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.

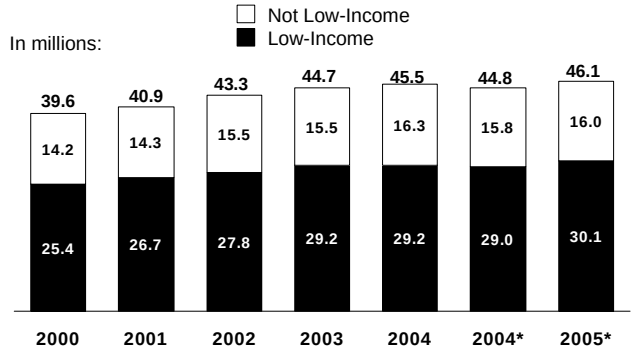
Key Evidence

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]

Figure 1

Uninsured Non-Elderly Americans by Low-Income Status, 2000-2005



* Revised method

Note: "Low-income" means <200% of the federal poverty level, which was $39,942 for a family of four in 2005. The Census Bureau periodically revises its Current Population Survey methods, precluding comparisons of data before and after the revision. Due to the most recent revision, year-to-year comparisons can be made for 1999-2004, and separately for 2004-2005.

SOURCES: Analysis of March 2006 Current Population Survey, Kaiser Commission on Medicaid and the Uninsured and Urban Institute. Hoffman et al, *Health Coverage in America: Data Updates,* 2000-2004, Kaiser Commission on Medicaid and the Uninsured.

- Nearly two-thirds of uninsured non-elderly Americans are low-income, with family income below 200% of the federal poverty level.[3]

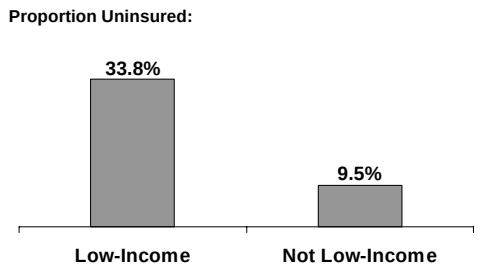
- Eighty percent of uninsured Americans come from working families. Almost 70% have at least one full-time worker in the family and another 11% have a part-time worker in the family.[4]

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]

Figure 2

Uninsured Rate Among People in Working Families by Low-Income Status, 2005



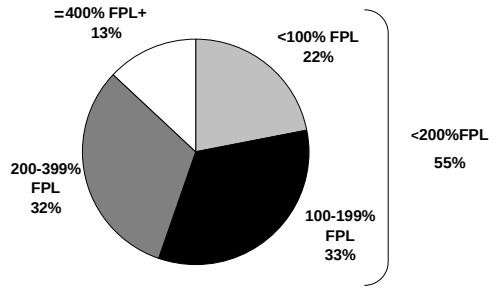
Note: "Low-income" means <200% of federal poverty level, which was $19,971 for a family of four in 2005.

SOURCE: Analysis of March 2006 Current Population Survey, Kaiser Commission on Medicaid and the Uninsured and Urban Institute.

- 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]

Figure 3

Uninsured Workers by Income, 2005



Total = 22.6 million uninsured workers

Note: "FPL" means federal poverty level, which was $19,971 for a family of four in 2005.
SOURCE: Clemans-Cope et al, *Changes in Employer-Sponsored Health Insurance Coverage: 2001-2005,* Kaiser Commission on Medicaid and the Uninsured, October 2006.

- 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]

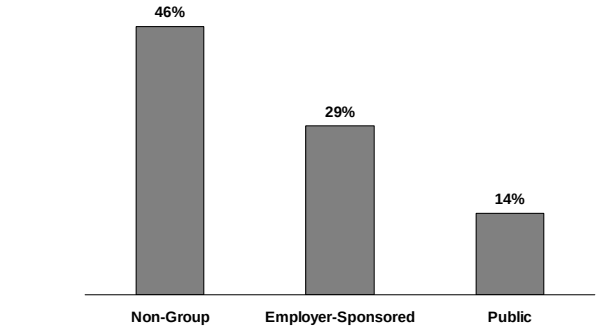
- Survey data indicate that in 2003, about half of non-elderly adults holding individual insurance policies faced deductibles of $500 or more; of these adults, two-thirds faced deductibles of $1,000 or more. Among adults with income below $35,000, those with a deductible of at least $500 were significantly 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]

Figure 4

Proportion of Low-Income Insured Families with High Out-of-Pocket Burden, by Type of Coverage



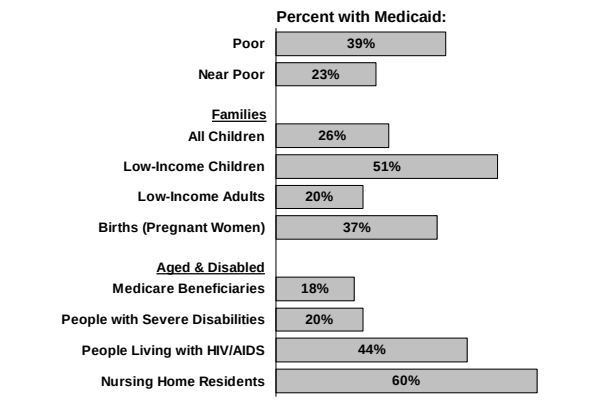
Notes: Non-elderly families only. "Low-income" defined as <200% of federal poverty level. "High burden" defined as out-of-pocket spending (excluding premiums and dental care) exceeding 5% of family income.
SOURCE: Shen and McFeeters, "*Out-of-Pocket Health Spending Between Low- and Higher-Income Populations: Who is at Risk of Having High Expenses and High Burdens?*" Medical Care, 44 (3), March 2006.

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]

Figure 5

Medicaid's Role for Selected Populations



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

- 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]

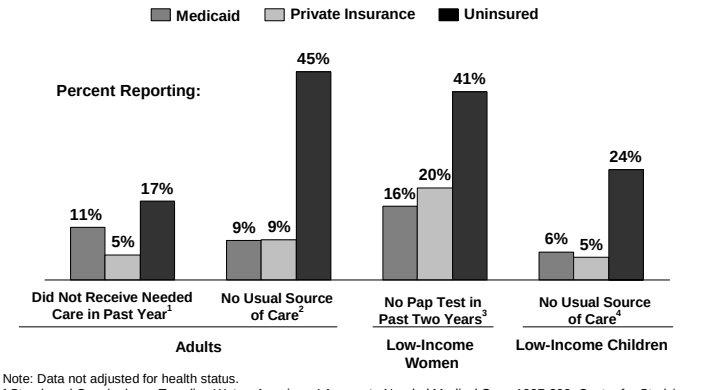
- Medicaid fills major gaps in Medicare benefits for 7.5 million low-income Medicare beneficiaries, covering long-term care, vision and dental care, and other services that are limited or excluded in Medicare's benefit package, and assisting with Medicare's premiums and cost-sharing. Medicaid's share 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]

Figure 6



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

- 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]

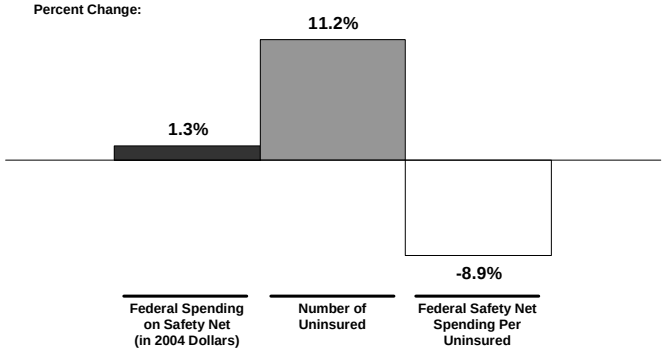
- Administrative costs in Medicaid are about half as large as administrative costs in private insurance. In 2003, they accounted for 6.9% of total Medicaid spending, compared with 13.6% of total private health insurance spending.[84]

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]

Figure 7

Growth in Federal Spending on Safety Net vs. Growth in Uninsured, 2001-2004



SOURCE: Hadley et al, *Federal Spending on the Health Care Safety Net from 2001-2004: Has Spending Kept Pace with the Growth in the Uninsured?* Kaiser Commission on Medicaid and the Uninsured, November 2005.

- 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]

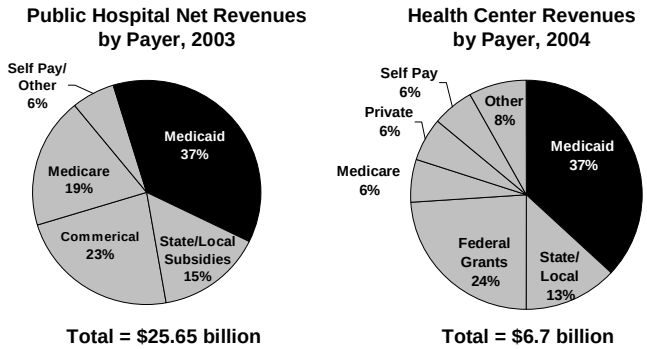
- Medical school faculty at teaching hospitals, historically a mainstay of care for the poor, report more difficulty obtaining specialty services, high-tech care, and even routine inpatient care for uninsured than for privately insured patients. Nearly 1 in 4 clinical faculty reported that they were 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

Figure 8

Medicaid Financing of Safety-Net Providers



SOURCES: *National Association of Public Hospitals and Health Systems, 2003*, National Association of Public Hospitals and Health Systems, October 2005. Rosenbaum and Shin, *Health Centers Reauthorization: An Overview of Achievements and Challenges*, Kaiser Commission on Medicaid and the Uninsured, March 2006.

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]

- 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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