Insuring the Uninsured: Will the 2004 Election Provide an Answer?

Thomas Bodenheimer, MD

A June 2004 report revealed startling new statistics on uninsured Americans (1). A total of 82 million Americans—1 of 3 people younger than 65 years of age—were uninsured at some point during 2002–2003 (1). Conducted by the well-regarded Lewin Group, the study found that two thirds of the 82 million were uninsured for 6 months or more, with half lacking coverage for at least 9 months. These figures, based on U.S. Census Bureau Current Population Survey data, are far higher than the commonly cited number of 43.6 million uninsured for the entire calendar year 2002 (2).

Despite these findings, proposals to expand health insurance rarely grace headlines about the 2004 presidential election, crowded out by concerns over jobs and Iraq. Even in the health care penumbra, other issues command more attention. Controversy swirls around the 2003 Medicare Modernization Act. Drug reimportation from Canada is high on the wish list of seniors and of governors—Republican and Democrat—concerned with Medicaid pharmacy costs. Embryonic stem-cell research and abortion rights are on constituents' minds. Physicians want legislative action to control malpractice premiums.

Recent polls indicate that most Americans desire a government guarantee that people receive coverage for basic health care services, but far fewer people are willing to pay more taxes to insure the uninsured. The polling data suggest that the climate for expanding health insurance is less favorable than it was 10 years ago (3). According to analyst Jonathan Oberlander, "The most relevant political fact about U.S. health politics is not that 15 percent of the population is uninsured but that 85 percent is insured" (4).

Responding to voters' lack of enthusiasm to pay for expanded health care coverage, politicians from both parties have changed their view on how to insure the uninsured. In the past, many health coverage proposals called for increasing taxes. Under the new thinking, health coverage is stimulated by *reducing* a person's taxes by providing a tax credit to purchase private health insurance. The tax credit approach is a central feature of the health proposals of both presidential candidates in 2004.

After discussing a historical categorization of universal health insurance strategies, this paper summarizes the Bush and Kerry health insurance plans, critiques these proposals, and explores the broader concept of using tax credits to facilitate the purchase of individual insurance policies. The paper concludes by describing physician organizations' approaches to insuring the uninsured.

The Three Varieties of Universal Health Insurance Proposals

For 90 years, reformers in the United States have argued for the passage of universal health insurance, a government guarantee that every person is covered for basic health care services. This political movement has seen 5 periods of intense legislative activity, alternating with stretches of political inattention. In 1912–1919, 1946–1949, 1963–1965, 1970–1974, and 1991–1994, expanding health insurance was the topic of major national debate. In 1916, 1949, 1974, and 1994, proposals were defeated and reconsigned to the back burner. In 1965, the passage of Medicare and Medicaid brought a major advance.

While the details of universal health insurance proposals may be inscrutable, the basic features of all proposals are simple. Only 3 varieties exist: 1) government-funded public programs such as Medicare, Medicaid, or the Canadian "single-payer" system; 2) employer-based systems in which people receive insurance through their jobs; and 3) individual-based insurance through which people purchase their own health coverage. Every health insurance expansion proposal is based on 1, 2, or all 3 of these models (5).

From 1912 to 1972, almost all universal health insurance proposals were government-funded "single-payer" plans, by which the government would levy taxes and pay physicians, hospitals, and other providers when people needed care. The most prominent of these was the Wagner–Murray–Dingell bill, supported by Harry Truman in the 1948 election. A major effort from the American Medical Association, assisted by the growth of employment-based private insurance, killed that proposal. The passage of the government-financed Medicare and Medicaid programs in 1965 was followed in a few years by Senator Edward Kennedy's single-payer plan. To counter Kennedy's efforts, President Nixon introduced the first-ever universal health insurance program based on private health insurance companies. The central feature of Nixon's plan was an employer mandate, which legally required employers to insure their employees. The Clinton plan of the early 1990s, also an employer mandate, had many similarities to Nixon's proposal (5).

Rather than offering everyone insurance through the government, or requiring employers to insure their employees, the current Washington poster child features individually purchased insurance. This strategy, launched around 1990 by the conservative Heritage Foundation, was called the "individual mandate"—everyone would be legally required to purchase individual health insurance just

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For author affiliation, see end of text.

Table 1. **Health Savings Accounts**

Definition: A savings account established exclusively to pay for medical expenses for a person with a high-deductible health insurance policy (8–11).
Money can be kept in the account for an indefinite period; the value can grow tax-free and be used to pay medical expenses on a tax-free basis.
Under the Bush proposal, the health savings account would be tax-free and the premium for the high-deductible insurance policy would be tax deductible.

as drivers are required to purchase auto insurance. To make insurance more affordable, the individual mandate proposed that lower-income people receive tax breaks to help in the purchase of health insurance (6). From the individual mandate approach came the tax credit concept that features prominently in the 2004 election health insurance proposals, although the 2004 tax credit proposals are voluntary rather than required. Tax credits can assist in the purchase of individual or group insurance. Previously an idea limited to Republicans, tax credits have recently attracted many Democrats (7). Even though 46% of the general public and 56% of Democrats supported a government-funded single-payer system in a 2003 Harvard School of Public Health/Robert Wood Johnson Foundation survey (3), most Democratic politicians have moved away from the single-payer approach.

THE CANDIDATES' PROPOSALS FOR INSURING THE UNINSURED

Bush Proposal

The Bush proposal is simple. A tax credit to purchase individual health insurance would be available to individuals and families who do not participate in employer-based coverage or public health insurance programs and would equal up to $1000 for individuals and up to $3000 for families with children. For people who owe taxes, the amount of the credit would be deducted from their tax payment. The tax credit is refundable, meaning that people who do not owe taxes would receive the money from the government. The full credit would be available to individuals with incomes below $15 000 per year and families with incomes below $25 000. The tax credit phases down as income rises above these levels and phases out entirely when income reaches $30 000 for individuals and $60 000 for a family of 4. The Bush proposal views health insurance as belonging to the individual rather than to the employer.

The Bush plan also proposes a tax deduction for the value of the health insurance premium for people who purchase a high-deductible individual insurance policy in combination with a health savings account (**Table 1**) (8–11) . Health savings accounts were authorized by the 2003 Medicare Modernization Act (although they have nothing to do with Medicare) (12).

Kerry Proposal

The Kerry proposal is complicated (13). It combines various tax credit schemes with the expansion of Medicaid and the State Children's Health Insurance Program (SCHIP). Kerry's proposal contains elements of all 3 varieties of health insurance: individual, employment-based, and government-funded. The Kerry plan is far more generous than the Bush plan, but heaven help the poor bureaucrat (or confused family) who has to figure out who is eligible for what.

Individual

People age 55 to 64 years with incomes below 300% of the federal poverty level (**Table 2**)—about $28 000—receive a tax credit that pays for 25% of an insurance premium. People who are between jobs and have incomes below 300% of the federal poverty level receive a 75% tax credit. People not covered by the above provisions receive a tax credit that limits health insurance premiums to 6% of their income (for people below the federal poverty level), phasing up to 12% of income for people at 300% of federal poverty level.

Employment-Based

Small employers receive a tax credit of 50% if they purchase health insurance for their low- and moderate-income employees (those with incomes <300% of the federal poverty level).

Government-Funded

Medicaid and SCHIP (**Table 3**) would be expanded. All children under 300% of the federal poverty level, all families under 200% of the federal poverty level, and all childless adults under 100% of the federal poverty level would have coverage under these public programs. To ensure that eligible people actually enroll in the program, the enrollment process would become far easier.

Under Kerry's proposal, the federal government also pays 75% of the cost of medical cases that reach $50 000, thereby reducing private health insurance premiums and making insurance more affordable.

Table 2. **Federal Poverty Guidelines**

Definition: Income levels below which individuals or families are considered to be living in poverty.
The guidelines are updated on the basis of the consumer price index and are issued each year by the U.S. Department of Health and Human Services. The guidelines are used to determine eligibility for certain federal programs.
In 2004, the federal poverty level is $9310 for an individual and $18 850 for a family of 4.

Table 3. **Medicaid and the State Children's Health Insurance Program***

Medicaid

This federal government– and state-funded, state-administered program covers about 40 million people.

Some eligibility requirements are federally mandated, but others vary from state to state.

About 30% of people below the federal poverty level remain uninsured either because they are ineligible for Medicaid or because the Medicaid application process is so cumbersome that they do not receive their entitled benefits.

SCHIP

In 1997, the federal government created SCHIP as a companion program to Medicaid; this was the first significant expansion of health insurance since 1965.

SCHIP covers uninsured children in families with incomes that are at or below 200% of the federal poverty level but are above the Medicaid income eligibility level.

States legislating a SCHIP program receive generous federal matching funds and can administer SCHIP through Medicaid or by creating a separate program. By 2003, 4 million children had been enrolled in the program.

* SCHIP = State Children's Health Insurance Program.

Evaluations of the Candidates' Proposals

In a 22 January 2004 editorial, *The New York Times* lamented that the Bush Administration tax cuts for the wealthy have made significant extension of health insurance impossible (14). Other analysts concur that the tax cuts drained the federal budget of surpluses that could have been used to expand health insurance (7).

According to Kenneth Thorpe, professor of public health at Emory University, the Bush proposal would expand health insurance to only 2.5 million previously uninsured people and over 10 years would cost $90 billion—funds required to make up for reduced tax revenues resulting from use of tax credits (12). A policy director for the Bush campaign did not dispute Thorpe's figures (15). Kerry's proposal is far more expansive and expensive, insuring 27 million uninsured people and costing an estimated $653 billion over 10 years (13).

According to the Bush Administration's Director of the Office of Management and Budget, the Administration's federal budget proposal does not include enough funds for the Bush tax credit plan (16). In contrast, Kerry has proposed a mechanism to finance his plan: rolling back the Bush tax cuts for people with incomes over $200 000. There is a difficulty with Kerry's financing plan; it appears that he would use the same funds for other purposes.

The Thorpe analysis projects that in 2008, the Bush proposal would cost an estimated $3800 per newly insured person compared with $3200 for Kerry's plan (15). The Kaiser Family Foundation generates a Bush plan cost of $4780 (in 2003 dollars) per newly insured person (17). These figures depend on estimates of how many people who already have insurance would use the tax credits (18). For example, if the program costs $10 billion per year and is used by 10 million uninsured people, the cost per newly insured person is $1000. If the same program is used by 5 million insured and 5 million uninsured people, the cost is $2000 per newly insured person. The Kaiser Family Foundation cost estimate is based on a microsimulation analysis by Massachusetts Institute of Technology economist Jonathan Gruber. He estimates that 15.6 million people will use the Bush plan; only 1.3 million of them (fewer than in the Thorpe analysis) would be newly insured (17).

If these analyses are accurate, the Bush proposal carries a high cost per newly insured person. In 2008, the average annual health expenditure for people younger than 65 years of age is projected to be $3150, well below the estimates of the Bush plan's cost per newly insured person (19, 20).

The most serious critique of the Bush plan is the paltry level of the tax credit in comparison with the cost of individual insurance policies. An analysis of individual insurance premium costs in California found that a $1000 tax credit "would cover only about 40% of the average premium cost for single coverage . . . A $1000 credit would cover the premium for about one-fourth of 30-year-olds but fewer than 5% of 50-year-olds. The tax credits would provide even less premium coverage for sicker enrollees" (21). Gabel agrees, arguing that "A $1000 tax credit should be more than adequate to buy individual coverage for healthy, young, single males, but it would not even come close for their middle-aged peers" (22). The conservative Heritage Foundation, the wellspring of tax credits, also finds the level of the Bush credits too low (23).

The health care costs to an individual deciding whether to use the Bush tax credit include not only the cost of the premium above the level of the credit but also the costs of care not covered by the insurance policy. Two analysts calculated that individuals taking up the Bush tax credit would still pay $2520 per year for their health care, and this figure would be far higher for people in poor health (24). In testimony presented to the House Ways and Means Subcommittee on Health in February 2002, Professor Gruber noted that individual tax credits would favor younger and healthier individuals. He argues that for a 40-year-old man in excellent health, the average cost of nongroup insurance is roughly $2000 per year, a cost that rises dramatically with age and poor health status. Gruber estimates the cost of a nongroup policy for the typical uninsured family to be roughly $10 000 (17). Gabel's calculations find the Bush tax credit of little help for a 55-year-old healthy person and almost no help for a 55-year-old person in poor health (22).

Kerry's tax credits are more generous, and—because they are calculated as a percentage of the insurance premium rather than a fixed dollar amount—discriminate less against older and sicker people with high insurance premiums. Because Kerry covers many lower-income people through Medicaid/SCHIP expansion, those who are most vulnerable do not have to pay a portion of the insurance premium. Clearly, with a more expensive program such as Kerry's, people receive more assistance.

The Debate over Individual Insurance Coverage and Tax Credits

A debate rages in health policy circles over the pros and cons of purchasing health insurance as an individual rather than purchasing it as a member of an employer-sponsored group. Currently, a mere 3% of the population is covered through individual insurance; 55% receive employment-based insurance, 27% are covered under government programs (Medicare, Medicaid, and SCHIP), and 15% are uninsured (2). A major goal of some conservative policymakers and politicians is to eliminate employment-based insurance and insure the entire population through individual coverage; government would subsidize low-income people with refundable tax credits (7). Under this vision, even Medicare beneficiaries would purchase individual coverage, with financial assistance from a federal government voucher. The Bush proposal falls within this conservative agenda. The fear of some experts that individual tax credits will encourage employers to drop insurance for their employees is welcome news to conservatives anxious to undermine job-based coverage. Conservatives also call for tax-deductible health savings accounts, also a feature of the Bush plan.

The conservative critique of employment-based insurance argues that job-based insurance may be a fleeting benefit; people are left without insurance if they lose a job, change jobs, or are employed by a business that drops employee coverage. Moreover, because employers pay for most of the premium, health care consumers are not conscious about health care costs and overuse medical services. In addition, individual insurance affords people greater choice of insurance plan (24–26). The underlying philosophy is one of individual ownership, a concept that also supports vouchers for Medicare and individual savings accounts to replace Social Security.

Arguments against individual insurance cite the actual workings of the individual insurance market. Individual insurers in almost every state practice medical underwriting, requiring a medical examination and review of medical records before issuing a policy. People with chronic illnesses can be denied insurance or are charged high premiums. Premiums for people in their early sixties are 3 to 5 times as high as those for people in their early twenties (27). Because of the costs of marketing and underwriting, administrative costs for individual insurance reach 25% to 40% of the premium dollar, compared with 10% for large-employer group insurance. Individual insurance usually has high deductibles (average, $1500 to $2000 compared with $100 to $300 for job-based coverage) and fewer benefits, thereby hurting people in poor health (22).

Opponents of individual insurance point to advantages of job-based coverage: simplicity of enrollment without medical underwriting, reduced administrative expense, pooling of health risks, lower premiums, and negotiation of contracts by experienced health benefit managers (28, 29).

Kerry's tax credit plan proposes a solution to the inequities and inefficiencies of the individual insurance market. Kerry would open the Federal Employees Health Benefits Program (FEHBP), currently for federal employees and members of Congress, to nonfederal employees. People eligible for Kerry's tax credits would purchase their insurance through the FEHBP, thereby gaining the benefits of the group insurance market.

Physician Organizations and Insuring the Uninsured

How do the presidential campaign proposals intersect with the proposals of physician organizations?

The American Medical Association (AMA) seeks to "expand health insurance options through changes in the federal tax code that will facilitate the transition from an employer-based to an individually owned insurance system" (30). The AMA thus joins those conservative politicians and policymakers who aim to eliminate job-based insurance. Specifically, the AMA favors the creation of tax credits for the purchase of individual health insurance and opposes the expansion of Medicaid/SCHIP. Recognizing the problems with the individual insurance market, the AMA would allow low-income people to purchase their private insurance through purchasing pools modeled after the FEHBP (31). The AMA's Council on Medical Service, but not the entire AMA, has called for replacing portions of Medicaid and SCHIP with refundable tax credits by which low-income people can purchase individual insurance policies (32). The AMA also favors expansion of health savings accounts as an individual insurance mechanism (30).

The April 2002 proposal of the American College of Physicians (ACP) calls for a step-by-step approach, eventually making health insurance affordable to everyone within 7 years. Like the Kerry plan, the ACP proposes a mix of Medicaid/SCHIP expansion and tax credits. Everyone below the federal poverty level would be eligible for Medicaid, and all uninsured individuals above the federal poverty level would receive financial assistance to buy into Medicaid/SCHIP or purchase individual or job-based insurance. The financial assistance could be in the form of a refundable tax credit or a direct dollar subsidy (voucher). For low-income people, the premium subsidy should be 80% to 90% of the average cost of a health insurance policy that provides a basic benefits package. Individuals could obtain insurance though a pooled group mechanism modeled on the FEHBP. The ACP premium subsidy is more generous than the Bush or Kerry tax credits. The ACP admits that tax credits are not the most efficient way to subsidize the purchase of health insurance but believes that the approach is the most politically viable (33).

The American Academy of Family Physicians proposes a federally administered public insurance mechanism for basic preventive and ambulatory services and outpatient

prescription drugs, and for catastrophic costs above $5000 per year for an individual and $8000 for a family. Individuals and families could continue to use current coverage arrangements (Medicare, Medicaid, and employment-based insurance) for services (for example, hospitalization) not covered under the basic benefits. Money flowing through current coverage arrangements would be redirected to the federal government for the basic and catastrophic benefits; additional funding would come from new federal taxes (34).

Physicians for a National Health Program, a physician advocacy organization, supports single-payer health care reform. This plan would improve Medicare and expand it to the entire population. The expansion would be financed by an employer payroll tax that takes the place of current employer private health insurance premiums, a health income tax on the wealthiest 5% of Americans, and a repeal of the Bush tax cuts (35).

Conclusion

It is difficult to be optimistic that the richest nation on the planet will soon solve its chronic problem of widespread uninsurance. Of the tens of millions entering the November voting booth, few will be voting with universal health insurance uppermost in their minds. The budget deficit, in conjunction with rising national security spending, does not bode well for a major extension of health insurance. On the other hand, postelection Congress might piece together a hybrid approach, combining Medicaid/SCHIP expansion with FEHBP-linked tax credits to cover a portion of those without insurance. The famous statement of Winston Churchill comes to mind: "Americans always try to do the right thing—after they've tried everything else."

From the University of California, San Francisco, San Francisco, California.

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Requests for Single Reprints: Thomas Bodenheimer, MD, Department of Family and Community Medicine, University of California, San Francisco, Building 80-83, San Francisco General Hospital, 1001 Potrero Avenue, San Francisco, CA 94110; e-mail, tbodenheimer@medsch.ucsf.edu.

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