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ISSUE BRIEF

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Health Coverage Issues: The Uninsured and the Insured

The availability and adequacy of health insurance coverage in the United States is an important issue among consumers, health care providers, employers, insurers, and policy-makers, and one that is difficult to resolve. According to the most commonly used estimates, there are currently about 46 million people under the age of 65 who are uninsured. Another 10 million or more are transitionally uninsured — that is, without coverage for some portion of the year.¹

As policy-makers at the federal, state and local levels tackle the problem of the uninsured, it is important to understand both the sources of coverage for those who are insured, as well as the characteristics of those who are not. This issue brief provides an introductory discussion of where Americans get their insurance and discusses who the uninsured are and why they are uninsured.

This paper is an update of a September 2003 issue brief. It establishes the direction for future issue briefs that will provide insights on fundamental questions facing policy-makers and health coverage sponsors, such as:

- What is health insurance coverage?
- What are ways to provide health care for the uninsured?
- What are the roles of individuals, employers, and government in health care financing?

To help clarify the reasons why people lack insurance and to aid in our discussions in future briefs, we have partitioned the uninsured into the following categories:

1. Financially Uninsured – Voluntary
2. Financially Uninsured – Unaffordable
3. High-Risk
4. Low-Income – Eligible for Public Programs (Not Enrolled)
5. Low-Income – Not Eligible for Public Programs

This discussion is presented in the context of health insurance coverage and does not include other personal insurance products such as disability or long-term care. Terms used, such as health insurance coverage or health coverage, are intended to be generically inclusive unless specifically stated. Insured is used throughout this paper to include those individuals with insured health coverage, including HMOs, as well as those individuals covered by self-insured employer or union medical plans and public programs, such as Medicaid. Throughout

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this paper, the focus will be directed at the civilian population aged under 65. This paper also recognizes that there are “counting” differences in the sizes of various uninsured and Medicaid populations, but those differences do not affect the underlying issues.²

WHERE DO AMERICANS GET THEIR INSURANCE COVERAGE?

While Medicare provides nearly universal health insurance coverage to nearly all elderly Americans, the under-65 population obtains health insurance coverage through a variety of private and public sources (Table 1).

Table 1
Sources of Health Insurance Coverage Among the Non-elderly

Source of Coverage	2002		2003		2004	
	Number (in millions)	Percent	Number (in millions)	Percent	Number (in millions)	Percent
TOTAL	251.7		253.6		255.9	
Employer	163.7	65%	161.8	64%	161.7	63%
Other Private ³	16.5	7%	16.5	7%	17.0	7%
Medicaid/SCHIP	30.0	12%	32.5	13%	34.2	13%
Other Public ⁴	13.6	5%	14.0	6%	14.5	6%
Uninsured	43.3	17%	44.7	18%	45.5	18%

Derived from the March Current Population Survey published as revised August 2005 (see www.census.gov).

The numbers in Table 1 total 273 million in 2004 (269 million in 2003 and 267 million in 2002) whereas the total non-elderly U.S. population was 255.9 million in 2004. As is typical with such studies, this disparity is due to overlap among the groups. For example, an individual might have had coverage through Medicaid and other public coverage at some time in the year, and therefore could be counted in both categories. However, the uninsured were without coverage for the entire year.

Source of coverage categories may also be collected differently, defined differently by different analysts, and represent different points in time. The American Academy of Actuaries is not attempting to reconcile counts from other sources and government agencies, all of which have invested substantially in the tabulation process. We have shown the numbers in Table 1 as reported by the Census Bureau, based on the Current Population Survey (CPS). The CPS estimates are the most commonly used estimates of the uninsured. As outlined in endnote 1, the Congressional Budget Office estimated that for 1998 between 21 million and 31 million people were uninsured for the entire year; that each day some 40 million, on average, were uninsured; and that during the year approximately 60 million were uninsured at some time.

In many cases, being aware of overlaps and alternative definitions in categorizing the insured and uninsured, and being aware of how the populations are counted helps identify policy issues that need to be addressed. In measuring the size of such populations, it is important to factor in this overlap and to identify the source from which an individual obtains primary coverage.

- *Employment-Based Coverage.* Most of the insured have employment-based coverage, either through their own employer or union, or as a spouse or dependent. About 162 million, or 63 percent of the under-65 population, had employer-sponsored health insurance coverage in 2004.

The popularity of employer-based programs has been heightened by the tax-favored status to both employer and employee, and the generally lower personal contribution requirement from the employee. Employer contributions and the resulting benefits (insured or self-insured) are a tax-deductible business expense and are not taxable income to the employee. Employee contributions can be structured to be payable on a pre-tax basis. In addition, economies of scale can reduce administrative loads and stabilize various risks, especially for larger groups.

- *Other Private Coverage.* Other private coverage provides a source of health coverage for 17 million individuals. The majority of individuals in this category have been reported as self-employed or workers (and their families) who do not have access to employer group coverage. While self-employed individuals can use premiums to reduce their taxable income, the remaining workers who do not have access to employer group coverage must purchase their own (and their family's) health insurance with less favorable tax treatment.
- *Medicaid and SCHIP.* Medicaid and the State Children's Health Insurance Program (SCHIP) are federal programs implemented at the state level that pay for medical care for much of the nation's individuals and families with low incomes and limited resources. Medicaid provides health coverage to certain categories of low-income adults and children. SCHIP is health coverage for children in low-income families whose incomes exceed Medicaid eligibility requirements. Within broad federal guidelines, each state has flexibility when determining its own Medicaid and SCHIP income and resource eligibility levels and benefits. As a result, the programs vary greatly across states. Together, Medicaid and SCHIP cover about 34 million children and adults, or about 13 percent of the non-elderly population.²
- *Other Public Coverage.* Other public programs such as Medicare, Department of Veterans Affairs (VA) health care, and TRICARE are sources of health coverage for specific populations. Medicare, which provides coverage to the population aged 65 and older, also provides coverage to some disabled individuals and to those with end-stage renal disease. VA provides medical care for eligible veterans,⁵ TRICARE (formerly CHAMPUS) provides coverage for active duty and retired military members and their families, and CHAMPVA provides coverage to dependents of veterans severely disabled or deceased due to service-connected conditions. Together, these public programs cover about 14.5 million, or 6 percent, of the under-65 population. Most of the health care provided by VA and some of the health care provided by TRICARE is by direct service through VA hospitals, VA clinics and military treatment facilities. Throughout this paper, the focus will be directed primarily at the active non-Medicare eligible populations and only incidentally on the public program-eligible populations and those covered as a result of military service.

Uninsured. In the most recent years, it is estimated that about 46 million, or some 18 percent, of the under-65 population lacked health coverage for an entire year. The sections that follow provide additional information on the characteristics of the uninsured population.

WHO ARE THE UNINSURED?

Table 2 shows uninsured categories for 2002, 2003 and 2004 and the estimated number in each from a study done by the Kaiser Commission on Medicaid and the Uninsured.

Table 2
Characteristics of the Uninsured

	Number (in millions)		
	2002	2003	2004
Estimated Total Uninsured	43.3	44.7	45.5
<u>Characteristics</u>			
Workers and Their Families			
Full Time	30.0	30.8	31.3
Part Time	5.3	5.5	5.7
Low-Income Adults and Children	27.8	29.2	29.3
Low-Income Adults and Children Eligible for Medicaid or SCHIP	12.0*	12.5*	12.3*
Adults and Children in Poor Health	3.9	4.1	4.2
Low-Income Non-citizens in U.S. 5 Years or Less	2.9	3.4	2.8

Source: Kaiser Commission on Medicaid and the Uninsured, 2002, 2003 and 2004 Data Updates "Health Insurance Cover-

* This is the sum of: (a) the number of uninsured children in each year, multiplied by the estimated percentage (84%) of low-income children eligible for SCHIP or Medicaid (see “Enrolling Uninsured Low-Income Children in Medicaid and CHIP” updated May 2002, at <http://www.kff.org/medicaid/217703-index.cfm>), plus (b) the number of uninsured adults in each year, multiplied by the estimated percentage (30%) of low-income adults eligible for Medicaid.

If you add the population for each year in each category of Table 2, you will get a number approaching twice the total estimated uninsured population for that year. Again, the reason for this is overlap: an individual can be counted in more than one category. Also, the categories in Table 2 can be and are defined differently by different analysts.

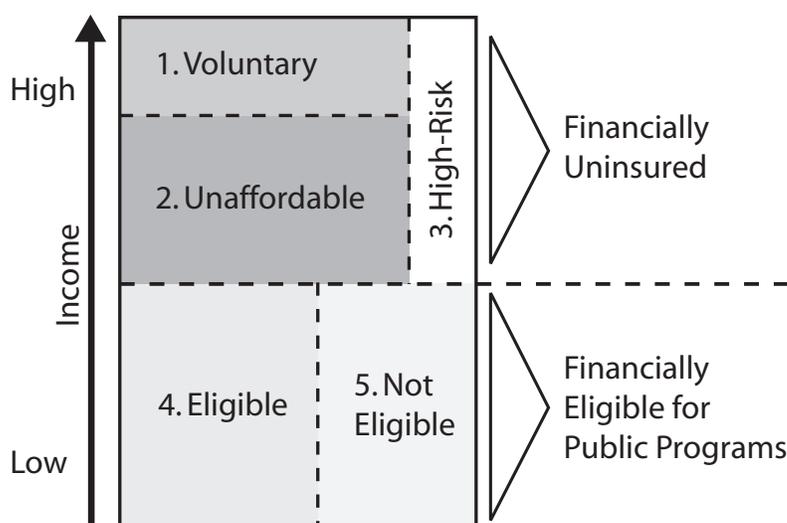
Categories of the Uninsured

To better describe the characteristics of the uninsured, we have partitioned the population into five major categories related to the principal reasons for the lack of health insurance. Figure 1 shows the distribution of these uninsured categories. The illustration is meant to facilitate discussion of the issues. For example, what uninsured categories would be impacted if a government initiative benefited those with higher or lower incomes, those who have difficulty enrolling in Medicaid or SCHIP, or those who are in very poor health? An understanding of issues facing those in each of the uninsured categories may lead to the development of more tailor made solutions.

The five uninsured categories illustrated are discussed below Figure 1. We discuss these categories as if they are mutually exclusive (no overlap between them) even though a person may have characteristics of more than one category and even though different readers may have a different view as to the primary reason this person is uninsured.

To develop these categories, we started with the estimates from the Kaiser report, and then used information from other studies and surveys to develop observations regarding the underlying cause of the uninsured status. Our portrayal in Figure 1 is based on these observations, and the relative proportionality of the number of uninsured by category would shift if our observations changed. In some cases, what is considered an appropriate assumption might also vary, depending on political and social factors. The illustration makes it easier to visualize the impact of income or income eligibility levels on the uninsured category someone would be in. If the actual size of any one category is smaller than illustrated, it still does not eliminate the problems we discuss facing the uninsured in that category.

Figure 1



Note: The income level at which an individual becomes eligible for public programs varies by state and program. Dashed lines represent that differences among categories vary based on various assumptions about how income influences a person’s ability and desire to acquire insurance, or about what changes are made in public program eligibility requirements.

Financially Uninsured

Those individuals not eligible for public programs who choose not to purchase insurance on their own or through their employer are considered financially uninsured. The financially uninsured can be broken into two categories:

- (1) *Voluntary*: those who choose not to purchase coverage, and
- (2) *Unaffordable*: those who want to purchase health coverage but cannot afford it (i.e., they do not have the resources).

Determining which category an individual falls into requires some assumptions about how many at each income level could conceivably buy health coverage but choose not to. Many political and social factors affect the decision about where to draw the line between these two groups.

Issues surrounding affordability raise concerns such as priority, attitude, and expectations in the U.S. population. The perception of what is affordable varies by the percent of insurance costs covered by the individual directly vs. a third party. Most of those with generous employer health benefits do not understand the size of the total health premium expenditure or the fee levels that hospitals or physicians charge for services. People buying individual health insurance frequently choose relatively high deductibles, compared to employer-provided coverage in larger group plans. This could be based on affordability issues, or because they choose benefit packages more appropriate to their personal situations compared to what the employer might offer.⁶

In 2001 nearly half of uninsured employees worked for smaller firms that did not offer health coverage. While almost all large employers offer health coverage, an increasing number of their employees remain without coverage. Many employers require a waiting period, some as long as 12 months, before new employees are eligible for coverage. Twenty percent of uninsured employees did not elect coverage even when their employer offered it. More than half those refusing coverage said their required contribution was too expensive. Low-income employees and those under age 25 had the lowest take-up rates. Part-time workers are less likely to be eligible for employment-based health coverage, even if their firms offer coverage to full-time employees.⁷

High-Risk

This category consists primarily of those people who are not eligible for employer-sponsored coverage and are financially uninsured due to medical conditions or occupations that cause insurers to either charge premiums too high for the individual to afford, or (in non-guaranteed issue markets) decline to offer coverage.

In a typical large group of covered individuals, a small percentage of individuals generates a substantial proportion of covered benefits. For example, in an insured population discussed in a previous Academy study, 12 percent of the individuals accounted for 77 percent of the total expected charges for the population.⁸ Some are high utilizers because of a one-time or random event; the others would be consistently high utilizers. Thus, the average cost of the high utilizers will be much greater than the average cost of the other covered individuals. While this example is for a large insured group, similar cost relationships exist in the uninsured population between high-risk individuals and the rest of the uninsured population who are not eligible for public programs.

The individuals in the high-risk category are expected to incur medical costs significantly higher than average due to their medical history (e.g., diabetics) or their occupational risks (e.g., coal miners.) It is estimated that the medical costs of less than 4 million people in the high-risk category could be as great as the medical costs of 10 million or more individuals of average health. The higher costs associated with providing voluntary health coverage to a pool of high-risk individuals can result in very high premiums, which can make the coverage unaffordable without external subsidies.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) increased the ability of this segment of the population to obtain health insurance, in part by guaranteeing the right to purchase coverage to certain individuals who lose employment-related coverage.⁹ While HIPAA does guarantee the availability of coverage to these individuals, when coupled with varying state legislation, there may not be a limit on the amount an insurer can charge for that coverage. If a state adopts a funding or pooling mechanism for high-risk individuals, risk spreading or subsidization occurs. However, if the state does not adopt such a funding mechanism, there is no limit on the premium that needs to

be charged to these high-risk individuals. Data for individuals covered by the portability coverage of HIPAA confirm that medical costs are significantly higher in this segment.

Low-Income — Eligible for Public Programs

According to the Centers for Medicare and Medicaid Services (CMS) program data, Medicaid and SCHIP provided coverage to more than 37 million people under the age of 65 in fiscal year 2002.² However, available studies provide strong indications that these programs are not reaching all the people they are designed to serve. (The Urban Institute has estimated that in 2000, approximately 30 percent of the non-elderly who were eligible for Medicaid or SCHIP were not enrolled in those programs.)

There are many reasons why someone who is eligible may be uninsured. Some are unaware of the Medicaid and SCHIP programs, or are unaware that they and/or their children qualify. Others are reluctant to enroll due to administrative, language, and/or cultural barriers; they may feel stigmatized by public assistance; or because they are healthy and feel no need to enroll. Indeed, prior enrollment is not usually required to receive health coverage under public programs. From time to time, States have increased their outreach efforts, and tried to reduce the administrative hassles associated with applying for Medicaid or SCHIP. Even with these improvements, Medicaid and SCHIP are unlikely to cover all who are eligible.

One of the sources of confusion when it comes to eligibility is that eligibility varies by state and varies over time as states struggle to manage their costs. As a result, there can be no consistent public knowledge about who is eligible and what the income requirement is.

For similar reasons, not all low-income veterans enroll for VA health care. One of the factors that depressed enrollment in the past was lack of access to VA hospitals. Although there are over 150 hospitals nationwide, many veterans live where there is no VA hospital nearby. However, from 1995 to 2003, VA increased the number of community-based outpatient clinics around the country from 102 to 676, making primary care much more accessible to veterans. Another reason some low-income veterans do not come to VA for health care may be that they are covered by other public programs such as Medicaid.

Having a low-income does not, by itself, qualify a person for public health coverage or cash assistance programs. For example, low-income childless adults who are not veterans may not qualify for any public program. The “Low-Income Not Eligible for Public Programs” (Not Eligible) category of the uninsured includes those who fail to meet the various non-income criteria that these programs require.

Cash assistance programs were some of the first public programs offered to low-income individuals and their families. Non-income criteria were also required to help limit eligibility to those deemed to have a socially acceptable reason to receive cash assistance. Since many public health insurance programs are extensions of cash assistance programs, their eligibility is often tied to non-income criteria.

Listed below are some of the non-income eligibility criteria that may be required by public programs:

1. Low assets	6. Under an age limit for children
2. Large family size	7. Disability or blindness
3. State of residence	8. Citizenship or U.S. residency status
4. Pregnancy	9. Military service
5. Marital status	10. High medical expenses

Those who meet non-income eligibility criteria can find they are later ineligible due to a change in marital or pregnancy status, age, or family size. If a state changes its optional program’s eligibility criteria for any reason, people will lose coverage in the public health insurance program affected. In addition, income eligibility requirements cause those

that are just above and below a low-income requirement to move in and out of eligibility for a public program as income changes.

The unaffordable and not eligible uninsured categories both include those unable to afford health insurance. The major difference between these two categories is the uninsured's potential eligibility for public assistance programs. The unaffordable would not be considered eligible for public assistance due to their moderate income levels.

Transitional Uninsured

In the above, we have classified the 46 million who were uninsured for all of 2004 into five categories. In addition to these categories, there are the transitional uninsured: individuals who have been uninsured for less than a year and are therefore not included in most attempts to count the uninsured. The transitional uninsured also include those who became uninsured before the end of the year and move to one of the long term uninsured categories in the following year. The number of transitionally uninsured individuals is significantly affected by national and local economies. Examples of transitional uninsured are:

- Those between jobs who do not purchase COBRA coverage for the transition period, and those newly unemployed who drop individually purchased coverage or COBRA coverage (possibly due to a substantial reduction in income) but eventually re-enter the employment-based insurance market;
- College or graduate students who, because of their age, are no longer eligible for coverage under their parents' policy;
- Early retirees not yet eligible for Medicare whose employers do not provide post-retirement health coverage;
- Those who no longer qualify for Medicaid or SCHIP due to a small increase in income;
- New employees waiting for their employer coverage to start; and
- Those other individuals who had coverage and lost it due to some event over which they had no control. Examples would be the state changing its eligibility requirements for Medicaid or SCHIP, the employer deciding not to provide group health insurance for any employees, dependents, or retirees, or an insurance company withdrawing from the individual market.

Some people who go without health insurance coverage during a transitional episode believe there is a lower risk of a significant medical expense compared to the cost of insurance. A recent study of people possibly bankrupted by a health related issue listed the reasons for their gap in health insurance as:

- 55.9 percent said the premiums were unaffordable;
- 7.1 percent were unable to obtain coverage due to pre-existing conditions;
- 2.9 percent did not see the need for health insurance;
- Most others "cited employment issues, such as a job loss or ineligibility for employer-sponsored coverage."¹⁰

Conclusion

As policy-makers consider options for reducing the number of uninsured, it is important to understand the sources of current health coverage, and the characteristics of the uninsured. In this brief we have tried to identify who the uninsured in the United States are and why they are uninsured. The causes range from a lack of understanding or desire for health coverage through public programs or private insurance, a lack of financial resources, poor health, or ineligibility for public programs. We discussed five categories of long-term uninsured: the financially uninsured (both voluntary and unaffordable); high-risk individuals; those who are low-income and eligible for public programs but who are not enrolled; and those who are low-income and not eligible for public programs as well as the transitionally uninsured. While in this paper we treated each of these groups as if the long-term uninsured could be partitioned into mutually exclusive categories, there may be multiple reasons why any one individual is uninsured.

Future issue briefs of the American Academy of Actuaries will build upon this issue brief by looking more closely at different approaches to expand coverage options for the uninsured.

¹ Like most estimates of the uninsured, the numbers in this brief are based primarily on the Current Population Survey (CPS), a monthly survey of about 50,000 households conducted by the Bureau of the Census for the Bureau of Labor Statistics. The CPS does not cover people not living in households such as the homeless, the institutionalized and college students. The insurance questions in the CPS are conducted in March of each year and intend to capture any health coverage held during the previous calendar year. Those not covered by any source of insurance in the prior year are classified as uninsured, meaning they lacked insurance for the entire year. In other words, the finding that 46 million Americans lacked health insurance in 2004 (45 million in 2003 and 43 million in 2002) implies that these people were without insurance for the entire year. Because the CPS-based estimates do not include those who lacked insurance for periods shorter than a year, they will understate the number of Americans who lacked insurance during any point in a year.

In May 2003, the Congressional Budget Office (CBO) published an in-depth paper on “How Many People Lack Health Insurance and For How Long.” That paper concludes that the CPS estimate of the uninsured more closely approximates the number of people who are uninsured at a specific point in time. The CBO estimates that between 21 million and 31 million people were uninsured for the entire year in 1998 - the most recent year for which reliable comparative data was available. The CBO also estimates that there are approximately up to 60 million people who may be uninsured at any time during the year (including, for example, those between jobs). The CBO study also discusses challenges in counting the Medicaid and Medicaid-eligible population.

² As acknowledged by the Census Bureau, the Current Population Survey (CPS) underreports Medicaid coverage compared with enrollment and participation data from the Center for Medicare and Medicaid Services (CMS). For instance, in 2002, the CPS reports 30 million non-elderly individuals were enrolled in Medicaid or SCHIP compared with 37 million according to CMS. The difference may be attributable to a number of issues: (1) the Medicaid/SCHIP population may be difficult for the Census surveyor to get at; (2) perhaps, the CPS numbers inadvertently reflect those enrolled in the program at the time of the survey as opposed to any time during the year; and (3) the CPS includes only individuals residing in the community, whereas, CMS data also includes residents of nursing homes and group quarters.

³ In our 2003 brief, “other private” excluded those who had employer coverage. In this brief, those with other private and employer coverage are included in both categories.

⁴ “Other public” was estimated by taking the sum of the Current Population Survey’s Medicare and Military health totals. Due to dual coverage issues between these two groups, this estimate may be slightly overstated.

⁵ Veterans eligible to enroll for VA health care under current (as of Fall 2005) criteria include veterans disabled due to service connected conditions, catastrophically disabled veterans, low-income veterans, former prisoners of war, veterans who received a Purple Heart, World War I veterans, and exposure veterans (atomic, Agent Orange, Gulf War etc.) Before January 2003, all veterans were able to enroll for VA health care; everyone enrolled at that time was allowed to remain enrolled after the criteria changed.

⁶ In order to determine which individuals cannot afford health insurance, policy-makers must address four questions. We believe these questions can benefit from an actuarial perspective.

1. What health care and health coverage expenditures should be considered essential and discretionary?

2. For an essential health care expenditure what is the most effective funding method: private insurance, government programs, non-profit organizations or direct payments from the individual?

3. What is a reasonable percent of income for an individual or family to pay for health care and for health coverage?

4. How do the answers to the above questions vary by an individual’s demographic and health characteristics?

The answers to these questions are outside the scope of this introductory issue brief, but must be answered to address lack of coverage for those individuals who truly cannot afford health coverage.

⁷ Source for data in paragraph: Kaiser Commission on Medicaid and the Uninsured report “Employer-Sponsored Health Insurance Coverage: Sponsorship, Eligibility, and Participation Patterns in 2001,” published July 2004.

⁸ 1995 American Academy of Actuaries Public Policy Monograph: “Medical Savings Accounts: Cost Implications and Design Issues”.

⁹ HIPAA also limits the use of pre-existing conditions, prohibits group plans from denying coverage or charging extra based on health status, and guarantees that employers or individuals who purchase coverage can renew that coverage regardless of any health conditions.

¹⁰ Health Affairs — Web Exclusive: “Market Watch Illness and Injury as Contributors to Bankruptcy” by David U. Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler. DOI 10.1377/hlthaff.W5.69