kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

POLICY BRIEF

January 2006

What Happens When Public Coverage Is No Longer Available?

By Sharon K. Long and John A. Graves, The Urban Institute

In the face of prolonged budget difficulties, a number of states have cut eligibility or are considering cuts in eligibility for public coverage.[1] In some cases, the planned cuts have been quite large, such as in Tennessee, Oregon, Mississippi and Missouri, which, when fully implemented, will eliminate Medicaid coverage for more than half a million people altogether. As of yet, little is known about the implications of losing public coverage on the insurance status of those no longer eligible for public coverage. It remains an open question as to how many will obtain private coverage and how many will become uninsured when public coverage is no longer an option. This policy brief uses the 2002 National Survey of America's Families to document the share of current public program enrollees who would have alternate coverage options—either through an employer or affordable coverage through the non-group insurance market—if public coverage were no longer available.

To preview our results, we find that very few of the low-income working age adults who are currently covered by public programs would have any insurance options in the absence of public coverage. Only 8 percent would have the possibility of obtaining employer-sponsored insurance (ESI) coverage, and less than 1 percent would likely find non-group premiums that cost less than 5 percent of their family's income. Altogether, we estimate that no more than 9 percent of these low-income adults would have access to an alternative source of insurance in the absence of public coverage.

It is only when income is above 150 percent of the federal poverty level (FPL) that other coverage options become available for more than a handful of adults who currently have public coverage. And, even then, only 1 in 4 of the parents and fewer than 2 in 5 childless adults would have an alternate insurance option. This research suggests that the vast majority of current enrollees affected by cutbacks in eligibility for public programs, particularly those with the lowest incomes, are likely to be left uninsured.

Data and Measures

The National Survey of America's Families (NSAF) provides detailed economic, health, and social characteristics for a representative sample of almost 45,000 families. For this analysis, we focus on the 7 million low-income adults aged 19 to 64 who had public insurance coverage (via Medicaid, the State Children's Health Insurance Program [SCHIP], or coverage through a state-specific program) in 2002.[2] We define low-income as family income less than 200 percent of the FPL.

Two key variables were constructed for this analysis: an indicator for whether the individual is offered insurance coverage by his or her current employer, and the premium the individual would face in the non-group market.

- **ESI Offer.** To identify individuals who are likely to be offered ESI coverage by their current employer, we constructed an ESI offer measure based on whether the individual reported having ESI through his or her own employer, or if he or she answered "yes" to the survey question, "Does your current employer offer health insurance to workers in the same position as yours?" Since this question seeks information about the type of job that the individual holds, not about his or her own circumstances, the respondent may answer "yes" to the question even if they themselves are not eligible to enroll in their employer's plan.[3] To link our offer measure to the individual rather than their position, we limit the ESI offer to those individuals who are most likely to be eligible for the ESI coverage--those who have worked for their employer for at least one year and those working full-time.[4]

- **Non-Group Premiums.** Because NSAF does not collect information on premiums, we apply the framework for generating estimates of non-group premiums developed by Hadley and Reschovsky for the Community Tracking Survey (CTS) to estimate the non-group premiums that would be faced by the individuals in our NSAF sample.[5] In this analysis we assume that non-group coverage is "affordable" if the estimated premium is less than 5 percent of family income.[6] We chose this level given the finding that low-income populations are much less likely to purchase health insurance coverage when it costs more than 5 percent of family income.[7]

Characteristics of Low-Income, Working-Aged Adults with Public Coverage

With few exceptions, public insurance is only available to low-income U.S. citizens who are pregnant women; children and, at lower-income levels, their parents (or caregivers); and aged, blind and disabled individuals. Only a few states have extended eligibility beyond those populations to cover low-income childless adults more generally. Not surprisingly given those eligibility criteria, low-income, working-aged adults with public coverage tend to be women (66 percent), in families with children (51 percent) and U.S. citizens (85 percent), as shown in Table 1. More than 40 percent report that they are in fair or poor health, while 50 percent report a physical or mental health problem that limits their ability to work. Although annual family income is quite low ($10,669, on average), 38 percent of the adults either work themselves or are in a family with a worker.

Consistent with the different pathways for eligibility for parents and childless adults, we find that the childless adults are much more likely to report that they are in fair or poor health (53 versus 33 percent) or that they have a physical or mental health condition that limits their ability to work (71 versus 31 percent). Further, only 23 percent of the childless adults have a worker in their family, compared to over half of the parents with public coverage. Finally, the average annual family income of childless adults on public coverage is $7,211, about half that of parents ($13,970).

Table 1: Characteristics of Low-Income Adults with Public Coverage

Characteristics	Low-Income Adults with Public Coverage		
	All (%)	Parents (%)	Childless Adults (%)
Age	38.2	34.3	42.4
Female	66.1	75.4	56.4
Married	25.9	38.6	12.5
Parents	50.5	100.0	0.0
U.S. Citizen	85.1	81.3	89.0
Race / Ethnicity			
White, non-Hispanic	51.0	44.0	58.4
Black, non-Hispanic	26.2	29.0	23.3
Other, non-Hispanic	3.1	3.3	2.8
Hispanic	19.7	23.7	15.5
In Fair/Poor Health	42.4	32.5	52.8
Has a Work Limitation	50.6	31.2	71.0
Self (or spouse) works	38.0	52.1	23.3
Annual Family Income	$10,669	$13,970	$7,211
Sample Size	3,875	2,479	1,396

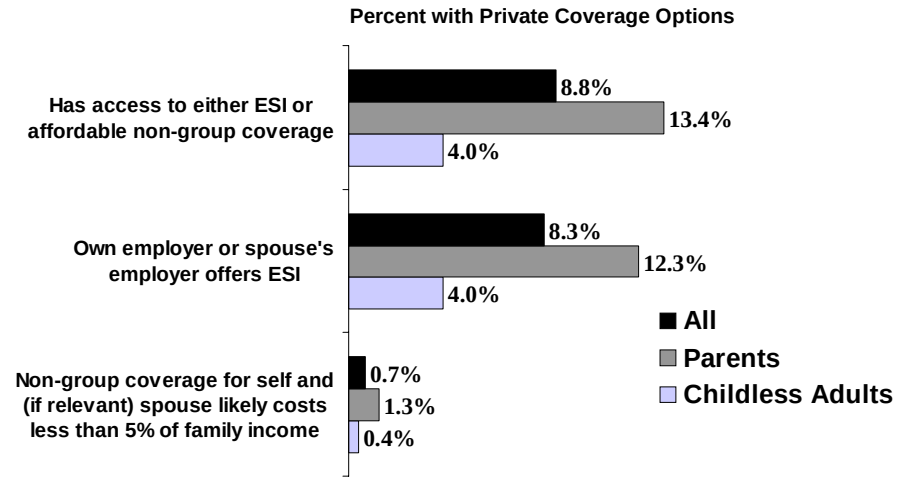
Source: Tabulations based on the 2002 National Survey of America's Families

Findings

In the absence of public coverage, an individual's coverage options narrow to obtaining ESI coverage through their employer or the employer of a spouse (or, for some young adults, a parent's employer) or purchasing coverage in the non-group market. The availability of these two coverage options to adults who currently have public coverage is summarized in Figure 1. We present the estimates for all low-income adults with public coverage, as well as separate estimates for parents (including pregnant women) and childless adults, as they face different eligibility standards in most states.

We find that the potential coverage options available to low-income adults in the absence of public coverage are quite limited. In 2002, only 8 percent of low-income working age adults had the possibility of obtaining ESI coverage, although 38 percent were working or had a spouse who was working (Table 1). Furthermore, less than 1 percent would likely face non-group premiums that were less than 5 percent of their family income. (By contrast, nearly 60 percent of the low-income adults face non-group premiums that are more than 25 percent of their income.) Altogether, we estimate that less than 9 percent of the low-income adults would have access to an alternative source of insurance in the absence of public coverage.

Figure 1: Low-Income Adults with Public Coverage Have Few Insurance Options in Absence of Public Coverage



Source: Tabulations based on the 2002 National Survey of America's Families.

When we look at the potential coverage options for parents and childless adults, we find that 12 percent of parents have access to ESI coverage, compared to only about 4 percent of childless adults. The latter is not surprising given that nearly all working-age childless adults with public coverage qualify for that coverage because of a disability that limits their ability to work. Indeed, as Table 1 shows, nearly 3 of 4 childless adults with public coverage report such a limitation.

The extent to which low-income adults have potential insurance options beyond public coverage does increase with income; however, it is rare for any of the adults with income below 100 percent of FPL to have access to ESI or to affordable non-group coverage in the absence of public coverage (Table 2). When income increases above 100 percent of the FPL, the share of adults with access to ESI or affordable non-group coverage does rise, particularly for parents. However, even for these adults, only1 in 5 parents and 1 in 10 childless adults would have access to ESI coverage. This, despite the fact that more than two-thirds of parents and nearly 40 percent of childless adults with income between 100 and 200 percent of the FPL have at least one worker in the family (data not shown).

Table 2: The Insurance Options in the Absence of Public Coverage Vary by Income Level

Potential Coverage Options	Low-Income Adults with Public Coverage, by Income Level			
	<50% of FPL (%)	50 to 99% of FPL (%)	100 to 149% of FPL (%)	150 to 199% of FPL (%)
All Adults with Public Coverage				
Has access to either ESI or affordable non-group coverage	3.0	6.0	13.6	25.2
Own employer or spouse's employer offers ESI	3.0	6.0	13.2	20.7
Non-group coverage for self and (if relevant) spouse likely costs less than 5% of family income	0.0	0.0	0.4	5.3
Parents with Public Coverage				
Has access to either ESI or affordable non-group coverage	4.1	11.2	18.8	31.2
Own employer or spouse's employer offers ESI	4.1	11.2	18.1	23.8
Non-group coverage for self and (if relevant) spouse likely costs less than 5% of family income	0.0	0.0	0.7	8.9
Childless Adults with Public Coverage				
Has access to either ESI or affordable non-group coverage	1.8	1.7	6.3	16.8
Own employer or spouse's employer offers ESI	1.8	1.7	6.3	16.4
Non-group coverage for self and (if relevant) spouse likely costs less than 5% of family income (%)	0.0	0.0	0.0	0.4
Sample Size	1,074	1,430	897	474

Source: Tabulations based on the 2002 National Survey of America's Families.

Most of the gains in coverage options are observed for low-income adults with incomes above 150 percent of the FPL. For parents, much of this is due to the increased affordability of non-group coverage as income rises, while childless adults see a small gain in the availability of ESI coverage. It is likely that the increased affordability of non-group coverage for parents reflects the fact that a family of three with income at 100 percent of the FPL has a higher total income than a single individual with income at 100 percent of the FPL ($14,348 versus $9,183 in 2002). As a result, within different income groups based on the FPL, a parent will be better able to "afford" a given non-group premium than an otherwise similar childless adult.

Policy Implications

In the face of cutbacks in eligibility for public programs, the vast majority of the low-income adults who are currently enrolled in the programs would have few options for insurance coverage. ESI offer rates are low for this population and have been falling over time, particularly among small firms (which are more likely to employ low-income workers). In addition, as premiums for ESI have continued to climb, ESI has become less affordable for

low-income workers. The average annual employee contribution in 2005 was $2,713 for family coverage. With average family income for low-income adults with public coverage projected to be below $12,000 in 2005, that ESI premium would account for nearly 25 percent of the family's income. The other potential coverage option-non-group insurance-also is unlikely to be affordable for most low-income adults, as premiums tend to be quite high relative to family income, with many facing premiums in excess of 25 percent of their family's income.

While premium assistance programs or tax credits could help make the non-group coverage option more affordable, the premium subsidies would have to be substantial to bring the cost down to levels that are likely to generate much enrollment.[8] And those premium subsidies and tax credits would only address one of the costs of non-group coverage. Unlike Medicaid, which has no deductibles and minimal co-pay requirements, non-group coverage often requires both high deductibles and high co-payments when using care, making such coverage even less affordable for low-income families.

Given the lack of affordable alternatives for coverage, it is likely that, in the face of cutbacks in eligibility for public programs, the vast majority of affected current enrollees will become uninsured, with all the associated negative consequences. There is ample evidence that the uninsured have higher rates of morbidity and mortality than insured persons as they are less likely to obtain screening and prevention services, are more likely to delay seeking care when sick, and, even when seriously ill or suffering from identified chronic conditions, receive less care.[9] While it is clear that the poorer health of the uninsured has a significant impact on individuals and their families, it also has a significant economic impact on their communities. As the share of the community that is uninsured and, thus, in poorer health increases, local businesses face higher absenteeism and lost productivity, and there are increased demands on the local health care system to meet the needs of those who lack insurance.

ENDNOTES

[1] V Smith, R Ramesh, K Gifford, E Ellis, R Rudowitz and M O'Malley. 2004. "The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005." Washington, DC: Kaiser Commission of Medicaid and the Uninsured. Available at: http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=47041 (accessed September 29, 2005).

[2] A small number of individuals aged 18 to 64 receive coverage through the Medicare program. We exclude those individuals from this analysis.

[3] Unlike the offer question in NSAF, the offer question in the Current Population Survey (CPS) asks the respondent whether an offer was extended to the respondent specifically.

[4] Additional tabulations excluding the one-year and full-time restrictions yielded similar results to those reported here.

[5] J Hadley and JD Reschovsky. 2003. "Health and the Cost of Nongroup Insurance." *Inquiry* 40(3):235-53. Hadley and Reschovsky generated estimates of non-group premiums for their CTS sample through a two-step process. First, they estimated a model of non-group premiums using data from the CTS, which collects information on non-group premiums for the individuals in the sample who have non-group coverage. Their model captures the effect of worker demographics, health status, family structure, job characteristics, non-group market regulations in the state, and local market characteristics on the individual's non-group premium, while controlling for the unobservable factors that led the individuals to select into the non-group market via a Heckman selection model. Second, they then use the coefficient estimates from the model to predict the non-group premiums that would be faced by all members of their sample (regardless of insurance status). In estimating non-group premiums for our sample, we use the coefficient estimates from Hadley and Reschovsky's model and replicate their second step using NSAF data to obtain estimates of the non-group premiums that would be faced by our NSAF sample. We thank Jack Hadley and Jim Reschovsky for providing their coefficient estimates and other technical assistance to help us in generating our estimates of non-group premiums.

[6] For this analysis, we define the family as the health insurance unit (HIU). A HIU is defined as the members of a family who can be covered under one health insurance policy. This includes an adult respondent and his or her spouse, as well as any dependent children in the household. Dependent children are defined as any child under 18 years of age; all non-married 18 year-old children; and students under the age of 22 who live with their parents. In a small number of cases, grandchildren living in households with no parent present are assigned to the HIU of their grandparents. Additional family members or non-related boarders in the household are assigned their own HIU.

[7] Low-income families are quite sensitive to the cost of health insurance coverage, as reported in Ku, L., and T. A. Coughlin. 1999/2000. "Sliding Scale Premium Health Insurance Programs: Four States' Experiences." *Inquiry* 36(4):471–480; and Swartz, K., and D. W. Garnick. 2000. "Adverse Selection and Price Sensitivity When Low-Income People Have Subsidies to Purchase Health Insurance in the Private Market. *Inquiry* 37(1):45-60. The study by Ku and Coughlin estimated participation rates in four states that rely on sliding scale premiums for public coverage. On average, between 20 and 33 percent of eligible families enrolled if premiums were no more than 5 percent of annual income. By contrast, less than 10 percent of eligible families enrolled if out-of-pocket premiums rose above 7 percent of income. Similarly, Swartz and Garnick found that enrollment in a subsidy program for low-income uninsured in New Jersey dropped off quickly as the insurance premium rose relative to family income. As would be expected, raising the cut-off level above 5 percent of income in this study would generate higher estimates of the share of adults who would likely face "affordable" non-group premiums.

[8] Alker, J. 2005. "Premium Assistance Programs: How are They Financed and do States Save Money?" Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured. Available at http://www.kff.org/medicaid/7413.cfm (accessed December 20, 2005).

[9] J Hadley. 2005. "Consequences of the Lack of Health Insurance on Health and Earnings." A report for the Missouri Health Care Foundation. Washington, DC: The Urban Institute.

1330 G Street NW, Washington, DC 20005
Phone: (202) 347-5270, Fax: (202) 347-5274
Website: www.kff.org/KCMU

Additional copies of this report (#7449) are available
on the Kaiser Family Foundation's website at www.kff.org.

THE HENRY J. KAISER FAMILY FOUNDATION

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.