

HEALTH COVERAGE FOR LOW-INCOME AMERICANS:

AN EVIDENCE-BASED APPROACH TO PUBLIC POLICY

JANUARY 2007



**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.

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Foreword

In 2005, 46.1 million non-elderly Americans – more than 1 in 6 – lacked health insurance. An ordinary life event – a job loss or change, the loss of a spouse, a 19th birthday – can cause an individual or a family with health insurance to join the ranks of the uninsured. So can an extraordinary event. Hurricane Katrina added thousands to the nation’s poor and uninsured in a few days.

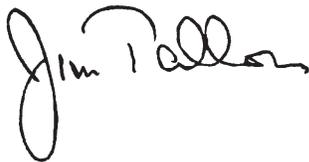
Research solidly documents both the critical role that health insurance plays in promoting access to needed care and improving health, and the ill consequences that ensue from not having coverage. In light of such evidence, the goal of expanding health coverage grows more pressing as the number of people who lack health insurance continues to climb. Low-income individuals and families are the most likely to lack health insurance and they make up the lion’s share of uninsured Americans. Therefore, to achieve a substantial reduction in the number of uninsured in our nation, policy solutions must be targeted to reach the low-income population.

How best to structure health coverage for low-income Americans has long been a subject of debate. In the last decade, the context for this debate has generally been a proposed expansion of coverage to reach more of the low-income uninsured population. However, more recently, state and federal policy initiatives that alter core aspects of Medicaid, the nation’s major safety-net health insurance program for low-income Americans, have gained increasing momentum. These developments thrust an analytic spotlight on fundamental questions concerning the needs of low-income people and the parameters of a health insurance program that assures their access to needed care.

In *Health Coverage for Low-Income Americans: An Evidence-Based Approach to Public Policy*, the Kaiser Commission on Medicaid and the Uninsured takes the approach that policy makers can learn much about how to proceed in providing health insurance for low-income Americans by considering the large body of evidence from public programs and health services research that is relevant to the central issues. Thus, the aim of the report is to lay an analytic foundation for the current and ongoing policy debate regarding coverage of low-income people. We conceive of it as a tool that policy and program officials and others can use systematically to assess the implications of proposals that would change Medicaid and to evaluate the merits and shortcomings of alternative strategies to broaden coverage of our nation’s low-income population.

We hope that by marshalling evidence to address key policy questions, we will help not only to foster improvement of our existing programs, but also to hasten progress toward a sound system of health insurance to meet the needs of all low-income Americans.

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Chairman



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Executive Director



Acknowledgments

This report would not have come about without the efforts of Julia Paradise, who not only conceptualized and articulated this project initially, but also led its development. Her commitment and diligence in synthesizing the key findings from decades of research enabled this work to come to fruition.

Rachel Garfield's thoughtful and useful comments lent additional clarity and rigor to the synthesis of the large literature reviewed here. Thanks are due also to the staff and associates of the Commission, who made valuable contributions over the course of many months as this document took shape.

Introduction

Research conducted over the last several decades shows overwhelmingly that people with health insurance are far more likely to obtain appropriate care than their uninsured counterparts, and that they are likely to have better health outcomes as a result. Insurance achieves these gains primarily by lowering the financial barriers to seeking health care.

Studies show that having insurance – or not having it – matters particularly for low-income individuals, both because their ability to pay for care out-of-pocket is extremely limited and because they are disproportionately likely to have chronic health care needs. Many studies have documented important disparities between the low-income population and others with respect to their health status, their health needs, their financial capacity to purchase care, the treatment they receive for specific conditions, and their health outcomes. Consistently, health insurance has been shown to reduce these disparities.

In the U.S., many in the low-income population do not have access to the market for private health insurance. This fact is reflected in the high uninsured rate among low-income Americans – 33% versus 10% for others who are not low-income. To bridge this coverage gap, the nation has established two major public programs, Medicaid and the State Children’s Health Insurance Program (SCHIP), which provide and finance health insurance for low-income Americans.

Medicaid is the principal safety-net health insurance program for low-income Americans. The Medicaid program covers over 50 million low-income people, and its beneficiaries include many of the poorest and sickest individuals in our nation. In 1997, SCHIP was created to widen the safety-net provided by Medicaid; it covers an additional 6 million low-income individuals, primarily children who do not qualify for Medicaid.

The experience of the Medicaid and SCHIP programs has produced a wealth of knowledge that is useful in defining the health insurance needs of low-income people. Over its 40-year history, Medicaid has evolved in important respects as a result of both federal policy changes and states’ exercise of their broad authority to shape the program. In addition, some states have obtained waivers to modify core elements of their Medicaid programs, resulting in distinctly different models of health coverage. SCHIP, by design, has fostered still other approaches to public coverage for a low-income population.

Due to difficult fiscal pressures at the state level and shifting federal health policy, public debate about Medicaid has intensified and federal law has been amended lately in ways that could significantly alter the contours of Medicaid coverage. In this environment, insights and lessons gained from Medicaid and SCHIP experience have become particularly relevant. The two programs’ respective achievements, the challenges each has confronted, and state and federal efforts to balance chronically competing pressures, illuminate the potential and limitations of alternative approaches to providing and financing coverage for low-income Americans. Findings from the broader field of health services research also help to enrich the picture.

In *Health Coverage for Low-Income Americans: An Evidence-Based Approach to Public Policy*, we have attempted to harness what has been learned from research to address core issues that are common to all systems for covering the low-income population, regardless of their particulars. It is hoped that bringing evidence to bear will highlight important policy concerns and provide an empirical basis for developing public policy and devising sound approaches to covering low-income Americans.

The report is organized as follows. The first part is devoted to the threshold question: What is the role for publicly sponsored health insurance? In this part, the characteristics and circumstances of the low-income population are documented and the limits of the private health insurance system as a source of coverage for low-income Americans are explained.

The second part turns to central questions about how to structure a publicly sponsored health insurance program for the low-income population. It begins with the issue of eligibility policy. Next, it addresses the matter of participation in public insurance and how to promote it. The subsequent three sections focus on distinct but interconnected aspects of financial access to care for low-income people – premiums, benefits, and cost-sharing. The sixth section addresses the fact that coverage does not guarantee access to care and discusses other factors that can facilitate or impede it. The seventh section deals with the fundamental matter of financing the coverage.

Each section begins with an overview that outlines the issue at hand, summarizes the relevant evidence, and based on the evidence articulates a perspective that is expressed in applied, programmatic terms. The overview is followed by a detailed review of the evidence in which the perspective is grounded. The report concludes by drawing together the perspectives presented in each section so that the framework of a well-designed program of coverage for low-income Americans comes more fully into view.

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.* 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 increased 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. The vast majority of uninsured Americans come from working families and over half of all uninsured workers are low-income.

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 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

* 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.

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.

Millions of Medicaid beneficiaries are low-income elderly or disabled Medicare beneficiaries. 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 in 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. 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 insurance, and increases in Medicaid spending for acute care have also been slower by comparison.

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.

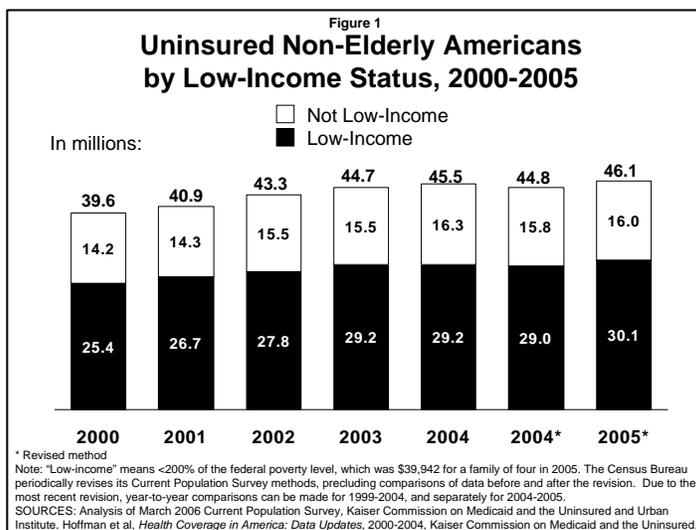
In analyses that model the major alternatives for reducing the number of low-income uninsured Americans, expansion of public insurance programs emerges as the strategy that can best target the formerly uninsured and those with the most health needs. As a result, it is estimated to be a more cost-efficient 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 American 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.

Key Evidence

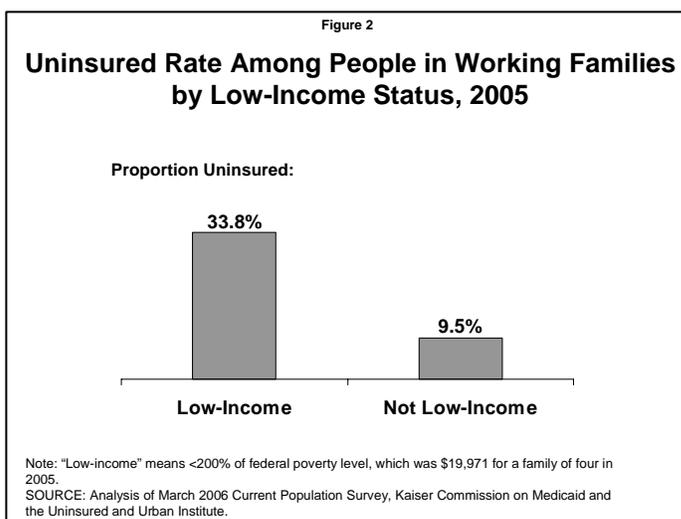
The number of uninsured non-elderly Americans has been rising, reaching 46.1 million in 2005. The majority are low-income and most come from working families.

- In 2005, 46.1 million non-elderly Americans lacked health insurance – 1.3 million more than in 2004. Over 80% of the new uninsured were low-income. Between 2000 and 2004, the number of uninsured grew by 6 million, and the uninsured rate also rose significantly, from 16.1% to 17.8%. More than 1 in 6 non-elderly Americans (17.9%) had no health insurance in 2005 (Fig. 1).^{1 2}
- Nearly two-thirds of uninsured non-elderly Americans are low-income, with family income below 200% of the federal poverty level.³
- Eighty percent of uninsured Americans come from working families. Almost 70% have at least one full-time worker in the family and another 11% have a part-time worker in the family.⁴

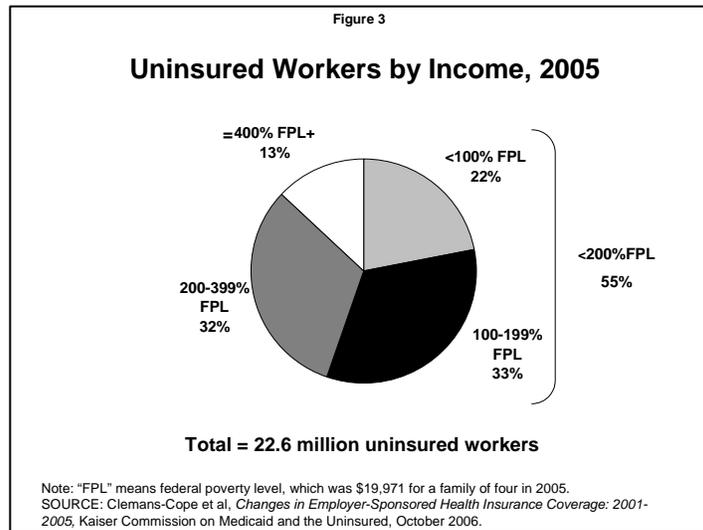


Most low-income uninsured Americans are workers and their dependents who lack access to employer-based health insurance. Those low-income uninsured workers who do have access to job-based coverage are often unable to afford their share of the premiums.

- Nearly three-quarters of low-income uninsured Americans come from families with at least one worker. In 2005, the uninsured rate among people in low-income working families was 34%, compared with about 10% for people in working families at or above 200% of the federal poverty level (Fig. 2).⁵



- In 2005, more than half of workers in poor families and over one-third of those in near-poor families had no offer of job-based coverage in the family; 70% of uninsured employees had no access to job-based coverage in the family. In 2005, over half of all uninsured workers were low-income (Fig. 3).⁶



- In 2005, a full-time minimum-wage worker faced an average annual premium cost for family coverage of \$2,713, an amount exceeding one-quarter of his or her annual earnings of \$10,712. In 2006, the family share of the average premium rose to \$2,973, and the total annual premium, including the employer's contribution, was \$11,480. Since the late 1990s, health insurance premium increases have outstripped both increases in workers' earnings and general inflation.^{7 8 9}

- Among the 20% of all uninsured workers who were eligible for but declined to enroll in their employer health plan in 2001, the reason cited most frequently (52%) was that it was too expensive. Participation among those who have access to employer-based coverage is lowest for low-income workers.¹⁰

- Decreases in ESI coverage – and increases in the uninsured rate – have been greatest in the low-income population. The share of poor employees who were covered through their own or their spouse's employer dropped from 37% in 2001 to 30% in 2005 and the rate among the near-poor dropped from 59% to 52%. Low-income workers accounted for two-thirds of the 3.4 million increase in the number of uninsured workers between 2001 and 2005.^{11 12 13}

Individual health insurance is very limited as a source of coverage for low-income people because of its high premiums.

- The individual (non-group) market plays a small role in providing health insurance to Americans, covering roughly 5% to 7% of the non-elderly population. There is a steep income gradient in participation in individual coverage: take-up rates are much lower among poor and near-poor candidates than among those at or above 200% of the poverty level. Researchers have found that few low-income individuals can afford to purchase coverage if the premiums exceed 5% of family income.^{14 15 16 17}

- In a survey of working-age adults who tried to purchase plans in the individual insurance market, more than half said it was very difficult or impossible to find an affordable plan. A study of seven states that have implemented some type of regulatory reform to improve access to individual insurance found that regardless of regulations, high premiums are a barrier to coverage for many in every state, including people who are healthy and relatively young.^{18 19 20}

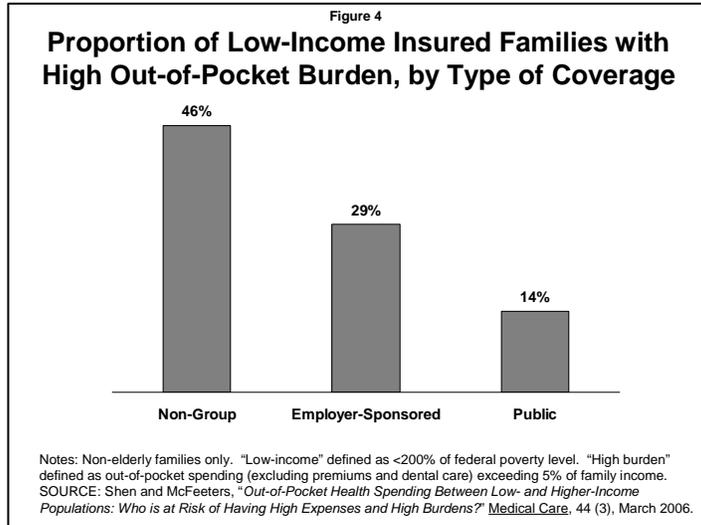
Coverage exclusions and applicant rejections based on health risk pose additional barriers to individual insurance.

- In states with weaker regulation of the individual insurance market, a significant percentage of applicants are rejected for coverage, leaving them with no option but expensive high-risk pools. Even for individuals who qualify for market plans, permanent exclusions can be imposed for pre-existing conditions and products often lack coverage for such important benefits as maternity care, mental health services, and prescription drugs. In the more weakly regulated states, premiums for a given insurance product differed as much as almost 15-fold based on age and health status. Research shows that while less expensive premiums are offered to the young and healthy, high-price coverage is the norm for older people and those with greater health needs.^{21 22 23 24}
- Close to half (45%) of uninsured non-elderly adults report having one or more chronic conditions. Low-income people are much more likely than others to be in fair or poor health, and much less likely to be in excellent or very good health; the correlation between low income and disability is also very strong.^{25 26 27 28 29 30}
- In a study examining the availability of individual health insurance in eight markets for seven hypothetical consumers with health problems ranging from hay fever to HIV, the consumers' applications were rejected 37% of the time. The HIV-positive applicant, whose condition was considered "uninsurable," was rejected every time. About half the time, the applications were accepted, but benefit restrictions, premiums surcharges, or both were imposed. The premium add-on averaged 38%. Coverage at the standard (healthy person) rate was offered in only 10% of the cases.³¹

In addition to its premiums, individual insurance exposes policy holders to deductibles and costs for non-covered benefits that low-income people may find difficult to afford.

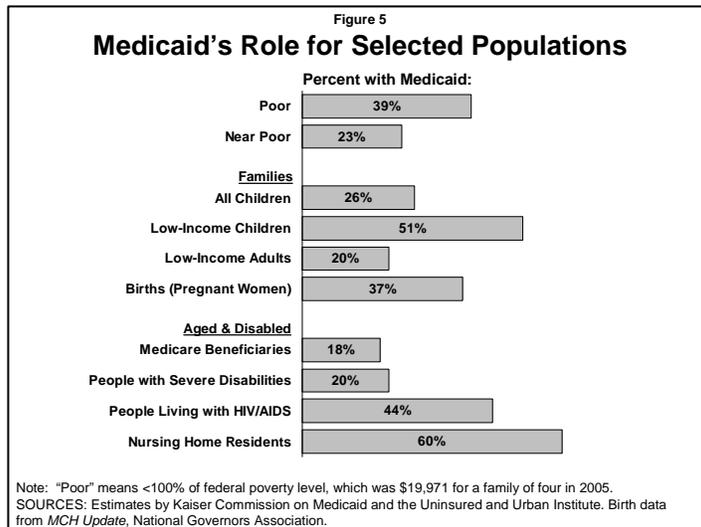
- A 2002 study assessing the potential of \$1,000 tax credits to increase coverage among women found that in markets where individual policies were available, those with annual premiums of \$1,000 or \$1,500 imposed deductibles that would consume as much as a third of the income of women who could qualify for the credit – even young, healthy women. Median annual deductibles for \$1,000-premium plans were \$1,500 for 25-year-old women and rose sharply to \$2,500 for 35-year-olds. Evidence suggests that because per capita health care costs have risen since the study took place, individual coverage available today for premiums of \$1,000 or \$1,500 would likely require substantially higher deductibles.^{32 33}
- Survey data indicate that in 2003, about half of non-elderly adults holding individual insurance policies faced deductibles of \$500 or more; of these adults, two-thirds faced deductibles of \$1,000 or more. Among adults with income below \$35,000, those with a deductible of at least \$500 were significantly more likely than those with a lower deductible (44% vs. 32%) to report at least one of four cost-related access problems (not filling a prescription, not getting needed specialist care, skipping a recommended test or follow-up exam, or having a medical problem but not visiting a doctor or clinic). Over half of those with deductibles of \$500 or more reported medical bill problems or medical debt, compared with 37% of those with lower deductibles.³⁴

- Individual insurance products often provide limited coverage for prescription drugs, no or very limited coverage for mental health care, and no maternity coverage. Rehabilitation and personal care services, which are critical for people with disabilities, frequently have annual or lifetime limits or are excluded altogether.^{35 36 37}
- Low-income families with private non-group insurance are at greater risk of bearing a high out-of-pocket burden than low-income families with either employer-sponsored insurance or public insurance. Among low-income adults, almost half of those with private non-group coverage report high out-of-pocket burden (family out-of-pocket expenses exceeding 5% of family income), compared with 29% of those with job-based coverage and 14% of those with public coverage who report high burden (Fig. 4).³⁸



Medicaid is the current source of coverage for tens of millions of Americans whose low income and comparatively poor health status leave them outside the private insurance market. Medicaid also fills major gaps in Medicare benefits and financial protection for millions of low-income Medicare beneficiaries.

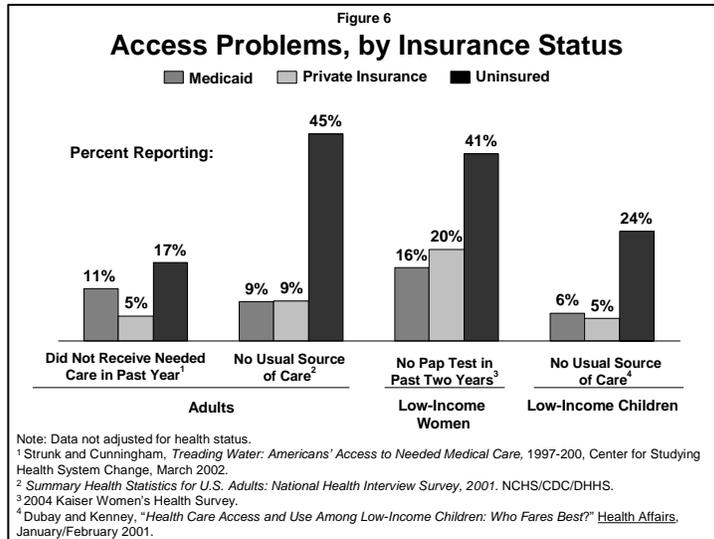
- The original Medicaid legislation provided eligibility to blind and disabled individuals and families with dependent children receiving cash assistance. It also extended Medicaid to low-income Medicare beneficiaries, assisting them with Medicare's out-of-pocket costs and supplementing its benefits. Over the last 40 years, Congress and the states have progressively expanded Medicaid to reach more of the low-income uninsured population and to cover services that neither the private sector nor Medicare covers, such as long-term services and nursing home care (Fig. 5).^{39 40}



- Medicaid covers half of all low-income children and one-quarter of all children in the U.S. From 2000 to 2004, while the recession and declines in employer-sponsored health insurance caused the number of uninsured Americans to rise by 6 million, Medicaid and SCHIP coverage protected children. Although declines in employer coverage were comparable for children and adults, public coverage offset the losses for children and the number of uninsured children actually dropped by 350,000 over that period. Analysis showing that the proportion of low-income children without insurance fell by more than one-third between 1997 and 2004 provides additional evidence of the impact of Medicaid and SCHIP in reducing uninsurance among low-income children.^{41 42 43}
- Medicaid is the safety-net for over 8 million low-income non-elderly Americans with disabilities and chronic illnesses, who are largely excluded from the private insurance market. Medicaid covers one-third of all children with chronic disabilities and 70% of such children who are poor. It covers 15% of all working-age adults with chronic disabilities and about 40% of the poor among them.⁴⁴
- Medicaid is a critical source of coverage for low-income Americans with HIV/AIDS, many of whom qualify when they become too disabled to work and as a result, lose both income and access to job-based health insurance. Medicaid is also an important payer of care for some of the most impaired people with mental illness in the United States; the program accounts for more than one-quarter of all spending for mental health and substance abuse care in the nation. Nearly 1 in 6 adults in Medicaid and 1 in 12 children in Medicaid use mental health or substance abuse services.^{45 46 47 48 49}
- Medicaid fills major gaps in Medicare benefits for 7.5 million low-income Medicare beneficiaries, covering long-term care, vision and dental care, and other services that are limited or excluded in Medicare's benefit package, and assisting with Medicare's premiums and cost-sharing. Medicaid's share of total spending on "dual eligibles" is almost as large as Medicare's; almost one-quarter of dual eligibles are in nursing homes.⁵⁰
- Studies exploring whether public coverage substitutes for private insurance rather than reducing the number of uninsured indicate that "crowd-out" of private coverage is rare among those below the poverty level. A 2005 analysis found that in 2002, only 8% of low-income working-age adults with public coverage had access to job-based insurance and less than 1% would likely have faced premiums that cost less than 5% of their family income. Crowd-out increases above the poverty level, but estimates of substitution in the low-income population vary widely. To illustrate, the above-mentioned study found that, among near-poor publicly insured workers (those between 100% and 200% of the poverty level), 1 in 5 parents and 1 in 10 childless adults had access to job-based coverage. A study of four states that expanded public coverage estimated that among the near-poor, 55% of the increase in program enrollment was associated with a decline in the number of uninsured, while 45% was associated with a decline in private coverage. Other research has attributed between 13% and 34% of the total decline in job-based coverage from 1988 to 1993 to the availability of Medicaid.^{51 52 53 54 55}

Medicaid provides access to needed care and limits out-of-pocket costs, which have been shown to deter timely use of services by low-income people. However, access gaps persist in Medicaid and SCHIP, and access under these programs varies by state.

- Almost universally, studies comparing Medicaid beneficiaries with the uninsured show that Medicaid beneficiaries have much better access to care. Research comparing Medicaid and private insurance has produced mixed findings, but there is substantial evidence that on key measures of access to preventive and primary care, Medicaid enrollees fare as well as – or especially in the case of children – better than their low-income counterparts with private coverage (Fig. 6).^{56 57 58 59 60 61 62 63 64 65 66 67 68}



- Inadequate access to specialty and dental care, in particular, has been a chronic problem in Medicaid and has also emerged as a problem in SCHIP. Evidence suggests that low provider participation in Medicaid, state variation in the scope of covered benefits, and discontinuities in beneficiary enrollment are contributing factors. Long travel time to appointments, limited office hours and long wait times in the office, and communication barriers constitute another set of access barriers.^{69 70 71 72 73 74 75}
- Medicaid beneficiaries have disproportionately high rates of emergency department (ED) visits. A study of ED visits related to chronic conditions that can be managed on an ambulatory basis found that in the case of ED visits that did not lead to hospitalization, Medicaid (and uninsured) patients were less likely than private patients to have follow-up with the doctor who referred them to the ED. The differences in ED visit rates were not due to group differences in disease severity; the authors suggest that the lower likelihood of follow-up care is consistent with the hypothesis that higher rates of preventable hospitalization are associated with a lack of access to outpatient care. Another study found that Medicaid patients had only marginally more success than uninsured patients in obtaining timely follow-up care for a set of serious conditions commonly encountered in EDs.^{76 77}
- Public coverage provides more financial protection than private health insurance for the low-income population. Among low-income families, 14% of those with public insurance report out-of-pocket costs (exclusive of premiums and dental) exceeding 5% of their income, compared with 29% of low-income adults with job-based coverage who report cost burdens at this level and nearly half of low-income families with individual coverage who report such costs.⁷⁸
- A recent analysis shows that among low-income adults under age 65, those with private insurance face more than twice as much in out-of-pocket health care costs as Medicaid beneficiaries. When adults with disabilities were excluded from the samples to improve

comparability, the gap in out-of-pocket exposure widened to nearly six-fold. In the case of children, the privately insured spend roughly seven times more out-of-pocket than those with Medicaid – whether children with disabilities are excluded from the sample or not.⁷⁹

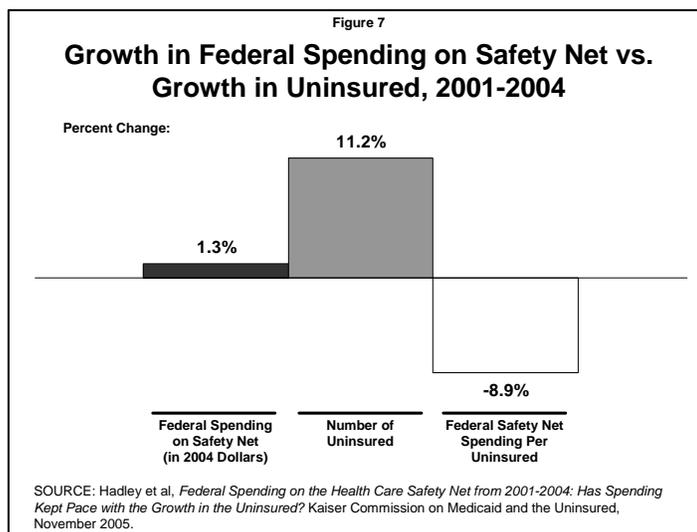
- A survey of non-elderly adults with disabilities found that, compared with those who had either private coverage or Medicare only, those with Medicaid as their sole source of coverage were significantly less likely to report postponing care or skimping on medication because of cost.⁸⁰

Per capita spending in Medicaid is low relative to private health insurance, and per capita spending has been rising more slowly in Medicaid than among the privately insured.

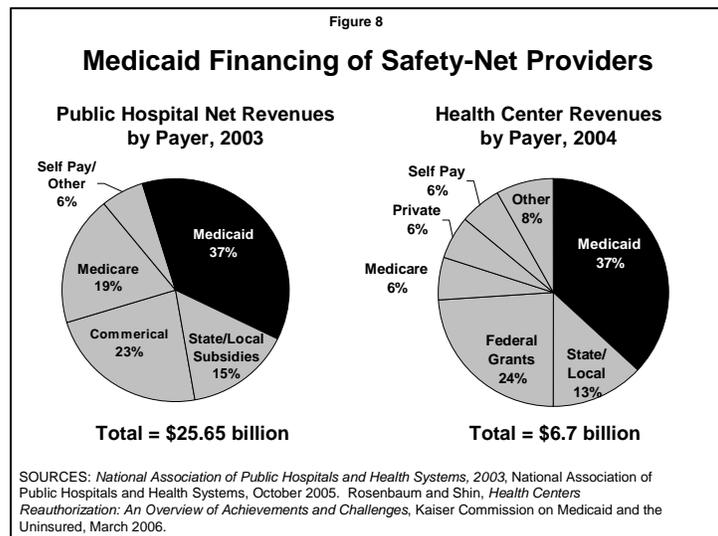
- When health status differences between Medicaid-covered adults and low-income adults with private coverage are adjusted, Medicaid spending per capita is substantially lower than spending per person among the privately insured – \$1,752 versus \$2,253 per year. The same holds true for children – Medicaid spending is \$749 per child, compared with \$1,098 per child with private insurance.^{81 82}
- Between 2000 and 2004, per capita spending grew more slowly in Medicaid than in private health insurance. During this period, acute-care spending per enrollee grew by 6.4% in Medicaid, while health spending per person with private insurance rose by 9.5%, and premiums for employer-sponsored insurance increased by 12.2%.⁸³
- Administrative costs in Medicaid are about half as large as administrative costs in private insurance. In 2003, they accounted for 6.9% of total Medicaid spending, compared with 13.6% of total private health insurance spending.⁸⁴

Federal support for the health care safety-net system has not kept pace with the increase in the number of uninsured Americans. Even where strong safety-net systems are in place, substantial gaps in health care access and utilization between the insured and the uninsured exist.

- Federal support, the most important source of funding for the health care safety-net, has not kept pace with the rising number of uninsured Americans. After adjusting for medical cost inflation and using constant 2004 dollars, total federal spending on the safety-net increased by only 1.3% between 2001 and 2004, while the number of people without insurance grew by nearly 5 million, or 11.2%. As a result, federal safety-net spending per uninsured person actually fell over this period, from \$546 to \$498 – a decline of 8.9% (Fig. 7). The amount of care received by the uninsured is already well below the average amount of care received by the insured.^{85 86}



- Health centers provided care to over 12 million patients in 2003, 40% whom were uninsured. Health centers provide access to preventive and primary care that generally meets the needs of their patients and research provides some evidence of superior performance by health centers compared with other providers for certain types of care. However, their ability to provide diagnostic procedures, specialist care, dental services, prescription drugs, and mental health services on-site is limited, and their uninsured patients often fail to get additional services for which they are referred, due largely to cost barriers. Health center physicians report that they have much more difficulty arranging specialty and non-emergency hospital care for their uninsured patients than for their patients with insurance.^{87 88 89 90 91 92}
- Research investigating the relationship between the strength of a safety-net system and access to care for low-income adults shows large gaps in health care access and use between insured and uninsured adults, regardless of the strength of a state's safety-net system. In all 13 states studied, whether safety-net systems were weak or strong, insured low-income adults were at least 30% more likely than their uninsured counterparts to have a usual source of care and more than 40% more likely to have a doctor visit; the disparities were much wider in some states. Findings at the local level were consistent with state-level findings.^{93 94}
- Medical school faculty at teaching hospitals, historically a mainstay of care for the poor, report more difficulty obtaining specialty services, high-tech care, and even routine inpatient care for uninsured than for privately insured patients. Nearly 1 in 4 clinical faculty reported that they were rarely or never able to obtain non-emergency admissions for uninsured patients, and nearly half were rarely or never able to obtain outpatient mental health or substance abuse services.⁹⁵
- A study examining the availability of community health centers found that only 38% of people under age 65 lived within five miles of a center; uninsured people were only somewhat more likely than those with private coverage to live close to centers (44% versus 36%). The same study found that high rates of insurance coverage in a community improved access more than the strong presence of community health centers did. Also, simulation results showed that investing in coverage expansions would lead to larger increases in access to care among low-income people than investing equivalent dollars in additional health center capacity.⁹⁶
- Safety-net institutions are chronically under-financed because they rely heavily on federal grants and Medicaid to fund care for their patients, a large share of whom are uninsured or Medicaid beneficiaries. Although originally, federally funded health centers were supported virtually entirely by federal grants, by 2004, centers relied on Medicaid for over one-third of their operating revenues; federal grants provided just 24% of their



operating funds. In public hospitals and freestanding acute-care children's hospitals, Medicaid accounts for over a third of net patient revenues (Fig. 8). Erosion of insurance coverage among low-income people has adverse implications for the financial viability of a safety-net already operating on thin margins.^{97 98 99 100 101}

- A study simulating the impact of decreased Medicaid/SCHIP enrollment (due to program cuts) on ED use indicates that while total ED volume would change little as a result, the proportion of all ED visits made by those lacking coverage would increase greatly. The shift would probably increase uncompensated care levels in EDs, and the effect would be most acute on urban public and other safety-net hospitals, which serve disproportionately large numbers of Medicaid and uninsured patients.¹⁰⁷

Tax credits that partially subsidize individual insurance are unlikely to stimulate much new purchase by the low-income uninsured, though they would ease premium burdens for current subscribers.

- The adequacy of tax credit amounts is important to whether people will use them. Tax credits at levels such as those currently proposed (for example, up to \$1,000 for single policies and up to \$3,000 for family coverage) are unlikely to bring premiums for individual insurance into an affordable range for most of the uninsured. The affordability problem would be even greater for those who are older or in imperfect health. One simulation study concluded that nearly half the poor would face after-credit premiums exceeding 16% of their income.^{108 109 110 111}
- Modest subsidies for individual insurance are estimated to have a small impact on take-up of this coverage (and on the uninsured rate) among the low-income uninsured. One model estimates that a 60% premium subsidy targeted to families below 200% of the poverty level without access to group insurance would reduce the number of uninsured families by 16%. Over three-quarters of the subsidy benefit would be realized by low-income families who currently purchase individual insurance at the full price.^{112 113}
- A recent case study examined the early impact of the health coverage tax credits enacted in the Trade Act of 2002 in Maryland, Michigan, and North Carolina. The refundable tax credits subsidize 65% of the premiums for qualified plans. Between 8% and 12% of potentially eligible individuals actually enrolled – a higher percent than the national average of 6.1%. The vast majority of informants interviewed for the study agreed that individuals' inability to pay their 35% of the premium was by far the most important factor limiting enrollment. Informants in North Carolina and Michigan believed that most eligible people who did not enroll went without coverage altogether. Informants in Maryland, whose uninsured population is higher-income than average, believe that many who did not enroll had other sources of coverage.¹¹⁴

Tax credits that subsidize individual coverage would cause some disruption of the group insurance market.

- Simulations of the impact of proposed tax credits and deductions estimate that these approaches would disrupt the group insurance market because they would reduce the current tax preference for employer-based insurance over individual insurance. Results show that some firms would stop offering health benefits to their workers. Also, the new subsidy would make individual coverage more attractive than group coverage for some workers who would switch. The model estimates that a small reduction in the number of uninsured would be achieved, but also that some losing job-based coverage would become newly uninsured.^{115 116 117}

Tax credits that subsidize premiums for job-based insurance appear to have limited potential to increase coverage.

- Researchers have found that if tax credits were offered to reduce the worker share of premiums for job-based coverage, coverage would increase some, but most of the subsidy would go to workers who are already insured (even without tax credits, 75% of poor workers who are offered insurance purchase it). Results from a simulation study show that only about 10% of those taking up the credit would be individuals who were previously uninsured. A tax credit for job-based coverage may also be limited in its effect since most uninsured workers lack access to job-based insurance.^{118 119}
- Tax credits to subsidize the employer directly may increase health insurance coverage if the subsidies induce additional firms to offer their workers insurance. However, under this approach, too, it appears that a substantial share of the subsidy dollars would benefit those who already have health insurance through their firms.¹²⁰

Purchasing pools have demonstrated limited success in expanding coverage and reducing premiums.

- In 2001, more than 1 in 4 uninsured workers were employed by a small firm (fewer than 10 employees). To improve the stability and affordability of health insurance costs for small firms and their employees, pooling arrangements have been tried. A study of the three largest statewide small-group insurance purchasing alliances (California, Connecticut, and Florida) showed that while these voluntary pools led to greater choice of plans offered to employees, the pools did not appear to attract additional small firms to offer insurance or to reduce health insurance premiums in the broader small-group market.^{121 122 123}
- Purchasing pools have to balance the competing objectives of broadening coverage and avoiding adverse selection. Including people with greater health needs in voluntary private purchasing pools is likely to raise premiums, potentially reducing employer participation in the pools.^{124 125}

Arrangements that pair high-deductible health plans (HDHP) with personal health spending accounts appear likely to impose financial barriers to access for the low-income population.

- The common theme of consumer-directed health care plans is that the high deductibles and generally higher out-of-pocket spending they feature are compensated for by sometimes lower premiums and tax-favored personal accounts for health spending. In 2006, the average worker contribution to the premium for family coverage was lower for a HDHP with a health savings account (HSA) than for the most common plan type, a PPO (\$2,115 versus \$2,915); for single coverage, the worker premium contributions did not differ significantly. However, the average annual deductibles for workers covered by HSA-qualified HDHPs were \$2,011 for single coverage and \$4,008 for family coverage, amounts that substantially exceeded firms' average contributions to HSAs – \$689 and \$1,139 for single and family coverage, respectively. These firm averages include the 37% of firms that make no contribution to their workers' accounts.^{126 127 128}
- Covered workers in lower wage firms – where 35% of more earn \$20,000 or less per year – pay a higher percentage of the premium for family coverage than covered workers in higher wage firms – where fewer than 35% earn \$20,000 or less per year. On average, covered workers in lower wage firms contribute 35% of the family premium while covered workers in higher wage firms contribute 26%.¹²⁹
- Research shows that while cost-sharing may be viewed as a tool to promote cost-consciousness in the general population, out-of-pocket burdens may impose substantial financial barriers to health care access for low-income people.^{130 131 132}

In comparative studies, expansion of public health insurance emerges as a more targeted and cost-efficient approach to broadening coverage of low-income Americans than tax credits for private insurance. Also, Americans view the nation's public insurance programs positively.

- Results from a micro-simulation comparing alternatives for achieving specified reductions in the number of uninsured show that expanding eligibility for public insurance to all poor or low-income people is a much better-targeted strategy than any tax credit policy currently under consideration. Specifically, a large majority (70% to 85%) of those who would become eligible under the public coverage expansion were previously uninsured, whereas a small proportion (3.5% to 45%) of those estimated to be reached by tax credits previously lacked coverage. The simulation also shows that a public insurance expansion is well-targeted to those with higher needs; it would reach a segment of the uninsured population that is older and less healthy than both the uninsured overall and the uninsured who would become covered under tax credit approaches.¹³³
- The same research indicates that expanding public health insurance is also more cost-efficient than tax credit approaches. Because they better target the formerly uninsured and those with greater health care needs, public insurance expansions obtain more insurance value per dollar of government spending, compared with tax credits.¹³⁴
- Results from another micro-simulation comparing different options show that 99% of public spending associated with an expansion of public insurance to adults goes to people below the poverty level. The other options modeled – tax credits and a public insurance expansion limited to parents – deliver only about a third of the public investment to the poor.¹³⁵

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- Focus groups conducted with parents of children enrolled in SCHIP and Medicaid found that these parents were generally highly satisfied with the benefits, providers, and services available to them under the programs. Among parents of low-income uninsured children who knew of either Medicaid or SCHIP, more than 4 out of 5 said they would enroll their child if told they were eligible. Parents whose uninsured children had previously been enrolled in Medicaid or SCHIP also had favorable views of the programs; 88% of these parents indicated they would enroll their child if told they were eligible.¹³⁶
 - According to a recent public opinion survey, nearly three-quarters of U.S. adults view Medicaid positively. Almost 8 in 10 would be willing to enroll in Medicaid if they needed health care and were eligible.¹³⁷

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HOW SHOULD PUBLICLY SPONSORED HEALTH INSURANCE BE STRUCTURED?

Policymakers considering how to structure a program of publicly sponsored health insurance for low-income Americans face a set of fundamental issues about its design. This section addresses seven core elements that play a large part in determining the scope, shape, impact, and sustainability of a publicly financed health coverage program. In the following pages, we outline the issues and present the evidence relevant to these defining policy dimensions:

- **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. 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.

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. 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.

Low-income adults are at especially high risk of being uninsured because their access to public as well as private coverage is very limited. 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.

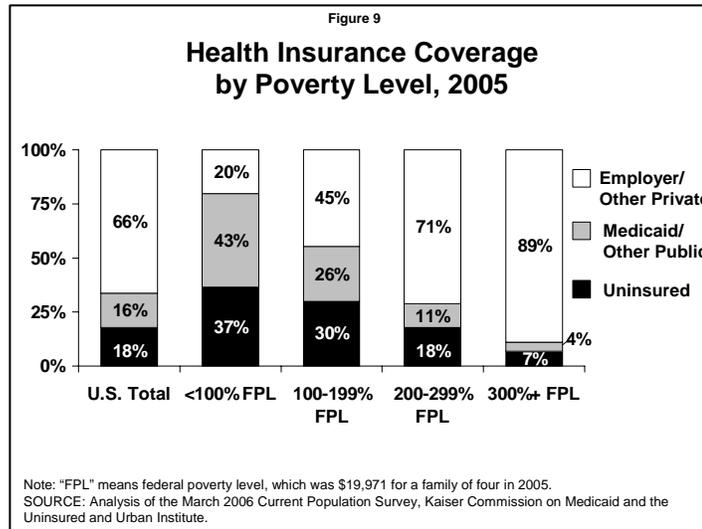
With respect to parents, federal Medicaid law ties minimum eligibility to the income standard each state used in its pre-1996 welfare assistance program. States have discretion to offer broader eligibility and many do; today, eligibility thresholds for parents vary widely across the states, ranging from 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 health 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.

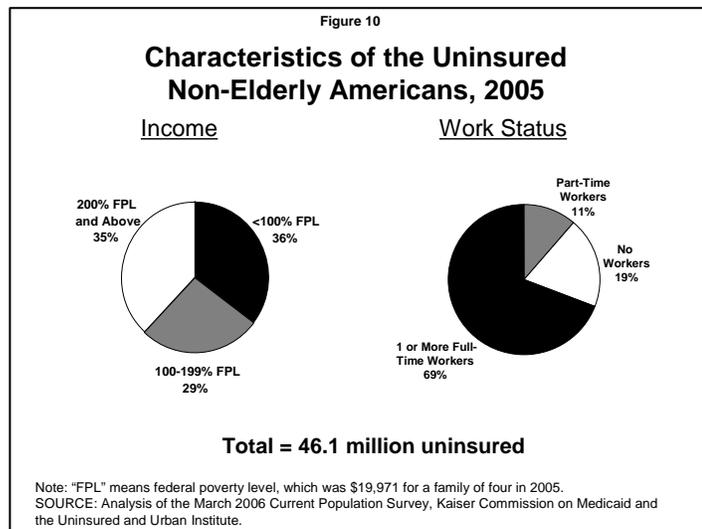
Key Evidence

Two-thirds of uninsured non-elderly Americans are poor or near-poor, and the vast majority of the uninsured come from working families. Most low-income working families lack access to health insurance through their jobs, and most uninsured workers are low-income.

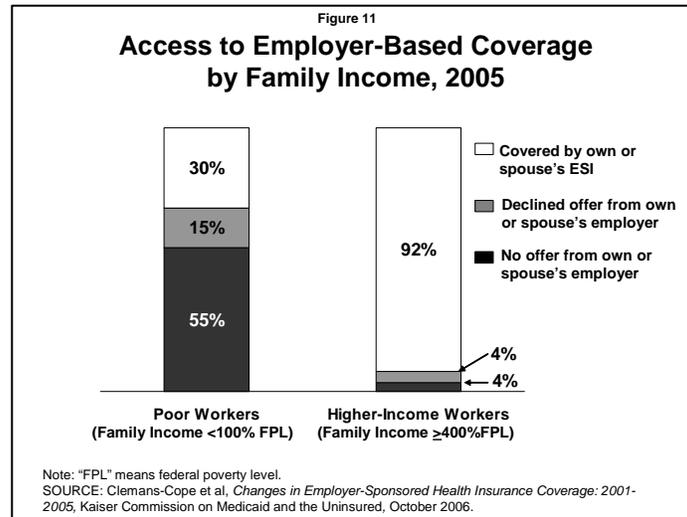
- More than 1 in 3 poor non-elderly Americans are uninsured and nearly a third of the near-poor lack coverage. By contrast, among those at or above 200% of the poverty level, about 1 in 10 is uninsured (Fig. 9).¹



- Low-income individuals and families make up almost two-thirds of the uninsured. The 2005 federal poverty threshold ("federal poverty level") was \$10,160 for a non-elderly individual and \$19,971 for a family of four. Eighty percent of all the uninsured and nearly three-quarters of the low-income uninsured come from working families (Fig. 10).^{2 3 4}



- In 2005, over 90% of higher-income workers (those at or above 400% of the federal poverty level) had access to employer-based coverage through their own work or their spouse's, but less than half of poor workers had an offer of health insurance from their own or their spouse's employer (Fig. 11).⁵



Working families are sometimes at a disadvantage relative to non-working families in their access to health coverage.

- Even after adjusting for demographic factors and health status, children of the working poor are less likely to have health insurance compared with children in non-working poor families. For these children, parental employment does not provide adequate access to employment-based coverage, yet it reduces the likelihood of eligibility for Medicaid.⁶

The poverty level represents a standard of living below which people require assistance to meet even basic needs.

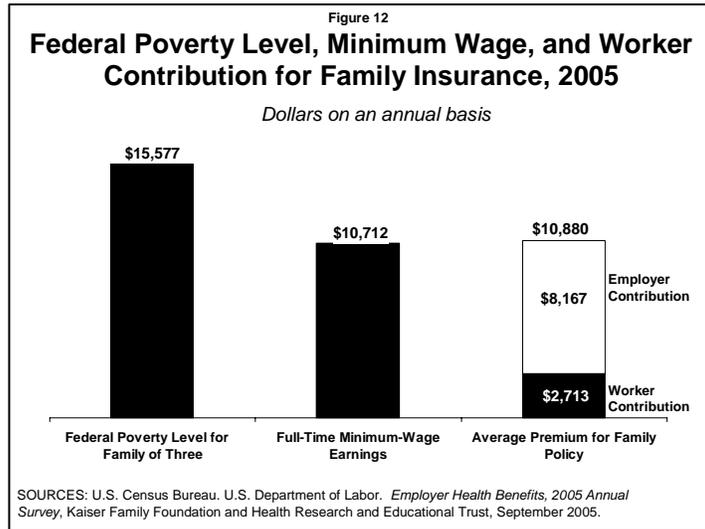
- Federal assistance programs commonly use the federal poverty level or a higher threshold as their eligibility standard. Examples include the Food Stamps Program (130%), WIC (185%), Low Income Home Energy Assistance Program (110%), the National School Lunch and School Breakfast Program (185%), and Head Start (100%).⁷
- Family budgets among those near poverty are extremely tight, dominated by basic needs for housing, food, transportation, and childcare. In many communities, income equivalent to 200% of the federal poverty threshold is not adequate to meet those needs, much less needs for health care.⁸

- About one-quarter of low-income families with a full-time, full-year worker are “food-insecure.” That is, they report that in the prior 12 months, they cut or skipped meals because of lack of money, worried that food would run out before they could afford to buy more, or ran out of food and lacked money to get any more. Likewise, one-quarter of such families are “housing-insecure,” reporting that they were unable to pay the mortgage, rent, or utility bill because of lack of money in the prior year. A study examining the extent of hardship among low-income non-elderly adults found that nearly three-quarters of this population had food (13%), housing (45%), or health care (54%) hardship in the past year, compared with 31% of adults with income above 200% of the poverty level.^{9 10}
- Many analysts consider the federal poverty threshold to be inadequate as a measure of the basic income needs of a working family. An alternative measure, “family budgets,” uses a market-basket approach to determine adequate income, identifying the items necessary for a working family to maintain a safe and decent living standard and the cost of providing each item at an adequate level. Data from the Bureau of Labor Statistics Consumer Expenditure Survey reveal that low-income families tend to spend less on basic necessities than recommended by a basic family budget, a finding that poverty researchers have cited as evidence that such families are not fully meeting their basic needs.¹¹

Many low-income families devote substantial resources to health care and the burden of health care costs has been increasing.

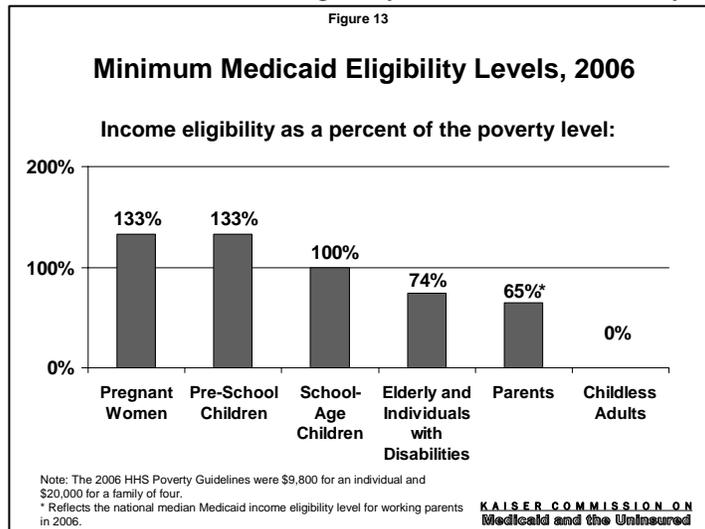
- Nationally, low-income families spend 7 of every 10 dollars on basic living expenses, including housing, transportation, and food, leaving little remaining income to cover other expenses. That remainder is split among many categories, with health care spending ultimately amounting to about 7% of their total spending. Many low-income families, even those who are insured, have large unpaid medical bills.¹²
- According to the Institute of Medicine, on average, food, shelter, transportation, and clothing account for 85% of the expenditures of families without health insurance.¹³
- Among the insured, low-income families are more likely than higher-income families to experience heavy health care cost burdens. More than one-quarter of low-income families report out-of-pocket health care costs (not including premiums or dental care) exceeding 5% of their family income, compared with 7% of higher-income people who report out-of-pocket burdens of this size.¹⁴
- The disparity in out-of-pocket burden as it relates to income is most pronounced among those with more extensive health needs. After taking differences in health insurance status into account, children with special health care needs in families below 200% of poverty are over 10 times more likely to experience burdensome out-of-pocket costs (i.e., exceeding 5% of family income) than those in families at or above 400% of poverty.^{15 16}

- The minimum wage, last raised in 1997, has eroded relative to the cost of living, while health care costs have climbed steeply. In the 1960s and 1970s, a full-time worker earning the minimum wage typically made enough to keep a family of three out of poverty. In 2005, however, the earnings of a full-time minimum-wage worker totaled \$10,712 – just 69% of the federal poverty level for a family of three in that year (\$15,577). The employee share of the average premium for a family policy in 2005 was \$2,713, which would have consumed one-quarter of the family’s total annual earnings (Fig. 12). In 2006, the employee share of the average family premium rose to \$2,973.^{17 18 19}

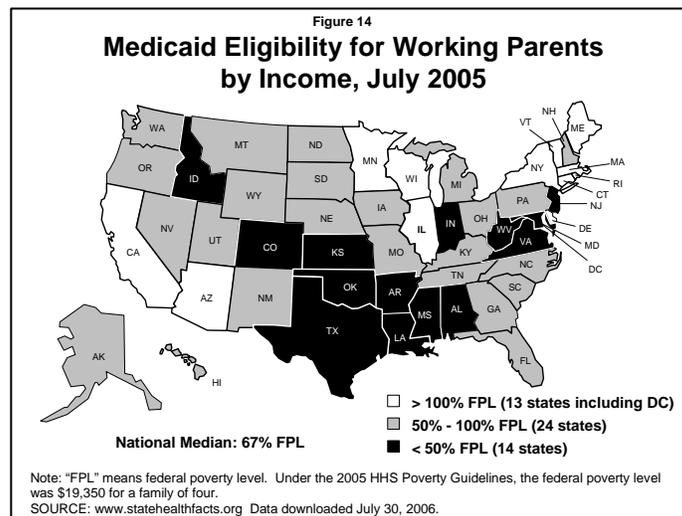


Low-income adults’ eligibility for public coverage is very limited, depends on family structure, and varies widely by state of residence.

- Federal law establishes minimum eligibility standards for the Medicaid program and gives states broad authority to expand beyond them. Federal Medicaid law establishes much more restrictive eligibility for adults than for children. Federal law guarantees Medicaid eligibility to infants and pre-school children up to 133% of the federal poverty level and to older children up to the poverty level. The federal “floor” for eligibility for seniors and severely disabled individuals is equivalent to about 74% of the federal poverty level. Federal minimum standards for other adults are much lower. The minimum eligibility standard for parents is tied to each state’s pre-1996 welfare assistance standard, rather than to the poverty level; in 2006 the median national eligibility standard for working parents was 65% of the federal poverty level. Federal law excludes adults without dependent children from Medicaid (Fig. 13).²⁰

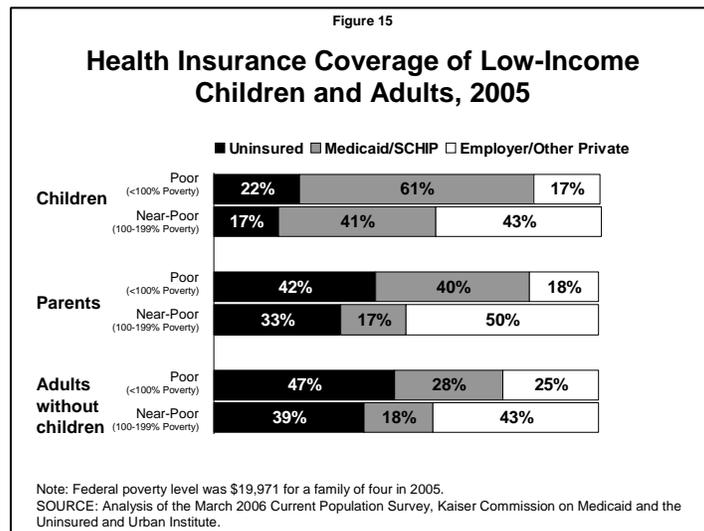


- Because Medicaid and SCHIP completely absorbed the declines in employer-based coverage between 2000 and 2004, none of the 6 million Americans added to the uninsured rolls were children and the number of uninsured children actually fell by 350,000. While public coverage did increase among adults during period, much more restrictive eligibility for adults prevented it from offsetting the losses of job-based coverage they experienced.²¹
- While virtually all low-income children qualify for Medicaid or SCHIP, only a third of low-income non-elderly adults were eligible for these programs in 2002. Even among adults below 50% of the poverty level, only about half qualified for publicly sponsored coverage.²²
- Often, low-income parents do not qualify for public coverage even though their children do. Reflecting their much more limited eligibility for publicly sponsored insurance, more than a third of all low-income parents lack health insurance, and the uninsured rate among poor parents exceeds 40%.²³
- Medicaid eligibility for low-income parents, because it is tied to states' pre-1996 welfare assistance standards, varies widely across the United States. To illustrate, eligibility for working parents ranges from 19% of the federal poverty level in Alabama and Arkansas to 275% of the federal poverty level in Minnesota (Fig. 14).^{24 25}

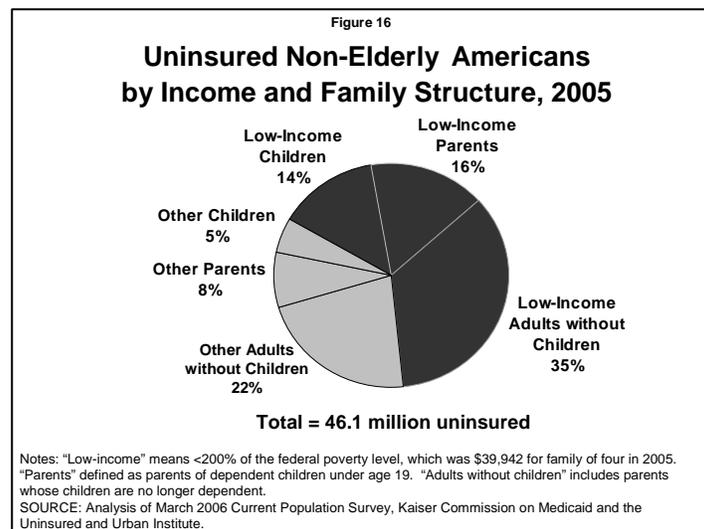


- Results from a simulation study show that if eligibility levels for parents were raised to the levels states have set for children in Medicaid and SCHIP, 70% of uninsured parents could be covered.²⁶
- Low-income adults without dependent children are far less likely to be eligible for public coverage than low-income parents (23% versus 50%). Below the poverty level, the disparity in eligibility between childless adults and parents is even wider (34% versus 77%).²⁷

- Because federal law categorically excludes adults without dependent children from Medicaid (unless they are severely disabled), states can receive federal Medicaid matching funds for adults only if they obtain a federal waiver. Some states cover childless adults under programs that are fully state-funded. As of January 2004, 14 states and the District of Columbia covered low-income childless adults. Ten states provided this coverage under Medicaid waivers, three operated state-only programs, and one state and D.C. operated both waiver and fully state-funded programs. In the other 36 states, adults without children – no matter how poor – were not eligible for any public coverage.²⁸
- Because Medicaid eligibility is so much more limited for adults than for children, poor and near-poor adults are much more likely than poor and near-poor children to be uninsured (Fig. 15).²⁹



- As a consequence of their limited eligibility for publicly sponsored health insurance, low-income adults are the largest group in the uninsured population. Low-income adults, including both parents and adults without children, make up half of all the non-elderly uninsured. Low-income childless adults alone constitute over one-third of the uninsured (Fig. 16).³⁰



Medicaid programs that cover low-income parents along with their children have promoted increased coverage and access of children as well as their parents.

- State experience and results from estimation models indicate that Medicaid eligibility expansions that include parents not only provide coverage to uninsured parents, but also increase the participation of eligible children. For example, one study found that about 80% of eligible children were enrolled in Medicaid in states with family coverage, compared with 57% of eligible children in states with less generous eligibility rules for parents.^{31 32}
- Children whose parents have had at least one physician visit are more likely to have had a physician visit, and health insurance appears to amplify this relationship. Evidence that access to care is better among children whose parents also have coverage than among children in families with child-only coverage suggests that insuring parents is an important mechanism for improving children's access as well.^{33 34 35 36 37}
- Medicaid/SCHIP coverage of low-income parents is associated with lower uninsured rates among low-income children. One analysis found that in states that expanded public coverage to parents at or above 133% of the poverty level, about 14% of low-income children were uninsured, compared with 25% of such children in states that did not cover all parents up to the poverty level. The study also found an insured rate of 90% among low-income children whose parents were insured, compared with 48% for low-income children whose parents were uninsured.³⁸

Endnotes

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- ²³ Dubay L and G Kenney, “*Addressing Coverage Gaps for Low-Income Parents*,” Health Affairs, March/April 2004.
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- ²⁸ Dorn S et al, *Medicaid and Other Public Programs for Low-Income Childless Adults: An Overview of Coverage in Eight States*, Kaiser Commission on Medicaid and the Uninsured, August 2004.
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- ³² Dubay L and G Kenney, *Covering Parents Through Medicaid and SCHIP: Potential Benefits to Low-Income Parents and Children*, Kaiser Commission on Medicaid and the Uninsured, October 2001.
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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. 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. Finally, family-based eligibility – a form of simplification – has been associated with increased participation.

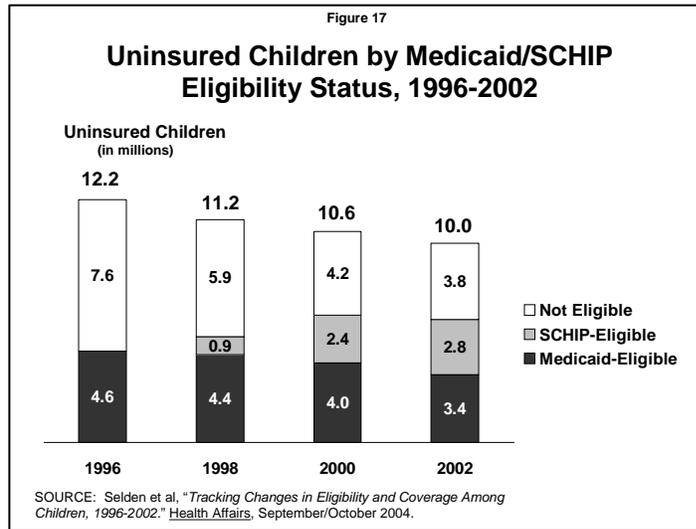
Studies indicate that the diversity represented in the low-income population calls for varied outreach strategies. Research suggests the need for outreach and marketing efforts that use multiple media and venues, appropriate languages, and messages that convey the value of the assistance and explain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

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.

Key Evidence

Many who are eligible for publicly sponsored health insurance are not enrolled in the programs. Inadequate outreach and gaps in knowledge about the programs pose barriers to participation.

- A large proportion of uninsured children are low-income children who are likely to be eligible for Medicaid or SCHIP (Fig. 17). Of the 9 million children who lacked insurance in 2005, 6.6 million were in families with income below 200% of the federal poverty level.^{1 2}



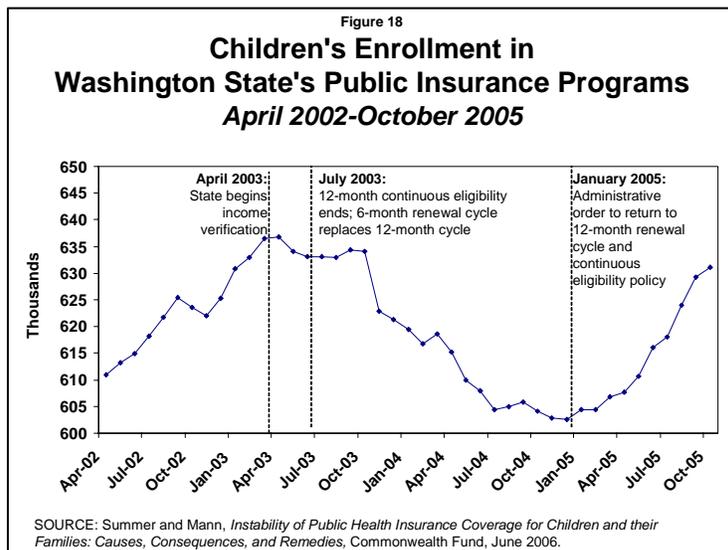
- Just over half of low-income adults without private insurance who qualify for public coverage are enrolled, and the poorest adults are least likely to enroll.³
- In research on children who are eligible for Medicaid or SCHIP but uninsured, parents' lack of awareness and knowledge about the programs emerge as major barriers to participation. Many parents, even if aware of the programs, do not think their children are eligible.^{4 5}
- In a national survey, nearly half (46%) of Spanish-speaking parents of uninsured but Medicaid-eligible children reported that they did not complete the enrollment process because the Medicaid information and forms were not translated into their language.⁶
- A national survey of low-income parents found that direct outreach efforts to inform parents about Medicaid failed to reach many parents. Parents whose eligible children were uninsured were the least likely to have been reached; only 1 in 4 parents of children who were eligible for Medicaid but uninsured had ever talked to someone or received information about enrolling in Medicaid.⁷
- There are many reasons eligible adults do not enroll in coverage, including lack of knowledge about eligibility, difficulty completing the enrollment process, and individual choices not to enroll. The low enrollment rates particularly among the poorest adults and those without dependent coverage suggest that these adults are less connected to assistance programs and that they would likely benefit from increased outreach efforts.⁸

Burdensome enrollment and renewal procedures present high barriers to participation for low-income people.

- Among parents seeking to enroll their children in Medicaid, the most-often-cited barriers to participation include difficulty assembling all the required documents and the overall hassle of the enrollment process. The "hassle factor" was defined as including the length of time it

takes to apply, enrollment offices not being open when parents could go, and the office being too hard to get to.⁹

- Researchers have found that children who are eligible for but not enrolled in Medicaid are somewhat healthier than children who are enrolled but are more likely to face obstacles to access and to have family out-of-pocket medical spending exceeding \$500. Citing these findings, the researchers suggest that a large portion of Medicaid-eligible children who are uninsured may face high barriers to Medicaid enrollment that deter their participation.¹⁰
- State officials interviewed in case studies have expressed concern that administrative barriers and confusion among parents of children enrolled in Medicaid or SCHIP are significant causes of disenrollment. Some parents in focus groups reported that they had not intended to disenroll their children, but did not realize what the renewal process entailed.^{11 12}
- States that have imposed more restrictive or burdensome enrollment and renewal policies and shorter eligibility periods in their Medicaid or SCHIP programs have documented subsequent declines in program participation. To illustrate, after a long period of rising enrollment of children in Washington State's public insurance programs, the caseload began to decline when the state instituted increased verification requirements, and it fell steeply when a few months later, the state eliminated its policy of 12-month continuous eligibility and required families to recertify every six months. When, by court order, the state reinstated 12-month eligibility, enrollment rebounded (Fig. 18).^{13 14 15 16 17}



- A study of four states found that states that require parents to actively verify eligibility to renew their children's SCHIP coverage experienced disenrollment rates as high as 50%. The study also found that up to 1 in 4 children who were disenrolled at recertification time returned to the SCHIP rolls within two months, suggesting that the children had not secured other coverage.¹⁸

Complex enrollment procedures impose administrative burdens and costs on states.

- Medicaid officials from states that eliminated the asset test for families reported that while their chief objective was to simplify the application process for families, the step was also seen as promoting larger agency goals of streamlining the eligibility determination process, improving worker productivity, and permitting the adoption of automated eligibility systems. While only one state was able to quantify its administrative cost savings from policy change, other states had a clear view that administrative savings were significant.¹⁹

- A study comparing the typical Medicaid enrollment process in New York City with the dramatically simplified enrollment process implemented following the September 11, 2001 terrorist attacks found that up to 80% of enrollment costs under the typical process are associated with the rules, verifications, and calculations surrounding eligibility. Outreach and health insurance education account for only about 20% of the costs. The study found further that enrollment costs would be reduced by about 40% in a simplified system, primarily from reduced time and costs associated with eligibility screening, application completion, and document assembly.²⁰
- A survey of 12 states that allow certain groups of Medicaid applicants to self-declare their income rather than submit pay stubs, tax returns, or other documentation found that this simplification measure led to increased productivity by eligibility workers. The reduced documentation requirements allowed faster processing of applications and generally increased the speed of eligibility determination. Most state officials reported that error rates did not increase as a result of the self-declaration of income policy, and the study found that by using effective third-party income verification procedures, the states were able to maintain low rates of eligibility error. Quality control audits documented that program integrity was effectively safeguarded.²¹
- An analysis of the potential impacts of allowing self-declaration of income for low-income families applying for Medi-Cal concluded that, net of new administrative costs associated with increased intakes, added case maintenance, and monitoring activities, a self-declaration policy would yield an annual \$3 million in state and federal administrative savings stemming from reduced time associated with processing eligibility.²²

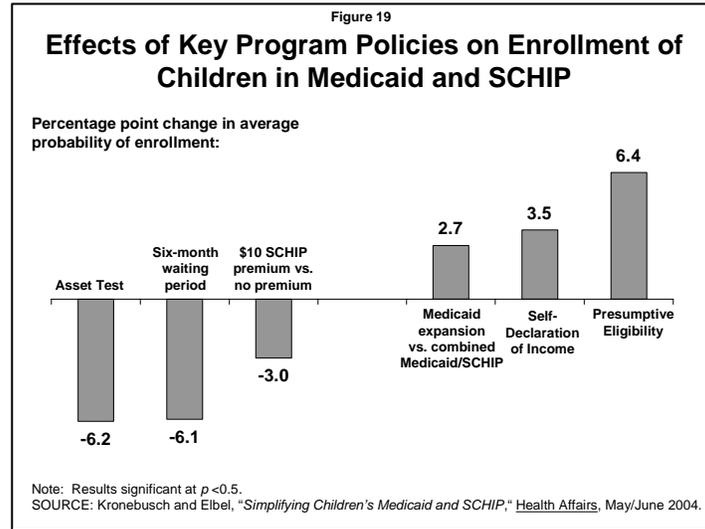
Instability in enrollment, which is exacerbated by burdensome renewal procedures and shorter enrollment periods, imposes costs on the providers that serve low-income patients.

- Research on the impact of unstable enrollment on providers is limited. However, a study of Washington’s Medicaid program examined this issue. The medical groups, hospitals, and health plan interviewed for the study cited payment delays and increased charity care associated with patients temporarily disenrolled from Medicaid. They also reported substantial administrative costs attributable to verifying Medicaid enrollment, troubleshooting enrollment problems, and seeking payment for patients retroactively re-enrolled by the state. The health plan cited the difficulty of managing care for patients who cycle on and off the program, particularly those with chronic illnesses or high-risk pregnancies, and children with asthma or other special health care needs.²³

Simple enrollment and renewal procedures facilitate participation.

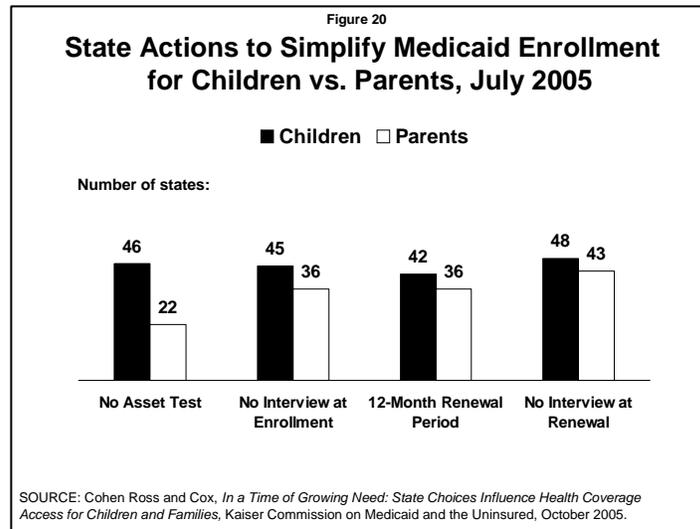
- Simple Medicaid and SCHIP enrollment and renewal procedures have been associated with relatively high rates of program enrollment and retention. For example, in states that renew SCHIP eligibility automatically unless the family reports changes that affect eligibility, SCHIP disenrollment rates are low compared with the rates in states that require active verification of eligibility for renewal.^{24 25 26 27 28 29}

- A study of the relationship between states' program design choices and children's enrollment in Medicaid and SCHIP found that enrollment simplification, type of SCHIP administrative model, waiting periods, and premiums all affect enrollment. Presumptive eligibility and allowing self-declaration of income both increase the probability of enrollment. Asset tests reduce enrollment, as do waiting periods and premiums. Enrollment levels were higher in SCHIP programs that were Medicaid expansions than in Medicaid/SCHIP combination programs or separate SCHIP programs (Fig. 19).³⁰



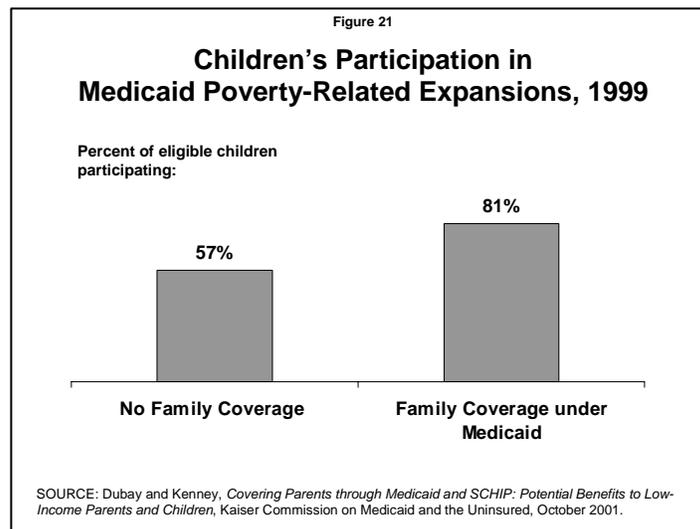
- Medicaid officials from states that eliminated the asset test for families applying for Medicaid reported that dropping the asset test made outreach and enrollment at the community level more successful and increased application activity. No state reported an increased Medicaid eligibility error rate due to removal of the asset test.³¹
- Eligibility for Medicaid and SCHIP can be linked to applications for other public assistance benefits such as Food Stamps and WIC. This "express lane eligibility" model reduces the burden of lengthy and repetitive applications on low-income families. California's "express lane eligibility" program has had success using the free school lunch application to identify and initiate enrollment of children who are income-eligible for Medicaid but not enrolled. Participating families have been very pleased with the process.^{32 33 34}
- Strategies in which private or public benefit programs automatically confer eligibility and benefits based on information available from related or complementary programs have demonstrated success in a number of spheres. Researchers estimate that with improvements in information technology and increased flexibility for Medicaid and SCHIP to accept income determinations from other means-tested programs, Medicaid and SCHIP could reach many eligible-but-uninsured low-income children and adults. To illustrate, over two-thirds (71%) of uninsured low-income children who are likely to be eligible for Medicaid or SCHIP live in families who participate in the National School Lunch Program, WIC, or the Food Stamp Program. The 53% of poor uninsured parents who have children already enrolled in Medicaid might be reached by auto-enrolling them on the basis of their children's Medicaid eligibility.³⁵

- Fewer states have taken steps to simplify Medicaid enrollment and renewal for parents than have done so for children. For example, while 46 states have eliminated asset tests for children, only 22 disregard assets for parents. Parents lag behind children similarly in other areas of Medicaid simplification (Fig. 20).³⁶



Family-based eligibility appears to boost participation.

- Researchers have found that expanding family coverage in Medicaid not only increases enrollment of parents, but also boosts participation among eligible children (Fig. 21). Other research shows that among Medicaid-eligible parents without private insurance, those whose children were enrolled in Medicaid were more likely than parents overall to enroll in Medicaid.^{37 38 39 40}



- An analysis of Medicaid and SCHIP disenrollment showed that children with a sibling in one of the programs were 39% less likely to drop out than those without siblings in either program.⁴¹

Diverse outreach and marketing efforts and clear messages about the value of coverage are needed to reach and inform those eligible to participate in public insurance programs.

- All six states studied in the congressionally mandated evaluation of SCHIP adopted multiple, diverse strategies to market SCHIP to families with uninsured children, and several reported that their approaches became more targeted over time. The states created new and appealing names for their programs, promoted them through radio and television advertising either statewide or to particular neighborhoods and/or ethnic markets, developed attractive print materials and distributed them strategically, enlisted health plans as outreach partners, and worked with community-based organizations to provide outreach and application assistance, especially for harder-to-reach populations.⁴²
- Several states developed SCHIP outreach strategies targeted to particular racial and ethnic groups. Participants in parent focus groups agreed that such strategies would be successful and also recommended reaching out to eligible families in the many places they go in their daily lives, including health care providers, community centers, grocery stores, schools, and places of worship.⁴³
- Participants in parent focus groups have expressed the importance of Medicaid and SCHIP marketing messages that emphasize that applying is simple and convenient and that coverage is valuable (i.e., it is no-cost or low-cost and offers many benefits). They also voiced the need for messages that convey that working families are eligible and provide details on who is eligible.⁴⁴
- Low participation in Medicare savings programs, which assist low-income Medicare beneficiaries with their premiums and out-of-pocket costs, has been attributed to lack of awareness about the programs and cumbersome eligibility determination and enrollment procedures. A government study found that in the year following a congressionally mandated outreach effort by the Social Security Administration, enrollment in these programs nationwide was nearly double that in each of the three previous years; 35 states had statistically significant additional increases in enrollment.⁴⁵

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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. Research shows a strong relationship between the affordability of health insurance premiums and coverage rates.

A substantial body of research documents that participation in public health insurance declines sharply as premiums rise. 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.

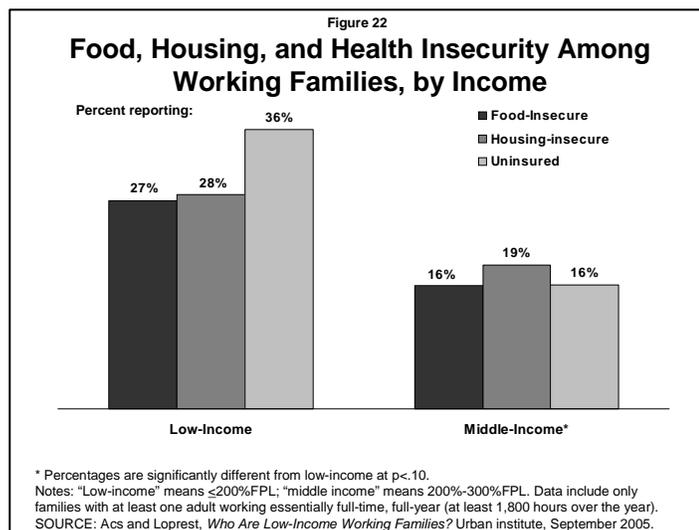
States also face increased administrative burdens associated with implementing and collecting premiums. Finally, findings that premiums lead to reduced enrollment suggest that states may realize savings from premiums, but that the savings may be due not to increased premium revenues, but to enrollment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

Key Evidence

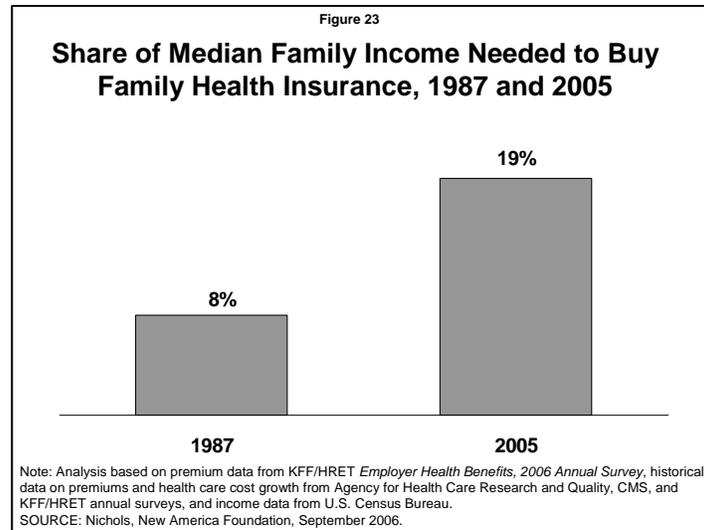
Low-income families devote the majority of their budgets to basic living expenses, with a small share available to meet other costs, including health care costs.

- Nationally, low-income families spend 7 of every 10 dollars on basic living expenses including housing, transportation, and food. Their remaining money is split among many categories, with health care spending ultimately amounting to about 7% of their total spending.¹
- An analysis of data from the 1997 and 1999 National Survey of America's Families (NSAF) found high levels of food, housing, and health care hardship among non-elderly adults in the U.S., particularly among the uninsured and low-income. Nearly three-quarters of low-income adults reported hardship of at least one of these kinds, compared with 31% reported by adults with income at or above 200% of the poverty level.²
- Data from the 2002 NSAF show that more than one in four low-income “high-work” families – that is, low-income families with at least one full-time, full-year worker – are food-insecure and a similar share is housing-insecure. More than one-third of these families lacked some health insurance coverage. These rates of food, housing, and health hardship are significantly higher than the rates experienced by middle-income high-work families – those with income between two and three times the poverty level (Fig. 22). Low-income high-work families are also more likely than middle-income high-work families to put off needed care due to lack of coverage or money and to have a child in poor health.³

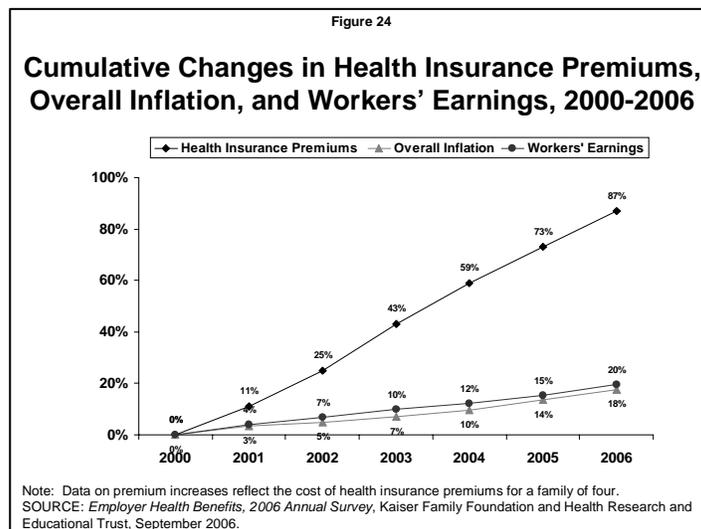


The premiums for employer-sponsored insurance (ESI) are often unaffordable for low-income families.

- Among all (not only low-income) uninsured workers who have access to job-based coverage, the reason most frequently given for declining to enroll is that the coverage is too expensive. Between 2001 and 2005, employee participation in ESI declined more among poor workers than other workers, suggesting a growing problem of affordability.^{4 5}



- In 2006, the worker's share of the average premium for job-based family coverage was \$2,973, or \$248 per month. This equates to more than one-quarter of a minimum wage worker's total earnings. The share of median family income required to purchase family health insurance rose from 8% in 1987 to 19% in 2005 (Fig. 23).^{6 7 8}
- Over the period 2000-2006, workers' earnings grew by 20%, while health insurance premiums grew by 87% (Fig. 24).⁹

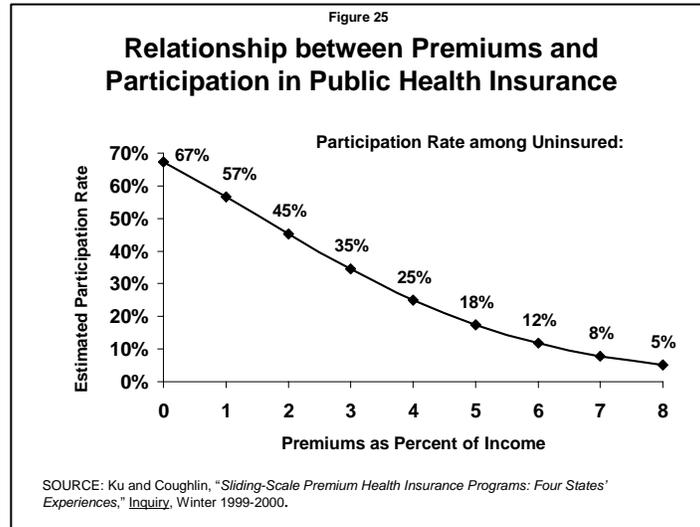


Premiums deter low-income individuals and families from participating in health insurance.

- Researchers have found a strong relationship between declines in affordability of health care – defined as the ratio of per capita health spending to median personal income – and increases in the uninsured rate among non-elderly workers.¹⁰

- An analysis of the decline in health insurance coverage among non-elderly Americans in the 1990s indicates that premium increases explain two percentage points of the 3.1 percentage point decline in coverage over the decade. The researchers suggest that the number of uninsured people could increase by 1.9 to 6.3 million in the decade ending 2010 if premiums rise at a rate of 1 to 3 percentage points per year, holding income and other variables constant.¹¹
- The Congressional Budget Office estimated that provisions of the Deficit Reduction Act of 2005 that authorize broader use of premiums in Medicaid would result in 45,000 enrollees losing coverage in 2010 and 65,000 losing coverage in 2015; about 60% of those losing coverage would be children.¹²
- A large body of research examining states' experiences shows that participation in Medicaid and SCHIP falls off sharply with premiums (and also in response to one-time fees charged for enrollment), and that even relatively low premiums led to significant coverage losses. State studies show that premiums most affect enrollment among those with the lowest income, but also lead to disenrollment among those with income above 150% of the poverty level.^{13 14 15 16 17 18 19 20 21}
- A seven-state study of the reasons eligible children lose or leave SCHIP found that almost 4 in 10 families whose children remained eligible for SCHIP but became disenrolled had problems paying their premiums. Families who paid more than \$20 per month in premiums were more likely to have trouble than those who paid less.²²
- When Oregon, under a recent Medicaid waiver, increased premiums for poor adults to \$6-\$20, established a lock-out period for non-payment of premiums, abolished premium waivers for extenuating circumstances, and introduced copayments, enrollment among those subject to premiums fell by nearly half, or roughly 50,000 people, in less than a year. Nearly one-third of surveyed disenrollees reported premium costs as a primary reason they lost coverage. In focus groups, disenrollees cited problems adhering to the strict payment policies as well as trouble affording the premium as primary factors leading to their loss of coverage.²³
- In July 2003, Maryland began charging premiums for about 6,400 children with income between 185% and 200% of the poverty level in its SCHIP program. In the first few months following the change, about 1,800 children – 28% of those subject to the premium – were disenrolled. A state survey of parents of disenrolled children showed that, in a majority of cases, the reason for disenrollment was that the children had obtained other insurance, but 1 in 5 parents cited a premium-related reason.²⁴

- A study examining the relationship between premium levels and participation in publicly subsidized health insurance programs found that, as the share of family income required for premiums rises from 1% to 3%, expected participation rates among the uninsured decrease from 57% to 35%. When premiums cost 5% of family income, expected participation is 18% (Fig. 25).²⁵



Strict or burdensome premium payment policies also affect participation adversely.

- Policies that result in termination of coverage when a family misses a premium payment or that impose a penalty period before the family can re-enroll can produce disruptions in the continuity of coverage.^{26 27}
- Penalty periods following missed premium payment, during which affected individuals are barred from enrolling in coverage, appear to have a significant impact on some of the most vulnerable families, such as those with the least income. An analysis of Georgia's three-month penalty period revealed that about 59% of children "locked out" of coverage came from families with income below 150% of the federal poverty level. A disproportionate number of the children subjected to the penalty period were African-American. There is evidence that disallowing hardship exceptions and other provisions for leniency also contributes to coverage losses.²⁸

While some people who are disenrolled from public insurance obtain other coverage, many become uninsured.

- Results from surveys conducted following premium increases in Oregon showed that 67% to 82% of those who left the rolls became uninsured. Over half of disenrollees in Rhode Island became uninsured after the state began charging premiums of around \$50 to those above 150% FPL, a higher-income group than in Oregon. And in Utah, survey results indicate that 63% of individuals disenrolled from the state's Medicaid waiver program became uninsured.^{29 30 31 32}

Losses of coverage contribute to increased emergency room use and increased pressures on safety-net health care providers.

- Some states that experienced coverage losses following the imposition of new or increased premiums for public insurance reported increased emergency room use by uninsured patients, increased pressure on clinics, and increased demand for charity care.^{33 34 35}

Premium payment policies impose administrative burdens and costs on states.

- Administering penalty periods following nonpayment of premiums has been shown to be costly. Michigan determined that the six-month penalty period it applied in its SCHIP plan, MICHild, was a drain on SCHIP resources and incompatible with the goal of reducing the number of uninsured children. The state found that nearly half its administrative reviews resulted from disputes related to the penalty period, and an estimate put the cost of such reviews at more than \$83,000 per year.³⁶
- In a June 28, 2005 hearing held by the Senate Special Committee on Aging, the Secretary of Human Services from New Mexico testified that, although the state legislature had directed the Department to seek federal authority to implement an annual enrollment fee in Medicaid, the costs of implementing such a fee were expected to roughly offset any savings from it.³⁷

Premiums may lead to savings for states, but the savings may accrue more from reduced enrollment than from increased revenues.

- Study findings that premiums lead to reduced enrollment suggest that states may realize savings from premiums but the savings may be due to not to increased premium revenues, but to enrollment declines.³⁸

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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 by insurance. 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. Nearly half of uninsured adults report having at least one chronic condition.

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 enrollees 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. That is, higher utilization in Medicaid is due to the lower health status of the Medicaid population. 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.

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.

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

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.

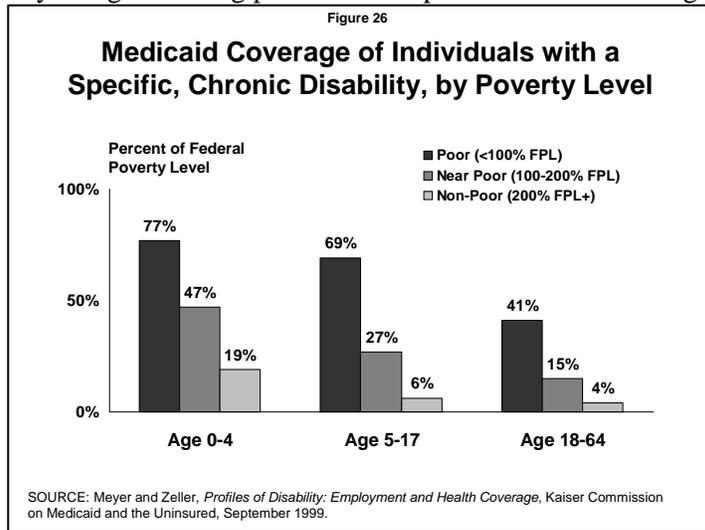
When fiscal realities constrain the capacity to expand coverage of the uninsured, offering a limited benefit package to previously uninsured individuals may result in important gains in access while laying a foundation for broader benefits when resources permit. However, reducing benefits for already-covered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

Key Evidence

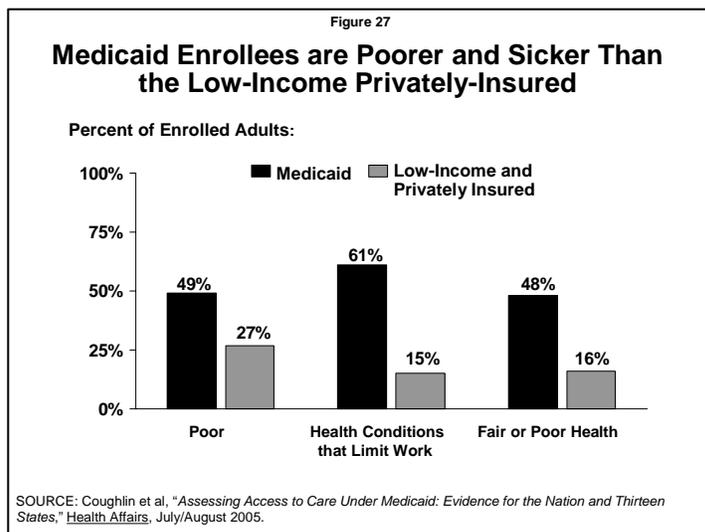
Low-income people are in worse health, have more health needs, and report more unmet need than others. People with disabilities tend to have lower income and greater medical needs than others. Many of the uninsured have chronic conditions.

- Low income is strongly correlated with poorer physical and mental health. Further, income has been shown to have a strong and significant relation to mortality; as income declines, mortality rates rise.^{1 2 3 4 5}

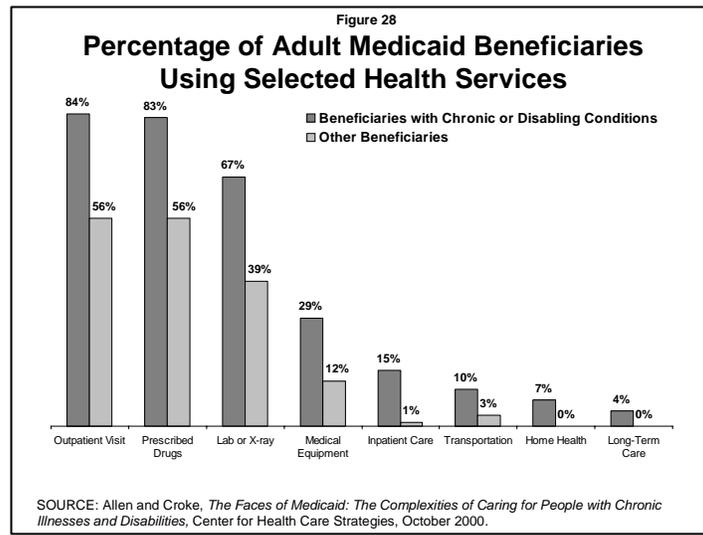
- The prevalence of major chronic illnesses (e.g., hypertension, asthma, diabetes, depressive symptoms) and physical disability is higher among poor and near-poor adults than among the non-poor, and much higher among working-age adults covered by Medicaid than among their privately insured counterparts. Disparities by income and insurance status also exist among children. Medicaid covers a large proportion of both children and working-age adults with disabilities who are poor, and it covers a substantial portion of children with disabilities who are near-poor (Fig. 26).^{6 7 8}



- Working-age adults enrolled in Medicaid are much poorer and more likely to have health problems than either low-income working adults with private coverage or uninsured adults. Almost half (49%) of adults enrolled in Medicaid are poor, compared with just over one-quarter (27%) of low-income adults with private insurance. Also, nearly half (48%) of Medicaid-enrolled working-age adults describe their health as fair or poor, while 16% of privately insured low-income adults do so. Over 60% of working-age adults with Medicaid report that they have health conditions that limit their work, compared with 15% of their low-income counterparts who are privately insured (Fig. 27).^{9 10}

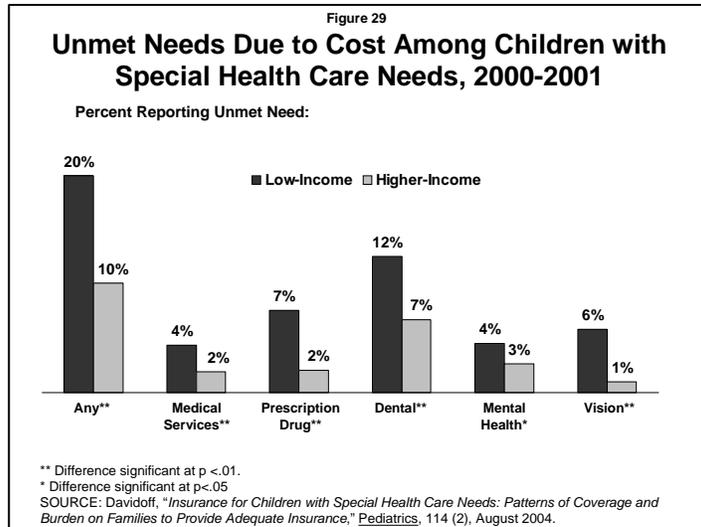


- Medicaid beneficiaries use a diverse array of health and long-term services (Fig. 28).^{11 12 13}



- Adults with mental and/or physical disabilities are lower-income and in much poorer health than the general non-elderly adult population. Among working-age adults, nearly 40% of those with disabilities have family income below 200% of the poverty level, compared with 22% of the non-disabled. The range of disabilities is extremely wide, including traumatic injuries, blindness, severe mental illness, developmental disabilities, HIV/AIDS, mental retardation, Down Syndrome, epilepsy, Parkinson’s Disease, and many other conditions.^{14 15}
- Close to half (45%) of uninsured adults report having at least one chronic condition.¹⁶
- People in fair or poor health are almost three times more likely than those in good or excellent health to report having an unmet need (11.9% versus 4.1%).¹⁷
- Children with special health care needs (CSHCN) use many more services than other children. A recent analysis found that they had about four times as many hospitalizations as other children, more than twice as many physician visits, and seven times as many visits to non-physician health professionals, including nurse practitioners, psychologists, physical therapists, and others. They used five times as many prescribed medications per year as other children.¹⁸

- Holding other factors constant, low-income CSHCN are much more likely than higher-income CSHCN to report having unmet needs. One study found that 20% of low-income CSHCN experienced some unmet need, compared with 9.9% of higher-income CSHCN (Fig. 29). Another study found that nearly 1 in every 3 poor CSHCN has unmet needs for one or more kinds of health care, including primary and specialty care, ancillary services, and supplies and equipment; over a quarter of near-poor CSHCN had unmet needs. CSHCN who are uninsured are more likely to face access problems and to report unmet medical, dental, prescription drug, vision, and mental health care needs than insured CSHCN. Underinsured CSHCN are disproportionately represented in low-income families and are significantly more likely than fully insured children to have unmet health needs. Their families are also more likely to report difficulty in obtaining a specialty referral and to experience financial problems.^{19 20 21 22 23 24}



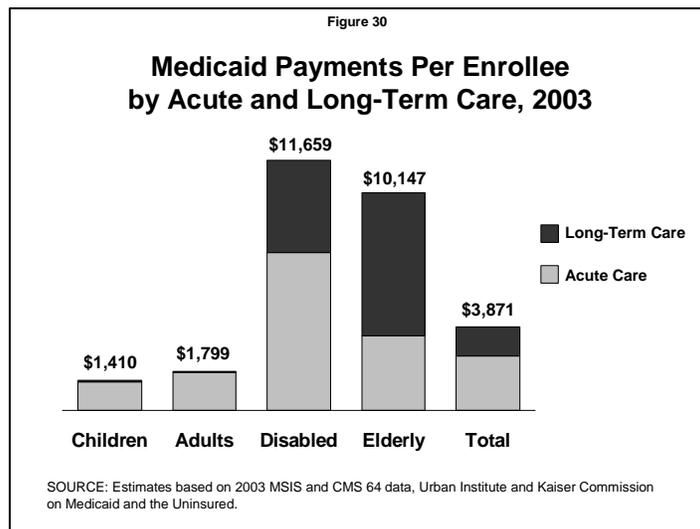
Most private health plans, as well as Medicare, do not cover the range of services needed by many low-income people.

- Private health insurance often excludes or limits coverage of several categories of care that are critical for many in the low-income population, including but not limited to people with disabilities. To illustrate, the Blue Cross/Blue Shield Standard PPO, the dominant insurer under the Federal Employees Health Benefits Program, provides no coverage of institutional care for people with mental retardation, home and community-based services, case management services, personal care services, or non-emergency transportation. The plan's coverage of many other benefits – including nursing home care, home health care, mental health care, dental and vision care, and physical, occupational, and speech therapy – is limited.^{25 26 27}
- A national survey of working-age adults with physical disabilities, mental disabilities, or both found that the privately insured were significantly more likely than those with Medicaid to report postponing care because of higher cost-sharing and more limited benefits. For the same reasons, the adults covered by Medicare only (i.e., no supplemental coverage) were more than 12 times as likely to have postponed care and more than seven times as likely to have skimped on medicine due to cost than the adults with Medicaid only.²⁸
- Among low-income children, those with private insurance but no dental benefits are as likely to report unmet dental needs as uninsured children. Children with dental coverage, whether public or private, are about half as likely to have unmet dental needs as privately insured children who do not have dental benefits, and they are significantly more likely to receive preventive dental care.^{29 30}

- While private health plans typically cover some services important to children with disabilities, such as mental health care, home health care, and physical, occupational, and speech therapy, these benefits are usually limited and designed for short-term rather than chronic care. A study of utilization by children with special health care needs found that, controlling for many demographic and health status variables, privately insured children had significantly lower odds than publicly insured children of using therapeutic services, social work services, non-medical care coordination, transportation, and housing modifications. Although the lower odds may reflect unmeasured differences between the two groups of children, the authors cite research indicating that the scope of benefits covered by private health insurance may not be adequate for children with special health care needs.^{31 32}
- Under private health insurance, coverage of mental health care, home health care, physical, occupational, and speech therapy, and other benefits may be conditional on a determination that the medical condition is expected to improve. This restriction may preclude children with disabilities from obtaining services important to preserving or maximizing their function.³³
- A study of the adequacy of private insurance for children with special health care needs found that the most commonly sold HMO and PPO products covered most basic medical services, and nearly all covered preventive care, immunizations, and behavioral health services. However, audiology, optometry, partial hospitalization for mental health/substance abuse, nutrition counseling, and medical supplies were not covered in at least 25% of the plans. Most plans limited mental health visits, and some excluded or limited coverage for certain mental disorders.^{34 35 36}
- The breadth of benefits appears to play a role in medical debt. A recent study examining medical debt and access to care among privately insured working-age adults found that medical debt is a common problem. In 2003, about 1 in 6 privately insured working-age adults had medical bills they described as being very difficult to pay and/or that had a major impact on their lives. Nearly a fifth of the adults with medical debt had income below \$20,000. While almost all the insured had prescription drug coverage, those with medical debt were less likely than the others to have dental, vision, maternity, mental health, and preventive care coverage. Insured adults with medical debt often skimped on their care much as adults who had no insurance at all did.³⁷
- Medicare, which covers the nation's elderly and non-elderly individuals with severe disabilities, includes very limited long-term care benefits and until recently, no outpatient prescription drug benefits. Disabled Medicare beneficiaries without supplemental coverage through a private source or Medicaid are significantly more likely than those with such "wrap-around" coverage to report having postponed care, gone without equipment or items, and skimped on medicine due to cost. As one measure of the magnitude of Medicare's gaps, Medicaid's share of total spending on "dual eligibles"—low-income Medicare beneficiaries who also qualify for Medicaid—is almost as large as Medicare's.^{38 39}

The scope of covered benefits affects low-income people’s ability to access needed care and their financial burdens. Limited Medicaid benefits have left individuals with significant unmet needs and reduced access to care.

- In a national survey of non-elderly adults with disabilities, close to one-third said that prescription drugs and dental care were a cause of serious cost problems for them. Close to half (46%) reported they went without needed items such as glasses and equipment due to cost, and 17% of those with a mental disability said that they had serious problems paying for mental health services.⁴⁰
- Following Massachusetts’ elimination of most dental coverage for adults in MassHealth, the state’s Medicaid program, 100,000 fewer MassHealth adult enrollees received dental services reimbursed by MassHealth than in the previous year. Both beneficiaries and providers reported an increase in untreated dental problems and a reduction in corrective and restorative treatments for MassHealth enrollees, and beneficiaries described living with pain, diminished self-esteem, and negative effects on employment and their families’ finances due to dental problems.⁴¹
- When Utah reduced Medicaid benefits for extremely poor adult beneficiaries to finance a primary care-only benefit for additional adults, both groups experienced access problems and financial hardship. A majority of both groups reported using or needing services that were not covered. The limited coverage or cost associated with services led one-third of the newly insured people to miss or postpone care, and over half reported difficulty paying for medical expenses. Among those with reduced benefits, nearly a quarter missed or postponed care, and over a third reported difficulty paying medical expenses. Likewise, studies in other states that have used waivers to limit Medicaid benefits have found that individuals have difficulty obtaining needed care due to the limits on benefits.^{42 43 44 45 46}
- Researchers studying the impact of Medicaid caps on the number of prescription drugs that can be covered have found that the use of clinically essential medications declines markedly, particularly for people with mental health problems or chronic pain. Exacerbations of chronic illness increase and the use of emergency services and admissions to nursing homes rise sharply.^{47 48 49 50}
- Medicaid per capita spending varies widely by eligibility subgroup. The much higher per capita costs associated with disabled and elderly enrollees reflects their much greater use of acute care, as well as their use of institutional long-term care and other long-term services and supports (Fig. 30).⁵¹



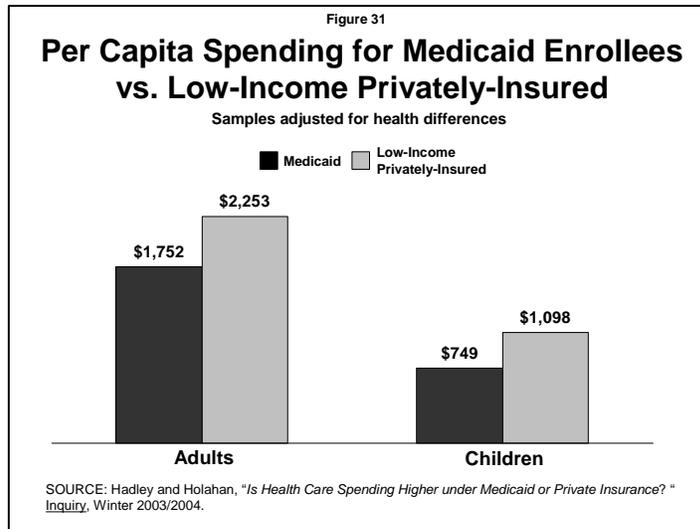
Medicaid benefits are comprehensive to address the diverse health and long-term care needs of its beneficiaries.

- Federal Medicaid law mandates a wide range of acute as well as long-term care benefits, and states can cover many other services at their option. Medicaid benefits span the spectrum of care needed by a low-income population with diverse health needs, including – in addition to the benefits typical of commercial insurance – many services for which private health coverage tends to be limited or excluded. These services include nursing home care, community-based long-term care, rehabilitation services, mental health and substance abuse services, dental and vision care, non-physician practitioner services, and medical equipment and supplies.^{52 53}
- Medicaid’s Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit requires states to cover all federally authorized Medicaid benefits for children under age 21, including benefits that, for adult beneficiaries, states cover on an optional basis. Congress designed EPSDT to be comprehensive, encompassing early intervention services to identify the needs of children at elevated risk, as well as the full range of acute and long-term care services and case management services often needed by children with chronic conditions and disabilities. Research provides evidence that EPSDT has provided for preventive and well-child care and treatment of illness and disability for low-income children who would have gone without it in the absence of this Medicaid benefit.^{54 55 56 57 58}
- For children in Medicaid, the expectation that a service will lead to improved function is not a criterion for coverage of the service; Medicaid also covers services on the basis that they enable children to maintain their existing level of function.⁵⁹
- Medicaid is the nation’s main source of coverage for people in nursing homes and individuals in intermediate care facilities for individuals with mental retardation (ICF/MR). Coverage of institutional care by other insurers is very limited.⁶⁰
- Medicaid supplements Medicare for almost 7.5 million low-income Medicare beneficiaries, including more than 5 million seniors and 2 million individuals with disabilities. Medicaid fills key gaps in Medicare benefits for these “dual eligibles,” particularly for nursing home care, and it also subsidizes their Medicare premiums and out-of-pocket costs.⁶¹

Although Medicaid benefits are comprehensive, Medicaid-covered adults are no more likely to use a service than comparable low-income adults with private coverage. Medicaid-covered children are more likely than privately insured low-income children to use services.

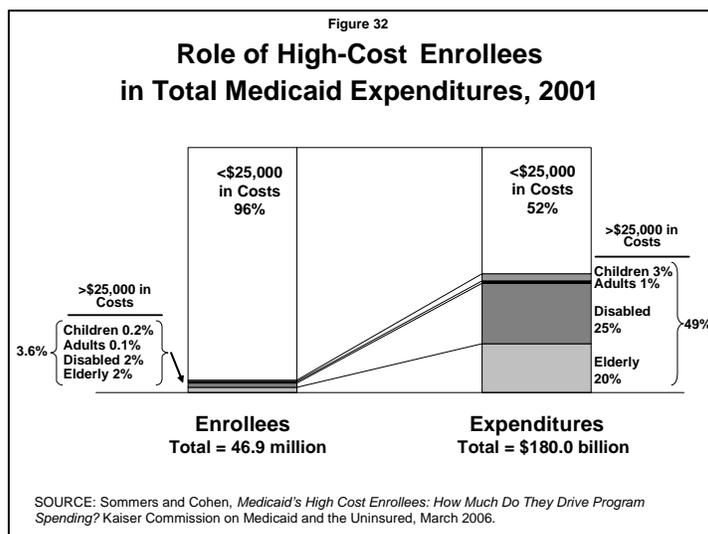
- When the greater poverty, worse health, and higher prevalence of disability in the Medicaid population are taken into account, adults in Medicaid are no more likely to use doctor visits, hospital days, and other broad categories of service than low-income adults with private insurance. Though their per capita spending is lower than that for low-income children with private insurance, children in Medicaid are more likely than their privately insured peers to use a service, perhaps due to the program's emphasis on assuring care for children.⁶²

- Dental and other optional services, often associated with controversy about the breadth of the Medicaid benefit package, have been found to account for a small proportion of Medicaid per capita spending – generally less than 15%. These services account for a significantly larger proportion of per capita spending for the low-income population with private insurance.⁶³



- Medicaid per capita spending is low relative to per capita spending among the low-income privately insured, once health status differences between the two groups are adjusted. This finding holds for both adults and children (Fig. 31).⁶⁴

- A small share of Medicaid beneficiaries account for a large share of Medicaid expenditures (Fig. 32). In federal fiscal year 2001, nearly half of Medicaid spending was attributable to the 3.6% of Medicaid beneficiaries whose spending exceeding \$25,000 in that year. Those with spending under \$5,000 represented more than 85% of Medicaid enrollees but accounted for only 23% of all spending. More than half of all enrollees had spending of less than \$1,000 in 2001, including more than 1 in 10 Medicaid enrollees who had zero spending.⁶⁵



The content of Medicaid benefits for adults varies widely from state to state.

- Because of broad state discretion – both to determine which optional services to cover and to place limits on the amount, duration, and scope of all services – the content of Medicaid benefits for adults depends on where they live. To illustrate, although inpatient hospital care is a mandatory service, many states cap the number of inpatient days allowed for adults. Similarly, while all states have elected the option to cover prescription drugs, adults in some states face sharp limits on the number of prescriptions Medicaid will cover (e.g., three or four per month). Dental coverage for adults tends to be extremely limited in all states that cover it, and, in six states, adults have no dental coverage at all.^{66 67}

Medicaid provides a range of institutional and community-based long-term services, and it has focused increasingly on improving the integration of beneficiaries with long-term care needs in the community.

- Because of the diverse array of services needed by people with disabilities, Medicaid covers a comprehensive package of services, including rehabilitation, habilitation, mental health, and other long-term services. These services, not commonly offered by private insurance, assist people with disabilities in maximizing their independence, living in the community, and working.⁶⁸
- Federal law requires all state Medicaid programs to cover institutional services but they are generally not required to provide home and community-based services. Most states have used the flexibility allowed under law to provide community-based care. However, since states most often provide home and community-based long-term care services as optional benefits or through waivers, funding and eligibility have been limited. Despite substantial growth in home and community-based care, many states have waiting lists for services.⁶⁹

States have adopted strategies in their Medicaid programs to foster appropriate utilization of services.

- Federal law stipulates that Medicaid benefits are covered subject to “medical necessity.” The law defines the medical necessity standard applied to EPSDT, but states have discretion in defining medical necessity otherwise. Within broad federal guidelines, states also determine the amount and duration of services offered under their Medicaid programs. States may place appropriate limits on a Medicaid service based on such criteria as medical necessity or utilization control. For example, states may place a reasonable limit on the number of covered physician visits or may require prior authorization to be obtained prior to service delivery.^{70 71}
- While evidence on the impacts of managed care arrangements on access for the low-income population is mixed, numerous studies have found that Medicaid managed care is associated with a variety of improvements in utilization and outcomes, including increased use of preventive and primary care, lower unmet need, lower emergency department use, and reduced preventable hospitalizations. More targeted strategies, such as disease management, also appear to offer potential to promote more appropriate utilization of services by the low-income population.^{72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89}
- States can and do use a variety of tools to manage utilization of prescription drugs in Medicaid. A 2005 survey of state Medicaid prescription drug policies found that nearly all of

the 37 responding programs impose limits on the quantity of a drug that can be dispensed per prescription. When dispensing limits are hit, most programs subject beneficiaries to some form of prior authorization, rather than deny them drugs that may be medically necessary. More than two-thirds of the programs operate preferred drug lists (PDL). States are relying increasingly on prior authorization to control use of brand-name drugs.⁹⁰

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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.

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. Research has not substantiated concerns that low or no cost-sharing might lead to over-utilization.

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. 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.

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 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.

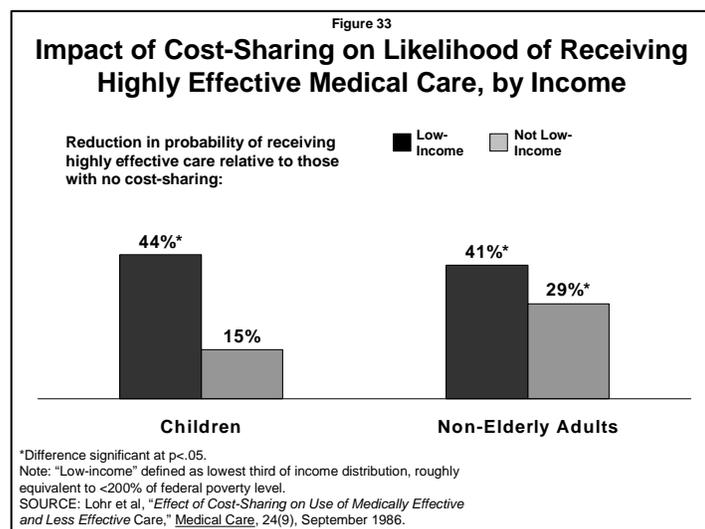
Key Evidence

Medical bill problems impede access to health care.

- A 2003 national survey found that 1 in 6 privately insured adults – 17.6 million adults – were continuously insured but reported substantial problems paying their medical bills. The survey results indicate that after adjusting for social, economic, and health factors, the privately insured with medical debt limit their care in many of the same ways and as often as those who have no health insurance. A quarter or more of respondents in both groups reported that they skipped a test or treatment, did not fill a prescription cost, and/or postponed care due to cost.¹
- People in families with problems paying medical bills are five times more likely to report an unmet medical need in the past year and four times more likely to report delaying care in the past year due to cost concerns, compared with people in families with no medical bill problems. Also, 30% of individuals in families with bill problems report that they did not get prescription drugs because of cost, compared with 7% of those in families without bill problems.²
- An analysis of out-of-pocket expenses and unmet need related to obtaining prescription drugs found that families who spent more than 5% of their income on out-of-pocket costs for prescription drugs were more than twice as likely to report an unmet need for prescription drugs as families who spent 5% or less of their income on such costs (15.4% versus 6.3%).³
- The Congressional Budget Office estimated that provisions of the Deficit Reduction Act of 2005 that permit states broader use of premiums and cost-sharing in Medicaid and authorize higher cost-sharing would result in reduced Medicaid spending of \$1.9 billion over five years and \$9.9 billion over ten years. CBO attributed about 70% of the savings to increased cost-sharing, and estimated that about 80% of the savings from higher cost-sharing would come from decreased use of services.⁴

Cost-sharing can reduce the use of appropriate care and contribute to worse health outcomes in the low-income population.

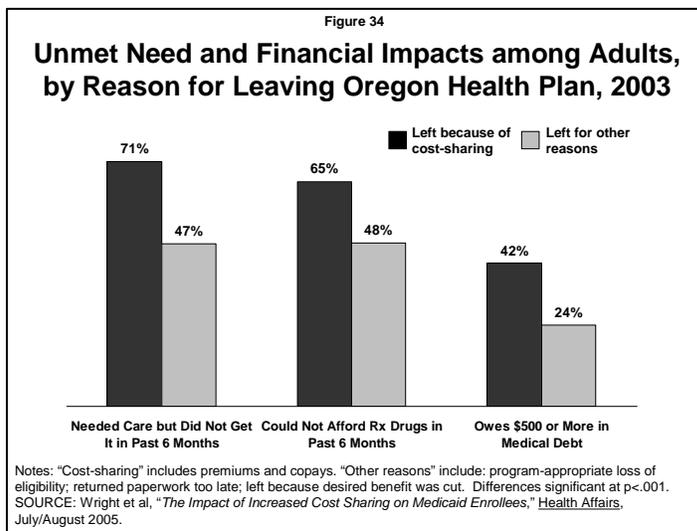
- The RAND Health Insurance Experiment (HIE) investigated the impact of cost-sharing on utilization and health outcomes. It found that both children and adults in cost-sharing plans had reduced use of highly effective care compared with those in plans with no cost-sharing (Fig. 33), and the effect of cost-sharing was stronger in the low-income groups. Among people who were poor and sick, those in plans with cost-sharing had reduced use of all types of



health services studied compared with those in the free-care plan. The reduced utilization adversely affected health outcomes in this population. In particular, the poor with hypertension had their blood pressure lowered more on the free-care plan than on the cost-sharing plans, and the impact on predicted mortality rates – a drop of about 10% – was substantial for the free-care group. More broadly, serious symptoms were less prevalent on the free plan than on the cost-sharing plans, especially for those who began the Experiment poor and with serious symptoms. There also appeared to be a beneficial effect on anemia for poor children in the free-care plan.^{5 6 7 8 9 10}

- Researchers have found that the use of prescription drugs is sensitive to price in general, but also specifically in low-income groups. A study of the impact of a new cost-sharing requirement on prescription drugs in Quebec found that the use of essential, as well as less essential, drugs declined substantially among welfare recipients and the low-income elderly in response to the cost-sharing. The rate of serious adverse events (hospitalization, long-term care admission, or death) and emergency department visits associated with reduced use of essential drugs also rose.^{11 12 13 14}

- Studies examining the impact of copayments have found that they reduce access to and use of prescription drugs and other ambulatory care among Medicaid beneficiaries and other poor populations. A survey of adults conducted after the Oregon Medicaid program increased premiums and introduced copayments showed that 44% of those who left the rolls disenrolled for cost sharing-related reasons. Those who left for cost sharing-related reasons were significantly more likely than those who left for other reasons not to have received needed care in the past six months, to have skipped buying prescription drugs because of cost, and to owe \$500 or more in medical debt (Fig. 34).^{15 16 17 18 19 20}

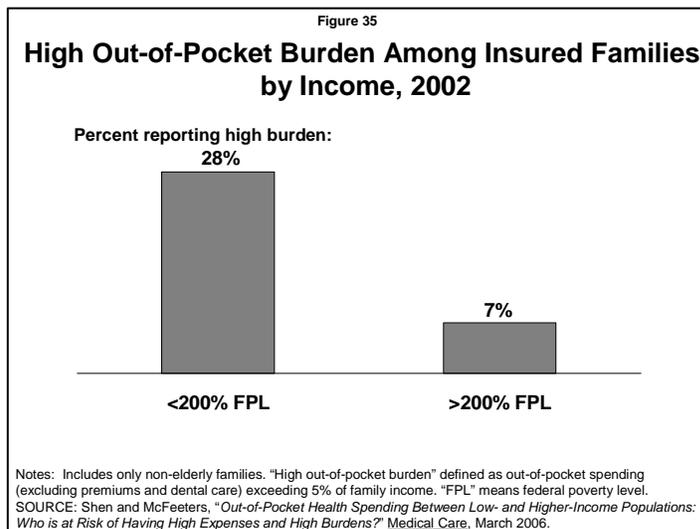


- A review of study findings from states that have recently increased or imposed new cost-sharing requirements in their Medicaid, SCHIP, or other public coverage programs found that cost-sharing led to unmet medical need and financial stress among some beneficiaries, even when amounts were nominal or modest.²¹
- A study of the impact of Medicaid copayments shows that elderly and disabled Medicaid beneficiaries living in states with copayment requirements have significantly lower rates of drug use than their counterparts in states without copayments. The primary effect of copayments – to reduce the likelihood that Medicaid beneficiaries fill any prescriptions during the year – burdens those in poor health disproportionately.²²
- A growing body of studies provide additional evidence that cost-sharing reduces low-income people's use of appropriate care and adversely affects their health outcomes.^{23 24 25 26}

- Nearly all of the 22 studies included in a 2004 review of the research literature found that, among seniors, cost-sharing reduces either the appropriate use of services or health status, or both. In one of the studies that did not find this result, generous provisions were in place to protect vulnerable populations from incurring undue financial risk as a result of cost-sharing.²⁷
- A review of study findings from states that have recently increased or imposed new cost-sharing requirements in their Medicaid, SCHIP, or other public coverage programs found that cost-sharing led to unmet medical need and financial stress among some beneficiaries, even when amounts were nominal or modest.²⁸

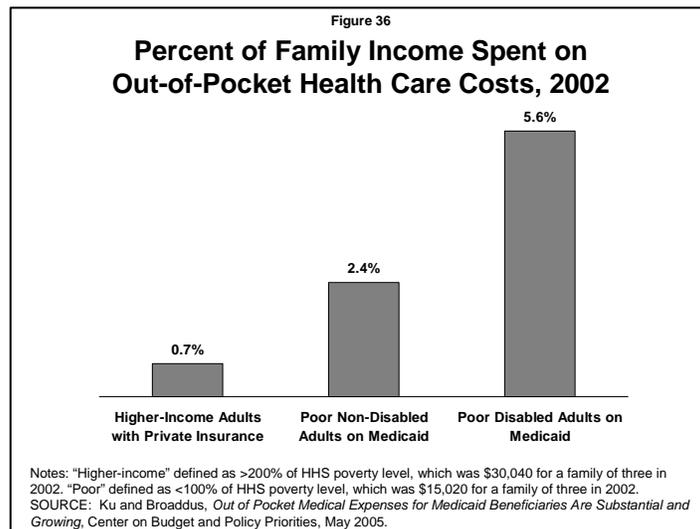
Cost-sharing and out-of-pocket costs for care that is not covered place a disproportionately heavy financial load on low-income people.

- Low-income people are more likely than others to face out-of-pocket health care costs that exceed 5% of their family income. Findings from a 2003 household survey indicate that about 1 in 5 low-income families have problems paying their medical bills. Among those at or above 400% of the poverty level, fewer than 1 in 10 families report this difficulty. About half of all families with medical bill problems are low-income. Other research provides evidence that, among the insured, 28% of low-income families incur out-of-pocket costs (exclusive of premiums and dental care) exceeding 5% of family income, compared with 7% of families with higher income (Fig. 35).^{29 30}



- Analysis shows that the share of family income spent on medical expenses rises as income falls. In 2001, poor families with children spent \$75.25 out-of-pocket (excluding premiums) per \$1,000 of income, compared to \$15.55 per \$1,000 of income paid by families with income above 400% of the federal poverty level. The regressive nature of cost-sharing is also apparent in the distribution of high out-of-pocket burden. Research indicates more than one-quarter of families below poverty have total out-of-pocket spending (including premiums) that exceeds 10% of their family income – compared with 6.3% of families with income over 400% of the poverty level who have out-of-pocket spending at this level.^{31 32}
- An analysis of out-of-pocket spending by the insured population shows that the median share of income devoted to health care costs (not including premiums) is 4% for poor non-elderly families insured throughout the year, compared with 1% for non-elderly insured families at or above twice the poverty level. The extremely large difference between the two groups in their average out-of-pocket burden – 18% versus 2% – reveals that some poor families bear a much larger out-of-pocket burden.³³

- Low-income individuals and families facing out-of-pocket expenses have very little remaining income to meet other needs. One study found that, among working-age adults with chronic conditions whose families had problems paying medical bills in the past year, 68% had problems paying for other necessities, such as food and shelter, 64% were contacted by a collection agency, 55% put off major purchases, and 50% had to borrow money. Nine in 10 families experienced at least one of these impacts and almost one-quarter experienced all four.^{34 35}
- A study of children with special health care needs found that, in 2000, the children under 200% of the poverty level were 11 times more likely to have out-of-pocket costs exceeding 5% of family income than the children at or above 400% of the poverty level.³⁶
- In a 2003 survey, 1 in every 5 low-income families reported they had trouble paying medical bills, compared with fewer than 1 in 10 families with income of at least 400% of the poverty level.³⁷
- In 2002, poor working-age, non-disabled adults in Medicaid spent an average of \$210 for out-of-pocket health costs (including deductibles, copayments, coinsurance, and expenses for non-covered care) – much less than the \$548 spent by privately insured adults with income at or above 200% of the poverty level. However, because the Medicaid adults' average income was about one-ninth that of the comparison adults (\$8,846 versus \$80,325), their out-of-pocket costs consumed a substantially larger share of their income: 2.4% versus 0.7%. Poor disabled adults in Medicaid spent an average of 5.6% of their income on out-of-pocket medical costs (Fig. 36).^{38 39}



Out-of-pocket costs place a heavier financial burden on individuals with extensive needs for health care, and the burden is heaviest of all for those with both greater health needs and low income.

- Compared with others, people living with chronic conditions are more likely to spend a greater share of their income on out-of-pocket medical costs. While 12% of all non-elderly adults in 2003 had family out-of-pocket costs exceeding 5% of family income, 19% of those with chronic conditions faced this level of out-of-pocket costs. Chronically ill adults with low-income were hardest-hit: 38% of such adults had out-of-pocket health costs exceeding 5% of family income, compared with 8% of chronically ill adults with income above 400% of the poverty level.⁴⁰

- Some 14% of all U.S. families report problems paying their medical bills, but among families with a member in fair or poor health, one-quarter report medical bill problems. Compared with their counterparts without medical debt, privately insured non-elderly adults with medical debt are twice as likely to report their health status as only fair or poor (21% versus 9%).^{41 42}
- An analysis based on 2000-2002 data from the Medical Expenditure Panel Survey found that among high-cost (i.e., in top 20th percentile of health spending) low-income non-elderly adults, even those with public coverage carry significant out-of-pocket burdens, averaging more than 12% of family income. Also, nearly one-quarter of low-income families with at least one family member in fair or poor health reported going without needed care for financial reasons, twice the proportion associated with families in which no one is in fair or poor health.⁴³
- Between 2000 and 2003, the proportion of low-income, privately insured, chronically ill people with out-of-pocket costs exceeding 5% of family income rose from 28% to 42%. This 50% increase likely reflects the impact of increased cost-sharing for insured people, as well as health care cost inflation that outpaced increases in income.⁴⁴
- In 2000, average out-of-pocket expenses for special-needs children were twice those for other children. Out-of-pocket expenses were also highly skewed, with more than half of all out-of-pocket spending for special-needs children attributable to the children with expenses in the top decile.⁴⁵

Research findings on Medicaid beneficiaries and the low-income population have not substantiated concerns that no or low cost-sharing contributes to overuse of health care.

- Medicaid beneficiaries use about the same amount of services as the low-income privately insured population, once health status differences between the two populations are controlled.^{46 47}
- Low-income people are about twice as likely to report an unmet need as higher-income people. Among those with access problems, cost is the most frequently cited barrier to getting needed care.⁴⁸
- Studies probing the causes of higher use of emergency departments by Medicaid beneficiaries compared with the privately insured population have concluded that frequent emergency department use is associated with chronic illness and high use of health care in general, and that systemic inadequacies in health care access (e.g., lack of equipment for asthma care, limited office hours, waiting time to be seen by a physician) are key contributing factors.^{49 50 51 52 53 54}

Cost-sharing may expose providers to financial losses.

- Citing Medicaid's prohibition against refusing care based on a beneficiary's nonpayment of cost-sharing, some providers have characterized unpaid cost-sharing as an indirect reduction in Medicaid reimbursement. Concerns about the impact of cost-sharing on providers as well as on access to care have emerged in state policy deliberations. Some have expressed concern that cost-sharing will eventually lead to legislated reductions in provider payment, increased levels of state audits, and administrative complexity.^{55 56}

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- A study of the impact of Medicaid drug copayments found that Medicaid recipients in the states that impose copays reported paying nothing for one-third of their prescriptions fills (compared with three-quarters in the states with no copays). In virtually every case, Medicaid was listed as the sole payment source. This means that pharmacies in copay states failed to collect anything from patients for one of every three Medicaid prescriptions dispensed.⁵⁷

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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 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.

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. Other studies have produced mixed findings concerning an association between Medicaid fee levels 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.

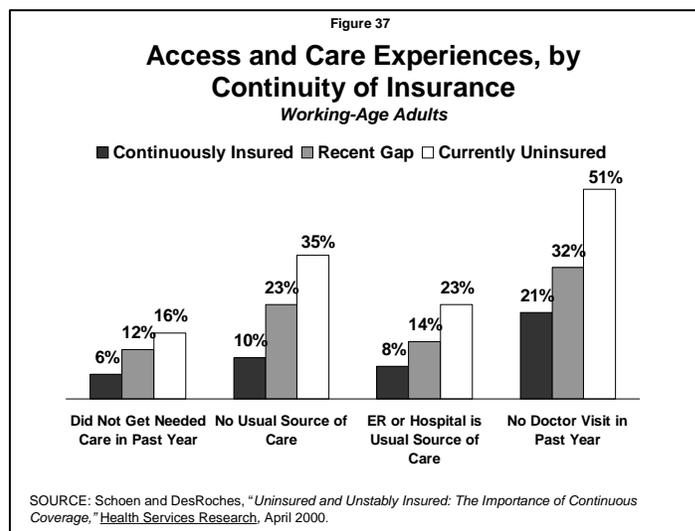
A further goal of access to care is the receipt of high-quality care. As the science of quality measurement and improvement evolves and new uses of quality information emerge, research is highlighting distinctive issues that arise in the context of the low-income population.

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 Americans.

Key Evidence

Cycling on and off public coverage is problematic because instability in health coverage reduces individuals' access to care.

- Studies show that many low-income individuals and families cycle on and off the Medicaid and State Children's Health Insurance Program (SCHIP) rolls and experience spells without insurance. Burdensome application requirements, premiums, short eligibility periods, low provider reimbursement, and lack of provider contact have been linked to this instability in public coverage.^{1 2 3 4 5}
- Relative to stable coverage, cycling on and off coverage has been found to lead to poorer access to and use of care, poorer management of chronic conditions, increased hospitalizations, and, ultimately, poorer health outcomes. Data from three different surveys analyzed in one study indicate higher rates of access problems, less connection with regular sources of care, and more medical cost problems among adults who had recent lapses in coverage relative to adults with continuous insurance. The insured adults with a recent lapse in insurance reported these problems at rates approaching the levels found among currently uninsured adults (Fig. 37).^{6 7 8 9 10 11 12 13 14 15 16}



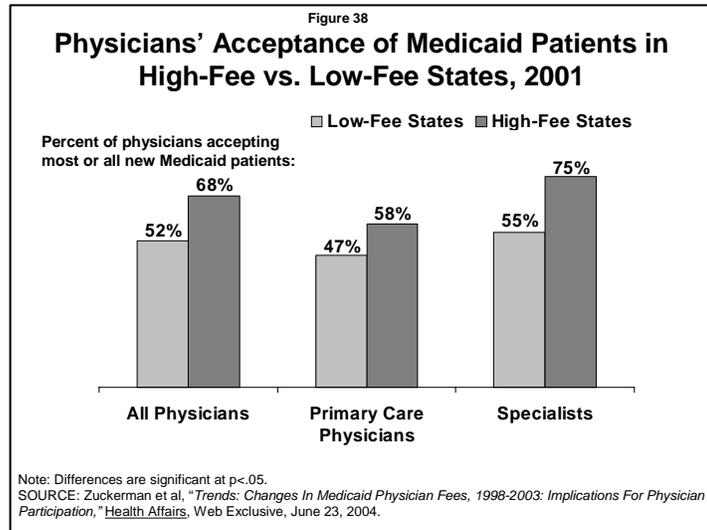
- The National Committee on Quality Assurance has a one-year standard for quality monitoring of health plans. The reasoning is that health plans need at least a year to affect performance, and thus should not be held accountable for levels of services to those enrolled for less than a year. Research examining the business case for provider investments in quality improvements has pointed out the challenges in aligning financial incentives properly in a fragmented health system in which the patient moves among different providers, employers, and payers.^{17 18 19}

Inadequate participation of providers and plans can hinder appropriate access to care. Acceptable payment rates appear necessary but perhaps not sufficient to garner adequate provider participation.

- High Medicaid acceptance rates by physicians in a community have been shown to be an important factor affecting access to care for Medicaid enrollees. An analysis that modeled the impact of the supply of physicians accepting Medicaid on beneficiary access to care found a significant association between higher predicted participation rates and a higher probability of having a usual source of care, a lower probability of having unmet medical needs, and a higher probability of being satisfied with the choice of specialists. Another study related the low use of oral health services in the low-income population to the

inadequate supply of dentists willing to treat them. Other research found that increased Medicaid reimbursement led to significantly less drop-out of eligible children from Medicaid, ostensibly due to wider access to care for enrollees and more incentive for providers to keep patients enrolled.^{20 21}

- Provider surveys point to low payment and excessive paperwork and administrative burdens as leading reasons for provider unwillingness to serve Medicaid patients. The evidence from other research is mixed on the question of whether higher Medicaid payment levels lead to higher provider participation rates and beneficiary access (Fig. 38). Several studies suggest that other provider practice, health system, and community characteristics also affect provider participation.^{22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37}



- Provider participation in Medicaid is particularly limited among dentists and in some specialties. Physicians report more difficulty making specialty referrals for their Medicaid patients than for their patients with private insurance or Medicare.^{38 39 40}
- A recent study evaluated the impact that reforms to South Carolina's Medicaid Dental program had on the number of children receiving dental services through the program. In 2000, the state increased reimbursement rates for dentists, streamlined Medicaid billing procedures, and worked with community partners to recruit dentists to the program and encourage compliance among patients with appointments and treatments. As a result of the reforms, there was a statistically significant increase in the monthly number of children receiving dental services through Medicaid.⁴¹
- Although EPSDT requirements entitle children to the full range of Medicaid benefits permitted under federal law, research indicates that low provider payment rates, provider shortages, inadequate screening of children, poor data reporting, patient care-seeking behavior, and other factors have kept EPSDT from accomplishing its full potential to secure access to care for low-income children.^{42 43 44 45}
- Numerous studies on the use of emergency departments (EDs) suggest that, independent of insurance coverage, inadequate access to primary care is associated with higher rates of ED use overall and for non-urgent care. Findings from a site visit study in 12 nationally representative communities in 2005 are illustrative. Respondents reported that the use of EDs for primary care has intensified recently, a fact many attributed to inadequate access to primary care, especially for Medicaid enrollees and the uninsured. They cited increasing unwillingness among primary care physicians to accept more patients, and some respondents reported that primary care physicians routinely refer Medicaid and uninsured patients to EDs for non-urgent care. Frustrated with trying to secure specialty care for low-income patients,

some primary care physicians refer patients to the ED in the hope that they will gain access to specialty care.^{46 47 48 49 50 51 52}

Managed care and other organized care delivery systems have had mixed results in improving access and coordination of care for low-income populations. Approaches designed for the general population may need to be refined for the low-income population.

- Research on the relationship between managed care arrangements and health care access in the low-income population and in Medicaid has produced mixed evidence. Some studies find improved access to and use of preventive and primary care, higher satisfaction, lower unmet need, lower emergency department use, and reduced preventable hospitalizations associated with managed care. However, others indicate increased unmet need and reduced utilization and still others show no consistent effect of managed care on access.^{53 54 55 56 57 58 59 60 61 62 63 64 65 66}
- Studies have provided evidence that disease management initiatives can improve chronic disease management among low-income people and improve health outcomes. Researchers found that Virginia Medicaid patients whose doctors received instruction on recommended asthma care and drugs, training in patient communication, and lists identifying patients needing follow-up had reduced emergency visits and better use of some asthma drugs. Community-level gains occurred as well, relative to communities where the training was not offered. Other research found that outcomes improved for a largely low-income diabetic population served by health centers participating in a diabetes management program.^{67 68}
- Studies of Medicaid disease management programs in several states indicate that these programs have promise but have yet to be rigorously evaluated. Unique characteristics of the Medicaid population and program appear to pose special challenges. In particular, instability in Medicaid enrollment and provider turnover mitigate the potential impact of the initiatives. In addition, limited medical history data and data lags in Medicaid hinder timely identification of high-risk beneficiaries. Regarding management of chronic mental health and substance abuse disorders, the difficulty of coordinating between the Medicaid agency and multiple other state and community agencies with different priorities, constituencies, and funding has been noted. Provider resistance and concerns that disease management may reduce Medicaid beneficiaries' access to providers have also been cited.^{69 70 71 72}

A constellation of issues distinct from health insurance coverage, including transportation, child care, and time off from work, as well as minority race/ethnicity, health literacy, and cultural competence of health care providers, may present obstacles to health care access for low-income Americans. Addressing these barriers can improve access for this population.

- Medicaid enrollees have cited convenience of location and waiting time for both routine and urgent care as important considerations in their choice of health plans. While they indicate strong feelings about other aspects of care, they often report their choice of plans being constrained by their transportation needs. In a survey on access to prenatal care among low-income and uninsured women who deliver at safety-net hospitals, transportation and lack of insurance were the most commonly cited obstacles to timely and adequate prenatal care.^{73 74}
- A study comparing the impact of three different health insurance models on improving health care access for low-income children found that one of several key factors associated with the most successful model was the availability of after-hours care in settings other than the emergency room.⁷⁵

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- In a model controlling for Medicaid status and numerous other factors, children living below or near the poverty level were at significantly greater risk of going without needed services than those with more income, a research finding that may suggest the presence of non-financial barriers, such as transportation barriers and limited control over work hours. Other research has documented the role of waiting time for appointments, lack of transportation, lack of childcare for siblings, low levels of parental education, lack of parental knowledge about prevention and health care needs, and other non-financial barriers in impeding access to care.^{76 77 78 79 80}
 - The Institute of Medicine has found that understanding and use of health information are lower among certain populations, including the elderly, those with less education, the poor, minorities, and groups with limited English proficiency such as recent immigrants. Adults with limited health literacy have less knowledge of disease management and of health-promoting behaviors, report poorer health status, and are less likely to use preventive services.⁸¹
 - Ethnic minorities, especially Hispanics and Asians, report less satisfaction with their care, more difficulty getting appointments, less satisfaction with their physicians' listening skills and explanations, and less trust in their doctors. Language has been documented as an additional barrier.^{82 83 84 85 86}
 - Some health services research uses “preventable hospitalization” – hospitalization for a condition that can be managed effectively on an outpatient basis – as a proxy measure for inadequate access to primary care. Studies showing that racial/ethnic and socioeconomic disparities in preventable hospitalization rates persist even when insurance differences are controlled suggest that the mechanisms of access have not been fully explained.^{87 88 89}
 - Inadequate health literacy, language barriers, and poor cultural competence are strongly correlated with poorer knowledge and self-care among people with various chronic diseases. Research on disease management, which often emphasizes improved self-care, suggests that patient education materials need to address lower health literacy, language barriers, and racial and ethnic diversity in the Medicaid population.^{90 91 92 93 94 95}
 - A study of strategies to improve asthma care for children in Medicaid managed care found that patients of the practice sites with the highest cultural competence scores were more likely to use preventive asthma medications, had better control of their asthma at follow-up, and had better parent ratings of care. Asthma patients in practice sites that had policies to promote access and continuity of care (e.g., 24/7 telephone advice, promoted preventive asthma visits, better follow-up care) also had better outcomes than patients in other sites.⁹⁶

Those with worse health status are at higher risk of having access problems.

- People who report fair or poor health are almost three times as likely not to get needed care as people who report their health as good or excellent – 13% versus 4.6% in 2001. People with health problems are also more likely to delay care than healthier people. Greater difficulty getting care among those in worse health reflects, in large part, their greater need for care and more frequent opportunities to encounter problems with the health care system.⁹⁷

Efforts to improve quality and market strategies that rely on quality information may face distinctive challenges with respect to the low-income population.

- Efforts to improve quality in Medicaid managed care face an array of challenges not present in the private insurance sector. These include turnover in health plans and enrollment, the high prevalence of special health care needs, gaps in knowledge about which activities and structures improve the health of beneficiaries, and the need for a commitment of sufficient public dollars for quality monitoring and improvement.⁹⁸
- There is some evidence that public reporting of health care quality information has a positive impact on quality improvement, but public reporting has also prompted concerns related to disadvantaged populations. For example, a study that found low comprehension of quality indicators across privately insured, Medicaid-covered, and uninsured consumers nonetheless found that the privately insured had a significant advantage in their grasp of concepts key to using quality information for decision-making. Also, some have cautioned that public reporting of quality information that does not adjust well for health differences might lead providers to avoid higher-risk patients, many of whom are concentrated in the low-income population.^{99 100 101}

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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.

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. 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, as can be seen in SCHIP. The allocation of federal SCHIP 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.

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.

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. 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. The federal government also possesses broad borrowing authority that the states do not. And while the states are required to balance their budgets, the federal government can deficit spend.

Because of the constrained and highly variable fiscal capacity of 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.

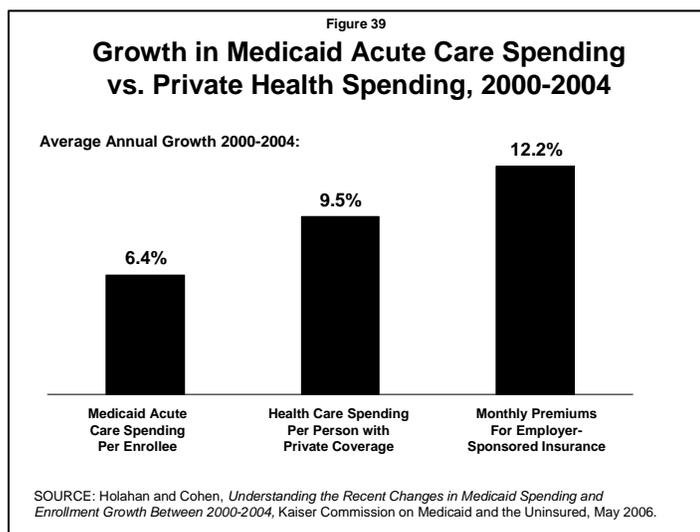
Financing that is determined by enrollment and utilization directs public dollars most efficiently to meet health coverage and care needs. Evidence from public programs whose financing is capped and allocated by formula shows that accurately matching funds to needs is difficult and that funding levels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

Key Evidence

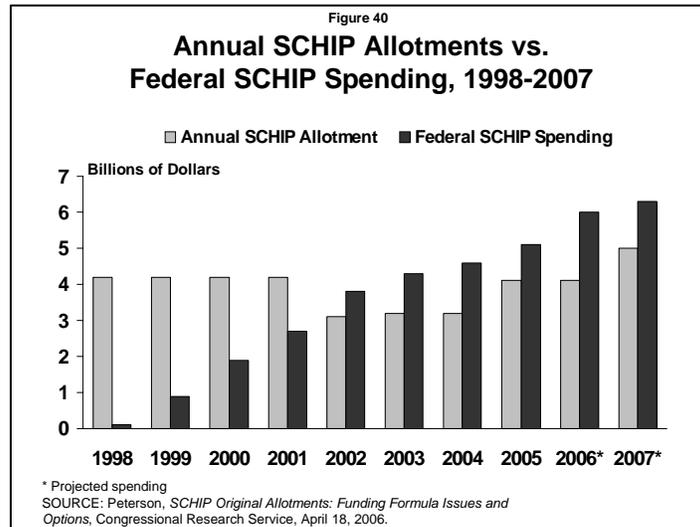
Financing that is based on actual enrollment and use of services has enabled Medicaid to respond to changing needs for coverage and care.

- In the recent economic downturn, Medicaid enrollment expanded to cover millions of low-income Americans who would otherwise have become uninsured.¹
- As-needed financing has allowed Medicaid to respond promptly in a rapidly evolving public health and clinical care environment. For example, the guarantee of federal matching funds has helped states to cover thousands of low-income Americans affected by the HIV/AIDS pandemic and to ensure them access to new life-saving drugs and therapies as they emerge.²
- Between 2000 and 2004, Medicaid and the State Children's Health Insurance Program (SCHIP) extended coverage to millions of people affected by increasing unemployment and poverty rates and the erosion of employer-based coverage. Medicaid more than offset the losses of job-based coverage among children in this period, and without Medicaid, the increase of some 6 million uninsured adults would have been even larger.³
- The availability of federal matching funds as needed has enabled state Medicaid programs to respond to unanticipated emergencies, such as the terrorist attacks of September 11, 2001, by covering many thousands affected by the disaster.⁴
- While per capita health spending has been increasing across the board, Medicaid per capita spending has been rising more slowly than per capita spending among those with private insurance (Fig. 39).⁵



SCHIP's capped funding has allowed the federal government to limit its outlays and given states leverage to control their program spending, but inadequate and mistargeted funds have limited the program's impact.

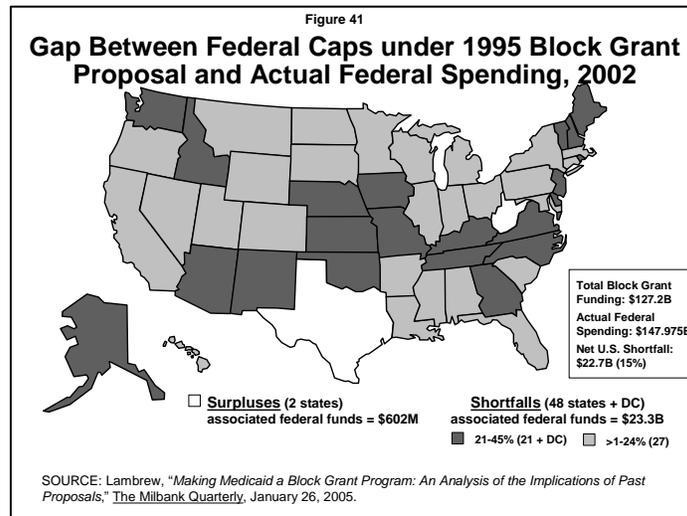
- The legislation establishing SCHIP in 1997 fixed year-by-year federal funding levels for a ten-year period. The law also specified the formula for allocating federal funds to the states. Over time, actual federal SCHIP spending has not tracked well with annual SCHIP allotments (Fig. 40). For SCHIP's first four years, the total amount provided to states in original allotments exceeded federal SCHIP spending for the year. Beginning in FY 2003, however, states' total annual federal SCHIP spending exceeded the total amounts originally allotted, resulting in greater reliance by many states on unspent funds redistributed from other states.^{6 7 8}



- The cap on federal matching funds for SCHIP has permitted states to cap enrollment in SCHIP programs, thereby limiting state outlays.⁹
- Federal actuaries project that if annual federal SCHIP allotments are frozen at \$5 billion as the President's budget for FY 2007 proposes, SCHIP enrollment will decline after 2006 and the number of uninsured children will rise, unless states finance coverage for these children with state-only dollars.¹⁰
- The Congressional Research Service projects that 18 states may likely face shortfalls of federal SCHIP funds in FY 2007 under current law. If, when SCHIP is reauthorized, appropriations are frozen at the FY 2007 level, CRS projects that the number of states with shortfalls will likely rise annually for several years.¹¹

Program experience shows the tendency of capped financing to become insufficient to meet actual program needs.

- An analysis of the Medicaid block grant proposed in 1995 shows that federal spending under the block grant would have exceeded the level of actual federal Medicaid spending from 1996 to 1999. On the other hand, in 2002 alone, federal payments under the block grant would have fallen \$23 billion (or 16%) short of the amount of actual federal Medicaid spending that year (Fig. 41). Over the 7-year budget period used by the Congressional Budget Office, federal Medicaid payments under the block grant would have been between \$4 billion and \$18.5 billion (1% to 2%) beneath the amount of actual federal spending during that time.¹²



- Federal funds earmarked for the AIDS Drug Assistance Program (ADAP) are capped and allocated to the states according to a formula. (ADAP is a source of prescription drugs for low-income people with HIV/AIDS who have no or limited drug coverage.) In March 2005, due to ADAP budget shortfalls, 11 state ADAPs had waiting lists representing 627 people in need of services. In additional actions, 12 ADAPs had capped enrollment, reduced the number of drugs offered, tightened eligibility, or taken other cost-containment measures that adversely affected access.¹³
- The federal government appropriates funds to the Indian Health Service (IHS) to provide health care to American Indians and Alaska Natives (AIAN). A government study shows that because IHS appropriations have not kept pace with growth in the AIAN population and health care costs, current appropriations provide only 59% of needed federal funding for the system. According to the study, it would take an additional \$1.8 billion to provide IHS users with services at the same level as provided in a mainstream health plan, such as that offered to federal employees.^{14 15}
- The history of other block grants, such as the Social Services Block Grant, is that the real value of the block grant declines significantly over time.^{16 17}

Distributing federal funds based on a pre-set formula leads to inequities and targeting problems.

- The impact of the block grant proposed for Medicaid in 1995 would have varied considerably across states, ranging in 2002 from a shortfall of at least 20% in 25 states to caps that exceeded actual federal spending in Texas and West Virginia.¹⁸

The formula used to allocate federal funds under the Ryan White CARE Act is based on AIDS case burden rather than HIV infection. As a result, allocations may not reflect recent trends in the epidemic or the full burden of affected individuals in all jurisdictions.¹⁹

Federal matching of state spending produces shared financial responsibility and is a means of promoting national priorities while maintaining state flexibility.

- Shared financing has mitigated the full cost impact of Medicaid on both states and the federal government. States' access to federal matching payments has led to greater expansion of coverage than the states would have been able to achieve with state revenues alone.²¹
- Federal matching enables states to obtain substantial federal support while retaining broad discretion to shape and administer their programs. This arrangement accommodates the wide variation in state policy priorities and choices, and it permits states to change course without placing their ability to receive federal matching funds at risk or requiring restructuring of the financing system.^{22 23}
- The state dollars at stake in Medicaid give states a strong interest in managing the program, controlling costs, and obtaining better value for the dollars the program spends. In 2006, all states implemented at least one new Medicaid cost containment strategy (e.g., provider payment freezes or cuts, eligibility restrictions) and 49 states planned at least one for 2007. At the same time, all but one state implemented more expansive policies in FY 2006 and 49 states have adopted policies in FY 2007 to enhance provider rates or to expand or restore benefits or eligibility. As their revenue situations improve, states are also investing in disease management and other quality improvement initiatives.²⁴
- Federal matching rates have been used as a lever to influence state policy. The enhanced federal match rate for SCHIP was one factor that spurred states' swift implementation of the program. Higher federal match rates have also been provided for selected Medicaid services and activities (e.g., improved Medicaid management information systems, availability of family planning services) to promote federal goals.^{25 26}

Shared financing has also created tensions between the states and the federal government, and raised concerns about accountability, fiscal management, and equity.

- Some states have used a variety of mechanisms, combining legal intergovernmental transfers (IGT) and the disproportionate share hospital (DSH) and upper payment limit (UPL) programs, to leverage federal Medicaid matching funds with limited or no state funds involved. These "creative financing" strategies have increased the effective federal share of Medicaid in the states that have employed them, distorting the federal-state financing partnership defined by the statutory Medicaid matching formula and obscuring Medicaid spending patterns.^{27 28 29 30 31}
- Some states have used federal funds generated through creative financing arrangements to strengthen Medicaid coverage or to provide additional resources to safety-net providers serving the Medicaid and low-income uninsured populations. However, other states have diverted these federal funds to a range of other purposes, including non-health-related purposes. States' use of these "federal maximization" mechanisms has raised legitimate questions about the program's financial integrity and accountability for the use of public funds.^{32 33 34 35}

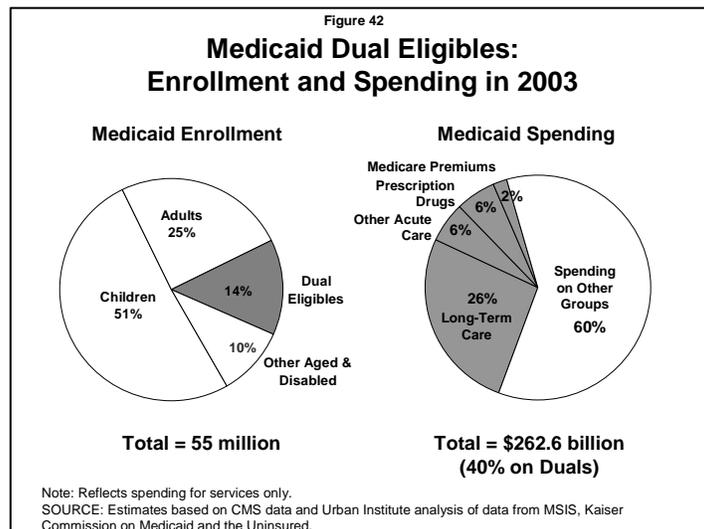
- Historically, the level of federal investment in financial management of Medicaid has been low and it has declined even as Medicaid spending has increased. Until recently, the federal agency with responsibility for Medicaid has lacked a dedicated source of funds for financial management and program integrity activities, and though it represents a quarter of a trillion dollars in federal and state expenditures, Medicaid has had no published, comprehensive financial management plan similar to Medicare's. The Deficit Reduction Act of 2005 created and provided funding for a new Medicaid Integrity Program, which includes a requirement that CMS develop a comprehensive Medicaid program integrity plan. A range of measures used in the private sector and in Medicare and other government programs could be adopted to significantly improve Medicaid's financial and program management without altering the program's basic financing structure.^{36 37}

The federal matching formula has been criticized for several shortcomings. A recent temporary enhancement of the federal share to provide fiscal relief to states demonstrated the important role of the federal-state financing balance in ensuring Medicaid's sustainability.

- Because of lags in the data used to compute the federal Medicaid assistance percentage (FMAP) and the absence of a countercyclical adjustment to provide fiscal relief to states in recessionary periods, match rates may not be aligned well with states' economic circumstances. In addition, analysts widely agree that the formula used to determine the FMAP does not adequately reflect the different fiscal capacities of the states or take into account the circumstances of states with high concentrations of poor citizens.³⁸
- A survey of the 50 states indicates that the temporary increase in the federal share of Medicaid costs, a form of federal fiscal relief during the economic downturn, helped states to preserve Medicaid coverage. Forty-two states reported that the federal fiscal relief helped them to meet increased Medicaid costs by resolving budget shortfalls. Over half the states reported that they used the fiscal relief to avoid, minimize, or postpone Medicaid cuts or freezes. The survey also found concern among states that, when the fiscal relief expired in June 2004, they would lack the fiscal resources necessary to fill the gaps left.³⁹

A large share of Medicaid spending is determined by the cost of low-income Medicare beneficiaries.

- Almost 7.5 million Medicaid enrollees are low-income Medicare beneficiaries. These individuals, known as "dual eligibles," make up 14% of Medicaid enrollees and 18% of Medicare beneficiaries. They account for 40% of Medicaid spending (Fig. 42). Dual eligibles are both poorer and in worse health than other Medicare beneficiaries. Nearly three-quarters have annual income below \$10,000, compared with 12% of all other Medicare



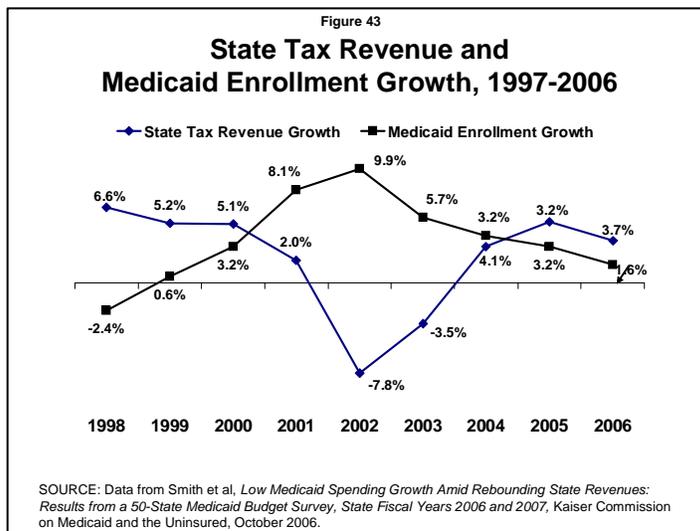
beneficiaries. Nearly one-quarter of dual eligibles are in nursing homes, as contrasted to 2% of other Medicare beneficiaries; over half are in fair or poor health, twice the rate for others in Medicare. On average, total health care costs for dual eligibles are double those of other Medicare beneficiaries. Medicaid covers 38% of their total costs.⁴⁰

- In 2003, two-thirds of Medicaid spending on behalf of dual eligibles was for long-term care services, 14% was attributable to prescription drugs, 15% went for other acute health care services, and payment of Medicare premiums made up the remaining 5%. While Medicare now covers prescription drugs, states remain obligated to finance a portion of this coverage through a payment to the federal government and Medicaid continues to fill in the other gaps in Medicare for dual eligibles.^{41 42}

Many of the pressures driving the cost of public coverage are outside states' control.

- Major factors driving the cost of covering low-income Americans include rising health care costs, growth in enrollment of disabled individuals and low-income Medicare beneficiaries with high health needs, and increasingly, the aging of the population. These trends and dynamics are largely or entirely beyond states' control. Some regions and states will feel the cost pressures associated with an aging population sooner and more strongly than others.⁴³

- Countercyclical effects play a role in squeezing states' budgets. Economic downturns tend to increase demands for public assistance and spending at the same time that state revenues decline (Fig. 43). Medicaid researchers have estimated that a one percentage point increase in the national unemployment rate from 4.5% to 5.5% could increase Medicaid enrollment 3.6%, adding over 1.5 million beneficiaries if states



maintained their current eligibility standards. If the unemployment rate rose to 5.5%, enrollment could grow by 7.2%, or 3.3 million beneficiaries. In a weakened economy, states are likely to lack the means to pay for the costs of these new enrollees.^{44 45 46 47}

- More people became eligible for Medicaid during the economic downturn due to rising unemployment, increased poverty, and declining employer-based coverage rates. Medicaid and SCHIP coverage among children increased by 5.2 percentage points, or 4.3 million children, over the period 2000-2004. Medicaid coverage of adults, for whom eligibility is much more limited, increased by 1.2 percentage points, or 2.6 million.⁴⁸
- From 2001 through 2004, states experienced severe fiscal stress. Over that period, cumulative state budget shortfalls exceeded \$250 billion. Revenue growth began to rebound in FY 2005; for the first time since 1998, state revenue growth exceeded Medicaid cost growth in FY 2006.⁴⁹

- The economic recovery has been uneven across the country. Nationwide, state revenue growth from 2005 to 2006 averaged 3.7% after accounting for inflation and legislative, but growth was slowest in the Great Lakes region (-0.3%) and fastest in the Rocky Mountain region (7.2%).⁵⁰

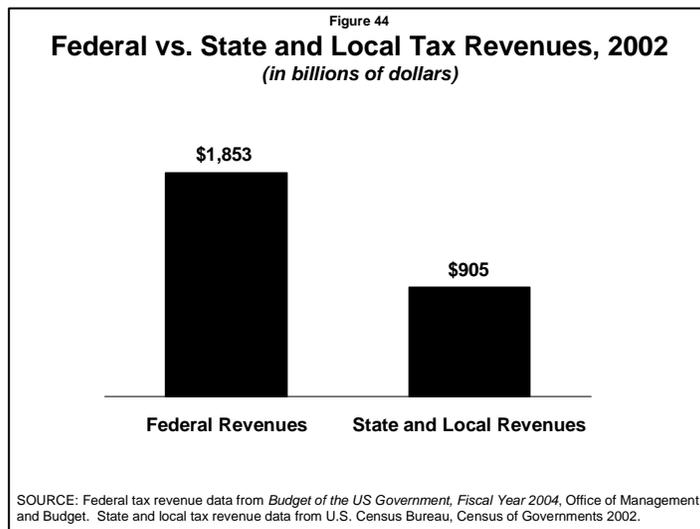
Health care provided to those who lack health insurance imposes substantial costs on the nation that are financed primarily by taxpayers.

- According to the Institute of Medicine, the nation spends roughly \$35 billion annually – 2.8% of total national spending for personal health care services – on the uncompensated health care that is provided to those who are uninsured for all or part of a year. The IOM estimates that 75% to 85% of these costs are covered by taxpayers, primarily through government subsidies to hospitals and clinics.⁵¹

Underlying constraints in state fiscal capacity limit states' ability to absorb the increasing costs of covering low-income Americans. Fiscal capacity is much greater at the federal level.

- The federal government and state and local governments are not equal fiscal partners. Since the 1950s, the federal government has typically collected almost twice as much revenue as all state and local governments combined (Fig. 44).^{52 53}

- Many states expect longer-term spending to outpace revenue, resulting in structural deficits. Research shows that key factors underlying state structural deficits include state tax policy that has not adapted to the economy's shift from goods to services, the erosion of state corporate and income taxes, the growth of internet and online commerce, excessive reliance on slower-growing tax sources such as sales and excise taxes, and federal policies that impede states ability to tax certain activities.^{54 55}



- In a March 2006 survey of state legislative fiscal offices, almost half the states estimated that available revenues would fall short of projected expenditures in one or more of FY 2007, FY 2008, and FY 2009.⁵⁶
- State constitutions require states to balance their budgets, meaning that state revenues need to be in balance with spending. By contrast, the federal government can deficit spend. Additionally, a number of states have constitutional or other requirements that make it difficult for policymakers to modernize tax codes and adjust to budgetary needs, and there is little political will to raise taxes and fees among elected officials and the public in most states.^{57 58}

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- Due to state budget and fiscal constraints, even more constrained and variable resources at the local level, and different state and local tax policy preferences, approaches that rely heavily on state and local funding to cover the uninsured tend to produce wide variation in coverage. Citing the federal government's dominant role in government finance, and the growing demands that covering the low-income population places on more fragile state finances, some fiscal policy analysis concludes that federal financing mechanisms are needed to stabilize support for publicly sponsored health insurance for low-income Americans.^{59 60}

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CONCLUSION

In August 2006, the Census Bureau released its latest statistics on the uninsured in the United States. 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% and it was 22% among poor children. 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 the rise in the number of uninsured Americans.

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.

While the nation's policymakers will determine the precise shape of any program, the relevant research literature suggests that the following are key elements in the structure of an effective program to meet the coverage and care needs of the low-income uninsured population:

- **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.

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- **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 accounts for countercyclical pressures at the state level, the national trends causing costs to rise, 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.

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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