

# National Conference of State Legislatures

## STATE HEALTH LAWMAKERS' DIGEST

POLICY, RESEARCH AND PRACTICES TO INFORM THE DECISION-MAKING PROCESS

VOLUME 1 NUMBER 3

### The Changing Face of the Uninsured

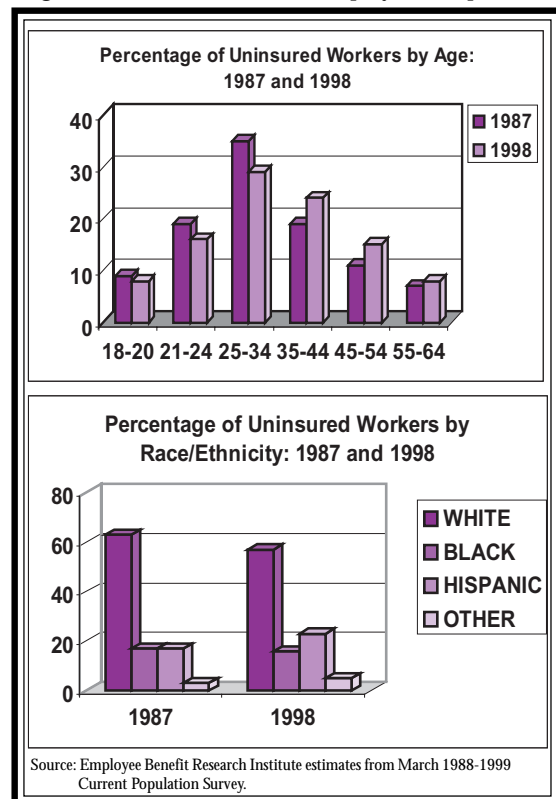
About 42.5 million people, or 15.5 percent of the national population (17.5 percent of the non-elderly population) were uninsured in 1999, according to the Census Bureau's most recent Current Population Survey (CPS). This is the first hesitation since 1987 in a steady upward trend. The uninsured include extremes of health, age and income. Most are employed or are in families headed by workers. According to a Kaiser Commission analysis of 1998 census data, 74 percent are in families with at least one full-time worker and 56 percent are low-income.

Changes in who is uninsured reflect broader demographic, economic and policy changes. Although the youngest workers are likeliest to be uninsured (sometimes referred to as "young immortals" for their belief that they don't need coverage) the age profile has shifted as America grays (see chart). Older Americans are most likely to be insured, but those who are uninsured are particularly likely to face high premiums, making the slight drop in coverage in the 55- to 64-year-old group especially troubling. Changes in the structure of retirement health coverage resulted in an 8 percent to 9 percent decrease in coverage offered to early retirees from 1991 to 1997. The full effects of this change likely will be exacerbated by the impending retirement of the first baby boomers.

In a survey of uninsured adults in 2000, almost 75 percent cited cost as a major reason for being uninsured. Indeed, for 47 percent that was the single most important reason, followed by not being offered it on the job (15 percent), or being between jobs or unemployed (15 percent). Just under half (47 percent) of workers below the poverty line continue to lack coverage, but rates of uninsurance have grown slowly for the near poor. Meanwhile, inflation and cost sharing have made premiums unaffordable to a growing number of middle-income employees. 22 percent of uninsured workers earned more than 400 percent of the federal poverty level (FPL) in 1998, compared to 15 percent in 1987.

Researchers recently have focused on how poverty and minority status interact. Compared with 1994 (the last time fewer than 15.5 percent of the population were uninsured) poor minorities are likelier to lack coverage (28.1 percent vs. 23.3 percent for blacks, 43.7 percent vs. 39.8 percent for Hispanic), and make up a greater proportion of the uninsured. Like the nation as a whole, the uninsured are increasingly Hispanic: 19.2 percent of all uninsured in 1987 were Hispanic; whereas in 1999 they represented more than 25 percent of the uninsured.

Self-employed workers and employees of small firms (fewer than 25 employees) have always been less likely to offer coverage, but they comprise a dwindling share of the uninsured work force (down from 50 percent to 47 percent). The most troubling change is among workers in large firms (more than 1000 employees), who experienced a 53 percent increase in the likelihood of being uninsured. Although they are still likelier to have coverage, the sheer number of workers in large firms translates to an important percentage of uninsured in those companies (28 percent in firms with more than 500 workers).



# In The Abstract

## ACCESS TO INSURANCE

### Employer Health Benefits: 2000 Annual Survey

**STUDY AND RESULTS** This report presents findings from a survey of more than 3,000 public and private employers. Through graphs and charts, the report illustrates various trends, including cost, employee coverage, health plan enrollment and choice, and prescription drug and mental health benefits.

**FINDINGS** Health insurance premiums are increasing (up 8.3 percent between 1999 and 2000), due in part to higher spending for prescription drugs. In addition, more small businesses are offering health insurance, with a 65 percent rate of enrollment among those offered insurance across all business sizes. According to employers, the most common reason for employees not choosing coverage is because workers are covered elsewhere (72 percent) not because they can't afford the premiums (11 percent).

**FIND THIS STUDY** *Employer Health Benefits: 2000 Annual Survey* by the Kaiser Family Foundation and Health Research and Educational Trust can be found at <http://www.kff.org>. For individual copies, contact the Kaiser Family Foundation at (800) 656-4533.

### Health Care After Welfare: An Update of Findings from State-Level Leaver Studies

**STUDY AND RESULTS** This Center on Budget and Policy Priorities document analyzes 25 studies-conducted by states or counties-of children and families leaving welfare between January 1997 and summer 1999. Studies were conducted from three to 18 months after the subjects left welfare. The authors looked at the percentages of children and adults in these surveys who retained Medicaid, obtained private or employer-sponsored insurance, or lapsed into uninsurance.

**FINDINGS** Virtually all children leaving welfare remain eligible for Medicaid or SCHIP, as do a smaller number-but still a majority-of their parents. Nevertheless, about half of parents and a third of children lost coverage. In most studies, fewer than half the parents who left welfare for work were offered employer-sponsored coverage, and not all of them purchased it when it was offered. In nearly all states, at least one parent in four was uninsured after leaving welfare.

In many states, one child in five was uninsured after his or her parent left welfare. As a whole, these studies suggest that many states have not de-linked Medicaid and welfare sufficiently and that many families lost Medicaid inappropriately.

**CAVEAT** The author stresses that the investigators who conducted these studies used different methods, took very different study samples, and interviewed subjects at different time intervals after they left welfare. As a result, although comparisons among studies may reveal broad trends, they are statistically imprecise.

**FIND THIS STUDY** *Health Care After Welfare: An Update of Findings from State-Level Leaver Studies*, by Jocelyn Guyer. August 2000, Center on Budget and Policy Priorities. The publication can be ordered free of charge by calling (202) 408-1080. It also is available online at [www.cbpp.org](http://www.cbpp.org).

**OTHER STUDIES** See also Bowen Garrett and John Holahan, "Health Insurance Coverage after Welfare", *Health Affairs*, 19, no. 1 (Jan./Feb. 2000); and Leighton Ku and Brian Bruen, *The Continuing Decline in Medicaid Coverage*, Urban Institute, December 1999.

## GROUPS AT RISK

### HEALTH INSURANCE, ACCESS AND HEALTH STATUS OF CHILDREN: FINDINGS FROM THE NATIONAL SURVEY OF AMERICA'S FAMILIES

**STUDY AND RESULTS** In the Urban Institute's newest installment of "Assessing the New Federalism," examines insurance coverage for children age 18 and younger in 13 states—Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington and Wisconsin. The report uses data from the National Survey of America's Families (NSAF) to study recent trends in access and coverage by comparing type of coverage, income group and age.

**WHAT'S IMPORTANT** Overall, the proportion of uninsured children has not declined between 1997 and 1999. Higher-income children are slightly less likely to be insured than they were two years ago, due to declines in employer-sponsored coverage. The insurance rates of low-income children have remained virtually unchanged, despite widespread implementation of the State Children's Health

Insurance Program (SCHIP). Low-income children also are four times as likely as higher-income children to be uninsured. These findings suggest that gains from SCHIP/Medicaid programs may not yet be readily apparent and that efforts to enroll eligible children may need to be strengthened.

**FIND THIS STUDY** "Health Insurance, Access and Health Status of Children: Findings from the National Survey of America's Families" was published by the Urban Institute in October 2000 as part of its series, *Snapshots of America's Families*. It can be ordered by calling (202) 261-5079 or can be downloaded from <http://newfederalism.urban.org/nsaf/index.htm>.

**RELATED STUDIES** The Children's Defense Fund's "Children in the States 2000" also provides current insurance information for children at the state level (<http://www.childrensdefense.org/states/data.html>).

### Working Without Benefits: The Health Insurance Crisis Confronting Hispanic Americans

**STUDY AND RESULTS** Using data from the March 1999 Current Population Survey and the Commonwealth Fund 1999 National Survey of Workers' Health Insurance, this report examines reasons behind the coverage crisis and the effect that lack of health insurance has on the Hispanic community. Hispanic Americans are twice as likely to be uninsured as the general population. Nearly 40 percent of Hispanics under age 65 do not have insurance, and 9 million of the 11 million uninsured Hispanics are in working families. Lack of coverage limits Hispanics' timely access to health care and leads many individuals to forego care altogether.

**WHAT'S IMPORTANT** Several factors contribute to the high uninsured rate of Hispanic Americans, including concentration in low-wage and small firm jobs that do not offer insurance. Buying coverage in an individual (non-employer) market is almost always too expensive.

**FIND THIS STUDY** *Working Without Benefits: The Health Insurance Crisis Confronting Hispanic Americans* (publication #370), published in March 2000 by the Commonwealth Fund, can be ordered by calling (888) 777-2744, or it can be downloaded from <http://www.cmwf.org>.

**RELATED STUDIES** *Can't Afford to Get Sick: A Reality for Millions of Working Americans* (publication #347), published by GAO in September 1999.

### Health Insurance for the Near Elderly

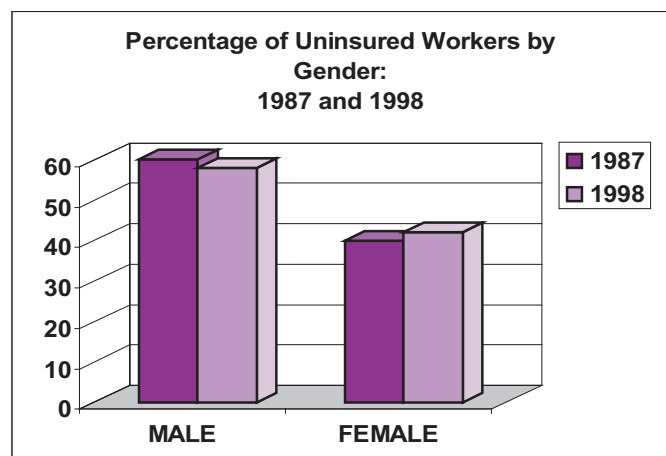
**STUDY AND RESULTS** This report examines private health insurance coverage for the near elderly—those between the ages of

55 and 64. It specifically looks at their health, employment, income and health insurance status; their ability to obtain employer-based health insurance if they retire before becoming eligible for Medicare; and use of and costs associated with buying individual market or employer-based continuation policies.

**FINDINGS** Roughly 86 percent of the near elderly have access to some type of health insurance. However, health coverage is a concern for many in this age group who retire early or who lose access to employer-based policies. Private health coverage may be too expensive for some of them because often both their health and income decline at the same time they leave the work force. Their health care expenditures are about 45 percent higher than those of the younger group, while their median family incomes are about 25 percent lower. Fewer than 40 percent of large employers offer retiree health coverage, and that number continues to decline.

**WHAT'S IMPORTANT** In most states, some of the near elderly who try to buy policies in the individual insurance market may be denied, may have certain conditions or body parts excluded from coverage, or may pay significantly higher premiums than the standard rate. Although many states have tried to increase access to health insurance coverage, obtaining policies still may be expensive, especially for less healthy individuals who may have high expected costs.

**FIND THIS STUDY** *Private Health Insurance: Declining Employer Coverage May Affect Access for 55- to 64-Year-Olds by the U.S. General Accounting Office (GAO/HEHS-98-133, June 1998).*



# What Works

## Counting the Uninsured

The Census Bureau's Current Population Survey (CPS) March supplement has collected coverage information annually for several decades, making it a benchmark for trends in the number of uninsured. However, the CPS routinely yields larger estimates of the uninsured than other surveys and is only a moderately useful source for state-level information, although state-level estimates can be built using a three-year average of CPS data. The CPS tends to undercount people on Medicaid; the Urban Institute adjusts CPS data for this undercount using income eligibility and state Medicaid enrollment levels. The Employee Benefit Research Institute (EBRI) has just issued an excellent comparison of the CPS and other surveys, ([http://www.ebri.org/health\\_findings.htm](http://www.ebri.org/health_findings.htm)).

States have long relied on national data collected by both federal agencies and private groups to track changes in their populations. Growing concern about the accuracy of such surveys has led some states—including **Florida, Massachusetts, Minnesota, New Mexico, Oregon, Vermont, and Wisconsin**--to begin their own data collection. Small differences in how state surveys are conducted and how questions are worded can lead to different results, making comparison among such surveys difficult. Designing surveys requires trade-offs. A large sample and personal interviews—by phone or face-to-face—improve completeness and accuracy but raise costs. Standardized questions allow results to be compared over time and place but limit flexibility. Long or personal surveys may not get finished. Groups of particular policy interest—the very low-income, newcomers and minorities—may lack phones, require translators or distrust official strangers.

### Florida Health Insurance Study

In 1997, the Florida Legislature created the Florida Health Insurance Study (FHIS) as a multi-year, multi-project study to obtain information on coverage and safety-net access on both a statewide and a regional basis. The study was managed by Florida's consolidated state health agency, and survey research was contracted to the University of Florida. A distinguished advisory panel of national and state experts provided advice and consultation to the state team.

The telephone survey counted more than 37,000 people in

more than 14,000 households and conducted almost 1,000 interviews in Spanish. Its sampling design allows accurate estimates in each of 17 districts. The groups that were likeliest to lack insurance were "oversampled," that is, surveyed in larger proportions. This has the effect of holding a magnifying glass over the area that most concerns policy makers. Statistical weights then are used to create estimates that match the proportions of each group in the total population.

To ensure consistency with national surveys, many questions were drawn from various national surveys. The survey asks whether a person is covered under various programs, then probes whether those who are not covered under any of the programs named actually are uninsured and, if so, why. In addition to the phone survey, in-person interviews were conducted by a market research firm that specializes in "hard to reach" populations in settings in three telephone-poor Florida communities (<http://www.fdhc.state.fl.us/Text/Publications/index.shtml>).

### Wisconsin Family Health Survey

Since 1989, Wisconsin has conducted a continuous random telephone survey to collect information about health and insurance status and use of health services. In recent years, the surveys have contacted about 2,500 households (representing about 6,500 people) annually, averaging around 200 a month. The project is conducted by the Health Department, using the services of the University of Wisconsin Survey Research Laboratory for survey sampling and interviewing. The survey takes random samples from each of five geographic areas, plus a sixth sample from telephone exchanges in Milwaukee that are known to include a higher proportion of black families. The questions used in the survey were designed by the Wisconsin Bureau of Health Information. Many are the same from year to year, although new topics sometimes are added. Recently, a question was added to reconcile discrepancies in answers to questions about coverage, with a resulting drop in the number of households that reported they were uninsured (<http://www.dhfs.state.wi.us/stats/healthinsurance.htm>).

### Federal-State Partnerships

Two federal-state partnerships hold promise for collecting comparable state-level data on insurance. The Department of Health and Human Services (HHS) recently awarded \$13.6 million in state planning grants to 11 states to develop designs for providing access to health insurance coverage to all citizens of the State, including gathering information on

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# Who Knows

**Peter Cunningham, Ph.D.**, Senior Health Researcher, Center for Health System Change (RWJ) and **Paul Fronstin, Ph.D.**, Senior Research Associate, Employee Benefit Research Institute (EBRI)

## Has who is uninsured changed?

**PC:** I wouldn't say that there have been any major shifts. Most of the uninsured are members of working families who are in that gap where they are not eligible for public coverage and are not offered coverage by their employer. I would say that there may be some smaller shifts—some increase [in uninsurance] in the upper income ranges, primarily resulting from self-employed people who no longer can afford purchasing a separate policy for themselves because of the expense. We saw for the first time in the past 10 years a decrease in the uninsurance rate for children, which I think is a combination of both public coverage expansions and the strong economy.

## What do we now know and understand about the uninsured population that we didn't before?

**PC:** One is that the uninsured problem is especially severe among Hispanics, [who] make up about one quarter of the uninsured. Because the Hispanic population is increasing, unless something is done to address the problem among Hispanics, the uninsurance rate will go up merely because of these demographic changes. Another not so well known problem is that the uninsured rate is especially high among young adults. The policymakers tend to focus on the groups that are commonly perceived as vulnerable—children, near elderly—but the uninsurance problem actually is less severe for those groups than for young adults.

**PF:** I think one of the things we understand now is that cost is the big issue. People just can't afford it. There is a small group of people who can afford it and don't want it, but if that group is covered, you still have 40 million people without health insurance coverage. I think the other thing is understanding the dynamics of how long [people are] uninsured, who's uninsured the longest, and why they are uninsured for so long. We have a better grasp on that, but we still have a long way to go before we completely understand these dynamics.

## Is a different strategy needed now to reduce uninsurance?

**PC:** Short of universal coverage, what we probably need are a combination of things. One is an expansion of public programs such as SCHIP and Medicaid to cover more low-income families. That, combined with perhaps some sort of tax incentives—subsidies or credits—to help people purchase health insurance. Even with all that, it's not clear how much of a dent we're going to make. One thing policymakers have to grapple with is that virtually all the policy proposals during the past five years have relied on strictly voluntary programs. With a program like SCHIP, you're not just automatically eligible. You have to go through an enrollment and application process and a lot of people are not going to sign up for that reason. I think one thing—without advocating anything in particular—that policymakers need to be aware of is the limits of proposals that rely on voluntary sign-up. There always will be people who for one reason or another are not going to enroll. As long as we rely on that, then we're still going to have a significant uninsured problem.

**PF:** I think the strategy that we haven't tried is education. And the education I'm talking about letting both workers and employers know why it's important and why they should spend the money. I think if evidence of the benefits of offering insurance go beyond the insurance component—benefits such as more productive workers, less turnover, the other costs of not offering coverage that are offset by offering it—I think more people might be covered.

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## Continued from page 4.

the uninsured in the state. States proposed a mixture of new data gathering and analysis of existing data sets.

Every state currently administers a telephone survey of health behaviors as part of the CDC's Behavioral Risk Factor Surveillance System (BRFSS). A collaborative project of CDC and the states, the surveys are administered by state health departments under federal guidelines. The surveys consist of a core module that all states use, optional add-on modules that states may choose to use, and state-added questions. This design allows states to compare information while also gathering data of state concern (<http://www.cdc.gov/nccdphp/brfss/about.htm>).

# On The Horizon

## EMPLOYER-SPONSORED INSURANCE

Employer-sponsored health insurance is the mainstay of the U.S. health financing system for people under age 65. Although employer-based coverage rates have remained flat since 1993 or even have risen slightly, low-income workers, workers in firms that employ greater proportions of low-wage workers and small business employees remain disproportionately uninsured.

As sharp premium increases and the prospect of a cooling economy loom, small businesses again are beginning to feel the effects of rising health insurance costs. According to a Henry J. Kaiser Family Foundation survey, premiums increased 3.7 percent from 1997 to 1998, 4.8 percent from 1998 to 1999, and 8.3 percent from 1999 to 2000. If—as analysts predict—premiums continue to rise, smaller and less profitable firms may drop coverage and larger firms may offer reduced coverage. Moreover, some large corporations have warned that proposed legislation that allows individuals to sue their employer-sponsored plans could cause larger firms to withdraw from the market altogether in fear of litigation. In light of the widening coverage gaps, a number of alternatives have been proposed.

Several strategies aim to reform the employer-based system by improving economic incentives and augmenting the purchasing power of disadvantaged employees and employers. Changes in federal and state tax policies would improve economic incentives in **defined contribution programs**, in which workers receive cash transfers or vouchers from employers to purchase coverage from a selection of plans. **Premium assistance programs** aid small businesses and low-income workers through public and private partnerships. These have

been modestly successful in a few states (**Washington, Massachusetts, California**) but the cost of subsidies and concerns about crowd-out have limited their size and effectiveness. **Insurance purchasing pools** to give small firms and self-employed individuals the leverage typically available to larger businesses have been a mainstay of state experimentation, with limited effect. Some states (**New Mexico, Arizona**) use **reinsurance programs** to bring carriers together to manage risk and insure against losses. This approach is designed to make private insurance more available by compensating for disparities in health.

Another set of proposals creates alternatives to an employment-based system. State and/or federal **tax** proposals to induce workers to purchase individual coverage range in complexity from simply equalizing the deduction self-employed and employed workers get for health coverage, to **tax credit** schemes that may include complex risk and income adjustments. **Medical savings accounts (MSAs)** are proposed to encourage consumer responsibility through catastrophic medical coverage and individual tax-exempt medical savings accounts.

Reports of the demise of employer-based coverage may be exaggerated. But if—or more likely when—coverage again falls, policymakers will turn to these proposals to augment or even replace the employer-sponsored system. Given the equipoise of the current Congress, the likeliest federal action would be to allow states greater scope to continue these experiments. A March 2000 in-depth review of this issue is in New Jersey's *Forum Issue Brief* No. 33 "The Future of Employer-Based Health Plans" (<http://www.forumsinstitute.org/publs/ib33.pdf>). Also see *Health Affairs* 18, no. 6 (November/December 1999).

## Digging Deeper

The **Kaiser Commission on Medicaid and the Uninsured** has information on the uninsured and major shifts in insurance coverage. <http://www.kff.org>. Of special interest is its chart book on *Uninsured in America* at <http://www.kff.org/content/archive/1407/>. The **Urban Institute** web site includes the *Survey of American Families*, which contains state-level data from 13 states on access and coverage for both children and adults, by race and ethnicity. <http://newfederalism.urban.org/nsaf/index.htm>. The U.S. **Census Bureau** web site contains statistics on the uninsured, including data on the number of uninsured people by state, low income uninsured children by state and demographic data on the uninsured. <http://www.census.gov/hhes/www/hlthins.html>. The **Center for Studying Health Systems Change** site includes information about uninsured children and children's health insurance coverage. <http://www.hschange.com>

The **Employee Benefit Research Institute (EBRI)** web site (<http://www.ebri.org>) contains various articles about the working uninsured. Its issue brief on *Small Employers and Health Benefits: Findings from the 2000 Small Employer Health Benefits Survey* is a good source of data on the working uninsured.

The **Blue Cross/Blue Shield of America** web site has information about the percentage of uninsured people per state and a state-by-state comparison of the uninsured. <http://bcbshealthissues.com/special/uninsured>.

*State Health Lawmakers' Digest is a product of the Forum for State Health Policy Leadership at the National Conference of State Legislatures. State Health Lawmakers' Digest was produced with the generous support of the Robert Wood Johnson Foundation. For more information, please call Donna Folkemer at (202) 624-5400.*