
American College of Physicians

**UNIVERSAL COVERAGE:
RENEWING THE CALL TO ACTION**

**Position Paper of the
AMERICAN COLLEGE OF PHYSICIANS**

**Approved by the Board of Regents
April 22, 1996**



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Executive Summary

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With the demise of efforts to pass federal health care reform legislation and political changes from the November 1994 elections, the issue of the uninsured has largely dropped off the national agenda. Despite inattention, the problem of the uninsured is still with us and the numbers are growing. Further, developments in the public and private sectors may well lead to increases in the number of uninsured in the near term. Out of this concern, and in an effort to refocus attention, ACP commissioned a status report on health care coverage. The results of that study by the Urban Institute are highlighted in this paper and presented in full in a separate report.

Approximately one out of every six people under age 65 -- over 18 percent of the non-elderly population -- is without health insurance for the entire year. By one estimate, 42 million people are now at risk of facing health care costs without any insurance coverage for the entire year. Three quarters of uninsured people are full-time or part-part-time workers. The working poor are most heavily affected: 45 percent of workers whose incomes are below the poverty level had no medical coverage. Health care benefits accrue more to upper income and white people than to lower income and non-white individuals. Almost 30 percent of the poor and near-poor have no coverage from any source. Though somewhat problematic to define and measure, *underinsurance* is a significant problem as well.

Employer-provided coverage appears to be declining. The College takes as a serious warning sign the finding that between 1988 and 1993, the rate of employer sponsored coverage fell from 67% to 61.1% of the non-elderly population. If the lower rate of employer coverage in 1993 had prevailed in 1988, 12.5 million fewer people would have been covered through employer plans. Recent developments may lead toward rapid escalation of uninsured numbers. At least one study, using Congressional Budget Office projections, estimates the potential addition of 23 million uninsured people by 2002 if Medicaid eligibility is frozen through budget cuts and employer-sponsored coverage continues to decline.

The essential issue for physicians is the impact of insurance status on access to health care and on health status and outcomes. Studies show consistently that the use of medical services is lower among the uninsured than among the insured. Even for acutely ill individuals, the uninsured are two-thirds as likely to have seen a physician as those who have insurance. Other analyses, linking insurance coverage to health status and outcomes, find that the uninsured are more likely to have potentially avoidable hospitalizations, are usually sicker at the time of admission, and have higher average mortality rates.

The American College of Physicians cannot accept these documented differences in access to medical care. We cannot be complacent when research shows that uninsured patients receive fewer services and have higher mortality rates than patients with insurance coverage. There can be no more important issue in health policy today than to eliminate these disparities in medical care. Seeking to play a leading role in this debate, the American College of Physicians will adhere to the following principles:

1. The nation must achieve universal health care coverage -- that is, each individual must have insurance coverage that pays for medical care.
2. Universal coverage is likely to be achieved incrementally. Proposals that expand coverage in phases are likely to be more successful. We also reaffirm the approach taken in our 1992 paper that, in our pluralistic system, solutions must involve both public and private reforms.
3. Given recent trends, it is prudent to explore alternatives to employer-based insurance as the mainstay of our system of coverage. Continuity of coverage through changes in job status is essential.
4. Access to care also depends on the availability of health care facilities and professionals. We encourage steps to fill gaps in the infrastructure of health care delivery, particularly in inner cities and rural areas, and oppose budget cuts or other proposals that diminish the ability of institutions and professionals to provide care where people need it.
5. The College opposes any proposal that would increase the number of uninsured. For that reason, we have and will continue to oppose the elimination of guaranteed coverage for eligible individuals under the Medicaid program. Similarly, we will continue to oppose Medicare proposals that jeopardize the availability and quality of care for Medicare beneficiaries.

The ACP's purpose in this paper and in commissioning the Urban Institute study is to focus the nation's attention once again on the problem of the uninsured. America's leaders and citizens must recognize the potentially severe medical problems that face individuals and families who have no health coverage. A period of education and recognition of the problem is an essential precursor to building a consensus around a solution. Just as the 1992 election set the stage for consideration of comprehensive reform legislation, so we again call on political leaders of both parties to address these issues during the 1996 campaigns.

As physicians, we confront the results of inaction every day as we see patients whose illnesses or deaths might have been avoided had those people had health care coverage. This nation cannot afford to waste its precious human resources. Universal coverage remains the goal of the American College of Physicians. We ask others to join us.

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In 1990, and again in 1992, the American College of Physicians committed itself to the goal of achieving universal health care coverage (American College of Physicians, 1990, 1992). The College called universal coverage a medical and moral imperative. Recognizing that the health care system was inadequately serving patients, physicians, and public and private payers and purchasers of care, ACP supported passage of comprehensive reform legislation in 1994.

With the demise of that reform effort and political changes from the November 1994 elections, the issue of the uninsured has largely dropped off the national agenda. Despite inattention, the problem of the uninsured is still with us, and, not surprisingly, the numbers are growing. Further, developments in the public and private sectors may well lead to more rapid increases in the number of uninsured in the near term. Out of this great concern, and in an effort to refocus attention on this problem, ACP commissioned a status report on health care coverage. The results of that study by the Urban Institute are highlighted in this paper and presented in full in a separate report (Blumberg and Liska, 1996).

Rising Numbers of Uninsured: Approximately one out of every six people under age 65 -- over 18 percent of the non-elderly population -- is without health insurance for the entire year. In some large states, one fifth to one quarter of the population under 65 has no coverage -- for example, California (19 percent), Texas (24 percent). More than 42 million people are now at risk of facing health care costs without any insurance coverage for the entire year. In addition, the median time that an individual remains uninsured increased from 4.2 months in the late 1980s to 7.1 months by 1993. For large numbers of people, these periods are much worse: more than

half of the uninsured in 1993 were expected to be uninsured for more than 2 years (McBride, 1994; Thorpe, et al., 1995).

It cannot be assumed from the data that many people choose to be uninsured. Putting so many people at extreme financial risk is unconscionable. Further, as noted below and documented in the Urban Institute paper, the uninsured are at medical risk as well; they receive less care, and possibly lower quality care, than insured individuals.

The problem of no insurance cuts increasingly through much of American society. We learned during the health care debate of 1993-94 that three quarters of uninsured people are full-time or part-time workers. The working poor are most heavily affected: according to the Census Bureau (1995), an astonishing 45 percent of working people whose incomes are below the poverty level (\$15,150 for a family of four in 1995) had no medical coverage. Non-workers among this same income group had more coverage than workers because of Medicaid. Recent losses in coverage have significantly affected people who are *above* the poverty level: from 1988 to 1993, the number of people without insurance in this group increased by 5.7 million. Articles in the general press have described both the real and the perceived insecurity of lower and middle income working households, at a time of economic growth. We suggest that an important element of this insecurity derives from exposure to potentially catastrophic health care expenses.

Though somewhat problematic to define and measure, *underinsurance* is a significant problem as well. If underinsurance is defined as being at risk of out-of-pocket expenditures that exceed 10 percent of family income, then some 18.5 percent of people who have private coverage, or 29 million people, were underinsured in 1994 (Short and Banthin, 1995). This number is almost 50 percent higher than the estimate of underinsurance that was quoted frequently during the health care reform debate. Adding this number to the number of people

frequently during the health care reform debate. Adding this number to the number of people who were uninsured for either all or part of the year, the authors estimate that about one third of the population below age 65, or approximately 75 million people, were inadequately insured in 1994.

Shortcomings of Private and Public Coverage: The United States has developed an incomplete system of coverage that mixes employer-provided insurance, individually purchased private insurance, and public coverage through Medicare, Medicaid, and publicly funded clinics and other public health initiatives. Employers in 1993 covered only 61 percent of non-elderly Americans, compared with 67 percent in 1988. Coverage varies greatly with size of firm. Only 28 percent of workers in firms employing fewer than 25 people had employer-provided insurance in their own names (Census Bureau, 1995). This figure increases to 68 percent in firms with more than 1,000 employees.

Employer-provided coverage appears to be declining. The College takes as a serious warning sign the finding that between 1988 and 1993, the rate of employer-sponsored coverage fell from 67% to 61.1% of the non-elderly population. If the lower rate of employer coverage in 1993 had prevailed in 1988, 12.5 million fewer people would have been covered through employer plans. The largest decline was for the near poor (incomes of 100-200 percent of the poverty level). Given competitive pressures in the marketplace, especially as American companies increasingly compete with international businesses that do not pay directly for health costs, this decline may continue. The adequacy of employer-provided insurance as the mainstay of our health care coverage network may be in question.

Public coverage plays a critical secondary role, but obviously does not fill the gap. Medicaid covers only about half of all people below the poverty line. Despite some gains for

percent of the group below 200 percent of the poverty line had no insurance in the period 1990-92. Budget cuts plus potential Medicare and Medicaid program changes will likely exacerbate this problem.

A Medical Imperative: The essential issue for an organization of physicians is the impact of insurance status on access to health care and on health status and outcomes. Section IV of the Urban Institute paper reviews a number of studies that have shown consistently that the use of medical services is lower among the uninsured than among the insured. This lower use is not just a matter of avoiding preventive care -- not that that is a minor issue. Even for acutely ill individuals, the uninsured are two-thirds as likely to have seen a physician as those who have insurance. Seriously injured children are significantly less likely to have received medical attention. Children under 3 who experience gaps in insurance coverage are far less likely than insured children to have a continuous, regular source of care. Surely these findings are an indictment of our current haphazard means of providing health care coverage.

While linking insurance coverage to health status and outcomes is difficult, studies have raised some very disturbing questions. Research by Lurie, et al. (1984) showed that loss of Medical coverage in California led to reduced access to care and deterioration in hypertensive and diabetic patients. Recent studies noted in the Urban Institute report provide evidence that the uninsured are more likely to have potentially avoidable hospitalizations, are usually sicker at the time of admission, and have higher average mortality rates. For example, an analysis of 699 uninsured persons found that the expected number of deaths would have been 25 fewer -- 103 instead of 128 in the sample -- had those people had insurance. Another study found that in 10 of 16 age-sex-race-specific groups, controlling for case-mix and severity of illness, the probabilities of dying in the hospital ranged from 20 to 320 percent greater for the uninsured.

An interesting, contrasting perspective on the potential effects of insurance coverage on health outcomes is suggested in a study of survival rates after the age of 80 (Manton and Vaupel, 1995). Among this group, where health insurance is above 98 percent through the Medicare program, life expectancy at the age of 80 exceeds that of Sweden, France, England, and Japan. In contrast, for Americans under 65, who have lower rates of insurance coverage than comparable persons in these other countries, the mortality rate is greater.

A Moral Imperative: The studies on access to services and on health outcomes put to rest the myth that endures in some quarters that people without insurance somehow “manage” to receive care. Obviously some get attention, through emergency rooms, public clinics, and charity care from hospitals, physicians, and other health care professionals. This has varied greatly from community to community; while a charitable tradition remains strong in some areas, given current financial pressures and institutional restructuring, charity or “uncompensated” care is not a reliable way to assure that patients receive care. As physicians, we cannot accept documented differences in access to medical care. We cannot be complacent when research shows that uninsured patients receive fewer services and have higher mortality rates than patients with insurance coverage. *There can be no more important issue in health policy today than to eliminate these disparities in medical care.*

The question of health insurance also raises the issues of income and racial inequality. Not surprisingly, health care coverage is another arena in which benefits accrue more to upper income and white people than to lower income and non-white individuals. Almost 30 percent of the poor and near-poor have no coverage from any source. Employers provide coverage for only about 30 percent of this group -- significantly lower percentages than for higher income levels. While employers provide coverage for 67 percent of whites, they provide coverage for only 48 percent

of non-whites. Overall, 21 percent of non-whites are uninsured, compared to 15 percent of whites. These enduring inequities must be addressed.

Future Prospects: There is no indication that the trend towards less coverage and more uninsured will be reversed. On the contrary, recent developments may lead toward rapid escalation. Most disturbing are proposals for Medicaid block grants, eliminating guaranteed coverage for eligible individuals and cutting back on funding. In the past, Medicaid has been able to partially offset economic downturns. With capped funding, states would no longer be able to absorb people who lose jobs and employer-provided health coverage in a recession. The result may be that millions of low-income people will be added to the uninsured. Thorpe, et al. have estimated the potential effects of limiting Medicaid increases to 4.5 percent per year, as proposed in budgets under consideration in the fall of 1995. If states responded by freezing the number of beneficiaries, the number of uninsured would increase by 5 million above the Congressional Budget Office's baseline projection of 44 million uninsured in 2002.

Proposals to take incremental steps, such as insurance reform and public subsidies, may have positive impact, if properly structured. However, issues such as price sensitivity and budget constraints will limit the gains. Risk segmentation -- dividing patients into pools according to health risk and rating them accordingly -- is a critical issue that must be addressed with any incremental changes because it has the potential of exacerbating the problem.

Developments in the private sector are continuing cause for concern. We have noted that the number of people covered by employers has substantially decreased. The downsizing of large corporations continues, as does the transformation of the economy from manufacturing to high technology, service, and entertainment sectors. These developments all suggest lower levels of insurance coverage. Assuming that employer-provided coverage continues to decline at the same

rate as in 1989-1993, and that people who lose coverage are not picked up by the Medicaid program -- i.e., that Medicaid eligibility is frozen at current levels -- Thorpe, et al. project the number of uninsured in 2002 at almost 67 million people!

Private payers are increasingly unwilling to accept the "cost shift" that some have labeled as America's unofficial policy for covering the uninsured. The result is enormous pressure, especially felt by community and teaching hospitals, to cut back on the numbers of uncompensated patients. An additional concern is that increasing Medicare payments to managed care organizations siphon off funding for graduate education and for disproportionate share payments -- both of which help institutions care for the uninsured -- unless those components are taken out of the premium calculation for risk-bearing plans.

Finally, there is increasing concern about the amount of money taken out of the system for non-medical uses. While there is disagreement about the size of "administrative" costs -- some estimates have been in the range of one fifth to one quarter of total spending -- the transaction costs of the American system appear high, particularly compared with those of other nations. The California Medical Association, for example, has released data that show percentages of patient revenue spent on medical care ranging from 95 to 70 percent. Recently, physicians and others have been dismayed by the size of profits accumulated by for-profit managed care organizations and other health plans or insurers. Whether it results from wasteful administrative costs, fraud and abuse, or profits, the diversion of premium dollars for non-medical purposes means that fewer people are receiving fewer services. Finding the most efficient level of administrative spending and debating and defining the appropriate or reasonable level of profit-making are challenges that must be addressed as the nation searches for solutions to the problems of the uninsured.

Guiding Principles: As we seek to build a consensus that the issue of the uninsured must be addressed, the American College of Physicians will adhere to the following principles:

1. The nation must achieve universal health care coverage -- that is, each individual must have insurance coverage that pays for medical care.

2. Universal coverage is likely to be achieved incrementally. Proposals that expand coverage in phases are likely to be more successful. We also reaffirm the approach taken in our previous paper (American College of Physicians, 1992) that, in our pluralistic system, solutions must involve both public and private reforms.

3. Given recent trends, it is prudent to explore alternatives to employer-based insurance as the mainstay of our system of coverage. Continuity of coverage through changes in job status is essential.

4. Access to care also depends on the availability of health care facilities and professionals. We encourage steps to fill gaps in the infrastructure of health care delivery, particularly in inner cities and rural areas, and oppose budget cuts or other proposals that diminish the ability of institutions and professionals to provide care where people need it.

5. The College opposes any proposal that would increase the number of uninsured. For that reason, we have and will continue to oppose the elimination of guaranteed coverage for eligible individuals under the Medicaid program. Similarly, we will continue to oppose Medicare proposals that jeopardize the availability and quality of care for Medicare beneficiaries.

Call to Action: In 1992, the College made recommendations for comprehensive reform of the health care system. Those recommendations were similar to proposals made by other organizations and individuals. Clearly there is no consensus now around that approach or any other approach. Specific solutions at this time are premature. Our purpose in this paper and in

commissioning the Urban Institute study is to focus the nation's attention once again on the problem of the uninsured. America's leaders and citizens must recognize the potentially severe medical problems that face individuals and families who have no health coverage -- and recognize that these problems cut across income groups. A period of education and recognition of the problem is an essential precursor to building a consensus around a solution. Shared commitment to solving the problem is probably a greater challenge than developing the proposals to extend health care coverage. Just as the 1992 election set the stage for consideration of comprehensive reform legislation, so we again call on political leaders of both parties to address these issues during the 1996 campaigns.

As physicians, we confront the results of inaction every day as we see patients whose illnesses or deaths might have been avoided had they had health care coverage. This nation cannot afford to waste its human resources. Universal coverage remains the goal of the American College of Physicians. We ask others to join us.

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The Uninsured in the United States: A Status Report

Prepared for the American College of Physicians

The Urban Institute

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DRAFT

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**ANTICIPATING THE NUMBER OF UNINSURED AMERICANS AND THE
DEMAND FOR UNCOMPENSATED CARE:**

**THE COMBINED IMPACT OF PROPOSED MEDICAID REDUCTIONS AND
EROSION OF EMPLOYER-SPONSORED INSURANCE**

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November 1995

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The Council and the authors intend to submit these papers, or revisions thereto, for publication. We request that these papers not be cited or circulated without the permission of the authors.

12/11

I spoke w/ David Shachtman who said we could cite + quote from these studies.

-Pauline

INTRODUCTION

DRAFT

The rising number of Americans without health insurance has been a public policy issue for some time. In this analysis we add to the debate by estimating the combined impact on the number of uninsured of recent declines in employer-sponsored insurance (ESI) and anticipated cuts in the Medicaid program. We also estimate the effect this expected growth in the number of uninsured will have on the demand for uncompensated care.

On a typical day during 1994, over 39.7 million, or about 15 percent of the population, were uninsured. This was up from 13 percent (34.5 million) of the population uninsured in 1990. Not only were more Americans uninsured, but the length of time without insurance increased. During the late 1980s, the median time an American was uninsured was 4.2 months. That rose to 7.1 months by 1993 (Bennefield 1993).

The growing numbers of uninsured raises concerns about the impact on individual health, as well as the strain placed on the health delivery system from increased uncompensated care. Historically, the cost of this uncompensated care has been borne, in part, by the privately insured in the form of higher prices. In recent years, intensifying pressures from competition and managed care has made it more difficult for providers to shift unreimbursed costs to private payers.

The Medicaid program has been a significant source of coverage for low-income Americans. Yet escalating costs have led Congress to propose reducing the rate of growth of Medicaid spending by \$182 billion between 1996 and 2002. This may impact the number of persons covered under Medicaid, and therefore increase the number of uninsured. The budget limits in these proposals would require at best a substantial restructuring of current programs. Under the House and Senate bills, Medicaid spending would be constrained to about a 4.8 percent annual growth rate in spending. This compares with Congressional Budget Office (CBO) projections of a 10.1 percent annual growth rate, if the program continues on its existing trajectory.

These Medicaid constraints come at a time when the number of Americans receiving health insurance through employer-sponsored insurance (ESI) continues to decline. The most recent data from the March 1994 Current Population Survey (CPS) reports that 56.8 percent of the population now receive health insurance through employer-sponsored programs, compared to 61 percent four years ago (Thorpe 1995). The accelerated decline in ESI is expected to continue, as jobs shift from the manufacturing sector, where workers are more likely to receive health insurance, to the service sector, where health benefits are less prevalent.

In developing our estimates, we first establish a baseline trajectory of the number of uninsured for the years 1996-2002, using the methodology developed by the Congressional Budget Office (CBO). These estimates are then updated using the March 1995 CPS numbers for the uninsured. We then consider two possible scenarios: First, we examine the impact of Medicaid reductions on baseline estimates of the number of uninsured, holding Medicaid

enrollment constant.¹ In the second scenario, we project the number of uninsured assuming a faster pace of erosion of ESI consistent with trends over the last four years, in combination with Medicaid reductions (fixed enrollment). Finally, we project the increased demand for uncompensated care and the impact this will have on the hospital sector. We begin with an introductory discussion of what it means to be uninsured. What really is at stake?

I. WHY IS THE NUMBER OF UNINSURED IMPORTANT?

The rising number of uninsured is important for two reasons: the adverse impact on individuals, and the burden placed on the health care system in responding to the demand for uncompensated care.

Impact on Health Status of Individuals

There has been some debate about the policy relevance of being uninsured when, in fact, many of the uninsured are young and relatively healthy. The rising number of uninsured, some argue, merely reflects individuals who choose to forgo health insurance rather than face eroding wages. It also may reflect the fact that many individuals without any form of third party coverage and with limited incomes receive substantial amounts of free care when in need.

Yet we know that nearly 60 percent of the uninsured are poor or near poor,² and that these low-income groups are known to have higher risks of disease and mortality (Pappas et al. 1993, Adler et al. 1993). Several studies have also documented that while the uninsured receive substantial amounts of free care, they face delayed access to that care and lower utilization of health care services than those with either public or private third party coverage.³ A study of five hospitals in Massachusetts, for example, found that poor (income less than \$10,000) uninsured patients were twice as likely as insured patients to report delays in care (Weissman et al 1991). Once in the hospital, uninsured patients receive fewer services than privately insured patients (Blendon 1988, Weissman 1989, Hadley 1991, Franks

¹Assuming that Medicaid enrollment levels will be frozen is a conservative approach. Between 1992 and 1994, Medicaid enrollment grew an annual average of 6.45 %. The total growth in Medicaid beneficiaries between 1990-94 was 47 percent (HCFA, Form 2082 data). CBO estimates that Medicaid enrollment will grow from 36.8 million in 1995 to 45.9 million by 2002, representing a growth rate of 3.3 Percent per year (Urban Institute, Impact of Budget Resolution Conference..)

²During the period 1990-92, 29.2% of the uninsured (under age 65) were poor, and 29.7% of the uninsured were near poor (100-199% of the federal poverty line). The federal poverty line for a family of three is currently \$12,590. (Health Needs and Medicaid Financing: Kaiser, 1995)

³ For an exhaustive discussion of the literature, see the U.S. Congress, Office of Technology: Does health insurance make a difference? OTA-BP-H-99. Washington: U.S. Government Printing Office, September 1992.

1993), raising questions about the quality of care received. Uninsured children, too, consistently receive less services than their insured counterparts (Monheit and Cunningham 1992, Newacheck and Halfon 1992, Stoddard et al 1994). Uninsured status is often correlated with other characteristics, such as being poor, black, or without a usual source of care, which places a person at risk for receiving less care than needed (Weissman 1991, Weissman and Epstein 1989, Wenneker and Epstein 1989, Yelin et al 1983). Therefore, it seems clear that uninsured persons are potentially at risk for delays in health care, for receiving less than appropriate health services, and for receiving poorer quality health care than insured persons -- factors leading to poorer health, diminished functional status and quality of life.

Demand for Uncompensated Care

The number of uninsured is also an important factor for the health care system as a whole. Uncompensated care is generated largely by the uninsured. Totals of uncompensated care provided by hospitals are routinely reported. The CBO traced approximately 77 percent of hospital uncompensated care charges and 89 percent of uncompensated physician charges to the uninsured in 1993.⁴ The volume of uncompensated care provided by hospitals has also risen steadily over time. In 1980, uncompensated care costs totaled \$3 billion, or 3.9% of hospital costs. By 1993, uncompensated care accounted for \$15.9 billion, or 6% of all hospital costs (AHA Annual Survey of Hospitals, 1994).

II. RECENT TRENDS IN THE NUMBER OF UNINSURED (1989-1995)

Point-in-Time Estimates of the Number of Uninsured

Estimates of the uninsured used in this analysis are based on the March 1995 Current Population Survey (CPS). Another common source of data used to generate estimates of the uninsured is the Survey of Income and Program Participation (SIPP).⁵ There is potential bias in any survey tool. Hence, we reference a sensitivity analysis comparing point-in-time estimates of the number of uninsured from both survey instruments for the calendar year 1991 (Bennefield 1994).

⁴CBO Staff memorandum, "Single Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates", April 1993.

⁵The CPS is a point-in-time survey, whereas the SIPP is a multi-panel, longitudinal survey, both of which are conducted by the U.S. Bureau of the Census in the Department of Commerce. Questions concerning health insurance status vary considerably, but as seen here, generate similar estimates (Bennefield 1994).

Table 1: Alternative Estimates of the Number of Uninsured, 1991.

SOURCE OF ESTIMATE	NOT COVERED BY HEALTH INSURANCE
SURVEY OF INCOME AND PROGRAM PARTICIPATION (SIPP)	13.2%
CURRENT POPULATION SURVEY (CPS)	14.1%

SOURCE: BENNEFIELD 1994

NOTE: THE SIPP AND CPS ARE CONDUCTED BY THE U.S. BUREAU OF THE CENSUS.

As seen in Table 1, there were nominal differences in the estimates, with 14.1 percent uninsured according to the CPS and 13.2 percent indicated by the SIPP. Using CPS data, therefore, will not greatly bias our projections of the number of uninsured.

Among the uninsured, children represent a particularly vulnerable group. During the decade 1977-1987, there was a 40 percent increase in the proportion of children with no health insurance (Cunningham and Monheit 1990). This trend was reversed in the next four years, even though private insurance declined from 73.3 percent in 1988 to 69.3 percent in 1992. To make up for this reduced private coverage, nearly 5 million children were added to the Medicaid rolls, representing a 45 percent increase (10.0 million to 14.5 million).⁶ Had Medicaid coverage not expanded, perhaps as many as 3 million of the children that lost private coverage would have been added to the rolls of the uninsured.

In 1992, 8.3 million children (12.4 percent of all non-institutionalized children) were uninsured. Particularly at risk were adolescents, minorities, children living with a single parent and children in poor or near-poor families (Newacheck 1995). The majority of uninsured children were members of two-parent families and were non-Hispanic white. Nearly two-thirds were in families with incomes just above the poverty level who were not eligible for Medicaid coverage.

Studies have yielded different interpretations of the decline in dependent coverage among the ESI population and concurrent increases in the number of children enrolled in Medicaid. Some analysts believe that the decline in ESI dependent coverage was partly generated by the liberalization of Medicaid eligibility for children. Cutler and Gruber (1995), for example, estimated that as much as 50-75% of the increase in Medicaid coverage for women and children between 1987-1992 was accompanied by a reduction in private insurance coverage.

⁶This led to the percentage of children with some form of health coverage actually increasing slightly in the 1988-1992 period, from 86.9 percent to 87.6 percent.

An alternative explanation for this reduction in the number of children covered under ESI was offered by Thorpe (1995). He attributed the reduction of ESI primarily to changes in the structure of working families receiving health insurance through their employers. According to his analysis, there were more children in families where a parent did not have ESI coverage. He supported his thesis by referring to the fact that the number of workers receiving insurance through ESI has remained stable, but the average family size of ESI covered workers has decreased. Given these conflicting studies, it is unclear the extent to which Medicaid expansions "crowded out" private coverage. However, virtually all analysts agree that there have been declines in ESI dependent coverage, and that Medicaid has become a major source of health coverage for children. Whether this declining trend in private coverage for children will be reversed by a tightening in Medicaid eligibility must await future analyses. In this paper, we adopted a middle ground and kept the number covered at current levels.

Longer Spells of Uninsurance for the Newly Uninsured

Not only is the number of individuals uninsured at any point in time increasing, but so is the length of time individuals remain uninsured. As seen in Table 2, approximately 54 percent of the uninsured in 1993 will be uninsured for over two years. Tables 3 and 4 show that the median length of time without insurance (for all persons with observable starts to their uninsured spells) has crept up from 4.2 months in the 1987-89 period to 7.1 months in the February 1991-93 period. The historical trend toward shorter uninsured spells is no longer valid. The proportion of spells lasting more than 9 months increased from 62% to 67% from 1984-1987⁷ (McBride 1994).

The length of time the uninsured remain uninsured is an important consideration, since policy interventions would differ depending on whether or not the target population was chronically uninsured (spells lasting over two years). Conflicting reports exist concerning the proportion of chronically uninsured. McBride estimated this proportion using within sample survival regression models on longitudinal data. He concluded that over half of the uninsured population will remain so for periods lasting more than 25 months, and about 75 percent will be without coverage for more than a year (McBride 1994).⁸

⁷These estimates include only the first uninsured spell a person endures.

⁸First, a count of all uninsured at a point-in-time, December 1988, was taken. This date was the final month of the survey period. This count then could be traced back through the prior 28 months to see how long individuals had been uninsured thus far. Finally, McBride used a within-sample survival regression model to estimate how long the uninsured in December 1988 would continue to be uninsured after the survey period was complete.

Table 2: Length of Uninsured Spell (Point in Time) for Uninsured Population

LENGTH OF SPELL	PERCENTAGE OF UNINSURED	TOTAL UNINSURED (MILLIONS)*
1 TO 4 MONTHS	3.5	1.4
5 TO 8 MONTHS	11.6	3.9
9 TO 12 MONTHS	9.8	3.9
13 TO 16 MONTHS	8.1	3.2
17 TO 24 MONTHS	13.0	5.2
OVER 25 MONTHS	53.9	21.4
TOTAL	99.9**	39.7

SOURCE: AUTHORS' TABULATION USING METHODOLOGY FROM MCBRIDE 1994.

NOTES: *ESTIMATED BY APPLYING "PERCENTAGE OF UNINSURED" TO CENSUS BUREAU ESTIMATE OF UNINSURED PERSONS FROM THE 1993 CPS. ASSUMES CONSTANT PROPORTION OF UNINSURED TO INSURED.

**ERROR DUE TO ROUNDING.

Table 3: Length of Spell Without Insurance for the Newly Uninsured Population with Observable Starts to Spell, by Employment Status and Income Level, Selected Years (Median Months).

	1987-89	1990-92	1993-93
MEDIAN, ALL SPELLS	4.2	6.0 (0.6)	7.1 (0.2)
EMPLOYMENT STATUS (FOR PERSONS 18 AND OVER)			
FULL TIME	4.0	4.6 (0.9)	5.7 (1.1)
PART TIME	5.5	6.8 (1.6)	7.5 (0.5)
UNEMPLOYED*	6.3	7.8 (0.7)	7.7 (0.5)
NOT IN LABOR FORCE**	5.6	7.2 (0.3)	8.8 (3.2)
RATIO OF INCOME TO POVERTY LEVEL			
UNDER 1.00	4.8	7.2 (0.2)	7.5 (0.3)
1.00 AND OVER	4.0	4.9 (0.7)	6.3 (1.3)
1.00 TO 1.24	7.1	6.8	
1.25 TO 1.49	7.2	7.0	
1.50 TO 1.99	3.9	6.2	
2.00 TO 2.99	3.9	6.2	
3.00 AND OVER	3.7	3.7	

SOURCE: DYNAMICS OF ECONOMIC WELL-BEING: HEALTH INSURANCE (ANALYSIS OF SURVEY OF INCOME AND PROGRAM PARTICIPATION, DEPARTMENT OF COMMERCE)

NOTES: STANDARD ERRORS IN PARENTHESES BESIDE MEDIAN.

*UNEMPLOYED REFERS TO A PERSON WHO HAD NO JOB DURING A GIVEN MONTHS AND SPENT ONE OR MORE WEEKS LOOKING FOR EMPLOYMENT OR WAS ON LAYOFF.

**NOT IN THE LABOR FORCE REFERS TO A PERSON WHICH HELD NO JOB DURING THE MONTH AND SPENT NO TIME LOOKING OR WAS ON LAYOFF.

The distribution of spell length also varies by demographic characteristics. Those most vulnerable to longer periods without insurance are the poor and working poor (those between 100 and 150 percent of the federal poverty line). As seen in Table 3, it appears that median spell length without insurance has increased markedly for both groups. Not surprisingly, comparative spell length also varies inversely with education. Persons 18 and over with one or more years of college also experience shorter spell lengths than high school graduates with no additional schooling and those with less than four years of high school. As expected, full-time employees have significantly shorter median spell lengths compared to part-time employees, the unemployed, and those not in the labor force.

Table 4 captures comparisons across demographic subgroups, showing that certain populations experienced longer median lengths of uninsured spells. In the 1991-93 period, Hispanic persons remained uninsured for a longer time, and more whites experienced longer spells without insurance. Hispanics had significantly different spell lengths at 7.7 months as compared to White persons (not of Hispanic origin) with 6.0 months and Black persons with 7.1 months. This is a shift from the 1990-92 estimate when the Hispanic and Black populations were close in median spell length at 7.2 and 7.3 months, respectively, contrasted to White persons (not of Hispanic origin) at only 4.9 months.

Table 4: Length of Spell Without Insurance for the Newly Uninsured Population with Observable Starts to Spell, by Race, Education, Sex, and Age, Selected Years (Median Months).

	1987-89	1990-92	1991-93
MEDIAN, ALL SPELLS	4.2	6.0 (0.6)	7.1 (0.2)
RACE			
HISPANIC	4.5	7.2 (0.2)	7.7 (0.3)
WHITE (NOT OF HISPANIC ORIGIN)	4.1	4.9 (0.8)	6.0 (1.0)
BLACK	4.0	7.3 (0.1)	7.1 (0.2)
EDUCATION			
LESS THAN 4 YEARS OF HIGH SCHOOL	7.1	7.6 (0.4)	10.00 (2.1)
HIGH SCHOOL GRADUATE	5.3	7.1 (0.8)	7.2 (0.4)
1 OR MORE YEARS OF COLLEGE	3.8	4.0 (0.1)	5.1 (1.1)
SEX			
FEMALE	4.0	5.5 (0.8)	6.6 (1.4)
MALE	4.7	6.5 (0.9)	7.2 (0.2)
AGE			
UNDER 18 YEARS	4.0	4.8 (1.5)	5.1 (1.0)
18 TO 24 YEARS	4.0	6.4 (1.3)	7.3 (0.4)
25 TO 34 YEARS	5.0	5.4 (1.1)	7.1 (0.4)
35 TO 44 YEARS	4.0	7.4 (0.5)	7.2 (0.5)
45 TO 64 YEARS	7.1	6.4 (1.5)	7.7 (0.5)

SOURCE: DYNAMICS OF ECONOMIC WELL-BEING: HEALTH INSURANCE (ANALYSIS OF SURVEY OF INCOME AND PROGRAM PARTICIPATION, DEPARTMENT OF COMMERCE)

NOTE: STANDARD ERRORS IN PARENTHESES BESIDE MEDIAN.

III. IMPACT OF PROPOSED REDUCTIONS IN MEDICAID BUDGET

Summary of Proposed Changes

Both the House and Senate have proposed versions of MediGrant bills aimed at reducing federal spending for Medicaid. These proposals would reduce Medicaid spending by \$182 billion between 1996-2002. To facilitate efforts to meet the proposed budget targets, states would receive unprecedented flexibility in program design and allocation of funds. The benefit package, eligibility criteria and rate paid to providers would all be left to state authority in an effort to encourage innovation. Specifically, these MediGrant bills replace individual entitlement and minimum eligibility standards and benefits with block grants to

states. Immunization services for children would be the only required benefits, with non-binding language addressing state efforts with regard to children, pregnant women, and the disabled.⁹ States would have the option of re-establishing individual entitlement to a newly defined set of services for certain groups, or of providing medical assistance to the poor through alternative means, such as grants to health centers, sub-block grants at the county level or other arrangements.

Table 6 presents CBO baseline expenditure projections from 1996-2002, as well as budget targets put forth in the House and Senate bills. Projections for enrollment growth are also included. The CBO projects an annual growth rate in spending of 10.2% which includes a 3.3% annual growth in enrollment. In comparison, under either the House or Senate bills, Medicaid spending would be constrained to an annual growth rate of 4.5 and 4.8 percent respectively. This means that states would be facing a 30 percent reduction in federal Medicaid dollars by 2002 as compared to revenues they could expect under current policy. If, however, enrollment increases were to continue at projected levels, the resulting growth in Medicaid spending per beneficiary would be constrained to only 1.2 percent per year under the House proposal.

⁹ These proposals allow states unprecedented flexibility in program design and allocation of funds. As Rosenbaum and Darnell (1995) have pointed out, while both bills require the state to set aside a certain portion of the MediGrant funds for children, pregnant women and the disabled, the total amount of the set aside equals 41.9 percent of average total state and federal Medicaid spending between fiscal year 1992 and 1994. Over half the block grant amounts can be spent at the total discretion of states. Cost-sharing is also allowed in both bills, except in the case of pregnant women and children under 100 percent of the federal poverty line, and all state restrictions are removed regarding provider payments, disproportionate share payments, federally qualified health centers, and minimum thresholds of eligibility and service provision.

Table 6: Baseline and Proposed Growth in Federal Medicaid Spending (Billions) and Recipients (Millions).

	1996	1997	1998	1999	2000	2001	2002	AVERAGE GROWTH (PERCENTAGE)
SPENDING (\$BILLIONS)								
CBO BASELINE	99.2	110	122	134.8	148.1	162.7	177.7	10.2
HOUSE PROPOSAL*	95.7	102.1	106.2	110.5	114.9	119.5	124.3	4.5
SENATE* PROPOSAL	94.1	100.5	104.9	109.5	114.4	119.5	125.7	4.8
ENROLLEE BASELINES (MILLIONS)								
CBO	38.4	40.0	41.2	42.4	43.7	45.0	46.4	3.3
HHS	37.4	39.0	40.5	42.1	43.8	45.6	47.4	4.0

SOURCE: THORPE 1995, CONGRESSIONAL BUDGET OFFICE 1995.

NOTES: CBO REFERS TO THE CONGRESSIONAL BUDGET OFFICE.

HHS REFERS TO THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES.

The proposed formula to allocate federal Medicaid dollars would continue to be based on per capita income, with annual growth rates related to expected state enrollment growth rates. In addition, there would be limits on maximum and minimum spending growth. Higher growth states would receive grants with slightly higher growth rates in the years following the initial block grant, but overall federal spending would be limited to a national growth rate target.

At issue is how states will respond to the slower growth in federal Medicaid payments. State responses will no doubt vary. However, regardless of how states choose to exercise their newfound flexibility, it appears unlikely that states will be able to live within the proposed budget figures without constraining services and eligibility. A recent analysis by Holahan et al. estimates the possible range of savings that might be garnered through aggressive cost-saving strategies, short of cutting eligibility. Table 7 summarizes the menu of policy options designed to reduce the growth of Medicaid spending per beneficiary.

Table 7: Potential Cost Savings from Redesigning Medicaid Programs, by Selected Options

DESIGN OPTION	SAVINGS AS PERCENTAGE OF BASELINE 2002 SPENDING
ENROLL ALL ADULTS AND CHILDREN IN MANAGED CARE	1.6
REDUCE PROVIDER PAYMENTS FOR ACUTE SERVICES BY 10 PERCENT	1.8
ELIMINATE TWO-THIRDS OF ALL OPTIONAL ACUTE CARE SERVICES	5.1
ELIMINATE 50% OF FEDERAL DISPROPORTIONATE SHARE PAYMENTS	3.9
REDUCE NURSING HOME PAYMENTS BY 10 PERCENT	2.0
FREEZE NURSING HOME BEDS FOR TWO YEARS	0.4
ESTATE RECOVERY AND SPOUSAL ASSETS INCLUDED IN NURSING HOME ELIGIBILITY	0.8
REDUCE HOME HEALTH CARE SPENDING BY ONE-THIRD	1.8
MOVE ICF-MR PATIENTS TO LOWER COST SETTING	1.0
TOTAL SPENDING CUTS PER BENEFICIARY	18.4

SOURCE: HOLAHAN, ET AL. 1995 NOTE: ESTIMATES DO NOT INCLUDE INTERACTIVE EFFECTS. *ICF-MR REFERS TO INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED.

To the extent that states want to maximize such spending reductions, they could adopt each of the options outlined below. However, even the most optimistic savings projections yield a combined savings of 18.4 percent, well short of the 30 percent reduction in spending per beneficiary needed to stay within budget figures.

In responding to the need to constrain spending further, states may choose to retain current categories of persons eligible for Medicaid but control costs through waiting lists, time limits, or reductions in services available to each beneficiary. Alternatively, states may remove whole groups from Medicaid eligibility (e.g. those over 100% of poverty line, those eligible through "spending down", non-U.S. citizens). Even with more aggressive implementation of capitated managed care, reductions in provider payments and reductions in services provided; changes in eligibility seem likely. Therefore, given the enrollment dilemma states will face, we believe at a minimum the number of individuals permitted to

receive Medicaid coverage will not grow from today's levels under the new federal spending limits.

Assessing the Impact of Medicaid Budget Limits with Baseline Growth in the Number of Uninsured: SCENARIO 1

To establish a baseline, we began with CBO estimates of health insurance coverage developed during the last session of Congress. The CBO estimated private and public coverage through the year 2005. We built on this analysis by rebasing their 1995 estimate of the number of uninsured with the most recent data from the March 1995 CPS. This data placed the number of uninsured at 39.7 million, slightly less than the earlier estimate of 40.1 million. This included over 1 million uninsured children between the ages of 10 and 18 living in poverty, currently scheduled to receive Medicaid coverage by the year 2002. Another 8 million or so individuals had Medicaid, but were also covered by Medicare or private insurance. Our baseline estimates beyond 1995 used projections of the uninsured as a percent of the population developed from the March 1995 CPS. According to our application of the CBO methodology, the baseline number of uninsured will rise modestly during the next 7 years, from 39.7 million (15.2% of total population) to 43.8 million (15.8%),¹⁰ as seen in Table 8.

We then estimated the number of uninsured, including groups such as the medically needy and others expected to receive coverage under current law, assuming that Medicaid enrollment will be kept at current levels. In this scenario, states would freeze current levels of enrollment, and focus on containing cost growth to the average 4.5% per year per beneficiary allowed in the proposed budgets. Using these assumptions, the projected number of uninsured rises to 48.7 million by the year 2002, compared with the 43.8 million in the baseline projections.

The Combined Impact of Medicaid Budget Limits and Accelerated Erosion of ESI: SCENARIO 2

In our second scenario, we project the continued rate of decline in ESI as seen over the past four years. Between 1989 and 1993, the percent of the population covered by ESI fell from 61% to 57%. This reduction occurred almost exclusively among dependents of workers, as the number of workers covered by ESI remained stable over the period. Given the well documented shift of jobs from the manufacturing sector of the economy, where

¹⁰These assumptions, however, likely understate the number of newly uninsured. In particular, the CPS undercounts the number of Medicaid enrollees. Program counts place the number of Medicaid enrollees at 33.4 million in fiscal year 1993. The March 1994, however, estimates the number of Medicaid enrollees during the same year at 31.7 million, approximately 5 percent lower than program counts. The disparity in the most recent March 1995 CPS is greater. CPS estimates the number of Medicaid enrollees at 31.6 million, nearly 10 percent lower than program counts. Thus, our estimates for the uninsured are likely quite conservative.

workers are more likely to receive health insurance through their employer, to the service sector, where workers are much less likely to receive health coverage through their employer, and given the growth in temporary and part-time work without benefits, it seems reasonable to anticipate that the recent rate of decline in ESI coverage will continue.

If the decline in ESI coverage continues on the same trend as 1989-1993, and changes in the Medicaid program prevent expansions in Medicaid eligibility, then those losing ESI have an increased likelihood of becoming uninsured. In Scenario 2, the combined effect of reduced Medicaid revenues and continued declines in ESI increases the number of projected uninsured to 66.8 million by 2002.

Table 8: Alternative Scenarios for the Number of Uninsured.

	1995	1996	1997	1998	1999	2000	2001	2002
UNINSURED BASELINE	39.7	40.7	41.1	41.7	42.3	42.6	43.2	43.8
BASELINE OF THOSE INSURED BY								
ESI	149	149.5	150.1	150.6	151.1	151.5	151.9	152.3
OTHER	16.5	16.4	16.4	16.4	16.3	16.6	16.5	16.4
MEDICARE	33.9	34.2	34.7	35.1	35.6	36.0	36.5	37.0
MEDICAID	23.0	23.7	24.4	25.1	25.8	26.5	27.2	27.9
TOTAL POPULATION	262.1	264.5	266.7	268.9	271.1	273.2	275.3	277.4
UNINSURED SCENARIO 1	39.7	41.4	42.4	43.8	45.1	46.1	47.2	48.7
UNINSURED SCENARIO 2	39.7	43.7	47.3	51.2	55.2	58.8	62.8	66.8

750% inc.

SOURCE: THORPE 1995, CONGRESSIONAL BUDGET OFFICE 1995.

NOTES: BASELINES ARE PROJECTIONS BY THE CONGRESSIONAL BUDGET OFFICE.

ESI REFERS TO EMPLOYER-SPONSORED INSURANCE.

IV. ANTICIPATED DEMAND FOR UNCOMPENSATED CARE

Traditionally, care for the uninsured has been provided through a complex web of direct public financing¹¹ and cost-shifting to patients with public and private health coverage. Although hospitals have been the primary source of services for the uninsured, physicians, community health centers and others have also provided a substantial volume of free care. The CBO recently estimated that hospital and physicians provided approximately \$20 billion in uncompensated care in 1991. This will rise to approximately \$28 billion in 1995. Not all uncompensated care is traced to the uninsured, however. As reported earlier, studies have linked approximately 77 percent of uncompensated hospital care to the uninsured. The remaining amount is traced to individuals who do not pay their deductibles or coinsurance. The uninsured are reported to account for 89 percent of uncompensated care provided by physicians.¹²

In considering the capacity of the health care delivery system to respond to an increased demand for uncompensated care, we focused on hospitals, the largest suppliers of uncompensated care. Table 9 shows the baseline growth in the number of uninsured and the expected baseline rise in hospital uncompensated care.

Our baseline for uncompensated care is derived from the American Hospital Association (AHA) Annual Survey. The AHA survey estimates that community hospitals provided \$15.9 billion in uncompensated care costs during 1993. This represents approximately 6 percent of all hospital costs. These costs are projected to increase to \$16.6 billion in 1994 and \$17.7 billion in 1995. CBO figures indicate that the uninsured account for 77% of uncompensated care charges. Thus, in 1994, approximately \$12.7 billion in uncompensated care can be traced to the uninsured. The remaining 23% can be traced to insured persons who do not or cannot pay their cost sharing amounts.

To calculate the future volume of uninsured uncompensated care, we first estimated the growth in total uncompensated care. We assumed that the volume of such care grew at the same rate as hospital costs (although traditionally it has grown faster). Second, we calculated baseline per capita uninsured uncompensated care by taking 77 percent of this figure and dividing it by the baseline number of uninsured. Third, the per capita was multiplied by the number of uninsured in each scenario. The remaining volume of uncompensated care traced to uninsured patients was estimated to grow at the hospital cost growth rate. This assumed that the per capita costs of uncompensated care observed today will remain unchanged despite the likely changes in the composition of the uninsured. No changes in the Medicare and Medicaid programs were assumed. As presented in Table 9,

¹¹Public hospitals have received direct financing for uncompensated care from state and local tax appropriations. During 1993, these appropriations amounted to \$3.1 billion (CBO).

¹²CBO Staff memorandum, "Single Payer and All-Payer Health Insurance Systems Using Medicare's Payment Rates", April 1993.

the baseline growth in uncompensated care will increase at a rate similar to the previous 15 years -- from \$17.7 billion in 1995 to \$29.3 billion in the year 2002, or at a rate of 6 percent of total hospital expenditures.

Table 9: Baseline and Alternative Projections of the Demand for Uncompensated Care (\$billions) and the Number of Uninsured (millions). 1995-2002.

	1995	1996	1997	1998	1999	2000	2001	2002
BASELINE UNINSURED	39.7	40.7	41.1	41.7	42.3	42.6	43.2	43.8
BASELINE UNCOMPENSATED CARE	17.7	19.0	20.3	21.9	23.6	25.4	27.3	29.3
SCENARIO 1 UNINSURED	39.7	41.4	42.5	43.8	45.1	46.1	47.4	48.7
SCENARIO 1 UNCOMPENSATED CARE	18.3	20.0	21.8	23.8	25.9	28.2	30.7	33.4
SCENARIO 2 UNINSURED	39.7	43.7	47.4	51.2	55.2	58.8	62.8	66.8
SCENARIO 2 UNCOMPENSATED CARE	18.3	20.8	23.7	26.9	30.4	34.3	38.5	43.2

SOURCE: AUTHOR'S PROJECTIONS DERIVED FROM THE 1993 AMERICAN HOSPITAL ASSOCIATION'S ANNUAL SURVEY OF HOSPITALS AND DATA FROM THE PROSPECTIVE PAYMENT ASSESSMENT COMMISSION.

Under the assumptions of our Scenario 1, in which we used the more conservative estimates regarding the erosion of ESI and assume no growth in Medicaid enrollment, the potential demand for uncompensated care grows to \$33.4 billion. In our second scenario, in which we assumed the decline in ESI continues on the same trend as 1989-1993 and Medicaid enrollment was again held constant, the demand for uncompensated care reaches \$43.2 billion.¹³

It is important to note that the distribution of uncompensated care discussed above will not be uniform across hospitals. Table 10 illustrates the distribution of uncompensated care across hospital types in selected years, as well as the ratio of uncompensated care to total costs in 1993.

¹³We slightly understate the impact on hospitals of growing levels of uninsured. For example, national uncompensated care was \$16 billion in 1993 (6% of \$266 billion) and in our hospitals (6% of \$233 billion=\$14 billion). In 1995 this would total nationally nearly \$18 billion (6.4% of \$300 billion in costs). Since we are using a subset, the total is slightly less around \$16 billion or so. However, we calculate a per capita using total number of uninsured. This slightly understates per capita costs. This is not really a big deal though since Maryland only has about 0.6 million uninsured on a base of 39.7. So we have understated total uncompensated care across all hospitals by about 5%.

Table 10: Distribution of Uncompensated Care Costs Across All Hospitals (Percentage), Selected Years, and Uncompensated Care Costs as Percentage of Total Costs, 1993

HOSPITAL TYPE	1980	1985	1993	UNCOMPENSATED CARE AS PERCENTAGE OF TOTAL COSTS, 1993
LARGE URBAN	43.1	41.4	59.5	6.4
OTHER URBAN	40.3	43.1	30.3	5.6
RURAL	16.5	15.5	10.2	5.1
MAJOR PUBLIC TEACHING	22.7	13.7	24.8	18.5
MAJOR NON-PUBLIC TEACHING	9.9	11.5	12.5	5.0
OTHER TEACHING	28.1	30.1	26.4	4.9
NON-TEACHING	39.4	44.6	36.1	4.8

SOURCE: DERIVED FROM THE 1993 AMERICAN HOSPITAL ASSOCIATION'S ANNUAL SURVEY OF HOSPITALS AND DATA FROM THE PROSPECTIVE PAYMENT ASSESSMENT COMMISSION.

Note that large urban hospitals provided nearly 60% of uncompensated care having steadily increased their share from 43% in 1980. At the same time, the share of other urban hospitals declined from 40% to 30% over the same period. The proportion of uncompensated care provided by major teaching hospitals also increased from 9.9% in 1980 to 12.5% in 1993. Major public teaching hospitals together with other teaching facilities provided about a quarter of all uncompensated care. It is also important to note that large urban hospitals had a higher ratio of their total costs consumed by uncompensated care than other hospitals (6.4%), with the exception of major public hospitals in which 18.5% of costs were attributable to uncompensated care.

The last column of Table 10 indicates the ratio of uncompensated care costs to total cost for each hospital type, showing the financial impact uncompensated care had on these facilities in 1993. Large urban hospitals provided a large and growing share of uncompensated care (6.4% of costs in large urban hospitals, compared to 5.6% in other urban and 5.1% in rural hospitals). The ratio of uncompensated total costs was also higher in large urban hospitals compared to major private teaching institutions (6.4% versus 5%).

Table 11 presents the percent of total costs consumed by uncompensated care in each of our scenarios. Under current policy, we assumed that uncompensated care would account for a stable proportion of hospital costs, namely 6 percent. Under scenario 1,

uncompensated care rises to \$33.4 billion or 6.8%. Under the second scenario, it increases to \$43.2 billion or 8.8% of total hospital costs.

Table 11: Uncompensated Care as Percent of Hospital Costs

	1995	1996	1997	1998	1999	2000	2001	2002
BASELINE	6	6	6	6	6	6	6	6
Scenario 1	6.2	6.3	6.4	6.5	6.5	6.6	6.7	6.8
Scenario 2	6.2	6.6	7	7.3	7.7	8.1	8.4	8.8

In summary, the number of uninsured will likely increase due to reductions in federal Medicaid funding and may become substantially higher if the recent trends in ESI persist. The amount of uncompensated care will vary directly with the number of uninsured. This will have a large impact on hospitals as revenues from previously insured private payers decline, but most of their demand for services and the cost associated with them will persist. Large urban and teaching hospitals will bear a disproportionate burden of the impact of these changes, and the ability of these institutions to meet the growing demand for uncompensated care seems uncertain.

V. CONCLUSIONS

The proposed changes in Medicaid could result in increased efficiency in the health care system, and certainly will afford states the opportunity to develop innovative strategies for providing health care. We may see several new types of programs that specialize in providing quality care for low-income persons in a more efficient manner. In addition, state leaders have long cited the burden of federal regulatory requirements as a deterrent for enhanced innovation and collaboration among policy makers and providers at the state level. They have also objected to federal mandates which have often come without sufficient federal funding for implementation, constituting an additional financial burden to states. The new flexibility allowed under current proposals is welcome news at the state level, although this flexibility comes at a great cost to states in terms of reduced federal revenues.

This reduction in the rate of growth of federal revenues raises several important concerns regarding the financial environment that states and, in turn, hospitals will face in providing care to Medicaid enrollees and to the uninsured. The expected rise in the number of uninsured and in the care they will demand raises several potential problems. Without significant expansions of coverage at either the national or state level, hospitals could be forced to restrict care to the uninsured, reduce quality of care, raise more revenues from private payers, or all of the above. The scenarios outlined above indicate that the level of uncompensated care demanded by the uninsured could rise sharply, potentially accounting for nearly 9 percent of hospital costs by the year 2002. Current rates are about 6 percent. The combined impact of reduced revenues, increasing numbers of uninsured, and increased

competition may be too much for some hospitals. As recently as November 3rd, The New York Times reported that a Wall Street credit rating firm, Moody's, is anticipating downgrading its ratings of several major hospitals in anticipation of the impact of Medicare and Medicaid cuts. As one Moody executive noted, "Regardless of the measures hospitals take, the cuts will reduce profit margins materially and lead to the closure of weaker performers."

Of particular concern is the continued reduction in private health insurance. Although preliminary data from March 1995 seem to indicate the trends have stabilized for the time being, these reductions remain a cause for concern. Should the Congress and President agree to reduce the growth in Medicaid to the levels currently discussed, and should the declines in ESI coverage continue, the number of uninsured could rise to nearly 67 million. Analyses by the Urban Institute indicate that efforts to reduce spending per Medicaid enrollee would generate at most 60 percent of the reductions needed to meet these new block grant budgets. Although many believe that Medicaid managed care can generate significant long-run savings for these populations, it is unlikely that managed care will generate substantial savings in the near future. It will take time for states to implement more aggressive capitated models. Also, most of the policy options under discussion focus on women and children and do not address the fact that the lion's share of Medicaid spending is for the elderly and disabled. The health care needs of the SSI, blind and disabled may make it difficult to realize large savings from managed care for these populations. Even in the most successful programs, managed care has usually resulted in savings of no more than about 5 percent. Hence, the remaining savings would have to come from reducing the number of individuals receiving Medicaid coverage. In this case, state and national policy makers would have to develop auxiliary approaches to providing care for an ever rising tide of uninsured patients.

In conclusion, we anticipate increased numbers of uninsured, increased demand for uncompensated care, and a decreased capacity of the delivery system to meet this need. The majority of the uninsured constitute a vulnerable population with no political voice. While we do not accept the premise that any decrease in funding for the health care of these populations will necessarily decrease the quality and availability of needed services, we are concerned that the magnitude of the reductions could generate serious problems. We therefore strongly recommend that a substantial monitoring effort be developed to track access to needed medical care, and the quality of care available to our nation's most vulnerable populations.

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Uninsured File

NUMBER OF UNINSURED AMERICANS

- There were approximately 40 million Americans without health insurance in 1993. This was about 15% of the U.S. population.
- The number uninsured Americans is growing:
 - The number of uninsured Americans grew from about 30 million people in 1979 to about 40 million people in 1993.
 - The number of uninsured Americans is currently growing by about 1 million people each year.
- The erosion of employer sponsored health insurance is part of the reason for the growth in the number of uninsured Americans.
 - Between 1989 and 1993, the number of Americans with employer-sponsored health insurance fell from 152 million to 148 million.

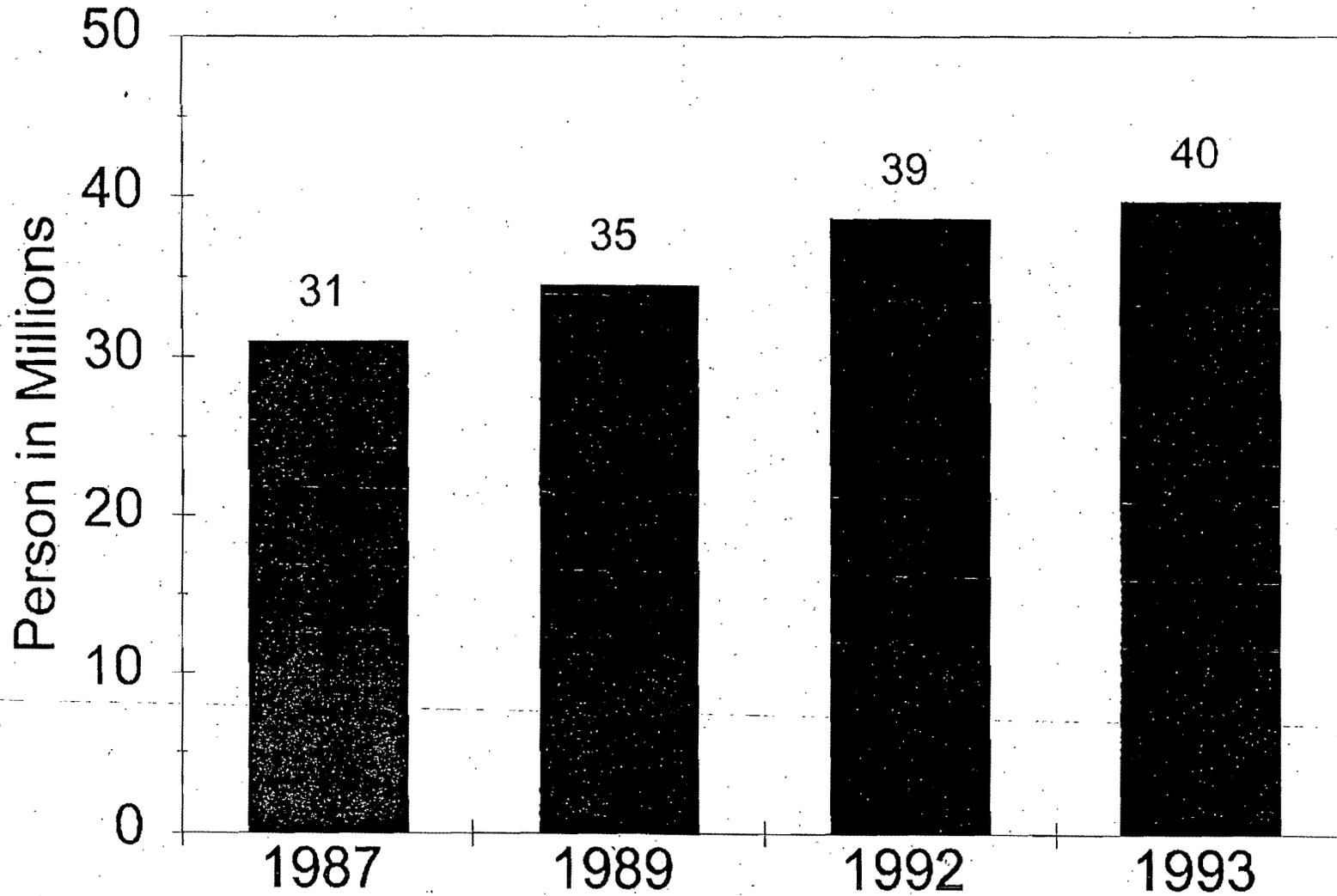
Notes:

Administration estimates based on the Current Population Survey (CPS).

There are differences in estimates of the number of uninsured which reflect differences in methodology and data interpretation. For example, the Urban Institute has a lower estimate (36 million people in 1994) of the number of uninsured primarily for two reasons. The first is that the Urban Institute is not adjusted to the 1990 census, which produces a lower count of the uninsured. Second, the Urban Institute adjusts its estimates to account for a perceived under reporting of the number of people covered by Medicaid. The Employee Benefit Research Institute (EBRI) has a higher estimate of the number of uninsured (41 million in 1993) because they make a downward adjustment in the number of insured children to account for a perceived inconsistency between two questions on the CPS.

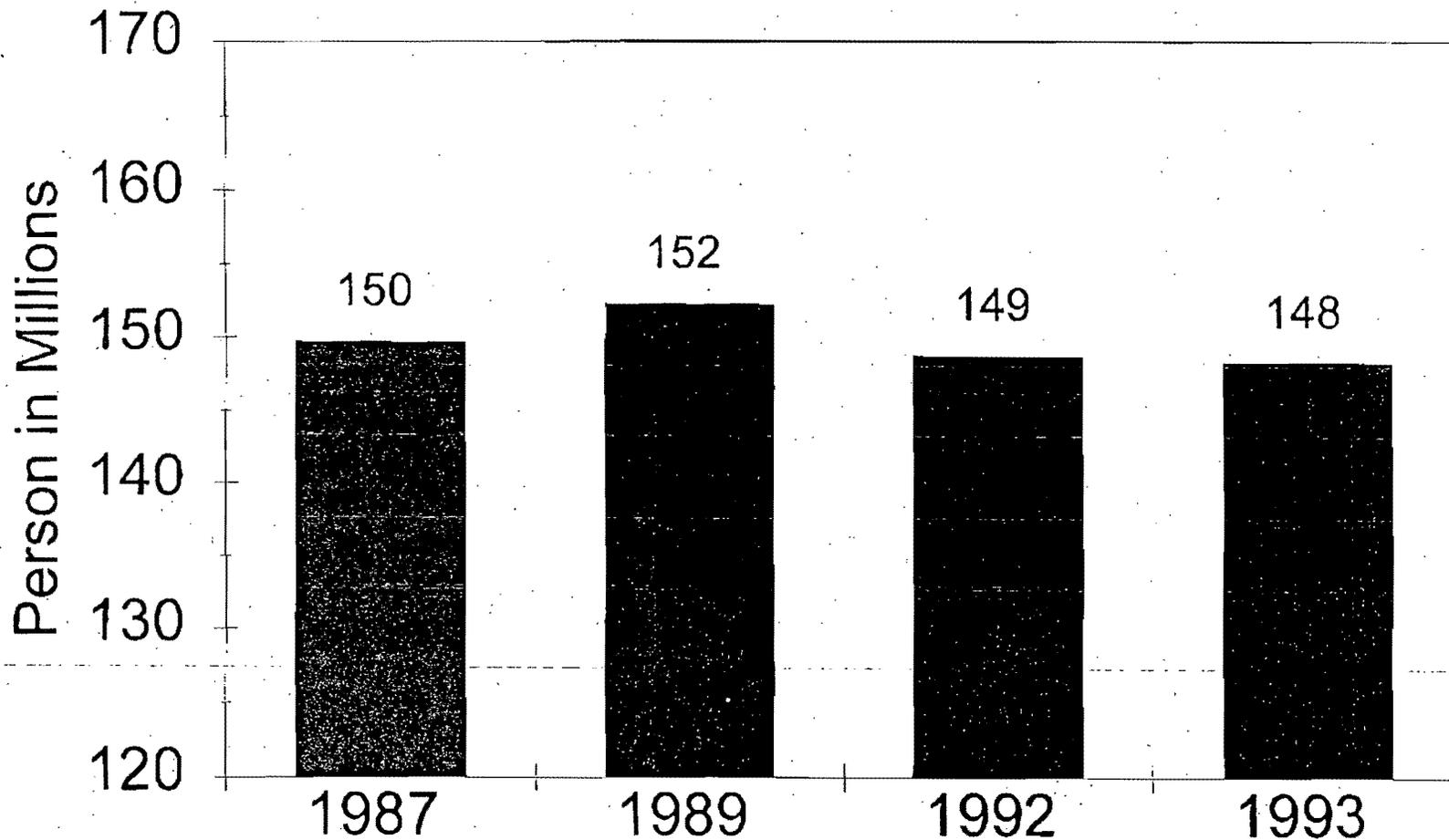
Changes in the CPS design in 1988 produce inconsistencies in insurance coverage information before and after 1987. Beginning in 1988, the CPS asked all respondents (rather than just employed people) whether they were insured under employer-sponsored plans. In addition, method of counting the number of insured children was improved.

Trends in the Number of Uninsured



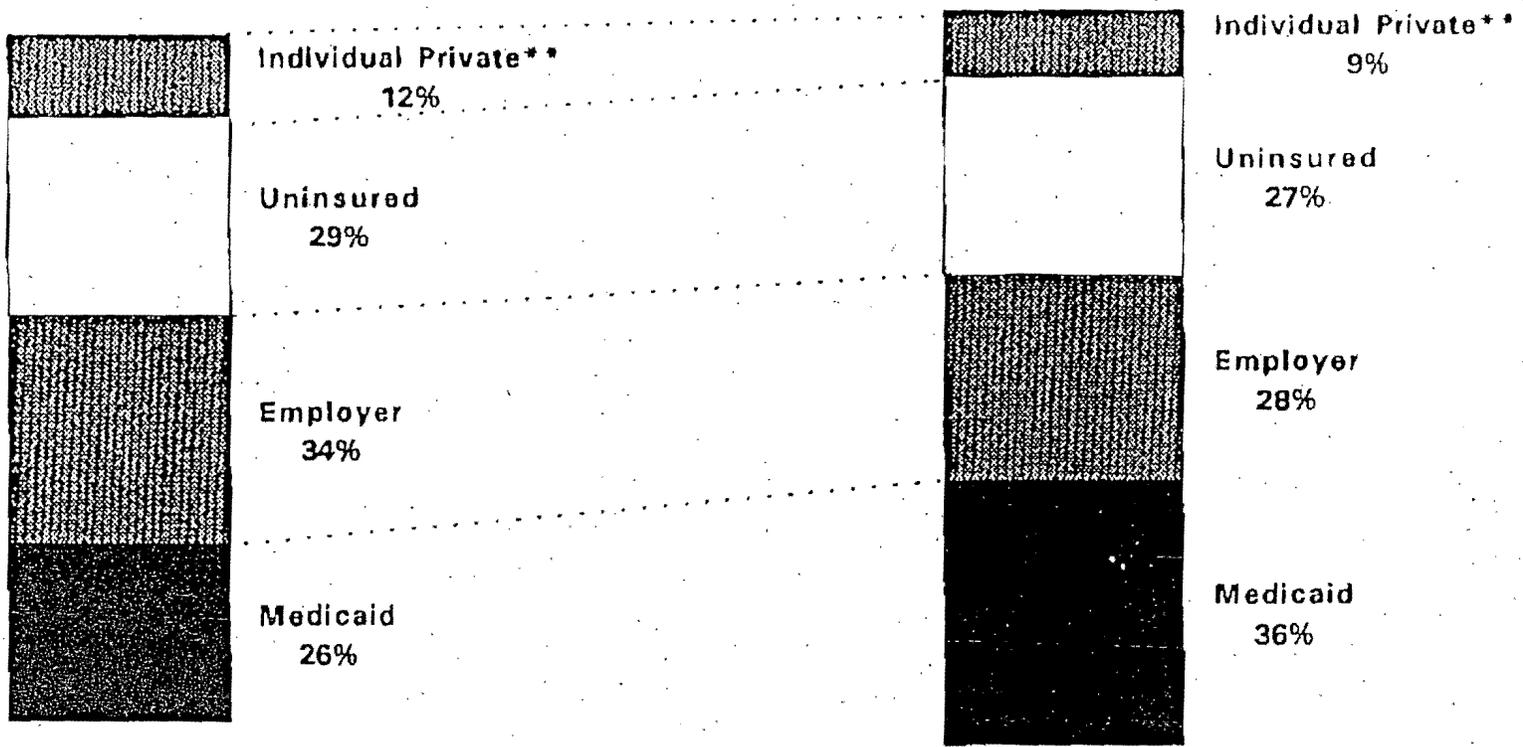
SOURCE: Current Population Survey

Trends in the Number of People Covered by Employer-Sponsored Insurance



SOURCE: Current Population Survey

Trends in Health Insurance Coverage for Low-Income Population*, 1988 and 1994



Total = 66 Million People
1988

Total = 75 Million People
1994

* Below 200 percent of the Federal poverty level.

** Includes coverage for the military and veterans.

Note: The Federal poverty level was \$14,800 for a family of four in 1994.

Source: Urban Institute estimates based on 1988 and 1992 Current Population Surveys, 1994.

The Kaiser Commission on

THE FUTURE OF MEDICAID

DRAFT

DISCUSSION DRAFT -- NOT FOR DISTRIBUTION

POSSIBLE RESPONSES TO DEMAND THAT TRUSTEES SPECIFY MEDICARE REFORMS

Background: House Republicans are likely to pass a bill requiring that the Medicare Trustees issue a report to Congress by June 30, 1995, detailing specific actions to ensure the short-run solvency of the Medicare Trust Funds (both the HI and SMI Trust Funds). If the Senate considers a similar bill, the Administration needs to develop a strategy for a response.

Legal Analysis (incomplete): Congress generally has no legal recourse against the Trustees if they do not meet the June 30 deadline. Many Congressionally-set deadlines for studies are missed, with no legal consequences. However, there is a political risk if the deadline is missed. Congressional Committees can be expected to hold hearings where the Trustees are grilled harder and more personally than ever, since the Republicans are desperate for dollars. They will do anything to humiliate, cajole, or shame the Administration into providing needed cover for Medicare cuts. This process will no doubt severely strain relations with the Hill.

Financial analysis: The HI Trust Fund needs around \$80-100 billion (7-year figure) in additional revenues or spending cuts to ensure solvency through 2005 (the exact figure depends on the time path of savings/revenues). Around \$160 billion (7-year figure) in additional revenues or spending cuts is needed to ensure that the HI Trust Fund maintains a reserve fund equal to one year's expenditures through 2005. Once the Baby Boom generation starts to retire in droves (i.e., by 2020), the entire system will be under severe financial stress, requiring additional reform steps.

Options: Several alternatives are presented below. These alternatives are nowhere near exhaustive. Moreover, portions of the alternatives can be mixed and matched with others to create composite alternatives (perhaps an infinite number of them).

ALTERNATIVE 1: RELY ON SENATE DEMOCRATS TO DELAY OR SCUTTLE ALTOGETHER

- Administration works with Senate Democrats to ensure that bill is not passed. Potential strategies could involve filibusters, lengthy amendment strategies, etc.

Pros:

- Does not use up much political capital.
- Administration keeps low profile and is not perceived as defending status quo.
- Recognizes the political nature of this bill and draws battle lines on political grounds.

Cons:

- Very unclear if there is even a majority of Senate Democrats willing to do this.
- Public could perceive this effort as evidence that the Administration and Senate Democrats are not serious about addressing Medicare solvency issue.
- Congressional Republicans likely to become more antagonistic toward Trustees (and perhaps the rest of the Administration).

ALTERNATIVE 2: DIRECT BLOW-OFF STRATEGY

- Administration vetoes bill and states that the time frame permitted and the callousness of their approach illustrates all too well that the Republicans are using the Trust Fund as a political football and a bank for their tax cuts. We will simply say that we won't participate in such a sham.

Pros:

- Administration does not respond to what is essentially a political strategy with a policy response.
- Administration sends strong message that it will address Medicare only on its own terms or within the context of wider reforms in a serious manner.
- If we carry-off throughout the entire Administration (no off-the-record second guessing) the President could appear strong, particularly if it is combined with a restated, but more clear, commitment to produce, or work with Congress to produce, a plan once the President's previously outlined criteria have been met.

Cons:

- Elite press probably attacks Administration for missing opportunity to address Medicare Trust Fund solvency.
- Uses up political capital to sustain veto.
- Congressional Republicans likely to become more antagonistic toward Trustees (and perhaps the rest of the Administration).

ALTERNATIVE 3: INDIRECT BLOW-OFF STRATEGY

- Administration signs bill or allows it to become law, but issues report shortly thereafter which states that Medicare reform must be done in the context of overall health care reform.

Possible Variation: Report states that solvency of Medicare Trust Funds could be improved if revenues that would be used for proposed tax cuts instead are directed to Trust Funds.

Pros:

- Could be perceived by the public as a reasonable response to the bill's demands, even though it does not address expenditures.
- Does not use much political capital.
- Administration does not respond to what is essentially a political strategy with a policy response.
- Repeats current message on health care.
- Does not provide political cover to Republican attempts to cut Medicare expenditures.

Cons:

- Public and media could perceive this report as non-responsive and evidence that the Administration is not serious about addressing Medicare insolvency.
- Elite press attacks Administration for missing opportunity to address Medicare Trust Fund solvency.
- Congressional Republicans become more antagonistic toward Trustees (and perhaps rest of Administration).
- Could be criticized for using funds that do not exist as a specific part of the budget proposal (this might only be an elite press problem).
- Transfer of general fund revenues to Medicare Trust Fund might be criticized as an undesirable precedent.

ALTERNATIVE 4: RESTRUCTURING BAND AID RESPONSE

- Administration signs bill or allows it to become law. Report focuses on the transfer of some items from Medicare Part A to Part B (e.g., home health care). Premiums charged for Part B could (but need not) increase to cover costs of this service.

Pros:

- Seems like a reasonable response to bill's requirements.
- Would substantially increase the solvency of HI Trust Fund by removing a large (e.g., \$15-20 billion per year for home health care) and fast-growing cost component.
- If Part B premium is increased to cover part of increased cost of benefits, this would reduce Federal deficit (a premium equal to 25 percent of the actuarial cost of home health care would reduce deficit by about \$5 billion per year).
- If Part B premium is increased to cover part of increased cost of total Part B benefits, beneficiaries would be paying part of the cost of a fast-growing component of Medicare benefits.

Cons:

- Beneficiaries may view this shift as breaking an implicit contract, to the extent they counted on receiving these benefits in return for HI taxes.
- Could be portrayed as increasing the burden of beneficiaries.
- Could be portrayed as an accounting fiction, especially if Part B premiums are not increased to cover the cost of benefits shifted to the SMI Trust Fund.

ALTERNATIVE 5: SERIOUS BUT PARTIAL RESPONSE THAT BEGINS TO ADDRESS THE TRUST FUND ISSUE

- Administration signs bill or allows it to become law. Report lists \$X billion (perhaps \$50 billion) in Medicare Part A cuts; suggests that proposed tax cuts be scaled down and the additional revenues dedicated to Trust Funds.

Pros:

- Appears to be responsive to law.
- Elite press may see this as responsible policy toward Medicare.
- Could be viewed as a "down payment" on a larger plan to address long-term Medicare solvency.

Cons:

- Provides political cover to Republican attempts to cut Medicare (suggested cuts are almost certain to be adopted).
- Release of an Administration proposal could diffuse the anger of providers who bear brunt of cuts (currently directed solely at Congressional Republicans). The rest of our base supporters may also conclude it is premature to throw any semblance of a lifeline to the Republicans.
- To the extent that general fund revenues are transferred to Medicare Trust Fund, this option might be criticized as setting undesirable precedent.

ALTERNATIVE 6: POTUS HEALTH REFORM PROPOSAL RESPONSE

- Administration signs bill or allows it to become law. Report presents a viable health care reform proposal. This could incorporate increased insurance coverage as well as reforms to Medicare, Medicaid, and other health programs.

Pros:

- Consistent with Administration message that reform of Medicare can only take place in the context of overall health care reform.
- Could be an opportunity for Administration to achieve a bipartisan breakthrough on a major policy issue.

Cons:

- Provides policy response to what is essentially a political demand.
- The "sources of funds" portion of the proposal provides political cover to Republican attempts to cut Medicare (suggested cuts are almost certain to be adopted).
- Release of an Administration proposal could diffuse the anger of providers who bear brunt of cuts (currently directed solely at Congressional Republicans).

ALTERNATIVE 7: SUGGEST THAT POLITICALLY "POPULAR" REVENUE OPTIONS (BOTH REAL AND UNLIKELY) BE UTILIZED TO STRENGTHEN TRUST FUND

- Administration signs bill or allows it to become law. Report suggests that certain revenue streams be earmarked for deposit into Medicare HI Trust Fund. Possible candidates include: increased excise taxes on tobacco or alcohol; increased HI payroll tax; reduction in tax expenditures claimed by special interests (e.g., tax subsidies provided to American living abroad, to oil and gas industries); and closing tax loopholes (e.g., expatriation proposal, limiting corporate dividend received deduction to pro rate dividends).

Pros:

- It is possible to raise enough revenue to make the HI Trust Fund solvent.
- Could be perceived by the public as a reasonable response to the bill's demands, even though it does not address expenditures.
- Senator Bradley is already pushing idea of dedicating a tobacco tax and/or "corporate welfare" tax breaks.

Cons:

- Administration likely to be characterized as promoting "tax and spend" policies.
- Transfer of general fund revenues to Medicare Trust Fund might be criticized as setting undesirable precedent.
- Congressional Republicans likely to become more antagonistic toward Trustees (and perhaps the rest of the Administration) because the bill focuses on Medicare spending restraints and the response focuses on revenues.



CENTER ON BUDGET AND POLICY PRIORITIES

October 19, 1994

TRENDS IN HEALTH INSURANCE COVERAGE, 1987 TO 1993

by Laura Summer and Isaac Shapiro

In early October, new health insurance coverage data for 1993 were issued by the Census Bureau as part of its annual report on poverty and income trends and other economic indicators. More detailed, unpublished data on health insurance coverage from the Census Bureau also became available. This analysis examines this new information for 1993 and compares it to data from earlier years. (Some comparisons are available back to 1987 while others are available back to 1988.)

Coverage Deteriorates Rapidly

The basic trend in health insurance coverage is unmistakable. Both the number of people and the proportion of the population that lack health insurance for the entire year have increased steadily since 1987.¹ The problem has grown worse during both recessionary and recovery periods.

- According to the Census data, the number of people without health insurance for the entire year rose from 31 million in 1987 to 39.7 million in 1993, an increase of nearly nine million people in a relatively short time span.
- During this same period, the proportion of the population without insurance increased from 12.9 percent to 15.3 percent.

¹ When the Census Bureau released the 1993 poverty, income, and health insurance data, the Bureau also revised its 1992 data to reflect population counts from the 1990 Decennial Census. The revision yielded higher numbers and rates of people lacking health insurance coverage than the 1992 figures published initially. The comparisons between 1992 and 1993 in this paper use the revised 1992 health insurance data. The revisions do not affect comparisons between 1987 or 1988 and 1993.

- Every year from 1987 to 1993, both the number and the proportion of the population without health insurance increased. (In some years, though, the increases were not large enough to be "statistically significant."²)
- From 1992 to 1993, the number of people without coverage rose significantly, by 1.1 million. Some 15 percent of the population lacked coverage in 1992, compared to the 15.3 percent without coverage in 1993 (this change was not statistically significant).

The Large Majority of the Uninsured Are Not Poor

As would be expected, a larger proportion of the poor than of the non-poor lack health insurance. Among those who were poor, 29.3 percent had no health insurance in 1993. Some 12.8 percent of the non-poor lacked insurance.

The large majority of people without coverage, however, are not poor. Of those without insurance last year, some 28.2 million — 71 percent — had incomes above the poverty line.

Similarly, from 1988 to 1993, the lion's share of the growth in the health insurance gap occurred among people who are not poor.³ Both the number and the proportion of those living above the poverty line but lacking health insurance grew during this period.

- Since 1988, the first year for which information on the

Table 1
People with no Health Insurance
(in millions)

	<u>All</u>	<u>Non-poor</u>	<u>Poor</u>
1993	39.7	28.2	11.5
1988	32.6	22.9	9.7
1987	31.0	N/A	N/A
1988-1993 <u>Increase</u>			
Number	7.1	5.3	1.8
Percent	100%	74%	26%

² The Census Bureau data are based on surveys of the U.S. population. Accordingly, the data are not absolutely precise reflections of the population's characteristics. "Statistical significance" tests are performed to determine if the difference between surveys conducted in different years are due to the imprecision of the surveys or to actual changes over time. Changes are usually considered statistically significant if the mathematical test suggests there is at least 90 percent certainty that the direction of the change noted is correct.

³ The year-to-year patterns do vary somewhat. For example, from 1992 to 1993, just 45 percent of the increase in the number of people lacking health insurance coverage occurred among the nonpoor. By contrast, from 1991 to 1992, some 78 percent of the increase occurred among the nonpoor. The one-year changes reflect, in part, statistical variation, so the long-term picture is more telling.

income status of the uninsured is available, the number of people who are not poor but who lack health insurance has jumped by 5.3 million. Some 74 percent of the overall growth in the number of uninsured during this five-year period occurred among the non-poor.

- The proportion of non-poor people without health insurance rose from 10.8 percent to 12.8 percent during this period.

Health insurance trends among the poor have been mixed. The *number* of poor people without health insurance coverage has increased since 1988, rising by 600,000 just between 1992 to 1993. But in many of these years, the increase in the number of poor people without insurance related to an overall rise in the size of the poverty population. From 1988 to 1992, the *proportion* of the poverty population lacking health insurance coverage decreased from 30.3 percent to 28.7 percent. As discussed later, an expansion in Medicaid coverage helps explain this decrease.

The increase in 1993 in the number of poor people lacking coverage does not, however, appear to be due entirely to the increase in the size of the poverty population. While 28.8 percent of the poor lacked health insurance coverage in 1992, some 29.3 percent of the poor were without coverage in 1993.⁴ In 1993, ongoing expansions in Medicaid coverage appear to have been offset by other trends. Among the offsetting factors could be a growth in the number of working poor, many of whom lack health insurance through their jobs.

Data Understate the Problem

These figures understate the dimensions of the health insurance problem because they represent only people who reported they lacked health insurance for the *entire* year examined — for example, for *all* of 1993. People who had health insurance for as little as one month in 1993 would not be counted as uninsured. It is likely that millions of other people lacked coverage for *some* part of 1993.

A Census report from earlier this year documents this point: While 35.4 million people were uninsured for all of 1991, a much larger number — 60 million people — lacked health insurance coverage for at least one month during a 32-month period

⁴ The difference was not statistically significant.

beginning in February 1990. This represents about one-quarter of the entire U.S. population.⁵

Decline in Employment-Related Coverage

The decline in health care coverage reflects a decrease in employment-related health insurance. The share of the population receiving health insurance through a job has declined every year since 1988 (the first year for which such data are available). The net drop during this period has been dramatic.

- In 1988, some 62 percent of Americans were covered by employment-related health plans. By 1993, the figure had fallen to 57.2 percent.

	All	Non-Poor	Poor
1993	57.2%	65.4%	11.2%
1988	62.0%	69.3%	12.8%

- If the same proportion of Americans had job-related health coverage in 1993 as in 1988, another 12.5 million individuals would have had such coverage last year.

During years when unemployment is on the rise, one might expect a large number of people to lose their job-related coverage. From 1990 to 1992, some part of the erosion in employer-related coverage can be attributed to the rising unemployment; many workers lost their health insurance when they lost their jobs.

But employment-related coverage has weakened during recovery years as well. In 1993, for example, the general employment picture brightened, but employment-related health coverage deteriorated.

- In 1993, the unemployment rate dropped from its 1992 level of 7.4 percent to 6.8 percent. The number of unemployed people fell by 650,000, while the number of employed people rose by 1.7 million people.
- Nevertheless, half a million fewer people had employer-related coverage in 1993 than in 1992. The share of the population with employer-related

⁵ Bureau of the Census, *Health Insurance Coverage — Who Had a Lapse Between 1990 and 1992?*, Statistical Brief, March 1994.

health insurance coverage fell from 58 percent in 1992 to its 57.2 percent level in 1993. It appears that the loss of employment-related coverage in 1993 occurred primarily because some employers ceased offering coverage.

With a steadily smaller share of the population receiving health insurance coverage through work, it is not surprising that the proportion of non-poor people lacking health insurance has risen substantially.⁶

Medicaid Coverage Grows

From 1988 to 1993, the proportion of the population with *private* health insurance declined significantly, primarily because of the decline in employer-based coverage.⁷ At the same time, the proportion of the population with *government*-provided health insurance increased. The decline in private coverage would have led to an even sharper drop in overall coverage if government coverage had not expanded.

In particular, increased enrollment in the Medicaid program tempered the rise in the total number of uninsured people. In the period between 1987 and 1993, Medicaid rolls increased by 11.3 million people. In 1993, some 12.2 percent of the population was covered under Medicaid, up from 8.4 percent in 1987.

A large part of the growth in the Medicaid program stemmed from expansions in Medicaid eligibility for pregnant women and young children. Almost one quarter of *all* children under 18 years of age — some 23.8 percent — were covered by Medicaid in 1993, a sizeable jump from the 15.5 percent covered in 1988.

Much of the growth in the Medicaid program has occurred among the near-poor population. Recent Medicaid expansions have made significant numbers of pregnant women and children from near-poor families eligible for Medicaid coverage (see box).

⁶ Employment-related coverage decreased among both the poor and the non-poor. The proportion of poor people with employment-related coverage fell from 12.8 percent in 1988 to 11.2 percent in 1993. Nevertheless, the share of the poverty population with health care coverage increased during this time, largely because the expansion in Medicaid coverage more than offset the decline in employer-related coverage.

⁷ Most private health insurance is obtained through employers, so it follows that the decline in the proportion of people covered by employment-related coverage is mirrored by a decline in the proportion of the population that has private health insurance. Some 74.7 percent of the population had private health insurance coverage in 1988; this proportion declined to 70.3 percent in 1993.

Recent Medicaid Expansions

In recent years, the Medicaid program has been expanded in several ways. Beginning in 1987, states had the option to extend Medicaid coverage to young children whose families have incomes above their state's AFDC income limit but below the poverty line. Starting in April 1990, states were required to extend Medicaid coverage to all children under age six from families with incomes below 133 percent of the poverty line. States are also required to cover all poor children born after September 30, 1983. This will result in virtually all poor children through age 18 being covered by 2002.

Eligibility for pregnant women has also been expanded. States must cover all pregnant women with family incomes below 133 percent of the poverty line. States may set income limits for pregnant women and infants as high as 185 percent of the poverty line.

- In 1993, about 40 percent of Medicaid beneficiaries had incomes above the poverty line, up from 36 percent in 1988.
- More than one third of the children covered by Medicaid in 1993 — some 36 percent — were not poor. This is a substantial increase from 1988, when 28 percent of the children enrolled in Medicaid had incomes above the poverty line.
- A portion of the increases in Medicaid enrollment likely stemmed from the decrease in employer-based coverage, as some families that lost coverage at work signed up for Medicaid.

Even with expansions in the program, Medicaid still covers fewer than half of all poor people. Some 48 percent of the poor were enrolled in Medicaid in 1993. Among poor children, 67 percent had Medicaid coverage in 1993.

One fifth of all poor children — 20.1 percent, or 3.2 million children — had no health insurance at all in 1993. Many of the children in this group either were eligible for Medicaid but had not enrolled in the program or will become eligible for Medicaid sometime in the next decade as a result of Medicaid eligibility expansions enacted in the past few years. These data suggest that greater efforts are needed to inform poor parents of their children's potentially eligibility for Medicaid.

The extent of Medicaid coverage varies among racial and ethnic groups. Some 61.5 percent of poor blacks had Medicaid coverage in 1993, compared with 47.6 percent of poor Hispanics and 40.1 percent of poor non-Hispanic whites.⁸

The Uninsured

Some groups were more likely to be uninsured than others. Hispanics were most likely to be uninsured. Nearly one in three Hispanics — 31.6 percent — lacked coverage in 1993. An even larger proportion of *poor* Hispanics — 40.8 percent — lacked health care coverage. The concentration of Hispanic workers in low-wage jobs that provide few benefits may contribute to the low insurance rates for Hispanics.

Some 20.5 percent of all blacks — and 23.5 percent of poor blacks — had no coverage. Among all non-Hispanic whites, 12.1 percent had no insurance. But more than one quarter of poor whites — 27.7 percent — were uninsured.

Members of female-headed families were more likely to lack coverage than members of married-couple families. Some 18.8 percent of the people in female-headed families lacked health care coverage last year, compared with 12.4 percent of the people in married-couple families.

Among poor families, however, the opposite was true. Some 18 percent of the people in poor female-headed families had no health insurance while 34.8 percent of people in poor married-couple families lacked insurance. This is a reflection of the close link between Medicaid and the AFDC program. AFDC recipients, most of whom are members of female-headed families, are automatically eligible for Medicaid coverage. The difference in coverage rates also reflects the fact that more married-couple families than female-headed families are working-poor families who do not receive health insurance through their jobs and who do not qualify for Medicaid.

Differences Among States

The Census Bureau also released state-by-state data on health insurance coverage (see Table 3). There is a wide range in the proportion of state populations lacking coverage.

- In five states — Arizona, Louisiana, New Mexico, Oklahoma, and Texas — as well as the District of Columbia, more than one-fifth of the

⁸ The data on non-Hispanic whites in this paper are authors' calculations based on Census data.

Table 3
Percent of Population Not Covered by
Health Insurance, by State, 1993

Alabama	17.2
Alaska	13.3
Arizona	20.2
Arkansas	19.7
California	19.7
Colorado	12.6
Connecticut	10.0
Delaware	13.4
District of Columbia	20.7
Florida	19.6
Georgia	18.4
Hawaii	11.1
Idaho	14.8
Illinois	12.6
Indiana	11.9
Iowa	9.2
Kansas	12.7
Kentucky	12.5
Louisiana	23.9
Maine	11.1
Maryland	13.5
Massachusetts	11.7
Miami	11.2
Minnesota	10.1
Mississippi	17.8
Missouri	12.2
Montana	15.3
New England	11.9
Nevada	18.1
New Hampshire	12.5
New Jersey	13.7
New Mexico	22.0
New York	13.9
North Carolina	14.0
North Dakota	13.4
Ohio	11.1
Oklahoma	23.6
Oregon	14.7
Pennsylvania	10.8
Rhode Island	10.3
South Carolina	16.9
South Dakota	13.0
Tennessee	13.2
Texas	21.8
Utah	11.3
Vermont	11.9
Virginia	13.0
Washington	12.6
West Virginia	18.3
Wisconsin	8.7
Wyoming	15.0

Source: U. S. Census Bureau

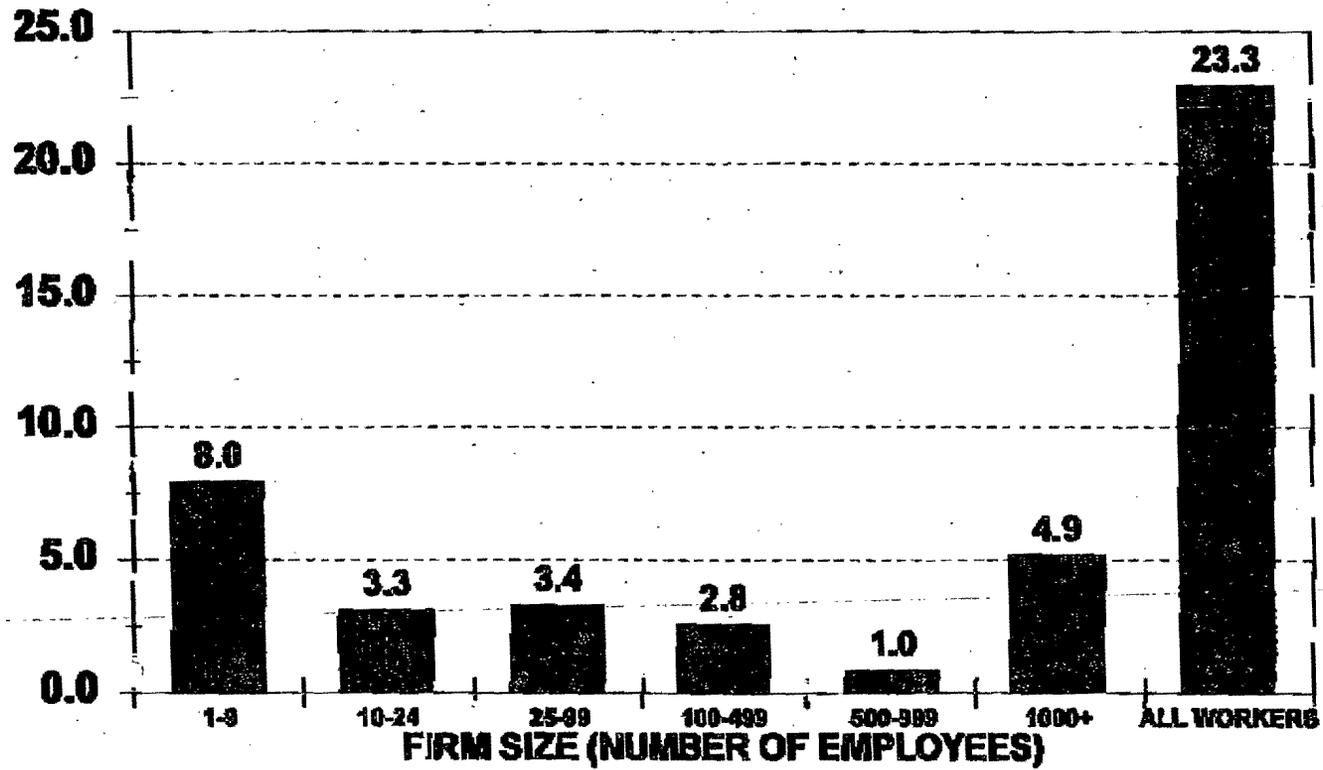
population had no health care coverage in 1993. In general, people living in Southern and Southwestern states were most likely to lack health insurance coverage.

In California, the nation's largest state, nearly one in five residents lacked health insurance.

By contrast, in several states relatively few people lack coverage. In at least two states — Iowa and Wisconsin — less than one-tenth of the population did not have health insurance coverage in 1993.⁹

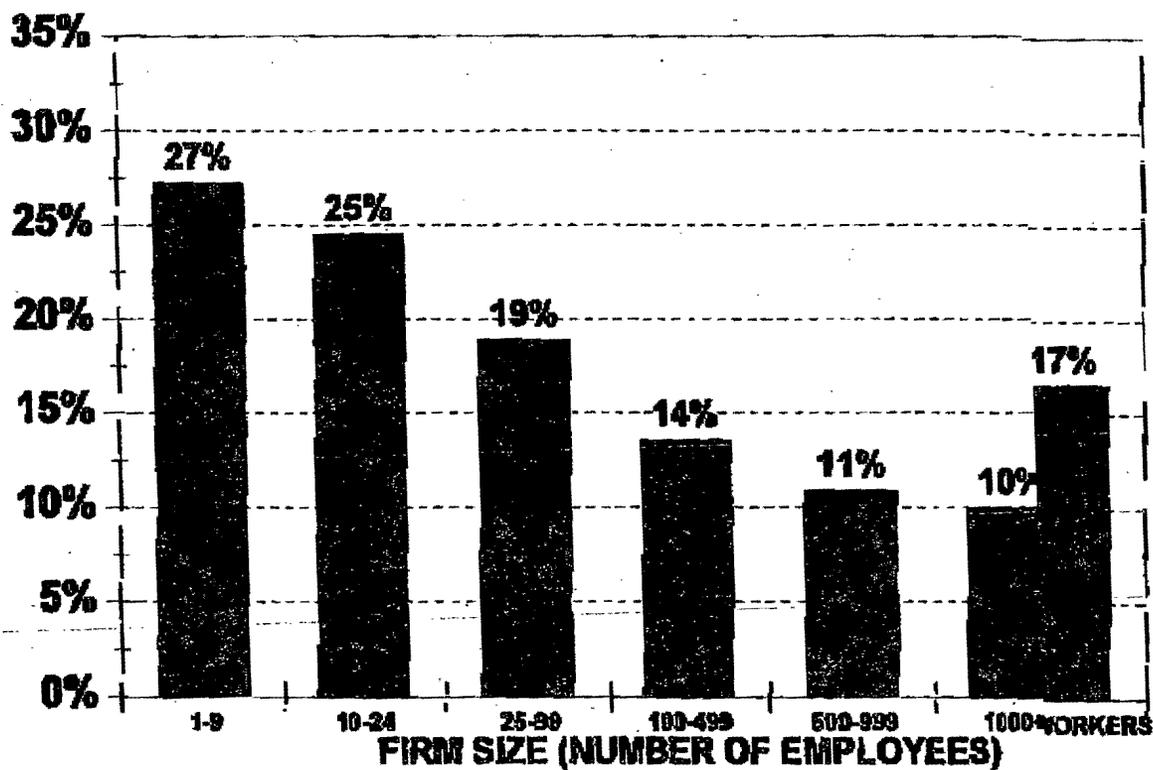
⁹ The Census data indicate that 11.1 percent of Hawaii's residents lack health insurance, but this figure does not adequately reflect Hawaii's state-specific health insurance plan that is designed to provide universal coverage. The Census questionnaire does not fully account for people who receive state-specific health insurance, but the Bureau says it is likely that this only has a significant impact on coverage numbers in Hawaii, the state with the most extensive state-specific coverage by far.

UNINSURED IN MILLIONS: EMPLOYEES BY FIRM SIZE



SOURCE: TABULATIONS BY ASPE OF THE MARCH 1995 CURRENT POPULATION SURVEY

PERCENT UNINSURED: EMPLOYEES BY FIRM SIZE



SOURCE: TABULATIONS BY ASPE OF THE MARCH 1995
CURRENT POPULATION SURVEY

- All 18 million Medicaid children will be at risk under the Republican bill that offers them no true guarantee of basic health care.
 - Without standards for benefits, children may receive only one week of hospital care per year or a limited set of vaccinations — not a real guarantee of care.
 - Without the current Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, doctors might identify serious health problems but not be able to treat the child the “T” in EPSDT has been severely limited.
 - Without real protections against cost sharing, poor children’s families could face huge hospital deductibles or copayments for prescription drugs.
- The 2.5 million children who are between 13 and 18 would receive Medicaid under current law, but are denied even the limited “guarantee” under the Republican bill. [note: I don’t really remember how CDF did their number, so we need to check this]
- Given the meaningless “guarantee” for all children and the removal of any guarantee for older children, the already staggering number of uninsured children — 10 million children — will rise.

Health Insurance Coverage of Children Less than 18 Years

	Number of Children In the State	Number of Uninsured	Percent	Number of Medicaid	Percent
Total	70,513,000	10,004,000	14%	13,115,000	19%
Alabama	1,162,000	229,000	20%	158,000	14%
Alaska	177,000	17,000	10%	25,000	14%
Arizona	1,226,000	259,000	21%	217,000	18%
Arkansas	591,000	113,000	19%	72,000	12%
California	8,963,000	1,794,000	20%	2,280,000	25%
Colorado	1,006,000	124,000	12%	100,000	10%
Connecticut	757,000	82,000	11%	105,000	14%
Delaware	147,000	15,000	10%	19,000	13%
District of Columbia	150,000	21,000	14%	62,000	41%
Florida	3,549,000	536,000	15%	746,000	21%
Georgia	2,037,000	315,000	15%	349,000	17%
Hawaii	241,000	18,000	7%	28,000	12%
Idaho	330,000	45,000	14%	50,000	15%
Illinois	3,270,000	310,000	9%	602,000	18%
Indiana	1,801,000	185,000	10%	315,000	17%
Iowa	754,000	82,000	11%	77,000	10%
Kansas	696,000	58,000	8%	99,000	14%
Kentucky	1,003,000	133,000	13%	243,000	24%
Louisiana	1,274,000	221,000	17%	364,000	29%
Maine	282,000	33,000	12%	45,000	16%
Maryland	1,295,000	160,000	12%	173,000	13%
Massachusetts	1,459,000	140,000	10%	199,000	14%
Michigan	2,604,000	213,000	8%	495,000	19%
Minnesota	1,224,000	95,000	8%	157,000	13%
Mississippi	684,000	109,000	16%	171,000	25%
Missouri	1,204,000	118,000	10%	248,000	20%
Montana	223,000	22,000	10%	27,000	12%
Nebraska	481,000	43,000	9%	40,000	8%
Nevada	394,000	69,000	18%	34,000	9%
New Hampshire	279,000	38,000	14%	34,000	12%
New Jersey	2,064,000	223,000	11%	303,000	15%
New Mexico	506,000	132,000	26%	116,000	23%
New York	4,714,000	665,000	14%	1,033,000	22%
North Carolina	1,595,000	190,000	12%	285,000	18%
North Dakota	181,000	13,000	7%	21,000	12%
Ohio	3,107,000	304,000	10%	527,000	17%
Oklahoma	857,000	177,000	21%	139,000	16%
Oregon	852,000	108,000	13%	157,000	18%
Pennsylvania	2,980,000	331,000	11%	514,000	17%
Rhode Island	234,000	21,000	9%	32,000	14%
South Carolina	967,000	143,000	15%	171,000	18%
South Dakota	237,000	19,000	8%	29,000	12%
Tennessee	1,408,000	148,000	10%	320,000	23%
Texas	5,776,000	1,389,000	24%	1,149,000	20%
Utah	859,000	60,000	9%	38,000	6%
Vermont	160,000	9,000	6%	25,000	16%
Virginia	1,727,000	192,000	11%	209,000	12%
Washington	1,346,000	141,000	10%	245,000	18%
West Virginia	399,000	40,000	10%	102,000	26%
Wisconsin	1,338,000	85,000	6%	155,000	12%
Wyoming	143,000	19,000	13%	13,000	9%

Tabulations from the March 1995 CPS, rounded to the nearest thousand

Note: CPS has historically undercounted Medicaid coverage due to reporting problems.

HCFA reported about 16 million children on Medicaid in 1994 (person years).

Uninsured Children

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Wyoming	143,000	19,000	13%

Tabulations from the March 1995 CPS, rounded to the nearest thousand. Children less than 18

Fact on Insurance & Employment

Job Turnover is High

- The fast-moving economy has created job turnover.
 - The proportion of job displacements remains high despite the end of the recession.
 - A recent *New York Times* poll found that half of all respondents worried that they or someone in their family would be laid off.
- One in four workers will make an unemployment claim over a four-year period.
- Over 15 million workers received unemployment in 1995.

Health Insurance is Linked to Jobs

- Workers with job changes are more than 3 times more likely to have gaps in insurance than continuous workers.
- Over 50% of the uninsured lost insurance due to a job change. Many of these are spouses and children of the worker.
- Over one-third of workers who had a job with insurance, became unemployed and received unemployment compensation become uninsured.

Michael,

Here are the statistics you have requested. Many of these people have no insurance so Kennedy-Kassebaum will not help them. Therefore, the construction of the message should be as follows:

“Today an estimated xxx million Americans have xxxxx disease. (you can choose just one or as many as you want). The Kennedy-Kassebaum law will ensure that these individuals will no longer have to worry about losing their health insurance because of their condition.”

The point here is that there needs to be two sentences to clarify that Kennedy-Kassebaum will not help all individuals that have these health conditions.

HEALTH STATISTICS

- Today, an estimated 16 million Americans have diabetes, with 1,700 new cases being diagnosed every day. [National Institutes of Health, National Institute on Diabetes and Digestive and Kidney Diseases]
- Over 10 million Americans have a history of cancer. [American Cancer Society]
- At least 50 million Americans suffer from cardiovascular disease, including 13 million with coronary disease. [National Institutes of Health, National Heart, Lung, and Blood Institute]
- Over 200,000 people are living with AIDS and between 650,000 to 900,000 more are living with HIV. [Department of Health and Human Services, Center for Disease Control and Prevention]

DRAFT

**Coverage of Uninsured Children
Under Medicaid Expansions
and Proposed Children's Health Insurance Program
Millions of Children, 1997**

Total Uninsured Children in 1997	8.6
Uninsured Children Over 240% of Poverty and Not Eligible for a Premium Subsidy	1.8
Uninsured Children Under 240% of Poverty and Eligible for a Premium Subsidy or Coverage Through Medicaid Expansions	6.8
Uninsured Children That Will Be Covered Through Current Law Expansions Of Medicaid	1.8
Remaining Uninsured Children Under 240% of Poverty Eligible for a Premium Subsidy	5.0
Uninsured Children Likely To Participate in New Kids' Program	1.9
Previously Uninsured Children Covered By Medicaid and New Kids' Program	3.7

NOTES:

Children in Families Under 133% of poverty receive full premium subsidy.
Premium subsidy phases out at 240% of poverty.

Program is assumed to be a capped amount provided to states and not an individual entitlement.

DRAFT

**Number of Children Participating in Kids' Program: 1997
(Persons in millions)**

	Formerly Uninsured	Medicaid Optional Coverage	Employer-Sponsored Insurance	Non-Group Insurance	Other	TOTAL
Participants	1.9	1.3	1.2	2.0	0.5	6.9

**Distribution of Federal Funds and Participants
By Income Quintile: 1997**
(Persons in millions, dollars in billions)

SELECTED PROGRAMS		Income Quintiles					Total
		1st	2nd	3rd	4th	5th	
Kids' Program (Full Coverage in 1997) Free to 133% PL; 240% PL Phase-Out	<i>Participants</i>	0.4	1.8	2.7	1.2	0.3	6.4
	<i>Subsidies</i>	10%	44%	39%	6%	1%	\$5.1
Free to 133% PL; 300% PL Phase-Out	<i>Participants</i>	0.4	1.9	3.2	1.7	0.4	7.6
	<i>Subsidies</i>	8%	38%	43%	9%	1%	\$6.3
Temporarily Unemployed	<i>Participants</i>	0.9	2.4	2.6	1.8	0.4	8.2
	<i>Subsidies</i>	22%	38%	26%	11%	2%	\$4.0
Kids + Temporarily Unemployed Free to 133% PL; 240% PL Phase-Out	<i>Participants</i>	1.0	3.3	4.5	2.3	0.5	11.7
	<i>Subsidies</i>	15%	42%	34%	8%	2%	\$8.3
Free to 133% PL; 300% PL Phase-Out	<i>Participants</i>	1.0	3.4	4.9	2.8	0.7	12.8
	<i>Subsidies</i>	13%	38%	38%	10%	2%	\$9.6
Long Term Care Program High Option (1)	<i>Participants</i>	0.2	0.2	0.1	0.0	0.0	0.5
	<i>Subsidies</i>	60%	26%	13%	2%	1%	\$1.8

NOTE: The 1997 costs represent a full year of subsidies; in the "Uses Table", only 75% of these subsidies are displayed since the programs begin on January 1, 1997.

(1) Assumes implementation in FY 1998

Income Quintiles are Annual Cash Income (1994\$):

1st Quintile: \$0 - 9,400

2nd Quintile: \$9,400-20,400

3rd Quintile: \$20,400 - 35,000

4th Quintile: \$35,000 - 57,500

5th Quintile: \$57,500

Fact Sheet on the Uninsured

General Statistics

- 40.3 million Americans are uninsured.¹
- Fully 85% (34 million) of the uninsured are workers or are in families of workers.²

Uninsured Children Statistics

- Of the 40 million uninsured, 10 million are children.³
- Of that, 80% (8 million) of the uninsured children have a parent who is a worker.⁴
- Of the 10 million uninsured children, about 3 million are eligible for Medicaid but are not currently enrolled.⁵

Statistical Back-Up for Workers In-Between Jobs

- Almost 3 out of 5 people who lose their health insurance do so because of a change in their employment.⁶
- 45% of the children who lose their health insurance do so due to a change of employment of their parents.⁷

¹ Employment Benefits Research Institute (EBRI). November 1996.

² EBRI 1996.

³ EBRI 1996.

⁴ EBRI 1996.

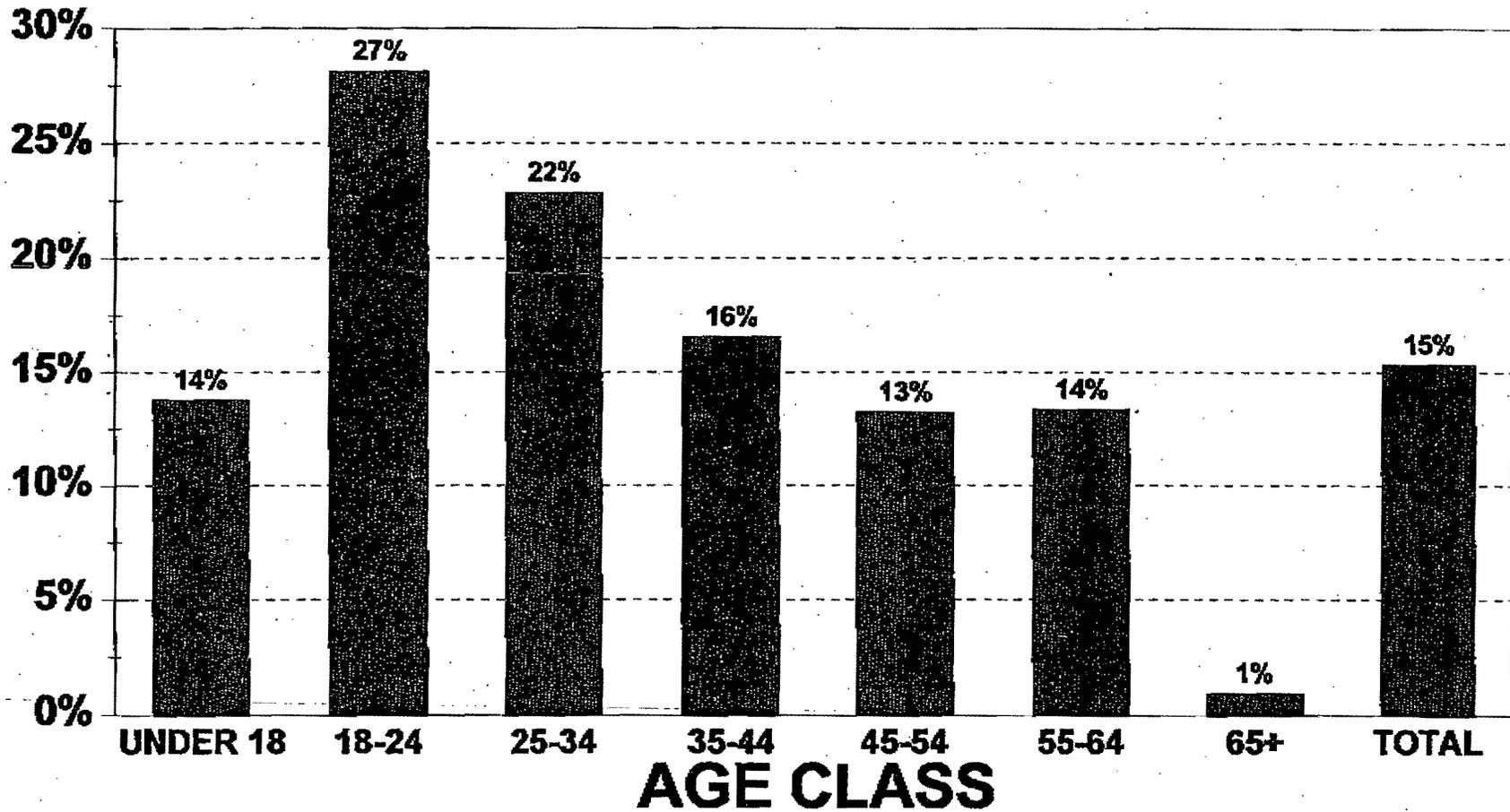
⁵ EBRI 1996.

⁶ Sheils, John and Alecxi, Lisa. Recent Trends in Employment Health Insurance Coverage and Benefits. Washington, D.C. Final Report Prepared for the American Hospital Association. 1996.

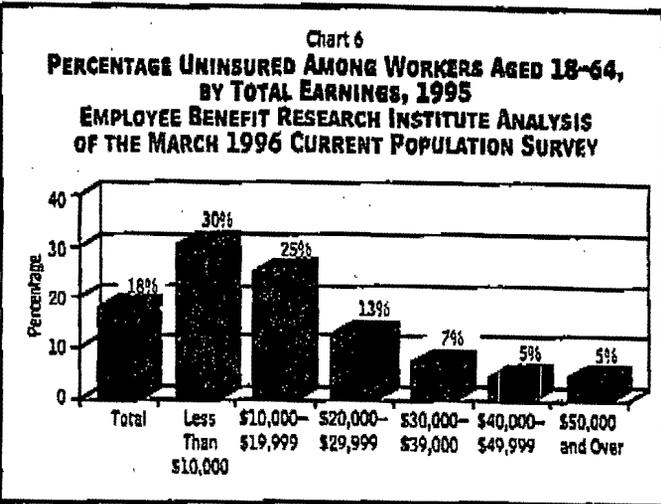
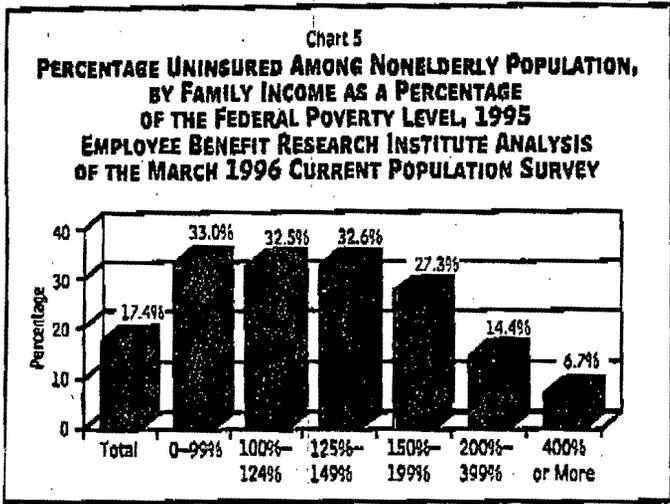
⁷ Sheils and Alecxi. 1996.

PERCENT UNINSURED BY AGE CLASS

MARCH 1996 CURRENT POPULATION SURVEY



SOURCE: TABULATIONS BY ASPE



Family Type

Single individuals and individuals in single-parent families were more likely to be uninsured than married couples either with or without children (chart 7). Married couples and two-parent families may have higher income levels, and both adults may be employed, increasing their chances of receiving employment-based coverage and, if not covered through an employer, they may be better able to afford individually purchased private health insurance.

Age

Individuals aged 45-54 were less likely to be uninsured (13.3 percent), and individuals aged 21-24 were more likely to be uninsured (32.3 percent) than those in all other age groups in 1995 (chart 8). The high proportion of young adults without health insurance may occur because they are no longer covered by a family policy and may not have established themselves as permanent members of the work force, as many are still in school. Some young adults may have also lost access to Medic-

aid, which covered them through age 18 in some states. In addition, many in this group may think that they do not need health insurance because they are young and healthy. Finally, young workers may be ineligible for an employment-based plan because of waiting periods imposed prior to eligibility.

Race and Origin

While 71 percent of the nonelderly population is white, this group comprised 54.3 percent of the uninsured 1995 (table 6). Individuals of Hispanic origin were more likely to be uninsured than other groups (35.0 percent). This may be due in part to the fact that 61 percent of the Hispanic population reported income of less than 200 percent of the federal poverty level. However, even at higher income levels, Hispanics were generally more likely to be uninsured than other racial groups and were less likely to be covered by private health insurance (table 6). In addition, Hispanics were more likely to be noncitizens than whites or blacks, and noncitizens were more likely to be uninsured than citizens.

