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T-56
(revised)

The Erosion of Health Insurance Coverage Among the Nonelderly Population: Public Policy Issues and Options

Statement of

Deborah J. Chollet, Ph.D.*

Hearing before the

United States House of Representatives
Committee on Small Business

May 6, 1987

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*Deborah J. Chollet is a Senior Research Associate of the Employee Benefit Research Institute (EBRI). EBRI is a non-profit, non-partisan public policy research organization.

EMPLOYEE BENEFIT RESEARCH INSTITUTE
2121 K Street, NW / Suite 600 / Washington, DC 20037-2121
Telephone 202-659-0670 FAX 202-775-6312

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Deborah J. Chollet, Ph.D.
Senior Research Associate
The Employee Benefit Research Institute

Introduction

The lack of health insurance coverage among many Americans is drawing increasing attention as a public policy issue. Although most of the nonelderly population is covered by employer-based health insurance, many are not. In 1985, 17 percent of the nonelderly population--more than 37 million people--reported having no insurance coverage from either a private plan or a public insurance program. Among the nonagricultural, nonmilitary population, 35 million reported no insurance coverage of any type during 1985.[1]

The significant minority of nonelderly Americans without health insurance coverage may confront serious difficulties in obtaining necessary health care except on an emergency basis. People without health insurance use much less health care than those with insurance, even controlling for health status or medical condition (Monheit, et al., 1985). Noncoverage has been linked with higher mortality rates in general, and higher rates of infant mortality in particular (Grossman and Goldman, 1981).

Furthermore, the health care that people without insurance may command but for which they are unable to pay imposes costs on providers and on insured consumers. The estimated provider burden of uncompensated health care in the United States is 5 percent of gross revenues--about $13 billion in 1986

(Chollet, 1987). The cost of uncompensated care shifted to insured patients in the form of higher charges for care has not been measured, but is presumed to be commensurate with the cost for providers. Because nearly 80 percent of the nonelderly population with insurance coverage of some kind are covered by an employer plan, employers who provide health insurance benefits for their workers presumably pay most of these shifted costs.

This testimony describes the emerging uninsured population in the United States and the characteristics of the uninsured population in 1985. The discussion focuses on the nonmilitary, nonagricultural population of the United States under age 65. Various public policy options to address noncoverage among this population are identified, and their maximum potential effectiveness in reducing the number of uninsured is estimated. Estimates of effectiveness are provided for each option independently and in combination with other options. Finally, possible external impacts of public policy that would affect employer plans are evaluated, with particular attention to the potential for reducing employment opportunities for some workers.

The Emerging Uninsured Population

The number of people reporting no health insurance coverage of any type--35 million people in 1985, excluding the agricultural and military populations--has steadily grown since the 1982 economic recession. Between 1982 and 1985, the nonelderly nonagricultural civilian population without health insurance of any type increased by 4.5 million people, nearly 15

percent. Most (nearly three-quarters) of this increase in the uninsured population occurred among workers; the number of workers without health insurance has grown by more than 22 percent since 1982 (see Table 1). The number of children without coverage, however, has also grown. In 1985, nearly 20 percent of all children under age 18 had no health insurance coverage from any source--an increase of nearly 16 percent since 1982.

The erosion of employer-based coverage among workers and dependents is an important source of the growing number of nonelderly people without health insurance. In 1982, more than 67 percent of the population had coverage from an employer plan; this percentage declined to nearly 65 percent in 1984 (EBRI, 1986a) and edged upward to 66 percent in 1985.

The decline in employer-based coverage has been most apparent among nonworkers--primarily children (see Table 2). Although the rate of employer coverage among workers has declined (from 78 percent in 1982 to 76 percent in 1985), employer plans have actually covered a growing number of workers--nearly 88 million workers in 1985, compared to 84 million in 1982. Among nonworkers, however, both the rate and the number of people covered by employer plans have declined. In 1982, employer plans covered more than 47 million nonworkers, including 36 million children. In 1985, employer plans covered 44 million nonworkers, and fewer than 35 million children. The rate of employer coverage among nonworkers declined from 55 percent in 1982, to less than 52 percent in 1985.

The number and proportion of the nonelderly population with other private

(nonemployer) insurance coverage has also declined since 1982; again, the decline is most apparent among children. In 1982, nearly 13 percent of the nonelderly population and nearly 9 percent of children reported nonemployer private coverage; in 1985, less than 12 percent of the nonelderly population and 7 percent of children reported coverage from such a plan.

The declining coverage from employer plans reported among nonworkers (and among children in particular) is related to eroding employer coverage among workers. While the number of civilian nonagricultural workers increased nearly 7 percent between 1982 and 1985, the number of workers with health insurance coverage from an employer plan rose less than 5 percent. One reason for the slower growth in covered workers compared to total employment may be the ongoing redistribution of employment toward jobs that historically have not offered benefits--jobs in small firms and in low-coverage industries. This pattern of changing employment is consistent with the faster growth of employment in low-wage jobs since 1979.

Between 1979 and 1983 (the most recent year for which data are available), total employment shifted slightly toward wage and salary jobs in firms with fewer than 1,000 workers; more than half of these (27 percent of all workers) were employed in firms of fewer than 25 workers (see Table 3). The potential acceleration of this trend toward greater employment in small firms over the economic recovery years following 1982 may explain some of the decline in employer coverage as a percent of total employment during those years. In 1983, the rate of employer-based health insurance coverage among workers in smaller establishments was less than one-half the rate reported among workers

in very large establishments (see Table 4).

The redistribution of workers toward industries that have historically lower employer coverage rates may also explain the erosion of employer-based health insurance coverage among workers. Industries with historically lower rates of health insurance coverage have shown relatively rapid gains in employment since 1980. Between 1980 and 1985, employment in industries with below-average rates of employer health coverage (retail trade, services and construction) grew more than four times as fast as employment in industries with above-average rates of coverage (17 percent, compared to 4 percent) (see Table 5). In 1985, low-coverage industries accounted for 35 percent of total employment, compared to 30 percent in 1982.

Who Are the Uninsured?

Nearly one-half of all nonelderly without health insurance in 1985 (49 percent, or 17 million people) were workers (see Figure 1). Another one-third (32 percent, or 11 million people) were children age 18 or younger. Only 19 percent of the uninsured were nonworking adults--that is, people over age 18 who neither worked nor looked for work during 1985.

More than two-thirds (69 percent) of the uninsured were either themselves full-time full-year workers (that is, workers who worked or sought work 35 weeks or more, and worked 35 hours or more in a typical week), or lived in families headed by a full-time full-year worker. About 17 percent of the

uninsured lived with a full-year worker who reported some unemployment in 1985; but more than half (52 percent) of the uninsured population lived in families of full-time workers who were steadily employed throughout the year. Relatively few uninsured (17 percent) lived in families headed by a part-year or part-time worker, or in families headed by a nonworker (14 percent). This distribution of the uninsured by the work status of the family head is presented in Table 6.

A significant minority of the uninsured in 1985--more than 9 percent--lived with a spouse or parent who themselves had coverage from an employer plan. Among children without health insurance, 20 percent lived with a parent who reported coverage from an employer plan. Available data do not indicate whether (1) the insured worker's plan offered no coverage for dependents or (2) dependents' coverage was available, but the worker did not elect that coverage. Data on health plan provisions in medium-size and large establishments in the United States indicate that employee contributions for dependents' coverage are increasingly common (U.S. Department of Labor, 1987). Some employers have eliminated most or all contributions to dependents coverage to achieve comparable benefits for married and single employees in a marketplace increasingly concerned with pay equity. Nevertheless, the personal earnings of at least some employer-covered workers with an uninsured spouse or child suggest that the likely amount of an employee contribution to dependents' coverage, were it offered, might have been affordable. For approximately one quarter of uninsured children living with an employer-covered parent (or, rarely, a spouse), the parent earned more than $20,000 in 1985, worked full-time and reported an employer contribution to his

or her own coverage. Approximately 4 percent lived with an employer-covered parent who earned $40,000 or more in 1985.

These uninsured living with employer-insured workers, however, are not typical of the uninsured as a group. In 1985, 62 percent of the uninsured lived in families with income less than 200 percent of the federal poverty standard; nearly a third (32 percent) lived in families with below-poverty income (see Figure 2)[2].

The typical family structure of people without insurance coverage differs markedly from that of people with either private insurance coverage or public program coverage, reflecting differences in access to employer coverage and to Medicaid benefits. In particular, the uninsured are much more likely than the privately insured population to live in single-adult or single-parent families; and they are more likely than the publicly insured population to live in families without children or in two-parent families with children.

While less than one third (32 percent) of the total population lived in single-adult or single-parent families in 1985, one half of all uninsured people lived in single-adult or single-parent families. One quarter (25 percent) of the uninsured lived in single-parent families--that is, in families with children but no spouse present (see Table 7). While nearly half of the total population lived in two-parent families with children in 1985, only 35 percent of the uninsured lived in families of this type.

The majority of uninsured children in 1985 (55 percent) lived in

two-parent families where typically one or both parents were full-year workers (see Table 8). However, nearly half (45 percent) of uninsured children under age 18 in 1985 lived in single-parent families; most of these children (37 percent of all uninsured children) lived in families headed by single women.

Uninsured children living in poverty were substantially more likely to live in single-parent families (57 percent compared to 45 percent among all uninsured children), and more likely to live in families headed by single women. In 1985, fully half of all uninsured children in poverty lived in families headed by single women. Nearly half of these children (31 percent of uninsured poor children) lived with single women that were workers (see Figure 3).

Rates of noncoverage vary substantially among states. States characterized by high unemployment or low rates of employer health insurance coverage among workers (e.g., Arkansas, New Mexico, Oklahoma and Florida), and/or low rates of Medicaid coverage (e.g., Louisiana), have particularly high proportions of their populations uninsured. In 1985, more than one-quarter of Oklahoma's population (25.3 percent) reported no health insurance of any type, including Medicaid. In fourteen states and the District of Columbia, 20 percent or more of the nonelderly population was uninsured (see Table 9).

Noncoverage Among Workers

Employer plans are the predominant source of health insurance in the United States. In 1985, more than three quarters of all nonagricultural civilian workers in the United States (76 percent) reported coverage from an employer plan; these plans provided coverage to two-thirds of the nonelderly population. Eighty percent of covered workers (61 percent of all workers) had coverage from their own employer plan; the rest were covered as dependents of another worker. However, in 1985, 15 percent of all civilian nonagricultural workers reported no coverage from an employer plan, from another private plan or from any public program; more than three-quarters of the uninsured population are associated with these workers.

Workers without employer-based insurance coverage are characterized by relatively low earnings. In 1985, fully three quarters of all uninsured workers earned less than $10,000 (see Figure 4). Nearly all (93 percent) earned less than $20,000. The relatively low earnings reported by uninsured workers were not necessarily related to part-time or part-year work. Among (never-unemployed) full-time full-year workers without health insurance coverage, 69 percent earned less than $10,000; and 92 percent earned less than $20,000. About one third of all full-year workers earning less than $10,000 were uninsured (see Table 10).

Workers who earn less than the federal minimum wage are more likely to be uninsured than higher-wage workers. While 16 percent of all workers earned, on average, less than the federal minimum wage in 1985, these workers

accounted for more than 35 percent of all uninsured workers (see Table 11). Approximately 40 percent of all workers in the United States are in jobs or occupations not subject to the federal minimum wage.[3]

More than half of all uninsured workers in 1985 were employed in two industries: retail trade (24 percent) and services (28 percent) (see Figure 5). Another 16 percent of all uninsured workers were self-employed. Among workers employed in retail trade or in any service industry other than professional and related services, the rate of noncoverage varied between 23 percent (in retail trade) and 32 percent (in personal services). Nearly one-quarter (24 percent) of all self-employed workers were uninsured in 1985; although fewer workers nation-wide are employed in construction, they reported a comparable rate of noncoverage (see Table 12).

Most uninsured workers are employed in small firms. In 1982, two-thirds of workers who reported no coverage from their own employer were either self-employed (27 percent) or employed in firms with fewer than 25 employees (40 percent). Although these data do not reflect the coverage that small-firm employees may receive as dependents of other workers' plans, the total coverage rate among small-firm employees is probably also lower than that among large-firm employees. In 1985, 15 percent of all workers (and 20 percent of covered workers) had employer-based health insurance only as a dependent.

Table 13 provides summary demographic information on uninsured workers. In 1985, men who were employed at any time during the year were slightly more

likely than women workers to be uninsured (15 percent among men compared to 14 percent among women). The greater propensity of women to have health insurance (despite lower average earnings which alone would suggest a lower probability of coverage) is consistent with the findings of earlier research (Chollet, 1984). Young workers are particularly likely to be uninsured. Workers age 21 to 24 show the highest rate of noncoverage; workers in this age group are less likely to have direct employer coverage than older workers, and less likely to have indirect coverage (from a parent or spouse's plan) than are younger workers. In 1985, more than half of uninsured workers (52 percent) were under age 30; 35 percent were younger than age 25.

Options for Change

Various options for improving coverage rates among the nonelderly are under discussion within the public policy community, including members of the Reagan Administration and members of Congress and their staffs. These options are of three general types: (1) options that would encourage individuals to buy coverage; (2) employer-related options and (3) Medicaid-related options.

Encouraging Individuals to Buy Health Insurance. Relatively few nonelderly Americans purchase individual health insurance. In 1985, fewer than 12 percent of the nonelderly population reported health insurance coverage from a private nonemployer insurance plan, compared to 66 percent that reported coverage from an employer plan (EBRI, May 1987). Among nonworker adults (the group most likely to have individual coverage) fewer

than 21 percent reported coverage from an individual plan, compared to more than 33 percent covered as dependents under an employer plan.

The relatively low rate of individual insurance purchase in the United States is a result of at least two factors. First, individual insurance is expensive relative to both the average price of a group plan with comparable benefits and average family income. Informal industry estimates suggest that insurance premiums for individual coverage may average more than 130 percent of large-group premiums for the same benefits. The higher cost of individual coverage relates to the health care risk posed by individuals without access to an employer group and to the cost of administering individual plans.

Second, people that would buy individual coverage may be more likely to be uninsurable than the population with access to an employer plan. That is, they may be more likely to have a health condition that would predictably generate large claims against the plan. Such people, who represent a poor insurance risk, may be unable to buy individual insurance coverage at any price. Although 14 states have formed insurer-underwritten financing pools for uninsurable residents, most have no arrangement other than the state Medicaid program. In such states, uninsurable people that are categorically or financially ineligible for Medicaid benefits may have no insurance option outside of an employer group.

The low income that characterizes most of the uninsured population suggests that relatively few might purchase insurance coverage if they had to pay the full cost. In 1985, one-third of the nonelderly uninsured population lived in

families with income below the federal poverty standard; two-thirds reported family income less than 200 percent of poverty. Past research suggests that employer plans--the principal source of insurance coverage in the United States--have achieved widespread coverage among workers precisely because they provide a subsidy to participants: they do not rely on individual decisions to purchase coverage at market prices (Chollet, 1984). The relatively high family income reported by some uninsured people suggests that individual preferences for health insurance may also be an important obstacle to achieving universal insurance coverage through a system of individual, voluntary purchase.

States that have examined the possibility of establishing a state-wide insurance plan to provide coverage to uninsured residents have recognized that a substantial subsidy (reducing the price to participants) may be critical to achieving widespread participation. However, the problem of financing a subsidy for participants in a voluntary health insurance plan may be exacerbated by individual preferences. Insurance coverage that would be attractive to most consumers without access to an employer plan and provide adequate protection may be more expensive than the standard individual or group insurance plans that are now marketed--raising the subsidy needed to induce widespread participation.

Furthermore, deductible and copayment provisions that are standard in individual or employer health insurance plans may be too stringent to adequately protect the low-income families that make up more than one-half of the uninsured population. An insurance plan with lower cost-sharing by

participants (commensurate with their lower incomes) could be structured for the same cost by reducing benefits--for example, reducing the scope of services covered by the plan. However, plans that provide only narrow or catastrophic coverage may be unattractive to consumers at virtually any price if they are seeking to finance basic health care services. In addition, such scaled-down insurance plans may be prohibited by law in many states that require insurance plans to cover a variety of specific services or the services of specific provider types.

To date, only the state of Washington has authorized a subsidized, voluntary individual health insurance plan for its uninsured population. In March 1987, Washington legislators authorized the establishment of a managed-care "basic health" plan for uninsured individuals with family income below 200 percent of poverty; coverage under this plan is to commence in July 1988. The plan is to be financed from general revenue appropriations and federal matching funds associated with any Medicaid participation that may occur, as well as from enrollee premiums. Premiums and coinsurance provisions are to be scaled to family income and adjusted for family size. Prior to July 1, 1989, the plan must accept individuals with preexisting health conditions (that is, people that are uninsurable); after that date, the plan administrator may exclude new applicants that are uninsurable, based on the plan's cost experience for enrollees with preexisting health conditions.

In addition to authorizing a basic health care plan for its low-income uninsured population, Washington state also authorized a health care financing pool for its uninsurable population in April 1987. This plan is to be

underwritten by commercial insurers doing business in the state; enrollee premiums are limited to 150 percent of the average small-group premium charged by the state's five largest commercial insurers. Net aggregate losses to the plan that may result from claims that exceed the premium limit are to be financed by the participating insurers. Washington is the fourteenth state to establish this type of health care financing pool for residents that are unable to qualify for individual insurance from a commercial carrier. However, allowable premiums for coverage in these plans--typically much more than the price of individual coverage--may discourage high levels of participation among the uninsurable population, many of whom may have low or moderate family income.

Employer-related options. Employer-based strategies to expand health insurance coverage among the nonelderly population are, on the face of them, appealing to public policy makers. First, they represent a public policy option that may involve little or no direct public expenditure, compared to the expenditures that might be associated with a service-providing public program. Second, most uninsured people are workers or dependents of workers. In 1985, 81 percent of the uninsured were either themselves workers or the nonworking spouse or child of a worker. Public policy makers view employer plans, therefore, as an opportunity to bring most of the uninsured into an established system of private health insurance coverage.

The potential costs of an employer-based strategy for further expanding private health insurance, however, are considerable. Most uninsured workers are low-wage workers. In 1985, 75 percent earned less than $10,000; more than

a third (35 percent) earned less than the federal minimum wage. The cost of health insurance for these workers, if paid by the employer, could represent a substantial increase in labor costs--potentially 15 to 20 percent or more for workers earning less than $10,000.[4]

A mandatory increase in real compensation of this magnitude could affect employment and job availability for low-skilled workers, the nature of available low-wage jobs, and product prices. (The potential labor market effects of an increase in minimum compensation are discussed in a later section.) Thus, public policy makers who look to employer-related strategies as a way to expand health insurance coverage among workers and their dependents must also address competing objectives: full employment, economic growth and competitiveness in world markets.

The average cost of health insurance coverage, if paid by the workers themselves, is likely to be prohibitive, however. That is, simple access to insurance coverage from an employer without an employer contribution is unlikely to produce a significant expansion in coverage.

Public policy toward employer plans is generally formulated as either an incentive or a mandate. Since employer contributions to health insurance coverage are already tax-exempt both to the employer and the employee, remaining options for broadening tax incentives relate primarily to the individual income tax deduction for individual insurance purchase and the deductibility of insurance purchase by self-employed workers.[5]

New regulation of employer plans related to tax qualification authorized by the Tax Reform Act of 1986 might achieve some expansion of the coverage provided by existing plans, if the Act's nondiscrimination rules induce employers to extend coverage to more part-time workers. The 1986 Tax Reform Act requires insured and self-insured employer plans to meet various nondiscrimination tests based on their employees who work more than 17-1/2 hours per week. However, potential reduction in the availability of part-time work and the number of part-time workers could offset any expansion of coverage, producing no net change in the actual number of covered workers.

An alternative federal policy to expand employer-based health insurance could be to mandate coverage. Several members of Congress have endorsed such a mandate in principle. The anticipated cost of health insurance for small employers, however, may be the most significant obstacle to federally mandating health insurance coverage for workers.

Public policy to expand employer-based coverage could target various groups of the uninsured who are themselves workers or associated with workers, for example:

(1) dependents of employees covered by an employer plan;

(2) all employees or some subset of employees (for example, full-time employees or employees who are subject to the federal minimum provisions of the Fair Labor Standards Act); or

(3) both qualified employees and their dependents.

Each of these options would target different numbers of the uninsured. Assuming some level of employer contribution, each would also imply different

levels of employer cost.

Table 14 provides estimates of the maximum potential effectiveness of alternative employer-related strategies targeted to each of the above populations. The estimates assume that none of the strategies would affect self-employed workers or their dependents, and that no changes in employment occur as employer health coverage expands.

Qualified wage and salary employees are are alternatively defined as (1) all employees; (2) employees that work 18 hours or more per week (approximately the 17.5-hour rule used to test nondiscrimination in health benefits under the 1986 Tax Reform Act); and (3) employees that work 35 hours or more per week. Changes in the work-hour rule used to define qualified employees produce differences in the target populations by redefining workers (as qualified employees only) and nonworkers (as nonqualified employees as well as nonworkers). Increasing the number of work hours that defines a qualified employee (1) decreases the count of workers (i.e., qualified employees); (2) potentially increases the count of workers' dependents, both adults and children; and (3) increases the count of nonworkers and their dependents.

If employer coverage had been extended to dependents of covered wage and salary workers, the total number of uninsured might have declined by nearly 9 percent and the number of uninsured children might have declined by more than 2 million. For the purpose of extending dependents' coverage, differences in the hours-worked definition of qualified employees would have produced little

difference in the number of adults or children in the target population.

A strategy that would expand coverage to all workers (with no dependents provision) could achieve substantially larger increases in coverage by targeting a much larger group of the uninsured. However, the work-hours rule used to define qualified employees is critical to the number of workers who might be affected. A rule targeting only full-time wage and salary workers (35 hours per week) might have extended coverage to 28 percent of the total uninsured population in 1985. Use of an 18-hour rule might have extended coverage to 37 percent of the uninsured.

A strategy targeting both employees and their dependents would obviously target the largest population and largest proportion of the uninsured. How qualified employees are defined is critical to the number of uninsured who might obtain employer coverage. Using a 35-hour week to define qualified employees, a strategy targeting wage and salary workers and their dependents might have achieved coverage for over half (54 percent) of the uninsured in 1985. An 18-hour rule might have achieved coverage for two-thirds of the uninsured (66 percent).

The anticipated cost of health insurance coverage for employers (and workers) is the single greatest obstacle to defining public policy that would successfully expand employer coverage. Since a large proportion of uninsured workers are employed by small employers, discussion has focused on ways to reduce the cost of coverage for small employers. Unlike larger groups, small employers may be unable to obtain any discount on a community-rated health

insurance plan to reflect their potentially more favorable claims experience, since their group size is too small to be separately rated.

Options for reducing the cost of health insurance to small employers include: (1) extending to insured employer plans the federal protection from state regulation that larger, self-insured plans enjoy; and (2) facilitating small-group insurance pools to gain the economies of scale associated with a larger group.

State-mandated health insurance benefits are common, and are generally unpopular among employers as well as organized labor. State mandates are of two general types: (1) requirements that particular services or providers be covered by insured plans, and/or (2) requirements that insured plans offer separated workers continued coverage or conversion coverage (that is, the option to convert coverage to a self-paid individual plan regardless of health status). Those who oppose state mandates claim that mandated benefits impose substantial costs for plan benefits and administration. Moreover, they claim that some state-mandated benefits more apparently serve the interests of health service providers rather than the best interests of workers.

In fact, substantial cost may be associated with some state-mandated benefits. In Maryland, for example, state-mandated insurance benefits were estimated to raise the combined average cost of group and individual Blue Cross and Blue Shield coverage by more than 11 percent in 1984; outpatient mental health benefits alone were estimated to raise total plan costs by more than 4 percent, and the cost of major medical coverage by more than 27 percent

(Dyckman and Anderson, 1985). State taxes on insurance premiums may also raise small plan costs by several percentage points.

These costs imposed on insured plans have apparently induced many employers to self-insure. Self-insured plans may avoid state-mandated benefits and taxation under the protection of the 1974 Employee Retirement Income Security Act (ERISA) which exempts employee benefit plans from state regulation. In 1985, 42 percent of workers in establishments of approximately 250 workers or more who participated in an employer health plan had all or part of their benefit provided on a self-insured basis (EBRI, 1986b).

Congress may be reluctant to exempt insured plans from state regulation, however, for several reasons. First, lacking a better measure, the cost of state-mandated benefits is seen as an indicator of the value of these benefits to insured workers and individuals, even if relatively few plan participants account for most of the cost of these benefits. The perception that at least some people benefit from these statutes makes eliminating them politically difficult. Second, although the decision to override state-mandated benefits might be justified in terms of their cost-effectiveness, information to support that argument is not generally available.

Whether pooling small employer groups would significantly lower average plan cost is uncertain. In fact, groupings of small employers would probably retain some important costs that are much lower for single-employer groups of comparable size. For example, average employee turnover in small firms is higher than in large firms, and the expected lifetime of the firm itself is

shorter. Greater movement in and out of the plan raises administrative cost and potentially the difficulty of underwriting even a large group. The administrative cost associated with billing and record-keeping for a grouping of small employers might also not be significantly less than for small employers individually.

Second, similarity among employees in a single large-employer group may make underwriting much easier than for participants in a group of many small employers with no particular similarity. Some researchers have suggested that multi-employer groups may be most feasible if they were industry-specific (Bovbjerg, 1986) and geographically compact, minimizing the difficulty of managing plan costs across areas with different medical practices and provider reimbursement systems. However, regardless of how multi-employer groups may be defined, their potential for reducing the cost of insurance coverage is unknown.

Because the inherent advantages of pooling are unmeasured, the public policy discussion of small employer pools has pursued ways to explicitly reduce participant cost, including (1) federal strategies to facilitate state and local subsidies to the pool, and (2) defining a minimum package of benefits that would be less comprehensive and therefore less costly than conventional employer or individual plans.

Last year Congress considered legislation that would have specifically authorized states to levy a payroll tax on employers for the purpose of financing state-level insurance pools.[6] This type of legislation might

clarify state taxing authority by explicitly preempting ERISA's potential protection of self-insured employers from nonfederal taxation related to financing a health insurance pool.

Defining a minimum benefits plan to reduce costs has proven politically difficult. Such a plan might provide, for example, catastrophic coverage with a high deductible and a limit on out-of-pocket costs for covered services. However, many argue that any acceptable plan should cover some primary care services, particularly prenatal care. The insertion of such coverages establishes a threshold cost for the plan, and a precedent for adding basic coverage for other services.

Moreover, there is little evidence that a minimum-benefit, catastrophic insurance plan would be attractive to employers or individuals. Rather, available evidence suggests that insurance plans that are attractive to most consumers are fairly comprehensive and, therefore, relatively costly--potentially too costly for the target population. Although some minimum-benefits plan might be made affordable with public subsidies, negotiated provider discounts, and managed care to control plan cost, the complexity of a workable plan has made formulation of federal policy difficult.

Despite these difficulties, however, public policy to expand coverage by pooling small employer groups may be more effective than public policy to form an insurance pool from which individuals would buy coverage. Whereas all of the administrative costs associated with pooling small employers would also occur in an insurance pool for individuals, defining a low-cost insurance

product which would be attractive to workers with an employer contributi8on might be easier, since workers might perceive their own costs of participating in the plan to be miinimal. While such a product might not provide adequate financing for basic care, it might ensure access for episodes of high-cost care (for example, neonatal care) and reduce cost shifting from the uninsured population for catastrophic illnesses.

Medicaid-related strategies. Medicaid is a state-based public insurance program for the poor in specific eligibility categories. Medicaid is intended to serve children, the disabled, and the elderly. Most nonelderly people who receive Medicaid coverage qualify through a federal or state income assistance program, usually Aid to Families with Dependent Children (AFDC) and, less commonly, Supplemental Security Income (SSI); these programs automatically confer Medicaid eligibility. Like Medicaid, AFDC is a federal-state program, and levels of qualifying income are determined by the states. In 1986, AFDC qualifying income was, on average across all states, less than 48 percent of the federal poverty standard; the median level of AFDC qualifying income was 47.5 percent of the federal poverty standard. In 1986, only 43 percent of the nonelderly poor qualified for Medicaid benefits (Chollet, 1987).

Options for expanding Medicaid eligibility among the poor and the near-poor might include:

- extending Medicaid coverage to all children under age 18 living in families with income below the federal poverty standard;

- o extending Medicaid coverage to parents of dependent children in families with income below the federal poverty standard;
- o extending Medicaid coverage to all persons below the federal poverty standard without dependent children, possibly on a buy-in basis; and
- o allowing all persons within 200 percent of the federal poverty standard to buy Medicaid coverage.

In 1985, these populations--below-poverty children and adults in families with children, below-poverty adults without children, and the nonpoor population with income less than 200 percent of poverty--were 62 percent of the nonelderly uninsured population.

Although current federal law allows states to extend Medicaid coverage to financially eligible children under age 18, about 20 states currently do so. The 1984 Deficit Reduction Act (DEFRA) required all states to extend coverage to financially eligible children under age 5 by 1988. The first option listed above would extend coverage to these children immediately and raise states' qualifying income level to the federal poverty standard.

Current federal law requires states to provide Medicaid coverage to adults in families that qualify for AFDC benefits--typically single mothers, and to all financially eligible pregnant women. States may also extend Medicaid to parents in intact families that may not qualify for AFDC benefits if they financially qualify and if the primary family worker (typically the father) is unemployed. In 1985, 25 percent of all Medicaid recipients (5.5 million people) were adults in families with dependent children, covered under these current-law provisions. The second option listed above would make such

coverage mandatory, potentially requiring states to cover all parents in intact families if they financially qualify for benefits, thus including the working poor. In addition, qualifying income would be raised to the federal poverty standard.

Current law does not allow for people who do not categorically qualify for Medicaid benefits to buy coverage from state Medicaid programs. The possibility of accomodating a "buy-in" Medicaid population, however, is frequently mentioned as one option for insuring the poor who do not categorically qualify for Medicaid, as well as the near-poor (potentially, people with income between 100 percent and 200 percent of the federal poverty standard).

Table 15 presents estimates of the 1985 uninsured population that might have benefited from the four Medicaid-related strategies listed above. Expanding Medicaid coverage to all poor children would have provided coverage to an additional 4.3 million children, 38 percent of all uninsured children in 1985. Expanding Medicaid coverage to adults in below-poverty families with dependent children would have provided coverage for 2.4 million people. If Medicaid had covered these two populations in 1985 (an additional beneficiary population of 6.7 million people), the total Medicaid population would have increased by approximately one-third over its actual 1985 level. Differences among states in the potential growth of their respective Medicaid populations might have been substantial, owing to demographic differences and to differences among states' levels of qualifying income relative to the federal poverty standard.

The other categories of individuals who might be authorized to buy Medicaid coverage--poor adults not living with children and the near-poor population--represent a larger percentage of the uninsured population and potentially a much greater expansion of the Medicaid program. These populations together totalled nearly 15 million people in 1985, 42 percent of the uninsured. Including the near-poor as well as the poor population without insurance coverage would have more than doubled the population participating in Medicaid in 1985.

In combination, these Medicaid options might have assisted 21.6 million uninsured in 1985--62 percent of the total uninsured population. About 37 percent of those newly covered by Medicaid would have been children; another 37 percent would have been adults who either did not work or worked less than full-time. About 26 percent would have been full-time workers.

For individuals who might buy into Medicaid, the potential cost may be low relative to the cost of comprehensive private insurance coverage. In 1985, Medicaid spending for all beneficiaries averaged $1,720 per beneficiary. However, for the AFDC population (excluding the elderly, blind or disabled populations who qualify for Medicaid, as well as other nonelderly SSI recipients), Medicaid spending averaged $600 per beneficiary. For AFDC children, Medicaid spending averaged $453; for adults in families with dependent children, Medicaid spending averaged $860 (see Table 16). The potential Medicaid buy-in premium for a family of two adults and two children, therefore, might have totaled $2,626, or $219 per month.

For families with near-poverty income, however, this cost is likely to be prohibitive. In 1985, poverty income for a family of four was $10,990; 150 percent of poverty income for a family of four was $16,485. A $2,626 annual Medicaid premium would have totaled almost 16 percent of gross family income for people living at 150 percent of the federal poverty standard. For a two-adult family of four with income at 200 percent of the federal poverty standard (potentially the highest income level qualifying for a Medicaid buy-in), a $2,626 annual Medicaid premium would have totalled nearly 12 percent of gross family income. Historic Medicaid costs, moreover, reflect Medicaid reimbursements to providers that are substantially below charges. This level of discount might not be feasible in the long term if the Medicaid population--and providers' Medicaid caseloads--were substantially expanded.

The potential cost of a Medicaid buy-in relative to income suggests that the population to be served--poor and near-poor uninsured--may require a substantial subsidy to afford coverage. If Medicaid were to finance 70 percent of the premium for the above two-adult family of four, the family's net premium payment for coverage would equal $66 per month--approximately 5 percent of gross family income at 150 percent of poverty.

Combining Private and Public Strategies

The growing number of the uninsured and the substantial cost associated with providing health insurance coverage for them suggests that Congress may consider a combining private and public strategies in order to distribute the

cost burden as widely as possible. Table 17 presents the potential effectiveness of combining employer-related and Medicaid-related strategies, based on the 1985 uninsured population. For the purpose of estimating workers and dependents who would be affected by each of the employer-related options, qualified employees are defined as those who work 35 hours or more per week.

The tabulations presented in Part A of Table 17 assume that employers extended coverage to all dependents of currently covered wage and salary workers, providing new coverage to 3 million dependent adults and children in 1985. If employer coverage were primary to Medicaid (that is, people with employer coverage did not participate in Medicaid), sequentially expanding Medicaid to include all poor uninsured without access to an employer plan might have assisted an additional 10.9 million uninsured--raising Medicaid's 1985 beneficiary population by 50 percent. Including the near-poor population in Medicaid would have reduced total noncoverage by two-thirds. The net uninsured population--people who would not have been assisted either by the expansion of employer coverage to dependents or by any of the Medicaid-related options--would have exceeded 11 million people. These people would have been the 1985 uninsured population with family income at or above 200 percent of poverty. Of the newly insured, 13 percent would have obtained their coverage from employer plans.

Part B of Table 17 assumes that employers extended coverage to all workers but extended no additional coverage to dependents, beyond that already provided in 1985. This employer-related option would have provided new employer coverage to 9.6 million workers. Sequentially expanding Medicaid

coverage might have assisted an additional 16.6 million uninsured, leaving a net uninsured population of 8.5 million people. In this scenario, 37 percent of the newly insured population would have obtained their coverage from employer plans.

Finally, Part C of Table 17 assumes that employers were to extend coverage both to workers and their dependents--the most comprehensive of the listed employer-related strategies. In this scenario, employers would have provided new coverage to 18.7 million workers and dependents in 1985. Sequentially expanding Medicaid coverage might have assisted an additional 10.9 million uninsured, leaving a net uninsured population of 5.3 million--15 percent of the uninsured population in 1985. Of the newly insured population, 63 percent would have obtained their coverage from employer plans.

Mandatory Compensation and Unemployment

In an effort to expand private-sector coverage, Congress is likely to seriously consider mandating that employers provide health insurance benefits to workers and/or their dependents. The implications of such a mandate for employment, however, are an important consideration, since most workers without coverage earn low wages and may be particularly vulnerable to layoffs. Furthermore, uninsured workers are concentrated in relatively few industries. These industries--retail trade, services, and construction--are the nation's "growth" industries; new employment in these industries has led economic growth since the 1981-1982 recession.

The relationship between compensation and employment is a complicated one. The simplest economic models of wages and employment suggest that increases in mandatory compensation over the level of compensation determined by the market (for example, a higher minimum wage or the imposition of a mandatory benefit) will reduce employment in jobs subject to that change. The incentive to lay off workers, however, may be mitigated by employers' ability to (1) improve their workers' productivity; (2) reduce other forms of compensation, including wages and other benefits; or (3) raise the prices of their products. Because employers can react to mandatory increases in compensation in a variety of ways, the impact of such an increase on unemployment is largely an empirical question.

Most studies of the effects of mandatory compensation have focused on the impact of raising the federal minimum wage. In particular, the effect of minimum-wage increases on employment among teen-agers has been extensively researched, since teen-agers tend to work in lower-wage jobs that may be most affected by legislation mandating minimum compensation. Among teen-agers, a 10 percent increase in the minimum wage reduces employment by 1 to 3 percent; a consensus of research also indicates that unemployment among teen-agers in response to a higher minimum wage is reduced because some of them stop looking for jobs. The unemployment effect might be greater among adults with similar wages but a stronger attachment to the labor force.

Workers in retail trade, services, and low-wage manufacturing may be particularly vulnerable to reduced employment because of mandatory health insurance coverage. In 1985, 24 percent of all uninsured workers were

employed in retail trade; another 39 percent were employed in services or manufacturing. While there is no consensus on the size of the effect, most studies indicate that the imposition of the minimum wage reduced employment in these industries (Brown et al., 1982).

Imposing a mandatory minimum health insurance benefit is presumably equivalent to raising the minimum wage in its effect on employment in low-wage jobs. Employment among workers earning more than the minimum wage may also be reduced by mandated minimum health insurance coverage, although employment among these workers may be less vulnerable than employment among minimum-wage workers.

Based on research findings for teen-agers (where a 10 percent increase in the minimum wage reduced employment by from 1 to 3 percent), a 20 percent effective increase in minimum compensation due to mandatory health insurance coverage might reduce employment among workers at or near the minimum wage by 2 to 6 percent. This impact might be reduced by scaling back the level and scope of coverage required as a minimum health insurance benefit, minimizing plan cost. However, since many uninsured workers (35 percent) apparently earn less than the federal minimum wage, this may be a conservative estimate of the employment losses likely to result from mandating health insurance as an employee beneit.

Summary

In 1985, 37 million people in the United States--17 percent of the nonelderly population--reported no health insurance coverage from any private or public insurance plan. Among the nonagricultural, nonmilitary population, 35 million reported no insurance coverage during 1985. The number of people under age 65 without insurance coverage grew 15 percent between 1982 and 1985; the number of workers without coverage grew more than 19 percent.

The slower growth of employer-based coverage relative to a rapidly growing work force and the redistribution of workers into jobs that do not offer coverage have apparently been major sources of the erosion in health insurance coverage among the nonelderly. While the number of civilian nonagricultural workers increased nearly 7 percent between 1982 and 1985, the number of workers with health insurance from an employer plan rose less than 5 percent. The slower growth in covered workers compared to total employment may be the result of an ongoing redistribution of employment toward jobs that historically have not offered benefits--jobs in small firms and in low-coverage industries. Between 1982 and 1985, employment in industries with below-average rates of employer coverage (retail trade, services and construction) grew by 17 percent, compared to 4 percent employment growth in industries with higher coverage rates.

Nearly half of all nonelderly without health insurance coverage in 1985 (49 percent) were workers; about one third (32 percent) were children age 18 or younger. Three of every five people with health insurance coverage (86

percent) lived with a worker; more than two-thirds (69 percent) lived with a full-time full-year worker (that is, a worker who worked or sought work 35 weeks or more, and worked 35 hours or more in a typical week). More than half of the uninsured (52 percent) lived with a full-time full-year worker who was steadily employed throughout the year. Nearly two-thirds of the uninsured in 1985 (62 percent) lived in poverty or within 200 percent of poverty.

The relatively low family incomes of most uninsured reflect the predominantly low earnings levels of uninsured workers. In 1985, three-quarters of all uninsured workers earned less than $10,000. More than one-third earned less than the federal minimum wage. Half of all uninsured workers were employed as wage and salary workers in two industries: retail trade and services. Nearly 16 percent of uninsured workers were self-employed.

Public policy options to expand health insurance coverage among the nonelderly population are of three general types: those that would encourage individual coverage purchase; employer-related options; and Medicaid-related options.

Despite the initiation of at least one state-wide insurance plan (Washington) designed to encourage individual purchase of health insurance, the success of such a plan may be compromised by the low incomes of most of the uninsured population. It is likely that relatively few of the uninsured could afford to buy adequate insurance coverage (that is, coverage of a wide range of services with cost-sharing scaled to income) without significant subsidization.

Employer-related coverage options might: (1) extend coverage to dependents of covered workers; (2) extend coverage to workers; or (3) to extend coverage to both workers and their dependents. The potential impact of options 2 and 3 depends critically on how qualified employees are defined; that is, what work-hour rule is adopted. If employees that work 18 or more hours per week qualify for coverage, extending coverage to these workers and their dependents might have provided coverage to nearly two-thirds of the nonelderly population that was uninsured in 1985. Extending coverage to employees that worked 35 hours or more and to their dependents might have provided coverage to nearly 54 percent of the nonelderly population that was uninsured in 1985.

Medicaid-related coverage options might: (1) extend Medicaid coverage to all children under age 18 in poverty; (2) extend Medicaid coverage to parents of children in poor families; (3) extend Medicaid coverage to other adults in poverty; or (4) extend coverage to the near-poor population (defined here as individuals and families with income between 100 and 200 percent of poverty). Extending Medicaid coverage to all children in poverty and their parents would have reduced the 1985 uninsured population by 19 percent in 1985. Covering all people in poverty would have reduced noncoverage by more than 42 percent. Although allowing the near-poor population to buy into Medicaid might have reduced the uninsured population by an additional 30 percent, a median subsidy of 70 percent of the cost of Medicaid coverage for this population might have been necessary to induce substantial participation. For a two-adult family of four, a 70-percent subsidy would have reduced the Medicaid premium (priced at the marginal cost for Medicaid's AFDC population) to 5 percent of gross family

income.

A combination of employer-related options and Medicaid-related options might have reduced the number of uninsured significantly--to as few as 15 percent of the actual 1985 uninsured population. If employers had extended coverage to all qualified employees (defined as those who worked 35 hours or more) and their dependents, and all poor and near-poor uninsured without access to an employer plan were provided Medicaid coverage, a net 5.3 million people (all with income above 200 percent of poverty) would have remained uninsured. Of the newly insured population, 63 percent would have obtained their coverage from employer plans; 37 percent would have obtained coverage from Medicaid.

Mandating employer coverage, however, may have important effects on the number and characteristics of available jobs, as well as on product prices. Because employers can react to mandatory increases in a variety of ways, the impact of mandatory new benefits on unemployment is largely an empirical question. Available research suggests that the unemployment effects of increases in the minimum wage (and presumably minimum real compensation) are largest among low-skilled workers. Industry-specific research on unemployment effects suggests that employment in retail trade may be particularly sensitive to higher minimum compensation. In 1985, nearly 24 percent of all uninsured workers were employed in retail trade.

Endnotes

[1] Tabulations of the March 1986 Current Population Survey reflect responses to questioning about sources of health insurance coverage during 1985. Due to the relatively extensive recall required by the question, responses probably reflect (1) noncoverage at the time of questioning (March 1986) for some respondents; and (2) a significant spell of noncoverage during 1985 for others. Historically, the CPS reported noncoverage is slightly higher than noncoverage reported in panel surveys that require shorter recall periods, but lower than surveys that measure noncoverage only at the time of questioning.

[2] The federal poverty standard is adjusted for family size. The 1985 federal poverty standard for a nonelderly family of two was $7,230 in 1985; the poverty standard for a family of four was $10,990.

[3] Supervisory and professional workers as well as workers in small establishments in particular industries are exempted from minimum wage provisions of the Fair Labor Standards Act. Service and retail trade workers in small establishments (defined in terms of annual gross revenues) comprise more than 80 percent of all nonagricultural nonsupervisory workers exempted from the federal minimum wage (Welch, 1982).

[4] The 1986 Wyatt Survey of Group Health Insurance Benefits estimated the average cost of health insurance benefits among small employer plans (with fewer than 100 participants) at $1,554 per participant; for very large plans (with 5,000 or more participants), plan cost averaged $1,552 per participant. Other group sizes reported average cost of $1,380 or more. Other industry surveys have reported somewhat higher average costs across all group sizes.

[5] Under current law, individuals may deduct expenditures for health insurance if they, together with other health-related expenses, exceed 7 percent of adjusted gross income. The 1986 Tax Reform Act allows qualified self-employed workers to deduct 25 percent of expenditures for health insurance from adjusted gross income.

[6] S. 1615 (introduced by Senator Kennedy, D-MA) and its companion bill H.R. 4742 (introduced by Congressman Stark, D-CA) would have encouraged states to establish insurance pools for the uninsured, to be underwritten by all employers with a health insurance plan and 20 or more employees. A version of this proposal was incorporated in the House-passed version of the Omnibus Budget Reconciliation Act of 1986 (OBRA); this bill would have required all employers with 20 or more employees to underwrite state-level health insurance pools, regardless of whether they offered insurance coverage to workers.

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Table 1

The Civilian Nonagricultural Populationa/ Without Health Insurance and Percent by Own Work Status, 1982 and 1985

Work Status	1982 People (millions)	1982 Percent	1985 People (millions)	1985 Percent	Percent Change 1982-1985
Total	30.3	15.6%	34.8	17.4%	14.9%
Workers	16.0	13.9%	19.1	15.5%	19.4%
Family Head b/	10.4	14.1%	12.3	15.6%	18.3%
Other	5.6	13.4%	6.8	15.3%	21.1%
Nonworkers	14.2	18.2%	15.6	20.4%	11.0%
Children c/	9.6	17.0%	11.1	19.7%	15.6%
Other	4.7	21.3%	4.6	22.8%	2.1%

Source: EBRI tabulations of the March Current Population Survey and the March 1986 Current Population Survey.

a/ Data exlude people under age 65 employed in the military or in agriculture, and members of their families.

b/ The family head worker is the family or subfamily member with the greatest earnings; all other family members with earnings are designated as secondary workers. Family head workers include unrelated individuals who are workers.

c/ People under age 18 who reported no earnings and were not the family head.

Table 2

Civilian Nonagricultural Population a/ With Private Health Insurance Coverage by Own Work Status and Source of Coverage, 1982 and 1985

Work Status	1982 Total Private Coverage	1982 Employer Coverage	1982 Other Private Coverage	1985 Total Private Coverage	1985 Employer Coverage	1985 Other Private Coverage
			(in millions)			
Total	146.9	130.8	24.0	147.6	131.8	23.0
Workers	92.9	83.7	14.7	97.1	87.6	14.8
Family Head b/	57.5	51.1	9.9	60.3	53.6	10.0
Other	35.4	32.6	4.8	36.8	34.0	4.8
Nonworkers	54.0	47.1	9.3	50.6	44.3	8.2
Children c/	39.5	36.1	4.9	37.7	34.9	4.1
Other	14.5	10.9	4.4	12.8	9.4	4.1
			(percent within work status group)			
Total	75.8%	67.5%	12.4%	73.9%	66.0%	11.5%
Workers	80.4%	72.4%	12.7%	78.8%	71.0%	12.0%
Family Head b/	78.1%	69.4%	13.4%	76.5%	68.0%	12.0%
Other	84.4%	77.7%	11.6%	82.7%	76.4%	10.8%
Nonworkers	69.1%	60.3%	11.8%	66.1%	57.9%	10.7%
Children c/	70.1%	64.3%	8.7%	66.8%	61.9%	7.3%
Other	66.3%	50.0%	19.9%	63.4%	46.5%	20.3%

Source and Notes: See table 1.

Table 3

Distribution of Firms and Employees by Firm Size, 1977 and 1982

Firm Size (Number of Employees)	1977 Number of Firms (thousands)	1977 Number of Employees (millions)	1982 Number of Firms (thousands)	1982 Number of Employees (millions)
Total	2,884.5	49.8	4,256.2	61.7
Under 20	2,605.2	10.7	3,886.4	16.0
20-99	240.8	9.2	320.4	12.2
100-499	32.3	6.2	42.5	8.0
500-999	3.0	2.1	3.5	2.4
1,000-2,499	1.7	2.6	2.0	3.1
2,500-4,999	0.6	2.2	0.7	2.3
5,000-9,999	0.3	2.4	0.4	2.8
10,000 or more	0.4	14.3	0.4	14.9
		(percent of total)		
Total	100.0%	100.0%	100.0%	100.0%
Under 20	90.3%	21.5%	91.3%	25.9%
20-99	8.3%	18.5%	7.5%	19.8%
100-499	1.1%	12.4%	1.0%	13.0%
500-999	0.1%	4.2%	0.1%	3.9%
1,000-2,499	0.1%	5.2%	0.0%	5.0%
2,500-4,999	0.0%	4.4%	0.0%	3.7%
5,000-9,999	0.0%	4.8%	0.0%	4.5%
10,000 or more	0.0%	28.7%	0.0%	24.1%
Note:				
Average Firm Size	17.3		14.5	

Source: U.S. Department of Commerce, Bureau of the Census, General Report on Industrial Organization: Enterprise Statistics, 1977; and ibid, 1982.

Table 4

Civilian Workers by Participation in an Employer-based Health Insurance Plan and Firm Size, 1983
(numbers in millions)

Firm Size	Total	Participants			Nonparticipants a/		
		Number of Workers	Percent of Workers Within Firm Size	Percent of All Participants	Number of Workers	Percent of Workers Within Firm Size	Percent of All Nonparticipants
Total b/	85.3	51.3	60.1%	100.0%	34.0	39.9%	100.0%
Self-employed	9.1	0.1	1.3%	0.2%	9.0	98.7%	26.5%
Under 25	21.2	7.7	36.2%	15.0%	13.5	63.8%	39.7%
25-99	10.2	6.7	65.4%	13.0%	3.5	34.6%	10.4%
100-499	10.8	8.1	75.1%	15.8%	2.7	24.9%	7.9%
500-999	4.4	3.5	79.9%	6.9%	0.9	20.1%	2.6%
1000 or more	29.5	25.2	85.3%	49.1%	4.3	14.7%	12.8%

Source: Employee Benefit Research Institute tabulations of the May 1983 Current Population Survey.

a/ Includes those who reported that they did not know if they were included in their employer's health insurance plan.

b/ Total excludes 13.7 million workers who reported that they did not know their firm's size.

Table 5

Total Nonagricultural Civilian Employment, Rates of Employment Growth, and Employer-based Health Insurance Coverage by Industry, 1985

Industry	1985 Employment: Number of workers a/ (000's)	1985 Employment: Percent of all workers	Rate of Employment Change, 1980-1985	Percent of Workers with Employer Health Plan, 1985 b/
All workers	103,163	100.0%	8.3%	75.8%
		High-coverage industries		
Mining	939	0.9%	-4.1%	88.8%
Manufacturing	20,879	20.2%	-4.8%	88.2%
Transportation, communication & public utilities	7,548	7.3%	15.7%	87.5%
Finance, insurance & real estate	7,005	6.8%	16.9%	86.1%
Wholesale trade	4,341	4.2%	10.7%	84.1%
Professional & related services	21,563	20.9%	8.6%	81.7%
Public Administration	4,995	4.8%	-6.5%	87.6%
Total, high-coverage	67,270	65.2%	4.2%	85.6%
		Low-coverage industries		
Construction	6,987	6.8%	12.4%	66.2%
Retail trade	17,955	17.4%	10.4%	63.7%
Business & repair services	5,321	5.2%	60.6%	66.0%
Personal services	4,352	4.2%	13.4%	50.3%
Entertainment & recreation	1,278	1.2%	22.1%	59.4%
Total, low-coverage	35,893	34.8%	17.0%	62.9%

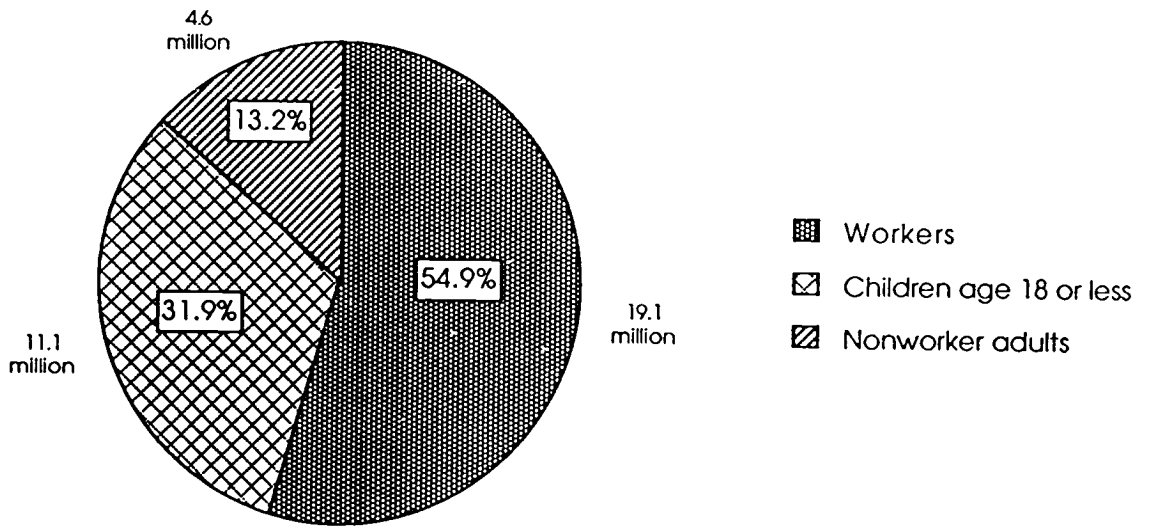
Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey; and U.S. Department of Commerce, Bureau of the Census, Statistical Abstract of the United States, 1987, page 388.

a/ Excludes agriculture, forestry, fisheries, and miscellaneous services.

b/ Includes wage and salary workers. Excludes the self-employed.

Figure 1

Nonelderly Population Without Health Insurance Coverage by Own Work Status, 1985



Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

Table 6

Nonelderly Population by Selected Sources of Health Insurance Coverage and Employment Status of Family Head, 1985

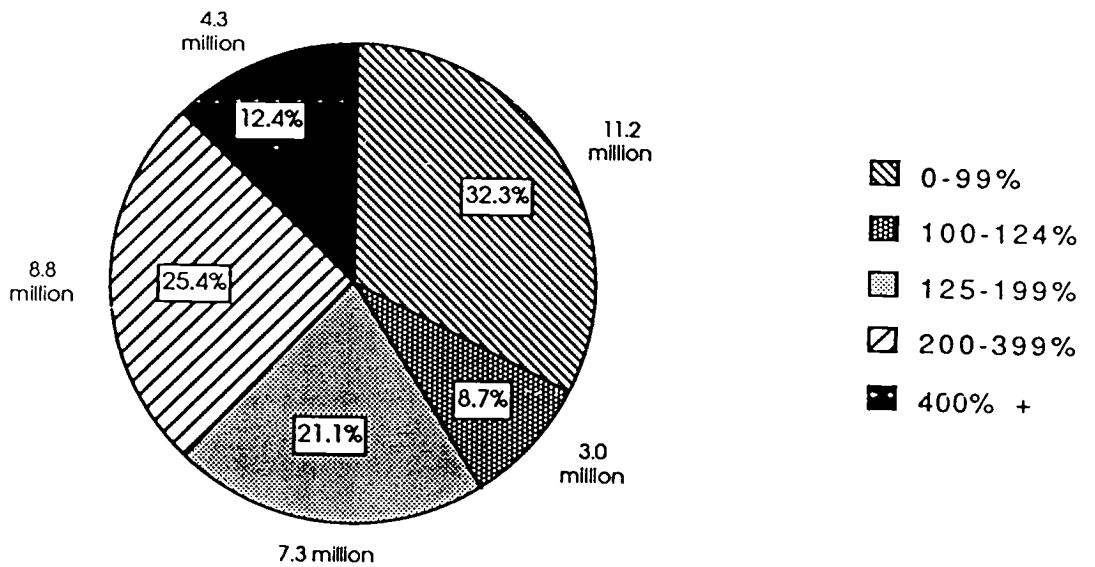
Work Status of Family Head	Total	Insured Population: Private & Public				No Health Insurance Coverage
		Total	Employer-provided			
			Total	Direct	Indirect	
		(in millions)				
Total	199.8	165.0	131.8	68.3	63.5	34.8
Full-year, full-time workers	143.5	125.3	115.7	59.4	56.3	18.2
Full-year, part-time workers	8.7	5.9	3.1	1.7	1.3	2.8
Sometime unemployed workers	19.6	13.6	9.9	5.3	4.6	6.0
Part-year workers	10.3	7.1	3.1	1.8	1.3	3.2
Nonworkers	17.7	13.1	a	a	a	4.7
		(percent within source of coverage groups)				
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Full-year, full-time workers	71.8%	75.9%	87.8%	87.0%	88.7%	52.3%
Full-year, part-time workers	4.4%	3.6%	2.4%	2.5%	2.0%	8.0%
Sometime unemployed workers	9.8%	8.2%	7.5%	7.8%	7.2%	17.2%
Part-year workers	5.2%	4.3%	2.4%	2.6%	2.0%	9.2%
Nonworkers	8.9%	7.9%	a	a	a	13.5%
		(percent within worker categories)				
Total	100.0%	82.6%	66.0%	34.2%	31.8%	17.4%
Full-year, full-time workers	100.0%	87.3%	80.6%	41.4%	39.2%	12.7%
Full-year, part-time workers	100.0%	67.8%	35.6%	19.5%	14.9%	32.2%
Sometime unemployed workers	100.0%	69.4%	50.5%	27.0%	23.5%	30.6%
Part-year workers	100.0%	68.9%	30.1%	17.5%	12.6%	31.1%
Nonworkers	100.0%	74.0%	a	a	a	26.6%

Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

a--Number too small to be statistically reliable.

Figure 2

Nonelderly Population Without Health Insurance Coverage by Family Income as a Percent of Poverty, 1985



Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

Table 7

Nonelderly Population and Population Without Health Insurance by Family Type and Family Head's Employment Status, 1985

Family Type and Unemployment/ Poverty Status	Total	No Health Insurance		
	(millions)	(millions)	(%)	(%)
Total	199.8	34.8	100.0%	17.4%
Spouse Present,				
No Child Present	40.2	5.1	14.7%	12.7%
Full-year worker	35.1	4	11.5%	11.4%
Part-Year Worker	1.6	0.3	0.9%	18.8%
Nonworker	3.5	0.8	2.3%	22.9%
Spouse Present,				
Child Present	95.6	12.1	34.8%	12.7%
Full-year worker	91.0	10.8	31.0%	11.9%
Part-Year Worker	2.3	0.7	2.0%	30.4%
Nonworker	2.3	0.6	1.7%	26.1%
No Spouse Present,				
No Child Present	34.3	8.7	25.0%	25.4%
Full-year worker	27.7	6.2	17.8%	22.4%
Part-Year Worker	2.4	0.9	2.6%	37.5%
Nonworker	4.2	1.6	4.6%	38.1%
No Spouse Present,				
Child Present	29.6	8.8	25.3%	29.7%
Full-year worker	18.0	5.9	17.0%	32.8%
Part-Year Worker	4.0	1.2	3.4%	30.0%
Nonworker	7.6	1.7	4.9%	22.4%

Source: EBRI tabulations of the March 1985 Current Population Survey.

Table 8

Children Under Age 18 Without Health Insurance by Family Type and Poverty Status, and Sex and Work Status of the Family Head, 1985

	Total	Family Income as a Percent of Poverty			
		0-99%	100-124%	125-199%	200% +
			(in millions)		
All Uninsured Children	10.8	4.2	1.1	2.4	3.1
Family Type and Work Status					
Spouse Present	5.9	1.8	0.6	1.4	2
Family Head is:					
Full-year worker	5.2	1.4	0.6	1.3	1.9
Part-year worker	0.3	0.1	a	0.1	a
Nonworker	0.3	0.2	a	a	a
Spouse Absent	4.9	2.4	0.4	1.0	1.1
Family Head is:					
Male	1.0	0.3	0.1	0.2	0.3
Full-year worker	0.7	0.2	a	0.2	0.3
Part-year worker	0.1	0.1	a	a	a
Nonworker	0.1	a	a	a	a
Female	4.0	2.1	0.3	0.8	0.8
Full-year worker	2.5	0.9	0.3	0.6	0.7
Part-year worker	0.5	0.4	a	a	a
Nonworker	1.0	0.9	a	a	a
			(percents within family status groups)		
All Uninsured Children	100.0%	100.0%	100.0%	100.0%	100.0%
Family Type and Work Status					
Spouse Present	54.6%	42.9%	54.5%	58.3%	64.5%
Family Head is:					
Full-year worker	48.1%	33.3%	54.5%	54.2%	61.3%
Part-year worker	2.8%	2.4%	a	4.2%	a
Nonworker	2.8%	4.8%	a	a	a
Spouse Absent	45.4%	57.1%	36.4%	41.7%	35.5%
Family Head is:					
Male	9.3%	7.1%	9.1%	8.3%	9.7%
Full-year worker	6.5%	4.8%	a	8.3%	9.7%
Part-year worker	0.9%	2.4%	a	a	a
Nonworker	0.9%	a	a	a	a
Female	37.0%	50.0%	27.3%	33.3%	25.8%
Full-year worker	23.1%	21.4%	27.3%	25.0%	22.6%
Part-year worker	4.6%	9.5%	a	a	a
Nonworker	9.3%	21.4%	a	a	a
			(percents within poverty status groups)		
All Uninsured Children	100.0%	38.9%	10.2%	22.2%	28.7%
Family Type and Work Status					
Spouse Present	100.0%	30.5%	10.2%	23.7%	33.9%
Family Head is:					
Full-year worker	100.0%	26.9%	11.5%	25.0%	36.5%
Part-year worker	100.0%	33.3%	a	33.3%	a
Nonworker	100.0%	66.7%	a	a	a
Spouse Absent	100.0%	49.0%	8.2%	20.4%	22.4%
Family Head is:					
Male	100.0%	30.0%	10.0%	20.0%	30.0%
Full-year worker	100.0%	28.6%	a	28.6%	42.9%
Part-year worker	100.0%	100.0%	a	a	a
Nonworker	100.0%	a	a	a	a
Female	100.0%	52.5%	7.5%	20.0%	20.0%
Full-year worker	100.0%	36.0%	12.0%	24.0%	28.0%
Part-year worker	100.0%	80.0%	a	a	a
Nonworker	100.0%	90.0%	a	a	a

Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

a--Number too small to be statistically reliable.

Table 9

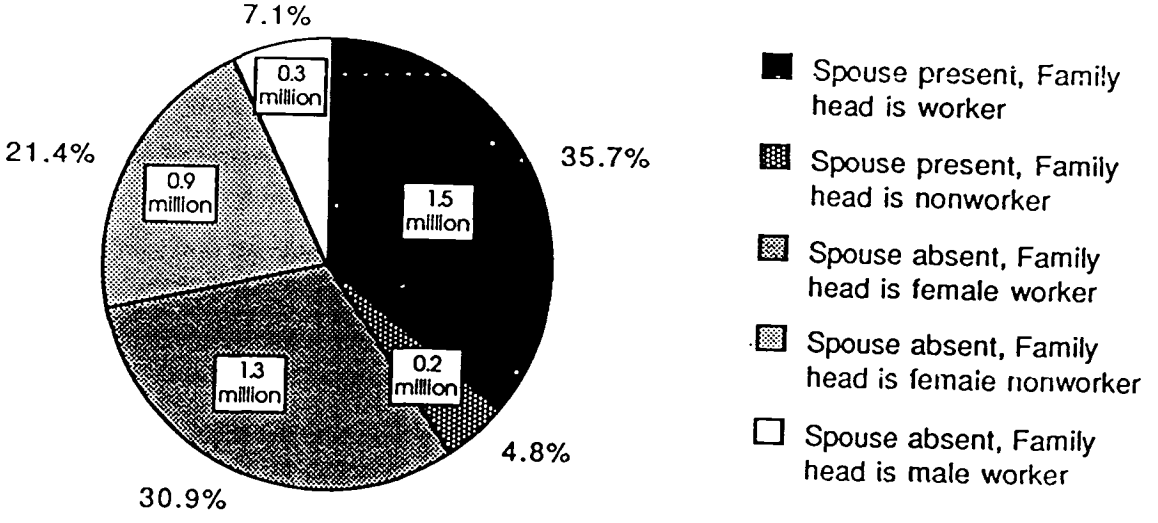
Nonelderly Population by Selected Sources of Health Insurance Coverage and Region and State, 1985

	Total	Total Private	Total Employer	Total Public	Medicaid	No Health Insurance	
	(thousands)	(%)	(%)	(%)	(%)	(thousands)	(%)
Total	199,765	73.9%	66.0%	12.0%	8.0%	34,759	17.4%
New England	10,733	80.9%	74.0%	9.9%	6.7%	1,302	12.1%
Maine	929	78.6%	71.1%	14.3%	9.2%	109	11.7%
New Hampshire	863	84.4%	78.3%	a	a	109	12.6%
Vermont	454	78.6%	71.1%	a	a	a	a
Massachusetts	5,022	78.8%	72.4%	10.9%	8.2%	657	13.1%
Rhode Island	790	80.2%	73.0%	a	a	101	12.8%
Connecticut	2,675	85.0%	77.5%	8.2%	4.9%	258	9.7%
Middle Atlantic	31,412	75.2%	67.8%	13.0%	10.5%	4,521	14.4%
New York	15,226	70.3%	64.2%	15.9%	13.7%	2,471	16.2%
New Jersey	6,517	80.5%	72.3%	9.3%	6.6%	806	12.4%
Pennsylvania	9,669	79.3%	70.4%	10.9%	8.2%	1,245	12.9%
East North Central	35,678	76.2%	69.0%	13.3%	10.5%	4,894	13.7%
Ohio	9,191	76.8%	69.7%	11.3%	8.3%	1,332	14.5%
Indiana	4,537	79.0%	71.1%	6.6%	3.6%	769	16.9%
Illinois	10,137	73.9%	67.5%	14.4%	11.6%	1,469	14.5%
Michigan	7,886	74.9%	67.0%	18.2%	15.2%	940	11.9%
Wisconsin	3,928	80.3%	72.2%	13.2%	11.2%	383	9.8%
West North Central	13,928	78.4%	68.1%	10.6%	7.2%	1,957	14.1%
Minnesota	3,410	81.9%	71.3%	10.5%	7.4%	383	11.2%
Iowa	2,135	77.9%	68.1%	12.4%	10.7%	272	12.7%
Missouri	4,234	74.3%	65.5%	11.4%	7.4%	697	16.5%
North Dakota	500	82.4%	67.7%	a	a	a	a
South Dakota	504	76.5%	64.3%	a	a	89	17.7%
Nebraska	1,224	80.0%	68.3%	7.8%	a	185	15.1%
Kansas	1,920	80.4%	69.2%	9.3%	5.4%	273	14.2%
South Atlantic	32,627	73.1%	64.8%	12.0%	6.4%	6,123	18.8%
Delaware	519	74.9%	69.2%	a	a	93	17.9%
Maryland	3,641	77.9%	69.8%	10.0%	6.0%	546	15.0%
District of Columbia	517	62.7%	53.9%	18.2%	a	117	22.7%
Virginia	4,549	76.4%	70.7%	10.0%	5.2%	754	16.6%
West Virginia	1,571	68.4%	58.3%	17.9%	13.0%	292	18.6%
North Carolina	5,066	77.1%	69.2%	10.9%	4.3%	824	16.3%
South Carolina	2,713	76.6%	68.8%	12.9%	7.9%	392	14.4%
Georgia	4,968	71.5%	65.2%	14.2%	8.5%	904	18.2%
Florida	9,083	68.3%	57.6%	11.6%	5.2%	2,200	24.2%
East South Central	12,511	70.4%	61.5%	11.8%	7.4%	2,641	21.1%
Kentucky	3,001	72.3%	62.0%	10.7%	6.7%	638	21.2%
Tennessee	3,944	69.1%	60.9%	13.2%	8.3%	834	21.1%
Alabama	3,432	72.5%	64.3%	9.5%	6.5%	686	20.0%
Mississippi	2,134	66.6%	57.6%	14.6%	8.1%	483	22.6%
West South Central	22,487	69.9%	62.5%	9.8%	5.2%	5,255	23.4%
Arkansas	1,928	64.4%	56.6%	16.9%	9.3%	469	24.3%
Louisiana	3,741	72.4%	62.7%	8.1%	4.0%	822	22.0%
Oklahoma	2,762	68.2%	59.0%	10.3%	4.4%	698	25.3%
Texas	14,056	70.3%	63.9%	9.2%	5.1%	3,266	23.2%
Mountain	10,889	74.7%	65.3%	9.6%	3.8%	2,114	19.4%
Montana	668	74.2%	62.1%	11.5%	a	123	18.4%
Idaho	800	74.2%	64.2%	a	a	169	21.2%
Wyoming	419	77.6%	69.0%	a	a	a	a
Colorado	2,795	77.2%	68.1%	7.1%	3.4%	513	18.4%
New Mexico	1,228	64.8%	57.8%	16.2%	6.9%	286	23.3%
Arizona	2,658	73.7%	62.0%	9.6%	a	570	21.4%
Utah	1,481	80.8%	74.2%	7.5%	a	206	13.9%
Nevada	839	73.0%	63.3%	10.6%	a	179	21.3%
Pacific	29,499	70.3%	62.6%	13.3%	9.1%	5,951	20.2%
Washington	3,565	75.0%	65.2%	13.6%	8.0%	589	16.5%
Oregon	2,268	77.9%	67.1%	8.7%	4.5%	388	17.1%
California	22,422	68.3%	61.5%	13.7%	9.9%	4,803	21.4%
Alaska	439	76.6%	62.4%	a	a	77	17.4%
Hawaii	805	80.6%	70.7%	13.8%	a	95	11.8%

Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.
a--Number too small to be statistically reliable.

Figure 3

Children Under Age 18 Without Health Insurance Living in Poverty by Family Type, 1985

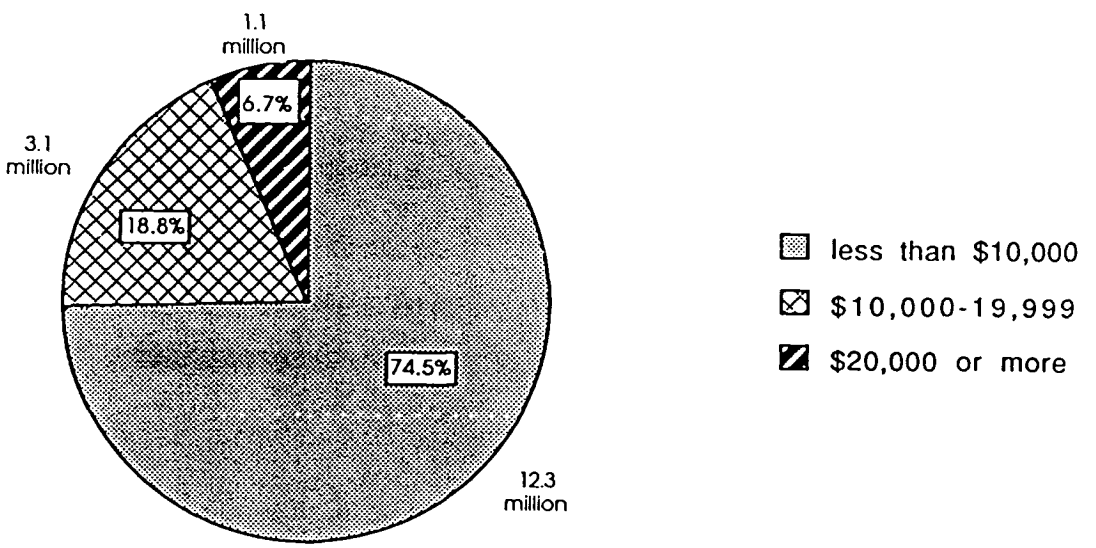


Note: The number of uninsured poor children living with a single male nonworker is too small to be statistically reliable

Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

Figure 4

Workers Age 18-64 Without Health Insurance Coverage by Personal Earnings, 1985



Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

Table 10

Full-year Workers Age 18-64 by Sources of Health Insurance and Personal Earnings, 1985

Personal Earnings	Total	Employer-based Coverage			No Coverage
		Total	Direct	Indirect	
		(millions)			
Total	98.5	77.1	65.5	11.6	13.3
Under $10,000	31.3	16.6	9.3	7.3	9.2
$10,000-19,999	30.3	25.8	23.0	2.9	3.0
$20,000-29,999	19.4	18.1	17.2	0.9	0.7
$30,000-39,999	9.8	9.3	9.0	0.3	0.3
$40,000-49,999	3.8	3.6	3.5	0.1	a
$50,000 or more	3.9	3.6	3.5	0.1	0.1
		(percent within coverage groups)			
Total	100.0%	100.0%	100.0%	100.0%	100.0%
Under $10,000	31.8%	21.5%	14.1%	63.0%	69.0%
$10,000-19,999	30.8%	33.5%	35.1%	24.6%	22.5%
$20,000-29,999	19.7%	23.5%	26.3%	7.9%	5.4%
$30,000-39,999	9.9%	12.1%	13.8%	2.7%	1.9%
$40,000-49,999	3.8%	4.7%	5.3%	0.9%	a
$50,000 or more	4.0%	4.7%	5.3%	0.9%	0.7%
		(percent within earnings groups)			
Total	100.0%	78.3%	66.5%	11.8%	13.5%
Under $10,000	100.0%	52.9%	29.5%	23.4%	29.3%
$10,000-19,999	100.0%	85.3%	75.9%	9.4%	9.9%
$20,000-29,999	100.0%	93.4%	88.7%	4.7%	3.7%
$30,000-39,999	100.0%	95.2%	92.0%	3.2%	2.6%
$40,000-49,999	100.0%	95.9%	93.2%	2.7%	a
$50,000 or more	100.0%	92.6%	89.8%	2.7%	2.5%

Source: EBRI tabulations of the March 1986 Current Population Survey.
a/ Number too small to be statistically reliable.

Table 11

Workers Age 18-64 by Selected Sources of Health Insurance Coverage and Hourly Earnings as a Percent of the Federal Minimum Wage, 1985

Hourly Wages as a Percent of Minimum Wage	Total	Insured Population: Private & Public							No Health Insurance Coverage
		Total Insured	Private				Public		
			Total Private	Employer-provided			Total Public	Medicaid	
				Total	Direct	Indirect			
		(in millions)							
Total	112.4	95.9	92.6	85.1	68.4	16.7	6.6	2.6	16.5
0-99%	18.3	12.5	11.1	8.3	3.2	5.0	2.0	1.1	5.8
100-124%	8.8	6.3	5.8	5.0	2.7	2.3	0.9	0.5	2.5
125-199%	24.5	20.0	19.3	17.6	13.2	4.4	1.5	0.6	4.5
200-399%	40.6	37.6	37.1	35.7	31.7	3.9	1.6	0.4	3.0
400% or more	20.2	19.4	19.3	18.6	17.5	1.1	0.7	0.1	0.8
		(percents within source of coverage groups)							
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
0-99%	16.3%	13.0%	12.0%	9.8%	4.7%	29.9%	30.3%	42.3%	35.2%
100-124%	7.8%	6.6%	6.3%	5.9%	3.9%	13.8%	13.6%	19.2%	15.2%
125-199%	21.8%	20.9%	20.8%	20.7%	19.3%	26.3%	22.7%	23.1%	27.3%
200-399%	36.1%	39.2%	40.1%	42.0%	46.3%	23.4%	24.2%	15.4%	18.2%
400% or more	18.0%	20.2%	20.8%	21.9%	25.6%	6.6%	10.6%	3.8%	4.8%
		(percents within minimum wage groups)							
Total	100.0%	85.3%	82.4%	75.8%	60.9%	14.9%	5.9%	2.4%	14.7%
0-99%	100.0%	68.3%	60.7%	45.3%	17.5%	27.6%	10.7%	5.7%	31.7%
100-124%	100.0%	71.6%	65.6%	56.4%	30.7%	25.7%	9.8%	5.3%	28.3%
125-199%	100.0%	81.6%	78.8%	71.2%	54.1%	17.9%	6.3%	2.6%	18.3%
200-399%	100.0%	92.6%	91.5%	87.8%	78.1%	9.7%	3.9%	0.9%	7.4%
400% or more	100.0%	96.0%	95.5%	92.1%	86.9%	5.3%	3.5%	0.6%	3.8%

Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

Table 12

Workers Age 18-64 by Selected Sources of Coverage and Industry of Primary Employment, 1985

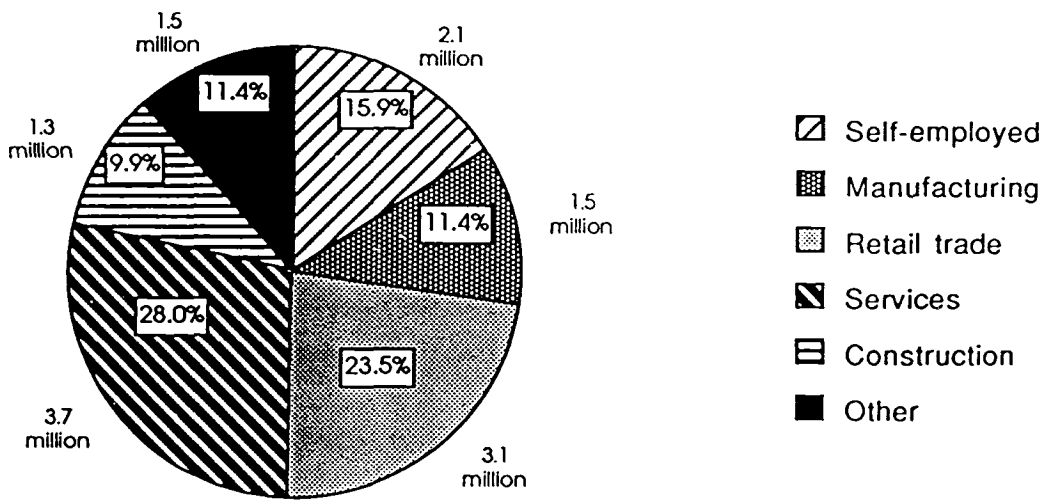
		Employer-based coverage				
	Total	Total	Direct	Indirect	No Coverage	
	(millions)	(%)	(%)	(%)	(millions)	(%)
Total	112.4	75.6%	60.8%	14.8%	16.6	14.8%
Self-employed	9.7	51.5%	28.9%	21.6%	2.3	23.7%
Mining	1.1	81.8%	81.8%	a	0.1	9.1%
Construction	6.3	66.7%	55.6%	11.1%	1.5	23.8%
Manufacturing	21.9	88.1%	81.7%	6.4%	1.9	8.7%
Transportation, Communication & Other Public Utilities	7.6	86.8%	80.3%	6.6%	0.6	7.9%
Wholesale trade	4.1	82.9%	73.2%	9.8%	0.4	9.8%
Retail trade	17.6	63.6%	39.8%	23.9%	4.1	23.3%
Finance, Insurance & Real Estate	6.6	86.4%	72.7%	13.6%	0.5	7.6%
Business & Repair Services	5.3	66.0%	49.1%	17.0%	1.2	22.6%
Personal Services	3.7	48.6%	27.0%	21.6%	1.2	32.4%
Entertainment & Recreation Services	1.3	53.8%	30.8%	23.1%	0.3	23.1%
Professional and Related Services	21.9	81.7%	63.9%	17.8%	2.2	10.0%
Public Administration	5.4	88.9%	79.6%	9.3%	0.3	5.6%

Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

a--Number too small to be statistically reliable.

Figure 5

Full Year Workers Age 18-64 Without Health Insurance Coverage by Industry of Primary Employment, 1985



Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

Table 13

Workers Age 18-64 by Selected Sources of Health Insurance Coverage by Sex and Age, 1985

	Total	Total Private	Employer-based		Total Public	Uninsured	
			Direct	Indirect			
	(millions)	(%)	(%)	(%)	(%)	(millions)	(%)
Total	112.4	82.4%	60.9%	14.9%	5.9%	16.5	14.7%
Men	60.2	82.4%	68.2%	8.1%	5.0%	9.3	15.4%
Women	52.2	82.3%	52.5%	22.7%	6.9%	7.3	13.9%
Age							
18-20	7.9	70.6%	20.1%	42.7%	9.7%	1.9	23.6%
21-24	13.3	66.6%	48.2%	11.8%	6.3%	3.9	29.3%
25-29	17.5	80.6%	65.7%	10.1%	4.4%	2.9	16.6%
30-44	43.3	86.3%	66.4%	14.9%	5.0%	4.8	11.1%
45-54	17.6	87.6%	67.0%	13.6%	6.2%	1.8	10.3%
55 +	12.7	87.8%	65.9%	9.0%	7.8%	1.2	9.8%

Source: EBRI tabulations of the March 1986 Current Population Survey.

Table 14

Reduction in the Uninsured Population from Expanding Employer Coverage: Alternative Definitions of Qualified Employees, 1985

Definition of Qualified Employee: Hours Worked per Week	Total Uninsured a/	Population Affected				Net Uninsured
		Total	Wage & Salary Workers	Dependents of Wage & Salary Workers		
				Adults	Children	
			(in millions)			
All Dependents Covered						
More than 0 hours	34.8	3.0	0.4	0.3	2.3	31.7
18 hours or more	34.8	3.1	0.4	0.3	2.4	31.6
35 hours or more	34.8	3.0	0.3	0.4	2.3	31.7
All Employees Covered						
More than 0 hours	34.8	14.3	14.3	0.0	0.0	20.4
18 hours or more	34.8	13.0	13.0	0.0	0.0	21.8
35 hours or more	34.8	9.6	9.6	0.0	0.0	25.2
All Employees and Dependents Covered						
More than 0 hours	34.8	24.4	14.3	1.5	8.5	10.4
18 hours or more	34.8	22.9	13.0	1.6	8.3	11.9
35 hours or more	34.8	18.6	9.6	1.7	7.4	16.1
			(percents)			
All Dependents Covered						
More than 0 hours	100.0%	8.7%	1.1%	0.9%	6.8%	91.3%
18 hours or more	100.0%	9.0%	1.0%	1.0%	7.0%	91.0%
35 hours or more	100.0%	8.7%	0.7%	1.2%	6.7%	91.3%
All Employees Covered						
More than 0 hours	100.0%	41.3%	41.3%	0.0%	0.0%	58.7%
18 hours or more	100.0%	37.3%	37.3%	0.0%	0.0%	62.7%
35 hours or more	100.0%	27.6%	27.6%	0.0%	0.0%	72.4%
All Employees and Dependents Covered						
More than 0 hours	100.0%	70.2%	41.3%	4.4%	24.5%	29.8%
18 hours or more	100.0%	65.9%	37.3%	4.5%	24.0%	34.1%
35 hours or more	100.0%	53.6%	27.6%	4.8%	21.1%	46.4%

Source: EBRI tabulations of the March 1986 Current Population Survey (U.S. Department of Commerce, Commerce, Bureau of the Census).

Note: Detail may not add to totals due to rounding.
a/ Includes self-employed and nonworkers and their respective dependents.

Table 15

Reduction of the Uninsured Population from Expanding Medicaid Coverage: Alternative Options by Beneficiary Type, 1985

Type of Medicaid-related Policy	Total	Workers	Nonworkers	
			Adults	Children
		(in millions)		
Total Uninsured	34.8	11.5	12.0	11.3
Medicaid Options:				
Cover All Children in Poverty	4.3	-	-	4.3
Cover Adults in Families With Children in Poverty	2.4	0.9	1.5	-
Cover Other Adults in Poverty	4.5	1.4	3.2	-
Cover All People Living in 100-200% of Poverty	10.4	3.5	3.2	3.6
Total, All Medicaid Options	21.6	5.8	7.9	7.9
Net Uninsured	13.2	5.7	4.0	3.4
		(percent within population group)		
Total Uninsured	100.0%	100.0%	100.0%	100.0%
Medicaid Options:				
Cover All Children in Poverty	12.3%	-	-	38.0%
Cover Adults in Families With Children in Poverty	7.0%	7.7%	12.9%	-
Cover Other Adults in Poverty	13.0%	11.7%	26.5%	-
Cover All People Living in 100-200% of Poverty	29.8%	30.6%	26.9%	32.2%
Total, All Medicaid Options	62.2%	50.1%	66.3%	70.2%
Net Uninsured	37.8%	49.9%	33.7%	29.8%
		(as a percent of all uninsured)		
Total Uninsured	100.0%	33.1%	34.5%	32.4%
Medicaid Options:				
Cover All Children in Poverty	12.3%	-	-	12.3%
Cover Adults in Families With Children in Poverty	7.0%	2.6%	4.4%	-
Cover Other Adults in Poverty	13.0%	3.9%	9.1%	-
Cover All People Living in 100-200% of Poverty	29.8%	10.1%	9.3%	10.4%
Total, All Medicaid Options	62.2%	16.6%	22.9%	22.7%
Net Uninsured	37.8%	16.5%	11.6%	9.7%

Source: EBRI tabulations of the March 1986 Current Population Survey.

Table 16

Number of Medicaid Recipients and Expenditures by Basis of Eligibility, Fiscal Year 1985

Basis of Eligibility	Number of Recipients (thousands)	Percent of All Recipients	Total Expenditures (millions)	Percent of Total Expenditures	Expenditures per Recipient
All Eligibility Categories	21,808.3	100.0%	$37,507.6	100.0%	$1,720
Age 65 or older	3,061.4	14.0%	14,096.3	37.6%	$4,605
Blind	80.3	0.4%	249.4	0.7%	$3,106
Permanently and totally disabled	2,936.4	13.5%	13,202.8	35.2%	$4,496
Dependent children under age 21	9,752.4	44.7%	4,414.3	11.8%	$453
Adults in families with dependent children	5,517.5	25.3%	4,746.4	12.7%	$860
Other SSI recipients	1,213.7	5.6%	798.4	2.1%	$658

Source: Unpublished data from the U.S. Department of Health and Human Services, Health Care Financing Administration.

Note: Figures may not add to total due to rounding. In addition, eligibility figures may not add to to totals because a recipient may be eligible under more than one category.

Table 17

Effects of Combined Employer and Medicaid Expansion Coverage on the Uninsured Population: Alternative Options by Qualified Employer-based Groups and Type of Beneficiary, 1985

Policy Type	Total	Wage & Salary Workers	Dependents of Wage & Salary Workers		Self-employed Workers and Their Dependents			Nonworkers and Their Dependents		Net Uninsured
			Adults	Children	Workers	Adults	Children	Adults	Children	
Part A				(in millions)						
Dependents Covered	34.8	0.3	0.4	2.3	0.0	0.0	0.0	0.0	0.0	31.7
Medicaid Coverage Options:										
Children in Poverty	31.7	0.0	0.0	1.7	0.0	0.0	0.2	0.0	2.0	27.7
Poor Adults with Children	31.7	0.8	0.2	0.0	0.1	0.1	0.0	1.2	0.0	29.3
Other Poor Adults	31.7	1.1	0.2	0.0	0.2	0.2	0.0	2.9	0.0	27.3
People 100-200% of Poverty	31.7	3.0	0.5	1.9	0.5	0.3	0.3	2.3	0.6	22.4
Total, All Options	31.7	4.9	0.9	3.6	0.8	0.5	0.5	6.4	2.7	11.5
				(percent of all uninsured)						
Dependents Covered	100.0%	0.7%	1.2%	6.7%	0.0%	0.0%	0.0%	0.0%	0.0%	91.3%
Medicaid Coverage Options:										
Children in Poverty	91.3%	0.0%	0.0%	4.9%	0.0%	0.0%	0.7%	0.0%	5.9%	79.8%
Poor Adults with Children	91.3%	2.2%	0.7%	0.0%	0.3%	0.3%	0.0%	3.5%	0.0%	84.3%
Other Poor Adults	91.3%	3.2%	0.5%	0.0%	0.5%	0.4%	0.0%	8.2%	0.0%	78.4%
People 100-200% of Poverty	91.3%	8.6%	1.3%	5.5%	1.3%	0.8%	0.8%	6.7%	1.8%	64.5%
Total, All Options	91.3%	14.0%	2.5%	10.4%	2.2%	1.6%	1.4%	18.4%	7.7%	33.1%
Part B				(in millions)						
All Employees Covered	34.8	9.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	25.2
Medicaid Coverage Options:										
Children in Poverty	25.2	0.0	0.0	2.0	0.0	0.0	0.2	0.0	2.0	21.1
Poor Adults with Children	25.2	0.0	0.3	0.0	0.1	0.1	0.0	1.2	0.0	23.7
Other Poor Adults	25.2	0.0	0.2	0.0	0.2	0.2	0.0	2.9	0.0	22.1
People 100-200% of Poverty	25.2	0.0	0.6	2.7	0.5	0.3	0.3	2.3	0.6	18.9
Total, All Options	25.2	0.0	1.0	4.7	0.8	0.5	0.5	6.4	2.7	8.5
				(percent of all uninsured)						
All Employees Covered	100.0%	27.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	72.4%
Medicaid Coverage Options:										
Children in Poverty	72.4%	0.0%	0.0%	5.7%	0.0%	0.0%	0.7%	0.0%	5.9%	60.8%
Poor Adults with Children	72.4%	0.0%	0.7%	0.0%	0.3%	0.3%	0.0%	3.5%	0.0%	68.2%
Other Poor Adults	72.4%	0.0%	0.6%	0.0%	0.5%	0.4%	0.0%	8.2%	0.0%	63.6%
People 100-200% of Poverty	72.4%	0.0%	1.7%	7.9%	1.3%	0.8%	0.8%	6.7%	1.8%	54.2%
Total, All Options	72.4%	0.0%	3.0%	13.6%	2.2%	1.6%	1.4%	18.4%	7.7%	24.5%

Table 17

(continued)

Effects of Combined Employer and Medicaid Expansion Coverage on the Uninsured Population: Alternative Options by Qualified Employer-based Groups and Type of Beneficiary, 1985

Policy Type	Total	Wage & Salary Workers	Dependents of Wage & Salary Workers		Self-employed Workers and Their Dependents			Nonworkers and Their Dependents		Net Uninsured
			Adults	Children	Workers	Adults	Children	Adults	Children	
Part C										
					(in millions)					
All Employees and Dependents Covered	34.8	9.6	1.7	7.4	0.0	0.0	0.0	0.0	0.0	16.1
Medicaid Coverage Options:										
Children in Poverty	16.1	0.0	0.0	0.0	0.0	0.0	0.2	0.0	2.0	14.1
Poor Adults with Children	16.1	0.0	0.0	0.0	0.1	0.1	0.0	1.2	0.0	14.9
Other Poor Adults	16.1	0.0	0.0	0.0	0.2	0.2	0.0	2.9	0.0	13.3
People 100-200% of Poverty	16.1	0.0	0.0	0.0	0.5	0.3	0.3	2.3	0.6	13.2
Total, All Options	16.1	0.0	0.0	0.0	0.8	0.5	0.5	6.4	2.7	5.3
					(percent of all uninsured)					
All Employees and Dependents Covered	100.0%	27.6%	4.8%	21.1%	0.0%	0.0%	0.0%	0.0%	0.0%	46.4%
Medicaid Coverage Options:										
Children in Poverty	46.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.7%	0.0%	5.9%	40.6%
Poor Adults with Children	46.4%	0.0%	0.0%	0.0%	0.3%	0.3%	0.0%	3.5%	0.0%	43.0%
Other Poor Adults	46.4%	0.0%	0.0%	0.0%	0.5%	0.4%	0.0%	8.2%	0.0%	38.2%
People 100-200% of Poverty	46.4%	0.0%	0.0%	0.0%	1.3%	0.8%	0.8%	6.7%	1.8%	37.9%
Total, All Options	46.4%	0.0%	0.0%	0.0%	2.2%	1.6%	1.4%	18.4%	7.7%	15.2%

Source: EBRI tabulations of the March 1986 Current Population Survey.