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Health Insurance
Data Brief #1

Improving Access To Health Insurance

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This is the first of a five-part series by the Center for Economic and Policy Research (CEPR) on health insurance coverage in the United States. Other Data Briefs in this series examine access to health insurance generally, employer-provided health insurance for employees, changes in the share of Americans receiving employer-provided health insurance as a dependent on another family member's plan, and interactions between the private and public health insurance systems.

The data used in this analysis is from CEPR's analysis of the Survey of Income and Program Participation. CEPR creates user-friendly Data Sets from this survey and makes the data and programs available to other researchers via our website (www.cepr.net).

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Executive Summary

The current U.S. health care system is individualized and based on employment. For those who have access to a good job with comprehensive health benefits, employer plans work. However, this system fails the nearly 113 million Americans under age 65 who went without employer-provided health insurance for at least some part of 2002. Further, in the percentage of the public with employer-provided health insurance coverage is dropping rapidly, primarily hitting those dependent on another family member's employer-provided plan. The fall in dependent coverage has led to a larger percentage point decline in the share of children covered than adults.

Access to health insurance is unequal. Children, Latinos, and young adults (ages 18 to 25) are least likely to have health insurance. Having a job does not ensure health insurance coverage: low-wage workers are about half as likely as high-wage workers to have employer-provided health insurance from either their own employer or a family member's. Women low-wage workers are half as likely as male low-wage workers to have health insurance through their own employer. In 2002, less than half (47.3 percent) of low-wage workers had employer-provided health insurance from either their own employer or a family member's over the whole year. Increasingly, low-wage workers are turning to Medicaid to cover their children.

Policy responses have been inadequate and, over the past decade, Congress has done little to expand health insurance coverage. The last major initiative was in 1997, when Congress increased coverage for the children of the working poor through the State Children's Health Insurance Program (SCHIP). The expansion of Medicaid through SCHIP was insufficient to overcome the loss of employer-provided health

insurance as coverage fell for children during the economic contraction. Even so, more children on Medicaid are in families where someone has employer-provided health insurance compared to a decade ago. Future legislative solutions must focus on increasing access to health insurance as well as ensuring equity across age, race, and income levels.

Improving Access to Health Insurance

The American health care system is individualized and based on employment. Most individuals obtain health insurance coverage through their employer and, for those lucky enough to have coverage, they have relatively good access to the health care system. This structure works for many workers and their families: most people with jobs paying above the median wage are able to garner health insurance benefits from their employers, and most of these workers are able to use their employer's plan to cover family members. However, nearly 113 million Americans under age 65 did not access health insurance coverage from an employer during at least part of 2002. Further, access to health insurance coverage in the United States is highly inequitable and those without health insurance coverage are disproportionately Latinos, children, and young adults.

At present, the employer-based system appears to be undergoing an apparent fundamental shift. Over the most recent recession and recovery, while employer-provided health insurance coverage remained steady among employees, it fell among those accessing it as a dependent on another family member's employer-provided plan, especially among children. Thus employer-provided health insurance coverage fell overall and fewer non-elderly Americans – about three-in-five (61.6 percent) – received employer-provided health insurance at all. At the same time, the share of children on Medicaid who lived in a family where someone had employer-provided health insurance nearly doubled to 11.1 percent, indicating a shift for children from employer-provided to government-funded health insurance.

The crisis in access to health insurance coverage is not new, but there have been few major policies advanced at the national level over the past decade to address the problem. Over the 1990s and into the 2000s, health care costs rose much faster than inflation, and costs for dependent or family coverage have shifted from employers to employees. In 1997, Congress responded to the rising lack of coverage among children by expanding Medicaid through the State Children's Health Insurance Program (SCHIP). Even so, the share of children covered under Medicaid/SCHIP fell throughout the late 1990s and has only begun to rise in the early 2000s. (See *Health Insurance Data Brief #1*)

The shift toward Medicaid is adding to the financial stress in the states, many of which have faced record budget deficits in recent years. Current policy proposals must address the flaws in access to health insurance coverage including not only the shift

away from employer-provided dependent health insurance coverage, but also the inequities in coverage for Latinos and other minorities, children, and young adults.

Increasingly, employers are not providing health insurance coverage to dependents

Access to employer-provided health insurance coverage decreased over the most recent economic contraction, falling from 64.0 in 1999 to 61.6 percent in 2002. While employers have not been dropping coverage for employees, they have decreased coverage to family members. Between 1999 and 2002, the share of workers with employer-provided health insurance who cover another family member fell from 56.0 percent down to 51.6 percent. The fall in dependent coverage led to a larger decline in the share of children covered than adults. By 2002, 69.2 percent of children with health insurance received it from their parent's employer-provided health plan, a drop of 6.5 percentage points in just three years. (See *Health Insurance Data Briefs #3* and *#4* for more information about employer-provided health insurance coverage.)

Lack of employer-provided health insurance is more of a problem for low-wage workers and their families than for high-wage workers. Low-wage workers are half as likely as high-wage workers to have employer-provided insurance from either their own firm or a family member's. Less than half (47.3 percent) of low-wage workers had any employer-provided health insurance during all of 2002. For many low-wage workers, other family members are not filling in this gap. (See *Health Insurance Data Brief #2.*)

Children, Latinos, and young adults are especially unlikely to have health coverage from an employer. Between 1999 and 2002, the share of children covered the whole year (from any source) fell by 3.5 percentage points, from 74.9 down to 71.4. Latinos are less likely than other racial/ethnic groups to be covered, even once we account for differences in other characteristics, both because they do not receive health insurance from their employers, and they access Medicaid in smaller shares than other racial/ethnic groups. Among adults, young adults (ages 18 to 25) are least likely to have health insurance. This is especially important because young adults have special health care needs, given that nearly 60 percent of all first births occur to mothers aged 18 to 25 (See *Health Insurance Data Briefs #1* and *#2.*)

Rising cost for employers led to cost-shifting to employees

Rapidly rising health care costs have made health care, and especially dependent coverage, increasingly expensive to provide. Health insurance premiums rose faster

than overall inflation and workers' earnings in every year between 1992 and 2003 except 1996 and for the past three years, there have been double-digit increases in costs.[1]

Employers have dealt with higher health benefit costs by shifting expenses onto employees. The Bureau of Labor Statistics reports that the share of employees who must contribute to their employer-provided health plan rose significantly between 1989 and 2003, from 47 percent to 82 percent for individual coverage and from 66 percent to 92 percent for dependent coverage. At the same time, the share of premium costs paid by employees has also risen: the average monthly contribution for a single worker increased by 11.2 percent between 1989 and 2003, and dependent coverage increased by 42.5 percent.[2] This trend has accelerated in recent years.

In 2002, among companies offering health insurance, a third increased employees' co-payments, coinsurance or share of the premiums.[3] Families are not only paying more for premiums, but also for co-payments and other coinsurance costs, deductibles, and "extras," like eyeglasses and prescription drugs.[4]

More families are accessing Medicaid in addition to employer-provided health insurance

Before the creation of SCHIP in 1997, Medicaid was only available to families living below the poverty threshold, although the exact rules were set by the states. In families above poverty, the large majority of the individuals covered by Medicaid were children under 6 and pregnant women living below 133 percent of the poverty line.[5] Today SCHIP expands coverage to children – but not their parents – in families between 100 and 200 percent of the poverty threshold.[6] Under SCHIP, states can either expand their Medicaid program to cover more children, establish a separate program, or both.

SCHIP's implementation did not immediately increase coverage for children. Although funding increased, many states were slow to spend these new federal funds, and administrative changes due to welfare reform actually reduced coverage.[7] The share of children on Medicaid/SCHIP fell between 1996 and 2000,[8] partially due to the booming economy, but also due to changes in Medicaid implementation at the state and local level. As states began to tighten the rules for welfare receipt, many denied Medicaid benefits to eligible individuals due to antiquated administrative systems that did not de-link welfare and Medicaid.[9] Thus many individuals eligible for Medicaid assistance were deemed ineligible.[10]

Latinos were particularly affected by the limitations on immigrant receipt of public benefits after the implementation of welfare reform. The Personal Responsibility and Work Opportunity Reconciliation Act (commonly known as "welfare reform")

prevented states from using federal monies to cover the health care costs of Legal Permanent Residents and undocumented immigrants with residencies of less than five years in the United States.[11] In addition, state-based propositions, such as California's Propositions 187 and 227, created a national debate around immigrant access to a wide variety of state and federal assistance programs which potentially played a limiting role on immigrant Latinos' ability and willingness to apply for such assistance programs.

Medicaid coverage increased during the economic contraction. Twenty states have implemented state-funded programs to cover the benefits of legal immigrants. States have also worked out some of the kinks in their administrative systems to ensure that eligible working poor families can access Medicaid and SCHIP.[12] By 2003, almost all of Medicaid/SCHIP funds were being spent by states.[13]

Coverage under Medicaid/SCHIP may fall in coming years because of rising costs and limited federal funds. Medicaid expenditures per person grew an average of 11 percent a year from 1980 to 2000, far outpacing inflation.[14] These rising costs, combined with fiscal constraints from the recession and budget crisis, have led many to cut eligibility, increase cost-sharing, limit medical procedures covered, and even freeze health programs to contain costs.[15] Six states – Alabama, Colorado, Florida, Maryland, Montana, and Utah – stopped enrolling eligible children into their SCHIP programs due to budget cuts.[16] In addition, the Bush Administration has proposed to cut funding by $16 billion over 10 years, which would lead to even deeper restrictions on eligibility and increased cost-sharing for Medicaid and SCHIP recipients.[17]

Some states, however, have recently implemented measures to address the lack of health insurance coverage in their states. For example:

- Maine passed legislation in 2003 to create universal health coverage within the next five years.
- California's "pay or play" legislation, signed into law in 2003, requires employers to either provide health insurance to their employees or pay into a state fund for the uninsured.
- Vermont ensures that 96 percent of children have access to health care under the Dr. Dynasaur program.

Legislative solutions: current health care proposals

Increasing access to health coverage and ensuring equity in eligibility are two achievable goals. Given the current health insurance system, the only ways to achieve these goals is to either mandate that everyone purchase health insurance or to move

away from employer-based coverage and create a universal health care system. If Congress were to require everyone have health insurance, as we do with car insurance, employers could continue to provide coverage for their employees, but those without employer coverage would have to buy-in to a plan. If costs for non-employer-based plans remain as unaffordable as they are currently, this would create hardship for those without employer-coverage, who are disproportionately children, young adults, and low-wage workers.

Three bills before Congress would move towards a universal health care system, ensuring that all Americans have health insurance coverage are:

- The **US National Health Insurance Act** (HR 676) would expand Medicare to cover all Americans, not only those over 64.
- The **Health Security for All Americans Act** (HR 5269 in 107th, soon to be re-introduced), would establish a state-based universal health system for all Americans.
- The **States' Right To Innovate in Health Care Act of 2003** (H.R. 2979) would provide grants to states to achieve universal health care.

In addition, the **Health Care That Works for All Americans Act of 2003** (S. 581) would establish a Citizens' Health Care Working Group to assess the possibilities for creating a universal health care system in the public and private systems.

Many bills that Congress is considering are more limited in scope and focus on increasing coverage for specific groups. Two such bills currently under consideration are:

- The **Health Care Freedom of Choice Act** (HR 1117) would make medical expenses, including health care and drug costs, tax deductible for individuals. This would likely benefit higher-income families since the deductions are not refundable
- The **Immigrant Children's Health Improvement Act** (H.R. 1689, S. 854) would eliminate the ban on Medicaid and SCHIP access for all legal immigrants. This would only affect immigrant children and would do little to increase coverage of other groups.

Other bills focus on limiting costs, without addressing the health insurance coverage issue directly. For example, the **Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2003,** otherwise known as the Malpractice Liability bill (HR 5, S 507, S 607), would limit liability and health care lawsuits. Although this plan

would decrease costs incurred by health care providers, it would do little to increase access for low- and moderate-income individuals or improve equity.

Both major party presidential candidates, President George Bush and Senator John Kerry, have put forth plans to address the issue of health insurance coverage. Neither candidate, however, has put forth a plan that would ensure coverage for all Americans.

President George Bush's approach is to encourage everyone to purchase health insurance. To this end, he has proposed a refundable tax credit for low- and moderate-income individuals and families who are not covered by their employers' health insurance program.[18] The proposed credit is only $1,000 for individuals and $3,000 for families, grossly inadequate for most moderate-income families. Average family health care costs are estimated to reach $14,500 by 2006.[19] In addition, outside estimates find that the Bush proposal would only cover about 10 percent of the uninsured.[20]

President Bush has also supported Health Savings Accounts and Associated Health Plans. Health Savings Accounts would likely benefit higher income families who have funds to set aside for health care expenditures. Associated Health Plans would allow small businesses to pool together to provide insurance for employees. However, the Congressional Budget Office estimates that it would cover only about 330,000 new people, a small fraction of the uninsured. Further, the proposed legislation would exempt small businesses from state laws that dictate what kinds of services health insurance must cover.

Senator John Kerry's[21] approach is to make it possible for more people to buy-in to health insurance through creating an affordable, federally subsidized plan. He proposes to create a group option to buy in to the federal employee benefits program with a tax credit for uninsured individuals.[22] He would also limit premiums, expand state programs for low- and moderate-income families, and provide a tax credit for small firms. According to outside estimates, Kerry's plan would cover about two-thirds of the uninsured.[23]

Conclusions

Employers are increasingly not covering their employees' families on their health insurance plans. Overall, employer-provided health insurance coverage fell from 1999 to 2002, almost entirely because of falling dependent coverage, largely among children. The culprit has been the rapid growth in health care costs and the rising share of costs that employers have shifted onto their employees.

Congress has done little to stem rising health care costs for working Americans. The most important policy development was the passage of SCHIP in 1997. However, the share of children receiving Medicaid/SCHIP still did not rise until the economic contraction in the 2000s.

More children on Medicaid are now living in families where an adult has an employer-provided health insurance plan. Thus, cost-shifting has not only been from employers to employees, but also from employers to government. This has posed difficulties for many states that cannot afford to expand Medicaid in the midst of the current fiscal crisis. Many states are, in fact, cutting Medicaid coverage or services to cut costs.

While the current employer-based system of health insurance coverage works for many Americans, it does not work for the two-out-of-five non-elderly Americans who do not have employer-provided health insurance. This number is likely to grow rapidly in the near future without further Congressional action. A universal health care system that provides coverage for all Americans would address both declining employer-provided health insurance, as well as ensure equity in access to coverage.

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