1. EXECUTIVE SUMMARY

This paper examines the health insurance status of adolescents, age 10 to 18 years, and addresses these questions:

- How many adolescents are without health coverage and why are some adolescents insured and others not?
- Has the number of uninsured adolescents changed over time? If so, why has this change occurred?
- How many adolescents would be affected by three potential approaches to reducing the number of uninsured: a mandate that employers provide health insurance to their workers (and their dependents); an expansion of the Medicaid program; or a combination of the two?

Data for this study come from Current Population Surveys (CPS) fielded in 1980 to 1988 by the U.S. Bureau of the Census. Each March, a supplement to the survey asks a variety of questions about work history and income during the previous year, and includes a set of health insurance questions. Responses to these questions are the basis for the analyses presented in this paper.

In 1988, new questions were introduced to the health insurance supplement and others were changed materially. The March 1988 CPS data that are currently available for public use are incomplete and preliminary. However, in light of today's pressing debate concerning the uninsured, this preliminary report has been prepared based on currently available information. An update, incorporating the final results from the 1988 and 19891 March surveys, will be released before the end of 1989. These final results may affect OTA's estimates of the proportion of adolescents who are currently uninsured, and, thus, estimates of the effects of an employer mandate or expanded Medicaid eligibility, but OTA does not expect these changes to be significant. They will not affect OTA's estimate of the increase in uninsured adolescents between 1979 and 1986.

How Many Adolescents Are Without Health Insurance and Who Are They?

Approximately 4.6 million adolescents, aged 10 to 18, 15 percent overall, were without public or private health coverage in 1987. Adolescents are slightly more likely to be uninsured than younger children and adults aged 25- to 54-years-old.[3] Those adolescents who do have health insurance are more than twice as likely as 25- to 54-year-olds to be covered by Medicaid.

Sociodemographic Characteristics of Uninsured Adolescents

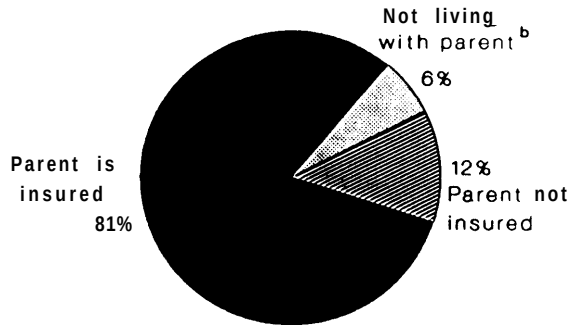
Most adolescents, age 10 to 18, live with their parents. Twelve percent of all adolescents live with uninsured parents (figure 1) and almost two out of three uninsured adolescents live with parents who are also uninsured (figure 2). To a large extent, then, the problems of uninsured adolescents are the problems of uninsured parents.

Family income is the most important determinant of health insurance status for all age groups. The poor, regardless of other factors, are the most likely to be uninsured. Adolescents in poor or near-poor families are much more likely to be uninsured than others; approximately 30 percent are without

1 At the time this Background Paper was published, data from the March 1989 CPS were not available for analysis. Because of question wording changes initiated in March 1988, data collected in 1988, 1989, and subsequent years will never be able to be compared to data collected from March 1980 through March 1986. However, when the March 1989 CPS becomes available, some analysis will be able to be made comparing 1987 and 1988. (Note that the data collected each March pertain to the previous calendar year; thus, data collected in March 1980 pertain to calendar year 1979, and data collected in March 1989 pertain to calendar year 1988).

2 19- to 24-year-olds are at greatest risk for being uninsured.

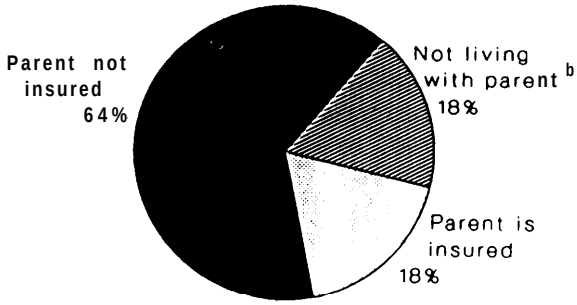
Figure 1--- Percent of Adolescents Who Live With Uninsured Parent, Insured Parent, or No Parent, 1987[a]



[a]Refers to the insurance status of the household head unless only the spouse had employment-based health coverage.
[b]Includes adolescents not living with their parents and married adolescents living with their parents.

SOURCE: Office of Technology Assessment, 1989, based on estimates from the March 1988 Current Population Survey.

Figure 2--- Parent's Insurance Status of Uninsured Adolescents, 1987[a]



[a]Refers to the insurance status of the household head unless only the spouse had employment-based health coverage.
[b]Includes adolescents not living with their parents and married adolescents living with their parents.

SOURCE: Office of Technology Assessment, 1989, based on estimates from the March 1988 Current Population Survey.

any coverage, public or private (table 1).[3] In contrast, half as many adolescents whose family income is between 150 and 299 percent of poverty and less than 5 percent of adolescents in families at 300 percent of poverty or above are uninsured.

Despite the strong relationship between low family income and the likelihood of being uninsured, it should be recognized that for adolescents, as for adults, it is by no means true that all the uninsured are poor. While 41 percent of uninsured adolescents live below the Federal poverty level, one-third of uninsured adolescents are between 100 and 199 percent of poverty, and more than one-quarter are at 200 percent of poverty or above.

Several other demographic characteristics have fairly strong relationships with health insurance status independent of family income. These include Hispanic ethnicity, parent's education, parental self-employment, and region. Hispanic adolescents are much more likely than others to be uninsured regardless of family income. This may be because Hispanics are more likely than others to work in agriculture and domestic service where coverage rates are historically low. If Hispanic families living in poverty are more likely than others to include both husband and wife, they will be less likely to be eligible for Medicaid. In addition, Hispanic adolescents who are "undocumented aliens" are not routinely eligible for Medicaid; eligibility is a State option.

Although black adolescents are much more likely than whites to live in or near poverty, and to be uninsured, the correlation between race and lack of health insurance coverage almost disappears when family income is taken into account.

At each income level, adolescents whose parents have little formal education are much more likely to be uninsured than adolescents whose parents have had more education. Among adolescents in middle and upper-income families, those whose parents are self-employed are much more likely than others to be uninsured. Almost one out of five Southern and Western adolescents are uninsured while less than one out of ten Northeastern and Midwestern adolescents are without coverage.

Further analysis shows that regional variations in coverage are due primarily to differences in income-specific rates of Medicaid and private health coverage. In the South, it appears that more stringent Medicaid income eligibility requirements are key to the greater proportion of uninsured adolescents. If income-specific Medicaid coverage rates were as high in the South as in the North, the proportion of Southern adolescents without health insurance would drop by approximately 25 percent. In the West, lower rates of private coverage appear to be the most critical factor although lower Medicaid coverage rates are important as well. If income-specific rates of private insurance coverage were as high in the West as in the North, the proportion of uninsured Western adolescents would be reduced by about 19 percent. These results make clear that public policies designed to expand health coverage, such as an employer mandate or expansion in Medicaid, would have markedly different effects in Western and Southern States than in the North.

Trends in Adolescent Insurance Coverage, 1979-1986

The proportion of adolescents without health insurance increased by 25 percent between 1979 and 1986 (figure 3). In the early 1980s, the rise in the uninsured was strongly associated with increased poverty combined with a decline in Medicaid coverage of the poor and near-poor. Later, in the mid-1980s, as the country recovered from recession, these trends reversed somewhat. However,

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3 Poor refers to those with family incomes below 100 percent of the Federal poverty level, and near-poor describes families living between 100 and 150 percent of the Federal poverty level.

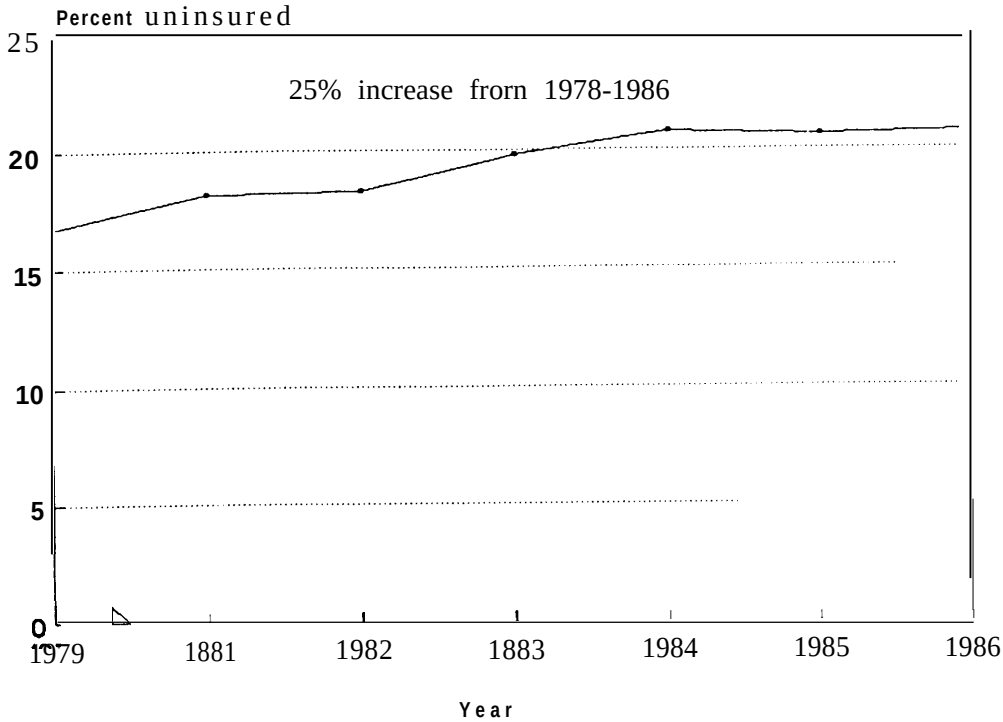
Table 1--- Health Insurance Status of Adolescents, Age 10-18, by Family Income, 1987

Family income as a percent of the Federal poverty level[a]	Proportion of all adolescents at the specified poverty Level[b]	Health insurance status: No health insurance coverage	Insured: private and public: Private only	Medicaid only	Other[c]	Total
less than 50 percent	9.2%	30.9%	16.6%	48.4%	4.2%	100.0%
50 to 99 percent	10.1	32.2	23.6	38.1	6.1	100.0
100 to 149 percent	9.5	29.4	53.4	10.7	6.5	100.0
150 to 199 percent	9.7	21.5	69.2	3.1	6.2	100.0
200 to 299 percent	19.2	10.3	82.8	1.0	6.0	100.0
300 percent and above	& J 100.0%	4.6	90.7	0.2	4.6	100.0

[a] In 1987, the Federal poverty level was $9,056 for a family of three.
[b] There were 31.0 million adolescents, age 10-18, in 1987.
[c] Includes CHAMPUS, Medicare, or a combination of public and private coverage.

SOURCE: Office of Technology Assessment, 1989, based on estimates from the March 1988 Current Population Survey.

Figure 3--- Trends in the Proportion of Uninsured Adolescents, Age 10-18, 1979-1986[a]



a 1980 and 1988 data are not available; 1987 data are not comparable.

SOURCE: Office of Technology Assessment, 1989, based on estimates from the March 1980 through March 1987 Current Population Surveys.

the proportion of the adolescent population at each income level with private insurance declined substantially. It is important to note that due to a combination of factors (including a decline in the absolute number of 10- to 18-year-olds from 1979 to 1986), there was no change in the aggregate number of uninsured.

The decline in Medicaid coverage was greatest among adolescents living in or near poverty and was largely due to regulations issued under the 1981 Omnibus Reconciliation Act of 1981 (OBRA) that limited the working poor's eligibility for Aid to Families with Dependent Children (AFDC) and Medicaid benefits. In 1979, 48 percent of adolescents living in families between 50 to 99 percent of poverty had Medicaid coverage. By 1983, this had dropped to 38 percent and rebounded slightly to 42 percent in 1984 and 1986. Meanwhile, almost half of the adolescents in families with incomes from 100 to 149 percent of poverty who were in the Medicaid program in 1979 had lost coverage by 1982.

The decline in private coverage was also most significant among the poor. In 1979, 17 percent of adolescents in households below 50 percent of poverty were covered by some form of private insurance, but by 1986, only 11 percent were enrolled in a private health plan. Adolescents in families between 50 to 99 percent of poverty experienced a similar trend; the proportion with private health coverage dropped from 27 to 22 percent during the same time period.

A principal reason why more adolescents were uninsured in 1986 than in 1979 is simply that more lived with uninsured parents in 1986 than in 1979. During this period, the proportion of adolescents who lived with uninsured parents increased from 8.8 to 10.5 percent, accounting for 37 percent of the overall 1979 to 1986 increase in uninsured adolescents. At the same time, the uninsured *rate* among adolescents who lived with uninsured parents also rose, increasing from 92 to 96 percent (contributing an additional 10 percent to the overall climb in the uninsured).

Eighteen percent of the overall rise in the proportion of adolescents without health coverage was due to a fall in the coverage rate among adolescents not living with a parent; in 1979, 61 percent were uninsured, by 1986 the proportion without coverage increased to 74 percent. The proportion of adolescents who obtained health insurance from their own jobs declined precipitously.

Estimated Effects of Employer Mandates and Medicaid Expansions

Two types of proposals have been prominently advanced to reduce the number of uninsured. So-called "employer mandates" require that employers offer group health insurance policies and pay a significant amount of the premiums for all employees who work more than a specified number of hours per week. Proposals to expand Medicaid require that categorical eligibility requirements be relaxed and/or that income eligibility limits be increased, thereby requiring or encouraging all States to make Medicaid available to all those eligible below certain income levels.

Numerous factors determine the effects of an employer mandate: Who is included in an employer mandate is especially important. How many hours per week must be worked? Does coverage begin on the first day of employment or after awaiting period? Are the self-employed included? Are employee dependents covered? Will small firms be exempt? What level of benefits must be provided? How much must the employer contribute to the premium?

Similarly, the effect of an expansion in Medicaid depends on a number of policy decisions. For example, what is the minimum eligibility income level? Are the changes in eligibility mandatory or optional for the States? Are two-parent families with workers eligible or must one parent be absent or unemployed?

Estimated Effects of Employer Mandates

The following assumptions were used in estimating the effect of an employer mandate on the number of uninsured adolescents:

- The self-employed are exempt. All other "permanent" employees who work more than the required number of hours per week are covered (i.e., with no exemptions for firm size or industrial classification).
- Employees working 26 weeks or more in the preceding year are considered "permanent" workers and would be covered under the mandate.
- The effects of the mandate are estimated using three different assumptions about the number of hours of work at which workers are covered: 18 hours, 25 hours, and 30 hours.
- Adolescents who do not live with their parents are not covered as dependents under the mandate; however all other unmarried adolescents age 18 or younger would be covered by the mandate if their parents were covered as well.

If employees who worked 30 hours or more per week were included, approximately 2.55 million uninsured adolescents, or 55 percent of all adolescents currently without health coverage, would become insured. Although reducing the hourly work threshold does increase the number of uninsured who would become covered, its effect is relatively minimal (at least within the range of 18 to 30 hours per week). For example, if the hourly work threshold was reduced to 25 hours per week, an additional 60,000 adolescents (1.3 percent of all those uninsured) would be covered. If the threshold was 18 hours per week, an additional 136,000 adolescents (or 3 percent of all uninsured adolescents) would be covered.

Estimated Effects of Medicaid Expansion

Proposals to expand Medicaid may mandate or give States the option to broaden Medicaid eligibility. Currently States have the flexibility, within limits, to set their own eligibility levels for the AFDC and Medicaid programs. Some States have relatively broad eligibility policies while others are much more restrictive. However, with few exceptions, adolescents are eligible for Medicaid only if they are in a family with a so-called "deprivation factor"; that is, a family with an absent parent or one whose principal breadwinner is unemployed.[4]

If the current categorical requirement of a "deprivation factor" is maintained, the potential for an expansion in Medicaid to cover significant portions of uninsured adolescents is severely limited. If all adolescents in single-parent households with incomes below 100 percent of poverty were covered by Medicaid, approximately 707,000 of the 4.6 million uninsured adolescents would be covered. However, even if States were required to extend eligibility standards to all such adolescents, it is doubtful that all would enroll. In fact, many of the 8 percent of *uninsured* adolescents who were in single-parent households in 1987, with incomes below 50 percent of poverty, were already eligible to receive Medicaid benefits.

If categorical requirements were dropped, and all adolescents with family income below a specified standard were eligible for Medicaid, then significant portions of the currently uninsured could be covered by a Medicaid expansion. For example, if households with family incomes below 100 percent of poverty were included, more than 40 percent of currently uninsured adolescents would be covered. An additional 19 percent of uninsured adolescents would be included if the income standard was raised to 149 percent of poverty.

Combined Approach: Employer Mandate With A Medicaid Expansion

If employers were required to cover all workers who worked 18 hours or more and

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4 This remains unchanged by the Family Support Act of 1988 (Public Law 100-485).

Medicaid was available to all adolescents in families with income below 200 percent of poverty, then only 7 percent of adolescents without health coverage would remain uninsured. An employer mandate that included employees of at least 30 hours per week combined with a Medicaid expansion that included all adolescents below 100 percent of poverty would cover over 80 percent of uninsured adolescents.

Most of the adolescents left out by the combination of an employer mandate and Medicaid expansion are children of the self-employed. If the self-employed were included under a "combination" mandate, the vast majority of uninsured adolescents would become covered.

Of the proposals evaluated, clearly the single greatest impact would come from an employer mandate.