

UNDERSTANDING THE UNINSURED: TAILORING POLICY SOLUTIONS FOR DIFFERENT SUBPOPULATIONS

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The U.S. Census Bureau estimates that the number of people in the U.S. who are without health insurance rose to 47 million in 2006, up from 44.8 million in 2005.¹ These latest Census figures mean 15.8 percent of U.S. residents are uninsured.

Health care costs are high in the U.S. and rising at an alarming rate. In 2006 we spent \$2.1 trillion (16 percent of our gross domestic product) on health care,² and this spending is predicted to double by 2015.³ These rapidly-increasing costs are driving up the cost of health insurance and contributing to an "affordability" crisis for individuals, employers and state and federal governments charged with overseeing public programs. As costs continue to increase year after year, so too does the number of uninsured persons. Part of the key to stemming the growth in the uninsured population, therefore, will be gaining control over the growth of health care costs.

People without health insurance are heterogeneous, and understanding this diverse group is important for policymakers looking to design solutions to the problem. Different approaches are needed for different subpopulations of the uninsured.

Toward this end it is helpful to place the uninsured into subgroups based on their program eligibility, income and demographics. This issue brief uses 2006 data from the 2007 Current Population Survey (CPS) to estimate the size of the uninsured population in four categories: (i) eligible for public programs but not enrolled, (ii) lower income (<200 percent of FPL), (iii) middle income (200–399 percent of FPL), and (iv) higher income (≥400 percent of FPL). This work updates similar analyses produced by NIHCM Foundation for 2001.⁴ We also provide additional refinement of these segmentation groups by parental status and consider the impact of

TABLE 1: SUBPOPULATIONS OF THE UNINSURED

| | Eligible for public programs but not enrolled | Lower Income <200% FPL | Moderate Income | | Higher Income 400%+ FPL |
|------------------|---|---------------------------|--------------------|--------------------|----------------------------|
| | | | 200-299% FPL | 300-399% FPL | |
| Total | 12.0 million | 14.4 million | 8.3 million | 4.5 million | 7.3 million |
| Children | 6.1 | 0.6 | 1.2 | 0.7 | 1.0 |
| Parents | 3.6 | 4.8 | 2.0 | 0.8 | 1.1 |
| Childless Adults | 2.4 | 9.1 | 5.1 | 3.0 | 5.2 |

Note: Estimate of the non-elderly uninsured population for 2006. Numbers may not sum exactly due to rounding.
Source: NIHCM Foundation analysis of data from the March 2007 Current Population Survey.

life transitions on insurance status, focusing on young adults and the near elderly.

In addition to segmenting the uninsured population into more distinct groups, we present a range of policy options that have been proposed or implemented to extend coverage to these subgroups. We do not endorse any particular policy option. Instead, this brief is meant to serve as a primer on available options and not a prescription defining the optimal solution.

Undocumented Immigrants

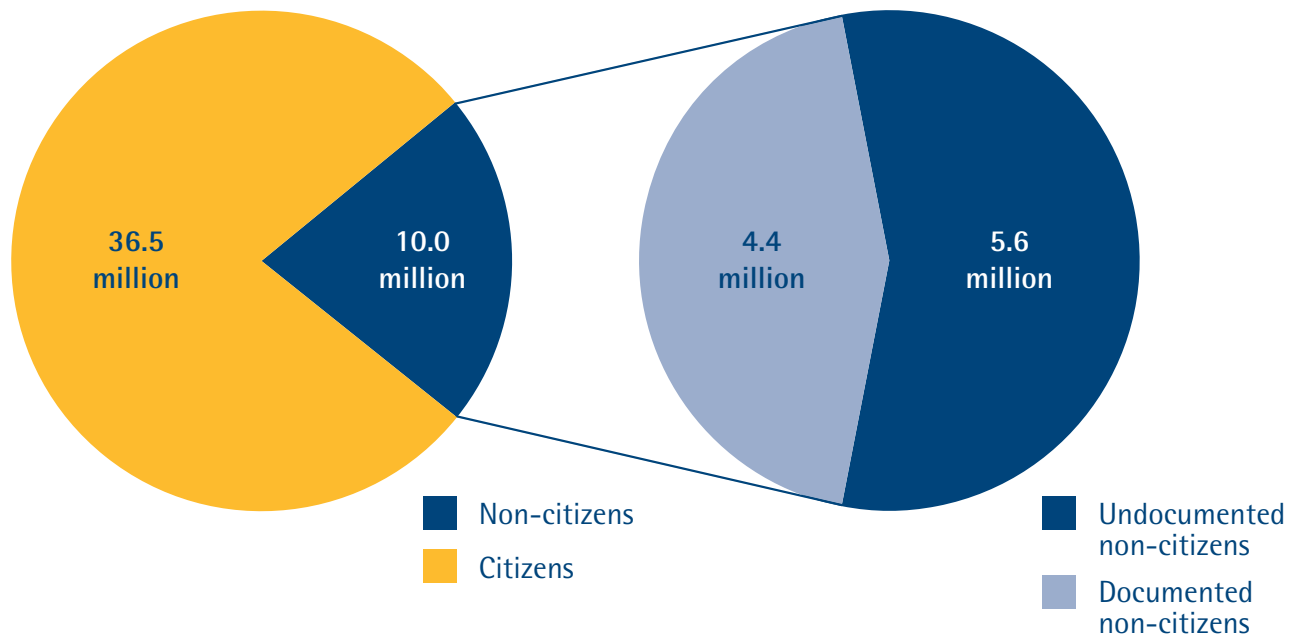
As explained in more detail in the Methods Overview at the back of this paper, the estimates presented throughout this paper rely on data as reported by the Census Bureau. These reported data indicate that there are 10 million non-citizens among the 46.5 non-elderly uninsured. Because the CPS does not collect information on legal status among non-citizens, both legal and undocumented immigrants are included in the 10 million.

Earlier research has incorporated data from numerous government sources to develop a model for assigning legal status to each immigrant found in the CPS data.⁵ Legal immigrants include refugees, legal permanent residents (e.g., green card holders), and legal temporary residents (i.e., those in the country legally for a specified period and purpose). This model was subsequently applied to 2004 data from the CPS to estimate legal status among uninsured non-citizens.⁶ Applying this analysis to the 2007 CPS, we estimate that 5.6 million of the 10 million uninsured non-citizens are undocumented immigrants, whereas 4.4 million are legal residents (Figure 1).

Uninsured People Who Are Reachable by Current Public Programs

As shown in Table 1, 12 million people – or approximately one of every four non-elderly uninsured persons – were eligible for public health insurance programs in 2006 but not enrolled. Reflecting the historical focus of

FIGURE 1: CITIZENSHIP AND IMMIGRANT DOCUMENTATION STATUS
All non-elderly uninsured



Source: NIHCM Foundation analysis of data from the March 2007 Current Population Survey, based on prior research to model legal status among non-citizens in the CPS.

public programs on children first, then on parents, and lastly on childless adults, this group is predominantly composed of low-income children and parents. We find 6.1 million uninsured children (age 18 or younger) who are eligible for either Medicaid or the State Children's Health Insurance Program (SCHIP), accounting for 64 percent of all uninsured children. The vast majority are in families with incomes below 200 percent of the federal poverty level (FPL).

Parents' eligibility thresholds are set well below those of children; as of July 2007, the median eligibility threshold for traditional Medicaid was 63 percent of FPL for working parents and 41 percent for non-working parents.⁷ Due to this more restrictive eligibility, only 29 percent of uninsured parents (3.6 million) are reachable through current public programs.

Childless adults have historically been ineligible for public coverage unless they are aged or disabled. Through the Health Insurance Flexibility and Accountability (HIFA) initiative introduced in 2001, the Centers for Medicare and Medicaid Services has allowed states to expand coverage to groups that previously were excluded from publicly sponsored coverage, such as childless adults.⁸ As of July 2007, only seven states had expanded Medicaid eligibility to include childless adults, with eligibility thresholds ranging from 35 percent of FPL in Michigan to 200 percent of FPL in New Mexico.⁹ Reflecting these eligibility restrictions, only 10 percent of uninsured childless adults (2.4 million) were eligible for public programs in 2006.

People who are eligible for public programs may fail to enroll in them for a number of reasons. Some may be unaware of the programs or not know how to enroll. Others may be reluctant to participate because of the stigma associated with "welfare" programs. In addition to poor take-up among eligible individuals, research also suggests that poor retention of previous program enrollees is responsible for a large number of the people who are eligible for but not enrolled in public coverage.¹⁰ Administrative hassles can inhibit both enrollment and retention. New enrollees, particularly those with lower education, can be discouraged by the burdensome paperwork often required to enroll in a program initially, and existing enrollees can be involuntarily disenrolled if they do not complete the renewal paperwork. Lastly, some states have implemented enrollment caps; where

these come into play even eligible people who have successfully completed all enrollment paperwork would not be enrolled.

The Deficit Reduction Act (DRA) of 2005 has added to Medicaid's enrollment/renewal process by requiring that individuals provide proof of U.S. citizenship. In states that use a combined application and enrollment process for Medicaid and SCHIP, the DRA may have implications for SCHIP, as well. Despite its original intent to restrict enrollment among undocumented immigrants, some observers have raised concerns that the DRA has resulted in inappropriate enrollment denials and/or delays for large numbers of citizens.¹¹ Three states that have tracked enrollment by race/ethnicity after passage of the DRA found that enrollment has fallen more dramatically for whites and African Americans than for Hispanics, a finding attributed to the former groups having less ready access to the necessary documentation.¹²

Recent experience in Florida provides a vivid illustration of the impact that difficult administrative processes can have on enrollment of eligible persons in public programs. From 2003 to 2004, the state enacted a series of reforms designed to significantly tighten the regulations governing eligibility for and enrollment in the Florida Healthy Kids program. Most notably, the state ended passive renewal of coverage and continuous enrollment; families now were required to submit a renewal form with documentation of income, and were able to do so only during two open enrollment months rather than on a rolling basis.¹³ Families missing the open enrollment period were disenrolled from the program without notice. The state also instituted an enrollment cap and eliminated the waiting list – meaning that even families who managed to satisfy all enrollment requirements on time could be denied enrollment at that time and would not be contacted later if a slot opened up. Compounding these changes is the fact that the program is administered by three different agencies, each with its own set of requirements. New documentation requirements in addition to proof of citizenship were also added during this period, and practical obstacles, such as a 30-minute time out on the application website, further complicated the enrollment process. As a result of these changes, Florida's SCHIP enrollment decreased by 39 percent from June 2004 to June 2005 (a loss of nearly 128,000

children), which was the largest drop in enrollment of any of the 50 states.¹⁴ With low program enrollment, the state returned almost \$20 million in federal matching funds in 2005.¹⁵ More recently, the state has taken several steps to streamline bureaucracy and improve outreach, and enrollment rebounded by about 16,000 children between July and November 2007.¹⁶

Policy Options

Strategies and solutions to increase enrollment and retention among those eligible for public programs include increasing outreach and education activities, simplifying eligibility determination, and facilitating the enrollment and reenrollment processes. With more than six out of ten uninsured children eligible for public programs but not enrolled, children have the most to gain from policy solutions aimed at increasing enrollment in existing programs. However, child health coverage programs now reach 79 percent of their target population, which suggests more aggressive methods may be required to reach the remaining eligible children.¹⁷ One possible avenue to improve program take-up is for Medicaid and SCHIP to adopt automatic enrollment methods that dispense with the need for individuals to complete applications. Automatic enrollment relies on data sharing with other means-tested programs to determine categorical eligibility after eligibility in a more restrictive public program is verified.¹⁸ Removing binding enrollment caps would be another way to increase enrollment among eligible persons. Most strategies for reducing program dropout revolve around simplifying the renewal process. These options include changing from biannual to annual reenrollment, providing enrollees with renewal forms that have been pre-populated with their prior-year data, and using passive enrollment for SCHIP programs so that families must update their eligibility information only when there have been significant changes in their situations.¹⁹ There is also evidence that programs that cover parents and children together result in higher retention of eligible children.²⁰

It is worth noting that improving outreach and facilitating program enrollment and retention among currently eligible persons will have limited appeal to states if their budgets and federal matching funds are not sufficient to support higher enrollment levels. Faced with budget constraints, states may be fearful of making enrollment "too easy" for current eligibles

and being overwhelmed by enrollment and burgeoning program costs. (Current state budget realities also point to the decreasing likelihood that states will be able to expand program eligibility to additional populations, much less enroll all who are currently eligible.)

Improving program take up among eligible persons also will have limited success in reducing the number of uninsured parents and childless adults – only about 30 percent of the more than 12 million uninsured parents and 10 percent of the nearly 25 million uninsured childless adults are now eligible for public coverage.

Uninsured People Who Are Not Eligible for Current Public Programs

Segmentation by Income

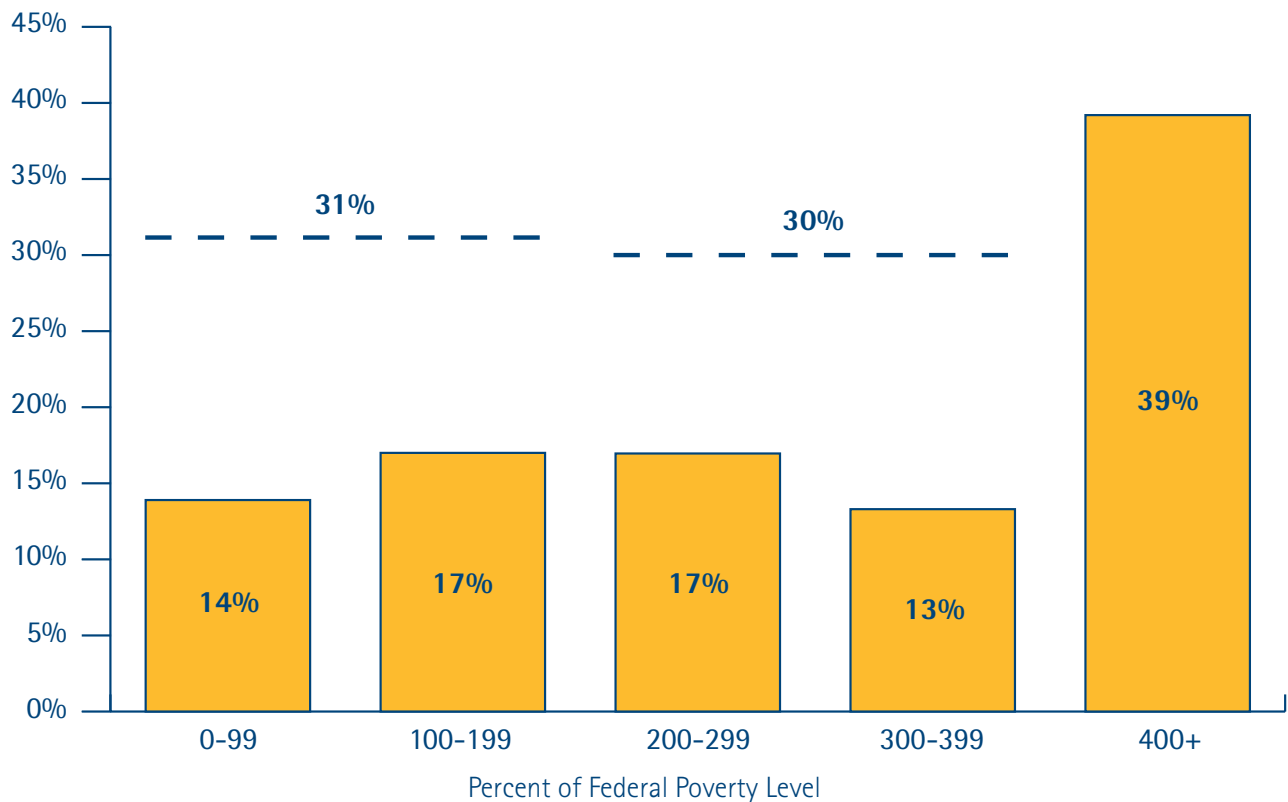
Approximately three-quarters of all non-elderly uninsured persons in the U.S. – 34.5 million out of 46.5 million – are not eligible for current public programs (Table 1). Here we take a closer look at these individuals by income, considering a lower-income group (< 200 percent of FPL), a middle-income group (200-399 percent of FPL) and a higher-income group (\geq 400 percent of FPL). The middle-income group was not created with the intention of defining the middle class, but rather due to the size of the population it represents and for its placement between the lower- and higher-income categories. As shown in Figure 2, 31 percent of U.S. residents are in the lower-income group, 30 percent are in the middle-income group, and 39 percent are in the higher-income group.

Lower Income (<200 Percent of FPL)

At 200 percent of the federal poverty level, a family of four earns \$41,300 and an individual earns \$20,420 (Table 2). People in this income category have the highest rates of uninsurance and a high reliance on coverage from public sources, particularly those below 100 percent of FPL (Figure 3).

As shown in Table 1, we estimate that 14.4 million uninsured people have incomes below 200 percent of FPL but are not eligible for public coverage. This group represents 31 percent of the total uninsured population and 42 percent of the uninsured population that is not eligible for public coverage. Figure 4 shows clearly that nearly all of the people in this situation are childless

FIGURE 2: DISTRIBUTION OF U.S. POPULATION BY FEDERAL POVERTY LEVEL



Source: NIHCM Foundation analysis of data from the March 2007 Current Population Survey.

adults (9.1 million) and parents (4.8 million), and approximately one-third of each of these groups has income below 100 percent of FPL (3.2 million childless adults and 1.5 million parents). These statistics reflect the categorical exclusion of childless adults from most state programs and the relatively low income cut-off points for parents that were cited earlier.

Middle Income (200–399 Percent of FPL)

Nearly one-third of the U.S. non-elderly population is in what we have termed the “middle-income” group (Figure 2).

We estimate that there are 12.8 million uninsured persons in this middle-income group, representing about 28 percent of the total uninsured (Table 1). As was the case with the lower-income group, Figure 4 illustrates the point that the vast majority of these individuals are childless adults (8.1 million) and parents (2.8 million). We also find 1.9 million uninsured children in middle-income families who were

not eligible for public coverage in 2006. Approximately two-thirds of the middle-income uninsured had family incomes in the lower half of the segment.

Crafting policy solutions for the 12.8 million uninsured people in this group is especially difficult given that the vast majority are covered by insurance (Figure 3).

Higher Income (≥ 400 Percent of FPL)

As shown in Figures 2 and 3, 39 percent of the total non-elderly population in the U.S. have family incomes at or above 400 percent of FPL, and 93 percent of these people are covered by insurance (91 percent private and 2 percent public). However, 7 percent of these higher-income people are without insurance coverage. These 7.3 million individuals represent approximately 16 percent of the total uninsured population (Table 1). Childless adults again comprise the largest share of the higher-income uninsured group (5.2 million), followed by 1.1 million parents, and one million children (Figure 4).

TABLE 2: 2007 HHS FEDERAL POVERTY GUIDELINES

| FPL | Individual | Family of 4 |
|------|------------|-------------|
| 100% | \$10,210 | \$20,650 |
| 200% | \$20,420 | \$41,300 |
| 300% | \$30,630 | \$61,950 |
| 400% | \$40,840 | \$82,600 |

Source: Federal Register, Vol. 72, No. 15, January 24, 2007, pp. 3147–3148.

Note: The HHS 2007 poverty guidelines reflect price changes through 2006 so they are approximately equal to the Census Bureau poverty thresholds for 2006. The numbers in this table apply to the 48 contiguous states and the District of Columbia; Alaska and Hawaii have higher poverty thresholds.

Comparisons with CPS data from 2005 indicate a one-year net increase of 370,000 uninsured adults and 150,000 children in this income group. However, the adult increase is largely attributable to strong growth in the total number of people with income above 400 percent of FPL (coverage rates remained approximately stable), whereas the increase in uninsured children was attributed to a slight decline in coverage through employment-based plans.²¹

Policy Options

Solutions for reaching the 34.5 million uninsured non-elderly persons who are not eligible for current public programs may include expansions of these public programs, strengthening private market options, or some combination of these two approaches. The cost and political feasibility of these options will be linked in some fashion to the income level and characteristics of the groups being targeted.

Additionally, choices must be made about how comprehensive the reforms should, and can, be. Some advocate for a comprehensive approach that utilizes a mix of public- and private-sector solutions in a coordinated manner in an effort to achieve universal coverage. Others believe that incremental reforms designed to tackle priority subpopulations of the uninsured may be more pragmatic.

Efforts to increase coverage through expanded public programs or improvements in the private market need to be coupled with initiatives to control health care

spending. Increased spending on health care translates into higher health insurance premiums. Thus, failure to control spending will exacerbate insurance affordability issues for both public and private payers and can cause coverage rates to decline.

Expanding Public Coverage

Key policy decisions around expanding public coverage include which additional categories of people should qualify and what income level should be used to determine eligibility. Selecting an appropriate income threshold requires making judgments regarding the affordability of health insurance and is greatly influenced by political and fiscal realities.

Affordability. Different conceptual approaches may be used to define affordability. Under a normative definition, health insurance is deemed to be affordable if the person's income is high enough to purchase both adequate health insurance and a socially acceptable minimum level of basic necessities. A behavioral approach, on the other hand, considers what people are actually spending on health insurance at various income levels and attempts to select an income threshold below which the percent of income spent on health insurance would not be unreasonably burdensome. At lower income levels people are generally expected to devote a smaller share of their incomes to health insurance because so much of the remaining income will be needed for other essentials.

Both conceptual approaches are typically implemented using thresholds that relate income to the federal poverty

level, but different policymakers and researchers have used a wide range of thresholds. Adding to the uncertainty of selecting a definitive affordability threshold is evidence that income is not a perfect predictor of whether a person has health insurance. Analyses by Bundorf and Pauly, for example, showed that regardless of the threshold used some people below the threshold nonetheless obtained private coverage and, conversely, a portion of those deemed able to afford coverage did not purchase it.²²

While income is not the only determinant of whether a person is able to buy insurance, Levy and DeLeire have demonstrated that low-income people who buy insurance spend less on basic needs (such as food), while higher-income purchasers spend less on entertainment and new cars.²³ Thus, lower-income uninsured persons are more likely to be “unafforders” who could benefit from initiatives to reduce their cost of insurance since purchasing insurance cuts into their basic needs.

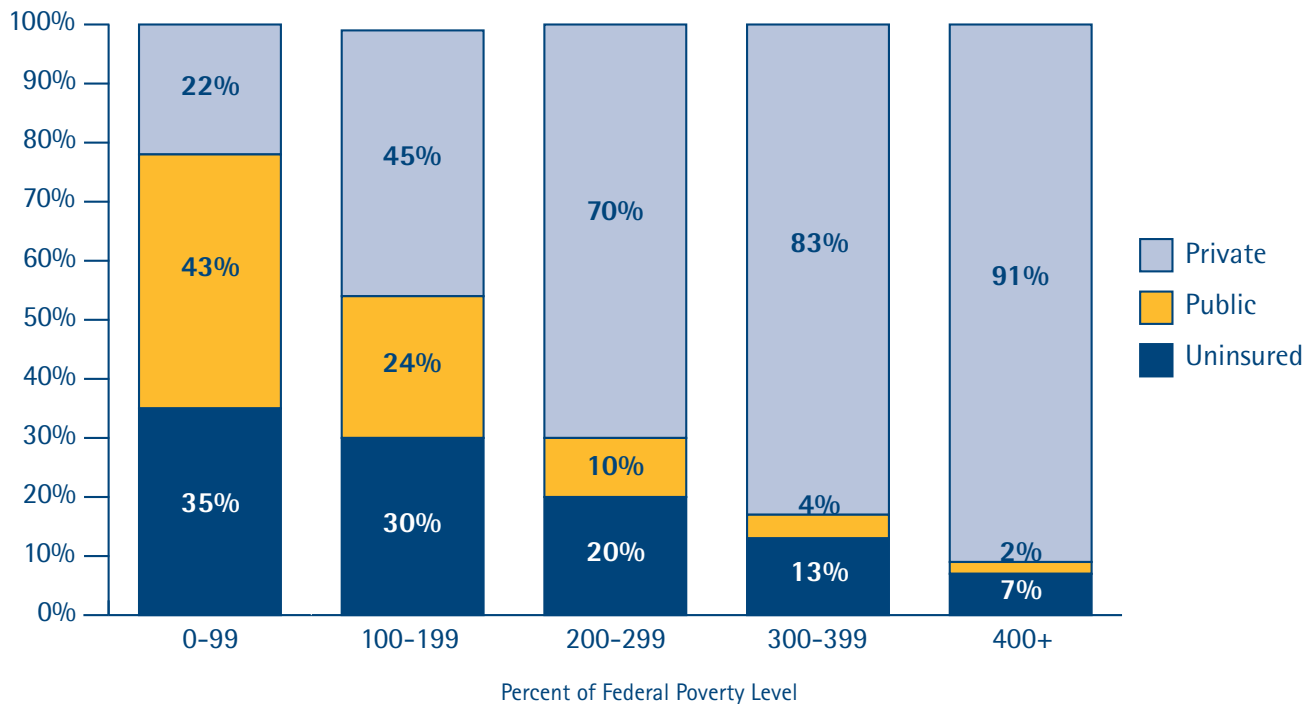
Additionally, it is worth noting that due to geographic variations in the cost of living, a given threshold will

have different implications depending on the market. For example, a family of four living in Texas would need an income of \$55,119 to achieve purchasing power equivalent to \$61,950 (three times the FPL) while the same family would need \$87,118 if they lived in California.²⁴ Thus, different affordability thresholds may need to take market price differences into account.

Childless Adults and Parents. As described above and illustrated by Figure 4, lower-income uninsured persons who do not qualify for current public programs are predominantly childless adults, followed by parents. Extending program eligibility to these groups up to 100 percent of FPL would reach 3.2 childless adults and 1.5 million parents (almost 14 percent of currently-ineligible uninsured persons and 10 percent of all uninsured). Moving to 200 percent of FPL would extend program eligibility to another 5.9 million childless adults and 3.3 million parents.

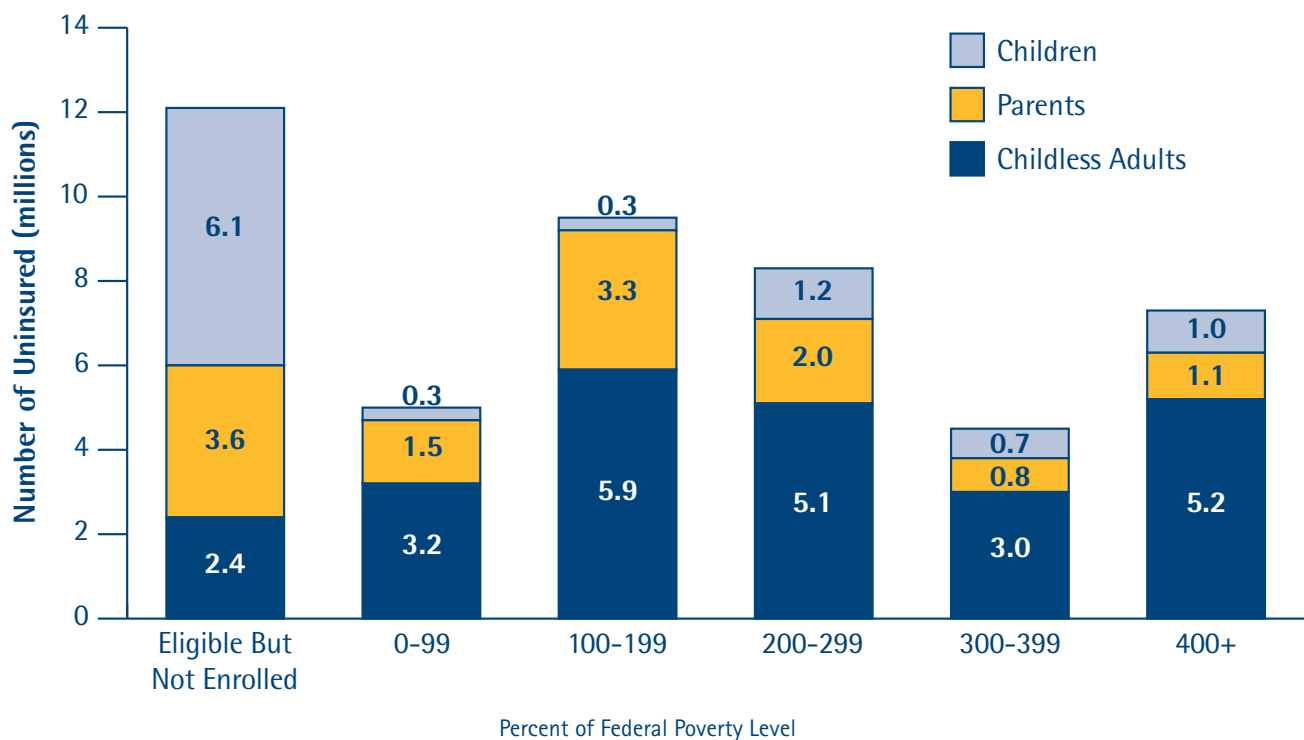
To date, however, few states have moved in the direction of expansive public program eligibility for

FIGURE 3: COVERAGE TYPE BY FEDERAL POVERTY LEVEL



Note: Persons reporting both private and public coverage during 2006 are classified as private. Percents may not sum to 100 percent due to rounding. Source: NIHCM Foundation analysis of data from the March 2007 Current Population Survey.

FIGURE 4: UNINSURED SEGMENTS BY PARENTAL STATUS



Source: NIHCM Foundation analysis of data from the March 2007 Current Population Survey.

childless adults and parents. Only seven states provided public coverage to childless adults as of July 2007 (Figure 5); eligibility thresholds in those states ranged from 35 percent of FPL to 200 percent, but access to the coverage was sometimes further restricted based on additional criteria or enrollment limits. For example, Idaho's coverage for childless adults was available only to employees of small businesses.²⁵

Parents with dependent children have access to traditional Medicaid program coverage, but qualifying income thresholds are generally quite low. In 2007 half of the states excluded working parents from this coverage if they had incomes above 63 percent of FPL, and only four states had expanded traditional Medicaid program eligibility to working parents with incomes at or above 200 percent of FPL.²⁶ Non-working parents have an even harder time qualifying for traditional Medicaid in many states since their eligibility cutoffs are often lower (and never higher) than those of working parents. While a small number of states have

used federal waivers or state-funded programs to expand eligibility to parents at higher income levels, the available programs generally either provide a lower level of benefits or require more cost sharing than the traditional Medicaid program.

The difficulty of meeting the budget neutrality requirement of the HIFA waivers may have contributed to the small number of states that have extended public coverage to childless adults. Budget neutrality might be achieved through system-wide savings realized by covering the populations targeted by the HIFA waivers (e.g., reductions in state indigent care expenditures), by spending down surplus federal SCHIP funds (which are not available in all states), or by making the current state programs less generous. Another constraint on state actions in this area was posed by the Deficit Reduction Act of 2005, which prevents states from using SCHIP funds to begin new programs to cover nonpregnant childless adults (existing programs were grandfathered until the end of their waiver period).

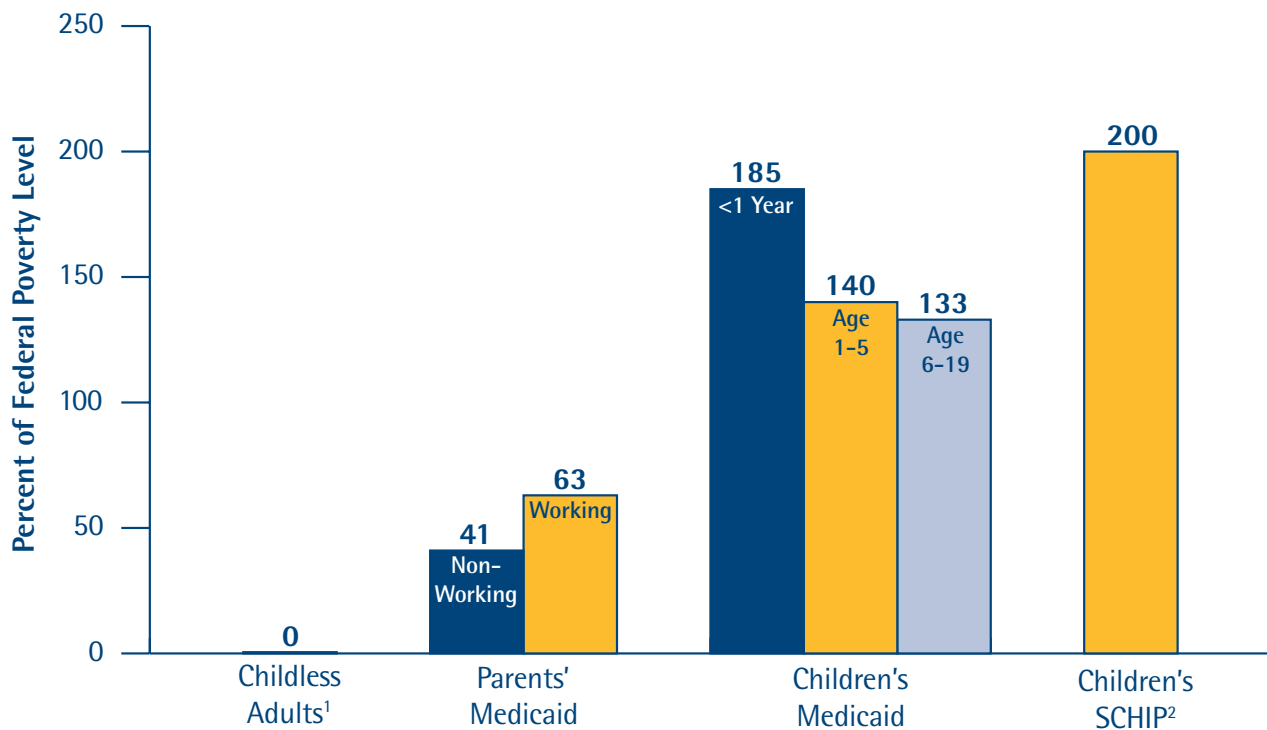
Additionally, recent economic woes and the resulting budget shortfalls now being experienced by many states, coupled with new Administration restrictions on Medicaid and SCHIP expansions, are likely to curtail states' abilities to expand their public programs and may even lead some to implement cuts.²⁷ Massachusetts' experience with its Commonwealth Care program illustrates the limiting role a budget plays in states' activities. Demand for the subsidized insurance program has greatly surpassed original planning, and the program is expected to double in size over the next three years. This unanticipated demand may force the state to cut back the program.²⁸

Crowd Out. Concerns about crowd out arise when considering expansions of public programs to higher income levels. Crowd out occurs when public coverage is substituted for private coverage, and it increases with income, as those with higher income levels are more

likely to have private insurance (Figure 3). Likewise, since the proportion of the population that is uninsured falls as income rises, expanding eligibility to higher income levels is a rather blunt instrument for reaching the target population.

Estimation of the size of any crowd out is difficult, and results differ according to the methods and data used, the program studied, and the time period considered. Estimates range from little or no crowd out to as much as 60 percent.²⁹ The Congressional Budget Office found that 25 to 50 percent of children enrolled in SCHIP would have had employer coverage if SCHIP were not available.³⁰ After reviewing the current literature, Blewett and Call estimate 0 to 15 percent crowd out for low-income children and 35 to 50 percent for higher income children and longer-term enrollees, with an overall rate of 35 to 50 percent.³¹ Additionally, Gruber asserts that crowd

FIGURE 5: MEDIAN STATE ELIGIBILITY THRESHOLDS FOR VARIOUS PUBLIC PROGRAMS, JULY 2007



Source: NIHCM Foundation compilation of data from the Kaiser Family Foundation (for children and parents) and from the Centers for Medicare and Medicaid Services and GAO testimony before the Senate Committee on Finance (for childless adults).

¹ Only 7 states provided coverage to childless adults in July 2007. One state (Illinois) subsequently ended coverage, while another state (Indiana) added new coverage.
² Computed across 37 states offering separate SCHIP programs.

out occurs as a family phenomenon, with crowd out estimates being higher if entire families enroll together and only half as large if only the individual's eligibility is considered.³² This is because enrollment of children in public coverage is more likely if parents are also eligible.

States have implemented anti-crowd out provisions in an attempt to prevent public coverage from replacing private coverage. The two main strategies for limiting crowd out have been waiting periods and cost sharing. In 2007, CMS issued a guidance mandating that states utilize five crowd out strategies before expanding SCHIP eligibility above 250 percent of FPL. These provisions require states to demonstrate that 95 percent of eligible children below 200 percent of FPL are enrolled in their public plans, and impose new cost sharing restrictions and a one-year period of uninsurance before receiving coverage.³³ Cost sharing for public coverage is an attempt to reduce the differential in out-of-pocket costs between public and private coverage. Despite the intention of crowd out protections, research suggests that they may suppress enrollment take-up rates in public programs among the uninsured by more than the crowd out of private coverage they are preventing.³⁴

In thinking about expanding public coverage and the possible substitution of public coverage for private coverage, the relative cost and generosity of benefits under the public and private plans present an equity issue. Lower-income workers with costly or limited employment-based coverage may find public coverage more appealing, but would be prevented from selecting this option by stringent crowd out protections. Options to be considered in the interest of ensuring equity among these low-income persons include providing government premium assistance to individuals who retain their private coverage, such that the worker's share of premium costs in the private market is reduced to what he would pay for public coverage, and permitting low-income workers to opt for public coverage but requiring their employers to contribute to the public coffers the amount they had been paying for private coverage.³⁵

Sliding Scales. One policy solution that can help to deal with the ambiguity around defining affordability and setting an income cut-off point for public assistance – and somewhat temper the cost of such expansions – is the adoption of a sliding scale, whereby the amount of public

AFFORDABILITY OF INSURANCE IN THE PRIVATE SECTOR

Private-sector insurance may be obtained through an employer or through the individual (or non-group) market. When employment related, the employer may share a significant portion of the premium, and premium costs are exempt from taxable income for both employers and employees. In 2006 the average total premium for employer-sponsored coverage was \$11,480 for family coverage and \$4,242 for individual coverage.³⁶ Despite a slowing in the rate of premium increases in the past three years, annual premium increases have far outpaced the growth in inflation and in workers' wages since 1999.³⁷ While employees are still paying about the same share of total premiums as they were two decades ago, the increase in employee contributions has nonetheless reflected the rapid escalation of premium costs. Between 2000 and 2006, the average employee contribution rose by nearly \$300 (87 percent) for single coverage and by \$1,354 (84 percent) for family coverage, compared with cumulative wage growth of only 20 percent. Significantly higher contributions are typically required of covered workers in small firms.³⁸ Since most economists would argue that workers actually pay the full cost of their health insurance premiums through reduced wages, these rising costs are contributing to wage stagnation and making health insurance seem even less affordable. In addition to these premium increases, recent years have also seen enrollees facing higher out-of-pocket costs in the form of deductibles and copayments.³⁹

Those who seek health insurance in the individual market bear the full cost of the policy explicitly and most often pay with after tax dollars. Mean premiums for coverage purchased in the individual market were \$5,799 for family policies (covering about three family members, on average) and \$2,613 for individual policies in 2006–2007. The cost of these policies differs markedly by age, however, with the mean cost for those aged 60 to 64 about four times higher than the mean cost for people under age 18.⁴⁰ Additionally, preexisting conditions make it difficult for many people to find affordable individual policies and prevent some from obtaining an individual policy.

assistance declines as income rises. This approach can be applied to expansions of SCHIP and Medicaid eligibility, such that those with higher incomes are required to share a higher portion of the SCHIP premium.

Sliding scales can also be used in combination with private coverage. Massachusetts, for example, subsidizes private coverage for low-income people who are not eligible for its public programs or for employer-based coverage. Those earning less than 150 percent of FPL receive a full premium subsidy, while those earning between 151 and 300 percent of FPL are required to pay an increasing portion of the premium.

In contrast to "all or nothing" eligibility thresholds, sliding scales and the gradual phase out of subsidies avoid the "notch" effect where all benefits are lost when income edges just slightly past the threshold. In designing these types of sliding scales, policymakers will have to make choices about how quickly subsidies will be phased out as income rises. If benefits decline quickly over a small income range, the marginal tax rate will be relatively high, providing a disincentive to work since a small increase in earnings will cause the loss of a large subsidy amount. Conversely, a gradual decline of benefits over a larger income range will raise program costs.

Private Market Solutions

Most solutions for improving private markets focus on the small group and individual markets. Options available to policymakers include employer and/or individual mandates ("pay or play" initiatives), tax credits, initiatives to facilitate the purchase of affordable coverage by individuals with preexisting conditions or other high risks, and insurance exchanges to help consumers navigate the complex market for insurance products. Additionally, it is worth noting that the private market is also developing products that are targeted to specific subpopulations of the uninsured. These include policies with benefit structures tailored to appeal to particular age and cultural segments. Company self-reported data show promising results, thus many insurers are expanding these efforts.

Mandates. Mandates require people to offer or obtain health insurance when they otherwise would not have done so voluntarily. Employer "pay or play" mandates attempt to realign the cost of providing coverage by requiring employers either to offer health insurance to

their workforce or pay a fine to reimburse the government for providing coverage for their employees. According to the National Conference of State Legislatures, employer health insurance mandates have been considered by 31 states. Most proposed laws apply only to large firms, which is a primary criticism of the utility of employer mandates in reaching the uninsured. For example, the proposal in New York State exempts firms of less than 100 workers from its mandate, which means about 60 percent of uninsured workers would not be covered.⁴¹ While low-income workers are the intended beneficiaries of employer mandates, they often are disproportionately excluded when the legislation is formulated. Additionally, employer mandates increase costs to employers, which results in employment reductions, particularly among the least skilled workers.⁴²

State employer mandates have also faced legal challenges under the Employee Retirement Income Security Act (ERISA) of 1974. Due to a preemption under ERISA, large employers that are self-insured cannot be forced to offer health coverage. Straight mandates to provide coverage are most problematic. "Pay or play" mandates, which give employers an option to pay a tax rather than offer coverage, may fare better but are still being challenged under ERISA with recent court decisions going against the mandates.

Individual mandates require individuals to purchase affordable coverage or face a penalty. Only one state – Massachusetts – has implemented an individual mandate, and it is too early to determine how that initiative is faring.⁴³ When developing an individual mandate, a delicate balance must be struck between affordability and adequate coverage. There is contention around the size of the burden placed on the individual as well as the package of benefits that constitutes an acceptable level of coverage. Mandates have also been attacked on the grounds of equity because they may force younger and healthier enrollees to subsidize insurance premiums for the larger population. As with employer mandates, concerns also exist surrounding the ability of these measures to reach lower-income uninsured when people are exempted based on affordability grounds.

As evidenced by trends in automobile insurance coverage, simply instituting a mandate does not guarantee compliance. The effectiveness of a mandate

can be increased by developing policies that have affordable options for compliance, meaningful penalties that are neither too large nor too small, and timely enforcement.⁴⁴

Tax Credits. Tax credits (or premium subsidies) have been commonly proposed as a way to provide financial assistance and incentives to employers and individuals to offer and obtain private coverage.⁴⁵ The credits may be designed as a fixed-dollar contribution (a “flat” credit), or they may be tailored so that different groups receive different amounts. For example, they might be more generous for those with lower incomes, or could be adjusted for factors that will affect premium costs, such as health status, age and family size. In contrast to income tax deductions, which reduce taxable income, tax credits are deducted from total taxes owed, resulting in a larger subsidy on a dollar for dollar basis.

Details of tax credit proposals vary according to the amount and structure of the credit and eligibility requirements. Giving tax credits directly to employers – especially small employers – can help them provide coverage for their workers and give workers access to the tax advantages of employer-sponsored coverage. Tax credits provided to individuals might be more appropriately thought of as vouchers since they subsidize the cost of purchasing insurance in either the employer or the individual market. In this way, the credits extend the current employment-based premium tax subsidies to the individual market.⁴⁶ Most proposals for individual tax credits call for the credit to be “refundable” (so that the individual receives the full amount of the credit even if his tax liability is lower than this amount) and “advancable” (so that the individual does not have to use his own, limited funds first in order to claim the credit later).

Improving Access to Coverage for High-Risk Individuals. Government sponsored high-risk insurance pooling, as exemplified in programs such as the Maryland Health Insurance Plan, is a strategy that can assist people with preexisting medical conditions or other high risks to purchase private insurance.⁴⁷ Currently, 34 states offer high-risk pools.⁴⁸

Government-sponsored reinsurance programs also have been proposed as a way to keep premiums lower. The difficulty of accurately predicting which, and how

many, enrollees will incur very high costs in any given year means that insurance premiums include charges to cover the risk of high expenditures associated with adverse selection. Reinsurance can help to eliminate the need for this “risk premium,” lowering total premiums. One way to structure reinsurance is an “excess-of-loss” design, which sets various dollar thresholds to define distinct cost groups. The originating insurer is responsible for all costs for cases below the lowest threshold, and for a portion of the costs for cases above this threshold. As the patient’s expenditures reach higher cost groups, the insurer receives a larger reinsurance payment but is still responsible for a portion of the costs.⁴⁹ New York has adopted this strategy in its Healthy New York program, and has demonstrated significant reductions in premiums for all program enrollees.⁵⁰ “Aggregate stop loss” reinsurance is an alternative structure, which is used when the costs of the total insured population end up being unexpectedly high (even if individual cases are not high cost). Arizona has used this aggregate stop loss approach, and also reports significant program savings.⁵¹ While reinsurance programs can be applied to all types of insurance markets, they may be particularly helpful in reducing premium costs in the individual and small group markets, where adverse selection is a principal concern and risk premiums are high.

Community rating, guaranteed issue requirements and mandatory open enrollment periods, which require insurers to accept all comers and charge them the same premium regardless of health status, are another means to broadening access to non-group insurance for those with high risks. These mechanisms, however, tend to raise premium costs for all in the plan because sicker enrollees are grouped with healthier enrollees when setting premiums. Over time, as more low-risk enrollees drop out, premiums will spiral upward, pricing additional lower-risk enrollees out of the market and leaving premiums still higher for remaining enrollees.

Insurance Exchanges. Insurance exchanges can help simplify the complex shopping process for individual consumers and small businesses who are faced with myriad plan choices, little comparable information for selecting the policy that best meets their needs, and no bargaining power to negotiate favorable prices. Exchanges may solicit bids and negotiate premiums, and provide a place for one-stop shopping, often with

MASSACHUSETTS: EXAMPLE OF A MULTI-PRONGED APPROACH

The much-publicized comprehensive health care reform recently enacted by Massachusetts is a multi-pronged approach⁵² that illustrates how many of the strategies discussed in this brief might be used in combination. Massachusetts' reform is based on the principle of shared responsibility between the public and private sectors for expanding access to affordable and adequate health care.

The Commonwealth Health Insurance Connector

- An independent public authority, the Commonwealth Health Insurance Connector, was created to administer many of the reforms, including determining standards for affordable and adequate coverage and offering the Commonwealth Choice plans.

Individual Mandate

- The state enacted the nation's first "individual mandate" requiring most adults over 18 to obtain health insurance or face a financial penalty for noncompliance. Some adults are exempt from the mandate because they do not qualify for publicly subsidized coverage but cannot afford the mandated coverage.

Employer Mandate

- Employer mandate requires that employers with more than 10 full-time employees make a "fair and reasonable" contribution (as defined by the Connector) to employees' health benefits or pay up to \$295 per uninsured employee into the Commonwealth Care Trust Fund.
- To further reduce premium costs, employers subject to the mandate must also set up a Section 125 "cafeteria plan" that allows employees to pay for health coverage with pre-tax dollars.

Assistance for Low-Income Children and Families

- The state expanded eligibility for its Medicaid/SCHIP program, MassHealth, to include children up to 300 percent of FPL.
- The Commonwealth Care Health Insurance Plan (CCHIP) was created to subsidize private coverage for low-income people who are not eligible for MassHealth or for employer coverage. Those earning less than 150 percent of FPL receive a full premium subsidy through CCHIP, while those earning between 151 and 300 percent of FPL are required to pay an increasing portion of the premium based on a sliding scale.

Assistance for Moderate Income Persons and Small Businesses

- For those with income above 300 percent of FPL and for businesses with up to 50 employees, the state offers a series of Commonwealth Choice plans, which are private plans selected in response to a state request for bids. While premiums for Commonwealth Choice plans are not subsidized, the negotiations between the state and the bidding plans coupled with a three-tiered benefit structure resulted in relatively low premiums in the first year of the program.

Individual and Small Group Market Reforms

- To improve the individual market, the non-group and small group markets were combined, expanding plan choice and establishing a much larger rating pool for setting premiums.

Provisions for Young Adults

- Young adults were targeted by a provision allowing them to remain as dependents on their parents' policy for two additional years and by the creation of new insurance products with limited coverage and lower costs.

a standardized means of comparing options. Exchanges may also facilitate the administration of current proposals to permit the general population to buy into the Federal Employees Health Benefits Program or a new “Medicare-like” public program. Historically, however, many exchanges have floundered due to difficulties attracting consumers and insurers.

The “Commonwealth Connector” that was created as part of the Massachusetts reform is an insurance exchange. Among other functions, it obtains bids for plans offered to small businesses and higher-income people not otherwise eligible for state assistance. As of late 2007, approximately 16,000 people had enrolled in one of the unsubsidized Commonwealth Choice plans.⁵³

It is also important to note that unless the exchange has a population of customers who must purchase their coverage through the exchange, the exchange will attract higher risk enrollees if it uses community rating to set premiums and non-exchange alternatives do not. This would be a key sticking point if a federal exchange were established using guarantee issue and community rating, and state markets used other mechanisms to determine premiums in the individual and small group markets.⁵⁴

The Impact of Transitions

Transitions are a cause for being uninsured as people typically lose coverage when they change or lose a job, retire before age 65, or age out of a parent’s policy or public program. Additionally, within the Medicaid and SCHIP populations, transitions due to recertification requirements are a major issue, as discussed earlier in this paper. Thousands of people fall into these transition gaps each year and might be helped by solutions aimed at easing the impact of the transition. Young adults and the near elderly are two segments of the population that merit additional consideration.

Young Adults

Young adults (ages 19-24) are uninsured at a much higher rate than other age segments, with 31 percent of all young adults being without insurance (Figure 6). Young adults often lose coverage when they turn 19 or graduate from high school or college. Nearly one-half of

high school graduates who do not enroll in college and two out of five college graduates will be uninsured some time in the year after graduation.⁵⁵ Young adults who continue their education often can continue to receive health insurance as dependents on their parents’ family plan, but they lose their eligibility upon graduation.

Despite the common perception that “young invincibles” choose not to purchase health insurance believing that they do not need it, research shows that young adults value insurance but face access and affordability constraints.⁵⁶ Young adults often have difficulty finding jobs that offer health benefits since many entry-level jobs are low-wage, temporary, or in small companies – all characteristics of jobs with a lower likelihood of offering insurance. Younger, healthier enrollees also face premiums that are higher than their expected utilization of services when community rating is used to set premiums, since they are placed in the same risk pool as older, less healthy enrollees. Being uninsured restricts use of health care services. In the past year, almost 60 percent of uninsured young adults had gone without health care because of cost.⁵⁷

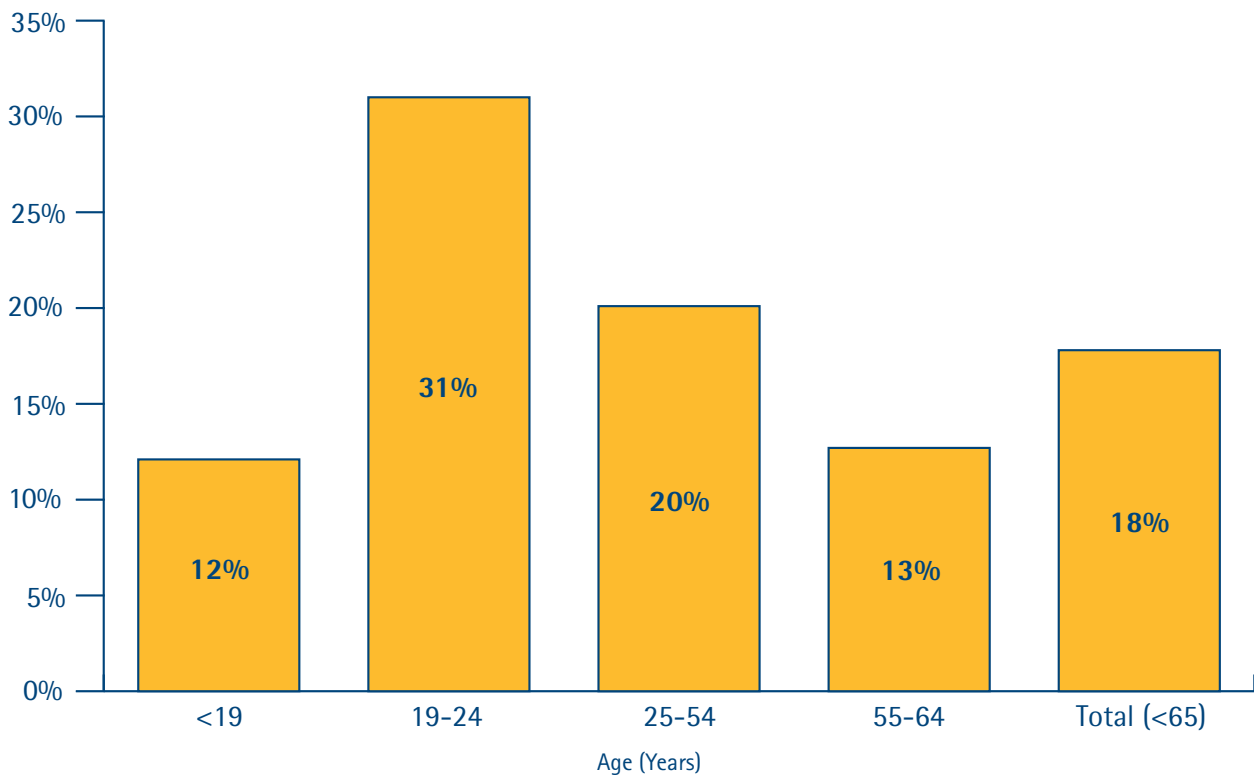
Policy Options

Policy solutions to address uninsured young adults include increasing age cutoffs for eligibility, mandating coverage in college, and creating more affordable insurance options. Young adults could benefit from extending dependents’ eligibility on private family coverage. As of November 2007, 17 states had increased the age of dependency on private insurance, with upper age limits ranging from 24 to 30 years old.⁵⁸ Low-income uninsured young adults could also be helped by expanding eligibility for children’s public programs beyond age 18 or by expansions of public programs for adults. Ensuring that colleges require students to have health insurance and offer coverage would also help to reduce the number of uninsured in this age group. Regarding affordability, some states have adopted a more flexible “age banding” system in place of community rating requirements, which allows young people to purchase coverage without subsidizing costs for older, sicker enrollees.⁵⁹

Near Elderly

Approximately 13 percent of those aged 55-64 years are uninsured. Although this rate of uninsurance is not particularly high when compared to other age segments,

FIGURE 6: PERCENT OF EACH AGE COHORT WITHOUT INSURANCE



Source: NIHCM Foundation analysis of data from the March 2007 Current Population Survey.

the lack of insurance is potentially of greater consequence due to the health needs of the near elderly. The near elderly are at greater risk for chronic health conditions that require regular access to care for effective management. Their higher utilization of health services also makes them more costly to health insurers than their younger counterparts. These factors make coverage options on the individual market expensive for those who are not eligible for employer-sponsored coverage, especially when one also considers the impact of paying in after-tax dollars.

Insurance coverage among the near elderly varies by work status and income. The highest uninsurance rates are found for low-income non-retirees (35 percent in 2002), reflecting the lower general availability of employment-based coverage for low-income workers. Other segments of the near elderly population fare better. Those who retire due to disability have high rates of coverage through Medicaid and Medicare, and those of middle and upper incomes are better able to afford to

purchase private insurance or more likely to have access to coverage from a current or previous employer.⁶⁰

With costs of providing health benefits increasing steadily, however, employers have cut back on retirement benefits. In 2006, 35 percent of large firms (200 or more workers) offered retiree health coverage – down from 66 percent in 1988.⁶¹ This decline affects not only elderly retirees who might have been counting on employer-provided insurance to supplement their Medicare benefits, but also early retirees who must now rely on the individual market until they reach age 65. This situation is particularly problematic for those who have already taken early retirement with employer coverage, and then see that coverage reduced or eliminated, and for those whose retirement occurred earlier in life than they had been anticipating (e.g., due to employer downsizing or other layoffs). Research by the Employment Benefit Research Institute shows that while 40 percent of surveyed workers planned to retire

before age 65, two-thirds of workers actually did so, often for reasons beyond their control such as health problems or changes at their employer.⁶²

Affordability is likely to be an issue for at least some portion of the near elderly due to their reliance on savings and pension income and their increased likelihood of having preexisting conditions, which raise the cost and difficulty of obtaining private coverage. With the leading edge of the baby boom generation entering prime retirement age, and many of those wishing or forced to retire before age 65, the decline in retirement benefits could result in higher uninsured rates in the future.

Policy Options

There are numerous potential policy solutions for the near elderly. One that is directly targeted to this age group is allowing near-elderly adults to purchase insurance through Medicare. Other possible solutions are more general and attempt to make private coverage more accessible and affordable, especially for people with higher risks. These options include approaches like supporting state high-risk pools by federal grants and funding state-based reinsurance for private coverage.⁶³

OVERVIEW OF STUDY METHODS

The Current Population Survey (CPS) is the most widely cited source of data for estimating the size and characteristics of the uninsured population. In March of each year, respondents are asked whether they had any of a list of different possible types of insurance at any time during the prior year. Those who answer "no" for all possible types of insurance are asked a follow-up question to confirm their lack of insurance from any source, and those for whom this status is confirmed are considered to be uninsured. Anyone answering "yes" to any of the insurance questions is treated as being insured for the year, regardless of the duration of that coverage or whether there was also a spell without insurance. Thus, in its purest sense, the CPS estimate reflects the number of people who were uninsured for the entire year. This is a different number, conceptually, than the number of people who were uninsured at a given point in time or who were ever uninsured during the prior year.

Most analysts who use the CPS consider its data to represent "point-in-time" estimates, in essence reflecting the insurance situation at the time of the survey. They justify this interpretation on the grounds that the CPS estimates are similar to results from other surveys that ask about insurance status at the time of the survey, and because of doubts that the CPS respondents can accurately recall their insurance situations for the entire prior year.

Numerous assumptions and analytic decisions are necessary when using the CPS (or any other database) to study the uninsured. Many of these analytic decisions can involve very complex modeling efforts and supplemental sources of data. Depending on their interpretation of the CPS numbers as full-year or point-in-time estimates, equally thoughtful analysts can differ greatly in their modeling approaches, sometimes leading to wide variation in the final results. Thus, a clear exposition of methods used and an understanding of how the chosen approach is likely to affect results are critical. In the work presented in this brief, we have opted for a straightforward modeling approach that uses the CPS data as reported in order to be internally consistent and minimize distortions arising from multiple, complex adjustments to the reported data.

Determination of Insurance Status

Insurance status is determined using March 2007 responses to questions about whether the sampled person was covered by any of a range of possible health insurance options at any time during 2006. Those indicating no coverage by any private or public insurance program at any time in 2006 are classified as uninsured. Those citing some type of coverage are further classified according to whether they have public or private coverage; respondents with both public and private coverage in 2006 are classified as having private coverage.

It is well established that the CPS overestimates the number of uninsured persons because some proportion of respondents who were enrolled in public programs at some point during the prior year fail to acknowledge that coverage. Other researchers have made adjustments to account for this "Medicaid undercount" using dramatically different assumptions and adjustment methods. A key difference is their assumption about whether the CPS data are full-year or point-in-time estimates. Accordingly, their estimates of the Medicaid undercount vary dramatically from a low of about 900,000 to a high of more than 9 million.⁶⁴ We make no attempt in the work presented here to adjust for the Medicaid undercount. As a result, our estimate of the uninsured non-elderly population ties exactly to the 46.5 million reported by the CPS, but this number is overstated. Much of the overstatement likely occurs among the group of people deemed to be eligible for public coverage.

Determination of Eligibility for Public Programs

To subdivide the uninsured population into groups that are eligible for public coverage and those that are not, we used information about the person's age, family size and structure, income, citizenship status, and state of residency to simulate program eligibility according to state-specific rules. State public program eligibility rules were drawn from Kaiser Family Foundation (KFF) materials.⁶⁵ We considered Medicaid for infants (age 0), young children (ages 1-5), older children (ages 6-18), working parents, and non-working parents. In its discussion of eligibility for children, KFF also reports on rules for separate state programs (SCHIP). State coverage of childless adults was determined through National Conference of State Legislators tracking of Health Insurance Flexibility and Accountability (HIFA) waivers. Eligibility determination considered whether the person met the state's poverty requirement for specific public programs open to the person based on age and parental status. We did not code other program eligibility rules, such as asset tests, state waiting periods or enrollment caps. Non-citizens were identified using the CPS self-report of citizenship status and were screened for public program eligibility only if they reported having entered the U.S. in 2001 or earlier; those entering after that date would not have been eligible for public coverage in 2006 due to the requisite five-year waiting period.

Income Level

Income level relative to the federal poverty threshold that is relevant for the person's family size and structure is a key part of our analysis. Our approach treats the "primary family" as distinct from any related subfamily unit residing in the same household, and uses the income and the family structure that applies to each primary family/subfamily unit. For each unit, we consider income from all sources and do not account for the state-specific income "disregards" that play into the determination of program eligibility. We believe that the net impact of our decisions causes us to understate the number of people in the lowest categories of income (when income is defined using Medicaid eligibility rules) and, thus, to understate the number of people we find to be eligible for public programs. Finally, we use the annual income figure reported by the CPS to determine eligibility for the full year, rather than introduce assumptions about how the income is distributed throughout the year in order to more closely replicate the monthly determination of eligibility that actually occurs in the Medicaid program.

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