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# The Sources of Insurance

*Private, Public, the Uninsured, and Reforms for the Future*
*By Max Pappas and Kristopher Rawls*

## *Executive Summary*

Central to every discussion about how to improve health care in the United States is the number of those who are uninsured. This paper looks at the various sources of health insurance in America and at the number of people who are uninsured and finds the wrong number of uninsured is too often used in policy reform debates.

According to the Census Bureau, there were 46 million uninsured Americans in 2007—about 15.3 percent of the population. The more relevant number for policy makers to consider is 16 million, or about 5 percent of the population.

The difference between 16 million and 46 million: the millions of people who qualify for but do not take government insurance benefits already offered, the population making more than $50,000 a year who are uninsured, and uninsured non-citizens.

An accurate understanding of how many Americans are uninsured and why is critical to formulating successful health care policy for the future. While 16 million is still a large number, at just one-third the often used 46 million uninsured, it is likely to call for a different set of reforms.

Government intervention has stifled the market for health care severely and now the choice lies between more government intervention and less. Policy makers should consider free market reforms to lower the cost of insurance to help the 16 million Americans that may be struggling to purchase it. By taking the road of market based reform, Americans can allow the stifled free market to work again and enjoy lower premiums, more coverage, and more choices without skyrocketing costs and liabilities and without more government programs.

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## *Introduction*

Health care reform is at the top of the political agenda and central to the debate as always is the number of uninsured Americans. The Census Bureau reports that in 2007 both the percentage and number of people without health insurance decreased. The percentage without health insurance was 15.3 percent, down from 15.8 percent in 2006, and the number of uninsured was 45.7 million, down from 47 million, while the number of people with health insurance increased to 253.4 million in 2007 from 249.8 million in 2006. A closer look at the numbers suggests policy makers should consider about 16 million or 5 percent of the US population as the uninsured they are looking to address.

Americans face uneasy questions in the near future regarding health care and insurance. Recent surveys suggest that 50 percent of Americans believe that government can better run health insurance than private companies and this perception appears to be on the rise. This should be a wake up call for citizens of our country to read past the rhetoric of politics and examine the facts regarding American health insurance and the reforms necessary to sustain it.

**"A closer look at the numbers suggests policy makers should consider about 16 million or 5 percent of the US population as the uninsured they are looking to address."**

The president and many members of Congress have expressed continued and recent interest in decreasing the number of uninsured Americans. There are two ways government can do that: either mandate insurance for more Americans through government programs or reduce the cost of insurance with free market reforms. To make an informed choice between the two options, data on the uninsured should be examined. This paper will provide background on how Americans receive health insurance through private and public means, the facts behind the uninsured rate, and offer some free market reforms that can bolster the long term viability of the health insurance market for every American citizen.

### *Types of Coverage*

In broadest terms, the insurance market in America includes three categories of coverage: private insurance, public insurance, and no insurance coverage.[1] According to the 2008 census report, 67.9 percent of people in the United States were covered by private insurance, 27.8 percent were covered by publicly funded insurance, and 15.3 percent lacked insurance altogether.[2] When analyzed in greater detail, interesting dynamics emerge in each of the separate structures.

### *Private Insurance*

Private insurance plans have two primary means by which they deliver health care to individuals. Individuals can either purchase health care directly from providers or, as is more common, receive health care coverage through their employers. The majority of people (59.3 percent) purchase plans through their employer and forgo direct purchases.[3] Plans provided by private insurers directly to consumers only account for about 8.9 percent of total purchases; a very small percentage of the overall private market. Why is this?

#### *World War II and the 1950s*

The history of the private third-party payer system is rooted in public policy implemented during Word War II. Price and wage controls were rampant as a means for subsidizing the war. Since all workers' wages were indexed with inflation, the "little steel rule" as it was called, employers were finding it difficult to lure potential workers into the

[1] Note that these forms of insurance are not mutually exclusive; people may be covered by one or more of these types throughout the year.

[2] DeNavas-Walt, Carmen; Proctor, Bernadette; and Smith, Jessica. "U.S. Census Bureau, Income, Poverty, and Health Insurance Coverage in the United States: 2008." U.S. Government Printing Office. Washington DC 2008. http://www.census.gov/prod/2007pubs/p60-233.pdf

[3] Ibid: Figure 7.

marketplace. To remedy this, many companies began to offer "fringe benefits," for their workers, the most common being health care benefits.[4] The Revenue Act of 1942 entrenched the role of third-party employer insurance by offering full tax deductions for employer-purchased insurance coverage. By the mid 1950s, nearly all employers were offering some form of health insurance to their employees and it became typical to seek jobs that offered better insurance coverage relative to wages.[5]

**"The third-party payer system is a primary factor in the precipitous health cost rise in America."**

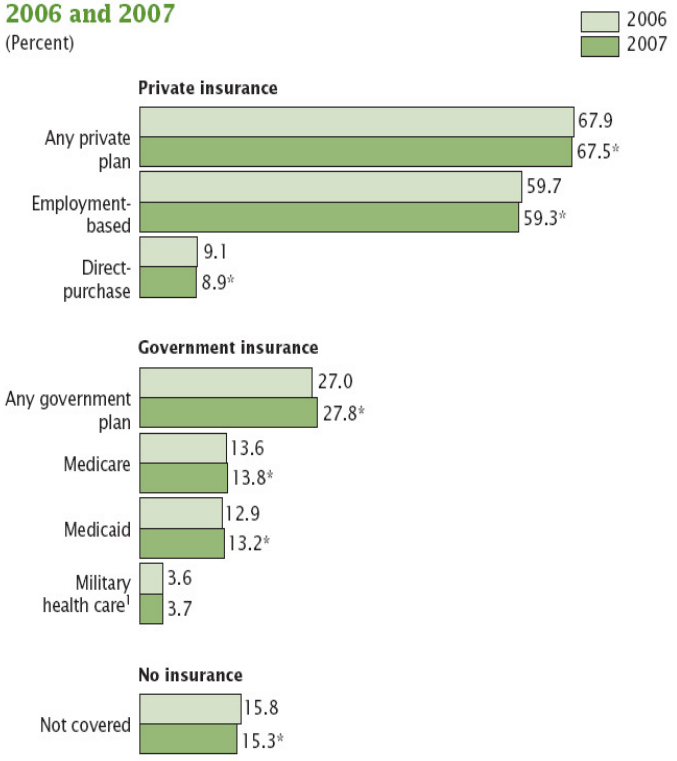
The third-party payer system is a primary factor in the precipitous health cost rise in America. With third-party insurance, consumers are insulated from true health care costs. This creates disproportionate increases in insurance premiums.[6] Florence King, discussing insurance in the 1950s, noted "Now that health care was 'free,' human nature kicked in. People began running to the doctor for the least little thing. Ask them why and they would recite the usual maxims about an ounce of prevention, but it was never long before the truth compulsively popped out: 'I hate to waste my insurance.'"[7] People had little incentive to keep doctor visits scarce or seek out new prescriptions or treatments since they were no longer paying the majority of the bill. Over time rates increased as employees demanded more and more coverage for more and more medical expenses. In reality, insurance that was created to protect worker's health was now being sought to maintain it. This, in turn, brought higher premiums, more expensive research, and a disconnect between prices and consumers that plagues the current healthcare market. The link between individuals and the cost of their health care was effectively severed, leaving little incentive for individuals to be concerned about prices. What was once a good and affordable deal, soon transformed into a structural failure.

## *Public Insurance*

Over 27 percent of Americans are covered by taxpayer financed public insurance. These Americans are covered by Medicare, Medicaid, State-Child's Health Insurance Programs, military health care, and sometimes a combination of these options.

### *Medicare*

Figure 7.
**Coverage by Type of Health Insurance: 2006 and 2007**
(Percent)




* Statistically different at the 90-percent confidence level.

[1] Military health care includes CHAMPUS (Comprehensive Health and Medical Plan for Uniformed Services)/Tricare and CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs), as well as care provided by the Department of Veterans Affairs and the military.

Note: The estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the year.

Source: U.S. Census Bureau, Current Population Survey, 2007 and 2008 Annual Social and Economic Supplements.

[4] Yamagishi, Takakazu. "Health Insurance for National Defense: The Impact of WWII on the Health Insurance Systems in Japan and the United States." Annual Meeting of the American Political Association 2006.
[5] King, Florence. "The Great Uninsured." *National Review* 15 Apr. 2006: pg 32-34.
[6] Rawls, Kris. "Market Failures of a Third Party Payer System." Freedomworks Foundation 2008.
[7] King, "The Great Uninsured": pg 33.

In order to qualify for Medicare, individuals must be over 65 (currently) or be receiving OASDI benefits as a survivor or disabled person. There is no means test for this program and it offers four separate coverage components A, B, C, and D. Part A of Medicare deals with hospital visits and doctor care, and is funded through the OASDI tax, specifically the 2.9 percent standardized tax rate paid by every working American. Part B finances co-pay supplements and is funded through general revenue taxes. Part C deals mainly with special supplies and mechanical support and is also funded through general revenues. Part D, which was created in 2003, covers prescription drug purchases and has the same financing mechanism as parts B and C.[8] The costs and liabilities of Medicare for taxpayers are expected to skyrocket in the next few decades, which will create a substantial financial burden on the American people. According to the 2009 Medicare Trustees Report, expenditures for the program in 2008 were around $468 billion, or 3.2 percent of gross domestic product. The unfunded obligation is estimated to reach $13.4 trillion by 2083. Part D is expected to more than double in cost in less than a decade, while the percentage of GDP constituted by Part B is expected to more than double from 1.28 percent in 2008 to 2.60 percent in 2030.[9] Since Medicare expenditures are expected to increase faster than workers' earnings, there is no doubt that if Congress continues to disregard the fiscal reality of Medicare, the American health care system's demise will eventually provide a bitter reality check.

*Medicaid*

Medicaid, which is run individually by states through federal and local funding, covers about 13.2 percent of people in America. The program deals primarily with single parents with dependents, pregnant women, and those who are living near or in poverty. Medicaid is means tested in order to ensure only disadvantaged people with little income, assets, or potential capital will qualify for benefits. Many states supplement their own Medicaid programs with higher tax rates for their specific programs. Despite this, federal tax dollars account for more than half of all payments into Medicaid[10] as noted by the Center for Medicare and Medicaid Services (CMS).[11]

*State Children's Health Insurance Program (S-CHIP)*

S-CHIP was created in 1996, as part of the Temporary Assistance to Needy Families program, to provide some insurance coverage for families with children with incomes too high to qualify for Medicaid. Since the programs inception in 1996, total outlays have reached approximately $40 billion. On February 4, 2009 President Obama signed a bill at the cost of $33 billion over the next five years to expand the program to offer coverage to households earning up to 300 percent of the federal poverty level (over $63,000 per year for a family of four in 2009). The S-CHIP expansion brings the total cost of the program from 1996 to 2013 to $73 billion.[12] The role and expansion of S-CHIP has been controversial, both at national and state levels. Some states have expanded S-CHIP coverage independently and create their own standards for eligibility and expenditures.

[8] Thomas, William. *2004 Green Book*. Committee on Ways and Means
U.S. House of Representatives Washington, DC 2006. http://waysandmeans.house.gov/media/pdf/greenbook2003/108Transmittal.pdf

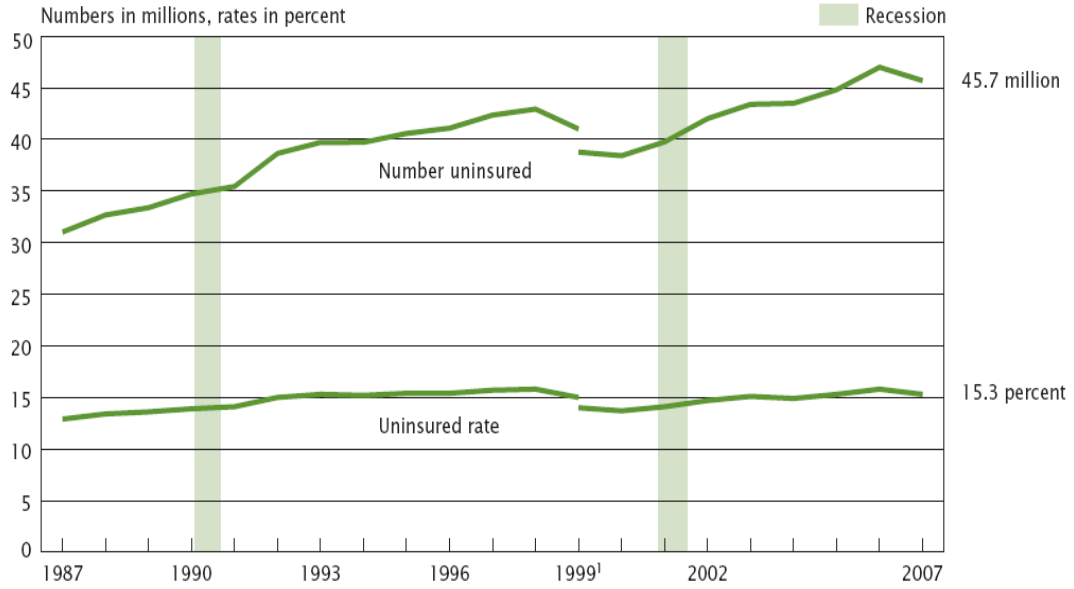
[9] "2008 Annual Report." The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds 2008.

[10] "Total Medicaid Spending, FY2006." Urban Institute and Kaiser Commission on Medicaid July 2007. http://www.statehealthfacts.org/comparemaptable.jsp?ind=177&cat=4

[11] The CMS was established on July 30, 1965 through Title XIX of the Social Security Act. This agency monitors, allocates, and establishes criteria for all of the Medicaid programs in America.

[12] Federal CHIP Expenditures, FY 1998-2007, (in millions), 1998-2007. Kaiser Family Foundation.

Figure 6.
**Number Uninsured and Uninsured Rate: 1987 to 2007**




[1] Implementation of Census 2000-based population controls occurred for the 2000 ASEC, which collected data for 1999. These estimates also reflect the results of follow-up verification questions that were asked of people who responded "no" to all questions about specific types of health insurance coverage in order to verify whether they were actually uninsured. This change increased the number and percentage of people covered by health insurance, bringing the CPS more in line with estimates from other national surveys.

Note: Respondents were not asked detailed health insurance questions before the 1988 CPS. For information on recessions, see Appendix A.

Source: U.S. Census Bureau, Current Population Survey, 1988 to 2008 Annual Social and Economic Supplements.

## *The Uninsured*

Through war, an influx of immigration, and a number of recessions the uninsured rate has stayed relatively constant, moving between 12 and 16 percent since 1987 (figure 6).

Currently, the estimate commonly given for the number of people in America who are uninsured is 47 million.[13] However, this figure disregards important demographic characteristics of those without insurance. The rising number of Americans without insurance is often presented as the moral imperative for mandating and guaranteeing universal coverage for all citizens. However, when the demographics of the uninsured are examined closely, these claims lose some credibility. In the August 2008 Census Report, the number of uninsured working Americans was estimated at 26.8 million with about 21 million of those working full time and the other 5.8 million in work-related activities or part time jobs.[14]

*Immigrants*

Of the 47 million people without insurance 12.4 million were foreign born, of which 9.7 million were non-citizens.[15] According to the Census Bureau, the number of illegal immigrants without insurance is difficult to calculate accurately, but it is believed to be the largest factor contributing to climbing uninsured rates in recent years.

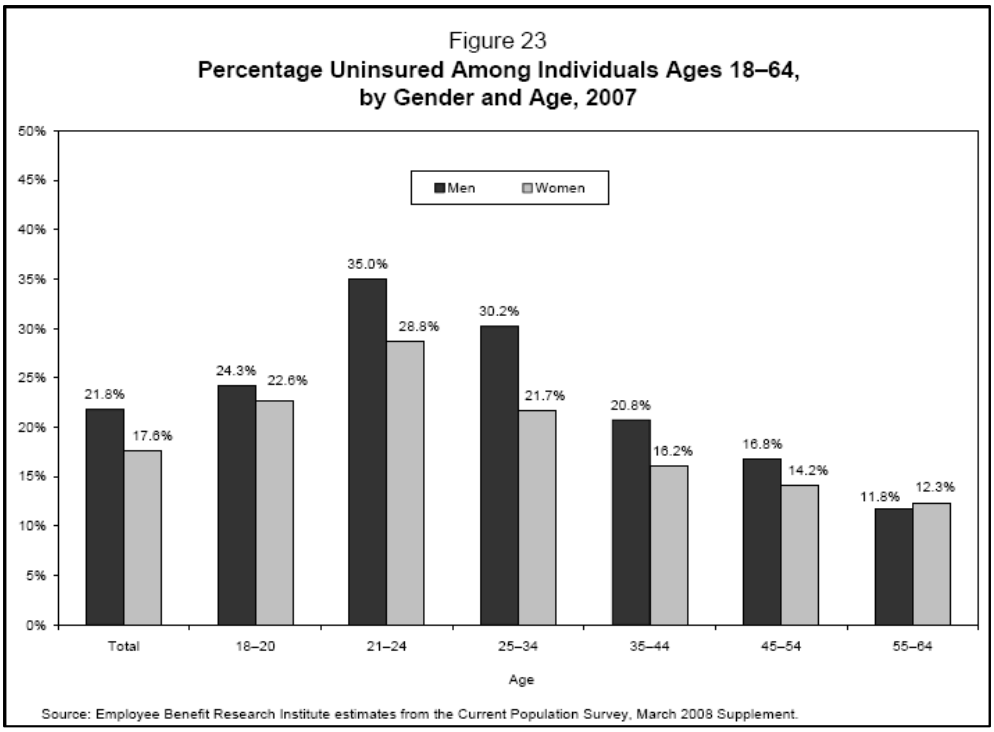
Legal immigrants are ineligible for federally-matched Medicaid coverage during their first five years of residence in the United States, and undocumented immigrants and temporary immigrants are generally ineligible for Medicaid regardless of the length of time in the country. However, all immigrants are eligible to receive Emergency Medicaid for medical emergencies. Many low-income non-citizen adults work in firms or industries that do not offer employer-sponsored coverage, making them particularly hard hit by the current tax code that does not give individuals the same tax advantages in purchasing health care as employers.[16]

[13] DeNavas. "U.S. Census Bureau, Income, Poverty, and Health Insurance Coverage in the United States 2008": pg.24.

[14] Ibid: pg 21 table 6.

[15] Ibid: pg.21 table 6.

[16] Schwartz, Karyn and Samantha Artiga. "Health Insurance Coverage and Access to Care for Low-Income Non-Citizen




*Children*

Around 8.1 million children were reported as uninsured in 2007.[17] Almost all of these children, and close to 20 percent of all uninsured people, were eligible for Medicaid or Children's Health Insurance Programs but did not take benefits.[18] Some argue this is caused by a lack of knowledge about eligibility requirements, rapid changes in qualification measurements, as well as the complexity of applications for the programs. Greater use of existing programs would bring the total number of uninsured down nearly 20 percent, covering the most deprived children of American society with health insurance, without any change to current law and without the creation of any new program.

**"Of the 45.6 million uninsured, 17.5 million had a household income greater than $50,000 per year in 2007 and 9.1 million had incomes over $75,000."**

*Income*

Of the 45.6 million uninsured, 17.5 million had a household income greater than $50,000 per year in 2007 and 9.1 million had incomes over $75,000.[19] These Americans did not qualify for public insurance, given their incomes, and have elected to stay out of the private insurance market. This correlates with the fact that about 40 percent of all uninsured Americans are between the ages of 25-44. These younger Americans have less incentive to undertake large insurance premiums and also are less likely to have chronic health problems than older health care recipients and so may choose to forgo health insurance and pay health care costs out of pocket.

*The Uninsured*

Given the many non-citizens not eligible for insurance, the millions of people who qualify for but do not receive insurance benefits, and the population making $50,000 or more a year who are also uninsured, the more accurate number of Americans who are struggling to afford insurance is around 16 million.[20,21] Although this number is still large (around 5 percent of the population) it is significantly smaller and only about a third of the 46 million frequently cited. One must be careful about accurately counting the number of Americans struggling to afford

Adults." Kaiser Commission on Medicaid and the Uninsured June 2007.

[17] Lee, Christopher. "Number of Uninsured Children Rises." *Washington Post* 5 Sep. 2006; Pg A06 http://www.washingtonpost.com/wpdyn/content/article/2006/09/04/AR2006090400958.html

[18] Colvin, Geoff. "We All Pay For the Uninsured" *Fortune 500 Magazine* 1 May 2008. http://money.cnn.com/2008/04/29/magazines/fortune/colvin_aetna_csuite.fortune/index.htm?postversion=2008050106

[19] DeNavas. "U.S. Census Bureau, Income, Poverty, and Health Insurance Coverage in the United States 2006": pg. 21 table 6

[20] Colvin, Geoff. "We All Pay For the Uninsured."

[21] U.S. Census Bureau, Housing and Household Economic tatistics Division. Last Revised: August 26, 2008. http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

insurance. Some estimates, for instance, count households earning over $50,000 and the children less than 18 years of age living in those households twice. Such double counting produces a higher number of Americans struggling for insurance than might actually exist. Other estimates that fail to focus on those struggling to purchase insurance overestimate the number by reporting people who voluntarily opt out of the system or are eligible for government insurance but do not take it. Accurate data that clearly define these groups can be found through the Census Bureau.[22]

*Healthcare for the Uninsured*

Many uninsured Americans get treatment for medical illness by going to hospitals or emergency rooms, which by law cannot keep an individual from being treated, regardless of whether or not they have insurance or pre-existing conditions. In 2004, the estimated total of uncompensated cost for those without insurance was around $40.7 billion.[23] The majority of this cost was picked up by local, state, and federal tax dollars (85 percent) with the remainder paid by physicians and those who pay physicians.[24] Sixty three percent of these costs were accrued in hospitals, 18 percent in physician offices, and the final 19 percent in clinics or direct care facilities.[25] These statistics show that those without insurance are overwhelmingly relying on hospital visits to receive health care. Many of the uninsured wait until their conditions are so serious that they need emergency care, which inflates prices for these individuals and taxpayers greatly.

Hospitals are not meant to give chronic care and for the uninsured this can result in pernicious and unavoidable circumstances, the most serious being the unnecessary loss of life. The Institute of Medicine estimates that over 18,000 unnecessary deaths for people without insurance are being recorded every year.[26] Adopting a more market based approach to healthcare can reduce costs and provide individuals more flexibility and greater options for acquiring health care, preventing some of these unnecessary deaths.

**"With an extension of tax exemptions, the direct purchase insurance market would be revitalized and capable of competing directly with employer based insurance plans."**

## *Possible Reforms*

In order for the health insurance market to become affordable and sustainable, many significant reforms are necessary. Initially, in order to allow the healthcare insurance market to begin to right itself, four specific reforms are needed. These pillars of health insurance reform are the practical basis of viable action.

*Tax Exemptions*

One significant reform to implement would be an extension of tax exemptions for independent, direct purchase insurance plans. Currently, individuals seeking the portability and flexibility of a non-employment based plan have to spend after tax dollars to pay for it. With an extension of tax exemptions, the direct purchase insurance market would be revitalized and capable of competing directly with employer based insurance plans. By creating a level playing field for all health insurance purchases a better functioning market would emerge, driving down prices as individuals would have incentive to pick and purchase plans tailored to their needs rather than be forced to choose the coverage packaged by their employer.

[22] Data is calculated from the Census Bureau's Table Creator found at: http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

[23] Hadley, Jack, Ph.D. and Holahan, John, Ph.D. "The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?" Kaiser Commission on Medicaid and the Uninsured 10 May 2004.

[24] Ibid: pg 3.

[25] Ibid: pg 2.

[26] *Hidden Costs: Value Lost Committee on the Consequences of Uninsurance*. Institute of Medicine National Academic Press 2002. http://books.nap.edu/openbook.php?record_id=10719&page=181

This would have the added benefit of starting to de-link health care from employment. Currently, when one loses his or her job, health insurance is also lost. With equal tax treatment for employer and employee purchased care, more Americans would buy their own insurance and be able to take it from job to job and keep the same coverage while between jobs, or when leaving an employer to become self-employed.

*Purchasing Across State Lines*

Another important reform needed to create a well functioning health insurance market is to allow individuals to shop for insurance plans across state lines. Today, insurance providers are required to offer insurance plans on a specific state-by-state basis. This convention, although initially intended to allow states flexibility in determining their health care allocations, has in reality stifled the overall insurance market and posed undue restrictions on consumers. There is a stark contrast in options afforded to citizens of different states, one that artificially inflates insurance prices, reduces competition, and suppresses the financial flexibility of employers. Families in Minnesota are forced to buy a health plan that contains 62 mandates, while families in Idaho can buy a plan with 13 mandates. Specifically in Minnesota, health insurance companies are required to cover medical expenditures for such things as cleft palate disorder, marriage therapy, and dieticians.[27] These arbitrary choices in coverage increase prices that consumers are locked into the second they become residents. If a family in Minnesota desires to opt out of the coverage schemes regulated by their state and instead buy a plan that suits their needs from Idaho (or any other state) they should be allowed to do so.

Expanding the insurance market by removing barriers to the purchase of insurance across state lines would increase competition and consumer choice driving down costs as millions of Americans put downward pressure on health care prices by shopping around for the best value—something they have no reason to do in the current system.

*Health Savings Accounts and Catastrophic Care Insurance*

Americans should be given the option to use health savings accounts, financing health maintenance, while purchasing catastrophic coverage. Health savings accounts would make consumers savvier and more aware of the costs of health care. Similar to a 401(k) or IRA for retirement, workers could dedicate before tax dollars to health savings accounts that could be set aside and mandated to be used only for healthcare costs. With this type of reform, costs for health maintenance would decrease and those without insurance would no longer be plagued by disproportionately higher reimbursement rates. This would also eliminate the moral hazards of third party insurance and minimize the haggling and bartering between insurance companies and health providers who currently set prices without the consent or knowledge of consumers. Furthermore health savings accounts would allow the catastrophic health insurance market to become cheaper and easier to access for all Americans, especially the young working Americans who see little justification in paying the high premiums of the current market.

*The End of Community Rating*

Community rating requires insurers to provide the same coverage to all individuals within a selected territory regardless of age, gender, or health status. This fundamentally alters the role of insurance by prohibiting risk-based premiums, and substantially raises the cost of coverage. Community rating programs in New Jersey and New York have stifled competition and increased premiums for those without insurance to rates they cannot afford or refuse to pay.[28] Community rating

[27] Bunce, Victoria, Craig. "Health Insurance Mandates in the States 2008" Council for Affordable Health Insurance 2008.

[28] Rooney, Partick and Perrin, Dan. *American's Health Crisis Solved: Money Saving Solutions, Coverage for Everyone.* John Wiley & Sons Inc. Hoboken, NJ 2008.

prices consumers out of the insurance market and exposes them to undue risk and harm. Without eradicating the antiquated government imposed system of community rating, the health insurance market cannot become a competitive, consumer friendly market.

## *The Future*

The health insurance debate in America is riddled with inaccuracies, fallacies, and sometimes just plain lies. Without information and education, the citizens of the United States remain vulnerable to the soft, easy draw of more government-sponsored health insurance rather than free market reforms that would lower costs and prevent government-imposed rationing of health care. The 46 million uninsured statistic is inaccurate. A more reasonable number on which to focus policy reforms is around 16 million. Counting non-Americans, those who can afford but choose to opt out of insurance, and those eligible for government health insurance but do not opt in generates a flawed number of uninsured Americans. Understanding how many Americans are uninsured and why is critical to formulating successful health care policy.

Government intervention has stifled the market for health care severely and now the choice lies between more government intervention and less. Policy makers should consider free market reforms to lower the cost of insurance to help the 16 million Americans that may be struggling to purchase it. By taking the road of market based reform, Americans can allow the stifled free market to work again and enjoy lower premiums, more coverage, and more choices without skyrocketing costs and liabilities.