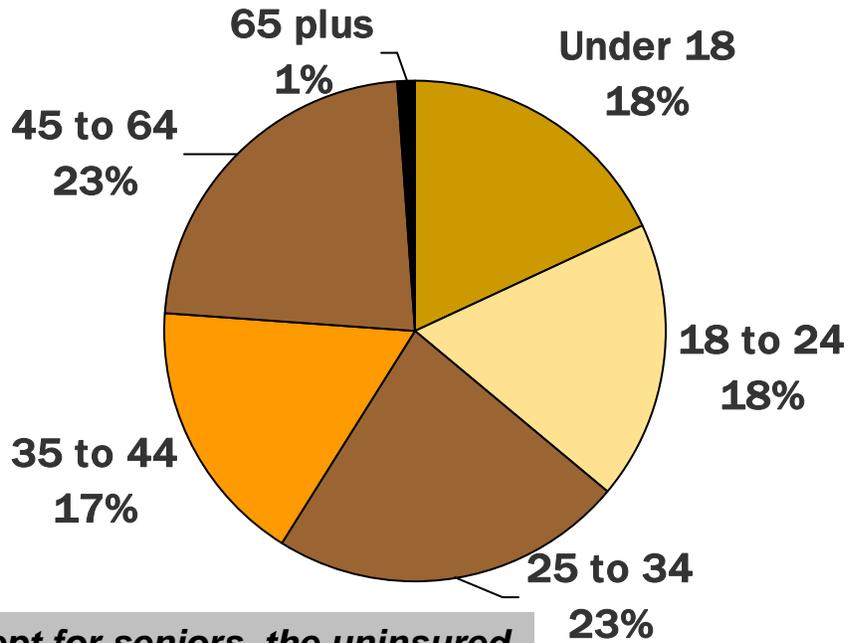
(e.g., among those who make less than \$25,000, 27.5% are uninsured)



Source: U.S. Census Bureau, Current Population Survey, 2007 Annual Social and Economic Supplement. Table HI02. U.S. Bureau of the Census.

Age and Coverage: Age is another important factor to examine in considering the problems of the uninsured. The uninsured are found among all age groups, with the clear exception of the elderly. Medicare’s close to universal coverage means the problems of the uninsured are problems on the non-elderly subpopulation. Among the non-elderly, the distribution of the uninsured is fairly evenly balanced with the uninsured being found in all age categories.

Chart 6
Percentage of the Uninsured by Age, 2006
(e.g., 18% of the uninsured are between 18 - 24)

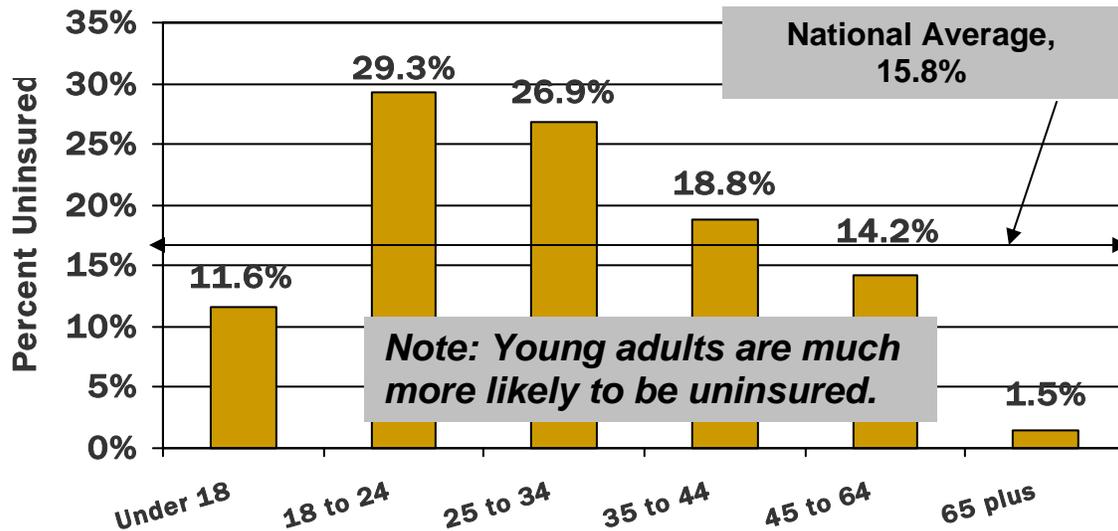


Note: Except for seniors, the uninsured are found among all age groups.

Source: U.S. Census Bureau, Current Population Survey, 2007 Annual Social and Economic Supplement. Table HI02. U.S. Bureau of the Census.

While the uninsured may be found in all the non-elderly age categories, some age categories have a much higher likelihood of being uninsured. Chart 7 illustrates the strong correlation between age and insurance coverage. Young adults 18 - 24 are at least twice as likely to be uninsured as those between 45 and 64. These young adults may have aged out of coverage on their parents' plans, they may not be in the work force, and/or they may have an employer that does not offer coverage. Additionally, some members of this age group do not see the same need for coverage. This is a relatively healthy age group and they may not yet have family obligations that would encourage them to purchase coverage for a spouse and children.

Chart 7
The Percentage without Health Insurance
for Different Age Groups, 2006
 (e.g., 29.3% of 18 to 24 year olds are uninsured)

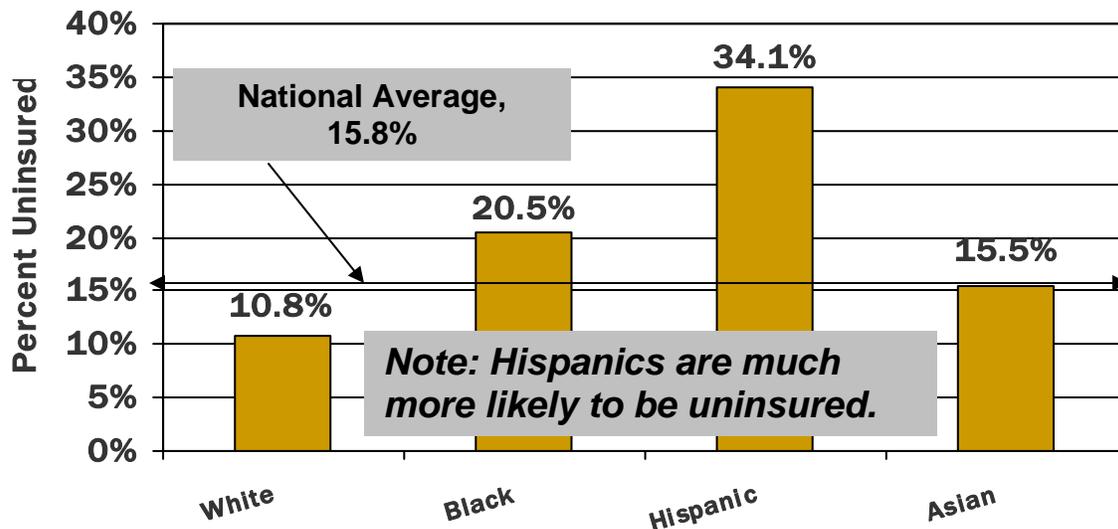


Source: U.S. Census Bureau, Current Population Survey, 2007 Annual Social and Economic Supplement. Table HI02. U.S. Bureau of the Census.

Race/Ethnicity and Coverage: There are clear differences in health insurance coverage between the different racial and ethnic groups in the country. Chart 8 displays the coverage rates for the four largest racial/ethnic groups in the country. For this analysis the Census Bureau counted only people who identified themselves as fully “White, not Hispanic”; “Black, not Hispanic”; “Hispanic” or “Asian”. People of different racial/ethnic groups and mixed racial/ethnic backgrounds were not included in this particular analysis.

Hispanics have the highest percentage without health insurance - 34.1 percent in 2006. Blacks have the next highest with 20.5 percent in 2006. Asians had 15.5 percent uninsured and whites had 10.8 percent uninsured in 2006. How race/ethnicity interacts with the other factors is an open question. What part of the higher rate for Hispanic is really associated with a higher percentage of immigrants within the Hispanic subpopulation? Is this a problem for immigrants no matter what racial/ethnic group they come from or is there some aspect of this problem that is specifically severe for the Hispanic subpopulation unrelated to immigration? Many of these questions need much further and more rigorous research to help inform the policy discussion.

Chart 8
The Percentage without Health Insurance for
Different Racial/Ethnic Groups, 2006
 (e.g., 34.1% of Hispanics do not have insurance)



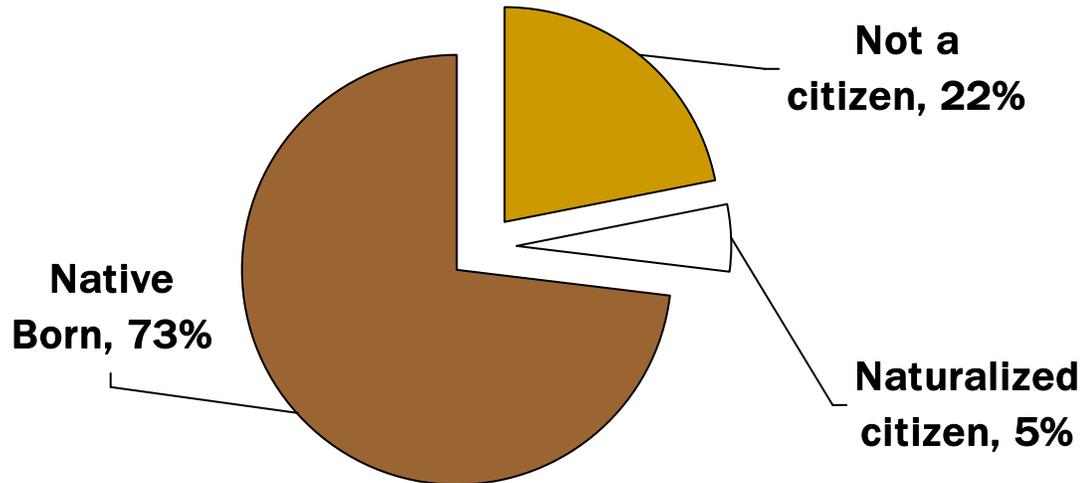
Source: U.S. Census Bureau, Current Population Survey, 2007 Annual Social and Economic Supplement. Table HI01. U.S. Bureau of the Census.

Immigration and Coverage: The interaction between immigration status and coverage status poses very challenging policy choices. Chart 9 shows the distribution of the uninsured by citizenship and immigration status. The latest data from the Census Bureau estimates that while non-citizens comprise about 8 percent of the population they comprise 22 percent of the uninsured or about 10.2 million people.⁴

There is no reliable way to accurately estimate how many of these non-citizens are in the country legally or illegally. Understandably, immigrants here illegally are not particularly forthcoming about their status when interviewed by Census Bureau interviewers. However, based on the types of jobs and benefits available to illegal immigrants, it is reasonable to deduce that illegal immigrants are more likely to be uninsured than legal immigrants.

⁴ U.S. Census Bureau, Current Population Survey, 2007 Annual Social and Economic Supplement. http://pubdb3.census.gov/macro/032007/health/h09_000.htm. Table HI09. US Bureau of the Census.

Chart 9 -
Percentage of the Uninsured by Immigration Status, 2006
(22% of those uninsured are not citizens)



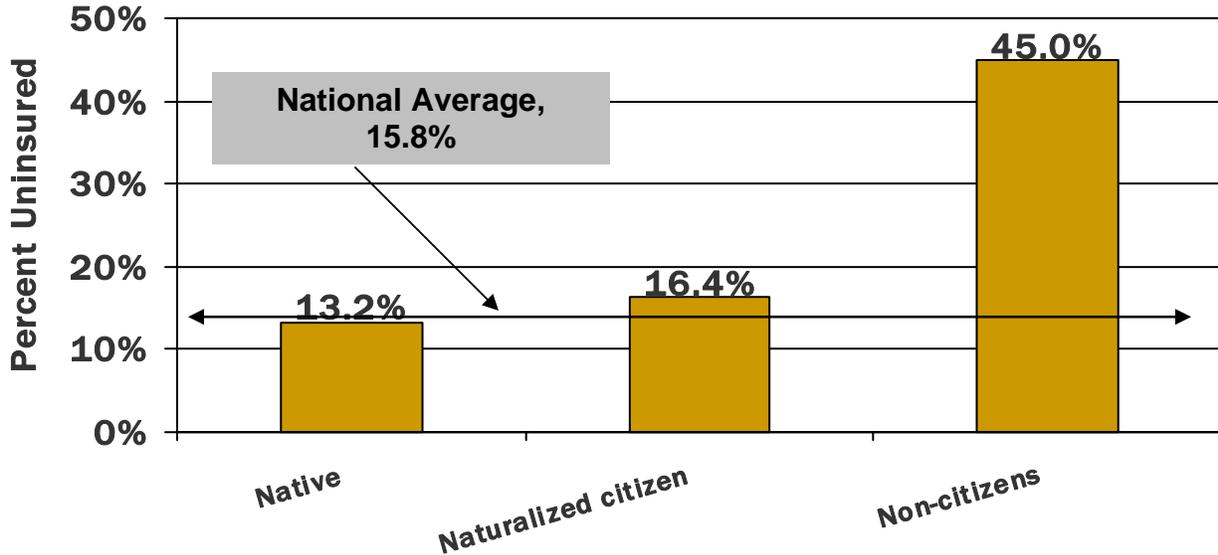
Note: Non-Citizens make up only 8% of the population, but 22% of the uninsured.

Source: U.S. Census Bureau, Current Population Survey, 2007 Annual Social and Economic Supplement. Table HI09. US Bureau of the Census.

Even among those immigrants that are here legally, restrictions are placed on some forms of government-based coverage. For example, legal immigrants are ineligible for Medicaid or SCHIP until they have been legal permanent residents for five years. In addition, when an immigrant is sponsored for immigration by an American citizen, the resources of an immigrant's sponsor are counted in addition to those of the immigrant's family.

If nothing else, it is important to note that the Census Bureau's estimate of 47 million uninsured in 2006 is not 47 million Americans; it is 47 million people living in the United States. The Census Bureau's estimate of uninsured Americans is 37 million in 2006.

Chart 10
The Percentage Without Health Insurance
By Immigration Status, 2006
 (45% of non-citizens do not have insurance)



Source: U.S. Census Bureau, Current Population Survey, 2007 Annual Social and Economic Supplement. Table HI09. U.S. Bureau of the Census.

Like age, citizenship correlates strongly with insurance coverage. Non-citizens are approximately three times more likely to be uninsured than are native or naturalized citizens.

This section has illustrated how diverse the different subpopulations of the uninsured can be. Other than being uninsured, they often have little else in common.

2. Policy Dimensions

Designing and assessing proposals to provide health care access to those without insurance is remarkably complex.

Affordability of coverage becomes a necessary policy dynamic when considering proposals that expand coverage either through voluntary or mandatory measures directed at individuals, firms, or insurance pools.

Assuming that the goal of providing coverage for everyone in this country is achievable, it is unnecessary to triage subpopulations of the uninsured to determine when and in what order they should be included.

However, in the event that policy makers have to make some hard choices about who will be assisted in gaining coverage due to budget constraints or the realities of political compromise, a conceptual framework to help make such decisions is provided below.

Chart 11 illustrates the conceptual framework. Three dimensions are chosen here representing three of the more common concerns:

- Desire for coverage
- Time without coverage
- Citizenship

Desire for coverage

A key dimension is desire for coverage, which can be broken down as follows:

- Those who do not seek coverage, even if it is available and affordable.
- Those who seek coverage but cannot afford it.
- Those desperate for coverage, willing to pay almost any price if it were only available, e.g., some groups of the chronically ill.

Those favoring universal coverage in its broadest sense have sought coverage regardless of an individual's desire for coverage. This would include the single, healthy, young adult who doesn't see a need for health insurance at this point in life.

Those favoring a phased-approach to health coverage may have a greater policy concern for the uninsured 55 year-old diabetic with complications than the new, healthy, college graduate.

Time without coverage

A second dimension is time without coverage. The somewhat limited data on coverage indicates a range in the number of people uninsured for brief periods of time versus those uninsured for an entire year or more. We know that at a minimum the longer the person is uninsured the longer the potential gap in screenings and other preventive services. In this example, if a policymaker were looking to phase-in insurance, the highest priority might be given to the people uninsured for the longest period of time, e.g., over two years.

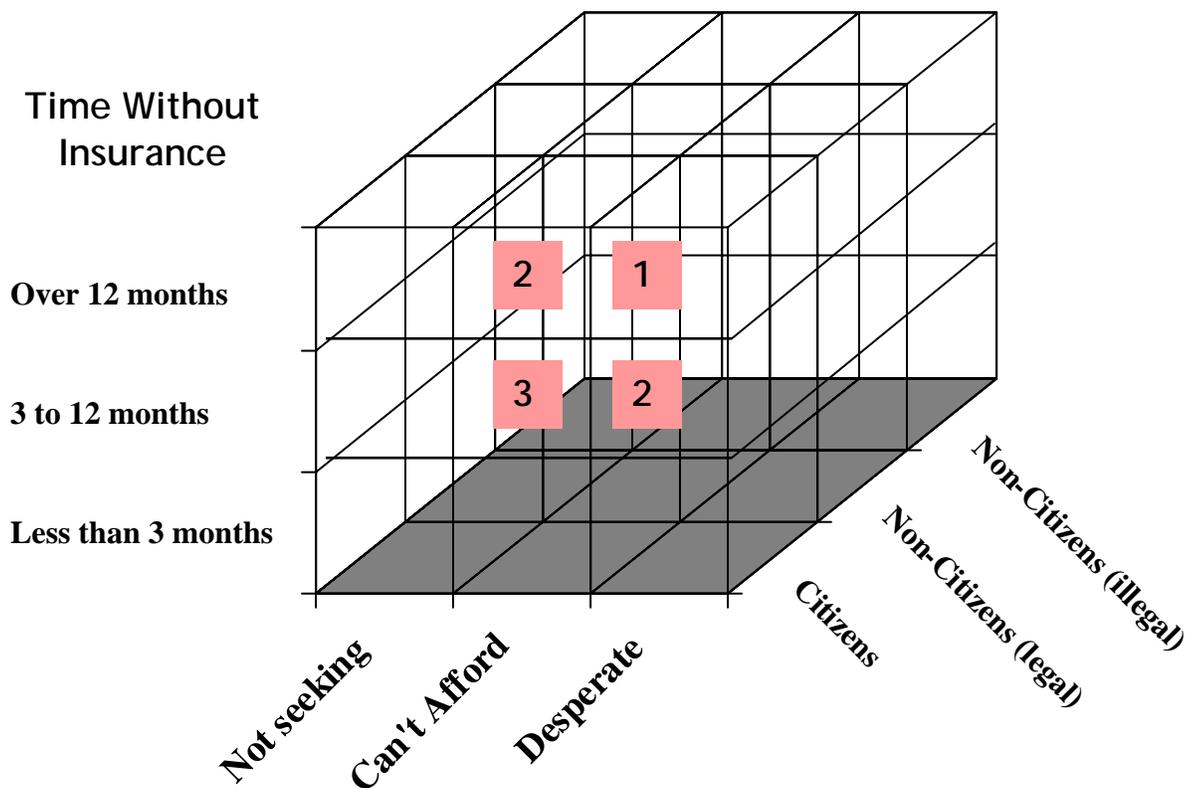
Citizenship status

The third key dimension is citizenship status. As noted above more than 20 percent of the uninsured are not U.S. citizens. There may be neither a

political consensus nor the budget to extend coverage to all people living in the United States. A likely scenario would have coverage first offered to citizens, either native or naturalized. There may be a further consensus over coverage to legal immigrants. Gaining the political consensus necessary to offer coverage to illegal immigrants seems unlikely.

Chart 11 below provides a visual way to think about the interactions among the three policy dimensions outline above. For example, people falling in the high priority on all three dimensions are assigned an overall priority of 1. The assignment of priorities will vary from policymaker to policymaker and person to person based on their individually held judgments.

Chart 11
Conceptual Tool for Thinking about the Uninsured



Other dimensions

Age may provide yet another dimension on which to prioritize coverage. Children are a vulnerable population as well as a relatively inexpensive

population to insure. Medical need may provide another dimension although it may be difficult to determine who is most medically needy.

3. Matching the Right Policy to the Right Population:

It is unlikely that only one option would meet the needs of all these different subpopulations. For small businesses with moderate income employees, a successful solution might include access to both purchasing pools, so they have options similar to larger firms, and an improved tax advantage to help offset the cost of coverage.

For the uninsured without employment-based coverage, it could be made much more affordable if they had access to the same tax advantages as employer-based coverage.

For immigrants, legal or illegal that same combination of incentives would probably not be anywhere near as effective. Also, especially for the illegal immigrants, it seems unlikely that expanded government programs would prove effective. Asking illegal immigrants to interact with government intake and eligibility officials is unlikely to generate much trust and compliance. This subpopulation may be better served through a clinic approach which ensures care, if not coverage, and is closer to the model of care found in many of their home countries.

The various policy tools that could be brought to bear to best meet the needs of these different subpopulations all have ideological implications for policymakers. It is not unusual that when confronted with a challenging policy problem many Democrats are more comfortable trying government-based approaches and many Republicans are more comfortable trying market-based approaches. These preferences were apparent in the design options for a Medicare drug benefit.

In crafting a solution to the problem as complex as the uninsured, there will be ample opportunities to try both market-based and government-based solutions. Policymakers will need to carefully consider the circumstances of the subpopulation involved to judge which type of design will be the most successful. A systematic examination of the composition of the uninsured, a prioritization of those to receive insurance assistance, and identification and review of the mix of tools available to help the uninsured gain access to healthcare will help shape a scientifically sound and viable policy in the future.