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by

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# **Rising Health Care Costs and Numbers of People Without Health Insurance**

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## **Introduction**

President-elect Bush is calling for a new spirit of cooperation in Washington. Such a spirit is particularly needed for dealing with the uninsured. Problems connected to health insurance are going to be on President-elect Bush's desk over the next four years and the country will need bipartisan cooperation to address them. In particular, two issues related to health care costs have implications for who has health insurance and how we pay for medical care.

First, the cost of health insurance and now the rapidly rising costs of medical care have made affordability the major problem for the vast majority of the uninsured. Moreover, affordability is a concern for a growing number of lower-middle income and middle income families. To reduce the price of health insurance, we need to restructure it so it is coverage for very large, catastrophic health care expenses — and not a perceived entitlement to pre-paid health care.

Second, the mapping of the human genome has tremendous implications for health insurance and what is considered an insurable medical event. Many researchers believe we will have highly accurate tests for various genetic diseases within the decade. It is quite likely that genetic therapies to treat genetic conditions will be successfully developed within the next 25 to 50 years. These advances mean that health insurance as we know it will change — and we need to be prepared for that in terms of thinking through how we will finance care for conditions that will no longer be insurable.

In what follows, I expand upon these issues and their impact on the numbers of people without health insurance. The plan of the paper is as follows. First, I briefly describe who does not have health insurance currently, and why their characteristics imply that affordability is the

main reason they are uninsured. In the second section, I discuss the implications of the rising health care costs on who has health insurance, and how rising premiums need to be addressed in efforts to reduce the numbers of uninsured. In the third section, I discuss the larger question posed by the mapping of the human genome — the need to plan now for how we will finance care for people with genetic conditions that will not be covered by private health insurance. Finally, I offer some brief conclusions.

### **Who Are the 44 Million Uninsured Americans?**

After two decades of steady increases in the number of non-elderly without health insurance, the number declined modestly (and insignificantly) between 1999-2000, according to the Current Population Survey (CPS). While the decline is encouraging, it should be viewed as an anomaly. Health care expenditures are rising rapidly again, driven especially by expanded pharmaceutical use. As a result, between 2000-2001, health insurance premiums just increased by a minimum of 10-30 percent for people in large groups, and more for people in small groups or in the individual market (Kaiser Family Fund and HRET 2000). These increases will lead to more people becoming uninsured in the future, many of whom will have higher incomes than the people who currently are uninsured.

People who do not have health insurance are a very heterogeneous group of people. Among the approximately 44 million who were uninsured almost a year ago (according to the March 2000 CPS), four demographic and socio-economic characteristics stand out:<sup>1</sup>

*Age:* As Figure 1 shows, a fourth of all uninsured are children less than 18 years of age. This is in spite of the progress made with the eligibility criteria expansions for Medicaid and the implementation of the State Children's Health Insurance Programs (CHIPs). (These programs have been successful in terms of lowering the proportion of children without insurance from

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<sup>1</sup> The data behind the four figures that follow are from the March 1999 CPS, as analyzed in Swartz (2000).

about 20% a decade ago to 15.5% today.) Including children, 81% of the uninsured are younger than 45. Thus, the uninsured are predominantly young. However, the 19% of the uninsured who are 45 to 64 years of age are a source of great worry to insurance companies because people in these age cohorts are likely to incur large medical expenses.

*Family Income:* As can be seen in Figure 2, more than half of the uninsured in 1999 had annual family incomes (in 1998) below \$25,000. Two-thirds had incomes below \$35,000.

It also appears that a fifth of the uninsured had family incomes at or above \$50,000. This proportion is a testament to both the strong economy and the effects of welfare reform. But almost half of these “high income” uninsured live with their siblings, or adult children, or parents — that is, people are sharing a house and because they are related, their income is pooled for “family income” calculations. This phenomenon explains why half of the high-income uninsured have family incomes above \$50,000. But when the income of the uninsured is analyzed in terms of family units considered eligible for insurance by insurers — so-called insurance family units — only 12% of the uninsured have insurance family unit incomes above \$50,000.

When the uninsured are analyzed in terms of income relative to the poverty level (not shown here), two-thirds have family incomes below 250% of the federal poverty level. (The 1998 poverty level of income for a family of 4 was \$16,600, and for a family of 3 it was just over \$13,000.)

Thus, in analyzing the uninsured in terms of income, it is clear that they are predominantly poor to middle-income individuals and families. Affordability of health insurance premiums is an issue for them.

*Health Status:* A common misperception of the uninsured is that they are sick and in poor health. However, as Figure 3 shows, only 2.5% of the uninsured (a million people) report being in poor health. Another 7% indicate they are in fair health. While these self-reported health status responses may be under-reporting serious health conditions, it is nonetheless the case that the uninsured do not include large numbers of people in poor health.

*Labor Force Status of Adults:* As has been true for at least the last two decades, 60% of the uninsured 18 to 64 year old adults are employed, and another 8% are unemployed but looking for work (see Figure 4). The remaining one-third are out of the labor force (retirees, unable to work, or people whose major activity is working at home but not for pay). Many uninsured workers are not offered coverage by their employers.

The uninsured adults who are in the labor force are also people who are least likely to be helped by a strong economy, and most likely to have their jobs at risk in a poor economy. They are disproportionately less likely to have obtained an education beyond high school — two-thirds had only a high school diploma or had not finished high school. Among all adults who have not finished high school, more than a third (37%) are uninsured; and more than a fifth of those with only a high school diploma were uninsured. The educational attainment of the uninsured is consistent with the occupations that have the highest numbers of uninsured workers and the highest proportions of workers who are uninsured.

*Summary:* Although the uninsured consist of many different types of people, they are predominantly poor and disproportionately children. The financial circumstances of the uninsured are explained in large part by the fact that the adults are disproportionately less educated and a large percentage of the uninsured adults work in unskilled and less-skilled occupations. Clearly, a lack of skills and education affects not only the incomes of the uninsured but also their chances of obtaining jobs that offer health insurance as a fringe benefit.

The children without health insurance are also quite poor. Thirty percent of the uninsured with incomes below 250% of the poverty level are children. These poor children account for just over 75% of all uninsured children.

Thus, the question facing us is: how do we design policies to address the causes of poor people and children being uninsured? In particular, since the price of health insurance relative to the incomes of the uninsured seems to be the primary reason they are uninsured, what can be done to make insurance more affordable to the uninsured? Affordability is especially important also for currently insured people who may be paying substantial shares of employer-sponsored

insurance premiums.

### **Implications of Rising Health Care Costs for Affordability of Insurance**

As I noted in the Introduction, two factors will cause health insurance issues to land on President Bush's desk in the next four years. First, health care costs and insurance premiums will continue to rise, pricing more people out of the market. Second, the mapping of the human genome and advances in genetic testing accuracy will exacerbate adverse selection problems in insurance markets.

#### *Rising Health Care Costs*

Health care costs are rising again largely because we have been making exceptional advances in medical technology and pharmaceuticals. Many of these advances are producing better health for millions of Americans (McClellan 2000). But most of the treatments are costly, and because many involve conditions that previously might not have been treated, aggregate health care expenditures are now rising rapidly (Hogan, Ginsburg, and Gabel 2000). This year, we are seeing health insurance premiums increase at rates of 10-30 percent for people in large groups, and higher rates for people in small groups or with individual coverage (Kaiser Family Fund and HRET 2000).

Managed care has not been the promised magic bullet in restraining these costs. The explanation is straightforward. The shift towards managed care has increased the proportion of the population who now have benefits packages without extensive cost-sharing requirements. This cost-sharing structure has increased the perception that health insurance policies are pre-paid health care — a perception of entitlement that increases people's demand for all available treatments. When managed care plans have directly restrained this use, the public has rebelled against restrictions on the physicians, hospitals and treatment options they can use. This has brought us first-dollar coverage without managed care's constraints on utilization.

Ironically, the strong economy and tight labor market of the past few years are contributing to rising health care costs and the number of uninsured. The tight labor market has

made it difficult for employers (as the major sponsors of health insurance) to restructure health insurance so that employees face higher cost-sharing requirements. Similarly, employers have responded to employee unhappiness with managed care constraints by permitting more choice of health care providers in their plan offerings. Thus, managed care's ability to restrict people's use of more expensive providers has been blunted in part because of the strong economy. Whether the current softening of the economy continues so that employers feel they can exert more pressure on employees for changes in their health insurance policies is an open question at this point.

Although the number of uninsured declined between March 2000 and 1999, that decline is likely to be an anomaly in the two plus decades we have been tracking the number of people without insurance. To put this in perspective, and relate it to what it more likely to occur this year, the number of uninsured rose by more than a million people between March 1998 and 1999, in spite of the tight labor market. Some of the increase in uninsured numbers is due to people leaving welfare rolls and Medicaid, but much of the increase is due to people who apparently cannot afford their share of the rising health insurance premiums. As we just saw, most of the uninsured have low to low-middle family incomes. The premium increases of 10 to 30% that are now going into effect for 2001 for large groups (and more for small employers and individuals) will cut into the family budgets of similar people, and it is likely that more low to middle income people will opt to be uninsured or their employers will stop offering health insurance as a benefit.

Current proposals to provide financial incentives to low-income uninsured people so they will purchase health insurance (direct subsidies or tax based incentives) start with the assumption that the type of health insurance we have today — especially managed care coverage — is what everyone should have. But as I noted earlier, the types of policies that most people have today are first-dollar coverage plans — that is, the vast majority of insured people pay very little cost-sharing at the point of obtaining medical services, and do not face a deductible. The proposals for providing financial incentives for uninsured people to purchase health insurance all involve

this type of first-dollar coverage. However, it is highly unlikely that government provision of subsidies or tax-based incentives will be able to keep pace with the rising premiums that will continue so long as insurance encourages greater use of high-cost services. The result will be a large portion of the population who will be unable to afford their share of the premium (the premium net of the subsidy) and will be disappointed that they were not helped by these proposals. The numbers of people without insurance will begin to increase again. Thus, these proposals are only partial solutions — they will help people for a short period of time, but then they will not be sufficient to help many people unless there are large increases in government funding.

*On the Horizon: Genetic Testing Will Alter Insurance*

Looming over the issues of rising medical costs and affordability of insurance is the fact that tests for many genetic conditions will become highly accurate during the next decade. Insurers will not want to cover care for conditions that people will have a very high probability of having, and individuals who know they are very unlikely to have certain conditions will not want to pay for coverage for those conditions. As a result, the very nature of health insurance is about to change. Adverse selection problems caused by the availability of highly accurate genetic tests will start pushing the issue of affordable health insurance into middle- and upper-middle classes, groups that have been able to afford health insurance until now.

**Restructuring of Health Insurance is Needed**

The dilemma facing health policymakers is this: On the one hand, standardized policies (in conjunction with other regulations) are an effective means to prevent insurers from selecting against high-risk people. As a result, standardized policies can increase access to insurance for all types of people. But on the other hand, the majority of standardized policies currently available are generous and expensive – making them unaffordable to low-income people. Further, low-risk younger people who do not focus on the insurance aspect of managed care policies and see them as pre-paid medical care that they are not likely to use, view the

standardized policies as poor value and do not purchase them. Thus, creating less comprehensive policies that would cost less increases the likelihood that low-risk and low-income people will choose coverage rather than being uninsured. But permitting such policies almost surely will result in a two-tiered system of full-insurance policies bought only by high-risk people (who will be discouraged from the less comprehensive policies) as well as by some high-income, low-risk people, and then less comprehensive policies for low-income and low-risk people. Offering different types of policies runs the risk that people will separate not just in terms of what they know about their own risks, but also on income.

One option for addressing the dilemma is to reverse the trend towards managed care plans and encourage employers and individuals to adopt indemnity policies that do not provide first-dollar coverage but are catastrophic in nature. By that, I mean policies that have high deductibles and coinsurance rates that discourage more questionable visits to a provider. The level of the deductible should be set high enough that some high proportion of the population – somewhere between 70 and 90% – will have annual medical expenses below the deductible. The deductible level also should be set equal to some proportion of people’s family incomes – perhaps 7% or 10% – so the deductible does not become a regressive way of rationing health care to people with lower incomes.<sup>2</sup> Setting the deductible equal to a percent of a person’s income rather than determining higher deductibles for higher income groups avoids the well-known “notch” effect at the points where the deductible jumps with increased income. So as to reinforce public health objectives, expenses for immunizations, well-child care, screening tests, and preventative medicine should be exempted from the deductible. The cost effect on the premium of exempting different types of services from the deductible would need to be estimated.

Preliminary estimates from the 1996 Medical Expenditure Panel Survey (MEPS) indicate that the top 1% of the population accounted for 28% and the top 5% accounted for 55% of all

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<sup>2</sup> This proposal is quite similar to that of Feldstein (1971).

medical expenditures.<sup>3</sup> Further, 68% of the population had annual medical expenditures below \$1,000, 80% below \$2,000, and 91.5% below \$5,000; only 4% of the population had expenditures above \$10,000. However, these latter estimates include people without health insurance, as well as people with Medicare and Medicaid so they are likely under-estimates of the effects of health insurance on health care spending. Gruber and Feldstein (1995) analyzed medical spending of insured non-elderly people, using the 1987 National Medical Expenditure Survey (NMES) and adjusting income and medical spending to 1995 dollars and levels. They also did not analyze individual health spending but spending by insurance family unit (IFU). They estimated that 52% of IFUs had medical spending below \$1,000, 66% below \$2,000, and 81% below \$5,000; 10% had spending above \$10,000. Both sets of estimates indicate that a deductible for individuals could be set between \$2,000 and \$5,000, and most people would not have expenditures that would qualify for insurance coverage.

However, we also know that health care expenditures are highly skewed. Berk and Monheit (1992) estimated that through 1987, 30% of the population accounted for about 90% of total medical expenditures, and 10% of the population accounted for about 70% of total medical expenditures in the years studied. This means that setting a deductible equal to \$5,000, for example, would not affect most health care spending – as Gruber and Feldstein estimated, 79% of all medical spending came from the 19% of the IFUs with expenditures above \$5,000 (Gruber and Feldstein, 1995). On the one hand, people with such high medical expenditures certainly may have expenses that are catastrophic in terms of the fraction of their income that is being spent on medical care – and therefore insurance should be stepping in to pay for such care. On the other hand, the marginal cost of health care above the deductible is zero and people will not be sensitive to the costs of medical care above the deductible.

One way to insure that people will be sensitive to medical care costs and view insurance as paying for catastrophic levels of care is to set the deductible equal to a percent of income

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<sup>3</sup> Personal communication from Alan Monheit, January 5, 2000.

rather than a dollar amount as discussed above. In 1997, median family income of families with a non-elderly householder was \$47,825 (U.S. Bureau of the Census, 1998). As a rough approximation, if the deductible were set equal to 10% of family income, half of all IFUs would have deductibles below almost \$5,000. The other half would have progressively higher deductibles, which would increase the amounts of spending for which people would be sensitive. Another way to increase the level of health care spending for which people are sensitive to costs would be to combine a high deductible with a coinsurance rate for expenditures above the deductible and a stop-loss limit on total out-of-pocket spending that could be a percent of income. Under this plan, an individual pays the full cost of health care up to the deductible, and then the coinsurance percent of the costs above the deductible until the total out-of-pocket expenditures equal a percent of income. There are numerous possible permutations of a plan with a coinsurance rate and a stop-loss on out-of-pocket expenditures.<sup>4</sup>

The aggregate effect on health care spending of a catastrophic insurance policy depends on the price elasticity of demand for health care, of course. But the reason for advocating a restructuring of health insurance to a catastrophic plan is that the price elasticity of demand for physician and hospital care is somewhere between -0.2 and -0.5 (Newhouse, et al. 1993; Gruber and Feldstein 1995; Phelps 1997). These price elasticities imply that health care demand will decline under a catastrophic plan, since people will face the full costs of care up to the deductible.

The administrative details of catastrophic insurance policies might be debated but I would urge the following be implemented. The deductible should be set for an individual rather than a family. The RAND health insurance experiment demonstrated that people are quite responsive to price, and that a deductible per individual is preferable to a family deductible if one of the

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<sup>4</sup> For example, Gruber and Feldstein (1995) estimated the effects of two plans with 50% coinsurance rates up to a maximum limit on spending of 10 and then 15% of income, and a third plan that is a catastrophic deductible plan where the deductible is 15% of income. They did not combine a deductible with a coinsurance rate above the deductible until a stop-loss is met.

goals is to reduce unnecessary demand for health care (Newhouse, et al, 1993). On the other hand, income should be pooled for the family unit in which the individual is living. This is consistent with other government practices of measuring a person's economic well-being by family income. Income should be measured in an annual accounting time-frame, and the previous year's income should be the basis for determining an individual's deductible for the current year. An annual accounting period is far less expensive to administer than monthly or quarterly accounting periods, particularly because family units can experience changes in composition during the year. An appeals process could be created to deal with families that have significant changes in income or family composition and therefore experience a hardship during a year. People with chronic conditions who perennially exceed their deductibles could be permitted to spread their deductible over the year rather than having to meet it before the insurance began to pay for their medical costs. Finally, supplemental insurance plans (including medical savings accounts) to pay the deductible would not be permitted. Such policies would defeat the purpose of creating catastrophic insurance policies.

There are several advantages of shifting health insurance to indemnity coverage with catastrophic deductibles. First, the premium will be substantially lower than premiums for current policies because people will be responsible for medical expenditures up to the level of the deductible. This will permit insurance policies to be affordable to a larger fraction of people with low incomes. Lower premiums with less comprehensive coverage will also be more attractive to low-risk people who do not want full-coverage and therefore may not purchase coverage now. Second, as Feldstein argued more than 25 years ago, catastrophic policies reduce the welfare loss associated with generous health insurance (Feldstein, 1973). Gruber and Feldstein (1995) estimated the welfare gains and losses associated with different coinsurance rates and deductible or stop-loss levels as a percentage of income, and levels of risk aversion held by individuals. Their estimates show that welfare loss will be reduced most if the deductible or combination of deductible and stop-loss on out-of-pocket spending reaches further up the distribution of health care spending – but individuals also value having the risk of higher

expenditures shifted to insurance. Thus, they argue that the net welfare gain is greater under a plan with a relatively high coinsurance rate and a stop-loss than a plan with a high deductible that is below the stop-loss level. Third, catastrophic policies help remind people that health coverage is not pre-paid medical care, which is how the current managed care plans are often viewed. Catastrophic insurance by its very nature permits consumers to pay insurers to bear the small risk of some very costly event occurring to the consumer. Fourth, catastrophic insurance will force consumers to bear the full marginal costs of health care up to the point where their use of health care exceeds the deductible. Making people more aware of the true costs of health care also will help reduce consumption of health care that has a marginal benefit below the marginal cost. The moral hazard incentives to consume health care beyond the point where the marginal costs equal the marginal benefits are removed for expenditures below the deductible.

There are, to be sure, problems with indemnity coverage. Primary among them is the issue of how health care providers, especially physicians, are paid. Historically, indemnity insurance has paid providers on the basis of a fee schedule or some proportion of “usual and customary” charges for services provided. This payment system, combined with asymmetric information between consumers and providers, has obvious incentives for providers to provide more services. However, if individuals have to pay all of the charges up to the deductible level and then a percentage of charges above the deductible up to a maximum or stop-loss level, providers may be more prudent in their provision of services. Related to the incentives to provide more services under a fee schedule payment arrangement is the notch effect at the deductible level. Once a person has met the deductible, the level of restraint on consuming more health care services is greatly reduced. A coinsurance rate up to a further maximum out-of-pocket expenditure level (also set equal to some percent of family income) will mitigate the notch effect. However, people who have health care expenditures above the deductible will generally be very sick and decisions about further services usually involve quite lumpy expenditures. That is, additional services for very sick people typically cost thousands of dollars. According to Berk and Monheit (1992), the average expenditure for individuals in the top 1% of

health care spenders in 1987 was \$47,331 (in 1987 dollars). As noted above, high deductible and a coinsurance rate will help restrain low cost medical services, but they are unlikely to affect expenditures above the deductible or the stop-loss level. As Aaron (1991) has argued, the only way to reduce health care expenditures for such very sick people is to ration services to them rather than relying on consumer or provider cost-sharing mechanisms to reduce such care. Restructuring insurance so it is catastrophic insurance will focus attention on the need to either invent lower cost methods of treating what are currently high-cost illnesses or ration services for high-cost illnesses.

Some may argue that a political disadvantage of shifting to indemnity coverage is that managed care plans have become a dominant force within health care. However, managed care cannot restrain the rate of increase in health care expenditures — it is increasingly evident that managed care has not been able to deliver on the promise to do so. Further, the backlash of consumers against managed care provides strong evidence that consumers do not want managed care as we have known it (Swartz, 1999).

Restructuring insurance so it is catastrophic indemnity coverage will not fully resolve the issue of making insurance financially attractive to very low-income people. Substantial subsidies will be needed for very low-income people if we expect large proportions of them to become insured (Swartz 1988; Marquis and Long 1995). Currently, if uninsured low-income people need medical care, they rely on the health safety net present in most communities — hospitals and physicians who will provide care in hospital outpatient departments, clinics, or community health centers. In emergencies involving surgery or hospitalization, uninsured people also can obtain inpatient hospital care. In this environment, there is little incentive for a low-income person to obtain health coverage that will not pay for any care until a deductible that is high relative to their income has been met.

For many uninsured low-income people, the problem with using the health safety net is that it is extremely difficult to obtain appointments with physicians at clinics or hospital outpatient departments, and to have continuity or constancy in the source of care. In addition,

uninsured low-income people may resent the rebuffing they get from physicians in private office settings who will not see patients who do not have health insurance. Evidence is emerging, however, from several demonstrations that were implemented to gauge the demand among low-income people for policies with limited outpatient benefits (for example, New York State's short-lived Voucher Program). Low-income people are indeed willing to pay small amounts – \$17 to \$30 per month – to obtain such policies. The attractiveness of such policies appears to be that they provide an entrée card to medical providers outside of the health safety net. The absence of benefits for inpatient hospital services does not leave people any worse off than they are when they are completely uninsured – the health safety net is still there for them.

The significance of the popularity of subsidized policies with limited outpatient benefits is that it contradicts the need for standardized insurance policies as a means of increasing access to insurance for all types of people. Clearly, the limited benefits policies are attractive to low-income people who otherwise might not purchase coverage. This raises the question whether the dilemma described above shouldn't be addressed by permitting several types of standardized policies to be sold to people – limited outpatient benefits policies for low-income people, and, for people with higher incomes, standardized policies that include catastrophic, high deductibles so that low-risk people will be willing to obtain coverage. The answer to this question depends on the extent to which higher income people would be permitted to purchase limited outpatient benefit policies.

### **Concluding Comments**

Reducing the number of Americans without health insurance can be accomplished by a variety of means. We could create a mandatory system of government sponsored coverage, much like Medicare. Or we can choose to retain the current system based primarily on private sector coverage. The advantage of retaining private health insurance is that competition between insurers provides pressures for efficiency and efforts to reduce costs.

But if the dominant form of health coverage available in the private sector continues to be

first-dollar coverage, it will become (if it is not already) too expensive for many people. We are already seeing indications that affordability of health insurance is an issue for people with higher levels of income. If this persists, we soon will reach a point where people will separate themselves — or be separated — not just on perceived health expenditure risk but also on income. If this happens, the divide between the “haves” and the “have nots” could become a cause for a social disaster. There is an urgent need, therefore, to restructure health insurance so that it is affordable — and accessible — for most Americans.

The real problems underlying health insurance — rising costs and a first-dollar coverage structure of health insurance that encourages the use of more expensive protocols — are not addressed by the current proposals to help the uninsured. These proposals will not be very successful so long as the costs of insurance keep rising at their current rates. Subsidy proposals will work for a short time to reduce the numbers of uninsured but as the costs of medical care and health insurance continue to rise, they will need much more money if they are to continue to attract the uninsured. I am not saying the programs to help low-income people in their purchase of insurance should be discarded while we restructure health insurance. I am simply saying that focusing on these proposals without simultaneously trying to restructure health insurance will lead to huge disappointments.

Restructuring of health insurance — perhaps so that it is more catastrophic in nature (with catastrophe defined relative to income) — needs to occur if insurance is to be affordable for most Americans. In addition, looming over the need to restructure insurance policies is the fact that within the next decade we will have highly accurate tests for a large variety of genetic diseases, and within the next 50 years we will have genetic therapies that are safe for dealing with many genetic diseases. The implications of these advances — many of which will cost us less than current treatment methods for various diseases — are enormous. Fear of adverse selection will cause insurers to decline to cover costs related to certain genetic diseases. Health insurance as we have known it will change — and we need to think of that in our efforts to reduce the number of uninsured.

Thus, President-elect Bush and the Congress cannot escape the issues surrounding rising health care costs and the number of people without health insurance. For starters, policymakers should discuss the need for moving the country away from first-dollar coverage of medical services. The use of financial incentives for individuals to plan for and budget for predictable medical care services would return us to thinking of health insurance as insurance rather than an entitlement of pre-paid medical care. Cost-sharing requirements also should become linked to one's income so that insurance is reserved for catastrophic medical expenses. And finally, we need to start planning for how insurance will change as a result of coming advances in treating genetic diseases and conditions. The role of government in financing medical care related to genetic therapies needs to be anticipated. The current rapid rise in health care costs and health insurance premiums should be a catalyst to all of us to restructure insurance and determine how we will finance care for genetic diseases before millions more Americans become uninsured.

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