Chapter 1

A Health Insurance System in Crisis?

Susan Mitchell* does not have health insurance. She is a freelance editor and writer who until three years ago was an employee of a medium-sized company in Washington, D.C. Health insurance had been part of her compensation. Susan writes public relations announcements and edits documents that are sent to the firm’s clients. When the company felt pressure to reduce its labor costs, it eliminated Susan’s job but asked whether she would work on a freelance basis, doing the same work she had been doing as an employee.

By changing the terms of Susan’s employment, the company reduced its fringe benefit costs—Susan is no longer eligible for the company’s health insurance and pension benefits. She had the option to continue her health insurance coverage under a government provision known as COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). COBRA enables people who have been laid off or who leave a job to continue in the group insurance policy for up to eighteen months as long as they pay 102 percent of the total premium themselves.1

For several months, Susan kept up the payments for the company’s health insurance. Then trouble began. Because the company offered a relatively generous policy, the total premium was $1,137 a month for coverage for two adults. Susan’s husband, Ed, works on commission as a wholesaler for small boat and marine products in the northern Virginia and Maryland area. The company Ed works for treats its salespeople as independent contractors and does not offer them a health insurance plan. Between them, the Mitchells earn about $70,000 a year, and they were confident that they could find good coverage for less than $1,137 per month. They discovered, however, that at fifty-four and fifty-three years

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*Susan’s name has been changed to protect her identity, as have the names of all the uninsured people I describe in the book. None of the people described is a composite.
of age, they were viewed as suspect applicants. They applied to several insurance companies for individual health insurance but could only find policies that would cost them even more than they were already paying. Now they are uninsured, and Susan is looking for a job that offers a decent health insurance benefit. With each passing month, however, it is clear that Susan’s profession is changing: as it moves into the freelance realm, opportunities for editing and writing jobs are scarce with firms that offer permanence and benefits.

THE UNINSURED ARE NO LONGER ONLY THE POOR

In 2004, 45.5 million Americans under age sixty-five did not have any type of health insurance. Among them, 36.5 million were adults, and two-thirds of these adults were employed. Another 7 percent of the adults were actively looking for work, so only one-quarter of these uninsured adults were out of the labor force. Many working adults are in situations similar to that of the Mitchells: they are in jobs or employment circumstances that do not include employer-sponsored health insurance.

Most Americans think of the uninsured as low-income people who work for small employers that do not offer health insurance or are temporarily unemployed. That image is partially correct. Among all people under age sixty-five without health insurance, the majority (70 percent) are poor or low-income. But as the number of uninsured has grown over the past twenty-five years, the likelihood that a middle-class person will be uninsured has increased too. Today one in ten working-age adults (twenty-three to sixty-four years old) with an annual income above the median household income ($44,430 in 2004)—putting them in the middle class—are uninsured; in 1979 only 6 percent fit this description. Over the past twenty-five years, more and more middle-class people like the Mitchells have found themselves uninsured or scrambling to pay for health insurance. Health insurance is now out of reach not only for low-income people but also for a growing share of middle-class Americans.

Until recently, if the economy was doing well, the proportion of the population with private health insurance increased. Because this was accepted wisdom, most of the incremental efforts to increase insurance coverage were targeted at the poor and near-poor. But the number of uninsured did not decline markedly during the late 1990s in spite of a tight labor market and low unemployment rates.

What has changed over the last three decades to cause more middle-class people to be without health insurance? Why are more workers of all incomes uninsured? What do these changes imply for efforts to in-
crease private health insurance coverage? There are two key parts to the answer.

Significant Shifts in Employment

During the last twenty-five years, there have been three important shifts in employment. The first is the continued decline in manufacturing employment and the related decline of unionized, blue-collar jobs. As late as the early 1980s, manufacturing employed almost 22 percent of all workers; even at 22 percent, benefits practices in manufacturing played a standard-setting role for the rest of the labor market. The example these jobs could set for the rest of the economy had been significantly reduced by 2004, when only 11 percent of all workers were in manufacturing. The changes since 1979 in employment by industry are eye-opening. Two of the service industries, known as “business and professional services” and “education and health services,” now employ the largest shares of the labor force (12.4 percent and 12.7 percent, respectively). Between 1979 and 2004, the number of people working in each of these industries more than doubled. Employment in “leisure and hospitality services” and “financial-activities services” also grew more quickly than the labor force as a whole. The service-providing industries as a group not only absorbed people who lost manufacturing jobs but also absorbed the 46 percent growth in the size of the labor force between 1979 and 2004.

The decline of manufacturing jobs had important implications for health insurance provision. During the years from the 1940s to the 1970s, health insurance coverage grew as a fringe benefit that was strongly associated with union manufacturing jobs. These jobs—especially those connected to the manufacture of automobiles and airplanes, basic materials such as steel and aluminum, and items for the booming housing market such as durable appliances and crafted windows—also paid salaries that enabled people with just a high school education to be solidly in the middle class. David Autor estimates that between 1979 and 1999 the fraction of workers who were in blue-collar occupations slipped from 32 percent to less than 25 percent.

The decline in manufacturing’s share of all jobs also gave rise to the second employment shift: a rising share of workers employed in small firms, which are far less likely than large companies to offer health insurance. Approximately 52 percent of firms with three to nine employees offered health benefits in 2004, while 99 percent of firms with more than two hundred employees offered coverage. If nothing else had changed in the economy except the shift from manufacturing to services, the pro-
portion of workers without health insurance would have increased simply because the services sector has many small firms.

A third shift in employment has been the change in employer-employee relationships, which has caused a growing number of people (like Susan Mitchell) to be self-employed or to work as temporary or contract workers. The number of self-employed workers has grown at almost the same rate as the size of the labor force. In 1979, 9.8 percent of the workforce reported that they were self-employed; by 1996 that fraction had risen to 10.5 percent. This increase does not include the growing number of people who work as independent contractors. People who are independent contractors often have long-term relationships with firms and work on projects that last as long as a year, sometimes followed by other projects and new contracts offered by the same company. In surveys of workers, independent contractors may respond that they are regular employees. Anecdotal evidence and ethnographic studies of occupations suggest, however, that the number of nonpermanent employees—indeed contract workers and temporary workers with assignments of a month or more—has increased in the last ten years. Firms that sponsor health insurance for employees typically do not offer it to nonpermanent workers in order to save on insurance costs per worker, as was the case with Susan Mitchell’s employer.

The Rising Costs of Medical Care

The second part of the answer to the question of why more middle-class people are uninsured today is that medical costs (after adjusting for inflation) are far higher than they were twenty-five years ago. In 1980 total health care expenditures per person in the United States were $2,535 (in 2004 dollars); in 2004 they were $6,280. The explosive growth in options for treating diseases, conditions, and traumas cannot be overstated. Diagnostic tests and imaging equipment now available were unheard of before the 1980s. MRI (magnetic resonance imaging) machines were not invented until 1983, and they have already progressed through several generations of improvements. Laparoscopic surgery has reduced many complicated and dangerous surgeries to outpatient procedures, with the patient returning home in the evening and being ready to resume normal activities within twenty-four to forty-eight hours. Prior to 1980, many conditions, including arthritic knees and hips, torn rotator cuffs, or hernias, would have been much more difficult to treat. Many went untreated because of concern that the treatment was too dangerous.

The 1970s mark the beginning of our ability to treat health care problems that we now label “chronic.” Before then, physicians had few choices to offer people with cancer, cardiovascular disease, or arthritis. Today
medical providers don’t tell patients whose knees ache, “Take some aspirin; such pains are part of growing old.” There are now better pain relievers for arthritis and the option of joint replacement surgery. The surgical techniques available for treating orthopedic or joint problems were only gleams in surgeons’ eyes fifteen years ago. Similarly, treatment options for cancer and cardiac conditions are strikingly improved. People who would have died of cancer within months now have ten-year survival rates accompanied by longer “disease-free” time. The change from being doomed by a diagnosis to being a cancer survivor is due to advances in surgical techniques and the development of new chemotherapies and new drugs that permit more aggressive use of chemotherapies. The creation of drugs that break up stroke-causing blood clots and drugs that lower blood pressure and cholesterol levels has significantly altered how cardiovascular diseases are treated. All these pharmaceuticals were developed over the past twenty-five to thirty-five years and have become recommended treatment options during the past decade. Although the costs of these drugs per person are often low (less than $1,000 a year for some of the prescriptions for cardiac conditions), the number of people in the population who have these conditions can be in the many millions. This is one reason why total health expenditures have grown so much.

Other advances related to a wide variety of acute medical problems have occurred in the last twenty-five years. We are now able to save many more babies born prematurely, and we can even perform life-saving surgery on babies in the womb. Surgeons routinely do organ transplants for many more types of organs and tissue and have created techniques that save people who have suffered traumatic injuries that only a decade ago they would not have survived. New drugs have dramatically improved treatments for mental illnesses and for infectious diseases that were unheard of in the 1970s—for example, HIV/AIDS and SARS.

These medical advances, however, have greatly increased our average expenditures for health care. True, they have brought enormous benefits and improved the quality of life for millions of people. At the same time, the new options create considerable variation in the costs for treating a particular problem. How an oncologist decides to treat a cancer patient depends enormously on the stage of the cancer, the underlying health of the patient, and the patient’s ability to tolerate chemo and radiation treatments. Even having a baby can vary in costs by $10,000 or more depending on whether the delivery is vaginal or caesarean and on the types of complications that may arise. The increased variation in costs of care and the growth in average costs of medical care mean that insurers are less able to predict costs for individuals and small groups of people. The risks for insurers are greater than they were twenty-five years ago.

Since health insurance premiums closely track expenditures for medi-
cal care, they also have more than doubled (after adjusting for inflation) since 1979. The rapid rate of growth in health insurance costs has been an eye-popping contributor to the cost of labor for companies facing increased competitive pressures. The decline in U.S. manufacturing jobs in the 1980s was a response to lower labor costs abroad. In the 1990s employers responded to rising labor costs by shedding employees who were not part of their “core business competencies” and outsourcing jobs to business service firms that often were small and did not offer health coverage. Within the last five to eight years, companies have become more aggressive about hiring more people as nonpermanent employees as another way to restrain labor costs.

As a result of these employer responses to the increased cost of health insurance, it is no longer just the poor and low-income who cannot afford health insurance. The growth in the number of middle-class people who are uninsured has been faster than the growth of people with middle-class incomes; thus, the chance that a middle-class, working-age adult will be uninsured has risen to one in ten. Many of these people are self-employed or working in small firms that do not offer insurance. Their only option for obtaining coverage is the individual insurance market, where premiums are higher than they are in large companies.

These middle-class workers fall into two groups. In one group are young and healthy people who have never spent—or can they imagine spending—more than a couple of hundred dollars a year for medical care. They have limited knowledge of potential health problems and associated medical costs. Moreover, they often misunderstand the concept of insurance—that by paying a premium they are paying to avoid the risk of having to pay for expensive care themselves. Thus, when the annual premium is greater than $3,000 or $4,000 for an individual or $8,000 for a family policy, they balk at paying. Most people, even those with employer-sponsored health insurance, tend to resist paying more than 5 percent of their income for health coverage.

The other group of middle-class people who are uninsured are over forty-five years of age or have had some health problems. They are far more likely to face much higher premiums or to have trouble obtaining insurance. They often have their applications turned down or are offered policies with severe restrictions on the services covered. Depending on their age, they frequently cannot find a decent insurance policy for less than $700 a month for single coverage, $1,000 a month for coverage for two adults, or more for a family policy. If they are denied coverage, there is not much they can do to obtain coverage; if they earn only a little more than the $44,400 threshold for being middle-class and are offered policies at these premiums, they may not be able to afford them.
INSURER AVOIDANCE OF PEOPLE LIKELY TO HAVE HIGH EXPENSES

Sixty-three percent of Americans under age sixty-five had health insurance through an employer or union (employment-based coverage) in 2004. They constitute the vast majority of people with private health insurance. Another 7 percent purchase individual (nongroup) private insurance. Everyone else in the United States is either uninsured or has some type of public insurance. As we saw with Ed Mitchell when he was insured, many of the 63 percent with employment-based coverage have their insurance through a spouse or parent whose employer or union sponsors it. If the worker loses that coverage, the loss affects the spouse and children too.

People with employment-based insurance are beneficiaries of two significant advantages that greatly reduce their out-of-pocket costs for health insurance. One is the fraction of the premium paid by the employer. In the case of an individual policy for just the employee, employers generally pay between 70 and 95 percent of the premium; on average they pay 84 percent. Employers pay, on average, 74 percent of family policy premiums, although the percentage varies considerably.

The second advantage of employment-based coverage is that it is significantly less expensive per person to sell insurance through employer groups than to individuals. Insurance sold through groups carries a lower risk for an insurer because almost everyone in the employer group enrolls in the group policy. The insurer does not worry that the people who want health insurance are those who believe they will need expensive medical care in the coming year. In the case of small groups (especially those with fewer than twenty-five employees) and individuals, insurers face a greater risk of high medical costs per person. Without many people over whom the risk of very high costs can be shared, the premiums are higher than in large groups. The higher premiums often are high enough to discourage healthy people from enrolling, so it is likely that the applicants are those who suspect they will have high medical expenses. Premiums per person also are lower in large groups because insurers save on costs related to administering the policy and collecting premium payments. Employers often take on many of the tasks of those two functions. It is also less expensive for insurers to market a policy to one large group than to hundreds or thousands of separate individuals.

Thus, the 63 percent of non-elderly Americans with employment-based health insurance have a relatively good deal: the premiums are lower, and the employer typically pays a large fraction of it. In 2005 the average total premium per month for employer-sponsored health plans
was $335 for single coverage and $907 for family coverage. Workers in large companies were paying average out-of-pocket costs of about $55 per month for single coverage and about $200 per month for family coverage.13

People who do not have access to employment-based coverage lack these advantages. The only other source of private health insurance is the individual (nongroup) market. It can be difficult to find a suitable policy, and part of the search may involve consulting with an insurance agent, whose main interest is selling a product. Even if a person succeeds in identifying a desirable policy, the most significant factor that affects the premium is insurers’ concern that the policy has attracted “adverse selection.” Adverse selection occurs when a disproportionate share of people who apply for health insurance suspect that they have medical problems that will require expensive medical care in the near future.

The potential threat of adverse selection in the small-group and individual insurance markets is real. Because we have a voluntary system of health insurance purchases, young and healthy people are less likely to apply for and buy coverage. The result is a catch-22: insurers charge higher premiums for small-group and individual coverage because the risk of people with high costs is greater than it is in the large employer groups. In response to the higher premiums, young and healthy people decide that, because their own expected medical costs plus whatever they are willing to pay for the value of insurance are less than the premium, they will not buy coverage.

Insurers have responded to the increased threat of adverse selection in the small-group and individual insurance markets by becoming more sophisticated in their use of mechanisms to avoid it. They spend a great deal of effort and money trying to select the most desirable applicants—those who they expect will be low-cost—and protecting themselves from others who they predict will be high-cost. They deny coverage to some people based on their age and prior medical history; they offer restricted coverage; and in states where they are required to insure anyone who applies, they charge unaffordably high premiums of $1,500 or more per month. The end result is that young and healthy people can obtain individual insurance at relatively low premiums, especially in states where insurers are permitted to use a wide variety of selection mechanisms. But those older than forty and those who have had health problems are frequently unable to obtain coverage at all.14 In states where the premiums must be the same for everyone regardless of age or health status (known as community-rated premiums), middle-aged and less healthy people can obtain coverage, but the premiums are generally high. Young and healthy people resist paying these premiums and are more likely to be uninsured.
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THE IMPLICATIONS OF BEING UNINSURED

Being without health insurance is a risky business, although it may not seem so at first glance. People who are young and healthy generally do not become sick, so it is reasonable to assume that their yearly medical expenses will be close to zero. Indeed, half of all those under age sixty-five spent less than $500 (in 2005 dollars) on medical care in 1996. We do not have the expenditure data for 2005 yet, but because these people are healthy, the $500 amount is likely to be only slightly higher in 2005. (The increase will reflect changes in the practice of medicine since 1996 that are not accounted for with adjustments for inflation between 1996 and 2005.) But these people face risks—they might get hurt in a car accident or become ill with a condition that requires long-term medical attention. The risks of a period without health insurance can extend beyond the time without coverage. As insurers have become more selective about whom they cover with small-group or individual policies, any type of prior medical problem can cause a person to be denied coverage or charged significantly higher rates than a similar healthy person. Even an indication of a future problem, such as above-normal blood test levels, can result in denial of coverage. In addition, individual and small-group insurance policies generally do not cover services for at least a year for preexisting medical conditions. Thus, even for healthy people the risks of being without insurance include the risk of difficulty in getting health insurance in the future.

For people who are older or for those who have had medical problems, the risks of being uninsured are more apparent. If such a person has a chronic condition or is diagnosed with a cancer or other life-threatening illness, the risk is that he or she will not get the same quality of care that an insured person would receive. This risk then expands to becoming sicker or dying earlier than an insured person with the same disease. These risks are genuinely frightening to people as they age.

Society also runs risks by having a significant number of uninsured people. Typically, they do not seek medical care when they first notice symptoms, and they do not visit physicians for regular checkups or for preventive care, such as screenings for cancer. When they do seek medical care, their problems often cost more to treat because they were neglected at an early stage. Medical care provided to uninsured people is not free—we all pay for it in the form of higher taxes and the higher prices charged by medical providers.

THE PLAN OF THIS BOOK

This book is about people who do not have health insurance and what might be done to help them. The book is divided into three parts. The
first part describes why people are uninsured, while the second part examines government policies that might make private health insurance more affordable and available to these people. The third part is about the need for a new health insurance structure that would enable more people to have health insurance.

In chapter 2, we begin by analyzing who is uninsured and the changes over the past twenty-five years in the types of people who are uninsured. Specifically, we explore why being uninsured is now a problem confronting the middle class and people twenty-five to forty-four years of age. Changes in the economy, employer-employee relationships, demographic patterns, and new public programs to cover poor and low-income children have affected the population of the uninsured. In discussing how the uninsured have changed since 1979, I rely on a nationally representative dataset—the Current Population Survey (CPS), conducted by the U.S. Census Bureau—and on information obtained from interviews with more than forty people who are uninsured or who run small businesses and struggle with offering coverage to their employees. I use the experiences of six middle-class uninsured workers and three small-business owners to illustrate the reasons why being without health coverage now threatens millions of Americans. Unlike the CPS, the sample of people I spoke with is not a scientific sample, but these interviewees do represent a wide variety of occupations and experiences in the labor force.

The focus in chapter 3 is on why some people have problems obtaining health insurance as part of the compensation they receive for work. We examine job options for different types of people and the impacts of changes in the U.S. labor market over the past twenty-five years on employer-sponsored health insurance coverage. We also investigate the relationship between premiums and employer-group size and its effect on workers’ chances of having employer-sponsored coverage.

How insurers compete with each other and why some people cannot buy insurance is the subject of chapter 4. Insurers are very concerned about adverse selection, and they compete by using selection mechanisms to reduce their risk of covering very high-cost people. As a result, people who might incur high medical costs have difficulty obtaining health insurance; either they are denied coverage or they are charged very high premiums. If the risk of extremely high-cost people were lowered, insurers would reduce both premiums and their use of selection mechanisms that prevent people from buying coverage.

If we want to maintain private insurance, proposals to expand health coverage must address insurers’ risk of extremely high-cost people. The second part of the book investigates three proposals that might address this risk and thereby make private insurance affordable and accessible to more people. In chapter 5, we examine two potential mechanisms for
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reducing insurers’ fear of adverse selection: high-risk pools and an assessment mechanism that might be used to relieve carriers of the financial burden of high-risk enrollees. Both of these mechanisms rely on predicting who in a group of people is likely to have high medical costs.

Chapter 6 focuses on a third mechanism for addressing the risk of adverse selection: the federal government reinsuring the small-group and individual insurance markets. Reinsurance is insurance for insurers, protecting them from extreme risks. If the federal government were to provide a reinsurance program that took responsibility for people who have the top 1 percent of all medical expenses among everyone covered by small-group or individual insurance, it could reduce premiums for such coverage by 20 to 40 percent. How much premiums might decline would depend on how the reinsurance is structured. In addition, because a government-sponsored reinsurance program would reduce insurers’ incentives to select against people they suspect will be high-cost, more people would find that insurance is available to them when they apply. The reductions in premiums together with the increased availability of coverage might induce as many as one-third of the uninsured to become insured. The total costs of such a program would depend on the structure of the reinsurance. A rough estimate is that it would cost between $6 billion and $20 billion a year to help at least 15 million uninsured persons purchase coverage in the individual and small-group insurance markets. This is about the same amount of money being discussed to help clean up after Hurricanes Katrina, Rita, and Wilma just in 2005. By comparison, the annual federal tax subsidy for employer-sponsored health insurance is now estimated to be more than $140 billion.19

There are precedents for government taking the worst risks in other situations, enabling markets to operate more efficiently. Today the catastrophe reinsurance markets and secondary mortgage markets would not exist without the federal government’s assumption of responsibility for the worst risks in these markets. Three health-related government programs also make the government responsible for large shares of the costs of the highest-risk cases. Medicare has provided additional payments to hospitals for very expensive cases (known as outliers) since 1983. Medicare pays a hospital for 80 percent of its costs above the threshold that defines an outlier case. The Medicare prescription drug benefit (Medicare Part D) established risk corridors such that if an insurer has an individual with expenses in excess of a complicated formula of costs, the Centers for Medicare and Medicaid Services provides a reinsurance payment. Among the state programs for the uninsured, Healthy New York stands out as the first with an explicit reinsurance component that reimburses insurers with enrollees who have annual expenses above a threshold defined on a per-person basis. Healthy New York reimburses insurers
for 90 percent of a person’s annual costs between $5,000 and $75,000. In 2004 the program paid out less than $35 million for such expenses, less than what had been budgeted for the reinsurance pool. These precedents are described more fully in the appendix.

The third part of the book is about how we could move from the current situation of rising numbers of uninsured to a situation where health insurance would be affordable and accessible for more people. Why the United States needs a new structure for its system of health insurance and how it might be configured are the focus of chapter 7. The appendix, as noted, describes precedents for government taking responsibility for the worst risks.

A FINAL NOTE

Although the lack of health insurance now extends well into the middle class, the majority of the uninsured are poor or low-income. The primary way to help poor and low-income uninsured has been obvious for some time. We need to expand government assistance—we cannot continue to believe that they will be able to buy private coverage on their own. The economic boom of the late 1990s provided ample evidence that a strong economy and tight labor markets do not cause health insurance to trickle down to large numbers of the working poor. But because many others have proposed and written about policies that would help the poor and low-income uninsured, the problems they face in obtaining health insurance are not the focus of this book.

Instead, this book focuses on what is different about the uninsured today and on policies that could allow us to maintain a system of health insurance based on private insurance. The uninsured are different from those of twenty-five years ago in three significant ways. They account for a larger share of our under-sixty-five-year-old population: one in six are now uninsured. More middle-class people now face the prospect of being uninsured: one in ten working-age, middle-class adults are without insurance. An increasing number of people are in skilled occupations that ensure middle-class incomes but do not always come with employer-sponsored health insurance. And perhaps most sobering, a significant number of adults twenty-five to forty-four years of age are uninsured—so many that between 20 and 25 percent of all adults in this twenty-year age cohort are uninsured. This is not good for them, and it’s not good for the country’s ability to maintain private insurance.

We are on the edge of a crisis. Health insurance is out of reach for an ever-expanding number of people. Unless we do something quickly to help younger adults and middle-class people buy health insurance, our system of private insurance will collapse.