Public versus Employment-related Health Insurance: Experience and Implications for Black and Nonblack Americans

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THE UNITED STATES DEPENDS ON A MIXTURE OF private insurance—mostly employment-related—and public programs to finance the bulk of health services for acute care. Although this system works well for the vast majority of its citizens, the number of people who remain uninsured is large and growing. Lack of health insurance is generally acknowledged to be a problem, notably because the uninsured have less access to medical care (Davis and Rowland 1983; Robert Wood Johnson Foundation 1987). Many policy options have been put forth that would deal with part or all of this uninsurance problem—including mandated employer coverage of workers and their dependents, and expansions of the federal/state Medicaid program.

The purpose of this article is to examine these issues in the specific context of differences for blacks and nonblacks in sources of insurance and the potential effectiveness of selected policy options. The article is organized in the following way. The first section examines racial differences in sources and the extent of health insurance. Next, the changes that were experienced between 1980 and 1985 are considered. Finally, the implications of some illustrative policy options are shown.

Sources of Health Insurance

There are many sources of health insurance. The majority of workers and their dependents are covered through employment-related insurance,

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sponsored by employers or labor unions. Premiums that support these plans may be fully paid by the employer, or they may be shared by the employer and the employee. The widespread use of this insurance source has been encouraged by the favorable tax treatment of compensation taking the form of employer-paid premiums. The other principal source of health insurance is public programs. Nearly all of the elderly, and some disabled, are insured through Medicare. In addition, some people with low incomes and assets receive Medicaid benefits, provided they meet certain categorical requirements regarding family structure, age, blindness, or disability. Finally, a small share of the population is covered only through some other insurance mechanism, which principally is private individual policies. This last mechanism is limited in use because of the very high premiums for such coverage, resulting from high administrative costs and adverse selection.

Despite these many sources, substantial numbers of people remain uninsured for their health care expenses. In some cases, individuals may be uninsured by their own choices or the choices of their parents—for example, when they choose for themselves or their dependents not to participate in an employment-related plan. In other cases, a person's employer may not offer a health plan. In yet another instance, some individuals are neither employed nor do they qualify as a dependent on a family member's plan. Provided they are not eligible for some public program, say by virtue of family structure or income, this latter group is likely to be uninsured.

Table 1 records the sources of health insurance for blacks and nonblacks in 1985, both for people of all ages and for three age groups—specifically, children, nonelderly adults, and the elderly. Because some people have more than one type of insurance, the classification in the table is based on a hierarchy. Individuals insured by an employment-related plan are classified in the first category, "employment-related," regardless of any additional public or other coverage they might have. Those with no employment-related coverage, but who had either Medicare or Medicaid, are classified in the "public" group. An individual without either employment-related or public coverage, but who had some other insurance, is placed in the "other" group. Finally, individuals who reported no source of health insurance are classified as "uninsured."

Considering people of all ages, blacks are more likely to be covered by public insurance or to be uninsured than nonblacks; and they are

TABLE 1
Sources of Health Insurance, by Race and Age, 1985

	Total	Employment-related*	Public, not employment-related**	Other, neither employment-related nor public***	Uninsured
		POPULATION (in millions)			
Black					
All ages	28.2	13.2	7.8	1.0	6.3
17 and under	9.5	4.0	2.9	0.2	2.4
18–64	16.4	9.0	2.8	0.7	3.8
65 and over	2.2	0.2	2.0	****	0.1
Nonblack					
All ages	206.0	127.7	32.3	15.2	30.8
17 and under	53.2	35.7	4.4	3.0	10.0
18–64	128.2	89.6	6.2	11.9	20.6
65 and over	24.6	2.4	21.7	0.3	0.2

	PERCENTAGE				
Black					
All ages	100%	47%	28%	3%	22%
17 and under	100	42	31	2	25
18–64	100	55	17	4	23
65 and over	100	8	89	1	2
Nonblack					
All ages	100	62	16	7	15
17 and under	100	67	8	6	19
18–64	100	70	5	9	16
65 and over	100	10	88	1	1

Source: Author's tabulations of the March 1985 Current Population Survey, which covers the civilian, noninstitutionalized population.
Note: Details may not add to totals because of rounding.

* This category includes respondents covered by private insurance plans sponsored by a current employer or union, and those covered by CHAMPUS (Civilian Health and Medical Program of the Uniformed Services). A small number of veterans who have no insurance, but who receive medical care from Veterans Administration facilities are included in this category because the data do not allow them to be separated from people covered by CHAMPUS. All respondents with employment-related coverage, whether or not they had public or other coverage, were classified in this category.

** This category includes respondents covered by Medicaid, Medicare, or both; provided that they did not have employment-related coverage.

*** This category includes respondents covered by individual insurance plans, provided that they were not covered by employment-related or public plans.

**** Less than 50,000.

less likely to be covered by private insurance. Lower rates of private insurance are reflected both by employment-related (47 percent versus 62 percent) and by other insurance (3 percent versus 7 percent). In contrast, 28 percent of blacks, but only 16 percent of nonblacks, have some source of public insurance. Over 6 million blacks are uninsured. They are about 1.5 times as likely as nonblacks to be uninsured (22 percent versus 15 percent).

Turning to specific age groups, black children are almost four times as likely to have only public insurance (31 percent versus 8 percent), while the corresponding multiple for nonelderly black adults is over three (17 percent versus 5 percent). Correspondingly, although about 70 percent of nonelderly nonblacks have employment-related insurance, only about one-half of blacks have this source of health insurance. The elderly, black and nonblack alike, are almost universally insured under Medicare. (Medicare is the second payer for the working elderly with employment-related insurance.) Clearly, the problem of being uninsured is almost exclusively limited to populations under 65 years of age.

These sharp differences in the sources of health insurance are in all likelihood a reflection of underlying differences in the structure and economic circumstances of black and nonblack families.

This article employs two concepts of the family to investigate this claim. The first and more common concept, used by the Bureau of the Census, defines a family as "a group of 2 persons or more, 1 of whom is a householder, residing together and related by birth, marriage, or adoption." The second concept, the "health insurance unit," is based on traditions of the private insurance industry. A health insurance unit includes a head, a spouse, all dependent children up to age 19, and older dependent children who are full-time students. In general, the family can include more people than would be included in the health insurance unit.

To illustrate, consider a husband and wife who have two children, aged 16 and 21, residing at home. The husband is employed and is covered by an employment-related policy that is fully paid by his employer. The husband, whose insurance plan allows for coverage of qualified dependents, but only at employee expense, elects not to insure the rest of the family. The 21-year-old works full-time but for an employer who provides no insurance benefits. These four people represent a single family. The 21-year-old, however, could not be covered as a dependent on the father's policy and, therefore, is a

separate health insurance unit. (Tabulations in this article would show the husband as having employment-related insurance, and the other three family members as uninsured. Tabulations based on family income would consider the combined income of all four members. Tabulations on characteristics of insurance units would divide the family into two units and describe their characteristics separately.)

Table 2 records tabulations of black and nonblack people by selected characteristics of their health insurance units or of their families. Blacks are far more likely than nonblacks to live in single-headed units with children (29 percent versus 8 percent) or as single individuals (31 percent versus 24 percent). A corollary to these facts is that they

TABLE 2
Selected Characteristics of People in Health Insurance Units, by Race, 1985

	Black		Nonblack	
	In millions	Percentage	In millions	Percentage
Total*	28.2	100%	206.0	100%
DEMOGRAPHIC STRUCTURE**				
Individual adult	8.7	31	48.4	24
Couple without children	3.1	11	46.8	23
Couple with children	8.1	29	94.3	46
Single with children	8.3	29	16.5	8
NUMBER OF WORKERS***				
No worker	11.8	42	51.7	25
One worker	11.2	40	96.6	47
Two or more workers	5.2	18	57.6	28
FAMILY INCOME AS A PERCENTAGE OF THE POVERTY LEVEL****				
Under 1.00	9.6	34	24.4	12
1.00 to 1.49	4.1	15	19.1	9
1.50 and above	14.5	51	162.5	79

Source: Author's tabulations of the March 1985 Current Population Survey, which covers the civilian, noninstitutionalized population.
Note: Details may not add to totals because of rounding.
* This table shows the distribution of people by race, when they are grouped by the characteristics of either their health insurance unit or their family.
** Demographic structure describes the composition of the health insurance unit. Since health insurance units may be subsets of families, these tabulations differ from those describing the structure of families.
*** Number of workers in the health insurance unit, where a worker is defined as a person who works at least 17.5 hours per week.
**** Family income is used for this characteristic because there is no poverty measure applicable to the health insurance units.

The changes for blacks were modest in comparison to those for nonblacks, however. The absolute number of nonblack people covered under employment-related insurance remained essentially unchanged over the period and those covered by other insurance declined by 7 percent, despite a 4 percent growth in total nonblack population. A much larger growth in public insurance (17 percent)—about 60 percent of which was among the elderly—was enough to yield an increase in the total number of nonblack people covered by insurance. An even larger addition to the population, however, left 5.9 million more nonblacks uninsured in 1985 than in 1980, for a 24 percent increase (or 20 percent more than could be accounted for by population growth alone). The relative decline in private insurance affected nonblacks more, both because it lagged further behind population growth and because nonblacks depend relatively more on private insurance.

The respective roles of private versus public insurance are also reflected in the effect on the number of uninsured for various age groups (see table 4). The relatively larger role of public insurance for blacks, and black children in particular, largely accounts for the fact that there was essentially no change in the number of uninsured black children between 1980 and 1985. Greater coverage by private insurance of nonblacks (and lower coverage by public insurance) is associated with the 19 percent increase in uninsured nonblack children. The 30 percent increase in the numbers of uninsured blacks and nonblacks aged 18 to 64 reflects the failure of private insurance enrollment to keep pace with population growth in this age group. (Not shown in table 4 is the fact that growth in employment-related coverage fell 4 percentage points below population growth for both black and nonblack 18 to 64 year olds during this period.)

Implications of Illustrative Policy Options

The large size of the uninsured population and its rapid increase in this decade have contributed to mounting concern. Numerous policy responses have been suggested; some would increase private coverage and others would increase public coverage. Most of the options are incremental and, even in combination with one another, would not bring about universal insurance. The purpose of this section is to suggest the implications for blacks and nonblacks of two commonly

TABLE 4
Change in the Number of Uninsured, by Race and Age, 1980–1985

	1980		1985		Change*	
	In millions	Percentage	In millions	Percentage	In millions	Percentage
BLACK						
All ages	5.6	22%	6.3	22%	0.7	12%
17 and under	2.5	26	2.4	25	−0.1	−3
18–64	3.0	20	3.8	23	0.9	29
65 and over	0.1	7	0.1	2	−0.1	−65
NONBLACK						
All ages	24.9	13	30.8	15	5.9	24
17 and under	8.4	15	10.0	19	1.6	19
18–64	15.8	13	20.6	16	4.8	30
65 and over	0.7	3	0.2	1	−0.5	−69

Source: Author's tabulations of the March 1980 and March 1985 Current Population Surveys, which covers the civilian, noninstitutionalized population.
Note: Differences between 1985 and 1980 details may not equal the changes shown because of rounding.
* The change in millions is calculated as the difference between the number of persons uninsured in 1985 and the corresponding figure for 1980. The percentage expresses this change as a percentage of the 1980 figure. The apparently large percentage changes for persons aged 65 and over is the result of calculating from a small base.

discussed options—one that would require all employers to provide a basic health insurance plan to employees and their dependents, and another that would expand Medicaid eligibility for the categorically needy to 150 percent of the poverty level.

The employer-mandate option illustrated here would require all employers to provide health insurance to all full-time employees, their spouses, and their dependent children. A full-time employee would be defined as one who works 17.5 hours or more per week. Employees would be required to accept the insurance and to cover their entire families. The self-employed would also be subject to the mandate. The implications for the uninsured of such a plan are shown in table 5. Of the roughly 37 million uninsured in 1985, about 24 million (66 percent) would gain health insurance coverage. There would be some racial differences in impact, however, since the black uninsured are considerably less likely to live in a health insurance unit with a full-time worker than are nonblacks (50 percent versus 69 percent). Therefore, just as nonblacks depend relatively more on employment-related insurance currently, so would they disproportionately benefit from policy options that would expand employment-related insurance.

Another approach to reducing the numbers of uninsured involves expansions in Medicaid eligibility. There are many ways that this could be done. One commonly discussed way, principally affecting single mothers with dependent children, would be to increase the income limits of the categorically needy to become eligible. If the Medicaid income standard were made uniform nationally so as to qualify all those units with incomes below 150 percent of the federal poverty level, about 5 million (13 percent) of the uninsured would be covered. Consistent with the overall family structure and economic characteristics discussed above, the black uninsured would be much more likely to receive insurance from this option than the nonblack uninsured (28 percent versus 10 percent). Alternative Medicaid eligibility expansions—for example, ones that would modify the categorical eligibility rules by allowing other family types, such as two-parent families, to benefit—might result in a less disproportionate outcome between blacks and nonblacks.

The bottom panel of table 5 records that the combined options would, by insuring about 27 million people, reduce the uninsured population to nearly one-quarter of its former size. This combined option would have a somewhat more balanced effect across blacks and

TABLE 5
Effects on the Number of Uninsured of Illustrative Policy Options, by Race, 1985

	Total	Black	Nonblack
	CURRENT LAW		
Uninsured			
In millions	37.1	6.3	30.8
Percentage	100%	100%	100%
	ILLUSTRATIVE EMPLOYER MANDATE		
Newly insured			
In millions	24.3	3.1	21.1
Percentage	66%	50%	69%
Continuing uninsured			
In millions	12.8	3.1	9.6
Percentage	34%	50%	31%
	ILLUSTRATIVE MEDICAID EXPANSION		
Newly insured			
In millions	5.0	1.8	3.2
Percentage	13%	28%	10%
Continuing uninsured			
In millions	32.1	4.5	27.6
Percentage	87%	72%	90%
	BOTH ILLUSTRATIVE OPTIONS		
Newly insured			
In millions	27.2	4.2	22.9
Percentage	73%	67%	75%
Continuing uninsured			
In millions	9.9	2.1	7.8
Percentage	27%	33%	25%

Source: Author's simulations based on the March 1985 Current Population Survey, which covers the civilian, noninstitutionalized population.
Note: Details may not add to totals because of rounding.

nonblacks than would either of the options taken alone. Still, one-third of currently uninsured blacks would remain uncovered, compared to one-quarter of nonblacks. This remaining disparity might be explained, in part, by the larger proportion of adult black males who are single and who are either unemployed or are out of the labor force.

This brief discussion of policy options has been limited in two important ways. First, the analysis, which was guided by the themes

of these volumes, was limited to two dimensions—the potential for reducing the number of uninsured, and proportionate effects by race. Many other dimensions—including total social costs and benefits, effects on the federal budget, and unintended negative effects on employment—are also relevant to the public policy debate.

Second, the discussion only considered options that address health insurance directly. Yet, the data presented here suggest that black/nonblack differences in health insurance may derive from more fundamental differences in family structure and labor-force attachment. Changes in these other attributes, whether or not they are stimulated by public policy, would also affect the number and characteristics of the uninsured. Finally, lines of causation in this area are somewhat blurred. Specifically, some observers argue that black family composition is as much influenced by Medicaid eligibility rules as Medicaid enrollment reflects black family composition.

References

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