

# The Robert Wood Johnson Foundation's Efforts to Cover the Uninsured



Robert Wood Johnson  
Foundation

BY ROBERT ROSENBLATT

Chapter Three,  
excerpted from The Robert  
Wood Johnson Foundation  
Anthology:

**To Improve Health  
and Health Care  
Volume IX**



Edited by  
Stephen L. Isaacs and  
James R. Knickman

*Published 11/2005*

## *Editors' Introduction*

The United States is the only developed country without universal access to health insurance, and today forty-five million Americans—many of them minorities or poor people—lack coverage for basic health care. It is now well established that people without health insurance receive less medical care, even needed medical care, and are in poorer health than people who have coverage. It is also known that the lack of health insurance has led to the overuse of hospital emergency rooms—an expensive last resort—and, because people are sicker when they finally decide to get care, has led to unnecessarily high-cost hospitalizations and treatment.

This chapter, by Robert Rosenblatt, a former *Los Angeles Times* correspondent and currently a freelance writer specializing in health care issues, traces the Foundation's thirty-plus years of effort to increase Americans' access to health insurance. Rosenblatt observes that the Foundation has used three fundamentally distinct but not necessarily mutually exclusive strategies in addressing this enduring problem. It has supported efforts to bring about fundamental overhaul of the system (though it has never agreed on a single approach to doing so). It has worked to expand insurance coverage incrementally. And it has funded research to provide a better understanding of the dynamics of the system and an empirical basis for policy decisions.

The story of the Foundation's efforts to expand insurance coverage does not have a happy ending at this point: the percentage of uninsured Americans remains approximately the same in 2005 as it was thirty years ago. Nonetheless, the Foundation's commitment to expanding health insurance coverage is unwavering, and this chapter places the Foundation's work into a perspective that provokes thoughts about the next steps.

---

There is a doctor in California's San Fernando Valley who will see patients the same day they call for an appointment. This doctor—let's call him David Dawson—will talk at some length about a patient's medical history and then perform an examination. The price is \$85, payable in cash or by credit card. Many of Dr. Dawson's patients have medical insurance, through jobs in Los Angeles' high-tech companies or the entertainment industry, that would pay for a visit to another doctor. But these patients are willing to pay cash for the privilege of seeing a doctor who will spend extra time with them, will see them immediately, and can make a phone call to a specialist on their behalf if they have trouble getting past the primary care gatekeeper at their own health management organization. "I'm a facilitator, not just a doctor," Dawson says. He also is a safety valve for the already well-insured in our \$1.7 trillion health care system. For his middle-class and upper-class patients, insurance alone isn't enough to assure peace of mind. They go outside the system to get help from Dawson.

Meanwhile, hundreds of thousands of low-income California families are ignoring the chance to buy a bargain, heavily subsidized health policy for their children through the state's Healthy Families program. It offers coverage at up to \$9 a month per child, with a maximum of \$27 a month regardless of the size of the family. "The policy has an actuarial value of \$1,500, and yet they still won't sign up," says a health policy expert. (Let's call him Harry Samuels.) While many poor people don't realize their kids are eligible for government-subsidized health insurance and others are deterred by complicated enrollment forms, Samuels is frustrated that it's so hard to practically give away good coverage.

Dawson and Samuels are real, but they don't want their real names used, Dawson for reasons of privacy, and Samuels because he thinks that his colleagues in the foundation and academic worlds would ostracize him for casting doubt on the dream of universal health coverage through an insurance policy for all, rich and poor alike.

These two stories illustrate the complexity of moving the country toward a better health insurance system. On the one hand, if coverage is not comprehensive and immediate, it does not meet the type of care that many people want. On the other hand, many uninsured families, with competing demands on their limited resources, are unwilling or unable to pay insurance premiums even when low-cost coverage is available.

The Robert Wood Johnson Foundation works the same turf as Samuels, and has been pursuing the goal of universal access to health care since it opened for business in 1972. The biggest of all foundations dealing exclusively in the health field, Robert Wood Johnson disburses more than \$400 million a year to improve health and health care in the United States. It is a vast sum for the nonprofit world, but relatively little in the grand scheme of things; the American health system spends nearly \$5 billion *a day*, consuming about 15 percent of the entire output of goods and services in the national economy. Through leadership, inspiration, discussion, and a flow of grant money, the Robert Wood Johnson Foundation has been trying to bring about a nation in which everyone has access to good health care. Much of the time, this revolves around ideas for getting health insurance coverage for those who don't have it.

Stable, affordable health coverage for all Americans has been a consistent goal of the Foundation, and the inability to achieve it is the biggest failure, said Steven Schroeder, who was the Foundation's president from 1990 until 2002. This failure "was the single most bitter pill" of all Foundation efforts, he said. "It was the hardest by far. It broke our hearts."

Over 15 percent of the American population lacks health insurance, roughly the same percentage as when the Robert Wood Johnson Foundation began operating as a national philanthropy in 1972 and the same as in 1993, when President Clinton proposed a plan to provide health care for all. And the political climate today is more challenging and less receptive to the idea of government action to fashion a health care umbrella sheltering every American.

Although there is no universal care in America, the population is healthier than it has ever been. Between 1990 and 2003, there was a 34 percent drop in deaths from infectious disease, a 32 percent decline in infant mortality, and a 17 percent decline in deaths from heart disease.<sup>1</sup> Not only are people healthier but also the medical care system can do much more for them than it could just a generation ago. The first heart bypass operation was performed at the Cleveland Clinic in 1967, and now it is one of Medicare's routine procedures, even for people 85 and older. Cataract surgery once meant a week in the hospital, your head strapped to a rigid frame. Now it can be done as an outpatient procedure at an eye surgeon's office, and you can be playing tennis again in a couple of days.

The blessings of modern health care are unevenly distributed, however, and depend on the ability to pay for the care. The health care you get often comes down to the kind of job you have and the income of your family (the biggest single source of personal bankruptcies is medical expenses), and whether you have health insurance. The Foundation would like to see affordable health care for all Americans, giving them the security of knowing that they can pay the bills for a serious illness without going broke and that they can get the preventive care, such as routine checkups and immunizations, that will keep them healthy.

---

### Three Approaches

The Foundation has taken a three-pronged approach to the issue of health insurance coverage, with the emphasis shifting at different times and represented by three different constituencies within the Foundation and the field of health policy.

First are ambitious reformers, who dream of changing the system so that everyone has health insurance coverage—something enjoyed by the citizens of every other industrial country. They have a big vision, pondering ways to get Congress and the president to place in the hands of the uninsured a card they can take to the doctor's office and the hospital with confidence that the bills will be paid.

The second group consists of hopeful pragmatists. They would like to solve the health care puzzle piece by discrete piece—a successful new primary care clinic here, an expanded school health program there, an enrollment drive for Medicaid in a third location. Washington may someday do the job, but people get sick right now and need help paying for their treatment, the hopeful pragmatists argue. Using this approach, the Foundation has funded a wide variety of programs since the 1980s, many of them designed to expand insurance coverage to children.

A third group is made up of numbers gurus, policy analysts who gather and examine information so that policy-makers will know better how and where people get their health care services. The numbers gurus want to understand insurance markets, consumer behavior, and other arcane topics, and to offer the ambitious reformers and the hopeful pragmatists their analysis and numbers so they can work better and smarter.

Because of the work of the numbers gurus, we know a lot more about who the uninsured are, how they got that way, and how they move through and out of the system. We also have lots of information on the complexities of small group insurance, most of it discouraging. We know it is virtually impossible to design any plan to expand significantly the current level of coverage among small firms. “For many of them [the small businesses] any premium beyond zero dollars is too much,” observed Jack Meyer, president of the Economic and Social Research Institute, in Washington, D.C., which has done considerable health policy research for the Foundation. The numbers gurus have produced lots of plans for covering the uninsured, courtesy of sophisticated thinkers underwritten by the Foundation. Many of those plans got an initial burst of publicity but are now gathering dust on the shelves in the offices of health care policy experts.

The Foundation has always featured a mixture of work from all three of these groups. Currently, the ambitious reformers seem to be forging ahead, powered by Cover the Uninsured Week, an unprecedented public education campaign to keep health care coverage on the national policy agenda. A recent draft statement by the Foundation’s staff states: “Over three decades, the Foundation has commissioned a significant body of research and funded projects that have explored the potential of various local, state, and private sector options for expanding coverage. Results of its research and field work have led the Foundation to conclude that while health care is delivered locally, *it cannot be made available to all without a change in federal policy*” [italics added].

The ambitious reformers face a steep uphill climb. The current climate in Washington is daunting, with the president and Republican majorities in both houses of Congress seemingly averse to any far-reaching new federal health care coverage efforts. It will be even harder than in earlier years to figure out ways to spread the benefits of health care, because coverage is so much more costly than ever before, with a corporate policy for an individual exceeding \$3,000 a year and a family policy costing about \$10,000. “We must come to grips with the cost question,” says Stuart Schear, a former senior communications officer at the Foundation, who oversaw the Foundation’s campaign to make covering the uninsured a national political priority. “Health care is extraordinarily expensive, and in our next phase of work we will start research and analysis to look at what are the causes of the increase and what can be done to restrain them.”

---

## Reforming the System

The dream of bringing quality health care to everyone has been a recurring theme in American society, since long before the Robert Wood Johnson Foundation opened its doors in 1972. President Franklin Roosevelt had considered including health insurance in the package of proposals that eventually became the foundation of Social Security and unemployment insurance in 1935. But the idea was scrapped for fear of touching off a dispute with the American Medical Association, which regarded any government intrusion into the delivery of health care as socialized medicine. The idea surfaced again as a proposal from President Harry Truman. The AMA called it socialism and defeated it.

Medicare was created in 1965, bringing health insurance coverage to those over sixty-five and to disabled people of all ages. At the same time, Medicaid was created as a program enabling poor people to get health care. This burst of expansionary government funding of health care may have been a historical anomaly. The legacy of President John F. Kennedy, combined with the overwhelming electoral victory of Lyndon Johnson and the Democratic Party in 1964, created a spirit of enthusiastic activism that resulted in the passage of important social legislation.

For the vast majority of insured Americans, insurance through the workplace was and is the standard way to get health coverage. Your employer decides whether or not to offer health insurance and picks the plans from which you choose. The cost is tax-deductible for the company, and is not counted as income for the worker. The genesis of coverage at work was the World War II freeze on wages. To attract workers without increasing pay levels, Henry J. Kaiser, who was building ships for the Navy, offered free health coverage through a unique collection of Kaiser clinics, Kaiser owned-hospitals, and panels of doctors working full-time for Kaiser.

Health insurance coverage spread quickly after World War II; unions made health insurance a basic demand in their bargaining with the nation's large manufacturing companies. The benefit spread rapidly through industry, with both unionized and nonunion firms adopting it. Today, 61 percent of American workers are covered by employer-sponsored health insurance. The percentage ebbs and flows with the economy, but it is now declining, because the rapidly rising cost is putting health insurance beyond the reach of many small firms and many workers.

When the Robert Wood Johnson Foundation began its operations, during the Nixon Administration, policy experts believed, optimistically, that some form of national health insurance was just a few steps away from becoming a reality. "The uneven availability of continuing medical care of acceptable quality is one of the most serious problems we face today," David Rogers, the Foundation's first president, wrote in the 1972 *Annual Report*. "We need to better provide health services of the right kind, at the right time, to those who need it. Therefore, in its initial years, the Foundation will try to identify and encourage efforts to expand and improve the delivery of primary, frontline care."

Confident that the system was heading toward national health coverage, the Foundation's early focus was on training the personnel who would be delivering the new health care services. It gave money to academic health centers, funding new medical and dental students, residency programs in primary care and pediatrics, and training for nurse practitioners and physicians' assistants. A new cadre of Clinical Scholars and Health Policy Fellows was given financial support. The Foundation "supported

programs that attracted talented young people at elite institutions and promulgated the importance of health services research, primary care, and public health,” wrote two former Foundation executive vice presidents.<sup>2</sup>

Increasing access to care was the goal as the Foundation staff and grantees envisioned an expanded national system of care. But the vision of national health coverage as just around the corner dissipated by the middle of the decade. By 1980, it had become clear that cost was a formidable obstacle to attaining the goal of universal access.

During the 1980s, the Foundation’s attention turned to the states—in part because many state governments wanted to expand health insurance (and reduce their own Medicaid costs) for their residents and partly because of the hope that models might be developed that could be used by other states or, eventually, by the federal government.

One approach the Foundation adopted was building coalitions of interested and influential organizations. Between 1981 and 1989, the Foundation funded the *Community Programs for Affordable Health Care*. Under this \$14 million program, coalitions were formed among a broad range of interest groups, including business, labor, insurers, and hospital managers, to figure out ways to keep down the inflation of medical costs. Many experts believe that insurance coverage will expand only when health care costs are controlled. Eleven hospital sites received Foundation grants and technical assistance to help them figure out how they could save money while still providing first-rate care. But the program failed. Building coalitions turned out to be more difficult than originally envisioned, and the cost problem proved to be seemingly intractable, as it continues to be. “Effective cost containment strategies entail making tough choices, such as paying lower salaries, imposing restrictions, and contracting with certain doctors and not others,” the medical journalist Carolyn Newbergh wrote. “But community leaders, who prefer to be known for expanding and improving their community’s health care services, didn’t want to gore anyone’s ox.”<sup>3</sup> Perhaps, though, the program did not succeed because it focused on the wrong level of government. As three Foundation officials wrote in 1990, “The program’s central flaw, perhaps, was its misguided assumption that cost containment could be achieved through intervention at the community or local level, when the true levers of power and control existed (and still exist) at the national and state levels of the health care system.”<sup>4</sup>

In 1985, the Foundation funded another state-oriented systems reform initiative, the *Health Care for the Uninsured Program*. It was designed to test innovative, incremental strategies for making health insurance coverage more available and affordable to small businesses. Under the \$6.5 million program, fourteen states either developed new insurance products or subsidized existing ones. The Florida Health Access project, for example, used a state purchasing cooperative to lower premiums. The Arizona Health Care Group lowered premiums by subsidizing administrative and marketing costs. The state of Washington’s Basic Health Plan used direct subsidies to provide coverage to low-income, uninsured individuals. There was a study of local insurance markets and underwriting practices. In addition, there was a major survey of more than 1,300 small companies with twenty-five or fewer workers at four sites—Denver; Flint, Michigan; Tampa; and Tucson.

The results from the program were revealing. The cost of insurance emerged as a major obstacle to small firms' purchasing health insurance for their employees. One lesson from the program was that health insurance, even if heavily subsidized, was unaffordable for small businesses. Writing in the journal *Health Affairs*, the program's evaluators observed, "Because of current underwriting practices, some small businesses would find it difficult to respond to any financial incentives or government mandates to provide health benefits to their employees."<sup>5</sup>

A second, and more disturbing, lesson to emerge from this program was that "there is a fairly hard-core group of small-business owners who do not want to provide health insurance benefits to their employees." This conclusion of the evaluators was buttressed by the statistic that "almost half the employers in our survey who do not offer health insurance indicated that they were not interested in doing so."<sup>6</sup> The relevance for national policy was highlighted in the conclusion of the program's directors that "efforts to expand the current employer-based insurance system are not likely to achieve universal financial access to health care without requiring [emphasis added] universal participation."<sup>7</sup>

These lessons seem to be resolutely ignored as policy-makers proclaim the need for affordable new policies that will be bought by entrepreneurs eager to insure their employees. Foundation research has shown repeatedly that it is extremely hard to make progress with this approach. California, for example, established a special program to help the marketing of affordable policies to small businesses, with a wide range of choices on coverage and limits on prices. By the end of the 1990s, only 2 percent of the eligible firms in the state, with an aggregate workforce of 140,000 people, were participating. About 80 percent of them already had health insurance coverage, and their companies switched to the state-backed alliance to get better prices, according to Columbia University professors Lawrence Brown and Michael Sparer.<sup>8</sup>

The push for a national health care approach revived again in the 1990s. Harris Wofford, a Democrat running for a United States Senate seat in Pennsylvania, defeated the heavily favored Republican candidate, former U.S. attorney general Richard Thornburgh. Wofford surged in the polls after he made health care access his key issue, saying that if criminals are entitled to have a lawyer, voters should be guaranteed access to a doctor. With Wofford's victory, health care became a big issue in the next presidential campaign.

In 1992, Bill Clinton was elected president with a pledge to bring secure health care to all Americans. The Foundation was invited to help educate first lady Hillary Clinton and other key administration officials about the complexities of health care. Dozens of Foundation grantees were enlisted to testify at public sessions. The audience at various times included Mrs. Clinton, Tipper Gore, the wife of vice president Al Gore, and Donna Shalala, the secretary of Health and Human Services. There were sessions in Iowa, Michigan, and Florida, with the final one in Washington.

"Mrs. Clinton basically listened," Schroeder recalled. "It got tremendous media coverage and we were not prepared for it. We were kind of naïve. It was portrayed as a partisan issue. We said we were just helping people understand what was out there in the health field." The Foundation, and its staff and grantees, were accused of being a group of big-government liberals.

The accusation stung, and although Schroeder insists that the Foundation's trustees never told the staff to back away, the Foundation has been cautious in its approach since then. Although the Foundation's reticence is due, in large part, to its having been burned by its role during consideration of the Clinton health care reform plan, there are other factors too. The Foundation has a long-standing policy of emphasizing the visibility of its grantees rather than promulgating any plan that it favors. And the Foundation can't go too far in supporting any specific proposal without raising concern about losing credibility as a neutral source of unbiased information on health and health care.

With the failure of the Clinton health reform plan, the drive toward national reform dissipated. Employers asked for financial relief against rising health care costs, and insurance companies delivered with managed care mechanisms, moving millions of people into health maintenance organizations, or HMOs. Patients had to stay within designated networks of doctors and hospitals. Primary care doctors became gatekeepers for the system, and seeing a specialist without getting a referral sometimes became a lengthy bureaucratic process. The relentless inflation in health care costs was slowed, but there was a consumer backlash. Insurers were ordering hospitals to send women home within twenty-four hours after giving birth—a practice that was denounced in the press and ultimately banned by Congress. Employers and legislators were inundated with complaints, and they ordered the insurance plans to ease their restrictive practices. Managed care restraints were loosened, costs rose, and access again became an issue.

The Foundation had a creative response, prompted by Jack Ebeler, at the time a senior vice president of the Foundation. He talked with Ron Pollack, the executive director of Families USA, a liberal advocacy group, and Chip Kahn, then the president of the Health Insurance Association of America, an industry trade group. They had fought on opposite sides of the health policy wars for years but respected each other. The result was the convening of a “strange bedfellows conference” of disparate interest groups contending over the coverage issue. Everyone had a plan, a first choice to deal with the coverage crisis. The idea of convening the strange bedfellows was to get beyond the second choice—doing nothing—to find some common ground. The participating groups—including the U.S. Chamber of Commerce, the Service Employees International Union, the American Hospital Association, and the AFL-CIO—all could agree that the coverage issue was paramount and that everyone should have access to health care through insurance. Participants signed letters to Congress urging federal action to cover the uninsured. The strange bedfellows have continued to meet and to search for acceptable approaches to expanding coverage.

The Foundation decided to make a major commitment to bringing the issue beyond the Washington beltway to the broadest possible national audience. This led to Cover the Uninsured Week, in 2003, with hundreds of local events and campaigns to keep the spotlight on the plight of the millions of Americans who lacked coverage. The campaign heightened awareness. Polling by the Foundation showed that coverage had replaced costs as the top health issue, with 23 percent citing it compared with 16 percent a year before.<sup>9</sup>

In 2004, the Foundation funded a second Cover the Uninsured Week, which featured more than 2,700 local events, including all fifty states and the District of Columbia. More than 250 national organizations and 2,500 local groups were involved. There were rallies, health fairs, speeches, and theatrical depictions of the lives of the uninsured. The Foundation spent nearly \$7 million and raised \$2.6 million from other supporting organizations. A third Cover the Uninsured Week was held in May 2005.

The focus, however, was on the problem, rather than on specific solutions. Sometimes this was frustrating for participants in the awareness campaign, who wished to focus on specific remedies for the 800-pound-gorilla issue of cost.

Now, in 2006, comes the hard part for the Foundation and the nation—finding solutions to the problems trumpeted through Cover the Uninsured Week. “Action on the federal level is key to expanding coverage and making it affordable and stable for all Americans,” a staff policy paper concluded. The circle has been closed, going back to 1972, when the Foundation began.

---

### Pragmatic and Incremental Approaches

Although the Foundation has looked to promote health care reform that could lead to universal coverage—and, in fact, it promises to judge its success by whether a national policy ensuring stable and affordable coverage for all has been adopted by 2010—the Foundation has simultaneously sought smaller-scale opportunities to expand insurance coverage. Most often, this incremental strategy focused on the states, which were seen as laboratories where new approaches to covering the uninsured could be developed and incubated. This was the essence of pragmatism—if we can’t get the job done through national efforts, let’s help the states get it done, one by one.

As one example, the findings from the earlier Health Care for the Uninsured program indicated that small businesses would not provide coverage for their employees, even if offered price breaks (a concept at the heart of a number of federal health reform proposals). As a follow-up, the Foundation funded a variation of the program called *State Coverage Initiatives*. Under the new program, which was authorized in 1992, state governments received grants to test ways that they can increase health insurance coverage. For example:

- Arkansas created a buy-in for small employers to get coverage for their low-paid workers under the state’s Medicaid program.
- New Mexico devised a basic benefits package for small companies, with the state acting as a vendor and collector of premiums to keep down administrative costs.
- Oregon received help with a federal waiver to expand its Medicaid program to cover more people.
- Rhode Island had a program to provide insurance for low-income families.

In the mid-1990s, with the failure of the Clinton health reform plan having dealt a severe blow to the possibility of universal health care, the Foundation was searching for new ways to expand health insurance coverage. One way was to provide coverage for children, a group that the Foundation had been concerned with for many years. In 1990, the Foundation had funded a Healthy Kids program

in Florida, which used subsidized insurance, initially through schools, to bring coverage to more than 60,000 children. With additional funds from the Foundation, the Florida approach, with variations, was replicated in a number of states.<sup>10</sup>

Building on its experience in funding innovative ways to bring health insurance to children, the Foundation in 1997 developed a new \$13 million three-year initiative called *Covering Kids* that would help local coalitions in fifteen states try to identify children eligible for Medicaid and sign them up. *Covering Kids* came just as Congress was considering a new health insurance program for children, the State Children's Health Insurance Program, or SCHIP, which was eventually passed as part of the Balanced Budget Act of 1997. Senator Edward M. Kennedy, a liberal Democrat, and Senator Orrin Hatch, a conservative Republican, sent their staff members out of a meeting on Capitol Hill, shut the door, and worked out a deal to provide generous funding to the states to provide health insurance for children. States had the choice of expanding eligibility under the current Medicaid program, creating a new health program for children, or doing some of each.

Suddenly there was new government support and resources for expanded health access, and the Foundation seized the opportunity to support the federal effort to expand coverage for children. In 1998, the Foundation authorized an additional \$34 million to transform the *Covering Kids* program into a nationwide effort, with projects in every state and the District of Columbia. One hundred seventy-three pilot projects, and 4,200 public and private organizations, joined coalitions to enroll eligible but unregistered children in Medicaid and SCHIP by developing simplified application forms, doing outreach, and persuading state officials to reduce restrictions such as means tests and in-person interviews.

As private insurance coverage has diminished in the past three years, Medicaid and SCHIP have filled the gap, at least for children. The proportion of the population covered by employer-sponsored insurance fell from 67 percent to 63 percent between 2001 and 2003, but the proportion of low-income children covered by the public programs rose sharply—from 38 percent to 49 percent—an increase of almost five million children. According to a report by the Center for Studying Health System Change, a research group funded by the Foundation, "Public insurance clearly picked up the slack as the United States moved through a recession and jobless recovery and employer coverage declined. SCHIP, enacted in 1997, played a major role and has been remarkably successful in providing a safety net to children who otherwise might be uninsured."<sup>11</sup>

Steven Schroeder considers the Foundation's role in increasing the enrollment of children as one the Foundation's greatest accomplishments. Much of the expansion in kids' coverage is due to the billions invested by the federal and state governments. But as the program's evaluators noted,

Unquestionably there are children with health coverage now who would not have had coverage except for the efforts of state and local *Covering Kids* initiative grantees. It is not possible, of course, to isolate the exact number. It is worth noting, however, that during the period that the *Covering Kids* initiative has been operational, a downward trend in the number of children enrolled in Medicaid reversed and began to increase. Furthermore, enrollment in SCHIP has increased dramatically since the first program was implemented in 1998. Federal reports indicate that more than three million children were covered by SCHIP during fiscal year 2000.<sup>12</sup>

In addition, the evaluators reported, “Covering Kids had served as a change agent in many states, and had encouraged a fundamental change in states’ perception of the Medicaid program—from a welfare program to a health insurance program with a consumer focus. Furthermore, the program had generated groups of individuals in each state who were now knowledgeable about Medicaid eligibility to an extent that would not have been possible without the Covering Kids initiative.”

Some states have expanded eligibility to the parents of children enrolled in SCHIP. In 2001, to take advantage of federal revenues available for this new family eligibility, the Foundation expanded Covering Kids into *Covering Kids & Families*, a five-year \$65 million program. The Southern Institute on Children and Families, which administers the programs, has worked closely with state officials in fashioning programs that will allow the parents of SCHIP children to be covered by governmental health insurance.

Yet these programs threaten to become victims of their own success. Medicaid costs are growing far faster than the tax revenues of the states, which pay anywhere from 17 percent to 50 percent of total program costs. Medicaid, which consumed about 8 percent of state budgets a generation ago, is now verging on 25 percent—an intolerably large figure for many states. As the Medicaid and SCHIP programs enroll more children and their parents, the costs to the states rise and the strain on precious state resources increases. Even though spending for children’s health care consumes a relatively modest share of state Medicaid budgets (most children are healthy most of the time), some states have tried to curb the growth in spending by making it harder for parents to enroll their children. Among the tools some states have used are a temporary freeze on new enrollment and a requirement to be re-certified for eligibility every six months instead of yearly.

---

## Collecting and Analyzing Data

Meanwhile, the Foundation has been supporting organizations and individuals who have been steadily and often quietly producing a variety of reports that help policy-makers and the public understand some of the complexities of the health care system, and that suggest just how hard it will be for the Foundation to achieve its long-sought goal of access to health care for every American. Organizations include:

- *Changes in Health Care Financing and Organization*, or HCFO. Headquartered at AcademyHealth in Washington, D.C., HCFO has been funded since 1988. It awards grants to researchers whose research is aimed at providing reliable information for policy-makers and public officials as they reshape the health care system. HCFO replaced the Program for Demonstration and Research on Health Care Costs, which the Foundation had funded between 1982 and 1987, but which evaluators considered to be too limited because of its focus on clinical data.
- The Center for Studying Health System Change. The Center provides insights both at the macro level, looking at the whole structure of the intricate national web of health care, and the micro level, periodic visits and in-depth reports about the widely divergent health care markets in twelve communities. Along with its other research, the Center tracks changes over time. It conducted a baseline study in 1996–1997, encompassing 32,000 households, 12,000 doctors, and 22,000 employers at sixty random sites. The study is repeated periodically, providing a wealth of information on health coverage, costs, and trends.<sup>13</sup>

- The State Health Access Data Assistance Center, or SHADAC, at the University of Minnesota. SHADAC supports the development of state-specific data sets and analysis on issues of health insurance coverage.
- The Economic Research Initiative on the Uninsured at the University of Michigan. This organization carries out and publishes economic research on health insurance. It has done extensive research on the dynamics of insurance coverage and the effect of being uninsured.
- The Urban Institute's National Survey of America's Families. The Urban Institute surveyed families in thirteen states, providing a comprehensive look at the well-being of children and adults under sixty-five. It studies issues of access and health insurance coverage among low-income families.
- The Economic and Social Research Institute, in Washington, D.C. The Institute conducts a wide range of research on health and social policy. Its recent publications include reports on safety net hospitals, strategies for covering the uninsured, and Medicaid coverage for poor adults.
- The Institute of Medicine. The IOM has produced six reports on the consequences of being uninsured.

The Foundation has gone beyond the gathering of facts illuminating the health care system and has ventured into the area of “what if,” looking at the statistical basis of a universal health care system and how it might be structured. According to a Foundation-commissioned report by the Economic and Social Research Institute, covering all the uninsured would cost between \$75 billion and \$150 billion a year. The report, entitled *Covering America: Real Remedies for the Uninsured*, showed a broad and imaginative range of thinking from liberal to centrist to conservative. One author proposed a combination of an individual mandate and tax credits whereby all Americans would have to maintain a basic level of coverage. Tax credits would assure that they spent no more than 10 percent of income for their insurance coverage. Another suggested repealing the tax-free status of health insurance premiums paid by employers and employees, with the resulting billions of dollars in tax revenues going to the states to help low-income families buy health insurance. Another called for the expansion of Medicaid and the State Children's Health Insurance Program, combined with tax credits, to encourage small firms to offer coverage.

These reports, and others like them, represent serious thinking. Yet there is a danger that they will remain unread except by aficionados of the health care debate and thus be limited in their influence. In recent years, the Foundation has expanded its efforts to communicate findings from its grantees' research through vehicles such as an expanded Web site, support for grantee Web sites, convening of meetings of leading thinkers and actors in health insurance, and support of the journal *Health Affairs*. The Foundation also has funded an initiative to analyze the research on specific health policy issues and summarize the conclusions that it is possible to draw based on the research. Syntheses of existing research have been done on topics such as ways to make individual health insurance policies more affordable, how to reduce health insurance premiums for small businesses, and whether increasing publicly funded health insurance would reduce the need for private insurance.

Despite these efforts, such reports appear to have had limited influence on the debate. This seems to be a persistent theme in the Foundation's work toward the goal of universal coverage. It assembles ideas and information and then fails to promote them aggressively. Although it has endorsed a set of general principles enunciated by the Institute of Medicine for "guiding the debate,"<sup>14</sup> the Foundation has been reluctant to support aggressively any particular approach that might lead to stable and affordable coverage for all Americans.

---

## Conclusion

The Foundation's approach to covering the uninsured has shifted as the national discussion has ebbed and flowed from worries about access to fears about runaway costs. Its most noteworthy achievements so far in bringing about expanded coverage have been at the margin—promoting and publicizing the availability of government health insurance for children and their parents, helping state and local officials do a better job of administering the programs under their control, stimulating state experiments in coverage, prodding them to take advantage whenever there are more federal dollars to disburse, giving training and enthusiasm to the local activists who labor on these issues, and keeping the issue of health insurance alive through public communications campaigns.

At the same time, the Foundation has supported the generation of a vast amount of data to help deepen understanding of how the health care system works and to examine ideas for expanding health insurance coverage. What is not certain is whether this knowledge and these ideas help shape the debate. They are disseminated to and known by experts, but will policy-makers and government officials choose to use them? The Foundation itself seems reluctant to inject itself more actively into the policy debate by promoting solutions, perhaps out of concern that it might be accused of stepping over the line and lobbying or perhaps for fear of risking its reputational capital.

Many of the Foundation's staff members and many of its grantees have had visions of the magical day when every American would have a card guaranteeing admittance to the doctor's office or the hospital without fear of going bankrupt. But these dreams have gone unrealized. There has not been a broad, consistent constituency among the nation's policy-makers for such expansive notions of health reform. The Foundation has been constrained in efforts to push in that direction. It is, after all, a vehicle of philanthropy dependent on the tax code, not a political animal or an activist caucus. Yet the Foundation now has a strategic objective of stable and affordable health care coverage for all Americans by 2010. This has been the impossible dream so far. Can it become a reality now?

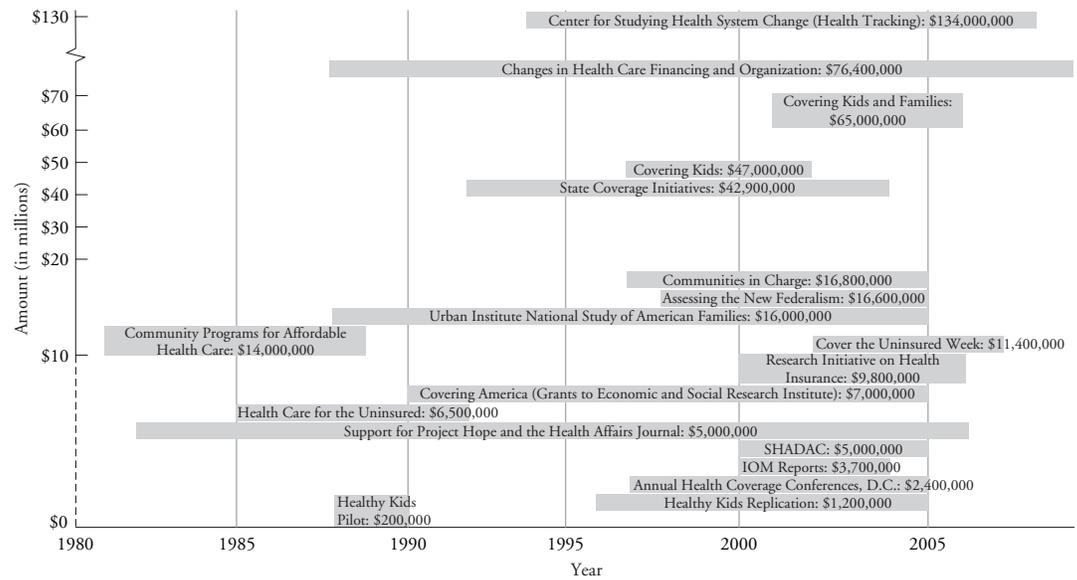
---

## Notes

1. *America's Health: State Health Rankings*. United Health Foundation, American Public Health Association, and Partnership for Prevention, 2003, p. 14.
2. Sandy, L. G., and Reynolds, R. "Influencing Academic Health Centers, The Robert Wood Johnson Foundation Experience." *To Improve Health and Health Care 1998–1999: The Robert Wood Johnson Foundation Anthology*. San Francisco: Jossey-Bass, 1998.
3. Newbergh, C. "The Robert Wood Johnson Foundation's Efforts to Contain Health Care Costs." *To Improve Health and Health Care, Vol. VII: The Robert Wood Johnson Foundation Anthology*. San Francisco: Jossey-Bass, 2004.
4. Schroeder, S. A., Cohen, A., and Cantor, J. "Perspectives: The Funders." *Health Affairs*, 1990, 9, pp. 29–33.

5. Zellers, W. K., McLaughlin, C. G., and Frick, K. D. "Small-Business Health Insurance: Only the Healthy Need Apply." *Health Affairs*, 1992, 11, pp. 174–180.
6. McLaughlin, C. G., and Zellers, W. K. "The Shortcomings of Voluntarism in the Small-Group Insurance Market." *Health Affairs*, 1992, 11, pp. 28–40.
7. Helms, W. D., Gauthier, A. K., and Campion, D. M. "Mending the Flaws in the Small-Group Market." *Health Affairs*, 1992, 11, pp. 7–27.
8. Brown, L. D., and Sparer, M. "Window Shopping: State Health Reform Politics in the 1990s." *Health Affairs*, 2001, 20(1), p. 55.
9. Brown, M. Robert Wood Johnson Foundation Report on Cover the Uninsured Week, forthcoming, p. 33.
10. Holloway, M. "Expanding Health Insurance for Children." *To Improve Health and Health Care 2000: The Robert Wood Johnson Foundation Anthology*. San Francisco: Jossey-Bass, 1999.
11. Strunk, B. C., and Reschovsky, J. D. "Trends in U.S. Health Insurance Coverage, 2001–2003." *Tracking Report, Insurance Coverage and Costs, Results from the Community Tracking Study, 2004*, 9. Washington, D.C.: Center for Studying Health System Change.
12. Health Management Associates. *Covering Kids Initiative Assessment Project, Final Report*, January 19, 2001, p. 4.
13. Newbergh, C. "The Health Tracking Initiative." *To Improve Health and Health Care, Vol. VI: The Robert Wood Johnson Foundation Anthology*. San Francisco: Jossey-Bass, 2003.
14. Institute of Medicine. *Insuring America's Health: Principles and Recommendations*. Washington, D.C.: National Academies Press, 2004.

Appendix. Initiative to Cover the Uninsured



Copyright © 2006 by the Robert Wood Johnson Foundation, Route One and College Road East, Princeton, New Jersey 08543. Reprint permissions requests should be sent to [permissions@rwjf.org](mailto:permissions@rwjf.org). Visit [www.rwjf.org](http://www.rwjf.org) to learn more about our work.