HEALTH COVERAGE FOR LOW-INCOME AMERICANS:

AN EVIDENCE-BASED APPROACH TO PUBLIC POLICY

EXECUTIVE SUMMARY

JANUARY 2007

THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON
Medicaid and the Uninsured

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 bipartisan group of national leaders and experts in health care and public policy.

EXECUTIVE SUMMARY

In 2005, 46.1 million non-elderly Americans – more than 1 in 6 – lacked health insurance. Since the year before, 1.3 million people joined the ranks of the uninsured, and 80% of the new uninsured were people living below or near poverty. The uninsured rate in the nation also rose significantly, reaching 18%, and the rate was much higher in the low-income population. This latest increase in the uninsured follows an increase of 6 million between 2000 and 2004, driven primarily by declining employer-sponsored health insurance that hit low-income workers and their families the hardest.

More than one-third of uninsured Americans have family income below the federal poverty level – $19,971 for a family of four in 2005. Nearly another third have income between 100% and 200% of the poverty level. Low-income Americans, whose financial means are thinly stretched to meet basic needs, are also in poorer health and have higher rates of chronic disease and disability than those at higher income levels. Assuring health coverage for this vulnerable population is an important national priority as a matter of both personal and public health.

In general, over the last decade, debates about how to structure health coverage for low-income Americans have arisen primarily in the context of efforts to expand health insurance coverage. However, more recently, fiscal pressures at both the state and federal level have prompted initiatives to redesign Medicaid, the nation's principal health coverage program for low-income people, introducing new questions regarding the future shape of this program.

In *Health Coverage for Low-Income Americans: An Evidence-Based Approach to Public Policy,* the Kaiser Commission on Medicaid and the Uninsured reviews and synthesizes the evidence from a large body of relevant research and public program experience to address a set of core issues related to structuring coverage for low-income Americans. The aim of the report is to provide a foundation, grounded in evidence, for developing public policy and devising sound approaches to covering low-income people.

In the full report that accompanies this Executive Summary, the Commission documents in detail the evidence base that underpins the set of conclusions we reach for policy. The first part of the report is devoted to the threshold question: What is the role for publicly sponsored health insurance? The second part of the report turns to central issues in designing a public coverage program for low-income people. The Commission's working premise is that achieving policy improvements will require striking a balance between optimal program design and available fiscal resources.

The following statements summarize the policy conclusions that emerged from the Commission's analysis of the research literature:

- ***Role for Publicly Sponsored Health Insurance*.** While a variety of approaches have the potential to increase health coverage and access for uninsured Americans, expanding publicly sponsored health insurance offers the most targeted and efficient strategy to achieve this result in the low-income population. Through an expansion of public insurance programs, coverage can be extended to previously uninsured individuals with the lowest income and the poorest health.

- ***Eligibility*.** Basing eligibility for publicly sponsored health coverage on low income, without categorical restrictions, could substantially reduce the number of uninsured Americans and assure coverage for those least able to pay.

- ***Participation.*** Simple enrollment and recertification processes that minimize burdens on applicants are likely to promote participation. Well-designed outreach is also important.

- ***Use of Premiums.*** Premiums can be expected to depress participation among people living in or near poverty. In the low-income population, the use of premiums to generate revenues for financing needs to be balanced carefully against the goal of increasing health coverage.

- ***Scope of Benefits.*** The relatively poor health status and multiple health problems of low-income Americans, combined with their limited ability to afford care out-of-pocket, mean that comprehensive benefits are important to provide protection adequate to meet the diverse health needs of this population.

- ***Use of Cost-Sharing.*** Even at low levels, cost-sharing can adversely affect access to care for low-income people. Given current gaps in access for this population and efforts to promote better management of chronic disease, the use of cost-sharing should be weighed judiciously and, if adopted, relate to income.

- ***Access to Care.*** Having health insurance is necessary but not sufficient to assure access to care. Continuous coverage, adequate provider networks, coordination of care, and elimination of a variety of both financial and non-financial barriers to access are needed to realize the full potential of coverage.

- ***Financing.*** Financing that is determined by enrollment and utilization directs public dollars most efficiently to meet health coverage and care needs. Federal matching of state spending permits the costs of coverage to be shared and can promote national priorities while preserving state policy discretion. A federal-state financing partnership that takes into account the national trends causing health care costs to rise, countercyclical pressures at the state level, and the federal government's greater fiscal capacity could provide a strong and sustainable source of support for a program of health coverage for low-income Americans.

In the coming months and years, as policy makers and others examine options for covering low-income Americans, including approaches that could reshape Medicaid, we hope that this synthesis of the research evidence will help to inform key policy decisions and provide a useful tool for appraising the strengths and limitations of the alternatives under consideration.

What is the Role for Publicly Sponsored Health Insurance?

The issue

In 2005, 46.1 million non-elderly Americans lacked health insurance. The number of people without coverage rose by 6 million from 2000 to 2004, driven primarily by declining employer-sponsored health insurance over this period. Between 2004 and 2005, 1.3 million people joined the ranks of the uninsured.[1] Low-income Americans – those with family income below 200% of the federal poverty level – make up almost two-thirds of the uninsured.

Research conducted over several decades shows overwhelmingly that people without health insurance are much less likely to obtain appropriate care than their insured counterparts and consequently have worse health outcomes. Various proposals to address the problem of the uninsured have been offered, including: expansion of Medicaid and the State Children's Health Insurance Program (SCHIP), the nation's public insurance programs for low-income people; increased direct support for safety-net health care providers; tax credits to subsidize the purchase of private health insurance; and wider use of arrangements that combine high-deductible health plans and health savings accounts. Recent legislation that increases states' ability to fundamentally restructure Medicaid has brought the debate about how to cover the low-income population into sharper focus.

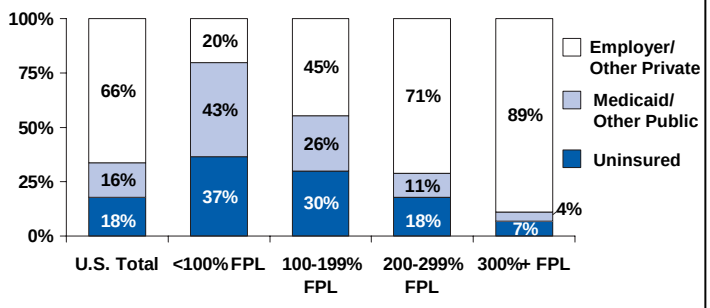
To evaluate alternative approaches to covering low-income uninsured Americans, we first consider the profile of the uninsured and the reasons they are uninsured, and then review the evidence relevant to the strategies being debated.

The evidence

While employer-sponsored insurance (ESI) is the dominant source of health insurance in the U.S., the ESI rate has been declining steadily and the erosion has been greatest among low-income workers. The ESI rate falls sharply with income and the uninsured rate rises as a direct consequence (Fig. 1). The vast majority of uninsured Americans come from working families and over half of all uninsured workers are low-income.

Figure 1

Health Insurance Coverage by Poverty Level, 2005



Note: "FPL" means federal poverty level, which was $19,971 for a family of four in 2005.
SOURCE: Analysis of the March 2006 Current Population Survey, Kaiser Commission on Medicaid and the Uninsured and Urban Institute.

The main reason that uninsured workers lack coverage is that their employers do not sponsor health benefits. More than half of all workers in poor families and over one-third of those in near-poor families have no offer of job-based coverage in the family. For uninsured workers who

[1] The Census Bureau periodically revises its CPS methodology, precluding comparisons of data before and after the revision. Due to the most recent revision, comparisons across years can be made between 1999 and 2004, and for 2004-2005.

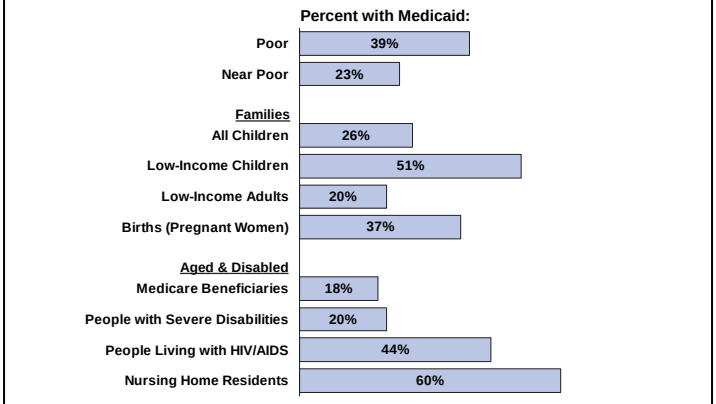
have access to employer-sponsored coverage, affording their share of the premium is often a barrier.

The individual (non-group) insurance market is not a major source of coverage for low-income people either. In the individual insurance market, high premiums pose the main obstacle for low-income workers. Deductibles, coverage exclusions, benefit limitations, and the rejection of applicants based on their health risk represent further obstacles.

Forty years of experience in the Medicaid program has provided substantial evidence regarding the impact of publicly sponsored health insurance on access to coverage and care. Most of the millions of Americans covered by Medicaid, who include many of the sickest and poorest in the nation, would be uninsured in the program's absence. Among people below the poverty level, Medicaid is unlikely to "crowd out" private insurance, which is generally not available to the poor. As Medicaid eligibility moves up the income scale, substitution effects increase.

Figure 2

Medicaid's Role for Selected Populations



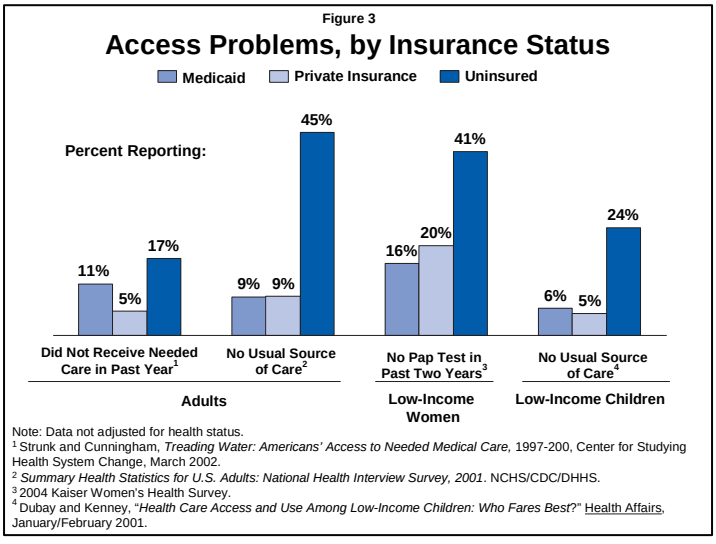
Note: "Poor" means <100% of federal poverty level, which was $19,971 for a family of four in 2005.
SOURCES: Estimates by Kaiser Commission on Medicaid and the Uninsured and Urban Institute. Birth data from *MCH Update*, National Governors Association.

Millions of Medicaid beneficiaries are low-income elderly or disabled Medicare beneficiaries (Fig. 2). Medicaid pays Medicare's premiums and cost-sharing on behalf of these "dual eligibles" and fills in major gaps in their Medicare benefits, especially for long-term care, which Medicare largely excludes.

Consistently, studies indicate that Medicaid beneficiaries have better access to care than their counterparts who are uninsured. Research comparing access under Medicaid and private insurance has produced mixed findings. Medicaid performs at least as well as private coverage on several key measures of primary access and financial protection (Fig. 3). At the same time, inadequate access to many kinds of care, stemming from low provider participation, gaps in covered benefits, and the constellation of access obstacles associated with poverty, has been a chronic problem in the Medicaid program. Per capita spending in Medicaid is low relative to private health insurance, and increases in Medicaid spending for acute care have also been slower by comparison.

Figure 3

Access Problems, by Insurance Status



Note: Data not adjusted for health status.
[1] Strunk and Cunningham, *Treading Water: Americans' Access to Needed Medical Care,* 1997-200, Center for Studying Health System Change, March 2002.
[2] *Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2001*. NCHS/CDC/DHHS.
[3] 2004 Kaiser Women's Health Survey.
[4] Dubay and Kenney, "*Health Care Access and Use Among Low-Income Children: Who Fares Best?*" Health Affairs, January/February 2001.

A substantial and growing body of research sheds light on the potential of various approaches to addressing the health needs of the uninsured. Studies of the impact of the safety-net system on access to care provide solid evidence of its important role for many in the low-income population. But federal support for safety-net providers has not kept pace with the rising number of uninsured Americans. Also, researchers have found that the safety-net system does not provide access to the full scope of care that patients need. Further, there are gaps within the safety-net between insured and uninsured patients' access to care as safety-net providers report difficulty obtaining needed care for their uninsured clients. Geographic proximity to health centers and other safety-net providers is uneven too. Finally, analyses showing safety-net providers' heavy reliance on revenues from insured patients – especially those covered by Medicaid – suggest that absent increased health insurance coverage, additional safety-net funding alone is not adequate to ensure access to care for the low-income population.

Other research shows that solutions that use tax policy to stimulate the purchase of private insurance can generate some increased coverage and also ease cost burdens on currently insured low-income individuals and families. But the research indicates that tax credits at the levels typically proposed do not have the capacity to achieve significant new coverage among the low-income uninsured. Even with the help of such tax credits, the premiums for individual coverage remain largely out of financial reach for low-income people. Policies with more affordable premiums are likely to have prohibitively high deductibles, limited benefits, or both. Also, tax credits for directly purchased coverage are estimated to cause some disruption of the group insurance market. Studies modeling the impact of tax credits to subsidize job-based coverage indicate that their main effect would be to reduce premiums for workers who already take up coverage, rather than to stimulate additional participation by uninsured workers or more employer offers of health insurance. Finally, approaches based on purchasing pools have a record of weak performance in expanding coverage and reducing premiums.

Recently, approaches that combine high-deductible health plans with personal health spending accounts have attracted interest as a strategy for both providing health insurance at a lower premium and increasing consumer control and responsibility. These arrangements generally consist of high-deductible catastrophic plans that cover a reduced scope of benefits, often coupled with tax-favored personal accounts for health spending. In 2006, the average worker contribution to the premium for family coverage in a high-deductible health plan was lower than the average worker contribution for family coverage in a PPO. However, because firms' contributions to personal spending accounts were, on average, much lower than the deductible amount, enrollees faced sizable up-front out-of-pocket costs, a known barrier to health care access for those with limited financial means.

In analyses that model the major alternatives for reducing the number of low-income uninsured Americans, expansion of public insurance programs emerges as the strategy that can best target the formerly uninsured and those with the most health needs. As a result, it is estimated to be a more cost-efficient investment of public dollars compared with the other approaches. Evidence that the Medicaid program is viewed positively by those who have had program experience and by the public at large suggests that publicly sponsored coverage is also likely to be well-accepted.

A variety of approaches have the potential to accomplish some increased health coverage and access to care for uninsured Americans. However, to achieve this result in the low-income population, expanding publicly sponsored health insurance emerges as the most effective and efficient of the different strategies. Expanding public insurance programs is a highly targeted means of extending coverage to previously uninsured individuals with the lowest income and the poorest health. The safety-net delivery system is an important component of access for low-income people, especially in medically underserved areas, but it is not a substitute for insurance coverage and it relies on Medicaid for much of its financing.

How Should Publicly Sponsored Health Insurance be Structured?

- **Eligibility**
- **Participation**
- **Use of Premiums**
- **Scope of Benefits**
- **Use of Cost-Sharing**
- **Access to Care**
- **Financing**

Eligibility

The issue

Progressively over time, Congress has broadened eligibility for Medicaid to reach more of the nation's low-income children and families, seniors, and people with disabilities. Federal minimum eligibility standards for Medicaid have been raised for some groups, and states have been granted extensive authority to expand Medicaid coverage further. Also, the State Children's Health Insurance Program (SCHIP) was enacted in 1997 to expand coverage to low-income uninsured children who do not qualify for Medicaid. These changes reflect evolving public policy goals (e.g., assuring access to adequate prenatal care and early intervention services, supporting employment for individuals with disabilities), federal efforts to fill persistent and growing gaps in the private health insurance market, and Medicaid's effectiveness in covering the low-income population.

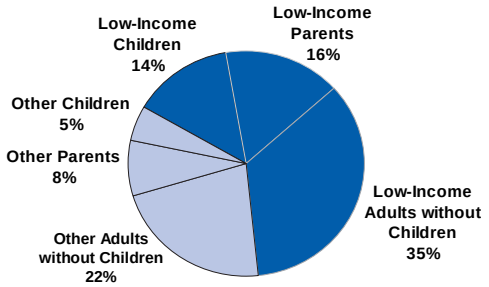
Although states have expanded coverage by broadening eligibility in their Medicaid and SCHIP programs, over 30 million low-income non-elderly Americans – mostly adults – were uninsured in 2005. Adults without children, who are categorically ineligible for Medicaid, are at particularly high risk of being uninsured. Indeed, low-income adults account for more than one-third of the uninsured. Among non-elderly Americans living below the poverty level, more than 1 in 3 were uninsured in 2005 and more than 1 in 4 of the near-poor (those between 100% and 200% of the poverty level) lacked coverage.

The evidence

Nearly two-thirds of uninsured non-elderly Americans are low-income (income below 200% of the poverty level) – more than a third are poor and nearly another third are near-poor (Fig. 4). Poor adults account for more than 1 in every 4 uninsured Americans and near-poor adults make up almost another quarter. Eighty percent of uninsured Americans come from working families.

Figure 4

Uninsured Non-Elderly Americans by Income and Family Structure, 2005



Total = 46.1 million uninsured

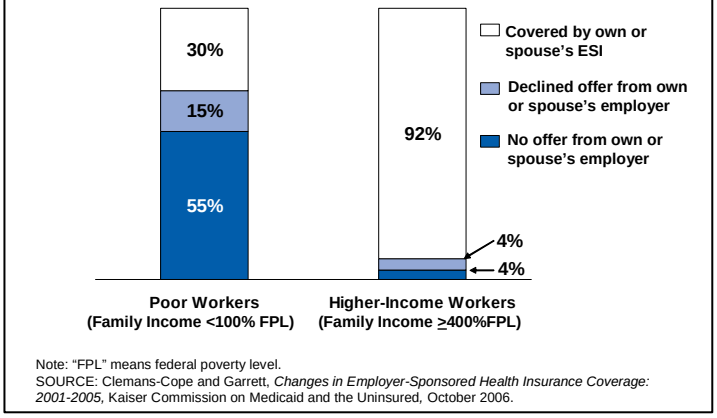
Notes: "Low-income" means <200% of the federal poverty level, which was $39,942 for family of four in 2005. "Parents" defined as parents of dependent children under age 19. "Adults without children" includes parents whose children are no longer dependent.
SOURCE: Analysis of March 2006 Current Population Survey, Kaiser Commission on Medicaid and the Uninsured and Urban Institute.

People living below or near the poverty level have difficulty meeting even basic needs for housing, food, transportation, and childcare. Many poor families devote substantial resources to health care and the burden of health care costs on the poor is increasing.

Between 2000 and 2004, the number of uninsured Americans grew by 6 million, driven primarily by steady erosion in job-based health insurance. Two-thirds of the growth in the uninsured occurred among those below 200% of the poverty level, reflecting the movement of many middle-income Americans into poor and near-poor groups, where access to job-based coverage is limited and the odds of being uninsured are much higher (Fig. 5). Although both children and adults were affected by declining employer-sponsored insurance, increased enrollment in Medicaid and SCHIP more than offset the private coverage losses among children. By contrast, although Medicaid mitigated coverage losses among adults, the number of adults without insurance still rose by 6 million. Between 2004 and 2005, the number of uninsured Americans grew by 1.3 million, 84% of whom were low-income.

Figure 5

Access to Employer-Based Coverage by Family Income, 2005

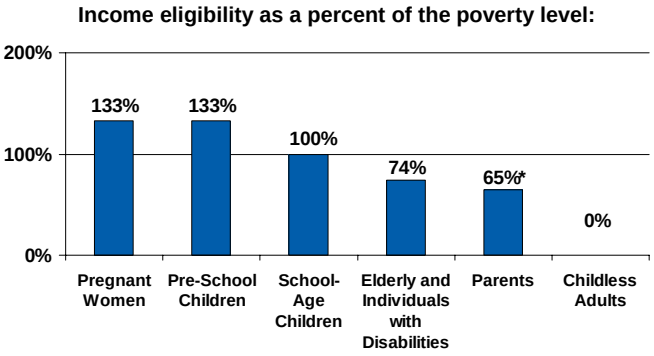


Note: "FPL" means federal poverty level.
SOURCE: Clemans-Cope and Garrett, *Changes in Employer-Sponsored Health Insurance Coverage: 2001-2005*, Kaiser Commission on Medicaid and the Uninsured, October 2006.

Low-income adults are at especially high risk of being uninsured because their access to public as well as private coverage is very limited (Fig. 6). Adults' eligibility for Medicaid generally hinges on their having dependent children. Adults without dependent children – regardless of how poor they may be – are excluded from Medicaid unless they are severely disabled or pregnant. To obtain federal matching funds to cover them under Medicaid, states must acquire a federal waiver.

Figure 6

Minimum Medicaid Eligibility Levels, 2006



Note: The 2006 HHS Poverty Guidelines were $9,800 for an individual and $20,000 for a family of four.
* Reflects the national median Medicaid income eligibility level for working parents in 2006.

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With respect to parents, federal Medicaid law ties minimum eligibility to the income standard each state used in its pre-1996 welfare assistance program. In 2006, the median national eligibility standard for working parents was 65% of the federal poverty level, but eligibility thresholds for parents vary widely across the states, ranging from 19% of the federal poverty level in Alabama and Arkansas to 275% in Minnesota.

Because of narrow Medicaid eligibility for parents in most states, while virtually all children below 200% of the poverty level are eligible for Medicaid or SCHIP, many of their parents, even the poor, cannot qualify. Studies have found that when public insurance provides eligibility to low-income parents as well as their children, coverage and access also increase among children.

Providing eligibility for public coverage on the basis of income, without the categorical restrictions that now apply in Medicaid, could substantially reduce the number of low-income uninsured Americans and assure coverage for those least able to pay. Evidence that poor people lack access to private health insurance and cannot afford to pay for care out-of-pocket provides a strong basis for extending Medicaid to all Americans below the federal poverty level. Allowing federal matching dollars for coverage of adults without children would improve Medicaid's reach within the low-income population and target assistance to some of the poorest of the uninsured. As public dollars permit, income eligibility could be broadened for both parents and adults without dependent children to cover more low-income uninsured Americans.

Participation

The issue

Participation in publicly sponsored health insurance programs depends on the success of program outreach, the ease of enrollment and recertification processes, and ultimately, enrollment action on the part of the individual. When employers offer coverage, employee enrollment generally takes place more automatically through the employment and payroll process.

Once individuals become aware of an assistance program, the decision to participate or not is influenced by multiple factors, including the level of need for assistance, its perceived value, and the burden associated with applying for and enrolling in the program. Limited finances and other pressures facing those living near poverty make this population sensitive to the burden associated with seeking entry into a program and likely to be deterred by procedural barriers.

Tens of millions of people currently participate in Medicaid and the State Children's Health Insurance Program (SCHIP), but millions more who could benefit from the programs are not aware of them, do not believe they are eligible, or are discouraged by the enrollment process.

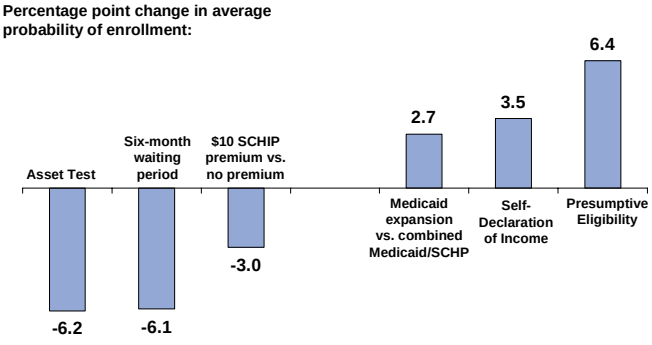
The evidence

Many who are eligible for public health insurance are not enrolled. Data from surveys and focus groups indicate that among individuals who are eligible for Medicaid or SCHIP but uninsured, lack of knowledge about the programs' eligibility rules hinders their participation.

Researchers have also found a relationship between the burden or ease of Medicaid and SCHIP application and enrollment procedures and participation in the programs (Fig. 7). Low-income individuals report that complex applications and enrollment procedures impose difficult material burdens on them. Requirements for extensive documentation and procedures that impose transportation costs or necessitate time off from work prevent many low-income families from obtaining or retaining needed coverage. By the same token, streamlined and simple application and enrollment procedures with minimal requirements appear to lead to increased participation without fundamentally weakening program integrity. Simple procedures also ease program administration for states and providers.

Figure 7

Effects of Key Program Policies on Enrollment of Children in Medicaid and SCHIP



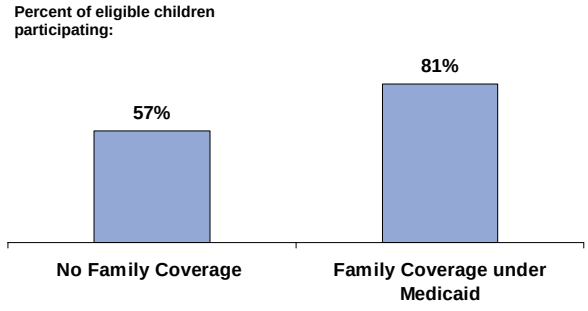
Note: Results significant at p <0.5.
SOURCE: Kronebusch and Elbel, "*Simplifying Children's Medicaid and SCHIP*," Health Affairs, May/June 2004.

Finally, family-based eligibility – a form of simplification – has been associated with increased participation (Fig. 8).

Studies indicate that the diversity represented in the low-income population calls for varied outreach strategies. Research suggests the need for outreach and marketing efforts that use multiple media and venues, appropriate languages, and messages that convey the value of the assistance and explain how to obtain it.

Figure 8

Children's Participation in Medicaid Poverty-Related Expansions, 1999



SOURCE: Dubay and Kenney, *Covering Parents through Medicaid and SCHIP: Potential Benefits to Low-Income Parents and Children*, Kaiser Commission on Medicaid and the Uninsured, October 2001.

The rate of participation in health insurance programs for low-income people is sensitive to the burden of enrollment and recertification requirements. Also, experience with public programs suggests that diverse outreach strategies are needed to reach the target population effectively. Simplification of enrollment and renewal procedures, family-based coverage, and improved outreach could all help to increase and stabilize participation in publicly sponsored health coverage among low-income people.

Use of Premiums

The issue

For health insurance to achieve coverage of the low-income population, it must be affordable. Historically, Medicaid has largely prohibited premiums for its low-income beneficiaries and it subsidizes the Medicare premium on behalf of low-income Medicare beneficiaries. State Children's Health Insurance Program (SCHIP) plans that are separate from Medicaid can charge premiums and other cost-sharing amounts up to 5% of family income; there are limits on the premiums permitted for children in families with income below 150% of the poverty level.

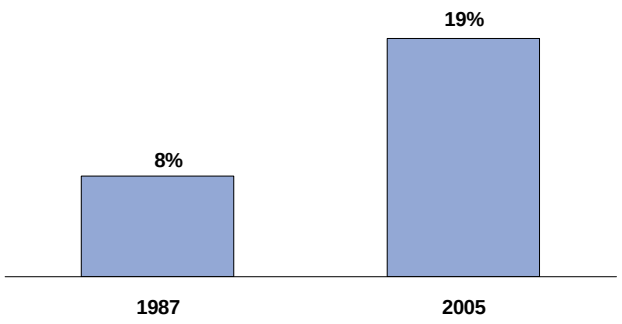
Some state and federal policy officials support increased flexibility to charge premiums for publicly sponsored health insurance, both to reduce public costs and to promote individual responsibility. The use of premiums is also viewed by some as a way to accustom beneficiaries to features typical of private health insurance**.**

The evidence

Studies show that low-income families strain to meet their costs for housing, transportation, and food, and have little income for other needs, including health care. For people living near poverty, even modest premiums present a financial hardship. In recent years, increases in health insurance premiums have dramatically outpaced increases in workers' earnings (Fig. 9). Research shows a strong relationship between the affordability of health insurance premiums and coverage rates.

Figure 9

Share of Median Family Income Needed to Buy Family Health Insurance, 1987 and 2005

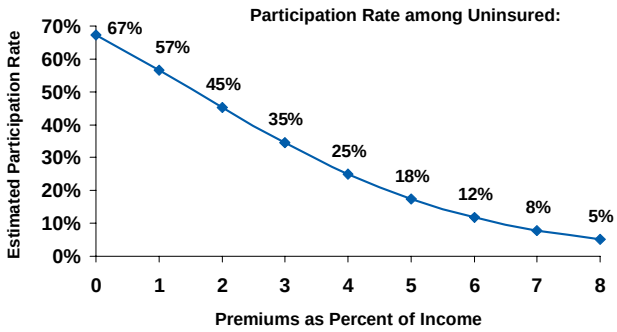


Note: Analysis based on premium data from KFF/HRET *Employer Health Benefits, 2006 Annual Survey*, historical data on premiums and health care cost growth from Agency for Health Care Research and Quality, CMS, and KFF/HRET annual surveys, and income data from U.S. Census Bureau.
SOURCE: Nichols, New America Foundation, September 2006.

A substantial body of research documents that participation in public health insurance declines sharply as premiums rise (Fig. 10). Restrictive premium payment policies, such as a lack of payment grace periods and lock-out periods for families who miss a payment, also contribute to coverage losses. The impact of premiums on family budgets and coverage is largest among the poorest in the population. Increases in emergency department use and heightened pressure on safety-net providers that may follow enrollment declines associated with premiums affect both personal health and the health care delivery system.

Figure 10

Relationship between Premiums and Participation in Public Health Insurance



SOURCE: Ku and Coughlin, "*Sliding-Scale Premium Health Insurance Programs: Four States' Experiences*," Inquiry, Winter 1999-2000.

States also face increased administrative burdens associated with implementing and collecting premiums. Finally, findings that premiums lead to reduced enrollment suggest that states may realize savings from premiums, but that the savings may be due not to increased premium revenues, but to enrollment declines.

The progressive decline of private health insurance reveals that affordability is a major barrier to coverage. Premiums are most difficult to afford for those with the most limited finances. Few people living in or near poverty, if they have access to coverage, can manage to pay for it; if they do, the cost burden is great and they retain scant resources for other needs. Because premiums can be expected to depress participation in health coverage by low-income people, the use of premiums to contain public costs needs to be balanced carefully against the goal of increasing coverage of this population. Premium schedules that scale premiums to income and flexible application of payment policies are both important to mitigate adverse effects on participation and current coverage.

Scope of Benefits

The issue

The low-income population is diverse, including newborns, young and older children, working adults, people with disabilities, and seniors. Because of their limited means, low-income people face particularly steep financial barriers to obtaining care that is not covered. If they do not obtain needed care, they may experience adverse health consequences that may, in turn, have wider public health and economic implications.

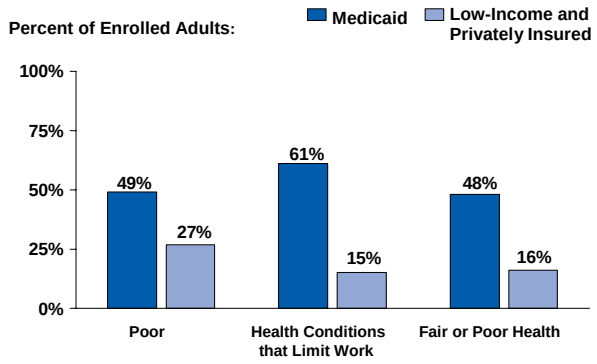
On the other hand, budget pressures at the federal and state level, concern that comprehensive benefits could lead to inappropriate utilization and spending, and equity issues have been raised as reasons to offer limited benefits in the nation's public health insurance programs. Also, some have argued that leaner benefits can be justified in the context of efforts to expand coverage with constrained resources.

The evidence

An abundance of evidence shows that low-income people tend to be in worse health than others. It also confirms that people with worse health status have greater needs for care and report more unmet need. Many low-income Americans, particularly seniors and adults and children with severe physical and mental disabilities, need rehabilitation and long-term care as well as acute medical care. The low-income population enrolled in Medicaid is both poorer and sicker than the low-income population with private insurance (Fig. 11). Nearly half of uninsured adults report having at least one chronic condition.

Figure 11

Medicaid Enrollees are Poorer and Sicker Than the Low-Income Privately-Insured



SOURCE: Coughlin et al, "*Assessing Access to Care Under Medicaid: Evidence for the Nation and Thirteen States*," Health Affairs, July/August 2005.

Commercial insurance often does not cover the scope of benefits needed by many low-income people. Experience in some states with Medicaid waivers indicates that limited benefit packages may leave individuals with significant unmet needs. And Medicaid's large role in supplementing Medicare for low-income Medicare beneficiaries reveals the magnitude of the gaps in Medicare-covered benefits.

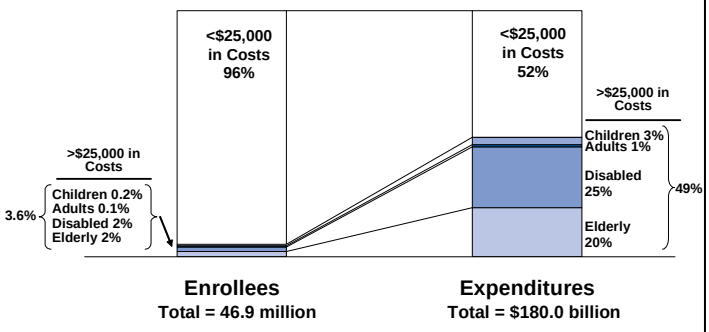
Medicaid provides more comprehensive benefits than private insurance. However, researchers have shown that when differences between the health and disability status of the two insured populations are adjusted, utilization of basic services by adults in Medicaid is similar to utilization by low-income privately insured adults. Children in Medicaid are more likely than their privately insured peers to use a service. Other research shows that Medicaid spending is highly concentrated among Medicaid's sickest and most disabled beneficiaries

and that their intense consumption of care, not high use of Medicaid services in general, drives the program's high total spending (Fig. 12).

States use an array of available strategies, such as managed care, prior authorization, drug formularies, and disease management to manage utilization in Medicaid. In some cases, states also set limits on the "amount, duration, and scope" of the Medicaid benefits they cover.

Figure 12

Role of High-Cost Enrollees in Total Medicaid Expenditures, 2001



SOURCE: Sommers and Cohen, *Medicaid's High Cost Enrollees: How Much Do They Drive Program Spending?* Kaiser Commission on Medicaid and the Uninsured, March 2006.

Because states have discretion both to define the scope of required Medicaid benefits they will cover and to offer optional benefits, there is wide variation in the content of Medicaid coverage nationally, especially for adults, and a variety of benefit gaps and disparities persist. Currently, because the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit entitles children to the full range of services permissible under federal law to treat all diagnosed conditions, Medicaid benefits for children are more comprehensive and uniform.

The diverse health needs and limited resources of the low-income population point to a need for a benefit package that is comprehensive in scope, including rehabilitation and long-term care as well as acute health services. Experience from Medicaid does not support claims that broad benefits are associated with over-utilization of care; in fact, the research documenting unmet need in Medicaid suggests barriers to access and under-utilization in the program. Clinically sound management of health care use is critical to assure the receipt of appropriate, high-quality care.

When fiscal realities constrain the capacity to expand coverage of the uninsured, offering a limited benefit package to previously uninsured individuals may result in important gains in access while laying a foundation for broader benefits when resources permit. However, reducing benefits for already-covered groups to finance slim benefits for a new group can result in reduced access and more unmet need in the previously covered population and inadequate access for those who are newly insured.

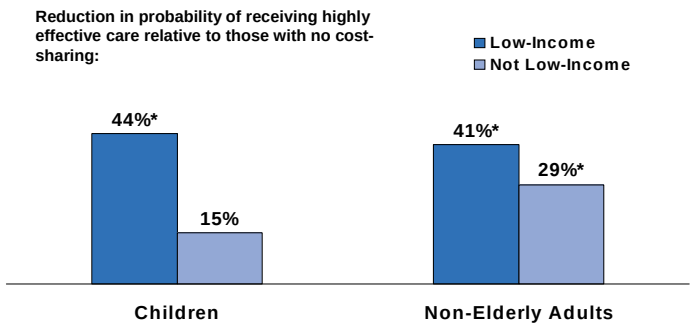
Use of Cost-Sharing

The issue

Cost-sharing, usually in the form of copayments and deductibles, is sometimes advanced as a means to increase personal responsibility for health care and discourage unnecessary utilization. However, cost-sharing creates different financial burdens for individuals at different income levels. The burden of cost-sharing tends to be heavier for low-income people because their finances are limited and their health care needs are often significant – a result with important implications for low-income people's access to care.

Figure 13

Impact of Cost-Sharing on Likelihood of Receiving Highly Effective Medical Care, by Income



*Difference significant at p<.05.
Note: "Low-income" defined as lowest third of income distribution, roughly equivalent to <200% of federal poverty level.
SOURCE: Lohr et al, "*Effect of Cost-Sharing on Use of Medically Effective and Less Effective* Care," Medical Care, 24(9), September 1986.

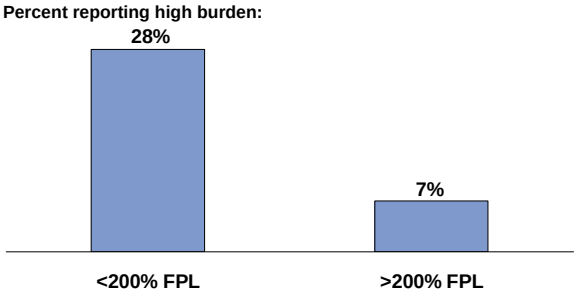
Historically, federal Medicaid law has limited beneficiary cost-sharing to nominal levels. While the Deficit Reduction Act of 2005 greatly increased state authority to impose cost-sharing in Medicaid, cost-sharing remains prohibited or limited for certain groups and certain services. The State Children's Health Insurance Program (SCHIP) also builds in protections, limiting copayment amounts for children in families with income below 150% of the poverty level, and limiting total out-of-pocket spending (i.e., premiums, deductibles, and copayments) to 5% of family income.

The evidence

Research examining the experience of Medicaid beneficiaries and the low-income population has found adverse effects of cost-sharing. In particular, evidence shows that cost-sharing causes low-income people to delay or reduce their use of care, leading to poor health outcomes (Fig. 13). Research has not substantiated concerns that low or no cost-sharing might lead to over-utilization.

Figure 14

High Out-of-Pocket Burden Among Insured Families by Income, 2002

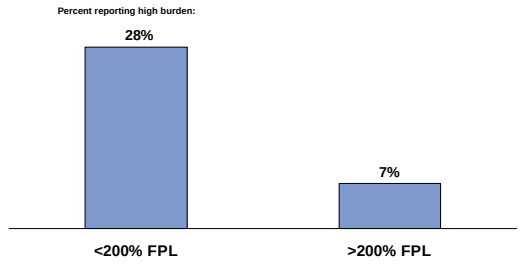


Notes: Includes only non-elderly families. "High out-of-pocket burden" defined as out-of-pocket spending (excluding premiums and dental care) exceeding 5% of family income. "FPL" means federal poverty level.
SOURCE: Shen and McFeeters, "*Out-of-Pocket Health Spending Between Low- and Higher-Income Populations: Who is at Risk of Having High Expenses and High Burdens?*" Medical Care, March 2006.

Even low levels of out-of-pocket spending can impose heavy financial burdens on low-income people, and out-of-pocket health costs consume a disproportionately large amount of their income (Fig. 14). The financial burden of cost-sharing is heavier on people with more extensive needs for care, and heaviest on those with both greater health needs and low income.

Figure 14

Prevalence of High Out-of-Pocket Burden Among Insured Families, by Family Income, 2002



Notes: Includes only non-elderly families. "High out-of-pocket burden" is defined as out-of-pocket spending (excluding premiums and dental care) exceeding 5% of family income. "FPL" means federal poverty level,
SOURCE: Shen and McFeeters, *"Out-of-Pocket Health Spending Between Low- and Higher-Income Populations: Who is at Risk of Having High Expenses and High Burdens?"* Medical Care, March 2006.

When individuals and families cannot pay their out-of-pocket costs, the resulting medical debt is a barrier to obtaining health care. Research shows that people with medical bill problems are much more likely than those without medical bill problems to report unmet medical needs and delays in care. Many, even among those with private insurance, experience significant problems paying their medical bills, and evidence indicates that privately insured adults with medical debt limit their care in many of the same ways and as often as adults with no health insurance.

Cost-sharing also affects the providers who serve the low-income population. Providers are responsible for collecting cost-sharing amounts. In addition, their net reimbursement is reduced if they provide care to patients who do not pay their cost-sharing.

While cost-sharing is being used increasingly in the private insurance market to promote cost-consciousness and handle rising health care costs, the evidence shows that for low-income people, cost-sharing can affect access to care and health outcomes adversely. Even at low levels, cost-sharing can place a disproportionately heavy burden on the tight budgets of low-income individuals and families, especially those with the most health needs. In light of current gaps in access for low-income Americans and efforts to promote effective management of chronic disease, cost-sharing, if used, should be applied judiciously and on an income-related basis. To advance health goals, specific populations and/or services could be exempted from cost-sharing.

Access to Care

The issue

Health insurance is necessary but not sufficient to assure that low-income Americans obtain access to needed health care. A widely accepted view of access suggests that access depends not only on insurance, but also on characteristics of the individual, health care system variables, and other factors that can facilitate or impede the process of getting care. This conception of access highlights considerations separate from health insurance that need to be addressed in structuring health care for the low-income population.

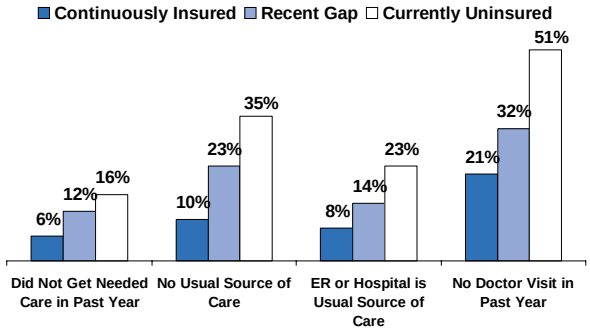
The evidence

Many in the low-income population cycle on and off of health insurance over the course of a year, obtaining coverage for themselves and/or their children, but losing eligibility some months later due to administrative requirements for recertification, a change in their income, non-payment of premiums, or other reasons. Researchers examining the impact of this dynamic on access to care have found that the gains in access that are associated with being insured do not materialize when coverage is unstable (Fig. 15).

Figure 15

Access and Care Experiences, by Continuity of Insurance

Working-Age Adults

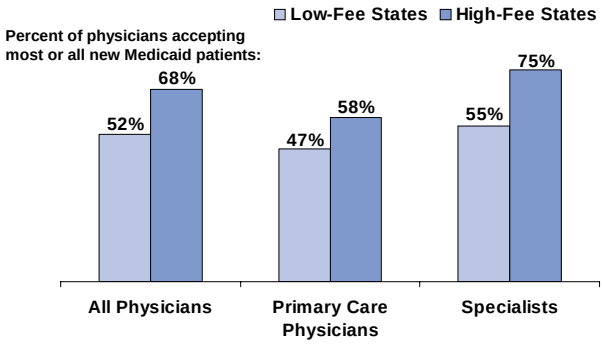


SOURCE: Schoen and DesRoches, "*Uninsured and Unstably Insured: The Importance of Continuous Coverage,"* Health Services Research, April 2000.

Access to care in Medicaid is linked to the supply of providers willing to accept the program's low-income beneficiaries, and provider participation in Medicaid is chronically inadequate. In provider surveys, low Medicaid payment rates and burdensome administrative requirements emerge as leading barriers to provider acceptance of Medicaid (Fig. 16). Other studies have produced mixed findings concerning an association between Medicaid fee levels

Figure 16

Physicians' Acceptance of Medicaid Patients in High-Fee vs. Low-Fee States, 2001



Note: Differences are significant at p<.05.
SOURCE: Zuckerman et al, "*Trends: Changes In Medicaid Physician Fees, 1998-2003: Implications For Physician Participation,"* Health Affairs, Web Exclusive, June 23, 2004.

and provider participation, and the literature suggests that numerous factors affect Medicaid physician supply.

Access may be influenced also by the organization of health care delivery. Findings from research on the impact of managed care and disease management in Medicaid are varied and indicate that these arrangements can improve the coordination of care for low-income individuals, but can also impede access. This mixed evidence points to a need for more study of the mechanisms that affect access to care for low-income people under these arrangements.

The adequacy of the delivery system to address access barriers that are associated with low socioeconomic status is also an important variable. For the low-income population, transportation and arranging time off from work may present barriers to obtaining care. Individuals' ability to understand and navigate the health care system effectively also influences their access; in the low-income population, lower health status, lower health literacy, and language and cultural barriers may present particular challenges in this regard. Disparities in access to care that persist even within the insured low-income population suggest that the factors underlying access are not fully understood.

A further goal of access to care is the receipt of high-quality care. As the science of quality measurement and improvement evolves and new uses of quality information emerge, research is highlighting distinctive issues that arise in the context of the low-income population.

Stable, continuous health coverage is essential to improved access to care and ultimately, to improved health. Much evidence indicates that Medicaid's historically low payment levels have dampened provider participation, limiting access, particularly to specialty services. Provider payment levels that are adequate to secure provider participation, effective coordination of care, and measures to address an array of both financial and non-financial barriers to access are needed to convert the potential of health coverage into actual access to care for low-income

Financing

The issue

The system for financing public coverage for the low-income population has a great impact on the program's capacity to meet national goals related to health care coverage and fiscal sustainability – goals that generate some competing pressures.

Medicaid, our health insurance program for low-income people, faces multiple financial challenges. The cost associated with covering low-income Americans is growing due to rising health care costs, demographic pressures, shifts in the economy, and expensive gaps in Medicare for over 7 million low-income Medicare beneficiaries. Separate from these ongoing and mounting pressures on Medicaid costs, the recent economic downturn illustrated the countercyclical pressures on the program. In the weak economy, job loss, eroding private health insurance, and rising poverty led to increased enrollment in Medicaid and simultaneously, state revenues declined. That is, states' fiscal capacity to sustain Medicaid is most strained under the economic conditions in which Medicaid is most needed.

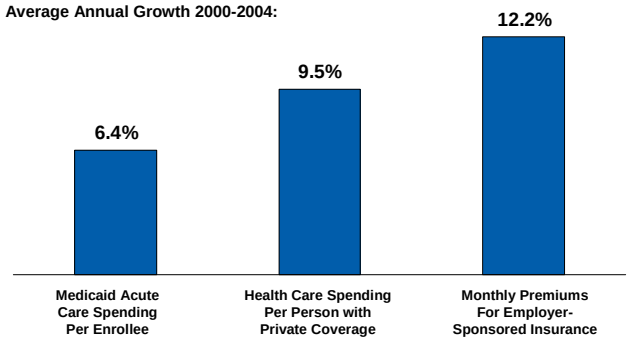
In considering financing issues, the experiences of Medicaid and SCHIP – two publicly sponsored coverage programs with distinctly different financing structures – are informative. State fiscal stresses generated by Medicaid have highlighted a number of limitations of the program's financing structure, and different responses with sharply different implications have been proposed. Some have pointed to the State Children's Health Insurance Program's (SCHIP) capped appropriations as a model for financing coverage for the low-income population, citing the controllability and predictability of spending under this approach. Others emphasize that financing determined by actual enrollment and utilization is a critical source of Medicaid's flexibility to respond to changing needs, but they propose a rebalancing of the state-federal financing partnership to more equitably reflect the much greater fiscal capacity of the federal government.

The evidence

While systemic pressures on the Medicaid program continue to push aggregate Medicaid spending upward, growth in per capita Medicaid spending has been modest compared with premium trends and increases in health spending in private insurance (Fig. 17).

Figure 17

Growth in Medicaid Acute Care Spending vs. Private Health Spending, 2000-2004



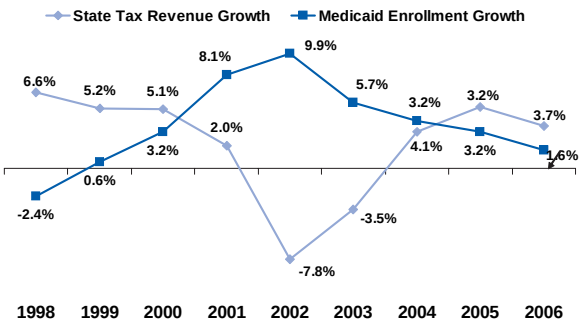
SOURCE: Holahan and Cohen, *Understanding the Recent Changes in Medicaid Spending and Enrollment Growth Between 2000-2004,* Kaiser Commission on Medicaid and the Uninsured, May 2006.

Medicaid's financing structure is responsive to changes in needs for coverage and care and it accommodates state policy choices, but a corollary result is that total Medicaid enrollment and spending fluctuate

(Fig. 18). Federal outlays for capped programs are more predictable, but the trade-off is that funding does not always relate to actual needs and becomes increasingly inadequate to meet growing needs over time. Under capped funding arrangements, important equity problems have also emerged. To illustrate, in SCHIP, the allocation of federal funds has not always aligned well with the actual distribution of low-income uninsured children and funds for the program have fallen short of need, leaving uninsured children who meet the income eligibility requirements without coverage.

Figure 18

State Tax Revenue and Medicaid Enrollment Growth, 1997-2006



SOURCE: Data from Smith et al, *Low Medicaid Spending Growth Amid Rebounding State Revenues: Results from a 50-State Medicaid Budget Survey, State Fiscal Years 2006 and 2007,* Kaiser Commission on Medicaid and the Uninsured, October 2006.

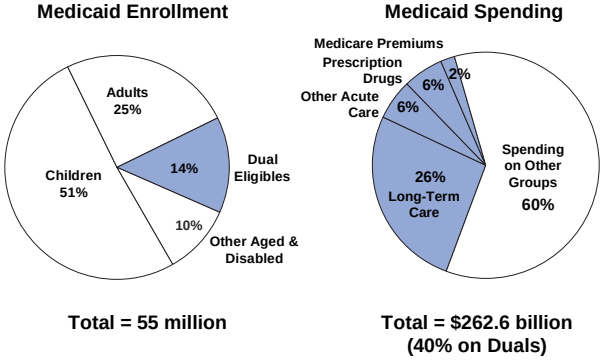
Both Medicaid and SCHIP demonstrate that shared federal-state financing promotes shared accountability and interests. In both programs, the matching arrangement has also helped to promote national health objectives while maintaining flexibility for states. The enhanced federal matching rate in SCHIP (relative to Medicaid) contributed to the program's popularity and swift implementation in the states, resulting in coverage for several million previously uninsured low-income children.

Shared financing has also created tensions between the states and the federal government, which state budget crises have heightened. These tensions are crystallized in many states' use of mechanisms to leverage federal Medicaid funding with limited or no state matching funds involved, changing the effective federal match rate.

The importance of the balance between federal and state financing is apparent in the impact of an 18-month increase in the federal Medicaid match rate, granted to give states temporary relief from the fiscal stress generated by effects of the economic downturn. The enhanced federal match proved an effective tool for improving the program's financial stability. The federal government was able to shoulder an increased share of Medicaid costs when state revenues ebbed and the demand for public coverage grew due to the economic downturn.

Figure 19

Medicaid Dual Eligibles: Enrollment and Spending in 2003



Note: Reflects spending for services only.
SOURCE: Estimates based on CMS data and Urban Institute analysis of data from MSIS, Kaiser Commission on Medicaid and the Uninsured.

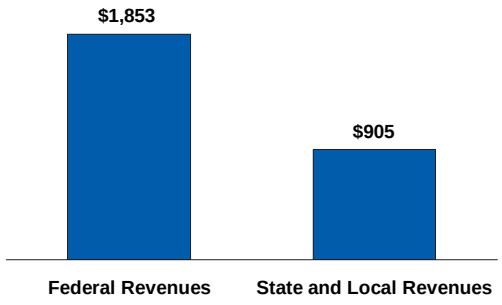
The Medicaid program, thought of mostly as a health insurance program for low-income families, finances other important needs as well. Forty percent of Medicaid spending is on behalf of 7.5 million "dual eligibles," low-income Medicare beneficiaries who also qualify for Medicaid (Fig. 19). For these individuals, who are much poorer and in much worse health than other Medicare beneficiaries, state Medicaid programs pay Medicare's premiums and coinsurance and fill in major gaps in Medicare benefits, particularly for long-term care.

In addition, Medicaid spending is affected by many other pressures that are outside states' control. Rising health care costs, aging and disability trends, economic downturns, and erosion in the private health insurance market all drive Medicaid costs upward. In this environment, the federal government and states are not equal fiscal partners. The federal government's larger revenue base and broader authorities give it a much greater fiscal capacity. Since the 1950s, the federal government has typically collected almost twice as much revenue as all state and local governments combined (Fig. 20). The federal government also possesses broad borrowing authority that the states do not. And while the states are required by their constitutions to balance their budgets, the federal government can deficit spend.

Figure 20

Federal vs. State and Local Tax Revenues, 2002

(in billions of dollars)



SOURCE: Federal tax revenue data from *Budget of the US Government, Fiscal Year 2004*, Office of Management and Budget. State and local tax revenue data from U.S. Census Bureau, Census of Governments 2002.

Because of the constrained and highly variable fiscal capacity of the states, and given states' different policy preferences, approaches that rely heavily on state funding to cover the uninsured tend to produce wide variation in coverage. In light of the federal government's dominant role in government finance and the growing pressures on more fragile state finances, federal stabilizing mechanisms could strengthen the financing system for publicly sponsored coverage for low-income Americans.

Financing that is determined by enrollment and utilization directs public dollars most efficiently to meet health coverage and care needs. Evidence from public programs whose financing is capped and allocated by formula shows that accurately matching funds to needs is difficult and that funding levels tend to deteriorate over time.

Federal matching of state spending permits the costs of coverage to be shared and can promote national priorities while preserving state policy discretion. A federal-state financing partnership that takes into account the national trends causing health care costs to rise, countercyclical pressures at the state level, and the federal government's greater fiscal capacity could provide a strong and sustainable source of support for a program of health coverage for low-income Americans.

CONCLUSION

In August 2006, the Census Bureau reported that in 2005, 46.1 million non-elderly Americans were uninsured – 1.3 million more than in 2004. The uninsured rate also rose significantly, reaching 18% overall; among poor families, the rate was 37%. The number of children lacking coverage reached 9 million and children accounted for close to a quarter of the growth in the uninsured between 2004 and 2005. Over the period 2000-2004, significant declines in employer-sponsored coverage that hit low-income workers and their families the hardest were a driving factor in pushing the number of uninsured Americans up by 6 million.

Low-income Americans consistently dominate the uninsured numbers and their uninsured rates are the highest. The Commission's analysis of a large body of research reveals that while a variety of approaches have the potential to increase health coverage and access for uninsured Americans, expanding publicly sponsored health insurance offers the most targeted and efficient strategy to achieve this result in the low-income population. Through an expansion of public insurance programs, coverage can be extended to previously uninsured individuals with the lowest income and the poorest health.

As policy makers consider how to broaden health coverage for the growing number of low-income Americans, a wealth of evidence is available to help them understand the needs of this population and determine what approaches to addressing their needs are most promising. While public policy to deal with the thinning fabric of health insurance coverage in the U.S. is forged under political, economic, philosophical, and other pressures, the strong empirical foundation for policy in this area gives decision-makers a firm analytic foothold. By assembling the evidence and distilling its practical implications, we hope this report will help to guide effective action on this major national concern.

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