

*- Ann W. ...*

*Paul Fowler  
ERRE*

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*(ML)*



**FAX TRANSMISSION**  
**THE HENRY J. KAISER FAMILY FOUNDATION**  
2400 Sand Hill Road  
Menlo Park, CA 94025  
650/854-9400  
Fax: 650/854-7465

TO: Chris Jones  
FAX #: 456-5557  
FROM: Lay Lentz  
DATE: \_\_\_\_\_ # PAGES: \_\_\_\_\_

*John Houlton - Urban - CHIP*

*Done* *Fee*

*(617) 496-5407*  
*(202) 297-1590*

KIDS

Government health insurance

State/year	Medicaid		Medicare		Military health care /1		Not covered	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
United States:								
1999.....	14,479	20.0	355	0.5	2,080	2.9	10,023	13.9
1998.....	14,274	19.8	325	0.5	2,240	3.1	11,073	15.4
1997 2/.....	14,683	20.5	395	0.6	2,163	3.0	10,743	15.0
1996.....	15,502	21.8	484	0.7	2,291	3.2	10,554	14.8
1995.....	16,524	23.2	348	0.5	2,336	3.3	9,795	13.8
1994 3/.....	16,132	22.9	228	0.3	2,708	3.8	10,003	14.2
1993 4/.....	16,693	23.9	48	0.1	2,307	3.3	9,574	13.7
1992 5/.....	15,109	22.0	97	0.1	2,378	3.5	8,716	12.7
1991.....	13,514	20.4	52	0.1	2,425	3.7	8,379	12.7
1990.....	12,094	18.5	88	0.1	2,408	3.7	8,504	13.0
1989.....	10,100	15.7	43	0.1	2,425	3.8	8,548	13.3
1988.....	9,961	15.6	62	0.1	2,469	3.9	8,350	13.1
1987 6/.....	9,681	15.2	53	0.1	2,567	4.0	8,193	12.9
Texas:								
1999.....	1,005	18.1	23	0.4	118	2.1	1,343	24.1
1998.....	1,083	18.9	7	0.1	110	1.9	1,453	25.4
1997 2/.....	1,253	21.2	52	0.9	107	1.8	1,468	24.9
1996.....	1,139	20.4	68	1.2	176	3.2	1,367	24.5
1995.....	1,297	23.6	28	0.5	140	2.5	1,234	22.4
1994 3/.....	1,370	23.7	9	0.2	135	2.3	1,389	24.0
1993 4/.....	1,229	23.0	-	-	253	4.7	1,159	21.7

1992 5/.....	1,129	22.1	4	0.1	211	4.1	1,046	20.4
1991.....	844	17.6	-	-	198	4.1	1,098	22.9
1990.....	750	15.5	6	0.1	230	4.8	1,003	20.8
1989.....	636	12.7	7	0.1	247	4.9	1,202	24.0
1988.....	570	11.2	1	-	237	4.6	1,366	26.7
1987 6/.....	582	11.6	-	-	281	5.6	1,209	24.1

ALL PERSONS

Government health insurance

State/year	Medicaid		Medicare		Military health care /1		Not covered	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
<b>United States:</b>								
1999.....	27,890	10.2	36,066	13.2	8,530	3.1	42,554	15.5
1998.....	27,854	10.3	35,887	13.2	8,747	3.2	44,281	16.3
1997 2/.....	28,956	10.8	35,590	13.2	8,527	3.2	43,448	16.1
1996.....	31,451	11.8	35,227	13.2	8,712	3.3	41,716	15.6
1995.....	31,877	12.1	34,655	13.1	9,375	3.5	40,582	15.4
1994 3/.....	31,645	12.1	33,901	12.9	11,165	4.3	39,718	15.2
1993 4/.....	31,749	12.2	33,097	12.7	9,560	3.7	39,713	15.3
1992 5/.....	29,416	11.5	33,230	12.9	9,510	3.7	38,641	15.0
1991.....	26,880	10.7	32,907	13.1	9,820	3.9	35,445	14.1
1990.....	24,261	9.7	32,260	13.0	9,922	4.0	34,719	13.9
1989.....	21,185	8.6	31,495	12.8	9,870	4.0	33,385	13.6
1988.....	20,728	8.5	30,925	12.7	10,105	4.1	32,680	13.4
1987 6/.....	20,211	8.4	30,458	12.6	10,542	4.4	31,026	12.9
<b>Texas:</b>								
1999.....	1,887	9.4	2,287	11.4	576	2.9	4,665	23.3
1998.....	1,895	9.5	2,070	10.4	591	3.0	4,880	24.5
1997 2/.....	2,128	10.8	2,053	10.4	482	2.4	4,835	24.5
1996.....	2,184	11.4	2,020	10.5	652	3.4	4,680	24.3
1995.....	2,142	11.4	1,960	10.4	637	3.4	4,614	24.5
1994 3/.....	2,286	12.1	1,911	10.1	760	4.0	4,579	24.2
1993 4/.....	2,170	11.9	1,969	10.8	929	5.1	3,980	21.8

1992 5/.....	1,993	11.1	1,940	10.8	837	4.7	4,144	23.1
1991.....	1,540	9.1	1,877	11.0	849	5.0	3,755	22.1
1990.....	1,291	7.6	1,681	10.0	853	5.1	3,569	21.1
1989.....	1,178	7.0	1,673	9.9	941	5.6	3,770	22.3
1988.....	1,112	6.7	1,572	9.4	936	5.6	3,958	23.7
1987 6/.....	1,081	6.5	1,596	9.6	1,070	6.4	3,509	21.1

Gene Sperling

THE KAISER COMMISSION ON  
**Medicaid and the Uninsured**

# Memo

**To:** Chris Jennings and Jeanne Lambrew

**From:** Diane Rowland

**Date:** 10/12/00

**Re:** Data on Health Care in Texas

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FYI, here is our data on health coverage in Texas versus the U.S. This packet includes:

- Estimates of the **uninsured** (number and rate) in the U.S. and Texas for nonelderly, adults only, and low-income/higher-income children;
- **Medicaid enrollment** data for the U.S. and Texas from June 1997 to December 1999, as well as some facts on the Medicaid enrollment process in Texas; we also included a state-by-state table with Medicaid enrollment data;
- Four slides on **SCHIP enrollment** in Texas, New York, California, and Florida.

Give me a call if you have any questions about the data.

Hope the information is helpful—

## Urban Institute Estimates of the Uninsured:

Uninsured Adults and Children in Texas and the U.S., 1994-1999					
	Texas		United States		Texas National Rank of Percent Uninsured
	(millions)	%	(millions)	%	
<b>1994</b>					
<b>Nonelderly</b>	<b>4.53</b>	<b>26.5</b>	<b>39.75</b>	<b>17.3</b>	<b>2nd (NM, TX)</b>
Children <200% FPL	1.17	36.7	7.62	22.8	
Children 200%+ FPL	0.27	9.8	3.08	7.6	
All Adults	3.10	27.8	29.05	18.8	
<b>1995</b>					
<b>Nonelderly</b>	<b>4.58</b>	<b>27.0</b>	<b>40.56</b>	<b>17.5</b>	<b>2nd (NM, TX)</b>
Children <200% FPL	1.02	35.0	7.63	22.9	
Children 200%+ FPL	0.32	11.4	2.98	7.2	
All Adults	3.24	28.9	29.95	19.1	
<b>1996</b>					
<b>Nonelderly</b>	<b>4.65</b>	<b>26.7</b>	<b>41.87</b>	<b>17.8</b>	<b>3rd (AZ, NM, TX)</b>
Children <200% FPL	1.13	37.3	8.25	24.8	
Children 200%+ FPL	0.33	11.6	3.16	7.6	
All Adults	3.20	27.7	30.25	19.0	
<b>1997</b>					
<b>Nonelderly</b>	<b>4.78</b>	<b>25.7</b>	<b>43.11</b>	<b>18.3</b>	<b>3rd (AR, AZ, TX)</b>
Children <200% FPL	1.13	35.1	8.02	24.9	
Children 200%+ FPL	0.43	14.4	3.57	8.2	
All Adults	3.23	27.5	31.53	19.6	
<b>1998</b>					
<b>Nonelderly</b>	<b>4.86</b>	<b>27.0</b>	<b>43.92</b>	<b>18.4</b>	<b>2nd (AZ, TX)</b>
Children <200% FPL	1.18	39.1	8.06	25.7	
Children 200%+ FPL	0.39	12.9	3.81	8.5	
All Adults	3.29	27.5	32.05	19.7	
<b>1999</b>					
<b>Nonelderly</b>	<b>4.63</b>	<b>25.8</b>	<b>42.13</b>	<b>17.5</b>	<b>2nd (NM, TX)</b>
Children <200% FPL	1.00	36.1	7.11	23.2	
Children 200%+ FPL	0.43	14.2	3.68	8.1	
All Adults	3.20	26.3	31.34	19.1	

Source: Urban Institute analyses using the March Current Population Survey, 1995-2000, prepared for the Kaiser Commission on Medicaid and the Uninsured.

Notes: Excludes active military members. For all years, persons with Indian Health Services as their only source of health insurance are considered uninsured.

## Medicaid and Texas

### Monthly Medicaid Enrollment

	United States (millions)	Texas (millions)
June 1997	31.27	1.944
December 1997	30.83	1.893
December 1998	30.89	1.825
December 1999	31.99	1.797
<i>Change from June 1997 to December 1999</i>	<i>+ 1.1 (+2.3%)</i>	<i>-0.147 (-7.6%)</i>

SOURCE: Compiled by Health Management Associates from state Medicaid enrollment reports.

- From Dec 98 to Dec 99, only 8 states had a decline in Medicaid enrollment:
 

Arkansas (-4%)	New York (-1%)
Georgia (-4%)	Pennsylvania (-0.7%)
Iowa (-.02%)	Texas (-1.6%)
Montana (-2%)	West Virginia (-2.5%)
- Texas has many barriers to Medicaid enrollment:
  - 1 of 4 states with no joint CHIP/Medicaid application
  - 1 of 11 states that requires a face-to-face interview for Medicaid (not required for CHIP)
  - 1 of 9 states that has asset test for children under Medicaid (not required for CHIP)
  - 1 of 12 states that requires re-determination for Medicaid more than one time per year

**Total Medicaid Enrollment in 50 States and the District of Columbia**  
**June 1997 to December 1999**

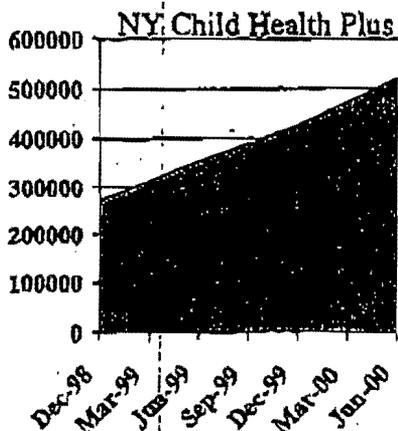
State	Monthly Enrollment in Thousands				Percent Change			
	Jun-97	Dec-97	Dec-98	Dec-99	June 97 to Dec 99	Dec 97 to Dec 98	Dec 98 to Dec 99	June 97 to Dec 99
Alabama	497.4	491.5	511.5	530.0	32.8	4.1%	3.6%	6.6%
Alaska	62.2	60.0	63.9	76.4	14.2	6.4%	19.6%	22.8%
Arizona	397.3	385.1	372.9	407.4	10.1	-3.2%	8.3%	2.5%
Arkansas	297.9	321.2	370.5	355.8	57.7	15.4%	-4.0%	19.4%
California	5,176.5	4,988.7	4,987.9	5,033.0	(145.4)	0.4%	0.8%	-2.8%
Colorado	259.5	253.1	246.1	258.8	(0.7)	-2.8%	5.2%	-0.3%
Connecticut	310.4	307.0	315.3	324.8	14.4	2.7%	3.0%	4.6%
DC	133.1	131.7	131.3	142.0	8.9	-0.3%	8.1%	6.7%
Delaware	75.9	76.4	82.2	89.5	13.6	7.6%	8.8%	18.0%
Florida	1,454.9	1,460.0	1,465.0	1,597.8	142.7	0.3%	9.1%	9.8%
Georgia	946.6	941.4	942.5	904.4	(42.2)	0.1%	-4.0%	-4.5%
Hawaii	161.0	160.7	151.8	152.5	(8.6)	-5.6%	0.6%	-5.3%
Idaho	86.8	86.7	86.1	93.0	6.2	-0.7%	8.0%	7.1%
Illinois	1,305.0	1,290.3	1,233.8	1,292.3	(12.7)	-4.4%	4.7%	-1.0%
Indiana	490.8	495.1	520.3	582.7	91.9	5.1%	12.0%	18.7%
Iowa	213.7	210.7	201.1	201.0	(12.7)	-4.6%	-0.02%	-5.9%
Kansas	183.1	175.7	187.8	188.9	5.7	-4.6%	12.7%	3.1%
Kentucky	528.8	519.0	511.0	525.4	(1.3)	-1.5%	2.8%	-0.2%
Louisiana	541.7	537.8	538.3	621.4	79.8	-0.3%	15.9%	14.7%
Maine	155.3	151.0	159.9	166.5	11.3	5.9%	4.1%	7.2%
Maryland	461.7	446.7	465.3	574.1	112.4	4.2%	23.4%	24.3%
Massachusetts	687.0	747.5	656.8	910.5	223.5	14.6%	6.3%	32.5%
Michigan	1,103.1	1,081.9	1,052.9	1,081.9	(41.3)	-2.7%	0.9%	-3.7%
Minnesota	456.2	436.1	420.9	439.7	(18.5)	-3.5%	4.5%	-4.0%
Mississippi	409.3	392.9	396.1	427.1	17.8	0.8%	7.8%	4.3%
Missouri	589.7	572.9	600.8	721.9	152.2	4.8%	20.2%	26.7%
Montana	74.0	72.8	72.7	71.3	(2.7)	0.0%	-2.0%	-3.7%
Nebraska	148.9	151.2	168.1	180.6	31.7	11.2%	7.4%	21.3%
Nevada	92.9	97.5	99.5	101.1	8.2	2.0%	1.7%	8.8%
New Hampshire	80.3	78.4	78.0	82.1	1.8	-0.5%	5.3%	2.3%
New Jersey	665.2	658.7	674.6	690.7	25.5	2.4%	2.4%	3.8%
New Mexico	255.6	249.7	275.0	298.2	42.6	10.1%	8.4%	16.7%
New York	2,918.7	2,858.7	2,746.5	2,719.9	(188.7)	-3.9%	-1.0%	-6.8%
North Carolina	828.5	822.0	814.7	848.0	19.5	-0.9%	4.1%	2.4%
North Dakota	45.3	42.7	42.4	42.9	(2.4)	-0.7%	1.1%	-5.3%
Ohio	1,107.8	1,080.8	1,082.8	1,071.6	(36.2)	0.2%	0.8%	-3.3%
Oklahoma	282.5	291.3	318.8	393.1	110.6	9.4%	23.3%	39.1%
Oregon	379.7	373.8	379.7	385.7	6.0	1.6%	1.6%	1.6%
Pennsylvania	1,475.2	1,449.4	1,408.1	1,396.8	(78.4)	-3.0%	-0.7%	-5.3%
Rhode Island	124.0	125.0	127.0	146.0	22.0	1.6%	15.0%	17.7%
South Carolina	393.6	414.9	471.8	517.4	123.8	13.7%	9.7%	31.5%
South Dakota	60.3	60.3	65.3	70.0	9.7	8.3%	7.3%	16.1%
Tennessee	1,188.6	1,231.1	1,288.8	1,315.9	127.2	4.7%	2.1%	10.7%
Texas	1,944.1	1,892.7	1,825.0	1,798.8	(147.5)	-3.6%	-1.6%	-7.6%
Utah	133.9	133.2	133.5	133.6	(0.4)	0.2%	0.1%	-0.3%
Vermont	85.1	85.4	85.1	88.8	4.7	-0.4%	5.5%	5.5%
Virginia	522.1	505.5	492.4	492.5	(29.5)	-2.6%	0.0%	-5.7%
Washington	732.0	724.3	710.6	727.7	(4.3)	-1.9%	2.4%	-0.6%
West Virginia	300.3	303.2	270.4	283.8	(36.5)	-10.8%	-2.5%	-12.1%
Wisconsin	435.5	412.8	394.3	437.9	2.5	-4.5%	11.1%	0.6%
Wyoming	32.8	33.1	33.0	33.2	0.5	-0.5%	0.7%	1.4%
<b>Total</b>	<b>31,273.7</b>	<b>30,829.3</b>	<b>30,885.8</b>	<b>31,985.1</b>	<b>711.4</b>	<b>0.2%</b>	<b>3.6%</b>	<b>2.3%</b>

SOURCE: Compiled by Health Management Associates from State Medicaid enrollment reports.

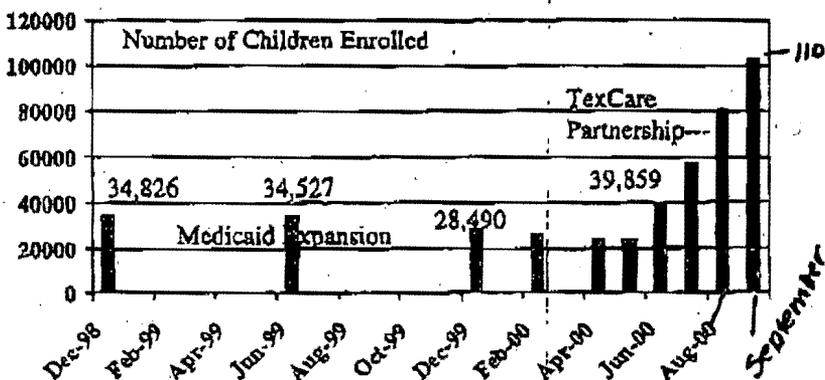
SCHIP Enrollment - latest monthly count

### New York SCHIP Enrollment Dec 1998 to June 2000

- Separate State CHIP program : "Child Health Plus"
- Enrollment up from 270,683 in Dec '98  
425,522 in Dec '99  
522,058 in June '00  
539,469 in July '00



### Texas SCHIP Enrollment\* Dec. 1998 to Sept. 2000

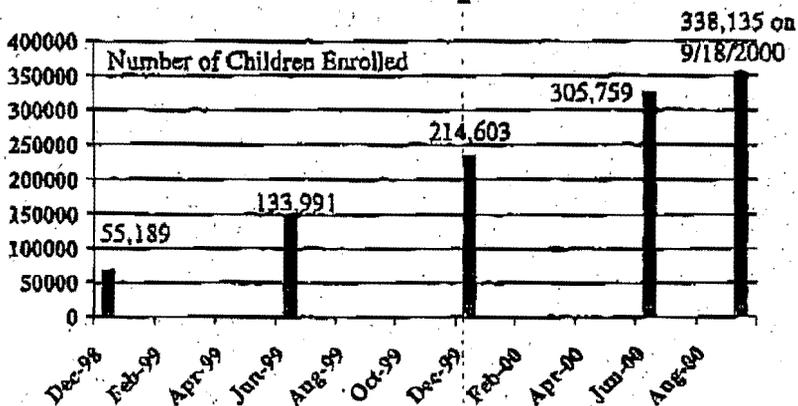


110,000 → 100,000 kids

\*Medicaid Expansion began 7/98 for 15-19 year olds to 100% FPL.  
Separate program began 5/2000 for 0-19 year olds to 200% FPL.  
Source: TexCare Partnership and Texas Medicaid, Sept., 2000. Medicaid expansion enrollment for 8/00 and 9/00 estimated by HMA.

## California SCHIP Enrollment\*

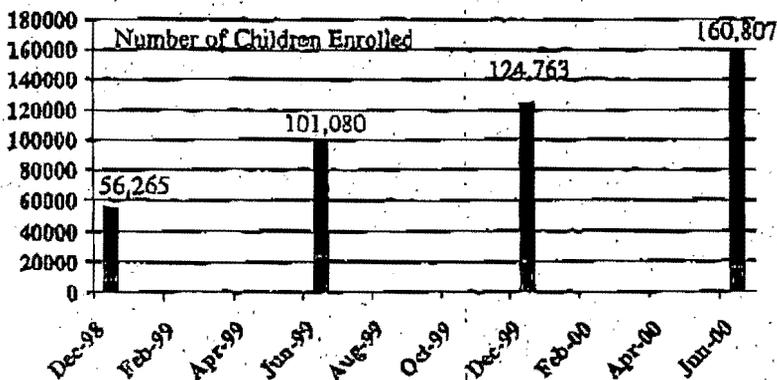
### Dec. 1998 to Sept. 2000



\*Medicaid Expansion began 3/98 for 15-19 year olds to 100% FPL.  
 Separate program began 7/1998 for 0-19 year olds to 250% FPL.  
 Source: MRMIIB and MediCal, Sept., 2000.

## Florida SCHIP Enrollment\*

### Dec. 1998 to Sept. 2000



\*Medicaid expansion and separate programs began April 1998.  
 Expansion covered 15-19 year olds to 100% FPL. Separate program covers 0-19 year olds to 200% FPL.  
 Source: FL Agency for Health Care Administration

Number      Percent  
(in thousands)

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United States:

1999.....	42,554	15.5
1998.....	44,281	16.3
1997 2/.....	43,448	16.1
1996.....	41,716	15.6
1995.....	40,582	15.4
1994 3/.....	39,718	15.2
1993 4/.....	39,713	15.3
1992 5/.....	38,641	15.0
1991.....	35,445	14.1
1990.....	34,719	13.9
1989.....	33,385	13.6
1988.....	32,680	13.4
1987 6/.....	31,026	12.9

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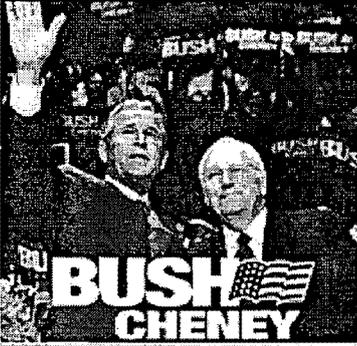
Texas:

1999.....	4,665	23.3
1998.....	4,880	24.5
1997 2/.....	4,835	24.5
1996.....	4,680	24.3
1995.....	4,614	24.5
1994 3/.....	4,579	24.2
1993 4/.....	3,980	21.8
1992 5/.....	4,144	23.1
1991.....	3,755	22.1
1990.....	3,569	21.1
1989.....	3,770	22.3
1988.....	3,958	23.7
1987 6/.....	3,509	21.1

1.2

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Issues

## Health Care and the Uninsured

There are 43 million uninsured Americans – 4 million more than when the current Administration took office. Governor Bush will reverse this trend by making health insurance affordable for hard-working, low-income families. His plan will provide them with a \$2,000 refundable health credit so that they can choose health plans and physicians that fit their needs. He will also make it easier for small businesses, which employ 60 percent of the uninsured, to obtain lower cost insurance through associations. Finally, Governor Bush will remove federal regulations that restrict state flexibility in designing and implementing programs for the uninsured. Governor Bush will put the consumer, not the government, in charge of health care decisions.

### Governor Bush's Approach

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**Make Health Insurance Affordable:** Families caught between poverty and prosperity make up the largest segment of the uninsured. In fact, 80 percent of the uninsured are working Americans or their dependents. This number is driving the dramatic increase in the uninsured since 1993. Governor Bush believes these families should have the opportunity to purchase a health plan of their own – a basic plan that includes hospitalization and physician benefits, and a discounted prescription drug.

**Help Small Businesses:** Almost 60 percent of all workers without health insurance are employed by small businesses. The high price these businesses must pay for health insurance is often passed on to their employees, who, in turn, cannot afford the coverage. Since the road to the middle class is often through employment with small businesses, which provide 65 percent of workers with their first job, Governor Bush is committed to making health insurance more affordable for these businesses and their employees.

**Remove Regulatory Barriers for the States:** The 1997 State Children's Health Insurance Program (S-CHIP) was intended to be a flexible block grant program, designed to allow states to expand Medicaid and/or develop new private sector programs to cover the 7.2 million uninsured children in families with incomes under 200 percent of the poverty level. However, federal regulations have limited states' ability to innovate. Governor Bush will lift these restrictions so that states can develop 21st century health care delivery systems.

**Empower Individuals:** Governor Bush believes that people should have every opportunity to manage more of their own health care needs. He will empower individuals with greater freedom of choice by lifting the artificial restrictions on Health Flexible Savings Accounts and Medical Savings Accounts.

### Governor Bush's Proposals

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To help individuals and families afford quality health care, Governor Bush will:

Offer a Refundable Health Credit: Families that don't qualify for

Medicaid and other government assistance and who don't get insurance through their employer, will be offered a \$2,000 health credit (\$1000 for individuals) to assist in purchasing a basic health insurance plan. Those most in need will receive the most help:

For example, if a family earning \$30,000 purchases a health insurance plan costing \$2,222, the government will contribute \$2,000 (90 percent), and the family will pay just \$18.50 per month (\$222 annually, or 10 percent).

If a family earning \$50,000 purchases the same \$2,222 health plan, the government's contribution will be \$667, and the family's contribution will be \$129 a month (\$1,555 annually, or 70 percent).

**Permit Small Businesses to Purchase Association Health Plans:** In order to make health insurance more affordable for small businesses, Governor Bush supports allowing these companies to purchase health plans from multi-state trade associations, such as the Chamber of Commerce, so that they can enjoy the same economies of scale that large employers have and realize the significant savings that group purchasing brings.

**Strengthen S-CHIP:** Governor Bush supports lifting restrictions on state flexibility so that States have the freedom to implement creative solutions for expanded coverage of the uninsured under S-CHIP. His Administration will work in partnership with states – not act as a roadblock – to state innovation.

**Empower Individuals with Greater Freedom of Choice:** Governor Bush supports expanding and reforming two innovative health care options for individuals: Medical Savings Accounts and Flexible Savings Accounts. By removing many of the structural design flaws and tax disincentives, individuals will have greater freedom of choice and be empowered to make their own health care choices.

### **Texas Record**

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**Expanded Access to Health Insurance for Children**  
Governor Bush signed legislation to create the Children's Health Insurance Program as well as an optional, parallel program for immigrant children. These two programs will ensure that 423,000 Texas children will receive health insurance.

**Directed Additional Funding for Health Care Programs**  
In 1999, Governor Bush directed an additional \$1.8 billion dollars to health care initiatives in Texas. This is in addition to the over \$4 billion that is already spent on health care for the uninsured.

**Created endowments for public health initiatives, including:**  
Tobacco education programs aimed at teaching children and young adults about the risks associated with tobacco use, and funding for enforcement activities aimed at restricting youth access to tobacco. Emergency medical services and trauma care, including funds that support the Texas' Community and Hospital based system, which ensures that no Texan goes without health care.

**Led the nation in adopting a strong Patients' Bill of Rights including:**  
Allowing patients to appeal HMO decisions to an independent review panel and in some cases sue their HMO if they are hurt by a health care treatment decision.  
Giving women direct access to their obstetricians and gynecologists and ensuring women will be covered for a minimum of 48-hours in the hospital after childbirth.  
Requiring health plans that cover mastectomy or related procedures to allow patients 48 hours inpatient care following a mastectomy and coverage for reconstructive surgery after a mastectomy.  
Ensuring doctor choice by giving employees the right to choose their own doctor, even outside their health plan, so long as they are willing

[REDACTED] to pay additional costs of that coverage.

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- **Expand health insurance options for Americans facing unique barriers to coverage.** Some vulnerable groups of Americans lack access to employer-sponsored insurance and insurance programs like Medicare or Medicaid. This proposal: restores state options to provide Medicaid and S-CHIP coverage to pregnant women, and children; expands state options to insure children aged 19 and 20 through Medicaid and S-CHIP; establishes a Medicare buy-in option for vulnerable persons age 55-65 and makes it more affordable through a tax credit equal to 25 percent of their Medicare premiums; provides a 25 percent tax credit to make COBRA continuation coverage more affordable for workers in between jobs; improves access to affordable insurance by providing tax incentives and technical assistance to establish voluntary purchasing coalitions for workers in small businesses; and extends the transitional Medicaid program for people leaving welfare for work.

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Revised Final 9/29/00 9:15 a.m.

John Pollack

**PRESIDENT WILLIAM JEFFERSON CLINTON  
STATEMENT ON  
RECORD GAIN FOR CHILDREN'S HEALTH INSURANCE  
THE WHITE HOUSE  
September 29, 2000**

Good morning. Thank-you, Deborah Bredbenner (BREAD-benner), for sharing your story with us. Your experience echoes that of too many American families, and highlights the pressing need for Congress to expand access to quality, affordable health care. This is just one of many issues that Congress is overdue in addressing.

Just a few minutes ago, I signed the Continuing Resolution which Congress sent to me yesterday. This stop-gap funding measure will keep the government running for now, but I hope Congress will get down to business and pass the remaining appropriations bills. September has come and gone, and the American people are still waiting for Congress to fulfill its obligations. These kids behind me have been back in school for a month, but Congress still hasn't turned in its first assignment – insuring that schools have the resources they need to meet the high standards we expect. The time for tardiness is over; let's see some progress.

Sadly, Deborah's story is all too common. Millions of people like her get up every day, go to work and play by the rules, but still have a tough time finding affordable health insurance. That's why Secretary Shalala, Hillary and I have been working so hard to make sure that families can get the care they need.

Yesterday we got more evidence that our step-by-step approach is working. The census data shows that the number of uninsured Americans fell by 1.7 million in 1999, the first major drop in a dozen years. This is a dramatic turnaround, one that signals a new beginning for American families seeking quality, affordable health care.

I am particularly pleased that nearly two thirds of these newly insured are children – like many of those with us here this morning. Today I am proud to announce that, since I signed CHIP into law, we have enabled 2.5 million children to get insurance through this program.

Vice President Gore has proposed a Family Care initiative, which would expand CHIP to cover the parents of eligible children. If we do this, we can cover nearly a quarter of all uninsured people in America.

Parents like Deborah and Chris Bredbenner know what a difference health insurance can make. Not just in emergencies, but for routine care. Consider the child who doesn't get treated for an ear infection, who might suffer permanent hearing loss. If they can't hear, they might have a harder time in school. Or consider the toll of untreated asthma, which will cause American students to miss 10 million school days this year alone.

That's why we need to keep pushing forward until all our children are covered. To help accomplish this, the Department of Health and Human Services is awarding \$700,000 in grants today, to develop new and even more effective ways to identify and enroll uninsured children. These grants will be used not only to get kids enrolled, but keep them enrolled, so that they can get the care they need.

These grants will build on our recent success in improving outreach and enrollment around the country. If you look at how states are doing with CHIP, you'll see that those with the best outreach programs had the most success in boosting the number of people covered. States like Indiana, Ohio and Maine have done a great job, and I hope other states will look to them for leadership. I also hope that every working parent searching for children's health insurance will call the toll-free number on these kids' t-shirts: 1-877-KIDS-NOW.

We need to remember that the rising number of uninsured isn't a problem that developed overnight, and that it won't disappear overnight, either. In some ways, it reminds me of the challenges we faced with the deficit when Vice President Gore and I took office in 1992. Some people told us there was nothing we could do to stem the rising tide of red ink. In fact, the numbers on that national debt clock in New York were flashing by so fast that people's eyes were glazing over.

But we saw a better way. We made the tough choices, cut spending, and invested in the American people. Together, we turned the tide. And today, as this fiscal year comes to a close, we're posting the biggest surplus in American history – \$230 billion – and paying off another \$223 billion in national debt.

This economic turnaround didn't just happen by chance; it happened by choice. And that's what we're seeing with this new turnaround in health care coverage – smart choices starting to pay off. So let's keep moving in the right direction, and take the following steps.

First, Congress should act this fall to enable hundreds of thousands of people between the ages of 55 and 65 to buy into Medicare. These are the Americans who have the most difficulty finding affordable health insurance, and this group is only going to get bigger as the Baby Boomers age.

Second, Congress should pass our proposed tax credit for small businesses, which would strengthen their hand in negotiating quality, affordable health insurance options for their employees.

Third, Congress should restore Medicaid benefits to the most vulnerable of America's legal immigrants, including children. A few days ago, the House Commerce Committee voted to pass this important measure. Surely we can work together to restore these people's benefits, and do it this year.

Finally, America is still waiting for Congress to pass a Medicare prescription drug benefit, our \$3,000 tax credit for long-term care, and a strong Patients' Bill of Rights. It's high

time for Congress to put progress before partisanship, and finally vote on these commonsense proposals.

By any measure, we are living in extraordinary times. But we still have work to do. Step by step, we need to build on the success we celebrate today. If we tackle these challenges together – and I know we can – every American family can look forward to getting the health care they need, and enjoying the peace of mind they deserve.

Thank you.

## STATEMENT BY DEBORAH BREDBENNER

Thank you, Secretary Shalala.

Good morning, Mr. President and other distinguished guests.

I am here to share my story with you so that you will understand how important health insurance coverage is to me and my children – and to millions of families across the country just like mine.

Mr. President, I know that thanks to your leadership, my family is a lot luckier than most – because of the CHIP program, we have insurance for our kids. The most important thing to me as a working mother is to make sure my children have health insurance. My children have been enrolled in the Maryland CHIP program for two years now, and I want to tell you: this program has been a blessing to our family.

Bryant, my son, has asthma. He uses inhalers and sees the doctor regularly. Without careful monitoring, his asthma attacks could spiral out of control. Because of the CHIP program, we can afford the medication he needs – without going broke.

My daughter Melissa is a pretty healthy toddler – but she needs to see her pediatrician regularly, just like every other child. Because of the Maryland CHIP program, she gets the preventive care she needs to stay healthy. And I know that if she were ever to get sick, we'd be able to afford to take her to the doctor.

Recently, we had a scare. The doctors thought that Bryant had viral meningitis. Thankfully, he's okay, but he was in and out of the hospital for three days. And thanks to the CHIP program, all I had to worry about during those three days was his health – not how we would pay for his care.

Mr. President, you know how it is being a parent – you care more about your kids than you do your own self. And if I had to choose between having health insurance for them or for me, I'd choose them every time.

Frankly, we can't afford to purchase health insurance for me. I wanted to sign up through my job, but over half of my paycheck would have gone for the premiums for the first three months, and then, a third of my check each month after that. Mr. President, my husband and I are trying to support two children. We can't afford to lose a third of my paycheck each month – so I don't have health insurance.

I'm very fortunate to have good health, and I don't need to see the doctor often. But because I don't have insurance, I haven't been able to the doctor for my regular checkups. Recently, I had to go to the doctor for an attack of bronchitis, and I had to pay out of pocket. And I thought, what would happen if I got really sick? It would devastate my family financially. All I can do is hope that I don't get sick.

Mr. President, I've worked all my life, and I want to be clear that I don't want a handout. It would be a big relief if I had access to health insurance because I know that then, I would be able to be there for my family. And I know that every day you're in office, you're working to help with that.

And now, it is my honor to introduce someone who has fought harder than anyone else to ensure that America's families have access to affordable, high quality health insurance – the President of the United States, William Jefferson Clinton.

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# Health Insurance Coverage

# 1999

Issued September 2000

## Consumer Income

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.

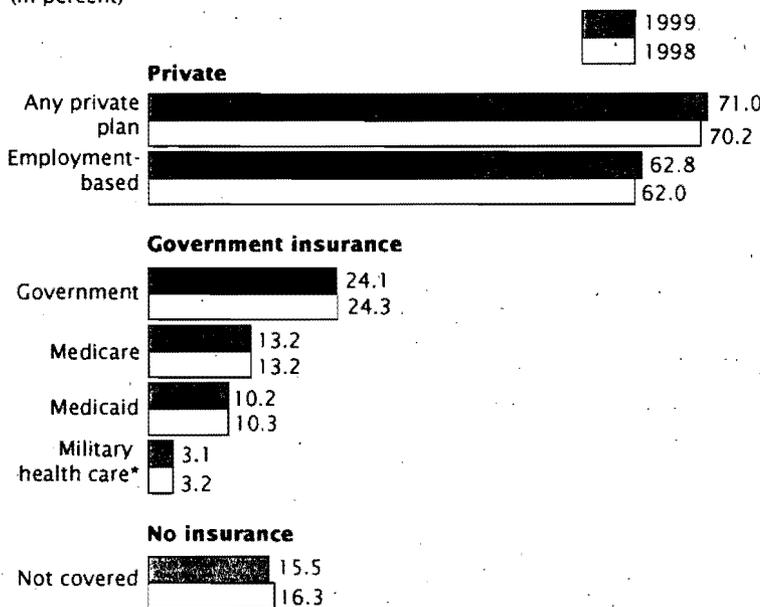
### Other highlights:<sup>2</sup>

- 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

<sup>2</sup>Confidence 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.<sup>1</sup>

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.

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



**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.(±)
<b>Total</b>				
Number (in thousands).....	42,554	462	44,281	458
Percent .....	15.5	0.2	16.3	0.2
<b>Total Poor</b>				
Number (in thousands).....	10,436	531	11,151	548
Percent .....	32.4	1.4	32.3	1.3
<b>Race and Ethnicity</b>				
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 <sup>1</sup> .....	33.4	0.6	35.3	0.6
<b>Age</b>				
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
<b>Nativity</b>				
Native .....	13.5	0.2	14.4	0.2
Foreign born.....	33.4	0.8	34.1	0.8
<b>Household Income</b>				
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
<b>Work Experience (people 18 to 64 years)</b>				
Worked during year.....	17.4	0.3	18.0	0.3
Did not work.....	26.5	0.7	27.0	0.7

<sup>1</sup>Hispanics 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.<sup>3</sup> 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).

<sup>3</sup>Hispanics may be of any race.

- 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).<sup>4</sup>

<sup>4</sup>The 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.<sup>5</sup>**

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-

<sup>5</sup>Employment-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.<sup>6</sup>

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.

<sup>6</sup>Changes 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).

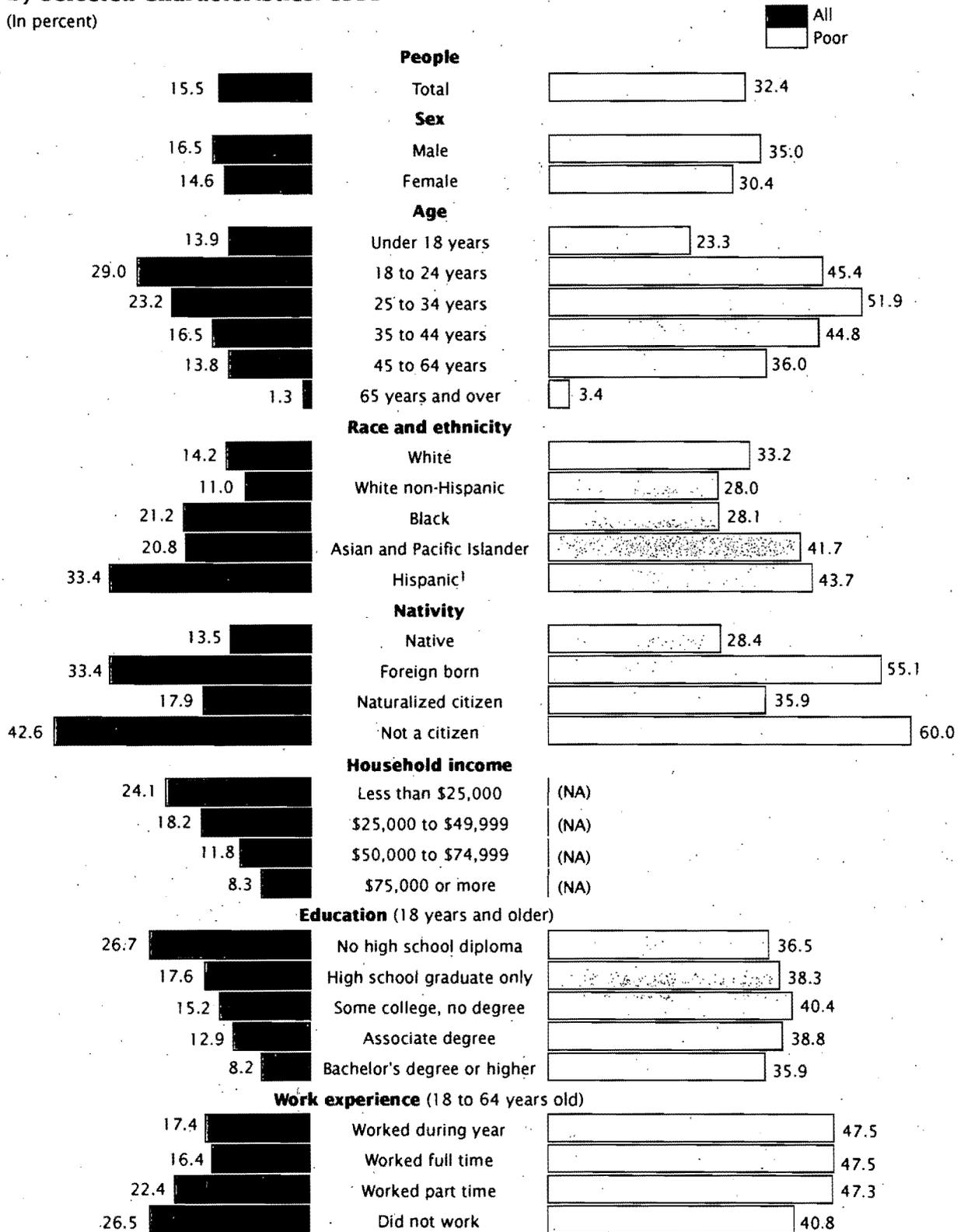
Among the poor, adults ages 18 to 64 had a markedly lower health insurance coverage rate (55.8 percent) in 1999 than either children (76.7 percent) or the elderly (96.6 percent).

*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.<sup>7</sup> 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.<sup>8</sup>

<sup>7</sup>Because 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.

<sup>8</sup>The 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)



<sup>1</sup> 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
<b>People</b>								
Total	274,087	42,554	15.5	271,743	44,281	16.3	*-1,727	*-0.8
<b>Sex</b>								
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
<b>Race and Ethnicity</b>								
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 <sup>1</sup>	32,804	10,951	33.4	31,689	11,196	35.3	*-245	*-2.0
<b>Age</b>								
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
<b>Nativity</b>								
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
<b>Region</b>								
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
<b>Household Income</b>								
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	-
<b>Education (18 years and older)</b>								
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
<b>Work Experience (18 to 64 years old)</b>								
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.

<sup>1</sup>Hispanics 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
<b>Poor People</b>								
Total	32,258	10,436	32.4	34,476	11,151	32.3	*-715	0.1
<b>Sex</b>								
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
<b>Race and Ethnicity</b>								
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 <sup>1</sup>	7,439	3,254	43.7	8,070	3,553	44.0	*-299	-0.3
<b>Age</b>								
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
<b>Nativity</b>								
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
<b>Region</b>								
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
<b>Education (18 years and older)</b>								
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
<b>Work Experience (18 to 64 years old)</b>								
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.

<sup>1</sup>Hispanics 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 <sup>1</sup> .....	31,755	10,894	34.3

<sup>1</sup>Hispanics 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.<sup>9</sup> However, the 3-year average uninsured rate for Hispanics (34.3 percent) was higher.<sup>10</sup>

<sup>9</sup>Data 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.

<sup>10</sup>The 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).<sup>11</sup> 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

<sup>11</sup>Natives 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.<sup>12</sup>

<sup>12</sup>The 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).<sup>13</sup> 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

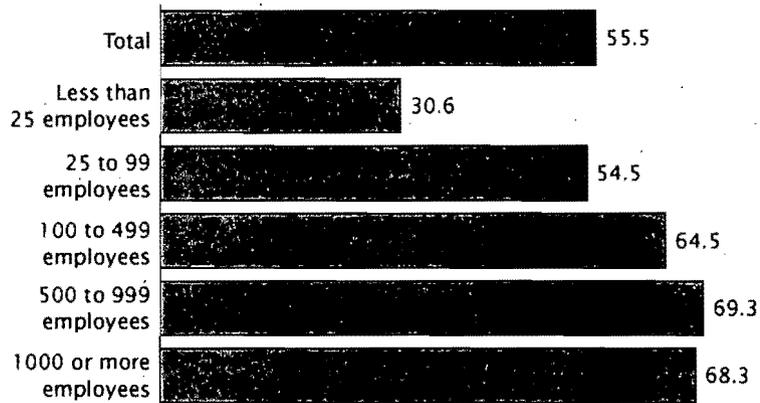
this drop; no change occurred in employment-based coverage. Poor children made up 28.2 percent of all uninsured children in 1999.

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**

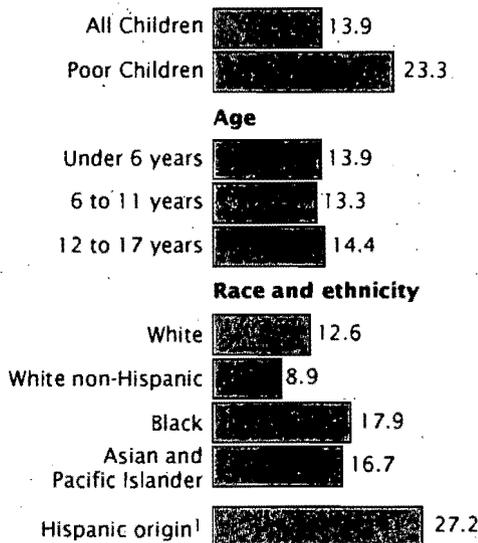
(In percent)



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

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

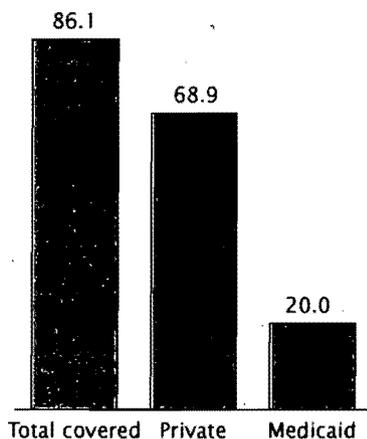
(In percent)



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

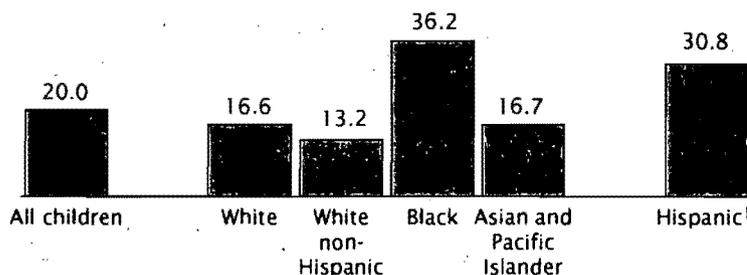
<sup>13</sup>Workers were classified as part time if they worked fewer than 35 hours per week in the majority of the weeks they worked in 1999.

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)



<sup>1</sup> 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.<sup>14</sup>

### 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

<sup>14</sup>In 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	Stan- dard error	Per- cent	Stan- dard error	Per- cent	Stan- dard error	Per- cent	Stan- dard error	1998-1999		1997-1998		Per- cent	Stan- dard error
									Per- cent	Stan- dard error	Per- cent	Stan- dard 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.

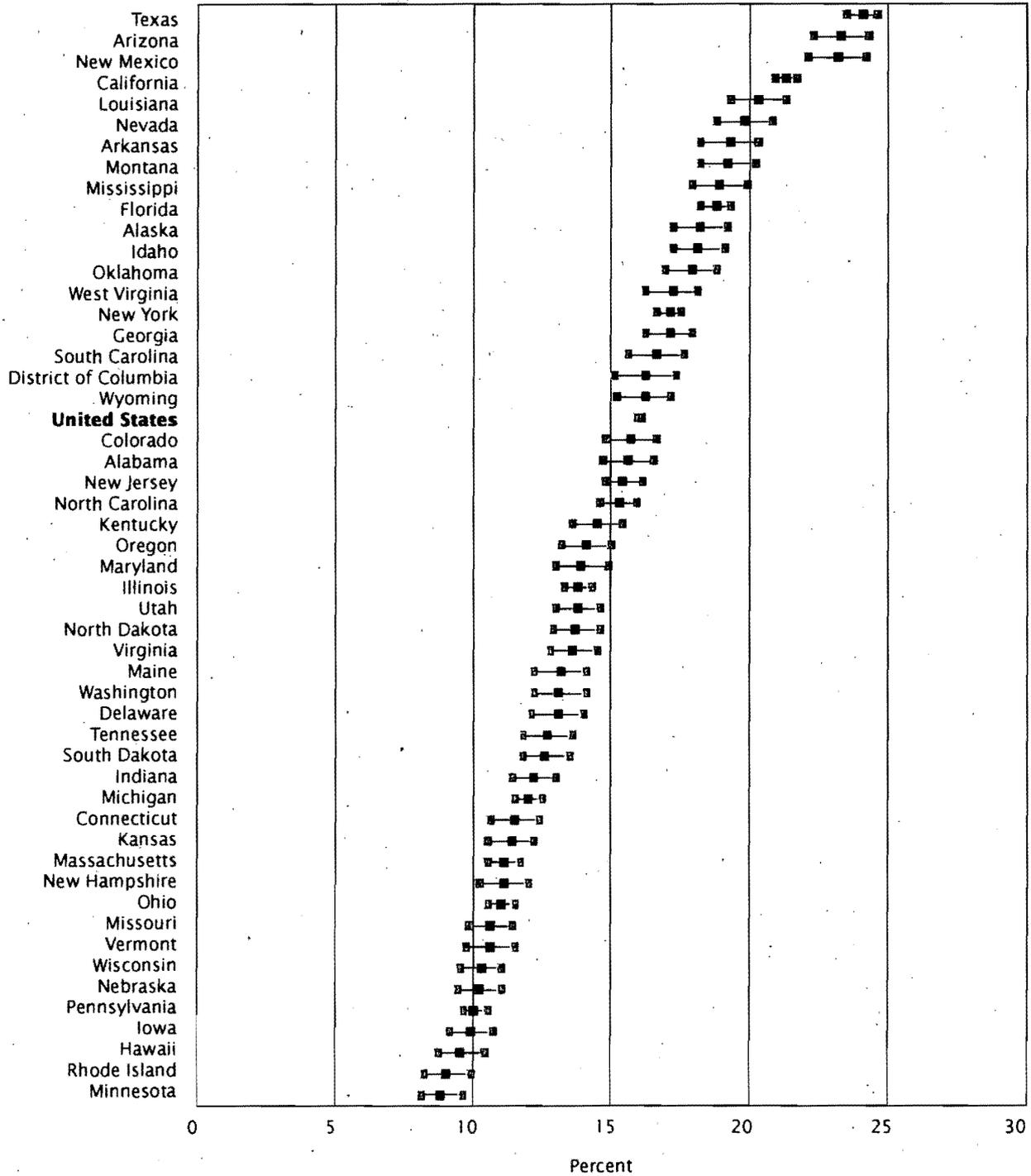
\*Statistically significant at the 90-percent confidence level.

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**

90-percent confidence interval  
Midpoint



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](mailto: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).<sup>15</sup> 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.

<sup>15</sup>HCFA 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).<sup>16</sup> Congress has appropriated additional funds to

<sup>16</sup>Data 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/hithins/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](mailto:charles.t.nelson@census.gov).

**Contact:**

Robert J. Mills  
301-457-3242  
[hhes-info@census.gov](mailto:hhes-info@census.gov)

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 <sup>1</sup>	
<b>ALL RACES</b>									
<b>NUMBERS</b>									
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	166,578	66,067	27,854	35,887	8,747	44,281
1997 <sup>2</sup>	269,094	225,646	188,532	165,091	66,685	28,958	35,590	8,527	43,448
1996	266,792	225,077	187,395	163,221	69,000	31,451	35,227	8,712	41,718
1995	264,314	223,733	185,881	161,453	69,776	31,877	34,655	9,375	40,582
1994 <sup>3</sup>	262,105	222,387	184,318	159,634	70,183	31,645	33,901	11,165	39,718
1993 <sup>4</sup>	259,753	220,040	182,351	148,318	68,554	31,749	33,097	9,560	39,713
1992 <sup>5</sup>	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	32,880
1987 <sup>6</sup>	241,187	210,161	182,160	149,739	56,282	20,211	30,458	10,542	31,026
<b>PERCENTS</b>									
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 <sup>2</sup>	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 <sup>3</sup>	100.0	84.8	70.3	60.9	26.8	12.1	12.9	4.3	15.2
1993 <sup>4</sup>	100.0	84.7	70.2	57.1	26.4	12.2	12.7	3.7	15.3
1992 <sup>5</sup>	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 <sup>6</sup>	100.0	87.1	75.5	62.1	23.3	8.4	12.6	4.4	12.9
<b>WHITE</b>									
<b>NUMBERS</b>									
1999	224,806	192,943	166,191	145,878	52,139	18,676	31,416	6,848	31,863
1998	223,294	189,706	163,690	143,705	51,690	18,247	31,174	7,140	33,588
1997 <sup>2</sup>	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	20,858	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 <sup>3</sup>	216,751	186,447	160,414	137,966	54,288	20,464	29,978	8,845	30,305
1993 <sup>4</sup>	215,221	184,732	158,586	128,855	53,222	20,642	29,297	7,689	30,489
1992 <sup>5</sup>	213,198	183,479	158,612	129,665	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 <sup>6</sup>	203,745	179,845	161,338	132,264	44,028	12,163	27,044	8,482	23,900
<b>PERCENTS</b>									
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 <sup>2</sup>	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 <sup>3</sup>	100.0	86.0	74.0	63.7	25.0	9.4	13.8	4.1	14.0
1993 <sup>4</sup>	100.0	85.8	73.7	59.9	24.7	9.6	13.6	3.6	14.2
1992 <sup>5</sup>	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 <sup>6</sup>	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 <sup>1</sup>	
<b>BLACK NUMBERS</b>									
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 <sup>2</sup>	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 <sup>3</sup>	33,531	28,928	17,147	15,607	12,693	9,007	3,167	1,683	6,603
1993 <sup>4</sup>	33,040	26,279	16,590	13,693	12,588	9,283	3,072	1,331	6,761
1992 <sup>5</sup>	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 <sup>6</sup>	29,417	23,555	15,358	13,055	10,380	7,046	2,918	1,497	5,862
<b>PERCENTS</b>									
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 <sup>2</sup>	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 <sup>3</sup>	100.0	80.3	51.1	46.5	37.9	26.9	9.4	5.0	19.7
1993 <sup>4</sup>	100.0	79.5	50.2	41.4	38.1	28.1	9.3	4.0	20.5
1992 <sup>5</sup>	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 <sup>6</sup>	100.0	80.1	52.2	44.4	35.3	24.0	9.9	5.1	19.9
<b>HISPANIC NUMBERS</b>									
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 <sup>2</sup>	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 <sup>3</sup>	27,521	18,244	11,743	10,729	7,829	6,226	1,677	630	9,277
1993 <sup>4</sup>	26,646	18,235	12,021	9,981	7,873	6,328	1,613	530	8,411
1992 <sup>5</sup>	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 <sup>6</sup>	19,428	13,456	9,845	8,490	4,482	3,214	1,029	631	5,972
<b>PERCENTS</b>									
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 <sup>2</sup>	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 <sup>3</sup>	100.0	66.3	42.7	39.0	28.4	22.6	6.1	2.3	33.7
1993 <sup>4</sup>	100.0	68.4	45.1	37.5	29.5	23.7	6.1	2.0	31.6
1992 <sup>5</sup>	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 <sup>6</sup>	100.0	69.3	50.7	43.7	23.1	16.5	5.3	3.2	30.7

<sup>1</sup>Includes CHAMPUS (Comprehensive Health and Medical Plan for Uniformed Services)/Tricare, Veterans', and military health care. <sup>2</sup>Beginning 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.

<sup>3</sup>Health 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. <sup>4</sup>Data collection method changed from paper and pencil to computer-assisted interviewing. <sup>5</sup>Implementation of 1990 census population controls. <sup>6</sup>Implementation of a new March CPS processing system.

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

U.S. Department of Commerce  
Economics and Statistics Administration  
U.S. CENSUS BUREAU  
Washington, DC 20233

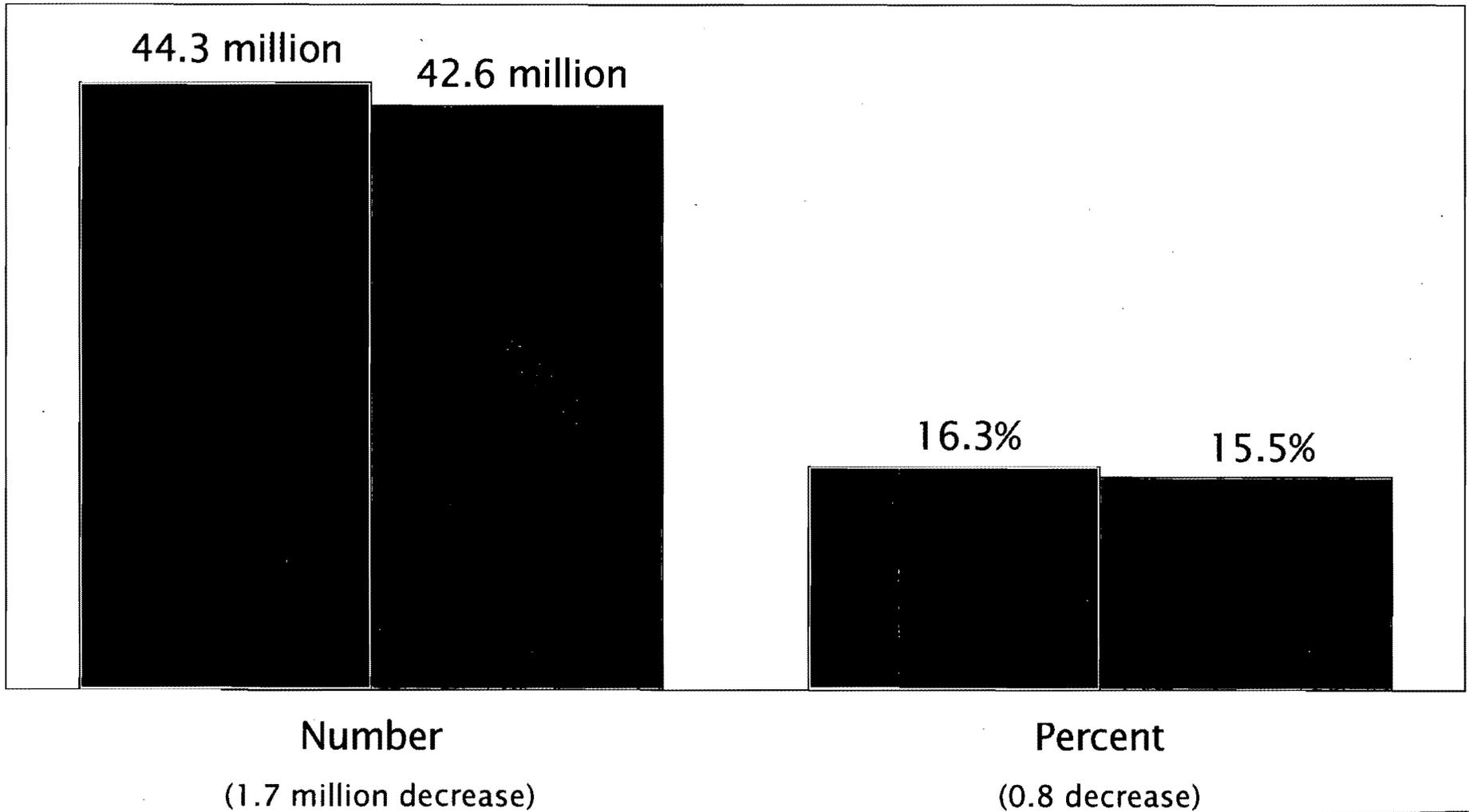
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# People Without Health Insurance Coverage: 1998 and 1999

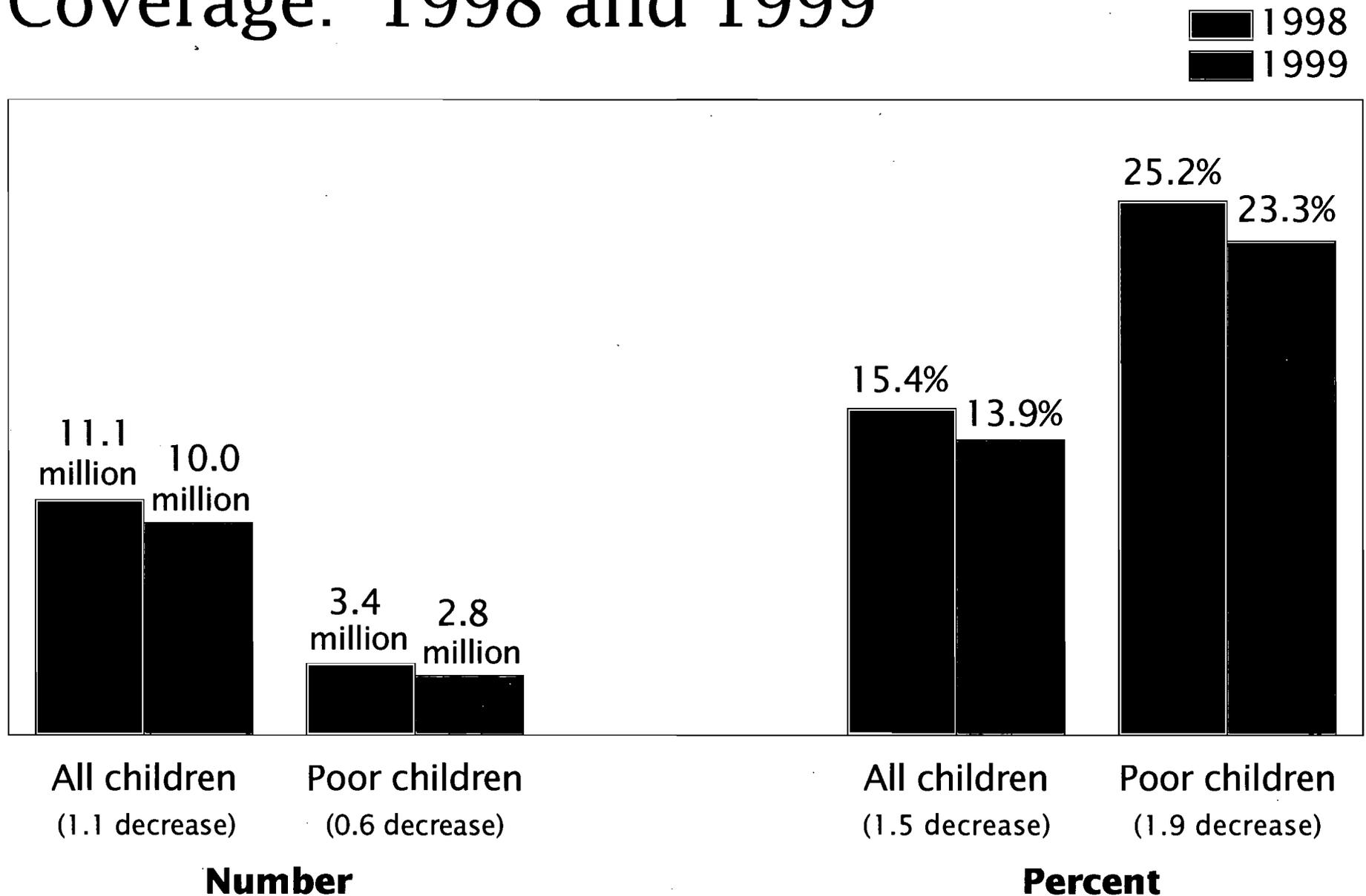
1998  
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Source: U.S. Census Bureau, Current Population Survey, March 1999 and 2000.

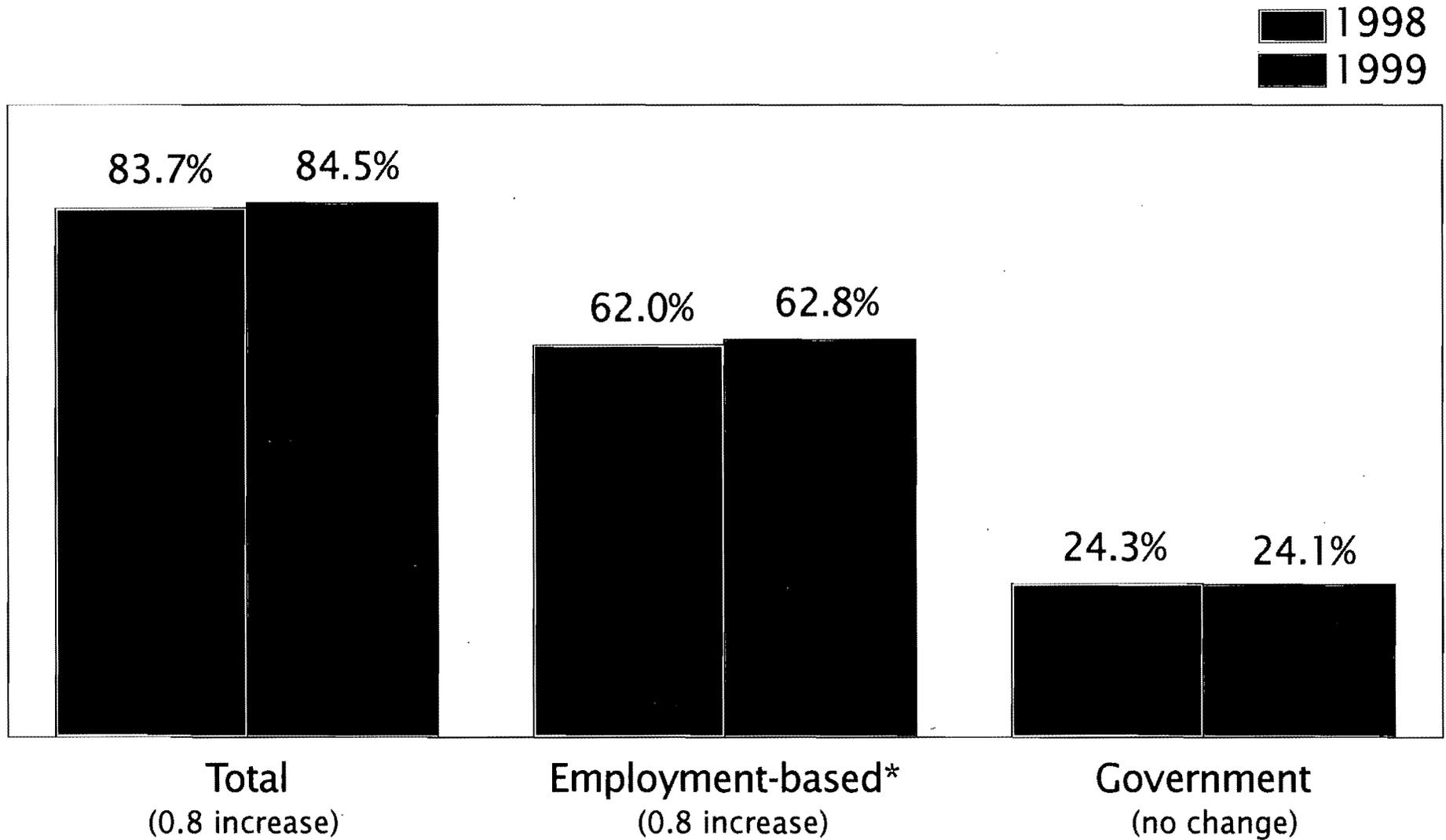
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12:01 a.m., September 29, 2000

# Children Without Health Insurance Coverage: 1998 and 1999



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

# Changes in Health Insurance Coverage by Type of Insurance: 1998 and 1999



\*Reflecting the employment-based health insurance coverage rates, private health insurance rates from all sources increased from 70.2 percent to 71.0 percent between 1998 and 1999.

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

# Health Insurance Coverage by State: 1997 to 1999

(Comparison of 2-year moving averages)

## **Proportion With Health Insurance Increased in 15 states**

Arizona  
Arkansas  
California  
Connecticut  
Iowa  
Maine  
Massachusetts  
Mississippi  
Missouri  
New Jersey  
New York  
North Dakota  
Rhode Island  
Tennessee  
Texas

## **Proportion With Health Insurance Decreased in 8 states**

Hawaii  
Illinois  
Louisiana  
Nevada  
New Mexico  
Vermont  
Washington  
Wisconsin

## Introduction

Kaiser  
Report -  
it doesn't  
actually  
look that  
great  
after all.

**F**orty-four million Americans—more than one in six nonelderly residents of the United States—are living without health insurance.<sup>1</sup> By itself, the number is hard to comprehend. Imagine that every resident of the nine northeastern states lacked health insurance—or every resident of California and Texas, our two most populous states.

Ten years ago, 34 million U.S. residents—one in seven under age 65—lacked health insurance. Despite a booming economy, both the numbers of uninsured and the proportion of the population they represent have increased. Today, more people in every city and town, in every neighborhood, and on every rural delivery route, have to figure out how to live without insurance. Ten million more people—equivalent to the entire population of Pennsylvania.

Who are the uninsured? For the most part, they defy common stereotypes.

- Most are people who work or their dependents. Almost three-quarters (74%) come from families with at least one full-time worker. Only 16% come from families where no one is employed. They're the people who serve you in convenience stores and fast-food restaurants, clean your carpets and your offices, care for your children and aging relatives, and fix your computers and your cars.
- Most are not poor. More than two-fifths (44%) come from families with incomes *above* 200% of the poverty line (\$34,100 for a family of four.) Just under a third (29%) come from near-poor families, with incomes between 100 and 200% of the poverty line. Just over a quarter (27%) come from families with incomes *below* the poverty line (\$17,050 for a family of four.)
- Almost three-quarters (73%) are adults. Because of government insurance programs that target children, adults are at greater risk of being uninsured than children.
- Most live in families in which at least one other person is covered by health insurance (64%). Only a little more than a third (36%) live in families in which all members are uninsured.
- Just over half of the uninsured are white (52%), although minorities, particularly Hispanics, are at much greater risk of being uninsured than whites.

<sup>1</sup> The figure of 44 million uninsured comes from Census Bureau estimates for 1998. In the fall of 2000, the Census Bureau is expected to release estimates of how many Americans were uninsured in 1999.

How does not having health insurance coverage make a difference in their lives?

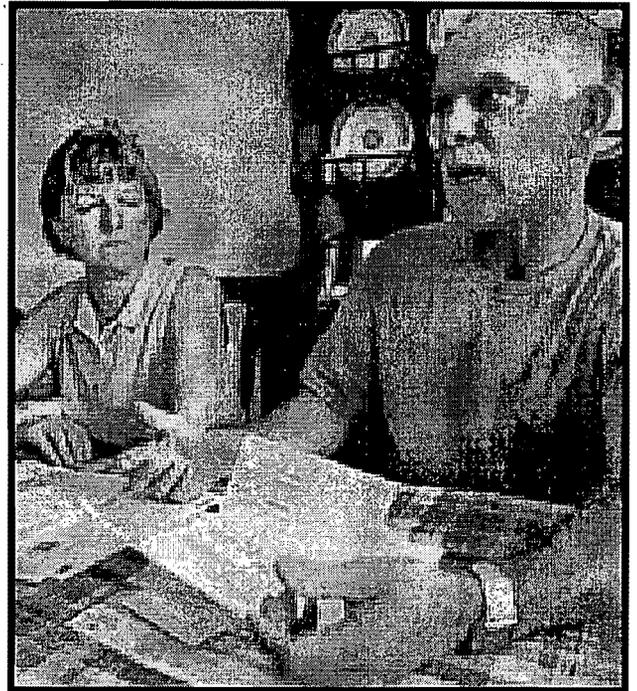
- The uninsured often forgo medical care. For example, at least 30% of uninsured adults failed to fill prescriptions or skipped recommended medical tests or treatments in the past year.
- Being uninsured affects children, as well. They are less likely to be treated for common childhood illnesses, like sore throats and ear infections. Even their chances of receiving medical attention for injuries are about 30% less than children who have insurance.
- The consequences of delaying or forgoing needed care are not trivial. The uninsured are hospitalized at least 50% more often than the insured for "avoidable conditions" such as pneumonia and uncontrolled diabetes.
- Because the uninsured are less likely to obtain regular preventive care, they are more likely to be diagnosed in the late stages of a cancer, and more likely to die from it.

### The reasons behind the growth in numbers

Why has the number of uninsured—and their share of the overall population—increased in the last decade, a period of unprecedented prosperity and rapid and sustained economic growth?

From the late 1980s through the early 1990s, the number of uninsured grew largely because employer-sponsored health coverage was declining. Since the mid-1990s, however, the number of employees and dependents covered by employer-sponsored coverage has increased. However, that increase has not been sufficient to offset a substantial decline in Medicaid coverage of the low-income population. Some of this decline may be the result of the improved economy, but much is probably related to federal and state welfare reforms. Welfare reforms enacted in 1996 unintentionally affected the Medicaid enrollment process, creating considerable confusion which resulted in many eligible families going without coverage. And many parents who have left welfare have taken low-wage positions, which are less likely to offer affordable health insurance (or any at all). In fact, half of mothers are uninsured one year after leaving welfare.

The growth in the number of uninsured over the last decade would have been even greater but for Congress's expansion of Medicaid, beginning in the late 1980s, and its enactment in 1997 of the Children's Health Insurance Program (CHIP) to provide coverage for near-poor children (up to 200% of



the poverty line in most states.) As of December 1999, 1.8 million children were receiving insurance through CHIP.<sup>2</sup>

As significant as these developments have been to ensuring that more poor and near-poor children have access to health care, it's important to note that

many uninsured children who are eligible are still not enrolled in Medicaid or CHIP. And several million uninsured children remain *ineligible* for either program under current eligibility guidelines. In addition, adults in general continue to be much more likely to be uninsured than children. Only low-income adults who are pregnant, disabled, elderly, or have dependent children are eligible for Medicaid (and then parents' income eligibility levels are generally lower than their children's.)

### *The Kaiser Survey of Family Health Experiences*

Recognizing that health insurance coverage was shifting rapidly, the Kaiser Family Foundation began a longitudinal survey in 1995 to study how changes in the delivery and financing of health care have affected American families over time. A sample of 1,400 households was scientifically selected by the National Opinion Research Center (NORC) at the University of Chicago to ensure that it contained a representative mix of families with members who were uninsured, privately insured, or covered by Medicaid. The goal of the study was to get a fuller picture of the impact of the changing health system, over time, on health insurance coverage, access to care, and health status. In particular, the

foundation wanted to be able to compare the experiences of families that were uninsured with those that had either public or private health coverage.

The *Kaiser Survey of Family Health Experiences* was unique among health surveys because it interviewed the same families annually over three years. In addition, it focused on the experiences of *families*, rather than individuals, which distinguished it from most other studies. That distinction is important because it is their families' experiences that define most Americans' views of the health care system. And most Americans base their decisions about insurance coverage with the health needs of all family members in mind.

The first interviews were performed between October 1995 and January 1996 by trained surveyors who visited each family in its home. The interviews in the second and third years were conducted mostly by telephone, beginning in November of subsequent years. Willingness to continue participating in the survey was high, yielding a sample of 1,060 families that participated for all three years.

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<sup>2</sup> Smith, VK. CHIP Program Enrollment December 1998-December 1999. July 2000. *Kaiser Commission on Medicaid and the Uninsured Report #2195*.

### **The next step: *In Their Own Words***

In the spring of 2000, the Kaiser Family Foundation decided to try to obtain an even fuller picture of families' experiences with insurance and the health care system by sending journalists to interview a few of the families that had taken part in the longitudinal survey. The goal was to let families express in their own words what not having insurance meant to their ability to obtain health care when they needed it, and to their financial security.

The National Opinion Research Center contacted about 260 of the original families with uninsured members to assess their willingness to be interviewed by a journalist in their homes. More than half of these agreed. From this group, eight families were selected for the profiles contained in this report. These eight were chosen because they live in a variety of states, reflect a variety of family types, contain family members who are currently uninsured, and were available and willing to be interviewed during the summer of 2000. They were not selected because the stories they had to tell were the most dramatic, but rather because they seemed to be typical. Although these families were selected from a nationally representative sample of American households, these eight, by themselves, do not represent a scientifically selected sample, but rather a convenience sample.

### **The stories**

What follows are eight very personal stories of eight unique families and their experiences living without health insurance. To help put these individual families' stories into perspective, each one is accompanied by charts containing relevant data from the longitudinal survey and other national surveys. These illustrations are designed to help you understand just how common are each of these families' circumstances.

Who are the people in these stories? They're people like Patricia Nelson, of Louisville, Tennessee, a widowed mother who works in a family business that's not yet solvent enough to offer insurance to its five employees.

They're people like Yolanda Smith, of Paterson, New Jersey, a customer service representative whose employer does offer health insurance, but at a price she can't afford.

They're people like Carmen and Francisco Mendivil, of Tucson, Arizona, who are self-employed and mired in medical-related debt.

They're people like Monty and Charlynn Taylor of Guthrie, Oklahoma, who can no longer justify paying the premiums for their employer-sponsored insurance, with its high deductible and co-pays.

Even though each of these eight families' stories is different, there are many common themes:

- In every case, the cost of insurance is the primary reason these families are uninsured. "The thing is, you can't get private insurance for a price you can afford," Patricia Nelson laments.
- Many uninsured regularly endure pain or discomfort because they can't afford to pay for a visit to a doctor or to buy prescription medicine. A prescription drug relieves the pain of fibromyalgia for Dianna Oden, a waitress in Mosier, Oregon, but she can't afford to buy it, even though, she confides, "There are times that I don't think I can make it through another work day."
- Some have amassed ruinous debt to obtain necessary care. In her 20s, Shannon Combs of Hemet, California, declared bankruptcy because she saw no way of ever repaying thousands of dollars' worth of bills for emergency surgery. "When you're that far in debt, there's no other way to deal with it, unless you have parents who can help you, which I don't," she says.
- The uninsured are sometimes wary of government-financed insurance programs for which they might qualify. In some uninsured families in which children might qualify for government-subsidized insurance, the bureaucratic obstacles to applying make parents reluctant to actively pursue it. "They treat you differently," says Rose Ann Cervantes, a mother of three in Corpus Christi, Texas. "It's just not pleasant."
- There are few insurance safety nets for low-income working-age adults unless they are disabled, pregnant, or have dependent children. So, for example, Derek Combs, of Hemet, California, has a pregnant wife and 4-year-old daughter who are eligible for government-financed coverage, though he's not.
- In families in which some but not all members are insured, the insured person often forgoes care out of guilt. "How could I say to them, 'Oh, yeah, I'm going to go get my dental needs taken care of, but you can't?'" asks Tom Pafford of Elon, Virginia, whose wife and 19-year-old son are uninsured.

Although these families have eight compelling stories to tell—about delaying care, piling up debt, living in pain, and deferring their dreams to pay off medical bills—as you read them, remember that these are just eight families' stories.

There are 44 million other uninsured Americans out there with stories of their own.

## The Families and Their Stories

***"Lord, keep us well."***

*The Pafford Family, Elon, Virginia*

***"I constantly worry: What if something happens?"***

*The Cervantes and Zamora Families, Corpus Christi, Texas*

***"Sometimes there was insurance, and sometimes there wasn't."***

*The Nelson Family, Louisville, Tennessee*

***"I need some kind of help."***

*The Smith Family, Paterson, New Jersey*

***"I wanted to be able to take care of my baby."***

*The Combs Family, Hemet, California*

***"I barely get finished paying one bill when the next one comes in."***

*The Mendivil Family, Tucson, Arizona*

***"Is there something else I should be doing?"***

*The Taylor Family, Guthrie, Oklahoma*

***"Sometimes I feel like I'm 90 years old."***

*Dianna Oden, Mosier, Oregon*

## **THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM: PRELIMINARY HIGHLIGHTS OF IMPLEMENTATION AND EXPANSION**

*President Clinton, with overwhelming bipartisan support from the Congress, created the State Children's Health Insurance Program (S-CHIP) in 1997, allocating \$48 billion over the next 10 years to expand health care coverage to uninsured children. This new program, together with Medicaid, provides meaningful health care coverage to millions of previously uninsured children – including coverage for prescription drugs, vision, hearing, and mental health services. Today, every state has implemented S-CHIP, providing health insurance coverage to over 2 million children nationwide since the beginning of the program. The success of this Federal-State partnership is one of the most significant achievements of the Clinton-Gore Administration. This summary includes highlights from state-submitted evaluations of their S-CHIP programs.*

### **BACKGROUND**

The State Children's Health Insurance Program (S-CHIP) enables states to insure children from working families with incomes too high to qualify for Medicaid but too low to afford private health insurance through separate state programs, Medicaid expansions, or a combination of both. Each state with an approved plan receives enhanced Federal matching payments for its S-CHIP expenditures up to a fixed state "allotment". As of July 1, 2000, 50 States, the District of Columbia and five U.S. Territories have implemented S-CHIP, covering over 2 million children. In addition, the number of children enrolled in Medicaid has increased because of state-wide outreach and eligibility simplification efforts.

Of these approved plans, 15 States have created a separate child health program, 23 States have expanded Medicaid, and 18 States have developed a combination of a separate state program and a Medicaid expansion program. In addition, many states have already amended their programs to expand eligibility beyond their original proposal. Prior to S-CHIP's creation, only 4 states covered children with family incomes up to at least 200 percent of the Federal poverty level (about \$33,000 for a family of 4). Today, 30 states have plans approved to cover children with incomes up to at least this level.

However, millions of eligible children remain uninsured. One study found that two-thirds of eligible uninsured children are in two-parent families. Over seventy-five percent of the parents of these children work, and only 5 percent receive welfare. Nearly all low-income parents believe having health insurance coverage for their child is very important, and two-thirds of them have tried to enroll their children in Medicaid. However, over 57 percent of these attempts were unsuccessful. Studies indicate that lack of coverage negatively affects access to care among low-income children – 41 percent of parents of eligible uninsured children postponed seeking medical care for their child because they could not afford it.

States have made strong progress in implementing their S-CHIP programs, seeking and implementing new and innovative ways to identify and enroll uninsured children in both Medicaid and S-CHIP. The steady growth of the S-CHIP program is evidence of the success of this Federal-State partnership and the nation's commitment to ensuring that all children have health insurance coverage.

## **STATE EVALUATIONS**

The S-CHIP statute requires States to regularly report on their progress toward covering low-income children under S-CHIP, and required that each State or Territory with an approved child health plan must submit to the Secretary of Health and Human Services an evaluation of its S-CHIP Program by March 31, 2000. These evaluations provide States with an opportunity to document program achievements, assess the effectiveness of their programs, and identify ways in which the State or the Federal government might improve program performance.

Working with the states, the Department of Health and Human Services (HHS), and other interested parties, the National Academy of State Health Policy facilitated the evaluation process and created an "evaluation framework" for the States that enabled them to report their findings in a standardized manner. The states' evaluations provided HHS with valuable information on best practices as well as challenges facing states in the implementation of their programs. This information, which is available to the public, will be used to provide continuing technical assistance to facilitate future program innovations. The States' evaluations will be posted on the HCFA web site at [www.hcfa.gov](http://www.hcfa.gov).

The forty-seven state evaluations submitted as of July 1, 2000 offer important insights into the experiences and future direction of S-CHIP. The information that follows is a short description of preliminary findings from the States' reports, quarterly enrollment data currently available, and regional office reviews of Medicaid enrollment and eligibility processes.

### **STRONG ENROLLMENT TRENDS CONTINUE**

Nearly 2 million children were covered by S-CHIP between October 1, 1998 and September 30, 1999, a doubling in enrollment from December 1998, and initial reports indicate that these strong enrollment trends are continuing through the first quarter of 2000 (although data from all states is has not yet been submitted). For example, from the second quarter of fiscal year 1999 (April 1 – June 30, 1999) to the second quarter of 2000 (April 1 – June 30, 2000), enrollment increased by more than 80 percent in the 43 states for which there are data. During that time period, 19 states reported that their enrollment had more than doubled, and nine of those states reported that their program enrollment had tripled.

### **ELIMINATING BARRIERS TO INITIAL AND CONTINUED ENROLLMENT**

States reported having worked aggressively to simplify their application, enrollment, and re-enrollment processes to ensure that eligible families can easily apply, enroll, and remain enrolled. Steps such as using a joint and mail-in applications, offering presumptive eligibility, allowing retroactive eligibility, and providing continuous eligibility are all important strategies for simplifying the enrollment process and providing opportunities for families to apply and remain enrolled in Medicaid and S-CHIP.

## **Coordinating Enrollment and Eligibility Requirements for Medicaid and S-CHIP**

In order to ensure that children receive the most generous benefit package for which they are eligible, 29 states – over 85 percent of those with separate state programs or combination programs – report using a joint application to enroll families in their Medicaid or separate child health program. These states confirmed that using one application for both Medicaid and their separate child health program reduces paperwork, minimizes processing errors, and offers a less intrusive, more family-friendly approach to the application process.

In addition, 39 states have eliminated face-to-face interviews in Medicaid for children or in both Medicaid and the State's separate S-CHIP program.

In addition, only seven states currently require an assets test for children enrolling in Medicaid or the S-CHIP program. Out of the 17 states with combination programs, 16 have dropped the assets test in both their Medicaid expansion and their separate state program, while one has dropped it for the S-CHIP program but not Medicaid. Thirteen of the 17 states with Medicaid expansions have dropped their assets test. Over the past several years, states have dropped this requirement in the face of mounting evidence and state experience that it serves as a barrier to enrollment.

North Carolina's Health Choice For Children Program. North Carolina has successfully implemented strategies to simplify the application and enrollment procedures for families for both Medicaid and S-CHIP. The state:

- Uses a joint application for Medicaid and S-CHIP;
- Guarantees eligibility for 12 months in S-CHIP and Medicaid;
- Provides a simplified two-page application in English and Spanish;
- Allows mail-in applications;
- Cross-trained eligibility workers so they would have the expertise to determine Medicaid or S-CHIP eligibility from the application in one review, shortening the time involved in processing applications and minimizing potential errors; and
- Automatically notifies families when it is time for them to re-enroll their children in Medicaid or S-CHIP.

Ohio's Healthy Start. Ohio recently eliminated burdensome eligibility verification requirements, such as proof of residency and birth date, for children applying for Medicaid (which includes their S-CHIP Medicaid expansion). In addition, the state:

- Uses a two page simplified application;
- Allows applications to be mailed-in; and
- Eliminated requirement for a face-to-face interview before determining eligibility.

As of July 1, 2000, Ohio also expanded coverage for parents through Medicaid up to 100 percent of the poverty level.

Oklahoma's SoonerCare. Oklahoma, which has also implemented important simplification measures in its Medicaid expansion program, has been consistently successful in its outreach and enrollment efforts. The state has:

- Simplified their application from 16 pages to 1 page;
- Over 40 outstationed eligibility workers that travel the state and conduct on-site enrollment at community based sites; and
- Eliminated the assets tests and accepts self-declaration of income.

### **Providing Children With Immediate Access to Health Care Services**

The Balanced Budget Act of 1997 provided states with new authority to make children "presumptively eligible" for Medicaid in order to provide them with immediate access to health care services. This new authority allows designated providers/individuals to enroll children in the programs on a temporary basis, relying on information supplied by the family, until the final eligibility determination is made by the appropriate State agency. Ten states have taken advantage of this new authority in either Medicaid or S-CHIP. In the states with separate programs, five states have taken advantage of this new authority in both programs, despite evidence that this option allows children to receive health care services promptly, ensures providers are paid for services delivered, and enhances opportunities for families to apply for coverage in community based settings.

Nebraska's Kids Connection. Nebraska allows providers eligible to receive Medicaid payments and agencies authorized to determine eligibility for programs such as Head Start, child care services, or WIC to determine presumptive eligibility for Medicaid. Nebraska has found that presumptive eligibility provides an opportunity for continuity of care and implementation of treatment upon evaluation by the provider.

### **Providing Consistent Access to Health Care Services**

The Balanced Budget Act of 1997 gave states the option to enroll children in S-CHIP and Medicaid for up to 12 months, regardless of changes in income or family circumstances. Thirty-two states –over 60 percent – have taken advantage of this new authority to ensure that children enrolled in S-CHIP do not lose their coverage unnecessarily as a result of temporary changes in income or fluctuation in monthly paychecks. All but four States have taken advantage of this new option in Medicaid as well as S-CHIP. These states provide continuous eligibility for either 6 or 12 months after a child has been determined eligible for S-CHIP, even if there is a change in the family's income, assets, or size.

Maine's CubCare. Families have a simple renewal process in which the family is sent a letter containing their income information and is asked simply to respond to the letter to continue their eligibility for the program.

- Single application for CubCare and Medicaid;
- Mail-in applications; and
- Eliminated the assets test.

Redetermination processes also affect continuity of care, since unnecessary disenrollment disrupts access to care, and hinders state efforts to increase enrollment. States reported that disenrollment rates from separate child health programs were, on average, lower than Medicaid expansion disenrollment rates; and attributed this to the more stringent requirements in Medicaid that require families to report changes in age or income. It is important to note that income and other eligibility reporting requirements are state options and not mandatory.

This information can yield important insights for States regarding processes that may need to be simplified or barriers to enrollment or retention that merit further examination.

### **Ensuring that Families Moving From Welfare to Work Retain their Health Insurance**

Welfare reform created a unique challenge to ensuring that eligible families enroll in Medicaid and now S-CHIP. Prior to reform, Medicaid eligibility was linked to welfare. The President insisted in signing the welfare reform law that all families who would have been eligible for Medicaid prior to the law remain eligible. However, HCFA received a number of reports indicating that states had not made the necessary adjustments to state and/or local policies, systems and procedures in order to ensure that individuals in families transitioning to work were enrolled Medicaid and S-CHIP when eligible. To address this issue, last August, HCFA initiated comprehensive, on-site reviews of state Medicaid enrollment and eligibility processes. These reviews included interviews with state officials and case file checks to assess compliance with current law and to develop recommendations for improvements. After completion of the reviews in all 50 states, we are aware of serious problems in a number of states.

In some situations, state policies have been out of compliance with Federal regulations. For example, in some states, families and children are disenrolled from Medicaid without the state reviewing whether the parent or child continues to be eligible under another eligibility category. More frequently, State practices and procedures, often due to delays in reprogramming computer systems to account for the delinking of cash assistance and Medicaid, have led to problems. For example, in some states, when cash assistance ended, Medicaid was automatically terminated even though in almost all cases the children and the parent would have been eligible for continued coverage.

While states have made great strides in reducing the barriers to enrollment for children, many of these same barriers continue to operate to keep low-income families from receiving the Medicaid coverage they need as they move from welfare to the workplace. These barriers undermine State welfare reform goals and limit our ability reach our enrollment targets for children. For example, most states still retain a face to face interview requirement for low-income families needing Medicaid, and do not allow families to apply or to retain eligibility through a mail-in systems.

However, despite these problems, a number of states have taken strong action to ensure that families are not unnecessarily or erroneously terminated from health insurance coverage. They include:

Delaware. The state of Delaware has developed a computerized eligibility system that automatically evaluates an individual's eligibility across programs, ensuring that families retain their eligibility for Medicaid and food assistance as they move in and out of the welfare systems. The system evaluates the eligibility of everyone in the family, because even if a parent is determined to be ineligible, the children in the family could still retain their eligibility.

Washington. Upon identifying that the state's computerized eligibility and enrollment system was automatically disenrolling individuals leaving welfare who were still eligible for Medicaid, the state has attempted to reinstate close to 100,000 individuals to coverage. In addition, the state streamlined its Medicaid eligibility reviews by relying on available information in Food Stamp files to recertify Medicaid eligibility. This eliminates unnecessary requests for information from low-income working families and reduces burdens for State and local Medicaid agencies

### **IMPLEMENTING INNOVATIVE OUTREACH STRATEGIES**

The success of S-CHIP programs nationwide is dependant on aggressive, broad-based outreach efforts to identify and enroll eligible children. Low-income working families who have never been eligible for traditional public assistance programs – but who are now eligible for S-CHIP and Medicaid – may not realize that they can receive benefits. In some states, the application process can be long, arduous, and beyond the ability of many families to complete. Cultural barriers, like difficulties in language comprehension, also pose a barrier for some families. States have taken strong action to reach out to families to educate them about this new program and encourage them to apply.

#### **School-based Outreach Strategies**

Because schools are accepted by parents as a conduit for important information, school systems are an ideal place to identify and enroll uninsured children in Medicaid or CHIP. In addition, health insurance promotes access to needed health care, which experts confirm contributes to academic success. Children without health insurance suffer more from asthma, ear infections, vision problems - treatable conditions that dramatically interfere with classroom participation. And children without health insurance are absent more frequently than their peers. States with particularly innovative and aggressive school-based outreach strategies include:

New Jersey's KidCare. At the beginning of the school year, Governor Whitman sent a letter to school principals about KidCare and provided each school with 500 brochures on S-CHIP and Medicaid to distribute to parents. Schools, together with local parent-teacher organizations, are also using report card days and direct mailings as opportunities to share information about S-CHIP. Parents completing the application for the Free and Reduced Cost Lunch program can request to receive information about NJ KidCare. School nurses and child study team members have been trained to assist families in completing applications. As a result, New Jersey has signed over 19,000 children to Kid Care, the state's S-CHIP and Medicaid program through strong school-based strategies.

Illinois KidCare. Applications for the free and reduced price lunch program in Illinois have a check-off box on the application form for parents interested in receiving further information about KidCare. The Chicago Public Schools distributed information on KidCare as part of their Report Card Pick-up Days in November 1998 and April 1999 at over 600 public schools. KidCare staff have presentations statewide to school administrators, principals, nurses, social workers, and teachers interested in learning more about KidCare to get eligible students enrolled.

### **Community-Based Efforts**

Many states collaborate with community based organizations to ensure that outreach and enrollment strategies are precisely targeted to the needs of local communities. States with particularly innovative and aggressive community-based outreach strategies include:

Indiana's Hoosier Healthwise. In an attempt to reduce the stigma associated with local welfare offices, a key barrier to Medicaid enrollment, the State successfully identified 500 independent enrollment centers throughout Indiana. These enrollment centers include community action centers, child care centers, health centers and hospitals, schools, and various service providers. They have processed over 20,000 applications through the enrollment centers.

### **Targeted Populations**

Outreach efforts geared towards the mainstream population may not be effective for many children eligible for Medicaid and S-CHIP. Vulnerable populations often face socioeconomic or linguistic issues, low literacy levels, geographic isolation, or other barriers that make it difficult for them to enroll in health insurance. States with particularly innovative and aggressive community-based outreach strategies include:

Arizona's KidsCare has launched a concerted effort to reach children in Hispanic families. Activities include:

- Developing Spanish-language applications;
- Creating mass media messages that appealed to the Hispanic population;
- Airing announcements about the program on Spanish language radio and television stations;
- Producing special editions of the Arizona Farmworkers Coalition on KidsCare; and
- Placing the KidsCare logo on the side of traditionally Hispanic businesses, such as "Paletas," ice cream pushcarts used during the summer.

Georgia's PeachCare. Georgia has implemented a concerted effort to reach children in rural areas. The state has:

- Sponsored public service announcements by well-known community members, participated in local parades, and made presentations at local churches;
- Working with local businesses to provide table mats in restaurants, print flyers on grocery bags, and insert "stuffers" in local phone bills; and
- Distributing information on PeachCare to fast food restaurants and small businesses to pass on to their employees.

Health Insurance Coverage File

**REACHING THE UNINSURED:  
ALTERNATIVE APPROACHES TO EXPANDING HEALTH INSURANCE ACCESS**

**September 2000**

**A Report by  
The Council of Economic Advisers**

**REACHING THE UNINSURED:  
ALTERNATIVE APPROACHES TO EXPANDING HEALTH INSURANCE ACCESS**

**EXECUTIVE SUMMARY**

The lack of affordable and accessible health insurance remains a major problem for millions of Americans. Without health insurance, many people forego needed health care and suffer adverse health consequences. This has economic consequences as well. This report evaluates three major policy options to make health insurance more affordable. The key findings are:

- **While there are multiple barriers to coverage, lack of affordability remains the primary reason why 44 million Americans lack health insurance.** Though 82 percent of the uninsured are in working families, 56 percent of the uninsured have incomes of less than 200 percent of poverty. Low-wage jobs are less likely to offer health care coverage—and, when offered, often have unaffordable premiums. However, low-incomes are not the only barrier to coverage. Many Americans with incomes well above poverty—such as people who have lost access to employer-based coverage; the near-elderly and people with chronic illness—have difficulty obtaining quality insurance at a reasonable price.
- **Lack of health insurance has economic and health consequences.** Studies show that people without health insurance are less likely to seek health care, resulting in worse health. For example, uninsured pregnant women who fail to get adequate prenatal care have newborns that are at a 31 percent greater risk of being born with adverse health outcomes. In addition, uninsured people often incur higher-than-necessary costs. One study found that expanding Medicaid led to a 22 percent decrease in avoidable hospitalizations of participants. The costs associated with lack of insurance are passed on to the public at large.
- **Tax deductions will do little to improve coverage.** Studies indicate that extending tax deductibility to individually purchased policies would do very little to expand insurance coverage—considerably less than tax credit or direct subsidy programs would. The simulated plans reviewed in this study suggest that the proportion of participants who would be newly insured under a tax deduction plan would be about one-third the proportion of participants who would be newly insured under a tax credit plan. The proportion of participants who would be newly insured under a tax deduction plan would be about one-tenth the proportion of participants who would be newly insured under a direct provision plan. Because tax deductions disproportionately help people with higher incomes, these plans would benefit predominantly middle and upper-income households who already purchase coverage, but would only modestly improve the affordability of insurance for most uninsured people, and thus lead to very few newly insured.
- **While more effective than deductions, tax credits are not the most efficient way to expand coverage.** In contrast to tax deductions that disproportionately benefit those with higher incomes, tax credits provide the same benefit to all eligible taxpayers who take advantage of them. Thus, they are more likely than deductions to help the low-income

uninsured. To expand coverage to significant numbers of uninsured, tax credits must be refundable, since many uninsured have little to no tax liability, and they must be large enough to cover most of the premium costs for the low-income. However, such large, refundable tax credits could also encourage people who currently have group insurance to switch into the more expensive individual market. Therefore, tax credits are less efficient – the cost per newly insured person is higher than direct provision programs narrowly targeted at the uninsured.

- **Refundable tax credits can complement direct insurance programs and also address the inequity in the current tax treatment of health insurance.** Quality individual health insurance purchased with a refundable tax credit equal in value to the employer deduction could eliminate the current tax advantage enjoyed by those who have employer-provided group insurance. In addition, the Administration has proposed allowing tax credits to be coupled with public program expansions to make such expansions more affordable – i.e. allowing the application of tax credits towards coverage through Medicare, Medicaid or SCHIP buy-ins or through individual health insurance with reforms. However, as stated above, by themselves, tax credits are not the most efficient means of providing affordable insurance to uninsured Americans.
- **Direct provision of health insurance through public programs is the most efficient way of targeting low-income families.** Simulation results indicate that direct provision of health insurance, such as the proposed plan to insure parents of children in SCHIP and Medicaid, effectively reaches the uninsured at a relatively low cost for the benefits provided to the newly insured. The costs are relatively low not only because of lower administrative costs, but also because there is less “crowd-out” of current employer-based coverage in direct insurance programs than in tax credit proposals. The simulation reviewed in this paper suggests that over two-thirds of the participants would be newly insured. This proportion of newly insured participants is between seven and ten times the proportion of newly insured participants for the simulated tax deductions. Thus, this is the best first step in expanding health coverage to the uninsured.

**REACHING THE UNINSURED:  
ALTERNATIVE POLICIES TO EXPAND HEALTH INSURANCE COVERAGE**

**1. INTRODUCTION**

This report documents a serious policy issue—the lack of health insurance for tens of millions of Americans. Without health insurance, many Americans forego needed health care and suffer adverse health consequences. This has economic consequences as well. The lack of insurance is particularly prevalent among low-wage working Americans and their families, because many of their employers do not offer health coverage, and many of these families cannot afford individual insurance coverage. With regular jobs and incomes above the poverty level, however, many of these hard-pressed families do not qualify for existing government insurance programs, such as Medicaid. A number of policy proposals, including alternative tax treatments (such as tax deductions and tax credits) direct provision of health insurance to specific groups in need of coverage, and allowing individuals to “buy-in” to government insurance programs such as Medicare have been suggested to address the rising numbers of the uninsured. Recent studies that have simulated the effects of some of these proposals indicate that certain types of programs may be more efficient and effective than others in increasing health insurance coverage.

**2. HEALTH INSURANCE COVERAGE AND THE CONSEQUENCES OF BEING UNINSURED**

**A. The Scope of the Problem**

In 1998, about 1 in 6 Americans—an estimated 44.3 million individuals—went without health insurance for the entire calendar year.<sup>1</sup> Despite a robust economy and low unemployment rates, the number of uninsured increased from about 31 million in 1987.<sup>2</sup> The lack of coverage is not solely a function of employment status, because over 80 percent of the non-elderly uninsured either work or live in families with a worker.<sup>3</sup> Instead, many of these workers find that insurance is either unavailable from their employer or is simply unaffordable. They also find that while they cannot afford insurance, their effort to earn a living makes them ineligible for existing government programs (like Medicaid) that provide insurance for the poorest Americans.<sup>4</sup>

The lack of health insurance in the United States is strongly related to income (Chart 1). In families with income below the poverty line, 43 percent of adults did not have health insurance. In contrast, in families with income greater than 300 percent of poverty, only 9 percent of adults are uninsured. Fifty-six percent of uninsured nonelderly people are in families with incomes below 200 percent of poverty. The source of coverage also varies with income. More than 80 percent of families with incomes over 300 percent of poverty receive health care

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<sup>1</sup> Jennifer A. Campbell, *Health Insurance Coverage: 1998*, U.S. Census Bureau, Current Population Reports, P60-208 (Washington: U.S. Government Printing Office, 1999).

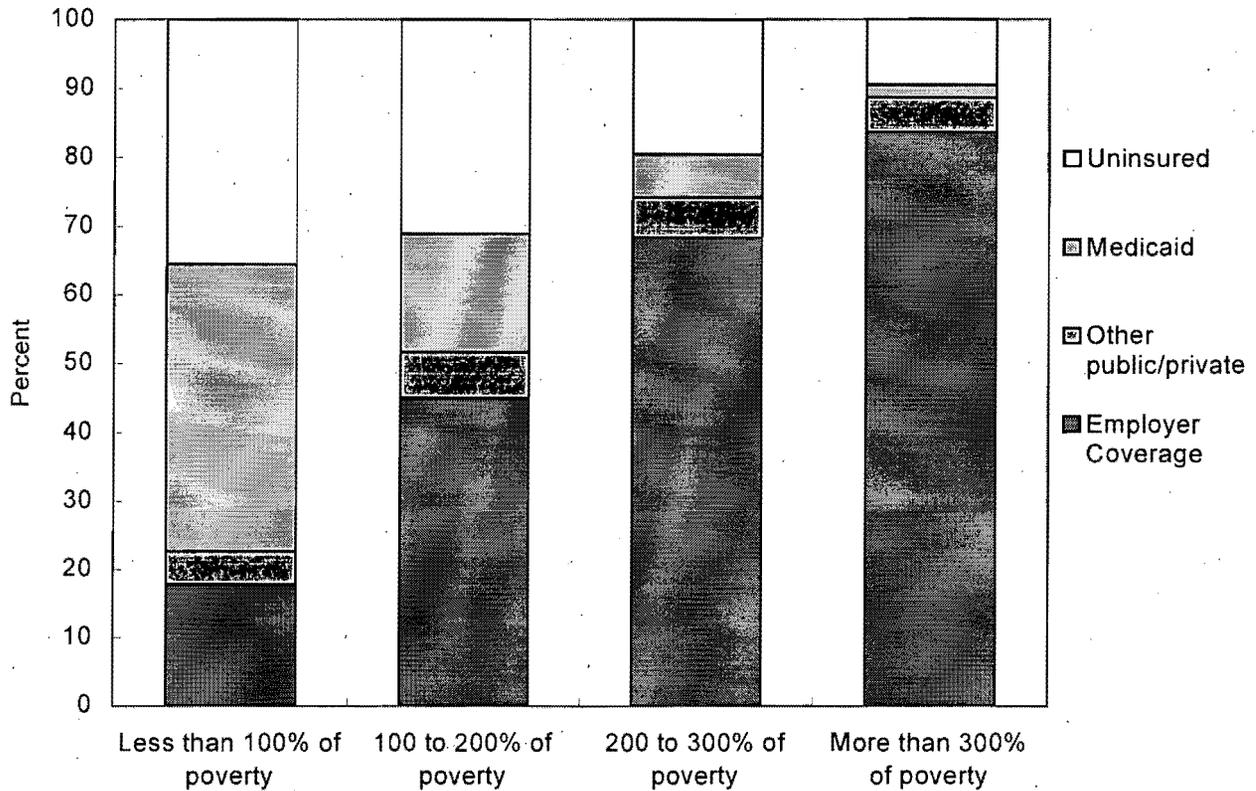
<sup>2</sup> Ibid.

<sup>3</sup> Kevin Quinn, *Working without Benefits: The Health Insurance Crisis Confronting Hispanic Americans* (New York: The Commonwealth Fund, 2000).

<sup>4</sup> Catherine Hoffman and Alan Schlobohm, *Uninsured in America: A Chart Book*, 2nd ed. Kaiser Commission on Medicaid and the Uninsured (Menlo Park: The Henry J. Kaiser Family Foundation, 2000).

coverage through an employer. For families below the poverty line, meanwhile, Medicaid is the source of coverage for nearly a third of all families.

Chart 1. Health Insurance Coverage of Non-elderly People by Family Income, 1998



Source: US Census Bureau tabulations (August 2000)

Overall, the vast majority of Americans who have health insurance receive it through their employers. The percentage of workers insured through the workplace has generally declined since the late 1970s, with low-wage workers being the hardest hit. This decline is due in part to firms' restricting eligibility to exclude many part-time and temporary workers from health insurance coverage.<sup>5</sup> The effect of this decline is magnified by the increasing use of temporary workers. The employer-based system means that young adults have a particularly high risk for non-coverage because they are more likely to hold part-time and temporary jobs. Too old to be covered by their parents' plans but too young to be established in jobs providing health insurance, 30 percent of those aged 19 to 29 are uninsured.<sup>6</sup> Affordable access can also be a problem for the near elderly (those aged 55-64) in the individual insurance market. As health status generally declines with age, insurance may be more important for the near elderly. At the same time, exclusions for pre-existing conditions and high premiums related to expected costs

<sup>5</sup> Ellen O'Brien and Judith Feder, *Employment-Based Health Insurance Coverage and Its Decline: The Growing Plight of Low-Wage Workers*, Kaiser Commission on Medicaid and the Uninsured (Menlo Park: The Henry J. Kaiser Family Foundation, 1999).

<sup>6</sup> Kevin Quinn, Cathy Schoen, and Louisa Buatti, *On their Own: Young Adults Living without Health Insurance* (New York: The Commonwealth Fund, 2000). The authors find that 80 percent of adults aged 19 to 29 take up employer-provided insurance, when it is offered, compared with 84 percent of 30-to-64 age group.

can restrict access and affordability for the early retirees who are no longer covered by employment-based health insurance. Employees of small businesses (less than 100 employees) are also less likely to have insurance: one-fourth of small business employees are uninsured, compared to one-eighth of the employees in firms with 100 or more workers. Racial and ethnic minorities are less likely to be insured than whites, because members of minority groups are less likely to have employer-sponsored health insurance coverage, as they are disproportionately likely to work in low-wage jobs. Approximately 12 percent of non-Hispanic whites, 22 percent of blacks, 35 percent of Hispanics, and 21 percent of Asians and Pacific Islanders were uninsured in 1998.<sup>7</sup>

## **B. An Investment in Health**

Because lack of insurance leads to a host of adverse health consequences and higher medical costs, health insurance, although seemingly expensive, may be a good investment for society. Uninsured people experience worse health problems and thus increase the cost of care to society. One study valued the increase in longevity and improved quality of life between 1970 and 1990 at \$77,000, while the increase in medical spending per person was only \$25,000. While much of this increase in longevity and quality of life may be due to non-medical reasons, such as better nutrition or more exercise, if even a third of the improvement is due to medical spending, the investment is worthwhile.<sup>8</sup> Public investment in health insurance might extend the benefits of longevity and quality of life to more people. In addition, if individuals can be treated routinely, they may maintain better health at a lower cost.

### *The health effects*

Uninsured Americans are more than three times as likely to delay seeking care, and between three and five times less likely to obtain medical/surgical care, dental care, or prescription drugs.<sup>9</sup> Additionally, people who lack insurance coverage often require medical attention for medical complications that could have been prevented by earlier treatment. Thus, they are often hospitalized for conditions that might have been avoided altogether.<sup>10</sup> Uninsured people are often diagnosed at later stages of diseases, when the chance of recovery is diminished. Moreover, failure to receive routine care has far reaching consequences. For example, uninsured pregnant women receive prenatal care later in their pregnancy and make fewer doctor visits than the privately insured. As a result, their newborn infants are at a 31 percent greater risk of being born with adverse health outcomes, including low birth-weight, which is a major cause of physical disability, mental retardation, and other costly health problems (see Box 1).<sup>11</sup>

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<sup>7</sup> Hoffman and Schlobohm, *Uninsured in America*.

<sup>8</sup> David M. Cutler and Elizabeth Richardson, *Your Money and Your Life: The Value of Health and What Affects It*, Working Paper W6895 (Boston: National Bureau of Economic Research, 1999). These values are in constant 1990 dollars.

<sup>9</sup> *No Health Insurance? It's Enough to Make You Sick—Scientific Research Linking the Lack of Health Coverage to Poor Health* (Philadelphia: American College of Physicians-American Society of Internal Medicine, 1999).

<sup>10</sup> Joel S. Weissman, Constantine Gatsonis, and Arnold M. Epstein, "Rates of Avoidable Hospitalization by Insurance Status in Massachusetts and Maryland," *Journal of the American Medical Association* 268:17 (1992).

<sup>11</sup> *No Health Insurance? It's Enough to Make You Sick—Scientific Research Linking the Lack of Health Coverage to Poor Health* (Philadelphia: American College of Physicians-American Society of Internal Medicine, 1999).

### **Box 1. The Value of Prenatal Care**

Prenatal care is currently underused, limiting its ability to cost-effectively improve infant health. Innovations in neonatal care have dramatically increased the life expectancy of low-birth-weight infants, counteracting in part the lack of pre-natal care. But this care has a high price tag. Intensive neonatal care for a low birth-weight infant can cost more than \$2,000 per day and more than \$100,000 over the course of treating one infant.<sup>12</sup> By increasing prenatal care coverage, we may be able to take advantage of preventive medical care, resulting in healthier infants at lower costs. At a relatively low cost of about \$400-\$500 per woman, prenatal medical screening and appropriate care could reduce the incidence of low birth-weight by about 20 percent.<sup>13</sup>

Access to prenatal care is often a problem for low-income and uninsured women. Almost 60 percent of uninsured women do not begin prenatal care until after their first trimester. Among uninsured women, almost 70 percent reported difficulty paying for prenatal care. Additionally, a full 15 percent of uninsured mothers were refused prenatal care when looking for a provider. Evidence suggests that increased eligibility for medical care decreased the number of women who went without prenatal care and the number of women who delayed prenatal care beyond the first trimester.<sup>14</sup> To the extent that cheaper prenatal care can substitute for much more expensive neonatal care, the overall costs of achieving improved infant health outcomes might be reduced.

The health benefits of routine preventive care measures are evident in the rapid progress made in treating cardiovascular disease over the last 50 years. Although heart disease remains the leading cause of death for Americans, cardiovascular disease mortality has fallen dramatically.<sup>15</sup> Part of this decline is due to advances in medical technology, but much of it is because of increased prevention. Less than half of the decline in cardiovascular disease mortality can be attributed to medical technological advances for post-heart attack treatment. Better preventive care, rather than responsive medical care, has accounted for most of the decline. Almost a third of the reduction in heart disease was due to reducing risk factors in individuals diagnosed with coronary disease.<sup>16</sup> Access to early diagnosis and medical care is an effective method of treating cardiovascular disease.

#### ***The economic cost***

Lack of health insurance for the poor may be costly. The uninsured more often obtain care in the emergency room than in a physician's office, and emergency room care is more expensive than office visits. Further, because of inadequate care, the health problems of the uninsured are often more severe and hence more expensive to treat. Evidence indicates that

<sup>12</sup> David M. Cutler and Ellen Meara, *The Technology of Birth: Is It Worth It?*, Working Paper W7390 (Boston: National Bureau of Economic Research, 1999).

<sup>13</sup> Janet Currie and Jeffrey Grogger, *Medicaid Expansions and Welfare Contractions: Offsetting Effects on Prenatal Care and Infant Health?*, Working Paper W7667 (Boston: National Bureau of Economic Research, 2000).

<sup>14</sup> Ibid.

<sup>15</sup> Based on Centers for Disease Control calculations for the entire U.S. population in 1997. Heart disease is estimated to have killed 726,974 people that year.

<sup>16</sup> Calculations based on MG Hunink, L Goldman, AN Tosteson, MA Mittleman, PA Goldman, LW Williams, J Tsevat, and MC Weinstein, "The Recent Decline in Mortality from Coronary Heart Diseases, 1980-1990: The Effect of Secular Trends in Risk Factors and Treatment," *Journal of the American Medical Association* 277.7 (1997).

Medicaid expansions are associated with significant increases in primary care utilization and reductions in expensive avoidable hospitalizations. One recent study found that increases in Medicaid eligibility were associated with a 22 percent decline in avoidable hospitalizations.<sup>17</sup>

Lack of insurance creates a public cost. The costs of hospital care for people who cannot pay are often absorbed by providers, passed on to the insured through higher cost health care and health insurance, or paid by taxpayers through higher taxes to finance public hospitals and public insurance programs.

### 3. OVERVIEW OF CURRENT FEDERAL HEALTH INSURANCE POLICIES

There are several ways whereby the Federal government traditionally seeks to improve the public's access to health insurance. One approach is through provisions in the U.S. tax code that lower the price of insurance. A second is by providing free or low-cost health insurance through public programs. A third method is through laws and regulations enhancing access to insurance. This section provides a brief overview of these approaches.

The current tax system encourages health insurance by allowing income exclusions and deductions for health insurance expenses. Employer-provided health insurance has long had a tax preference, originating during World War II when the IRS ruled that increased health benefits were outside the limits of federal wage controls.<sup>18</sup> Eventually, the exemptions were codified by Congress. This status continues today.<sup>19</sup> One study estimates that the tax exemptions (including both the income and payroll tax exemptions) will cost the Federal government approximately \$125.6 billion in lost tax revenues in 2000.<sup>20</sup>

There are some inequities inherent in the current system. The system provides a tax subsidy that varies directly with the tax rate of the individual or family receiving coverage—the higher the tax rate, the higher the implicit tax subsidy (see Chart 2). For individuals who are in the highest federal income tax bracket, the tax policy reduces the relative “price” of health insurance compared to other goods that must be purchased with after-tax dollars by 39.6 cents on the dollar. In contrast, for those with low incomes—who are in a low tax bracket—the current

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<sup>17</sup> Leemore Dafny and Jonathan Gruber, *Does Public Insurance Improve the Efficiency of Medical Care? Medicaid Expansion and Child Hospitalizations*, Working Paper W7555 (Boston: National Bureau of Economic Research, 2000).

<sup>18</sup> Jon Gabel, “Job-Based Health Insurance, 1997-1998: The Accidental System Under Scrutiny,” *Health Affairs*, Vol 18, No 6 (1999).

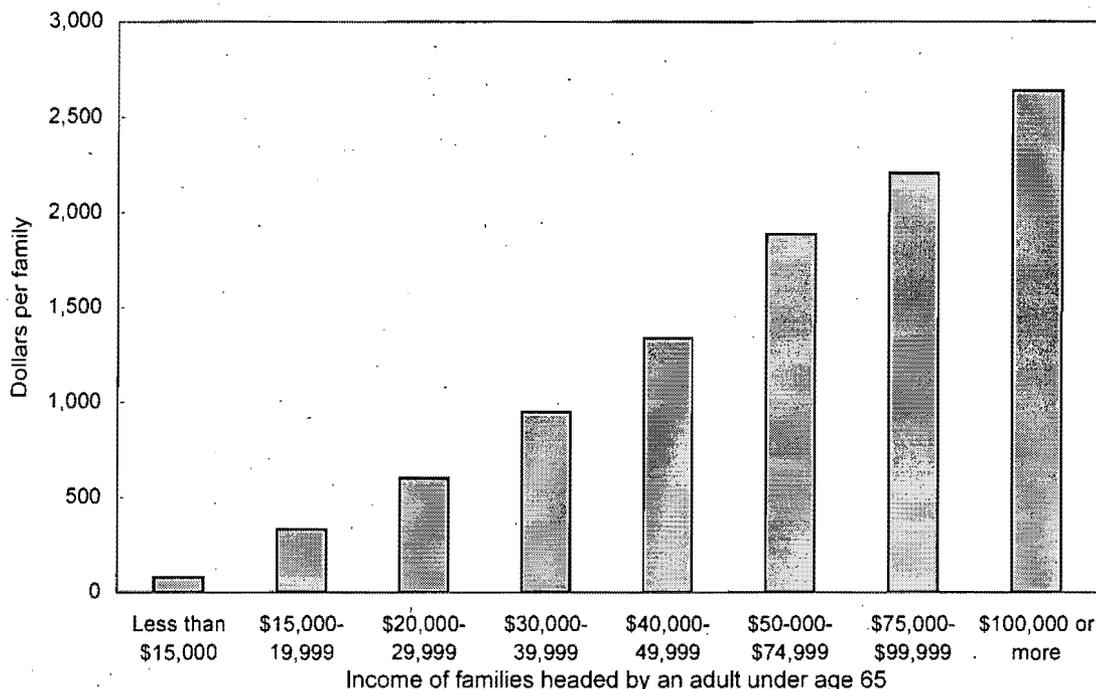
<sup>19</sup> Other tax provisions include: itemized deductions for any medical spending above 7.5 percent of adjusted gross income; flexible spending plans (Section 125) that allow employees' shares of premiums to be made on a pre-tax basis; a phased-in deduction for self-employed workers; and a demonstration of Medical Savings Accounts for some self-employed and workers in small businesses.

<sup>20</sup> John Sheils, Paul Hogan, and Randall Haight, *Health Insurance and Taxes: The Impact of Proposed Changes in Current Federal Policy: Prepared for The National Coalition on Health Care* (Washington, DC: The Lewin Group, Inc., 1999). This estimate also includes the foregone tax revenue due to the exclusion of income from Social Security and Medicare hospitalization insurance taxes.

tax reduces the relative “price” of health insurance by only 15 cents on the dollar or not at all, if no taxes are owed by the individual.<sup>21</sup>

A second inequity arises for those who do not get health insurance through their workplace, but who purchase insurance in the individual market. Because the exemption only applies to employer-provided group insurance, their subsidy, if any, is much smaller.<sup>22</sup>

Chart 2. Average Federal Tax Benefit from Health Insurance Exemption, 2000



Source: John Sheils, Paul Hogan and Randall Haight, "Health Insurance and Taxes: The Impact of Proposed Changes in Current Federal Policy," October 1999, The Lewin Group, Inc.

Note: Calculations incorporate likelihood of receiving employer-provided health benefits and the value of the tax benefit of employer-provided health insurance

With the introduction in 1965 of Medicare and Medicaid to provide health insurance for elderly and low-income Americans, the government began to provide health insurance directly. Over 32 million elderly and 4 million disabled received basic medical insurance through Medicare Part B in 1998.<sup>23</sup> Medicaid offers federal assistance to States that provide medical care to low-income Americans. Historically, eligibility for Medicaid was linked to eligibility for cash welfare. Beginning in the late 1980s, Medicaid has shifted toward a more general health insurance program that includes low-income working people.<sup>24</sup> The 1996 Personal Responsibility and Work Opportunity Reconciliation Act, particularly, allowed Medicaid

<sup>21</sup> The exclusion from the employer and employee shares of the Social Security tax and state and local income taxes further reduces the after tax price (in the case of high income earners only the Medicare tax would typically apply). However, future Social Security benefits may also be reduced.

<sup>22</sup> The tax code includes a phased-in deduction for self-employed individual insurance purchases. See footnote 21.

<sup>23</sup> These statistics for Medicaid, SCHIP and Medicare are based on publicly available estimates by the Health Care Financing Administration.

<sup>24</sup> Lara Shore-Sheppard, Thomas Buchmueller, and Gail Jensen, "Medicaid and Crowding out of private insurance; a re-examination using firm level data." *Journal of Health Economics*, 19 (2000), 61-91

coverage to low-income families. Medicaid served over 41 million people in 1998. In 1997, the State Children's Health Insurance Program (SCHIP) was created to target the growing number of uninsured children in families that have too much income to be eligible for Medicaid but too little to afford private insurance. SCHIP provides states with funding to provide health insurance through Medicaid, a non-Medicaid program, or a combination of both. Combined, these programs insure over 74 million Americans – but through strict eligibility rules, leave out many of the uninsured. For example, people age 62 are not eligible for Medicare, and the uninsured parents of children enrolled in SCHIP are not eligible themselves. (The Administration's budget includes a proposed expansion of SCHIP.)

Federal and state governments have enacted policies to improve access and affordability to private health insurance. Two Federal health-care initiatives were designed to make it easier for workers with health-care coverage to maintain that coverage when they are in-between jobs. The health continuation rules enacted under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1986) enable workers to purchase continued coverage for a limited time when they change jobs or lose eligibility for health insurance. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was designed to extend individuals' ability to maintain private health insurance by limiting exclusions for pre-existing conditions in employer health plans and for workers converting to individually purchased insurance. State regulation of the insurance market is varied. Eight states require guaranteed issue of all products in the individual insurance market; another five states require guaranteed issue of a standard product only. Fifteen states limit rating in the individual market; two require pure community rating.

#### **4. CONSIDERATIONS IN ASSESSING PROPOSALS TO EXTEND COVERAGE**

While the current system of tax incentives and direct provision programs assists millions of Americans in obtaining health insurance, there are many who remain uninsured because they either are ineligible or do not take advantage of them. A number of proposals have been considered to extend coverage to the uninsured. Prior to discussing individual proposals, it is useful to lay out the basic economic issues that are important in assessing the various proposals.

##### **A. Distributional Effects**

Different types of subsidies will have different distributional effects. As described in the previous section, expanding tax deductibility for health insurance premiums will provide more benefit to higher-income people. In contrast, a tax credit directly reduces tax payments by the amount of the credit, and is therefore worth *the same to all taxpayers able to take advantage of it*. To take full advantage of a non-refundable tax credit, however, an individual must pay at least as much in taxes as the amount of the credit. Because almost half of the uninsured do not pay any taxes against which either a deduction or credit can be applied, neither tax deductions nor tax credits reduce the cost of health insurance for this group.<sup>25</sup> If a tax credit is made *refundable*, however, it will reduce the cost of health insurance to all lower-income individuals, because a refundable credit is payable even to those individuals who do not owe any taxes at all.

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<sup>25</sup> Jonathan Gruber, *Tax Subsidies for Health Insurance: Evaluating the Costs and Benefits*, Working Paper 7553 (Boston: National Bureau of Economic Research, 2000).

Limiting eligibility for tax credits targets the benefits to specific income groups. Direct government provision of health insurance can also be targeted to specific income levels by eligibility criteria. While Medicare eligibility is not income-related, Medicaid and SCHIP eligibility are.

### **B. Crowding Out and the “Cost per Newly Insured.”**

Policies that are designed to extend coverage to those currently uninsured can cause some people who currently have insurance to drop it in favor of government-provided insurance or individually purchased insurance motivated by a tax subsidy. Equivalently, some employers may stop offering coverage (or reduce their contribution) and tell their employees to take advantage of the new government insurance or tax subsidy. *This is known as “crowding out” of existing insurance—when new government subsidized insurance crowds out employer-provided insurance.* It means that government dollars go not just to newly insured; some fraction of the money goes to those who had employer-provided coverage and are now switching to a new government-subsidized plan. If the new subsidy provides a much higher benefit than the value of the tax exclusion, then crowding out can be severe and the cost to the government of each net newly insured person can be pushed up substantially. Moreover, if firms drop coverage, some employees may choose not to purchase individual insurance, leading to a smaller net increase in coverage, or possibly even a net decrease.

Studies of the Medicaid child eligibility expansions of the late 1980s and first half of the 1990s found that about 10 to 20 percent of the increase in Medicaid coverage was due to a reduction in private insurance coverage. Most of these studies examined Medicaid expansions that did not contain anti-crowd-out provisions. Because Medicaid covers mostly low-income people who are less likely to have private insurance, crowding out might be expected to be modest.

To prevent crowding-out, some proposals have excluded eligibility of people who previously had private insurance. However, this penalizes people who had already purchased health insurance in the private market and are not eligible for the new subsidies. The amount of crowding out will likely increase as eligibility for subsidies is extended up the income scale. Crowding out will also likely increase as the generosity of a subsidy increases. Therefore crowding out might be limited by targeting subsidies to the lowest income families, who are unlikely to be covered by health insurance, or by limiting subsidies to relatively modest amounts.

### **C. Encouraging Participation**

Many families do not take advantage of insurance programs that are available to them. For individuals at low-income levels, even modest costs (such as nominal premiums or co-payments) may dramatically decrease enrollment and utilization. This may especially affect families without health-insurance problems, who could risk remaining uninsured to pay for more pressing needs such as food and housing. In addition, a complex application process designed to determine eligibility may have the unintended side effect of dramatically reducing coverage for otherwise qualified individuals. A subsidy that is received only after expenses have been paid may also deter individuals who do not have the funds to pay the insurance premiums up front.

## **D. Issues with Different Types of Insurance**

The type of health insurance that the government subsidizes is important. Traditional employer-based insurance is often called “group” coverage, because a firm’s employees form a risk pool of individuals who are all charged the same rate regardless of their individual health status. In contrast, individuals seeking health insurance on their own must purchase insurance in the “non-group” market, where fewer regulatory protections apply. A third option is a public insurance product: either by public provision of insurance, or by a “buy-in” provision. The following are some of the major issues associated with these different types of policies.

### *Accessibility of insurance*

In the non-group market, individuals can face difficulties with access to insurance. Insurers can often vary the benefits package to limit coverage, or exclude individuals with pre-existing conditions from coverage. In many states, insurers can charge different premiums based on the perceived risk of coverage, making health insurance unaffordable for some people. State regulations can address these problems—for example, fifteen states limit rating in the individual market, restricting how much insurers can base premiums on a person’s health<sup>26</sup>—but such solutions can lead to adverse selection problems (discussed below). Small businesses can also face accessibility issues. Insurers recalculate premiums each year based on the experience of the firm. Because firms with fewer employees have a small risk pool, a few serious, costly illnesses among employees could significantly increase premiums in subsequent years. These increases could be passed on to the employees, or the firm could drop health insurance coverage. Larger firms, with larger risk pools are less likely to have such access problems. Publicly-provided insurance provides guaranteed issue to those meeting the criteria established by the government.

### *Adverse selection*

Health insurance is based on the premise that, by offering a single rate to a group of individuals, those people who do not have health expenses in a particular year help pay the costs of those people who do experience health-related expenses—people pool their risks. *Adverse selection occurs when low-risk individuals do not believe they benefit from the risk pooling, and therefore leave the risk pool.* As these relatively healthy people leave the original pool, the average cost per person remaining in the pool will increase. When the costs and therefore the premiums for insurance begin to climb, still more people will elect not to purchase health insurance and there can be a spiral of rising premiums and declining enrollments. This could lead to prohibitively high premiums for those still desiring to purchase health-care insurance.

Adverse selection can affect both the group and the non-group markets. The existing tax subsidy for employment-based group health insurance encourages healthy workers to remain in the group pool, because the subsidy for individually purchased insurance is smaller. If alternative subsidies are available for individual insurance, healthy people may decline employer-based coverage for individual coverage priced to suit them. In response to restrictions on individual

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<sup>26</sup> Deborah Chollet, “Consumers, Insurers, and Market Behavior,” *Journal of Health Politics, Policy, and Law*, 25:1 (2000).

rating, healthy people may also leave the individual market and not carry any health insurance. Even if young, healthy individuals find low-premium policies that reflect their lower risk rather than choosing to drop insurance altogether, higher risk people might still face prohibitively high premiums because the market becomes segmented into different risk pools.

### *Administrative costs*

The administrative expense of selling and billing to many individual policyholders is much larger than when a group of people are represented by a benefits manager. This means that administrative costs are often higher in the non-group than in the group market. Estimates of the amount of premiums paid relative to benefits received suggest that non-group insurance is substantially more expensive than group insurance. *Individuals buying insurance in the non-group market pay on average about \$1.50 in premiums for each \$1 in benefits, a substantially higher ratio than the \$1.15 in premiums paid for \$1 of benefits in the group insurance market.*<sup>27</sup> Small businesses also face relatively high administrative costs.<sup>28</sup> The administrative cost of Medicare is 3 percent of benefit payments.

## **5. SIMULATING THE IMPACT OF ALTERNATIVE POLICY PROPOSALS: EXAMPLES FROM THE LITERATURE**

Economists have built simulation models that estimate the value and cost of different policy options for extending health insurance coverage. These models include estimates of the effects of some or all of the factors discussed above—such as crowding out and take-up rates. The available simulations suffer from some inevitable limitations. They look at a range of different policies that differ sharply in overall cost and eligibility, and the workings of the models are not terribly transparent. Seemingly small changes in proposals can have a big impact on the estimates. Moreover, some of the simulations present short-term effects, even though the policies are likely to require many years before the full effects on the health insurance market play out. But despite these limitations, the models provide a way to quantitatively compare alternative policy choices that go beyond the more qualitative discussion of issues given above. In this section we will briefly present the simulation results for alternative policies aimed at incrementally expanding coverage.

### **A. Tax Policies**

A simulation model developed by Jonathan Gruber examines the effects of two tax proposals to extend coverage.<sup>29</sup>

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<sup>27</sup>Mark V. Pauly and Allison M. Percy, "Cost and Performance: A Comparison of the Individual and Group Health Insurance Markets," *Journal of Health Politics, Policy and Law*, 25.1 (2000).

<sup>28</sup> If the credit is available to anyone purchasing private insurance, taxpayers may file tax returns solely for the purpose of claiming the new tax credit. That could be costly for the IRS to administer. A solution to this problem could be to limit the credit to working individuals and families with earnings above a *de minimis* amount. Those people almost all file tax returns, and as noted earlier, 80 percent of the uninsured are employed or married to an employed person. However, the restriction would exclude many early retirees and other working-age people who are out of the work force, but ineligible for Medicaid.

<sup>29</sup> Gruber, *Tax Subsidies for Health Insurance: Evaluating the Costs and Benefits*.

- The first proposal is a refundable tax credit of up to \$1,000 per individual and \$2,000 per family for non-group health insurance.
  - The second proposal is a tax deduction for individually purchased health insurance, available whether or not the household itemizes deductions.<sup>30</sup> (Unlike the Patients' Bill of Rights proposal, the deduction would not be available to individuals whose employers contribute to their health insurance, regardless of how small the contribution is.<sup>31</sup>)
- Each proposal would be fully available to individuals with incomes up to \$45,000 and to families with incomes up to \$75,000, and phased out to zero by incomes of \$60,000 for individuals and \$100,000 for families. The results of these simulations are in the table below.<sup>32</sup>

Although Gruber's analysis does take into account the immediate effect of the subsidy on employers' decisions to discontinue coverage or employees opting out of employer plans, it does not take into account the long-run effects. For example, after healthy individuals opt out of their employers' plans to obtain individually purchased health insurance, employers' premiums (especially for small firms) will rise, causing more employers to drop coverage or causing some additional employees to opt out. These second round effects may lead to higher crowding out in the long run.<sup>33</sup>

Table 1: Tax Policy Simulation Results (Gruber)

	Refundable Tax Credit for Non-group Insurance	Tax Deduction for Non-group Insurance
All \$ figures in 1999 dollars		
Total participants (millions)	18.4	6.3
Percent of participants previously uninsured	25.7%	9.2%
Net increase in number of insured people (in millions)	4.03	0.25
Percent decrease in the uninsured population	9.5%	0.6%
Number of currently insured who lose coverage (in millions)	0.69	0.34
Percent of participants with incomes below 200% of poverty	53%	32%
Percent of costs spent on participants with incomes below 200% of poverty	56%	29%
Government cost per participant	\$723	\$138
Government cost per newly insured person	\$3,296	\$3,544
Total government cost (in billions)	\$13.3	\$0.9

<sup>30</sup> The deduction would be "above-the-line," which means that it would be available to taxpayers whether or not they itemize deductions.

<sup>31</sup> The Patients' Bill of Rights would allow a deduction for individuals covered under an employer plan as long as the employer contribution does not exceed 50 percent of the premium.

<sup>32</sup> Because there has been limited experience with tax subsidies for health insurance, the estimates of behavioral responses to tax subsidies are based on less solid evidence than that available for simulations of direct subsidies below.

<sup>33</sup> As discussed earlier, this process of adverse selection could in theory cause premiums to spiral up to the point where premiums are unsustainable.

*The striking drawback to the tax deduction plan is that the size of the uninsured population falls by less than one percent.* (Table 1). Of the 6.3 million participants in this plan, only 580,000 were not previously covered by health insurance. In addition, an estimated 340,000 people who were originally insured under an employer plan become uninsured. Another 300,000 people are dropped from employer plans and move to the individual insurance market. On net, the proposal would increase coverage by about a quarter of a million people. Thus, though the benefit level to each participant is only \$138, because 91 percent were previously insured, the cost to the government per newly insured participant is \$3,544. Moreover, only 29 percent of the benefits would go to those with incomes below 200 percent of poverty; only 6 percent goes to those in poverty. Thus, though the total cost of this plan is modest, this is not an effective way to extend coverage to the uninsured.

In contrast, the refundable tax credit increases the number of those insured by 4 million, but at a much higher cost. A higher percentage of participants come from the uninsured population—25.7 percent (4.7 million people), compared to 9.2 percent (580,000 people) for the tax deduction. The refundable credit causes some crowding out: over one million people are dropped by firms and purchase individual insurance, and about 3.6 million voluntarily switch from employer-provided insurance to non-group insurance. About 700,000 people who were insured through their employer become uninsured. The net increase in the number of insured people is about 4 million. Because the refundable tax credit is more effective in reaching the uninsured, the government cost per newly insured is slightly smaller under the refundable tax credit than the tax deduction (\$3,296 versus \$3,544), even though the refundable tax credit provides participants with a much higher level of benefits (\$723 versus \$138). This higher level of benefits raises the total cost of the tax credit plan relative to the tax deduction plan, but even if it were designed to have the same overall cost—which would require narrow targeting—the refundable tax credit could be expected to be more cost effective at reaching the uninsured than a tax deduction.

Another set of researchers—sponsored by the Kaiser Family Foundation—also simulated the effects of refundable tax credits and tax deductions.<sup>34</sup> The simulation model that they use is different from that of Gruber, and the particular features of the tax proposals that are analyzed are somewhat different from those examined by Gruber.<sup>35</sup>

- The first proposal is a sliding-scale refundable tax credit covering full policy costs for all families with incomes at or below 150 percent of the federal poverty level with private health insurance (either direct purchase or through employment). The credit would decline with income until it was phased out completely at 500 percent of the federal poverty level (about \$85,000 for a family of four).
- The second proposal is a policy that would allow individuals without access to employer-sponsored insurance to deduct 80 percent of the premium from taxable income on their tax returns.

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<sup>34</sup> Judith Feder, Cori Uccello, and Ellen O'Brien, *The Difference Different Approaches Make: Comparing Proposals to Expand Health Insurance*, The Kaiser Project on Incremental Health Reform (Menlo Park: The Henry J. Kaiser Family Foundation, 1999).

<sup>35</sup> The Kaiser researchers used their own estimates of behavioral responses to tax subsidies and so their findings would not be directly comparable to the Gruber study even if both studies examined exactly the same tax provisions. Most notably, Gruber assumed a significant number of people would be dropped from their employer-provided group health insurance as a result of the availability of subsidies for non-group insurance.

The simulation incorporates the predicted participation among the eligible population based on historical data from participation in similar plans, the expected costs of the offered plans, and the expected switching of people who were already insured to the more generous full (or near full) subsidy. The table below provides the results of the simulation.

Table 2: Tax Policy Simulation Results (Kaiser)

All \$ figures in 1998 dollars	Refundable Tax Credit for Non-group Insurance	Tax Deduction for Non-group Insurance
Total adult participants (millions)	42.5	6.1
Percent of participants previously uninsured	18%	7%
Number of newly insured (in millions of people)	7.7	.4
Percent of non-elderly adult uninsured who become covered	26%	1%
Percent of participants with incomes below 200% of poverty	46%	21%
Percent of costs spent on participants with incomes below 200% of poverty	73%	14%
Government cost per participant	\$912	\$265
Government cost per newly insured	\$5,156	\$3,953
Total government cost (in billions)	\$38.7	\$1.6

A comparison of the refundable tax credit and the tax deduction using the Kaiser model produces the same general conclusions as those reached using the Gruber model. The refundable tax credit reaches a larger fraction of the uninsured (26 percent) than does the tax deduction (1 percent). It is also much better targeted to the poor than the tax deduction, providing almost 73 percent of its funds to persons below 200 percent of poverty. However, the Kaiser refundable tax credit plan provides a very generous subsidy, so it is expensive and has higher take-up rates. Eighty-two percent of the people who use the subsidy were previously insured.

The Treasury Department analyzed the effects of the tax deduction plan proposed in the Patients' Bill of Rights (PBOR), which provides an above-the-line tax deduction for premiums for non-employer acute care health insurance, or employer health benefits if employer contributions are less than 50 percent of the premium. Because eligibility for the subsidy is extended to the insured whose employer pays less than 50 percent of the premium, many more currently insured individuals would be eligible for this subsidy than the deductions considered in the Gruber and Kaiser simulations, which assume that anyone whose employer contributes at least a dollar is ineligible for a deduction. Further, employers who contribute only a bit more than 50 percent of the premium could reduce their contributions to 49 percent and reduce the after-tax cost to their employees. The PBOR proposal would benefit many people currently covered by employment-based health insurance. Accordingly, the Treasury estimates assume that most of the cost of the deduction would go to currently insured workers whose employers would contribute less than 50 percent of premiums.

Another important difference of the Treasury analysis is that it models a fully phased in policy that has been in effect for 10 years. The Treasury Department estimates that, under this plan, 1.2 million additional people would acquire insurance in 2010, but 600,000 people who were insured through their employer would become uninsured, resulting in a 600,000 net increase in the insured population. The policy would reduce tax revenues by \$11 billion in 2010, so the cost per newly insured person would be about \$18,000.<sup>36</sup>

Overall, tax deductions provide a very small subsidy for the majority of the uninsured, who are lower-income, and thus do very little to increase coverage. Refundable tax credits provide a bigger subsidy that does not increase with income—indeed they could even be designed to provide the largest subsidy to those with the lowest incomes who are least likely to have insurance coverage. Thus, by targeting the people who are left out of the current system, credits can be more effective, more progressive and less disruptive of the employer health insurance market than tax deductions. However, credit proposals, like the ones simulated above, which have broad eligibility may be quite expensive, because the total cost of the tax credit proposals is high when the subsidy attracts many participants who are already insured. For the same reason, they also present the greatest threat to the market for employment-based health insurance. Therefore, they are considerably less efficient than the direct provision proposals described below.

A final drawback of the refundable tax credit plans evaluated here is that the credits direct people to the individual market which, today, is inaccessible to many individuals because they have pre-existing conditions that render them ineligible for insurance. It also can be unaffordable to many people due to adverse selection. Insurance regulation can help address the accessibility and affordability problems that exist today. Another alternative is to allow refundable tax credits to be used for public group plans such as Medicare, Medicaid, or SCHIP buy-ins.

However, these tax credit plans can be valuable in addressing a different problem—the inequities inherent in the current tax treatment of health insurance. As described above, those currently covered by employer-provided health care receive tax breaks, but those who purchase their own insurance receive very little tax benefit. Therefore, a refundable tax credit that approximately equals the value of the employer deduction would provide equity with the tax advantage currently enjoyed by those who have employer-provided insurance.

## **B. Direct Government Provision of Health Insurance**

The simulation model developed by a Kaiser Family Foundation study is also used to examine the effectiveness of two alternative options that increase the direct provision of health insurance to certain segments of the population.

- The first option is a large-scale plan that would extend government-provided insurance coverage to all uninsured adults with incomes below the poverty level.

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<sup>36</sup> A significant part of the difference between the Treasury and Gruber estimates is expected increases in health insurance costs. Treasury assumes that insurance costs will roughly double between 1999 and 2010; thus, Gruber's estimate of \$3,544 per newly insured person in 1999 would correspond to about \$7,000 at 2010 levels. Most of the rest of the difference is attributable to the difference in policies estimated.

- The second option is a proposal very similar to the Administration's proposal to extend government-provided health insurance to parents of children who are eligible for the Medicaid and SCHIP programs. Under this plan, adults in families with incomes up to 100 percent of the poverty line would receive health insurance that was completely paid for by the government. Families with incomes above the poverty level but below state-determined eligibility limits (typically 200 percent of poverty<sup>37</sup>) would pay a premium of 2 or 4 percent of income, depending on whether one or two parents were covered.

Table 3: Direct Provision Simulation Results (Kaiser)

All \$ figures in 1998 dollars	Coverage to all poor adults	Coverage to Parents of Medicaid/SCHIP Children
Total participants (millions)	9.3	3.0
Percent of participants previously uninsured	69%	69%
Number of newly insured people (millions)	6.2	2.1
Percent of non-elderly adult uninsured who become covered	22 %	7%
Percent of participants with incomes below 200% of poverty	100%	93%
Percent of costs spent on participants with incomes below 200% of poverty	100%	94%
Government cost per participant	\$2,484	\$2,271
Government cost per newly insured	\$3,582	\$3,306
Total government cost (in billions)	\$23.0	\$6.7

The results for the two plans are very similar (Table 3), except, of course, for the fact that the broader plan covers many more people and is correspondingly more expensive. The cost per participant is slightly lower in the narrower plan, because some SCHIP parents will contribute a small premium.

The majority of the participants in both plans are newly insured. There is some crowding out evident in this simulation, as 31 percent of participants were previously covered by some other type of insurance. But that is a very low figure relative to the options considered earlier. *Over two-thirds of the participants in the programs are newly insured.* This is because the eligibility for these programs is targeted to lower-income people, who are less likely to be covered by other insurance, and the programs have a generous enough subsidy to get high participation.

<sup>37</sup> State upper income eligibility limits vary from 133 percent of poverty to 350 percent of poverty.

The Office of Management and Budget has estimated the cost of the Administration's FamilyCare proposal, a different proposal with some of the features of the simulation covering parents of children on SCHIP and Medicaid (second column of Table 3), and finds the cost comparable to the simulation's estimated cost per newly insured person. The Administration proposal is broader, projecting 5 million newly insured people, because it includes provisions for the coverage of immigrants, Medicare buy-in for individuals between 55 and 65, and outreach programs to eligible populations.

## 6. CONCLUSIONS

This report highlights a number of troubling features of the current state of health insurance in the United States.

- Over 44 million Americans—about 1 in 6—are not covered by health insurance. This lack of health insurance has worsened over the past decade, even as the economy has been booming. *Forty-three percent of adults in households below the poverty line did not have health insurance coverage in 1998.* Minorities are less likely to be covered by insurance than the average.
- For families without health insurance, health problems often go untreated—leading to poorer health outcomes, including a higher likelihood of being hospitalized with conditions that could have been treated out of the hospital or avoided altogether. *Uninsured Americans are more than three times as likely to delay seeking care.* For many uninsured families, major health problems can lead to financial devastation. Health insurance, while seemingly expensive, may be the most cost-effective way to ensure a healthy society. The benefits of prenatal care, often delayed because of a lack of health insurance, for example, are enormous.
- The cost burden of the uninsured falls on the public at large, because ultimately the entire society absorbs the costs of medical treatment for individuals who are unable to pay for medical care.
- The federal tax code provides a very large subsidy for the purchase of employer-based health insurance by not including employer premium contributions in taxable income. But, because the effective subsidy depends on an employee's marginal tax rate, the value of the health benefit to households rises sharply with household income. Low-income households receive little or no tax incentive to participate in health insurance plans—a key reason that so many low-income households do not have coverage.

A number of policy responses to the problem of the uninsured are discussed in this report, using a discussion of the economic issues involved and quantitative estimates from simulation models. The analysis suggests that some approaches are likely to be more effective than others.

- **Tax deductibility is not an effective policy to extend coverage.** Studies indicate that extending tax deductibility to non-group policies would expand medical insurance coverage only modestly, and would do very little to expand insurance coverage to low-income

families. It would provide a tax break to predominately middle- and upper-income households already purchasing such coverage.

- **Refundable tax credits may reach some low-income families, but, to the extent that tax credits encourage the use of non-group insurance, this creates different problems.** Initiatives of this sort can be scaled to provide a reduction in the number of uninsured—at substantial cost to the government. Refundable tax credits are far more effective in targeting low-income families than are new tax deductions, because a refundable tax credit can be used by families at lower-income levels to reduce the cost of insurance. However, serious problems exist in the non-group insurance market. Lack of availability, adverse selection and administrative costs make the non-group insurance market inefficient and expensive. The difficulties can be addressed with appropriate insurance regulation, which would have to be part of any substantial effort to expand coverage through tax subsidies for non-group coverage. Alternatively, tax credits can be used for individuals to buy insurance through small business purchasing groups or public programs that do not have these problems.
- **Direct provision of health insurance, like the SCHIP initiative, would be particularly effective in targeting low-income families.** Research indicates that this type of initiative, while not affecting as many uninsured people as some of the tax credit proposals, is very effective at reaching the lower-income uninsured for a relatively small total cost. Thus, direct provision has an advantage over tax credits in more effectively making health insurance affordable and accessible for many Americans. *Simulations suggest that over two-thirds of expanded direct provision participants would be newly insured.*
- **Serious problems arise in the non-group insurance market.** Lack of availability, adverse selection and administrative costs make the non-group insurance market inefficient and expensive. This means that policies that encourage households to move into this market are problematic. To an extent these difficulties can be overcome with appropriate insurance regulation, which would have to be part of any substantial effort to expand coverage through tax subsidies for non-group coverage.

Reversing the trend of declining insurance coverage among Americans will require a major commitment by the public sector. One common theme in these studies is that there is no silver bullet that will easily or inexpensively resolve the problem of the uninsured in America. Indeed, taken as a whole, these studies suggest that a careful blend of different policies may be required to reach the uninsured effectively. For Americans at moderate income levels, direct provision policies, such as the Administration's proposal to expand SCHIP to cover adult members of families with eligible children, are particularly cost-effective. Although well intentioned, tax changes (even when based on more-efficient refundable credits rather than tax deductions) are not very effective at reaching a high percentage of the uninsured, because the uninsured are predominantly low-income and the poor simply cannot afford insurance even at a reduced cost. However, tax-credit programs, with insurance regulation or for purchase of public insurance, can be useful to families as their incomes rise and they become ineligible for subsidies through direct provision programs. Such a combination of programs might offer an effective way to provide health insurance to those who have been left out of the current health-care system.

Uninsured / Coverage File

**REACHING THE UNINSURED:  
ALTERNATIVE APPROACHES TO EXPANDING HEALTH INSURANCE ACCESS**

**September 2000**

**A Report by  
The Council of Economic Advisers**

**REACHING THE UNINSURED:  
ALTERNATIVE APPROACHES TO EXPANDING HEALTH INSURANCE ACCESS**

**EXECUTIVE SUMMARY**

The lack of affordable and accessible health insurance remains a major problem for millions of Americans. Without health insurance, many people forego needed health care and suffer adverse health consequences. This has economic consequences as well. This report evaluates three major policy options to make health insurance more affordable. The key findings are:

- **While there are multiple barriers to coverage, lack of affordability remains the primary reason why 44 million Americans lack health insurance.** Though 82 percent of the uninsured are in working families, 56 percent of the uninsured have incomes of less than 200 percent of poverty. Low-wage jobs are less likely to offer health care coverage—and, when offered, often have unaffordable premiums. However, low-incomes are not the only barrier to coverage. Many Americans with incomes well above poverty—such as people who have lost access to employer-based coverage; the near-elderly and people with chronic illness—have difficulty obtaining quality insurance at a reasonable price.
- **Lack of health insurance has economic and health consequences.** Studies show that people without health insurance are less likely to seek health care, resulting in worse health. For example, uninsured pregnant women who fail to get adequate prenatal care have newborns that are at a 31 percent greater risk of being born with adverse health outcomes. In addition, uninsured people often incur higher-than-necessary costs. One study found that expanding Medicaid led to a 22 percent decrease in avoidable hospitalizations of participants. The costs associated with lack of insurance are passed on to the public at large.
- **Tax deductions will do little to improve coverage.** Studies indicate that extending tax deductibility to individually purchased policies would do very little to expand insurance coverage—considerably less than tax credit or direct subsidy programs would. The simulated plans reviewed in this study suggest that the proportion of participants who would be newly insured under a tax deduction plan would be about one-third the proportion of participants who would be newly insured under a tax credit plan. The proportion of participants who would be newly insured under a tax deduction plan would be about one-tenth the proportion of participants who would be newly insured under a direct provision plan. Because tax deductions disproportionately help people with higher incomes, these plans would benefit predominantly middle and upper-income households who already purchase coverage, but would only modestly improve the affordability of insurance for most uninsured people, and thus lead to very few newly insured.
- **While more effective than deductions, tax credits are not the most efficient way to expand coverage.** In contrast to tax deductions that disproportionately benefit those with higher incomes, tax credits provide the same benefit to all eligible taxpayers who take advantage of them. Thus, they are more likely than deductions to help the low-income

uninsured. To expand coverage to significant numbers of uninsured, tax credits must be refundable, since many uninsured have little to no tax liability, and they must be large enough to cover most of the premium costs for the low-income. However, such large, refundable tax credits could also encourage people who currently have group insurance to switch into the more expensive individual market. Therefore, tax credits are less efficient – the cost per newly insured person is higher than direct provision programs narrowly targeted at the uninsured.

- **Refundable tax credits can complement direct insurance programs and also address the inequity in the current tax treatment of health insurance.** Quality individual health insurance purchased with a refundable tax credit equal in value to the employer deduction could eliminate the current tax advantage enjoyed by those who have employer-provided group insurance. In addition, the Administration has proposed allowing tax credits to be coupled with public program expansions to make such expansions more affordable – i.e. allowing the application of tax credits towards coverage through Medicare, Medicaid or SCHIP buy-ins or through individual health insurance with reforms. However, as stated above, by themselves, tax credits are not the most efficient means of providing affordable insurance to uninsured Americans.
- **Direct provision of health insurance through public programs is the most efficient way of targeting low-income families.** Simulation results indicate that direct provision of health insurance, such as the proposed plan to insure parents of children in SCHIP and Medicaid, effectively reaches the uninsured at a relatively low cost for the benefits provided to the newly insured. The costs are relatively low not only because of lower administrative costs, but also because there is less “crowd-out” of current employer-based coverage in direct insurance programs than in tax credit proposals. The simulation reviewed in this paper suggests that over two-thirds of the participants would be newly insured. This proportion of newly insured participants is between seven and ten times the proportion of newly insured participants for the simulated tax deductions. Thus, this is the best first step in expanding health coverage to the uninsured.

**REACHING THE UNINSURED:  
ALTERNATIVE POLICIES TO EXPAND HEALTH INSURANCE COVERAGE**

**1. INTRODUCTION**

This report documents a serious policy issue—the lack of health insurance for tens of millions of Americans. Without health insurance, many Americans forego needed health care and suffer adverse health consequences. This has economic consequences as well. The lack of insurance is particularly prevalent among low-wage working Americans and their families, because many of their employers do not offer health coverage, and many of these families cannot afford individual insurance coverage. With regular jobs and incomes above the poverty level, however, many of these hard-pressed families do not qualify for existing government insurance programs, such as Medicaid. A number of policy proposals, including alternative tax treatments (such as tax deductions and tax credits) direct provision of health insurance to specific groups in need of coverage, and allowing individuals to “buy-in” to government insurance programs such as Medicare have been suggested to address the rising numbers of the uninsured. Recent studies that have simulated the effects of some of these proposals indicate that certain types of programs may be more efficient and effective than others in increasing health insurance coverage.

**2. HEALTH INSURANCE COVERAGE AND THE CONSEQUENCES OF BEING UNINSURED**

**A. The Scope of the Problem**

In 1998, about 1 in 6 Americans—an estimated 44.3 million individuals—went without health insurance for the entire calendar year.<sup>1</sup> Despite a robust economy and low unemployment rates, the number of uninsured increased from about 31 million in 1987.<sup>2</sup> The lack of coverage is not solely a function of employment status, because over 80 percent of the non-elderly uninsured either work or live in families with a worker.<sup>3</sup> Instead, many of these workers find that insurance is either unavailable from their employer or is simply unaffordable. They also find that while they cannot afford insurance, their effort to earn a living makes them ineligible for existing government programs (like Medicaid) that provide insurance for the poorest Americans.<sup>4</sup>

The lack of health insurance in the United States is strongly related to income (Chart 1). In families with income below the poverty line, 43 percent of adults did not have health insurance. In contrast, in families with income greater than 300 percent of poverty, only 9 percent of adults are uninsured. Fifty-six percent of uninsured nonelderly people are in families with incomes below 200 percent of poverty. The source of coverage also varies with income. More than 80 percent of families with incomes over 300 percent of poverty receive health care

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<sup>1</sup> Jennifer A. Campbell, *Health Insurance Coverage: 1998*, U.S. Census Bureau, Current Population Reports, P60-208 (Washington: U.S. Government Printing Office, 1999).

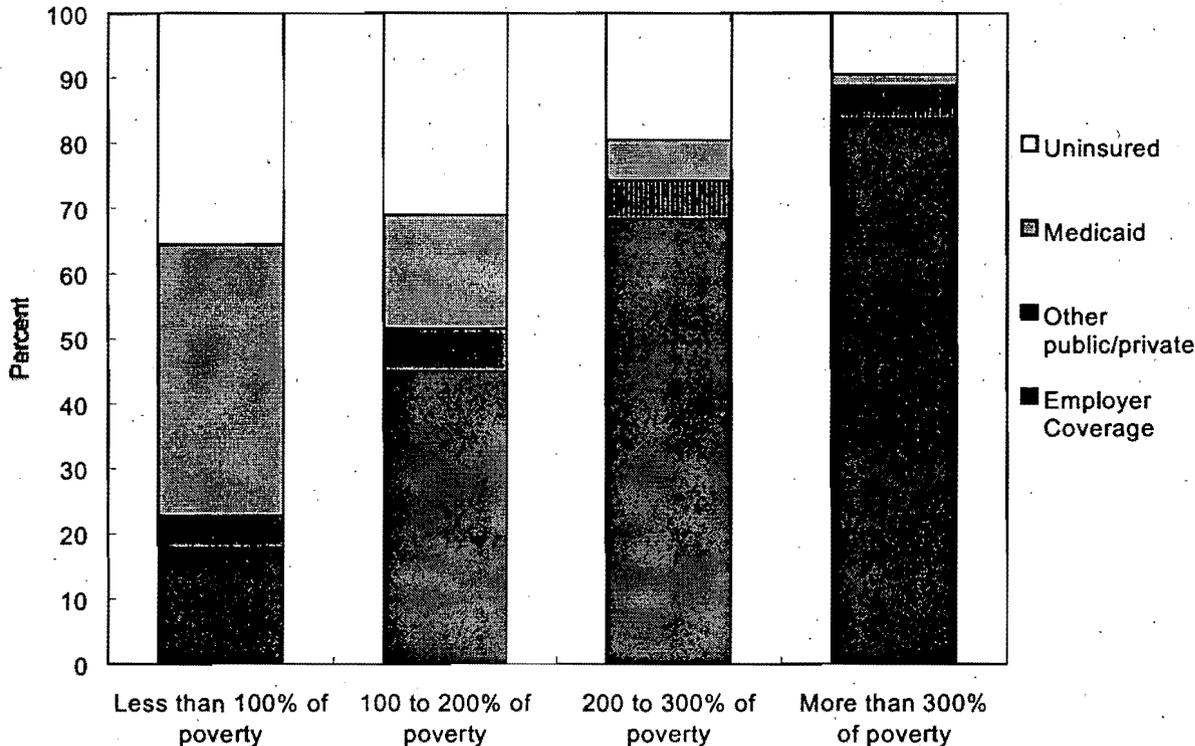
<sup>2</sup> Ibid.

<sup>3</sup> Kevin Quinn, *Working without Benefits: The Health Insurance Crisis Confronting Hispanic Americans* (New York: The Commonwealth Fund, 2000).

<sup>4</sup> Catherine Hoffman and Alan Schlobohm, *Uninsured in America: A Chart Book*, 2nd ed. Kaiser Commission on Medicaid and the Uninsured (Menlo Park: The Henry J. Kaiser Family Foundation, 2000).

coverage through an employer. For families below the poverty line, meanwhile, Medicaid is the source of coverage for nearly a third of all families.

Chart 1. Health Insurance Coverage of Non-elderly People by Family Income, 1998



Source: US Census Bureau tabulations (August 2000)

Overall, the vast majority of Americans who have health insurance receive it through their employers. The percentage of workers insured through the workplace has generally declined since the late 1970s, with low-wage workers being the hardest hit. This decline is due in part to firms' restricting eligibility to exclude many part-time and temporary workers from health insurance coverage.<sup>5</sup> The effect of this decline is magnified by the increasing use of temporary workers. The employer-based system means that young adults have a particularly high risk for non-coverage because they are more likely to hold part-time and temporary jobs. Too old to be covered by their parents' plans but too young to be established in jobs providing health insurance, 30 percent of those aged 19 to 29 are uninsured.<sup>6</sup> Affordable access can also be a problem for the near elderly (those aged 55-64) in the individual insurance market. As health status generally declines with age, insurance may be more important for the near elderly. At the same time, exclusions for pre-existing conditions and high premiums related to expected costs

<sup>5</sup> Ellen O'Brien and Judith Feder, *Employment-Based Health Insurance Coverage and Its Decline: The Growing Plight of Low-Wage Workers*, Kaiser Commission on Medicaid and the Uninsured (Menlo Park: The Henry J. Kaiser Family Foundation, 1999).

<sup>6</sup> Kevin Quinn, Cathy Schoen, and Louisa Buatti, *On their Own: Young Adults Living without Health Insurance* (New York: The Commonwealth Fund, 2000). The authors find that 80 percent of adults aged 19 to 29 take up employer-provided insurance, when it is offered, compared with 84 percent of 30-to-64 age group.

can restrict access and affordability for the early retirees who are no longer covered by employment-based health insurance. Employees of small businesses (less than 100 employees) are also less likely to have insurance: one-fourth of small business employees are uninsured, compared to one-eighth of the employees in firms with 100 or more workers. Racial and ethnic minorities are less likely to be insured than whites, because members of minority groups are less likely to have employer-sponsored health insurance coverage, as they are disproportionately likely to work in low-wage jobs. Approximately 12 percent of non-Hispanic whites, 22 percent of blacks, 35 percent of Hispanics, and 21 percent of Asians and Pacific Islanders were uninsured in 1998.<sup>7</sup>

## **B. An Investment in Health**

Because lack of insurance leads to a host of adverse health consequences and higher medical costs, health insurance, although seemingly expensive, may be a good investment for society. Uninsured people experience worse health problems and thus increase the cost of care to society. One study valued the increase in longevity and improved quality of life between 1970 and 1990 at \$77,000, while the increase in medical spending per person was only \$25,000. While much of this increase in longevity and quality of life may be due to non-medical reasons, such as better nutrition or more exercise, if even a third of the improvement is due to medical spending, the investment is worthwhile.<sup>8</sup> Public investment in health insurance might extend the benefits of longevity and quality of life to more people. In addition, if individuals can be treated routinely, they may maintain better health at a lower cost.

### *The health effects*

Uninsured Americans are more than three times as likely to delay seeking care, and between three and five times less likely to obtain medical/surgical care, dental care, or prescription drugs.<sup>9</sup> Additionally, people who lack insurance coverage often require medical attention for medical complications that could have been prevented by earlier treatment. Thus, they are often hospitalized for conditions that might have been avoided altogether.<sup>10</sup> Uninsured people are often diagnosed at later stages of diseases, when the chance of recovery is diminished. Moreover, failure to receive routine care has far reaching consequences. For example, uninsured pregnant women receive prenatal care later in their pregnancy and make fewer doctor visits than the privately insured. As a result, their newborn infants are at a 31 percent greater risk of being born with adverse health outcomes, including low birth-weight, which is a major cause of physical disability, mental retardation, and other costly health problems (see Box 1).<sup>11</sup>

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<sup>7</sup> Hoffman and Schlobohm, *Uninsured in America*.

<sup>8</sup> David M. Cutler and Elizabeth Richardson, *Your Money and Your Life: The Value of Health and What Affects It*, Working Paper W6895 (Boston: National Bureau of Economic Research, 1999). These values are in constant 1990 dollars.

<sup>9</sup> *No Health Insurance? It's Enough to Make You Sick—Scientific Research Linking the Lack of Health Coverage to Poor Health* (Philadelphia: American College of Physicians-American Society of Internal Medicine, 1999).

<sup>10</sup> Joel S. Weissman, Constantine Gatsonis, and Arnold M. Epstein, "Rates of Avoidable Hospitalization by Insurance Status in Massachusetts and Maryland," *Journal of the American Medical Association* 268.17 (1992).

<sup>11</sup> *No Health Insurance? It's Enough to Make You Sick—Scientific Research Linking the Lack of Health Coverage to Poor Health*. (Philadelphia: American College of Physicians-American Society of Internal Medicine, 1999).

### **Box 1. The Value of Prenatal Care**

Prenatal care is currently underused, limiting its ability to cost-effectively improve infant health. Innovations in neonatal care have dramatically increased the life expectancy of low-birth-weight infants, counteracting in part the lack of pre-natal care. But this care has a high price tag. Intensive neonatal care for a low birth-weight infant can cost more than \$2,000 per day and more than \$100,000 over the course of treating one infant.<sup>12</sup> By increasing prenatal care coverage, we may be able to take advantage of preventive medical care, resulting in healthier infants at lower costs. At a relatively low cost of about \$400-\$500 per woman, prenatal medical screening and appropriate care could reduce the incidence of low birth-weight by about 20 percent.<sup>13</sup>

Access to prenatal care is often a problem for low-income and uninsured women. Almost 60 percent of uninsured women do not begin prenatal care until after their first trimester. Among uninsured women, almost 70 percent reported difficulty paying for prenatal care. Additionally, a full 15 percent of uninsured mothers were refused prenatal care when looking for a provider. Evidence suggests that increased eligibility for medical care decreased the number of women who went without prenatal care and the number of women who delayed prenatal care beyond the first trimester.<sup>14</sup> To the extent that cheaper prenatal care can substitute for much more expensive neonatal care, the overall costs of achieving improved infant health outcomes might be reduced.

The health benefits of routine preventive care measures are evident in the rapid progress made in treating cardiovascular disease over the last 50 years. Although heart disease remains the leading cause of death for Americans, cardiovascular disease mortality has fallen dramatically.<sup>15</sup> Part of this decline is due to advances in medical technology, but much of it is because of increased prevention. Less than half of the decline in cardiovascular disease mortality can be attributed to medical technological advances for post-heart attack treatment. Better preventive care, rather than responsive medical care, has accounted for most of the decline. Almost a third of the reduction in heart disease was due to reducing risk factors in individuals diagnosed with coronary disease.<sup>16</sup> Access to early diagnosis and medical care is an effective method of treating cardiovascular disease.

#### ***The economic cost***

Lack of health insurance for the poor may be costly. The uninsured more often obtain care in the emergency room than in a physician's office, and emergency room care is more expensive than office visits. Further, because of inadequate care, the health problems of the uninsured are often more severe and hence more expensive to treat. Evidence indicates that

<sup>12</sup> David M. Cutler and Ellen Meara, *The Technology of Birth: Is It Worth It?*, Working Paper W7390 (Boston: National Bureau of Economic Research, 1999).

<sup>13</sup> Janet Currie and Jeffrey Grogger, *Medicaid Expansions and Welfare Contractions: Offsetting Effects on Prenatal Care and Infant Health?*, Working Paper W7667 (Boston: National Bureau of Economic Research, 2000).

<sup>14</sup> Ibid.

<sup>15</sup> Based on Centers for Disease Control calculations for the entire U.S. population in 1997. Heart disease is estimated to have killed 726,974 people that year.

<sup>16</sup> Calculations based on MG Hunink, L Goldsman, AN Tosteson, MA Mittleman, PA Goldman, LW Williams, J Tsevat, and MC Weinstein, "The Recent Decline in Mortality from Coronary Heart Diseases, 1980-1990: The Effect of Secular Trends in Risk Factors and Treatment," *Journal of the American Medical Association* 277.7 (1997).

Medicaid expansions are associated with significant increases in primary care utilization and reductions in expensive avoidable hospitalizations. One recent study found that increases in Medicaid eligibility were associated with a 22 percent decline in avoidable hospitalizations.<sup>17</sup>

Lack of insurance creates a public cost. The costs of hospital care for people who cannot pay are often absorbed by providers, passed on to the insured through higher cost health care and health insurance, or paid by taxpayers through higher taxes to finance public hospitals and public insurance programs.

### 3. OVERVIEW OF CURRENT FEDERAL HEALTH INSURANCE POLICIES

There are several ways whereby the Federal government traditionally seeks to improve the public's access to health insurance. One approach is through provisions in the U.S. tax code that lower the price of insurance. A second is by providing free or low-cost health insurance through public programs. A third method is through laws and regulations enhancing access to insurance. This section provides a brief overview of these approaches.

The current tax system encourages health insurance by allowing income exclusions and deductions for health insurance expenses. Employer-provided health insurance has long had a tax preference, originating during World War II when the IRS ruled that increased health benefits were outside the limits of federal wage controls.<sup>18</sup> Eventually, the exemptions were codified by Congress. This status continues today.<sup>19</sup> One study estimates that the tax exemptions (including both the income and payroll tax exemptions) will cost the Federal government approximately \$125.6 billion in lost tax revenues in 2000.<sup>20</sup>

There are some inequities inherent in the current system. The system provides a tax subsidy that varies directly with the tax rate of the individual or family receiving coverage—the higher the tax rate, the higher the implicit tax subsidy (see Chart 2). For individuals who are in the highest federal income tax bracket, the tax policy reduces the relative “price” of health insurance compared to other goods that must be purchased with after-tax dollars by 39.6 cents on the dollar. In contrast, for those with low incomes—who are in a low tax bracket—the current

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<sup>17</sup> Leemore Dafny and Jonathan Gruber, *Does Public Insurance Improve the Efficiency of Medical Care? Medicaid Expansion and Child Hospitalizations*, Working Paper W7555 (Boston: National Bureau of Economic Research, 2000).

<sup>18</sup> Jon Gabel, “Job-Based Health Insurance, 1997-1998: The Accidental System Under Scrutiny,” *Health Affairs*, Vol 18, No 6 (1999).

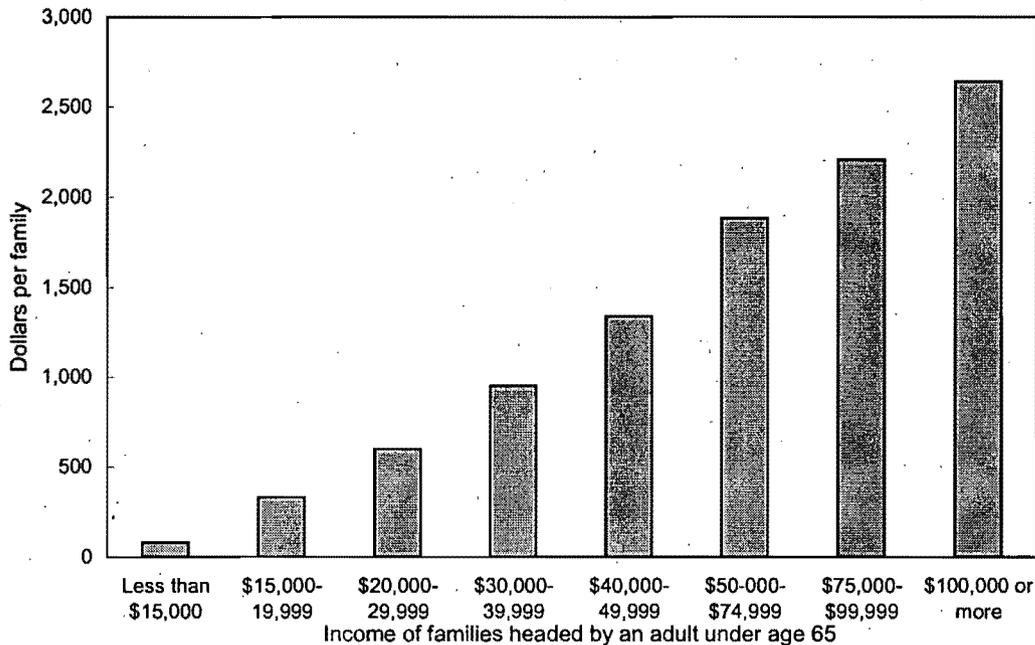
<sup>19</sup> Other tax provisions include: itemized deductions for any medical spending above 7.5 percent of adjusted gross income; flexible spending plans (Section 125) that allow employees' shares of premiums to be made on a pre-tax basis; a phased-in deduction for self-employed workers; and a demonstration of Medical Savings Accounts for some self-employed and workers in small businesses.

<sup>20</sup> John Sheils, Paul Hogan, and Randall Haught, *Health Insurance and Taxes: The Impact of Proposed Changes in Current Federal Policy: Prepared for The National Coalition on Health Care* (Washington, DC: The Lewin Group, Inc., 1999). This estimate also includes the foregone tax revenue due to the exclusion of income from Social Security and Medicare hospitalization insurance taxes.

tax reduces the relative “price” of health insurance by only 15 cents on the dollar or not at all, if no taxes are owed by the individual.<sup>21</sup>

A second inequity arises for those who do not get health insurance through their workplace, but who purchase insurance in the individual market. Because the exemption only applies to employer-provided group insurance, their subsidy, if any, is much smaller.<sup>22</sup>

Chart 2. Average Federal Tax Benefit from Health Insurance Exemption, 2000



Source: John Sheils, Paul Hogan and Randall Haight, “Health Insurance and Taxes: The Impact of Proposed Changes in Current Federal Policy,” October 1999, The Lewin Group, Inc.

Note: Calculations incorporate likelihood of receiving employer-provided health benefits and the value of the tax benefit of employer-provided health insurance

With the introduction in 1965 of Medicare and Medicaid to provide health insurance for elderly and low-income Americans, the government began to provide health insurance directly. Over 32 million elderly and 4 million disabled received basic medical insurance through Medicare Part B in 1998.<sup>23</sup> Medicaid offers federal assistance to States that provide medical care to low-income Americans. Historically, eligibility for Medicaid was linked to eligibility for cash welfare. Beginning in the late 1980s, Medicaid has shifted toward a more general health insurance program that includes low-income working people.<sup>24</sup> The 1996 Personal Responsibility and Work Opportunity Reconciliation Act, particularly, allowed Medicaid

<sup>21</sup> The exclusion from the employer and employee shares of the Social Security tax and state and local income taxes further reduces the after tax price (in the case of high income earners only the Medicare tax would typically apply). However, future Social Security benefits may also be reduced.

<sup>22</sup> The tax code includes a phased-in deduction for self-employed individual insurance purchases. See footnote 21.

<sup>23</sup> These statistics for Medicaid, SCHIP and Medicare are based on publicly available estimates by the Health Care Financing Administration.

<sup>24</sup> Lara Shore-Sheppard, Thomas Buchmueller, and Gail Jensen, “Medicaid and Crowding out of private insurance; a re-examination using firm level data.” *Journal of Health Economics*, 19 (2000), 61-91

coverage to low-income families. Medicaid served over 41 million people in 1998. In 1997, the State Children's Health Insurance Program (SCHIP) was created to target the growing number of uninsured children in families that have too much income to be eligible for Medicaid but too little to afford private insurance. SCHIP provides states with funding to provide health insurance through Medicaid, a non-Medicaid program, or a combination of both. Combined, these programs insure over 74 million Americans – but through strict eligibility rules, leave out many of the uninsured. For example, people age 62 are not eligible for Medicare, and the uninsured parents of children enrolled in SCHIP are not eligible themselves. (The Administration's budget includes a proposed expansion of SCHIP.)

Federal and state governments have enacted policies to improve access and affordability to private health insurance. Two Federal health-care initiatives were designed to make it easier for workers with health-care coverage to maintain that coverage when they are in-between jobs. The health continuation rules enacted under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1986) enable workers to purchase continued coverage for a limited time when they change jobs or lose eligibility for health insurance. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was designed to extend individuals' ability to maintain private health insurance by limiting exclusions for pre-existing conditions in employer health plans and for workers converting to individually purchased insurance. State regulation of the insurance market is varied. Eight states require guaranteed issue of all products in the individual insurance market; another five states require guaranteed issue of a standard product only. Fifteen states limit rating in the individual market; two require pure community rating.

#### 4. CONSIDERATIONS IN ASSESSING PROPOSALS TO EXTEND COVERAGE

While the current system of tax incentives and direct provision programs assists millions of Americans in obtaining health insurance, there are many who remain uninsured because they either are ineligible or do not take advantage of them. A number of proposals have been considered to extend coverage to the uninsured. Prior to discussing individual proposals, it is useful to lay out the basic economic issues that are important in assessing the various proposals.

##### A. Distributional Effects

Different types of subsidies will have different distributional effects. As described in the previous section, expanding tax deductibility for health insurance premiums will provide more benefit to higher-income people. In contrast, a tax credit directly reduces tax payments by the amount of the credit, and is therefore worth *the same to all taxpayers able to take advantage of it*. To take full advantage of a non-refundable tax credit, however, an individual must pay at least as much in taxes as the amount of the credit. Because almost half of the uninsured do not pay any taxes against which either a deduction or credit can be applied, neither tax deductions nor tax credits reduce the cost of health insurance for this group.<sup>25</sup> If a tax credit is made *refundable*, however, it will reduce the cost of health insurance to all lower-income individuals, because a refundable credit is payable even to those individuals who do not owe any taxes at all.

<sup>25</sup> Jonathan Gruber, *Tax Subsidies for Health Insurance: Evaluating the Costs and Benefits*, Working Paper 7553 (Boston: National Bureau of Economic Research, 2000).

Limiting eligibility for tax credits targets the benefits to specific income groups. Direct government provision of health insurance can also be targeted to specific income levels by eligibility criteria. While Medicare eligibility is not income-related, Medicaid and SCHIP eligibility are.

### **B. Crowding Out and the "Cost per Newly Insured."**

Policies that are designed to extend coverage to those currently uninsured can cause some people who currently have insurance to drop it in favor of government-provided insurance or individually purchased insurance motivated by a tax subsidy. Equivalently, some employers may stop offering coverage (or reduce their contribution) and tell their employees to take advantage of the new government insurance or tax subsidy. *This is known as "crowding out" of existing insurance—when new government subsidized insurance crowds out employer-provided insurance.* It means that government dollars go not just to newly insured; some fraction of the money goes to those who had employer-provided coverage and are now switching to a new government-subsidized plan. If the new subsidy provides a much higher benefit than the value of the tax exclusion, then crowding out can be severe and the cost to the government of each net newly insured person can be pushed up substantially. Moreover, if firms drop coverage, some employees may choose not to purchase individual insurance, leading to a smaller net increase in coverage, or possibly even a net decrease.

Studies of the Medicaid child eligibility expansions of the late 1980s and first half of the 1990s found that about 10 to 20 percent of the increase in Medicaid coverage was due to a reduction in private insurance coverage. Most of these studies examined Medicaid expansions that did not contain anti-crowd-out provisions. Because Medicaid covers mostly low-income people who are less likely to have private insurance, crowding out might be expected to be modest.

To prevent crowding-out, some proposals have excluded eligibility of people who previously had private insurance. However, this penalizes people who had already purchased health insurance in the private market and are not eligible for the new subsidies. The amount of crowding out will likely increase as eligibility for subsidies is extended up the income scale. Crowding out will also likely increase as the generosity of a subsidy increases. Therefore crowding out might be limited by targeting subsidies to the lowest income families, who are unlikely to be covered by health insurance, or by limiting subsidies to relatively modest amounts.

### **C. Encouraging Participation**

Many families do not take advantage of insurance programs that are available to them. For individuals at low-income levels, even modest costs (such as nominal premiums or co-payments) may dramatically decrease enrollment and utilization. This may especially affect families without health-insurance problems, who could risk remaining uninsured to pay for more pressing needs such as food and housing. In addition, a complex application process designed to determine eligibility may have the unintended side effect of dramatically reducing coverage for otherwise-qualified individuals. A subsidy that is received only after expenses have been paid may also deter individuals who do not have the funds to pay the insurance premiums up front.

#### **D. Issues with Different Types of Insurance**

The type of health insurance that the government subsidizes is important. Traditional employer-based insurance is often called “group” coverage, because a firm’s employees form a risk pool of individuals who are all charged the same rate regardless of their individual health status. In contrast, individuals seeking health insurance on their own must purchase insurance in the “non-group” market, where fewer regulatory protections apply. A third option is a public insurance product: either by public provision of insurance, or by a “buy-in” provision. The following are some of the major issues associated with these different types of policies.

##### *Accessibility of insurance*

In the non-group market, individuals can face difficulties with access to insurance. Insurers can often vary the benefits package to limit coverage, or exclude individuals with pre-existing conditions from coverage. In many states, insurers can charge different premiums based on the perceived risk of coverage, making health insurance unaffordable for some people. State regulations can address these problems—for example, fifteen states limit rating in the individual market, restricting how much insurers can base premiums on a person’s health<sup>26</sup>—but such solutions can lead to adverse selection problems (discussed below). Small businesses can also face accessibility issues. Insurers recalculate premiums each year based on the experience of the firm. Because firms with fewer employees have a small risk pool, a few serious, costly illnesses among employees could significantly increase premiums in subsequent years. These increases could be passed on to the employees, or the firm could drop health insurance coverage. Larger firms, with larger risk pools are less likely to have such access problems. Publicly-provided insurance provides guaranteed issue to those meeting the criteria established by the government.

##### *Adverse selection*

Health insurance is based on the premise that, by offering a single rate to a group of individuals, those people who do not have health expenses in a particular year help pay the costs of those people who do experience health-related expenses—people pool their risks. *Adverse selection occurs when low-risk individuals do not believe they benefit from the risk pooling, and therefore leave the risk pool.* As these relatively healthy people leave the original pool, the average cost per person remaining in the pool will increase. When the costs and therefore the premiums for insurance begin to climb, still more people will elect not to purchase health insurance and there can be a spiral of rising premiums and declining enrollments. This could lead to prohibitively high premiums for those still desiring to purchase health-care insurance.

Adverse selection can affect both the group and the non-group markets. The existing tax subsidy for employment-based group health insurance encourages healthy workers to remain in the group pool, because the subsidy for individually purchased insurance is smaller. If alternative subsidies are available for individual insurance, healthy people may decline employer-based coverage for individual coverage priced to suit them. In response to restrictions on individual

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<sup>26</sup> Deborah Chollet, “Consumers, Insurers, and Market Behavior,” *Journal of Health Politics, Policy, and Law*, 25.1 (2000).

rating, healthy people may also leave the individual market and not carry any health insurance. Even if young, healthy individuals find low-premium policies that reflect their lower risk rather than choosing to drop insurance altogether, higher risk people might still face prohibitively high premiums because the market becomes segmented into different risk pools.

### *Administrative costs*

The administrative expense of selling and billing to many individual policyholders is much larger than when a group of people are represented by a benefits manager. This means that administrative costs are often higher in the non-group than in the group market. Estimates of the amount of premiums paid relative to benefits received suggest that non-group insurance is substantially more expensive than group insurance. *Individuals buying insurance in the non-group market pay on average about \$1.50 in premiums for each \$1 in benefits, a substantially higher ratio than the \$1.15 in premiums paid for \$1 of benefits in the group insurance market.*<sup>27</sup> Small businesses also face relatively high administrative costs.<sup>28</sup> The administrative cost of Medicare is 3 percent of benefit payments.

## **5. SIMULATING THE IMPACT OF ALTERNATIVE POLICY PROPOSALS: EXAMPLES FROM THE LITERATURE**

Economists have built simulation models that estimate the value and cost of different policy options for extending health insurance coverage. These models include estimates of the effects of some or all of the factors discussed above—such as crowding out and take-up rates. The available simulations suffer from some inevitable limitations. They look at a range of different policies that differ sharply in overall cost and eligibility, and the workings of the models are not terribly transparent. Seemingly small changes in proposals can have a big impact on the estimates. Moreover, some of the simulations present short-term effects, even though the policies are likely to require many years before the full effects on the health insurance market play out. But despite these limitations, the models provide a way to quantitatively compare alternative policy choices that go beyond the more qualitative discussion of issues given above. In this section we will briefly present the simulation results for alternative policies aimed at incrementally expanding coverage.

### **A. Tax Policies**

A simulation model developed by Jonathan Gruber examines the effects of two tax proposals to extend coverage.<sup>29</sup>

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<sup>27</sup>Mark V. Pauly and Allison M. Percy, "Cost and Performance: A Comparison of the Individual and Group Health Insurance Markets," *Journal of Health Politics, Policy and Law*, 25.1 (2000).

<sup>28</sup>If the credit is available to anyone purchasing private insurance, taxpayers may file tax returns solely for the purpose of claiming the new tax credit. That could be costly for the IRS to administer. A solution to this problem could be to limit the credit to working individuals and families with earnings above a *de minimis* amount. Those people also all file tax returns, and as noted earlier, 80 percent of the uninsured are employed or married to an employed person. However, the restriction would exclude many early retirees and other working-age people who are out of the work force, but ineligible for Medicaid.

<sup>29</sup>Gruber, *Tax Subsidies for Health Insurance: Evaluating the Costs and Benefits*.

- The first proposal is a refundable tax credit of up to \$1,000 per individual and \$2,000 per family for non-group health insurance.
  - The second proposal is a tax deduction for individually purchased health insurance, available whether or not the household itemizes deductions.<sup>30</sup> (Unlike the Patients' Bill of Rights proposal, the deduction would not be available to individuals whose employers contribute to their health insurance, regardless of how small the contribution is.<sup>31</sup>)
- Each proposal would be fully available to individuals with incomes up to \$45,000 and to families with incomes up to \$75,000, and phased out to zero by incomes of \$60,000 for individuals and \$100,000 for families. The results of these simulations are in the table below.<sup>32</sup>

Although Gruber's analysis does take into account the immediate effect of the subsidy on employers' decisions to discontinue coverage or employees opting out of employer plans, it does not take into account the long-run effects. For example, after healthy individuals opt out of their employers' plans to obtain individually purchased health insurance, employers' premiums (especially for small firms) will rise, causing more employers to drop coverage or causing some additional employees to opt out. These second round effects may lead to higher crowding out in the long run.<sup>33</sup>

Table 1: Tax Policy Simulation Results (Gruber)

All \$ figures in 1999 dollars	Refundable Tax Credit for Non-group Insurance	Tax Deduction for Non-group Insurance
Total participants (millions)	18.4	6.3
Percent of participants previously uninsured	25.7%	9.2%
Net increase in number of insured people (in millions)	4.03	0.25
Percent decrease in the uninsured population	9.5%	0.6%
Number of currently insured who lose coverage (in millions)	0.69	0.34
Percent of participants with incomes below 200% of poverty	53%	32%
Percent of costs spent on participants with incomes below 200% of poverty	56%	29%
Government cost per participant	\$723	\$138
Government cost per newly insured person	\$3,296	\$3,544
Total government cost (in billions)	\$13.3	\$0.9

<sup>30</sup> The deduction would be "above-the-line," which means that it would be available to taxpayers whether or not they itemize deductions.

<sup>31</sup> The Patients' Bill of Rights would allow a deduction for individuals covered under an employer plan as long as the employer contribution does not exceed 50 percent of the premium.

<sup>32</sup> Because there has been limited experience with tax subsidies for health insurance, the estimates of behavioral responses to tax subsidies are based on less solid evidence than that available for simulations of direct subsidies below.

<sup>33</sup> As discussed earlier, this process of adverse selection could in theory cause premiums to spiral up to the point where premiums are unsustainable.

*The striking drawback to the tax deduction plan is that the size of the uninsured population falls by less than one percent.* (Table 1). Of the 6.3 million participants in this plan, only 580,000 were not previously covered by health insurance. In addition, an estimated 340,000 people who were originally insured under an employer plan become uninsured. Another 300,000 people are dropped from employer plans and move to the individual insurance market. On net, the proposal would increase coverage by about a quarter of a million people. Thus, though the benefit level to each participant is only \$138, because 91 percent were previously insured, the cost to the government per newly insured participant is \$3,544. Moreover, only 29 percent of the benefits would go to those with incomes below 200 percent of poverty; only 6 percent goes to those in poverty. Thus, though the total cost of this plan is modest, this is not an effective way to extend coverage to the uninsured.

In contrast, the refundable tax credit increases the number of those insured by 4 million, but at a much higher cost. A higher percentage of participants come from the uninsured population—25.7 percent (4.7 million people), compared to 9.2 percent (580,000 people) for the tax deduction. The refundable credit causes some crowding out: over one million people are dropped by firms and purchase individual insurance, and about 3.6 million voluntarily switch from employer-provided insurance to non-group insurance. About 700,000 people who were insured through their employer become uninsured. The net increase in the number of insured people is about 4 million. Because the refundable tax credit is more effective in reaching the uninsured, the government cost per newly insured is slightly smaller under the refundable tax credit than the tax deduction (\$3,296 versus \$3,544), even though the refundable tax credit provides participants with a much higher level of benefits (\$723 versus \$138). This higher level of benefits raises the total cost of the tax credit plan relative to the tax deduction plan, but even if it were designed to have the same overall cost—which would require narrow targeting—the refundable tax credit could be expected to be more cost effective at reaching the uninsured than a tax deduction.

Another set of researchers—sponsored by the Kaiser Family Foundation—also simulated the effects of refundable tax credits and tax deductions.<sup>34</sup> The simulation model that they use is different from that of Gruber, and the particular features of the tax proposals that are analyzed are somewhat different from those examined by Gruber.<sup>35</sup>

- The first proposal is a sliding-scale refundable tax credit covering full policy costs for all families with incomes at or below 150 percent of the federal poverty level with private health insurance (either direct purchase or through employment). The credit would decline with income until it was phased out completely at 500 percent of the federal poverty level (about \$85,000 for a family of four).
- The second proposal is a policy that would allow individuals without access to employer-sponsored insurance to deduct 80 percent of the premium from taxable income on their tax returns.

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<sup>34</sup> Judith Feder, Cori Uccello, and Ellen O'Brien, *The Difference Different Approaches Make: Comparing Proposals to Expand Health Insurance*, The Kaiser Project on Incremental Health Reform (Menlo Park: The Henry J. Kaiser Family Foundation, 1999).

<sup>35</sup> The Kaiser researchers used their own estimates of behavioral responses to tax subsidies and so their findings would not be directly comparable to the Gruber study even if both studies examined exactly the same tax provisions. Most notably, Gruber assumed a significant number of people would be dropped from their employer-provided group health insurance as a result of the availability of subsidies for non-group insurance.

The simulation incorporates the predicted participation among the eligible population based on historical data from participation in similar plans, the expected costs of the offered plans, and the expected switching of people who were already insured to the more generous full (or near full) subsidy. The table below provides the results of the simulation.

Table 2: Tax Policy Simulation Results (Kaiser)

	Refundable Tax Credit for Non-group Insurance	Tax Deduction for Non-group Insurance
All \$ figures in 1998 dollars		
Total adult participants (millions)	42.5	6.1
Percent of participants previously uninsured	18%	7%
Number of newly insured (in millions of people)	7.7	4
Percent of non-elderly adult uninsured who become covered	26%	1%
Percent of participants with incomes below 200% of poverty	46%	21%
Percent of costs spent on participants with incomes below 200% of poverty	73%	14%
Government cost per participant	\$912	\$265
Government cost per newly insured	\$5,156	\$3,953
Total government cost (in billions)	\$38.7	\$1.6

A comparison of the refundable tax credit and the tax deduction using the Kaiser model produces the same general conclusions as those reached using the Gruber model. The refundable tax credit reaches a larger fraction of the uninsured (26 percent) than does the tax deduction (1 percent). It is also much better targeted to the poor than the tax deduction, providing almost 73 percent of its funds to persons below 200 percent of poverty. However, the Kaiser refundable tax credit plan provides a very generous subsidy, so it is expensive and has higher take-up rates. Eighty-two percent of the people who use the subsidy were previously insured.

The Treasury Department analyzed the effects of the tax deduction plan proposed in the Patient's Bill of Rights (PBOR), which provides an above-the-line tax deduction for premiums for non-employer acute care health insurance, or employer health benefits if employer contributions are less than 50 percent of the premium. Because eligibility for the subsidy is extended to the insured whose employer pays less than 50 percent of the premium, many more currently insured individuals would be eligible for this subsidy than the deductions considered in the Gruber and Kaiser simulations, which assume that anyone whose employer contributes at least a dollar is ineligible for a deduction. Further, employers who contribute only a bit more than 50 percent of the premium could reduce their contributions to 49 percent and reduce the after-tax cost to their employees. The PBOR proposal would benefit many people currently covered by employment-based health insurance. Accordingly, the Treasury estimates assume that most of the cost of the deduction would go to currently insured workers whose employers would contribute less than 50 percent of premiums.

Another important difference of the Treasury analysis is that it models a fully phased in policy that has been in effect for 10 years. The Treasury Department estimates that, under this plan, 1.2 million additional people would acquire insurance in 2010, but 600,000 people who were insured through their employer would become uninsured, resulting in a 600,000 net increase in the insured population. The policy would reduce tax revenues by \$11 billion in 2010, so the cost per newly insured person would be about \$18,000.<sup>36</sup>

Overall, tax deductions provide a very small subsidy for the majority of the uninsured, who are lower-income, and thus do very little to increase coverage. Refundable tax credits provide a bigger subsidy that does not increase with income—indeed they could even be designed to provide the largest subsidy to those with the lowest incomes who are least likely to have insurance coverage. Thus, by targeting the people who are left out of the current system, credits can be more effective, more progressive and less disruptive of the employer health insurance market than tax deductions. However, credit proposals, like the ones simulated above, which have broad eligibility may be quite expensive, because the total cost of the tax credit proposals is high when the subsidy attracts many participants who are already insured. For the same reason, they also present the greatest threat to the market for employment-based health insurance. Therefore, they are considerably less efficient than the direct provision proposals described below.

A final drawback of the refundable tax credit plans evaluated here is that the credits direct people to the individual market which, today, is inaccessible to many individuals because they have pre-existing conditions that render them ineligible for insurance. It also can be unaffordable to many people due to adverse selection. Insurance regulation can help address the accessibility and affordability problems that exist today. Another alternative is to allow refundable tax credits to be used for public group plans such as Medicare, Medicaid, or SCHIP buy-in.

However, these tax credit plans can be valuable in addressing a different problem—the inequities inherent in the current tax treatment of health insurance. As described above, those currently covered by employer-provided health care receive tax breaks, but those who purchase their own insurance receive very little tax benefit. Therefore, a refundable tax credit that approximately equals the value of the employer deduction would provide equity with the tax advantage currently enjoyed by those who have employer-provided insurance.

## **B. Direct Government Provision of Health Insurance**

The simulation model developed by a Kaiser Family Foundation study is also used to examine the effectiveness of two alternative options that increase the direct provision of health insurance to certain segments of the population.

The first option is a large-scale plan that would extend government-provided insurance coverage to all uninsured adults with incomes below the poverty level.

<sup>36</sup> A significant part of the difference between the Treasury and Gruber estimates is expected increases in health insurance costs. Treasury assumes that insurance costs will roughly double between 1999 and 2010; thus, Gruber's estimate of \$3,544 per newly insured person in 1999 would correspond to about \$7,000 at 2010 levels. Most of the rest of the difference is attributable to the difference in policies estimated.

- The second option is a proposal very similar to the Administration's proposal to extend government-provided health insurance to parents of children who are eligible for the Medicaid and SCHIP programs. Under this plan, adults in families with incomes up to 100 percent of the poverty line would receive health insurance that was completely paid for by the government. Families with incomes above the poverty level but below state-determined eligibility limits (typically 200 percent of poverty<sup>37</sup>) would pay a premium of 2 or 4 percent of income, depending on whether one or two parents were covered.

Table 3: Direct Provision Simulation Results (Kaiser)

All \$ figures in 1998 dollars	Coverage to all poor adults	Coverage to Parents of Medicaid/SCHIP Children
Total participants (millions)	9.3	3.0
Percent of participants previously uninsured	69%	69%
Number of newly insured people (millions)	6.2	2.1
Percent of non-elderly adult uninsured who become covered	22 %	7%
Percent of participants with incomes below 200% of poverty	100%	93%
Percent of costs spent on participants with incomes below 200% of poverty	100%	94%
Government cost per participant	\$2,484	\$2,271
Government cost per newly insured	\$3,582	\$3,306
Total government cost (in billions)	\$23.0	\$6.7

The results for the two plans are very similar (Table 3), except, of course, for the fact that the broader plan covers many more people and is correspondingly more expensive. The cost per participant is slightly lower in the narrower plan, because some SCHIP parents will contribute a small premium.

The majority of the participants in both plans are newly insured. There is some crowding out evident in this simulation, as 31 percent of participants were previously covered by some other type of insurance. But that is a very low figure relative to the options considered earlier. *Over two-thirds of the participants in the programs are newly insured.* This is because the eligibility for these programs is targeted to lower-income people, who are less likely to be covered by other insurance, and the programs have a generous enough subsidy to get high participation.

<sup>37</sup> State upper income eligibility limits vary from 133 percent of poverty to 350 percent of poverty.

The Office of Management and Budget has estimated the cost of the Administration's FamilyCare proposal, a different proposal with some of the features of the simulation covering parents of children on SCHIP and Medicaid (second column of Table 3), and finds the cost comparable to the simulation's estimated cost per newly insured person. The Administration proposal is broader, projecting 5 million newly insured people, because it includes provisions for the coverage of immigrants, Medicare buy-in for individuals between 55 and 65, and outreach programs to eligible populations.

## 6. CONCLUSIONS

This report highlights a number of troubling features of the current state of health insurance in the United States.

- Over 44 million Americans—about 1 in 6—are not covered by health insurance. This lack of health insurance has worsened over the past decade, even as the economy has been booming. *Forty-three percent of adults in households below the poverty line did not have health insurance coverage in 1998.* Minorities are less likely to be covered by insurance than the average.
- For families without health insurance, health problems often go untreated—leading to poorer health outcomes, including a higher likelihood of being hospitalized with conditions that could have been treated out of the hospital or avoided altogether. *Uninsured Americans are more than three times as likely to delay seeking care.* For many uninsured families, major health problems can lead to financial devastation. Health insurance, while seemingly expensive, may be the most cost-effective way to ensure a healthy society. The benefits of prenatal care, often delayed because of a lack of health insurance, for example, are enormous.
- The cost burden of the uninsured falls on the public at large, because ultimately the entire society absorbs the costs of medical treatment for individuals who are unable to pay for medical care.
- The federal tax code provides a very large subsidy for the purchase of employer-based health insurance by not including employer premium contributions in taxable income. But, because the effective subsidy depends on an employee's marginal tax rate, the value of the health benefit to households rises sharply with household income. Low-income households receive little or no tax incentive to participate in health insurance plans—a key reason that so many low-income households do not have coverage.

A number of policy responses to the problem of the uninsured are discussed in this report, using a discussion of the economic issues involved and quantitative estimates from simulation models. The analysis suggests that some approaches are likely to be more effective than others.

- **Tax deductibility is not an effective policy to extend coverage.** Studies indicate that extending tax deductibility to non-group policies would expand medical insurance coverage only modestly, and would do very little to expand insurance coverage to low-income

families. It would provide a tax break to predominately middle- and upper-income households already purchasing such coverage.

- **Refundable tax credits may reach some low-income families, but, to the extent that tax credits encourage the use of non-group insurance, this creates different problems.** Initiatives of this sort can be scaled to provide a reduction in the number of uninsured—at substantial cost to the government. Refundable tax credits are far more effective in targeting low-income families than are new tax deductions, because a refundable tax credit can be used by families at lower-income levels to reduce the cost of insurance. However, serious problems exist in the non-group insurance market. Lack of availability, adverse selection and administrative costs make the non-group insurance market inefficient and expensive. The difficulties can be addressed with appropriate insurance regulation, which would have to be part of any substantial effort to expand coverage through tax subsidies for non-group coverage. Alternatively, tax credits can be used for individuals to buy insurance through small business purchasing groups or public programs that do not have these problems.
- **Direct provision of health insurance, like the SCHIP initiative, would be particularly effective in targeting low-income families.** Research indicates that this type of initiative, while not affecting as many uninsured people as some of the tax credit proposals, is very effective at reaching the lower-income uninsured for a relatively small total cost. Thus, direct provision has an advantage over tax credits in more effectively making health insurance affordable and accessible for many Americans. *Simulations suggest that over two-thirds of expanded direct provision participants would be newly insured.*
- **Serious problems arise in the non-group insurance market.** Lack of availability, adverse selection and administrative costs make the non-group insurance market inefficient and expensive. This means that policies that encourage households to move into this market are problematic. To an extent these difficulties can be overcome with appropriate insurance regulation, which would have to be part of any substantial effort to expand coverage through tax subsidies for non-group coverage.

Reversing the trend of declining insurance coverage among Americans will require a major commitment by the public sector. One common theme in these studies is that there is no silver bullet that will easily or inexpensively resolve the problem of the uninsured in America. Indeed, taken as a whole, these studies suggest that a careful blend of different policies may be required to reach the uninsured effectively. For Americans at moderate income levels, direct provision policies, such as the Administration's proposal to expand SCHIP to cover adult members of families with eligible children, are particularly cost-effective. Although well intentioned, tax changes (even when based on more-efficient refundable credits rather than tax deductions) are not very effective at reaching a high percentage of the uninsured, because the uninsured are predominantly low-income and the poor simply cannot afford insurance even at a reduced cost. However, tax-credit programs, with insurance regulation or for purchase of public insurance, can be useful to families as their incomes rise and they become ineligible for subsidies through direct provision programs. Such a combination of programs might offer an effective way to provide health insurance to those who have been left out of the current health-care system.