

Health Care - Uninsured

QUESTIONS AND ANSWERS ON THE UNINSURED STATISTICS
October 5, 1999

Q: Yesterday, in reaction to a report of an increase in the number of uninsured, the President said that "The First Lady and I and the rest of us were right in 1994." Isn't this statement an indication that the President himself thinks that the you cannot rely on incremental reforms to insure Americans?

A: The President was simply saying that had we enacted the Health Security Act all Americans would be insured. He was not saying that targeted reforms should not be pursued. With a Republican Congress that has shown little interest in the uninsured, the President has been faced with two choices: do nothing or take aggressive steps to improve the accessibility and affordability of coverage.

While the President still firmly believes that every single American should be insured, he has not passed up opportunities to expand access to quality, affordable health insurance. In 1996, he enacted a law to enable workers to change jobs without fearing the loss of health insurance, among other provisions. In 1997, he worked with Congress to create the Children's Health Insurance Program (CHIP) that provides millions of working families with an affordable insurance option. And the President continues to support policies like the Medicare buy in, small business purchasing coalitions, and the Jeffords-Kennedy Work Incentives Improvement Act that provide vulnerable options with new, affordable health insurance choices. Incremental policies not only provide immediate needed help to American families but takes steps towards reaching the goal of eliminating the lack of insurance.

Q: You claim that there are a million fewer uninsured with income below \$25,000. Isn't this because there are just fewer people below \$25,000?

A: Although there has been dramatic income gains and fewer Americans in poverty, even controlling for this trend, the rate of uninsured below \$25,000 decreased. The rate takes into account the decline in the number of people in that income category. The reported increase in the uninsured of 1 million results from there being 2 million more Americans without insurance with incomes above \$25,000 and 1.1 million fewer uninsured with income less than \$25,000. Consistent with this finding, the rate of lack of insurance for those with income above \$25,000 has increased - with a dramatic hike for those with income above \$50,000 (from 10.1 to 11.7 percent for those with income between \$50,000 to \$75,000).

These trends are not temporary. Comparing 1995 to 1998, the rate of being uninsured for those with income below \$25,000 grew one-third to one-fifth the rate increase for higher income categories.

UNINSURED BY INCOME						
	1995	1996	1997	1998	1995-1998	1997-1998
< \$25,000	18,713	18,47	18,361	17,229	-1,484	-1,132
Rate	23.9%	24.3%	25.4%	26.2%	5.4%	-0.8%
\$25-49,999	13,697	13,565	14,527	14,807	1,110	0,280
Rate	16.2%	16.6%	18.1%	18.8%	16.0%	3.9%
\$50-74,999	4,974	5,63	5,878	6,703	1,729	1,025
Rate	9.3%	10.0%	10.1%	11.7%	25.8%	15.8%
\$75,000+	3,197	4,03	4,882	5,542	2,345	0,660
Rate	6.7%	7.6%	8.1%	8.3%	23.9%	2.5%

Note: Rate changes are percent change of rates (not the subtraction of rates)

7

Q: The economy is doing well and the poverty rate has fallen, so why is the number of uninsured increasing?

A: The problem of the uninsured in the United States is a complicated issue. We have just received the 1998 Census data and will be analyzing the data closely in the coming days. But it appears that the increase in the proportion of uninsured between 1997-1998, which is not statistically significant, is not concentrated among the poor. Neither the number nor the rate of uninsured poor people increased significantly. In fact, the number of the uninsured who are classified as poor dropped by 87,000.

However, the rate of uninsured among the middle class did go up: the percent of people with income between \$50,000 and \$75,000 who lack insurance increased from 10.1 to 11.7 percent -- or over a million people. This appears to be happening because slightly fewer middle-class people are insured through their employers. Also, as people leave poverty, fewer are eligible for Medicaid, limiting access to affordable options.

Q: What is the Administration going to do to reduce the numbers of uninsured?

A: The President has been aggressively pushing to enroll the millions of Americans now eligible for coverage and urging the Congress to pass additional reforms that would succeed in insuring more people. We will step up efforts both to create new options and to increase participation in existing options. The Administration's efforts include:

Ensuring rapid, aggressive implementation of the new Children's Health Insurance Program (CHIP) which targets uninsured children of working families. In addition to approving all state plans, the Administration has launched an aggressive public-private outreach campaign to educate families about this new program. Last month, the Departments of Health and Human Services, Justice and Education and 10 national, nonprofit organizations, kicked off more than 45 community events to enroll children around the country in CHIP and Medicaid. These efforts focused on outreach to minority communities, including the Hispanic community to which we have distributed Spanish language television and radio PSAs and print articles and op-eds on how to enroll in CHIP and Medicaid. Earlier this year, the President, along with the National Governors' Association, launched the Insure Kids Now campaign, including a national toll free number, 1-877-KIDS-NOW and the *insurekidsnow.gov* web site, which gives families specific information on how to enroll in CHIP and Medicaid.

Improving Medicaid. This Fall, HHS will send teams to work with state officials this fall to review programs and identify and remove possible barriers to enrollment in Medicaid and CHIP. Earlier this year, we also took action to assure and encourage legal immigrants to receive health insurance through Medicaid and CHIP. Since 1993, HHS has approved several Medicaid waivers to states for comprehensive health care reform projects to control costs and expand coverage and waivers for welfare reform projects. When fully implemented, these demonstration projects will extend health coverage to 2.2 million parents and children who otherwise would be uninsured.

Creating new insurance options. The President also continues to support policies to improve the affordability and accessibility of health insurance. These proposals include the Medicare buy-in for certain people ages 55 to 65; new Medicaid options including the ability to cover legal immigrants in Medicaid or CHIP; the small business purchasing coalitions; and the Work Incentives Improvement Act that allows more people with disabilities return to work by providing Medicare and a Medicaid buy-in.

Q: Why hasn't CHIP reduced the number of uninsured children already?

A: We are encouraged that the CPS numbers show the number of uninsured children remained stable from 1997 to 1998. We expect that this number will begin to decline now that CHIP is fully implemented. CHIP was only passed by Congress and signed by President Clinton in August of 1997. To date, HHS has approved 56 plans -- all 50 states, 5 U.S. territories and the District of Columbia. So far, we estimate that 1.3 million children have been enrolled and states expect to enroll 2.6 million by October 2000. In 1998, the year that the Census data covers, 43 states had programs in operation, but only 4 states had been enrolling children throughout that year.

We will continue to work with state and local communities and forge more public-private partnerships in our efforts to enroll all eligible children in CHIP and Medicaid.

Q: Isn't welfare reform and Medicaid declines the reason why the uninsured has increased?

A: Since it appears that the increase in the uninsured is concentrated in the middle class, and there have been slight declines in the uninsured who are low-income, the data do not validate that welfare reform contributed to the increase in the number of uninsured.

This Administration has demonstrated an unprecedented commitment to reducing the numbers of uninsured and would not take any action that would reduce access to health insurance for low-income people.

Q: But isn't it true that Medicaid rolls have declined due to welfare?

A: Why Medicaid rolls are declining is a complex question with no easy answer. One explanation is that the improving economy has made it possible for many low-income people once enrolled in the Medicaid program to find jobs that offer health insurance benefits. The Census data show that the decline in Medicaid coverage occurred only among poor people, where there was also an offsetting increase in private coverage. Another answer is that individuals may not realize they are still eligible for the Medicaid program even if their income increases slightly. A recent report from the General Accounting office found that Medicaid enrollment has not declined as rapidly as welfare rolls, suggesting that Federal and state efforts to provide protections and new options have had a positive effect on enrollment.

It is also important to note that the Census Bureau explicitly warns that the changes in Medicaid coverage estimates from one year to the next should be viewed with caution, since Census Bureau data under-reports Medicaid coverage. In fact, preliminary 1998 Medicaid enrollment data from the Health Care Financing Administration show that there were close to 40 million Medicaid enrollees, while the 1998 Census Bureau numbers only report 28 million Medicaid enrollees. As such, it would not be appropriate to rely on the Census Bureau data to draw conclusions about the effect of welfare reform on Medicaid.

THE WHITE HOUSE
WASHINGTON

the uninsured

November 13, 1998

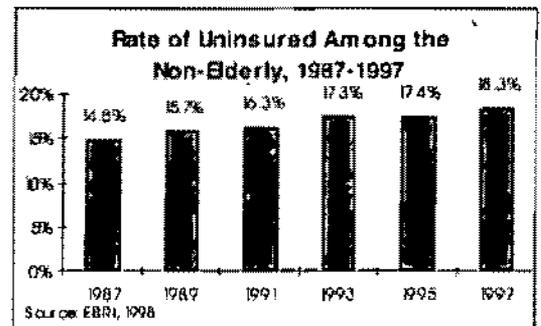
INFORMATIONAL MEMORANDUM TO THE PRESIDENT

FROM: *CLJ* Chris Jennings and Jeanne Lambrew ^{JML}

THROUGH: Bruce Reed, Gene Sperling

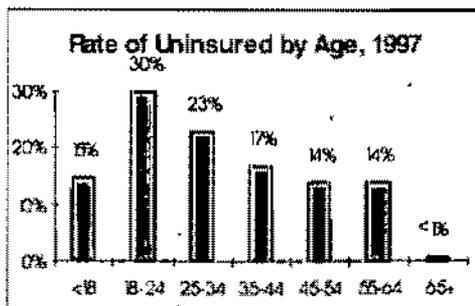
SUBJECT: Recent Uninsured Trends and Analyses

As you know, the Census Bureau recently estimated that 43.7 million Americans are uninsured -- an increase of 1.7 million from 1996 and nearly 5 million from 1992. Insurance coverage is one of the few social indicators that has not improved in the last several years. This contradicts the theory that a strong economy with low unemployment yields a high demand for workers, and thus better benefits like health insurance. It is even more disappointing given record-low health care cost growth in the last several years, which should make insurance more affordable and thus more common. This increase has important consequences since the uninsured are four times more likely to not receive needed health care, have hospitalization rates for preventable conditions that are 50 to 75 percent higher, and place growing uncompensated care burdens on the nation's providers.



Because of the importance of this problem and your expressed interest in these data, we are providing you an analysis of the numbers and recent insurance coverage trends, as well as a summary of their policy implications.

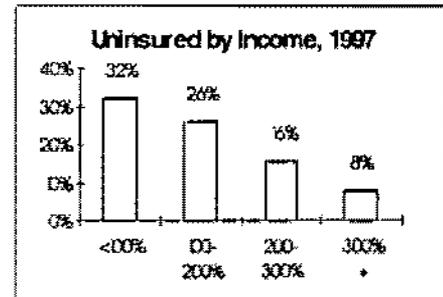
Uninsured by age: Most of the uninsured in America are young; over 80 percent are under age 45 (35.2 million). These uninsured are disproportionately ages 18 to 24 -- 30 percent of whom are uninsured compared to 15 percent of children. The number of uninsured children did not increase in 1997, remaining at 10.7 million. This contrasts dramatically with last year's data that showed that 800,000 of the 1.1 million additional people who were uninsured were children. The change



appears to be the result of the unprecedented focus on children's health in 1997. Beginning with the State of the Union and ending with the establishment of your Children's Health Insurance Program (CHIP), the Federal Government and the states started taking actions to address this serious problem. Next year, after Census' data reflects a full year's operation of CHIP, we would expect the number of uninsured children to fall.

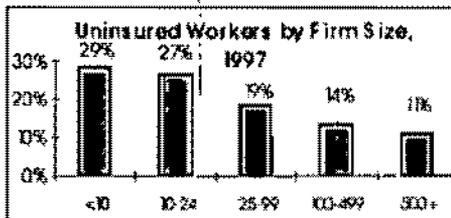
While the likelihood of being uninsured is higher among younger adults, the number of uninsured is growing faster among older adults. One million of the additional 1.7 million uninsured people in 1997 were age 35 or older. The increase is particularly concentrated among people ages 55 to 65; the number of uninsured people in this age group grew faster than all other age groups (7 percent growth). This trend is cause for concern because people ages 55 to 65 become more likely to develop a health problem and less likely to have employer insurance (because their spouses retire and join Medicare, they move to part-time or self-employment which typically does not offer insurance, or they retire). As a result, this age group is disproportionately relies on individual health insurance -- where premiums have been skyrocketing in recent years and underwriting practices remain prevalent. Because of the demographics, there is no doubt that the coverage problem will increase exponentially as the number of people in this age cohort is projected to rise by over 60 percent by 2010.

Uninsured by income: Not surprisingly, people with less income are less likely to have health insurance. Although only 13 percent of the U.S. population, poor Americans (with income less than \$16,000 for a family of 4) represent 26 percent of the uninsured -- fully one-third have no insurance. However, reflecting the strong economy, the poverty rate continues to fall and the number of uninsured below 100 percent of poverty did not increase between 1996 and 1997.



Despite the link between lack of insurance and low income, over 80 percent of the uninsured are in working families. The lack of insurance is growing among the middle class; all of last year's additional 1.7 million uninsured had income above the poverty level, with the greatest concentration of people between 100 and 200 percent of poverty. Inexplicably, although still small in number, the uninsured with income above 500 percent of poverty (over \$80,000 for a family of 4) rose at an extraordinary 20 percent growth rate in 1997.

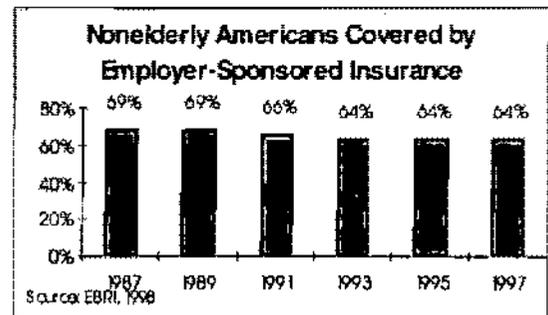
Job characteristics and the uninsured: Workers in small firms are less likely to have access to affordable, job-based health insurance. Nearly half of uninsured workers are in firms with fewer



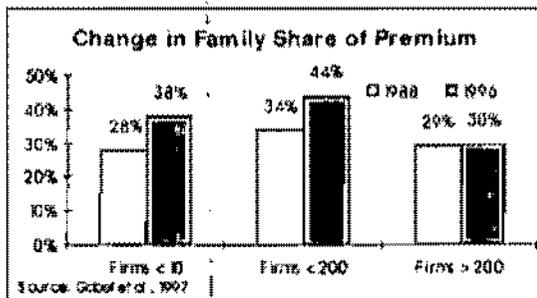
than 25 employees. Compared to over 95 percent of large firms, about half of firms with fewer than 10 employees and three-fourths of firms with 10 to 24 employees offer coverage. These facts underscore the need to find better ways for small businesses to pool resources and leverage to bargain for more affordable benefits.

The rate of being uninsured is also high among people who work full time but only for part of the year, most likely due to job change or loss (27 percent). A recent Census study found that over 40 percent of workers with at least one job interruption had a gap in coverage. Because most people are insured through work, insurance coverage often ends with employment changes -- underscoring the importance of the Kassebaum-Kennedy portability and COBRA protections.

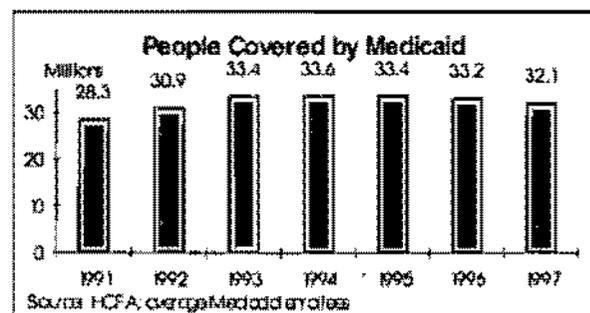
TRENDS IN EMPLOYER-SPONSORED INSURANCE. On the face of it, it does not appear that the increase in the uninsured is directly linked to a decline in employer-sponsored health insurance (ESI). The erosion that occurred in the late 1980s and early 1990s has ended. About 64 percent of nonelderly Americans had employer-based insurance in 1997, virtually unchanged from 1995 and 1996. In recent years, access to job-based health insurance has actually increased, even among small businesses. However, this has not translated into increased ESI coverage because a smaller proportion of people with access to ESI are purchasing it.



Even though more employers are offering health insurance, fewer employees are taking this coverage, primarily because they have to pay more of the premiums. The employee share of premiums has risen, especially in smaller firms. As a result, fewer employees are purchasing this coverage. For example, in 1987, 90 percent of workers in firms with fewer than 10 workers who had access to employer-based coverage took it, compared to 85 percent in 1996. These take-up rates drop as the share of the premium paid by the employee increases. This trend clearly affirms that health insurance affordability plays the most significant role in people's likelihood of buying health insurance.



TRENDS IN MEDICAID. The most notable drop in insurance coverage in 1997, reported by both the Census Bureau and HCFA, appears to come from the number of people covered by Medicaid. There are three possible explanations for this trend. The first and likely most significant factor is that, as the economy has strengthened, fewer people are eligible for Medicaid. This is supported by the fact that the poverty rate has declined, the number of poor covered by ESI has increased, and there was no increase in the number of uninsured children eligible for Medicaid (still 4.7 million). Second, there may be fewer people aware of their continuing Medicaid eligibility in the wake of state and Federal welfare reform. Third, it is becoming more likely that Medicaid beneficiaries misreport that they are covered by private insurance in the Census survey. States have been taking actions to "destigmatize" Medicaid by changing the name of their programs (e.g., TennCare, MinnesotaCare). Also, about 50 percent of Medicaid beneficiaries are enrolled in managed care plans, which are usually private plans. Thus, beneficiaries can easily mistake their coverage for private coverage.



FUTURE TRENDS IN THE UNINSURED. Given the complexity of these trends, it is unclear whether the rise in the number of uninsured will continue. Several compelling factors suggest that it will not and may actually decrease modestly. The Office of National Health Statistics projects that the proportion of Americans covered by employment-based insurance will rise as continued low unemployment will make employers more likely to use insurance to attract workers. Medicaid coverage may increase as well as additional low-income parents become eligible because of the "100-hour rule" welfare-to-work regulation you instituted this past summer and/or due to the states' continued use of Medicaid waivers, which have already covered over one million Americans. We also expect to see a decrease in the number of uninsured children beginning to showing up in next year's Census Report as the effects of CHIP take hold.

As the baby boom generation ages, however, more people will move into the 55 to 65 year old age bracket -- where the proportion of people with ESI is declining and uninsured is increasing. Furthermore, significant premium increases for next year, as some recent reports have projected, may make insurance unaffordable to greater numbers of Americans. While these conflicting trends make it extremely difficult to predict the future with any sense of confidence, it seems unlikely that we will see another significant increase in the uninsured next year.

IMPACT OF ECONOMIC AND EDUCATION SUCCESSES ON THE NATION'S HEALTH. This problem of the uninsured contrasts with tremendous improvements in other national health indicators. Your impressive economic accomplishments have had an impact on the costs of health insurance. For the first time in well over 30 years, health inflation was below general inflation in 1995 and 1996, thus actually reducing the real costs of health insurance. Moreover, gains in education, income and employment have contributed towards record high life expectancy (76.5 years for those born in 1997), a record low infant mortality rate (7.1 deaths per 1,000 live births), an AIDS death rate that is half of what it was in 1992, and a record-high immunization rates. And, historic increases in the investment in biomedical research during your Administration offer real hope for new (and hopefully cost-effective) treatments and cures for the diseases that will otherwise place unprecedented burdens on the nation's economy and health care system when the baby boom retires.

POLICY IMPLICATIONS. The uninsured in America remains one of the most challenging domestic social problems. Not only is the problem large in size, it is complex, crossing income, age and geographic boundaries. Despite its complexity, one fact is clear: making health insurance affordable is and always will be the key to significantly expanding coverage. Even for an employee whose employer pays for 80 percent of the premium, the family share of the premium is typically over \$1,100 per year -- more than one out of every \$10 of income for a minimum-wage worker. This cost is obviously much higher for people without access to employer-based insurance, especially if they have a history of illness. While traditional insurance regulation can help reduce insurance premium variation and discrimination, independent analysts will not project any substantial coverage expansions resulting from these interventions. In a non-mandate environment, they believe that only significant subsidies can induce a substantial reduction in the uninsured.

Ironically, our ability to propose policies to make insurance more affordable is limited by our success in reducing national health spending. In the last 5 years, hundreds of billions of dollars in excess Medicare and Medicaid spending have been squeezed out of these programs and used productively to help eliminate the deficit, finance children's health coverage, extend the life of the Medicare Trust Fund, and to make the Medicaid program a much more predictable and affordable safety net. However, substantial reductions in Medicare and Medicaid mean that these traditionally utilized funding sources cannot be relied on as offsets for major coverage expansions, let alone long-term Medicare reforms. With this in mind, outside funding sources from the tax code, tobacco, or elsewhere would be needed for a significant coverage expansion.

Administration & Republican coverage expansion ideas. The range of coverage options, currently being prepared through the traditional NEC/DPC/OMB budget process, will include some previous and new targeted coverage expansions. As this memo has documented, the most recent data validate the case for coverage expansions to the pre-65 and "workers-in between-jobs" populations. We also will continue to focus on administrative and possibly legislative outreach policies to encourage enrollment in CHIP and Medicaid to ensure your children's health initiative is a success. However, recognizing the questionable political and budgetary viability of these proposals, we are also reviewing options more likely to be well received in this Congress.

First, we are contemplating policies to encourage states to expand using existing options. With the 100-hour rule regulation, all states can now cover parents of children on Medicaid. Other states have used Medicaid 1115 waivers to cover all people up to certain income levels. Because this would likely require greater financial incentives, one option is making coverage expansions a priority on a short list of acceptable uses for the Federal share of state tobacco settlements.

As an alternative to coverage expansion options, we expect Secretary Shalala to advocate for a significant investment in public health infrastructure. This investment would be used to adapt the safety net to the rapidly changing health system. This idea would likely be better received than a coverage expansion by Republicans. However, if not a capped mandatory grant program, it would either require raising the discretionary caps or place a major strain on the current caps. Also, it would likely be perceived by some Democrats as giving up on coverage expansions.

Since there is bipartisan concern about small businesses' problem in accessing insurance, we are also considering enhancing our previously-proposed small business purchasing coalition grant initiative. We could more aggressively encourage these coalitions by directing OPM to provide technical advice for their establishment and operation, so that they more closely resemble FEHBP. We are also examining granting them non-profit status, to facilitate foundation support.

In 1999, Republicans, too, may consider small business group purchasing policies (although in the past, their versions have been significantly flawed). It is more likely, however, that, if Republicans decide to address the coverage issue at all, they will focus on the use of tax incentives for the purchase of individual health insurance. Encouraging individual insurance is intriguing because nation's reliance on voluntary, employer-based coverage has clearly not been an unqualified success. Moreover, if there is to be any significant investment in health care that the Republicans could possibly support, it would almost inevitably come from the tax code.

While acknowledging that tax credits are at least initially appealing, they are no panacea. They are extremely inefficient and expensive, as many of the assumed recipients would already have coverage. For independent experts to validate that the previously uninsured would take advantage of this policy, the credit would have to be quite large. In addition, if used for individual (rather than employer-based) insurance, they would require the type of major insurance reforms that have been historically opposed by Republicans. The individual market is the least regulated, most expensive, most "cherry-picked" and most unstable insurance market.

Notwithstanding legitimate concerns, we believe that tax credits may be the only health coverage expansion vehicle that could be produced by this Congress. As such, we are reviewing possible options for your consideration. For example, it might be possible to merge policies to promote small group purchasing coalitions with tax credits for participating employers or employees. Limiting the tax credit to such entities could further encourage a long-overdue expansion of small business coops. However, such approaches also raise equity concerns (e.g., why discriminate against an employee/employer who does not have access to, or does not want to be in, a purchasing coop) and political arguments (e.g., isn't this too similar to the Health Security Act). DPC, NEC, OMB, Treasury and HHS are reviewing this purchasing coalition/tax credit idea and other tax incentive approaches. We will keep you apprised of developments in this area, as well as other coverage options, as the budget process unfolds.

THE WHITE HOUSE



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Health Care - Uninsured

~~TOP SECRET~~

Recent Trends in Health Insurance: Embargoed Until 9/29/98



	1994	1995	1996	1997
OVERALL				
Uninsured (millions)	39.7 m	40.6 m *	41.7 m **	43.4 m **
Uninsured	15.2%	15.4% *	15.6% *	16.1% **
Private coverage	70.3%	70.3%	70.2%	70.1%
Medicaid	12.1%	12.1%	11.8%	10.8%
POOR				
Uninsured (millions)	11.1 m	11.0 m *	11.3 m	11.2 m
Uninsured	29.1%	30.2%*	30.8% *	31.6%
Proportion of uninsured who are poor	27.8%	27.1%	27.0%	25.9%
Medicaid	46.2%	46.4%	45.5%	43.3%
UNINSURED BY AGE				
0 to 17 years	14.2%	13.8%	14.8%	15.0%
18 to 24 years	26.7%	28.2%	28.9%	30.1%
25 to 34 years	22.0%	22.9%	22.3%	23.3%
35 to 44 years	16.0%	16.6%	16.3%	17.3%
45 to 64 years	13.3%	13.3%	13.7%	14.1%
65 + years	0.9%	0.9%	1.1%	1.0%
UNINSURED BY INCOME				
< \$25,000	23.2%	23.9%	24.3%	25.4%
\$25,000 - 49,999	15.4%	16.2%	16.6%	18.1%
\$50,000-74,999	8.7%	9.3%	10.0%	10.1%
\$75,000 +	7.0%	6.7%	7.6%	8.1%
WORKERS WITH EMPLOYER-SPONSORED INSURANCE				
All firms	53.3%	53.2%	53.1%	53.0%
< 25 workers	27.9%	28.3%	28.2%	28.4%
25-99 workers	52.6%	53.7%	53.9%	52.4%
100-499 workers	63.2%	63.5%	63.1%	61.8%
500-999 workers	67.4%	65.1%	66.1%	66.7%
1000 + workers	67.9%	67.7%	67.1%	66.6%

* Insignificant change; ** Significant change; if no asterisk, no test available.

Uninsured Children Less than 18 Years Old

	1995	1996	1997
OVERALL UNINSURED			
Total (number)	9.8	10.7 **	10.7 *
Total	13.8%	14.8% **	15.0%
Private	66.1%	66.3%	66.9%
Medicaid	23.2%	21.8%	20.5%
POVERTY AND THE UNINSURED			
Poor uninsured (number)	3.1 m	3.4 m *	3.4 m *
Poor uninsured ¹	21.4%	23.3% *	23.8%
UNINSURED BY AGE			
< 6 years	13.3%	13.8%	14.4%
6 to 11 years	13.5%	14.6%	13.9%
12 to 17 years	14.5%	16.1%	16.7%
UNINSURED BY RACE			
White	13.4%	13.9%	14.1%
Black	15.3%	18.6%	18.9%
Hispanic	26.8%	28.9%	28.6%

* Insignificant change; ** Significant change; if no asterisk, no test available.