Backgrounder

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America's Unstable Health Insurance System: Recommendations for Increasing Stability and Coverage

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American health care, both the public and private delivery systems, is deeply flawed, from barriers to access and high costs to inconsistent quality of care and a lack of reliable information on the price of medical services. State and federal officials need to find the most effective strategies to improve the financing and delivery of health care.

Among the many problems facing American health care, the instability of existing health insurance coverage is a pervasive difficulty for individuals and families. Tens of millions of Americans "churn" through the health insurance system annually, repeatedly gaining and losing coverage due to the current structure's inability to accommodate the dynamic U.S. economy, particularly the high mobility of the American workforce.

At the policy level, the solution to this problem is clear: Americans should personally own their health insurance policies, just as they own other types of insurance policies that they take for granted. If individuals and families could own their own health insurance policies, they could retain their coverage and maintain continuity of care as they change jobs, move back into the workforce, or move off public programs. Health insurance would thus become portable, just like many other types of insurance.

Three Barriers to Personal Ownership and Portability

Three major barriers preclude this kind of personal ownership and portability in health insurance:

Talking Points

- Tens of millions of Americans "churn" through the health insurance system annually, repeatedly gaining and losing coverage because of the current insurance structure's inability to accommodate the dynamic U.S. economy, particularly the high mobility of the American workforce.
- Once regarded as stable and dependable, employer-sponsored insurance no longer addresses the needs of many workers in a changing labor market.
- While most Americans still receive their health insurance coverage through their employers, employer-sponsored coverage has declined steadily in recent years, and this decline is expected to continue.
- Unlike with other types of health insurance, most individuals and families have no property right in their health insurance policies.
- Private ownership would guarantee portability of coverage, ensure the critical continuity of care, promote mobility in employment, and allow persons to get off public programs without the drastic penalty of losing their health coverage.

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- The federal tax treatment of health care subsidizes employer-sponsored insurance (ESI), but not health insurance policies purchased by individuals and families in the non-group market.
- In many states, the state policies and regulations that shape and direct health insurance markets do not facilitate the purchase of affordable health plans or allow for the portability of health plans.
- The large public programs, including Medicaid and the State Children's Health Insurance Program (SCHIP), are not designed to enable individuals and families to move easily from public assistance to private health insurance. In other words, getting off public assistance is difficult, regardless of the person's desire to do so.

Once these political and structural obstacles are overcome, more Americans will be able to purchase secure health care coverage to own and retain their own health insurance. In other words, they will not be churning through an unstable health insurance system.

Policymakers can address the problems of churning and uninsurance by making three major changes:

- **Congress should change federal tax law to provide direct tax relief to individuals and families for the purchase of health insurance coverage.** This would enable them to own their coverage and take it with them from job to job. Portability of coverage is the chief remedy for the instability of the existing health insurance markets.
- **Until Congress makes these changes, state policymakers should redesign state health insurance markets to promote personal ownership of health plans**, enabling individuals and families to keep coverage regardless of employment changes.
- **State and federal policymakers should reform public health programs**, notably Medicaid and SCHIP, guaranteeing enrollees a reliable, predictable funding stream for health care while designing assistance so that they can use it to buy private coverage, thus facilitating a seamless transition into private coverage. The right welfare policy would enable individuals to move off welfare and into the private economy.

Churning in Health Coverage

For tens of millions of Americans, the existing health insurance markets are unstable, characterized by "churning." Churning occurs in the market when people repeatedly gain and lose their health insurance, resulting in frequent spells of uninsurance. Churning, while a category of uninsurance, is different from being chronically uninsured, which is generally defined as being uninsured for one year or more. Churning is an unstable pattern of health insurance coverage.

Although the actual number of "churners" is difficult to pinpoint, many of the 47 million people uninsured in 2006 were not the same as the 44.8 million people uninsured in 2005. In fact, 89.5 million people were uninsured for at least one month during 2005 and 2006, which is significantly more than is reflected in the Census Bureau's Current Population Survey (CPS) estimate of 47 million. Both liberal and conservative health policy analysts agree that the uninsured population is dynamic and diverse and that many of the uninsured are uninsured for different lengths of time. For example, of the 89.5 million people uninsured during 2005 and 2006, 36 percent were uninsured for five months or less, and 38 percent were uninsured for more than one year.[1]

The fundamental cause of churning is the lack of personal ownership and portability of health insurance policies. Unlike with other types of health insurance, most individuals and families have no property right in their health insurance policies. Their policies are effectively owned by others, usually employers or the government, who determine the insurance policies and eligibility for enrollment.

1. Families USA, "Wrong Direction: One out of Three Americans Are Uninsured," September 2007, p. 4, at *http://familiesusa.org/assets/pdfs/wrong-direction.pdf* (March 5, 2008). On this same point, see Edmund F. Haislmaier, "Health Care Reform in Maryland: Doing It Right," Heritage Foundation *Lecture* No. 1002, March 20, 2007, at *www.heritage.org/research/healthcare/hl1002.cfm*.

In the current system, maintaining consistent coverage for most people depends on staying with the same employers or meeting the often changing qualifications for public programs. This is unrealistic, and as a result, millions of people become "churners," moving on and off private and public health insurance plans.

The Precarious Status of Private Insurance Coverage

Private insurance is the most common type of health insurance, covering approximately two-thirds of Americans, but the private insurance market is composed primarily of employer-sponsored insurance. While this type of insurance arrangement has provided health coverage for 60 percent to 70 percent of Americans for many years, ESI coverage has eroded in recent years. ESI coverage has declined steadily since 2000, and this decline is projected to continue.[2]

Regrettably, the much smaller non-group market for health insurance cannot serve effectively as the "safety net" for those who lose employer-sponsored coverage because of current tax laws and regulations. The non-group market is practically inaccessible to millions of Americans, largely because it does not receive the same favorable tax treatment as ESI and because in some states the laws subject individuals to strict underwriting or exclusion from this kind of non-group coverage.

The main vehicle for financing Americans' health care is private health insurance—specifically, employer-sponsored coverage. Originating in the 1930s with Blue Cross and Blue Shield on a limited basis, the proliferation of employer-sponsored health insurance since World War II is mainly attributable to the effective federal subsidy that employers and employees receive almost exclusively through ESI. Since employer contributions to health insurance premiums are tax deductible and the value of employees' health benefits at work are excluded from the calculation of their income and payroll taxes, employer-sponsored health insurance can be obtained at a significant discount compared to premiums paid in after-tax dollars in the non-group market.[3] Consequently, only 10 percent of the 180 million people with private insurance in 2006 purchased it in the non-group market.[4]

Today's health insurance markets do not operate on a level legal playing field. Tax rules and insurance regulations differ dramatically. However, given the progressive decline in ESI coverage and the increasingly large numbers of Americans who find themselves with breaks in employer-based coverage, federal and state policymakers should start leveling the playing field and reducing the churning in health insurance markets.

Declining Employer Coverage. As noted, employer-sponsored health insurance has been eroding. Since 2000, the percentage of the non-elderly population with ESI has declined from approximately 68 percent to 62 percent.[5] The major cause of this decline was the employers' decline in sponsorship, as well as changes in eligibility of employees and employees deciding not to participate in health insurance plans.[6] Additionally, job-specific factors (e.g., company size, occupation, and industry) influence the likelihood that employers will offer health insurance to their employees.

Size Matters. Although the majority of workers in the private sector have ESI, the percentage varies

2. Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2007 Current Population Survey," Employee Benefit Research Institute *Issue Brief* No. 310, October 2007, p. 5, Figure 1, at *www.ebri.org/pdf/briefspdf/EBRI_IB_10-20073.pdf* (November 15, 2007).
3. David Blumenthal, "Employer-Sponsored Health Insurance in the United States—Origins and Implications," *The New England Journal of Medicine*, Vol. 355, No. 1 (July 6, 2006), pp. 82–88.
4. Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured," p. 5.
5. Employee Benefit Research Institute, *EBRI Databook on Employee Benefits*, Chap. 26, at *www.ebri.org/publications/books/index.cfm?fa=databook* (November 15, 2007).
6. Lisa Clemans-Cope and Bowen Garrett, "Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation: 2001–2005," Henry J. Kaiser Family Foundation *Issue Paper*, December 2006, at *www.kff.org/uninsured/upload/7599.pdf* (March 5, 2008).

substantially by company size. In 2005, approximately 52 percent of employees in companies with fewer than 10 employees had ESI versus 85 percent in companies with more than 100 employees. Moreover, even though the ESI rate among all companies has declined since 2001, the sharpest declines have occurred in smaller companies.[7]

Occupation Matters. A disparity also exists in health coverage among occupational groups. Particularly troubling is that ESI is declining among all occupations, more in some than in others. Occupations that already had the lowest rates of ESI have experienced larger declines than occupations with higher rates of ESI. In 2005, the lowest ESI rates were in the construction (55 percent) and service (57 percent) occupations, while the highest rates were in the professional (87 percent) and management (90 percent) occupations. The largest decreases occurred in construction (–10 percentage points) and services (–7 percentage points), while the decreases in professional positions (–3 percentage points) and management (–2 percentage points) were relatively small.[8]

Industry Matters. In 2006, 88 percent of workers in the public sector and 70 percent in the private sector had ESI compared with fewer than 50 percent of self-employed workers.[9] Additionally, the percentage of workers in manufacturing and wholesale/retail trade that had ESI was greater than the percentage of workers with such coverage in other industries. Almost 78 percent of workers in manufacturing had ESI versus less than 52 percent in agriculture, forestry, fishing, mining, and construction.[10]

Securing private health insurance has become more difficult. Simply having a job no longer guarantees that the worker will be offered health insurance. It is now necessary to have a job in the right industry in a certain type of company that employs a minimum number of people, and even this could change. Even more discouraging for many Americans is that the backup plan—purchasing health insurance in the non-group market—may not even be possible because of the unequal tax treatment and restrictive underwriting rules.

Increased Churning. Due to the decreasing rates of private coverage through ESI and the obstacles to purchasing non-group plans, more people are churning through the health care system. On this point, there is widespread agreement in the professional literature, ranging from the findings of the Congressional Budget Office (CBO) to independent analyses in the academic community and public policy organizations.[11] For example, a Commonwealth Fund study found that 12 percent of those beginning a two-year period with ESI had at least one spell of uninsurance. Additionally, 21 percent of those with non-group insurance experienced one or more spells of uninsurance, and 26 percent had another coverage transition. In total, over 45 million people were unable to retain their original type of private insurance coverage for two years.[12]

Once regarded as stable and dependable, ESI no longer addresses the needs of many workers. The structure of the labor market is changing. Since 2001, the percentage of self-employed and contingent workers (temporary and contract workers) has increased, as has the number of people working for small businesses.[13]

Self-employed workers and employees working for small businesses are unlikely to have ESI

7. *Ibid.*, p. 21.
8. *Ibid.*, p. 28.
9. Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured," p. 14. These figures reflect ESI both through own-name coverage and through dependent coverage.
10. *Ibid.*, p. 13.
11. For one of the best analyses of churning over a four-year period, see Pamela Farley Short and Deborah R. Graefe, "Battery-Powered Health Insurance? Stability in Coverage of the Uninsured," *Health Affairs*, Vol. 22, No. 6 (November/December 2003), pp. 244–255.
12. Kathryn Klein, Sherry Glied, and Danielle Ferry, "Entrances and Exits: Health Insurance Churning, 1998–2000," Commonwealth Fund *Issue Brief*, September 2005, p. 10, at *www.commonwealthfund.org/usr_doc/klein_855_entrancesexits_ib.pdf* (March 5, 2008).

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because small businesses by definition do not employ enough people to create a significant insurance pool. One advantage of ESI is the ability to pool many people with different levels of health risk to provide insurance at an affordable price that is not substantially affected by any one individual's health care costs. In contrast, an insurance pool with only a few people in a small business is very susceptible to sharp premium hikes from one worker's health costs. Contingent workers may be employed in a company offering health insurance but are generally excluded from participating. Of course, employers are not legally required to offer health insurance to part-time or contingent workers even if they offer it to full-time employees.

More and more employers are becoming frustrated with the current insurance market and feel that it cannot be sustained, especially with the escalating costs of health insurance premiums. Although there is disagreement on whether to abandon the employer-based system entirely or to reform it to make it more viable, most business leaders agree that the current system is not sustainable for the long term.[14]

The Insecurity of Government Insurance Coverage

Assuming that public-sector health care coverage is stable would be a mistake. The empirical evidence tells a very different story. While the private health insurance markets clearly need reform, public insurance programs also need to be reformed.

The three major public health insurance programs are Medicare, Medicaid, and the State Children's Health Insurance Program. Medicare, which covers all Americans age 65 and older and many with disabilities, has no problem with churning or lack of coverage, but these are major problems for Medicaid and SCHIP. Medicaid, enacted as Title XIX of the Social Security Act of 1965, covers low-income children and their caretakers, the elderly, the blind, and disabled individuals.[15] SCHIP, created under the Balanced Budget Act of 1997, was designed to assist states with providing insurance coverage to children in low-income families that do not qualify for Medicaid. Its size and scope have expanded since 1997 and are still being debated. One clear distinction between Medicaid and SCHIP is that Medicaid is an entitlement and SCHIP is a block grant.[16]

People move on and off Medicaid and SCHIP when personal incomes, eligibility rules, or administrative requirements change. These programs are designed to be safety nets, but they do not always operate as such for the people who need assistance the most. A much better alternative would be to stabilize coverage for enrollees by guaranteeing them a reliable and predictable source of government funding that would enable them to buy their own private health insurance plans or to participate in a plan offered or partially financed by their employers.

Gaps in Assistance. Medicaid and SCHIP cover almost 45 million Americans, or approximately 14 percent of the non-elderly population.[17] In contrast to the trends in employer-sponsored insurance, public insurance coverage among the non-elderly population increased from 14.6 percent in 2000 to 17.5 percent in 2006.[18] This increase was in part an offset to the decline in employer-sponsored cover-

13. Clemans-Cope and Garrett, "Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation: 2001–2005."
14. Paul Fronstin, "The Future of Employment-Based Health Benefits: Have Employers Reached a Tipping Point?" Employee Benefit Research Institute *Issue Brief* No. 312, December 2007, p. 1, at *www.ebri.org/pdf/briefspdf/EBRI_IB_12-20073.pdf* (December 18, 2007).
15. Centers for Medicare and Medicaid Services, "Key Milestones in CMS Programs," at *www.cms.hhs.gov/History/Downloads/CMSProgramKeyMilestones.pdf* (November 15, 2007).
16. Kaiser Commission on Medicaid and the Uninsured, "Health Coverage for Low-Income Populations: A Comparison of Medicaid and SCHIP," Henry J. Kaiser Family Foundation *Issue Brief*, April 4, 2006, at *www.kff.org/medicaid/upload/7488.pdf* (March 5, 2008).
17. Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured," p. 5, Figure 1.
18. *Ibid.*

age, especially for children. The percentage of children with public insurance increased by 6 percentage points, while the percentage for adults increased by only 1.6 percentage points.[19]

Although the percentage covered by Medicaid and SCHIP has increased, these programs struggle to enroll and retain eligible people. Families have trouble keeping up with complex and/or frequent renewal procedures. Transitions between Medicaid and SCHIP are not smooth, and this prohibits families from moving seamlessly up the income scale while retaining health insurance coverage for their children. Policies and procedures for paying premiums, such as annual versus monthly payments, also contribute to retention problems.

Public-Sector Churning. The children and families that Medicaid and SCHIP cannot retain fall into the ranks of the uninsured and churn through the system. The Commonwealth Fund study found that 30 percent of those who begin the period with Medicaid experience one or more spells of uninsurance—more than twice the rate of those with private group insurance.[20] Instead of trying to expand these public programs, which are already constrained and unable to provide continuous coverage, policymakers should reevaluate the role of public programs in the lives of Americans.

The ultimate goal should be to help those who qualify for public assistance to move out of poverty, and the programs should be designed to support this mobility. Policymakers should strive to create a fluid system in which families receive the financial support necessary to purchase health insurance at all income levels. In this type of program, families would own their health insurance so that when they earned enough income to leave public programs, they could retain it.

Reducing Uninsurance

The problems with the existing structures of both public and private health insurance are abundantly clear: Americans cannot depend on them to provide continuity of health coverage, and without continuity of coverage, they cannot be assured of continuity of care. Private ownership of health insurance coverage, just like private ownership of every other type of insurance coverage, would largely resolve that problem for persons, whether their financing is public or private. Private ownership would not only give Americans greater control over their health care options, but also relieve a great deal of their understandable anxiety about health insurance.

Private ownership would guarantee portability of coverage, ensure the critical continuity of care, promote mobility in employment, and allow persons to get off public programs without the drastic penalty of losing their health coverage. Combined with a new system of tax treatment and/or subsidies for health care coverage, the ability to choose and own their health plans would allow millions of currently uninsured Americans to obtain health coverage.[21]

Currently, structural obstacles and financial constraints preclude people from buying and keeping their own insurance. Three major policy changes could overcome these obstacles:

- **Establish a fair and equitable health care tax policy.** Employers who wish to offer health insurance should be able to continue to deduct that expense as they do other business-related expenses. However, Congress should restructure the tax treatment of health insurance to ensure that tax breaks go directly to individuals and families regardless of where they work. Access to affordable health insurance coverage should no longer be an accident of employment.

  Congress could accomplish this in a variety of ways, such as a universal standard deduction with a refundable health care tax credit, which would replace the current tax exclusion for health care benefits, or a targeted tax credit for individuals and families who do not or cannot get health insurance through their places of

19. *Ibid.*, p. 7.
20. Klein *et al.*, "Entrances and Exits," p. 10.
21. For an extensive discussion of the possibilities of expanded health insurance coverage through comprehensive tax reform, see Grace-Marie Arnett, ed., *Empowering Health Care Consumers Through Tax Reform* (Ann Arbor: University of Michigan Press, 1999).

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work.[22] Changing the tax treatment of health insurance would also level the playing field between the group and non-group markets, ending ESI's unfair advantage over health insurance options offered in the non-group market.

- **Reform the health insurance markets.** In many states, health insurance markets are defective. This is particularly true of the small group markets, which are supposed to serve employees in small firms, and the individual or non-group insurance markets. Until Congress changes the tax laws, state officials should seek other options to allow for personal ownership and portability of health insurance, but only in strict compliance with federal laws on government employment and employee benefits.

  One option is to facilitate movement toward a defined-contribution system for health coverage through a statewide health insurance exchange, enabling an employee to use an employer's defined contribution to buy a health plan tax-free, own it, and take it from job to job.[23] If state officials created a statewide exchange or other ways of pooling, self-employed workers and other non-traditional types of workers could have the opportunity to purchase more affordable health insurance.

- **Reform the public health programs.** The public health programs need to be reformed to give dependent individuals the financial means to buy the health care that they want and need while enabling them to become independent and make the transition into the private economy and the private health insurance market.

  While these objectives could be accomplished in a variety of ways, one possibility is to transform the existing funding into a system of subsidies that would enable individuals to secure the coverage of their choice.[24] For example, SCHIP could be converted into a refundable tax credit for children of low-income families, which would enable them to keep their private coverage, participate in employer-based coverage, or purchase an individual health plan appropriate to their personal needs.[25]

By helping these individuals to buy or maintain private coverage, public health program reforms would expand personal choice, secure superior coverage, and help families to move out of poverty.

Conclusion

America's health insurance markets are characterized by churning, with tens of millions of individuals gaining and losing their health insurance each year because of changes in their circumstances, often a loss or change of employment. This phenomenon of churning characterizes both public-sector and private-sector coverage.

The right remedy for this problem is personal ownership and portability of health care coverage. There is no reason why Americans should not own and control their own health insurance just as they own and control other types of insurance coverage. In other sectors of the economy, this is the norm and is taken for granted. With portability and continuity of coverage, Americans will also enjoy continuity of care and experience far less anxiety about health insurance than they do today.

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22. For a discussion of tax policy alternatives, see Nina Owcharenko, "Health Care Tax Credits: Designing an Alternative to Employer-Based Coverage," Heritage Foundation *Backgrounder* No. 1895, November 8, 2005, at *www.heritage.org/research/healthcare/bg1895.cfm*.
23. For a brief discussion of the purpose and function of a statewide health insurance exchange, see Robert E. Moffit, "The Rationale for a Statewide Health Insurance Exchange," Heritage Foundation *WebMemo* No. 1230, October 5, 2006, at *www.heritage.org/research/healthcare/wm1230.cfm*.
24. For a brief discussion of Medicaid reform, see Nina Owcharenko, "A Road Map for Medicaid Reform," Heritage Foundation *Backgrounder* No. 1863, June 21, 2005, at *www.heritage.org/research/healthcare/bg1863.cfm*.
25. See Nina Owcharenko and Stuart M. Butler, "SCHIP: Crafting a Better Compromise to Cover Kids," Heritage Foundation *WebMemo* No. 1635, September 24, 2007, at *www.heritage.org/research/healthcare/wm1635.cfm*.