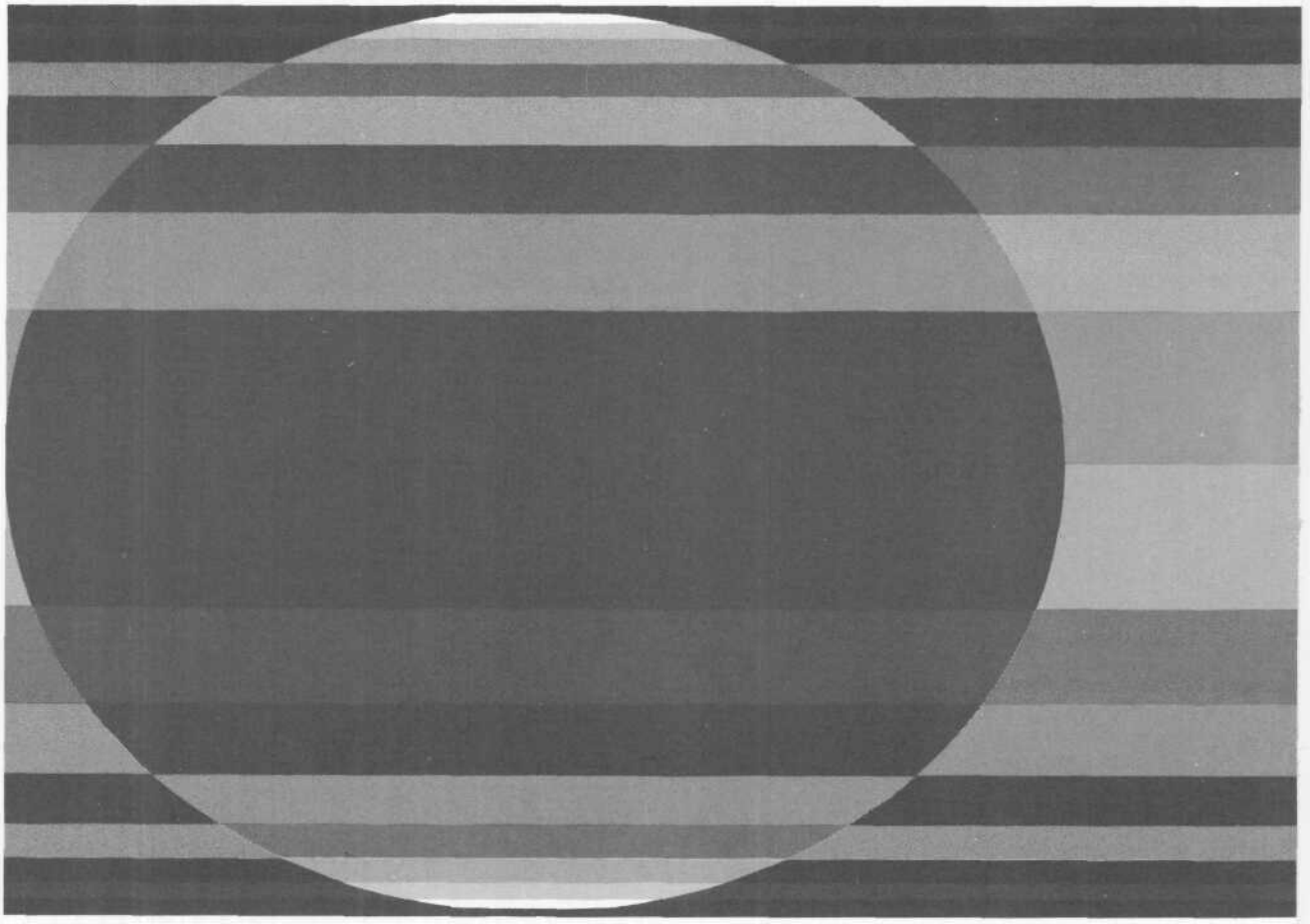
BACKGROUND PAPER

Profile of Health Care Coverage: The Haves and Have-Nots

MARCH 1979



Congress of the United States
Congressional Budget Office

PROFILE OF HEALTH-CARE COVERAGE: THE HAVES AND HAVE-NOTS

The Congress of the United States
Congressional Budget Office

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Washington, D.C. 20402

NOTE

Much of the analysis in this study is based on the Survey of Income and Education (SIE) conducted in 1976 by the U.S. Bureau of the Census. Many of the conclusions, therefore, are based on 1976 data. Supplementary sources are discussed in Chapter II.

PREFACE

At the request of the Senate Budget Committee, the Congressional Budget Office prepared this background paper to provide basic information on health-care coverage. In addition to offering estimates of the size of the uncovered population in 1978, the paper describes the covered and uncovered populations, discusses the adequacy of health-care coverage, and identifies policy implications that will be developed in succeeding CBO papers on issues related to health insurance.

The paper was prepared by Maureen Baltay of CBO's Human Resources and Community Development Division under the supervision of Robert D. Reischauer and David S. Mundel. The author gratefully acknowledges the following current and former CBO staff members who have assisted in the essential computer programming and data manipulations: Deborah Haas, Fay Jan Lim, John Shiels, Paul Warren, and Toni Wright. Numerous reviewers, especially the staffs of the Senate and House Budget Committees and of the Department of Health, Education, and Welfare, contributed constructive comments. The manuscript was edited for publication by Johanna Zacharias and Robert L. Faherty, assisted by Brice S. McDaniel. The several drafts were typed by Toni Wright.

In keeping with CBO's mandate to provide objective analysis, the study offers no recommendations.

Alice M. Rivlin
Director

March 1979

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SUMMARY

In 1978, more than 90 percent of all Americans either had private health insurance or were eligible for public programs that protect them to some degree from financial losses that might be associated with medical care. But approximately 5 to 8 percent of all Americans did not have such protection, and a higher percent of those who were covered had inadequate protection. These gaps are regarded as one reason for enacting national health insurance.

Knowing the size and character of the uncovered population is important to evaluating alternative health insurance proposals. The size of the uncovered population largely determines how much the various proposals would cost. Knowing the characteristics of the uncovered enables one to assess the effectiveness of alternative plans in providing protection to the uncovered.

WHO ARE THE UNCOVERED?

By and large, the uncovered are from lower-income families (those with incomes below $10,000) and are young. Unemployed individuals and young adults are more likely than others to be uncovered (see Summary Table 1).

Lower-Income Persons

Persons from lower-income families are twice as likely to be without health-care coverage as are those from higher-income families. Over half of the uncovered population comes from these lower-income families. Lower-income individuals--whether employed or unemployed--are less likely to be covered. Many of these lower-income persons are not eligible for medicaid because they do not have dependent children, are not blind or disabled, or have incomes that are too high to qualify for the program in their states. Many do not work for employers who provide group health insurance coverage and are not able to afford individual health insurance.

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SUMMARY TABLE 1. PERCENT OF POPULATION WITHOUT HEALTH-CARE COVERAGE AND PERCENT DISTRIBUTION OF THE UNCOVERED BY INCOME, AGE, AND EMPLOYMENT STATUS, 1976

Income, Age, and Employment Status	Percent of the Total Population	Percent of the Uncovered	Percent of the Population Group without Coverage
Income (in Dollars)			
Less than 5,000	13.2	22.6	17.4
5,000 to 9,999	20.0	32.6	16.6
10,000 to 14,999	21.1	19.1	9.2
15,000 or more	45.6	25.7	5.7
Age			
Less than 6 years	9.0	12.2	13.9
6 to 18 years	23.8	26.2	11.2
19 to 24 years	10.9	21.9	20.5
25 to 44 years	25.6	23.4	9.3
45 to 64 years	20.4	15.3	7.6
65 years and over	10.3	1.0	1.0
Employment Status			
Employed	42.8	34.7	8.2
Full-time wage earner	31.2	19.8	6.5
Part-time wage earner	7.7	9.1	12.1
Self-employed	3.9	5.7	14.9
Unemployed	3.9	10.1	26.8
Not in Labor Force			
Retired	5.0	1.0	2.0
Other a/	48.3	54.3	11.4

NOTE: Components may not add to 100 percent because of rounding.

SOURCE: SIE 1976, adjusted for underreporting of coverage by public programs.

a/ Includes housekeepers, pre-school or in-school children, and other persons unable to work.

Young Adults

Young adults are almost twice as likely as any other age group to be without coverage and, although they account for only 11 percent of the population, they account for 20 percent of the uncovered. The number of 19- to 24-year olds without coverage is disproportionately high for several reasons. First, many insurance companies do not cover family members over age 18 unless they are in school; consequently, young adults not in school who are unemployed or in jobs that do not provide insurance are often without coverage. Second, medicaid does not cover young adults without dependent children, even if they have low incomes. Finally, people in this age group tend to be more healthy and thus may not be motivated to purchase their own insurance.

The Employed

Although less than 10 percent of the employed population lacks coverage, the employed account for over one-third of the uncovered. For the most part, the uncovered employed work in industries with relatively low wages, high proportions of part-time or self-employed workers, and large seasonal fluctuations in employment, or in firms that have health insurance plans with long waiting periods before coverage is provided. One-third of the uncovered full-time wage earners are heads of families. When an employed family head is without health insurance, the chances are 4 in 5 that the family is without coverage as well. One-third of the uncovered family members who are not in the labor force are dependents of employed family heads who lack coverage.

The Unemployed

In the spring of 1976, when the aggregate unemployment rate was higher than 8 percent, over one-fourth of the unemployed were without health coverage. These individuals accounted for one-tenth of the uncovered population, and over half of them were aged 16 to 24. During periods of lower unemployment, the percent of unemployed without coverage would probably be higher because fewer workers in the ranks of the unemployed would be on temporary layoffs: many workers on temporary layoffs continue to be eligible for employment-related health benefits. The unemployed are not always the principal wage earner, however,

and they may be covered under the policies of family heads who continue to be employed. When family heads are unemployed, the coverage of family members not in the labor force may be affected as well as their own. Fifteen percent of the uncovered unemployed are family heads; 4 percent of the uncovered family members not in the labor force are dependents of these unemployed and uncovered workers.

Dependents

The overwhelming majority of the uncovered are members of families rather than single persons. Some family members lack coverage even though the family head is covered because the family head with job-related health insurance either waives or is not offered the opportunity to insure his or her dependents. Over half of the uncovered who are not in the labor force are in families headed by someone with health coverage (see Summary Table 2). Fifty percent of the unemployed who are uncovered are members of families in which the head is covered.

WHAT IS KNOWN ABOUT THE ADEQUACY OF COVERAGE?

Policymakers are concerned that the insurance held by people meet certain standards. To evaluate the adequacy of coverage--defined as either protection against large absolute health expenditures or expenditures large in relation to income--requires detailed information on four factors:

- Financial resources of the family;
- Health status of the members and the likelihood of their incurring health-care expenditures of certain types;
- Family preferences concerning risk and the value placed by them on health care as compared with other goods;
- Types of coverage available to a family, including information on the breadth and depth of benefits. 1/

1/ Breadth of coverage refers to the scope of services for which a person is insured. Depth of coverage refers to the out-of-pocket expenditures for which a person is liable under the terms of coverage.

SUMMARY TABLE 2. PERCENT DISTRIBUTION OF THE UNCOVERED BY FAMILY STATUS, AGE, AND EMPLOYMENT STATUS, 1976

Age and Employment Status of the Uncovered	Single Persons	Family Heads	Family Members With Covered Head Private	Family Members With Covered Head Public	Family Members With Uncovered Head
Total Uncovered	11.3	14.1	23.9	20.9	29.6
Age					
Less Than 18 years	2.6	0.4	23.8	26.3	47.0
19 to 24 years	17.7	11.1	36.4	15.2	19.5
25 to 44 years	16.0	28.2	18.0	16.9	21.0
45 to 64 years	16.9	31.2	27.4	22.7	15.0
65 years and Over	11.5	16.8	51.4	11.1	9.1
Employment Status					
Full-time wage earner	20.9	32.2	21.2	9.8	15.8
Part-time wage earner	18.6	14.2	27.1	17.2	22.9
Self-employed	14.9	45.5	11.3	11.3	16.9
Unemployed	19.5	15.0	33.7	16.1	15.5
Retired	16.0	45.0	23.6	11.0	4.4
Other not in labor force	4.6	3.5	23.9	27.7	40.2

NOTE: Components may not add to 100 percent because of rounding.

SOURCE: SIE 1976, adjusted for underreporting of coverage by public programs.

No single existing data source provides all the outlined information. What data are available suggest that, while most persons with private insurance appear to be protected against high absolute medical expenditures, at least 15 percent do not have protection against this sort of catastrophe through

private insurance. It is not known, however, how many of these persons with shallow private insurance are covered simultaneously by public programs such as veterans' medical care that would protect them from financial loss in case of a major illness.

Neither is there an accurate estimate of those who are inadequately insured against income-related catastrophic expenses. In 1978, roughly 9 percent of all families had out-of-pocket medical expenses that exceeded 15 percent of their gross income. There is no way to estimate the additional persons whose expenditures were not large in 1978 but who had open-ended payment liabilities under the terms of their insurance contracts.

Families incurring high out-of-pocket health expenditures do have partial recourse through the tax code provision that permits unreimbursed medical expenses in excess of 3 percent of adjusted gross income to be deducted from income before calculating taxes. This form of relief, however, is available only to those who itemize their tax deductions. Furthermore, this provision affords substantial relief only to those families or individuals whose incomes--and marginal tax rates--are fairly high.

POLICY IMPLICATIONS OF THE PATTERNS OF COVERAGE

The uncovered are a varied group, and thus using any single dimension, such as unemployment, to define the population to be covered by a national health insurance plan will help only some of them. Moreover, because many covered individuals have characteristics similar to those of the uncovered, use of any single dimension is likely to provide assistance to many people who already have coverage, thus raising the net budgetary cost of national health insurance if it is publicly financed.

Any plan that relies exclusively on employers to provide insurance will not encompass all of the uncovered population. Nevertheless, the extent of health-care coverage could be significantly improved by certain alterations in employer-provided policies. Such changes might include automatic protection for all dependents of a covered family head, notwithstanding the age of dependents. This change alone would reduce the number of uncovered by 20 percent. Increasing the provision of coverage during temporary layoffs and reducing the waiting times for job-related health insurance coverage are other possible changes that would reduce the vulnerability of those with job-related insurance to fluctuations of the economy.

If all uncovered workers and their dependents had employer-provided coverage, and if all the self-employed were covered, the number of uncovered would be cut in half. This change would affect roughly one-fourth of the employed population, but the financial impact on certain industries could be large. Retail trade, construction, agriculture, and services would incur the greatest costs because these industries currently have the lowest rates of group health coverage.

Changes in existing public programs such as medicaid could also substantially reduce the uncovered population. For example, medicaid coverage could be extended to the poor families with an unemployed head in those 23 states that do not cover them now; it could also be extended to low-income individuals who are not members of families with dependent children. Alternatively, the categorical requirements could be eliminated entirely, and eligibility could be based only on financial criteria. These changes would decrease the number of uncovered by perhaps as much as one-fourth. Medicaid for medically needy, nonwelfare recipients, now available in 29 states, might also be extended to every state and eligibility requirements standardized to eliminate existing uncertainties about program requirements.

Establishing minimum benefit packages that set deductibles and coinsurance levels as well as covered services would have a more widespread financial impact on employers than simply requiring insurance. Despite the fact that most workers have group health insurance that covers a broad range of services, the depth of the coverage or dollar liability of the insured varies considerably. The magnitude of the impact on employers would of course depend upon what was defined as the minimum acceptable benefit and cost-sharing package.

CHAPTER I. INTRODUCTION

The great majority of the U.S. population is protected to varying degrees from high health-care expenses. The sources of this protection are health insurance sold by private companies and publicly financed programs. Some people, however, have inadequate protection against the extreme financial loss health-care costs can bring about; others have no coverage at all. This situation has been cited as one of the reasons for enacting some type of national health insurance.

The number of people without health-care coverage or with coverage below certain levels will in large measure determine the cost of health insurance proposals. Furthermore, knowing what people are uncovered is important to modifying the existing health care financing system or to devising ways to phase in a uniform, federal system. This paper, therefore, presents current information about the size and characteristics of the population without coverage. It also summarizes what is currently known about the breadth and depth of private coverage.

PRIVATE COVERAGE

The principal form of health-care coverage is private health insurance. This protection against the financial loss that can result from medical care is in most instances acquired by people as a group, either through their employers or through membership in an association. Less commonly, private policies are purchased directly by an individual or family.

PUBLIC COVERAGE

In addition to private insurance, there are public programs that provide either insurance-type benefits or direct services. These latter are generally at least as comprehensive as those financed by private insurance. By financing or providing services, these programs--like private insurance--protect against the financial losses that can result from medical care. The

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most important of the public programs are medicare, medicaid, veterans' programs, and the Civilian Health and Medical Program of the United States (CHAMPUS). 1/

Medicare is the federal health insurance program for the aged and disabled. It pays for a broad range of health services to most individuals age 65 and over, and to the disabled under 65 who have been entitled to social security for two years or who are being treated for chronic kidney disease.

Under medicaid, all states except Arizona offer basic health services to eligible low-income persons. The cost of providing these services is shared by the federal government, but each state determines its own eligibility criteria and sets benefits above the minimum established by federal law. Almost all recipients of cash welfare programs are automatically eligible. In addition, 29 states extend medicaid to families that satisfy all but the income requirements for welfare and that either have incomes which meet state definitions of "medically needy" or incur medical expenses which lower their incomes to medically needy levels. The latter requirement is frequently referred to as the medicaid "spend down."

The Veterans Administration (VA) operates a network of hospitals, outpatient clinics, and nursing homes to meet the medical needs of eligible veterans. It also reimburses eligible veterans for care obtained in nonfederal facilities when federal facilities are not available. Veterans who are service-disabled, who are age 65 or over, who receive a VA pension, or who swear that they are unable to pay for care can receive VA health services.

The Department of Defense (DoD) provides health care for active duty personnel, dependents and survivors of active duty members, and military retirees and their dependents or survivors.

1/ In this paper, coverage excludes workman's compensation, disability benefits, accident insurance, and coverage in public hospitals and clinics, or neighborhood health centers. The Federal Employees Health Benefits Program is counted as employer-provided private insurance.

Most of the eligible civilians receive their medical care in the private sector under CHAMPUS rather than in military hospitals. CHAMPUS is paid for by DoD but administered by private insurance companies.

CHAPTER II. HOW MANY PERSONS LACK HEALTH-CARE COVERAGE?

Estimating the number of persons with and without health-care coverage is a difficult task complicated by several factors. No two sources provide the same estimate of the number of persons with any single type of health benefit. Different sources often use different measures of program activity--some record benefit recipients, others record those eligible or potentially eligible for a program. Difficulties also arise because many people have multiple forms of coverage that must be identified before the remaining uncovered population can be estimated.

Taking into account these difficulties, a reasonable estimate can be set: five to eight percent of the U.S. population had no health-care coverage in calendar year 1978.

SOURCES OF DATA

Unfortunately, no insurance company or federal agency collects information on the uninsured per se. As a result, information about them must be surmised: the noncovered are the total population minus those people known to have some sort of coverage. How does one estimate the size of the covered population?

Two general sources of information about health-care coverage exist--program data and survey data. Program sources, such as insurance company and public program enrollment figures, give reasonably accurate counts of the number of insurance policies issued and the number of beneficiaries of particular programs. But many people have more than one kind of health-care coverage, and program data do not, as a rule, provide any information about such overlaps. So, simply adding the numbers of beneficiaries of different programs considerably overstates the total number of persons with coverage.

A figure for covered persons can also be extrapolated from sample surveys of the population. Surveys can yield estimates of how much program overlap there is, but they may underestimate

the actual number of insured and eligible. Survey respondents sometimes are unaware of--or do not remember--their eligibility for particular benefits; others may be reluctant to reveal it.

Because of these shortcomings, relying exclusively on either program or survey data is a mistake. Survey data adjusted to reflect program information, however, are likely to provide a more accurate picture. This paper, therefore, relies heavily on such adjusted data. The principal source has been the Survey of Income and Education (SIE), conducted in 1976 by the U.S. Bureau of the Census. Other surveys have been used to corroborate information from the SIE. 1/

VARIATIONS IN ESTIMATES

Ascertaining the total number of people with some kind of health-care coverage requires estimating the number with private insurance and the number eligible for public programs and then eliminating the overlap that certainly exists. This procedure is especially difficult because of discrepancies in estimates of insurance coverage and problems in defining eligibility for public programs.

Private Insurance

All sources are generally agreed that approximately 13 million elderly have private insurance, but there is wide discrepancy in estimated coverage of the population under 65. In 1976, according to the SIE, 79 percent of persons under age 65 had private health insurance. The Health Interview Survey, however, estimated that 78 percent of non-aged persons had insurance; the Center for Health Administration Studies estimated 82 percent; and the Health Insurance Institute estimated 164

1/ These are Center for Health Administration Studies (CHAS), University of Chicago, 1975-1976; Health Interview Survey, National Center for Health Statistics, 1976; and Health Plans Provisions Survey, Bureau of Labor Statistics, 1976.

million persons or 86 percent. 2/ The estimate of the Health Insurance Institute, which uses numbers of policies issued as its starting point, is considerably higher than those derived from surveys. There is reason to believe, however, that the survey estimates may be low. As was mentioned earlier, people sometimes have difficulty recalling certain benefits or are unaware of them altogether.

Earlier studies of employment benefits and health insurance noted underreporting of health insurance on surveys. Certain employees are more likely to be unaware of health (or other) benefits they in fact have--for example, new employees, seasonal workers who may be covered under a multi-employer plan, workers whose employers pay all the premium costs, or those whose own contributions are automatically deducted from their paychecks. 3/

That there is some underreporting of private group health insurance is thus a reasonable assumption. It is not clear, however, how much underreporting of health insurance has occurred on the SIE or any other survey, because negative responses from

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2/ The Health Insurance Institute bases its estimates on gross enrollment figures reported by insurance companies, Blue Cross-Blue Shield plans, and other private plans. The enrollment figures are adjusted by duplication factors derived from a one-day sample of insurance claims in 1973, which have subsequently been updated to reflect more recent experience.

3/ Some limited discussion of underreporting of private health insurance coverage is contained in John Krizay and Andrew Wilson, The Patient as Consumer (Lexington Books, 1974), Appendix C; and Walter W. Kolodrubetz, "Group Health Insurance Coverage of Full-Time Employees, 1972," Social Security Bulletin. April 1974, pp. 17-35. Krizay and Wilson found that even some participants in the Federal Employees Health Benefit Program--participation which requires some employee action--were not certain whether they were insured. Only one study--Ronald Andersen, Joanna Lion, and Odin Anderson, Two Decades of Health Services: Social Survey Trends in Use and Expenditures (1976), Appendix 1--attempted to verify positive responses to health insurance coverage questions. It found that some respondents erroneously reported having private insurance (overreporting), but it did not attempt to see if people who said they had no insurance in fact did.

employees to questions about coverage have not been verified. The Health Insurance Institute figures cannot be used as a check on the accuracy of the survey because they are not adequately adjusted for duplicate group health insurance coverage possible in two-earner families.

Because of these uncertainties, a range of estimated private insurance coverage is used. The upper end of the range (170 million people) is derived from the Health Insurance Institute (HII) estimate, which has been reduced to take into account more duplicate coverage than reflected in the HII numbers arising from the increased employment of married women in jobs that may provide health benefits. 4/ The low end of the range (165 million) was estimated from the average of the health survey estimates. Table 1 shows discrepancies between the SIE and program sources of information and the values used to estimate the number of people with health-care coverage.

Public Programs

A similarly large discrepancy exists between survey estimates and program data with respect to the number of people eligible for public programs. According to the SIE, 12 million people were covered by medicaid at the time of the survey, but program data show considerably more people eligible at that time. Medicaid eligibility is automatically conferred on almost all recipients of cash payments under the Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) programs. In addition, more than half of the states cover the medically needy. During the time of the survey, welfare recipients alone totaled almost 16 million, 35 percent more than the number of SIE respondents who said they were covered by medicaid. 5/

4/ Howard Hayghe, "Families and the Rise of Working Wives--An Overview," Monthly Labor Review, May 1976, pp. 12-19.

5/ U.S. Department of Health, Education, and Welfare, National Center for Health Statistics, Public Assistance Statistics May 1976, (October 1976), and Supplemental Security Income for the Aged. Blind, and Disabled, Monthly Statistics, June 1976.

TABLE 1. COMPARISON OF SURVEY AND PROGRAM ESTIMATES OF HEALTH-CARE COVERAGE, 1976 a/: PERSONS IN MILLIONS

Type of Coverage	Unadjusted SIE b/	Program Data c/	Used to Compute Coverage
Private Insurance	163	177 d/	165-170
Medicare	22	24 e/	23
Medicaid	12	22 f/	22
VA and CHAMPUS	8	21 g/	21

a/ Coverage figures indicate total enrollment in each program.

b/ SIE 1976 sample of 140,000 households with 440,000 individuals. Although there are other surveys of health coverage, they cannot be compared in the same fashion because information about coverage under some public programs is not recorded for all survey respondents.

c/ In order to be consistent with the SIE, all program data exclude to the extent possible recipients in Puerto Rico and the Virgin Islands and the institutionalized population.

d/ Health Insurance Institute, Source Book of Health Insurance Data, 1977-1978.

e/ Noninstitutionalized medicare beneficiaries estimated by CBO on the basis of medicare budget data and estimates in CBO, Long-Term Care: Actuarial Cost Estimates (August 1977).

f/ CBO estimate of medicaid eligibility based on SIE demographic and income data and data from the Aid to Families with Dependent Children, Supplemental Security Income, and medicaid programs.

g/ VA 1979 budget estimates 12 million eligible veterans. CHAMPUS eligibles estimated by DoD.

Six percent of aged persons reporting receipt of social security or railroad retirement income neglected to report coverage by medicare, even though they are clearly eligible. One might have expected medicare coverage to have been reported very accurately since it is a well-publicized program with straightforward eligibility standards. This again demonstrates the confusion of people about their benefits.

ELIGIBILITY VERSUS UTILIZATION OF BENEFITS

Part of the difference in estimates of public coverage is attributable to differences in definition. One source may tabulate the number of persons who actually received benefits; another may indicate those eligible for benefits whether or not they actually enrolled or used them. This distinction between use and eligibility is critical in estimating numbers of medicaid and VA beneficiaries--especially those beneficiaries whose eligibility is not automatic (such as military retirees for CHAMPUS) or contractual (private insurance) but is determined upon application for benefits.

A person may be covered by either private or public insurance without ever claiming benefits. Thus, the number of claims may not reflect the number of persons with coverage. Most recipients of cash assistance are automatically eligible for medicaid, but there is also an eligible group deemed medically needy that is not easy to identify. Medicaid program data record only those persons whose bills are paid by medicaid. While welfare data can be used to measure the total number of cash assistance recipients eligible for medicaid, there is no source of data on the corresponding nonwelfare group eligible for medicaid from whom monthly medicaid recipients are drawn. In order to present a more realistic estimate of the average number of persons eligible for medicaid than comes from the SIE, it is therefore necessary to estimate the eligible medically needy and then to simulate total medicaid eligibility using demographic and income data from the SIE.

Program data show that only 40 percent of eligible welfare recipients actually received medicaid benefits at the time of the survey. Because there is some evidence that far fewer medically needy people actually take advantage of medicaid than could, a participation rate of 30 percent was selected for the

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medically needy population. 6/ Under this assumption, there were an estimated 6 million eligible medically needy at the time of the survey, of whom 2 million actually received medicaid. 7/ The estimated number of eligible medically needy plus the cash welfare recipients constitute a total medicaid-eligible population of 22 million people. In order to reflect this corrected estimate on the SIE, all families meeting the categorical requirements for medicaid were identified (that is, aged, disabled, female-headed with dependent children, families headed by an unemployed father in states which covered them, and so on). A low-income screen was set across all states and was gradually raised until 16 million recipients were identified. Similarly, in states with medicaid programs for the medically needy, the income screen was raised further until another 6 million persons were identified and assigned medicaid coverage. The simulation thus implicitly corrected for the undercount of eligible welfare recipients and generated an eligible medically needy population. 8/

Only veterans with service-connected disabilities are recorded as having VA coverage on the SIE. Under the laws governing eligibility for veterans' medical care, all 29 million veterans might be eligible for care at some point. Nevertheless, some veterans are far likelier to use VA care than are others. While the service-disabled have an absolute entitlement and

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6/ In a study of the medicaid spend-down done by Urban Systems Research and Engineering, Inc., for the U.S. Department of Health, Education, and Welfare, it was estimated that in 1974 the state of Massachusetts was only providing benefits to 5 percent of the potentially eligible spend-down population. In the five states studied, there was confusion about program requirements on the part of case workers, public ignorance of the existence of the program, and discouragement of spend-down applications.

7/ Of 16 million medicaid-eligible cash assistance recipients, only 7 million were actually receiving medicaid at the time of the survey.

8/ The major effect of this simulation is to raise the percent of medicaid eligibles with incomes below $5,000 from 52 percent to 61 percent and to reduce the percent with incomes $10,000 or greater from 17 percent to 10 percent.

top priority for VA care, less than one-fourth of VA hospital admissions are service-disabled veterans. Most admissions are nondisabled veterans who are over 65 or who state that they are unable to pay necessary medical expenses. Eligibility for VA care has therefore been attributed to disabled veterans, those age 65 or over, and to lower income veterans under 65. This generates an estimate of eligible veterans that is the same as that used by the Veterans Administration.

DUPLICATION OF COVERAGE

As was stated earlier, many persons are covered by more than one program at a time. An estimated 60 percent of medicare recipients have private insurance, usually a supplementary policy that covers bills not paid by medicare. (See Table 2 and Appendix Table A-1 for greater detail.) Thirty-eight percent of all medicare recipients are covered by other public programs.

TABLE 2. ESTIMATED OVERLAPS OF PUBLIC AND PRIVATE PROGRAMS, 1976: PERCENT OF PROGRAM ELIGIBLES

Program	Program Alone	Program Plus Other Public Programs	Program Plus Other Private Programs
Medicare	20.4	38.2	59.3
Medicaid	46.7	35.2	32.1
Veterans Administration	16.1	25.4	72.1
CHAMPUS	51.0	16.3	39.6

SOURCE: SIE 1976, adjusted for underreporting of coverage by public programs.

Medicaid distributions show a similar overlap in coverage. The low-income elderly often receive medicaid as well as medicare. The extent of the overlap between medicare and medicaid

reflects the practice of many state medicaid programs to pay the out-of-pocket costs for the elderly poor who are covered by medicare.

Thirty-two percent of medicaid eligibles also have private insurance. Private coverage is evenly split between coverage under group policies and individually purchased insurance, although almost twice as many medicaid eligibles with incomes of less than $5,000 have individual insurance as have group insurance. Almost 40 percent of those with both medicaid and private coverage are elderly people who also have medicare. The multiple coverage of the elderly may be explained in part by a desire of persons with reduced retirement income and substantial health needs to minimize the risk of high out-of-pocket health costs.

Private insurance among nonelderly medicaid eligibles is the result of several different factors. A child whose father is absent technically may have private coverage under an employer's plan of his father and may also have medicaid because his mother is on welfare. A temporarily unemployed person may have carryover insurance coverage from his job and at the same time be eligible for welfare and have medicaid because he has no current income. A nonwelfare family may be eligible for medicaid because of high medical expenses not covered by its health insurance policies.

More than 70 percent of VA eligibles and almost 40 percent of CHAMPUS eligibles have private coverage as well. Many VA eligibles have private health insurance either because they are employed and automatically covered by a group policy or because they want to provide protection for their dependents who are not eligible. Many CHAMPUS eligibles retire from the military at a relatively early age and begin second careers that offer insurance policies as fringe benefits.

THE SIZE OF THE UNCOVERED POPULATION

After reconciling discrepancies in estimates and adjusting for persons with more than one type of coverage, the number of persons without health-care coverage in 1976 can be estimated. Circumstances have changed since 1976, however, so that the number of uncovered people in 1978 is lower. While the population has grown--which would increase both the number of covered and of uncovered--the number of employed has grown faster. At

the time of the 1976 SIE, the unemployment rate was about 8 percent and the economy was just emerging from a recession. The unemployment rate had dropped to about 6 percent in 1978. Because most people obtain health coverage through their employers, the increase in the number of employed generates an increase in the number of people with health insurance. The increase is not one-for-one, however, because most of the newly employed had been covered under parents' or spouses' health insurance policies or under public programs during 1976. Nevertheless, the net increase in coverage accompanying the increase in employment more than offsets the increase in the number of uncovered due to population growth. This reduces the uncovered by 1 million persons between 1976 and 1978 and results in an estimate of 11 to 18 million uncovered persons, between 5 and 8 percent of the population. 9/ Table 3 summarizes the adjustments made to the 1976 SIE to arrive at the estimate of the uninsured for 1978.

TABLE 3. ESTIMATED NUMBER OF PERSONS WITHOUT HEALTH-CARE COVERAGE IN 1978: IN MILLIONS a/

Uncorrected Number of Persons without Coverage, 1976	26
Adjusted for 1976 undercounts	
Medicaid	less 2
Other public programs	less 3
Private insurance	less 2 to 9
Adjusted for net increases between 1976 and 1978 in population and employment-related insurance	less 1
Estimated Number of Persons without Coverage in 1978	11 to 18
Uncovered as a Percent of the Population	5 to 8

a/ Duplicate coverage has been netted out in all adjustments.

9/ CBO population, labor force, and employment figures tie to official population estimates of the Bureau of the Census (continued)

After 1978, unless whole new classes of people acquire health coverage through extensions of public programs or of private insurance to new employee groups, the number of uncovered may be expected to increase. A slight increase might be expected as the outcome of normal population growth. A somewhat larger increase may be anticipated should there be a rise in the unemployment rate.

9/ (continued)
as do the estimates generated by the Census Bureau's Survey of Income and Education. Estimates of the uncovered in 1976 therefore are calculated from a total noninstitutionalized population of 212 million persons. Statistical experts believe that an estimated 2.5 percent of the population was inadvertently missed during the 1970 census, so that all official census population estimates for succeeding years are correspondingly low. If this is so, then the probable actual number of persons at the time of the SIE was 218 million. Were this larger population used instead of official figures, it would result in a higher estimate of the uncovered population.

Although no one knows the age or income of the people believed missing, it was assumed that 65 percent of them have incomes of below $5,000, that 25 percent have incomes of between $5,000 and $10,000, and that they have the same distribution of health coverage as the enumerated population with those incomes. Recalculating the number of covered and uncovered using the higher population base yields a 1976 estimate of the uncovered of 16 to 19 million persons or 7 to 9 percent of the larger population.

CHAPTER III. WHO ARE THE UNCOVERED?

The choice among various health insurance proposals depends not only on how many people lack health-care coverage but also on who they are. Because of the range in the estimate of under-reporting of private health insurance by SIE respondents, the 1976 SIE information, adjusted only for underestimates in public coverage, serves as the basis for the following detailed distributional breakdowns. 1/ The characteristics described are those often used to define eligibility for public programs: income, age, and employment status.

INCOME AND AGE

People with family incomes below $10,000 are almost twice as likely to lack health-care coverage as are people with incomes between $10,000 and $15,000. Compared with those in the $15,000-and-over income group, they are three times more likely to lack coverage. 2/ These lower-income persons make up 55 percent of the uninsured population (see Table 4).

The proportion of the uncovered represented by each age group is not very different from its proportion of the total population. But there are two exceptions. The elderly, who are 10 percent of the population, are only 1 percent of the uncovered. Those in the 19-to-24 age group have the highest

1/ See Appendix Table A-2 for the effect of public program adjustments on the distribution of the uncovered by income and employment status. The major effects of the adjustments are to reduce the percent of the uncovered with incomes below $5,000 from 30 percent to 23 percent and to raise the percent uncovered with incomes of $15,000 or more from 20 percent to 26 percent. Conclusions of the analysis are unaffected.

2/ Income has an even larger effect on coverage when age, sex, race, education, industry of employment, and employment status of the family head are held constant.

TABLE 4. PERCENT OF POPULATION WITHOUT HEALTH-CARE COVERAGE AND PERCENT DISTRIBUTION OF THE UNCOVERED BY INCOME, AGE, AND EMPLOYMENT STATUS, 1976

Income, Age, and Employment Status	Percent of the Total Population	Percent of the Uncovered a/	Percent of the Population Group without Coverage
Income (in Dollars)			
Less than 5,000	13.2	22.6	17.4
5,000 to 9,999	20.0	32.6	16.6
10,000 to 14,999	21.1	19.1	9.2
15,000 or more	45.6	25.7	5.7
Age			
Less than 6 years	9.0	12.2	13.9
6 to 18 years	23.8	26.2	11.2
19 to 24 years	10.9	21.9	20.5
25 to 44 years	25.6	23.4	9.3
45 to 64 years	20.4	15.3	7.6
65 years and over	10.3	1.0	1.0
Employment Status			
Employed	42.8	34.7	8.2
Full-time wage earners	31.2	19.8	6.5
Part-time wage earners	7.7	9.1	12.1
Self-employed	3.9	5.7	14.9
Unemployed	3.9	10.1	26.8
Not in Labor Force			
Retired	5.0	1.0	2.0
Other b/	48.3	54.3	11.4

(continued)

TABLE 4. (Continued)

NOTE: Components may not add to 100 percent because of rounding.

SOURCE: SIE, 1976, adjusted for underreporting of coverage by public programs.

a/ This distribution is based upon an estimate of 163 million people with private health insurance. If the estimated number of privately insured were increased to 168 million on the assumption that 5 million people erroneously reported having no private health insurance on the SIE, the number of uncovered would fall to 16 million and the percent distribution of the uncovered would be as follows:

Income (in Dollars)	
Less than 5,000	27.3
5,000 to 9,999	37.2
10,000 to 14,999	18.3
15,000 or more	17.2
Employment Status	
Employed	31.4
Unemployed	11.8
Not in Labor Force	56.8

b/ Includes housekeepers, pre-school or in-school children, and other persons unable to work.

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proportion with no health-care coverage: while they are 11 percent of the total population, they are 20 percent of the uncovered. The proportion of uncovered 19- to 24-year-olds is even higher in the lower income groups--32 percent of those with incomes of less than $5,000 and 26 percent of those with incomes between $5,000 and $10,000 are uncovered (see Table 5).

TABLE 5. PERCENT OF THE POPULATION WITHOUT HEALTH-CARE COVERAGE AND PERCENT DISTRIBUTION OF THE UNCOVERED BY AGE AND FAMILY INCOME, 1976

Family Income (in Dollars)	Under 19	19 to 24	25 to 44	45 to 64	65 and over
	Percent of the Population Group without Coverage				
Less than 5,000	21.5	32.0	25.6	20.0	0.4
5,000 to 9,999	22.7	25.6	18.0	12.2	0.8
10,000 to 14,999	11.4	17.2	7.5	6.3	1.2
15,000 or More	5.5	15.2	4.8	3.8	2.3
All Incomes	11.9	20.5	9.3	7.6	1.0
	Percent Distribution of the Uncovered				
Less than 5,000	7.8	5.1	5.0	4.6	0.1
5,000 to 9,999	14.1	6.3	7.7	4.3	0.3
10,000 to 14,999	8.2	3.7	4.5	2.5	0.2
15,000 or More	8.3	6.7	6.2	3.9	0.4
All Incomes	38.4	21.9	23.4	15.3	1.0

NOTE: Components may not add to 100 percent because of rounding.

SOURCE: SIE 1976, adjusted for underreporting of coverage by public programs.

The disproportionately high number of 19- to 24-year olds without coverage could be caused by several factors. Because many insurance policies do not cover family members over age 18 unless they are in school, those who are not in school are more

likely to be uncovered if they are unemployed or in jobs that do not provide insurance. 3/ Low-income youths are not eligible for medicaid in their own right unless they have dependent children, and not many in this age group have dependents. Another possible reason for the lower health coverage of people in this age group is that they are among the healthiest and are not motivated to purchase their own insurance. This last reason is suggested by the fact that this age group still tends to have a lower rate of coverage when employment status, industry of employment, income, and other variables are held constant.

EMPLOYMENT STATUS

Because much health insurance is provided through employers, lack of coverage is to a large extent a function of whether one is employed or unemployed. 4/ It also depends upon other factors such as the industry in which one is employed, how long one has been in a particular job, or how long one has been unemployed.

The Employed

More than one-third of the uncovered are employed. Although there are many more uncovered full-time wage earners than uncovered part-time wage earners or self-employed persons, full-time workers are much less likely to lack coverage than either of the other groups. Only 6.5 percent of full-time wage earners are without coverage, compared with 12 percent of part-time wage earners and 15 percent of the self-employed. Insurance coverage among part-time workers is low because most employers do not provide health insurance or other fringe benefits to part-time workers. Among the self-employed, insurance coverage is lower

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3/ The uncovered 19- to 24-year-olds who are in school may receive health care in school clinics, which are not considered coverage in this paper. School health policies, on the other hand, are considered private group coverage.

4/ The unemployed are persons in the labor force who are jobless and are looking for a job. They are different from the group of persons who are not in the labor force who are composed of the retired, housekeepers, persons in school or preschool, and others not looking for work.

because, unless they can obtain group coverage through membership in an association, the self-employed must buy individual coverage that is more expensive.

The employed uncovered are principally in the agriculture and forestry, personal services, construction, and retail trade industries. The lower rate of coverage in these industries reflects several factors, such as the intermittent or seasonal nature of employment, the relatively higher proportion of part-time or self-employed workers in these industries, and the relatively lower wages of the workers, which means fewer resources to be devoted to health insurance.

In addition, many workers in all industries are subject to waiting periods, minimum weeks of work required before benefits can be received for the first time or reinstated after a layoff. In 1974, over one-fourth of the workers with health-care benefits were in plans with waiting periods of three months or longer (Table 6).

The Unemployed

Twenty-seven percent of the unemployed are without health coverage, compared with 8 percent of the employed. As Table 7 shows, the unemployed have the highest proportions without coverage regardless of income. Lack of coverage is high even among high-income unemployed. While only 4 percent of all full-time workers with incomes of $15,000 or more lack coverage, 21 percent of the unemployed with incomes of $15,000 or more have no coverage.

Although the unemployed have the highest proportion of people without health-care coverage, the rate of 27 percent may appear to be very low. The low rate may be explained by two factors:

- Some unemployed have coverage under policies of other family members;
- Some unemployed are out of work for only short periods and have coverage that is extended during layoffs. Length of layoff protection and waiting requirements

TABLE 6. PERCENT DISTRIBUTION OF WORKERS WITH HEALTH-CARE COVERAGE, BY INDUSTRY AND BY WAITING-PERIOD REQUIREMENT FOR BENEFITS, 1974: IN MONTHS

Industry	None	One	Two	Three	Four or More	Total
Total	38	28	8	16	11	100
Manufacturing	42	30	9	14	5	100
Construction	8	26	2	11	53	100
Mining	85	6	—	2	7	100
Transportation	28	36	14	9	14	100
Communications and Public Utilities	50	27	6	9	8	100
Wholesale and Retail Trade	32	22	6	23	17	100
Finance, Insurance, and Real Estate	39	19	8	31	3	100
Services	27	38	7	15	13	100
Other (Farming, Forestry)	50	15	2	30	4	100

NOTE: Components may not add to 100 percent because of rounding.

SOURCE: Andrea Novotny, "Private Industry Health Insurance Plans: Employment Requirements for Coverage in 1974," Social Security Bulletin, March 1977, pp. 28-33.

TABLE 7. PERCENT OF POPULATION WITHOUT HEALTH-CARE COVERAGE AND PERCENT DISTRIBUTION OF THE UNCOVERED BY EMPLOYMENT STATUS AND FAMILY INCOME, 1976

Family Income (in Dollars)	Full-Time Wage Earners	Part-Time Wage Earners	Self-Employed	Unemployed	Retired	Other Not in Labor Force
	Percent of the Population Group without Coverage					
Less than 5,000	24.2	27.2	25.1	34.7	1.7	15.5
5,000 to 9,999	12.6	20.3	19.4	32.3	1.5	18.8
10,000 to 14,999	5.2	17.1	12.3	23.4	1.8	10.9
15,000 or More	3.5	6.4	10.6	21.3	3.5	6.1
All Incomes	6.5	12.1	14.9	26.8	2.0	11.4
	Percent Distribution of the Uncovered					
Less than 5,000	4.0	2.5	1.4	2.5	0.2	12.2
5,000 to 9,999	6.2	2.6	1.6	2.8	0.2	19.1
10,000 to 14,999	3.6	1.5	0.9	1.8	0.1	11.4
15,000 or More	6.1	2.5	1.8	3.0	0.4	11.9
All Incomes	19.8	9.1	5.7	10.1	1.0	54.3

SOURCE: SIE 1976, adjusted for underreporting of coverage by public programs.

for reinstated or new coverage create a situation in which the period of loss of health insurance does not always coincide with the period of loss of employment.

Duration of Unemployment. The degree to which the unemployed lack health insurance depends on the status *of* the economy. During recession years, many temporary and expected layoffs augment the ranks of the unemployed. These short-term unemployed usually have good work histories. Many also have layoff protection--that is, benefits extended during layoff periods--and are eventually rehired. 5/ Therefore, covered workers experiencing short periods of unemployment are unlikely to lose their health insurance at all.

In nonrecession years, one would expect to see a higher proportion of the unemployed without coverage. During such periods, the unemployed are more heavily represented by new entrants into the labor force and by people who have been out of work for a long time. A U.S. Department of Labor survey of recipients of Federal Supplemental Unemployment Benefits (FSB) tends to support the notion that more long-term unemployed lack health insurance. 6/ FSB recipients were unemployed for an average of one year, compared with 16 weeks for all unemployed. Some 75 to 85 percent of all FSB recipients were without coverage. 7/

5/ In 1974, 40 percent of all workers with employer-provided health plans had layoff protection. Of these, over half had protection for three or more months, 19 percent had protection of less than three months, and 22 percent had protection that varied by length of employment. See Daniel N. Price, "Health Benefits for Laidoff Workers," Social Security Bulletin, February 1976, pp. 40-45.

6/ Federal Supplemental Benefits provided unemployment benefits to workers during their 39th to 65th weeks of unemployment. The program ended in March 1978.

7/ Unpublished data from "Study of Recipients of Federal Supplemental Benefits and Special Unemployment Assistance," prepared under contract for the U.S. Department of Labor by Mathematica Policy Research, Inc., January 1977.

Work Requirements. The number of weeks required to obtain health insurance for the first time, to reinstate lost coverage, and to maintain eligibility for coverage varies. There are also differences in the period beyond the date of a layoff or termination of employment during which a worker can retain his coverage. The complex interaction of these variables will have different outcomes depending upon whether a worker returns to his original employer or gets a job elsewhere. The net effect, however, is that the period of unemployment may not coincide with the period of lost coverage. 8/

FAMILY STATUS OF THE UNCOVERED

An individual's coverage status depends both on his own situation and the extent and type of coverage of other members of his family. For example, an unemployed worker may have coverage as a result of a spouse's or parent's work-related insurance although his own insurance has lapsed. Knowing the family status of uncovered persons provides some additional insight into why they lack coverage and how best the federal government could channel assistance toward them.

More than half of the uncovered are persons who are not in the labor force. But 90 percent of this group are dependents in families. It is possible for family members to lack coverage although the family head has coverage, reflecting in part the fact that some employed heads with job-related coverage either waive or are not offered the opportunity to insure the dependents. More than half of the uncovered not in the labor force are in families headed by someone with health-care coverage (see Table 8). In half of these cases, the head has private

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8/ For a thorough analysis of these phenomena, see Kenneth McCafree, Suresh Malhotra, and Gerald Glandon, The Impact of Rising Unemployment on the Loss of Job-Related Health Insurance Coverage, Batelle Human Affairs Research Center, December 1977. This report was prepared under contract for the National Center for Health Services Research (No. HRA-230-75-0139) and studied the loss of job-related health insurance coverage among 10 million workers in jointly administered health and welfare funds during the 1974-1975 recession.

coverage. This suggests that insuring a family rather than a single individual would appreciably reduce the uncovered population.

TABLE 8. PERCENT DISTRIBUTION OF THE UNCOVERED BY FAMILY STATUS, AGE, AND EMPLOYMENT STATUS, 1976

Age and Employment Status of the Uncovered	Single Persons	Family Heads	Family Members With Covered Head		Family Members With Uncovered Head
			Private	Public	
Total Uncovered	11.3	14.1	23.9	20.9	29.6
Age					
Less Than 18	2.5	0.4	23.8	26.3	47.0
19 to 24	17.7	11.1	36.4	15.2	19.5
25 to 44	16.0	28.2	18.0	16.9	21.0
45 to 64	16.9	31.2	14.0	22.7	15.0
65 and Over	11.5	16.8	51.4	11.1	9.1
Employment Status					
Full-time wage earner	20.9	32.2	21.2	9.8	15.8
Part-time wage earner	18.6	14.2	27.1	17.2	22.9
Self-employed	14.9	45.5	11.3	11.3	16.9
Unemployed	19.5	15.0	33.7	16.1	15.5
Retired	16.0	45.0	23.6	11.0	4.4
Other not in labor force	4.6	3.5	23.9	27.7	40.2

NOTE: Components may not add to 100 percent because of rounding.

SOURCE: SIE 1976, adjusted for underreporting of coverage by public programs.

A second large group of uncovered persons are employed; full- and part-time wage earners and the self-employed make up more than one-third of the uncovered. Fifty-three percent of uncovered full-time wage earners and 60 percent of the uncovered self-employed are either single persons or heads of families. In contrast, two-thirds of uncovered part-time wage earners are members of families headed by someone else and in most of these cases the head of the family is covered. In four out of five cases when an employed family head lacks coverage, his family is without coverage as well. Therefore, lack of insurance coverage among this group has ramifications for a much larger group of people. One-third of the uncovered dependents not in the labor force are dependents of these employed family heads.

Earlier in this study, two groups with disproportionately high chances of being uncovered were identified: persons aged 19 to 24 and the unemployed. Among uncovered 19- to 24-year-olds, over 70 percent are family members (not heads) and three-fourths of these are in families in which the head is covered. This reinforces the notion that the lack of coverage for this age group is at least partly the result of insurance stipulations to cover only dependents under age 19. Sixty-five percent of the uncovered unemployed are members of families--not heads. Fifty percent are members of families in which the head is covered and 57 percent of the uncovered unemployed are aged 16 to 24. This leads to the conclusion that many of the uncovered unemployed are in fact young people, excluded from parents' insurance policies, who are either looking for a first job or who have been laid off one that did not provide insurance with layoff protection.

Although the unemployed have been a legitimate focus of concern in past discussions of national health insurance, it appears from these data that lack of health insurance among the employed has even greater ramifications: not only are they a larger proportion of the uncovered, but more of them are family heads. Only 15 percent of the uncovered unemployed are family heads, compared with 32 percent of uncovered full-time wage earners. Moreover, the uncovered employed have eight times as many uncovered dependents as do the uncovered unemployed.

CHAPTER IV. WHO ARE THE COVERED?

More than nine-tenths of the population have some sort of health coverage. One fourth of the population have more than one source of coverage. The type of protection the covered population has is of importance to discussions about national health insurance.

INCOME AND AGE

Health-care coverage increases with income. About 83 percent of the population with incomes below $10,000 have coverage, while 93 percent of those with incomes above $10,000 have coverage (see Table 9). The type of coverage varies considerably by income group, however. More than three-fourths of the covered population with incomes below $5,000 have some public coverage; half have only public coverage (see Table 10). In contrast, almost three-fourths of persons with incomes between $5,000 and $10,000 have private coverage; one-half have private coverage only. Ninety-two percent of all persons with incomes between $10,000 and $15,000 have private insurance, and 96 percent of those with incomes above $15,000 have private insurance. (Tables 9 and 10 show the percent of the population with health-care coverage by type of coverage and socioeconomic characteristics. A more detailed tabulation of coverage by age and income is contained in Appendix Table A-3.)

As was discussed earlier, health-care coverage increases slightly with age (with the exception of the 19- to 24-year age group, whose rate of coverage is 10 percent lower than the average for all ages). The elderly have the greatest coverage in total and within each income group.

Public coverage is concentrated in the oldest age group. Ninety-eight percent of the elderly have public coverage; 38 percent have public coverage only. Among the elderly with incomes below $5,000, more than half have only public coverage, whereas 70 percent of those with incomes above $5,000 have both public and private coverage. In all other age groups, private coverage predominates.

TABLE 9. PERCENT OF POPULATION WITH HEALTH-CARE COVERAGE BY INCOME, AGE, AND EMPLOYMENT STATUS, 1976

Income, Age, and Employment Status	Percent of the Total Population	Percent of the Population Group with Coverage
Income (in Dollars)		
Less than 5,000	13.4	82.6
5,000 to 9,999	20.0	83.5
10,000 to 14,999	21.1	90.8
15,000 or More	45.6	94.3
Age		
Less than 6 years	9.0	86.2
6 to 18 years	23.8	88.8
19 to 24 years	10.9	79.5
25 to 44 years	25.6	90.7
45 to 64 years	20.4	92.4
65 years and over	10.3	99.0
Employment Status		
Employed	42.8	91.8
Full-time wage earner	31.2	93.5
Part-time wage earner	7.7	87.9
Self-employed	3.9	85.1
Unemployed	3.9	73.2
Not in labor force		
Retired	5.0	98.0
Other a/	48.3	88.6

NOTE: Components may not add to 100 percent because of rounding.
SOURCE: SIE 1976, adjusted for underreporting of coverage by public programs.

a/ Includes housekeepers, pre-school or in-school children, and other persons unable to work.

TABLE 10. DISTRIBUTION OF THE POPULATION WITH HEALTH-CARE COVERAGE BY INCOME, AGE, AND EMPLOYMENT STATUS AND BY TYPE OF COVERAGE, 1976

Income, Age, and Employment Status	Private Coverage Only	Public Coverage Only	Private and Public Coverage
Total Population	70.6	14.2	15.1
Income (in Dollars)			
Less than 5,000	22.9	51.8	25.2
5,000 to 9,999	49.8	24.0	26.1
10,000 to 14,999	71.8	8.1	20.1
15,000 or More	90.2	3.7	6.1
Age			
Less than 6 years	78.4	16.7	4.7
6 to 18 years	80.6	13.1	6.1
19 to 24 years	85.0	10.3	4.3
25 to 44 years	79.4	9.2	11.4
45 to 64 years	75.7	9.5	14.6
65 years and Over	1.5	38.1	60.4
Employment Status			
Employed	81.1	4.8	13.9
Full-time wage earner	82.9	3.2	13.7
Part-time wage earner	79.4	8.8	11.5
Self-employed	67.9	11.2	20.8
Unemployed	65.8	24.4	9.4
Not in labor force			
Retired	9.4	34.7	55.9
Other a/	67.9	19.8	12.2

NOTE: Components may not add to 100 percent because of rounding.

SOURCE: SIE 1976, adjusted for underreporting of coverage by public programs.

a/ Includes housekeepers, pre-school or in-school children, and other persons unable to work.

EMPLOYMENT STATUS AND COVERAGE

Employment status affects both the extent and the kind of health coverage. Of all employed persons, 92 percent have some coverage. Among the employed, full-time wage earners have the highest degree of coverage (94 percent) and the self-employed the lowest (85 percent). Only 73 percent of the unemployed have health-care coverage. Nine-tenths of all retirees have public coverage through medicare, VA, or CHAMPUS; 56 percent have both public and private protection. Private insurance is the major form of coverage in all other groups, although a relatively large proportion of the unemployed and persons not in the labor force rely on public coverage alone--24 percent as opposed to 3 to 11 percent for the employed groups.

Whether one has private insurance as health-care coverage depends to some extent on the industry in which one is employed. While 87 percent of the employed have private insurance, more than 90 percent of workers in such major industrial categories as mining, manufacturing, and transportation have insurance (see Appendix Table A-4). Lower-than-average private coverage of workers is found in agriculture, forestry and fisheries, construction, retail trade, personal services, and entertainment.

Private insurance among the employed also varies significantly with income. Only 57 percent of the employed with incomes below $5,000 have private insurance, whereas 94 percent of the employed with incomes of $15,000 or more have private insurance. The increase in insurance with income is not affected by whether employment is full time or part time. The increase in private coverage as income increases also occurs within industry groups, although the relative levels of workers covered still vary among industries.

CHAPTER V. WHAT IS KNOWN ABOUT THE ADEQUACY OF COVERAGE?

Policymakers are not only concerned with the number of persons who lack health-care coverage but also with the number who lack adequate coverage. While all would agree that the health insurance held by people should meet certain standards, the standards themselves are the subject of debate. Most believe that insurance should at least protect against large absolute expenditures resulting from hospitalization and related services. Protection against out-of-pocket expenditures that are large relative to income is another measure of adequacy used by some. While the first form of protection is available to most of the insured, the second type is available to a more limited number. Persons whose insurance policies set a limit on out-of-pocket expenditures, those with multiple forms of coverage, and those who, by itemizing their income tax deductions, can deduct out-of-pocket health expenses in excess of 3 percent of income may be protected against income-related catastrophic expenses. 1/

A less traditional view of adequate insurance is that coverage should create incentives for the insured to utilize certain "desirable" medical services, such as family planning and preventive medicine, even though these services are not particularly expensive. According to this view, coverage that restricts reimbursement for these services or that requires the insured to pay some initial expenses directly (the deductible) is inadequate. Ironically, lowering deductibles or using other means to reduce a person's liability for noncatastrophic expenses may also inflate health-care costs.

Even if there were agreement on what constitutes adequate health coverage, information detailed enough to permit *a* calculation of the number of people with adequate coverage is unavailable. Many factors go into making such a judgment. This

1/ Catastrophic expenses are discussed in the Congressional Budget Office, Catastrophic Health Insurance, Budget Issue Paper (January 1977). Tax provisions related to health care are analyzed in a forthcoming CBO paper, "Tax Subsidies for Medical Care."

chapter explores these factors and summarizes what information is now available on them.

INFORMATION NEEDED TO ASSESS ADEQUACY

To evaluate the adequacy of coverage, one must assess the coverage available to each family on the basis of that family's particular situation. This assessment requires detailed information on the following four factors:

- Financial resources of the family, not just the individual;
- Health status of the family members and the likelihood of their incurring health-care expenditures of certain types;
- Family preferences concerning risk and the value placed by the family on health care as compared with other goods and services; and
- Each type of coverage available to the family, including information on the breadth and depth of benefits. (Breadth of coverage refers to the scope of services for which a person is insured. Depth of coverage refers to the out-of-pocket expenditures for which a person is liable under the terms of coverage.)

Financial Resources

When determining a family's ability to pay for its health care, one has to look beyond the family's earned income. Unearned income and assets such as savings accounts, investments, and property holdings should also be taken into account.

Health Status

All other considerations aside, lack of insurance coverage or of coverage for particular services is of greatest consequence to persons most likely to need those services. Thus, for example, coverage for costly long-term care is more important to the elderly than it is to younger persons; persons under 65 are far less likely to need nursing home care of any duration.

Preference

Most workers with health insurance provided by their employers have little choice about the breadth or depth of health insurance they receive. For those persons who do have a choice, the policies chosen reflect their attitudes toward insurance as well as their financial situation and health-care needs. Some view insurance as protection against the slight risk of an unforeseen large health expense. High-income people, or young people with normal health expectations, may deliberately choose a low-premium policy with large copayments and deductibles. This may be because it is to their advantage to divert their resources to other purposes and meet a large share of normal medical expenses with out-of-pocket expenditures. 2/ Other persons might prefer to pay a higher but known premium for insurance coverage of even low levels of expenditure, rather than budget for unforeseeable health expenses. In contrast, persons with low income are likely to buy limited coverage because they can afford neither the underlying medical care nor the premium cost associated with more comprehensive coverage.

Type of Coverage

Information on all sources of coverage is necessary. One form of coverage may complement another: for example, an individual private policy or medicaid may pay expenses not covered by medicare, or VA may cover long-term care costs not reimbursed by private insurance. Even within private health insurance, people may have multiple policies that overlap or complement each other. There are also substantial ranges of both the breadth and depth of private coverage.

2] "Normal" refers to the level of expenditure. It does not necessarily follow that all of the outlays are predictable. For example, a family may anticipate a certain number of doctor visits based on past experience. An event such as breaking an arm may not be foreseen but the expenses associated with treating it are not very large.

THE BREADTH AND DEPTH OF INSURANCE COVERAGE

No single existing data source provides all the information outlined above. The SIE provides information on family income and multiple sources of coverage; it contains no data on family assets, preferences, health status, or provisions of private insurance policies. Other sources are superior to the SIE in some respects, but deficient in others. The most recent detailed information on private group insurance is obtained from employer and union reports to the Department of Labor under the Welfare and Pension Plan Disclosure Act of 1959. The reports provide good information on plan characteristics, but they contain no information on the characteristics of the enrollees. Moreover, reporting institutions exclude government and not-for-profit firms, and single establishments with fewer than 25 employees unless they are part of a multi-establishment association with a health plan. 3/

The omission of small plans is unfortunate. It is known that small firms are less likely to provide employment benefits such as group health insurance. 4/ It is not known whether those small firms with health plans have benefits like those of the larger firms or whether they are below average. Nevertheless, the data do represent the type of coverage available to roughly three-fourths of wage and salary workers and is used for the following discussion.

3/ Unpublished report by Leon Fraser, "BLS Health Plan Computerized Data," U.S. Department of Labor (January 1978).

4/ The SIE does not have information on the size of the firm; however, in a 1972 survey of full-time workers in private industry and government, it was estimated that small establishments are less likely to provide such benefits as group health insurance. The survey showed that only half the workers in establishments with fewer than 25 employees were in group health plans, whereas 90 percent of those in businesses with 100 or more employees were in health plans. Walter W. Kolodrubetz, "Group Health Insurance Coverage of Full-Time Employees, 1972," Social Security Bulletin, April 1974, pp. 17-35.

Group Insurance

More than 80 percent of the people with private coverage are members of group health plans (see Table 11). The great majority of workers with group health plans are covered for hospital inpatient and outpatient care, surgery, X-ray, post-hospital home health care, medical equipment, prescription drugs, psychiatric care, and family planning. Far fewer have coverage for post-hospital skilled nursing care (SNF), children's dental care or eyeglasses, and preventive care. The list below ranks services covered:

Percent of Insured Workers, by Type of Health Benefit

Hospital inpatient, outpatient, and surgery	100 percent
Drugs and X-ray	99
Psychiatric inpatient	97
Durable equipment and post-hospital home health care	94
Family planning	91
Outpatient mental health services	88
Post-hospital skilled nursing care	37
Children's dental care	32
Children's eyeglasses	14
Preventive care	9

SOURCE: Bureau of Labor Statistics, Office of Wages and Industrial Relations, Health Plan Provisions Analysis (January 1976).

The pattern of benefits provided varies across industries. For example, only 6 percent of transportation workers with health plans are covered for preventive services, but 44 percent of

TABLE 11. PERCENT OF PERSONS WITH PRIVATE HEALTH INSURANCE BY TYPE OF COVERAGE ACCORDING TO AGE, INCOME, AND EMPLOYMENT STATUS, 1976

Age, Family Income, and Employment Status	Percent of Population with Some Private Insurance	Type of Coverage: Private Only: Group Plan Only	Private Only: Individual Plan Only	Private Only: Both Group and Individual Plan	Private and Public: Group and Public	Private and Public: Individual and Public	Other
Total with Private Health Insurance	77.0	65.6	9.8	5.8	9.0	6.7	3.0
Age							
Less than 19 years	75.6	76.7	9.6	5.1	4.7	1.4	2.5
19 to 24 years	71.0	72.6	13.9	5.8	3.3	0.9	3.5
25 to 44 years	82.3	71.5	8.3	6.7	9.6	1.7	2.2
45 to 64 years	83.5	61.5	13.3	7.8	10.5	3.8	3.1
65 years and over	61.3	1.4	0.9	0.2	28.3	62.1	7.0
Family Income (in Dollars)							
Less than 5,000	73.1	23.8	18.7	2.5	15.9	32.6	6.6
5,000 to 9,999	63.3	47.2	13.2	4.6	16.9	14.4	3.7
10,000 to 14,999	83.4	64.1	8.6	5.4	14.6	4.9	2.4
15,000 or more	90.8	77.0	8.2	6.8	3.5	1.9	2.6
Employment Status							
Full-time wage earner	90.4	72.2	5.5	7.7	11.5	1.3	1.9
Part-time wage earner	80.0	67.3	12.4	5.6	6.1	5.1	3.4
Self-employed	75.4	32.0	34.5	5.8	6.0	14.5	7.2
Unemployed	55.1	62.9	17.9	5.2	7.3	3.9	2.7
Retired	64.0	9.4	4.2	1.1	30.5	48.4	6.5
Other not in labor force	71.0	67.6	10.8	4.8	6.2	7.5	3.2

NOTE: Components may not add to 100 percent because of rounding.

SOURCE: SIE 1976, adjusted for underreporting of coverage by public programs.

workers in mining have this coverage. Forty-two percent of covered transportation workers, however, have coverage for children's eyeglasses and only 1 percent of miners do. (Appendix Tables A-5 and A-6 show more of such details.)

Of the services that are not extensively covered by group policies, only skilled nursing care could be expected to result in high expenses for a family. Because these benefits are more likely used by the elderly and are covered under medicare, it is not unreasonable to find them absent from many employment-related policies. Generally, group policies cover the services that make up the major portion of health expenditures and that could create financial hardship. How well they actually protect an enrollee from financial hardship is a function of other elements of insurance plans, such as major medical expense coverage, amount of deductible, limits on number of hospital days, and whether or not there is a cap on out-of-pocket expenditures (that is, depth of coverage).

Over the past several years, basic hospital and surgical coverage has been supplemented increasingly with "major medical" coverage. 5/ As a result, in 1976, 90 percent of the workers in plans reported to the Department of Labor had comprehensive or supplemental major medical benefits (see Table 12). Seventy-eight percent of workers in plans are covered for the full cost of hospital room and board. Another shift has been from scheduled cash benefits for surgery to payment of "reasonable and customary" charges. This system automatically reflects changes in charges and has become the payment method for almost 40 percent of all covered workers.

More workers' major medical policies have a variable coinsurance feature. This shift, from uniform to variable coinsurance, means that workers have coverage that puts a limit on their out-of-pocket expenditures. Instead of a fixed coinsurance liability of, for example, 20 percent, the worker's out-of-pocket liability may be reduced to zero after his health-care

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5/ Major medical insurance is characterized by large benefits ranging up to $250,000 or no limit. The insurance--above an initial deductible--reimburses, in addition to hospital charges, the major part of all charges for out-of-hospital treatment, drugs, and medicine. The insured person as coinsurer pays the remainder.

TABLE 12. PERCENT OF COVERED WORKERS AT SPECIFIC HEALTH PLAN BENEFIT LEVELS IN 1974 AND 1976

Type and Level of Benefit (in Dollars)	1974	1976
Hospital Benefits		
Daily room and board benefits		
Less than 40	10	3
40 to 59	9	9
60 or more	6	9
Full cost of semiprivate room	73	78
Other	2	2
Duration (in days)		
Less than 70	12	10
70	17	14
71-119	2	2
120	26	25
121-364	2	2
365	25	30
366-729	2	a/
730 and over	4	6
Determined by dollar amount	10	11
Other	a/	1
Surgical Benefits		
Maximum for most expensive procedure		
Less than 400	15	7
400 to 599	24	16
600 to 999	13	15
1,000 or more	12	19
Reasonable and customary charge	27	39
Service benefit/no maximum	6	3
Not determinable	3	0
Comprehensive Major Medical Benefits		
Maximum lifetime benefit b/		
1 to 30,000	24	4
30,001 to 50,000	10	11
50,001 to 100,000	20	18
100,001 and over	33	56
Unlimited	0	4

(continued)

TABLE 12. (Continued)

Type and Level of Benefit (in Dollars)	1974	1976
Coinsurance feature c/		
Uniform	61	52
Variable	39	47
Supplemental Major Medical Benefits		
Maximum lifetime benefit b/		
1 to 10,000	12	3
10,001 to 20,000	23	12
20,001 to 30,000	17	11
30,001 to 50,000	14	14
50,001 to 100,000	5	14
100,001 and over	3	24
Unlimited	6	9
Coinsurance feature *cj*		
Uniform	93	80
Variable	7	20
Amount of Deductible d/		
1 to 50	22	e/
51 to 100	47	e/
101 or more	6	e/
No major medical or unknown deductible	25	e/

SOURCES: Dorothy R. Kittner, "Changes in Health Plans Reflect Broader Benefit Coverage," Monthly Labor Review, September 1978; and Daniel Price, "Private Industry Health Insurance Plans: Type of Administration and Insurer in 1974," Social Security Bulletin. May 1977. Both articles based on reports to the U.S. Department of Labor required by the Welfare and Pension Plan Disclosure Act of 1959.

a/ Less than 1 percent.

b/ May not add to 100 percent because some major medical policies (not shown here) may have maximum benefits per benefit period or per disability instead of per lifetime.

c/ Coinsurance is a provision by which both the insured person and the insurer share in a specified ratio, commonly 20:80, of the cost of services covered under a policy.

d/ The deductible is the amount of covered expenses which must first be incurred by the insured after which the insurer begins to pay a share.

e/ 1976 figures not available.

expenditures have passed a certain dollar threshold. A cap on out-of-pocket expenditures is one type of protection against catastrophic expenses. 6/

Individual Insurance

Some persons do not belong to groups that offer insurance plans. To compensate, some of these people purchase individual insurance policies (provided they are not prohibited by health or age restrictions set by insurance companies). Twenty-two percent of all persons with private insurance have individual policies; 10 percent have only individual insurance (see Table 11). A higher proportion of persons with incomes below $10,000 have individual insurance as their only source of health coverage. As might be expected, more of the self-employed have individual coverage than have group coverage and one-third of them have only individual coverage.

Individual policies tend to be more expensive than group insurance. This is because of their higher selling costs (they are sold to individuals and families rather than companies and unions) and because of the adverse selection of enrollees. Persons with poor health are more likely to buy health insurance than persons with average or good health if insurance is not provided by their employer. Therefore, the expected higher use of health services by these people is reflected in higher premiums. Because of the high costs of premiums associated with individual coverage, some people without group policies forego health insurance altogether; or, if they purchase it, probably obtain an individual policy with less comprehensive coverage or higher cost-sharing to lower their premiums. The latter point is necessarily conjecture, however, because there has been no systematic evaluation of the provisions of individual insurance policies.

6/ The Health Insurance Institute estimates that 88 percent of all insured under age 65 have catastrophic protection defined as benefit levels of $10,000 or more, Source Book of Health Insurance Data, 1977-1978.

SUMMARY

In summary, while most persons with private insurance appear to be protected against high absolute medical expenditures, at least 15 percent do not have this sort of catastrophic protection through private insurance. It is not known, however, how many of these persons with shallow private insurance are covered simultaneously by public programs such as VA that would protect them from financial loss in case of a major illness.

It is equally difficult to measure the number of insured persons with insufficient protection against out-of-pocket health expenditures that are high relative to income. An estimated 9 percent of all families had out-of-pocket expenses for medical care in 1978 that exceeded 15 percent of their gross income. 7/ This figure is not an accurate estimate of the number who may be inadequately insured against income-related catastrophic expenses because it includes families without any insurance and it excludes all persons whose expenditures were not large in 1978 but who had open-ended payment liabilities under the terms of their insurance contracts.

Families incurring high out-of-pocket health expenditures do have some limited recourse through the tax code provision that permits unreimbursed medical expenses in excess of 3 percent of income to be deducted from income before calculating taxes. This form of relief," however, is available only to those who itemize their tax deductions. Furthermore, this provision affords substantial relief only to those families or individuals whose incomes--and marginal tax rates--are fairly high.

7/ Congressional Budget Office, Catastrophic Health Insurance, Budget Issue Paper (January 1977).

CHAPTER VI. CONCLUSIONS

Several findings in this paper have implications for the design of any program that would extend health-care protection to persons now without it, or that would set minimum national standards for services covered but privately financed.

The uncovered are a varied group. Because of this diversity, using any single factor--such as unemployment--to define a population toward which to target assistance would help only some of the uncovered. Moreover, it would assist many persons who already have coverage. The result of such duplication would raise the net budget cost of national health insurance.

Because only 30 percent of the uncovered are actually employed by others, any plan that relied exclusively on employers to provide coverage could not encompass the entire uncovered population. Nevertheless, certain alterations in employer-provided policies could significantly improve the extent of coverage. One such change could be to make the coverage of any family head extend automatically to his or her dependents, regardless of their ages. This change alone would lower the number of uncovered by 20 percent. Standardized layoff protection and shortened waiting times for job-related health insurance are other possible changes. For people with job-related insurance, either of these approaches would lessen their vulnerability to the fluctuations of the economy.

If the self-employed were all covered, and if employer-provided coverage was extended to currently uncovered workers and their dependents, the number of persons now uncovered would be cut in half. These steps together with automatic dependent coverage would reduce the uncovered by 65 percent. While less than one-fourth of the employed population would be affected, the financial impact on certain industries could be large. Retail trade, construction, agriculture, and services would experience the greatest impact, because they currently have the lowest rates of group health coverage.

Establishing minimum benefit packages that set deductibles and coinsurance levels as well as covered services would have a more widespread impact on employers than simply requiring insurance. Despite the fact that most workers have group health insurance that covers a broad range of services, the depth of the coverage or dollar liability of the insured varies considerably and in many cases could be judged inadequate. How great the impact would be would of course depend on what was defined as the minimum acceptable benefit and cost-sharing package.

Finally, despite the existence of public programs--medicaid in particular--that should provide coverage to people who cannot afford private insurance or are ineligible for VA, medicare, or CHAMPUS, over 20 percent of the population without coverage have incomes lower than $5,000. Fifty-five percent have incomes below $10,000. Changes in medicaid could substantially reduce this uncovered population. For example, medicaid coverage could be extended to unemployed fathers in those 24 states that do not at present cover them. Medicaid could also be extended to low-income individuals who are not members of families with dependent children. Alternatively, the categorical requirements could be eliminated entirely and eligibility could be based only on financial criteria. These changes would decrease the number of uncovered persons by perhaps as much as one-fourth. The medicaid spend-down program might also be extended to every state, and eligibility requirements might be standardized to eliminate existing uncertainties about program requirements.

APPENDIX TABLES

TABLE A-1. ESTIMATED OVERLAP OF PUBLIC AND PRIVATE PROGRAMS, AND DISTRIBUTION BY AGE AND BY INCOME, 1976

Age and Income	Medicare			Medicaid		
	Medicare Only	Medicare and Other Public	Medicare and Private	Medicaid Only	Medicaid and Other Public	Medicaid and Private
Percent of Program Eligibles with: a/	20.4	38.2	59.3	46.7	35.2	32.1
Age						
Less than 6 years	32.2	60.3	14.1	74.3	5.1	21.1
6 to 18 years	33.1	54.6	17.2	65.3	5.6	29.7
19 to 24 years	49.2	34.8	21.8	80.2	6.1	14.8
25 to 44 years	28.4	48.6	34.2	60.4	12.4	30.0
45 to 64 years	21.9	46.8	46.8	47.2	32.0	30.1
65 years and over	19.7	37.0	61.9	3.9	95.1	43.7
Income (in Dollars)						
Less than 5,000	16.4	65.5	43.9	46.4	41.6	27.8
5,000 to 9,999	21.0	30.9	64.4	47.6	27.4	37.3
10,000 to 14,999	22.9	17.0	70.9	43.8	16.0	46.6
15,000 or more	24.8	14.7	71.4	51.5	9.0	42.2

(continued)

TABLE A-1. (Continued)

Age and Income	Veterans Administration			CHAMPUS		
	VA Only	VA and Other Public	VA and Private	CHAMPUS Only	CHAMPUS and Other Public	CHAMPUS and Private
Percent of Program Eligibles with: a/	16.1	25.4	72.1	51.0	16.3	39.6
Age						
Less than 6 years				68.9	7.5	24.7
6 to 19 years	43.5	35.9	29.4	55.2	9.3	37.3
19 to 24 years	39.0	12.1	54.3	68.5	7.9	27.5
25 to 44 years	19.0	6.9	76.9	56.0	12.5	37.3
45 to 64 years	16.0	17.0	74.1	32.0	20.1	56.3
65 years and over	1.5	94.8	62.4	0.8	98.9	55.1
Income						
Less than 5,000	30.2	45.2	37.9	34.5	55.7	22.9
5,000 to 9,999	20.1	28.5	66.2	63.6	20.6	23.2
10,000 to 14,999	10.1	11.0	85.9	57.9	18.1	33.8
15,000 or more	6.3	56.9	77.8	44.1	7.4	53.0

SOURCE: SIE 1976, adjusted for underreporting of coverage by public programs.

a/ Percents total to more than 100 percent of program eligibles because some persons have combinations of three types of coverage--the program plus other public plus private--and these have not been separately tabulated here.

TABLE A-2. EFFECT OF ADJUSTING SIE FOR UNDERREPORTING OF PUBLIC HEALTH-CARE COVERAGE ON THE PERCENT DISTRIBUTION OF THE UNCOVERED, BY INCOME AND EMPLOYMENT STATUS

Income and Employment Status	Percent Distribution of the Uncovered		
	Unadjusted SIE	Adjustments for Underreporting of: Medicaid	Adjustments for Underreporting of: Other Public Programs
Income (in Dollars)			
Less than 5,000	30.1	23.7	22.6
5,000 to 9,999	33.4	33.7	32.6
10,000 to 14,999	17.5	19.8	19.1
15,000 or more	19.6	23.3	25.7
Employment Status			
Employed	33.9	36.8	34.7
For wages	27.9	30.2	28.9
Self-employed	6.0	6.6	5.7
Unemployed	10.3	10.5	10.1
Not in labor force			
Retired	6.0	5.9	1.0
Other a/	49.7	46.8	54.3

NOTE: Components may not add to 100 percent because of rounding.

a/ Includes housekeepers, pre-school or in-school children, and other persons unable to work.

TABLE A-3. PERCENT OF THE POPULATION WITH HEALTH-CARE COVERAGE BY TYPE OF COVERAGE AND BY AGE AND FAMILY INCOME, 1976

Family Income and Age	Percent of Population Group Covered	Type of Coverage			
		Total Covered a/	Private Only	Public Only	Private and Public
Total Population	89.8	100.0	70.6	14.2	15.1
Less than $5,000					
All ages	82.6	100.0	22.9	51.8	25.2
Less than 6 years	79.0	100.0	16.8	68.0	14.8
6 to 18 years	78.2	100.0	24.2	60.0	15.4
19 to 24 years	68.0	100.0	60.0	32.7	6.6
25 to 44 years	74.4	100.0	32.8	49.6	17.5
45 to 64 years	80.0	100.0	38.7	42.4	18.7
65 years and over	99.6	100.0	0.1	54.3	45.6
$5,000 to $9,999					
All ages	83.5	100.0	49.8	24.0	26.1
Less than 6 years	76.1	100.0	64.8	27.0	8.1
6 to 18 years	77.9	100.0	56.5	29.1	14.2
19 to 24 years	74.4	100.0	74.5	18.4	7.1
25 to 44 years	82.0	100.0	59.3	20.2	20.3
45 to 64 years	87.8	100.0	60.9	15.8	23.1
65 years and over	99.2	100.0	1.0	32.4	66.6
$10,000 to $14,999					
All ages	90.8	100.0	71.8	8.1	20.1
Less than 6 years	88.0	100.0	91.2	5.8	2.3
6 to 18 years	89.0	100.0	87.6	7.3	5.0
19 to 24 years	82.8	100.0	87.4	6.4	5.9
25 to 44 years	92.5	100.0	69.4	7.0	23.5
45 to 64 years	93.7	100.0	64.3	6.0	29.6
65 years and over	98.8	100.0	2.7	26.2	71.0

(continued)

TABLE A-3. (Continued)

Family Income and Age	Percent of Population Group Covered	Type of Coverage: Total Covered	Private Only	Public Only	Private and Public
$15,000 or more					
All ages	94.3	100.0	90.2	3.7	6.1
Less than 6 years	93.6	100.0	95.9	2.5	1.6
6 to 18 years	94.8	100.0	94.4	2.8	2.6
19 to 24 years	84.8	100.0	96.3	1.7	1.5
25 to 44 years	95.2	100.0	95.0	2.3	2.6
45 to 64 years	96.2	100.0	91.4	2.8	5.7
65 years and over	97.8	100.0	4.3	26.2	69.5
All Incomes					
All ages	89.8	100.0	70.6	14.2	15.1
Less than 6 years	86.2	100.0	78.4	16.7	4.7
6 to 18 years	88.8	100.0	80.6	13.1	6.1
19 to 24 years	79.5	100.0	85.0	10.3	4.3
25 to 44 years	90.7	100.0	79.4	9.2	11.4
45 to 64 years	92.4	100.0	75.7	9.5	14.6
65 years and over	99.0	100.0	1.5	38.1	60.4

NOTE: Components may not add to 100 percent because of rounding.

SOURCE: SIE 1976, adjusted for underreporting of coverage by public programs.

a/ Includes a small number of persons with unknown type of coverage.

TABLE A-4. PERCENT OF EMPLOYED PERSONS WITH PRIVATE INSURANCE BY INDUSTRY AND INCOME, 1976

Industry	All Incomes	Less than $3,000	$3,000-$4,999	$5,000-$6,999	$7,000-$9,999	$10,000-$14,999	$15,000 or more
Total Employed	87	53	60	68	80	89	94
Agriculture, Forestry, Fisheries	72	52	56	58	69	77	86
Mining	93	63	68	71	92	93	96
Construction	80	46	48	55	69	83	89
Durable Manufacturing	94	56	69	80	88	95	97
Nondurable Manufacturing	93	67	68	81	89	94	97
Transportation, Communications, Public Utility	92	50	57	72	83	92	96
Wholesale Trade	92	62	74	74	81	92	96
Retail Trade	83	53	60	67	75	85	91
Finance, Insurance, Real Estate, Business, Repair	87	53	59	71	78	88	93
Personal Services	74	46	52	55	70	83	88
Entertainment	81	55	52	65	77	85	88
Professional Services	92	68	74	76	87	93	95
Public Administration	93	62	58	66	89	93	96

SOURCE: SIE 1976, adjusted for underreporting of coverage by public programs.

TABLE A-5. PERCENT OF INSURED WORKERS WITH TYPE OF HEALTH BENEFIT BY INDUSTRY, 1976 a/

Industry	Minimum Package b/	Prescription Drugs	X-ray	Psychiatric Inpatient	Durable Equipment
Total	100	99	99	97	94
Manufacturing	100	99	99	98	92
Mining	100	100	100	100	100
Construction	100	100	100	94	92
Transportation	100	99	99	97	99
Communications	100	100	100	99	99
Trade	100	100	98	98	94
Financial	100	100	100	100	100
Services	100	98	99	91	96
Other	100	100	88	100	89

(continued)

SOURCE: Bureau of Labor Statistics, Office of Wages and Industrial Relations, Health Plan Provisions Analysis, January 1976.

TABLE A-5. (Continued)

Post-Hospital Home Health	Family Planning	Outpatient Mental	Post-Hospital Skilled Nursing Facility	Dental for Children	Eyeglasses for Children	Preventive Care
94	91	88	37	32	14	9
92	94	90	44	27	9	6
100	100	100	60	31	1	44
94	93	74	22	61	54	18
96	97	87	14	78	42	6
100	91	92	21	54	2	5
96	89	86	47	27	18	15
99	84	93	39	27	4	4
92	88	88	24	14	11	19
99	57	81	8	1	—	--

a/ Excludes government, agriculture, self-employed, not-for-profit firms, and firms with fewer than 25 employees unless part of a multi-establishment association that has a health plan.

b/ Inpatient, outpatient, and surgery.

TABLE A-6. PERCENT DISTRIBUTION OF BENEFICIARIES OF EMPLOYER-PROVIDED GROUP COVERAGE WITH A NUMBER OF BENEFITS BY TYPE OF BENEFIT, 1976 a/

Number of Benefits	Percent of Workers with Number of Benefits	Minimum Package b/	Pre-scription Drugs	X-ray	Psychiatric Inpatient	Durable Equipment	Post-Hospital Home Health
Fewer than 6	0	100	0	0	0	0	0
6	c/	100	100	10	20	0	27
7	c/	100	70	26	44	50	37
8	2	100	87	65	71	21	48
9	2	100	100	94	79	65	61
10	8	100	100	100	96	89	92
11	39	100	100	100	98	94	92
12	31	100	100	100	99	99	99
13	14	100	98	100	99	100	99
14	4	100	100	100	99	100	100
15	c/	100	100	100	100	100	100
Percent of Workers with a Particular Benefit		100	99	99	97	94	94

(continued)

TABLE A-6. (Continued)

Number of Benefits	Percent of Workers with Number of Benefits	Family Planning	Out-patient Mental	Post-Hospital Skilled Nursing Facility	Dental for Children	Eyeglasses for Children	Pre-ventive Care
Fewer than 6	0	0	0	0	0	0	0
6	c/	44	0	0	0	0	0
7	c/	72	0	0	0	0	0
8	2	99	0	0	6	3	0
9	2	68	5	0	1	16	12
10	8	40	59	12	8	2	2
11	39	93	95	12	7	4	4
12	31	97	95	56	41	10	4
13	14	100	94	75	79	34	22
14	4	100	99	69	97	81	55
15	c/	100	100	100	100	100	100
Percent of Workers with a Particular Benefit		91	88	37	32	14	9

SOURCE: Bureau of Labor Statistics, Office of Wages and Industrial Relations, Health Plan Provisions Analysis, January 1976.

a/ Excludes government, agriculture, self-employed, not-for-profit firms, and firms with fewer than 25 employees unless part of a multi-establishment association that has a health plan.

b/ Inpatient, outpatient, and surgery.

c/ Less than 1 percent.

O