

Prospects for Reducing Uninsured Rates among Children: How Much Can Premium Assistance Programs Help?

Timely Analysis of Immediate Health Policy Issues

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Summary

With the reauthorization of the State Children's Health Insurance Program (SCHIP) under consideration in early 2009, an important question is the extent to which uninsured children could be covered under employer-sponsored insurance through premium assistance programs, which use public funding under Medicaid and SCHIP to subsidize employer-sponsored insurance (ESI). New data indicate that just 4.6 percent of all Medicaid-eligible uninsured children and 15.9 percent of all SCHIP-eligible uninsured children have a parent with ESI coverage, suggesting that premium assistance programs may not make a substantial dent in the uninsured problem facing children since, as a practical matter, they would target at most only an estimated 440,000 uninsured children who are eligible for public coverage. The fact that so few uninsured children have parents with ESI coverage highlights the importance of increasing take-up in Medicaid and SCHIP among eligible children.

satisfy a six-month waiting period before being allowed to enroll. In contrast, states operating premium assistance programs under a Section 1115 waiver have greater flexibility in designing their programs, limited by little other than the discretion of the Secretary of the Department of Health and Human Services.⁷

At least 20 states currently administer premium assistance programs⁸ and to date, enrollment levels have tended to be low. A 2007 study found that four out of six SCHIP premium assistance programs examined enrolled less than 1 percent of eligible children.⁹ In 2006, the three Medicaid premium assistance programs with the highest enrollment—Rhode Island, Massachusetts, and Pennsylvania—had enrolled 4.7, 3.4, and 1.9 percent, respectively, of their total Medicaid population in the premium assistance program.¹⁰ While evidence from some states, such as Rhode Island and New Jersey, shows that cost-savings can be achieved, enrollment in the program must be sufficiently high to offset the administrative costs associated with setting up and maintaining the program.^{11,12,13}

Seeking to encourage the creation of premium assistance programs under SCHIP, reauthorization legislation passed in 2007 would have given states a new option to implement premium assistance programs for children who are eligible for SCHIP but not already covered by private insurance. It also attempted to mitigate administrative

Introduction

One of the issues considered during the 2007 reauthorization debate was the use of premium assistance programs under Medicaid and SCHIP.¹ Premium assistance programs have been advocated as a mechanism for lowering public spending by maintaining or even increasing employer funding of health insurance coverage, increasing access to private providers, and keeping parents and children together on the same insurance policy.² At the same time, however, concerns have been raised that premium assistance programs may not be cost-effective relative to providing coverage directly through Medicaid and SCHIP, that they may promote crowd-out, and that it may be difficult to ensure that children receive the wrap-around benefits that are not included in the employer plan.³

Background

States can create premium assistance programs in one of four ways: through their Medicaid program under the authority of Section 1906 of the Social Security Act, through a separate SCHIP program, through a Section 1115 waiver, or using state funds.⁴ Programs created under Section 1906 or through a separate SCHIP program must meet a number of requirements for approval: the program must be shown to be cost-effective,⁵ the state must provide wrap-around benefits to cover services that are included in the Medicaid or SCHIP benefit package but excluded from the employer plan in which participants are enrolled, and cost sharing must not exceed 5 percent of family income.⁶ Children who drop other insurance coverage in order to enroll in an SCHIP premium assistance program must



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hurdles to operating premium assistance programs by requiring employers to provide states with information about the benefit packages in their plans, and it would have amended the Internal Revenue Code to expand the scope of qualifying events to include gaining or losing eligibility for Medicaid/SCHIP.¹⁴ This change would have allowed children to enroll immediately in an employer plan if they were found to qualify for premium assistance or if they lost their Medicaid/SCHIP direct coverage, instead of having to wait for the next open enrollment period. At the same time, it also would have changed the cost-effectiveness test.¹⁵

This brief examines the extent to which broader reliance on premium assistance programs could reduce uninsurance among Medicaid- and SCHIP-eligible children. We also examine the potential implications for program costs if premium assistance programs were expanded to all SCHIP-eligible children who have access to employer-sponsored insurance, including those who already have such coverage.¹⁶

Data and Methods

Our analysis relies primarily on the 2005 Annual and Social Economic Supplement (ASEC) to the Current Population Survey (CPS) which is a nationally representative survey of the non-institutionalized population.¹⁷ To identify children eligible for Medicaid and SCHIP coverage, we use a simulation model developed by researchers at the Urban Institute's Health Policy Center¹⁸ that assesses eligibility for Medicaid and SCHIP.¹⁹ Results from this model are similar to preliminary estimates based on more recent ASEC data from 2008. We assign a single source of coverage to individuals reported to have multiple types of coverage based on the following hierarchy: employer coverage; Medicaid, SCHIP,²⁰ or state coverage; Medicare or military coverage; and directly purchased coverage in the non-group market.²¹ While previous analysis of ESI access among eligible children used a coverage hierarchy

that counted Medicaid, SCHIP or state coverage prior to ESI, this analysis relies on a hierarchy that counts ESI first so as to most generously estimate the number of parents and children with access to ESI.²² This results in lower estimates of Medicaid/SCHIP coverage and higher estimates of ESI for both children and parents. Among all children reported to have Medicaid/SCHIP, some 17 percent are also reported to have ESI at some point during the year. Similarly, some 18 percent of all parents reported to have Medicaid/SCHIP coverage also reported having ESI during the prior year.²³

Information on parents' insurance status is used to classify children according to whether all, some, or no parents have ESI. Our primary measure is whether the child has at least one parent with ESI. This measure likely overstates the ease with which children could be added to an existing policy since the existence of families in which only one of the two parents is covered by ESI may indicate that the available family coverage is not affordable to that family. We also provide estimates of the share of uninsured children who have all (i.e., one parent in single-parent families and two parents in two-parent families) parents covered by ESI since that may be more indicative of the availability and affordability of dependent coverage through the employer plan.

While the ASEC lacks information on whether the parent's coverage could include a spouse or child (i.e., whether dependent coverage is offered), previous research indicates that only 6 percent of all employers offer insurance without dependent coverage to their employees.²⁴ The ASEC also lacks information on how much the employee would have to contribute to the premium payment for dependent coverage, though prior research has documented that employees have to contribute more toward dependent coverage (both in absolute and relative terms) than for single coverage.²⁵ Without information on the premium contributions that would be required for dependent coverage or the benefits and cost sharing associated with the

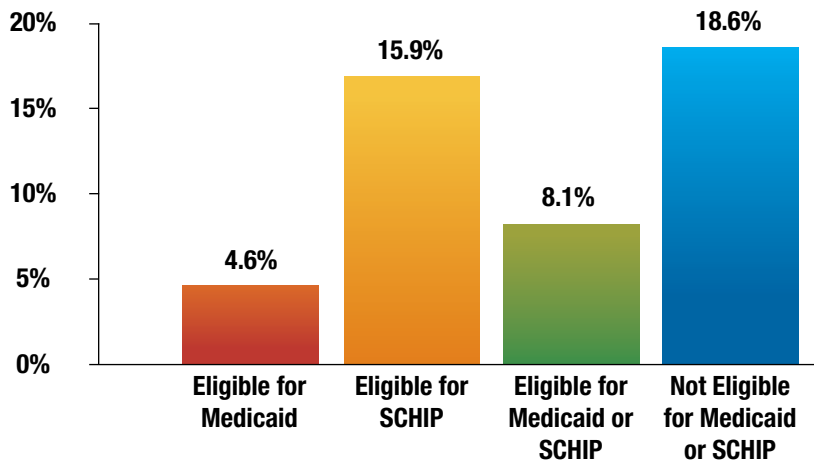
employer plan, we cannot gauge the cost-effectiveness of the premium assistance option for the children whose parents are already covered under an employer plan.

Our estimates overstate the extent to which uninsured children whose parents are covered by ESI could be brought into premium assistance programs since the ESI covering the parents may not include an option for dependent coverage and it may not be able to meet the cost effectiveness test or other requirements. At the same time, however, while our estimates focus on whether a parent has taken up ESI, as opposed to having an offer of ESI for themselves, it is possible that the subsidy available through the premium assistance program could induce some parents to take up employer-sponsored insurance coverage for both themselves and their children.²⁶ However, the fact that these parents have not taken up the offer for themselves (and their children) may be an indication that the ESI coverage that is available to them requires a large employee contribution, has high out-of-pocket cost sharing, or has a lean benefits package, which would make it difficult for the plan to meet the cost effectiveness test or to satisfy other requirements. It also seems unlikely that many parents who rejected ESI for themselves would choose to enroll themselves and their children in ESI with a premium assistance subsidy instead of enrolling their children directly in SCHIP.

Results

Among the 3.7 million uninsured children who are eligible for Medicaid, just 4.6 percent have a parent who is covered by ESI (figure 1). The 1.7 million uninsured children who are eligible for SCHIP have more access to employer coverage, but still just 15.9 percent have a parent who is covered by ESI. And the proportion of Medicaid/SCHIP eligible uninsured children who have *all* parents covered under ESI is even lower—3.0 percent of children eligible for Medicaid and 9.5 percent of children eligible for SCHIP (data not shown). Overall, just 8.1 percent

Figure 1. Uninsured Children With At Least One Parent With ESI by Eligibility for Medicaid and SCHIP



Note: The total number of uninsured children eligible for Medicaid is 3.7 million and the total number of uninsured children eligible for SCHIP is 1.7 million. An estimated 2.6 million uninsured children are not eligible for either Medicaid or SCHIP. Of the 5.4 million uninsured children eligible for Medicaid or SCHIP, 440,000 have at least one parent with ESI.

Source: Urban Institute Health Policy Center Eligibility Simulation based on the 2005 Annual Social and Economic Supplement to the Current Population Survey (Dubay et al. 2007; Holahan et al. 2007).

of all uninsured children who are eligible for either Medicaid or SCHIP coverage have at least one parent with employer-sponsored coverage.²⁷ Even if all the uninsured children who are eligible for Medicaid or SCHIP and who have a parent with ESI were to enroll in a premium assistance program, the number of uninsured children would decline by at most only 440,000, leaving approximately 5 million uninsured children who are eligible for public coverage but not yet enrolled.²⁸

While premium assistance programs have a limited scope for reducing the uninsurance problem among children who are eligible for Medicaid and SCHIP since so few of those children have parents with ESI, more aggressive reliance on premium assistance programs could provide ESI to up to 850,000 children who are currently enrolled in SCHIP but have a parent with ESI (figure 2).²⁹ Covering these children under premium assistance programs has the potential to benefit states and families by using the

employer contribution to help finance coverage, thus shifting costs from the state and federal government to employers; by allowing all family members to be on the same insurance plan; and by giving children potentially improved access to providers, since reimbursement rates are typically higher with employer-sponsored insurance than with Medicaid and SCHIP.³⁰ On the other hand, to the extent that full wrap-around coverage is not provided, shifting children from public to private coverage might reduce access to necessary care since employer-sponsored plans typically offer fewer benefits and have higher out-of-pocket cost-sharing than do Medicaid and SCHIP.³¹

For a much larger number of children, however, premium assistance programs could shift costs in the opposite direction, from private sources to the taxpayers. An estimated 7 million children could be eligible for SCHIP but are covered under their parent's ESI plan (figure 2). If these children

qualified for and received premium assistance, premiums now paid by the parents would be paid by public dollars instead. Taxpayer funds could also substitute for employer dollars since premium assistance programs could provide greater incentives for firms to reduce the amount they contribute for dependent coverage.³²

Policy Implications

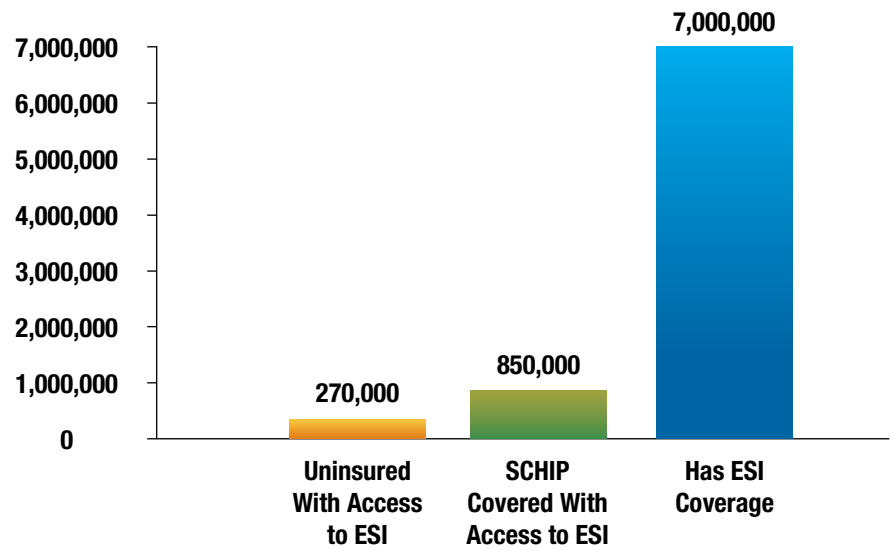
Premium assistance programs cannot address many of the existing coverage gaps among children since so few uninsured children have parents with employer-sponsored insurance coverage. In particular, premium assistance programs targeted at SCHIP- and Medicaid-eligible children would have a limited impact on the number of uninsured children since just 4.6 percent of Medicaid-eligible and 15.9 percent of SCHIP-eligible uninsured children have a parent who is covered by ESI. Even in a scenario in which all eligible uninsured children whose parents have ESI were brought in through premium assistance programs, the number of uninsured children would decline by just 440,000.³³ Premium assistance programs could have a greater impact if states expanded public coverage to more parents since that would likely increase the likelihood that the cost-effectiveness test could be met even for the parents who do not have ESI but have an ESI offer.

Moreover, to the extent that they reduce employer and employee contributions toward employer-sponsored coverage, expanding premium assistance programs under SCHIP could lead to a substantial substitution of public for private funding for health insurance coverage given that 7 million children qualify for SCHIP on the basis of their incomes but receive coverage through a parent's employer-sponsored insurance plan. Of the children who could potentially qualify for premium assistance programs under SCHIP, the number who already have ESI coverage is more than six times the number who

could potentially gain ESI, either by opting-out of direct public coverage or by a reduction in the uninsured. The administrative burdens associated with premium assistance programs, for both public programs and for employers, raise concerns as well. While policies such as waiting periods could reduce the extent to which premium assistance programs lead to reductions in private financing for health insurance coverage by limiting the enrollment of children who already have employer-sponsored coverage, such policies also raise serious equity issues.³⁴ Parents who previously paid for their children's health insurance would be denied assistance, while similarly situated parents who made a different choice would receive help.

Overall, many more uninsured children are eligible for public programs than have access to ESI through their parents. Therefore, policies to increase enrollment and retention in Medicaid and SCHIP have much greater potential than premium assistance programs to close coverage gaps among children.

Figure 2. SCHIP Income-Eligible Children by Coverage Status And Access to ESI



Note: Children are considered to have access to ESI if at least one parent in the family has ESI coverage. SCHIP income-eligible children refers to children who would qualify for SCHIP if they were not enrolled in ESI. See data and methods section for information on how coverage status was determined.

Source: Urban Institute Health Policy Center Eligibility Simulation based on the 2005 Annual Social and Economic Supplement to the Current Population Survey (Dubay et al. 2007; Holahan et al. 2007).

Notes

- ¹ Kenney, G. "The Failure of SCHIP Reauthorization: What Next?" Washington, DC: Urban Institute. 2008.
- ² Owcharenko, N. "Reforming SCHIP: Using Premium Assistance to Expand Coverage." Web Memo #1466. Washington, DC: The Heritage Foundation. 2007; Owcharenko, N. and R. Moffit. "Redesigning SCHIP to Strengthen Private Health Insurance for Working Families." Web Memo #1564. Washington, DC: The Heritage Foundation. 2007.
- ³ Alker, J. "Choosing Premium Assistance: What Does State Experience Tell Us?" Washington, DC: Kaiser Commission on Medicaid and the Uninsured. 2008; Belnap, D. and S. Schwartz. "Premium Assistance." State Health Policy Monitor, Vol. 1, Issue 3. Publication No. 2007-109. Portland, ME: National Academy for State Health Policy. 2007; Williams, C. "A Snapshot of State Experience Implementing Premium Assistance Programs." Portland, ME: National Academy of State Health Policy. 2003.
- ⁴ Williams 2003.
- ⁵ Under the cost-effectiveness test, the cost of covering an individual or the cost of the premium assistance program as a whole must not be more than what the state would have spent to enroll those individuals in Medicaid or SCHIP.
- ⁶ Coverage provided directly under SCHIP must also meet these benefit and cost-sharing requirements. For an overview of cost-sharing rules under Medicaid (before and after the 2005 Deficit Reduction Act) and SCHIP, see Hertz, A. "Medicaid Cost-Sharing under the Deficit Reduction Act of 2005." CRS Report for Congress. Order Code RS 22578. Washington, DC: Congressional Research Service. 2007.
- ⁷ Bonney, J. "Options for Premium Assistance Programs." Making Medicaid Work for the 21st Century, Issue Brief #2. Portland, ME: National Academy for State Health Policy. November 2004.; Kaiser Commission on Medicaid and the Uninsured. "Serving Low-Income Families through Premium Assistance: A Look at Recent State Activity." Washington, DC: Kaiser Commission on Medicaid and the Uninsured. 2003; Shirk, C., and J. Ryan. "Premium Assistance in Medicaid and SCHIP: Ace in the Hole or House of Cards?" National Health Policy Forum Issue Brief No. 812. Washington, DC: The George Washington University. 2006.; Williams 2003.
- ⁸ Belnap and Schwartz 2007.
- ⁹ Alker 2008.
- ¹⁰ Dickey, D. "ESI Premium Assistance: Experience in Other States." Presentation. Joint Fiscal Office, Vermont. August 8, 2006. <http://www.leg.state.vt.us/jfo/Healthcare/ESI%20Premium%20Assistance%20-%20Other%20States%20Experience.ppt>.
- Some states, including the three states with the highest enrollment shares in premium assistance programs, have eligibility expansions that include parents. Including parents may contribute to higher enrollment likely because subsidizing family coverage premiums is more likely to be cost-effective than subsidizing the child alone (Herman, M. "Premium Assistance Programs: Potential Help for the Uninsured?" Technical Assistance Memo. Washington, DC: National Conference of State Legislatures, Forum for State Health Policy Leadership. 2004). Other program features that may lead to higher enrollment are broad criteria for eligible employer plans; a state law change to make eligibility for the program a qualifying event; no minimum employer contribution to the premium (cannot be done in an SCHIP premium assistance program); expanding eligibility for premium assistance to all children who qualify for SCHIP or Medicaid rather than just a small subset (for example, those with incomes between 200 and 300 percent of the FPL); and a cost-effectiveness test that uses the employer's average per-employee plan cost rather than the individual's cost, which is easier to track (Williams 2003). However, none of these policies will reduce uninsurance substantially if few uninsured children have access to ESI coverage.
- ¹¹ Alker, J. "Premium Assistance Programs: How Are They Financed and Do States Save Money?" Washington, DC: Kaiser Commission on Medicaid and the Uninsured. 2005.
- ¹² Premium assistance programs require large administrative costs, particularly during program start-up (Herman 2004). Existing data sources and management systems in the state may not contain the information necessary to identify eligible children and verify that the employer plan meets the criteria described above. New data systems may also be needed to process the premium subsidy (usually deposited directly into the employee's bank account); to process the cost-sharing payments, especially when the enrollee reaches the out-of-pocket limit; and to administer the provision of wrap-around benefits excluded from the employer plan. These high start-up costs may deter some states from implementing premium assistance programs (Herman 2004).
- ¹³ Interestingly, these two states also provide full wrap-around benefits in their programs, demonstrating that a premium assistance program does not have to be lean in order to be cost effective (Alker 2005).
- ¹⁴ Alker, J. "Public/private Coverage in SCHIP Reauthorization: Premium Assistance and Other Issues." Presentation to the American Academy of Pediatrics. Washington, DC. September 29, 2007. <http://ccf.georgetown.edu/index/cms-filesystem-action?file=presentations%2Fjoan+-+aap+govt+affairs+ctte+9-29.ppt>; Children's Health Insurance Program Reauthorization Act of 2007. H.R. 976, 110th Cong, 1st Sess. (2007).
- ¹⁵ See Alker 2007. The bill also would have waived the 10 percent cap on administrative costs in SCHIP for premium assistance outreach and required that states conduct outreach and marketing to eligible children. The state also had to provide wraparound benefits and the employer had to contribute at least 40 percent of the premium cost for the ESI plan to be eligible for premium assistance (Alker 2007; Children's Health Insurance Program Reauthorization Act of 2007 (H.R. 976)).
- ¹⁶ We do not consider this issue in Medicaid since all Medicaid-eligible children with employer-sponsored insurance are already eligible to receive wrap-around services through Medicaid under current law. SCHIP programs, unlike Medicaid, are not permitted to provide wrap-around services to children with employer-sponsored coverage.
- ¹⁷ Estimates are derived from the 2005 ASEC prior to Census Bureau revisions to the assignment of dependent coverage to this file. The revisions resulted in lower estimates of uninsured children and higher estimates of privately-insured children.
- ¹⁸ Dubay, L., J. Holahan, and A. Cook. "The Uninsured and the Affordability of Health Insurance Coverage." *Health Affairs* 26(1): w22-w30. 2007; Holahan, J., A. Cook and L. Dubay. "Characteristics of the Uninsured: Who Is Eligible for Public Coverage and Who Needs Help Affording Coverage?" Washington, DC: Kaiser Commission on Medicaid and the Uninsured. 2007.
- ¹⁹ Estimates of eligibility take into account the underreporting of Medicaid and SCHIP on the CPS by adjusting the CPS partially to state administrative enrollment totals for Medicaid and SCHIP and reducing the uninsured and privately-insured by one-third and two-thirds, respectively, of the undercount. Estimates are adjusted for immigration status to reflect that some noncitizen children may not be eligible for coverage despite meeting income and resource requirements. The precision of eligibility estimates may be undermined by the fact that some individuals may report annual income on the CPS that implies that they are not eligible for public coverage, when in fact they were income eligible for Medicaid or SCHIP for one or more months of the year. In addition, child support disregards have not been taken into account in determining eligibility. Moreover, information on documentation status is not collected on the CPS. While an adjustment is made to the data to address this issue, it is derived from external estimates and may introduce error to the model. The misreporting of coverage on the CPS leads to imprecision in coverage estimates. While the adjustment for underreporting partially addresses this issue, uninsured estimates may be biased upward if the adjustment does not fully account for the undercount, or they may be biased downward if it overcorrects for this issue.
- ²⁰ Although the CPS added a question in 2001 asking respondents specifically about whether any family member had been enrolled in a separate SCHIP program, the distinction between Medicaid and SCHIP is unreliable.

Therefore, we define SCHIP enrollees as children whom we have simulated to be eligible for SCHIP, and who reported enrollment in Medicaid or SCHIP on the CPS.

²¹ A long-standing debate surrounds CPS uninsured estimates and whether they represent the number of individuals without coverage for the entire prior year (as intended) or at a point in time in the past year. The Census Bureau has commented that that CPS estimates more closely align with other surveys' point-in-time estimates (DeNavas-Walt, C., B. Proctor, and J. Smith, U.S. Census Bureau, Current Population Reports, P60-235, Income, Poverty, and Health Insurance Coverage in the United States: 2007, U.S. Government Printing Office, Washington, DC, 2008). In this analysis, estimates of coverage are interpreted as reflecting the average experience in the past year.

²² Kenney, G. and A. Cook. "Coverage Patterns among SCHIP-Eligible Children And Their Parents." Washington, DC: Urban Institute. 2007.

²³ Urban Institute tabulations of the 2005 ASEC to the CPS.

²⁴ Fronstin, P., R. Helman, and M. Greenwald, "Small Employers and Health Benefits: Findings From the 2002 Small Employer Health Benefits Survey," Issue Brief 253. Washington, DC: Employee Benefit Research Institute. 2003. http://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=171.

²⁵ Claxton, G., J. Gabel, B. DiJulio, J. Pickreign, et al. "Health Benefits in 2008: Premiums Moderately Higher, while Enrollment in Consumer-Directed Plans Rises in Small Firms." *Health Affairs* 27(6): w492-w502. 2008.

²⁶ Supplemental estimates from the 2005 Contingent Worker Supplement to the CPS that have been merged with the 2005 ASEC

and the Urban Institute Health Policy Center simulation model provide insights about the extent to which parents of uninsured Medicaid- and SCHIP-eligible children are not taking up offers of ESI that are available to them. These estimates indicate that about one quarter (24.6 percent) of all uninsured eligible children have a parent with an offer of employer coverage. An estimated 17.2 percent of uninsured Medicaid-eligible children have a parent with an offer; the share rises to 39.6 percent for uninsured children eligible for SCHIP. It is important to note that these estimates do not provide information on the extent to which parents have an offer of dependent coverage or provide information about what was offered. In addition, unlike the estimates used in the text, they do not include an adjustment for documentation status and they also reflect Census Bureau revisions to the 2005 ASEC that resulted in a lower number of uninsured.

²⁷ Among the uninsured children who are not eligible for Medicaid or SCHIP, fewer than a fifth have a parent who has employer-sponsored insurance (figure 1).

²⁸ To the extent that premium assistance programs could induce parents to take up an offer of ESI that they haven't already taken up, the number of uninsured children that could gain coverage under a premium assistance program could be somewhat greater than that reported here. However, the majority of Medicaid- and SCHIP-eligible uninsured children could not gain coverage because they do not have an offer of ESI.

²⁹ This enrollment estimate likely overstates access to ESI among children enrolled in SCHIP since families may be reporting on their coverage at different points over the course of the preceding year. This means that the parents may have had ESI coverage at a different time than when the children were covered under SCHIP.

³⁰ Owcharenko and Moffit 2007.

³¹ Alker, J. "Choosing Premium Assistance: What Does State Experience Tell Us?" Washington, DC: Kaiser Commission on Medicaid and the Uninsured. May 2008. See also Alker 2005.

Currently under SCHIP and in SCHIP reauthorization legislation passed in 2007 (H.R. 976), premium assistance programs are required to provide wrap-around benefits to enrollees. However, premium assistance programs under 1115 waiver authority are not required to provide these benefits.

³² The exact amount of the cost-shifting that would occur is difficult to estimate because it would depend on a number of factors including both the employer and employee shares of the premium, the amount of the potential subsidy through the premium assistance program, and the cost of covering a child in traditional Medicaid/SCHIP.

³³ Moreover, premium assistance programs targeted at the higher-income uninsured children who are not eligible for either Medicaid or SCHIP would only have a modest effect on children's coverage, since only a fraction (less than a quarter) have a parent with employer-sponsored coverage (data not shown).

³⁴ This equity issue is not specific to premium assistance programs under SCHIP as the SCHIP statute explicitly targets children who do not have employer-sponsored coverage. As a consequence, most states have some type of waiting period for general SCHIP coverage.

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