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“STRANGE BEDFELLOWS” JOIN FORCES ON AGREEMENT FOR UNINSURED AMERICANS

Families USA, Health Insurance Association of America, and American Hospital Association release plan to extend health coverage to those most in need

WASHINGTON, D.C. – Countering a trend of increased political acrimony and partisanship, three leading organizations with divergent points of view in the health policy arena – the Health Insurance Association of America (HIAA), Families USA, and the American Hospital Association (AHA) – have joined forces to expand health coverage for a substantial portion of America’s 43 million uninsured.

“As organizations representing the breadth of the health care community, we stand together to forge common ground to end the gridlock over extending health care coverage to the uninsured millions living in America today,” according to a statement by the three organizations.

Families USA, the national organization for health care consumers, and HIAA, the national trade association representing almost 300 insurance companies and health plans, battled over health care reform in 1993-1994 and continue to fight over the issue of a patients’ bill of rights. Yet over the last several months, the two rivals set aside their differences and negotiated a three-part proposal to significantly expand health insurance coverage. They have been joined by the AHA, a not-for-profit association of health care providers and individuals committed to health improvement of their communities.

The organizations are calling for “common ground and coalesced action as the debate on the uninsured begins,” according to the statement. “Political gridlock should no longer be an option in dealing with America’s uninsurance epidemic,” said Ron Pollack, Executive Director of Families USA. “We must transcend partisan, ideological, and interest-group boundaries to find common ground so we can move towards health coverage for everyone.”

“In the past, every group interested in extending coverage to the uninsured held out for their favorite approach, and their second choice always was the status quo,” observed HIAA President Chip Kahn. “As a result, nothing was accomplished. By coming together now, HIAA, Families USA, and the AHA are saying we can get started if we seek common ground.”

“People often say that no one in Washington can agree. Today, we’re happy to prove them wrong,” said Rick Pollack, AHA’s executive vice president. “With this step, we’ve laid a strong foundation we hope to build upon to improve access and coverage for all.”

The proposal focuses on low-wage workers and their families. Of the 43 million uninsured Americans, slightly more than half (23 million) have annual incomes below 200 percent of the federal poverty level. It contains the following elements:

- Medicaid would be expanded for all people under 65 years of age with annual incomes below 133 percent of the federal poverty level (\$18,820 for a family of three). Eligibility would be based strictly on income and would apply equally to parents, children, and childless adults. This expansion would be subsidized with enhanced federal matching funds well in excess of the current Medicaid funding formula.
- As is currently done for children, states would be given the option to provide coverage for parents and childless adults with incomes between 133 and 200 percent of the federal poverty level (\$28,300 for a family of three) through Medicaid or a program like the State Children's Health Insurance Program (S-CHIP). This expansion also would be subsidized with enhanced federal matching funds. Both the Medicaid and S-CHIP expansions would be developed to ensure optimal enrollment of people newly eligible for coverage.
- A non-refundable tax credit would be created to help low-income workers who turn down employer-sponsored coverage because they can't afford their share of the premium. This credit would be available to employers to help them defray the out-of-pocket premium costs of employees with incomes between 133 and 200 percent of the federal poverty level. For example, if a business currently pays 70 percent of the premiums for all workers in the company, it would receive a tax credit to pay all or part of the remaining premium for its low-income workers.

The three groups are working together to promote the proposal among interest groups and policymakers, and will reach out to the eventual President-Elect, the new Congress, and key stakeholder organizations to achieve bipartisan cooperation resulting in the enactment of expanded health coverage next year. They also acknowledge that their proposal would require a significant public investment.

"But – with the economy in good condition, the federal budget in surplus, and state budgets in good shape as well – there never has been a better time to make such an investment," their statement concludes.

November 20, 2000

FINDING COMMON GROUND FOR EXPANDED HEALTH COVERAGE TO THE UNINSURED

Introduction: Almost 43 million Americans are without health insurance today, approximately one out of every six people in the United States. With the number of Americans who lack health insurance at this epidemic level, expanding coverage deserves to be at the top of the policymaking agenda.

As organizations representing the breadth of the health care community, we stand together to forge common ground to end the gridlock over extending health care coverage to the uninsured millions living in America today. As a nation faced with unprecedented prosperity, we have a duty to marshal our resources to help uninsured working Americans. The time is right to press the new Congress and Administration to enact significant health coverage expansion to close the gap of the uninsured. The following proposal is the first step to build consensus around expanding coverage. This proposal will serve as the basis for common ground and coalesced action as the debate on the uninsured begins.

The Assumptions: In the formulation of this agreement, five assumptions served as guidelines:

1. *Providing health coverage for everyone will occur neither through modest increments nor through one comprehensive package.* Instead, progress will be made step by step. We are convinced that the first of these steps must achieve significant expansion of coverage.
2. *The proposal cannot take away, or appear to take away, health coverage from people who have it today.* Any proposal that changes the form of people's health coverage, or that appears to diminish the scope and quality of that coverage, or that threatens to result in increased costs for that coverage, is likely to result in unbeatable opposition.
3. *As a corollary of the second guideline, the proposal should build on the health coverage structures that work for many millions of insured people.* Using existing structures, public and private, will allow for quicker and more effective implementation, and it will avoid the creation of new bureaucracies and further fragmentation of the health system. Additionally, building on systems that currently work has a much better chance of gaining support from the public, policymakers, and interest groups. In the private sector, this means building on employment-based health coverage; in the public sector, this means building on Medicaid and the State Children's Health Insurance Program (S-CHIP).

4. *The proposal should use public resources in a way that maximizes new health coverage.* Since there are many competing demands for government resources – including other significant health care matters – a first-step proposal should make the best use of available resources to maximize coverage of the uninsured.
5. *The proposal should focus on low-wage workers, their families, and other low-income populations that are least capable of obtaining health coverage on their own.* Focusing the search for common ground on low-wage workers and other low-income populations not only makes good policy sense, it makes political sense as well. Even though this group has relatively little political clout, we believe it will be easier to first achieve a consensus on behalf of this group than other segments of the uninsured.

The Proposal: The proposal is designed as a policy framework, not as a set of legislative specifications. Two reasons prompted this. First, it articulates a clear vision for action. And, second, the framework approach allows for the involvement of additional stakeholders as legislation is developed.

The policy framework focuses on the low-wage working population with incomes below 200 percent of the federal poverty level – over half of America’s uninsured. The proposal has three parts.

First, the proposal would require an expansion of Medicaid for all people under 65 years of age with annual incomes below 133 percent of the federal poverty level (approximately \$18,820 for a family of three). Eligibility for such coverage would be based exclusively on income, no longer on membership in one of several prescribed categories (such as children or parents). To ensure that states have the financial resources to implement this expansion, enhanced federal matching funds would be provided significantly above the current Medicaid funding formula. To the extent that funds are limited, this part of our proposal would be phased in first.

Second, the proposal gives states the option of establishing Medicaid or S-CHIP-type coverage for non-aged adults with incomes between 133 and 200 percent of the federal poverty level. For states that choose this option, coverage would be based on income, not parental status. Like the Medicaid proposal for lower-income people, significantly enhanced federal matching funds would be made available. The two public program expansions would be developed to ensure optimal enrollment of those newly eligible for coverage – using, for example, mail-in application processes; fiscal carrots for states to meet enrollment targets; “presumptive eligibility” systems to enable social services agencies to temporarily enroll eligible people; out-stationing of state certification officials; one-year certification periods; and elimination of resource eligibility standards.

Third, the proposal establishes a non-refundable tax credit for businesses to encourage them to make employment-based coverage more affordable for their low-income workers. This tax credit should be established in tandem with the implementation of public program expansions for people with incomes between 133 and 200 percent of

the federal poverty level. The credit would be available to those employers who pay a larger share of the premium (than what is offered to other workers in the company) for those workers whose family incomes fall between 133 and 200 percent of the federal poverty level. For example, if a business currently pays 70 percent of the premiums for all workers in the company and decides to pay all or part of the remaining premium for its low-income workers, that business would receive a tax credit for that additional amount. The employer tax credit would be available only to companies that make contributions to their health plans commensurate with the contribution levels of other similarly situated employers. To ensure that this facet of our proposal strengthens existing coverage, the legislation would seek to secure, and not weaken, current employer coverage and contributions that workers receive through their jobs.

Why the Focus on Low-Wage Workers: Although more than 9 out of 10 privately insured Americans receive health coverage at the workplace, low-wage workers have more difficulty obtaining such coverage. Only 43 percent of those earning \$7 an hour or less are *offered* employment-based coverage, compared to 93 percent of U.S. workers who earn more than \$15 an hour. Even when coverage is offered, it is too expensive for many low-wage workers to purchase – both because low-wage workers have less discretionary income to spend on insurance premiums *and* because premiums, on average, are considerably more expensive for workers in low-wage firms than they are for workers in high-wage firms.

Similarly, public sector coverage for low-wage families (i.e., Medicaid and S-CHIP) leaves many uninsured. In effect, these programs divide low-income populations into three groups – children, the parents of children, and childless adults – and treat these groups very differently. This categorization and differential treatment of low-income populations is an unfortunate vestige of the 16th century Elizabethan Poor Laws that formed the basis of our nation’s welfare and Medicaid programs.

Children in most states are eligible for public sector coverage if they live in families with incomes below 200 percent of the federal poverty level (\$28,300 in annual income for a family of three). *Parents* receive considerably less protection: in almost two-thirds (32) of the states, a parent working at the minimum wage (\$5.15 per hour) is considered to have “too much income” to qualify for Medicaid if that parent works full time. As a result, parents leaving welfare for work often lose their Medicaid coverage even though they usually wind up in entry-level jobs that provide no health coverage. *Single adults or childless couples*, no matter how poor, are excluded from Medicaid coverage in the vast majority of states, unless they are disabled. As a result, there are many millions of low-wage working people and families who have no access to employment-based health coverage – or can’t afford such coverage – who remain ineligible for Medicaid.

The Rationale: The proposal represents the beginnings of consensus. It would extend health coverage to a very significant portion of people who are uninsured today. It achieves a reasonable balance between public sector and private sector approaches. It focuses priority attention to the people most in need of assistance. It builds on systems that work today and, therefore, does not create new bureaucracies or cause further

fragmentation of our health care system. It is designed to eliminate work disincentives by providing new health coverage opportunities to support low-income workers and people moving from welfare to jobs.

Undoubtedly, this proposal – like any that would result in a major increase in health coverage for lower-income families – will require a significant public investment. It is expected that such an approach will be expensive. But – with the economy in good condition, the federal budget in surplus, and state budgets in good shape as well – there never has been a better time to make such an investment.

This proposal, and the broad coalition-building effort to which we are committed, constitutes a viable first step to expand health coverage for many millions of uninsured Americans. Through a common effort, we have a real chance to proceed down the road toward health coverage for all Americans.

Building A Consensus For Expanding Health Coverage

A first-step proposal from some "strange bedfellows" that transcends ideological, partisan, and interest-group boundaries.

by Charles N. Kahn III and Ronald F. Pollack

ABSTRACT: Despite a flourishing economy and recent growth in employment-based health coverage, forty-three million Americans remain uninsured. Extending coverage to the uninsured is not an intractable public policy problem but could be addressed if the various health care stakeholders could only find common ground. We argue that to win broad-based support from across the ideological and political spectra, a meaningful proposal should achieve a balance between public- and private-sector approaches, focus attention on those who are most in need of assistance (low-income workers), and build on systems that work today. With the aim of pulling together a political coalition, we present a proposal specific enough to attract support but whose details will arise later, in the context of the legislative process.

EXPANDING
COVERAGE 1

ALMOST FORTY-THREE MILLION AMERICANS (approximately one of every six) are without health insurance today. This number has remained high despite a thriving economy—with unemployment and inflation down and individual and business incomes up. Once an inevitable slowdown occurs in the longest peacetime economic expansion in U.S. history, today's unacceptably high levels of uninsurance will undoubtedly get worse. Our nation's uninsurance epidemic deserves to be at the top of the policy-making agenda.

Efforts to broaden access to health coverage in the twentieth century have repeatedly ended in failure. In addition to Bill Clinton's unsuccessful attempt in 1993-1994, other presidents—including Franklin D. Roosevelt, Harry Truman, John F. Kennedy, Richard Nixon, and Jimmy Carter—have sought and failed to achieve meaningful coverage expansions.¹ (The lone exception is Lyndon Johnson, who, after an electoral landslide that was accompanied by overwhelming Democratic majorities in both chambers of Congress, suc-

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Chip Kahn is president of the Health Insurance Association of America (HIAA). Ron Pollack is executive director of Families USA.

“Coverage for everyone will occur neither through tiny increments nor through one comprehensive package.”

ceeded in enacting Medicare and Medicaid in 1965.)²

A combination of factors led to these failures. In each of those efforts, one or more of the large health interest groups strongly opposed the legislation and spent significant amounts of political and financial capital to rouse the public and mobilize members of Congress. Similarly, the pro-reform groups often overreached and were unwilling to compromise, which also contributed to defeat.

In effect, all of the players in health care reform—from the ideological right to the left, from the special interests to the reformers—came to the political process with strong convictions in support of their first-choice proposal. For each of these groups, their second-favorite choice was the status quo.³ And, indeed, the ultimate result of these efforts was the status quo, with more and more Americans losing health coverage.

If there is a lesson to be drawn from this history, it is that proposed changes to health care financing can easily alarm stakeholders, who may then erect roadblocks. Moreover, while the public's support for health coverage expansions is encouragingly broad, it is discouragingly thin and, as a result, is susceptible to a well-financed opposition campaign.⁴ Meaningful health coverage expansions, therefore, require broad-based support, transcending ideological, partisan, and interest-group boundaries.

The political landscape in our nation's capital today underscores this conclusion. In contrast to 1965, when Medicare and Medicaid were enacted, today neither the Democrats nor the Republicans truly control Congress, no matter which is in the majority. Without strong champions from both sides of the aisle, in both the House and the Senate, it will be virtually impossible to achieve significant coverage expansions. Indeed, considerably less ambitious proposals, such as the State Children's Health Insurance Program (SCHIP) in 1997 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996, succeeded only because they had substantial bipartisan support.⁵

It is critical, therefore, that common ground be sought for a proposal that can attract the key stakeholders in health care policy making. Further, we believe that providing health coverage for everyone will occur neither through tiny increments nor through one comprehensive package. Rather, progress will be made step by step. We are convinced that the first of these steps must achieve signifi-

cant expansion of coverage.

We propose to accomplish that, and have begun by initiating a process designed to involve key stakeholders, many of them "strange bedfellows." We believe that the proposal and process we are pursuing are substantively sound and politically achievable.

Guidelines For Developing A Viable Proposal

To develop this proposal to expand health care coverage, we have followed four guidelines that we believe to be fundamental to success. We address each of these in turn.

■ **Maintain current coverage levels.** The proposal cannot take away, or appear to take away, health coverage from people who have it today. Any proposal that appears to threaten existing health coverage for people who are insured is a political nonstarter. Simply stated, if asked to make a change that affects their own health coverage, many of those who are insured will not support reform efforts. This means that any proposal that changes the form of people's health coverage, appears to diminish the scope or quality of that coverage, or threatens to result in increased costs for that coverage is likely to provoke unbeatable opposition.

■ **Build on existing structures.** The proposal should build on the health coverage structures that currently work. There are fundamental reasons, both technical and political, for building on what works. Using existing structures, whether public or private, will allow for quicker and more effective implementation and avoid the creation of new bureaucracies and further fragmentation of the health care system. Additionally, building on what currently works has a much better chance of gaining support from the public, policy-makers, and interest groups.

Employment-based coverage. In the private sector this means building on employment-based health coverage. Today, 91 percent of privately insured Americans receive health coverage at the workplace.⁶ Even if one questions whether it made sense to build America's health coverage system on an employment-based model, it is the model with which most people feel comfortable. Replacing it will not only result in political turmoil, it also may do considerably more harm than good. Undermining the employment-based health coverage system could result in lost cost efficiencies realized today through group purchasing and would require greater government regulation to ensure that sick and frail persons retain affordable access to coverage. Moreover, it would engender enormous political opposition from workers, who might fear that employers' diminished health coverage contributions would not be offset by wage increases or other benefits.

Medicaid and SCHIP. In the public sector the proposal should build on Medicaid and SCHIP. Today, Medicaid covers forty-one million low-income persons, and the newly implemented SCHIP has already enrolled 2.5 million children.⁷ These two programs constitute the bulwark of health coverage for America's most vulnerable populations, the groups least likely to afford health coverage through the private sector. Moreover, as a recent Henry J. Kaiser Family Foundation survey indicates, the overwhelming majority (94 percent) of parents of children enrolled in Medicaid view it as a good program.⁸ Thus, by building on employment-based coverage as well as Medicaid and SCHIP, the first-step proposal would be based on what works today and would not need to create new bureaucracies or coverage structures.

■ **Maximize public funds.** The proposal should use public resources in a way that maximizes new health coverage. Providing coverage for the uninsured is not inexpensive. And since there are many competing demands for government resources—including those of other health care matters such as Medicare and prescription drugs—it is unlikely that sufficient funds would be made available in the near term to cover all of the uninsured. Therefore, a first-step proposal should make the best use of available resources to maximize coverage of the uninsured.

For all aspects of the proposal, the substitution of taxpayer funds for coverage already provided through private spending (“crowding out”) must be minimized. Since crowding out occurs more frequently among higher-income populations, it is best to first focus expansion efforts on those with incomes below 200 percent of the federal poverty level. This is consistent with our next guideline.

■ **Focus on those with greatest need first.** The proposal should focus on low-wage workers, their families, and other low-income populations that are least capable of obtaining health coverage on their own. Low-wage workers are less likely to be offered coverage through the workplace than are higher-paid workers: 93 percent of U.S. workers who earn more than \$15 an hour are offered health insurance by their employer, whereas only 43 percent of those earning \$7 an hour or less are offered such coverage.⁹ Even when coverage is offered, it is often too expensive for low-wage workers to purchase. In fact, such benefits are often more expensive for low-wage workers than they are for higher-paid workers. The average monthly contribution required for the lowest-cost family coverage plan is \$130 in firms where the typical wage is less than \$7 an hour but only \$84 in firms where the typical wage is more than \$15 an hour.¹⁰ As a result, almost a quarter of workers with incomes below 200 percent of poverty turn down coverage when offered.¹¹

In effect, low-wage workers experience a "triple whammy": They are less likely to be offered coverage by their employers, they have to pay considerably more for coverage when employers do offer it, and they have the least discretionary income available to pay for it.

Public-sector programs such as Medicaid and SCHIP also leave a large number of low-income persons without health coverage. In effect, these programs divide low-income populations into three groups—children, parents of children, and childless adults—and treat each group very differently. This categorization and differential treatment is an unfortunate vestige of the sixteenth-century Elizabethan Poor Laws that formed the basis of our nation's welfare system and, starting in 1965, the Medicaid program as well.¹²

Children, who in recent years have aroused the greatest political sympathy, are accorded better coverage than the two adult groups. Most states now consider children eligible for public-sector coverage if they live in families with incomes below 200 percent of the federal poverty level (\$28,300 for a family of three in 2000).

While low-income parents are viewed with some sympathy, they receive considerably less coverage protection than their children do. In thirty-two states a parent working at the minimum wage (\$5.15 per hour) has "too much income" to qualify for Medicaid if he or she works full time.¹³ In Louisiana, for example, a parent is ineligible for Medicaid if his or her income exceeds 22 percent of poverty. In Texas, it is 33 percent; in Michigan, 47 percent; and in Illinois, 51 percent. As a result, when parents leave welfare for work, they often lose their Medicaid coverage even though they are likely to wind up in entry-level jobs that provide no health benefits.

Single adults or childless couples, no matter how poor, are excluded from Medicaid coverage in the vast majority of states, unless they are severely disabled. As a result, many millions of low-wage working people and families who have no access to employment-based health coverage or cannot afford such coverage remain ineligible for Medicaid.

Thus, placing a priority on expanded health coverage for low-wage workers and others with low incomes makes good sense. This group is in greatest financial need and will have the most difficulty securing health coverage without public intervention and support. Moreover, although this group has little or no political clout, we believe that it will be much easier to achieve a consensus on its behalf than is true for other segments of the uninsured population.

A Proposal For Common Action

Our proposal was designed as a policy framework, not a set of legislative specifications. We chose this approach for two reasons.

First, we wanted to articulate a clear vision for action. Second, we deemed it important as part of the initial consensus-building process to start out with a framework that would later involve additional stakeholders in the development of legislation.

Our policy framework focuses on the low-wage working population with incomes below 200 percent of the federal poverty level. The proposal has three parts.

■ **Medicaid expansion.** First, the proposal would require an expansion of Medicaid to cover all persons with annual incomes below 133 percent of the federal poverty level (approximately \$18,820 for a family of three in 2000). Eligibility for such coverage would be based exclusively on income, no longer on membership in one of several prescribed categories that are, in fact, the absurd vestiges of long-obsolete laws. To ensure that states have the financial resources necessary to implement this expansion (and continue to support it even during economic downturns), federal matching funds would be provided well in excess of the current Medicaid funding formula. To the extent that funds are limited, this part of our proposal would be phased in first.

■ **Expansions for higher-income persons.** Second, we propose that states be given the option of establishing Medicaid or SCHIP-type coverage for adults with incomes between 133 and 200 percent of the federal poverty level. For states that choose this option, coverage would be based on income, not parental status. Similar to the Medicaid proposal for lower-income persons, more federal matching funds would be made available.

The public program expansions will be developed to ensure optimal enrollment of those newly eligible for coverage. As we develop legislative specifications, several mechanisms will be considered to achieve this, including the implementation of "presumptive eligibility" mechanisms that enable social service agencies to temporarily enroll eligible persons; fiscal "carrots and sticks" to state agencies so that they meet enrollment targets; elimination of resource standards of eligibility; mail-in application processes; putting state certification officials in the field; and the establishment of one-year (or longer) certification periods.

■ **Tax credits.** Third, we propose a nonrefundable tax credit for businesses to encourage them to make coverage affordable for their low-income workers. This tax credit should be established in tandem with the implementation of public program expansions for persons with incomes between 133 and 200 percent of poverty. The credit would be available to those employers that pay a larger share of the premium (than what is offered to other workers in the company) for workers with family incomes between 133 and 200 percent

“From the perspective of the uninsured, any so-called ideal plan that cannot get enacted is no solution at all.”

of poverty. For example, if a business currently pays 70 percent of the premiums for all workers and decides to pay all or part of the remaining premium for low-income workers, that business would receive a tax credit for that additional amount.

The employer tax credit would be available only to companies that make contributions to their health plans commensurate with the contribution levels of other similarly situated employers. To ensure that this facet of our proposal strengthens existing coverage, the legislation would seek to secure, not weaken, current employer coverage and contributions that workers receive through their jobs.

Although the tax credit constitutes a new approach to expanding coverage, it is a familiar element to the business community. It is comparable in structure to the Work Opportunity Tax Credit designed to encourage companies to hire persons from low-income communities. It can work to help extend coverage precisely because employers are familiar with it, and it will enable businesses to extend help to their low-wage workers at no cost to them.

**EXPANDING
COVERAGE****7**

A Good Second Choice

This proposal is neither Families USA's nor the Health Insurance Association of America's (HIAA's) ideal plan. For Families USA, health coverage expansion proposals based on tax incentives have never been a favored option. Indeed, Families USA would not have agreed to even the tax credit approach in this plan without its linkage to the Medicaid and SCHIP expansions. Similarly, HIAA's original "InsureUSA" plan envisaged a larger private-sector approach and a much more modest Medicaid and SCHIP expansion.

We expect that this proposal will not be considered ideal by other major health care organizations as well. However, from the perspective of forty-three million uninsured persons, any so-called ideal plan that cannot get enacted is an illusionary ideal. It is no solution at all.

The proposal outlined above presents a good second choice to our two organizations, and to others as well. It has the potential for increasing health coverage for a very large portion of persons who are uninsured today. It achieves a reasonable balance between public-sector and private-sector approaches. It focuses priority attention to those most in need of assistance. It builds on systems that work today and, therefore, does not create new bureaucracies or

cause further fragmentation of our health care system. It eliminates the cumbersome and unfair poverty categorizations in a way that is consistent with experimentation undertaken by a number of states. It is designed to eliminate work disincentives by providing new health coverage opportunities to support low-income workers and people moving from welfare to jobs.

It also does not trespass on the interests of key stakeholders in the health care system. Indeed, based on our preliminary discussions with numerous major stakeholder organizations, it can gain broad support and, hence, is politically achievable. It can be enacted, and it can provide prompt coverage for many uninsured Americans, individuals and families alike.

To be sure, this proposal, like any other that would result in a major increase in health coverage for lower-income Americans, will require a significant public investment. Although no reliable cost estimate can be made until detailed legislation is developed, it is obvious that this proposal will be expensive. But there has never been a better time to take on such an investment. The federal budget has a large projected surplus, and most state budgets are in good shape as well. Our economy continues to grow, while inflation remains moderate. There is a palpable thirst among many health interest groups to find common ground on a significant health coverage expansion. Thus, as a new president and Congress begin their work, this balanced proposal is well suited for inclusion as part of a blueprint for our nation's immediate future.

8

**BUILDING
CONSENSUS**

W E BELIEVE THAT THIS PROPOSAL, and the broad coalition-building effort to which we are committed, constitute our best—perhaps our only—near-term chance to expand health coverage for many millions of uninsured Americans. Certainly if our two organizations can find common ground for this noteworthy objective, it augurs well for many other groups to do likewise. Through a common effort, we have a real chance to proceed down the road toward health coverage for all Americans.

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The authors thank Ligeia Fontaine and Peggy Denker for their assistance.

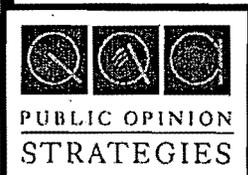
NOTES

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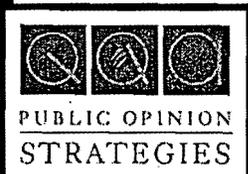


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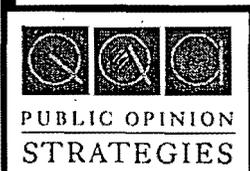


Methodology:

Public Opinion Strategies conducted a national survey from November 11-13, 2000 of 800 adults. The margin of error on a sample of this size is $\pm 3.46\%$.



**There is substantial
public support for
significant reforms to
help reduce the number
of uninsured Americans.**



Support for expanding Medicaid is strong.

Having Medicaid, the government health care program for the very poorest Americans, cover more low-wage workers and their families who today have no health care coverage.

% Strongly Favor

46%

% Total Favor

82%



PUBLIC OPINION
STRATEGIES

Support for expanding CHIP to certain adults is strong.

Providing additional federal funding to encourage states to provide health care coverage to working poor adults who do not get coverage through the Medicaid program but who still cannot afford health insurance coverage.

% Strongly Favor
48%

% Total Favor
83%

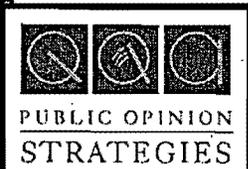


Support for an employer tax credit is strong.

Offering a tax credit to employers to help these employers pay some or all of the health insurance premium costs for those lower wage workers who today cannot afford to pay their own portion of this cost.

% Strongly Favor
56%

% Total Favor
86%



Respondents were then asked about the proposal as a whole package...and whether they would tell their Member of Congress to favor or oppose the overall proposal.

The question asked the following:

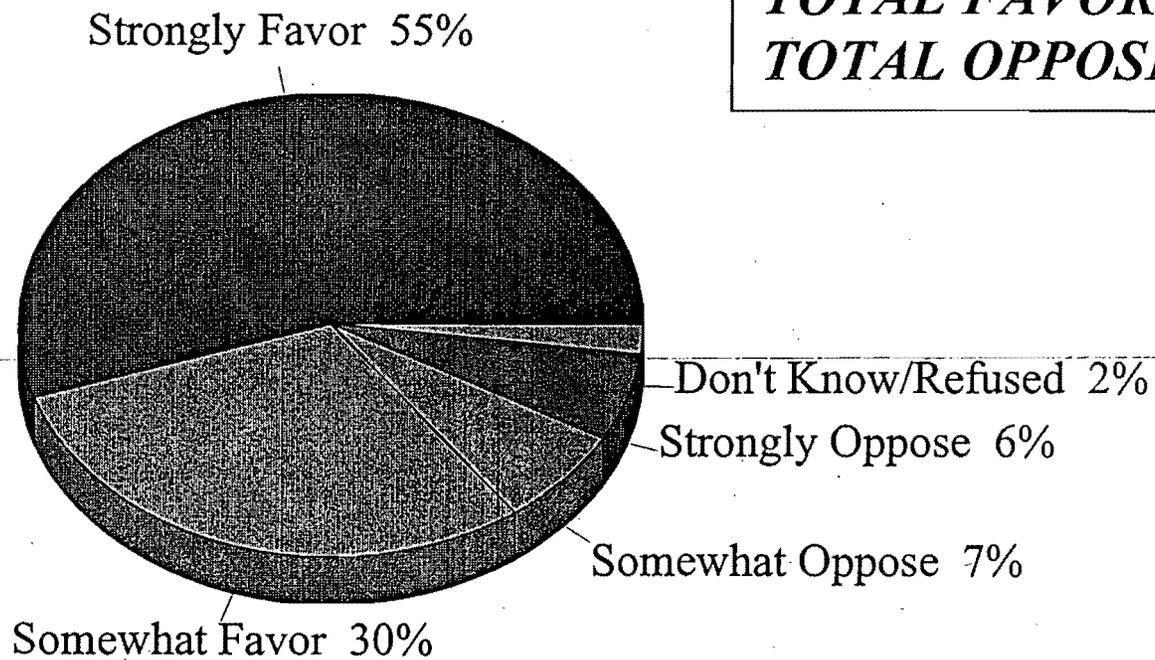
Now, thinking about a package that includes these three ideas:

Covering more low-wage workers directly through Medicaid, Providing additional federal funding to encourage states to provide health care coverage to working poor adults who earn a little too much to qualify for Medicaid Offering employers a tax credit to help pay the premium costs of health insurance for lower wage workers. Would you tell your Member of Congress they should favor or oppose this overall proposal?



PUBLIC OPINION
STRATEGIES

Here's how the overall proposal fared when all parts were included.



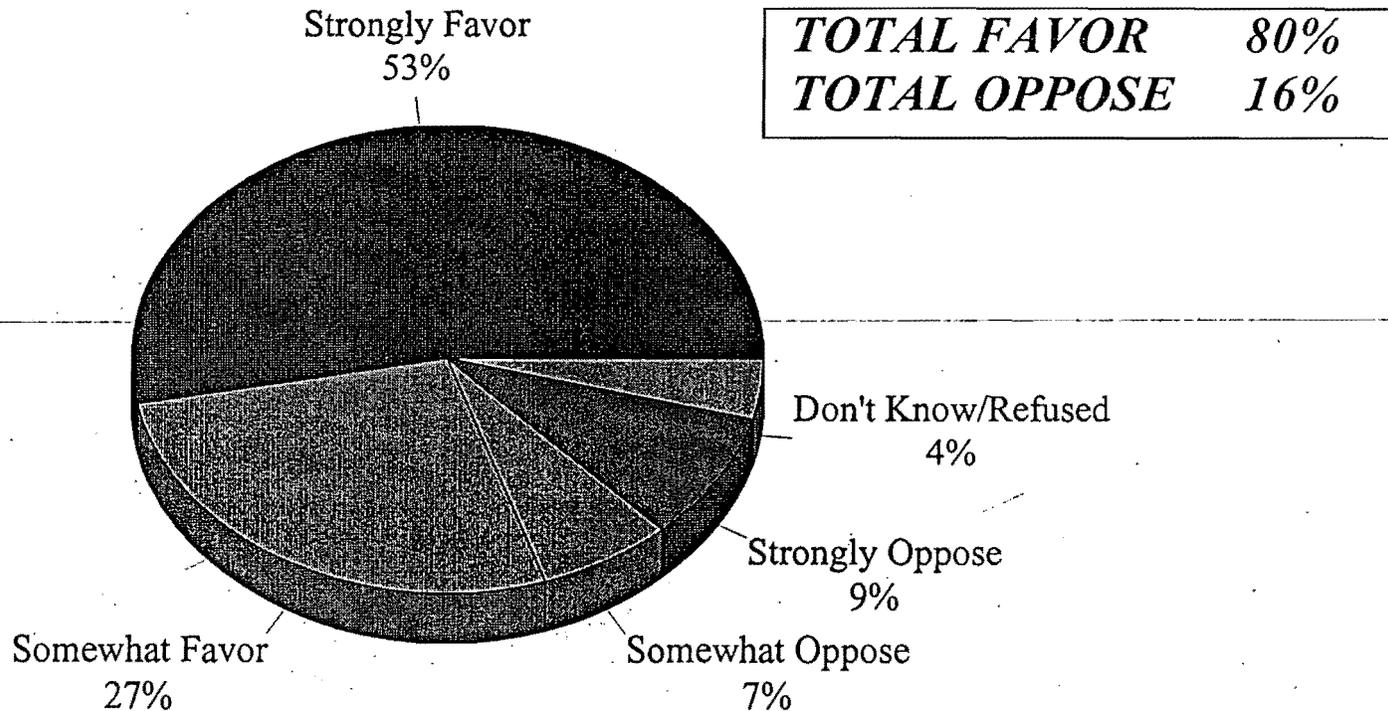
<i>TOTAL FAVOR</i>	85%
<i>TOTAL OPPOSE</i>	13%



PUBLIC OPINION
STRATEGIES

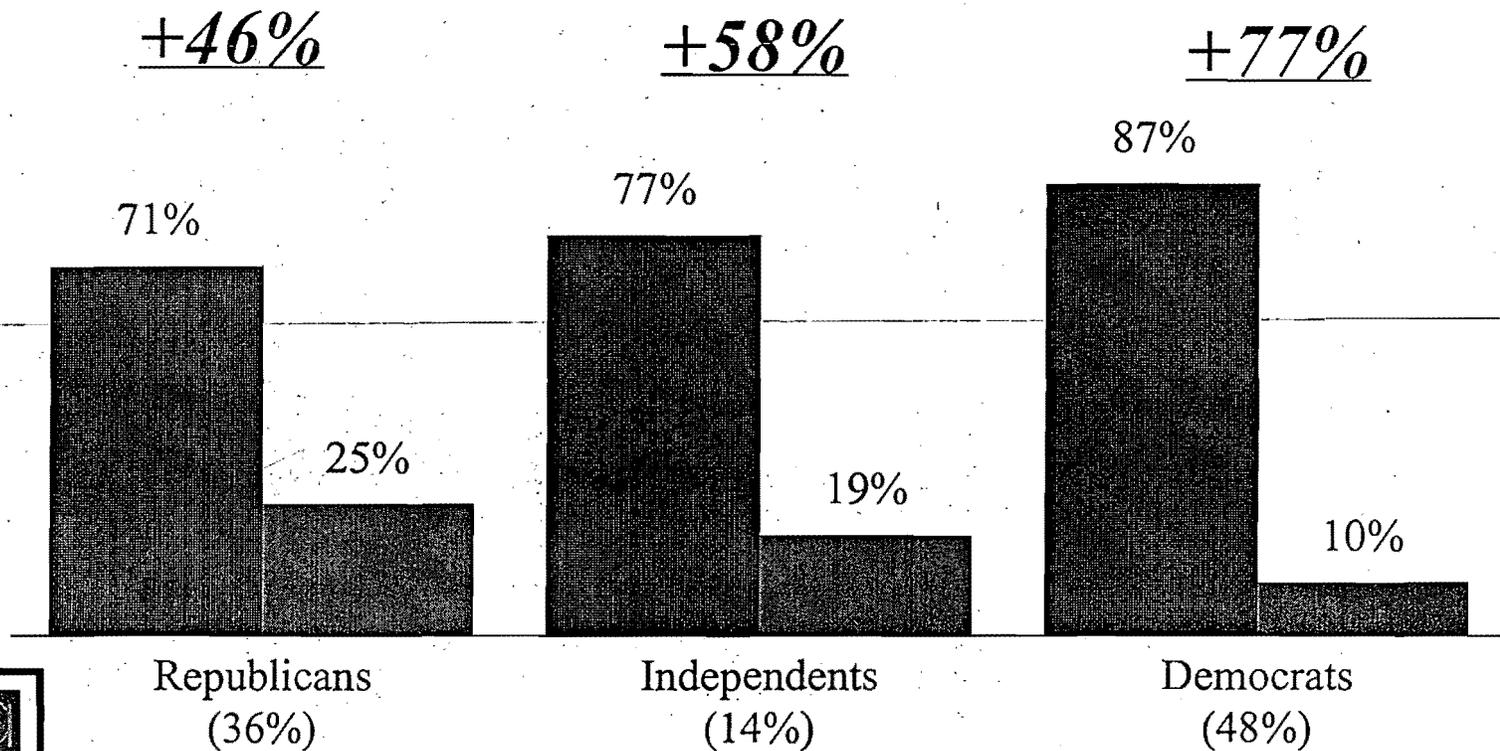
And support is almost unchanged when respondents are told this would take \$250 billion over the next decade from the surplus.

And if you learned that there is a projected federal government surplus of two trillion dollars over the next decade and this proposal would use roughly fifteen percent of the surplus or two hundred and fifty billion dollars, would you now tell your Member of Congress they should favor or oppose this overall proposal?



Importantly, a majority of both Republicans and Democrats support using the surplus for this proposal.

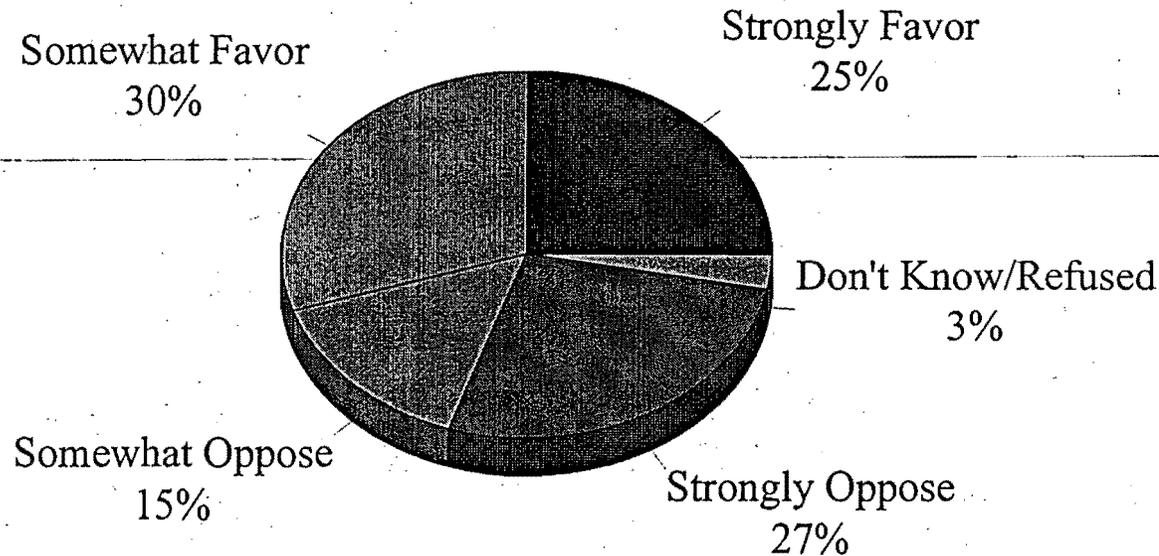
And if you learned that there is a projected federal government surplus of two trillion dollars over the next decade and this proposal would use roughly fifteen percent of the surplus or two hundred and fifty billion dollars, would you now tell your Member of Congress they should favor or oppose this overall proposal?



A majority of Americans even support this proposal at an increase of \$200 a year per taxpayer, which is the highest price tag we've ever tested in a survey.

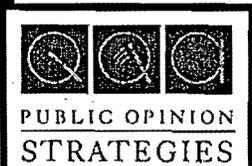
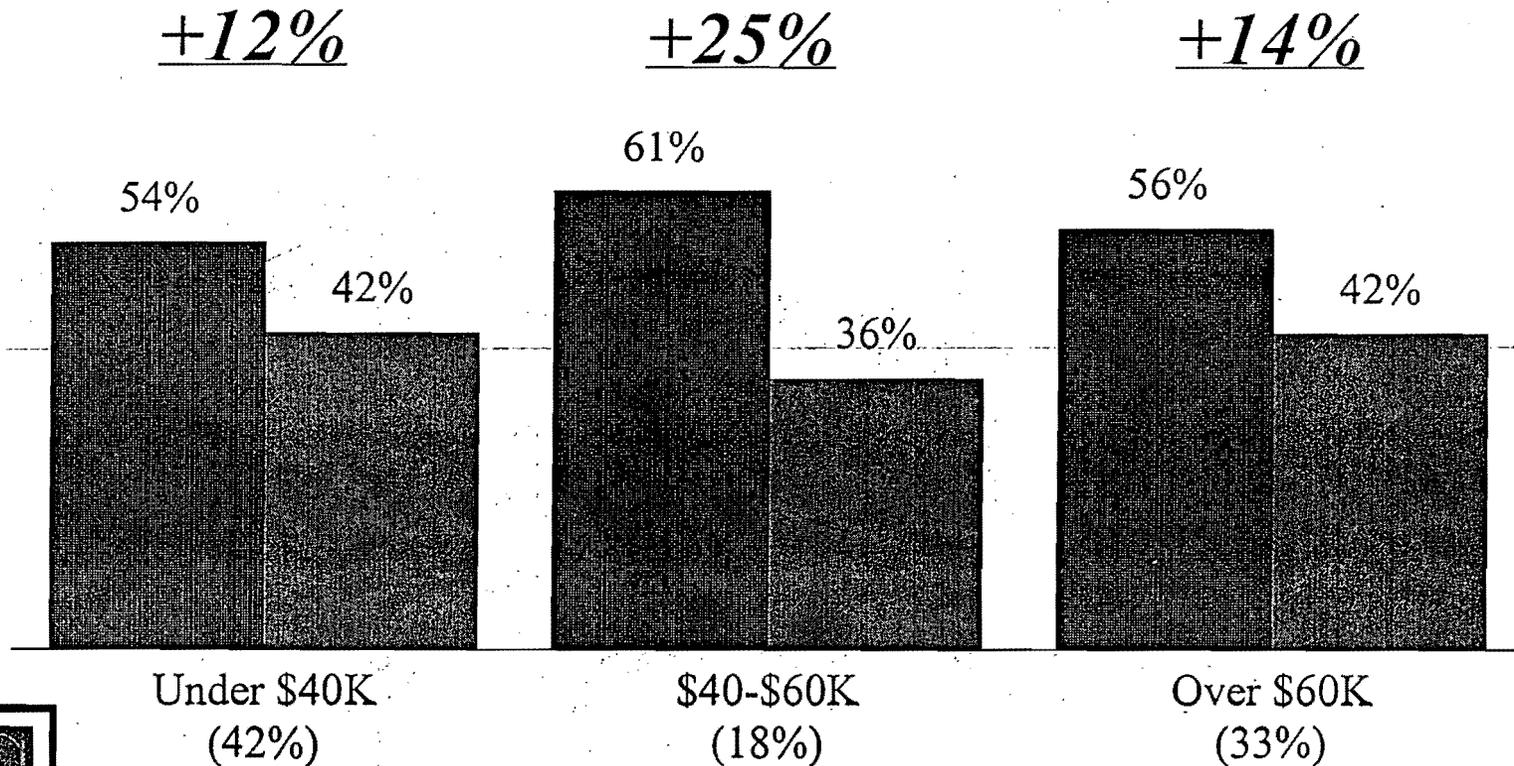
Now assuming there was no federal government surplus over the next decade and instead taxes had to be increased with the average taxpayer paying roughly two hundred dollars a year, would you now tell your Member of Congress they should favor or oppose this overall proposal?

TOTAL FAVOR	55%
TOTAL OPPOSE	42%



Support for the proposal with \$200 in additional taxes is strong across all income groups.

Now assuming there was no federal government surplus over the next decade and instead taxes had to be increased with the average taxpayer paying roughly two hundred dollars a year, would you now tell your Member of Congress they should favor or oppose this overall proposal?



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View Related Topics

November 21, 2000, Tuesday; Final Edition

SECTION: A SECTION; Pg. A23; THE FEDERAL PAGE

LENGTH: 824 words

HEADLINE: Unlikely Allies Back Health Care Plan; At Odds in 1994, Industry and Consumer Groups Seek Common Goals

BYLINE: Eric Pianin, Washington Post Staff Writer

BODY:

Once they were archenemies in the fight over national health care, but yesterday leading advocates of consumers, the insurance industry and hospitals jointly proposed a costly new plan to extend health insurance to more than half of the nation's 43 million uninsured.

The plan calls for a combination of expanded Medicaid and state-operated health insurance benefits and tax incentives for private employers who subsidize the premiums of low-income workers. It could cost the government as much as \$ 250 billion over the next decade, according to estimates.

Controversy over efforts to overhaul the health care system have long divided the two parties and led to one of President Clinton's worst political setbacks in 1994, when his proposal for extending health insurance to virtually every American ran into a buzz saw of opposition from special interest groups. But the architects of the plan unveiled yesterday said it may be possible to bridge ideological differences and pass major legislation in the coming Congress.

"In the past, every group interested in extending coverage to the uninsured held out for their favorite approach . . . and nothing was accomplished," said Charles N. "Chip" Kahn III, president of the Health Insurance Association of America. "By coming together now, we are saying we can get started if we seek common ground."

His group has joined forces with **Families USA**, an umbrella group of health consumer advocates, and the American Hospital Association. "Nothing will happen in this area unless we transcend partisan, ideological and special interest differences," said Ronald Pollack, executive director of **Families USA**.

Ironically, Kahn's association of mid-size health insurance companies and Pollack's health care consumer group were involved in some of the nastiest exchanges during the 1994 debate over Clinton's ill-fated reform plan.

Kahn's association mounted a \$ 15 million TV ad campaign featuring "Harry and Louise" that largely sank the administration's plan, which would have required employers to pay 80 percent of the cost of a basic package of benefits. The ads showed two actors sitting around a kitchen table expressing their fears about losing their opportunity to choose the kind of health care insurance they wanted under the administration's "big government" approach.

Pollack championed the Clinton plan and condemned the ad campaign as a gross distortion of what the president was trying to do. "Chip Kahn and I can't recall ever agreeing to anything," he said.

Early this year, however, Kahn and Pollack took part in a health care conference sponsored by the Robert Wood Johnson Foundation and discovered that they actually shared some ideas for reforming the health care system.

They agreed, for example, that the only way to gain congressional support for change was to build incrementally on the existing system, instead of attempting a massive overhaul, as Clinton sought to do.

They also agreed their approach should focus primarily on low-wage workers, their families and others who are least capable of obtaining health coverage on their own. The plan described yesterday has three parts:

* The first would expand Medicaid, the state-administered health care program for low-income people, to include all persons with incomes below 133 percent of the federal poverty level—or \$ 18,820 a year for a family of three. Many low-income people now are excluded from coverage because of a patchwork of state regulations and requirements.

* As they now do for children, states could provide health care coverage for parents and childless adults with incomes between 133 percent and 200 percent of the federal poverty level, or \$ 28,300 for a family of three. States would use increased federal matching funds to provide the expanded coverage through Medicaid or programs such as the State Children's Health Insurance Program.

* A tax credit would be created to help low-income workers who turn down employer-sponsored coverage because they can't afford their share of the premium. This credit would be available to employers to help them defray the premium costs of employees with incomes between 133 percent and 200 percent of the federal poverty level.

Kahn and Pollack said they will try to promote their plan among interest groups and will reach out to the president-elect, Congress and key stakeholder organizations with the goal of passing legislation next year. With the economy still strong and huge projected surpluses, "there never has been a better time to make such an investment," they said.

A new survey by Public Opinion Strategies shows that 85 percent of Americans interviewed favor a plan along those lines that would be financed from the \$ 2.2 trillion of non-Social Security surpluses projected for the coming decade; 55 percent said they would support the plan even if it required an increase of \$ 200 a year per taxpayer.

LANGUAGE: ENGLISH

LOAD-DATE: November 21, 2000

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November 21, 2000, Tuesday, Late Edition - Final

SECTION: Section A; Page 14; Column 6; National Desk**LENGTH:** 622 words**HEADLINE:** Ex-Enemies On Insurance Offer a Plan**BYLINE:** By ROBERT PEAR**DATELINE:** WASHINGTON, Nov. 20**BODY:**

Insurance companies, hospitals and a consumer group joined forces today and offered a proposal to provide health insurance to about half of the 42.6 million Americans who have no coverage.

The proposal was made by the Health Insurance Association of America, the American Hospital Association and the consumer group Families USA.

The three organizations called for federal tax credits and expansion of Medicaid and the new Children's Health Insurance Program to help people with incomes up to twice the poverty level. Under federal guidelines a family of three is considered poor if it has income of less than \$14,150 this year.

"As a nation faced with unprecedented prosperity," the groups said in a statement, "we have a duty to marshal our resources to help uninsured working Americans."

The insurers, who opposed President Clinton's plan for universal **health insurance coverage** in 1993 and 1994, and Families USA, a supporter of the Clinton plan, portrayed themselves as strange bedfellows. But they said their cooperation could point the way to bipartisan legislation for the new president and Congress.

The proposal has three elements:

*Medicaid, the federal-state program, would be expanded to provide coverage to anyone with income up to 33 percent above the poverty level. Coverage would be available to childless adults, often now ineligible for Medicaid, as well as to children and parents.

*States would be allowed to provide coverage, through Medicaid or a version of the Children's Health Insurance Program, to adults with incomes from 33 percent above the poverty level to twice the poverty level.

*The government would offer tax credits to employers to encourage them to provide coverage for low-wage workers. The tax credits would be available to employers who pay a larger share of the premiums for low-wage workers than for other employees.

For example, if a business now pays 70 percent of the premiums for all its workers and decides to pay all or part of the remaining premium for its low-wage workers, the company could receive a tax credit for the amount of its extra spending. The cost to an individual would depend on the cost of the coverage and the amount paid by the employer.

Charles N. Kahn III, president of the Health Insurance Association of America, and Ronald F. Pollack, executive director of Families USA, said they had focused on low-wage employees because these workers were less likely to be offered health benefits and less likely to be able to afford them.

More than 9 out of 10 privately insured Americans receive health coverage through employers. Ninety-three percent of workers who earn more than \$15 an hour are offered health benefits by their employers, as against only 43 percent of workers earning \$7 an hour or less.

As a result, "almost a quarter of workers with incomes below 200 percent of poverty turn down coverage when offered," Mr. Kahn and Mr. Pollack said in a description of their proposal.

The men had no estimate of the cost of their proposal, but said it could be expensive. As a rule of thumb, Mr. Pollack said, it costs \$1 billion a year to provide **health insurance coverage** for one million low-income people.

Senator Edward M. Kennedy, Democrat of Massachusetts, said, "The fact that these three respected organizations agree on a plan to expand **health insurance coverage** is an excellent sign that bipartisan cooperation and progress are possible on this important issue next year."

Mr. Kahn acknowledged that there were "many competing demands" for the money. Lawmakers of both parties have promised to provide prescription drug benefits to the elderly and to pump money into Medicare, to improve its financial condition.

<http://www.nytimes.com>

LANGUAGE: ENGLISH

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General News;health insurance coverage

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November 20, 2000, Monday

SECTION: PRESS CONFERENCE OR SPEECH

LENGTH: 7075 words

HEADLINE: NEWS CONFERENCE WITH THE HEALTH INSURANCE ASSOCIATION OF AMERICA, **FAMILIES USA**, AND THE AMERICAN HOSPITAL ASSOCIATION

TOPIC: EXPANDING HEALTH INSURANCE TO COUNTRY'S UNINSURED

PARTICIPANTS: CHIP KAHN, THE HEALTH INSURANCE ASSOCIATION OF AMERICA

BILL MCINTURFF, PUBLIC OPINION STRATEGIES

RICHARD POLLACK, THE AMERICAN HOSPITAL ASSOCIATION

RON POLLACK, **FAMILIES USA**

DR. LEW SANDY, THE ROBERT WOOD JOHNSON FOUNDATION

LOCATION: THE NATIONAL PRESS CLUB, WASHINGTON, D.C.

BODY:

DR. SANDY: Good morning. I'm Lew Sandy, a physician and executive vice president of the Robert Wood Johnson Foundation, the largest philanthropy in the United States devoted solely to improving health and health care for all Americans.

For over 28 years, our foundation has supported a wide range of programs and projects to assure access to health care for all Americans, improved care for vulnerable populations, help the country address the challenges of substance abuse, and help inform debates about health care, through research and analysis.

We know from all this work -- and I know from my years of practicing medicine -- that health coverage matters. The voluminous literature, going back over decades, shows over and over that people who don't have health coverage often delay potentially life-saving care, such as screenings and treatment for high blood pressure, cancer, diabetes, and heart disease.

To give you just one example, in my own practice, I've been caring for a middle-aged, second-generation Latino man for the last few years. Let me call him "Mr. Garcia." I first met Mr. Garcia in the emergency room at the hospital I was attending on the medical service. He had been admitted, through the emergency room, with a stroke, which left him unable to move his right arm and leg, and he had difficulty talking. He had severe high blood pressure. And I questioned his family, and I found out that Mr. Garcia and his family had known about his hypertension for some time. However, Mr. Garcia, although working full time, did not have health insurance offered by his employer and as a result did not receive any treatment for his high blood pressure.

Now Mr. Garcia received comprehensive care in the hospital, and he actually did wonderfully with inpatient and outpatient physical and occupational therapy. He's now able to walk with a cane and brace.

In our state, in New Jersey, we have an uncompensated care pool that paid the hospital a portion of the tens of thousands of dollars spent during his admission. And now that he's disabled, Medicaid pays for his doctor visits.

Now Mr. Garcia is an engaging and optimistic man, and he's grateful for the care that he has received. In some ways, he considers himself lucky. But I know that Mr. Garcia's stroke and the suffering and disability that he has endured, not to mention the cost, could have been avoided, had he simply had health coverage that allowed his high blood pressure to be treated.

The Robert Wood Johnson Foundation has long been committed to making certain that more Americans have health coverage. The foundation is working with others now so that at some time in the near future no American will be forced, like Mr. Garcia, to delay needed care because he or she was involuntarily uninsured.

With this in mind, I am really delighted to be here today to represent the foundation on what I think that most of you will agree is a historic day in the long history of health reform in this country.

The debate over expanding health coverage has lasted decades and has often been acrimonious and unproductive. Advocacy groups and the many interests at stake in health care have argued their own positions and, if not successful in making their own case, have preferred the status quo as their second-best option. Given this history, we think that this morning's event marks a major breakthrough.

Today, three national organizations which have disagreed vigorously over almost every issue in health policy in the past are joining together to announce they have reached a truly historic agreement. These three groups are the Health Insurance Association of America, the American Hospital Association, and **Families USA**. The chief officers of these organizations will speak here in a few minutes. Before they do, I would like to share a few perspectives on this event.

In recent years, underneath the surface disagreements and sparring over specific policy issues, we and others have felt that there is actually a great deal of potential for consensus on how to address the challenges of the uninsured. As a result, more than one year ago, the Foundation began working closely with these three organizations and five others on a project called Health Coverage 2000. We thought it made sense to bring together groups that had been antagonists in the past to talk about how we could together make progress on their issue of the uninsured.

Together, we held an all-day meeting here at the Press Club last January in which each of these eight groups presented full plans for expanding health coverage to millions more Americans. These original plans can still be read on our website at www.rwjf.org. The meeting was constructive in tone, and we and the eight national groups agreed that we should continue to work together. As a result, we are holding seven regional meetings on the uninsured, across the country.

The first took place in Memphis last week and can be viewed as a webcast on www.kaisernet.org, courtesy of the Kaiser Family Foundation. Through this Robert Wood Johnson Foundation-supported process, these former adversaries have developed highly productive relationships. Some have begun to see beyond their individual proposals to seek common ground. Three of these very strange bedfellows have come together today to announce what they view as the first key steps towards making certain that millions of Americans are covered. The Foundation does not endorse specific proposals of any kind, but it shares the same goal of extending coverage to millions of working Americans who have no health coverage.

The magnitude of this problem requires nothing less than the kind of mature and public-spirited effort that we are witnessing today. In fact, this is a time of deep division in America. It seems to many the solutions are elusive and that gridlock is a perpetual state of affairs. Yet what we see today at this event is that health care interests at the opposite poles of the spectrum, groups that have and continue to have fundamentally divergent views, can come together on this issue -- the issue of expanding coverage to the nation's uninsured.

You have in your press packet a copy of the **HIAA Families USA** proposal that will be presented today and will appear in the January issue of *Health Affairs*.

With that, please allow me to introduce Ron Pollack, executive director of **Families USA**, Chip Kahn, president of the Health Insurance Association of America, Rick Pollock, executive vice president of the American Hospital Association, and Bill McInturff, principle of Public Opinion Strategies.

Thank you. Ron.

MR. RON POLLACK: Thank you. (Clears throat.) Excuse me.

Thank you so much, Lew, and thank you in particular to the Robert Wood Johnson Foundation for having catalyzed this process. I want to thank Stuart Schear, who stands over here on my left. I saw Jack Ebebler, formally from the Foundation; and Steve Schroeder, who's not here today, president of the Foundation. The Foundation played an instrumental role in catalyzing the process leading to today's agreement.

Good morning.

The coalition effort we announced today focuses on the greatest shortcoming and morally least acceptable facet of America's health care system: 43 million Americans without health insurance.

Learning from the many past failures of health reform, it is clear that we must transcend partisan, ideological, and interest group boundaries to find common ground so that we move towards health coverage for every American.

Now, as Lew said, in the past failed efforts on health reform, everyone, from the special interest groups to the reformers, from the conservatives to the liberals; each of them clung tenaciously to their first-choice policy prescription for reform. And if they believed that their first choice would not prevail, they either walked away from the table or they opposed what was left on the table. In effect, as Lew said, their second favored choice was the status quo. And not surprisingly that's what we ended up with: the status quo, and many more and more people became uninsured.

We are here to say that political gridlock should no longer be an option in dealing with America's uninsurance epidemic. Now, when we started our work on this, there were five guidelines; five assumptions that, in effect, helped us reach an agreement. Let me quickly describe them for you.

First, we assumed that providing health coverage to everyone will occur neither through small increments nor through one comprehensive package.

This is going to be a step-by-step approach, and we believe that the first step must achieve significant expansion.

Number two, the proposal cannot take away or appear to take away health coverage from people who have it today. That's a political non-starter. We feel you can't threaten the form, scope or quality of coverage that most Americans have today.

Third, and as a corollary of our second assumption, the proposal should build on health care structures that work for many millions of insured Americans. In the private sector, that means building off of our employment-based coverage, which today serves more than nine out of 10 people who get their coverage in the private sector. In the public sector, that means working off of the Medicaid program that today serves 41 million low-income Americans, and the new Children's Health Insurance Program, which already enrolls 2.5 million children.

Fourth, the proposal must use public resources in a way that maximizes new health coverage. And what we mean by that is it is not limitless as to what Congress and the political process will make available for expanded coverage, and therefore, we must get as big a bang for the buck in terms of expanded coverage for the uninsured.

And lastly, the first-step proposal should focus on low-wage workers, their families and other low-income populations. They are the group that is least capable of obtaining health coverage on their own, and we believe it will be easier to achieve a consensus about this group than any other.

Now let me just say one word about the agreement. This agreement is a policy framework, not a set of legislative specifications. It articulates a clear vision and it will enable incoming coalition partners to help develop the legislative details. It is a balanced public and private-sector approach, and it focuses on people with incomes below 200 percent of the federal poverty level. And in other words, \$28,300 of annual income for a family of three.

There are three parts to this proposal. Number one, Medicaid should be expanded to all people under 65 years of age with incomes below 133 percent of the federal poverty level. Again, the definition of 133 percent of the federal poverty level today is \$18,820 for a family of three. To help facilitate this, we urge that there be an enhanced federal match well above the funding formula that the federal government provides to the states in the regular Medicaid program.

Number two, states should be given the position to establish a Medicaid or a CHIP-type coverage for non-aged adults between 133 and 200 percent of the federal poverty level.

In effect, coverage should be provided to adults as we are attempting to provide coverage today for children. Again, there should be an enhanced federal match and significant outreach should be undertaken, so that newly eligible people actually receive the coverage that they would be eligible for. In effect, we're eliminating all of the categories -- children, parents, non-parental adults -- and we're saying, "If you're low-income and you can't afford coverage, you will get it."

And lastly, a non-refundable tax credit would be provided to businesses to encourage them to make employment-based coverage affordable for their low-income workers, so that, for example, a business that provides 70 percent of the premium for all its workers, to the extent it provided special assistance to its low-wage workers to help cover the remaining 30 percent, they would get a dollar-for-dollar tax credit.

In sum, today we send a clear message, and that message is as follows:

Political gridlock should no longer be an option in dealing with America's uninsurance epidemic. We must transcend partisan, ideological, and interest-group boundaries so that common ground is found, so that we move towards health coverage for everyone.

Thank you. And now it's my pleasure to introduce perhaps the strangest bedfellow that I've been working with -- in fact, somebody said, "How did he get in the same bedroom, let alone" -- (laughter) -- my friend Chip Kahn.

MR. KAHN: Well, thanks, Ron, and good morning to everyone.

How many people a year ago thought that by Thanksgiving we'd be without a new president and that **HIAA and Families USA** would ever get together on anything?

The credit for getting us together goes to the Robert Wood Johnson Foundation, and particularly the leadership of Steve Schroeder, the foundation's president. I want to thank Lew Sandy for representing RWJ here today and for expressing so eloquently the foundation's unwavering commitment to bring together groups and individuals of different backgrounds and persuasions to solve the health-care coverage problem that's suffered by so many millions of Americans.

HIAA, Families USA, and the American Hospital Association believe that the framework that we are releasing today offers a constructive option for expanding coverage, because it builds upon what works. It would expand coverage without disrupting the existing coverage of the vast majorities of Americans, which, Ron has pointed out, has been the downfall of major efforts to expand coverage over the years.

As many of you recall, about a year ago, the foundation brought Ron and I together to announce our intention to start a process to find common ground on expanding coverage for America's uninsured. During the past year, during all the partisanship that took place in Washington, skeptics probably thought that the search for common ground by **HIAA and Families USA** would not hold. I am sure they thought that the process we envisioned to bring ourselves and other groups together was a pipe dream.

Today, we begin to prove the skeptics wrong. The process has begun.

That's why I am so pleased to stand before you today with Ron and Rick Pollack to say that we have agreed upon a common set of assumptions and a policy framework. We believe we can use this framework as a starting point to reduce the rolls of the uninsured. **HIAA's** board accepted these assumptions and approved this framework. And most importantly, the board I represent expressed its commitment to working with **Families USA**, AHA and other groups of varying point of view to build a coalition that sets as its priority to make it a national priority to get low-income Americans who lack insurance the coverage they so desperately need.

As you can imagine, the framework we are supporting today is not **HIAA's** first choice. Over a year ago, **HIAA** announced a broader initiative, Insure USA. That initiative relies more on private coverage to reduce the ranks of the uninsured. We feel as strongly about Insure USA today as ever, but today, in the name of achieving meaningful progress, we are joining with other groups to endorse an additional choice. Today, our board and membership are saying that they are willing to accept an option other than their preferred option. In other words, the initiative we endorse today represents a second choice, if you will; something that we can live with, in order to bring groups together to actually get something done.

As Ron points out, the proposal we are unveiling today has three parts. The first part, it would provide Medicaid coverage for Americans who are the least able to afford health coverage -- adults under 65 with incomes of less than 133 percent of poverty. However, it would not preclude any coverage that states have or may enact that increases that standard. That's an important point. This is a floor for the states, not a ceiling.

Second, our framework would enable states to provide coverage for working low-income Americans who currently cannot qualify for Medicaid. This would affect those Americans who fall between 133 and 200 percent of poverty.

The third portion would allow a non-refundable tax credit for employers who provide funds to help pay the employee's share of premium costs for low-income employees. Right now, employers, on average, pay about 75 percent of premiums, and employees pay the rest. We

know that almost a quarter of workers offered insurance, with incomes below 200 percent of poverty, are uninsured and turn that insurance down. They turn it down primarily because they can't afford their share of the premium. Extending a tax credit to employers is a practical way to increase employee participation in employer groups.

Our framework recognizes the strength and vitality of the employment-based coverage system we have today. It is the employer's role in coverage that has resulted in the first reduction in the numbers of uninsured in more than 20 years. The take-aways of this framework is that it expands coverage by building upon what works -- the public programs and the employer coverage that work today. Most importantly, it does so without disrupting the coverage that already is in place and that works well for the vast majority of Americans, which, as Ron points out, has been the major stumbling block in blocking progress in the past to helping the uninsured.

Earlier I mentioned how some skeptics doubted whether the strange bedfellows would stick together, but we have. Skeptics no doubt will say our prospects for action are slim, due to a divided Congress and the possibility of a weak presidency. I believe, however, that the pundits can be proven wrong and that the possibility exists for action. The process we begin today I hope will help open the door to opportunity. I believe that the opportunity is enhanced because the public cares so much about this issue. I don't want to scoop Bill McInturff of Public Opinion Strategies, but Bill will show us polling that reflects a strong public backing for efforts to expand help to the uninsured.

Many have said that expanding health coverage is something we must do. Today, looking at three different stakeholders who have found common ground, I truly believe that expanding health coverage is something that we can do. I know that I speak for Ron and Rick in saying that our three groups are ready to contribute to the "can do" by the new Congress and the new president.

Thanks for coming. I look forward to your questions. And now let me pass the podium on to my fellow strange bedfellow, Rick Pollack.

MR. RICHARD POLLACK: I was comfortable about all this except when we got to all these bedfellow analogies here. (Laughter.)

Thank you all very much for being here. We very much appreciate the leadership of the Robert Wood Johnson Foundation, and we certainly look forward to the insights of Bill McInturff.

I'm not going to repeat all of the details that have been outlined by Ron and Chip, but I think it's important to note that part of today's story is that while everybody says that no one in Washington can agree, today we are here and happy to prove them wrong.

The American Hospital Association is pleased to join with **Families USA** and the Health Insurance Association of America in efforts to keep expanding health care coverage as a top national priority. As a caregiver organization working on the front lines in providing services, we strongly believe that every American deserves access to basic health care services, services that are provided with the right care at the right time and in the right setting. With the steps that have been outlined here today, we can lay a strong foundation which we can then build upon to ensure coverage for all.

Now obviously, hospitals have a unique perspective. That's because, whether it is federal law or our mission to serve communities and people, we are America's health safety net, working 24 hours a day, seven days a week, 365 days a year to bring life, to sustain life and to save life, whether it be in the delivery room, the operating room, or the emergency room. And on this day alone, the emergency rooms of our nation's hospitals will serve 271,000 people, whether they have an insurance card or not.

That's 99 million visits a year.

And while America's hospitals care for people day in and day out who are both insured and uninsured, we see first-hand that the absence of coverage is a significant barrier to care, reducing the likelihood that people will get preventative, diagnostic, and chronic-care services at the right time and in the right place. And at a time when America is enjoying a strong economy and big surpluses, we can and we must do better.

Forty-three million people living in America today go without health insurance and the access to timely health care services it secures. The proposal you've just heard described represents a first step towards meeting the human needs of millions of people. And the proposal you just heard described also represents a first step in building that much-needed consensus to continue addressing the needs of the uninsured.

The plan begins with health coverage for low-income workers and their families; those that have the least access to affordable coverage. It builds on the success of Medicaid and state CHIP programs, with further expansions to higher-income groups. And it combines tax code incentives to help employers make health coverage more affordable to their low-income wage earners.

The proposal is not only concrete, but it's politically realistic. It recognizes our pluralistic health care system and builds on its strengths. We believe it serves as common ground on which to forge consensus to move toward making sure that every American has health care coverage.

I now want to turn the program over to Bill McInturff to share some polling information in this regard.

Bill.

MR. MCINTURFF: Thank you; Bill McInturff with Public Opinion Strategies. We've had the opportunity to work with CHIP and HA for a decade on health care for a decade on health care research. And let me talk a little bit about what we did; it's in the press package. This is very current data.

We were in the field last Sunday through Tuesday, so this is material after the election, where we were trying to assess people's interest in the health care issue and talk about these three proposals, and kind of assess people's interest in this legislation because, look, another aspect of this, in terms of developing congressional support, is our capacity to communicate to members of Congress in the U.S. Senate, that the public supports and is interested in these ideas. And I think that you'll find that there is substantial support for each of these three items individually, and more importantly, there is substantial support when these are combined as a package.

Here's how we tested them: We talked to 800 adults, as we said, last Sunday through Tuesday, and then we described each one briefly to each respondent, asking them if they favored or opposed each individual element of this proposal. And the first one is having Medicaid, which we, again, described so that people knew that we were talking about the government program for the very poorest Americans to cover more low wage workers and their families who -- that have no coverage. And what you're going to see across all of these is substantial support, with 46 percent strongly favoring; 82 percent overall favor. Another aspect of this proposal is to have additional federal funding to encourage states to cover more working adults who are still are not covered but make too much to earn Medicaid. And now we're at 48 percent favor, 83 (percent) total favor.

A couple things I'd like to do to put those numbers in perspective. We do a lot of work in a favor/oppose scale. We do, as you know, a lot of work in partisan politics. Anything above a 35 to 40 percent "strongly favor" is a very, very substantial number. So the fact that we're getting

numbers in the mid-40s and higher, as you describe expanding Medicaid and start working around these government programs, is significant support.

Now the third part of this is to have a tax credit for employers, so the employers can offer and pay additionally for the unpaid portion of the premium that is the responsibility of these low-wage workers. And now you're at 56 percent said "strongly favor," 86 (percent) total.

And again, what our experience has been, any time you deal with additional help for employers, most privately insured Americans get coverage through the employer, and this is something they're very, very comfortable with. And although this number is a little bit higher, it does not -- and it does not kind of all contradict the very broad support for all three elements of this proposal.

And then what we did in the questionnaire is, they'd heard each one in detail, and then what we said is, "Look, these are actually linked together into one overall package." And we reminded them of those three elements of the package and said, "If we combined those three elements, what do you think? Would you tell your member of Congress to favor/oppose this overall package?" And you get incredible levels of support, with 85 percent saying that their member of Congress should support this; with, again 55 percent saying they would strongly favor it.

Now for those of you who we've known, talked to you for a long time, you know one of my points about survey research is that you also have introduce some element of trade-off or pain, that this is not always that easy. There are kind of consequences for where this money comes from.

At this point in the questionnaire, we've just said, in general, these are (sic) the conceptual framework; do you favor/oppose? So we did one more thing to get a little bit tougher, and what we told them is:

Guess what? This costs real money. In fact, it's not that cheap. It costs \$250 billion over a projected decade, which is about -- which is a little more than about 15 percent of a \$2 trillion non-Social Security surplus. And so, in other words, we've introduced the concept that there is a trade-off now; this has -- costs billions of dollars over a decade, and that we'd be using this much of the surplus to support these proposals.

And then we said, "Now -- now what would you tell your member of Congress to do?" And again, importantly, in terms of using that much of the surplus, there's essentially no change in support. Support drops modestly, to 80 percent, with 53 percent "strongly favor." But essentially, there is very little resistance for using the surplus for this purpose.

And then we did something that I have never done before in a decade of health-care research, and that is, we gave people a price tag that is the highest price tag I've used in a decade of research, where our friends -- and HIAA, of course, has got actuarials -- so they said, "Okay, there's 125 million tax-paying units. It's \$250 billion. It's \$200 an average taxpayer."

And so we said to those folks: Okay, now let's presume there was no surplus at all, the surplus did not exist, and instead you and the average taxpayer had to pay \$200 a year to fund these three proposals; would you still tell them to do this?

Now, by the way, that's not what we're doing -- that's not how we're going to be talking about this on the Hill. But as a survey researcher, what I said was, look, I want to see how much people really, really want to do this, so let's start with the overall concept, let's use the surplus, and then let's whack them with \$200 a year to see what really happens.

And again, significantly, does support change? Sure it does. But what we drop to is 55 percent still saying they favor this proposal. And then -- I've gone on to the next slide in my enthusiasm

-- it's 55 percent with 42 percent, and then you still have a one-to-one strong favor, strong oppose. This is, again, the highest dollar figure I've ever tested, and you still receive significant majorities of the country saying they still want something done, which, by the way, measures and taps into the level of concern and interest people have in terms of helping the uninsured.

And again, that concern goes across all income groups. And across all income groups, where kind of divided folks into three categories -- under \$40,000; \$40,000-\$60,000 in household income; over \$60,000 -- what you see is, even with the lowest-income households, but across all income groups in America, people say that they would be willing to pay more in taxes to make sure that we can cover more working families and children and adults who are falling between the cracks and today have no coverage.

And again, our perspective, and the perspective we will be bringing as we work with these three groups and as we work with our members on the Hill and on the other side of the aisle, is to again remind people that, as we've described, we have this unique opportunity in terms of both federal and state surpluses, and that this is a priority people would like to see addressed.

And with that, sir, we'll turn it over. And we look forward to your questions. Thank you.

DR. SANDY: We want to thank Ron, Chip, Rick, Bill. Let's open it up for questions.

Yes?

Q I have a question for Ron. Doesn't this put -- (off mike) -- directly in competition, then, with another big -- (off mike) -- the Medicare prescription drug benefits? And what would be the implication of that? And how do you rank them in terms of priority?

MR. RON POLLACK: Well, there's no question that there are a lot of issues that are competing for priority attention. Our view is that this is the most serious problem with America's health care system today. It is the morally least tenable facet of America's health care system. And so it's our hope that this receives top priority attention. There's no question that there are other, very important health care issues that are competing for attention, but this is really the mother lode issue. And it is our hope that this issue gets addressed right at the outset.

DR. SANDY: Yes?

Q Another question for Ron Pollack. Mr. Kahn mentioned what HIAA's first choice would have been but they gave up to go along with this proposal -- (off mike) -- insurance, but I wondered, the response on your side -- (off mike)?

MR. RON POLLACK: Well, I think that from our standpoint, we've never been enamored with tax credits as an approach to expanding coverage. Similarly, HIAA has focused more heavily on private sector solutions, rather than public programs.

Our view was that you really need to achieve a balance. There needs to be something that, as Chip said, is a second-favorite choice; a second-favorite choice that works, that substantively will achieve significant expansion of coverage and, most importantly, something that's politically feasible.

Let me make one comment, though, about this issue about an ideal choice and what we all prefer. You know, each of us in the past have supported our ideal solution. But from the perspective of 43 million Americans, a so-called "ideal solution" which cannot be enacted simply does not deserve to be called ideal. And what we need to do is find something that is going to achieve meaningful progress and that's politically feasible, and it is my belief that this proposal is something that all major stakeholders in America's health care system can ultimately rally around. And my hope is that other groups are going to say similarly, "This may

not be my top choice, but this is a very good choice."

And so we actually want to make a tremendous virtue out of second choices here.

Q What other groups have you contacted to see what they'd be willing to support -- (off mike)?

MR. KAHN: Well, there are other groups that are involved in the Robert Wood Johnson process that co-sponsored the meeting last January and the regional meetings. We are talking to them. And there are other business groups and other provider groups and consumer groups that we're talking to.

I think I need to stress that we view this as the beginning of a process. In a sense, we're laying down a framework with a set of assumptions that we think will be of interest to many people that really helps us move the ball down the field. And so all of us are optimistic that as we go talk to groups that we can interest them and that we'll be back here a month from now or -- or six weeks from now with others, standing here saying "Here are more people," and that we can then go to the Hill with an array of groups and say, "Let's talk about how we can make progress."

Q There were seven groups originally, and I know many of them said, you know -- (off mike)?

MR. KAHN: We're talking to all those groups now, and I'm very optimistic about where we'll end up, but I guess I'd rather leave that for another day.

Q (Inaudible) -- anyone who can answer this. I understand that you want to give the uninsured coverage. In your efforts, are there -- if there are any efforts -- to work with the health care providers and the medical staff, and where our costs are going up so high -- (off mike). What are the projects that you're doing with the other side? (Off mike.)

DR. SANDY: Do you want to comment on the provider perspective?

MR. RICK POLLACK: Well, we're certainly going to be working with other providers in terms of making sure that they're a part of this whole effort. You know, one of the critical things that we have found in some of the research that's been undertaken here is that there are a lot of workers, low-wage earners, that have access to **health insurance coverage** that their employees (sic) offer, but they just can't afford to pay for it. One of the key proposals that's a part of this plan is to provide employers with assistance to further subsidize an ability for them to get the insurance.

So we would hope that that would be one of the ways to make it more affordable for a lot of folks.

Q What difference does it make who is elected president for the viability of this program?

MR. RICK POLLACK: I'll make a quick comment on that one. You know, we're in a situation where both presidents-elect, or however want to refer to them -- both candidates -- (laughter) -- they were very clear in saying that they wanted to move forward in making progress on this front. Both of them publicly stated that surplus money ought to be dedicated to expanding coverage to Americans. So I think we're in a pretty good situation in that both candidates have already said we're ready and willing to move in this direction.

Q I have a question for anybody. (Off mike) -- a mandate to the states -- (off mike) -- how will you expect the governors to react to that? (Off mike) -- childless couples. Isn't that sometimes a difficult political sale?

MR. RON POLLACK: First, let me take the question with respect to Medicaid. Yes, it is a

mandate. It would be applicable to all states. But there are two points that I want to make about this. First, many states are beginning to move in the direction of expanding coverage, starting with parents, and so that this fits a framework that states are already have been experimenting with, and some of the larger states, in particular, have already moved in this direction.

The second point I want to make with the Medicaid element is that what we've called for in this proposal is that there would be enhanced federal funding for this option. And for the states, that is perhaps one of the most important thing. They are terribly concerned about unfunded mandates. And what we're trying to achieve here is to make sure the states have the wherewithal to do the job and do it properly, and to do it consistently with where the states are already moving, especially with respect to parental coverage.

Now, your second question relates to non-parents, if I -- well, childless couples or singles. And, you know, one of the things that we wrote about in the article is that our differentiation of treatment of different groups, based on their family status, really is a vestige of the 16th century Elizabethan poor laws. Under the 16th century Elizabethan poor laws, you had to not just be poor, but you had to fit some tiny category.

And that's what we did in the 1930s when we adopted welfare laws; we did the same thing. You had to not just be a child, you had to be a dependent child. You had to be permanently and totally disabled. You had to be over 65 years of age, or you had to be blind. And when Medicaid was established in 1965, the pathway onto Medicaid was through receipt of welfare. So Medicaid really has its antecedents in Elizabethan poor laws.

One of the things that is historic about this proposal is that we're eliminating all of those categories. We are, in essence, saying if you're poor and you can't afford health care coverage, you're going to receive health care coverage under this proposal. And to be sure, the reason we've had categories is some groups are politically more popular than others; children may be the most popular, parents may be the second-most popular, and childless adults may be third popular. But we think that those are not distinctions upon which policy should be grounded and, therefore, we want to end those distinctions and say if you can't afford coverage, you will receive it. And that's what these two provisions do; the Medicaid provision and the CHIP-type expansion.

Q What's the breakdown on the cost -- (off mike)?

MR. KAHN: We haven't done a cost estimate, and partly because, as we have described, this is a policy framework, and to do a congressional budget office-type estimate, you'd have to have a lot more details. But generally, I think, the rule of thumb is about "a million-a billion." So you can pick up about a million people for about a billion dollars.

But there are a lot of implications in the proposal as to how much takeup there would be in the states, how much takeup there would be for employers. And the Congressional Budget Office or some other estimator would have to make assumptions on that, based on the details of legislative language which we have not done, purposefully, because this is, as we've said, a beginning of a process and we want to bring other people in as we get into the details of it.

Q So you're not saying what it would cost roughly to --

MR. KAHN: Those were numbers that we roughed out for purposes of the survey, but I wouldn't stand by those numbers as the estimate. I think, without any question, we are talking about a significant magnitude of dollars. And I guess I'd rather leave it there, but Bill may want to --

MR. MCINTURFF: Yeah, I just want to -- just from a survey perspective -- I just said, I understand that they were dealing with their constraints, in terms of it not having a specific

proposal. I just said, I need a number -- is it 100, is it 200, is it 500, and roughly what percent does it represent? And in my language, I used 250 out of 2 trillion, or about 15 percent; it's actually 12 and a half percent. I kind of rounded up.

So again, I just, from a survey perspective, I just wanted to have a number that was close enough that you could, in order of magnitude, have survey respondents have a way of assessing, you know, what kind of magnitude of the surplus we are using, and whether CHIP or the policy experts end up at, you know -- I don't want to be casual with billions -- but 50 billion over, or 50 billion above that. I think from a survey perspective, we wrote it based on numbers and percents that say that as long as it's in that range, we feel comfortable that people are reacting this comfortably from a survey perspective.

Q Yes, but 23 million people would benefit from this?

MR. RON POLLACK: The 23 million figure is the portion of the uninsured population whose income falls below 200 percent of the federal poverty level. So potentially, 23 million people could be touched by it. But that doesn't mean that they actually will get served. There -- as Chip indicated before, there are assumptions about what the takeup rate is going to be and a variety of other matters. But over half of today's uninsured have incomes below 200 percent of poverty.

MR. RICK POLLACK: And also, regardless of what these numbers may be, it's all against the backdrop of the trillion-dollar surplus; in fact seems to be growing every time they do a new reestimate.

Q You mentioned that -- (off mike) -- with regard to a mandate, but when -- (off mike) -- you said that that Medicaid -- (off mike) -- option; that the states would have the option of expanding -- (off mike).

MR. RON POLLACK: No, I said option with respect to the second element of this. The first --

Q (Off mike) -- the first?

MR. RON POLLACK: The first below 133, that would be -- everybody would get that.

For 133 to 200, that would be a state option.

Q Okay. And then secondly, the tax credit, what is the response from business? I mean, is this enough of an incentive for business -- (off mike)?

MR. KAHN: Well, we have gotten, in our discussions with business, a very positive response to the tax credit. In a sense, among the proposals that are in the framework, this is a new starter. It's a new concept, but it still builds upon the existing system and existing employer relationships, where employers already have to do taxes and it's just a question of them helping certain workers a little more, and then if they do it, they get a tax credit for it.

Q (Off mike) -- some indication of the ranking of the expense that it would be -- (off mike)?

MR. RICK POLLACK: We don't know. We really don't have good estimates yet.

DR. SANDY: Well, if there are no other questions, thank you all for coming. We thank the panel for both what they have presented and what their organizations have done. Thank you.

END

LANGUAGE: ENGLISH

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SHOW: ALL THINGS CONSIDERED (9:00 PM ET)

November 20, 2000, Monday

LENGTH: 519 words

HEADLINE: NEW HEALTH-CARE REFORM PROPOSED BY FAMILIES USA AND THE HEALTH INSURANCE ASSOCIATION OF AMERICA

ANCHORS: NOAH ADAM

REPORTERS: JULIE ROVNER

BODY:

NOAH ADAM, host:

Today, two health advocacy groups that have long been at odds announced a joint plan to help bring insurance to the estimated 43 million Americans who lack it. Leaders of the group say they hope their plan will serve as a blueprint for the closely divided Congress and whoever winds up as president. NPR's Julie Rovner reports.

JULIE ROVNER reporting:

They call it the strange bedfellows plan(ph), and that's no understatement. The Health Insurance Association of America, which led the opposition to President Clinton's health reform plan in 1993, is best known for the Harry and Louise commercials that featured a couple puzzling over the plan around a kitchen table. Families USA, by contrast, has been a stalwart ally of virtually all of President Clinton's health initiatives, and sponsored a national bus tour in support of the failed 1993-'94 health reform effort.

But seven years and three Congresses later, the problem of the uninsured remains largely unaddressed, and the leaders of the two groups, along with the American Hospital Association, say someone

has to break the logjam. Chip Kahn is president of the Health Insurance Association of America.

Mr. CHIP KAHN (President, Health Insurance Association of America): The initiative we endorsed today represents a second choice, if you will, something that we can live with in order to bring groups together to actually get something done.

ROVNER: The proposal, which could cost as much as \$ 250 billion over 10 years, has three major parts. The first would expand the existing Medicaid program that's mostly limited to low-income mothers and children, as well as some elderly and disabled people. Under the plan, states would be required to provide Medicaid to all individuals with incomes under about \$ 11,000 a year. The second part of the proposal would give states the option to use Medicaid or the Children's Health Insurance Program, to cover everyone with incomes up to about \$ 17,000. Families USA executive director Ron Pollack said those changes could reach more than half of Americans who currently lack health coverage.

Mr. RON POLLACK (Executive Director, Families USA): In effect, we're eliminating all of the categories--children, parents, non-parental adults--and we're saying, 'If you're low income and you can't afford coverage, you will get it.'

ROVNER: The final element of the proposal would create a new tax credit for employers who help low-income workers pay their share of health insurance premiums. Currently, employers who provide coverage pay an average of three-quarters of that cost, but for some workers, says Kahn of the Insurance Association, that's still not enough.

Mr. KAHN: We know that almost a quarter of workers offered insurance with incomes below 200 percent of poverty turn that insurance down. They turn it down primarily because they can't afford their share of the premium.

ROVNER: The group's commissioned Republican pollster Bill McInturff to see how the public would react. His survey found broad support for the proposal, even if it would use up 15 percent of the projected budget surplus, or cost taxpayers \$ 200 a year each. But as has been demonstrated repeatedly with health issues over the last decade, it takes more than public support to actually get policy made. Julie Rovner, NPR News, Washington.

(Soundbite of music)

LINDA WERTHEIMER (Host): This is NPR, National Public Radio.

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November 20, 2000, Monday, BC cycle

SECTION: Washington Dateline

LENGTH: 727 words

HEADLINE: Insurance, consumer, hospital interests join on health plan

BYLINE: By JANELLE CARTER, Associated Press Writer

DATELINE: WASHINGTON

BODY:

Six years after President Clinton's failed attempt to provide health insurance to all Americans, groups that battled relentlessly over the issue proposed a program Monday to cover millions of the nation's uninsured.

"Political gridlock should no longer be an option in dealing with America's uninsured epidemic," said Ron Pollack, executive director of **Families USA**, a liberal consumer group that backed Clinton's plan.

His nemesis back then, the Health Insurance Association of America with its "Harry and Louise ads," agrees. It helped draft the joint plan, which relies on a combination of expanding Medicaid and other government programs for the poor and new tax incentives to encourage businesses to buy private insurance for their low-wage workers.

"In the past, every group interested in extending coverage to the uninsured held out for their favorite approach. As a result, nothing was accomplished," said Chip Kahn, president of the association, which represents large insurance companies.

Once opposite poles on the issue, the two groups plus the American Hospital Association were unveiling a proposal they say could provide coverage to more than half of the 43 million Americans who now don't have any health insurance.

The proposal essentially targets an estimated 23 million people in low-wage families that fall below 200 percent of the federal poverty level - or about \$28,300 for a family of three. Those are people less likely to be offered health coverage on the job and, even when they are, they often can't afford the employee premium match.

Under the plan, Medicaid - the government's health care program for the poor - would be expanded to cover parents and single adults who often are ineligible for coverage. For instance, in two-thirds of the states, a parent who works full time at \$5.15 an hour is considered ineligible for Medicaid due to high income. And in most states, childless adults are ineligible for Medicaid unless they are disabled.

"We've got essentially three different classes of people. Kids are treated the best, parents considerably poorer and childless adults get virtually nothing," said Pollack. "This proposal gets rid of categories."

The plan also would give states the option of providing coverage for parents and childless

-adults through programs like the State Children's Health Insurance Program, which was created in 1997 for children whose families earn too much to qualify for traditional Medicaid.

In a nod to an idea long-backed by the health insurance industry, the plan proposes a non-refundable tax credit aimed at low-income workers who now reject employer-sponsored coverage because they can't afford the employee premium match. A business that now pays 70 percent of the premiums for employees would receive a tax credit to pay all or part of the remaining premium for its low-income workers.

The groups offered no cost estimate of their proposal, but it's sure to be in the billions of dollars annually. They described the plan as a framework that they hope will include other stakeholders as legislation is developed.

Capitol Hill lawmakers were expected to get the proposal Monday. Leaders of **Families USA** and the health insurance group outlined the proposal in an article to be published in the January-February issue of Health Affairs.

The compromise is a drastic change from the bitter battles waged by two of the most visible foes in the health care debate.

The Health Insurance Association of America, which has pushed to preserve the current system of employer-based coverage, spent \$17 million in 1994 to run the now-famous "Harry and Louise" ads.

The fictional couple in those ads worried that Clinton's proposal would turn health care decisions over to government bureaucrats, limit the choice of doctors and lead to the rationing of care.

On the other side, **Families USA** strongly supported Clinton's health plan and has lobbied for new patient protections, include the right to sue insurance companies over claim denials.

"People often say that no one in Washington can agree," said Rick Pollack, executive vice president of the American Hospital Association and no relation to the **Families USA** official. "Today we're happy to prove them wrong."

On the Net: <http://www.familiesusa.org>, <http://www.hiaa.org>, <http://www.aha.org>

LANGUAGE: ENGLISH

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General News;families USA

Insurance Coverage file

AGREEMENT: TOWARDS BUILDING A CONSENSUS FOR EXPANDING HEALTH COVERAGE TO THE UNINSURED

Introduction: Almost 43 million Americans are without health insurance today, approximately one out of every six people in the U.S. This number remains high despite a thriving economy – with unemployment and inflation down, and individual and business incomes up. Once a slowdown inevitably occurs in the longest peacetime economic expansion in U.S. history, today's unacceptably high levels of uninsured Americans will surely grow. Our nation's uninsurance epidemic deserves to be at the top of the policymaking agenda.

Families USA and the Health Insurance Association of America (HIAA) have agreed to work together to ensure that significant expansions of health coverage are enacted in the next Congress. We recognize, however, that most past efforts to expand coverage resulted in failure. In those failed efforts, one or more of the large health interest groups strongly opposed legislation and spent significant amounts of political and financial capital to rouse the public and mobilize members of Congress against change. Similarly, the pro-reform groups often over-reached and were unwilling to compromise, also contributing to defeat.

In effect, all the players in health reform – from the ideological right to the left, from the special interests to the reformers – came to the political process with strong convictions in support of their first-choice proposal. For each of these groups, their second favorite choice was the status quo. And, indeed, the ultimate result of these efforts was the status quo, with more and more Americans losing health coverage.

It is critical, therefore, that common ground be sought for a meaningful health coverage expansion proposal that can attract key stakeholders across ideological, political, and interest group boundaries. Although most stakeholders currently have their own favorite approaches to expanding coverage, our combined efforts are designed to promote a second favorite choice that becomes the basis for common ground and coalesced action.

The Assumptions That Guided Our Agreement: In the formulation of our agreement, five assumptions served as guidelines. Those guidelines are as follows:

1. *Providing health coverage for everyone will occur neither through tiny increments nor through one comprehensive package.* Instead, progress will be made step by step. We are convinced that the first of these steps must achieve significant expansion of coverage.
2. *The proposal cannot take away, or appear to take away, health coverage from people who have it today.* Any proposal that changes the form of people's health coverage, or that appears to diminish the scope and quality of that coverage, or that threatens to result in increased costs for that coverage, is likely to result in unbeatable opposition.

3. *As a corollary of the second guideline, the proposal should build on the health coverage structures that work for many millions of insured people.* Using existing structures, public and private, will allow for quicker and more effective implementation, and it will avoid the creation of new bureaucracies and further fragmentation of the health system. Additionally, building on systems that currently work has a much better chance of gaining support from the public, policymakers, and interest groups. In the private sector, this means building on employment-based health coverage; in the public sector, this means building on Medicaid and the State Children's Health Insurance Program (S-CHIP).
4. *The proposal should use public resources in a way that maximizes new health coverage.* Since there are many competing demands for government resources – including those of other health care matters (like Medicare and prescription drugs) – it is unlikely that sufficient funds will be made available in the near term to cover all of the uninsured. Therefore, a first-step proposal should make the best use of available resources to maximize coverage of the uninsured.
5. *The proposal should focus on low-wage workers, their families, and other low-income populations that are least capable of obtaining health coverage on their own.* Focusing first on low-wage workers and other low-income populations not only makes good policy sense, it makes political sense as well. Even though this group has relatively little political clout, we believe it will be much easier to achieve a consensus on its behalf than for other segments of the uninsured.

The Importance of Focusing on Low-Wage Workers: Although more than 9 out of 10 privately insured Americans receive health coverage at the workplace, low-wage workers have more difficulty obtaining such coverage. Only 43 percent of those earning \$7 an hour or less are *offered* employment-based coverage, compared to 93 percent of U.S. workers who earn more than \$15 an hour. Even when coverage is offered, it is often too expensive for low-wage workers to purchase – both because low-wage workers have less discretionary income to spend on insurance premiums *and* because premiums, on average, are considerably more expensive for workers in low-wage firms than they are for workers in high-wage firms.

Similarly, public sector coverage for low-wage families (i.e. Medicaid and S-CHIP) leaves many uninsured. In effect, these programs divide low-income populations into three groups – children, the parents of children, and childless adults – and treat these groups very differently. This categorization and differential treatment of low-income populations is an unfortunate vestige of the 16th century Elizabethan Poor Laws that formed the basis of our nation's welfare system and, starting in 1965, the Medicaid program as well.

Children in most states are eligible for public sector coverage if they live in families with incomes below 200 percent of the federal poverty level (\$28,300 in annual income for a family of three). *Parents* receive considerably less protection: in almost two-thirds

(32) of the states, a parent working at the minimum wage (\$5.15 per hour) is considered to have “too much income” to qualify for Medicaid if that parent works full time. As a result, parents leaving welfare for work often lose their Medicaid coverage even though they usually wind up in entry-level jobs that provide no health coverage. *Single adults or childless couples*, no matter how poor, are excluded from Medicaid coverage in the vast majority of states, unless they are disabled. As a result, there are many millions of low-wage working people and families who have no access to employment-based health coverage – or can’t afford such coverage – who remain ineligible for Medicaid.

Our Proposal: Our proposal was designed as a policy framework, not a set of legislative specifications. We opted for this approach for two reasons. First, we wanted to articulate a clear vision for action. Second, we deemed it important as part of the initial consensus-building process to start out with a framework that would later involve additional stakeholders in the development of legislation. The policy framework focuses on the low-wage working population with incomes below 200 percent of the federal poverty level – over half of America’s uninsured. The proposal has three parts.

First, the proposal would require an expansion of Medicaid for all people with annual incomes below 133 percent of the federal poverty level (approximately \$18,820 for a family of three). Eligibility for such coverage would be based exclusively on income, no longer on membership in one of several prescribed categories (such as children or parents). To ensure that states have the financial resources to implement this expansion, enhanced federal matching funds would be provided well in excess of the current Medicaid funding formula. To the extent that funds are limited, this part of our proposal would be phased in first.

Second, we propose that states be given the option of establishing Medicaid or S-CHIP-type coverage for adults with incomes between 133 and 200 percent of the federal poverty level. For states that choose this option, coverage would be based on income, not parental status. Like the Medicaid proposal for lower-income people, significantly enhanced federal matching funds would be made available. The two public program expansions would be developed to ensure optimal enrollment of those newly eligible for coverage – using, for example, mail-in application processes; fiscal carrots for states to meet enrollment targets; “presumptive eligibility” systems; out-stationing of state certification officials; one-year certification periods; and elimination of resource eligibility standards.

Third, we propose a non-refundable tax credit for businesses to encourage them to make employment-based coverage affordable for their low-income workers. This tax credit should be established in tandem with the implementation of public program expansions for people with incomes between 133 and 200 percent of the federal poverty level. The credit would be available to those employers who pay a larger share of the premium (than what is offered to other workers in the company) for those workers whose family incomes fall between 133 and 200 percent of the federal poverty level. For example, if a business currently pays 70 percent of the premiums for all workers in the company and decides to pay all or part of the remaining premium for its low-income

workers, that business would receive a tax credit for that additional amount. The employer tax credit would be available only to companies that make contributions to their health plans commensurate with the contribution levels of other similarly situated employers. To ensure that this facet of our proposal strengthens existing coverage, the legislation would seek to secure, and not weaken, current employer coverage and contributions that workers receive through their jobs.

The Logic of This Proposal: This proposal is neither Families USA's nor HIAA's ideal plan. For Families USA, health coverage expansion proposals based on tax incentives have never been a favored option. Indeed, Families USA would not have agreed to even the tax credit approach in this plan without its linkage to the Medicaid and S-CHIP-type expansions. Similarly, HIAA's original "InsureUSA" plan envisaged a larger private sector approach and a much more modest Medicaid and S-CHIP-type expansion. Hence, this proposal is not ideal from either of our perspectives.

We expect that it will not be considered ideal by other major health care organizations as well. However, from the perspective of 43 million uninsured people, any so-called "ideal" plan that can't get enacted is an illusionary ideal. It is no solution at all.

The proposal presents a good second choice to our two organizations – and, we believe, it will to others as well. It has the potential for increasing health coverage for a very significant portion of those people who are uninsured today. It achieves a reasonable balance between public sector and private sector approaches. It focuses priority attention to the people most in need of assistance. It builds on systems that work today and, therefore, does not create new bureaucracies or cause further fragmentation of our health care system. It eliminates the cumbersome and unfair poverty categorizations that are vestiges of the Elizabethan Poor Laws in a way that is consistent with experimentation undertaken by a number of states. It is designed to eliminate work disincentives by providing new health coverage opportunities to support low-income workers and people moving from welfare to jobs. And it does all this without trespassing on the interests of key stakeholders in the health care system.

To be sure, this proposal – like any other that would result in a major increase in health coverage for lower-income families – will require a significant public investment. Although no reliable cost estimate can be made until detailed legislation is developed, it is obvious that this proposal will be expensive. But – with the economy in good condition, the federal budget in surplus, and state budgets in good shape as well – there has never been a better time to take on such an investment.

We believe that this proposal, and the broad coalition-building effort to which we are committed, constitutes our best – perhaps our only – near-term chance to expand health coverage for many millions of uninsured Americans. Certainly if our two organizations can find common ground for this noteworthy objective, it augurs well for many other groups to do likewise. Through a common effort, we have a real chance to proceed down the road toward health coverage for all Americans.

Uninsured, Unemployed Workers and their Families: The Problem and Policy Options

Overview

Families who lose health insurance while they are between jobs are a small but important group of uninsured Americans. These families pay for health insurance for most of their lives, but go through brief periods without coverage when they are temporarily unemployed. If they experience a catastrophic illness during this transition, the benefit of their years' worth of premium payments is lost. They have to cover their health care costs alone at a time when they no longer have a major source of income. Worse, for families with an ill child or a worker with a chronic condition, the loss of health insurance while between jobs can make it financially impossible to regain coverage. This paper outlines the scope of this problem and policy options that help reduce it.

More People Experience Job Transitions

In today's economy, an increasing number of Americans will at some point lose their jobs. While the unemployment rate remains low and job creation remains high, the fast-moving economy has resulted in rapid job turnover and job elimination. In a *New York Times* article on the topic, economist Paul Krugman wrote, "What economists call 'labor market flexibility' is a euphemism for a certain amount of brutality. But it seems an unfortunate price we have to pay for having as dynamic an economy as we do." (Lohr, 1996).

About 9.4 million Americans (8% of all workers) lost their jobs due to plant or company closure, insufficient work, or elimination of their positions between January 1993 and December 1995. This number is about the same as in the early 1990s, when there was a recession, and is an increase from 5.9 million displaced workers between 1989 and 1991. Increasingly, these are white collar workers. While about 7 in 10 of the displaced workers were reemployed, more than half did not receive written advance notice of their job termination and probably spent time unemployed between jobs. Less than half of displaced workers were reemployed in full-time jobs with earnings the same or higher (USDL, 10/25/96).

Job loss and transitions do not affect a small subset of the population. In 1995, over 15 million American workers received unemployment compensation at some point (USDL, 12/17/96). An estimated one out of every four workers will make an unemployment claim once over a four year period. (Myer & Rosenberg, 1996). These workers' unemployment affects a larger number of people, including spouses and children. In a recent poll, one in two people were somewhat or very concerned that someone in their household would be laid off in the next two or three years (Lohr, 1996).

Changing Jobs Leads to Changing Insurance

In the United States, health insurance is usually linked to employment. Nearly 148 million (64% of the nonelderly, civilian population) receive health insurance through an employment-based plan (EBRI, 1996). About half of this number (76 million) are the workers themselves; the other half includes spouses and children gaining coverage through the worker's plan.

Since health insurance is often employment based, change in employment is a major reason why people lose health insurance. About 42% of workers with one or more job interruptions experienced at least a month without health insurance between 1992 and 1995. This compares to only 13% of full-time workers without job interruptions (Bennefield, 1996). According to one study, 58% of the two million Americans who lose their health insurance each month cite a change in employment as the primary reason for losing coverage (Sheils & Alecxih, 1996). This affects family as well as workers: nearly 45% of children who lose their health insurance do so due to a change in their parent's employment status (Sheils & Alecxih, 1996).

The Unemployed are Often Uninsured

In 1995, about 16 million of the 40 million uninsured were nonworkers (8.7 million), part-year workers and their dependents (3.0 million) and full year workers and dependents with some unemployment (4.4 million) (EBRI, 1996). This includes people who are out of the labor force, do not receive unemployment compensation, and/or did not receive insurance on their last job. This number is a point-in-time estimate; since unemployed workers usually spend only part of the year between jobs, this snapshot only captures some of the temporarily unemployed and uninsured.

While only a minority of the total uninsured, the unemployed are more likely to be uninsured than the rest of the population. Three times as many uninsured were unemployed, compared to the proportion of all adults who were unemployed and looking for work (Klerman, 1995). Over one-third of workers who left an insured job, became unemployed, and received unemployment compensation also became uninsured (Klerman, 1995). This is twice the proportion of uninsured in the general population.

Policies and Proposals for Uninsured, Unemployed Families

Three sets of policies exist today that assist uninsured, unemployed families. Additionally, several have been proposed to address the gaps left by these policies.

COBRA. The 1986 Consolidated Omnibus Reconciliation Act (COBRA) allows most employees to purchase health coverage from their former employer for up to 18 months

after their employment ends.¹ The employee must pay the full premium for this coverage (up to 102% of the group rate). Given the high premiums in the individual market and the possibility of denied coverage for pre-existing conditions, these premiums are probably the lowest that most unemployed, uninsured workers and their families can find.

Most researchers agree that COBRA has improved health coverage among the unemployed. About 20 to 30% of all eligible take the option (Flynn, 1992; Klerman, 1995; Berger, Black & Scott, 1996). In part, these rates underestimate COBRA's assistance since many of the unemployed join the health plans of spouses with employer-based insurance. When looking only at the unemployed with no access to spousal coverage, the rate of COBRA coverage increases to over 40%. Additionally, when only the unemployed who receive unemployment compensation are examined, 43% appear to have taken COBRA coverage (Klerman, 1995). On the whole, evidence supports claims that COBRA decreases the probability that a person between jobs is uninsured, reduces "job lock", and covers workers during pre-existing condition waiting periods (Gruber and Madrian, 1994; Klerman, 1995; Berger, Black & Scott, 1996).

One concern about the policy, however, is its use by low-income unemployed. The difference in take-up rates for low-income people is significant: only 15% of eligible unemployed with income below \$25,000 participated in COBRA and over two-thirds remained uninsured. This compares to a participation rate of 33% for unemployed with higher income, and an uninsured rate of 33% (Berger, Black & Scott, 1996).

Medicaid. Three Medicaid eligibility provisions help unemployed, uninsured families. In the 1988 Family Support Act, states were required to extend eligibility to two-parent families whose principal wage earner is unemployed (the Aid to Families with Dependent Children Unemployed Parent program (AFDC-UP)). To qualify, the worker must have worked a certain number of quarters or be eligible to receive unemployment compensation. In OBRA 1990, Medicaid eligibility was broadened to cover all poor children and pregnant women. To the extent that the unemployed, uninsured are poor, their children may be covered by Medicaid. Additionally, states have the option to pay for COBRA coverage for poor workers whose firm had 75 or more employees; few states have taken this option (Congressional Research Service, 1993). It is not known how many people have been covered through the AFDC-UP and COBRA coverage options.

HIPAA. The Health Insurance Portability and Accountability Act of 1996 (HIPAA or the

¹Employees of firms with fewer than 20 workers or who were terminated from their jobs under certain circumstances are not eligible for COBRA.

Kassebaum-Kennedy bill), makes it easier for workers and their families to maintain health insurance coverage. Under HIPAA, health plans are prohibited from imposing new pre-existing condition exclusions for enrollees with more than 12 months of previous continuous coverage.² Preexisting conditions are limited to 12 months and can be imposed only for conditions diagnosed or treated within the 6 months prior to enrollment.

However, HIPAA only helps those who maintain their health care coverage between jobs. If a worker loses coverage for more than sixty-three days while unemployed, these protections are no longer available. Since the Act's provisions begin in 1997, its implications for the unemployed and uninsured have yet to be determined. However, it is clear that it is extremely important that Americans are able to maintain their health care coverage while they are looking for a new job to benefit the guarantees in HIPAA.

Administration's Proposal. While COBRA, Medicaid, and HIPAA offer access to insurance for uninsured, unemployed families, the question of affordability remains largely unaddressed. Workers who are temporarily unemployed often are not qualified for Medicaid and cannot afford to buy into COBRA. At a time when they have lost a major source of income, they have to pay their health care costs alone. They (and their family) have no protection against the costs of a catastrophic illness, and they are unlikely to receive important preventive services which help avoid costlier services later.

Consequently, the Administration has put forth a new proposal to help workers who are between jobs. This program would provide temporary premium assistance for people who previously had health insurance through their employer, are in between jobs, and cannot afford COBRA or other coverage on their own. Families with income below poverty are eligible for a full subsidy, while families with income up to 240 percent of poverty can receive a partial subsidy for a basic benefits package. Only workers and dependents who receive unemployment compensation, do not have access to health insurance through a spouse, and are not eligible for Medicaid qualify for assistance. The program would be run as a capped entitlement to states, who would design the operation of the program. The Office of Management and Budget (OMB) estimates that this initiative will cost about \$2 billion a year [pending final budget decisions].

According to Administration analysis, over 3 million people, including 700,000 children, would participate in this program in 1997 (if it were fully implemented in that year). About 85% of these participants would be middle class (defined as being in the second through fourth income quintile).

²Enrollees who have up to twelve months of health care coverage are subject to pre-existing conditions for 12 months minus the number of months they have previously been insured.

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CHRIS - I'M KIND OF NERVOUS ABOUT THIS APPROACH BUT IT:
1 - solves Gen's "nationwide" issue
2 - may be attractive to Bruce w/ welfare connection.
?

One Option for Workers Changing Jobs

Policy

- **Grants to states:** Like the Children's Health Insurance Program, states would get allotments. The amount of the allotment depends on the number of states that apply.
- **Uses of funds:** Uninsured people with incomes up to 200 percent of poverty who are:
 - **Workers between / changing jobs:** Up to 6 months of transitional coverage
 - **People leaving welfare for work:** A second 12 months of coverage following the year of Medicaid transitional coverage
- **State match:** CHIP rate: up to 15 percent above current rate
- **Choice of Medicaid or a new program:** Like CHIP, the state may either use Medicaid or create a new program.

Advantages

- **Funds for all states:** Rather than 100 percent funding for a few states, this program gives all states the option to participate with state matching funds, which should be available since states are getting tobacco funds as well.
- **Add-on rather than a new program:** Builds on CHIP and Medicaid rather than creating a new matching rate, benefits structure, etc.
- **Builds on both welfare to work and workers security themes**

Disadvantages

- **No Medicaid base:** Unlike children, there is no fairly uniform coverage of poor adults. This program would begin eligibility at AFDC levels (averaging around 50 percent of poverty)
- **Moves toward block granting Medicaid:** In choosing this approach versus a Medicaid expansion, we could be viewed as supporting grant rather than entitlement programs.

Health Insurance Coverage

Consumer Income

1999

Issued September 2000

P60-211

Reversing a 12-year trend, the share of the population without health insurance declined in 1999, the first decline since 1987 when comparable health insurance statistics were first available. In 1999, 15.5 percent of the population were without health insurance coverage during the entire year, down from 16.3 percent in 1998. From 1987 to 1998, this rate either increased or was unchanged from one year to the next. Similarly, the number of people without health insurance coverage declined for the first time in 1999, to 42.6 million people, down 1.7 million from the previous year.

Other highlights:²

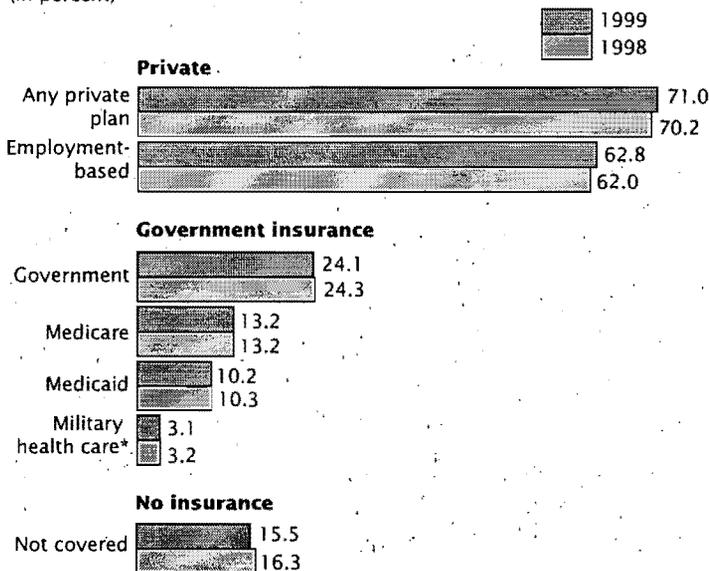
- The number and percent of people covered by employment-based health insurance rose significantly in 1999, driving the overall increase in health insurance coverage.
- Mirroring what happened for the total population, the proportion of uninsured children declined in 1999 — to 13.9 percent of children — the lowest rate since

²Confidence intervals for estimates are provided in Table A. The uncertainty in the estimates should be taken into consideration when using them.

The estimates in this report are based on the March 2000 Current Population Survey (CPS), conducted by the U.S. Census Bureau. Respondents provide answers to the survey questions to the best of their ability, but as with all surveys, the estimates may differ from the actual values.¹

¹A facsimile of the CPS March Supplement questionnaire is available electronically at <http://www.census.gov/apsd/techdoc/cps/cps-main.html>.

Figure 1.
Type of Health Insurance and Coverage Status: 1998 and 1999
(In percent)



*Military health care includes CHAMPUS (Comprehensive Health and Medical Plan for Uniformed Services)/Tricare, CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs), Veterans', and military health care.

Note: The estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the year.

Source: U.S. Census Bureau, Current Population Survey, March 2000.

Current Population Reports

By Robert J. Mills

Demographic Programs

U.S. CENSUS BUREAU

Helping You Make Informed Decisions

U.S. Department of Commerce
Economics and Statistics Administration
U.S. CENSUS BUREAU



Table A.
People Without Health Insurance for the Entire Year: 1998 and 1999

(In percent unless otherwise noted)

Characteristic	1999		1998	
	Estimate	90-pct C.I.(±)	Estimate	90-pct C.I.(±)
Total				
Number (in thousands).....	42,554	462	44,281	458
Percent	15.5	0.2	16.3	0.2
Total Poor				
Number (in thousands).....	10,436	531	11,151	548
Percent	32.4	1.4	32.3	1.3
Race and Ethnicity				
White non-Hispanic.....	11.0	0.2	11.9	0.2
Black	21.2	0.6	22.2	0.6
Asian and Pacific Islander.....	20.8	1.0	21.1	1.0
Hispanic ¹	33.4	0.6	35.3	0.6
Age				
Under 18 years	13.9	0.3	15.4	0.3
18 to 24 years	29.0	0.7	30.0	0.7
65 years and over.....	1.3	0.2	1.1	0.1
Nativity				
Native.....	13.5	0.2	14.4	0.2
Foreign born.....	33.4	0.8	34.1	0.8
Household Income				
Less than \$25,000.....	24.1	0.4	25.2	0.4
\$25,000 to \$49,999.....	18.2	0.3	18.8	0.3
\$50,000 to \$74,999.....	11.8	0.3	11.7	0.3
\$75,000 or more	8.3	0.2	8.3	0.3
Work Experience (people 18 to 64 years)				
Worked during year.....	17.4	0.3	18.0	0.3
Did not work.....	26.5	0.7	27.0	0.7

¹Hispanics may be of any race.

Source: U.S. Census Bureau, Current Population Survey, March 1999 and 2000.

- 1995. The number of uninsured children declined to 10.0 million.
- Although medicaid insured 12.9 million poor people, 10.4 million poor people still had no health insurance in 1999, representing about one-third of the poor (32.4 percent), which was not significantly different from 1998.
- Compared with the previous year, health insurance coverage rates increased for those with household incomes of less than \$50,000, but were unchanged for those with \$50,000 and higher household incomes.
- Hispanics (66.6 percent) were less likely than White non-Hispanics (89.0 percent) to be covered by health insurance.³ The coverage rate for Blacks in 1999 (78.8 percent) did not differ statistically from the coverage rate for Asians and Pacific Islanders (79.2 percent).
- American Indians and Alaska Natives were less likely to have health insurance than other racial groups, based on a 3-year average (1997-1999) — 72.9 percent, compared with 78.4 percent of Blacks, 79.1 percent of Asians and Pacific Islanders, and 88.4 percent of White non-Hispanics. However, they were more likely to have insurance than were Hispanics (65.7 percent).⁴

³Hispanics may be of any race.

⁴The difference in health insurance coverage rates between Blacks and Asians and Pacific Islanders was not statistically significant.

- Among the entire population 18 to 64 years old, workers (both full- and part-time) were more likely to have health insurance (82.6 percent) than nonworkers (73.5 percent), but among the poor, workers were less likely to be covered. Just over one-half, 52.5 percent, of poor workers were insured in 1999, while the rate for poor nonworkers in 1999 was 59.2 percent.
- The foreign-born population was less likely than the native population to be insured — 66.6 percent compared with 86.5 percent in 1999.
- Young adults (18 to 24 years old) were less likely than other age groups to have health insurance coverage — 71.0 percent in 1999 compared with 82.9 percent of those 25 to 64 and, reflecting widespread medicare coverage, 98.7 percent of those 65 years and over.

Employment-based insurance, the leading source of health insurance coverage, drove the increase in insurance coverage rates.⁵

Most people (62.8 percent) were covered by a health insurance plan related to employment for some or all of 1999, an increase of 0.8 percentage points over the previous year. The increase in private health insurance coverage reflects the increase in employment-based insurance; it also increased 0.8 percentage points to 71.0 percent in 1999 (see Figure 1).

The government also provides health insurance coverage, but there was no change between 1998 and 1999 in the overall government-pro-

⁵Employment-based health insurance is coverage offered through one's own employment or a relative's.

vided health insurance coverage rate. Among the entire population, 24.1 percent had government insurance, including medicare (13.2 percent), medicaid (10.2 percent), and military health care (3.1 percent). Many people carried coverage from more than one plan during the year; for example, 7.5 percent of people were covered by both private health insurance and medicare.

The poor and near poor are less likely to have health insurance than the total population.

Despite the medicaid program, 32.4 percent of the poor (10.4 million people) had no health insurance of any kind during 1999. This percentage — double the rate for the total population — did not change statistically from the previous year. The uninsured poor comprised 24.5 percent of all uninsured people.

Medicaid was the most widespread type of health insurance among the poor, with 39.9 percent (12.9 million) of those in poverty covered by medicaid for some or all of 1999. This percentage did not change statistically from the previous year.⁶

Among the near poor (those with a family income greater than the poverty level but less than 125 percent of the poverty level), 25.7 percent (3.1 million people) lacked health insurance in 1999. This percentage decreased significantly from 1998, however, when 29.9 percent of the near poor lacked health insurance. The percentage of the near poor who had private health insurance rose from 38.3 percent in 1998 to 41.7 percent in 1999. Government health insurance coverage among the near poor also increased, from 42.3 percent in 1998 to 43.9 percent in 1999.

⁶Changes in year-to-year medicaid estimates should be viewed with caution. For more information, see the Technical Note on page 12.

Key demographic factors affect health insurance coverage.

Age - People 18 to 24 years old were less likely than other age groups to have health insurance coverage during 1999. Their coverage rate (71.0 percent) rose by 1.0 percentage point from 1998. Because of medicare, most people 65 years and over (98.7 percent) had health insurance in 1999. For other age groups, health insurance coverage ranged from 76.8 percent to 86.2 percent (see Figure 2).

Among the poor, adults ages 18 to 64 had a markedly lower health insurance coverage rate (55.8 percent) in 1999 than either children (76.7 percent) or the elderly (96.6 percent).

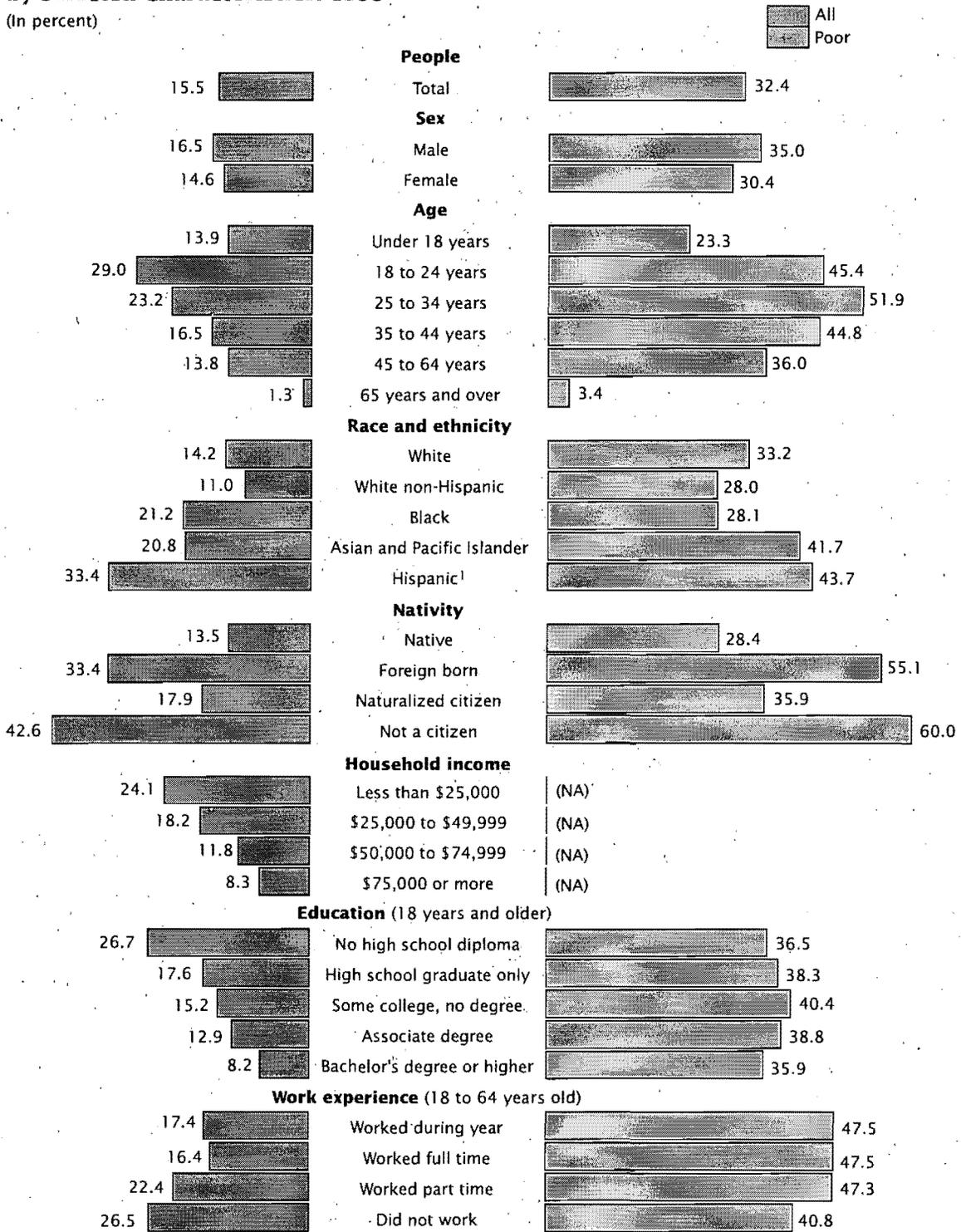
Race and Hispanic origin - The uninsured rate declined significantly in 1999 for Hispanics and White non-Hispanics — for Hispanics, from 35.3 percent to 33.4 percent and for White non-Hispanics, from 11.9 percent to 11.0 percent.⁷ Among Blacks, the uninsured rate dropped by 1 percentage point from 22.2 percent in 1998 to 21.2 percent in 1999. The uninsured rate among Asians and Pacific Islanders did not change significantly from 1998 — 20.8 percent of Asians and Pacific Islanders were without health coverage in 1999.⁸

⁷Because Hispanics may be of any race, use caution in comparing data for Hispanics and racial groups such as Blacks (3.0 percent of whom were Hispanic in 1999) and Asians and Pacific Islanders (1.7 percent of whom were Hispanic in 1999). Furthermore, the Hispanic population consists of many distinct groups that differ in socio-economic characteristics, culture, and recency of immigration. Because of differences among the individual groups, data users should exercise caution when interpreting aggregate data for this population.

⁸The Asian and Pacific Islander population consists of many distinct groups that differ in socio-economic characteristics, culture, and recency of immigration. Because of differences among them, data users should exercise caution when interpreting aggregate data for this population.

Figure 2.
**People Without Health Insurance for the Entire Year
 by Selected Characteristics: 1999**

(In percent)



¹ Hispanics may be of any race. NA Not Applicable.
 Source: U.S. Census Bureau, Current Population Survey, March 2000.

Table B.
People Without Health Insurance for the Entire Year by Selected Characteristics: 1998
and 1999

(Numbers in thousands)

Characteristic	1999			1998			Change 1998 to 1999	
	Total	Uninsured		Total	Uninsured		Uninsured	
		Number	Percent		Number	Percent	Number	Percent
People								
Total	274,087	42,554	15.5	271,743	44,281	16.3	*-1,727	*-0.8
Sex								
Male	133,933	22,073	16.5	132,764	23,014	17.3	*-941	*-0.8
Female	140,154	20,481	14.6	138,979	21,266	15.3	*-785	*-0.7
Race and Ethnicity								
White	224,806	31,863	14.2	223,294	33,588	15.0	*-1,725	*-0.9
Non-Hispanic	193,633	21,363	11.0	193,074	22,890	11.9	*-1,527	*-0.8
Black	35,509	7,536	21.2	35,070	7,797	22.2	*-261	*-1.0
Asian and Pacific Islander	10,925	2,272	20.8	10,897	2,301	21.1	-29	-0.3
Hispanic ¹	32,804	10,951	33.4	31,689	11,196	35.3	*-245	*-2.0
Age								
Under 18 years	72,325	10,023	13.9	72,022	11,073	15.4	*-1,050	*-1.5
18 to 24 years	26,532	7,688	29.0	25,967	7,776	30.0	-88	-1.0
25 to 34 years	37,786	8,755	23.2	38,474	9,127	23.7	*-372	-0.5
35 to 44 years	44,805	7,377	16.5	44,744	7,708	17.2	*-331	*-0.8
45 to 64 years	60,018	8,288	13.8	58,141	8,239	14.2	49	-0.4
65 years and over	32,621	422	1.3	32,394	358	1.1	*64	*0.2
Nativity								
Native	245,708	33,089	13.5	245,295	35,273	14.4	*-2184	*-0.9
Foreign born	28,379	9,465	33.4	26,448	9,008	34.1	*457	-0.7
Duration of U.S. residency								
Less than 10 years	11,206	5,103	45.5	10,363	4,686	45.2	*417	0.3
10 to 19 years	8,022	2,692	33.6	7,667	2,738	35.7	-46	*-2.1
20 to 29 years	4,605	1,131	24.6	4,178	1,093	26.2	38	-1.6
30 to 39 years	2,539	452	17.8	2,323	365	15.7	*87	2.1
40 years or more	2,008	86	4.3	1,916	126	6.6	*-40	*-2.3
Naturalized citizen	10,622	1,900	17.9	9,868	1,891	19.2	9	-1.3
Duration of U.S. residency								
Less than 10 years	997	304	30.5	1,079	332	30.8	-28	-0.3
10 to 19 years	3,118	716	23.0	2,863	727	25.4	-11	-2.4
20 to 29 years	2,851	527	18.5	2,559	506	19.8	21	-1.3
30 to 39 years	1,920	290	15.1	1,723	222	12.9	*68	2.2
40 years or more	1,735	62	3.6	1,645	103	6.3	*-41	*-2.7
Not a citizen	17,758	7,565	42.6	16,579	7,118	42.9	*447	-0.3
Duration of U.S. residency								
Less than 10 years	10,209	4,799	47.0	9,284	4,354	46.9	*445	0.1
10 to 19 years	4,904	1,976	40.3	4,804	2,011	41.9	-35	-1.6
20 to 29 years	1,754	604	34.4	1,619	587	36.3	17	-1.9
30 to 39 years	619	162	26.2	600	143	23.9	19	2.3
40 years or more	273	24	8.9	272	23	8.4	1	0.5
Region								
Northeast	52,038	6,641	12.8	51,876	7,247	14.0	*-606	*-1.2
Midwest	63,595	7,075	11.1	63,295	7,685	12.1	*-610	*-1.0
South	95,928	16,887	17.6	94,887	17,209	18.1	-322	*-0.5
West	62,526	11,950	19.1	61,684	12,140	19.7	-190	*-0.6
Household Income								
Less than \$25,000	64,628	15,577	24.1	68,422	17,229	25.2	*-1,652	*-1.1
\$25,000 to \$49,999	77,119	13,996	18.2	78,973	14,807	18.8	*-811	*-0.6
\$50,000 to \$74,999	56,873	6,706	11.8	57,324	6,703	11.7	3	0.1
\$75,000 or more	75,467	6,275	8.3	67,023	5,542	8.3	*733	-
Education (18 years and older)								
Total	201,762	32,531	16.1	199,721	33,208	16.6	*-677	*-0.5
No high school diploma	34,087	9,111	26.7	34,811	9,294	26.7	-183	-
High school graduate only	66,141	11,619	17.6	66,054	12,094	18.3	*-475	*-0.7
Some college, no degree	39,940	6,051	15.2	39,087	6,211	15.9	-160	*-0.7
Associate degree	14,715	1,902	12.9	14,114	1,730	12.3	*172	0.7
Bachelor's degree or higher	46,880	3,848	8.2	45,655	3,880	8.5	-32	-0.3
Work Experience (18 to 64 years old)								
Total	169,141	32,108	19.0	167,327	32,850	19.6	*-742	*-0.6
Worked during year	139,218	24,187	17.4	137,003	24,655	18.0	-468	*-0.6
Worked full-time	115,973	18,984	16.4	113,638	19,244	16.9	-260	*-0.6
Worked part-time	23,245	5,204	22.4	23,365	5,411	23.2	-207	-0.8
Did not work	29,923	7,921	26.5	30,323	8,194	27.0	-273	-0.6

- Represents zero or rounds to zero.

¹Hispanics may be of any race. *Statistically significant at the 90-percent confidence level.

Source: U.S. Census Bureau, Current Population Survey, March 1999 and 2000.

Table C.
Poor People Without Health Insurance for the Entire Year by Selected Characteristics:
1998 and 1999

(Numbers in thousands)

Characteristic	1999			1998			Change 1998 to 1999	
	Total	Uninsured		Total	Uninsured		Uninsured	
		Number	Percent		Number	Percent	Number	Percent
Poor People								
Total	32,258	10,436	32.4	34,476	11,151	32.3	*-715	0.1
Sex								
Male	13,813	4,830	35.0	14,712	5,247	35.7	*-417	-0.7
Female	18,445	5,606	30.4	19,764	5,904	29.9	-298	0.5
Race and Ethnicity								
White	21,922	7,271	33.2	23,454	7,922	33.8	*-651	-0.6
Non-Hispanic	14,875	4,158	28.0	15,799	4,508	28.5	-350	-0.5
Black	8,360	2,347	28.1	9,091	2,622	28.8	*-275	-0.7
Asian and Pacific Islander	1,163	485	41.7	1,360	439	32.3	46	*9.4
Hispanic ¹	7,439	3,254	43.7	8,070	3,553	44.0	*-299	-0.3
Age								
Under 18 years	12,109	2,825	23.3	13,467	3,392	25.2	*-567	*-1.9
18 to 24 years	4,603	2,088	45.4	4,312	2,013	46.7	75	-1.3
25 to 34 years	3,968	2,059	51.9	4,582	2,256	49.2	*-197	*2.7
35 to 44 years	3,733	1,672	44.8	4,082	1,775	43.5	-103	1.3
45 to 64 years	4,678	1,686	36.0	4,647	1,609	34.6	77	1.4
65 years and over	3,167	107	3.4	3,386	107	3.2	-	0.2
Nativity								
Native	27,507	7,817	28.4	29,707	8,612	29.0	*-795	-0.6
Foreign born	4,751	2,619	55.1	4,769	2,539	53.2	80	1.9
Duration of U.S. residency								
Less than 10 years	2,623	1,669	63.6	2,531	1,553	61.4	116	2.2
10 to 19 years	1,222	635	52.0	1,237	655	53.0	-20	-1.0
20 to 29 years	528	214	40.5	554	236	42.5	-22	-2.0
30 to 39 years	230	81	35.1	245	78	31.8	3	3.3
40 years or more	149	20	13.5	202	17	8.6	3	4.9
Naturalized citizen	968	347	35.9	1,087	383	35.2	-36	0.7
Duration of U.S. residency								
Less than 10 years	143	81	56.7	179	89	49.6	-8	7.1
10 to 19 years	278	110	39.5	290	135	46.7	-25	-7.2
20 to 29 years	259	86	33.4	292	108	37.0	-22	-3.6
30 to 39 years	166	53	31.9	165	40	24.3	13	7.6
40 years or more	121	17	13.8	161	11	6.6	6	7.2
Not a citizen	3,783	2,271	60.0	3,682	2,156	58.6	115	1.4
Duration of U.S. residency								
Less than 10 years	2,479	1,588	64.0	2,352	1,465	62.3	123	1.7
10 to 19 years	944	526	55.7	947	520	54.9	6	0.8
20 to 29 years	269	127	47.4	262	127	48.7	-	-1.3
30 to 39 years	64	28	43.3	80	38	47.3	-10	-4.0
40 years or more	27	3	12.2	41	7	16.3	-4	-4.1
Region								
Northeast	5,678	1,355	23.9	6,357	1,688	26.6	*-333	-2.7
Midwest	6,210	1,568	25.3	6,501	1,547	23.8	21	1.5
South	12,538	4,426	35.3	12,992	4,635	35.7	-209	-0.4
West	7,833	3,087	39.4	8,625	3,280	38.0	-193	1.4
Education (18 years and older)								
Total	20,149	7,611	37.8	21,009	7,759	36.9	-148	0.9
No high school diploma	7,888	2,876	36.5	8,286	2,984	36.0	-108	0.5
High school graduate only	6,810	2,611	38.3	7,242	2,762	38.1	-151	0.2
Some college, no degree	3,162	1,278	40.4	3,199	1,212	37.9	66	2.5
Associate degree	836	324	38.8	828	269	32.4	55	6.4
Bachelor's degree or higher	1,452	521	35.9	1,454	533	36.6	-12	-0.7
Work Experience (18 to 64 years old)								
Total	16,982	7,504	44.2	17,623	7,652	43.4	-148	0.8
Worked during year	8,649	4,104	47.5	8,709	4,053	46.5	51	1.0
Worked full-time	5,582	2,654	47.5	5,646	2,680	47.5	-26	-
Worked part-time	3,066	1,450	47.3	3,062	1,373	44.8	77	2.5
Did not work	8,333	3,400	40.8	8,914	3,599	40.4	-199	0.4

- Represents zero or rounds to zero.

¹Hispanics may be of any race.

*Statistically significant at the 90-percent confidence level.

Source: U.S. Census Bureau, Current Population Survey, March 1999 and 2000.

Table D.
People Without Health Insurance for the Entire Year by Race and Ethnicity
(3-Year average): 1997 to 1999

(Numbers in thousands)

Characteristic	Total	Uninsured	
		Number	Percent
Total	271,641	43,427	16.0
White	223,250	32,897	14.7
Non-Hispanic	192,962	22,463	11.6
Black	35,059	7,588	21.6
American Indian or Alaska Native	2,561	693	27.1
Asian and Pacific Islander	10,771	2,249	20.9
Hispanic ¹	31,755	10,894	34.3

¹Hispanics may be of any race.

Source: U.S. Census Bureau, Current Population Survey, March 1998, 1999, and 2000.

The Current Population Survey, the source of these data, samples 50,000 households nationwide and is not large enough to produce reliable annual estimates for American Indians and Alaska Natives. However, Table D displays 3-year averages of the number of American Indians and Alaska Natives and their 3-year average uninsured rate and provides 3-year average uninsured rates for the other race groups for comparison. The 3-year average (1997-1999) shows that 27.1 percent of American Indians and Alaska Natives were without coverage, compared with 21.6 percent for Blacks, 20.9 percent for Asians and Pacific Islanders, and 11.6 percent for White non-Hispanics.⁹ However, the 3-year average uninsured rate for Hispanics (34.3 percent) was higher.¹⁰

⁹Data users should exercise caution when interpreting aggregate results for American Indians and Alaska Natives (AIAN) because the AIAN population consists of groups that differ in economic characteristics. Data from the 1990 census show that economic characteristics of those American Indians and Alaska Natives who live in American Indian and Alaska native areas differ from the characteristics of those who live outside these areas. In addition, the CPS does not use separate population controls for weighting the AIAN samples to national totals. See Accuracy of Estimates on page 12 for a further discussion of CPS estimation procedures.

¹⁰The difference in health insurance coverage rates between Blacks and Asians and Pacific Islanders was not statistically significant.

Nativity - In 1999, the proportion of the foreign-born population without health insurance (33.4 percent) was more than double that of the native population (13.5 percent).¹¹ Among the foreign born, noncitizens were more than twice as likely as naturalized citizens to lack coverage — 42.6 percent compared with 17.9 percent.

Health insurance coverage rates among the foreign born increase with length of residence and citizenship. For example, while about half (53.0 percent) of noncitizen immigrants living in the United States less than 10 years had health insurance coverage, the rate rises to 91.1 percent for noncitizen immigrants living in the United States for 40 years or more. Among naturalized citizens, the comparable rates were 69.5 percent and 96.4 percent.

Educational attainment - Among adults, the likelihood of being insured increased as the level of education rose. Among those who were poor in 1999, there were no

¹¹Natives are people born in the United States, Puerto Rico, or an outlying area of the United States, such as Guam or the U.S. Virgin Islands, and people who were born in a foreign country but who had at least one parent who was a U.S. citizen. All other people born outside the United States are foreign born.

differences in health insurance coverage rates across the education groups.

Economic status affects health insurance coverage.

Income - The likelihood of being covered by health insurance rises with income. Among households with annual incomes of less than \$25,000, the percentage with health insurance was 75.9 percent; the level rises to 91.7 percent for those with incomes of \$75,000 or more (see Figure 2).

Compared with the previous year, coverage rates increased for those with household incomes of less than \$50,000, but were unchanged for those with \$50,000 or higher household incomes. For those with household incomes of less than \$25,000, the coverage rate increased 1.1 percentage points to 75.9 percent, whereas for those with incomes between \$25,000 and \$50,000, it increased 0.6 percentage points to 81.9 percent in 1999.¹²

¹²The difference in the increases for those with incomes of less than \$25,000 and those with incomes between \$25,000 and \$50,000 was not statistically significant.

Work experience - Of those 18 to 64 years old in 1999, full-time workers were more likely to be covered by health insurance (83.6 percent) than part-time workers (77.6 percent), and part-time workers were more likely to be insured than nonworkers (73.8 percent).¹³ However, among the poor, nonworkers (59.2 percent) were more likely to be insured than workers (52.5 percent). Poor full-time workers did not fare better than poor part-time workers — 52.5 percent and 52.7 percent, respectively.

Firm size - Of the 139.2 million workers in the United States (18-64 years old), 55.5 percent had employment-based health insurance policies in their own name (see Figure 3). The proportion generally increased with the size of the employing firm — 30.6 percent of workers employed by firms with fewer than 25 employees and 68.3 percent for workers employed by firms with 1000 or more employees, for example. (These estimates do not reflect the fact that some workers were covered by another family member's employment-based policy).

The uninsured rate for children decreased between 1998 and 1999.

The percentage of children (people under 18 years old) without health insurance in the United States dropped from 15.4 percent in 1998 to 13.9 percent in 1999. The increase in employment-based insurance accounted for most of the change; no change occurred in government health insurance coverage.

Among poor children, the uninsured rate also fell, from 25.2 percent in 1998 to 23.3 percent in 1999. An increase in government health insurance coverage accounted for most of

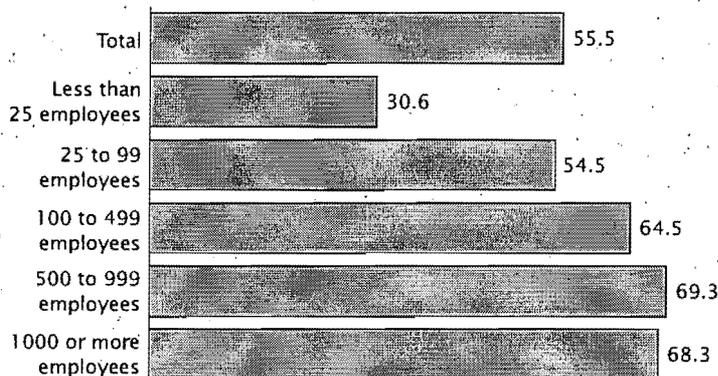
this drop; no change occurred in employment-based coverage. Poor children made up 28.2 percent of all uninsured children in 1999.

Among near-poor children (children in families with incomes greater

than the poverty level but less than 125 percent of the poverty level), the proportion without health insurance fell substantially from 27.2 percent in 1998 to 19.7 percent in 1999. Increases in both government health insurance

Figure 3.
Workers Age 18 to 64 Covered by Their Own Employment-Based Health Insurance by Firm Size: 1999

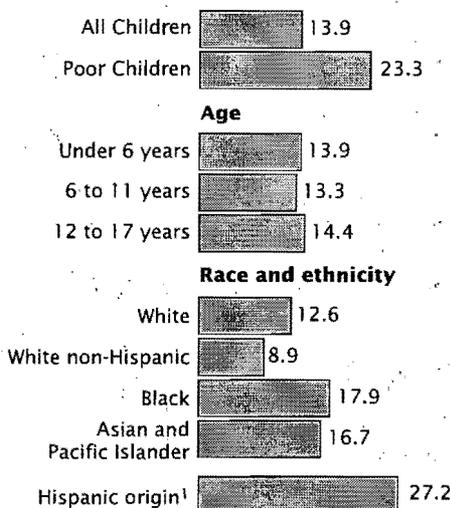
(In percent)



Source: U.S. Census Bureau, Current Population Survey, March 2000.

Figure 4.
Uninsured Children by Race, Ethnicity, and Age: 1999

(In percent)

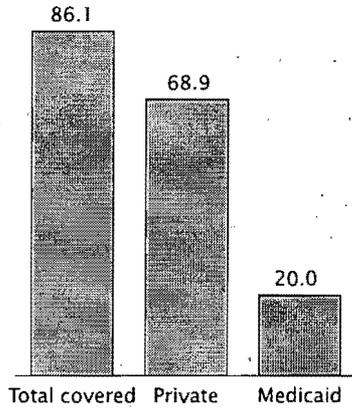


¹ Hispanics may be of any race.
Source: U.S. Census Bureau, Current Population Survey, March 2000.

¹³Workers were classified as part time if they worked fewer than 35 hours per week in the majority of the weeks they worked in 1999.

Figure 5.
Children by Type of Health Insurance and Coverage Status: 1999

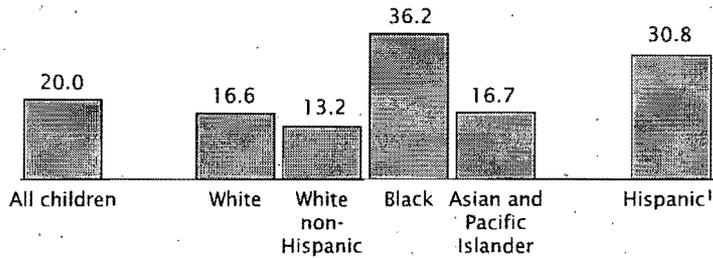
(In percent)



Note: Children may be covered by both private health insurance and Medicaid during the year.
Source: U.S. Census Bureau, Current Population Survey, March 2000.

Figure 6.
Children Covered by Medicaid by Race and Ethnicity: 1999

(In percent)



¹ Hispanics may be of any race.
Source: U.S. Census Bureau, Current Population Survey, March 2000.

coverage (from 40.6 percent to 43.8 percent) and private health insurance coverage (from 38.3 percent to 44.8 percent) accounted for the change. The State Children's Health Insurance Program, which expanded access to health coverage for low-income children under age 19, likely contributed substantially to the increase in government coverage.¹⁴

Children's characteristics affect their likelihood of health insurance coverage.

- Children 12 to 17 years of age were more likely to be uninsured than those under 12 — 14.4 percent compared with 13.6 percent.
- For Hispanic children and for White non-Hispanic children, the uninsured rate declined significantly in 1999 — from 30.0 percent to 27.2 percent for Hispanic

¹⁴In contrast, children are defined by the Census Bureau to be under 18 years of age.

children and from 10.6 percent to 8.9 percent for White non-Hispanic children. For Black children, the uninsured rate declined from 19.7 percent to 17.9 percent, whereas 16.7 percent of Asian and Pacific Islander children were uninsured in 1999, statistically unchanged from 1998 (see Figure 4).

- While most children (68.9 percent) were covered by an employment-based or privately purchased health insurance plan in 1999, one in five (20.0 percent) were covered by Medicaid (see Figure 5).
- Black children had a higher rate of Medicaid coverage in 1999 than children of any other racial or ethnic group — 36.2 percent, compared with 30.8 percent of Hispanic children, 16.7 percent of Asian and Pacific Islander children, and 13.2 percent of White non-Hispanic children (see Figure 6).

- Children living in single-parent families in 1999 were less likely to be insured than children living in married-couple families — 81.8 percent compared to 88.4 percent.

Some states had higher uninsured rates than others.

The proportion of people without health insurance ranged from 8.8 percent in Minnesota to 24.1 percent in Texas, based on 3-year averages for 1997, 1998, and 1999 (see Table E). The Census Bureau does not recommend that these estimates be used to rank the states, however. For example, the uninsured rate for Texas was not statistically different from that in Arizona, while the rate for Minnesota was not statistically different from Rhode Island or Hawaii, as shown in Figure 7.

Comparisons of 2-year moving averages (1997-1998 and 1998-1999) show that the proportion of people

Table E.
**Percent of People Without Health Insurance Coverage Throughout the Year
 by State (3-Year Average): 1997 to 1999**

State	1999		1998		1997		3-year average 1997-1999		2-year moving averages				Difference in 2-year moving average 1998-99 less 1997-98	
	Per- cent	Stand- ard error	Per- cent	Stand- ard error	Per- cent	Stand- ard error	Per- cent	Stand- ard error	1998-1999		1997-1998		Per- cent	Stand- ard error
									Per- cent	Stand- ard error	Per- cent	Stand- ard error		
United States	15.5	0.1	16.3	0.1	16.1	0.1	16.0	0.1	15.9	0.1	16.2	0.1	*-0.3	0.1
Alabama	14.3	0.8	17.0	0.9	15.5	0.8	15.6	0.6	15.6	0.7	16.2	0.7	-0.6	0.6
Alaska	19.1	0.9	17.3	0.9	18.1	0.9	18.2	0.6	18.2	0.7	17.7	0.7	0.5	0.6
Arizona	21.2	0.9	24.2	0.9	24.5	0.9	23.3	0.6	22.7	0.7	24.3	0.7	*-1.6	0.6
Arkansas	14.7	0.8	18.7	0.9	24.4	1.0	19.3	0.6	16.7	0.7	21.5	0.8	*-4.9	0.6
California	20.3	0.4	22.1	0.4	21.5	0.4	21.3	0.3	21.2	0.3	21.8	0.3	*-0.6	0.2
Colorado	16.8	0.8	15.1	0.8	15.1	0.8	15.7	0.6	15.9	0.7	15.1	0.6	0.9	0.6
Connecticut	9.8	0.8	12.6	0.9	12.0	0.8	11.5	0.6	11.2	0.7	12.3	0.7	*-1.1	0.5
Delaware	11.4	0.8	14.7	0.9	13.1	0.9	13.1	0.6	13.0	0.7	13.9	0.7	-0.9	0.6
District of Columbia	15.4	0.9	17.0	1.0	16.2	1.0	16.2	0.7	16.2	0.8	16.6	0.8	-0.4	0.7
Florida	19.2	0.5	17.5	0.5	19.6	0.5	18.8	0.3	18.3	0.4	18.5	0.4	-0.2	0.3
Georgia	16.1	0.7	17.5	0.8	17.6	0.8	17.1	0.5	16.8	0.6	17.5	0.6	-0.7	0.5
Hawaii	11.1	0.8	10.0	0.8	7.5	0.7	9.5	0.5	10.6	0.6	8.8	0.6	*1.8	0.6
Idaho	19.1	0.9	17.7	0.8	17.7	0.8	18.1	0.6	18.4	0.7	17.7	0.7	0.7	0.6
Illinois	14.1	0.5	15.0	0.5	12.4	0.4	13.8	0.3	14.6	0.4	13.7	0.4	*0.9	0.3
Indiana	10.8	0.7	14.4	0.8	11.4	0.7	12.2	0.5	12.6	0.6	12.9	0.6	-0.3	0.5
Iowa	8.3	0.6	9.3	0.7	12.0	0.8	9.9	0.5	8.8	0.5	10.7	0.6	*-1.9	0.5
Kansas	12.1	0.8	10.3	0.7	11.7	0.8	11.4	0.5	11.2	0.6	11.0	0.6	0.2	0.6
Kentucky	14.5	0.8	14.1	0.8	15.0	0.8	14.5	0.5	14.3	0.6	14.6	0.6	-0.2	0.6
Louisiana	22.5	0.9	19.0	0.9	19.5	0.9	20.3	0.6	20.7	0.7	19.2	0.7	*1.5	0.7
Maine	11.9	0.8	12.7	0.8	14.9	0.9	13.2	0.6	12.3	0.7	13.8	0.7	*-1.5	0.6
Maryland	11.8	0.8	16.6	0.9	13.4	0.8	13.9	0.6	14.2	0.7	15.0	0.7	-0.8	0.6
Massachusetts	10.5	0.5	10.3	0.5	12.6	0.6	11.1	0.4	10.4	0.4	11.4	0.5	*-1.1	0.4
Michigan	11.2	0.4	13.2	0.5	11.6	0.5	12.0	0.3	12.2	0.4	12.4	0.4	-0.2	0.3
Minnesota	8.0	0.6	9.3	0.7	9.2	0.7	8.8	0.4	8.7	0.5	9.2	0.5	-0.6	0.4
Mississippi	16.6	0.8	20.0	0.9	20.1	0.9	18.9	0.6	18.3	0.7	20.1	0.7	*-1.8	0.6
Missouri	8.6	0.7	10.5	0.7	12.6	0.8	10.6	0.5	9.6	0.6	11.6	0.6	*-2.0	0.5
Montana	18.6	0.9	19.6	0.9	19.5	0.9	19.2	0.6	19.1	0.7	19.5	0.7	-0.4	0.7
Nebraska	10.8	0.7	9.0	0.7	10.8	0.7	10.2	0.5	9.9	0.6	9.9	0.5	-	0.5
Nevada	20.7	0.9	21.2	0.9	17.5	0.9	19.8	0.6	20.9	0.7	19.3	0.7	*1.6	0.6
New Hampshire	10.2	0.8	11.3	0.8	11.8	0.8	11.1	0.5	10.7	0.6	11.5	0.7	-0.8	0.6
New Jersey	13.4	0.5	16.4	0.6	16.5	0.6	15.4	0.4	14.9	0.4	16.5	0.5	*-1.6	0.4
New Mexico	25.8	1.0	21.1	0.9	22.6	0.9	23.2	0.6	23.4	0.7	21.9	0.7	*1.6	0.7
New York	16.4	0.4	17.3	0.4	17.5	0.4	17.1	0.3	16.9	0.3	17.4	0.3	*-0.5	0.2
North Carolina	15.4	0.6	15.0	0.6	15.5	0.6	15.3	0.4	15.2	0.5	15.2	0.5	-0.1	0.4
North Dakota	11.8	0.8	14.2	0.8	15.2	0.8	13.7	0.5	13.0	0.6	14.7	0.7	*-1.7	0.6
Ohio	11.0	0.4	10.4	0.4	11.5	0.5	11.0	0.3	10.7	0.4	11.0	0.4	-0.2	0.3
Oklahoma	17.5	0.8	18.3	0.9	17.8	0.8	17.9	0.6	17.9	0.7	18.1	0.7	-0.2	0.6
Oregon	14.6	0.8	14.3	0.8	13.3	0.8	14.1	0.6	14.5	0.7	13.8	0.7	0.7	0.6
Pennsylvania	9.4	0.4	10.5	0.4	10.1	0.4	10.0	0.3	10.0	0.3	10.3	0.3	-0.3	0.3
Rhode Island	6.9	0.7	10.0	0.8	10.2	0.8	9.0	0.5	8.5	0.6	10.1	0.6	*-1.6	0.5
South Carolina	17.6	0.9	15.4	0.9	16.8	0.9	16.6	0.6	16.5	0.7	16.1	0.7	0.4	0.7
South Dakota	11.8	0.7	14.3	0.8	11.8	0.7	12.6	0.5	13.1	0.6	13.1	0.6	-	0.5
Tennessee	11.5	0.7	13.0	0.8	13.6	0.8	12.7	0.5	12.2	0.6	13.3	0.6	*-1.0	0.5
Texas	23.3	0.5	24.5	0.5	24.5	0.5	24.1	0.3	23.9	0.4	24.5	0.4	*-0.6	0.4
Utah	14.2	0.7	13.9	0.7	13.4	0.7	13.8	0.5	14.0	0.6	13.7	0.6	0.4	0.5
Vermont	12.3	0.8	9.9	0.8	9.5	0.8	10.6	0.5	11.1	0.6	9.7	0.6	*1.4	0.6
Virginia	14.1	0.8	14.1	0.8	12.6	0.7	13.6	0.5	14.1	0.6	13.4	0.6	0.8	0.5
Washington	15.8	0.9	12.3	0.8	11.4	0.8	13.1	0.6	14.0	0.7	11.8	0.6	*2.2	0.6
West Virginia	17.1	0.8	17.2	0.8	17.2	0.8	17.2	0.6	17.1	0.7	17.2	0.7	-0.1	0.6
Wisconsin	11.0	0.7	11.8	0.7	8.0	0.6	10.3	0.5	11.4	0.6	9.9	0.5	*1.5	0.5
Wyoming	16.1	0.9	16.9	0.9	15.5	0.8	16.2	0.6	16.5	0.7	16.2	0.7	0.3	0.6

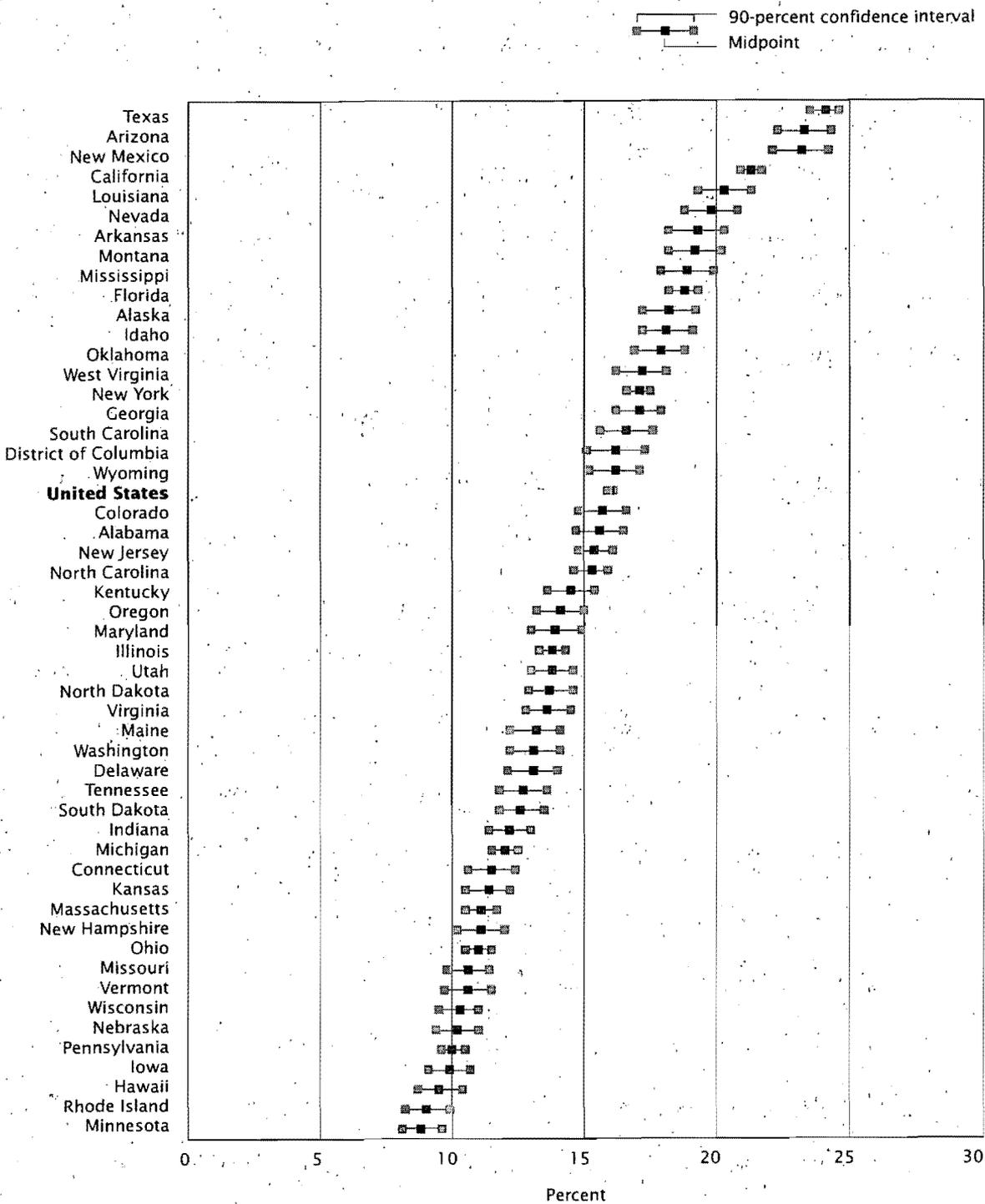
- Represents zero or rounds to zero.

*Statistically significant at the 90-percent confidence level.

Source: U.S. Census Bureau, Current Population Survey, March 1998, 1999, and 2000.

Figure 7.

Percent of People Without Health Insurance Coverage Throughout the Year by State, 3-year Average: 1997 to 1999



Source: U.S. Bureau of the Census, Current Population Survey, March 1998, 1999, and 2000.

without coverage fell in 15 states: Arizona, Arkansas, California, Connecticut, Iowa, Maine, Massachusetts, Mississippi, Missouri, New Jersey, New York, North Dakota, Rhode Island, Tennessee, and Texas. Meanwhile, the proportion of people without coverage rose in eight states: Hawaii, Illinois, Louisiana, Nevada, New Mexico, Vermont, Washington, and Wisconsin.

Accuracy of the Estimates

Statistics from surveys are subject to sampling and nonsampling error. All comparisons presented in this report take sampling error into account and meet the Census Bureau's standards for statistical significance. Nonsampling errors in surveys may be attributed to a variety of sources, such as how the survey was designed, how respondents interpret questions, how able and willing respondents are to provide correct answers, and how accurately answers are coded and classified. The Census Bureau employs quality control procedures throughout the production process – including the overall design of surveys, the wording of questions, review of the work of interviewers and coders, and statistical review of reports.

The Current Population Survey employs ratio estimation, whereby sample estimates are adjusted to independent estimates of the national population by age, race, sex, and Hispanic origin. This weighting partially corrects for bias due to undercoverage, but how it affects different variables in the survey is not precisely known. Moreover, biases may also be present when people who are missed in the survey differ from those interviewed in ways other than the categories used in weighting (age, race, sex, and Hispanic origin). All

of these considerations affect comparisons across different surveys or data sources.

For further information on statistical standards and the computation and use of standard errors, contact Jeffrey Stratton of the Demographic Statistical Methods Division on the Internet at dsmd_s&a@census.gov.

Technical Note

This report presents data on the health insurance coverage of people in the United States during the 1999 calendar year. The data, which are shown by selected demographic and socioeconomic characteristics, as well as by state, were collected in the March 2000 Supplement to the Current Population Survey (CPS).

Treatment of major federal health insurance programs

The Current Population Survey (CPS) underreports medicare and medicaid coverage compared with enrollment and participation data from the Health Care Financing Administration (HCFA).¹⁵ A major reason for the lower CPS estimates is that the CPS is not designed primarily to collect health insurance data; instead, it is largely a labor force survey. Consequently, interviewers receive less training on health insurance concepts. Additionally, many people may not be aware that they or their children are covered by a health insurance program and therefore fail to report coverage. HCFA data, on the other hand, represent the actual number of people who enrolled or participated in these programs and are a more accurate source of coverage levels.

¹⁵HCFA is the federal agency primarily responsible for administering the medicare and medicaid programs at the national level.

Changes in medicaid coverage estimates from one year to the next should be viewed with caution. Because many people who are covered by medicaid do not report that coverage, the Census Bureau assigns coverage to those who are generally regarded as "categorically eligible" (those who received some other benefits, usually public assistance payments, that make them eligible for medicaid). Since the number of people receiving public assistance has been dropping, the relationship between medicaid and public assistance has changed, so that the imputation process has introduced a downward bias in the most recent medicaid estimates.

Beginning with the publication of the 1997 Health Insurance Coverage report, the Census Bureau modified the definition of the population without health insurance in the Current Population Survey, as a result of consultation with health insurance experts. Previously, people with no coverage other than access to Indian Health Service were counted as part of the insured population. Beginning with the 1997 Health Insurance Coverage report, however, the Census Bureau counts these people as uninsured. The effect of this change on the overall estimates of health insurance coverage is negligible.

CPS sample expansion

Currently, March CPS interviews approximately 50,000 households across the country. One of its many uses is to allocate funds to states under the federal government's State Children's Health Insurance Program (SCHIP).¹⁶ Congress has appropriated additional funds to

¹⁶Data on low income uninsured children by state using the SCHIP allocation formula are available electronically on the Census Bureau's poverty website at <http://www.census.gov> or directly at <http://www.census.gov/hhes/hlthins/lowinckid.html>.

the Census Bureau to expand the CPS sample size and thus produce more reliable state estimates of the number of low-income children without health insurance (which are used in the SCHIP allocation formula). Although the legislation is specifically targeted toward producing better estimates of children's health insurance coverage at the state level, other state estimates from the March CPS will also improve. The expansion, which will be fully in effect in 2001, will roughly double the number of interviewed households in the March CPS. This doubling will be accomplished by increasing the monthly CPS sample and by administering the March supplement to additional households in February and April.

The Census Bureau plans to use data from the March 2001 CPS to evaluate the effect of the expansion on estimates from the survey. Official estimates from the March 2001 CPS, which will be released in September 2001, will be based on the original sample before the expansion. Release of data from the expanded sample will be delayed until the end of 2001, so that analysts can examine them thoroughly. If no problems are found (none are expected), the new sample cases will be fully integrated into the estimates released from the March 2002 CPS.

The Census Bureau is still working out the final details of the CPS sample expansion. A more detailed description of the expansion will be posted on the CPS Web site

(<http://www.bls.census.gov/cps/cpsmain.htm>) before the end of 2000. In the meantime, comments or suggestions should be sent to Charles Nelson, Assistant Chief, Housing and Household Economic Statistics Division, U.S. Census Bureau, by mail to Room 1071-3, Washington, DC 20233-8500, or by e-mail to charles.t.nelson@census.gov.

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Table A-1.
Health Insurance Coverage Status and Type of Coverage by Race and Ethnicity: 1987 to 1999

(Numbers in thousands. People as of March of the following year)

Year	Total people	Covered by private or government health insurance							Not covered
		Total	Private health insurance		Government health insurance				
			Total	Employment-based	Total	Medicaid	Medicare	Military health care ^a	
ALL RACES									
NUMBERS									
1999	274,087	231,533	194,599	172,023	66,176	27,890	36,066	8,530	42,554
1998	271,743	227,462	190,861	168,576	66,087	27,854	35,887	8,747	44,281
1997 ²	269,094	225,646	188,532	165,091	66,685	28,956	35,590	8,527	43,448
1996	266,792	225,077	187,395	163,221	69,000	31,451	35,227	8,712	41,716
1995	264,314	223,733	185,881	161,453	69,776	31,877	34,655	9,375	40,582
1994 ³	262,105	222,387	184,318	159,634	70,163	31,645	33,901	11,165	39,718
1993 ⁴	259,753	220,040	182,351	148,318	68,554	31,749	33,097	9,560	39,713
1992 ⁵	256,830	218,189	181,466	148,796	66,244	29,416	33,230	9,510	38,641
1991	251,447	216,003	181,375	150,077	63,882	26,880	32,907	9,820	35,445
1990	248,886	214,167	182,135	150,215	60,965	24,261	32,260	9,922	34,719
1989	246,191	212,807	183,610	151,644	57,382	21,185	31,495	9,870	33,385
1988	243,685	211,005	182,019	150,940	56,850	20,728	30,925	10,105	32,680
1987 ⁶	241,187	210,161	182,160	149,739	56,282	20,211	30,458	10,542	31,026
PERCENTS									
1999	100.0	84.5	71.0	62.8	24.1	10.2	13.2	3.1	15.5
1998	100.0	83.7	70.2	62.0	24.3	10.3	13.2	3.2	16.3
1997 ²	100.0	83.9	70.1	61.4	24.8	10.8	13.2	3.2	16.1
1996	100.0	84.4	70.2	61.2	25.9	11.8	13.2	3.3	15.6
1995	100.0	84.6	70.3	61.1	26.4	12.1	13.1	3.5	15.4
1994 ³	100.0	84.8	70.3	60.9	26.8	12.1	12.9	4.3	15.2
1993 ⁴	100.0	84.7	70.2	57.1	26.4	12.2	12.7	3.7	15.3
1992 ⁵	100.0	85.0	70.7	57.9	25.8	11.5	12.9	3.7	15.0
1991	100.0	85.9	72.1	59.7	25.4	10.7	13.1	3.9	14.1
1990	100.0	86.1	73.2	60.4	24.5	9.7	13.0	4.0	13.9
1989	100.0	86.4	74.6	61.6	23.3	8.6	12.8	4.0	13.6
1988	100.0	86.6	74.7	61.9	23.3	8.5	12.7	4.1	13.4
1987 ⁶	100.0	87.1	75.5	62.1	23.3	8.4	12.6	4.4	12.9
WHITE									
NUMBERS									
1999	224,806	192,943	166,191	145,878	52,139	18,676	31,416	6,846	31,863
1998	223,294	189,706	163,890	143,705	51,690	18,247	31,174	7,140	33,588
1997 ²	221,650	188,409	161,682	140,601	52,975	19,652	31,108	6,994	33,241
1996	220,070	188,341	161,806	139,913	54,004	20,856	30,919	6,981	31,729
1995	218,442	187,337	161,303	139,151	54,141	20,528	30,580	7,656	31,105
1994 ³	216,751	186,447	160,414	137,966	54,286	20,464	29,978	8,845	30,305
1993 ⁴	215,221	184,732	158,586	128,855	53,222	20,642	29,297	7,689	30,489
1992 ⁵	213,198	183,479	158,612	129,685	51,195	18,659	29,341	7,556	29,719
1991	210,257	183,130	159,628	131,646	49,699	17,058	28,940	7,867	27,127
1990	208,754	181,795	160,146	131,836	47,589	15,078	28,530	8,022	26,959
1989	206,983	181,126	161,363	132,882	44,868	12,779	27,859	8,116	25,857
1988	205,333	180,122	160,753	133,050	44,477	12,504	27,293	8,305	25,211
1987 ⁶	203,745	179,845	161,338	132,264	44,028	12,163	27,044	8,482	23,900
PERCENTS									
1999	100.0	85.8	73.9	64.9	23.2	8.3	14.0	3.0	14.2
1998	100.0	85.0	73.3	64.4	23.1	8.2	14.0	3.2	15.0
1997 ²	100.0	85.0	72.9	63.4	23.9	8.9	14.0	3.2	15.0
1996	100.0	85.6	73.5	63.6	24.5	9.5	14.0	3.2	14.4
1995	100.0	85.8	73.8	63.7	24.8	9.4	14.0	3.5	14.2
1994 ³	100.0	86.0	74.0	63.7	25.0	9.4	13.8	4.1	14.0
1993 ⁴	100.0	85.8	73.7	59.9	24.7	9.6	13.6	3.6	14.2
1992 ⁵	100.0	86.1	74.4	60.8	24.0	8.8	13.8	3.5	13.9
1991	100.0	87.1	75.9	62.6	23.6	8.1	13.8	3.7	12.9
1990	100.0	87.1	76.7	63.2	22.8	7.2	13.7	3.8	12.9
1989	100.0	87.5	78.0	64.2	21.7	6.2	13.5	3.9	12.5
1988	100.0	87.7	78.3	64.8	21.7	6.1	13.3	4.0	12.3
1987 ⁶	100.0	88.3	79.2	64.9	21.6	6.0	13.3	4.2	11.7

Table A-1.
Health Insurance Coverage Status and Type of Coverage by Race and Ethnicity: 1987 to 1999—Con.

(Numbers in thousands. People as of March of the following year)

Year	Total people	Covered by private or government health insurance							Not covered
		Total	Private health insurance		Government health insurance				
			Total	Employment-based	Total	Medicaid	Medicare	Military health care ¹	
BLACK NUMBERS									
1999	35,509	27,973	19,805	18,363	11,165	7,495	3,588	1,198	7,536
1998	35,070	27,274	18,663	17,132	11,524	7,903	3,703	1,111	7,797
1997 ²	34,598	27,166	18,544	17,077	11,157	7,750	3,573	1,100	7,432
1996	34,218	26,799	17,718	16,358	12,074	8,572	3,393	1,357	7,419
1995	33,889	26,781	17,106	15,683	12,465	9,184	3,316	1,171	7,108
1994 ³	33,531	26,928	17,147	15,607	12,693	9,007	3,167	1,683	6,603
1993 ⁴	33,040	26,279	16,590	13,693	12,588	9,283	3,072	1,331	6,761
1992 ⁵	32,535	25,967	15,994	13,545	12,464	9,122	3,154	1,459	6,567
1991	31,439	24,932	15,466	13,297	11,776	8,352	3,248	1,482	6,507
1990	30,895	24,802	15,957	13,560	11,150	7,809	3,106	1,402	6,093
1989	30,392	24,550	16,520	14,187	10,443	7,123	3,043	1,340	5,843
1988	29,904	24,029	15,818	13,418	10,415	7,049	3,064	1,385	5,875
1987 ⁶	29,417	23,555	15,358	13,055	10,380	7,046	2,918	1,497	5,862
PERCENTS									
1999	100.0	78.8	55.8	51.7	31.4	21.1	10.1	3.4	21.2
1998	100.0	77.8	53.2	48.9	32.9	22.5	10.6	3.2	22.2
1997 ²	100.0	78.5	53.6	49.4	32.2	22.4	10.3	3.2	21.5
1996	100.0	78.3	51.8	47.8	35.3	25.1	9.9	4.0	21.7
1995	100.0	79.0	50.5	46.3	36.8	27.1	9.8	3.5	21.0
1994 ³	100.0	80.3	51.1	46.5	37.9	26.9	9.4	5.0	19.7
1993 ⁴	100.0	79.5	50.2	41.4	38.1	28.1	9.3	4.0	20.5
1992 ⁵	100.0	79.8	49.2	41.6	38.3	28.0	9.7	4.5	20.2
1991	100.0	79.3	49.2	42.3	37.5	26.6	10.3	4.7	20.7
1990	100.0	80.3	51.6	43.9	36.1	25.3	10.1	4.5	19.7
1989	100.0	80.8	54.4	46.7	34.4	23.4	10.0	4.4	19.2
1988	100.0	80.4	52.9	44.9	34.8	23.6	10.2	4.6	19.6
1987 ⁶	100.0	80.1	52.2	44.4	35.3	24.0	9.9	5.1	19.9
HISPANIC NUMBERS									
1999	32,804	21,853	15,424	14,214	7,875	5,946	2,047	589	10,951
1998	31,689	20,493	14,377	13,310	7,401	5,585	2,026	503	11,196
1997 ²	30,773	20,239	13,751	12,790	7,718	5,970	1,974	526	10,534
1996	29,703	19,730	13,151	12,140	7,784	6,255	1,806	474	9,974
1995	28,438	18,964	12,187	11,309	8,027	6,478	1,732	516	9,474
1994 ³	27,521	18,244	11,743	10,729	7,829	6,226	1,677	630	9,277
1993 ⁴	26,646	18,235	12,021	9,981	7,873	6,328	1,613	530	8,411
1992 ⁵	25,682	17,242	11,330	9,786	7,099	5,703	1,578	523	8,441
1991	22,096	15,128	10,336	8,972	5,845	4,597	1,309	522	6,968
1990	21,437	14,479	10,281	8,948	5,169	3,912	1,269	519	6,958
1989	20,779	13,846	10,348	8,914	4,526	3,221	1,180	595	6,932
1988	20,076	13,684	10,188	8,831	4,414	3,125	1,114	594	6,391
1987 ⁶	19,428	13,456	9,845	8,490	4,482	3,214	1,029	631	5,972
PERCENTS									
1999	100.0	66.6	47.0	43.3	24.0	18.1	6.2	1.8	33.4
1998	100.0	64.7	45.4	42.0	23.4	17.6	6.4	1.6	35.3
1997 ²	100.0	65.8	44.7	41.6	25.1	19.4	6.4	1.7	34.2
1996	100.0	66.4	44.3	40.9	26.2	21.1	6.1	1.6	33.6
1995	100.0	66.7	42.9	39.8	28.2	22.8	6.1	1.8	33.3
1994 ³	100.0	66.3	42.7	39.0	28.4	22.6	6.1	2.3	33.7
1993 ⁴	100.0	68.4	45.1	37.5	29.5	23.7	6.1	2.0	31.6
1992 ⁵	100.0	67.1	44.1	38.1	27.6	22.2	6.1	2.0	32.9
1991	100.0	68.5	46.8	40.6	26.5	20.8	5.9	2.4	31.5
1990	100.0	67.5	48.0	41.7	24.1	18.2	5.9	2.4	32.5
1989	100.0	66.6	49.8	42.9	21.8	15.5	5.7	2.9	33.4
1988	100.0	68.2	50.7	44.0	22.0	15.6	5.5	3.0	31.8
1987 ⁶	100.0	69.3	50.7	43.7	23.1	16.5	5.3	3.2	30.7

¹Includes CHAMPUS (Comprehensive Health and Medical Plan for Uniformed Services) / Tricare, Veterans', and military health care. ²Beginning with the March 1998 CPS, people with no coverage other than access to Indian Health Service are no longer considered covered by health insurance; instead, they are considered to be uninsured. The effect of this change on the overall estimates of health insurance coverage is negligible; however, the decrease in the number of people covered by Medicaid may be partially due to this change.

³Health insurance questions were redesigned. Increases in estimates of employment-based and military health care coverage may be partially due to questionnaire changes. Overall coverage estimates were not affected. ⁴Data collection method changed from paper and pencil to computer-assisted interviewing. ⁵Implementation of 1990 census population controls. ⁶Implementation of a new March CPS processing system.

Source: U.S. Census Bureau, Current Population Survey, March 1988-2000.

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