TOWARDS INCREMENTAL PROGRESS: KEY FACTS ABOUT GROUPS OF UNINSURED

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ABOUT THE ECONOMIC AND SOCIAL RESEARCH INSTITUTE

The Economic and Social Research Institute is a non-partisan, non-profit research organization headquartered in Washington, D.C., and founded in 1987. Specializing in health and social policy research, ESRI conducts research and publishes studies directed at enhancing the effectiveness of social programs, improving the way health care services are organized and delivered, and making quality health care accessible and affordable.

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INTRODUCTION

Some national policymakers are interested in health reform strategies that cover particular groups of uninsured, rather than all uninsured Americans. Such incremental strategies follow the precedent of expansions over the past decade such as the State Children's Health Insurance Program (SCHIP) and Health Coverage Tax Credits (HCTCs) under the Trade Act of 2002.

The following fact sheets discuss various classifications of uninsured Americans who could become the focus of future incremental expansions, setting out key facts and basic policy design questions for each group. The following potential coverage clusters are discussed in turn:

- Employees of small business;
- Workers who lose their jobs;
- Workers who decline employer coverage;
- Low-income parents;
- Low-income, childless adults;
- The near-elderly;
- Young adults;
- Children; and
- Immigrants.

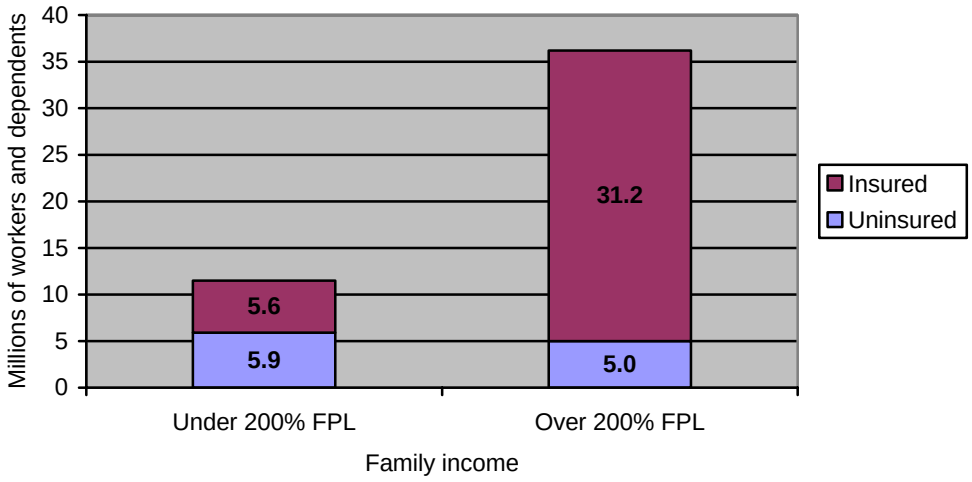
One caveat is important. These materials pull together, in one place, information from numerous researchers who applied different methods of analysis to data from different surveys that were conducted at different points in time. The goal is to help guide the development of sound policy by furnishing an accurate overall picture of each group of uninsured. However, the reader is urged to exercise great caution in adding together different estimates from varying sources; any precise number that results from such calculations may provide nothing more than a ballpark estimate.

EMPLOYEES OF SMALL BUSINESS

Key Facts

- Nearly half (49 percent) of the uninsured are either self-employed or work at firms with fewer than 25 workers.[1]
- Employer-based coverage varies with firm size. Among companies with fewer than 10 employees, only 52 percent offer health coverage. That percentage rises to 74 percent at firms with between 10 and 24 employees, 87 percent at firms with 25 to 49 workers, and 92 percent at firms with between 50 and 199 employees. Fully 99 percent of companies with more than 200 workers offer insurance.[2]
- Among low-income employees of small firms — that is, those with incomes below 200 percent of the Federal Poverty Level (FPL)[*] — 51.3 percent are uninsured. Above that income level, only 13.8 percent of small-firm employees lack health insurance.[3] The following chart translates these percentages into numbers of insured and uninsured individuals.

Workers and their dependents at establishments with fewer than 10 employees, by insurance status and family income: 2000



Source: Columbia University, Urban Institute, Center for Studying Health System Change, 2002.[4] Calculations by ESRI, August 2004.

Policy Design Issues

1. To reach the uninsured effectively, policies aimed at small companies need to provide significant subsidies for low-income workers, via tax credits or other mechanisms.
2. If such subsidies also go to higher-income employees of small firms, new federal health dollars could primarily be spent on the already insured or substitute for current health spending by employers.
3. At the state level, many health insurance pools for small firms have failed because of limited employer participation.[5] Any new program for small business needs to be designed carefully to overcome this problem.

[*] In 2004, the FPL is $15,670 a year for a family of three.

NOTES

[1] The self-employed comprise 14 percent and employees of the smallest firms make up 35 percent of uninsured workers. Catherine Hoffman and Marie Wang. *Health Insurance Coverage in America: 2002 Data Update*. Kaiser Commission on Medicaid and the Uninsured. January 2003. Calculations by ESRI (March 2003). *http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=29340*.

[2] Gary Claxton, Isadora Gil, Ben Finder, Erin Holve, Jon Gabel, Jeremy Pickering, Heidi Whitmore, Samantha Hawkins, Cheryl Fahlman. *Employer Health Benefits: 2004 Annual Survey*. Kaiser Family Foundation and Health Research and Educational Trust. September 2004. *http://www.kff.org/insurance/7148/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=46207*.

[3] Danielle H. Ferry, Bowen Garrett, Sherry Glied, Emily K. Greenman, and Len M. Nichols. "Health Insurance Expansions For Working Families: A Comparison Of Targeting Strategies." *Health Affairs.* July/August 2002. *http://www.healthaffairs.org/1130_abstract_c.php?ID=/usr/local/apache/sites/healthaffairs.org/htdocs/Library/v21n4/s33.pdf*.

[4] Ferry, et al., op cit.

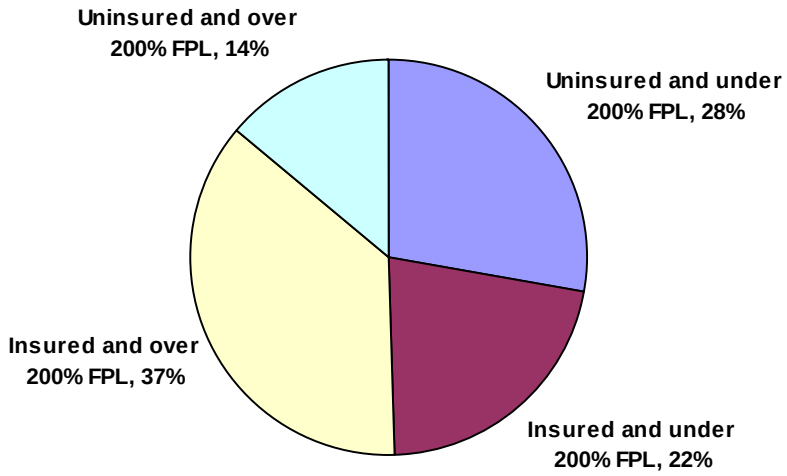
[5] Elliot K. Wicks. *Health Insurance Purchasing Cooperatives*. Economic and Social Research Institute, for The Commonwealth Fund. November 2002. *http://www.cmwf.org/programs/insurance/wicks_purchasingcooperatives_ib_567.pdf*.

WORKERS WHO LOSE THEIR JOBS

Key Facts

- During the average month from January 2002 through July 2004, 8.5 million Americans were unemployed,[1] the average duration of unemployment was 18 weeks,[2] and 21 percent of the unemployed had been without work for more than half a year.[3]
- Among recipients of unemployment insurance, 42 percent are uninsured by their final month of assistance. By contrast, 82 percent had insurance before they lost their jobs.[4]
- Among involuntarily unemployed workers with incomes below 200 percent of the federal poverty level (FPL),[*] 56 percent are uninsured six months after job loss. Above 200 percent FPL, only 27 percent are uninsured.[5]
- Even temporary gaps in coverage can reduce access to care and create financial hardship.[6] Moreover, many laid-off workers who regain employment nevertheless remain uninsured for some time; during their first six months on the job, 37 percent of workers have no access to coverage from their employers. (That figure falls to 9 percent after two years.)[7]

Distribution of involuntarily unemployed workers by income and insurance status, six months after involuntary job loss: 2002



Source: RAND, 2003.[8] Calculations by ESRI, July 2004. Note: this chart applies to the 2002 income distribution of involuntarily unemployed workers the 1996 coverage rates of workers above and below 200% FPL six months after job termination.

Policy Design Issues

1. Covering this group could fix one of the systemic flaws in the nation's health coverage system – namely, that loss of a job often ends health coverage.
2. Policymakers pursuing this approach could build on existing Health Coverage Tax Credits (HCTCs) under the Trade Act of 2002, which pay 65 percent of health insurance premiums for workers who lose their jobs because of foreign competition.[9] However, such an expansion may need to be coupled with adjustments to HCTCs that allow the credits to function more effectively.[10]
3. Alternatively, policymakers could create new Medicaid options to cover this group.
4. Assistance for laid-off workers needs to meet the needs of low-income households if it is to cover the uninsured rather than simply subsidize laid-off workers who already get health insurance through their spouses or other sources. For example, policymakers could consider providing particularly large subsidies for those unemployed workers who have the fewest resources.
5. Subsidies may need to be structured carefully to avoid discouraging re-employment.

[*] In 2004, the FPL is $15,670 a year for a family of three.

NOTES

[1] Bureau of Labor Statistics (BLS). *(Seas) Unemployment Level.* Series ID LNS13000000. January 2002-July 2004. Calculations by ESRI, August 19, 2004. *http://www.bls.gov/webapps/legacy/cpsatab7.htm*.

[2] BLS. *(Seas) Average Weeks Unemployed.* Series ID LNS13008275. January 2002-July 2004. Calculations by ESRI, August 19, 2004. *http://www.bls.gov/webapps/legacy/cpsatab9.htm*.

[3] BLS. *(Seas) Number Unemployed for 27 Weeks & over.* Series ID LNS13008636. January 2002-July 2004. Calculations by ESRI, August 19, 2004. *http://www.bls.gov/webapps/legacy/cpsatab9.htm*.

[4] Ralph E. Smith. *Family Income of Unemployment Insurance Recipients*. Congressional Budget Office, March 2004. *http://www.cbo.gov/ftpdoc.cfm?index=5144&type=1*.

[5] Kanika Kapur and M. Susan Marquis. "Health Insurance For Workers Who Lose Jobs: Implications For Various Subsidy Schemes." *Health Affairs.* May/June 2003 (Calculations by ESRI, July 2003). *http://www.healthaffairs.org/1130_abstract_c.php?ID=http://www.healthaffairs.org/Library/v22n3/s27.pdf*

[6] Sara R. Collins. *Health Care Costs and Instability of Insurance: Impact on Patients' Experiences with Care and Medical Bills*. Invited Testimony, Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, U.S. House of Representatives. The Commonwealth Fund. June 24, 2004. *http://www.cmwf.org/programs/insurance/collins_impact_test_760.pdf*.

[7] Bowen Garret. *Employer-Sponsored Health Insurance Coverage: Sponsorship, Eligibility, and Participation Patterns in 2001*. The Urban Institute, for the Kaiser Commission on Medicaid and the Uninsured. July 2004. Calculations by ESRI, August 2004. *http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=44478*.

[8] Kapur and Marquis., op cit.

[9] Stan Dorn, *The Trade Act of 2002: A Basis for Future Health Coverage of Unemployed Workers?* Economic and Social Research Institute, for the Alliance for Health Reform, December 2003, *http://www.esresearch.org/Documents/trade_act_Alliance.pdf*; Lynn Etheredge and Stan Dorn, *Extending Health Insurance to Laid-Off Workers: A Time for Action,* Economic and Social Research Institute, February 2003, *http://www.esresearch.org/newsletter/january03/stan_lynn_long.pdf*.

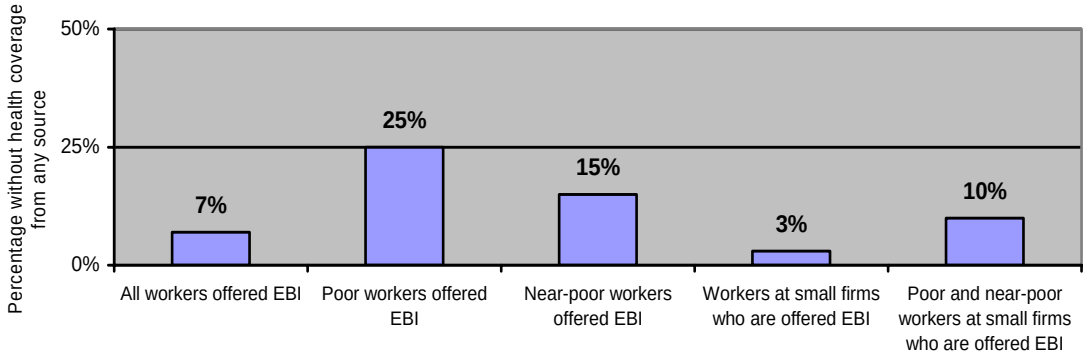
[10] Stan Dorn, *How Can National Policymakers Improve Health Coverage Tax Credits Provided under the Trade Act of 2002?* Economic and Social Research Institute for The California HealthCare Foundation, May 2004, *http://www.esresearch.org/newsletter/trade_act_options.pdf*; Stan Dorn and Todd Kutyla, *Health Coverage Tax Credits Under the Trade Act of 2002: A Preliminary Analysis of Program Operation*, Economic and Social Research Institute for The Commonwealth Fund and The Nathan Cummings Foundation, April 2004, *http://www.cmwf.org/programs/insurance/dorn_tradeactfullrpt_725.pdf*.

WORKERS WHO DECLINE EMPLOYER COVERAGE

Key Facts

- Although most uninsured workers (60 percent) have employers that do not provide health insurance, 22 percent are offered employer coverage but decline it. Another 19 percent of uninsured workers are ineligible for coverage their firms offer.[1]
- Two-thirds (65 percent) of the drop in employer-sponsored coverage from 1999 to 2002 was caused by a reduced acceptance of employer coverage offers, in significant part because many employers increased their workers' required premium contributions.[2] More than half (52 percent) of workers who turn down employer coverage report that they do so because such coverage is too expensive.[3]
- Among workers not enrolled in coverage provided by their employer, only 26 percent are uninsured. The remaining 74 percent are covered by a previous employer, the employer of a spouse or other family member, public coverage, or another source.[4]
- Only 7 percent of the many individuals offered employer-based coverage are uninsured. Even among workers with incomes below the federal poverty level (FPL)[*] who are offered coverage, more than 75 percent are insured. That figure rises to 85 percent for workers with incomes between 100 percent and 200 percent of FPL.[5]
- At small establishments with fewer than 100 workers, 97 percent of employees offered coverage are insured. Even among workers at such firms who have incomes at or below 200 percent of FPL, 90 percent are insured.[6]

Uninsurance among workers offered employer-based insurance (EBI): 1998 and 2000



Sources: Gruber and Washington, 2003 (three bars at left, data from Feb. and March 2001 CPS);[7] Glied, et al., 2003 (two bars at right, data from 1998 MEPS).[8] Notes: (1) Poor workers have income at or below 100% of FPL, and near-poor workers are between 101% and 200% of FPL. (2) Small firms are establishments with fewer than 100 workers. (3) The two bars on the right show particularly low rates of uninsurance among small-firm workers because the chart is limited to workers who are offered EBI. Only 14 percent of uninsured workers at small firms are offered but turn down EBI, compared to 29 percent of uninsured workers at larger firms.[9]

Policy Design Issues

1. Using tax credits, public programs, or other measures to help workers purchase employer-subsidized insurance could combine public resources with employer dollars, leveraging limited federal funding to provide additional help for uninsured workers.
2. It could be difficult to target the uninsured in providing assistance to workers who decline employer coverage. Even if subsidies were limited to such workers who have low incomes or who work for small firms, most assistance would likely go to those who were already insured without any government help.
3. Any new federal program in this area would need to be designed carefully to overcome the problems (such as low enrollment) experienced by a number of state-level programs that subsidize workers' share of employer coverage.[10] For example, substantial subsidies for low-income workers may be needed, along with "hassle-free" participation mechanisms for employers.

[*] In 2004, the FPL is $15,670 a year for a family of three.

NOTES

[1] Sara R. Collins, Cathy Schoen, Diane Colasanto, and Deirdre A. Downey. *On the Edge: Low-Wage Workers and Their Health Insurance Coverage*. The Commonwealth Fund. April 2003. *http://www.cmwf.org/programs/insurance/collins_ontheedge_ib_626.pdf*. Another study came to similar conclusions, finding that 64 percent of uninsured workers were employed by firms that did not offer coverage; 17 percent were ineligible for coverage offered by their employers; and 20 percent did not accept their employers' offers of health insurance. The latter study also found that, among those ineligible for coverage offered by their employers, 43 percent had not worked for the employer long enough to qualify for insurance; 37 percent worked too few hours to qualify; and 7 percent were contract or temporary workers ineligible for coverage. Bowen Garret. *Employer-Sponsored Health Insurance Coverage: Sponsorship, Eligibility, and Participation Patterns in 2001*. The Urban Institute, for the Kaiser Commission on Medicaid and the Uninsured. July 2004. Calculations by ESRI, August 2004. *http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=44478*.

[2] Linda J. Blumberg and John Holahan, *Work, Offers, and Take-Up: Decomposing the Source of Recent Declines in Employer-Sponsored Insurance,* Urban Institute, May 17, 2004, *http://www.urban.org/UploadedPDF/1000645_healthpolicyonline_no9.pdf*; John Holahan, *Changes in Employer-Sponsored Health Insurance Coverage,* Urban Institute, September 17, 2003, *http://www.urban.org/urlprint.cfm?ID=8583*

[3] Garret, op cit.

[4] Shailesh Bhandari. *Employment-Based Health Insurance: 1997.* Current Population Report P70-81. U.S. Census Bureau. December 2002. *http://www.census.gov/prod/2003pubs/p70-81.pdf*. Calculations by ESRI, July 2004.

[5] Jonathan Gruber and Ebonya Washington. *Subsidies to Employee Health Insurance Premiums and the Health Insurance Market.* National Bureau of Economic Research Working Paper 9567. March 2003. *http://www.nber.org/papers/w9567*

[6] Sherry Glied, Jeanne M. Lambrew, Sarah Little. *The Growing Share of Uninsured Workers Employed by Large Firms.* Columbia University and George Washington University, for The Commonwealth Fund. October 2003. *http://www.cmwf.org/programs/insurance/glied_largefirms_672.pdf*.

[7] Gruber and Washington, op cit.

[8] Glied, et al., op cit.

[9] Garret, op cit. Calculations by ESRI, August 2004.

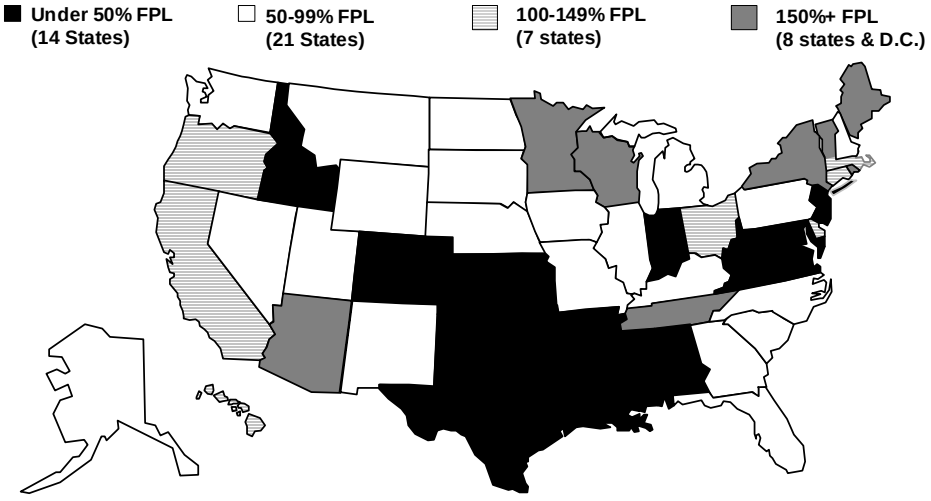
[10] Ed Neuschler and Rick Curtis. *Premium Assistance: What Works? What Doesn't?* Institute for Health Policy Solutions. April 2003. *http://ihps.org/Prem Asst-What Works IHPS April2003.pdf*.

LOW-INCOME PARENTS

Key Facts

- State Medicaid programs can cover parents up to any desired income level, without any need for waivers. States can also seek waivers to use unspent funds from the State Children's Health Insurance Program (SCHIP) to cover low-income parents. However, few states take full advantage of these options. The median state covers low-income working parents up to only 71 percent of the federal poverty level (FPL),* or $927 a month for a family of three.[1]
- Of 10.6 million parents who were uninsured in 2002, 5.6 million would qualify for Medicaid if eligibility for parents and children were based on the same criteria. An additional 1.8 million would gain access to insurance if each state's SCHIP eligibility rules applied to parents.[2]
- Nearly half (47 percent) of poor parents lack health coverage. Among near-poor parents with incomes between 100 percent and 200 percent of FPL, slightly less than one-third (30 percent) are uninsured.[3]

Medicaid coverage of working parents, by income: April 2003



Source: Center on Budget and Policy Priorities, July 2003. Notes: (1) In Pennsylvania, Utah, and Washington State, this map shows income eligibility for uncapped Medicaid, rather than programs with higher income eligibility levels but enrollment caps. (2) In 40 states, income eligibility levels for non-working parents were lower than for working parents.

Policy Design Issues

1. By offering increased SCHIP funding, with federal matching rates higher than Medicaid's, for low-income parents of children receiving Medicaid or SCHIP, national policymakers could encourage states to cover these parents. Not only would this help parents, Medicaid and SCHIP would enroll eligible children who are now uninsured. More children are covered when their parents gain access to the same source of health insurance.[4]
2. If subsidies reach parents with incomes up to SCHIP levels (200 percent of FPL or higher, in most states), policymakers may need to consider new safeguards to prevent these subsidies from substituting for current employer-based insurance.
3. Policymakers taking this approach would also need to decide whether enhanced SCHIP matching funds would be limited to parents who are ineligible for Medicaid under current law. While such a limit would reduce the spending of new federal dollars on the currently insured, it would also disadvantage states that previously extended generous coverage.

* In 2004, the FPL is $15,670 a year for a family of three.

NOTES

[1] Donna Cohen Ross and Laura Cox. *Preserving Recent Progress On Health Coverage for Children And Families: New Tensions Emerge*. Center on Budget and Policy Priorities, for the Kaiser Commission on Medicaid and the Uninsured. July 2003. *http://www.cbpp.org/7-30-03health.pdf*.

[2] Lisa Dubay and Genevieve Kenney. "Addressing Coverage Gaps For Low-Income Parents." *Health Affairs.* Vol 23, Issue 2, 225-234. March/April 2004. *http://content.healthaffairs.org/cgi/content/full/23/2/225*.

[3] Bowen Garrett, Len M. Nichols, and Emily K. Greenman. *Workers Without Health Insurance: Who Are They And How Can Policy Reach Them?* Urban Institute, prepared for the W.K. Kellogg Foundation. September 1, 2001. Calculations by ESRI, August 2004. *http://www.urban.org/UploadedPDF/310244_workershealthins.pdf*.

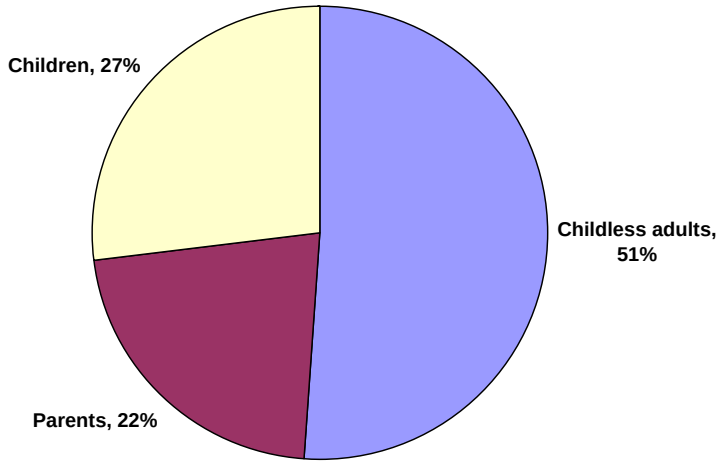
[4] Anna Aizer and Jeffrey Grogger, *Parental Medicaid Expansions and Health Insurance Coverage,* Economic Research Initiative on the Uninsured Working Paper 20, June 2003, *http://www.umich.edu/~eriu/pdf/wp20.pdf*; Richard E. Curtis and Edward Neuschler, "Premium Assistance," *Health Insurance for Children: Creative Solutions,* The Future of Children, Spring 2003, *http://www.futureofchildren.org/usr_doc/tfoc13-1_syn11.pdf*; Amy Davidoff, Lisa Dubay, Genevieve Kenney, Alshadye Yemane, "The Effects of Parents' Insurance Coverage on Access to Care for Low-Income Children," *Inquiry* 40, no. 3 (2003): 254–268, *http://www.inquiryjournalonline.org/inqronline/?request=get-document&issn=0046-9580&volume=040&issue=03&page=0254*; and Lisa Dubay and Genevieve Kenney, "Expanding Health Insurance Coverage to Parents: Effects on Children's Coverage under Medicaid," *Health Services Research* 38, no. 5 (2003): 1283–1302, *http://www.ingenta.com/isis/searching/Availability/ingenta;jsessionid=5mefb4mgd222f.circus?pub=infobike://bpl/hesr/2003/00000038/00000005/art00007&targetId=1090871634097*.

LOW-INCOME, CHILDLESS ADULTS

Key Facts

- More than one-third of all the uninsured (36 percent) have incomes below the federal poverty level (FPL).[1*] Among these poor uninsured, slightly more than half (51 percent) are childless adults.[2]
- Among the uninsured with family incomes below 200 percent of FPL, only 13 percent of childless adults qualify for public coverage, compared to 34 percent of parents and 84 percent of children. Even among the very poor uninsured with incomes below 50 percent of the FPL (currently $520 a month for a two-person household), only 25 percent of childless adults have access to public coverage, compared to 89 percent of parents and an even higher proportion of children.[3]
- One key reason for these facts is that federal law prohibits state Medicaid programs from covering adults—no matter how poor they are or how hard they work—unless they are pregnant, caring for dependent children, severely disabled, or elderly. In January 2004, only 14 states and D.C. covered such childless adults via waivers of normal federal rules or by using their own funds (without any federal match).[4]
- Fully 62 percent of childless adults with incomes below poverty are uninsured, as are 46 percent with incomes between 100 and 200 percent FPL.[5] For such adults with incomes above 200 percent of FPL, fewer than 10 percent lack coverage.[6]

Uninsured with incomes below poverty, by relationship to children: 2002



Source: Urban Institute analysis of March 2003 CPS data, prepared for the Kaiser Commission on Medicaid and the Uninsured.[7]

Policy Design Issues

1. Since so many of them are uninsured, poor, childless adults could receive publicly subsidized coverage with relatively little danger of either significant losses in employer-based insurance or new federal dollars going mostly to the insured.
2. National policymakers could help this population by giving state Medicaid programs the option, without any need for federal waivers, to cover all poor adults or households, without regard to the presence or absence of dependent children living at home.
3. To increase states' incentives to implement such an option, the federal government could raise its matching funding level, perhaps in capped amounts, as under the State Children's Health Insurance Program.[8] Federal costs could be limited by phasing-in enhanced funding based on income, with the poorest uninsured adults receiving coverage first.[9]
4. Alternatively, federal policymakers could require Medicaid to cover all poor adults. If policymakers pursuing this approach wish to avoid an unfunded mandate on states, the federal government would need either to fund all costs of expanded coverage or to directly operate this part of Medicaid.[10]

[*] In 2004, the FPL is $15,670 a year for a family of three.

NOTES

[1] Catherine Hoffman and Marie Wang. *Health Insurance Coverage in America: 2002 Data Update.* Kaiser Commission on Medicaid and the Uninsured. January 2003. Calculations by ESRI (March 2003). http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=29340.

[2] Stan Dorn, Sharon Silow-Carroll, Tanya Alteras, Heather Sacks, and Jack Meyer. *Medicaid and Other Public Programs for Low-Income Childless Adults: An Overview of Coverage in Eight States.* Economic and Social Research Institute, for the Kaiser Commission on Medicaid and the Uninsured, citing Urban Institute analysis. August 2004. *http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=46175*. Earlier research was to the same effect, concluding that 52 percent of poor uninsured were childless adults. Jeanne M. Lambrew, Arthur Garson, Jr. *Small But Significant Steps To Help The Uninsured.* January 2003. Prepared for The Commonwealth Fund. *http://www.cmwf.org/programs/insurance/lambrew_smallsignificant_585.pdf*.

[3] The numbers for adults come from Amy Davidoff, Anna S. Sommers. Jennifer Lesko, and Alshadye Yemane. *Medicaid and State-Funded Coverage for Adults: Estimates of Eligibility and Enrollment.* The Urban Institute, for The Kaiser Commission on Medicaid and the Uninsured. April 2004. *http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=35461*. The numbers for children under 200 percent of the FPL are from Lisa Dubay, Jennifer Haley, and Genevieve Kenney. *Children's Eligibility for Medicaid and SCHIP: A View from 2000.* The Urban Institute, March 2002. *http://www.urban.org/UploadedPDF/310435.pdf*. As to uninsured children with incomes below 50 percent of FPL, precise estimates of the percentage who qualify for Medicaid are unavailable, but it appears virtually certain to be higher than the corresponding percentage for parents. That is because, while every state provides Medicaid coverage to children with incomes above 100 percent of the FPL, fully 29 states use an eligibility cut-off below 49 percent of the FPL for at least some parents. Donna Cohen Ross and Laura Cox. *Preserving Recent Progress On Health Coverage for Children And Families: New Tensions Emerge*. Center on Budget and Policy Priorities, for the Kaiser Commission on Medicaid and the Uninsured. July 2003. *http://www.cbpp.org/7-30-03health.pdf*.

[4] Dorn, Silow-Carroll, et al., op cit.

[5] Danielle H. Ferry, Bowen Garrett, Sherry Glied, Emily K. Greenman, and Len M. Nichols. "Health Insurance Expansions For Working Families: A Comparison Of Targeting Strategies." *Health Affairs.* July/August 2002. *http://www.healthaffairs.org/1130_abstract_c.php?ID=/usr/local/apache/sites/healthaffairs.org/htdocs/Library/v21n4/s33.pdf*.

[6] Bowen Garret. *Employer-Sponsored Health Insurance Coverage: Sponsorship, Eligibility, and Participation Patterns in 2001*. The Urban Institute, for the Kaiser Commission on Medicaid and the Uninsured. July 2004. Calculations by ESRI, October 2003. *http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=44478*.

[7] Dorn, Silow-Carroll, et al., op cit.

[8] Such increases would need to be designed carefully, however, to avoid giving states incentives to use enhanced federal funding primarily to substitute for previous state spending, with relatively little expansion in coverage. State Medicaid programs have a long history of pursuing creative strategies to maximize their receipt of federal dollars, in some cases without corresponding increases in health coverage for low-income residents. For analyses of recent state strategies, see Statement of Kathryn G. Allen, General Accounting Office, *Medicaid: Intergovernmental Transfers Have Facilitated State Financing Schemes,* Testimony Before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives, GAO-04-574T, March 18, 2004. *http://www.gao.gov/cgi-bin/getrpt?GAO-04-574T*; General Accounting Office, *Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed,* GAO-04-228, February 2004, *http://www.gao.gov/new.items/d04228.pdf*. For an analysis of previous state efforts in this area, along with a bibliography of related GAO reports dating back to 1994, see Statement of Kathryn G. Allen. General Accounting Office. *Medicaid: State Financing Schemes Again Drive Up Federal Payments.* Testimony before the Senate Committee on Finance. GAO/T-HEHS-00-193. September 6, 2000. *http://www.gao.gov/new.items/he00193t.pdf*.

[9] Other possible approaches would phase-in enhanced funding based on age, starting with either the oldest or youngest uninsured, childless adults. Alternatively, capped amounts of enhanced funding could increase gradually over time, leaving it to each state to decide how to phase in coverage.

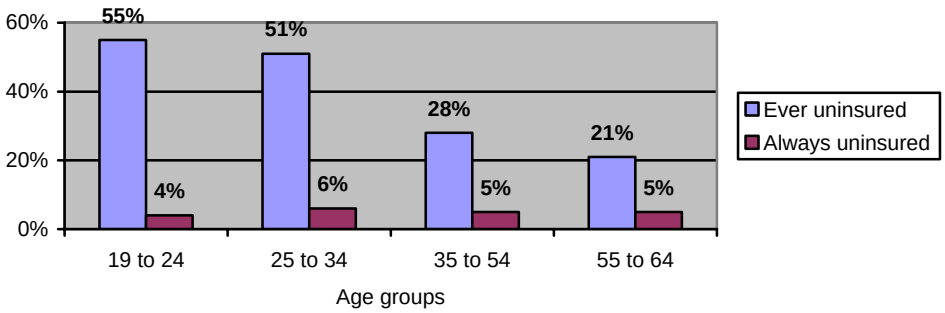
[10] For a fuller discussion of such approaches, see John Holahan, Alan Weil, Joshua M. Wiener, eds. *Federalism and Health Policy*. Urban Institute. July 22, 2003. *http://www.urban.org/url.cfm?ID=900646*.

THE NEAR-ELDERLY

Key Facts

- Only 13 percent of 55 to 64 year olds were uninsured during 2003, compared to 21.5 percent of younger adults.[1]
- Although the near-elderly are less likely to be uninsured than are younger adults, once older Americans lose coverage, they are much more likely to remain uninsured for extended periods of time. Among people who were uninsured at any point from 1996 through 1999, 22 percent of adults age 55-64 were uninsured for all four years, compared to 12 percent among the uninsured of all ages.[2]
- Near-elders' insurance status varies greatly based on income and retirement. Among 55-64 year olds with incomes below 200 percent of the federal poverty level (FPL),[*] only 16.7 percent of retirees are uninsured, compared to 35.2 percent of near-elders who are in the workforce (i.e., neither retired nor so ill as to preclude work).[†] Above 400 percent of FPL, uninsurance drops to 0.1 percent among retirees and 3.3 percent among healthy non-retirees.[3]
- The consequences of uninsurance are particularly severe with this age group, according to the Institute of Medicine.[4] One peer-reviewed, controlled study estimated that uninsurance among 55-64 year olds causes 13,000 premature deaths each year.[5]
- During their first two years on Medicare, seniors who were previously uninsured use 30 percent more physician care, on average, than do other enrollees, raising annual Medicare costs by $600 per previously uninsured senior.[6]

Insurance gaps by age over a four-year period: 1996-1999



How to read this chart: 55% of 19-24 year olds were uninsured at some point during 1996-1999, and 4% were uninsured throughout all of 1996-1999; among 25-34 year olds, 51% were uninsured at some point and 6% were uninsured throughout 1996-1999; etc. Source: Short and Graefe, 2003.[7] Calculations by ESRI, July 2004.

Policy Design Issues

1. Older adults without health coverage could benefit from other policies aimed at broader groups of uninsured. For example, in several state programs for low-income, childless adults, near-elders in their 50s and 60s comprise more than a third of all enrollees.[8]
2. One proposal specific to the near-elderly would let some[9] or all "buy into" Medicare, paying premiums based on a percentage of average Medicare costs.[10] However, many using this option could be near-elders who are now covered through the non-group market, rather than the uninsured. To have a substantial impact on the uninsured, a Medicare buy-in may need significant subsidies for low-income near-elders.
3. Another approach would provide tax credits for the near-elderly. Issues could arise like those affecting a Medicare buy-in, such as targeting the uninsured and providing extra subsidies for low income near-elders. This approach would also evoke concerns specific to tax credits, such as ensuring that credit recipients have access to coverage that policymakers regard as satisfactory.

[*] In 2004, the FPL is $15,670 a year for a family of three.

[†] Retirement is associated with receipt of employer-based insurance (EBI), often from former employers. For example, among near-elders below 200% of FPL, 62% of retirees have EBI, compared to 46% of non-retirees healthy enough to work, according to a recent Urban Institute study.

NOTES

[1] U.S. Bureau of the Census, Last Revised July 29, 2004, HI01. *Health Insurance Coverage Status and Type of Coverage by Selected Characteristics: 2003*, All Races. *http://ferret.bls.census.gov/macro/032004/health/h01_001.htm* accompanying Carmen DeNavas-Walt, Bernadette D. Proctor, Robert J. Mills, *Income, Poverty, and Health Insurance Coverage in the United States: 2003,* U.S. Bureau of the Census. Current Population Report P60-226, August 2004. An earlier survey of coverage during the first half of 2003 found that 19 percent of nonelderly Americans were uninsured, compared to 14 percent of adults age 55-64. Jeffrey A. Rhoades. *The Uninsured in America, 2003: Estimates for the U.S. Population under Age 65*. MEPS Statistical Brief #41. Agency for Healthcare Research and Quality. June 2004. *http://www.meps.ahrq.gov/papers/st41/stat41.htm*.

[2] Pamela Farley Short and Deborah R. Graefe. "Battery-Powered Health Insurance? Stability In Coverage Of The Uninsured." *Health Affairs.* Vol 22, Issue 6, 244-255. November/December 2003. *http://content.healthaffairs.org/cgi/content/full/22/6/244?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=short&andorexactfulltext=and&searchid=1090871866134_2825&stored_search=&FIRSTINDEX=0&volume=22&resourcetype=1&journalcode=healthaff*.

[3] John Holahan. Health Insurance Coverage of the Near Elderly. The Urban Institute, prepared for the Kaiser Commission on Medicaid and the Uninsured. July 2004. *http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=45109*. This report analyzed a third group of near-elders as well – namely, those who were not working because of illness or disability. Among that group, 12.4 percent of those with incomes below 200% of FPL were uninsured, as were 2.8 percent of those above 400% of FPL. The importance of income is confirmed by other research finding that 38 percent of 50-64 year olds with incomes below poverty were uninsured, compared to only 8 percent of those with incomes above 300% of FPL. Pamela Farley Short, Dennis G. Shea, and M. Paige Powell. *Health Insurance On The Way To Medicare: Is Special Government Assistance Warranted?* Pennsylvania State University for The Commonwealth Fund. July 2001. *http://www.cmwf.org/programs/insurance/Short_insurance_to_Medicare_457.pdf*.

[4] Committee on the Consequences of Uninsurance. *Care Without Coverage: Too Little, Too Late*. Institute of Medicine, May 21, 2002. *http://www.iom.edu/includes/viewobject.asp?id=4160*.

[5] J. Michael McWilliams, Alan M. Zaslavsky, Ellen Meara and John Z. Ayanian. "Health Insurance Coverage and Mortality Among The Near-Elderly." *Health Affairs.* Vol 23, Issue 4, 223-233. July/August 2004. *http://content.healthaffairs.org/cgi/content/abstract/23/4/223*.

[6] Li-Wu Chen, Wanqing Zhang, Jane Meza, Phani Tej Adidam, Keith Mueller, Louis Pol, Dennis Shea, and Roslyn Fraser. *The Pent-up Demand for Health Care of the Uninsured Near Elderly Approaching Age 65.* University of Nebraska Medical Center, for The Economic Research Initiative for the Uninsured (ERIU) at the University of Michigan. June 6, 2004. AcademyHealth 2004 Annual Meeting. *http://www.academyhealth.org/2004/ppt/chen3.ppt*.

[7] Short and Graefe, op cit.

[8] Only two such states have published relevant data – namely, Washington, which covers childless adults up to 200 percent of FPL, and Minnesota, which provides such coverage up to 175 percent of the FPL. According to the most recent available data, 35 percent of childless adults covered in Minnesota were age 50-64; and 29 percent of those covered in Washington were age 55-64, with more in their early 502. This high proportion of near-elderly enrollees may have resulted, in part, from Medicaid's automatic termination of coverage when dependent children grow up and their formerly eligible caretaker parents become ineligible "empty nesters." Stan Dorn, Sharon Silow-Carroll, Tanya Alteras, Heather Sacks, and Jack Meyer. *Medicaid and Other Public Programs for Low-Income Childless Adults: An Overview of Coverage in Eight States.* Economic and Social Research Institute, for the Kaiser Commission on Medicaid and the Uninsured, citing Urban Institute analysis. August 2004. *http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=46175*.

[9] For example, a Medicare buy-in could be limited to older individuals losing employer-based coverage or, to avoid concerns about triggering early retirements, to younger spouses of individuals who lose employer-sponsored insurance when they retire and qualify for Medicare. Jeanne M. Lambrew, Arthur Garson, Jr. *Small But Significant Steps To Help The Uninsured.* January 2003. Prepared for The Commonwealth Fund. *http://www.cmwf.org/programs/insurance/lambrew_smallsignificant_585.pdf*.

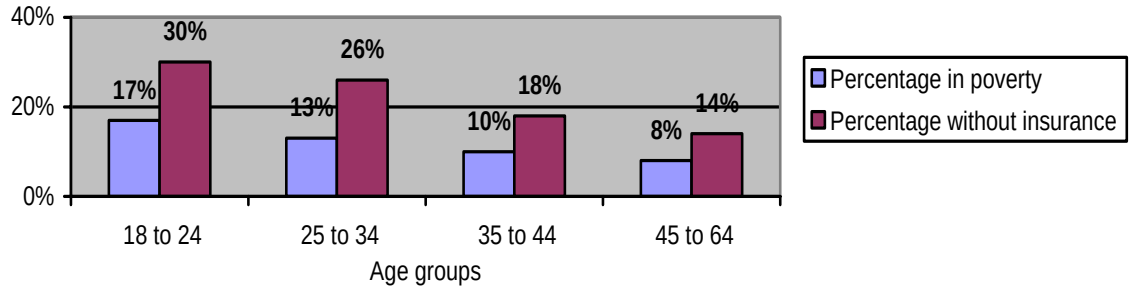
[10] Short, Shea, and Powell, op cit.; Richard W. Johnson. *Changing the Age of Medicare Eligibility: Implications for Older Adults, Employers, and the Government.* The Urban Institute, prepared for the National Academy of Social Insurance. December 2003. *http://www.urban.org/Template.cfm?Section=SearchbyIssue&NavMenuID=94&template=/TaggedContent/ViewPublication.cfm&PublicationID=8672*.

YOUNG ADULTS

Key Facts

- Young adults age 19 through 29[1] represent 30 percent of uninsured Americans, even though they make up only 17 percent of the non-elderly population.[2]
- Young adults are the fastest-growing age group among the uninsured, comprising one-third of the increase in uninsured from 39 million in 2000 to 43 million in 2002.
- One important reason young adults are the most likely age group to be uninsured is that parental insurance coverage typically ends after high school or college. Among high school graduates not going on to college, 51 percent are uninsured; and 38 percent of college graduates are uninsured during part of the year following graduation.
- Another important factor is income. Among the poor, 18 to 24 year olds are slightly more likely to have coverage than are somewhat older adults (54 percent coverage for poor, 18-24 year olds versus 52 percent for poor, 25-44 year olds).[3] But 18 to 24 year olds are far more likely to be poor than are even slightly older adults (poverty rates of 17 percent for 18-24 year olds versus 11 percent for 25-44 year olds).[4] Of uninsured 19-29 year olds, 68 percent have incomes under 200 percent of the federal poverty level,[*] and 38 percent live in poverty.
- To obtain employer-based insurance limited to the worker alone, employees must pay an average of $508 a year.[5] Nevertheless, despite their lower income, 80 percent of 19-24 year olds who are offered employer-based insurance accept it – slightly fewer than the 85 percent who accept such offers among workers of all ages.[6]
- Young adults are the least expensive age group to insure, with annual *per capita* costs averaging approximately $1,500, compared to $1,750 for children, $2,600 for adults age 30-49, and $5,000 for adults age 50-64.

Poverty and insurance coverage, by age: 2003



Source: U.S. Census Bureau, August 2004.[7] Calculations by ESRI, August 2004.

Policy Design Issues

1. Young adults without health coverage may benefit from other policies aimed at larger groups of uninsured workers, such as low-income, childless adults.
2. One option specifically targeting young adults would require private family coverage to include dependents through their early 20s, whether or not they attend school. Alternatively, insurers could be required simply to offer such coverage as an option for families, as under federal employee insurance today.[8] Of course, premiums for family coverage would increase if more dependents were included through early adulthood.
3. Another approach would give state Medicaid and State Children's Health Insurance programs the option to extend children's coverage to older teens and some adults in their 20s. Federal funding above standard Medicaid matching rates would increase states' implementation of such an option (but boost federal costs).[9]
4. A number of states require all college students to be insured, through a health plan offered by the school or another source. Federal action could encourage states or colleges elsewhere to impose similar requirements.
5. Including relatively inexpensive, young adults in broader insurance pools could lower average costs within pools, potentially reducing premiums and encouraging pool participation by others.

[*] In 2004, the federal poverty level is $15,670 a year for a family of three.

NOTES

[1] Similar results hold true for a more narrowly defined group of young adults. That is, 18-24 year olds comprise 10 percent of the total population but 19 percent of the uninsured. U.S. Bureau of the Census, Last Revised July 29, 2004, Table HI01. *Health Insurance Coverage Status and Type of Coverage by Selected Characteristics: 2003*, All Races. *http://ferret.bls.census.gov/macro/032004/health/h01_001.htm*, accompanying Carmen DeNavas-Walt, Bernadette D. Proctor, Robert J. Mills, *Income, Poverty, and Health Insurance Coverage in the United States: 2003,* U.S. Bureau of the Census. Current Population Report P60-226, August 2004 (hereinafter "Census Bureau 2003 Report"). Calculations by ESRI, August 2004.

[2] Sara R. Collins, Cathy Schoen, Katie Tenney, Michelle M. Doty, and Alice Ho. *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help*. The Commonwealth Fund. May 2004 (updated from prior report). *http://www.cmwf.org/programs/insurance/collins_riteofpassage_ib_649.pdf*. This study is the source of all the remaining un-footnoted facts and policy ideas in this fact sheet, except that the final bullet without a footnote also involves July 2004 calculations by ESRI.

[3] Census Bureau 2003 Report. Calculations by ESRI, August 2004. See also Robert J. Mills and Shailesh Bhandari. *Health Insurance Coverage in the United States: 2002*. U.S. Bureau of the Census. Current Population Report P60-223. September 2003. *http://www.census.gov/prod/2003pubs/p60-223.pdf*.

[4] Census Bureau 2003 Report, Tables H101 and H103. Calculations by ESRI, September 2004. The latter table is at *http://ferret.bls.census.gov/macro/032004/health/h03_001.htm*. In fact, median annual income of 18 to 24 year olds is $11,170, compared to $26,117 for all non-elderly adults. U.S. Bureau of the Census. *Table PINC-02. Marital Status--People 18 Years Old and Over, by Total Money Income in 2003, Work Experience in 2003, Age, Race, Hispanic Origin and Sex*. Last revised June 25, 2004. *http://ferret.bls.census.gov/macro/032004/perinc/new02_000.htm*.

[5] Kaiser Family Foundation and Health Research and Educational Trust. *Employer Health Coverage: 2003 Annual Survey.* September 2003. Calculations by ESRI, October 2003. *http://www.kff.org/insurance/ehbs2003-1-set.cfm*.

[6] Bowen Garret. *Employer-Sponsored Health Insurance Coverage: Sponsorship, Eligibility, and Participation Patterns in 2001*. The Urban Institute, for the Kaiser Commission on Medicaid and the Uninsured. July 2004. Calculations by ESRI, August 2004. *http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=44478*.

[7] Census Bureau 2003 Report.

[8] Jeanne M. Lambrew, Arthur Garson, Jr. *Small But Significant Steps To Help The Uninsured.* January 2003. Prepared for The Commonwealth Fund. *http://www.cmwf.org/programs/insurance/lambrew_smallsignificant_585.pdf*.

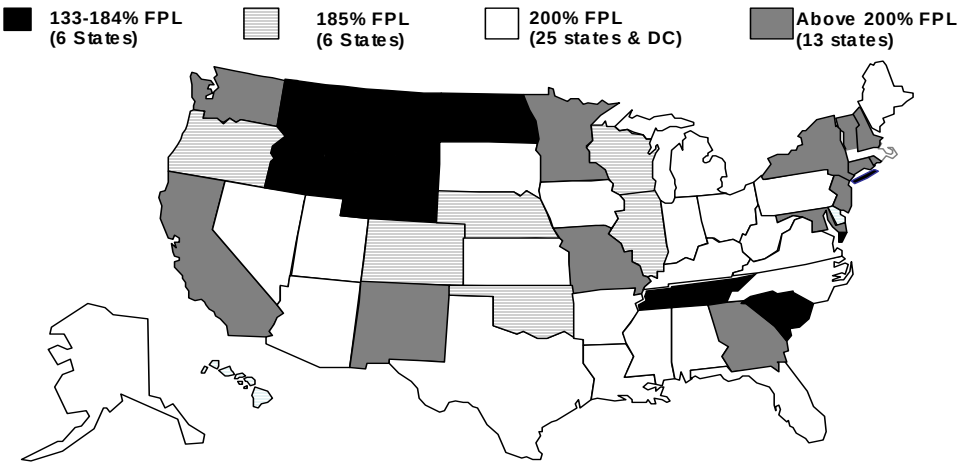
[9] Alternatively, this coverage could be mandatory. However, depending on its structure, such a mandate could impose unfunded costs on states.

CHILDREN

Key Facts

- More than half (56 percent) of all uninsured children nationally are eligible for but not enrolled in Medicaid or the State Children's Health Insurance Program (SCHIP).[1]
- Among children eligible for Medicaid or SCHIP, 70 percent are enrolled. If 85 percent were enrolled, 40 percent fewer children would be uninsured.[2]
- More than 69 percent of uninsured, low-income children (most of whom qualify for Medicaid or SCHIP) are enrolled in the National School Lunch Program, Food Stamps, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), or other means-tested programs.[3] However, because these programs use different eligibility rules than Medicaid and SCHIP, the uninsured children they serve usually cannot be enrolled automatically into child health programs, even though most qualify.
- State Medicaid and SCHIP programs can cover children with family incomes up to or even above 200 percent of the federal poverty level (FPL);[*] 38 states plus D.C. provide such coverage.[4]

Medicaid and SCHIP coverage of children, by maximum family income for eligible children: April 2003



Source: Center on Budget and Policy Priorities, July 2003. Notes: (1) In states with varying income-eligibility thresholds for children of different ages, this figure shows the lowest income ceiling for any group of children under age 19. (2) This map shows income eligibility for Medicaid and SCHIP, rather than other, capped programs.

Policy Design Issues

1. To expand coverage of uninsured children, policymakers generally need to increase efforts to enroll into SCHIP and Medicaid children who already qualify for coverage, rather than expanding eligibility beyond current law.[†]
2. According to a comprehensive review of take-up studies analyzing a broad range of public and private benefits, "it seems clear that automatic enrollment is the best way to increase take-up" of children's SCHIP and Medicaid coverage.[5] For example, children receiving other public benefits[6] or attending school could be enrolled automatically into health coverage, unless their parents objected.
3. Under a different approach, low-income parents of SCHIP- or Medicaid-eligible children could be offered SCHIP and Medicaid, which would increase their children's enrollment.[7]

[*] In 2004, the FPL is $15,670 a year for a family of three.
[†] One important exception to this general rule involves immigrant children, many of whom are denied federal matching funds for Medicaid or SCHIP coverage.

NOTES

[1] Genevieve M. Kenney, Jennifer M. Haley, Alexandra Tebay. *Children's Insurance Coverage and Service Use Improve.* Urban Institute. July 31, 2003. *http://www.urban.org/Template.cfm?NavMenuID=24&template=/TaggedContent/ViewPublication.cfm&ionID=8496*.

[2] Peter J. Cunningham. "SCHIP Making Progress: Increased Take-Up Contributes To Coverage Gains." *Health Affairs.* Volume 22, Number 4. July/August 2003. Calculations by ESRI, October 2003. *http://www.healthaffairs.org/1130_abstract_c.php?ID=http://www.healthaffairs.org/Library/v22n4/s28.pdf*. Other sources suggest lower enrollment rates of eligible children. For example, one recent analysis found a 44 percent enrollment rate. This analysis was based entirely on income, however, and did not take into account other limitations on Medicaid and SCHIP eligibility, such as immigration status. Karl Kronebusch and Brian Elbel, "Simplifying Children's Medicaid and SCHIP," *Health Affairs* (May/June 2004): 233-246, Supplemental Exhibit 3, Children's Eligibility, Enrollment, and Lack of Health Insurance, By State, 2001. *http://content.healthaffairs.org/cgi/data/23/3/233/DC1/3*.

[3] The Children's Partnership. *Uninsured Children And Program Participation, United States, 1997-1999* (undated Urban Institute analysis of data from the 1997 and 1999 National Surveys of America's Families). *http://www.childrenspartnership.org/expresslane/nationaldata.html*.

[4] Donna Cohen Ross and Laura Cox. *Preserving Recent Progress On Health Coverage for Children And Families: New Tensions Emerge.* Center on Budget and Policy Priorities, for the Kaiser Commission on Medicaid and the Uninsured. July 2003. *http://www.cbpp.org/7-30-03health.pdf*. See also Kaiser Commission on Medicaid and the Uninsured. *Health Coverage for Low-Income Children.* May 2002. *http://www.kff.org/content/2002/214403/214403.pdf*.

[5] Dahlia K. Remler and Sherry A. Glied. "What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs." *American Journal of Public Health*. January 2003, Vol 93, No. 1.

[6] For a broad exploration of this issue, see The Children's Partnership. *Express Lane Eligibility: Toolkit for Action.* 2003. *http://www.childrenspartnership.org/expresslane/*.

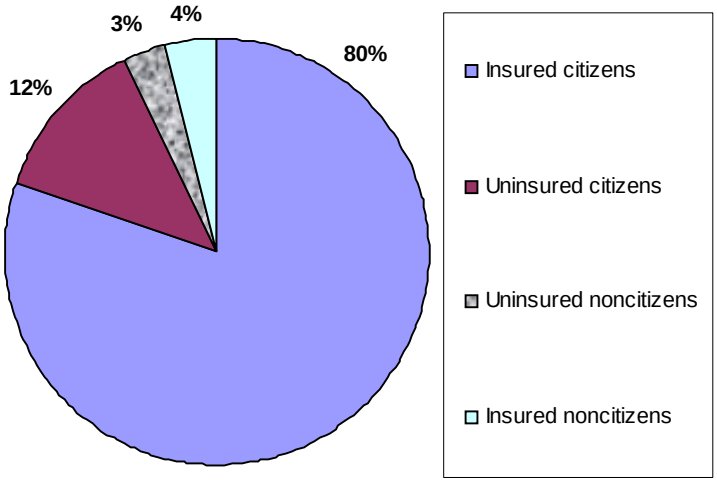
[7] Anna Aizer and Jeffrey Grogger, *Parental Medicaid Expansions and Health Insurance Coverage,* Economic Research Initiative on the Uninsured Working Paper 20, June 2003, *http://www.umich.edu/~eriu/pdf/wp20.pdf*; Richard E. Curtis and Edward Neuschler, "Premium Assistance," *Health Insurance for Children: Creative Solutions,* The Future of Children, Spring 2003, *http://www.futureofchildren.org/usr_doc/tfoc13-1_syn11.pdf*; Amy Davidoff, Lisa Dubay, Genevieve Kenney, Alshadye Yemane, "The Effects of Parents' Insurance Coverage on Access to Care for Low-Income Children," *Inquiry* 40, no. 3 (2003): 254–268, *http://www.inquiryjournalonline.org/inqronline/?request=get-document&issn=0046-9580&volume=040&issue=03&page=0254*; and Lisa Dubay and Genevieve Kenney, "Expanding Health Insurance Coverage to Parents: Effects on Children's Coverage under Medicaid," *Health Services Research* 38, no. 5 (2003): 1283–1302, *http://www.ingenta.com/isis/searching/Availability/ingenta;jsessionid=5mefb4mgd222f.circus?pub=infobike://bpl/hesr/2003/00000038/00000005/art00007&targetId=1090871634097*.

IMMIGRANTS

Key Facts

- Each year from 2000 through 2003, 21 percent of the uninsured were non-citizens. Nearly half (45 percent) of non-citizens lack health coverage,[1] primarily because many work at jobs that do not offer health insurance.[2]
- Among all foreign-born residents, 30 percent are naturalized citizens, 26 percent are undocumented immigrants, and 44 percent are non-citizens who live here legally.[3]
- Most uninsured non-citizens are legal residents. Among uninsured non-citizens who have lived in the U.S. for five years or less, 29 percent are undocumented.[4]
- Although emergency services are covered regardless of immigration status, welfare reform legislation enacted in 1996 ended federal funding for non-emergency Medicaid and SCHIP provided to legal immigrants during their first five years in the country.[5] Roughly 150,000 parents and children are uninsured because of the five-year ban.[6]
- In one exception to the ban, SCHIP funds can be used for undocumented women's prenatal care, which HHS classifies as coverage to unborn children.[7] By November 2003, 6 states implemented this option.[8] Moreover, as of May 2004, 21 states used their own dollars to cover some non-citizens ineligible for federal matching funds.[9]

Distribution of U.S. residents by insurance and citizenship status: 2003



Source: U.S. Census Bureau, August 26, 2004.[10] Calculations by ESRI, August 2004.

Policy Design Issues

1. National policymakers could increase states' flexibility to use federal matching funds in covering otherwise eligible individuals whose immigration status currently disqualifies them from Medicaid or SCHIP. For example, states could receive the option to insure otherwise eligible legal residents during their first five years in the U.S.
2. While increasing coverage among uninsured immigrants and their family members, such policies would also provide fiscal relief to states that now cover immigrant residents using state-only dollars. As a result, the federal government, which is partially responsible for immigrants' presence in the U.S., would pay more of their health costs.
3. Policies focused on immigrants can also affect citizens, as many families include both. Among the children of non-citizen parents, 72 percent are U.S. citizens,[11] including two-thirds (65 percent) of the children of undocumented immigrants.[12] More than a quarter of uninsured, non-citizen children have a brother or sister who is a U.S. citizen.[13]
4. While some controversial questions may face policymakers who consider expanding health coverage to uninsured immigrants, it seems highly unlikely that increased health coverage would boost immigration substantially. Between 1995 and 2000, the number of immigrant families with children grew four times faster in states with the least generous benefits for immigrants than in states with more generous safety nets.[14]

NOTES

[1] U.S. Bureau of the Census, Last Revised July 29, 2004, HI01. *Health Insurance Coverage Status and Type of Coverage by Selected Characteristics: 2003*, All Races. *http://ferret.bls.census.gov/macro/032004/health/h01_001.htm* (hereinafter "Census Bureau 2003 Report") accompanying Carmen DeNavas-Walt, Bernadette D. Proctor, Robert J. Mills, *Income, Poverty, and Health Insurance Coverage in the United States: 2003,* U.S. Bureau of the Census. Current Population Report P60-226, August 2004. Calculations by ESRI, August 2004.

[2] Joan C. Alker and Marcela Urrutia. *Immigrants and Health Coverage: A Primer.* Health Policy Institute, Georgetown University, and the National Council of La Raza, prepared for the Kaiser Commission on Medicaid and the Uninsured. June 2004. *http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=44857*.

[3] The latter number is divided as follows: 30 percent are legal permanent residents; 8 percent are refugees; and 5 percent are legal temporary residents. Jeffrey S. Passel, Randy Capps, and Michael Fix. *Undocumented Immigrants: Facts And Figures.* Urban Institute. January 12, 2004. *http://www.urban.org/UploadedPDF/1000587_undoc_immigrants_facts.pdf*.

[4] Olveen Carrasquillo, Danielle H. Ferry, Jennifer Edwards, and Sherry Glied. "Eligibility for Government Insurance if Immigrant Provisions of Welfare Reform Are Repealed." *American Journal of Public Health*. October 2003, Vol 93, No. 10. The Commonwealth Fund. Calculations by ESRI, August 2004. *http://www.cbpp.org/10-14-03health.htm*.

[5] The five-year ban does not apply to selected groups, such as certain refugees and immigrants with disabilities. However, the welfare legislation also narrowed immigrants' eligibility for health coverage in several ways outside the five-year ban. First, when the five-year ban ends for an immigrant, the immigration sponsor's income and assets can be taken into account in determining the immigrant's eligibility for Medicaid and SCHIP. Second, before welfare legislation, federal funding was provided for immigrants who were Permanent Residents Under Color of Law (PRUCOL) – that is, residing in the U.S. with the knowledge and permission of federal immigration authorities. The welfare bill limited federal funding to certain, narrowly defined immigration categories, excluding a small number of PRUCOL immigrants who previously qualified for federally matched health coverage. See Families USA, *Immigrants' Eligibility For Medicaid And CHIP,* February 2001, *http://www.familiesusa.org/site/DocServer/immigrants.pdf?docID=365*; Leighton Ku and Bethany Kessler, *TheNumber and Cost of Immigrants on Medicaid*, December 16, 1997, *http://www.urban.org/urlprint.cfm?ID=6233*.

[6] Altogether, 250,000 uninsured children were covered by the five-year ban in 1998-1999, of whom approximately half qualified for state-funded coverage but were not enrolled. Carasquillo, et al., op cit. CBO estimated that 155,000 children and 60,000 pregnant women would receive health coverage if states had the option to cover legal immigrants during their first five years in the country. Leighton Ku. *Report Documents Growing Disparities in Health Care Coverage Between Immigrant and Citizen Children as Congress Debates Immigrant Care Legislation*. Center on Budget and Policy Priorities. October 2003 *http://www.cbpp.org/10-14-03health.htm*.

[7] U.S. Department of Health and Human Services. "States May Provide SCHIP Coverage For Prenatal Care." *HHS News.* September 27, 2002. *http://www.cms.hhs.gov/schip/whitehouse/unborn.pdf*.

[8] Jennifer Ryan. *Sailing SCHIP Through Troubled Waters.* National Health Policy Forum. November 13, 2003. *http://www.nhpf.org/pdfs_ib/IB795_SCHIP_update.pdf*. Since then, Arkansas has implemented this option, raising the total number to 7. Leighton Ku, personal correspondence, September 3, 2004.

[9] Joan Alker and Marcela Urrutia. *Immigrants and Health Coverage: A Primer.* Health Policy Institute, Georgetown University, and National Council of La Raza, for The Kaiser Commission on Medicaid and the Uninsured. June 2004. *http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=44857*.

[10] Census Bureau 2003 Report.

[11] Randy Capps, Genevieve Kenney, and Michael Fix. *Health Insurance Coverage of Children in Mixed-Status Immigrant Families*. Urban Institute. November 7, 2003. *http://www.urban.org/UploadedPDF/310886_snapshots3_no12.pdf*.

[12] Passel, et al., op cit. Calculations by ESRI, August 2004.

[13] While the precise number has not been published, it exceeds 23 percent. Emil Parker and Martha Teitelbaum. *House and Senate Conferees on the Medicare Prescription Drug Bills Could Help Hundreds of Thousands of Children, Both Immigrants and Citizens, Obtain Health Coverage.* Children's Defense Fund. October 6, 2003. Calculations by ESRI, September 2004. *http://www.childrensdefense.org/childhealth/chip/ICHIA_report.pdf*.

[14] These differentials among states involved cash assistance rules. It is not clear whether they involved health coverage as well. In any event, it seems implausible that health coverage would attract orders of magnitude more immigrants than does cash assistance. Michael Fix and Ron Haskins. *Welfare Benefits for Non-citizens*. Brookings Institute. February 2002. *http://www.brookings.edu/es/research/projects/wrb/publications/pb/pb15.htm*.