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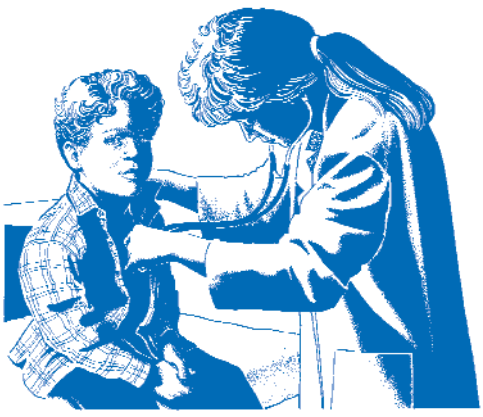
Who lacks health insurance coverage?

by Thomas F. Wildsmith

The most recent available data from the Health Insurance Association of America show that in 1998, approximately 44 million Americans lacked health insurance coverage (16% of the U.S. population). Since Medicare covers nearly all seniors, most discussions of the uninsured focus on the non-elderly population — those under age 65. In 1998, 43.9 million Americans below the age of 65 were uninsured, representing approximately 18% of the non-elderly population. Assuming the economy continues to grow as it has in recent years, this number is projected to rise to 55 million in 2008. Assuming an economic downturn, the number could rise to 60 million, or almost one out of four non-elderly Americans (24%).



The single best predictor of health insurance coverage is income. More than half (55%) of the uninsured live in households with a family income that is less than twice the federal poverty level. (For a family of four, the federal poverty level is $16,530.)

Employment is also a critical factor. Only about 16% of those living in families headed by a full-time, full-year worker are uninsured. In contrast, 28% of those in families headed by someone who does not work are uninsured. Where a person works is also important. Employees of small firms and their dependents are much more likely to be uninsured than those of large firms.

Young adults and the "working poor" (those with family incomes between one and two times the federal poverty level) appear to be particularly vulnerable. Adults are generally more likely than children to be uninsured, because children are much more likely to have public coverage such as Medicaid. Younger adults are more likely than older adults to lack coverage — 33% of males between the ages of 18 and 24 are uninsured, while only 13% of males between the ages of 45 and 64 are uninsured. The pattern for women is similar. And, while the working poor are twice as likely as those below the poverty level to have private health insurance (53% versus 25%), the percentage of the working poor who are uninsured remains relatively high (31%), because those covered by public programs drops by almost half (23% versus 45%).

In recent years, private employment-based coverage has increased slightly, but both the number and percentage of uninsured non-elderly has continued to grow as Medicaid coverage levels declined. The recent growth in employment-based coverage has been

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modest, however, and has occurred during the strongest economic expansion in recent memory. An economic recession would have the potential to significantly reduce the prevalence of private health insurance coverage. The drop in public coverage appears to be associated with welfare reform. While the intent of the reforms was to allow families to maintain public coverage as they moved into the labor force, miscommunication and implementation problems may have resulted in many losing coverage.

An article in the October 23/30, 1996, issue of the *Journal of the American Medical Association,* "Whatever Happened to the Health Insurance Crisis in the United States?" reported results of a national survey. The uninsured were asked why they lack health insurance, and two-thirds said that coverage is too expensive. Employment-related reasons were cited by 17%, and 8% indicated that they either do not want or do not need insurance. Only 1% said that they have a pre-existing medical condition and cannot obtain coverage. Similarly, the March/April 1999 issue of *Health Affairs* ("Why Are Workers Uninsured?") reports that when uninsured workers who were offered employer-sponsored health insurance in 1997 were asked why they declined it, two-thirds cite its high cost. These results are consistent with the relatively low enrollment levels of most state-sponsored high-risk pools.

Efforts to extend coverage to more Americans are unlikely to be successful unless they address the real reasons people often lack health insurance coverage. Most of the uninsured simply cannot afford the cost of coverage.

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Percentage by Income Categories						
						400% or
	Total	0–99%	100%–199%	200%–299%	300%–399%	More
Private	71%	24%	52%	74%	84%	90%
Employment-based	66%	18%	45%	68%	78%	86%
Other Private	7%	9%	9%	7%	6%	5%
Public	14%	45%	23%	11%	6%	5%
Uninsured	18%	36%	31%	20%	13%	8%

Source: William Custer and Pat Kelsche, *Health Insurance Coverage and the Uninsured: 1990-1998,* Health Insurance Association of America, December 1999
Note: The total for insurance categories may exceed 100% because individuals may have multiple sources of coverage.

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and determine if these incentives compromise acceptable levels of care. Actuaries could also gather valid samples and project whether a statistical difference exists among incentive plans and groups. At the same time, operations experts could examine how actual practices vary from marketing materials and interactions, along with evaluating the provider selection and credentialing process and the peer review and corrective process. Clinicians could analyze the degree to which the patient suffered harm. Again, the team would then present an integrated analysis to management so it can make informed decisions about what the company's risk management program should look like.

What is particularly appealing about this process is the way it clearly identifies the legal and business issues that spur litigation. This not only provides for the strongest possible defense if a company is sued, but it also positions the company to recover and protect itself from future litigation. Most importantly, however, it is good business.

Actuarial projections are invaluable in this and other risk management processes that fall outside the traditional boundaries for actuarial work. By creatively applying our skills, we serve our clients better and broaden the possibilities for our profession.