Uninsured in the United States, The
A Status Report
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The 1993-94 effort to reform the U.S. health care financing system focused on the problems associated with escalating medical costs and a growing population of persons without health insurance. Although comprehensive reforms were not enacted, these problems persist. In addition, changes in the private insurance market directed at containing costs and the political focus on deficit reduction may continue to exacerbate the problem of the uninsured.

Analyses of the Current Population Survey (CPS) suggest that between 39.0 and 42 million people, or 16.8 to 18.1 percent of the non-elderly population, can be expected to be without health insurance in 1996. These projections, based upon estimates of 37.9 million (Holahan, Winterbottom, and Rajan, 1995) and 40.9 million (Employee Benefits Research Institute (EBRI), 1995) uninsured in 1993, use the Congressional Budget Office assumption that the number of uninsured will increase by approximately the rate of growth in the total population (Congressional Budget Office, 1994). The perception that being uninsured is a problem that is entirely restricted to the poor is false; a third of the uninsured have family incomes over twice the federal poverty level (Winterbottom, Liska, and Obermaier, 1995).

There are real health consequences to being uninsured. The uninsured visit the doctor less, use more emergency room care, and are more likely to be hospitalized for chronic conditions that could be better controlled with reliable access to physician services (Franks, et al., 1993; Freeman and Corey, 1993; Hafner-Eaton, 1993). Most importantly, the lack of health insurance has been linked to a number of adverse health outcomes including an increased risk of mortality (Franks, Clancy, and Gold, 1993). Arguments that the uninsured receive the same levels of medical care despite their lack of coverage are contradicted by these studies.

While issues of underinsurance are also worthy of concern and attention, analysts have had greater difficulty studying them, and little literature on them exists. First, it is unclear how underinsurance should be defined. One could imagine the definition varying by individual income, health status, and preference for risk. For example, a low income individual with an insurance policy which includes a large deductible might be considered underinsured, whereas a higher income individual with the same policy might not. An individual with chronic mental illness and very limited mental health benefits is likely to be considered underinsured, while someone without those special needs might be considered appropriately covered with the same benefit package. Second, there is very little data available on the actual benefit content of the health insurance policies that individuals hold.

A recent study by Short and Banthin (1995) estimates the number of underinsured younger than 65 years using a number of alternative definitions of underinsurance and data from the 1987 National Medical Expenditure Survey (NMES). They find that when underinsurance is defined as those who would face out-of-pocket expenditures exceeding 10 percent of family income in the event of a catastrophic illness, 18.9 percent of the privately insured were underinsured in 1987. If the actuarial value of the largest federal employee plan is used as a standard of adequate insurance coverage, 16.4 percent of the privately insured were underinsured in that same year.

This paper outlines the magnitude of the problem of the uninsured, the potential consequences for access and health status that result from it, and ways in which current system trends and public policy reforms may affect the problem.

I. Changes in the Rates of Insurance Coverage Over Time

The number of non-elderly people without health insurance for the entire year can be projected to grow from between 31.7 and 33.7 million in 1988 to between 39.0 and 42.1 million in 1996. While the percent of the
population without health insurance has remained relatively stable over the last several years, the composition of the uninsured has changed dramatically.

Figure 1 shows changes in insurance coverage by income level. The rate of uninsurance increased by 2.5 percentage points between 1988 and 1993 for those with incomes over 100 percent of the federal poverty guideline. This increase translates into an additional 5.7 million persons without insurance. Uninsurance among the poor decreased by 4 percentage points over the same period, as signified by the circled bar (Holahan, Winterbottom, and Rajan, 1995). Medicaid coverage for those under 200 percent of poverty rose during this time, 8 percentage points for those below poverty and 7 percentage points for those between 100 and 200 percent of poverty. Also shown in Figure 1 (signified by the white bars) is the consistent decline of employer-sponsored coverage for all income levels. Over all income groups, the rate of employer coverage fell by 6 percentage points (from 67% in 1988 to 61.1% in 1993). If the lower rate of employer coverage in 1993 had prevailed in 1988, 12.5 million fewer people would have been covered through employer plans. The largest relative declines in employer sponsored insurance were seen for those families with incomes above the poverty line. Given the drop in employer sponsored coverage, the rate of uninsurance increased overall during this time, despite the expansion in the rate of Medicaid coverage from 8.5% to 12.4% of the non-elderly population.

There are two competing theories on the meaning of this phenomenon. The most widely held contention is that in the absence of expanded Medicaid coverage, the rate of uninsurance would have been substantially higher for the low income groups during this period. The second theory holds that expanded Medicaid coverage has the effect of displacing, or "crowding out", private coverage (Cutler and Gruber, 1995). In other words, the contention is that individuals with private health insurance will drop that coverage upon becoming eligible for Medicaid so that they may enroll in the public health insurance system at no direct cost to themselves. The empirical evidence available for testing these hypotheses is not strong. Further analysis using panel data is necessary in order to inform this discussion further. The current trends are clear, however: significant decreases in employer-sponsored insurance coverage and increases in rates of uninsurance for those above poverty.

II. Characteristics of the Uninsured

Since virtually all individuals over age 65 are covered by Medicare, the uninsured are primarily adults under age 65 and children. Figure 2 shows the total non-elderly population by type of insurance coverage over the 1990-92 period (Winterbottom, et al., 1995). A little over two-thirds of the population had some type of private insurance coverage, either employment based (directly through their own employer or through the employer of a spouse or parent) or private non-group coverage. Thirteen percent of the non-elderly were covered by publicly funded health insurance through Medicaid, Champus, the Veterans Administration, or state general assistance. Almost 16 percent of the population one out of every six adults and children below age 65 were without health insurance for the entire year.

Income. Figure 3 details insurance coverage by income level. Those with incomes below 100 percent of the poverty line are heavily concentrated in Medicaid coverage (49 percent of the poor) and uninsurance (29 percent of the poor). The poor are significantly under-represented in employer-sponsored coverage categories -- only 4 percent receive this type of insurance through their own employer. In contrast, 21 percent of the near poor (100 to 200 percent of poverty) receive coverage through their own employer, as do 37 percent of those between 200 and 400 percent of poverty and 49 percent of those with incomes of 400 percent of poverty or above. In addition, only 8 percent of the poor are covered through employer sponsored insurance that they receive indirectly, through the employer of a spouse or a parent. Twenty-seven percent of the near poor, and approximately 40 percent of those over 200 percent of poverty have coverage through this source. Therefore, employer sponsored insurance is the source of insurance coverage for the majority of families over 200 percent of poverty. This is not true for families in lower income groups, particularly those below the poverty line.

Medicaid fills in the private insurance gap for only about 50 percent of those under the poverty line. The Medicaid program pays for medical services for particular groups of low income individuals. While jointly funded by the states and the federal government, Medicaid is designed and administered by the states within broad federal guidelines. Consequently, there is considerable variation in eligibility rules across states, and benefits provided to enrollees vary as well. Eligibility for the program is, in general, based upon income and assets tests and being a member of certain categories of beneficiaries, for example, the aged, blind, disabled, those qualifying for Aid to Families with Dependent Children (AFDC), children, and pregnant women. Some states, operating under waivers from the federal government, have adopted more general income eligibility guidelines in an effort to move away from the constraints of the traditional categorical eligibility standards -- these programs are discussed in a later section.

There is little Medicaid coverage for those with incomes above poverty. However, even with Medicaid, the two lowest income groups have the highest rates of uninsurance. Almost 30 percent of individuals with family incomes below 200 percent of the poverty line were uninsured in 1990-92. The health care services access of the uninsured poor are aggravated by their very limited capacity to finance their care out of pocket. While the near poor (100-200 percent of the federal poverty line) have greater access to employer sponsored coverage than do the poor, they still have substantially less private coverage overall than higher income groups. In addition, the near poor have far less access to Medicaid coverage than the poor. The combination of these
two factors results in an important health insurance access problem for individuals and families with modest incomes (income ranges for the near poor as defined here are: $7,500 and $15,000 for individuals; $10,000 to $20,000 for families of size 2; $12,600 to $25,200 for families of size 3; and $15,150 to $30,300 for families of size 4).

**Age.** Adults are more likely to be uninsured than children (18 percent of adults are uninsured versus 11 percent of children), as shown in Figure 4. This is true even though adults are slightly more likely to have private insurance coverage than children, because Medicaid eligibility policies tend to favor children. Children have been the specific target of federal Medicaid expansions; by 2002, all children under 18 years of age living in families with incomes below the poverty line will be eligible for Medicaid under current law.[10]

Among adults, the highest rate of uninsurance is among young adults. More than 22 percent of those age 18-34 are uninsured, while among the 35-53 age group close to 14 percent are uninsured, and approximately 13 percent are uninsured among the 54 to 64 age group.[11] The higher rate of uninsurance among young adults might reflect a lower willingness to purchase insurance within this relatively healthy group. It is true that younger workers tend to be employed in firms that, by their characteristics (size, industry, etc.) are less likely to offer health insurance coverage. Is the choice of job a reflection of an individual's willingness to purchase health insurance?

It is extremely difficult to measure the extent to which being uninsured is voluntary. Very little data is available on individuals who are offered group insurance policies and turn them down.[12] In addition, the extent to which non-group policies are available to particular individuals is not known, and any demarcation of what premium level is or is not affordable to a specific person would be a purely subjective one.

**Race.** Access to health insurance also varies considerably by race (Figure 5). Non-whites are less likely to be covered by any type of employer-sponsored insurance than whites (48 percent of non-whites have such coverage versus 67 percent of whites), more likely to be covered by Medicaid (24 percent versus 8 percent), and more likely to be uninsured (21 percent versus 15 percent).

**Work Status.** Figure 6 shows the same distribution by the work status of the family head or spouse (Winterbottom, et al.,1995).[13] As one would expect, families with two full-time workers have the highest rate of private insurance coverage, while non-working families have the highest rate of Medicaid coverage. Somewhat surprising, however, is that those in families with only a part-time worker had a higher uninsurance rate than those where no work was reported at all 31 percent versus 20 percent. Even a modest income level can place one beyond public insurance eligibility levels, suggesting a possible disincentive towards working for the lowest income group.

Most of the uninsured adults are full-time workers. As shown in Figure 7, 57 percent of uninsured adults are working full-time, while another 20 percent have some type of part-time employment. Only 23 percent are not working at all.[14] The typical uninsured adult is, therefore, a worker. The general view of the uninsured as non-workers (Cantor and Stevens, 1995) is wrong.

The likelihood of insurance coverage varies not only with the characteristics of individuals and family members, but also with the characteristics of their employers, such as industry and firm size. For example, workers in the agriculture and construction industries had the highest levels of uninsurance -- 43 percent and 34 percent respectively (Figure 8). Workers in the insurance companies and 37 agents participating in the small business health insurance market revealed red-lining practices which excluded industries as diverse as physician groups, restaurants, law firms, mining companies, and hair salons.

Finally, rates of uninsurance vary substantially by firm size (Figure 9). Twenty-seven percent of workers in firms of 24 workers or less are uninsured, versus only 11 percent of workers in firms of 100 or more.

**Length of Spells of Uninsurance.** Not only do levels of uninsurance vary by individual and family demographic characteristics, but the length of uninsurance spells do as well. Swartz, et al. (1993 (A))
calculated the probability of becoming insured following a spell of uninsurance, controlling for income, industry of original employment (if any), labor force participation, education, marital status, region, age, race, and gender. Using data from the 1984 panel of the Survey of Income and Program Participation (SIPP), the authors looked at the characteristics of individuals in the month just before each period of uninsurance began. For those with annual incomes below $29,000 (in 1991 dollars), they found that income had no measurable effect on the duration of time uninsured. For persons with family incomes above this level, however, income had a significant and negative effect on the duration of uninsurance, i.e., the higher the family income, the shorter the time uninsured. In addition, those that were employed full time before the start of the period of uninsurance spell began and who remained employed following the start of the spell were likely to regain insurance faster than those who did not work during those months. Younger people (age 18-24) also had a higher rate of becoming insured than older people, with those in the 45-64 age group having the longest time uninsured.

As Swartz, et al., (1993 (B)) have shown, 48 percent of periods of uninsurance end within 5 months, while 19 percent last beyond 2 years. The median length of a spell is approximately 7 months. Consequently, the length of most spells of uninsurance are fairly short (less than a year), meaning that many more people are likely to experience some period of uninsurance than is indicated by an estimate of full year uninsured.

Summary. While analyses of the characteristics of the uninsured inform our understanding of the magnitude of the problem, they can also serve to focus attention on particular problem areas and specific populations in need. Several general lessons can be drawn from the evidence presented in this section.

- The vast majority of the uninsured are workers or the dependents of workers. Employment, even full-time employment, does not ensure insurance coverage.
- Medicaid does not provide coverage for all of those with incomes below the poverty level, so uninsurance remains a significant problem among the poor.
- The near poor (those between 100 and 200 percent of poverty) also have a very substantial uninsurance problem due to their ineligibility for public programs and limited access to private coverage through low wage employment.
- Health coverage represents another area of inequality between whites and non-whites; the latter are more likely to be uninsured.
- Uninsurance remains a greater problem among adults than children due to the recent Medicaid expansions targeted at the young. (Changes to the Medicaid program currently being considered, however, might affect the additional coverage currently afforded to children.)
- Strategies to address insurance coverage through the workplace must be sensitive to variations across industries and firm sizes. Differences in wage levels and employment turnover rates can have important implications for the potential success of particular coverage expansion approaches.
- Most spells of uninsurance are relatively short -- 48 percent end within 5 months. However, 19 percent of spells last more than 2 years.

III. The Uninsurance Problem and the Workplace

Given the dominance of employment based insurance in the current marketplace -- 64 percent of Americans received insurance coverage through an employer in 1990-92[16] -- we focus here briefly on issues related to employer responses to rising health care costs. Health care costs, which are already a large percentage of our GDP (projected at 14.1 percent in 1995 (CBO, 1995)) have been increasing at a rate faster than personal incomes (Levit, et al., 1994). Corporate spending on health care benefits increased from 28 percent to 56 percent of pre-tax profits from 1980-1989 (Roberts and Clyde, 1993). The rising costs of health insurance have important consequences for the composition of workers’ compensation packages. Because medical costs are rising faster than GDP, employers must either: increase consumer prices, lower profits, pass the increased costs back to workers in some way, or discontinue coverage.

The ability and tendency of an employer to increase consumer prices or to accept reduced profits will be a function of the level of competition in the particular industry, both in terms of the goods/services being produced and the labor market supplying the industry with workers. A highly competitive market for a good, for example, is likely to mean that it would be difficult for a particular firm to raise consumer prices, and profits are likely to be quite modest. Firms in such a situation will be more likely to discontinue coverage or to pass the increased costs back to workers. This is particularly true if other competing firms are not providing health insurance for their workers and consequently do not face the same price increases. However, in an industry where there is intense competition for workers with a particular skill, firms interested in keeping and attracting the best qualified workers will be more likely to continue insurance coverage and to avoid passing increasing costs back to workers when possible. Strategies for passing the costs back to workers include:

- slowing the rate of increase in wages, placing an increasing share of the total compensation package in health insurance benefits;
- increasing the share of premiums paid directly by workers; or
- reducing the value of insurance packages through decreases in covered services or increases in required cost sharing.
All such strategies place increasing financial burdens on workers and make employer sponsored health insurance less attractive. These issues are most difficult for low-wage workers where minimum wage constraints limit the ability of employers to pass increasing costs back through lower wages and for whom the tradeoff of wage compensation for fringe benefits is likely to be less advantageous.

Evidence of these mounting pressures can be gleaned from figure 1. Between 1988 and 1993, the rate of employer sponsored insurance coverage has fallen for every income group (Holahan, et al., 1995). The largest decline, 7 percentage points over that period, is seen for families with incomes between 100 and 200 percent of poverty. Significant declines were also seen for higher income families, however. Those between 200 and 399 percent of poverty experienced a 5 percentage point decline in employer sponsored coverage, while those with incomes at or above 400 percent of poverty experienced a 4 percentage point decrease. The lowest rate of decrease was seen for the families below the poverty level (2 percentage points); this is likely the result of the already low levels of employer sponsored coverage for this group.

IV. The Access and Health Status Implications of Uninsurance

Being uninsured affects one's ability to pay for health services, which, in turn, can have real consequences for health status. First, we present the differences between insured and uninsured persons in utilization and access to medical services. Second, we delineate the variations in health status and health outcomes between persons of differing health insurance status.

Access to Health Care Services. As shown earlier, the uninsured are disproportionately low-income, but do not qualify for public assistance either due to categorical ineligibility or because their modest incomes still exceed eligibility cut-offs. With competing demands for basic necessities, the high costs of health care relative to income affect their willingness and ability to utilize and pay for medical services. Depending on the methodology used, estimates of the uninsured's use of physician services have been estimated to be between 63 percent and 73 percent of that of the insured. Estimates of relative inpatient hospital use vary to an even greater extent, ranging from 31 percent to 81 percent (Spillman, 1992).

In an analysis using the 1980 National Medical Care Utilization and Expenditure Survey (NMCUES), Spillman (1992) found that uninsured adult men were 71 percent as likely as insured men to use any medical services over the course of a year; uninsured women were 79 percent as likely to use services as their insured counterparts. Uninsured children were 86 percent as likely to use services as the insured.

For those persons that used any medical services, the number of visits was also found to be lower in the uninsured group. Adults without insurance had approximately 30 percent fewer visits than comparable individuals with insurance, while uninsured children had 16 percent fewer visits on average. In other words, the average uninsured man using medical services had 3.4 visits as opposed to 5.0 visits for his insured counterpart. The averages for women were 4.4 visits for the uninsured versus 6.4 for the insured, and for children, 3.8 visits for the uninsured and 4.5 visits for the insured.

One possible explanation for the uninsured's lower utilization of health care services could be that they are relatively healthy individuals who elected not to purchase private insurance. However, using the 1989 National Health Interview Survey, Hafner-Eaton (1993) found that uninsured individuals were less likely to visit a physician regardless of whether they were well, acutely ill, or chronically ill. The chronically ill and "well" uninsured were half as likely to have had a physician visit as were the insured with the same health status. Significant differences held even for the acutely ill, with the uninsured two-thirds as likely to have had a physician visit as the ill insured. Not surprisingly, the acutely ill uninsured are less likely to forego medical care than the uninsured chronically ill or the well, but their use of physician services is still well below that of insured individuals.

Further evidence is provided by Marquis and Long (1994/95) who estimate the uninsured "access gap" -- the difference in health service utilization that can be attributed to health insurance status. Largely using data from the 1987 National Medical Expenditure Survey (NMCES), they estimate health service use separately for adults and children, controlling for differences in insurance status, demographic characteristics, income, area of residence, and health status. The model is then used to predict health service utilization for uninsured individuals if they were given health insurance similar to that which is typical among the pool of insured persons. The results indicate that health services consumption by uninsured adults is only 60-70% of the use they would be expected to have if they were to become insured. For adults, they estimate the "gap" in access between the uninsured and insured to be about 1 to 2 ambulatory care visits per year and 16 to 24 hospital inpatient days per 100 uninsured adults. Insured adults average 4 to 5 ambulatory visits per year, while uninsured adults average 2 to 3. For the insured, the number of hospital days per 100 adults averages 58 to 73 per year, whereas the uninsured average is 34 to 50 days per 100 adults.[17]

The size of the "access gap" is greater, however, for those in poor health. The uninsured in poor health have 60 to 80 fewer hospital inpatient days per 100 persons than they would if insured. The study also found that the "access gap" for children, while still significant, is somewhat smaller than for adults. Uninsured children were estimated to receive approximately 70 percent of the outpatient visits that they would have been insured, and about 75 to 85 percent of the inpatient days.

The impact of uninsurance on utilization levels can also be seen in analyses of particular medical conditions. Research by Overpeck and Kotch (1995) demonstrated that injured children -- even those with serious injuries -- without health insurance coverage were significantly less likely to have received medical attention. Those children without any coverage were only 73 percent as likely to have their injuries attended to by a medical professional. Fleishman and Mor (1993) found that among people with AIDS, outpatient visits per month,
inpatient days and inpatient admissions were significantly lower for those with no private insurance than for those with private coverage. However, public insurance seemed to provide comparable utilization to those with private insurance.

Hadley, et al. (1991) analyzed a large national sample of hospital discharges (abstracts submitted to the Commission on Professional and Hospital Activities in 1987), comparing condition on hospital admission and resource use in the hospital between privately insured and uninsured patients. The research found that the expected in-hospital mortality rate (an indicator of severity of illness upon admission) was significantly higher for the uninsured than the privately insured in 13 of the 16 age-sex-race categories studied. In other words, the uninsured were measurably sicker upon admission than were the insured, possibly an indicator that they waited longer before entering the hospital.

In addition, resource use in the hospital tended to vary according to insurance status. Length of stay for diagnoses for which there was greater discretion in terms of clinical necessity (such as unilateral inguinal hernia and uterine leiomyoma) were significantly shorter for the uninsured than for the insured. On the other hand, length of stay for the low discretion diagnoses (such as gastrointestinal hemorrhage and congestive heart failure) tended not to be significantly shorter for the uninsured. These results might indicate that physicians themselves make clinical choices in order to minimize adverse effects of lower utilization on the uninsured.

When examining utilization patterns from a procedure perspective as opposed to length of stay, the uninsured were also significantly less likely to receive high cost or high discretion procedures (for example, total knee replacement and coronary artery bypass graft surgery). Utilization rates were also significantly lower for the uninsured for a number of the other diagnosis-procedure combinations examined (colonoscopy, upper endoscopy procedure, and coronary arteriography). Finally, the analysis of resource use indicated that the uninsured tended to be less likely than the privately insured to have a completely normal tissue pathology result. This is an indication that biopsies tend to be performed on uninsured persons when there is little doubt about the presence of a condition, whereas the insured tend to have these procedures done even when considerable uncertainty about the results exists.

In summary, substantial evidence suggests that individuals without insurance receive fewer physician visits and inpatient hospital days, even adjusting for factors such as income and health status. The utilization disparities hold within groups of persons with similar health status. In addition, uninsured individuals are more likely to delay or forego medical care, even in the case of serious medical conditions. There is also some evidence (from the Hadley, et. al study) that physicians may be more likely to expend resources on the uninsured when the potential adverse health effects of lack of care are greatest. When considerable clinical agreement about the importance of hospital treatment exists, utilization by the uninsured tends not to be significantly different from the insured. When there is greater discretion in terms of the need for treatments, however, use by the uninsured tends to be significantly below that of the insured.

Health Status and Health Outcomes. While differences in health status of the uninsured relative to the insured have been documented, it is more difficult to attribute health outcomes to differences in insurance status. There is analytical support, however, for the contention that the uninsured are more likely to have potentially avoidable hospitalizations, are usually more ill at time of admission, and have higher average mortality rates. Here we present available evidence on the ways in which health status and health outcomes vary by insurance status.

Short and Lair (1994/95) also use the NMES data, and compare the self-perceived health status of individuals with differing health insurance status. Self-perceived health status is a measure based upon individuals' responses to a series of self-administered survey questions about their own health. The analysis indicates that individuals with private insurance are the "healthiest" group on average; next were the uninsured, followed by low-income persons with public insurance and chronically ill Medicare and Medicaid beneficiaries. A problem with one of the survey questions makes the actual differences between the health status of the uninsured and the publicly insured less clear, however. The NMES asked the question "Has a doctor ever told you that you had ... [condition]?” Since it is generally agreed that the uninsured visit the doctor less, it is more likely that the uninsured may have undiagnosed conditions that would not have been taken account of in this analysis. This problem would not, however, affect the finding that the privately uninsured were, on average, the "healthiest" group.

Franks et al. (1993), using longitudinal data from the National Health Examination Survey Epidemiologic Follow-up Study, analyzed the impact of insurance status on mortality rates over the period of 1971 to 1987. Adjusting for physical, economic, and behavioral factors, the study found that uninsured was associated with a 25 percent higher risk of mortality -- this is in the context of a 10.7 percent mortality rate in the full sample. To place these numbers in some perspective, in the sample studied, 128 of 699 uninsured persons died. The analysis suggests that if this group had been insured, the expected number of deaths would be 103 -- 25 fewer deaths. The lack of health insurance was associated with higher mortality rates for those with and without morbidity at the beginning of the study and for those with varying levels of income and education. This suggests that the health status benefit of having health insurance is not localized to specific subgroups.

Bindman et al. (1995) found that in areas where residents perceived their access to care as poor[19] the health care system had higher rates of hospitalization for chronic illnesses. With fewer physician visits and frequent lack of a primary care physician, individuals who faced reduced access such as the uninsured or the low-income are more susceptible to allowing the early stages of chronic illness such as hypertension and diabetes to proceed without diagnosis and treatment. Using a multivariate analysis controlling for prevalence of conditions, propensity to seek health care, and physician practice style, the authors found that as access to
care decreased, the probability of being hospitalized increased for five chronic medical conditions[20] (asthma, hypertension, congestive heart failure, chronic obstructive pulmonary disease, and diabetes).

In the study referred to previously, Hadley, et al (1991) also estimated differences in the probability of in-hospital death between privately insured and uninsured persons, controlling for case-mix differences, severity of illness upon admission, hospital characteristics, and community type. They analyzed 16 age-sex-race-specific groups separately. In 10 of the 16 age-sex-race-specific groups, the uninsured were significantly more likely to experience an in-hospital death than were the privately insured. The increased probabilities ranged from 20 percent to 320 percent. These results could indicate that there is an underprovision of care to uninsured hospitalized patients, or they could be reflective of case-mix differences that are not captured by the measures used. In addition, as noted by the authors, if the privately insured tend to be discharged to other facilities more frequently than are the uninsured, differences in in-hospital mortality rates might reflect a higher rate of mortality in those other facilities for the insured.

There is some evidence that both the health status and health outcomes of the uninsured are worse than those of the privately insured. As with much empirical research, analytical difficulties indicate that further research in this area is warranted.

V. The Potential Effect of the Changing Health Care Environment on the Uninsured

The overall health care market is experiencing dramatic structural changes as the result of ever evolving private sector and public sector reforms, some of which have already taken hold and some of which are currently under consideration by policy makers. These changes have significant implications for insurance status, explored in this section.

In recent years, the private health care market has seen a substantial increase in the number and type of managed care entities available, and the share of privately insured individuals enrolling in them. Public sector insurance has also experienced a significant shift towards managed care. Six states are operating under Medicaid waivers from the Health Care Financing Administration (HCFA), whereby they require at least some categories of Medicaid beneficiaries to enroll in managed care organizations. Seven more states have had their waivers approved but have not yet implemented them, while eleven additional states have their applications pending with HCFA.[21] Medicare beneficiaries are voluntarily enrolling in health maintenance organizations (HMOs) to a greater extent than they had previously (2.4 million are enrolled in fully capitated, risk-bearing plans), and some are also enrolling in preferred provider organizations (PPOs) under special demonstrations. In addition, significant changes in the ways in which public programs are currently being financed are being seriously considered by both members of Congress and the White House.

Changes in the health care financing environment such as these do not only affect the individuals directly covered by the particular form of private or public insurance. Market and regulatory reforms can have indirect impacts on all participants in the health care market, including the uninsured. Some types of reforms may even have implications for the number of individuals who are uninsured.

Private Sector. Managed care entities include health maintenance organizations (HMOs) of various organizational types (group, staff, network, independent practice associations (IPAs)), preferred provider organizations (PPOs), exclusive provider organizations (EPOs), and point of service (POS) plans. In addition, a more recent trend has been the consolidation and integration of managed care organizations with physician groups and hospitals into new entities referred to as Integrated Delivery Systems (IDSs).[22]

These organizations have developed and strengthened their shares of the health care market in response to purchasers' desires for more cost efficient mechanisms for the delivery of health care services. As the health insurance market has increased in competitiveness, managed care organizations have become more aggressive in their negotiating of price discounts with contracting providers. [23] Most managed care organizations also attempt to decrease utilization of health services (particularly inpatient hospital care) through use of more cost effective practice patterns.

As price competition in the private insurance marketplace increases, concerns about the historic implicit financing of uncompensated care necessarily arise. Analysts have concluded that some portion of hospital and physician fees is used to compensate for the lack of payments received from individuals who are uninsured and for others who do not cover the full costs associated with their care (Komisar, 1993), a phenomenon referred to as "cost shifting". Many believe that cost shifting has played a prominent role as an unofficial national policy on financing care for the uninsured. As competition forces down the average prices paid by health care consumers, we expect there to be a decreasing capacity for providers to "shift" the costs of caring for the uninsured to private payers in the manner in which they have in the past. There is some limited empirical evidence to support this contention. Analyses by ProPAC (Guterman, 1995 and ProPAC, 1995) show that payment to cost ratios for all community hospitals fell modestly between 1992 and 1993 from 131 percent to 129 percent.

This is not to say that it is necessarily appropriate to maintain high provider rates in order to finance health care for uninsured low income individuals, but instead to simply draw attention to the declining base for implicit financing of such care. A competitive environment will tend to diminish the ability of providers to pass these costs on to other consumers.

Medicaid: In the last few years, the potential for Medicaid to expand coverage to the previously uninsured has grown as a result of state waivers (under section 1115). Section 1115 waivers are designed, in part, to reduce current program expenditures per beneficiary through mandatory placement of beneficiaries in managed care settings and, in many cases, expand coverage eligibility to previously excluded individuals.
These managed care programs have ranged in oversight intensity from primary care case management to staff model HMOs. In addition, since 1988, the federal government has mandated expansion of coverage to pregnant women[24] and children in certain income categories. Federal regulations have also allowed expansions through 1902(r)(2) provisions of the Social Security Act to particular groups of categorically eligible individuals/families using more lenient income and assets requirements.

While these programs are still being evaluated, they allow sufficient flexibility that there is potential for them to expand coverage to a significant portion of the uninsured if funding is available. According to Holahan, et al. (1995), section 1115 waivers applied uniformly across all states and covering all those under 100 percent of poverty could cover from 6.5 to 13.5 million of the uninsured.[25] A similar expansion in every state which included eligibility for those up to 200 percent of poverty could reduce the uninsured by between 12.7 and 21.1 million.[26] However, these types of coverage expansions could only be achieved under 1115 waivers if the government costs could be covered by savings from restructuring delivery systems (e.g., requiring managed care participation) and/or from new revenues.

Current budget deliberations in Congress complicate the outlook for expansions through 1115 waivers and section 1902(r)(2). Existing state waivers have been approved using cost estimates based upon predicted trends in rates of increase in Medicaid spending under the current system. In other words, the estimates are based on the expected growth in Medicaid spending in the absence of any reforms or reductions in federal contributions. States that were expected to have high rates of growth therefore had more dollars to work with when designing waiver programs that had to be budget neutral with respect to the current system. Since reducing the federal budget deficit has become a high political priority, attention has turned to mechanisms for paring back the rate of increase in federal Medicaid spending.

In addition, the design and implementation of waiver programs can be characterized as being very fluid. Some states that have been granted waivers have not implemented them as they await further action by state legislators. Still others have reduced the scope of intended reforms due to state budget problems. The potential for increasing the number of insured through the waiver process thus appears less promising than had originally been hoped, even in the absence of any further budget cuts at the federal level.

Two general types of changes to the Medicaid program are being considered at the federal level: block grants and per capita expenditure caps. Block grants would put an end to the open-ended federal matching for the Medicaid program, providing lump sum payments of federal dollars that would increase each year at a specified rate. States would be given increased flexibility in determining program eligibility, benefits, reimbursement of providers, and delivery system reforms in order to accommodate these constraints. States might, for example, attempt to bring down spending per beneficiary, leaving the number of beneficiaries unchanged, or they might reduce the population of eligibles. Per capita expenditure caps would place limits on annual increases in spending per beneficiary. Under such a policy there would be no incentive to reduce the number of beneficiaries (the current entitlements to coverage could be left in place), but states would have to control the level of spending on each.

The Congressional "Medigrant" plan which was vetoed by President Clinton included a block grant; the President has said that he favors a per capita cap. As noted above, a per capita cap would be expected to have the least impact on the number of enrollees and, therefore, has less potential for increasing the pool of uninsured than does a block grant approach.

Urban Institute analyses predict that the Medigrant plan would lead to a reduction in federal Medicaid payments relative to current law projections of over 17% between 1996 and 2002, and over 28% in the year 2002. (Holahan and Liska, 1995). The grants would have increased by 4.8% on average each year between 1996 and 2002. In contrast, under the current system, the Congressional Budget Office projects that Medicaid expenditures will grow by 10.0 percent each year between 1996 and 2002.

Given such constraints on federal contributions, the ability of states to reduce expenditures per beneficiary will determine the number of Medicaid enrollees that each state will be able to finance. Holahan and Liska find that if the rate of growth of beneficiaries were not changed from current projections, the Medigrant spending limits would require national per beneficiary spending to grow by no more than 1.3% per year, or 1.7% below the rate of general inflation. This is very unlikely to occur. As a consequence, states would be likely to reduce the rate of growth in their Medicaid enrollment. In order to avoid decreasing enrollment below current absolute levels, states would have to contain annual spending increases to 4.8%, approximately half the real rate of growth experienced in the past. It is important to note as well that relative reductions in federal spending would vary considerably by state under this proposal. The implications for the number of persons losing Medicaid coverage would therefore vary by state as well.

Each state would have the discretion to find Medicaid savings by reducing spending on any number of groups of beneficiaries, including pregnant women and children, those receiving coverage due to their eligibility for AFDC, the medically needy, and the elderly. While the majority of the elderly enrolled in Medicaid are currently dually eligible for Medicaid and Medicare (through the Qualified Medicare Beneficiaries, the Specified Low-Income Medicare Beneficiaries, the Medicaid medically needy, or the Medicaid categorically needy programs) and would consequently remain covered by Medicare, the loss of coverage for Medicare copayments, deductibles, and/or premiums (currently paid for by Medicaid) could impose serious financial constraints in obtaining care. In addition, there is currently no other safety net for long term care for these individuals. Some percentage of the employed adults made ineligible for Medicaid coverage could enroll in employer sponsored insurance plans or private non-group plans to the extent that they are available to them, however this movement is likely to be extremely limited. Given their low incomes and a limited availability of employer plans, the crossover to private coverage is likely to be modest. The net result of such reductions in
Medicaid enrollment is likely to be an increase in the number of uninsured persons relative to current trends. In addition, even for those who are able to maintain other public coverage, such as through Medicare, access to services could be impeded.

Another important issue is the extent to which block grants remove the capacity of the Medicaid program to respond to economic downturns. Under the current system, a national or state/region specific recession will tend to lead to an increase in Medicaid eligibility and, consequently, in enrollment. One study (Wade, 1994), for example, found that as unemployment rate rises in industries in which AFDC and low income persons are likely to be employed, the number of Medicaid enrollees rises as well (this effect was significant for enrollment of children, but not significant for enrollment of adults). Under the current Medicaid entitlement, there is no budget ceiling to prevent enrollment expansion. Under a block grant system, economic changes would not lead to enrollment increases unless the state government(s) decided to fully fund the increase because the federal contributions to the program are fixed. Since state revenue tends to fall during a recession, such a scenario is unlikely. These financing limitations could lead to increased numbers of uninsured in areas hit by recessions.

The Medicaid reform proposal developed by the National Governors' Association (NGA) also includes an annual cap on federal Medicaid expenditures in each state; however, the plan differs from the Medigrant proposal in a number of ways. The NGA plan would provide for federal "umbrella" payments; a mechanism whereby states could receive additional federal payments on a per beneficiary basis in cases of "demonstrable need". The proposal also includes guarantees of eligibility for specific groups, including children up to age 12 (up to 133 percent of the poverty level for children under age 6; up to 100 percent of poverty for those 6 to 12) and pregnant women at or below 133 percent of the poverty level. The benefits provided to these groups would be at the discretion of each state, however.

The NGA proposal does not specify the annual rates of increase in federal payments or the amount of federal savings that is expected from the plan. It is therefore unclear how states might respond in terms of programmatic/eligibility changes. Consequently it is difficult to determine what effect these changes would have on the level of insurance coverage in each state. While the umbrella payments included in the plan might serve as a back-up financing system for some financially struggling states, it also leaves the federal government with an open-ended liability. In an era of fiscal restraint, such a situation is unlikely to be politically viable.

Medicare. Virtually all persons over 65 years of age receive insurance coverage through the Medicare program.[27] An additional 4 million non-elderly persons receive Medicare coverage as a result of a disability and 200,000 are covered as a result of end-stage renal disease (Kaiser Family Foundation, 1995). As of 1991, 12 percent of Medicare beneficiaries received assistance to pay for co-insurance and/or deductibles through the Medicare program, due to their low income status.[28] In addition, 75 percent of elderly Medicare beneficiaries purchased (either directly or through their former employer) private insurance policies that covered co-insurance, deductibles, and, at times, non-covered services such as out-patient prescription drugs (Chulis, et. al., 1993).

Proposals for achieving budgetary savings from the Medicare program were debated at length in 1995. Reforms which included incentives for the elderly to join managed care plans, provider payment rate reductions (including limits on payments to managed care plans), and increases in beneficiary out-of-pocket costs were all discussed, however, no consensus was reached. In addition, the original estimate of $270 billion in program savings over seven years was reduced through the debate, with no agreement reached as to what a viable savings level would be. Any combination of the sources of savings listed above is likely to have differing relative impacts on the level of insurance coverage and access afforded to the Medicare beneficiaries and to others, as well.

For example, two often discussed areas for reductions are in Medicare's disproportionate share hospitals (DSH) payments and graduate medical education (GME) payments. These adjustments to hospital payment levels are intended to compensate hospitals serving large shares of low income and uninsured persons, in the case of DSH, and those with additional expenses associated with teaching responsibilities (GME). Both of these additional payments are felt to function to some extent as cross-subsidization for the uncompensated care provided by the hospitals which receive them. It is possible that significant reductions in these payments in conjunction with the reduced payments associated with private insurance and Medicaid discussed earlier, could severely hamper these hospitals' ability to finance medical care for uninsured persons.

Increases in the share of Medicare costs that are borne by the beneficiaries themselves could have a detrimental effect on the degree of the comprehensiveness with which beneficiaries are protected from medical expenses. This is particularly true if precautions are not taken to income relate the changes. For example, significant increases in beneficiary premium shares for Medicare Part B (physician coverage) could lead to a lower rate of Part B enrollment. Given the high participation rate in Part B, however, increases would probably have to be quite large before significant effects on participation rates would be seen. When considering that Medicaid block grants and funding reductions might, on their own, lead to a decrease in Part B coverage for low income Medicare beneficiaries who are currently covered by both programs, a concurrent increase in Part B premiums for all Medicare beneficiaries could amplify the negative effect on Part B coverage. If such increases were adjusted to take into account beneficiaries’ ability to pay, such decreases in coverage could be lessened.

In addition, substantial increases in Medicare beneficiary payment obligations of any type (introduction of co-payments for home health care, for example) could have implications for beneficiaries' willingness to pay for private "Medigap" insurance policies. As copayments and deductibles for Medicare rise, the actuarial value
of a private policy which covers Medicare cost-sharing would rise accordingly. This is because the share of total medical expenses provided by the private policy would increase as the share covered by the government policy falls. Consequently, the price of Medigap policies would rise as well. Depending upon the relative increase in the price of these private policies, individual purchasers and employers who currently purchase the policies on behalf of their retired employees may be less likely to do so.

Decreases in the level of coverage of the elderly population, whether due to rising prices of Medigap policies, decreases in Medicaid coverage for the low income elderly, or increases in Part B premiums, could lead to access problems for some beneficiaries. Individuals with reduced coverage are likely to delay pursuit of medical treatment, which could lead to greater health care costs for these groups in the long run and may have important health status implications. Such scenarios are more likely due to the current absence of stop-loss coverage for Medicare beneficiaries -- in other words, because there is no annual or lifetime limit on potential beneficiary liability for medical expenses.

Public Hospitals. Health care services that are provided to the uninsured are generally captured under the category of uncompensated care. The burden of uncompensated care, defined as the sum of bad debt and charity care, is not distributed evenly across providers. Historically, a disproportionate share of uncompensated care has been provided by public hospitals, and public teaching hospitals tend to bear an even greater share of the burden than non-teaching public hospitals. The implications of the changing health care financing environment for public hospitals in particular may have substantial ramifications for the medical care provided to the uninsured.

There is a great deal of evidence that public hospitals provide a disproportionate share of uncompensated care. Dubay, et., al. (1993) analyzed the 1990 American Hospital Association (AHA) Survey (the most recent publicly available data on uncompensated care), and found that non-federal public hospitals had the highest share of uncompensated care charges relative to gross patient charges -- 8.2 percent versus 5.1 percent for non-governmental non-profits and 4.7 percent for-profits. This relative allocation also held when examining uncompensated care costs as a percentage of expenses: 8.7 percent for public hospitals, 5.2 percent for other non-profits, and 5.0 percent for for-profits in 1990.

Using 1979-1984 data from the National Hospital Discharge Survey (HDS), Frank, et al. (1990) found that the share of discharges attributable to uncompensated care was consistently higher in public hospitals than in any other hospital type.[29] In 1984, 11.6 percent of public hospital discharges were associated with uncompensated care, versus 6.6 percent in church-owned hospitals, 6.4 percent for non-church non-profit hospitals, and 4.3 percent in for-profit hospitals. Using the 1982 AHA Survey data, Sloan, et. al. (1986) found that 34.6 percent of all charity care and bad debt care is provided by public hospitals, while those hospitals accounted for only 18.4 percent of total charges. And while the analysts found no evidence that uncompensated care was a causative factor in hospital closings, they did find that hospital financial status was inversely associated with uncompensated care.

A recent study by the Prospective Payment Assessment Commission (ProPAC) (1995) found that urban governmental hospitals had losses owing to uncompensated care of 7.1 percent of total costs in 1993. This is compared to 4.5 percent uncompensated care losses for both the rural governmental hospitals and the non-governmental non-profit hospitals, and a 3.7 percent loss for for-profit hospitals. This analysis also demonstrated that the share of total hospital costs paid for by private payers is lowest in public hospitals -- 27.1 percent of costs in urban government hospitals and 31.4 percent of costs in rural government hospitals, versus 38.9 percent and 38.8 percent in non-governmental non-profits and for-profits, respectively.

Further evidence of the important role played by public hospitals in the provision of care to the uninsured is found in the work of Thorpe and Brecher (1987). Also using the 1982 AHA survey data, they studied the hospital markets in the 100 largest cities in the U.S. Thorpe and Brecher found that the volume of medical care delivered per poor uninsured person differed significantly between communities with and without public hospitals. The results indicate that cities with a public hospital provided 28 to 40 percent more adjusted admissions per uninsured poor person than did those cities without a public hospital. These results indicate that public hospital provision of care to uninsured persons does not simply displace similar care that would have been provided by private facilities, but instead actually increases the total amount of care provided to this population.

Given the disproportionate burden of providing uncompensated care that is carried by public hospitals, and the importance of the role that they play in providing access to care for the uninsured, it is important to consider how these hospitals might be differentially affected by changes in the health care market. Cuts in Medicaid and Medicare are likely to hit public hospitals hard as a share of total revenues, as public payers make up a larger share of public hospital costs than is true in other hospitals. In addition, competitive market pressures from private purchasers of medical care will affect public hospitals as well. While historically insurers had demonstrated a lack of aggressiveness in price negotiations with providers, and this flexibility allowed public hospitals to shift some portion of their uncompensated care costs on to private payers through higher prices, such flexibility is quickly diminishing. In order to maintain their current private payer market share, public hospitals will be forced to lower their payment rates from the levels which have contributed to the financing of health care for the uninsured in the past.

As public hospital prices fall, additional explicit sources of financing for care of the uninsured will be necessary if access to care for these populations is not to be compromised further. If Medicaid eligibility is to decrease as well, which seems likely under current proposals, the number of uninsured poor seeking care from public facilities will grow. A lack of additional funds for financing care for these groups may lead to either an inability of public hospitals to compete in the private market, thereby damaging their financial viability, or a
VI. Health Policy Reforms and Their Potential Effects on the Number of Uninsured

Although comprehensive health care reforms have been shelved for the time being, there continues to be some support for more incremental reforms, both at the state and national levels. And while a number of incremental health care reforms are promoted as having the potential to significantly decrease the number of uninsured, implementation of many such proposals are likely to have only modest effects in this regard. In fact, some incremental reforms could have the unintended effect of increasing the number of uninsured. Actual changes in the number of uninsured persons will be a function of the particular structure and financing of any given reform package, but some general insights can help inform expectations. Here we examine the two most widely discussed categories of incremental proposals: insurance reforms and subsidies for low income individuals and families.

Insurance Market Reforms. Insurance market reforms encompass a broad array of policies which can be implemented in a variety of combinations. These policies include reform of the rules of issue (guaranteed issue, renewability, portability, limits on pre-existing condition exclusions), mandated benefits, community rating, purchasing cooperatives, and other approaches as well. Of the broad array of insurance reform policies available, those that make insurance coverage more affordable are likely to have the most significant impact upon insurance coverage. Unfortunately, the health economics literature has demonstrated that the demand for health insurance is not very sensitive to price (Morrisey, 1992). Consequently, one cannot expect that substantial increases in insurance coverage will result from these types of policies.

Strategies designed to enhance market competition, such as data collection and dissemination, standard benefit packages, regulation of marketing practices, and repeal of anti-managed care laws, are policy options for lowering the price of private health insurance. Data collection and dissemination, particularly in the areas of diagnoses, treatments, outcomes, and costs, serve to create more informed purchasers of services, inducing providers and insurers to compete on quality and cost. Institution of uniform benefit packages allows purchasers of insurance to make simple comparisons of prices across plans, whereas current variations in benefit packages can make it difficult for purchasers to discern the best deal. Finally, the repeal of anti-managed care laws would eliminate state imposed impediments to the ability of network plans to price themselves competitively.

The potential effects of some other insurance market reform policies on the extent of insurance coverage are more ambiguous. For example, community rating and reform of the rules of issue are likely to make insurance more affordable for individuals and groups that are currently above average in cost, however, others would likely face an increase in premiums as a result. The net effect of such changes in relative cost will depend upon the success with which the currently insured are dissuaded from dropping coverage; this can be addressed through strategies such as age rating.

As a cautionary note, when using insurance market reforms as a tool for expanding insurance coverage, it is important to keep in mind the dominance of issues related to risk segmentation. Insurers today have extremely powerful incentives for selecting enrollees based upon their expected costs given that the most expensive 1 percent of the population accounts for 30 percent of all health spending, while the least expensive 50 percent incur only 3 percent of total health spending (Berk and Monheit, 1992). To the extent that an insurer can lower the health risk of a covered group, it can reduce expenses, and the premium necessary for profitability would decrease correspondingly. Any significant reforms to the insurance market are likely to affect the current extent of risk segmentation. Care must be taken not to impose combinations of policies that might worsen the existing situation.

The Health Insurance Reform Act of 1995, proposed by Senators Kassebaum and Kennedy, is currently being considered by Congress. The Kassebaum-Kennedy bill would have positive implications for the character of coverage for those who are currently insured; however, the effect that it would have in terms of decreasing the number of uninsured is minimal. This legislation includes limits on pre-existing condition exclusions, guaranteed issue for employer groups and for individuals seeking to purchase non-group policies after losing group coverage, guaranteed renewability, portability, and some assistance in forming private coalitions for group purchasing.

The limits on pre-existing condition exclusions, guaranteed renewability and portability are reforms that would improve insurance coverage for those currently covered, but would not affect the currently uninsured. The guaranteed issue provisions would increase access to insurance for those employer groups with 2 or more workers and for individuals moving from group coverage who are currently unable to purchase insurance at any price. There would be no constraint, however, on the premiums that could be charged to these groups and individuals; consequently, it is unclear how much of an increase in the number of insured persons would actually result. The provisions which would override state laws which currently prohibit private, voluntary coalitions from forming for purposes of purchasing insurance or for bargaining with insurers might lead to somewhat more of a competitive environment, and some decreases in the rate of growth of premiums might be seen. Such decreases might lead to a very modest increase in insurance coverage as premiums became more affordable to some, but price changes would have to be quite large in order to see significant movement.

Premium Subsidies for Low Income Individuals/Families. A number of variations on the idea of providing premium assistance for the low income population have been considered over the past few years. Some have suggested allowing low income families to buy into the Medicaid program at sliding scale rates, while others have advocated the provision of vouchers which could be used for the purchase of insurance.
from private sector insurers. Some policy makers have proposed that such programs be available to all family members that meet income eligibility requirements, while others advocate limiting programs to children and/or pregnant women. Obviously there are a multitude of possible configurations that could be designed. Regardless of the structure of the program, however, all subsidy based programs face similar difficulties when attempting to balance the main objective of expansion of coverage against the limitations of budgetary resources.

Absent insurance coverage mandates, subsidy programs designed to expand insurance coverage must address the incentives that individuals face when making the decision whether or not to participate. As the share of the premium that the individual has to contribute increases, the probability that person will participate falls. An analysis done by Lewin-VHI (1994) found that Medicaid participation rates were approximately 73 percent, and under the current Medicaid program, no beneficiary contributions are required. The researchers estimated that participation rates fall precipitously as individuals are required to pay an increasing share of the premium relative to their incomes. While these participation rates might not be accurate predictors of program enrollment for a broad population, it is very likely that individuals will be highly sensitive to their required contributions.

In a similar vein, individual behavior has been shown to be quite sensitive to changes in effective marginal tax rates -- the rate at which benefits decrease as income increases. This is an important consideration in designing the phase-out schedule for subsidy eligibility. For example, a program that provides full premium subsidies for families below 100 percent of poverty, and decreases the value of the subsidy in a linear way for families between 100 and 150 percent of poverty imposes substantially higher marginal tax rates than a schedule that phases out between 100 and 250 percent of poverty. The longer the phase-out range of the subsidy, the smaller is the incremental cost of coverage for each family as their income increases by a small amount. The smaller the incremental cost of coverage is, the less likely the family will be to opt out of insurance coverage.

Broad program design issues, such as whether the coverage is offered through the Medicaid program or private contractors could also have important ramifications for enrollee participation. To the extent that individuals perceive a social stigma associated with the Medicaid program, they will be less likely to enroll, even when eligible. Providing low income individuals with private insurance coverage would serve to diminish such barriers to enrollment, however that strategy might also mean higher program costs.

By keeping both the family share of the premium and marginal tax rates low, participation rates can be boosted. Providing coverage through a largely private sector program is likely to help in this regard as well. However, the larger the government share of the premium, and the more families eligible and applying for subsidization, the higher the governmental costs of the program. Therefore, budgetary constraints will, in the end, dictate the boundaries of subsidy and program design and as a consequence, the number of uninsured that would be afforded access to coverage.

VII. Conclusions

The number of uninsured is large and still growing. Families below 200 percent of poverty are particularly vulnerable to being without coverage, but significant numbers of higher income families experience bouts of uninsurance as well. Adults (below age 65) are more vulnerable than children, given that they have less access to coverage through public programs. Non-whites are more likely to be uninsured than their white counterparts, largely due to their lower incomes, on average and the characteristics of employment, such as firm size, industry, geographic location, etc.

Having a job does not, by any means, imply that an individual will have health insurance. Of those adults who are uninsured, almost 80 percent are employed, with three-quarters of the working uninsured engaged in full-time employment. It is definitely not true that the uninsured are predominantly non-working adults. In fact, households where at least one adult is engaged in part-time work are more likely to be uninsured than households with no adult working -- an effect which results from denial of Medicaid eligibility to many families with even very modest incomes.

Private insurance in the US today is closely tied to the workplace. The increasing level of health insurance premiums over time has made the sponsorship of health coverage less attractive to both employers and many workers. This is because many workers have been forced to accept slower wage growth or higher shares of their direct health care costs in exchange for continued employer-based coverage. As a likely result of the pressures created by medical costs rising faster than GDP, employment-based insurance coverage has fallen for all income groups between 1988 and 1993. Both uninsurance and public coverage have increased over the same time period.

What are the consequences of being uninsured? Substantial evidence indicates that utilization of health services and access to care are significantly lower for those without coverage relative to those with private insurance. The gaps between the insured and the uninsured appear with regard to both outpatient physician and hospital care. Even among individuals with definite health care needs, such as the chronically ill, the uninsured receive fewer services. There is also some evidence that the lack of insurance can affect health status and health outcomes, including mortality. More research in this area is encouraged, however.

The whirlwind of changes occurring in the health care market may also have serious implications for the uninsured. Efficiency gains prompted by increasing competitiveness among private sector insurers threaten one form of implicit financing of care for the uninsured -- the shifting of uncompensated costs to those with private coverage. In addition, potential cutbacks in the federal budget could mean substantial Medicaid funding reductions and the reversal of coverage gains from recent expansions and waiver programs.
 Depending upon the details, Medicare program reductions could also have adverse implications for beneficiary access and comprehensiveness of coverage as well as for sources of funding such as DSH and GME which tend to compensate hospitals with large shares of low income/uninsured patients. Public hospitals, disproportionately responsible for the provision of care to the uninsured, are likely to feel the effects of both Medicaid and Medicare cuts strongly.

All these changes in the private and public sector have the effect of reducing historic sources of financing for the care of the uninsured. If current access to health care services is to be maintained, alternative funding sources will be required. A broad array of policy alternatives for this purpose have been debated within the past few years. While comprehensive measures have been rejected for the near term, a number of incremental options are still under short term consideration. Two of the options often discussed are subsidization, either through vouchers for private insurance or the Medicaid program, and insurance market reforms.

Subsidization of health insurance premiums for those with low incomes or the expansion of Medicaid on an income-related basis are both strategies with the potential to significantly reduce the number of uninsured. These approaches can be quite costly, however, particularly under a voluntary system where the strength of the financial incentives to participate will have powerful influence over the program’s effect on reducing uninsurance. And while insurance market reforms are less expensive to governments than premium subsidization or public coverage, their promise for increasing insurance coverage is much weaker.

All in all, the near-term outlook for the uninsured is not positive. While from some perspectives, current changes in the structure of private sector insurance markets and increasing cost consciousness in the public sector are worthwhile and important moves, they may have detrimental ramifications for the already underserved. Social choices will likely be required to balance the ill effects of persistent and increasing numbers of uninsured and the costs of explicitly addressing the problem.

Notes

1. The primary focus of analyses of the uninsured is on the non-elderly because virtually all those age 65 and over are insured through the Medicare program. [Return]

2. While both the Holahan, et. al. and EBRI estimates are based upon the March 1994 Current Population Survey (CPS) and reflect the number of non-elderly people uninsured for the full 1993 calendar year, they differ as a result of differences in the way the two groups edit the CPS data. [Return]

3. In this paper, the most recent counts of individuals by health insurance status are taken from the 1994 Current Population Survey (CPS), which contains data from 1993. While the 1995 CPS is currently available, the questions in that survey regarding health insurance status were changed from previous years. As a result, estimates derived from the 1995 CPS are not comparable with those from previous years, and cannot be used to accurately illustrate trends in health insurance status. [Return]

4. The federal poverty guidelines vary by family size. For example, in 1995 the federal guideline for all 4 person families (except those residing in Alaska and Hawaii) is $15,150. [Return]

5. Catastrophic illness expenses are defined as being $25,000 for those identified as being in a low risk group, and $50,000 for those in a high risk group. [Return]

6. The 31.7 million estimate is from Holahan, Winterbottom, and Rajan (1995): the 39.0 million estimate is the Holahan, Winterbottom, and Rajan (1995) estimate for calendar year 1993 trended forward by projected population growth. The 33.7 million estimate is from EBRI (1995); the 42.1 million estimate is the EBRI (1995) estimate for calendar year 1993 trended forward by projected population growth. [Return]

7. Calculation for the non-poor (all those with incomes exceeding 100 percent of the federal poverty guideline) is from figures presented in Holahan, Winterbottom, and Rajan, 1995. This aggregated category is not shown in Table 1. [Return]

8. The federal poverty guidelines vary by family size and, with the exception of Alaska and Hawaii, are the same across all states, regardless of cost of living differences. The poverty guideline for a family of four is $15,150 in 1995. [Return]

9. Issues related to Medicare coverage and the elderly are discussed in a later section of this paper. [Return]

10. Legislative changes being considered which would give more flexibility to states to determine Medicaid eligibility could affect this guarantee. [Return]

11. These finer age break-downs for the rate of uninsurance are not shown in the table. [Return]

12. While the CPS occasionally asks an “offer” question on its survey, the question addresses whether the firm the individual works for offers insurance coverage, not whether or not the firm offers it to that particular individual. [Return]

13. A family is defined as a “health insurance unit” -- the members of a nuclear family who can be covered under one health insurance policy. [Return]

14. Here, uninsured adults who do not work themselves, but who have working spouses are listed as not
15. The self-employed are shown here as a separate category (not allocated across industry type) because their access to health insurance is likely to be more of a function of being self-employed than of the particular industry in which they work. [Return]

16. The data used by Winterbottom et al. are based on a three-year merged file of the 1991, 1992, and 1993 March Current Population Surveys. The data from the surveys correspond to calendar years 1990-1992, although the authors weighted the surveys in such a manner the statistics are mostly representative of the population in 1992. [Return]


18. The researchers also analyzed outcomes by insurance status. These results are presented below. [Return]

19. Access to health care was evaluated through a community resident survey. A minimum of 150 persons were administered closed-ended survey questions in each of 41 out of 250 zip code cluster in urban California. The 41 clusters were chosen at random. [Return]

20. As determined by hospital discharge data. [Return]

21. The status of 1115 waivers changes rapidly. These counts were accurate as of early April, 1996. [Return]

22. See Nichols, Marsteller, Verrilli, and Bovbjerg (1995) for an overview of such merger and integration issues. [Return]

23. There is still considerable variation, however, in the extent to which these organizations and systems agree to bear the risk of insurance. [Return]

24. Coverage for pregnant women is restricted to pregnancy related services only, and coverage terminates shortly after the birth of the child. [Return]

25. This analysis also estimated that approximately 1.8 million persons currently purchasing private non-group coverage and up to 3 million individuals currently in employer sponsored insurance plans would also enroll in Medicaid under the auspices of such an expanded program. The total cost to the government if no premium were charged to enrollees was estimated to fall between $13.2 and $21.0 billion, in 1994 dollars. [Return]

26. In this scenario, individuals between 100 and 200 percent of poverty would be expected to share in the cost of their coverage, and individual participation rates are adjusted to reflect this. Estimated government costs ranged from $22.3 to $49.6 billion in 1994 dollars. [Return]

27. According to the Health Care Financing Administration (1995), 97 percent of persons age 65 and over qualify for Medicare Part A (hospital care) based upon eligibility for Social Security benefits. Although Part B (physician) is voluntary, 97 percent of Part A beneficiaries currently enroll. [Return]

28. Evidence suggests that only 41 percent of eligible beneficiaries enroll in the state programs to buy Medicare coverage for poor seniors (Neumann, et al., 1994). [Return]

29. The HDS includes non-Federal short-stay hospitals. [Return]

30. The discussion contained in this section is based upon Blumberg and Nichols (1995). [Return]

31. The variety of insurance reform policies are defined and discussed in depth in Blumberg and Nichols (1995). [Return]

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**Figures**
Figure 1: Change in insurance coverage, 1988-1993
By income level

Note: "Other Public" includes Medicare, CHAMPUS, VA, and military health.
Figure 2: Source of insurance coverage for the nonelderly, 1990-92

- Uninsured for entire year: 15.8%
- Medicaid: 10.9%
- Other private: 7.5%
- Other public: 2.1%
- Own employer: 31.8%
- Spouse or parent employer: 31.9%

Note: "Other Public" includes Medicare, CHAMPUS, VA, and military health.
Figure 3: Rate of insurance coverage of the nonelderly within income levels, 1990-1991
By source of coverage

<table>
<thead>
<tr>
<th>Poverty Level</th>
<th>Percent</th>
<th>Own employer</th>
<th>Spouse or parent employer</th>
<th>Medicaid</th>
<th>Other public/private</th>
<th>Uninsured for entire year</th>
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<tbody>
<tr>
<td>&lt; 100%</td>
<td>49.0</td>
<td>7.4</td>
<td>0.5</td>
<td>0.7</td>
<td>12.3</td>
<td>4.4</td>
</tr>
<tr>
<td>100-200%</td>
<td>20.2</td>
<td>20.9</td>
<td>12.1</td>
<td>0.2</td>
<td>12.0</td>
<td>2.1</td>
</tr>
<tr>
<td>200-399%</td>
<td>27.4</td>
<td>27.6</td>
<td>12.7</td>
<td>1.2</td>
<td>12.0</td>
<td>3.3</td>
</tr>
<tr>
<td>400+</td>
<td>45.6</td>
<td>38.7</td>
<td>46.9</td>
<td>38.7</td>
<td>38.7</td>
<td>38.7</td>
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</tbody>
</table>

Note: "Other public/private" includes Medicare, CHAMPUS, VA, and military health and persons with private nongroup coverage.
Figure 4: Rate of insurance coverage for the nonelderly adults and children, 1990-1995
By source of coverage

![Chart showing the percentage of insurance coverage by source for children and adults.]

Note: "Other public / private" includes Medicare, CHAMPUS, VHA, and military health and persons with private nongroup coverage.
Figure 5: Rate of insurance coverage of the nonelderly for whites and non-whites, 1990-1992, By source of coverage

Note: "Other public/private" includes Medicare, CHAMPUS, VA, and military health and persons with private nongroup coverage.
Figure 6: Rate of insurance coverage of the nonelderly within work status groups, 1990-1992, By source of coverage

Insurance Coverage
- Own employer
- Spouse or parent employer
- Medicaid
- Other public/private
- Uninsured for entire year

Work Status
- No work
- Some PT
- One FT worker
- Two FT workers

Percent
- 65.8%
- 64.0%
- 31.1%
- 34.9%
- 41.1%
- 35.3%
- 41.6%
- 43.7%
- 39.8%
- 1.4%
- 6.4%
- 8.6%
- 6.8%
- 6.8%
- 3.5%
- 6.0%
- 6.1%
- 16.7%
- 14.6%
- 6.4%
- 8.6%

Figure 7: Work Status of Uninsured Nonelderly Adults, 1990-1992

- Full-time: 57.0%
- Part-time: 20.0%
- Not Working: 23.0%

Figure 8: Rate of uninsurance, 1993
By industry

Note: The uninsured are defined as individuals who responded being uninsured at any time during the year. "Other" includes mining, transportation, communications, finance, insurance, real estate, manufacturing, and wholesale trade.
Figure 9: Rate of uninsurance for workers age 18-59, 1992
By firm size

<table>
<thead>
<tr>
<th>Firm size (number of employees)</th>
<th>Percent by firm size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>16.7</td>
</tr>
<tr>
<td>&lt;25</td>
<td>27.4</td>
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<td>25-99</td>
<td>26.0</td>
</tr>
<tr>
<td>100+</td>
<td>10.6</td>
</tr>
</tbody>
</table>

Note: The uninsure are defined as individuals who did not report any type of health insurance over the entire year.

Other Publications by the Authors
- Linda J. Blumberg
- David Liska

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