JOINT ECONOMIC COMMITTEE
ROBERT F. BENNETT, CHAIRMAN MAY 13, 2004

THE COMPLEX CHALLENGE OF THE UNINSURED

Health insurance provides a myriad of benefits. It can make health care more accessible, improve the quality of care, and protect families' financial security in the face of unexpectedly high health expenses. In light of these benefits, it is important to understand the uninsured and the greatest areas of need.

In considering policy responses to this challenge, it is essential to understand how many and what types of Americans are uninsured. Such analyses are not an exact science: different surveys using different methodologies report different estimates of the number and characteristics of uninsured Americans. However, the surveys agree on one point: the uninsured are a diverse group, covering varying ages, incomes, and ethnicities and experiencing both short and long spells of being uninsured. There is no "typical" uninsured American.

Policymakers should be aware of the reasons why Americans become uninsured. The underlying factors behind lack of coverage turn out to be as complex as the demographics of the uninsured themselves. These factors include the link between employment and insurance, the strength of the economy, regulations and mandates, other factors driving the cost and affordability of health insurance, and personal choice.

Taken together, the diversity of the uninsured and the factors driving lack of coverage suggest that there are no easy solutions to this challenge. Policy efforts should be sensitive to the multifaceted dynamics of the uninsured and make it easier for Americans to get health insurance that addresses their specific needs. Tax parity for individuals and the further development of Health Savings Account options, for example, would make it easier for Americans to access lower cost insurance plans, if they choose, and would expand the availability of insurance independent of employers' decisions to offer it. Regulatory reform would complement such efforts by lowering the cost of care and making health insurance more affordable for all Americans. Ultimately, the goal should be an expanded array of insurance options that more adequately address the various needs of the uninsured.

HOW MANY AMERICANS ARE UNINSURED?

The uninsured are constantly changing – and difficult to count. How the uninsured population changes over time is central to understanding whether people are uninsured for short or long periods. In May 2003, the Congressional Budget Office (CBO) integrated estimates from several national surveys to analyze comprehensively the dynamic nature of the uninsured population. For 1998, the most recent year for reliable data across multiple studies, CBO found that:

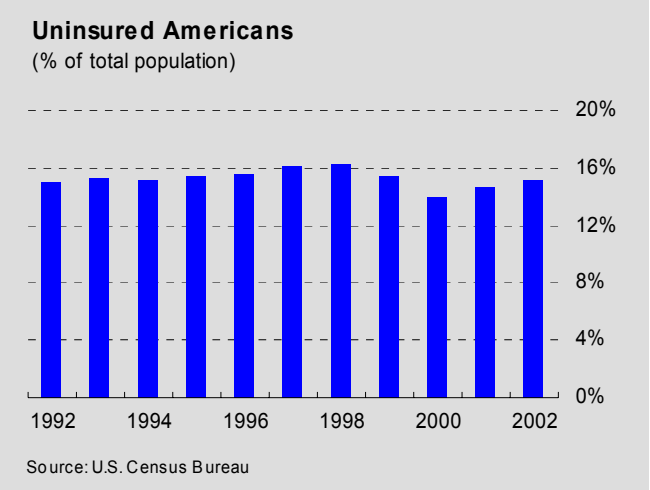
- 21 to 31 million Americans were uninsured for the entire year;
- 39 to 42.6 million Americans were uninsured at any specific point in time in the year; and
- 56.8 to 59 million people were uninsured at some time during the year.

CBO also estimated that one-half to two-thirds of Americans who experienced a period without insurance had coverage during some point that year. Additionally, the CBO found that more than three-quarters of the individuals who were uninsured at some point during a three year period (ending June 1999) were uninsured for less than 12 months. Only 6% were uninsured for more than 24 months.

The uninsured thus include a large number of people who are uninsured for a relatively short time (e.g., less than a year), a smaller number of people who appear to be *persistently* uninsured (e.g., more than a year), and a much smaller number of people who appear to be *chronically* uninsured (e.g., more than two years).

Estimates of the number of uninsured may be overstated. Methodologies for estimating the number of uninsured suffer from several shortcomings that may lead them to overestimate the number of uninsured. Many respondents are unsure of or forget their insurance status, which makes surveys tend to overestimate the ranks of the uninsured. Those eligible for Medicaid, in particular, may report themselves as uninsured even though they either have or could have Medicaid coverage. Indeed, fewer people indicate in surveys that they have Medicaid than are accounted for by the Medicaid program.[1] Additionally, although many fail to formally sign up for Medicaid when eligible, their health care costs are still covered by the program since a patient can apply when they seek care and are covered retroactively.

The number of uninsured, in relation to the population, has been relatively constant since 1992. In order to compare the number of insured across time, it is customary to rely on the most-cited estimates of the uninsured which come from the Current Population Survey (CPS) of the Census Bureau. According to these data, 43.6 million American were uninsured in 2002, representing 15.2% of the population. Although this figure is often presented as the number of people uninsured for a full year, most health analysts believe that this figure reflects the number of people who were uninsured at the specific time the survey questions are asked (a cross-sectional "single point in time"). As noted above, this is an important distinction because many individuals are uninsured only for short periods.



According to the CPS data, the fraction of Americans who report themselves as uninsured, while varying from year to year, has remained relatively constant over the past decade, at roughly 15% in both 1992 and 2002. The fraction of uninsured reached more than 16% as recently as 1998, and then fell to 14% during the climax of the economic boom in 2000.[2]

WHO ARE THE UNINSURED?

The uninsured come from widely varying backgrounds and circumstances. It would be easier to address the challenge of the uninsured if there were members of society that were consistently and continuously uninsured. However, the uninsured are made up of people from nearly every

demographic group (with the exception of seniors, who – because of Medicare – total less than 1% of the uninsured).[3]

Of particular note is the fact that a significant number of the uninsured are employed and that a significant number have middle-class incomes. In 2002, for example:

- About 57% of the uninsured were full-time working individuals (18-64 years old).[4]
- About two-thirds of the uninsured had incomes above $25,000.[5]

Some demographic groups are more likely to be uninsured. For example:

- Young adults (age 18-24) are more likely to be uninsured, with an uninsured rate of almost 30%. The likelihood of being insured drops as one gets older. About 25% of people between 25 and 34 are not covered, falling to 18% between 35 and 44, and 13% between 45 and 65.[6]
- Individuals with less education are more likely to be uninsured. People that did not complete high school or only received a high school diploma are five times more likely to be uninsured as someone with a bachelor's degree or higher.[7] The least educated are also most likely to have uninsured spells longer than 12 months.[8]
- Individuals with incomes below poverty are twice as likely to be uninsured.[9]
- Hispanics are more likely to be uninsured than are other racial and ethnic groups; in 2002 about 32% of Hispanics were uninsured.[10]

WHY DO AMERICANS BECOME UNINSURED?

Understanding the reasons for lack of insurance boils down to three interrelated questions: What factors drive the cost of health insurance? What factors drive individuals' ability to afford insurance? And what factors drive individuals' desire to purchase insurance?

The utilization of health insurance is driven largely by employment and employer decisions. In recent years, more than 60% of Americans have received their health insurance through employer plans; changes in employment or employer coverage thus have a major impact on the number of uninsured. For example, although the level of employer-sponsored insurance coverage has gradually declined from nearly 70 percent of non-elderly Americans in 1987 to just over 61 percent in 2002,[11] it did increase substantially for several years, from 1998 to 2000, helping reduce the uninsured rate. In 2001 and 2002, however, the level of employer-provided insurance declined, leading to a higher uninsured rate.

Such changes in the availability of health insurance reflect both the overall level of employment in the economy and employer's willingness and ability to provide health insurance. Insurance premiums for employers began to rise rapidly in 1999, after several years of moderation, and hit double-digit rates beginning in 2001 (10.9% in 2001, 12.9% in 2002, and 13.9% in 2003).[12] These cost increases undoubtedly made it more difficult for employers to offer insurance and their employees to pay their share of its cost. Nevertheless, the percentage of firms offering health benefits increased in these years hitting 66% in 2003. At the same time, the rate that employees utilized their employer coverage remained steady, varying between 83% and 84% over the last 5 years.[13] The decline in the number of

people receiving employer insurance in recent years thus appears to be primarily due to the 2000-2001 recession, rather than employers dropping coverage. As the U.S. economy continues to recover and employment growth improves, uninsured rates should fall as they have in the past.

Third-party payment drives up costs. Comprehensive employer-sponsored insurance and government programs shield individuals and families from the true cost of health care. As a result, the current system of financing health care creates little incentive to control utilization and costs.[14] Over time, health care spending has increased, leading to higher premiums and health care costs. As insurance becomes more expensive, some individuals are priced out of the market and employers drop coverage, thus increasing the ranks of the uninsured. Furthermore, as health spending and costs go up, it becomes more difficult as a society – and as taxpayers – to pay for the uninsured through public programs.

Regulations and mandates also make it more difficult to find affordable insurance. The health care sector is one of the most regulated sectors in the U.S. economy. Regulatory costs increase health expenditures by an estimated 6.4%, driving up health insurance premiums and reducing insurance coverage. One recent study estimates higher costs result in a 2.2% decrease in coverage – or almost 5 million uninsured who might otherwise be able to afford insurance coverage.[15] Small businesses and individuals are most likely to bear the added costs of regulation and mandates because they are subject to more regulatory costs, particularly at the state level. Many large companies, in contrast, self-insure and are therefore regulated under the federal Employer Retirement Income Security Act (ERISA), which preempts most forms of state-based health benefits regulation.[16]

Employers often offer insurance based on employee preferences. Health benefits are a means of attracting and retaining employees. Businesses that face relatively low insurance costs and employ workers who place a high value on insurance are most likely to offer insurance. Companies that attract workers over age 25 with a good education and families to support will likely offer insurance, for example, because their employees place a higher value on health benefits. Businesses with young, single, uneducated workers with high turnover probably will not, because workers for such companies likely value higher wages over health benefits – especially if the employee makes close to the minimum wage. Companies with many part-time workers that are covered by their spouses' insurance policy are also unlikely to offer health benefits due to lack of strong employee demand. In fact, a 2003 survey of businesses that do not offer insurance found that 36% do not offer it because most of their employees are insured elsewhere.[17]

Small employers are less likely to offer insurance than large employers. Some small companies do not earn enough revenue to pay both health benefits and competitive wages. Moreover, most small businesses face higher benefit costs because they do not enjoy the economies of scale of their larger competitors. They are at a disadvantage when it comes to insurers' costs of selling insurance to them as well as their relatively costs per worker in administering health benefits. Some risk pooling advantages for large employers may also exist.[18]

Employer-sponsored health insurance leaves people uninsured between jobs. A person's homeowners and auto insurance coverage typically remain stable and portable regardless of job status, because the policies are purchased by the individual covered by them. Not so for most health insurance, which is typically purchased by employers for their employees. In fact, most changes in employer results in a change in health insurance plan. Many in the ranks of the uninsured are between periods of employer-sponsored insurance. In fact, 50% of the uninsured regain health insurance within

four months.[19] Few *affordable* options are available for short-term unemployed and uninsured workers.

The tax system also affects the affordability of health insurance by favoring employed individuals and those with higher incomes. Because the value of employer-sponsored health insurance is excluded from federal income and payroll taxes, its after-tax price is relatively less expensive than insurance purchased in the non-group market. Except for the self-employed, there is no comparable tax relief for individuals and families who must purchase insurance on their own. Those with employer-paid health benefits and large incomes receive the largest tax benefit. Because the amount of the benefit's tax subsidy is based on marginal income tax rates plus payroll tax rates, the higher the income level, the higher the tax rate and the larger the value of the employee's tax exclusion.

Some Americans choose to be uninsured. Some people are offered insurance at work and choose not to take it because they feel they do not need it or because they place a higher value on other spending priorities, such as education, transportation, housing, etc.[20] Most of these people tend to be younger and healthier and believe that the cost of insurance is more of a consideration than their expected health risk. Others making a significant income may also choose to be uninsured simply because the insurance plan options available to them do not fit their preferences or are not worth their cost.

HOW MUCH CARE DO THE UNINSURED RECEIVE?

Many of the uninsured do not go entirely without care. Some uninsured individuals pay for care directly, from their own resources or those of friends and family. In addition, public hospitals, community health centers, facilities managed by the Department of Veterans Affairs, and other local health organizations all provide some care to the uninsured, usually with little or no compensation.

In 2004, for example, the uninsured will receive $125 billion in care, purchasing $33 billion out-of-pocket and receiving $41 billion in uncompensated care.[21] The remaining $51 billion came from private insurance sources, such as Tricare, CHAMPUS, and workers' compensation, and public sources, such as Medicaid and Medicare.

Not surprisingly, the amount of care that the uninsured receive is less than that received by those who are insured. In 2004, spending by the full-year uninsured ($1,629 per capita) was around 55% of that of the privately insured ($2,975 per capita), and spending by the part-year uninsured $2,466 per capita) was around 83%.[22]

CONCLUSION

Health insurance could be made more affordable and available by reducing the real costs of providing it and the health care services it helps to finance. Such steps would include reducing regulatory costs, which would reduce the costs of health care for all Americans, and implementing tax parity for non-workers, which would level the playing-field for Americans who do not have access to employer-provided insurance.

Health Savings Accounts (HSAs) are a good example of an insurance product that is affordable – due to the lower premiums accompanying high deductible health plan coverage – yet create an incentive for spending wisely – due to the savings aspect of the plans. The tax-preferred savings account mitigates the problem of job transition since funds can be drawn upon between employment

opportunities. Because of their low cost and flexibility, HSAs could provide a viable insurance plan alternative for many of the uninsured.

Policymakers should not target the uninsured as a single group that is "typical." Americans of all walks of life become uninsured because of a host of different reasons: the cost of insurance to themselves or their employer, the limitations of the employer-based insurance system, and, in some cases, calculated decisions about the importance of insurance relative to other spending priorities.

In light of the diversity of the uninsured and the range of factors driving lack of coverage, policymakers should focus on expanding the range of insurance choices available to Americans. With a broader selection of insurance choices, Americans will have greater likelihood of finding a plan to suit their particular needs, preferences, and pocketbook.

Leah Uhlmann
Health Economist

---

[1] Estimates of the "Medicaid undercount" range from about 5 percent to nearly 15 percent of the total "uninsured." See State Health Access Data Assistance Center, "Do National Surveys Overestimate the Number of Uninsured? Finding from the Medicaid Undercount Experiment in Minnesota," Issue Brief 9, January 2004, http://www.shadac.org/publications/issuebriefs/IssueBrief9.pdf; and Carl Irvine and Martin Zelder, "Medically Uninsured Americans: Evidence on Magnitude and Implications," *Public Policy Sources* no. 58, Fraser Institute, July 2002.

[2] Estimates of the uninsured for years 1999 and 2000 reflect several changes in methodology (follow-up verification questions, implementation of Census 2000 based population controls, adjustments for November 2001 weighting correction and 1990 census population controls, and sample expansion) that, on net, tend to drive the annual percentage of the uninsured 0.2% lower than would have been the case under pre-1999 methods. We have erred on the side of reporting the downward-biased figure for each year (1999 and 2000) when more than one figures was available (ex. 14% uninsured instead of 14.2% for 2000).

[3] Robert J. Mills and Shailesh Bhandari, "Health Insurance Coverage in the United States: 2002," U.S. Census Bureau Current Population Reports, September 2003.

[4] Ibid.

[5] Ibid.

[6] Ibid.

[7] Ibid.

[8] "How Many People Lack Health Insurance and for How Long?" Congressional Budget Office, May 2003. Moreover, reductions in the price of health care, or expansions in the overall demand for health inputs, disproportionately benefit the well-educated, who are more productive at managing their own health and are the first to adopt and benefit from new patient-intensive technologies. Dana Goldman and Darius Lakdawalla, "Understanding Health Disparities Against Education Groups," National Bureau of Economic Research working paper no. 8328, June 2001.

[9] Chris L. Peterson, "Health Insurance Coverage: Characteristics of the Insured and Uninsured Populations in 2002," Congressional Research Service Report for Congress, October 6, 2003.

[10] Mills and Bhandari 2003.

[11] See Leonard E. Burman, Cori E. Uccello, Laura L. Wheaton, and Deborah Kobes, "Tax Incentives for Health Insurance," Urban-Brookings Tax Policy Center Discussion Paper No. 12, May 2003, p. 3; and Robert J. Mills and Shailesh Eharidari, "Health Insurance Coverage in the United States: 2002," *Current Population Reports*, U.S. Census Bureau, September 2003, http://www.census.gov/prod/2003pubs/p60-223.pdf.

[12] "Employer Health Benefits: 2003 Annual Survey." Kaiser Family Foundation and Health Research and Educational Trust (HRET).

[13] Ibid.

[14] Tom Miller, "How the Tax Exclusion Shaped Today's Private Insurance Market," Joint Economic Committee report, December 17, 2003.

[15] Testimony of Christopher J. Conover, Ph.D., before the Senate Committee on Health, Education, Labor and Pensions, January 28, 2004.

[16] A RAND Health study on "State Efforts to Insure the Uninsured" found that state reforms that (1) mandated insurers to offer insurance to all employers who wanted to purchase a policy and (2) restricted the extent to which premiums could vary across groups with differing health characteristics had little overall effect on the number of small employees offering insurance and employee enrollment, small business decisions to add or drop insurance, or the size and variability of premiums. In fact, some states ended up with higher premiums. "State Efforts to Insure the Uninsured: An Unfinished Story," http://www.rand.org/publications/RB/RB4558.1/RB4558.1.pdf.

[17] "Employer Health Benefits: 2003 Annual Survey." Kaiser Family Foundation and Health Research and Educational Trust (HRET).

[18] Economists Mark Pauly and Bradley Herring recently observed that the relative advantages of the employer group market versus the individual insurance market in terms of risk pooling are overstated. Their advantage comes from greater tax benefits and lower marketing and administration costs. Mark V. Pauly and Bradley J. Herring, *Pooling Health Insurance Risks,* (Washington: AEI Press, 1999). A 2001 General Accounting Office study found that insurers' administration costs and expenses, other than benefits, typically account for about 20 percent to 25 percent of small employers' premiums compared to about 10 percent of large employers' premiums (but this differential has narrowed over the last decade). "Private Health Insurance: Small Employers Continue to Face Challenges in Providing Coverage," GAO-02-8, October 2001, p. 14

[19] "How Many People Lack Health Insurance and for How Long?" Congressional Budget Office, May 2003.

[20] Helen Levy and Thomas DeLeire, "What Do People Buy When They Don't Buy Health Insurance And What Does That Say About the Uninsured?" NBER Working Paper No. 9826, July 2003. Many people who cannot "afford" insurance end up buying it, and many people who can afford insurance opt to go without coverage. M. Kate Bundorf and Mark V. Pauly, "Is Health Insurance Affordable for the Uninsured," NBER Working Paper No. 9281, October 2002.

[21] Jack Hadley and John Holahan, "The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?" Kaiser Commission on Medicaid and the Uninsured, May 10, 2004.

[22] Ibid.

Committee Publications

Recent JEC reports include:

- "Recent Economic Developments: The Economy is Firing on All Cylinders" May 11, 2004. Reviews economic activity for the past month and highlights the employment growth surge.

- "4.2% Economic Growth in the 1st Quarter" April 29, 2004. Discusses the factors that contributed to robust economic growth in the first three months of 2004.

- "Who Pays the Income Tax?" April 14, 2004. A brief overview of how the nation's income tax share is distributed.

- "Medical Spending Growth & the Level of Insurance Coverage," February 25, 2004. Compares the decline in out-of-pocket health spending with the increase in total health spending.

Recent JEC hearings include:

- "The Burden of Health Services Regulation" May 13, 2004.

- "The Employment Situation: April 2004," May 7, 2004

- "Consumer-Directed Doctoring: The Doctor is In, Even if Insurance is Out" April 28, 2004.

- "The Economic Outlook, with Alan Greenspan" April 21, 2004.

Copies of the above publications can be found on-line at the committee's website at jec.senate.gov. Publications issued by the vice-chair and ranking member can be accessed via the same website.