

ELECTION 2004

Protecting the Uninsured

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According to the most recent data, nearly 45 million Americans — 15.6 percent of the U.S. population — did not have health insurance during a typical month in 2003. This represents an increase of 5 million people and more than 1 percent of the population since 1990 (see Figure). Despite intense public debate and concern over the issue of the uninsured, the proportion of the population without insurance remains higher than it was 20 years ago.¹

The uninsured are a diverse group, including not only unemployed people and their families, but also some who work full-time for firms that do not offer insurance and others who are self-employed and simply cannot afford to bear the full cost of insurance. In 2002, approximately 21 million to 31 million persons did not have health insurance all year, and 60 million others were uninsured at some time during the year. Of the former group, nearly 90 percent had a family member who was working full-time or part-time during the year.² Tabulations from the February 2001 Current Population Survey indicate that nearly two thirds of employed persons who are uninsured work for an employer that does not offer health insurance. The families of most of the uninsured have low-to-moderate incomes; nearly two thirds of these families make less than 200 percent of the federal poverty level (\$37,700 per year for a family of four).

Why should we care about the uninsured? Adults and children without insurance are given diagnoses at later stages of illness, receive fewer preventive and curative medical services, and have worse health care outcomes than those with insurance.³ The uninsured spend approximately 40 percent less than otherwise similar patients who have insurance, paying about 30 percent of the costs of their own health

care. The remaining costs are uncompensated, and most are passed on to the government; the federal government pays nearly \$25 billion per year to finance health care for patients without insurance.

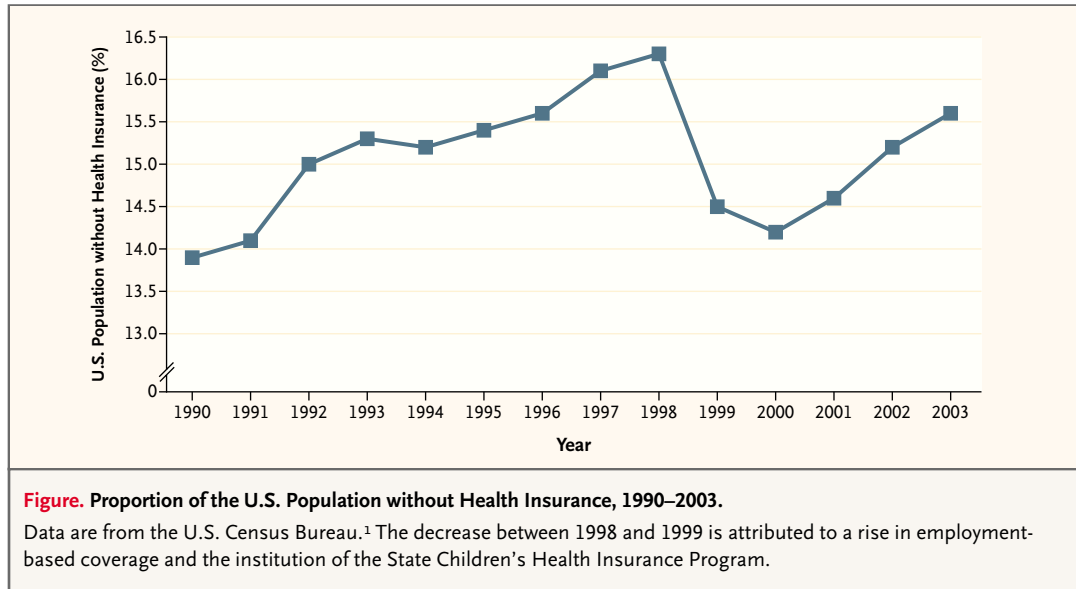
State and local governments also bear a substantial financial burden for uncompensated care. State tax dollars support public hospitals and in some cases private hospitals that serve as regional trauma centers and provide safety-net services. These large and growing financial burdens have, in some cases, required counties and states to ask for dedicated local tax increases.

The most recent concerted effort to ensure universal health coverage was President Bill Clinton's ambitious and far-reaching Health Security Act, which was put forth more than a decade ago. This plan would have provided universal coverage, while redesigning the financing, structure, and provision of health care. It was the scope and reach of the Clinton proposal that proved to be its downfall, and this lesson has shaped the current policy debate about the uninsured.

Health care has again emerged as a major issue in the presidential election, owing to the increasing cost of health insurance and anxieties among Americans who are insured about losing their jobs and insurance. President George W. Bush and Senator John Kerry have both advanced proposals to cover the uninsured and reduce health care costs.

The candidates' proposals, as they have been described in the campaign through September, differ sharply in terms of design, cost, and anticipated increase in coverage for the uninsured. The costs of the plans are, of course, closely tied to the number of people they envision covering. The Kerry proposal projects the enrollment of nearly 27 million uninsured people, at a cost to the federal govern-





ment of \$653 billion over the next 10 years. The Bush proposal is a more modest effort, increasing federal spending by about \$90 billion over the next 10 years and extending coverage to an estimated 2.4 million uninsured people.⁴ To put these figures into context, the new Medicare drug coverage is expected to cost about \$400 billion to \$540 billion over the next 10 years.

President Bush has advanced a series of incremental changes intended to increase coverage and lower health care costs. The plan includes a refundable tax credit (i.e., a credit that families receive even if they have no federal tax liability) of up to \$1,000 for a single person and \$3,000 for a family of four for the purchase of health insurance. These tax credits are fixed dollar amounts that decrease with income. A single person earning less than \$15,000 would receive \$1,000 to purchase insurance, and there would be no credit for single people earning more than \$30,000. Bush has also proposed allowing people to deduct the cost of qualified high-deductible health plans from their taxable income and to start a tax-deductible health savings account. Such tax-sheltered accounts for health care costs would provide an additional method for families to finance their health insurance; and because they make explicit the cost of health services, such accounts would be expected to increase consumers’ cost-consciousness when they use medical services.

Bush’s plan would also allow small businesses and associations to purchase insurance through large purchasing pools. Although this proposal

would increase the size of the risk pools for small employers, the Bush plan would provide no direct financial assistance to employers or workers for purchasing insurance. On balance, the risk pools could reduce the number of uninsured Americans by about 300,000. Finally, the president has proposed medical malpractice reforms modeled after those enacted in California that would establish a cap of at least \$250,000 for noneconomic damages. These reforms would be expected to reduce malpractice premiums, the practice of defensive medicine, and ultimately, health care costs.

Senator Kerry’s health care proposal differs dramatically from Bush’s in its approach to covering the uninsured and in the magnitude of the coverage it envisions. First, Kerry would extend coverage by Medicaid and the State Children’s Health Insurance Program (SCHIP) to people who are currently ineligible for such coverage — single adults and childless couples living below the poverty line and parents with incomes of less than 200 percent of the poverty line. He has also proposed extending the same coverage to more children by raising the cutoff level to 300 percent of the poverty line. Instead of continuing today’s federal–state matching arrangements in these programs, Kerry would have the federal government finance 100 percent of the costs of the expansion. Full federal funding is likely to result in higher rates of program enrollment.

Second, Kerry would create a Congressional Health Plan, modeled after the Federal Employees Health Benefits Program. The plan would allow small businesses with 50 or fewer workers that do

not offer health insurance today to choose from the same health plans offered to federal employees and receive a refundable 50 percent tax credit. Larger employers could also participate in the Congressional Health Plan. In addition, the federal government would pay 25 percent of the premiums for uninsured persons between 55 and 64 years of age and 75 percent for the unemployed.

Third, the Kerry plan includes a federal “stop-loss” (reinsurance) program that would pay 75 percent of the health care claims each year that exceeded a dollar (loss) threshold (e.g., \$30,000). This program is designed to reduce the cost of health insurance by 10 percent for qualifying firms. Kerry seeks to make insurance more affordable to employers and workers and to increase coverage through this approach.

Finally, Kerry has proposed reforms to our medical-malpractice system that would limit punitive damages and reduce the frequency of claims by requiring the use of a medical specialist to determine whether a claim is reasonable. He has also advanced an approach to reducing the costs of defending

malpractice claims through the use of nonbinding mediation before a case comes to trial.

Both candidates’ proposals build on the current system and avoid the broader restructuring and redistribution of coverage proposed a decade ago in President Clinton’s health plan. There are, however, substantial differences in the scope and costs of the two proposals. Limiting the restructuring of the health care system may improve the political prospects of both approaches.

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4. Thorpe KE. Federal costs and savings associated with Senator Kerry’s health care plan. Atlanta: Emory University, August 2, 2004. (Accessed September 17, 2004, at <http://www.sph.emory.edu/hpm/thorpe/kerry8-23-04.pdf>.)

CONQUERING POLIO

Isolation of Poliovirus — John Enders and the Nobel Prize

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When John Enders was informed, 50 years ago this month, that he was the sole recipient of the Nobel Prize in Medicine or Physiology for 1954, he declined the honor. He wrote to the Swedish authorities that he would accept the prize only if it could be shared with “those who did the work.” It was agreed that Thomas Weller and Frederick Robbins would be corecipients with Enders. This act, one of the most gracious in the history of the Nobel Prize, reveals the profound decency and modesty of John Enders.

John Franklin Enders was a Connecticut Yankee, born into a large family of prosperous bankers and insurance executives. He was educated at the St. Paul’s School and Yale with the expectation that he would join the other Enders men in the banking and insurance world. But his interests lay in Celtic and early English literature, and he went to Harvard

to pursue a thesis on the use of gender in Middle English.

As fate would have it, he shared living quarters with another graduate student, Hugh K. Ward, who had come from Australia to study with Hans Zinsler in the Department of Microbiology at Harvard Medical School. Enders frequently accompanied Ward to the laboratory in the evenings, and a long-latent interest in biology was roused in him. When he finally received his Ph.D. from Harvard in 1930, his thesis was about the purification of an anaphylactogenic carbohydrate from *Mycobacterium tuberculosis* that was separate and distinct from the protein that caused delayed-type hypersensitivity. Enders’s subsequent work with Ward resulted in a classic paper in the *Journal of Experimental Medicine* in 1933. Until then, the cause of the opsonic activity of serum had been unknown. Using type II