REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (A-99)
Status Report on Increasing Access for the Uninsured
(Reference Committee A)

EXECUTIVE SUMMARY

Council on Medical Service Report 2 provides an update to Council Report 7 (A-97), which provided detailed information on the characteristics of the uninsured and identified relevant federal and state legislative reforms. This report includes a discussion of the following:

- Ongoing legislative and Administrative initiatives that have the potential to impact the number of uninsured, including a brief discussion of the 1998 tobacco settlements that may increase financing for increased access to coverage.

- AMA policy related to universal coverage and access in a pluralistic market; priority access for children and pregnant women; individually owned insurance; and public programs for the poor.

- Information on the characteristics of the non-elderly uninsured in 1997, as reported by the Employee Benefits Research Institute (EBRI). This report compares findings from the Council's previous report, which summarized 1995 data as reported by EBRI.

- Suggested coverage priorities for each reported characteristic of the uninsured, which reflect a combination of public and private sector activities.

Based on this information, the Council concludes that AMA policy is well-positioned to foster successful efforts to increase access. Despite reporting an increase in the number of uninsured individuals, the report expresses optimism regarding ongoing federal and state initiatives. There is a finding, nevertheless, that individual insurance market reforms must be allowed to take place without additional benefit mandates that do little to assure patient protections. The Council makes four recommendations to eliminate what it has identified as barriers to access and to encourage effective outreach activities.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2 - A-99

Subject: Status Report on Increasing Access for the Uninsured

Presented by: Kay K. Hanley, MD, Chair

Referred to: Reference Committee A
(Marilyn K. Laughead, MD, Chair)

At the 1997 Annual Meeting, the House of Delegates adopted the recommendations contained in Council on Medical Service Report 7, which detailed characteristics of the uninsured; extensively reviewed AMA policy; discussed state activities to increase health care access; reviewed the anticipated impact of federal legislation that had recently been enacted, and presented 18 policy recommendations for increasing access for the uninsured. Using 1995 data from the Employee Benefits Research Institute (EBRI), the report discussed the number of uninsured according to employment status, age, income, education, race and citizenship.

In September 1998, the Census Bureau reported that 43.4 million people in the United States (16% of the population) were uninsured during the 1997 calendar year, representing an increase of 1.7 million people from 1996. There also is evidence that the number of people who lack coverage for at least part of the year is larger than that reported by the Census Bureau. While published estimates of the number of uninsured may differ depending on the design of the particular survey used to collect the data, or how the uninsured are defined and measured, most researchers agree that the number of uninsured has increased in recent years. These increases are puzzling, given the U.S. economy is experiencing one of the longest expansions in history. For example, in January 1999, the Labor Department reported that the nation's unemployment rate was at a 28-year low of 4.3%.

The following report provides an update to information contained in Council Report 7 (A-97). Included is a discussion of ongoing federal and state initiatives and recent Administration proposals that have the potential to impact the number of uninsured; AMA policy related to increasing coverage and access; and information on the characteristics of the non-elderly uninsured in 1997 by employment status, industry and firm size, income, education, age, and race and citizenship. Recommendations for increasing health insurance access based on identified coverage priorities are presented.

ONGOING INITIATIVES TO INCREASE ACCESS

Federal legislation highlighted in Council Report 7 (A-97) included the Health Insurance Portability and Accountability Act of 1996 (PL 104-191, “HIPAA”) and the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PL 104-193, the “Welfare Reform Act”). The Balanced Budget Act of 1997 (PL 105-33, “BBA”) was passed shortly after the adoption of the recommendations in Council Report 7 (A-97). Among the many health care related provisions of the BBA was the establishment of a sweeping new federal/state matching program to establish the State Children’s Health Insurance Program.

As the Council discussed in its Report 7 (A-97), and as numerous policy analysts have since noted, the impact of HIPAA and the Welfare Reform Act were limited in their ability to decrease the number of uninsured individuals. Specifically, the Council cited the lack of premium pricing controls as limiting the ability of HIPAA to ensure the availability of affordable individual insurance. Regarding the Welfare Reform Act, the Council noted in its report that, by eliminating the automatic qualifying link between Aid to Families with Dependent Children and Medicaid benefits, a separate application would be required for Medicaid coverage, thus adding an additional hurdle to enrollment.

Health Insurance Portability and Accountability Act of 1996

HIPAA was hailed as a way to ensure insurance portability and the exclusion of pre-existing condition limitations on coverage. However, the legislation has not closed the wide gaps in access to health insurance. HIPAA prohibited pre-existing and portability restrictions associated with individual insurance, but it did not prohibit insurers from charging prohibitive premiums, thereby making individual insurance inaccessible to those with limited incomes. The eligibility criteria to be protected under HIPAA limit the scope of the law's applicability. The HIPAA criteria include: (1) having 18 months prior coverage without a break in coverage of more than 63 days and the latest episode of coverage being under a group health plan; (2) exhaustion of COBRA coverage; (3) ineligibility for any other private or public coverage; and (4) previous coverage having ended no longer than 63 days prior. Therefore, its protections do not apply to the self-employed or those who have only worked in firms that do not offer employer-based coverage.

Policy resulting from Council Report 9 (A-98) requires insurance market revisions that allow individually purchased insurance to be viable. The strategy outlined in that report advocates increasing access to coverage by making individually owned insurance affordable for all income levels, but particularly for low-income wage earners who do not receive coverage through their work. Under the current tax system, which favors employer-based insurance, the need for individually owned insurance is limited to an identifiable set of individuals and their dependents: the self-employed, those in jobs that do not offer insurance, the unemployed, and early retirees. In 1997, 15.8 million individuals had private insurance not provided through employment. Necessary insurance market reforms include the use of insurance product pricing strategies calculated on community, rather than individual factors, and the development of alternative purchasing pools to the employer model.

Premium Price Restrictions. A critical requirement in making individually owned insurance viable is for insurance premiums to be calculated using factors other than those linked to an individual's health, such as age, and gender. The use of community rating or rating bands to calculate the price of individual insurance is one way to achieve affordability. About half of the states have implemented restrictions on the price insurance companies charge for individual insurance. On the other hand, as of January 1998, 22 states and the District of Columbia chose mechanisms using a high-risk insurance pool to comply with HIPAA guaranteed access requirements.

Purchasing Cooperatives. Another critical component in making individually owned insurance viable is to provide reasonable alternatives to employer-based insurance. One way of achieving this is to foster alternative methods of pooling risk. Such alternatives are variously termed purchasing cooperatives, choice cooperatives, voluntary choice cooperatives, health marts, and so forth. Data on the number of purchasing cooperatives in operation is unavailable, but it is known

that some 20 states have adopted legislation to encourage alternative health care purchasing models. Council on Medical Service Report 5 (A-99) details the experiences of institutions that embody the concepts envisioned for such alternatives to the employer-based model.

Impact of Individual Market Reforms. At least three separate analyses published in the past year – by the Urban Institute, the Galen Institute, and the Health Insurance Association of America – suggest that the impact of individual insurance market reforms to date have had the effect of increasing the number of uninsured. The individual market reforms analyzed by these organizations included premium restrictions, as well as limits on pre-existing conditions and guaranteed renewal.

Although there appears to be some evidence that the short-term effect of individual market reforms may have increased the overall number of individuals without coverage, the Council notes that the current regulatory and tax environment favors the employer rather than individual model for insurance coverage. Furthermore, the Council notes that there is some evidence that affordable coverage for individuals with greater health needs has become more accessible, whereas declines in coverage have occurred among younger, healthier individuals, who may have other reasons for declining coverage.

Individual insurance market reforms, such as premium price limitations, probably provide coverage to many people who would otherwise not have access to insurance. Nevertheless, the Council is concerned that pressures on insurers to provide more coverage for less will adversely impact efforts to increase access to health insurance coverage. The Council believes that the continued development of mandated benefits will inevitably increase the cost of insurance to a level that makes it unaffordable for many individuals and small employers. Although the degree of the impact of benefit mandates on access may not be well documented, third-party payors are likely to continue to use mandates as a rationale for increasing premiums. For these reasons, the Council believes that advocating for additional benefit mandates only serves to exacerbate the development of affordable, and therefore accessible, individual insurance products. The Council, therefore, opposes further development of AMA policy in support of new health benefit mandates unrelated to patient protection.

Children's Health Insurance Program (CHIP)

AMA policy developed by the Council recommends different levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access, and places particular emphasis on providing access to uninsured children (Policy H-165.882 [1] AMA Policy Compendium). The State Children's Health Insurance Program (variously known as CHIP and SCHIP), which was established by the Balanced Budget Act of 1997 (BBA), promises to be the most fundamental change in the Medicaid program since its inception. The BBA authorizes $24 billion in federal matching funds over five years (starting in 1998) to help states expand coverage to uninsured children. Although data are not yet available on the success of the CHIP programs, the Congressional Budget Office has estimated that CHIP will provide coverage to 2.3 million children a year after 1999, including children newly covered under the program and some near-poor children who would otherwise have other insurance at least some of the time. States are given a great deal of flexibility in designing their programs. They may develop new or expand existing insurance programs for children by either modifying the state's Medicaid program, creating a new separate program altogether, or a combination of approaches.

At the time this report was written, only two states—Washington and Wyoming—had not applied for CHIP funds. States are given substantial discretion in how they implement CHIP and their programs contain varying eligibility criteria and income caps. Whereas Medicaid typically covers children in families at or below 133% of the federal poverty level, CHIP typically provides coverage for children in families at or below 200% of poverty. The Medicaid program in Washington state already covers children up to 200% of poverty. Connecticut, Missouri, New Hampshire, Rhode Island and Vermont provide coverage up to 300% of poverty. Tennessee covers children up to 400% of poverty if they lack access to employer coverage. New Jersey's governor pledged in January 1999, to expand the state's CHIP program to cover children in families earning up to 350% of the federal poverty level.

Medicaid Eligibility. Children eligible for Medicaid are not eligible for CHIP. Accordingly, families of Medicaid-eligible children would not be eligible for CHIP programs that expand coverage to the families of CHIP-eligible children. Although states are given wide authority to establish their own programs, there are individuals whose coverage is mandatory under Medicaid. These include recipients of Supplemental Security Income, pregnant women, and children under six whose family income is at or below 133% of poverty. In addition, a phased-in provision will cover all children under the age of 19 in families at or below the federal poverty level and who were born after September 30, 1983. Under this provision, all children at or below 100% of poverty will be covered by Medicaid by 2002.

Family Coverage. CHIP authorizes states to provide coverage not only for children, but also for families. However, states seeking to establish family coverage must demonstrate not only that the family contains targeted low-income children who are eligible for CHIP benefits, but also that covering the entire family will not cost more than solely covering the eligible children in the family. At least two states have tried, one successfully, to use CHIP funds to extend coverage to the families of eligible children. In the plan approved for Massachusetts, family coverage is to be accomplished by subsidizing premium costs for families with access to employer-based insurance. Such an approach is consistent with AMA Policy H-165.882(8), which calls for alternative sources of financing premium subsidies for children's private coverage.

CHIP Challenges. At its January 1999 meeting, the Council met with staff from the Health Care Financing Administration (HCFA) to discuss the implementation of CHIP. Key program challenges identified in CHIP implementation include a requirement that administrative expenses not exceed 10% of total program expenditures, which has been problematic for states during the start-up phase when outreach expenses are high and enrollment is low. To address this difficulty, HCFA has been strengthening its outreach efforts. Another significant challenge has been to avoid the "crowd-out" phenomenon whereby an entitlement program attracts applicants who would otherwise be eligible for private or other public coverage. Strategies to avoid crowd-out have been a general limit of CHIP eligibility to 200% of the federal poverty level and establishment of waiting periods (generally of six months) for coverage to begin.

Outreach Efforts. HCFA has adopted a simplified enrollment strategy for CHIP and Medicaid, which includes a four-page application form that is being used by most states. HCFA does not require states receiving CHIP and Medicaid funds to use the simplified enrollment form. HCFA's model application form can be processed through the mail and allows applicants to fill in one form that can be used to determine whether they are eligible for coverage under CHIP or Medicaid. While some states have developed even shorter application forms, others use application forms that are 30 or more pages in length.

In February 1999, HCFA announced a national outreach campaign entitled "Insure Kids Now." Working with HCFA, the National Governor's Association established a toll-free hotline (1-877-KIDS-NOW) to provide CHIP and Medicaid information and to instruct callers on how to apply for coverage. In addition, HCFA has convened an Interagency Taskforce of more than 10 federal agencies to develop strategies and implement comprehensive outreach efforts. The various federal agencies have different means of exposure to eligible populations and, therefore, provide multiple opportunities to distribute program information and application forms. As a result of enrollment efforts regarding CHIP, HCFA staff indicated that many Medicaid-eligible children have been identified who previously were not enrolled in the Medicaid program.

Recognizing the critical need to enroll eligible children in CHIP and Medicaid, a number of private sector initiatives are under way to address the problem of enrolling eligible children. For example, in January 1999, the Robert Wood Johnson Foundation announced that it was providing $47 million in grants to public-private partnerships in states that establish efforts to increase enrollment and participation in Medicaid and other children's health insurance plans. In February 1999, Children's Health Matters, a Catholic charities program, announced that it was expanding its network of organizations committed to enrolling eligible uninsured children in Medicaid and CHIP.

HCFA's outreach efforts are consistent with AMA Policy H-290.982 [4], which advocates that the enrollment process for Medicaid and CHIP be streamlined, using such strategies as mail-in applications, shorter application forms, coordinating Medicaid and welfare application processes, and placing eligibility assistance in locations where potential beneficiaries are likely to encounter it. In addition, AMA Policy H-165.882 [11] calls on state medical associations, county medical societies, hospitals, emergency departments, clinics, and individual physicians to assist in identifying and encouraging enrollment in Medicaid.

Welfare Reform

Prior to the Welfare Reform Act, Medicaid eligibility was mandatory for recipients of Aid to Families with Dependent Children (AFDC). The Act repealed AFDC. Medicaid coverage continues to be mandated for recipients of Supplemental Security Income (SSI), although the Welfare Reform Act restricted some groups from SSI coverage.

Medicaid Link to Cash Assistance Ended. The Welfare Reform Act ended the federal entitlement program AFDC and replaced it with Temporary Assistance for Needy Families (TANF), which is a time-limited cash assistance entitlement program. Whereas Medicaid eligibility had been administratively linked to AFDC eligibility, states are not required to link TANF applications with Medicaid enrollment even if applicants would still be eligible for Medicaid. In fact, most people who would have been eligible for AFDC would still be eligible for Medicaid, although many welfare-to-work recipients mistakenly believed they were no longer eligible for Medicaid. As enrollment processes are continually streamlined and coordinated with other programs (such as CHIP) and other agencies, the Council is hopeful this unfortunate trend will be reversed.

Legal Immigrants. Medicaid benefits to legal immigrants who are not citizens have been sharply curtailed in accordance with the Welfare Reform Act as a result of restrictions on eligibility for SSI. Specifically, the Welfare Reform Act mandated a five-year ban on SSI and Medicaid eligibility for immigrants who entered the United States after August 22, 1996. After five years, immigrant access to Medicaid is a state option.

Tobacco and the Uninsured

In November 1998, state attorneys general for 46 states, several U.S. territories and the District of Columbia, reached a $206-billion settlement with the five largest cigarette manufacturers. Florida, Minnesota, Mississippi and Texas filed separately earlier and settled for $40 billion. The November 1998 settlement funds will be dispersed over 25 years beginning in 2000. Each state involved in the settlement must decide how it will spend its portion of the settlement. Many are proposing to use the settlement funds to provide additional funding for Medicaid and CHIP programs. Whether funding from the tobacco settlements will result in a net increase in health spending will depend on whether other sources of health funding are subsequently reduced.

In separate but consistent decisions, some states are increasing or reapportioning tobacco taxes to provide coverage for the poor. Such measures are consistent with AMA Policy H-165.882 [7], which supports an increase in taxes on tobacco products, with the increased revenue earmarked for income-related premium subsidies for purchasing private children's coverage. For example, Arizona has announced it will combine $36 million in state tobacco tax income with federal funding to finance its KidsCare program. The program initially covered children in families at or below 150% of the federal poverty level, with eligibility increasing to 200% of poverty by 2000.

THE ADMINISTRATION'S 2000 BUDGET PROPOSAL

At the time this report was written, the Administration's 2000 budget proposal included a number of provisions to address selected segments of the uninsured. One strategy would provide Medicare coverage to people with disabilities when they return to work. Currently, the loss of these benefits poses a substantial barrier to disabled individuals who might otherwise be able to participate in the
workforce: disabled individuals must pay the full Part A premium after 39 months of returning to work in order to continue in Medicare. The Administration's proposal would provide lifetime coverage under Part A if a disabled person loses their SSI because of their ability to work.

Addressing the high number of uninsured aged 55-64 (14.3%), particularly given their relatively high level of health care needs, the Administration's budget proposal would allow people as young as 55 to buy in to the Medicare program. People aged 62 to 65 would be able to buy in to Medicare by paying a full premium. In addition, at age 55, workers who involuntarily lost their jobs and employer-sponsored coverage would receive a similar buy-in option. Retirees aged 55 whose retirement health coverage is terminated by their former employer would be eligible for a new insurance option providing "COBRA" continuation coverage until age 65.

The Administration's budget proposed an increase of $34 million for CHIP development in U.S. territories. The proposal also would allow states to use up to 3% of their CHIP benefit spending amount for outreach activities and removes the outreach expenditure cap of 10% of total program expenditures.

Consistent with AMA Policy H-165.882 [15], which encourages the development and use of voluntary choice cooperatives, the Administration's budget proposal would provide a tax credit to small businesses that join voluntary coalitions to provide insurance coverage. The proposed initiative would also establish a tax credit to encourage foundations to develop purchasing coalitions. This initiative acknowledges the high percentage of uninsured individuals working in small firms.

RELEVANT AMA POLICY

At the 1998 Annual Meeting, the House of Delegates adopted the recommendations of Council on Medical Service Report 9. That report outlined a broad strategy for increasing coverage through a number of insurance market reforms that would make individually owned insurance affordable at all incomes levels. The initiatives are particularly designed to increase access to coverage for the working poor who do not have access to employer-sponsored coverage and who do not qualify for public health coverage programs.

In addition, the AMA has long-standing policies supporting a wide array of alternatives to increase coverage and access with an emphasis on reform efforts that assure pluralism in financing and patient choice of health plans. AMA policy places priority on providing coverage for children and pregnant women and suggests mechanisms for coverage among the poor.

Universal Access and Coverage in a Pluralistic Market

- Universal coverage and access to health care services should be accomplished through pluralism of health care delivery systems and financing mechanisms. (Policy H-165.920 [1])

- Incremental levels of coverage for different groups of the uninsured, consistent with finite resources, is as a necessary interim step toward universal access. (Policies H-165.882 and H-165.920 [2])

- Private health care insurance using pluralistic, free enterprise mechanisms rather than government mandated and controlled programs is preferred. (Policy H-180.978 [2])

- Health system reform plans should provide universal access free from rationing and should include reasonable basic benefits, patient education, and significant patient responsibility for their own health care choices and behavior. (Policy H-165.918 [1])

- Within their Medicaid programs, states are encouraged to ensure there is a pluralistic approach to health care financing delivery, including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches. (Policy H-290.982 [2])

- Health system reform plans should provide patients with a choice of plans and physicians. (Policy H-165.918 [2])

- Strategies for expanding patient choice in the private sector include advocating for greater choice of health plans by consumers, equal-dollar contributions by employers irrespective of an employee's health plan choice, and expanded individual selection and ownership of health insurance where plans are truly accountable to patients. (Policy H-165.881)

- The AMA supports efforts that will effectively provide universal access to an affordable and adequate spectrum of health care services, maintain the quality of such services, and preserve patients' freedom to select physicians and/or health plans of their choice. (Policy H-165.926)

Children and Pregnant Women

- Particular awareness should be placed on the special health access needs of pregnant women and infants, especially racial and ethnic minority group populations, in advocacy on behalf of patients. (Policy H-245.986)

- Particular emphasis should be placed on advocating policies and proposals designed to expand the extent of health expense coverage protection for presently uninsured children with funding preferably used to allow these children to select private insurance rather than being placed in Medicaid programs. (Policy H-165.882 [1])

- Alternative sources of financing premium subsidies for children's private coverage should be encouraged by both Congress and the states. (Policy H-165.882 [8])

- States, state medical associations, county medical societies, specialty societies, and individual physicians are encouraged to take part in educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible, due to administrative barriers or lack of understanding of the programs. (Policy H-290.982 [6])

- Access to prenatal care for all women, with alternative methods of funding, including private payment, third party coverage and/or governmental funding, depending on the individual's economic circumstances, should be supported through legislation and other appropriate means. (Policy H-420.978 [1])

- The health insurance industry, employers, and health plans are encouraged to make available to young adults who do not have health insurance extended family health expense coverage to age 28. (Policy H-180.964)

Individually Owned Insurance

- Individual insurance market reforms that would encourage coverage by persons who are not offered insurance through their employer should be supported. (Policy H-165.882 [14])

- The AMA supports the principle of the individual's right to select his/her health insurance plan and actively supports ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. (Policy H-165.920 [3])

- The AMA supports individually selected and individually owned health insurance as the preferred method for people to obtain health insurance coverage; and supports and advocates a system where individually-purchased and owned health expense coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it. (Policy H-165.920 [5])

- The AMA prefers a replacement of the present exclusion from employees' taxable income of employer-provided health expense coverage with a tax credit for individuals equal to a percentage of the total amount spent for health expense coverage by the individual and/or

his/her employer, up to a specified actuarial value or "cap" in coverage so as to discourage over-insurance. (Policy H-165.920 [12])

- The individual tax credit for all health expense coverage expenditures by individuals and/or their employers should relate to the individual's income, rather than being a uniform percentage of such expenditures. (Policy H-165.920 [13])

- Appropriate channels should be encouraged to serve as voluntary choice cooperatives, such as unions, trade associations, health insurance purchasing cooperatives, farm bureaus, fraternal organizations, chambers of commerce, churches and religious groups, ethnic coalitions, and similar groups. (Policy H-165.882 [15])

- The AMA supports legislation promoting the establishment and use of medical savings accounts (MSA)s and allowing the tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care, as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance. (Policy H-165.920 [7])

- Medical savings accounts (MSAs) should be offered to all individuals, without restrictions on company size or the total number of MSA enrollees; consumers should obtain their MSAs from a wide variety of sources, including banks, brokerage house and health insurers; and employees with dual coverage through a spouse's health insurance should consider establishing MSAs. Patients with MSAs and other health plans which do not incorporate preventive services, are encouraged to obtain appropriate preventive services. (Policy H-165.879)

<u>Public Programs for the Poor</u>

- The enrollment process for Medicaid programs and State Children's Health Insurance Programs should be streamlined by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care. (Policy H-290.982 [4])

- State medical associations, county medical societies, hospitals, emergency departments, clinics and individual physicians are encouraged to assist in identifying and encouraging enrollment in Medicaid of the estimated 3 million children currently eligible for but not covered under this program. (Policy H-165.882 [11])

- States should be required to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of tax credits; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system and

be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children. (Policy H-290.982 [7])

- Various funding options for expanding coverage are encouraged including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services. (Policy H-290.982 [8])

- Modest co-pays or income-adjusted premium shares should be available for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals. (Policy H-290.982 [9])

- The AMA supports an increase in the federal and/or state sales tax on tobacco products, with the increased revenue earmarked for an income-related premium subsidy for purchase of private children's coverage. (Policy H-165.882 [7])

CHARACTERISTICS OF THE UNINSURED

The Council reviewed a December 1998 Employee Benefits Research Institute (EBRI) analysis of 1997 data from the Current Population Survey. In addition, 1995 data from Council Report 7 (A-97) are provided for comparison, where applicable. The Council notes that the analysis of published statistics limits its ability to fully capture the intersection of the many elements contributing to whether an individual is insured. Nevertheless, consistent with its findings from 1997, the Council's analysis clearly indicates that the 43.4 million uninsured are more likely to be the near-poor, less educated, younger adults, of minority and non-citizen background, and employed in smaller firms. Among persons aged 65 and older, 32,082 (1.0%) were uninsured in 1997, with most of the elderly being covered by Medicare and some being covered by other programs as well.

Employment Status

During 1997, 64.2% of the nonelderly population had employment-based health insurance and almost 15% of the nonelderly had some form of public health insurance. Since 1993, EBRI reports that the portion of the population insured through employment has increased relative to the portion insured through public programs.

Family Head Employment Status	% of Total Uninsured in 1995	% of Total Uninsured in 1997
Workers	78.4	83.9
Full-year, full-time workers	52.7	59.5
Other workers	25.7	24.4
Non-Workers	21.6	16.1

Among individuals in families with a head of household employed full-time year-round in 1997, 14.6% were uninsured, compared with 13.9% in 1995. The vast majority of the uninsured (83.9%) in 1997 lived in families headed by workers, with only 16.1% of the uninsured living in families in which the family head did not work. The "other workers" category includes full-year part-time workers as well as seasonal workers. The comparison of 1995 with 1997, indicates a large

increase in the proportion of the uninsured whose families are connected to the work force, particularly among full-year full-time workers. At the same time, 1997 showed a large decline in the percentage of uninsured whose head of household was a non-worker. This trend may attest to the declining significance of employer-sponsored health insurance among part-time and low-wage workers. An analysis by the Center on Budget and Policy Priorities found that, among very low income parents, those who worked were twice as likely to be uninsured as those who were unemployed.

Coverage Priorities. The nonelderly unemployed lack the opportunity for employer-sponsored coverage and most likely are poor. Those who are employed seasonally or part-time are likely to receive low wages and be in jobs that do not offer employer-sponsored coverage. Among the employed with low-income and lacking employer-sponsored coverage, consistent with Policy H-165.882, the AMA should continue pursuing insurance market reforms that make individually owned insurance affordable. For children of the unemployed and working poor, widespread efforts by HCFA, the states, and the Administration, to provide access through Medicaid and CHIP should be strongly supported. Such efforts are consistent with AMA Policies H-290.982 [6], H-245.986 and H-165-882 [1].

Industry and Firm Size

As indicated in the table below, workers in the broad category of agriculture, forestry, fishing, mining and construction were the most likely to be uninsured (33.7%) compared with other industries. Wholesale and retail trade employees also represented a large portion of the uninsured (22.2%).

Industry	% of Sector Uninsured in 1997
Agriculture, forestry, fishing, mining and construction	33.7
Manufacturing	14.2
Wholesale and retail trade	22.2
Personal services	16.2
Public sector	8.0

Size of the firm is also an important indicator of insurance coverage, with workers in smaller firms and the self-employed more likely to be uninsured.

Firm Size (# of private sector employees)	% within Firm Size Uninsured in 1995	% within Firm Size Uninsured in 1997
Self-employed	25.1	24.1
Less than 10	32.7	34.7
10-24	27.6	29.7
25-99	20.3	20.9
100-499	15.3	15.8
500-999	13.0	12.7
1,000 or more	11.6	12.3

Among the self-employed in 1997, 24.1% were uninsured, and 32.6% of workers in private sector firms with fewer than 25 employees were uninsured. By contrast, 12.3% of employees in firms employing 1,000 or more were uninsured. The self-employed appear to be have improved their likelihood of having insurance since 1995, whereas the prospect of small firms providing insurance appears worse. Small firms have a higher per employee cost of coverage due to both greater risk and higher relative administrative cost. Some individual market reforms resulting from HIPAA may account for the increase in insurance coverage among the self-employed.

Coverage Priorities. Consistent with the barriers to access for the working poor, addressing the phenomenon of variable access to employer sponsored coverage based on industry and firm size suggests vigorous pursuit of AMA Policy H-165.882, supporting individual insurance market reforms that would encourage coverage by persons who are not offered insurance through their employers. The Administration's budget proposal for the year 2000 would provide a tax credit to small businesses that join voluntary coalitions to provide insurance coverage.

Income

Lack of insurance is largely predicted by income, so that efforts to increase coverage for the uninsured must be sensitive to income concerns. The AMA's plan for individually owned insurance as presented in Council Report 9 (A-98) addresses the income issue by proposing an income-sensitive tax credit that provides a greater credit for those with lower income (Policy H-165.920 [13]). Public programs are increasingly striving to provide coverage for the indigent, so that the greatest need for individually owned insurance is among those who are employed but are not offered insurance through their employment.

For 1997, the percent uninsured among the nonelderly population by family income level was as follows:

% of Federal Poverty Level	% within Level Uninsured in 1995	% within Level Uninsured in 1997
0-99	33.0	34.7
100-124	32.5	37.0
125-149	32.6	34.4
150-199	27.3	28.5
200-399	14.4	15.4
400 and up	6.7	7.7

For 1997, the percent of individuals uninsured at or just above the federal poverty level (37%) is greater than the percent uninsured below the poverty level (34.7%), attributing to the greater level of Medicaid coverage among those below the poverty level. The lack of insurance coverage increased at all income levels from 1995 to 1997. In addition, the percent increase in the number of uninsured among those at 100-124% of poverty from 1995 (32.5%) to 1997 (37.0%) reflects a particularly large increase that coincides with the implementation of welfare reform measures. Further analysis indicated that the number of Medicaid enrollees declined by some 3 million from 1995 to 1997. Furthermore, Medicaid enrollees accounted for less of a percentage of the insured in 1997 (11.0%) than in 1995 (12.5%).

Coverage Priorities. Again, consistent with Policies H-290.982 [6], H-245.986 and H-165-882 [1], the Council recommends strong support for efforts to increase access to poor children, using a variety of coverage strategies, including Medicaid and CHIP as well as individually owned insurance. Consistent with Policy H-290.982 [4] and ongoing HCFA efforts, the Council supports streamlining the application process for these programs to make them truly accessible. In addition, the Council supports additional funding mechanisms to expand Medicaid and CHIP access to the families of eligible children.

Education

Because education is a strong correlate with income, it is not surprising the likelihood of having insurance coverage increases with education. In 1996, almost two thirds of uninsured adults had no education beyond high school. This finding is consistent with the 1994 data reported in Council Report 7 (A-97). The finding also underscores the importance of developing outreach and program application materials that are accessible to individuals with low levels of education.

Age

The recent increase in the uninsured was largely composed of young adults. Individuals aged 21-24 in 1997 were the most likely to be uninsured, with 33.8% of this age group uninsured, which is an increase from 32% in 1995. The high proportion of the uninsured among young adults continues to reflect the lapse of family coverage for many prior to their entering the workforce. The second most likely uninsured age group was 18-20, which may be attributed to the fact that Medicaid eligibility for children ends at age 18 in many states. Those least likely to be uninsured were aged 45-54 (13.9%).

Age	% within Age Uninsured 1995	% within Age Uninsured 1997
Infants	16.7	16.5
1-5	12.7	13.9
6-12	13.7	14.1
13-17	14.4	17.0
18-20	23.0	25.9
21-24	32.3	33.8
25-34	23.0	23.5
35-44	17.0	17.4
45-54	13.3	13.9
55-64	13.0	14.3

Among those aged 55-64, retirees were more likely to be uninsured (16.7%) than those still in the work force (12.5%). Due to near-universal Medicare coverage for the elderly, the elderly are less likely than the nonelderly population to be uninsured. Whereas 16% of the total population was uninsured in 1997, the lack of insurance among the nonelderly population was 18.3%. Only 1% of persons aged 65 and older were uninsured in 1997.

Young adults aged 18-20 experienced a sharp decrease in coverage from 1995 (23%) to 1997 (25.9%). Young adults aged 21-24 also experienced an increase from 32% in 1995 to 33.8% in 1997. Despite AMA policy promoting extended coverage of young adults under their families

insurance, there is little evidence that such policies are being developed or purchased. Some colleges require students to be insured and some states require health insurers to provide policies that extend family coverage to children of college age.

Among children under the age of 18 who lacked health insurance, 10.7 million (14.9%) lacked health insurance in 1997, compared with 14% in 1995. Their lack of coverage was linked to income—7.3 million were in families with incomes below 200% of the federal poverty level, with 3.6 million of those children in families with incomes below 100% of poverty. Employment status of parents was related to the likelihood of children having coverage. Among children under age 18, only 12.7% were uninsured who had a full-year, full-time, working head of household. By contrast, 23.1% of children in families of full-year, but part-time workers were uninsured, and 22.9% of children in families of a part-year worker were uninsured.

Coverage Priorities. Many uninsured individuals aged 55-64 may have retired early and may be relatively comfortable financially. Therefore, a portion of the 16.7% of individuals aged 55-64 lacking insurance would benefit from affordable individually owned insurance as advocated in Policies H-165.882 and 165.920, as well as medical savings accounts as advocated in Policy H-165.920 [7]. The Council favors this approach over current proposals for a Medicare buy-in option for this age group. The Council has specific concerns such proposals will exacerbate the financially troubled Medicare program because it is doubtful whether the buy-in cost would be large enough to offset the additional program costs.

The large number of uninsured young adults is often attributed to their loss of coverage under family policies combined with their youthful state of health and sense of immortality. Policy H-180.964 supports the expansion of family insurance policies to cover children to age 28. Nevertheless, there is little evidence that such policies are being offered or purchased. The Council notes that because of their relative health, young adults are ideal candidates for catastrophic coverage under an MSA (Policy H-165.920[7]).

Regarding the lack of insurance by poor children, the Council's recommendations are noted above under the Income category. The Council is optimistic about the number of initiatives to increase access for uninsured children and is hopeful for their success.

Race and Citizenship

Hispanics were more likely than whites or blacks to be uninsured at all income levels (36.0%). Among blacks 22.9% were uninsured, while 14% of whites were uninsured. The proportion of Hispanics reporting income below 100% of the federal poverty level (27.5%) contributes to their lack of coverage, but Hispanics are also more likely be noncitizens, among whom the uninsured rate was 45.6%. The Welfare Reform Act restricted Medicaid benefits to previously eligible low-income legal immigrants who are not citizens.

Blacks were more likely to be uninsured than whites at all income levels except the level below 100% of poverty, where 33.3% of whites and 29.8% of blacks were uninsured. Among Hispanics at 100% of poverty, 42.6% were uninsured.

Whereas 16.3 % of the nonelderly population was uninsured, 45.6% of the noncitizen nonelderly population was uninsured in 1997. Council Report 7 (A-97) reported that 15.6% of citizens and 43% of noncitizens were uninsured in 1995.

Coverage Priorities. Because race and citizenship correlate with income and employment factors, the Council's recommendations regarding income and employment also apply to race and citizenship. In addition, the Council notes the particular difficulties enrolling Hispanics in public programs due to the potential language difference and believes that other ethnic minorities may experience similar challenges to effective outreach. Therefore, the Council supports outreach efforts that are appropriately bilingual and culturally accessible.

DISCUSSION

Despite the record number of uninsured individuals in an era of prosperity, the Council is optimistic about the proposals and programs that promise to increase coverage for millions. The Council believes HCFA's efforts to expand coverage to children in low-income families through Medicaid and CHIP will have promising results on the lives of millions of children. In March 1999, the National Governors' Association announced that, through a survey of states, it found that some 828,00 children were enrolled in CHIP programs in 1998. However, much work is yet to be done, and physician organizations should find opportunities to increase access within their states, using these state-based programs. Although HCFA has developed a simple four-page enrollment form for use in determining eligibility in either Medicaid or CHIP, states are not required to use the simplified form. In fact, it appears that at least one state continues to use longer forms purposely to discourage reliance on public assistance. Because of the documented high number of uninsured Hispanics and the likelihood of similarly affected ethnic minorities, the Council recommends targeted outreach efforts to enroll eligible children in Medicaid and CHIP. The Council supports innovative efforts to increase access through CHIP for families of eligible children. One state, Massachusetts, already has developed such a program by linking CHIP coverage to private sector coverage.

Data analyzed from 1997 continue to reveal that the vast majority of the uninsured are employed, and the AMA's proposal for individually owned insurance remains valid and viable. The Council is concerned, however, that early analyses of individual insurance market reforms indicate a possible increase in the number of uninsured individuals due to some aspects of those reforms. In particular, the Council believes that insurance reforms that contain additional benefit mandates should be avoided not only because they increase the overall cost of insurance, but because they are contrary to AMA policy on pluralism and patient choice, as well. The AMA's commitment to private sector reforms using pluralistic market mechanisms rather than government mandated and controlled programs is well documented in Policy H-180.978 [2]. The Council believes, however, that a direct statement of opposition to additional benefit mandates is warranted, due to the potential for the added cost of each mandate making insurance more costly and thereby jeopardizing insurance coverage. Nevertheless, the Council recognizes the need to allow for patient protection measures that may represent benefit mandates.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of this report be filed:

1. That the AMA oppose new health benefit mandates unrelated to patient protections, which jeopardize coverage to currently insured populations.

2. That the AMA urge the Health Care Financing Administration (HCFA) to require states to use its simplified four-page combination Medicaid / Children's Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form.

3. That the AMA urge HCFA to ensure that Medicaid and CHIP outreach efforts are approximately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations.

4. That the AMA encourage state medical associations, state specialty societies, and other physician organizations to work with appropriate state agencies to develop innovative programs to expand coverage for the uninsured.