Health Politics in the 1990's After the Health Security Act: Can the Gaps Be Filled?

J. Theodore Anagnoson, Ph.D.

Professor of Political Science, California State University, Los Angeles

Los Angeles, CA 90032-8226 anag999@silcom.com (323) 343-2245

Abstract

Since President Clinton's proposed Health Security Act was defeated, many groups in Washington have focused on the possibility of filling in the "gaps" in health insurance. The recently enacted children's health insurance bill (1997) is a good example of this approach. The purpose of this paper is to explore the possibility of filling in the gaps in health insurance, in particular, whether this approach, even if all the proposed gaps were filled (18-24 year olds, workers between jobs, 55-64 year olds, etc.), would provide health insurance for all or even most of the 42 million people who lack it. The conclusion is that "gap filling" has had some meaningful results, although these are generally modest. For a variety of reasons, the effort that produced the State Children's Health Insurance Program in 1997 seems unique. The political conditions that existed in 1997 seem unlikely to recur; providing health insurance to children has both political appeal and extremely low cost compared to other groups. Other legislation and administrative actions seem to have had modest results. In general, then, incremental approaches, as Marmor stated in 1994, are "politically possible," but are characterized by significant drawbacks, in particular the difficulty of working within the constraints of a system where employers have considerable choice and those without health insurance are both politically inactive and characterized by an extremely heterogeneous makeup.

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I. Introduction

In 1996, a 30-year old woman in Hastings, Nebraska needed an operation to replace her pacemaker. Her heart had, according to the Hastings Tribune of November 9, 1996, "what doctors call a congenital third-degree heart block. The top part of her heart has a hole in it. The bottom part doesn't connect properly and doesn't beat unaided." She uses a pacemaker, but it needed to be replaced and the officials at the Bryan Memorial Hospital wanted a $30,000 down payment before they would schedule the $90,000 surgery. Neither she nor her husband had health insurance provided through their jobs. They were too poor to purchase health insurance on the private market and too rich for Nebraska's Medicaid program. The Hastings Tribune termed her "caught in a health insurance gap" (Harms, 1996).

Since President Clinton's proposed Health Security Act was defeated, many groups in Washington have focused on the possibility of filling in the "gaps" in health insurance, and the term is widely used in the popular literature. The President himself spoke of filling in the gaps: "'What I tried to do before won't work,' Mr. Clinton conceded four months ago in a speech to the Service Employees International Union. "Maybe we can do it in another way. That's what we've tried to do, a step at a time until eventually we finish this'" (Pear, 1998a) Other examples include the Hawaii Star-Bulletin of May 8, 1997, which referred to the group between the very poor and those who can afford full coverage as a group with a health insurance "gap" (Honolulu Star-Bulletin, 1997). The St. Louis Business Journal refers to a health insurance "gap" that a medical savings account can fill (Desloge, 1997). An electronic journal for "twenty somethings" called *Whatever* discusses the "gap" for those who lack health insurance because they are in between jobs (Klein, 1995). The Children's Action Alliance termed children in Arizona who lack health insurance as the components of a widening "gap" in the state

between those with and those without health insurance. An article in the Journal of the American Medical Association in 1995 stated that by age three, 22.5% of all children will have had a period when they were without health insurance; 15% had a gap longer than six months (Alexander, 1995).

Health policy professionals tend to be more skeptical about the ability of the system to close gaps. Marmor, for example, states that incremental approaches "...may indeed be politically possible," but they are characterized by "significant drawbacks" (Marmor, 1994, 135). In particular, they will "only be able to rectify some of the problems of the present system -- though admittedly these are often very important ones." They fail to "set up the kind of program architecture that can be built upon" and use political capital on reforms that often could be far bolder (Marmor, 1994, 135-136). Chait, writing in The New Republic, terms the gap approach "the Clinton Plan chopped up into digestible nuggets," finding that "incrementalism doesn't seek to change the perverse incentives of the current market-driven system, nor does it address the issue of health care costs" (Chait, 1998). Here, we will define health insurance gaps in one of two ways:

- A "gap" occurs when an identifiable group of people has no health insurance or a person who is otherwise insured experiences a time period of uninsurance.
- A "gap" occurs when a health insurance policy fails to cover a particular service or covers a service with a large out-of-pocket requirement.

For the first meaning, an identifiable group of people, there are many ways to differentiate groups. We will use the age-demarcated groupings conventionally used in Washington to discuss the politics of filling health insurance gaps. Most of this paper deals with these gaps -- gaps that exist because a given group of people, or a proportion of a specified group, does not have health insurance coverage.

The second meaning, when a policy lacks a level or kind of coverage, is more difficult to conceptualize, in as much as the perfect health plan has yet to be devised. What might be a perfectly satisfactory plan at one time might be termed one with a "gap" at some later time. What was satisfactory in 1965 for Medicare may seem unsatisfactory in 1998. For example, Medicare continues to lack drug coverage and coverage of many diagnostic services. For the most part, we do not discuss these gaps in this paper.

The "gap" idea is important politically because of the attempt of the Clinton administration to fill one by one some of the gaps that the Health Security Act of 1994 aimed at. The recently enacted children's health insurance bill (1997) is a good example. The Kennedy-Kassebaum bill, in addition, attempted to close some of the "gaps" in coverage that affect people as they transition from one job to another. President Clinton's proposed coverage for those over age 55 but not yet eligible for Medicare is another example.

Our hypothesis is that smaller, incremental, and distributive policy changes are successful politically, or at least have a greater chance of being successful politically, but involve substantial limitations on achieving the long-term goal. "Gap filling," in short, allows the political system to pass and implement legislation, but the process cannot ultimately close the total health insurance gap.

Background: Attempting to fill specific gaps in health insurance is typical of the way Americans deal with policy problems. Harry S Truman made National Health Insurance a major item on his agenda; a coalition centered around the American Medical Association and allied groups defeated the proposal. Republicans and Southern Democrats, an alliance with great strength from World War II through the 1960s, defeated the legislation both before and after the election of 1948. In the wake of this defeat, Truman had his advisors draw up a program for health insurance for Social Security recipients (Marmor, 1994, 7). Bills proposing health insurance for the aged were introduced through the 1950s. Even with President Kennedy's strong support, the Senate defeated one such bill during the Kennedy administration. After the Kennedy assassination, President Johnson was able to use the swell of public opinion to pass a bill establishing both Medicare and Medicaid, both of which could be viewed, while enormously significant, as legislation filling in gaps rather than achieving comprehensive coverage for the entire population (Smith, 1995). Medicare aimed at the gap facing the aged; Medicaid, at the poor and disabled. An alternative interpretation of the Medicare legislation in 1965 is that it represented a more substantial change, the "inevitable extension of the New Deal agenda" (Brown, 1996, 163). See Dallek (1998, 203-211) for an account of the enactment of Medicare.

After 1965, those who wanted to expand Medicare believed that "salami tactics" (slicing off small groups of the public step by step) would eventually result in the extension of public benefits to one group after another, along the lines of how Social Security had been expanded since its enactment (Brown, 1996). In the words of Robert Ball:

> For persons who are trying to understand what we were up to, the first broad point to keep in mind is that all of us who developed Medicare and fought for it...had been advocates of universal national health insurance. We all saw insurance for the elderly as a fallback position, which we advocated solely because it seemed to have the best chance politically. Although the public record contains some explicit denials, we expected Medicare to be a first step toward universal national health insurance, perhaps with 'Kiddicare' as another step (Ball, 1995, 62-63).

President Richard Nixon's proposal, the Comprehensive Health Insurance Plan (CHIP), another comprehensive overhaul based on required health insurance for all employees, also failed to be enacted in the early 1970s (Marmor, 1994, 8).

Another incremental proposal was the Earned Income Tax Credit (EITC). The EITC was a competing proposal to President Nixon's Family Assistance Plan (FAP), which would have guaranteed a minimum income to families. Both proposals died after an extended debate in 1972. But in 1975, Senator Russell Long (D-LA), the program's originator, managed to insert it into the Tax Reduction Act of that year (Howard, 1994, 47-48).

Politics: The "gap" approach thus has a significant history in health policy. We can view the "gap" approach in another way politically. Much of the politics of the health and welfare area is redistributive -- politics that affects large groups, involves the general public on one side or the other, and involves the perception of being zero-sum, transferring resources from one group to another. In American politics, politicians have often attempted to redefine redistributive political situations into distributive ones, where benefits flow to a specific group that can be mobilized to support them, and costs are spread out across the general society. The gap movement involves the same idea -- focusing on specific groups who can be mobilized in support of policy change, but dampening the impact of the costs and attempting to spread them across society.

One of the goals of this paper is to assess the success of this notion -- is it possible in the process of pursuing change in an incremental way through distributive politics to achieve the same success over time that a comprehensive bill would have achieved?

II. Measuring Health Insurance "Gaps"

Almost an infinite number of variables are available with which to define a health insurance "gap." Some of the more common variables are included in Table 1, "The Probability of Being Uninsured." Nine different variables are included here, all from the Current Population Survey, and each indicating a substantial amount of difference on being uninsured.

A note on measuring the extent to which the public has health insurance: the Current Population Survey (CPS) does not ask respondents if they do not have health insurance; instead, an "uninsured" person is one who does not say that he or she had one of several forms of health insurance in the previous year: employer-sponsored insurance, Medicare, Medicaid, CHAMPUS, VA or military health care, privately purchased health insurance, or any other kind of health insurance. Alternative sources of information on health insurance include the Survey of Income and Program Participation (SIPP), the National Health Interview Survey (NHIS), and the Medical Panel Expenditure Survey (MEPS). While the framework of the questions asked is similar, the surveys differ in several ways, the most important of which seem to be

- whether individuals are asked about health insurance at a point in time or over a given period of time (the CPS asks whether individuals were covered by a given type of health insurance "at any time" in the previous year)
- the recall period (for the CPS, the recall period is the previous 14 months; individuals are interviewed in March about the previous calendar year as well as the previous week)

Discussions of the different surveys and how they measure health insurance and being uninsured can be found in Lewis, et. al., 1997, and U.S. Department of Health and Human Services, 1997a.

The variables point to a common theme: those who are otherwise in need or whose family structures change substantially are also more likely to be uninsured:

- About a third of Hispanics were without health insurance in 1996.
- 42% of non-citizens were uninsured.
- Almost a third of those in poverty and a quarter of those near poverty were uninsured.
- A quarter of adults who had completed less than the ninth grade and a fifth of those who had completed grades nine to 12 were uninsured.
- Living in a nuclear family seems to encourage or allow persons to be insured. Divorced, separated, and never married persons have high probabilities of being uninsured.
- Persons living in the South and West have high probabilities of being uninsured.
- Even those clearly not in need, such as those with incomes four or five times the Federal Poverty Line, have significant, if low, probabilities of being uninsured: 6% of those with family incomes of five times poverty or more were uninsured; 8% of those who were college graduates or had graduate training were uninsured.

More information on these basic probabilities may be found in Moyer, 1998a. Similar findings can be found for the Medical Expenditure Panel Survey (MEPS) in Vistnes and Monheit (1997).

Table 2 compares the composition of those with health insurance with the composition of those who are uninsured. The insured population is 48% male and 52% female, while the uninsured population is 54% male and 46% female. Thus, females are more likely to be insured than males, but the differences are not very large. The common theme of this table is that needy persons and those near poverty tend to be uninsured. Immigrants, persons of Hispanic descent, young adults, persons not married or not in a traditional family, persons with minimal levels of education and persons who reside in the South are more likely than average to be uninsured.

It is still the case that the uninsured also include a small number of persons in better circumstances. Some 10% of the uninsured are college graduates or have some graduate training; 8% had incomes of five times poverty or higher.

Political Involvement: Significant numbers of the uninsured -- almost half -- cannot vote. Twenty-five percent of the uninsured are under 18 years of age, 10.55 million. Another 14% are adult non-Hispanic, non-citizens, not eligible to register and vote. The two groups total 16.3 million of the 41.72 million who are uninsured, or 39%.

The poor are 28% of the total uninsured group, or 11.68 million. Those who are less than twice the Federal Poverty Line are 59% of the uninsured, or 24.6 million of the 41.7 million uninsured.

III. Children

Background: In early 1997, the expectation was that the President and the Congress would be gridlocked. Both the President and the Republican congressional leaders wanted the other side to commit to a program first. In August, 1996, the President had signed the welfare reform bill over the objections of many from the more liberal and pro-children interest groups. The President and the Republican leadership had agreed on the Health Insurance Portability and Affordability Act, also signed in August, to make it easier for workers who lose or change jobs to maintain their health coverage.

President Clinton stressed only general themes in his inaugural address. The next day, Senate majority leader Lott introduced 10 bills, but there was no bill on children's health insurance. Senate minority leader Daschle introduced a proposal including tax cuts, capital gains reductions, and children's health insurance in the form of a tax credit for 90% of the health insurance premium for each child in a family earning less than twice the Federal Poverty Line. To claim the credit, the children would have to be ineligible for Medicaid and not covered by employer-sponsored insurance (CQWR, 1/25/97).

In his budget proposal, the President proposed a modest children's health insurance program and a program to cover health insurance for workers between jobs. The children's program was intended to cover up to five million children in three ways: a. by finding those eligible for Medicaid but not enrolled and enrolling them; b. by allowing states to extend Medicaid coverage to a minimum of one year for all children regardless of changes month to month in the family's income; c. by providing states with a total of $750 million per year for five years to work with Medicaid or private insurers to cover more children (CQWR, 2/8/97).

Speculation was that the Republicans would be reluctant to agree to any program that would either be extremely expensive or involve any expansion of federal authority or bureaucracy. The Clinton proposal was deliberately modest; the first priority for both sides seemed to be an agreement on a reconciliation proposal to balance the budget by FY 2002.

There were several competing proposals to provide health insurance to those under 18, of which the most publicized was a proposal from Senators Kennedy and Hatch for a five-year, $20 billion block grant to the states to expand health insurance coverage for as many as five million children. Revenue to pay for this program would be raised by a 43-cent increase in the per package cigarette tax. The Kennedy-Hatch proposal was particularly significant because of its bipartisan sponsorship and the prominence of both senators. In addition, Senator Specter (R-PA) introduced a measure to provide the States with funds so that the working poor would have vouchers to help pay for their children's health insurance.

Need: While analysts differed on the exact numbers, most agreed that around 10.5 million children lacked health insurance at any given point (for a summary of the debate, see U.S. Department of Health and Human Services, 1997a). Crucial points during the analytic debate were

- the oft cited figure that most uninsured children had working parents,
- the proportion of employers offering health insurance was declining,
- the proportion of employers offering family coverage in health insurance plans was also declining, and
- the number of uninsured children was growing over time.

Table 3 contains estimates of the percent lacking health insurance for children in various subgroups. It shows that:

- Approximately 15% of all children lacked health insurance in 1996, a figure similar to the 16% for the public as a whole. (The Census Bureau, using the 28 month panel of the Survey of Income and Program Participation [SIPP] doubles that figure to 30% -- the proportion of all children who will have an insurance gap for at least one of the 28 months [U.S. Census Bureau, 1997a].)
- 14% of those five and below lacked insurance, a figure that rises slowly to 17% of those 15-17 years of age.
- The larger the company an adult in the family worked for, the more likely children in the family are to be covered. 23% of those whose parents worked in firms of less than 25 employees lacked health insurance; only 9% of those whose parents worked in firms of more than 1,000 employees fell into the same category.
- While 11% of Caucasian children lacked health insurance, 19% of African-American children did, and 29% of Hispanic children.
- 45% of non-citizens lacked health insurance.
- When children are either "other relatives" or "unrelated" to the family head (as opposed to the son or daughter), 44%-45% lack health insurance.
- 24% of those below the poverty line lack health insurance, a figure that falls as the income increases until only 4% of those whose incomes are more than five times the poverty line are uninsured.
- 45% of those with no adult worker in the family are uninsured, a figure that falls to 17% and 12% respectively for those with one and two adult workers.

Similar findings from the Medical Expenditure Panel Survey can be found in Weigers, et. al. (1998).

Table 4 shows the composition of the insured and uninsured child populations. It shows:

- 25% of the uninsured have a parent with insurance.
- Almost one-third (31%) of the uninsured are five years of age or below.
- Most of the uninsured are in families where at least one adult works. 62% of the uninsured are in families where an adult works full-time all year. Only 13% of the children who are uninsured have no working adult in their family.
- 46% of the children who are uninsured are Caucasian; 29% are Hispanic.
- 10% of the children who are uninsured are non-citizens.
- One-third of the children who are uninsured are poor (income below the Federal Poverty Line); another third have incomes between one and two times the poverty line, for a total of 70% with incomes below twice the poverty line.
- Over half of the children who are uninsured have adults in the family who work for small firms (less than 100 employees), in contrast to about a third of those with insurance.

Analytic and Political Problems: The major analytic and political problem is "crowd-out"; this phenomenon affects all gap-filling efforts that preserve the basic system of employer-sponsored health insurance. While the concept has been known in the design of public policies for some time, concern over its impact in the health insurance area originated with Cutler and Gruber (1995), a paper estimating that "approximately 50 percent of the increase in Medicaid coverage associated with the [recent Medicaid] eligibility expansions was offset by a reduction in private insurance coverage -- a crowding out rate of 50 percent" (Center for Health System Change, 1996a). While Dubay and Kinney (1995) estimated the crowd-out at much lower percentages, and other analysts pointed to changes in question wording and order that suggested much smaller increases in Medicaid enrollments, the issue confronted those attempting to design a health insurance program for children with a fundamental political problem.

"Crowding out" occurs when public programs are liberalized in an effort to increase the number of people with insurance coverage, and either individuals decline more expensive privately supplied insurance for cheaper publicly provided insurance, or employers decline to offer insurance, knowing that the public sector will pick up the slack (Dubay and Kinney, 1995). For instance, there have been arguments that the provision of Social Security reduces the extent to which individuals are willing to save for their retirement (Center, 1996a).

A second problem is the dispute over how many uninsured children there are, with different surveys yielding different results. These seem to vary with the nature of the question (the Current Population Survey does not ask respondents if they are uninsured -- analysts infer uninsured status from respondents who do not report any form of insurance), the time period examined (the Current Population Survey asks respondents in March about their insurance status during the previous calendar year, and other surveys ask about other recall periods), and whether the CPS or other surveys are adjusted for known underreporting of the receipt of Medicaid. For a review of these issues, see U.S. Department of Health and Human Services, 1997a. However, all of the surveys point to at least 7.5 million uninsured children, and probably as many as 10 to 11 million, depending on the survey used for the estimate, the length of time required before the child is counted as uninsured, and other factors.

Interest groups. The children's area contains a number of groups that lobby on their behalf, publicizing the need for American society to do more for children; among them are included the Children's Defense Fund and Families USA. In addition, the research and analyses of the Center for Budget and Policy Priorities and the Alpha Center have often focused on the need to do more for children also.

Result: Both houses of Congress passed similar proposals to balance the budget in May, 1997, including provisions for a children's health insurance package, highway construction, and other priorities. The bill included the following provisions:

- $20.3 billion in block grants to the states over a five year period to help the states expand health insurance for low income children (Ullman, 1998).
- States must contribute matching funds, with higher-income states contributing a higher amount. State matching contributions are about 70% of their Medicaid matching rate, that is, 30% lower than the match for Medicaid.

- States must submit a plan for the use of the funds to the Department of Health and Human Services. Alternative uses are: establishing new insurance plans for uninsured children; enrolling uninsured children in an expanded Medicaid, or some combination of these alternatives. "States may also fund direct provision of health care services to children, although a state may not use more than 10 percent of total child health spending for administration, outreach, and direct provision of services without a waiver from DHHS" (Ullman, 1998, "Program Overview").

The Congressional Budget Office estimates that an average of 2.3 million children a year will be covered by the State Children Health Insurance Plan after 1999. It estimates that the participation of children in Medicaid will also rise (U.S., Congressional Budget Office, 1998).

Concerning the extent to which the "crowd-out" phenomenon will affect those participating in the new children's program: "CBO estimates that 60 percent of the participants...would otherwise have been uninsured. The remaining 40 percent would have had some other form of coverage" (U.S., Congressional Budget Office, 1998).

Lessons: The lesson of the children's health insurance legislation is that children formed a unique group that was relatively easy to cover:

- First, children are politically popular, an easily identifiable and sympathetic group, and seem to have become more politically popular in recent years. The background information and context in Washington in the 1990s is important: a number of studies have documented the funds spent on senior citizens through Medicare, Social Security, and Medicaid, in comparison to the funds spent on children. The approval of the welfare reform bill the previous year set the stage for something to be done for low-income children in 1997, and in fact the Balanced Budget Act of 1997 included several children's health initiatives: the State Children's Health Insurance Program; provisions to increase the number of eligible children enrolled in Medicaid; creation of pediatric diabetes programs; and restoration of Medicaid benefits for a small group of children who lost SSI as a result of the welfare reform bill of 1996.
- Second, the bill became part of the budget reconciliation agreement between the administration and the Republican congressional leadership. It thus became part of a much larger legislative package on which both parties wanted agreement.
- Third, children are inexpensive to cover for health insurance; most packages run between under $1,000 per person per year to approximately $2,000 per person per year. In contrast, Medicaid spends $8,000 per elderly or disabled beneficiary per year (U.S., Congress, Committee on Ways and Means, 1996, 905).
- Fourth, the legislation identified a source of funding -- originally, the increase in the cigarette tax -- that seemed to have an indirect relationship to the goal of children's health.

Outcome: the legislation will likely cover 2.3 million children per year for health insurance, about a quarter of the 10 million child gap. This estimate, however, relies on assumptions about what actions the states will take to enroll children in both the new programs and Medicaid and is consequently subject to a good deal of uncertainty.

IV. Young People (18-24 year olds)

Young adults are the age group most likely to be uninsured; the percentage of those 18-24 with health insurance is 27 percent compared with 16 percent for the population as a whole. The 1996 Medical Expenditure Panel Survey (MEPS) found that 38% of young adults 19-24 lacked health insurance (Vistnes and Monheit, 1997, 4).

Current Situation. The age of 18 is traditionally the age when children are considered to be adults. The age of 25 is the age when most young adults have jobs and are well on their way to longer-term living arrangements. Between those two ages, most adults undergo a number of changes in family, occupation and educational status that traditionally change their health insurance status. The first transition is from high school to training or first job, community college, or four year college/university. A second transition is from training or college to first job. A further transition is to a new family status, either living separately from parents alone or with roommates or forming a new family.

For the college bound, health insurance coverage is usually required during the undergraduate years, optional during any years of graduate school, and then provided with a first job. Parents' policies often cover young adults while the latter are full-time students until an age between 21 and 23; it may not be usual for them to do so (data are lacking on this question). For those who do not go on to higher education, health insurance coverage from a parent's policy typically ends at age 18 or 21.

Health insurance gaps between the ages of 18 to 25 are the norm. Many young adults find that their first full-time jobs don't have any health insurance coverage; others find the coverage too expensive for their incomes. The rate at which employer-sponsored health insurance is declined is highest for those younger than 25 than for any other age group. Evidence from the 1996 Medical Expenditure Panel Survey (MEPS), for example, suggests that only 51% of workers younger than 25 are offered health insurance, and only 70% accept the offer. Comparable figures for those 25 to 34 are 76% and 80%; the figures for those 35-54 and 55-64 are similar (Cooper and Schone, 1997, 145).

There is also evidence that most young adults consider themselves healthy and unlikely to need much medical care, a further incentive not to purchase health insurance if the price of the policy is perceived as expensive relative to income. For those not offered health insurance through their jobs or a parent's policy, individual policies may be available, but again considered to be expensive relative either to income or to risk or both.

- Table 1 shows that 29% of those 18-24 lack health insurance coverage, as compared with 16% of the population as a whole. Over 30 percent of the 23 and 24 year olds lack health insurance (not shown), a percentage that rises steadily from 19 percent of 18 year olds. Nineteen percent of the 18 year olds are uninsured.
- Table 2 shows that those between the ages of 18 and 24 are 17% of those without health insurance, but only 8% of the population.
- Table 5 shows that only 54% of the workers between the ages of 18 and 24 have health insurance, as opposed to 73% of all workers. The percentage for those between 18 and 24 is the lowest for any age group of workers under age 65.
- Other data show that of the young adults who work full-time, 27 percent had no health coverage. Among part-time workers 18 to 24 years old, 23 percent were uninsured. Of those unemployed, 31 percent have no health coverage.
- The leading causes of death for 18-24 year olds are unintentional injuries, homicide, and suicide, followed by cancer, heart disease, and HIV infection.
- Data from the 1994 National Health Interview Survey (NHIS) show that 43 percent of 18-24 year olds consider their own health to be "excellent," and 32 percent consider their health to be "very good." Only 4 percent consider their health to be "fair" or "poor."

In addition, data from the 1996 Medical Expenditure Panel Survey shows that "over two-thirds of young adults who were full-time students had private health insurance, compared to only half of young adults who were part-time students and less than half of young adults who were not in school" (Vistnes and Monheit, 1997, 4). The MEPS shows striking disparities by race and ethnicity: over half of minority young adults were uninsured, compared to 31% of whites.

Many alternatives exist to increase the proportion of those between 18 and 24 who have health insurance, including:

- Partnerships between the public and the private sector to extend the age through which all young adults would be covered by their parents' health insurance policies and/or to urge educational institutions to standardize health insurance requirements for students.
- Allowing individuals to buy into public programs equivalent to either Medicare or Medicaid in each state, along the lines of the children's program discussed above.
- A special catastrophic health insurance program focused on this age group, subsidized by the federal government or a federal-state partnership.

Additional ideas may be found by analogy in a paper on children's health status (Rosenbaum, 1996).

No enacted legislation has targeted this group, in spite of the low probability of having health insurance within the group.

V. Working Adults (25-54 year olds)

Background: The inability of a voluntary employer-sponsored insurance program, even with the present tax incentives, to provide health insurance for every one in the United States or for specific groups, has vexed reformers since the modern system of health insurance emerged in the post-World War II period. Numerous proposals have sought to provide insurance for everyone in the United States or for specific groups, for example, the very poor and the disabled who were covered by Medicaid in 1965).

Need: Table 5 presents the percent who have health insurance among adult civilian wage workers 18 and older. These workers, comprising most of the workforce, are non-military workers who work for a wage, excluding workers who work without pay, those who are self-employed in unincorporated firms, very young workers (under 18), and military personnel. The data source is the 1997 Current Population Survey.

The general theme is that high wage workers, especially those who work for large firms, tend to be covered for health insurance through their employers. 73% of all workers have health insurance. Groups that tend to be substantially less insured include:

- Young workers, aged 18-24 (54%) and 25 to 34
- Hispanic workers (54%)
- Those who are not U.S. citizens (49%)
- Those who are neither married nor divorced, that is, widowed [58%], separated [57%], or never married [59%]
- Those who appraise their own health status as "fair" (60%) or "poor" (50%)
- Those who are parts of households but are neither the head, the spouse, nor a minor child, such as adult children of household heads (56%), other relatives of household heads (46%), or unrelated to the household head (48%)
- Those who are relatively poorly paid (less than $7.00 per hour), 51%
- Those who work other than standard full-time, all year schedules (full-time, part year; part-time)
- Those with less than a high school diploma (40% for those with 8 years or less of education, 54% for those with some high school)
- Those who work on farms or fisheries (42%), in service industries (56%), or as laborers (57%)
- Those who are self-employed (57%)
- Those who work in small firms (1-9, 51%; 10-24, 50%).

Those who are most unlikely to have health insurance mirror those who are most poorly paid or least educated in the U.S. economy.

The overall rate by age is significant: 73% of all workers have health insurance. But only 54% of those 18-24 are covered. Those 25-34 are covered at about the average rate (72%), and those 35-44 (79%), 45-54 (82%), and 55-64 (79%) are covered at rates above the average for all workers.

At every age range, however, the proportion of workers with insurance is 82% or below; that is, at least 18% of workers at every age rate are uninsured. There is a gap in every age group.

Figure 1 points to one additional significant point: high wage workers in small firms were more likely to have ESI than low wage workers in the largest firms. Low wage workers in the smallest firms were least likely to have health insurance coverage.

Monheit and Vistnes (1997) present similar findings from the MEPS.

Analytic and Political Problems: The major problem is fear of crowd-out, which affects every age group in this area. In general, employer-sponsored insurance appears to have been declining over the past decade, thus accentuating the fears. However, during the past three years, after a slight rewriting of the questions used to measure health insurance on the Current Population Survey, employer-sponsored insurance has not been declining; we do not know what will happen in September, 1998, when the March, 1998, Current Population Survey is released.

In addition, this group is so large -- literally 50 percent of the uninsured and over 20 million people -- that the costs of covering uninsured working adults can not be spread thinly across society. As a result, programs proposed for working adults have been targeted at more specific problems and smaller groups.

Results: **The Health Insurance Portability and Accountability Act**, passed in August of 1996 with provisions that went into effect July, 1997, provided that:

- Group health plans can deny coverage for preexisting medical conditions for only 12 months, or 18 months in the case of a late enrollee.
- Group health plans are generally prohibited from establishing eligibility for enrollment based on an individual's health status, medical condition (physical or mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.
- The legislation guarantees the availability for health coverage for small employers.
- The legislation guarantees availability of health coverage in the individual market for all eligible individuals, those who:
    - Have had at least 18 months of aggregate credible coverage;
    - Have been under a group health plan, a governmental plan, or church plan (or health insurance offered in connection with such plans) during the most recent period of insurance coverage;
    - Are not eligible for coverage under a group health plan, Medicare, or Medicaid, and who do not have other health insurance coverage;
    - Have elected and exhausted any option for continuation of coverage ("COBRA" coverage) that was available under the prior plan.
- The legislation also guarantees renewability of health coverage for all group health plans, unless the plan has failed to pay premiums, committed fraud, violated participation or contribution rules, terminated coverage, moved outside the service area, or ceased association membership.
- The legislation also guarantees renewability of health coverage in the individual market for all individuals, unless the individual has failed to pay premiums, committed fraud, terminated the plan, moved outside the service area, or ceased association membership.

The General Accounting Office estimated the number of people who could be helped by HIPAA in four categories:

- Individuals with health insurance who change jobs 11.5 m
- Dependents of individuals with health insurance who change jobs6.7 m
- Individuals no longer eligible for COBRA continuation coverage1.8-2.3 m
- Individuals facing job lock, those unwilling to leave their jobs

because of concerns about losing their health insurance coveage 1.0-3.6 m

The 11.5 million is the portion of the 20 million Americans who change jobs each year and have employer-sponsored insurance. The 6.7 million figure consists of the dependents of those who change jobs each year. An unknown proportion of these persons will be helped by national standards for waiting periods and preexisting conditions. The third figure, 1.8 to 2.3 million persons, consists of about 2 million persons who "would be able to convert from employer-based coverage to individual coverage (although at a higher premium) without having to meet preexisting condition exclusions" (U.S., General Accounting Office, 1995). The 1.0-3.6 million figure

consists of an estimated "1 million to 4 million additional workers [who] would change jobs if national portability standards were in effect" (U.S., General Accounting Office, 1995).

It is impossible to say whether the HIPAA standards will reduce the 42 million persons who do not have health insurance coverage. Some proportion of the above groups, without the legislation, would otherwise be uninsured, but the size of the proportion cannot be measured without more time since the HIPAA standards went into place in July, 1997.

Workers Between Jobs Proposal: The President's FY 97 and 98 budget proposals included proposals, officially "The Workers' Transition Health Care Initiative" and "Healthy Working Families," to provide health insurance for workers between jobs. The FY 98 proposal suggested spending $9.8 billion over five years to finance six months of coverage for workers who lose their health insurance when they lose their jobs.

This proposal was part of the President's budget in February of 1997, but was not enacted that year. The administration estimated in the FY 1998 budget that 3.3 million people, including nearly 700,000 children, would be helped.

Medicaid Expansion. In July 1998, federal rules were issued for the Medicaid program to allow states to eliminate or raise the limit on two-parent families who work more than 100 hours per month. The rules also allowed states to eliminate the marriage penalty on Medicaid, the provision that cut off Medicaid for many single mothers who married. Prior to the issuance of the new rule, 20 states required families with two parents to be working less than 100 hours per month in order to qualify for Medicaid. The other 30 states had received waivers under the old welfare law and had eliminated the 100-hour rule (Pear, 1998b). Administration sources said that the change would assist 135,000 to 200,000 people.

Lessons:

- This group is the most difficult group to cover within the constraints of the present system, because of fears of crowd-out and the size of the group, as explained above.
- The programs enacted or proposed are relatively modest in their objectives, focusing specifically on workers and adults in between positions that are normally covered by insurance.

VI. The "Near Elderly": 55-64 year olds

The near elderly are a rapidly growing population who face declining coverage through their employers and particular difficulties in purchasing insurance in the individual market. Recent proposals to help this group through a Medicare buy-in would improve access, but would not close most of the gap. Even these modest proposals have been unsuccessful to date, although they may find their way into a larger package of Medicare reforms.

Background: The Clinton Administration included a specific provision in the Health Security Act for early retirees. Most retirees aged 55 to 64 would have been eligible to purchase health insurance at 20% of the average premium. The government would have paid 80% at a cost of $11.6 billion from FY 1998-2000, $11.4 billion was paid for by a three-year assessment on employers that captured some of the money that they had been spending on retiree benefits. High-income retirees would not have been eligible for the subsidy.

Some other proposals to insure early retirees have been attached to the idea of increasing the Medicare eligibility age to match planned increases in the Social Security eligibility age. For example, the Kerrey-Danforth Bipartisan Commission on Entitlement Reform proposed that a Medicare buy-in option be considered along with a gradual increase in the age of Medicare eligibility from 65 to 70. Although the Social Security eligibility age will rise from 65 to 67, workers who choose to retire as early as age 62 are eligible for a reduced level of benefits. A Medicare buy-in would create a similar reduced benefit: Medicare benefits for a higher premium (U.S., Bipartisan Commission..., 1995, 16).

In 1997, the Senate voted to raise Medicare eligibility from age 65 to 67, without a corresponding Medicare buy-in. The provision failed in the House and was not included in the final budget agreement. However, the agreement did include directions for the National Bipartisan Commission on the Future of Medicare to "make recommendations of modifying age-based eligibility to correspond to changes in age-based eligibility under the OASDI program and on the feasibility of allowing individuals between the age of 62 and the Medicare eligibility age to buy into the Medicare program."

In January 1998, the Clinton Administration announced a limited buy-in proposal in the Administration's FY 1999 budget. It had three components:

- People ages 62 to 65 could buy into Medicare by paying a two-part premium.
- "Displaced workers" over 55 who have involuntarily lost their jobs and their health care coverage could buy into Medicare for a higher premium.
- Retirees ages 55 and older whose employers dropped their health coverage would have access to their former employers' health plans through COBRA coverage.

Rep. Pete Stark and Sen. Daniel Patrick Moynihan introduced similar legislation (HR 3470, S.1789) in March. In June, the Senate Committee on Labor and Human Resources held a hearing on the issue, but no further action has been taken.

Need: The near elderly form one of the fastest growing population groups in the United States. The Census estimates that in 1998 there are 22.6 million people in this age group, or 8 percent of the population. By 2020, when the baby boomers are all over 55, the group will be 41.7 million, and they will comprise 13 percent of the population.

Of the groups addressed in the paper, this age group, on average, is the most likely to have insurance. Table 1 shows that the percent without health insurance is 14% for those aged 55 to 64; the only percentage lower than that is 11 percent for those aged 45 to 54. Those 55 to 64 are about 7 percent of the uninsured population, or about 2.9 million people. Of those who are working (Table 5), 79 percent have health insurance, the second highest percentage among age groups in the workforce (the highest is age 45-54, at 82 percent; the lowest, disregarding those 65 and over, are young workers, aged 18-24, at 54 percent).

Those who do not have insurance, however, face particular problems. Their poor health status puts them at more financial risk if they do not have insurance, but it also makes it harder for them to purchase individual insurance. In addition, many people in this age group leave the workforce, and the prevalence of employer-sponsored retiree coverage is declining.

Poor health status: The potential cost of being uninsured is worst for the near elderly because they are increasingly likely to have serious health problems. In response to health status questions on the CPS, the 55 - 64 year old group has the highest percentage of those reporting fair or poor health status of any group under age 65:

Percent Reporting Fair or Poor Health Status, By Age	
Age	Percent
Under 18	3%
18 - 24	4%
25 - 34	6%
35 - 44	10%
45 - 54	15%

55 - 64	23%
65 +	37%
All	12%
Source: March, 1997 Current Population Survey, Tabulations by the authors.	

Those in poorest health status are more likely to have Medicare or Medicaid, but they are also more likely to be uninsured.

As shown in Table 6, other sources have also documented the risks that the near elderly face:

- They are much more likely to have specific health problems, for example, they are almost twice as likely as 45- to 54-year-olds to have heart disease or diabetes;
- They are much more likely to be hospitalized, and spend more time in the hospital; and
- They have the highest annual health care expenditures of any group under age 65.

The high medical expenditures of this group, estimated at approximately $5,000 on average, exemplify the risk that the near elderly face when they are uninsured. These expenditures also make it more difficult for this group to purchase insurance.

Table 7 presents some basic health insurance information for the near elderly, showing the very high rates of uninsurance among some groups, particularly those who consider their health to be only "fair" or "poor," those who have never been married, and those who are either working part-time or not working. In addition, quite striking differences exist between the insured population in this age group and the uninsured, particularly when the groups are broken down by income or work status.

Individually purchased coverage is expensive and may be hard to obtain: There are several ways in which insurance companies that sell policies to individuals may make it difficult for the near elderly to purchase meaningful insurance. Because individual insurance policies are regulated by the states, insurers use different combinations of the following in different states:

- varying premiums based on age
- varying premiums based on health status
- refusing to sell insurance based on health status
- excluding particular conditions from coverage

In the ten states studied by Chollet and Kirk (1998), a 60-year-old male purchasing an individual insurance policy could pay two to four times the premium for a 25-year-old male for the same policy. In addition, some insurers might charge as much as 50 to 100 percent more if an applicant has conditions such as obesity or hypertension.

In addition, most insurers regard the willingness to pay very high premiums as an indication that an applicant needs costly health care, so they may be likely to refuse to cover these individuals. The GAO reports that in the states that they studied that allow insurers to refuse coverage, about 15 percent of applicants are denied coverage.

Despite these barriers, "even at 200% of poverty, nearly half of those with no other source of insurance purchase in the individual market" (Schactman, 1998, 21). Many of those, of course, whose incomes are in the range of 200% of the poverty line, may have had a higher permanent or usual income, but had a bad year, which gave them a low income during the year in question.

Declining employer sponsored coverage: The majority of the near elderly continue to access health insurance through their current or former employers. However, two trends may decrease this coverage in the future. First, workers increasingly are retiring before age 65. Second, employers are decreasing their coverage of retiree health insurance.

GAO reports that fewer than half of 55- to 64-year-olds (43%) were employed full-time, full-year in 1996. About two-thirds were employed at least part time. Individuals aged 62 and over are even less likely to work, with only a quarter (26%) of 62- to 64-year-olds working full-time, full-year. This represents an overall decrease over time. Although more women in this age group are working than in 1960 (from under 40% to over 50%), near elderly men are much less likely to work (from 85% to 65%) (Schactman, 1998, 8).

There is evidence that firms are reducing their obligations to provide health insurance to early retirees. Private surveys (Foster Higgins, KPMG), although not necessarily representative of all employers, show that fewer employers are providing coverage, and many who continue to provide coverage are increasing retiree costs or eligibility requirements. Surveys by the Department of Labor and the CPS show similar trends.

Analytic and Political Problems: These trends build the case for a program that would improve access to insurance for the near elderly. However, proposals have faced resistance. We discuss three problems: adverse selection, the status of Medicare reform, and the high cost to enrollees.

> **Adverse selection**: In general, people are more inclined to purchase insurance if they expect to incur costs greater than the premium that they would have to pay. This phenomenon of adverse selection raises concerns that a buy-in program could face continual cost increases. For example, CBO estimated that participants would cost about 45 percent more than the average of all newly eligible people (62- through 64-year olds who are not already eligible for Medicare on the basis of disability or ESRD); the Administration estimated that they would cost 50 percent more. However, the Clinton Administration designed its program for 62- to 64-year-olds to cover these costs in a unique way. Before age 65, enrollees would pay a premium that would cover the costs of an average newly-eligible person. From age 65 through age 85, after enrolling in the traditional Medicare program, these enrollees would pay an additional premium to make up for the additional costs of the group that actually enrolled (U.S., Congress, Congressional Budget Office, 1998a).
>
> Both the Administration and the Congressional Budget Office assumed that potential enrollees in the 62- through 64-year-old group would weight the premium that they would pay before turning 65 more heavily than the additional premium that they would pay after turning 65. Thus, more healthy enrollees would be attracted than if participants had to pay the full cost up front.
>
> There is no similar provision for enrollees in the 55- through 61-year-old program. The premium would be about 50 percent higher than the average cost of all eligible 55- through 61-year-olds, but this would not cover costs. Because of adverse selection, people who would choose to enroll would, on average, always be more expensive than the premium charged. There would be an ongoing cost to the Medicare program to cover this difference.
>
> **The context of the Medicare and Social Security "crises"**: CBO estimated that the Medicare buy-in for 62- through 64-year-olds would cost the Medicare program $1.3 billion over the first five years of the program; these costs would be paid back over time through the additional premiums that enrollees would pay from age 65 through age 84. CBO estimated that net costs of the buy-in for 55- through 61-year-olds would be $130 million over five years (U.S., Congress, Congressional Budget Office, 1998a). The Clinton Administration's estimates were slightly higher. In addition, CBO and the Administration both estimated that a small number of people, about 1 percent of people ages 62 through 64 would retire earlier as a result of the Medicare buy-in. This would increase Social Security benefits by about $0.2 billion per year.
>
> These costs are modest in relation to the Medicare and Social Security programs' budgets. Moreover, in the Administration's budget proposal, all costs in the first five years were offset by a package of savings

proposals. Nonetheless, concern over the program's impact on the Medicare program, in particular, was a stumbling block for the buy-in proposal.

In addition, the leadership of the Bipartisan Commission on the Future of Medicare claimed the notion of any Medicare buy-in as part of the scope of their report. They urged the Congress to postpone discussion of the proposal until after the Commission had an opportunity to examine a buy-in as part of their larger deliberations. This resistance was another strong obstacle to the proposal's passage.

Cost to Enrollees: CBO estimated that in the first year, the premium for 62- through 64-year-old enrollees would average $316 per month. (Actual premiums would vary by geographic area.) From age 65 through age 84, these enrollees would pay $10 in addition to their Part B premium for every year that they had participated in the buy-in. (i.e., if they enrolled at 64, $10; if they enrolled at 63, $20; if they enrolled at 62, $30.)

The high cost to enrollees would limit the program's attractiveness. Of the uninsured 55- to 64-year-olds, 46 percent have family income under $20,000; the median income of the uninsured in this age range was $21750 in 1996. (GAO) However, a surprising number of lower-income near elderly purchase individual policies. To the extent that this would increase access to other people who would like to purchase insurance, or lower costs to people who are currently paying for expensive individual policies, it would be a helpful program.

Estimates of Impact of Buy-In: Because of the high cost of premiums and the targeted eligibility rules for people under age 62, the impact of the Medicare buy-in as proposed by the Clinton Administration would be limited. CBO estimated that approximately nine percent of the currently uninsured near elderly would enroll in the program. In addition, they predicted that some individuals would lose access to retiree health insurance, and that by 2003, three percent of this group would also enroll.

In total, CBO estimated that 320,000 people would participate in the 62- through 64-year-old program in 1999, increasing to 390,000 in 2003 and almost 500,000 in 2008. Of the first year's enrollees, two-thirds would otherwise have purchased private individual coverage, and 30 percent would have been uninsured. A small percentage would be people induced to retire by the option.

Of the 1 million people ages 55 through 61 who become eligible for unemployment insurance every year, only half had insurance through their employer for the last year. CBO estimated that only 2,000 would enroll in the first year, increasing to 18,000 by 2003.

Lessons:

- It is not enough to have the AARP on your side, although AARP was not a strong advocate on this issue
- One factor that has hurt this cause is a lack of perception that the program would help enough people; another is the lack of a subsidy
- The children's health legislation passed in 1997 had a vehicle: a balanced budget agreement that both parties wanted to see enacted. 1998 has lacked such a vehicle. The 103rd Congress, 2nd session has been the least active Congress in some time. However, if a major package of Medicare reforms that included an increase in the eligibility age for Medicare were to be passed in the next several years, the pre-retiree legislation might be included as part of a deal-sweetener.

We should note in passing that there are alternative ways that might be used to assist in closing this gap: changes to COBRA rules and regulations might assist many forced to leave their jobs before being eligible for Medicare. Similarly, tax incentives to employers might help more employers to retain health insurance for their retirees. Access to group pools, such as the Federal Employees Health Benefits Program (FEHBP) or the Public Employees Retirement Service (PERS) in California might assist in reducing the often high rates for those in the decade prior to 65. And individual market reforms might assist in specific states.

VII. Conclusions

- In general, the "gap" approach has had some meaningful results, although those are generally modest, as shown in Table 8.
- The most successful program is the one focusing on children. However, for a variety of reasons, in particular the unique political conditions that existed in 1997 and both the political appeal and low cost of health insurance for children, these conditions seem unique. Other legislation and administrative actions seem to have had much more modest results.

In general, then, incremental approaches, as Marmor stated in 1994, are "politically possible," but are characterized by significant drawbacks, in particular the difficulty of working within the constraints of a system where employers have considerable choice and those without health insurance are both politically inactive and characterized by an extremely heterogeneous makeup. Each of the incremental programs proposed to date is an important step for the group of people together, but the total does not seem likely to achieve the goal of universal coverage in the forseeable future.

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Table 1

Probability of Being Uninsured, by Demographic Group

		Percent Without Health Insurance			Percent Without Health Insurance
Total		16%			
Age			**Relationship to Family Head**		
	Under 18	15%		**Head/Spouse**	12%
	18 - 24	29%		**Own Minor Child**	13%
	25 - 34	22%		**Adult Own Child**	36%
	35 - 44	16%		**Other Relative**	36%

	45 - 54	11%		**Unrelated to HH Head**	38%
	55 - 64	14%		**Living Alone**	13%
	65 +	1%			
			Income/Federal Poverty Level		
Gender				**< FPL**	31%
	Male	17%		**1 - 1.99 FPL**	25%
	Female	14%		**2 - 2.99 FPL**	15%
				3 - 3.99 FPL	10%
Marital Status				**4 - 4.99 FPL**	8%
	Married	11%		**5 + FPL**	6%
	Widowed	6%			
	Divorced	20%	**Education**		
	Separated	26%		**< 8 years**	26%
	Never Married	28%		**9 - 12 years**	19%
				Some College	15%
Race/Ethnicity				**College Grad +**	8%
	Caucasian	12%			
	African-Am.	22%	**Health Status**		
	Other	21%		**Excellent**	13%
	Hispanic (1)	34%		**Very Good**	16%
				Good	19%
Citizenship				**Fair / Poor**	14%
	U.S.	14%			
	Other	42%			

Notes:

1. Hispanics of any race are counted as Hispanic.

- Source: 1997 Current Population Survey. Moyer, M. Eugene. 1998b. "The Uninsured in the March 1997 Current Population Survey, Charts from Tabulations by ASPE." Washington, D.C.: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Health Policy. http://aspe.os.dhhs.gov/health/unins97/ index.htm

Table 2					
Composition of the Insured and Uninsured Populations					
	Composition			**Composition**	
	of the Insured	**of the Uninsured**		**of the Insured**	**of the Uninsured**

	Population	Population		Population	Population
Total	100%	100%			
Age			**Income/Federal Poverty Level**		
Under 18	27%	25%	**< FPL**	11%	28%
18 - 24	8%	17%	**1 - 1.99 FPL**	18%	31%
25 - 34	14%	22%	**2 - 2.99 FPL**	18%	18%
35 - 44	16%	17%	**3 - 3.99 FPL**	16%	10%
45 - 54	13%	11%	**4 - 4.99 FPL**	12%	6%
55 - 64	8%	7%	**5 + FPL**	25%	8%
65 +	14%	1%			
			Education		
Gender			**< 8 years**	6%	11%
Male	48%	54%	**9 - 12 years**	43%	54%
Female	52%	46%	**Some College**	27%	24%
			College Grad +	24%	10%
Marital Status					
Married	60%	39%	**Health Status**		
Widowed	9%	3%	**Excellent**	36%	30%
Divorced,			**Very Good**	30%	31%
Separated	12%	17%	**Good**	23%	28%
Never Married	20%	42%	**Fair/Poor**	12%	11%
Race/Ethnicity					
Caucasian	75%	53%			
African-Am.	12%	17%			
Other	4%	6%			
Hispanic [(2)]	9%	24%			
Citizenship					
U.S.	96%	83%			
Other	4%	17%			
Relationship to Family Head					
Head/Spouse	49%	34%			
Own Minor Child	28%	23%			
Adult Own Child	4%	11%			
Other Relative	4%	12%			
Unrelated to HH Head	3%	10%			

Living Alone	12%	10%					

Source: March, 1997 Current Population Survey. Tabulations by M. Eugene Moyer, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. See Moyer, M. Eugene, 1998a.

Notes:

1. Percentages sum down to 100% except in cases of rounding error.

2. Hispanics of any race are counted as Hispanic.

Table 3							
Probability of Being Uninsured, Children							
		Percent Without Health Insurance				Percent Without Health Insurance	
		All	Children			All	Children
Total		16%	15%				
Age				Relationship to Family Head			
	0 - 5		14%		Son or Daughter	13%	13%
	6 - 9		14%		Other Relative	36%	45%
	9 - 11		15%		Unrelated	38%	44%
	12- 14		16%				
	15 - 17		17%				
				Income/Federal Poverty Level			
Family Adult's Firm Size					< FPL	31%	24%
	No Family Adult		19%		1 - 1.99 FPL	25%	23%
	Less than 25		23%		2 - 2.99 FPL	15%	12%
	25 - 99		16%		3 - 3.99 FPL	10%	7%
	100 - 499		13%		4 - 4.99 FPL	8%	5%
	500 999		8%		5 + FPL	6%	4%
	1,000 +		9%				
Race/Ethnicity				Health Status			
	Caucasian	12%	11%		Excellent	13%	12%
	African-Am.	22%	19%		Very Good	16%	16%
	Other	21%	16%		Good	19%	20%
	Hispanic (2)	34%	29%		Fair	15%	14%3
					Poor	12%	
Citizenship				Number of Adult Workers in the Family			
	U.S.	14%	14%		No Adult Workers		45%
	Other	42%	45%		One Adult Worker		17%
					Two Adult Workers		12%

Source: March, 1997 Current Population Survey. Tabulations by M. Eugene Moyer, Office of the Assistant Secretary for Planning and Evaluation, U.S. Dep't of Health and Human Services. See Moyer, M. Eugene, and Laura Brice, 1998.

Notes:

1. Hispanics of any race are counted as Hispanic.

2. Category for children includes both Fair and Poor self-reported health status.

Table 4 - Composition of the Insured and Uninsured Populations				
Children Only				
			Composition	
			Insured	Uninsured
			Population	Population
Parent or Spouse with Private Insurance				
	Parent/Spouse Privately Insured			25%
	No Privately Insured Parent or Spouse			75%
		Total:		100%
Age				
	0 - 5		34%	31%
	6 - 9		23%	22%
	9 - 11		11%	11%
	12 - 14		16%	17%
	15 - 17		16%	18%
		Total:	100%	99%
Family Adult's Work History				
	Full-Time, Full Year		75%	62%
	Part-Time, Full Year		3%	5%
	Full-Time, Part Year		9%	15%
	Part-Time, Part Year		3%	5%
	Not Employed		10%	13%
Race/Ethnicity				
	Caucasian		68%	46%
	African-Am.		15%	20%
	Other		5%	5%
	Hispanic (2)		12%	29%
Citizenship				
	U.S.		98%	90%
	Other		2%	10%
Relationship to Family Head				
	Son or Daughter		97%	87%
	Other Relative		2%	9%
	Unrelated		1%	3%
Income/Federal Poverty Level				
	< FPL		19%	34%

	1 - 1.99 FPL		20%	36%
	2 - 2.99 FPL		20%	16%
	3 - 3.99 FPL		15%	7%
	4 - 4.99 FPL		10%	3%
	5 + FPL		16%	4%
Family Adult's Firm Size				
	No Family Adult		10%	13%
	Less than 25		24%	40%
	25 - 99		12%	13%
	100 - 499		13%	11%
	500 - 999		6%	3%
	1000 +		36%	20%
Health Status				
	Excellent		51%	41%
	Very Good		29%	31%
	Good		16%	24%
	Fair/Poor		3%	3%

Notes:

1. Percentages sum down to 100% except in cases of rounding error.

2. Hispanics of any race are counted as Hispanic.

Source: March, 1997 Current Population Survey. Tabulations by M. Eugene Moyer, Office of the Assistant Secretary for Planning and Evaluation, U.S. Dep't of Health and Human Services See Moyer, M. Eugene, and Laura Brice, 1998.

Table 5								
Probability of Being Uninsured, Adult Workers								
		Percent With Health Insurance			**Percent With Health Insurance**			**Percent With Health Insurance**
Total		73%						
Age			**Relationship to Family Head**			**Major Industry**		
	18 - 24	54%		**Head/Spouse**	80%		**Agric., Const., Mining**	59%
	25 - 34	72%		**Minor Child of Head**	74%		**Other Services**	59%
	35 - 44	79%		**Adult Child of Head**	56%		**Retail**	59%
	45 - 54	82%		**Other Relative of Head**	46%		**Wholesale**	77%
	55 - 64	79%		**Unrelated to Household Head**	48%		**Professional Services**	80%
	65 +	51%		**Living Alone**	69%		**Manufacturing**	82%
							Finance, Ins., Real Est.	83%

Gender		**By Hourly Wage (% of workforce)**				**Transportation, Comm.**	83%
	Male	73%	**< $7 (32%)**	51%		**Public Administration**	89%
	Female	74%	**$7 - $13.99 (35%)**	77%			
			$14 - $20.99 (18%)	90%	**Class of Worker**		
Race/Ethnicity			**$21 + (15%)**	90%		**Private**	72%
	Caucasian	77%				**Federal**	87%
	African-Am.	65%	**By Amount of Work in 1996**			**State**	86%
	Other	68%	**Full-Time, Full Year**	82%		**Local**	87%
	Hispanic [(1)]	54%	**Full-Time, Part Year**	59%		**Self-Employed, Incorp.**	57%
			Part-Time, Full Year	58%			
Citizenship			**Part-Time, Part Year**	54%	**Firm Size (% of workforce)**		
	U.S.	75%				**1 - 9 (16%)**	51%
	Other	49%	**By Education**			**10 - 24 (10%)**	50%
			Up to 8	40%		**25 - 99 (13%)**	71%
Marital Status			**Some HS**	54%		**100 - 499 (15%)**	78%
	Married	82%	**HS Graduate**	70%		**500 - 999 (6%)**	82%
	Divorced	68%	**Some College**	75%		**1,000 + (40%)**	83%
	Widowed	58%	**College Graduate**	84%			
	Separated	57%	**Graduate School**	89%			
	Never Married	59%					
			By Major Occupation				
Health Status			**Farm, Fishery**	42%			
	Excellent	78%	**Service**	56%			
	Very Good	75%	**Labor**	57%			
	Good	68%	**Sales**	68%			
	Fair	60%	**Transportation, Moving**	70%			
	Poor	50%	**Machine Operators**	72%			
			Precision Tools	72%			
			Administrative Support	80%			
			Mgr., Professional, Technical	85%			

Source: March, 1997 Current Population Survey. Tabulations by M. Eugene Moyer, Office of the Assistant Secretary for Planning and Evaluation, U.S. Dep't of Health and Human Services. See Moyer, M. Eugene, 1998c.

Notes:

2. Hispanics of any race are counted as Hispanic.

3. Category for children includes both Fair and Poor self-reported health status.

Table 6
Health Conditions, Hospital Use, and Expenditures, by Age Range

	25-34	**35-44**	**45-54**	**55-64**
Conditions per 1,000 People[a]				
Arthritis	41.19	79.85	174.48	294.75
Cerebrovascular or Heart disease	30.06	49.51	99.02	189.75
Diabetes	9.35	20.17	46.74	86.09
Hypertension	40.42	82.45	176.21	285.88
Varicose veins	19.82	31.00	42.07	62.57
Hospital Use per 1,000 People[b]				
Hospital discharges	107.2	82.8	102.6	154.6
Days of care	412.8	425.8	571.6	948.7
Expenditures per Person[c]				
All medical services	$1,220	$2,234	$3,455	$5,024

a GAO tabulations of NCHS 1994 National Health Interview Survey.

b GAO tabluations of 1994 National Hospital Discharge Survey.

c GAO tabulations of 1987 National Medical Expenditure Survey, aged by AHCPR to represent 1998 dollars.

Table 7

Basic Health Insurance Information, Near Elderly, Ages 55-64

Probability of being Uninsured			**Composition of the Insured and Uninsured,**			
			Near Elderly Only, Aged 55-64			
					Composition	
	Percent Without				**Insured**	**Uninsured**
	Health Insurance				**Population**	**Population**
					(Adds down to 100% except for rounding)	
Total		14%				
Gender			**Gender**			
	Male	12%		**Male**	49%	42%
	Female	15%		**Female**	51%	58%
Work Status			**Work Status**			
	Full Time	10%		**Full Time**	54%	**38%**
	Part Time	17%		**Part Time**	12%	**15%**
	Retired	15%		**Retired**	21%	**23%**
	Non-work	23%		**Non-work**	12%	**23%**
Marital Status			**Marital Status**			
	Married	12%		**Married**	72%	60%
	Divorced/Separated	19%		**Divorced/Separated**	8%	**10%**
	Widowed	17%		**Widowed**	15%	**23%**
	Never Married	20%		**Never Married**	5%	**8%**

Health Status			**Health Status**			
	Exc/Good	13%		**Excellent**	20%	**15%**
	Fair/Poor	18%		**Very Good**	28%	**21%**
				Good	30%	34%
				Fair	13%	**20%**
				Poor	8%	**9%**
Over 200% of Poverty			**Income**			
	55-59	8%		**< FPL**	10%	33%
	60-61	8%		**1-1.99 FPL**	14%	26%
	62-64	8%		**2-2.99 FPL**	15%	12%
				3+ FPL	62%	28%
Age						
	55-59	13%				
	60-61	14%				
	62-64	16%				

Source: March, 1997, Current Population Survey.

Table 8

Health Insurance Gap-Filling -- Results

Gap	**Number of People (Millions)**	**Percent of the Uninsured**	**Legislation / Administrative Actions**		**Number of People Potentially Obtaining Insurance**
			Enacted/ Implemented	**Proposed**	
Children	10.4	25%	**State Children's Health Insurance Program**		2.3 m + **
18-24 Year Olds	7.1	17%			
Working Adults	20.9	51%	**Health Insurance**		****
25-54 Year			**Portability and**		
Olds			**Accountability**		
			Act		
				President's	3.3 m***
				Workers Bet-	
				ween Jobs	

				Program	
			Medicaid		135,000 -
			Expansion (Eli-		200,000
			mination of 100		
			hour rule), 7/98		
Near Elderly	2.9	7%		**President's**	0.5 m*
55-64 Year Olds				**Medicare Buy-in**	
				Proposal	
Totals	41.3	100%			3 m +

Notes:

* As of 2008. Number increases gradually from 320,000 to approximately 500,000 in 2008.

** After 1999.

*** Administration estimate in the FY 1998 budget. The 3.3 million people includes 700,000 children.

**** GAO estimates that some proportion of the 11.5 million workers with employer-sponsored insurance who change jobs plus their 6.7 million dependents will be helped by the legislation. Other groups include about 2 million persons helped by the preexisting condition exclusions and other workers who will be more able to change jobs because of national portability standards.