STAYING COVERED:
THE IMPORTANCE OF RETAINING HEALTH INSURANCE FOR LOW-INCOME FAMILIES

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Center on Budget and Policy Priorities

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EXECUTIVE SUMMARY

Expanding eligibility for health insurance coverage and increasing enrollment are important ways to reduce the number of uninsured people in the United States. Helping those who are already insured retain coverage is an equally vital but less appreciated method, as well as a cost-effective way to improve the continuity and quality of health care. If every person with public or private coverage at the beginning of a given year retained coverage throughout the next 12 months, the number of low-income children who are uninsured would decline by close to two-fifths over the course of a year. The number of uninsured low-income adults would decline by more than one-quarter. This report examines reasons why many low-income individuals lose coverage, the effects of insurance loss, and strategies that can help people retain coverage.

The Scope of Health Insurance Loss

People with low incomes are more vulnerable than those with higher incomes to the loss of insurance because they experience more fluctuations in family structure and employment status. They also often encounter eligibility and procedural barriers to obtaining and retaining publicly funded coverage through Medicaid and the Children's Health Insurance Program (CHIP). About one-fifth of low-income children and one-sixth of low-income adults who have Medicaid at the beginning of a given year become uninsured by the end of that year, according to analyses of 1996 and 1997 data from the Census Bureau's Survey of Income and Program Participation (SIPP).[1] Many lose coverage despite remaining eligible for Medicaid. In contrast, only about one-tenth of low-income individuals who begin the year with private health insurance become uninsured during a year. One reason for such discrepancies is the complications often associated with retaining Medicaid eligibility.

Stable Coverage Matters and Is Cost-Effective

Numerous studies show that stable health insurance coverage improves both access to health care and health status. Even brief gaps in insurance coverage can contribute to problems in accessing care, obtaining prescriptions, and paying medical bills. Stable coverage helps patients maintain continuous relationships with their physicians and other health care providers, which improves their use of preventive and primary care. Coverage gaps also undermine the effectiveness of insurance, since gaps of two or more months can make people subject to preexisting condition exclusions. For Medicaid beneficiaries,

[1] In this paper, "low income" indicates that a family's income is below 200 percent of the federal poverty level, or about $30,000 for a family of three in 2002.

maintaining coverage is also cost-effective, since the monthly cost of coverage drops as individuals are enrolled for longer periods.

Strategies to Improve Retention in Medicaid and CHIP

Key strategies that states have adopted in recent years to simplify their Medicaid and CHIP programs to make it easier for families to maintain coverage include:

- *Adopting 12-month continuous eligibility.* States have the option to guarantee Medicaid or CHIP coverage to children for 12 months regardless of fluctuations in family income or other circumstances, eliminating the need for the family to report changes or submit paperwork in a given year. Common in CHIP, this policy could be expanded to include children insured through Medicaid. Federal legislation could be modified to allow similar options for states to provide low-income parents with 12 months of continuous coverage.

- *Simplifying renewal procedures.* Useful strategies include making forms and notices clearer and easier to read, permitting renewal by mail or phone, and providing renewal assistance in the community and through providers. States could also simplify renewal forms and not require families to verify information that has already been documented and would not have changed since initial enrollment. States may also allow families to self-declare their income at renewal and verify the declarations using computer databases.

- *Coordinating Medicaid and CHIP renewal procedures.* In states with separate CHIP programs, joint Medicaid/CHIP applications are in almost universal use; but joint Medicaid/CHIP renewal forms are less common. Adopting common forms and procedures and sharing information between programs can smooth transitions so that children do not lose coverage when their eligibility shifts from one program to another.

- *Using passive renewal.* A few states use an innovative "passive renewal" approach for children's coverage in CHIP or Medicaid. Families are asked to report any changes in their circumstances when it is time to renew their children's eligibility. If nothing has changed, the child remains covered and the family does not need to take any action. This is similar to the way private insurance is handled in most workplaces.

- *Ensuring that beneficiaries' coverage is not terminated until their eligibility has been reassessed.* Under federal rules, an enrollee should not be dropped from Medicaid

until a review determines whether the person remains eligible for coverage under another Medicaid category.

- *Using eligibility information collected from other programs to extend coverage.* Many families with Medicaid insurance also participate in other public programs, such as the Food Stamp Program. States can use recent income information from Food Stamp or other public program records to extend a family's Medicaid coverage rather than requiring the family to submit a separate Medicaid renewal form or verify income.

- *Protecting families from losing coverage due to non-payment of premiums.* Some eligible low-income individuals in states where the CHIP and Medicaid programs require premiums do not apply for coverage because of this requirement; others lose coverage because they are unable to pay premiums on time. States that use premiums can adopt policies to make them more responsive to families' changing circumstances, such as easing lock-out policies that bar people from rejoining even if they pay past-due premiums, or shifting from monthly premiums to low annual enrollment fees.

- *Simplifying Medicaid and CHIP enrollment.* Some people lose Medicaid or CHIP coverage and need to reenroll a short time later. Efforts to streamline enrollment and make it easier to apply—e.g., permitting families to apply by mail or at community settings, simplifying application forms, and minimizing verification requirements—would minimize gaps in coverage.

Helping Individuals Move Between Public and Private Coverage

As low-income workers obtain better jobs and improve their circumstances, they ought to be able to shift into employer-sponsored health insurance coverage. The reverse also applies, but such transitions from private to public insurance are not as easy as they could be. As a result, many become at least temporarily ineligible for Medicaid or CHIP but are unable to afford private insurance. States could help those who have lost private coverage obtain public coverage more rapidly by:

- *Eliminating or liberalizing the Medicaid asset test for families.* Some workers who lose their jobs—even those with little or no income—are ineligible for Medicaid because their assets exceed state Medicaid limits. States could help these families by easing or eliminating the Medicaid asset test for adults, as most have done for children.

- *Eliminating waiting periods in CHIP or Medicaid.* Some states require that a person be uninsured for a certain period of time before he or she can obtain coverage under CHIP or Medicaid. Such policies were established to guard against crowd-out (the replacement of private coverage with public insurance), but most research points to low levels of crowd-out among low-income children. Many states do not impose waiting periods in CHIP; other states could reduce the length of waiting periods or allow exceptions for families who drop private coverage because their premium payment exceeds a certain percentage of their income.

Strategies to reduce coverage gaps for those who are shifting from public to private coverage include:

- *Simplifying Transitional Medical Assistance (TMA).* TMA extends Medicaid coverage for up to one year to help those who move from welfare to work or who obtain a higher-paying job. However, complex TMA eligibility rules and paperwork requirements effectively bar some families from obtaining coverage. Federal rules could be modified to make it easier to obtain TMA and to maintain coverage longer. In the meantime, states have the discretion to simplify report forms and to eliminate the need for families to submit verification of the information they report.

- *Helping low-wage workers enroll in Medicaid or CHIP.* Firms that employ low-wage workers could make it easier for their employees and their dependents to join or stay on Medicaid or CHIP. Employers could keep application materials in their personnel offices or arrange time off so workers could apply for coverage. They could help workers collect pay stubs or related information for eligibility determination, or enlist community-based groups to provide application assistance at the worksite.

- *Making it easier to shift to employer coverage after Medicaid or CHIP ends.* In most cases, workers may sign up for employer-sponsored insurance when they start the job, at annual open enrollment periods, or when there is a qualifying event, such as a spouse losing private coverage. However, the loss of Medicaid or CHIP is not usually a qualifying event, so the affected worker might be blocked from joining the employer's health plan until the next open enrollment period, which could be months away. In this circumstance, federal legislation could be modified to provide protections for those who lose Medicaid or CHIP.

STAYING COVERED: THE IMPORTANCE OF RETAINING HEALTH INSURANCE FOR LOW-INCOME FAMILIES

INTRODUCTION

Expanding eligibility for health insurance coverage and increasing enrollment are important ways to reduce the number of uninsured Americans. Helping those who are already insured *retain* coverage is an equally vital but less appreciated method, as well as a cost-effective way to improve the continuity and quality of health care. If every person with public or private coverage at the beginning of a year retained coverage throughout the next 12 months, the number of low-income children who are uninsured would decline by nearly two-fifths over the course of a year. The number of uninsured low-income adults would decline by more than one-quarter.

Millions of people lose public or private health insurance coverage every year, becoming uninsured for at least a brief period. For example, federal, state, and local officials worked hard to initiate the State Children's Health Insurance Program (CHIP) in the late 1990s and enrolled millions of low-income children. Once enrolled, however, many children did not retain coverage even though they remained eligible for CHIP or Medicaid. In addition, large numbers of families who became ineligible for welfare under state welfare reform initiatives improperly lost Medicaid coverage as well, because state or local agencies failed to separate Medicaid eligibility from welfare eligibility, as required by law.

Families with low incomes are more vulnerable to interruptions in coverage than are middle- and upper-income families. The main events that trigger changes in health insurance coverage for low-income families are changes in employment or family structure, such as job transitions, job loss, and divorce. Low-income families not only experience greater fluctuations in income, employment, and family structure, they also encounter eligibility and procedural barriers to enrollment in Medicaid and CHIP. While those with employer-sponsored insurance usually retain insurance unless a worker leaves a job, Medicaid and CHIP enrollees often are required to report even trivial changes in income or face disqualification. Similarly, a raise in salary does not affect a worker's eligibility for private insurance but could cause a worker to become ineligible for Medicaid or CHIP.

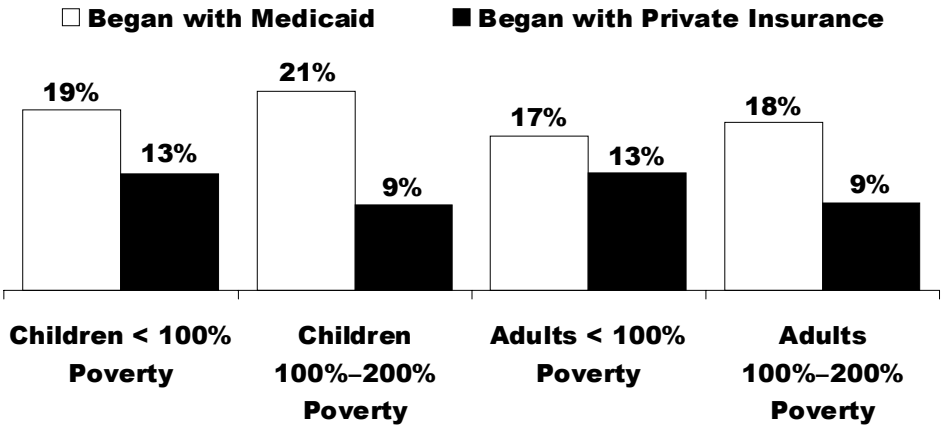
This report assesses the scope of interruptions in health insurance coverage among low-income families and reviews why retention of coverage is important. It also describes some of the problems in state Medicaid and CHIP programs and procedures that have led to the loss of coverage, and the ways in which states are addressing these problems. Finally, it examines the difficulties that individuals experience in making the transition between public and private insurance coverage and some possible solutions.

HOW MANY PEOPLE LOSE INSURANCE IN A GIVEN YEAR?

An analysis of data from the longitudinal Survey of Income and Program Participation (SIPP) shows that about one-fifth of low-income children and one-sixth of adults who begin a given year with Medicaid coverage are uninsured at the end of it. The authors conducted the analysis using data from 1996 and 1997 drawn from the 1996 SIPP panel, a nationally representative longitudinal survey conducted by the Bureau of the Census; these were the most recent data available at the time the analysis was conducted. The analysis essentially compared insurance and income status in the first and last months of the full year of enrollment.[2]

Medicaid recipients were much more likely to be uninsured a year later than were those who had private health insurance (Figure 1).[3] For example, 17 to 19 percent of poor children and adults with incomes below the federal poverty level (an annual income of about $15,000 for a family of three in 2002) who began the year with Medicaid became uninsured by the end of the year. In contrast, about 13 percent of poor children and adults who began the year covered by private insurance were uninsured by the end of the year. Of course, some poor children and adults who began the year uninsured gained public or private coverage by the end of the year, but these gains were offset by the number who had coverage but lost it during the year.

Figure 1. What Share of Medicaid or Private Beneficiaries Become Uninsured in a Given Year?



Source: Analyses of 1996–97 Survey of Income and Program Participation.

[2] It is important to note that the SIPP data are from a period before the CHIP expansions of children's health coverage and other subsequent insurance expansions (Mills, 2001; Broaddus et al., 2001). Although insurance coverage has changed since that time and there have been a number of policy changes, the general patterns of findings from SIPP should remain valid.

[3] "Private insurance" consists primarily of job-based insurance, but the category also includes some non-group insurance.

The situation was slightly different for those with incomes between 100 percent and 200 percent of the federal poverty level. Compared with poorer individuals, children and adults in this group who began the year with Medicaid were less likely to retain it throughout the year. Members of this group were more likely than poorer individuals to retain private coverage if they began the year with private coverage (Table 1).[4]

Table 1. Changes in Low-Income Child and Adult Health Insurance Coverage Between Months 1 and 12

STATUS IN MONTH 1		COVERAGE IN MONTH 12			
	% of Group with This Type of Insurance	Medicaid	Private Insurance	Uninsured	*Total*
Children Below 100% of Poverty					
Medicaid	58.8	73.8	6.9	19.3	*100.0*
Private Insurance	19.2	9.8	77.7	12.5	*100.0*
Uninsured	22.0	22.9	16.9	60.2	*100.0*
Total	*100.0*				
Children 100% to 200% of Poverty					
Medicaid	22.9	62.7	16.1	21.3	*100.0*
Private Insurance	56.6	3.6	87.2	9.2	*100.0*
Uninsured	20.6	14.6	23.8	61.6	*100.0*
Total	*100.0*				
Adults Below 100% of Poverty					
Medicaid	32.3	76.0	7.5	16.5	*100.0*
Private Insurance	29.1	4.0	83.4	12.6	*100.0*
Uninsured	38.6	9.6	18.6	71.8	*100.0*
Total	*100.0*				
Adults 100% to 200% of Poverty					
Medicaid	11.2	67.2	14.8	18.0	*100.0*
Private Insurance	56.8	2.3	88.3	9.4	*100.0*
Uninsured	32.0	5.4	24.7	69.9	*100.0*
Total	*100.0*				

Note: To understand how to read this table, consider the following example: of children from families with incomes below the federal poverty level, 58.8% were on Medicaid in month 1. When we follow those beneficiaries over time, 73.8% of that original group were still on Medicaid by month 12, while 6.9% had private insurance and 19.3% were uninsured. In some cases, sums do not total to 100% due to rounding.

Source: 1996 and 1997 data from the Survey of Income and Program Participation, analyzed by the Lewin Group and the Center on Budget and Policy Priorities.

[4] This report measures insurance retention in a simple fashion, looking at whether people had coverage in the first and twelfth months of a year. Obviously, a person could be covered in months 1 and 12 but lose coverage in the interim. Other reports, using different databases and analytical approaches, have also shown that many individuals who have Medicaid or CHIP coverage in one period become uninsured later (Ellwood and Lewis, 1999; Garrett and Holahan, 2000; Czajka and Olsen, 2000; Irvin et al., 2001; Riley et al., 2002). The other reports often show a larger percentage of individuals experiencing a coverage gap during the year than does this analysis, because some people lose coverage for a month or more but then regain it later in the year. A recent Commonwealth Fund survey provides additional insights (Duchon et al., 2001). It found that 15 percent of working-age adults were uninsured at the time of the survey and that an additional 9 percent had lacked insurance at some time in the prior year. Gaps in coverage were more common among those with low and moderate incomes.

Often, a family's insurance status changes because its income level changes. Table 2 shows the relationship between changes in income and insurance status over the course of the year. A family with a substantial income increase might lose Medicaid and gain private insurance, for example, while a family with an income drop might move from private insurance to Medicaid. In many cases, however, a family's insurance status changes even when its income remains relatively stable. A substantial proportion of low-income people lose insurance coverage during the year, even if they remain poor.[5] For example, about one-seventh (14%) of children from families below the poverty level in months 1 and 12 who received Medicaid in month 1 became uninsured by month 12. As of 1997, federal law extended Medicaid eligibility to all children age 14 or younger from families with incomes below 100 percent of poverty. Therefore, almost all of these children ought to have been Medicaid-eligible a year later. In addition, a large share of children from families with incomes below the poverty level in months 1 and 12 and who were uninsured in month 1 remained uninsured in month 12, even though most were Medicaid-eligible.

The risk of losing health insurance coverage is higher for those on Medicaid than for those with private coverage. One reason is that Medicaid eligibility depends on income level, so a family with rising income might lose Medicaid eligibility even if it cannot obtain employer-sponsored insurance. Another reason is that administrative barriers in state Medicaid programs cause a substantial number of children and adults to lose Medicaid coverage even though they remain eligible. These barriers are discussed below.

[5] Given CHIP's 1998 implementation and subsequent expansions, it is likely that more low-income children are now retaining coverage through the combination of Medicaid and CHIP than these SIPP data suggest. Nonetheless, reports indicate that retention of coverage in CHIP also is a problem.

Table 2. Changes in Low-Income Child and Adult Insurance and Poverty Status from Months 1 to 12

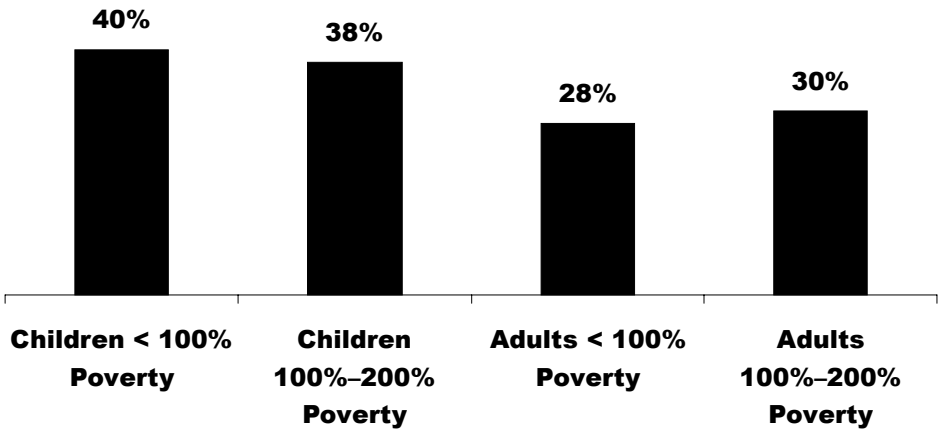
	INSURANCE STATUS IN MONTH 12, GROUPED BY POVERTY STATUS IN MONTH 12											
	Below 100% of Poverty				100%–200% of Poverty				Greater Than 200% of Poverty			
STATUS IN MONTH 1	Medicaid	Private Insurance	Uninsured	*Subtotal*	Medicaid	Private Insurance	Uninsured	*Subtotal*	Medicaid	Private Insurance	Uninsured	*Subtotal*
Children Below 100% of Poverty												
Medicaid	59.7	3.4	13.9	*77.0*	12.2	2.6	4.4	*19.2*	1.9	0.9	1.0	*3.8*
Private Insurance	6.0	27.8	7.7	*41.5*	3.0	24.7	3.5	*31.2*	0.7	25.1	1.4	*27.2*
Uninsured	16.6	6.9	38.0	*61.5*	5.2	6.1	17.5	*28.8*	1.1	3.9	4.7	*9.8*
Children 100% to 200% of Poverty												
Medicaid	23.8	2.3	7.5	*33.6*	30.4	9.6	10.9	*50.9*	8.5	4.2	2.9	*15.5*
Private Insurance	1.5	9.0	3.0	*13.5*	1.7	44.9	4.2	*50.8*	0.5	33.3	1.9	*35.7*
Uninsured	7.3	3.0	15.8	*26.1*	5.8	13.5	33.9	*53.1*	1.5	7.3	12.0	*20.8*
Adults Below 100% of Poverty												
Medicaid	60.3	3.0	11.1	*74.4*	13.0	2.8	4.1	*19.8*	2.7	1.8	1.3	*5.8*
Private Insurance	2.4	29.1	6.8	*38.3*	1.1	21.8	3.4	*26.3*	0.4	32.6	2.4	*35.4*
Uninsured	6.8	5.8	42.0	*54.6*	2.2	6.2	20.1	*28.5*	0.7	6.6	9.6	*16.9*
Adults 100% to 200% of Poverty												
Medicaid	21.2	2.9	7.1	*31.2*	35.9	7.5	8.1	*51.5*	10.1	4.5	2.8	*17.3*
Private Insurance	0.7	8.8	2.9	*12.4*	1.2	39.3	3.9	*44.4*	0.4	40.2	2.6	*43.2*
Uninsured	2.3	2.7	16.5	*21.5*	2.3	11.2	34.5	*48.0*	0.8	10.9	18.9	*30.6*

Note: To understand how to read this table, consider the following example: of children from families who were below the federal poverty level and on Medicaid in month 1, 59.7% were still below poverty and on Medicaid in month 12. Of the children who were below poverty and on Medicaid in month 1, a total of 77% of that original group were still below poverty by month 12, summed across all insurance types. About one-eighth (12.2%) of the children with incomes below poverty and on Medicaid in month 1 had incomes between 100% and 200% of poverty by month 12 but were still on Medicaid. In some cases, sums do not total to 100% due to rounding.

Source: 1996 and 1997 data from the Survey of Income and Program Participation, analyzed by the Lewin Group and the Center on Budget and Policy Priorities.

What would happen if everyone who begins a given year with private or public insurance coverage retained it for the full year, regardless of whether they changed jobs, gained income, got divorced, or experienced other such changes to their circumstances? Even without separate efforts to cover new individuals, shoring up and stabilizing coverage for those who have it could lead to a massive reduction in the ranks of the uninsured. Those who gained coverage during the course of a year, combined with those who had retained coverage, would reduce the overall number of uninsured. Figure 2 and Table 3 demonstrate that 100-percent retention could reduce the number of uninsured low-income children by almost two-fifths and the number of uninsured low-income adults by more than one-quarter. These figures are meant to illustrate the potential benefits of improving retention; although the improvements discussed in this report could substantially improve retention among low-income families, they would not lead to 100-percent retention.

Figure 2. Reduction in the Number of Uninsured over the Course of a Year



Source: Analyses of 1996–97 Survey of Income and Program Participation.

Table 3. How Many Would Be Uninsured If Everyone Who Had Coverage Retained It During the Year?

Poverty Status in Month 1	% Uninsured in Month 1	% Who Would Be Uninsured in Month 12 with Total Retention	% Reduction in Uninsurance
Children Below 100% of Poverty	22.0	13.2	39.8
Children 100% to 200% of Poverty	20.6	12.7	38.4
Adults Below 100% of Poverty	38.6	27.7	28.2
Adults 100% to 200% of Poverty	32.0	22.4	30.1

Source: 1996 and 1997 data from the Survey of Income and Program Participation, analyzed by the Lewin Group and the Center on Budget and Policy Priorities.

WHY RETENTION AND CONTINUITY OF COVERAGE MATTER

In addition to reducing the overall number of the uninsured, policies that promote retention and continuity of coverage would yield economic and health benefits.

Uninsured people are more likely to avoid or delay needed care because they cannot afford it. A 2001 Commonwealth Fund survey found that many people with brief gaps in coverage reported skipping or delaying medical care or leaving prescriptions unfilled because of cost.[6] Many of those with relatively brief spells of uninsurance reported serious financial consequences, such as being contacted by a collection agency for unpaid medical bills or having to deplete their savings or borrow money from some other source to pay medical bills. Delayed care also may lead to unnecessary illness or even death, as well as to inefficient and expensive use of emergency room or hospital care for preventable health conditions.[7]

Retention of health insurance coverage also is important because it can foster continuous relationships between patients and their health care providers; such relationships help patients obtain primary and preventive health services on a timely basis. Research has shown that having a regular source of health care can improve the quality of health care and reduce avoidable emergency room use or hospitalizations.[8] Although maintaining insurance does not guarantee a continuous patient–caregiver relationship since continuity can be disrupted because of changes in the type of insurance or for other reasons, loss of insurance makes a continuous relationship especially difficult.

Finally, the temporary coverage gaps that occur in transitions between public and private coverage can have long-lasting repercussions. Under the Health Insurance

[6] Duchon et al. 2001.

[7] Institute of Medicine 2002; Hadley 2002; Kasper, Giovanni, and Hoffman 2000; Lurie, Shapiro, and Brook et al. 1984; Bindman, Grumbach, and Osmand 1995; Newacheck et al. 1998.

[8] Gill and Mainous 1998; O'Malley et al. 1997; Christakis et al. 2001.

Portability and Accountability Act (HIPAA), a person who is uninsured for more than two months may be denied coverage for preexisting conditions in his or her subsequent private insurance plan. Such a coverage gap can weaken the effectiveness of whatever insurance policy an individual eventually gains. For example, a diabetic child who loses Medicaid or CHIP but gains private insurance four months later might find that the private plan excludes diabetes-related care as a preexisting condition.

Longer Periods of Coverage May Cost Less per Month

Monthly medical expenditures may decline when people have insurance coverage for a longer time span. First, as noted above, longer periods of coverage can be more efficient because they allow beneficiaries to obtain timely preventive and primary care and avoid unnecessary and expensive hospitalization or emergency room care. Second, some individuals obtain insurance in times of medical need and so require more care at the beginning of a period of insurance, which makes the initial months of coverage more expensive. Indeed, many people sign up for Medicaid or CHIP at a clinic or hospital. The cost of subsequent months of coverage may drop as these people use care on a continuing basis.

An analysis of the Medical Expenditure Panel Survey (MEPS) indicates that average monthly Medicaid expenditures fall as people are enrolled for longer periods (see text box below and Figure 3). Therefore, it does not cost twice as much to provide a person with coverage for twice as long because people tend to use fewer medical resources when they are covered for a longer period. In many cases, state Medicaid or CHIP programs provide care through managed care plans that receive a monthly capitation payment, regardless of how much care the patient actually receives. In cases such as these, the state might not realize any of the savings associated with longer enrollment because the fixed capitation payments do not fall when actual medical expenditures drop. In these situations, however, states could renegotiate the capitation rates for managed care plans, modifying rates to obtain the savings in actual medical expenditures. Alternatively, some states periodically "re-base" capitation rates to align payments with actual prior expenditures; in this event, medical savings could eventually lead to lower capitation rates through reconciliation with actual costs. In addition, Carol Irvin and colleagues (2001) observed that extending coverage through the use of 12-month continuous eligibility could lower Medicaid administrative costs by reducing the staff effort needed to process applications and handle related paperwork. They estimated that instituting this practice for children could reduce overall administrative costs between two and 12 percent.

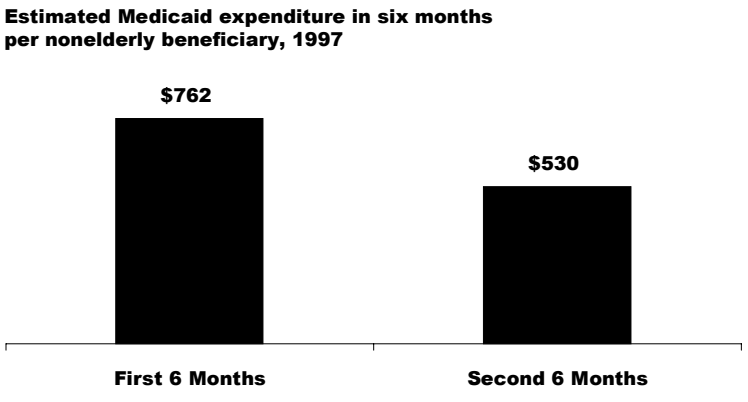
Lengthening Enrollment Periods Reduces Monthly Medicaid Expenditures

The 1997 Medical Expenditure Panel Survey (MEPS), a longitudinal, nationally representative survey conducted by the Agency for Healthcare Research and Quality, collects monthly data on insurance coverage, medical care use, and medical expenditures. In this report, MEPS data was used to analyze the factors that affect the average monthly Medicaid expenditure per person—in other words, the amount paid by Medicaid for medical expenditures divided by the months of Medicaid coverage—among individuals with incomes below 200 percent of the federal poverty level.

We found that the average monthly Medicaid expenditure for these individuals falls as the months of enrollment rise. Each month of Medicaid enrollment reduced Medicaid expenditures an additional $6.49 per month. This reduction was statistically significant with more than 99 percent confidence. As a result, we estimate that the second six months of Medicaid coverage costs about 30 percent less than the first six months of coverage in a year.

We obtained these results using weighted regression analysis, controlling for age, gender, race/ethnicity, urban/rural residence, self-reported health status, months of Medicaid coverage, and months of other insurance coverage, which included prior private insurance coverage.

Figure 3. Medicaid Expenditures Decline as the Period of Enrollment Lengthens



Source: Estimates based on CBPP analyses of 1997 MEPS survey.

A recent study by Carol Irvin, of Mathematica Policy Research, and colleagues (2001), based on an analysis of 1995 Medicaid claims data for children in four states, produced similar findings. That study found a reduction in monthly Medicaid expenditures when the length of enrollment was extended through the adoption of 12-month continuous eligibility.*

* Irvin et al. estimated that continuous enrollment reduced monthly costs by 1 to 8 percent. The disparity between that estimate and our estimate reflects the different ways in which the estimates are presented. When both estimates are expressed similarly, our estimate is within the range provided in Irvin's study.

STRENGTHENING RETENTION IN MEDICAID AND CHIP: COMMON PROBLEMS AND POSSIBLE SOLUTIONS

State Medicaid and CHIP programs have identified problems that can lead to the loss of coverage and are developing solutions for these problems. Two issues of particular concern are the low levels of Medicaid and CHIP retention among children and the loss of Medicaid coverage among families that lose welfare benefits.[9] Common procedural problems that interfere with the retention of coverage in Medicaid and CHIP include:

- frequent eligibility reviews and paperwork;
- complex renewal forms;
- cumbersome renewal procedures; and
- lack of coordination between renewal procedures for Medicaid and separate CHIP programs.

Some strategies that have been used across the country to address these problems are described below.

Reducing the frequency of eligibility reviews and guaranteeing coverage

In the past, Medicaid recipients' eligibility was generally reviewed every six months; enrollees were required to submit reports about their income or other circumstances as often as every month or quarter. These frequent reporting requirements were designed to obtain data about fluctuations in families' incomes—no matter how slight—so that families whose incomes were too high could be removed from the rolls. Because income fluctuations are common (especially for families with workers who earn hourly wages, work overtime, or work irregularly), many families cycled on and off Medicaid from month to month. Some families lost coverage even if their incomes did not actually change—an automatic loss of eligibility occurred if the administrative agency did not receive the family's paperwork in a timely manner.[10]

The Balanced Budget Act of 1997 gave states the option of enrolling children in Medicaid for 12 months regardless of fluctuations in family income, assets, or other circumstances, thus eliminating cumbersome reporting requirements during that period. Separate CHIP programs also have the option to provide 12 months of continuous enrollment. (The law requires an eligibility review at least every 12 months.) Twelve-

[9] National Governors Association 2000; CMS 2001, Riley et al. 2002; Hill and Lutzky 2002.

[10] The following example gives a sense of the effect of these reporting requirements: In 2002, California considered re-imposing a requirement that families on Medicaid report income and related changes in household circumstances every three months or face termination, although this policy was not adopted in the state's final budget. The state estimated that this change would reduce total enrollment by about 250,000 people, or about 4 percent of the total state caseload.

month continuous eligibility is an important way to improve the retention of children's health insurance coverage. Reducing the number of transactions required for maintaining coverage simplifies procedures for both the beneficiary and the eligibility office. As noted above, Carol Irvin and her colleagues found that 12-month continuous eligibility could yield significant administrative savings.

Most separate CHIP programs provide 12 months of continuous eligibility. Some states also offer continuous eligibility in Medicaid programs for children, but most do not. Instead, most states enroll children in Medicaid for 12 months but require families to report changes in their income or family composition, which could lead to a loss of eligibility during the year. Although 12-month continuous eligibility is an option for children, these options do not exist for parents or other Medicaid populations under federal law. Although states can institute 12-month renewal periods for parents, they must continue to require parents to submit information about income or related changes that can lead to a loss of coverage.[11]

Simplifying renewal procedures

Despite increased attention to simplifying the renewal process, most states have not yet taken full advantage of all available options. First, states must ensure that families are fully informed about the renewal process. Renewal notices and forms often are legalistic or confusing, posing significant hardship for family members who may not be familiar with the requirements for public programs or who have limited literacy skills.[12] Recent research in Rhode Island reveals that many families that did not renew their Medicaid eligibility did not know about the annual renewal cycles of state programs and thus could not navigate their first renewal successfully.[13] Half of the families in a recent study of children whose CHIP coverage had lapsed reported that they had not been told or did not recall being told that they would have to renew their child's coverage.[14] Education about the renewal process is currently conducted largely through notices sent 60 to 90 days before the renewal date; this initial contact may or may not be followed by one or more reminders in the mail or by telephone calls. States generally do not provide renewal information on the initial application or in other promotional materials about their programs, although this strategy is being considered. Many states are now using the word "renewal" rather than "re-determination" on forms and promotional materials, since the former term is more familiar and conveys the message that coverage can continue.

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[11] The use of special provisions under Section 1931 of the Medicaid statute can simplify reporting requirements for parents—disregarding changes in earnings during the 12 months that would ordinarily trigger a required income update—but there is no direct option to provide 12-month continuous eligibility for parents.

[12] Riley et al. 2002.

[13] Cahow 2001.

[14] Riley et al. 2002.

Passive Renewal Can Help Extend Coverage for More Than One Year

A few states have adopted an innovative renewal approach known as "passive renewal." This shifts the default renewal policy for CHIP or Medicaid programs from ending coverage if a renewal is not received to keeping children covered unless families provide evidence that continued coverage is not appropriate. (This policy is akin to the default policy in most workplaces, which allows employees to retain employer-sponsored coverage unless they elect to change plans or drop coverage.) Under passive renewal, families are required to submit CHIP or Medicaid renewal forms only if their income or other circumstances (e.g., family composition) have changed. A "non-response" is presumed to indicate that nothing relevant to eligibility has changed and so the child remains enrolled.

A comparison of several states found that Florida's separate CHIP program, which uses passive renewal, had almost twice as many children enrolled for two years or longer as did states that required more paperwork at renewal (Child Health Insurance Research Initiative 2002). In addition, Florida assesses a monthly premium, and those for whom premiums are not received are discontinued from the program. South Carolina has begun to use passive renewal in its Medicaid program. The state does not charge monthly premiums. Instead, it instructs families to report changes in circumstances but to do nothing if income and other relevant circumstances have remained the same. Utah and Georgia also use passive renewal in their separate CHIP programs.

In addition to providing basic, clear information about the renewal process, states can take steps to simplify procedures. The federal government has issued guidance that illustrates how states can use the same simplification techniques for renewal as have been successfully used for enrollment.[15] Core strategies for simplifying renewal procedures include using a joint renewal form for Medicaid and CHIP, eliminating the requirement for a face-to-face interview, reducing verification and paperwork requirements, and allowing renewals to be done "off-cycle" and at community locations other than the welfare office. Efforts to coordinate Medicaid and CHIP renewal procedures also are key to ensuring that children retain coverage when a change in family circumstances disqualifies them for one of the programs but makes them eligible for the other.

In many cases, states that have made significant progress in simplifying and coordinating Medicaid and CHIP enrollment procedures have not demonstrated comparable attentiveness to coordinating these programs' renewal procedures. Many states that have developed a joint application form for Medicaid and CHIP have yet to develop a joint renewal form. For example, Michigan allows families to apply for health coverage for their children using a simplified, joint Medicaid/CHIP application. At renewal,

[15] CMS 2001.

however, the forms and processes differ depending on the program under which the child is covered. Families with children enrolled in Michigan's Medicaid program (Healthy Kids) must complete a combined-program (Temporary Assistance for Needy Families, Food Stamp Program, Medicaid) renewal form, which is longer and more complicated than the original Medicaid/CHIP application, and then mail it to their local Family Independence Agency. In contrast, the Department of Community Health sends a renewal form preprinted with the most up-to-date information the family has provided to families with children enrolled in Michigan's CHIP program (MIChild). Families only have to indicate whether any of the information on the form has changed and mail it to the MIChild contractor. It will be particularly difficult for families with children in both programs to navigate the different procedures necessary to ensure that all children in the family stay covered for as long as they are eligible.

Recent studies indicate that verification rules requiring families to submit numerous documents to corroborate the information reported on their applications present a particularly difficult barrier to coverage; this also appears to be a problem at the time families renew coverage.[16] The federal guidance on simplifying enrollment and renewal procedures explains that states may consider instituting "self-declaration" policies at renewal, even if they have not yet adopted such policies at initial application.[17] According to the guidance, by the time of renewal the state will have been able to verify the family's income using routine computer-matching systems. Even if the data available are not current, they should be recent enough to enable the state to assess whether the family has reported income accurately in the past. Some states are implementing such strategies. New York, for instance, passed legislation in January 2002 to streamline procedures for Medicaid and its separate CHIP program, Child Health Plus; among the streamlining provisions was the elimination of the income verification requirement for families renewing Child Health Plus. New York's legislation indicates that the state may verify the family's information by matching it against the state wage reporting system and other databases.

Some simple management techniques also can help streamline the renewal process. Some states pre-print renewal forms with some or all of the eligibility data collected on the initial application. According to state officials, these forms simplify the renewal process, since families are only required to update information that has changed.

[16] Cox 2001; Riley et al. 2002.
[17] CMS 2001.

Core Features of a Simplified Renewal Process

State practices to simplify and improve renewal should include the following features:

- Information about renewal is available on most program materials; notices and other correspondence about renewal are clearly and simply written.
- Eligibility is renewed every 12 months for both Medicaid and CHIP.
- Eligibility is continuous during the 12-month period (i.e., fluctuations in income do not require reporting or occasion loss of eligibility).
- A simplified joint renewal form is used for both programs.
- Both programs allow renewal to be initiated and completed by mail.
- Renewal assistance is available at community locations other than the welfare or Medicaid office.
- Follow-up assistance is provided via telephone or community-based assistance.

Two procedures are already required under federal policy, but state or local agencies sometimes fail to implement them effectively:

- Medicaid eligibility is maintained until an assessment demonstrates that an individual no longer qualifies for coverage.
- Agencies use information already on file to renew Medicaid eligibility and do not require families to submit duplicate information.

Louisiana has adopted a multifaceted approach to simplifying the renewal process, with encouraging results. First, caseworkers search computerized records to see if the child is receiving another benefit, such as food stamps; if so, the family's income is automatically considered to be verified and health coverage can continue. For families whose health coverage cannot be continued automatically, the state created a new, simple renewal form. Although proof of income must be returned with the form, coverage will not be terminated if the form is returned without this proof as long as the wage information in the Department of Labor's database verifies that the child still qualifies. Finally, the state is taking steps to track the performance of local Medicaid offices in ensuring that caseworkers understand and follow the new procedures. In a February 2002 personal communication, Ruth Kennedy of the Louisiana Department of Health and Hospitals reported that the data show that case closures for procedural reasons have declined from 22 to 25 percent to less than 10 percent.

Many families receive assistance from community or clinic outreach workers when they enroll in CHIP or Medicaid, but such help may be missing when they renew. To fill this need, New York permits community-based outreach workers (state-funded "facilitated enrollers") to help families complete renewal paperwork. A family may receive assistance in filling out either an original application or a renewal form, and the worker can also track the success of the application or renewal. Some facilitated enrollers also maintain lists of families that are due for renewal, conduct outreach, and provide renewal assistance.

Massachusetts has gone a step further in its efforts to promote community-based renewals by initiating a pilot project called "Member Express Renewal." The state found that about 20 percent of families were not responding to mailed renewal notices, presumably because they did not understand what was required or needed help with the process. In response, the state developed Member Express Renewal to allow some families to renew their eligibility "off-cycle," when they visit a community clinic or other community location before the renewal date. For example, if a child who is not due to renew coverage until January 1, 2003, is scheduled for a pediatric clinic visit on September 1, 2002, her parent could fill out a simple form in the waiting room. If the form is successfully completed, the child's eligibility would be extended until September 1, 2003. The pilot has produced encouraging results. In the most recent month for which data are available, of the families that completed the Member Express Renewal process, 80 percent were not receiving cash assistance or food stamps—the criteria for being allowed to renew "off-cycle." Of those families, all were able to receive extended eligibility.[18]

"De-linking" Medicaid and welfare

The massive reduction in welfare caseloads that occurred under welfare reform during the late 1990s led to an unexpected drop in Medicaid participation.[19] Historically, families who received welfare under the Aid to Families with Dependent Children (AFDC) program were automatically entitled to Medicaid; when a family lost welfare it typically lost Medicaid as well.[20] The 1996 welfare reform law "de-linked" Medicaid and welfare, allowing families with incomes low enough to qualify for welfare to enroll in Medicaid, even if they did not receive a welfare check. De-linking was motivated by the belief that families that lose welfare due to new restrictive policies (e.g., time limits) should not also lose Medicaid coverage, which is not subject to the same rules. Under de-linking,

[18] Personal communication, Josh Greenberg, Health Care for All, Boston, MA, February 2002.

[19] Ku and Bruen 1999; Garrett and Holahan 2000.

[20] The key exception is Transitional Medical Assistance (TMA), under which families whose earnings rise above welfare levels may retain Medicaid coverage for up to one additional year. But TMA does not apply to those who lose welfare for reasons unrelated to earnings, such as welfare time limits or sanctions.

Medicaid eligibility is independent of welfare eligibility; the loss of a welfare check should be a "non-event" with respect to Medicaid coverage. Nevertheless, a substantial number of former welfare recipients have lost Medicaid coverage in recent years because caseworkers and administrative systems incorrectly terminated Medicaid at the same time as welfare benefits were terminated.

To help rectify this, the federal government and states developed a variety of processes to improve Medicaid retention.[21] One key requirement that was reinforced by the federal government is that an individual's Medicaid eligibility should not be discontinued until caseworkers have determined that no Medicaid eligibility criterion still applies. California places individuals into a "pending" category until this review is completed.

Using information from other benefit programs

A particularly important way states can facilitate renewals of coverage is by using information that has been collected by other public assistance programs.[22] Before terminating a family's Medicaid coverage, the state should look in its welfare and related databases to see if recent eligibility information for the family has been reported to other programs. For example, if a family submitted information for the Food Stamp Program that indicates the family would still qualify for Medicaid at that date, this information can be used to extend Medicaid eligibility for another year from the date of the report.

Several states have developed effective strategies to use information from other benefit programs for Medicaid renewal. In Washington State, recipients of TANF or food stamps generally have their eligibility reviewed every three months. After each review, a recipient's Medicaid 12-month eligibility period begins again; this process continues as long as the recipient completes the scheduled Food Stamp or TANF reviews and remains Medicaid-eligible. In Illinois, families with children are generally certified for 12 months in the Food Stamp Program and must submit a quarterly report regarding their financial circumstances. Each time a household submits a Food Stamp quarterly report, the state uses the information it contains to renew the household's Medicaid eligibility for a new 12-month period.

Information from other benefit programs also can be used to smooth the transitions between Medicaid and CHIP or between two eligibility categories. For example, if a family's income increases, the child might lose Medicaid eligibility under one category of coverage but remain eligible under another Medicaid category. If that family's income

[21] Westmoreland 2000; CMS 2001; Schott 2000.

[22] The approach of relying on information already available to the state agency is called an "ex parte" review.

rises a little more, the child might lose Medicaid eligibility altogether but become eligible for the separate state CHIP program. Administrative complications during these eligibility shifts can cause people to lose coverage even though they remain eligible for some form of public coverage.

Reducing the risk that premiums pose a barrier to coverage

Medicaid coverage usually is free to those who participate. However, as income eligibility levels rise, a number of states have begun to charge monthly premiums or annual enrollment fees. Many state CHIP programs and a few Medicaid expansion programs require premiums, generally from participants with incomes above the federal poverty level. Some states have established sliding scales for premiums. Research indicates that higher premiums depress participation rates in public insurance programs for low-income individuals.[23]

Non-payment of premiums is one of the leading causes of disenrollment in CHIP. For example, about one-third of all disenrollments from California's Healthy Families program in 2001 were attributed to non-payment.[24] A recent survey found that about 40 percent of families who disenrolled from CHIP reported difficulties affording premiums; of those who had to pay $20 or more per month, the proportion having difficulty doing so was 50 percent.[25] Monthly premiums also limited retention in Oregon's Medicaid expansion program, the Oregon Health Plan.[26] In addition, a study of Florida's Healthy Kids program found retention rates improved substantially after the state lowered premiums.[27,28]

Non-payment of premiums is a more common problem in Medicaid and CHIP than in employer-sponsored insurance or Medicare because Medicaid and CHIP have no mechanism to make automatic deductions for premiums from payroll or Social Security checks.[29] Instead, beneficiaries might forget or be unable to make the payment each month, increasing the risk of losing coverage. Under the current health insurance system, it is hard to envision an automatic deduction mechanism that could apply broadly and simply for low-income families in Medicaid or CHIP.[30]

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[23] Ku and Coughlin 2000.

[24] Data from California's Managed Risk Medical Insurance Board, available at www.mrmib.ca.gov.

[25] Riley 2002.

[26] Haber et al. 2000.

[27] Other policies associated with higher retention in that study were expanding CHIP eligibility and broadening the benefit package to include mental health services.

[28] Shenkman et al. 2002.

[29] McLaughlin and Crow, forthcoming.

[30] States could establish payroll deductions or electronic funds transfer options in conjunction with their Medicaid or CHIP programs, but such policies would require a high level of cooperation with beneficiaries and/or employers and it seems likely that only a small share of beneficiaries could ever use options like these.

A possible approach to reducing the disruptive effect of non-payment of premiums is to shift from monthly premiums to annual enrollment fees that guarantee 12-month continuous eligibility. Annual fees could improve retention, reduce disenrollment rates, and simplify program administration. States that use annual fees in CHIP in conjunction with 12-month continuous eligibility include Colorado, Alabama, and North Carolina.

If annual fees are too high, however, they could pose an even greater barrier than monthly premiums for some families. For example, it is probably harder for a low-income family to accumulate $120 at one time than 12 monthly payments of $10. In North Carolina, non-payment of the annual fee ($50 for one child, $100 for two or more children) was the leading reason applications were denied.[31]

In states that charge monthly premiums, a reasonable alternative might be to substitute an annual enrollment fee that is heavily discounted, e.g., 70 to 80 percent below the equivalent monthly premium levels. Although more research is needed to identify the proper levels and potential impacts of annual fees, annualizing the premiums could lower administrative costs by reducing the costs of billing, collecting, and processing premium payments, and lower monthly benefit costs per person by reducing disenrollment and increasing continuity of care, as discussed earlier. The administrative and benefit savings could be used to discount the annual fees.[32] Complications could arise from this option, however. For example, if a family with a child enrolled in a separate CHIP program loses income and becomes Medicaid-eligible, the family might not notify the state agency of the income change. This would deprive it of the opportunity to shift the child into Medicaid, which typically has broader benefits and lower cost-sharing than separate CHIP programs. Moreover, even modest fees could discourage some from applying initially.

Many states that charge premiums also institute a "lock-out" period. For example, children whose premiums are not paid for two months in a row might be prohibited from reentering CHIP for four additional months. States have instituted lock-out periods out of concern about adverse selection, in which individuals enroll in coverage when they are sick. Yet many participants are unaware of or do not understand the lock-out rules and fail to realize that their children can be barred from coverage for an extended period because they miss a few payments. There does not appear to be any research that demonstrates whether or not fears of adverse selection are well founded or if lock-out periods help

[31] Rosenbach et al. 2001.

[32] For example, assume a state imposes monthly premiums of $10 per month or $120 over the course of a year. Calculations indicate that lengthening enrollment through the use of an annual fee could save $70 to $100 in benefit costs on an annualized basis and $15 to $30 in administrative costs. The savings of $85 to $130 could be used to reduce the premiums from $120 (based on $10 per month) to a heavily discounted annual fee in the range of $20 to $35 per year.

prevent it; further research is warranted. While lock-out periods might prevent some adverse selection, they also can lengthen the period that children are uninsured.

At the very least, states should consider policies to mitigate negative effects, such as permitting families to reenroll if there were good reasons for missing premiums or if they pay back some significant portion of the owed premiums. For example, Oregon waived unpaid premium fees for a substantial number of families because the state established that a good-cause exemption was applicable.[33]

Simplifying application procedures

Despite all efforts to improve retention, some people will lose coverage for which they remain eligible and will want to reenroll in Medicaid or CHIP. Simplifying initial applications for Medicaid and CHIP (e.g., permitting applications by mail or at local health clinics) and eliminating unnecessary verification requirements will help these persons regain coverage promptly. Policies that block reentry, such as lock-out periods for non-payment of premiums, are particularly problematic since they guarantee that a person will remain uninsured for a number of months, regardless of need.

IMPROVING TRANSITIONS BETWEEN PUBLIC AND PRIVATE COVERAGE

Because low-income individuals often have unstable employment, they may shift from public to private insurance coverage when they find work or from private to public coverage when they lose it. The lack of coordination between public and private insurance policies may leave some of these people temporarily uninsured.

Workers who become unemployed and impoverished can experience problems when moving from private to public coverage.[34] In most states, for example, individuals who collect unemployment benefits or whose spouses are still employed have too much income to qualify for Medicaid (although their children might qualify for CHIP).[35] Even after exhausting their unemployment benefits, many unemployed parents might not qualify for Medicaid because of the value of assets they accumulated while they were working, such as savings accounts or family vehicles. States can address these problems by

[33] Haber et al. 2000.

[34] The Consolidated Omnibus Budget Reconciliation Act (COBRA), which permits employees to purchase group coverage through their former employers for 102% or less of the employer's premium, is an important public mechanism to help unemployed workers. This topic is too complex to discuss completely in this paper, but COBRA participation is relatively low because the premiums are too high for most of those who have lost their jobs (Zuckerman, Haley, and Fragale 2001). The recent Trade Act of 2002 offered tax credit subsidies for COBRA and related forms of insurance coverage for a limited population of displaced workers.

[35] Medicaid and CHIP eligibility levels vary from state to state, but the median income standard for parents is about 69 percent of the federal poverty level; for children, it is 200 percent of poverty (Broaddus et al. 2001).

raising or eliminating asset limits in Medicaid and CHIP. Most states have eliminated asset tests for children, but a majority still have asset tests for families and parents.[36]

Another step states can take is to relax or eliminate the waiting period that exists in many CHIP programs and a few Medicaid waiver expansion programs. Many states require that a child be uninsured for a certain number of months before qualifying for public benefits. Thus, a child of a parent whose work hours have been reduced and who can no longer afford employer-sponsored insurance might be blocked from enrolling in CHIP until the waiting period has passed. These waiting periods are designed to prevent "crowd-out," or the replacement of private coverage with public coverage, but research has found crowd-out to be quite limited because relatively few low-income families have access to affordable, employer-sponsored coverage.[37,38]

Although 38 state CHIP programs originally imposed waiting periods of one to 12 months, eight of these states had reduced or eliminated the waiting period by the end of 2001.[39] States that want to retain a waiting period could shorten its duration or exempt families in which members had recently lost jobs or for which premiums exceed a certain percentage of family income.

Unintended gaps also can occur as individuals move from public to job-based private coverage. Many jobs impose a waiting period before a worker or the worker's dependents become eligible for health insurance.[40] Jon Gabel and his colleagues (2001) reported that firms that require waiting periods of four months or more employ 11 percent of all workers. Among low-wage firms, the percentage requiring waiting periods of four months or more is even higher.

The transition to job-based private coverage can be particularly problematic for former welfare recipients. An Urban Institute study found that only one-third of former welfare recipients who find jobs can secure employer-sponsored coverage; another third stay on Medicaid and the remaining third become uninsured.[41] The loss of coverage can prevent an individual who is trying to work her way off of welfare from taking or keeping a job.

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[36] Cohen Ross and Cox 2002.

[37] CHIP regulations do not require that states establish waiting periods during which a child is uninsured, but they do permit alternative methods to monitor crowd-out.

[38] In addition, Medicaid and CHIP expansions are sometimes criticized on the grounds that they might encourage crowd-out. Most studies, however, report that the number of individuals who gain coverage under public expansions far exceeds the number who may otherwise have had private coverage (Cutler and Gruber 1996; Dubay 1999; Kronick and Gilmer 2002).

[39] Cohen Ross and Cox 2002.

[40] Under HIPAA, periods during which a person cannot obtain coverage because of a waiting period do not count toward determining whether there is a two-month coverage gap (and thus toward determining whether preexisting condition exclusions apply).

[41] Garrett and Holahan 2000.

To help those who are leaving welfare for work, federal law established a bridge policy, Transitional Medical Assistance (TMA), which provides up to one year of extended coverage to those who lose Medicaid due to increased earnings. TMA, however, has a complicated set of eligibility and reporting requirements that can make the program difficult for eligible individuals to use. For example, recipients must file status reports in the fourth, seventh, and tenth months after beginning TMA. The federal government could improve TMA by giving states the flexibility to ease these requirements.[42]

Helping Those Who Lose Public Coverage Enroll in Private Coverage

Medicaid or CHIP beneficiaries can experience a coverage gap when their public coverage ends and they want to join their employer's health insurance plan. Typically, workers may sign up for their employer's plan when they begin their jobs, during annual open enrollment seasons, or after "qualifying events" such as the birth of a child or the loss of a spouse's private coverage. Losing Medicaid or CHIP coverage usually does not count as a qualifying event, even if the loss is involuntary.

Suppose, for example, that a worker and her family have Transitional Medical Assistance (TMA) for 12 months after she starts a job and the worker does not sign up for private coverage initially because the out-of-pocket premiums are too high. When her TMA runs out, the worker may be blocked from joining the employer's plan for several months until the next open enrollment season arrives. Should the family's coverage gap exceed two months, any preexisting conditions would not be covered under the new private insurance plan.

The Health Insurance Portability and Accountability Act (HIPAA) requires that insurers offer a special enrollment period for employees who did not elect to join their employer-sponsored insurance plan when it was first offered because they had COBRA or other private insurance but whose separate insurance coverage has now ended. Unfortunately, similar protections are not available to employees who lose Medicaid or CHIP coverage. Amending HIPAA to extend similar protections to those losing Medicaid or CHIP could help employees make a smooth transition from public to private insurance without gaps in coverage.

Even without such legislation, employers and insurers have the flexibility to modify their plans so that the loss of Medicaid, CHIP, or similar public coverage counts as a qualifying event (or provide a special enrollment period). This would be particularly beneficial for companies with a large concentration of low-wage workers.

[42] Ku and Park 2002.

There also is much that employers can do to help smooth the transition from public to private coverage. They could increase awareness among employees about opportunities to obtain public coverage for themselves and their children. They could give employees time off to apply for coverage and help them collect wage information that might be needed to determine or retain Medicaid eligibility. They could counsel employees to notify the personnel office when their Medicaid or CHIP benefits expire, so they can promptly take up the employer's health plan. For example, many firms, particularly those with low-wage workforces, offer information about the Earned Income Tax Credit to their newly hired workers to help them increase their incomes by applying for the tax credit.

CONCLUSION

Expanded efforts to help people maintain health insurance could substantially reduce the number of uninsured people. If every person who began the year with insurance retained coverage throughout the year, the number of low-income children who are uninsured would decline by close to two-fifths over the course of a year, while the number of uninsured low-income adults would decline by more than one-quarter. Moreover, lengthening the time that individuals have coverage could be a cost-effective way to improve the continuity and quality of health care. National data indicate that average monthly Medicaid expenditures fall when people have coverage for longer periods. Procedural improvements in public programs such as Medicaid and CHIP, which are the primary sources of insurance for poor families, can improve retention rates in these programs. At a time when uninsurance levels are rising because of the economic downturn and states are concerned about balancing their budgets, efforts to improve retention of Medicaid and CHIP coverage are particularly relevant.

Areas Where Federal Legislative Changes Could Improve Retention

Most of the strategies discussed in this paper already are available to states or employers, but many are underused. Incremental changes to federal law could provide additional options for states or offer new ways of improving retention.

- *Strengthen Transitional Medical Assistance (TMA).* TMA could be strengthened and simplified through the creation of state options to (1) eliminate or ease the rule that an individual must have been eligible for regular Medicaid for three of the previous six months to qualify for TMA, (2) simplify rules that require TMA beneficiaries to report income frequently during the year, and (3) extend the length of TMA coverage up to 24 months. These changes would make it easier for those who are moving from welfare to work to retain their Medicaid coverage.

- *Permit 12-month continuous eligibility for families.* Currently, states may offer 12 months of continuous Medicaid or CHIP eligibility for children, but not for their parents. Permitting states to extend this option to low-income parents would make it easier for them to retain coverage.

- *Improve computer systems for cross-program eligibility coordination.* While federal guidance encourages states to use information from other benefit programs to extend Medicaid coverage and help children shift between Medicaid and CHIP, the lack of coordination in state computer systems often makes this difficult. The federal government could offer enhanced federal matching funds to help states develop and operate coordinated data systems for program eligibility. The federal government already offers 90 percent matching funds to develop Medicaid claims systems and 75 percent matching funds for the operational costs of Medicaid claims systems.

- *Create special enrollment periods for individuals losing Medicaid or CHIP.* HIPAA could be amended so that the loss of Medicaid, CHIP, or similar public insurance coverage triggers a special enrollment period or counts as a qualifying event that enables a worker to join the employer-sponsored plan. This would help ensure that workers can move smoothly from public coverage to private insurance.

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RELATED PUBLICATIONS

In the list below, items that begin with a publication number are available from The Commonwealth Fund by calling our toll-free publications line at **1-888-777-2744** and ordering by number. These items can also be found on the Fund's website at **www.cmwf.org.** Other items are available from the authors and/or publishers.

#587 *Assessing State Strategies for Health Coverage Expansion: Summary of Case Studies of Oregon, Rhode Island, New Jersey, and Georgia* (November 2002). Sharon Silow-Carroll, Emily K. Waldman, Jack A. Meyer, Claudia Williams, Kimberley Fox, and Joel C. Cantor. These summaries of case studies look at four states' unique as well as shared experiences and draw lessons for other states. (See pub. **#565** for the full case studies.)

#577 *Toward Comprehensive Health Coverage for All: Summaries of 20 State Planning Grants from the U.S. Health Resources and Services Administration* (November 2002, Web publication). Heather Sacks, Todd Kutyla, and Sharon Silow-Carroll, Economic and Social Research Institute. In 2000, the DHHS's Health Resources and Services Administration awarded grants to 20 states to create comprehensive coverage plans for all citizens. These summaries report on the progress of states' coverage expansion efforts, detailing the history of reform, data on uninsured populations, actions taken, and goals for future efforts. Available at www.cmwf.org.

#569 *Portability of Coverage: HIPAA and COBRA* (November 2002). Jack A. Meyer and Larry S. Stepnick. This issue brief weighs the strengths and weaknesses of the current federal laws designed to ensure the portability of worker's health insurance coverage. The authors find that, while the Health Insurance Portability and Accountability Act (HIPAA) and Consolidated Omnibus Budget Reconciliation Act (COBRA) provide some protections for workers leaving their jobs, neither law guarantees access to affordable coverage.

#567 *Health Insurance Purchasing Cooperatives* (November 2002). Elliot K. Wicks, Economic and Social Research Institute. This issue brief compares the expectations of health insurance purchasing cooperatives for small employers with the actual experiences of different co-ops and draws lessons about the potential for similar future purchasing efforts.

#565 *Assessing State Strategies for Health Coverage Expansion: Case Studies of Oregon, Rhode Island, New Jersey, and Georgia* (November 2002). Sharon Silow-Carroll, Emily K. Waldman, Jack A. Meyer, Claudia Williams, Kimberley Fox, and Joel C. Cantor. These case studies provide an in-depth account of four states' efforts to expand health coverage, detailing their relative strengths and weaknesses and highlighting what appear to be the key factors for success.

Consumer-Driven Health Plans: Are They More Than Talk Now? (November 20, 2002). Jon R. Gabel, Anthony T. Lo Sasso, and Thomas Rice. *Health Affairs* Web Exclusive. Available online only at http://www.healthaffairs.org/WebExclusives/2201Gabel.pdf.

Exploring the Limits of the Safety Net: Community Health Centers and Care for the Uninsured (November/December 2002). Michael K. Gusmano, Gerry Fairbrother, and Heidi Park. *Health Affairs,* vol. 21, no. 6. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845. Available online at http://www.healthaffairs.org/readeragent.php?ID=/usr/local/apache/sites/healthaffairs.org/htdocs/Library/v21n6/s27.pdf.

Medicaid Coverage for the Working Uninsured: The Role of State Policy (November/December 2002). Randall R. Bovbjerg, Jack Hadley, Mary Beth Pohl, and Marc Rockmore. *Health Affairs,* vol. 21, no. 6. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845. Available online at http://www.healthaffairs.org/readeragent.php?ID=/usr/local/apache/sites/healthaffairs.org/htdocs/Library/v21n6/s34.pdf.

The Perils of Buying Your Own Policy (September 2002, Web exclusive). Trudy Lieberman. *Consumer Reports.* Available in the Consumer Advice section of www.consumerreports.com.

#559 *The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care* (August 2002). Jennifer N. Edwards, Michelle M. Doty, and Cathy Schoen. Based on a Commonwealth Fund survey of health insurance in the workplace, this issue brief finds that two of five workers experienced increases in their premiums or cost-sharing, or both, during 2001. Although public support for job-based health insurance remains strong, many workers are not confident that employers will continue to offer coverage to them down the road. Workers are even more uncertain about their ability to get good health care in the future.

Health Insurance Expansions for Working Families: A Comparison of Targeting Strategies (July/August 2002). Danielle H. Ferry, Bowen Garrett, Sherry Glied, Emily K. Greenman, and Len M. Nichols. *Health Affairs,* vol. 21, no. 4. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845. Available online at http://www.healthaffairs.org/readeragent.php?ID=/usr/local/apache/sites/healthaffairs.org/htdocs/Library/v21n4/s33.pdf.

The Unraveling of Health Insurance (July 2002, Web exclusive). Trudy Lieberman. *Consumer Reports.* Available in the Consumer Advice section of www.consumerreports.com.

#509 *Family Out-of-Pocket Spending for Health Services: A Continuing Source of Financial Insecurity* (June 2002). Mark Merlis. This report examines trends in out-of-pocket spending, the components of that spending, and the characteristics of families with high out-of-pocket costs.

#556 *Do Enrollees in 'Look-Alike' Medicaid and SCHIP Programs Really Look Alike?* (May/June 2002). Jennifer N. Edwards, Janet Bronstein, and David B. Rein. *Health Affairs,* vol. 21, no. 3. In their analysis of Georgia's similar-looking Medicaid and SCHIP programs, the authors present three possible explanations for the differences in access to care between the two populations: Medicaid families are less familiar with and supportive of systems requiring use of an assigned primary care physician, the families face more nonprogram barriers to using care, and physicians have different responses to the two programs.

#527 *Are Tax Credits Alone the Solution to Affordable Health Insurance? Comparing Individual and Group Insurance Costs in 17 U.S. Markets* (May 2002). Jon R. Gabel, Kelley Dhont, and Jeremy Pickreign, Health Research and Educational Trust. This report identifies solutions that might make tax credits and the individual insurance market work. These include raising the amount of the tax credits; adjusting the credit according to age, sex, and health status; and combining tax credits with new access to health coverage through existing public or private group insurance programs.

#518 *Bare-Bones Health Plans: Are They Worth the Money?* (May 2002). Sherry Glied, Cathi Callahan, James Mays, and Jennifer N. Edwards. This issue brief finds that a less-expensive health insurance product would leave low-income adults at risk for high out-of-pocket costs that could exceed their annual income. The authors conclude that a safeguard similar to that provided by the State Children's Health Insurance Program (CHIP)—a spending cap of 5 percent of annual

income for low-income families—would be needed in conjunction with any move toward a stripped-down benefit package.

#540 *Individual Insurance: How Much Financial Protection Does It Provide?* (April 17, 2002). Jon R. Gabel, Kelley Dhont, Heidi Whitmore, and Jeremy Pickreign, Health Research and Educational Trust. *Health Affairs* Web Exclusive. This article demonstrates that a $1,000 tax credit would be more than adequate to buy individual coverage for healthy, young, single males, but it would not even come close for their middle-aged peers. Article available online only at www.healthaffairs.org/WebExclusives/Gabel_Web_Excl_041702.htm.

#506 *Erosion of Private Health Insurance Coverage for Retirees: Findings from the 2000 and 2001 Retiree Health and Prescription Drug Coverage Survey* (April 2002). The Henry J. Kaiser Family Foundation, Health Research and Educational Trust, and The Commonwealth Fund. The survey profiles retiree health coverage for Medicare-age (65+) retirees, including the amount retirees pay for coverage compared to active workers, cost-sharing for prescription drugs, and eligibility requirements for retiree benefits. Available online only at www.cmwf.org.

#521 *Work in America: New Challenges for Health Care* (April 2002). Karen Davis. In this essay—a reprint of the president's message from the Fund's *2001 Annual Report*—the author examines trends in the U.S. labor force over the past quarter century and how they affect health, health care, and health insurance coverage.

#508 *E-Health Options for Business: Evaluating the Choices* (March 2002). Sharon Silow-Carroll and Lisa Duchon. In this field report, the authors say that e-health tools—new Internet-based products that some employers and employees are now using to manage health benefits—have the potential to provide greater control to consumers and lower overall costs for administering benefits. The authors warn, however, that employees may face increased financial burdens as health care costs rise faster than employer contributions, and that adverse risk selection could raise costs and limit choice for some employees.

Pricing the Priceless: A Health Care Conundrum (2002). Joseph P. Newhouse. The book presents a study of medical care pricing and its social, political, and economic consequences. Copies are available from The MIT Press, c/o Triliteral, 100 Maple Ridge Drive, Cumberland, RI 02864, Tel: 800-405-1619, Fax: 800-406-9145, E-mail: mitpress-orders@mit.edu.

#512 *Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk* (December 2001). Lisa Duchon, Cathy Schoen, Michelle M. Doty, Karen Davis, Erin Strumpf, and Stephanie Bruegman. This report, based on The Commonwealth Fund 2001 Health Insurance Survey, finds that in the past year one of four Americans ages 19 to 64—some 38 million adults—was uninsured for all or part of the time. Lapses in coverage often restrict people's access to medical care, cause problems in paying medical bills, and even make it difficult to afford basic living costs such as food and rent.

#513 *Maintaining Health Insurance During a Recession: Likely COBRA Eligibility* (December 2001). Michelle M. Doty and Cathy Schoen. This issue brief, based on The Commonwealth Fund 2001 Health Insurance Survey, examines the potential as well as limits of COBRA eligibility as a strategy for protecting workforce access to affordable health care benefits.

#514 *Experiences of Working-Age Adults in the Individual Insurance Market* (December 2001). Lisa Duchon and Cathy Schoen. This issue brief, based on The Commonwealth Fund 2001 Health Insurance Survey, describes the difficulties faced by those without access to group health coverage in obtaining adequate, affordable individual health insurance.

#478 *Universal Coverage in the United States: Lessons from Experience of the 20th Century* (December 2001). Karen Davis. This issue brief, adapted from an article in the March 2001 *Journal of Urban Health: Bulletin of the New York Academy of Medicine,* traces how the current U.S. health care system came to be, how various proposals for universal health coverage gained and lost political support, and what the pros and cons are of existing alternatives for expanding coverage.

#511 *How the Slowing U.S. Economy Threatens Employer-Based Health Insurance* (November 2001). Jeanne M. Lambrew, George Washington University. This report documents the link between loss of health insurance and unemployment, estimating that 37 percent of unemployed people are uninsured—nearly three times as high as the uninsured rate for all Americans (14%). The jobless uninsured are at great financial risk should they become ill or injured.

#475 *Business Initiatives to Expand Health Coverage for Workers in Small Firms* (October 2001). Jack A. Meyer and Lise S. Rybowski. This report weighs the problems and prospects of purchasing coalitions formed by larger businesses to help small firms expand access to health insurance. The authors say that private sector solutions alone are unlikely to solve the long-term problem, and the public sector will need to step in to make health insurance more affordable to small businesses.

Managed Care and Market Power: Physician Organizations in Four Markets (September/October 2001). Meredith B. Rosenthal, Bruce E. Landon, and Haiden A. Huskamp. *Health Affairs,* vol. 20, no. 5. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#493 *Diagnosing Disparities in Health Insurance for Women: A Prescription for Change* (August 2001). Jeanne M. Lambrew, George Washington University. In this report, the author concludes that building on insurance options that currently exist—such as employer-sponsored insurance, the Children's Health Insurance Program (CHIP), and Medicaid—represents the most targeted and potentially effective approach for increasing access to affordable coverage for the nation's 15 million uninsured women.

#472 *Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools* (August 2001). Lori Achman and Deborah Chollet, Mathematica Policy Research, Inc. The authors argue that high premiums, deductibles, and copayments make high-risk pools unaffordable for people with serious medical conditions, and suggest that by lifting the tax exemption granted to self-insured plans, states could provide their high-risk pools with some much-needed financing.

#502 *Gaps in Health Coverage Among Working-Age Americans and the Consequences* (August 2001). Catherine Hoffman, Cathy Schoen, Diane Rowland, and Karen Davis. *Journal of Health Care for the Poor and Underserved,* vol. 12, no. 3. In this article, the authors examine health coverage and access to care among working-age adults using the Kaiser/Commonwealth 1997 National Survey of Health Insurance, and report that having even a temporary gap in health coverage made a significant difference in access to care for working-age adults.

#469 *Embraceable You: How Employers Influence Health Plan Enrollment* (July/August 2001). Jon Gabel, Jeremy Pickreign, Heidi Whitmore, and Cathy Schoen. *Health Affairs,* vol. 20, no. 4. In this article, the authors reveal that high employee contributions for health insurance often deter low-income workers from signing up for coverage, even when they are eligible.

#468 *Market Failure? Individual Insurance Markets for Older Americans* (July/August 2001). Elisabeth Simantov, Cathy Schoen, and Stephanie Bruegman. *Health Affairs,* vol. 20, no. 4. This study shows that adults ages 50 to 64 who buy individual coverage are likely to pay much more out-of-pocket for a limited package of benefits than their counterparts who are covered via their employers.

#457 *Health Insurance on the Way to Medicare: Is Special Government Assistance Warranted?* (July 2001). Pamela Farley Short, Dennis G. Shea, and M. Paige Powell, The Pennsylvania State University. The authors conclude that the loss of employer insurance should not be used as the primary justification for implementing Medicare buy-in or other reforms for over-55 and over-62 age groups, but instead propose that the better justification for such reforms is the poorer average health status of those nearing age 65.

#488 *Inquiry* (Summer 2001). Vol. 38, no. 2. Articles based on the 10-report series *Strategies to Expand Health Insurance for Working Americans,* which was released by the Fund in December 2000 and is available online at www.cmwf.org.

#449 *How the New Labor Market Is Squeezing Workforce Health Benefits* (June 2001). James L. Medoff, Howard B. Shapiro, Michael Calabrese, and Andrew D. Harless, Center for National Policy. To understand how labor market trends have contributed to the decline in the proportion of private-sector workers receiving benefits from their own employers—and to anticipate future trends—this study examines changes over a 19-year period, 1979 to 1998.

#464 *Health Insurance: A Family Affair—A National Profile and State-by-State Analysis of Uninsured Parents and Their Children* (May 2001). Jeanne M. Lambrew, George Washington University. This report suggests that expanding Medicaid and State Children's Health Insurance Program (CHIP) coverage to parents as well as children may not only decrease the number of uninsured Americans but may be the best way to cover more uninsured children.

#453 *Running in Place: How Job Characteristics, Immigrant Status, and Family Structure Keep Hispanics Uninsured* (May 2001). Claudia L. Schur and Jacob Feldman, Project HOPE Center for Health Affairs. This report looks at factors that influence health insurance coverage for Hispanics, the fastest-growing minority population in the United States. The analysis shows that characteristics of employment account for much, but not all, of the problem. Family structure seems to play some role, as does immigrant status, which affects Hispanic immigrants more than other groups.

Preparing for the Future: A 2020 Vision for American Health Care (April 2001). Karen Davis. *Academic Medicine,* vol. 76, no. 4. Copies are available from Karen Davis, President, The Commonwealth Fund, 1 East 75th Street, New York, NY 10021-2692.

#462 *Expanding Public Programs to Cover the Sick and Poor Uninsured* (March 2001). Karen Davis. In invited testimony before the Senate Finance Committee, the Fund's president presented a compelling case for expanding existing public health insurance programs to provide coverage for the most vulnerable segments of the nation's 42.6 million uninsured. She stressed the importance of expanding Medicaid and the Children's Health Insurance Program (CHIP) to cover parents of covered children.

#441 *Medicare Buy-In Options: Estimating Coverage and Costs* (March 2001). John Sheils and Ying-Jun Chen, The Lewin Group, Inc. This paper examines the need for insurance expansions for Americans approaching retirement age and analyzes the likely impact of Medicare buy-in options on program costs and their effectiveness in reducing the numbers of uninsured.

Universal Coverage in the United States: Lessons from Experience of the 20th Century (March 2001). Karen Davis. *Journal of Urban Health: Bulletin of the New York Academy of Medicine,* vol. 78, no. 1. Copies are available from the New York Academy of Medicine, 1216 Fifth Avenue, New York, NY 10029-5293.

#445 *Expanding Employment-Based Health Coverage: Lessons from Six State and Local Programs* (February 2001). Sharon Silow-Carroll, Emily K. Waldman, and Jack A. Meyer, Economic and Social Research Institute. As with publication **#424** (see below), this report describes the various ways states and local communities are making coverage more affordable and accessible to the working uninsured, but looks more closely at programs in six of the states discussed in the earlier report.

#459 *Betwixt and Between: Targeting Coverage Reforms to Those Approaching Medicare* (January/February 2001). Dennis G. Shea, Pamela Farley Short, and M. Paige Powell. *Health Affairs,* vol. 20, no. 1. The article examines whether eligibility for a Medicare buy-in should be based on age or ability to pay.

#439 *Patterns of Insurance Coverage Within Families with Children* (January/February 2001). Karla L. Hanson. *Health Affairs,* vol. 20, no. 1. Using the 1996 Medical Expenditure Panel Survey, this article examines patterns of health insurance within families with children, determining that 3.2 million families are uninsured and another 4.5 million families are only partially insured.

How a Changing Workforce Affects Employer-Sponsored Health Insurance (January/February 2001). Gregory Acs and Linda J. Blumberg. *Health Affairs,* vol. 20, no. 1. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#415 *Challenges and Options for Increasing the Number of Americans with Health Insurance* (January 2001). Sherry A. Glied, Joseph A. Mailman School of Public Health, Columbia University. This overview paper summarizes the 10 option papers written as part of the series Strategies to Expand Health Insurance for Working Americans.

#442 *Incremental Coverage Expansion Options: Detailed Table Summaries to Accompany Option Papers Commissioned by The Commonwealth Fund Task Force on the Future of Health Insurance* (January 2001). Sherry A. Glied and Danielle H. Ferry, Joseph L. Mailman School of Public Health, Columbia University. This paper, a companion to publication **#415,** presents a detailed side-by-side look at the 10 option papers in the series Strategies to Expand Health Insurance for Working Americans.

#476 *"Second-Generation" Medicaid Managed Care: Can It Deliver?* (Winter 2000). Marsha Gold and Jessica Mittler, Mathematica Policy Research, Inc. *Health Care Financing Review,* vol. 22, no. 2. This study of Medicaid managed care programs in seven states finds that the programs require state policymakers to make difficult trade-offs among the competing goals of improving Medicaid access, providing care for the uninsured, and serving those with special needs who are dependent on state-funded programs. Available online only at www.cmwf.org.

Medicaid's Complex Goals: Challenges for Managed Care and Behavioral Health (Winter 2000). Marsha Gold and Jessica Mittler, Mathematica Policy Research, Inc. *Health Care Financing Review,* vol. 22, no. 2. Copies are available from Marsha Gold, Mathematica Policy Research, Inc., 600 Maryland Avenue, SW, Suite 550, Washington, DC 20024, E-mail: MGold@mathematica-mpr.com.

#413 *Private Purchasing Pools to Harness Individual Tax Credits for Consumers* (December 2000). Richard E. Curtis, Edward Neuschler, and Rafe Forland, Institute for Health Policy Solutions. Combining small employers into groups offers the potential of improved benefits, plan choice, and/or reduced premium costs. This paper, part of the series Strategies to Expand Health Insurance for Working Americans, proposes the establishment of private purchasing pools that would be open to workers (and their families) without an offer of employer-sponsored insurance

or in firms with up to 50 employees. All tax-credit recipients would be required to use their premium credits in these pools. Available online only at www.cmwf.org.

#414 *Increasing Health Insurance Coverage Through an Extended Federal Employees Health Benefits Program* (December 2000). Beth C. Fuchs, Health Policy Alternatives, Inc. The FEHBP has often been proposed as a possible base to build on for group coverage. This paper, part of the series Strategies to Expand Health Insurance for Working Americans, proposes an extension of FEHBP (E-FEHBP) that would operate in parallel with the existing program. The proposal would require anyone qualifying for a tax credit to obtain it through E-FEHBP and would also permit employees of small firms (<10 workers) to purchase health insurance through the program. The proposal would also provide public reinsurance for E-FEHBP, further lowering the premium costs faced by those eligible for the program. Available online only at www.cmwf.org.

#416 *Transitional Subsidies for Health Insurance Coverage* (December 2000). Jonathan Gruber, Massachusetts Institute of Technology and The National Bureau of Economic Research, Inc. The unemployed and those switching jobs often lose coverage due to an inability to pay premiums. This paper, part of the series Strategies to Expand Health Insurance for Working Americans, suggests ways that the existing COBRA program could be enhanced to help avoid these uninsured spells. Available online only at www.cmwf.org.

#417 *Public Subsidies for Required Employee Contributions Toward Employer-Sponsored Insurance* (December 2000). Mark Merlis, Institute for Health Policy Solutions. Some uninsured workers have access to employer group coverage but find the cost of their premium shares unaffordable. This paper, part of the series Strategies to Expand Health Insurance for Working Americans, examines the potential for using a tax credit or other incentive to help employees pay their share of premium costs in employer-sponsored plans. The paper analyzes how such premium assistance might work as an accompaniment to a tax credit for those without access to employer plans. Available online only at www.cmwf.org.

#418 *A Federal Tax Credit to Encourage Employers to Offer Health Coverage* (December 2000). Jack A. Meyer and Elliot K. Wicks, Economic and Social Research Institute. Employers who do not currently offer health benefits to their employees cite costs as the primary concern. This paper, part of the series Strategies to Expand Health Insurance for Working Americans, examines the potential of offering tax credits (or other financial incentives) to employers of low-wage workers to induce them to offer coverage. Available online only at www.cmwf.org.

#419 *Allowing Small Businesses and the Self-Employed to Buy Health Care Coverage Through Public Programs* (December 2000). Sara Rosenbaum, Phyllis C. Borzi, and Vernon Smith. Public programs such as CHIP and Medicaid offer the possibility of economies of scale for group coverage for small employers as well as individuals. This paper, part of the series Strategies to Expand Health Insurance for Working Americans, proposes allowing the self-employed and those in small businesses to buy coverage through these public plans, and providing premium assistance to make it easier for them to do so. Available online only at www.cmwf.org.

#420 *A Workable Solution for the Pre-Medicare Population* (December 2000). Pamela Farley Short, Dennis G. Shea, and M. Paige Powell, Pennsylvania State University. Adults nearing but not yet eligible for Medicare are at high risk of being uninsured, especially if they are in poor health. This paper, part of the series Strategies to Expand Health Insurance for Working Americans, proposes new options to enable those 62 and older early buy-in to Medicare (or to subsidize other coverage) through premium assistance for those with low lifetime incomes and new health IRA or tax-deduction accounts for those with higher incomes. Available online only at www.cmwf.org.

#421 *Markets for Individual Health Insurance: Can We Make Them Work with Incentives to Purchase Insurance?* (December 2000). Katherine Swartz, Harvard School of Public Health. Efforts to improve the functioning of individual insurance markets require policymakers to trade off access for the highest-risk groups against keeping access for the lowest risk-groups. This paper, part of the series Strategies to Expand Health Insurance for Working Americans, discusses how individual insurance markets might best be designed in view of this trade-off. Available online only at www.cmwf.org.

#422 *Buying into Public Coverage: Expanding Access by Permitting Families to Use Tax Credits to Buy into Medicaid or CHIP Programs* (December 2000). Alan Weil, The Urban Institute. Medicaid and CHIP offer administrative structures and plan arrangements with the capacity to enroll individuals and families. This paper, part of the series Strategies to Expand Health Insurance for Working Americans, proposes permitting, but not requiring, tax-credit recipients to use their credits to buy into Medicaid or CHIP. Available online only at www.cmwf.org.

#423 *A Health Insurance Tax Credit for Uninsured Workers* (December 2000). Larry Zelenak, University of North Carolina at Chapel Hill School of Law. A key issue for uninsured adult workers is the cost of insurance. This paper, part of the series Strategies to Expand Health Insurance for Working Americans, proposes using a tax credit to help workers afford the cost of coverage. It assumes age-/sex-adjusted credits averaging $2,000 per adult or $4,000 per family, with a full refundable "credit" for those with incomes at or below 200% percent of poverty. The paper analyzes administrative and other issues related to the use of such tax credits. Available online only at www.cmwf.org.

#425 *Barriers to Health Coverage for Hispanic Workers: Focus Group Findings* (December 2000). Michael Perry, Susan Kannel, and Enrique Castillo. This report, based on eight focus groups with 81 Hispanic workers of low to moderate income, finds that lack of opportunity and affordability are the chief obstacles to enrollment in employer-based health plans, the dominant source of health insurance for those under age 65.

#438 *A 2020 Vision for American Health Care* (December 11/25, 2000). Karen Davis, Cathy Schoen, and Stephen Schoenbaum. *Archives of Internal Medicine,* vol. 160, no. 22. The problem of nearly 43 million Americans without health insurance could be virtually eliminated in a single generation through a health plan based on universal, automatic coverage that allows choice of plan and provider. The proposal could be paid for, according to Fund President Davis and coauthors, by using the quarter of the federal budget surplus which results from savings in Medicare and Medicaid.

Tracking Health Care Costs: Inflation Returns (November/December 2000). Christopher Hogan, Paul B. Ginsburg, and Jon R. Gabel. *Health Affairs,* vol. 19, no. 6. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#424 *State and Local Initiatives to Enhance Health Coverage for the Working Uninsured* (November 2000). Sharon Silow-Carroll, Stephanie E. Anthony, and Jack A. Meyer, Economic and Social Research Institute. This report describes the various ways states and local communities are making coverage more affordable and accessible to the working uninsured, with a primary focus on programs that target employers and employees directly, but also on a sample of programs targeting a broader population.

#411 *ERISA and State Health Care Access Initiatives: Opportunities and Obstacles* (October 2000). Patricia A. Butler. This study examines the potential of states to expand health coverage

incrementally should the federal government decide to reform the Employee Retirement Income Security Act (ERISA) of 1974, which regulates employee benefit programs such as job-based health plans and contains a broad preemption clause that supersedes state laws that relate to private-sector, employer-sponsored plans.

Customizing Medicaid Managed Care—California Style (September/October 2000). Debra A. Draper and Marsha Gold. *Health Affairs,* vol. 19, no. 5. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

Inadequate Health Insurance: Costs and Consequences (August 11, 2000). Karen Donelan, Catherine M. DesRoches, and Cathy Schoen. *Medscape General Medicine.* Available online at www.medscape.com/Medscape/GeneralMedicine/journal/public/mgm.journal.html.

#392 *Disparities in Health Insurance and Access to Care for Residents Across U.S. Cities* (August 2000). E. Richard Brown, Roberta Wyn, and Stephanie Teleki. A new study of health insurance coverage in 85 U.S. metropolitan areas reveals that uninsured rates vary widely, from a low of 7 percent in Akron, Ohio, and Harrisburg, Pennsylvania, to a high of 37 percent in El Paso, Texas. High proportions of immigrants and low rates of employer-based health coverage correlate strongly with high uninsured rates in urban populations.

#405 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. This summary report, based on The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70, reveals that those nearing the age of Medicare eligibility and those who recently enrolled in the program place high value on Medicare. At the same time, many people in this age group are struggling to pay for prescription drugs, which Medicare doesn't cover.

#406 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. This full report of findings from The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70 reveals that those nearing the age of Medicare eligibility and those who recently enrolled in the program place high value on Medicare. At the same time, many people in this age group are struggling to pay for prescription drugs, which Medicare doesn't cover.

#391 *On Their Own: Young Adults Living Without Health Insurance* (May 2000). Kevin Quinn, Cathy Schoen, and Louisa Buatti. Based on The Commonwealth Fund 1999 National Survey of Workers' Health Insurance and Task Force analysis of the March 1999 Current Population Survey, this report shows that young adults ages 19–29 are twice as likely to be uninsured as children or older adults.

#385 *State Experiences with Cost-Sharing Mechanisms in Children's Health Insurance Expansions* (May 2000). Mary Jo O'Brien et al. This report examines the effect of cost-sharing on participation in the State Child Health Insurance Program (CHIP).

#384 *State Experiences with Access Issues Under Children's Health Insurance Expansions* (May 2000). Mary Jo O'Brien et al. This report explores how the design and administration of state incremental insurance expansions affect access to health insurance coverage and, ultimately, access to all health care services.

#429 *Role of Insurance in Promoting Access to Care—Uninsured and Unstably Insured: The Importance of Continuous Coverage* (April 2000). Cathy Schoen and Catherine M. DesRoches. *HSR: Health*

Services Research, vol. 35, part II. Using data from three different survey databases, the authors report that, compared with those continuously insured, those insured but with a recent time uninsured are two to three times as likely to report access problems.

#370 *Working Without Benefits: The Health Insurance Crisis Confronting Hispanic Americans* (March 2000). Kevin Quinn, Abt Associates, Inc. Using data from the March 1999 Current Population Survey and The Commonwealth Fund 1999 National Survey of Workers' Health Insurance, this report examines reasons why 9 million of the country's 11 million uninsured Hispanics are in working families, and the effect that lack has on the Hispanic community.

Growing an Industry: How Managed Is TennCare's Managed Care? (January/February 2000). Marsha Gold and Anna Aizer. *Health Affairs,* vol. 19, no. 1. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, www.healthaffairs.org.

#361 *Listening to Workers: Challenges for Employer-Sponsored Coverage in the 21st Century* (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. Based on The Commonwealth Fund 1999 National Survey of Workers' Health Insurance, this short report shows that although most working Americans with employer-sponsored health insurance are satisfied with their plans, too many middle- and low-income workers cannot afford health coverage or are not offered it.

#362 *Listening to Workers: Findings from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. This full-length analysis of the Fund's survey of more than 5,000 working-age Americans finds that half of all respondents would like employers to continue serving as the main source of coverage for the working population. However, sharp disparities exist in the availability of employer-based coverage: one-third of middle- and low-income adults who work full time are uninsured.

#363 *A Vote of Confidence: Attitudes Toward Employer-Sponsored Health Insurance* (January 2000). Cathy Schoen, Erin Strumpf, and Karen Davis. This issue brief based on findings from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance reports that most Americans believe employers are the best source of health coverage and that they should continue to serve as the primary source in the future. Almost all of those surveyed also favored the government providing assistance to low-income workers and their families to help them pay for insurance.

#364 *Risks for Midlife Americans: Getting Sick, Becoming Disabled, or Losing a Job and Health Coverage* (January 2000). John Budetti, Cathy Schoen, Elisabeth Simantov, and Janet Shikles. This short report derived from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance highlights the vulnerability of millions of midlife Americans to losing their job-based coverage in the face of heightened risk for chronic disease, disability, or loss of employment.

#398 *Managed Care and Low-Income Populations in Texas: 1996–98 Update* (December 1999). Hilary Frazer, Marsha Gold, and Barbara Lyons. Copies are available from The Henry J. Kaiser Family Foundation, 1450 G Street, NW, Suite 250, Washington, DC 20005, Tel: 800-656-4533.

#397 *Managed Care and Low-Income Populations in Florida: 1996–98 Update* (December 1999). Anna Aizer, Marsha Gold, and Catherine DesRoches. Copies are available from The Henry J. Kaiser Family Foundation, 1450 G Street, NW, Suite 250, Washington, DC 20005, Tel: 800-656-4533.

#396 *Managed Care and Low-Income Populations: A Case Study of Managed Care in California* (December 1999). Debbie Draper, Marsha Gold, and Julie Hudman. Update of May 1996 report. Copies are available from The Henry J. Kaiser Family Foundation, 1450 G Street, NW, Suite 250, Washington, DC 20005, Tel: 800-656-4533.

#358 *Job-Based Health Insurance, 1977–1998: The Accidental System Under Scrutiny* (November/ December 1999). Jon R. Gabel. *Health Affairs,* vol. 18, no 6. In this article, the author describes how the U.S. employer-based health insurance system evolved following World War II and shows that the proportion of workers insured through their jobs has fallen steadily in the past two decades—a decline most prominent among disadvantaged groups.

#347 *Can't Afford to Get Sick: A Reality for Millions of Working Americans* (September 1999). John Budetti, Lisa Duchon, Cathy Schoen, and Janet Shikles. This report from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance finds that millions of working Americans are struggling to get the health care they need because they lack insurance or experience gaps in coverage.

#368 *Managed Care in Three States: Experiences of Low-Income African Americans and Hispanics* (Fall 1999). Wilhelmina A. Leigh, Marsha Lillie-Blanton, Rose Marie Martinez, and Karen Scott Collins. *Inquiry,* vol. 36, no. 3. This article examines the experiences of low-income Hispanics, African Americans, and whites enrolled in managed care plans in Florida, Tennessee, and Texas and compares them to their racial/ethnic counterparts enrolled in fee-for-service plans.

#403 *Managed Care and Low-Income Populations: Four Years' Experience with Tennessee* (May 1999). Anna Aizer, Marsha Gold, and Cathy Schoen. Update of July 1995 report. Copies are available from The Henry J. Kaiser Family Foundation, 1450 G Street, NW, Suite 250, Washington, DC 20005, Tel: 800-656-4533.

#402 *Managed Care and Low-Income Populations with Special Needs: The Tennessee Experience* (May 1999). Anna Aizer and Marsha Gold. Copies are available from The Henry J. Kaiser Family Foundation, 1450 G Street, NW, Suite 250, Washington, DC 20005, Tel: 800-656-4533.

#401 *Managed Care and Low-Income Populations with Special Needs: The Oregon Experience* (May 1999). Jessica Mittler and Marsha Gold. Copies are available from The Henry J. Kaiser Family Foundation, 1450 G Street, NW, Suite 250, Washington, DC 20005, Tel: 800-656-4533.

#400 *Managed Care and Low-Income Populations: Four Years' Experience with the Oregon Health Plan* (May 1999). Jessica Mittler, Marsha Gold, and Barbara Lyons. Update of July 1995 report. Copies are available from The Henry J. Kaiser Family Foundation, 1450 G Street, NW, Suite 250, Washington, DC 20005, Tel: 800-656-4533.

#399 *Managed Care and Low-Income Populations: Case Study of Managed Care in Maryland* (May 1999). Marsha Gold, Jessica Mittler, and Barbara Lyons. Copies are available from The Henry J. Kaiser Family Foundation, 1450 G Street, NW, Suite 250, Washington, DC 20005, Tel: 800-656-4533.