NEWS RELEASE

820 First Street, NE, Suite 510
Washington, DC 20002

Tel: 202-408-1080
Fax: 202-408-1056

center@cbpp.org
www.cbpp.org

CENTER ON BUDGET AND POLICY PRIORITIES

EMBARGOED UNTIL:
Revised October 8, 2003

CONTACT: Michelle Bazie
202-408-1080

NUMBER OF AMERICANS WITHOUT HEALTH INSURANCE ROSE IN 2002

Increase Would Have Been Much Larger If Medicaid and SCHIP Enrollment Gains Had Not Offset the Loss of Private Health Insurance

The ranks of those without health insurance grew from 41.2 million in 2001 to 43.6 million in 2002, according to new data the Census Bureau has just released.[1] The percentage who lack insurance rose from 14.6 percent in 2001 to 15.2 percent in 2002.

The primary factor behind the increase in the number of uninsured was an erosion in both adults' and children's private health insurance coverage, driven by the weak economy, rising unemployment and the increasing costs of health care. These developments made it harder last year for workers and their dependents to retain employer-sponsored health insurance coverage.

In response to the loss of private insurance coverage and the increase in the number of low-income families and other individuals, enrollment in the Medicaid program and the State Children's Health Insurance Program responded by expanding to pick up millions more people in 2002.

"If enrollment in Medicaid and the State Children's Health Insurance Program (SCHIP) had not grown in 2002, the number of Americans without health insurance would have been much higher," said Leighton Ku, Senior Fellow in Health Policy at the Center on Budget and Policy Priorities. Ku noted that enrollment in Medicaid grew by 3.2 million in 2002, while enrollment in SCHIP increased about 600,000 (not including children counted as Medicaid beneficiaries), according to state administrative data.

"Medicaid's ability to respond during economic downturns to cover substantial numbers of newly eligible people who would otherwise be uninsured depends directly on its status as an entitlement program, under which funding levels increase when need grows," Ku said. "Had federal Medicaid funding been capped under a block grant, as the Bush Administration proposed earlier this year, rather than rising automatically in response to the increased need, states would not have been able to afford to cover substantial numbers of additional people who lost their jobs and their health insurance, and the ranks of the uninsured would have swelled to a much greater degree."

[1] Robert Mills, *Health Insurance Coverage in the United States: 2002*, Current Population Reports P60-223, U.S. Census Bureau, September 2003. For the March 2003 Current Population Survey (CPS), being uninsured means that a person did not have any insurance coverage during 2002. Having Medicaid or private coverage means a person had that form of health insurance for at least some part of the year.

Although there that are signs the economy is now gradually recovering, evidence suggests that private health insurance coverage will continue to deteriorate in 2003. Unemployment rates have been modestly higher so far in 2003 than they were in 2002, and health care costs are still surging. Medicaid enrollment is continuing to grow, as well, although at a somewhat slower pace than in 2002. These developments indicate that the number of people without health insurance is likely to increase again in 2003, for the third consecutive year.

Key Findings from the New Census Data

- The percentage of non-elderly adults (those aged 18 to 64) with private health insurance slipped from 70.9 percent in 2001 to 69.6 percent in 2001 (see Table 1). A small part of this loss was offset by growth in Medicaid coverage, which increased from 6.7 percent of non-elderly adults in 2001 to 6.9 percent in 2002. The overall percentage of non-elderly adults who lacked health insurance climbed from 18.5 percent in 2001 to 19.5 percent in 2002.

- Private health insurance coverage for children also dropped, falling from 68.4 percent of children in 2001 to 67.5 percent in 2002. In contrast to what happened to coverage for adults, however, the loss of children's private insurance coverage was *entirely* offset by increases in enrollment in Medicaid and SCHIP. The percentage of children insured through one of these programs increased from 22.7 percent in 2001 to 23.9 percent in 2002. As a result, there was a very small reduction in the percentage of children who are uninsured — from 11.7 percent in 2001 and 11.6 percent in 2002 — although this change was not statistically significant.

Table 1
Changes in Selected Categories of Insurance Coverage, 2001 to 2002, Based on the Current Population Survey

	Private Health Insurance		Medicaid or SCHIP		Uninsured	
	2001	2002	2001	2002	2001	2002
Total U.S. Population	70.9%	69.6%	11.2%	11.6%	14.6%	15.2%*
Selected Subpopulations						
Children, under 18 years	68.4%	67.5%	22.7%	23.9%	11.7%	11.6%
Adults, 18 to 64 years	73.7%	72.2%	6.7%	6.9%	18.5%	19.5%*

* The change in the percentage of those uninsured is significant with 90 percent or better confidence. The Census Bureau reported significance levels for changes in the uninsured, but did not report them for changes in private insurance or Medicaid/SCHIP coverage.

Note: Coverage by other forms of health insurance (e.g., Medicare or military health coverage) is not shown in this table. People may report having more than one type of insurance during the year.

Source: March 2002 and 2003 Current Population Surveys, analyzed by the Center on Budget and Policy Priorities.

These new Census Bureau findings parallel other recently released data about health insurance coverage from the Centers for Disease Control and Prevention[2] and the Urban Institute.[3] The other surveys also found that growth in publicly-funded health insurance has helped to offset the loss of private insurance. The CDC data indicate that about 2.5 million more children and 1.6 million non-elderly adults were covered by public health insurance programs — principally Medicaid and SCHIP — in 2002.

Other findings of interest from the new Census data include:

- In 18 states, there was a statistically significant increase in the percentage of people who were uninsured between the 2000-2001 period and the 2001-2002 period. These states are Colorado, Idaho, Indiana, Maryland, Michigan, Mississippi, Missouri, Nevada, New Hampshire, New Jersey, North Carolina, Oregon, Pennsylvania, Rhode Island, Texas, Vermont, Virginia, and Wisconsin. One state — New Mexico — experienced a statistically significant reduction in the percentage of people who are uninsured.

- People who are poor were more than twice as likely to be uninsured as those who were *not* poor. The percentage of poor people who are uninsured stood at 30.4 percent in 2002, compared to 13.2 percent for those with incomes above the poverty line.

- The *number* of poor people who are uninsured rose from 10.1 million in 2001 to 10.5 million in 2002. The *percentage* of poor people who are uninsured, however, did not change significantly in 2002. The increase in the number of poor Americans without insurance was spurred by growth in the overall number of poor Americans, not by a change in the proportion of poor people with health coverage.

- Substantial racial and ethnic disparities exist in health insurance coverage. In 2002, some 10.7 percent of white, non-Hispanic Americans were uninsured, compared to 20.2 percent of African-Americans, 18.4 percent of Asians and 32.4 percent of Latinos.[4] The risk of being uninsured is particularly high for immigrants who are not citizens: 43.3 percent of non-citizens were uninsured.

---

[2] Leighton Ku, "CDC Data Show Medicaid and SCHIP Played A Critical Counter-Cyclical Role In Strengthening Health Insurance Coverage During The Economic Downturn," Center on Budget and Policy Priorities, Rev. Oct 8, 2003.

[3] Stephen Zuckerman, "Gains in Public Health Insurance Offset Reductions in Employer Coverage among Adults," *Snapshots of America's Families III, No. 9,* Sept. 2003. Genevieve Kenney, Jennifer Haley and Alexandra Tebay, "Children's Insurance Coverage and Service Use Improve," *Snapshots of America's Families III, No. 1,* July 2003.

[4] This year, the Census Bureau began presenting data about racial categories in a new way, letting people report being more than one race. Thus, the Bureau now reports data for those who report being only one race (e.g., Asian) or being that race alone or in combination with other races (e.g., Asian alone or in combination). For the sake of simplicity, we report percentages for those who are white alone, non-Hispanic, African-American alone and Asian alone.

- The percentages of white, non-Hispanic people and of African-Americans who are uninsured rose in 2002. The percentage who are uninsured did not change significantly among Latinos or Asians, but among both of these racial/ethnic groups, the percentage of people without insurance is very high.

Why Private Health Insurance Declined and Public Coverage Rose

Three key factors pushed the number of people with private health coverage lower in 2002. First, unemployment rates climbed from 4.7 percent in 2001 to 5.8 percent in 2002, and a large number of newly jobless workers and their dependents lost employer-sponsored health insurance. Second, some smaller businesses responded to soaring health care costs — employer-sponsored insurance premiums surged an average of 12.7 percent in 2002 — by dropping health coverage for their workers.[5] Third, many other businesses asked employees to pay more for health insurance, with the result that some employees could no longer afford to purchase coverage for themselves or their dependents.

The main reasons that Medicaid and SCHIP coverage increased were that more people fell into poverty and became eligible for benefits and also that more low-income people needed public coverage as a result of losing private health insurance. In addition, some states improved enrollment procedures in Medicaid or SCHIP, particularly for children, making it simpler for families of newly unemployed workers to enroll.

Medicaid enrollment grew despite the fact that some states were beginning to implement eligibility cutbacks by late 2002, in response to budget shortfalls. A larger number of states have instituted such cuts — or have changed enrollment procedures in ways that make it more difficult for eligible families to enroll or remain enrolled — in 2003.

Despite signs that the economy is beginning to recover, preliminary evidence suggests that health insurance trends for 2003 are likely to be similar to those for 2002 and that the number of uninsured people is likely to increase further this year. Unemployment rates so far in 2003 have modestly exceeded those of 2002, and private, employer-sponsored health insurance premiums are still growing at double-digit rates. (A recent survey reports an average increase of 13.9 percent in 2003.[6]) These trends suggest that private health insurance coverage is continuing to drop in 2003. States report that Medicaid caseloads are continuing to rise, but at a somewhat slower pace than in 2002.[7]

---

[5] Kaiser Family Foundation and Health Research and Education Trust, "Employer Health Benefits: 2002 Summary of Findings," August 2002.

[6] Kaiser Family Foundation and Health Research and Education Trust, "Employer Health Benefits: 2003 Summary of Findings," August 2003.

[7] Vernon Smith, et al., *States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004: Results from a 50 State Survey,* Kaiser Commission on Medicaid and the Uninsured, September 2003. This study reports that states estimate that Medicaid enrollment will rise 7.8 percent in 2003.

Medicaid's Responsiveness Depends on Its Entitlement Status

During economic downturns like that experienced in 2002, the "counter-cyclical" role of Medicaid as an entitlement program is evident. To cover more uninsured people through Medicaid — and to do so while also meeting rising costs for prescription drugs and long-term care, especially for the low-income elderly and disabled — costs more money. Medicaid expenditures rose more than 13 percent in 2002. Under Medicaid's entitlement funding structure, federal funding levels increased automatically in 2002 to match states' Medicaid expenditures, without being limited by predetermined federal funding caps or grant levels.

If Medicaid funding were capped under a block grant, as the Bush Administration proposed earlier this year, federal funding would not have been as responsive to mounting health care needs as the economy soured. A funding cap would have placed states in the awkward position of either having to pay for millions of new low-income enrollees entirely with state funds — something that would have been extremely difficult, if not impossible, for many states, given the budget shortfalls they faced — or to take harsh actions to cut Medicaid expenditures, such as eliminating health care coverage for various categories of low-income elderly and disabled people, parents, or children, placing eligible people who apply for Medicaid on waiting lists and leaving them uninsured until "coverage slots" open, or eliminating coverage for some important medical services. If states had been forced to hold down Medicaid enrollment in the face of rising poverty and eroding private health care coverage, many more Americans would have been uninsured last year.

The experience of other social programs provides evidence about how entitlement programs respond in a counter-cyclical fashion to meet increased demands for assistance when the business cycle turns down. In Medicaid and the Food Stamp Program — both entitlements — enrollment has grown during the economic slump in response to increased need.[8] In contrast, caseloads in the TANF block grant have been falling despite the poor economy and high unemployment levels,[9] and limited funding for child care from TANF and the Child Care Block Grant is leading to reductions in the number of children in working families who receive child care assistance.[10]

The economic slump also has led to a sharp drop-off in state revenues, causing serious state budget shortfalls. In response to these concerns, Congress passed bipartisan state fiscal relief legislation earlier this year that provided $10 billion in federal Medicaid aid by temporarily increasing the federal Medicaid matching rate, as well as an additional $10 billion in broad state fiscal relief grants. This fiscal relief is helping states cope with their budget crises in 2003 and the first half of 2004. Many states have been able, with these funds, to avert or lessen the

[8] Joseph Llobrera, "Food Stamp Caseloads Are Rising," Center on Budget and Policy Priorities, forthcoming revision, September 2003.

[9] Shawn Fremstad, "Falling TANF Caseloads Amidst Rising Poverty Should Be a Cause for Concern," Center on Budget and Policy Priorities, revised Sept. 5, 2003.

[10] Sharon Parrott and Jennifer Mezey, "New Child Care Resources Are Needed to Prevent the Loss of Child Care Assistance for Hundreds of Thousands of Children in Working Families," Center on Law and Social Policy and Center on Budget and Policy Priorities, July 15, 2003.

severity of Medicaid cutbacks that they otherwise would have instituted and that would have further increased the ranks of the uninsured.[11] Moreover, the fiscal relief legislation gives states an incentive to avoid restricting Medicaid eligibility from September 2003 through June 2004; states that restrict eligibility during that period would lose most of the additional federal Medicaid funds.

This federal fiscal relief expires in mid-2004. State budget outlooks remain dire in many states, and unemployment remains high. If state budget conditions and general employment growth do not improve significantly before the fiscal relief ends and the fiscal relief is not extended until a stronger economic recovery takes hold, larger cuts in the provision of health insurance coverage through Medicaid could begin being implemented about a year from now.

# # # #

[11] Vernon Smith, et al., *op cit.*