In 2000, roughly 38.5 million Americans, or 15 percent of the population, did not have health care coverage, according to the Census Bureau. This was the lowest number of uninsured in the U.S. in years due to historically low levels of unemployment and expansion of public health care programs to cover more people during a strong economy.

With a recession, analysts expect as more people lose jobs, they will lose health insurance. The Urban Institute found that with each percentage point increase in the unemployment rate, the number of uninsured grows by 1.2 million.

The U.S. Department of Labor placed the jobless rate at 5.6 percent in January 2002. Economists predict the unemployment rate might climb to 6.5 percent by June.

The expected increase in the number of uninsured is an alarming trend. With job losses, more people become eligible for public assistance. This comes at a time when states face enormous budget shortfalls and health care costs are growing at the fastest rate in a decade. Data shows that employer-sponsored insurance premiums grew 11 percent in 2001, the largest increase in almost a decade.

“Looking across the spectrum of human service programs in the states, I can’t think of a single one that hasn’t encountered increases in the number of uninsured,” said Dr. John Santa, administrator of the Office for Oregon Health Policy and Research.

Over the last five years, a time of budget surpluses, states expanded eligibility and launched aggressive outreach campaigns, driving up enrollment in state Medicaid and State Children’s Health Programs or SCHIP. Now states are faced with difficult choices. Do they roll back eligibility in

New data from the 2000 U.S. Census Bureau shows the nation had the lowest number of uninsured in years. However, rising unemployment and rising costs are expected to result in more people being uninsured.
Medicaid and SCHIP and undo the hard-won expansions of coverage to low-income families? Or, do they take funding from other programs, try to make the dollars stretch and look for more federal money?

**Who Are the Uninsured and Why?**

Individuals of all ages and backgrounds are uninsured and, contrary to popular belief, more than 80 percent of uninsured children and adults under age 65 live in working families.

There are several reasons why people lack insurance. Access to workplace insurance is varied. The unemployed and those working in certain sectors of the economy, such as small businesses and construction, are more likely to be uninsured. “If insurance is offered at your workplace, you may not be able to afford it and there are really no other viable options,” said Paula Roy, executive director of the Delaware Health Care Commission.

Some employees who are offered insurance may decide not to enroll. Often young adults, particularly male, between the ages of 18-29 and usually in entry-level positions making lower incomes do not think that they will need insurance and do not consider the impact of an unforeseen illness or injury on their finances. “The fact remains that, even those uninsured by choice, with the intent of paying for any medical bills they may incur, still create an unnecessary burden on the system,” said Santa.

Although most people who lose their job can maintain their employer insurance coverage by paying the premium themselves through COBRA policies for 18 months, many cannot afford to do so.

Being without health insurance can have detrimental effects on individual health and society. The uninsured are less likely than the insured to have a regular source of health care, less likely to visit a physician annually and less likely to receive preventive services. Because of this, the uninsured wait too long to get care and wind up in the emergency room where treatment is very expensive. Many uninsured cannot pay their hospital bill, which shifts costs to those who can pay, thus driving up costs for those with insurance.

**Challenging times**

With growing enrollments, rising health care costs and huge budget overruns, states...
have shifted from expanding coverage to desperately trying to maintain current levels of coverage. “Almost all states are constrained by having to balance a budget, making for some tough decisions,” said Vickie Gates, director of the State Coverage Initiatives Program, Academy for Health Services Research and Policy.

States are now looking for ways to do more with less. “Medicaid is good when the economy is great, but with our current economic state and rising healthcare costs, it is inflexible. Help is needed from the federal government, healthcare providers and advocates in order to support a measure other than the all-or-nothing approach,” said Santa.

Policy experts agree that simply dropping people from the rolls to balance budgets is not the best solution. “As the uninsured rate grows, states will have to pay for the uninsured in one way or another,” said Roy. “It is better to have these people in an appropriate primary care setting instead of inappropriate settings like emergency rooms. What you don’t spend here will pop up somewhere else.”

**Bang for the buck**

States are getting the most “bang for their buck” by using federal funding options, designing innovative benefit packages and trying cost-containment measures. States are trying to contain prescription drug costs through buying consortiums or multistate purchasing pools, increased use of generic drugs, formularies, prior authorization requirements, disease management and fraud and abuse detection. Other options to control costs include cutting payments to providers and case management to eliminate inappropriate care of patients.

**Federal Waivers:** Federal waivers offer states the flexibility to use available resources to expand coverage. The Health Insurance Flexibility and Accountability

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**State planning and demonstration grants**

States received public or private grants in 2001 to plan or implement new coverage models. The Health Resources and Services Administration State Planning Grants Program awarded 20 states more than $23 million dollars.

HRSA’s one-year grants allow states to develop plans for providing accessible, affordable health insurance. States must provide a report to the secretary of Health and Human Services that identifies the characteristics of its uninsured population.

“States tried to understand the issues around affordability, what motivates behavior, how people feel about insurance, what moves them to participate and what level of encouragement a state needs to have. They were particularly interested in substate information — differences in their rural vs. urban population, and characteristics of their minority population — knowing that they would be looking at how to design programs for these special groups,” Gates said.

“Planning grants have shown us that people need to be in appropriate settings of care,” Roy said. “Supporting the safety net to give primary and preventative care is just as important as finding insurance coverage for people.”

While states may not be able to immediately act on proposed expansion options, they are exploring ways to address the issues of the uninsured in the long-term. The grant program allows states to work with constituents and decision-makers. It gives states an opportunity to influence the federal government and provide options.
Illinois, Oregon, Utah and Washington, are using the flexibility of HIFA for their programs for the uninsured.

Oregon’s HIFA proposal, if approved, would expand coverage by designing two Medicaid benefit plans. One plan would offer rich benefits, similar to Oregon’s current plan, to the state’s most vulnerable residents — including children, the disabled, pregnant women and the very poor elderly. The second plan would provide less-rich benefits to other eligible adults.

“Not giving everyone the same rich benefit, but rather spreading resources around to two groups would make resources available to other people and allow Oregon to deal with the growing numbers of enrollment,” said Santa. Arizona used HIFA to coordinate funding and benefits between the Medicaid and SCHIP programs.

Cost Sharing: Some states plan to ask Medicaid and SCHIP enrollees to pay small premiums or co-payments. Oregon uses cost sharing by asking eligible adults to make co-payments for services and contribute monthly amounts of $6 to $25 toward their insurance premiums. This method allows the state to extend services to more people instead of cutting them back. Tennessee and Rhode Island also are adding cost sharing measures to their programs. The Kentucky Legislature approved a $1 co-pay in its 2002 session.

Public-Private Partnerships: Other states are using public-private partnership to help low-wage workers with premiums so they can afford employer-sponsored health insurance. “Because the employer is contributing half or more of the cost, the state can insure two of these people for every one person on Medicaid,” said Santa.

Tennessee, for example, provides TennCare Assist, a plan to help low-income families with access to private health insurance, and helps families pay their premiums under employer-sponsored plans.

With private insurance costs rising by double-digits, some employers might be forced to drop health care coverage. “If you are looking into vulnerable small employers, how long can they maintain coverage at these costs? In turn, low-income workers may not be able to afford their share of the premium,” Gates said.

Roy agreed. “We think that we need to listen to employers, especially small employers and work with the private sector to preserve those that offer insurance.”

State Children’s Health Insurance (SCHIP) Expansions: New Jersey expanded its Medicaid/SCHIP in 2000 to eligible uninsured parents and adults without children. Despite the great increase in enrollment, the program expanded eligibility in September 2001.

States could use available funding under SCHIP to provide prenatal care for more low-income pregnant women if HHS adopts a proposed a regulation allowing states to provide health insurance coverage under SCHIP to pregnant women.

Conclusion

States have made enormous strides in the last few years in expanding health insurance to more people. The challenge now is to maintain those gains while controlling rising expenditures. Roy recommends that state leaders understand and tap their existing resources to the fullest extent. States need to look closely at their own safety net system, including community health centers and federally qualified health centers for potential sources of funding and coordination of care for the uninsured.

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