

## Who are the uninsured, and why are they uninsured?

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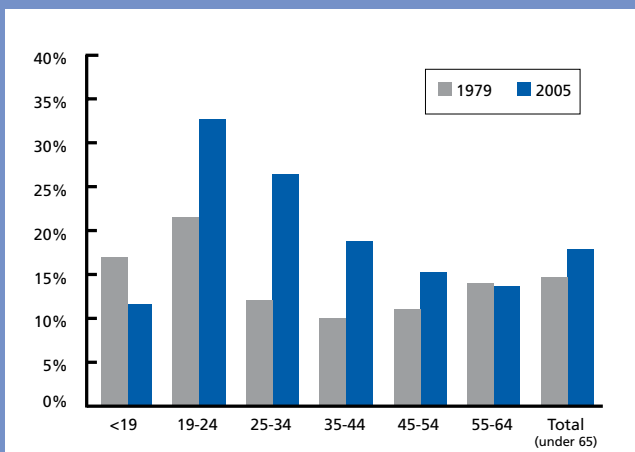


Since 2000, the number of uninsured Americans, both nationally and in New England, has risen by nearly 20 percent. In 2005, 46.6 million Americans and 1.5 million New Englanders lacked health insurance. For millions more Americans, the prospect of losing coverage is a tangible and real concern. In her recent book, *Reinsuring Health: Why More Middle-Class People Are Uninsured and What Government Can Do*, Katherine Swartz, Professor of Health Economics and Policy at the Harvard School of Public Health, finds that the lack of health insurance is a growing problem for young adults, moderate income households, and skilled workers.<sup>1</sup> This brief draws on her research to provide an overview of the characteristics of the uninsured population and how they have changed over time.

than doubled for 25- to 44-year-olds (see chart below). In contrast, 95 percent of the elderly population (65 years and older) have health insurance coverage through Medicare, and this share that has remained steady over the past two decades. Children also receive extensive public coverage through Medicaid and the State Children's Health Insurance Programs; in fact, over the past

### Individuals between 19 and 44 years old were twice as likely to be uninsured in 2005 than 25 years ago.

Likelihood of being uninsured by age



Source: Current Population Survey, 1980 and 2006

### Who are the uninsured?

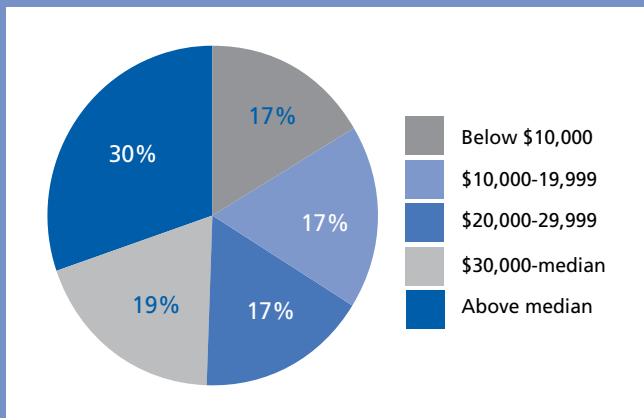
**Age.** The lack of health insurance has become especially acute for young adults. In 2005, more than half of the uninsured—58 percent—were between the ages of 19 and 44 years. A quarter of people between 25 and 34 years old and a fifth of 35- to 44-year-olds lacked health insurance. Moreover, over the past 25 years, the likelihood of being uninsured has more

quarter century, the share of the uninsured who are children has dropped from 40 percent to 20 percent (see sidebar).

**Income.** Although a large majority of the uninsured still live in low-income households, the lack of health insurance is increasingly affecting the middle class as well. In 2005, a third of the uninsured earned a household

## Lack of health insurance is a problem for both low- and moderate-income households

Distribution of the uninsured by household income. Median household income for 2005 was \$46,326.



Note: Limited to individuals under the age of 65.  
Source: Current Population Survey, 2006

income above the median household income (see chart above).

More than one in ten middle-class working-age adults and one in three lower-income adults lacked health insurance. Over the past 25 years, the likelihood of being uninsured has increased significantly for the working-age population in both income groups. For middle-class adults, this increase was especially pronounced; the likelihood of their being uninsured rose from 6.0 percent in 1979 to 10.6 percent in 2005.

### Why are more people uninsured?

**Decline in employment-based health insurance.** A major factor in the rising number of uninsured is that many of them have either lost or never had access to employer-based health insurance. Between 2000 and 2005, the share of Americans covered by employer-sponsored health insurance fell from 64 percent to 60 percent, representing a drop of 3 million people. Over the same period, the share of establishments, both public and private, offering coverage declined from 69 percent to 60 percent.

These trends reflect major changes in the economy and in employer-employee relationships over the past two decades. This period has seen a shift in employment from manufacturing—which had set the standard for generous health benefits and job longevity and security—to the service sector, where firms are

more likely to be small. The fraction of the private, non-government sector workforce employed in small establishments (fewer than 50 employees) increased from 37 percent in 1979 to 44 percent in 2005. Small firms are much less likely than large companies to offer health benefits. In 2003, only 36 percent of firms with fewer than 10 workers offered health insurance coverage, compared to almost all firms with 200 or more employees. In short, fewer people receive health insurance through their employer today largely because more employers simply do not offer it.

Additionally, many people who work for firms that do offer health coverage are not eligible for the benefit. The rapid increase in per capita health care expenditures over the past 25 years has led many firms to hire contractual, temporary, or other kinds of non-permanent workers who are often ineligible for fringe benefits. More workers, especially those younger than 40, are finding themselves in occupations where they are self-employed or work on a contract basis. At least 20 million workers—ranging from low-skill temp workers to highly-skilled professionals such as software engineers, accountants, writers, and consultants—are either self-employed or non-permanent employees. Their ineligibility for health benefits has transformed the lack of health insurance from a problem of the poor to one that increasingly affects middle-class workers as well as highly skilled professionals.

**Other barriers to coverage.** Individuals who do not get health insurance through their employer generally have to purchase it on their own. There are many challenges in extending coverage to individuals and small groups. In addition to having to pay more for non-group insurance, high-risk applicants, such as those with pre-existing conditions, are sometimes offered limited policies or simply denied coverage. Others find the application and enrollment procedures too confusing or cumbersome. Many lower-income people who

**It is much riskier—and therefore more costly—to insure individuals and small groups than large groups.**

are eligible for Medicaid or health insurance subsidies fail to insure themselves, deterred by factors such as lack of knowledge of their eligibility, transportation costs, and language or cultural barriers.

By far the biggest barrier to buying private health insurance, however, is that insurers in the individual and small-group markets charge higher premiums than those in the large-group markets (such as large companies and unions). Part of the higher premiums reflects higher administrative and marketing costs associated with selling coverage to individuals and small firms. But the factor that most contributes to higher premiums is that it is much riskier to sell insurance to individuals and small groups than to large groups. Because health insurance coverage in the United States is voluntary, insurers suspect that a disproportionate number of those who apply for coverage in the individual or small-group markets do so because they expect to incur very high medical expenses. In an effort to minimize the risk of this costly occurrence—known as “adverse selection”—insurers use a variety of mechanisms, such as refusing to issue a policy, excluding coverage for pre-existing conditions, and of course, charging higher premiums. These premiums, often as high as \$6,000 a year for individuals and \$14,000 for families, are out of reach for many young adults as well as lower-income, and often middle-class, families. High premiums discourage people who are young and healthy from buying insurance. This makes it difficult for private insurers to enroll enough people of varying ages, health statuses, and risk levels to create the large and stable risk pools that are the staple of a successfully functioning private insurance market.

## Insuring children

A modest success story in extending health coverage is the recent decline in the number of uninsured children with the introduction of the State Children’s Health Insurance Programs (SCHIP) in 1998. Between 1998 and 2004, the number of uninsured children fell by 27 percent, or nearly 3 million. In the same period, the share of children who were uninsured declined steadily from 15.6 to 11.2 percent. New England has fared even better: Since the mid-1990s, the number of uninsured children has declined by nearly 40 percent.

These downward trends are largely due to the expanded role of public health insurance programs. Income eligibility criteria for Medicaid have been increased to cover all children under 19 years in families earning less than the federal poverty level. Many states have set their Medicaid program eligibility ceilings at up to 200 percent of the poverty level and their SCHIP eligibility ceilings at up to 300 percent of the poverty level. Through these expansions, over 40 percent of all children are now covered by public health insurance.

Demographic factors have also contributed to the decline in uninsured children. Between 1980 and 2005, the birth rate fell from 15.9 to 14 live births per thousand people, causing the number of children per adult to decline. Also over the last two decades, the labor force participation rate has increased, particularly for married women and women with young children. For many families with children, higher participation rates have meant higher incomes, greater access to employer-sponsored family coverage, and wider choice among health insurance options.

The success in insuring children is not unqualified, however. In 2005, 217,000 children dropped out of public insurance programs, perhaps due to the introduction of new or increased premiums and other forms of cost sharing. The total number of uninsured children increased by 323,000—up for the first time in eight years.

### Policy implications

The lack of health insurance continues to affect poor and near-poor people disproportionately. Seventy percent of the uninsured have household incomes below the median. But contrary to popular perception, many of these low-income individuals are not covered by Medicaid. Some are ineligible for publicly supported health insurance because they do not have children. Others earn more than the eligible income threshold, but not enough to afford private insurance.

The lack of affordable health insurance is also a growing concern for the middle class. Because an increasing number of self-employed and contractual workers lack a viable source for health insurance, the need for individual and small-group insurance markets will

continue to grow. Dr. Swartz has suggested that government-sponsored reinsurance could allay insurers' concerns about adverse selection. Under a reinsurance plan, the government would assume most of the costs of the patients with the highest medical expenses in the small-group and individual markets—above \$50,000 a year, for example. Because insurers would no longer bear the entire risk and financial burden of enrolling customers with very costly medical needs, they could charge lower insurance premiums across the

board. Lower premiums would help stabilize the market and bring in more young and uninsured individuals, thereby reducing the risk level of the entire pool and ultimately salvaging private insurance as the backbone of our health insurance system.

#### Endnotes

<sup>1</sup> Katherine Swartz, *Reinsuring Health: Why More Middle-Class People Are Uninsured and What Government Can Do*. New York: Russell Sage Foundation, 2006.

This brief is the first in a series of New England Public Policy Center policy briefs stemming from a December 5, 2006 conference, "Covering the Uninsured: Costs, Benefits, and Policy Alternatives for New England." For additional publications on this topic, see <http://www.bos.frb.org/economic/neppc/conferences/2006/uninsured/>. To receive future policy briefs, please contact us at [neppc@bos.frb.org](mailto:neppc@bos.frb.org) or 617.973.4257.

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