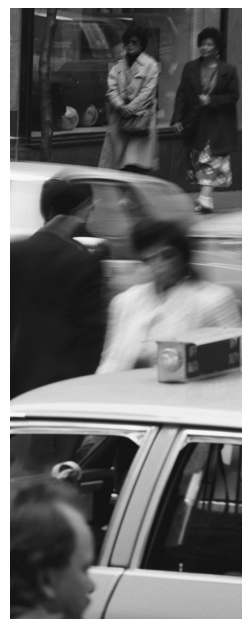
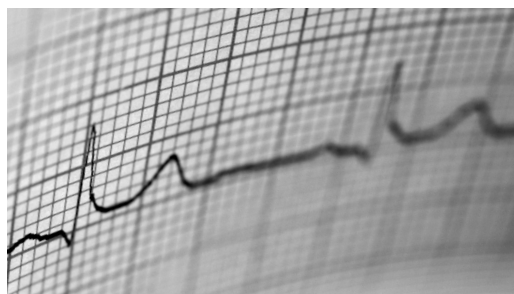


New York's Eligible but Uninsured



New York's Eligible but Uninsured

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Introduction

Forty percent of uninsured New Yorkers under age 65 are already eligible for an existing public health insurance program. As New York considers options for achieving universal health insurance through its “Partnership for Coverage” initiative, reaching this population will be critically important. Yet analyses show that traditional public program simplification reforms will reach only a limited share of these New Yorkers, suggesting that new and non-traditional strategies will be needed.¹

Reducing Uninsurance: The Broad View

An estimated 320,000 children/adolescents, aged 18 and under, and 1.95 million adults, aged 19-64, lack insurance in New York State. The uninsured comprise 7 percent of all children/adolescents and 17 percent of all adults in the state (Cook et al. 2007).² Public program eligibility levels

are higher for children/adolescents than for adults and, as a result, three out of four (250,000) uninsured children/adolescents are already eligible for Medicaid or the State Children’s Health Insurance Program (SCHIP, called Child Health Plus B in New York). In contrast, one out of three (650,000) uninsured adults is already eligible for Medicaid or Family Health Plus, as shown in Figures 1-3 (Cook et al. 2007). The majority of New Yorkers who are eligible for public coverage are enrolled in these programs: an estimated 86 percent of eligible children/adolescents and 70 percent of eligible adults (Table 1).³ Among those who are eligible but not participating in public coverage, some are enrolled in other coverage and the remainder are uninsured.

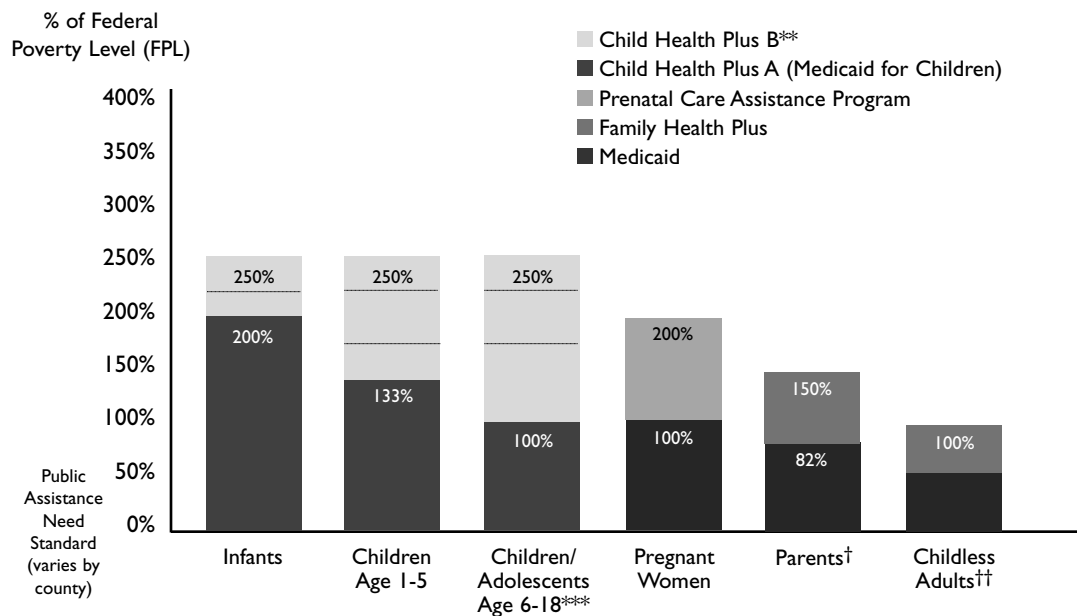
This issue brief focuses on the portion of eligible but unenrolled children/adolescents and adults who are uninsured. In total, we estimate that forty percent of all uninsured New Yorkers—900,000 of the state’s 2.3 million uninsured residents—are already eligible for public coverage. We refer to this group as “eligible but uninsured” or “EBU.”

¹ The United Hospital Fund/Commonwealth Fund report, *A Blueprint for Universal Health Insurance Coverage in New York* (Holahan et al. 2006) presented the results of modeling four public program simplification reforms: self-declaration of income, express lane eligibility, biennial renewal, and elimination of the Medicaid and Family Health Plus asset test. The modeling results indicated that the combination of these four reforms would enroll approximately 310,000 uninsured New Yorkers—just 27 percent of the eligible but uninsured—into a public health insurance program. An estimated 205,000 of these 310,000 would gain coverage as a result of biennial renewal.

² These data pertain to the non-elderly and are for 2005.

³ New York’s public program participation rate for children/adolescents is high relative to other states. A fifty-state comparison of children’s participation rates is available online at <http://ccf.georgetown.edu/index/cms-file-system-action?file=statistics/cps%20participation%20rates.pdf>.

Figure 1: New York State Eligibility for Medicaid, Child Health Plus, and Family Health Plus*



Notes:

* Medicaid and Child Health Plus A eligibility are expressed in net income, while Child Health Plus B and Family Health Plus eligibility are expressed in gross income, as written in the Health Care Reform Act of 2000 and Medicaid law. The 2007 Federal Poverty Level (FPL) is \$10,210 for an individual and \$17,170 for a family of three.

** Coverage for children in families with gross income above 160 percent FPL requires an income-related premium. With gross family income between 160 and 222 percent FPL, premiums are \$9/month/child (up to \$27); with gross family income between 223 and 250 percent FPL, premiums are \$15/month/child (up to \$45).

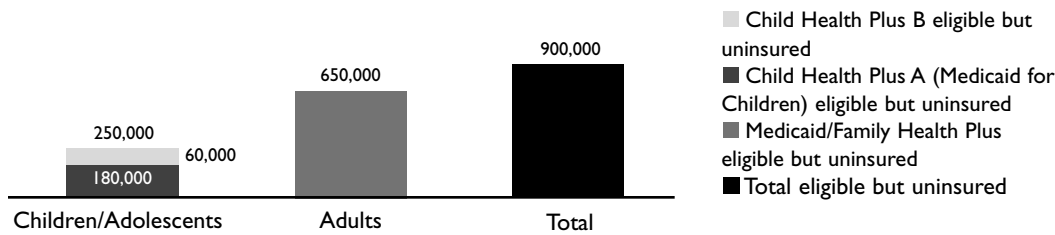
*** Through March 2005, the Child Health Plus A eligibility level for children aged 6-18 was 133 percent FPL. Effective April 2005, the Child Health Plus A eligibility level for children aged 6-18 years was lowered to 100 percent FPL; at that time, children in that age range in families with gross income between 100 and 133 percent FPL who were enrolled in Child Health Plus A were shifted into Child Health Plus B.

† “Parent” is defined as a parent of an individual under 21 years who lives in the household. Medicaid eligibility includes disabled adults and 19- and 20-year-olds with income up to 82 percent FPL. Family Health Plus eligibility includes 19- and 20-year-olds living with a parent with income up to 150 percent FPL.

†† “Childless adult” is defined as a non-disabled, non-elderly adult aged 21-64 who does not have a child under age 21 living in the household. Family Health Plus eligibility includes 19- and 20-year-olds, not living with their parent(s), with income up to 100 percent FPL.

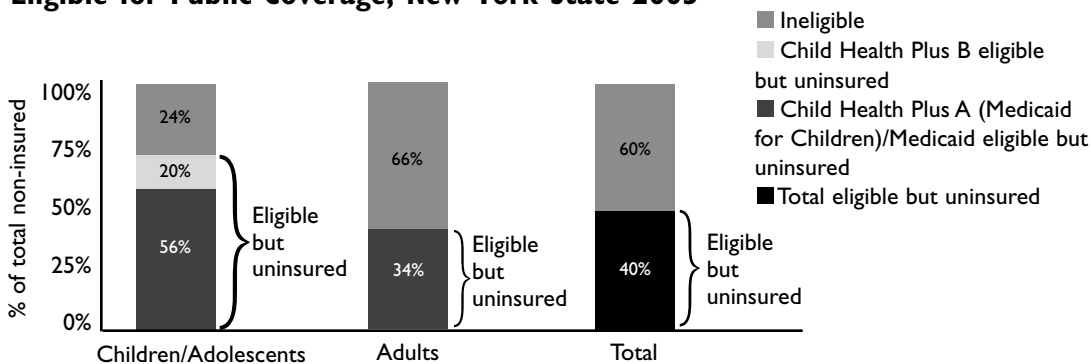
Note: Low-income, uninsured women who are diagnosed with breast or cervical cancer in screenings through New York’s Healthy Women Partnerships program are eligible for Medicaid coverage. To qualify for the screenings, women must have income levels below 250 percent FPL. Females and males of childbearing age with income up to 200 percent FPL are eligible for Medicaid Family Planning Services. As of July 2003, disabled workers aged 16-64 with net income of up to 250 percent FPL and non-exempt resources of up to \$10,000 are eligible for Medicaid coverage through the Medicaid Buy-In for Working People with Disabilities program (MBIWPD); enrollees with incomes above 150 percent FPL will eventually be subject to an income-related premium.

Figure 2: Estimates of Uninsured Children/Adolescents and Non-elderly Adults Eligible for Public Coverage, New York State, 2005



Notes: Child Health Plus A/Medicaid data and Child Health Plus B data include children/adolescents aged 0-18. Medicaid/Family Health Plus data include adults aged 19-64. Estimates of eligible but uninsured are for 2005. Numbers may not sum to totals due to rounding.
 Source: Urban Institute and United Hospital Fund. September 2007. *Health Insurance Coverage in New York, 2004-2005*.

Figure 3: Percentage of Uninsured Children/Adolescents and Non-elderly Adults Eligible for Public Coverage, New York State 2005



Notes: Child Health Plus A/Medicaid data and Child Health Plus B data include children/adolescents aged 0-18. Adult eligibility estimates include Family Health Plus. Estimates of eligible but uninsured are based on 2005 estimates of uninsured in New York State. Unless otherwise noted, other estimates presented in this report are based on 2004-2005 data.
 Source: Urban Institute and United Hospital Fund. September 2007. *Health Insurance Coverage in New York, 2004-2005*.

In 2007, policymakers took significant steps toward reaching this population, with a proposal to expand SCHIP eligibility, and several reforms simplifying public program rules in order to increase

participation and retention rates.⁴ The simplification reforms include presumptive eligibility for children in Medicaid; self-declaration of income, residency, and some income deductions at renewal (to be

⁴ New York's 2007-08 budget included provisions to expand eligibility for partially subsidized Child Health Plus B coverage to children with family income below 400 percent of the federal poverty level (\$68,680 for a family of three). This expansion was originally contingent upon federal waiver approval, which was denied by the Centers for Medicare and Medicaid Services (CMS) in September 2007, but may be reconsidered based upon the outcome of SCHIP reauthorization. New York State is challenging CMS' decision in court (as is a group of New York consumers) and has proposed full state funding of the expansion in the 2008-09 executive budget. See also <http://www.ny.gov/governor/press/0401074.html> for the Governor's press release about these reforms, <http://www.partnership4coverage.ny.gov> for information about the Governor's universal coverage initiative, and <http://www.budget.state.ny.us/> for information about the proposed 2008-09 executive budget.

Table 1: Children/Adolescents and Adults and Their Eligibility and Enrollment in Public Health Insurance Coverage, New York State, 2005

	Total	Uninsured	Eligible	Enrolled	Eligible but Uninsured (EBU)	Public Program Participation Rate	EBU as Percent of Uninsured
Children/Adolescents	4,850,000	320,000	2,600,000	1,590,000	250,000	86%	76%
Adults	11,680,000	1,950,000	2,680,000	1,520,000	650,000	70%	34%
Total	16,520,000	2,280,000	5,280,000	3,110,000	900,000	77%	40%

Source: Urban Institute Health Policy Center eligibility simulation, based on data from the 2006 *Annual Social and Economic Supplement of the Current Population Survey*, released in March 2007.

Note: “Eligible” for public coverage refers to the number of children/adolescents and adults who are simulated to meet New York’s public program eligibility rules (see page 16 for more on the simulation model). Only a portion of eligible persons enroll in public programs. The remainder either enroll in other coverage or are uninsured. The public program participation rate is estimated as the share of eligible enrolled persons out of the total of eligible enrolled persons and eligible but uninsured persons; it does not incorporate the share of eligible persons enrolled in other coverage.

implemented by April 2008); and twelve-month continuous eligibility for adult Medicaid enrollees (contingent upon federal approval). These policies are expected to have a significant impact on uninsured rates in the state, but it is likely that additional measures will be necessary to enroll and retain the hardest-to-reach among the eligible but uninsured. A better understanding of the characteristics of the EBU population, and how they compare to their enrolled counterparts, should help policy-makers target strategies for enrolling and retaining this group in public coverage, and ultimately reduce the number of uninsured New Yorkers.

The Uninsured: A Detailed Portrait

In this paper, we describe and contrast the characteristics of eligible children/adolescents and adults who are enrolled in public coverage and those who are uninsured. In general, New Yorkers who are uninsured despite being eligible for

public health insurance coverage are more likely to be non-citizens, in working families, and in better health than their counterparts who are enrolled in coverage. Eligible but uninsured adults are also far more likely to be childless.

These data are based on an eligibility simulation model using 2006 *Current Population Survey* (CPS) data; because CPS data are current to the calendar year prior to release, estimates in this brief are for 2005. The model simulates eligibility for New York’s public programs based on detailed program eligibility rules and eligibility pathways, and estimates the number of eligible children/adolescents and adults who are enrolled and the number who are uninsured (see page 16 for a more detailed description of the simulation model).

Eligible Children/Adolescents

Over 2.5 million children/adolescents in New York are eligible for public coverage. Half of all eligible children/adolescents are in families with incomes less than 100 percent FPL and seven out of ten live in working families. Over ninety percent are

Table 2: All Children/Adolescents Compared with Eligible Children/Adolescents, New York State, 2005

	All Children/Adolescents (thousands)	Percent of All Children/Adolescents	Eligible Children/Adolescents (thousands)	Percent of Eligible Children/Adolescents
Total – Children/Adolescents	4,850	100%	2,600	100%
Age				
0-5	1,390	29%	750	29%
6-18	3,460	71%	1,850	71%
Family Poverty Level				
<100% FPL	1,310	27%*	1,310	50%
101-200% FPL	920	19%*	920	35%
201%+ FPL	2,620	54%*	370	14%
Family Work Status				
Workers	4,080	84%*	1,840	71%
Non-workers	770	16%*	760	29%
Race/Ethnicity				
White only (non-Hispanic)	2,510	52%*	920	35%
Black only (non-Hispanic)	890	18%*	650	25%
Hispanic	1,050	22%*	790	30%
Other	410	8%	240	9%
Citizenship				
U.S. Citizen	4,590	95%#	2,410	93%
Non-U.S. Citizen	260	5%#	190	7%
Health Status				
Excellent/Very Good	3,800	78%*	1,820	70%
Good/Fair/Poor	1,050	22%*	780	30%

* Estimate is significantly different from reference group at the 95% confidence level.

Estimate is significantly different from reference group at the 90% confidence level.

Note: These estimates reflect adjustments for the under-reporting of public coverage. Figures may not sum to totals due to rounding.

U.S. citizens. Relative to all children/adolescents in the state, eligible children/adolescents are more likely to be low income, black or Hispanic, living in families with no workers, and in worse health (Table 2). Eligible children/adolescents also appear to be slightly less likely to be

citizens, compared with all children/adolescents.

Among children/adolescents enrolled in public coverage, over 90 percent are in families with income less than 200 percent FPL and almost two-thirds report being in excellent/very good health.

Table 3: Eligible Children/Adolescents Compared with Children/Adolescents Enrolled in Public Coverage, New York State, 2005

	Eligible Children/Adolescents (thousands)	Percent of Eligible Children/Adolescents	Enrolled Children/Adolescents (thousands)	Percent of Enrolled Children/Adolescents
Total – Children/Adolescents	2,600	100%	1,590	100%
Age				
0-5	750	29%	520	33%
6-18	1,850	71%	1,060	67%
Family Poverty Level				
<100% FPL	1,310	50%*	990	62%
101-200% FPL	920	35%*	470	29%
201%+ FPL	370	14%*	130	8%
Family Work Status				
Workers	1,840	71%*	1,000	63%
Non-workers	760	29%*	590	37%
Race/Ethnicity				
White only (non-Hispanic)	920	35%*	450	28%
Black only (non-Hispanic)	650	25%	450	28%
Hispanic	790	30%	560	35%
Other	240	9%	130	8%
Citizenship				
U.S. Citizen	2,410	93%	1,470	92%
Non-U.S. Citizen	190	7%	120	8%
Health Status				
Excellent/Very Good	1,820	70%#	1,040	65%
Good/Fair/Poor	780	30%#	550	35%

* Estimate is significantly different from reference group at the 95% confidence level.
 # Estimate is significantly different from reference group at the 90% confidence level.
 Note: These estimates reflect adjustments for the under-reporting of public coverage.
 Figures may not sum to totals due to rounding.

Compared with all eligible children/adolescents, those who are enrolled in public coverage are more likely to be poor, non-white, and in worse health than the total group of eligible children/adolescents (Table 3). While over 60 percent live in

working families, this is significantly less than the share of all eligible children residing in families with workers (71 percent).

Nearly ten percent (250,000) of New York's eligible children/adolescents are

Table 4: Children/Adolescents Enrolled in Public Coverage Compared with Eligible but Uninsured Children Adolescents, New York State, 2005

	Enrolled Children/ Adolescents (thousands)	Percent of Enrolled Children/ Adolescents	Eligible but Uninsured Children/ Adolescents (thousands)	Percent of Eligible but Uninsured Children/ Adolescents
Total – Children/ Adolescents	1,590	100%	250	100%
Age				
0-5	520	33%#	60	23%
6-18	1,060	67%#	190	77%
Family Poverty Level				
<100% FPL	990	62%	140	57%
101-200% FPL	470	29%	80	33%
201%+ FPL	130	8%	20	10%
Family Work Status				
Workers	1,000	63%	160	66%
Non-workers	590	37%	80	34%
Race/Ethnicity				
White only (non-Hispanic)	450	28%	70	30%
Black only (non-Hispanic)	450	28%	70	27%
Hispanic	560	35%	80	31%
Other	130	8%	30	12%
Citizenship				
U.S. Citizen	1,470	92%*	200	83%
Non-U.S. Citizen	120	8%#	40	17%
Health Status				
Excellent/Very Good	1,040	65%	180	72%
Good/Fair/Poor	550	35%	70	28%

* Estimate is significantly different from reference group at the 95% confidence level.

Estimate is significantly different from reference group at the 90% confidence level.

Note: These estimates reflect adjustments for the under-reporting of public coverage. Figures may not sum to totals due to rounding.

uninsured. Two-thirds of eligible but uninsured children/adolescents are from working families and just over eight out of ten are U.S. citizens. In addition, most EBU children/adolescents are aged 6-18, poor, and in excellent or very good health.

Compared with eligible children/adolescents who *are* enrolled in public coverage, eligible but uninsured children/adolescents are more likely to be older (aged 6-18) and non-citizens; they also *appear* to be more likely to live in families

with income above 100 percent FPL and to be in better health (Table 4).⁵

Policy Implications The data presented here indicate that, relative to all eligible children/adolescents, those who are enrolled in public coverage are among the most vulnerable: those who are poor, minorities, and in worse health. Those who are eligible but remain uninsured are older (school-age) and appear to be healthier and to live in families with slightly higher incomes relative to those who enroll. Confidentiality concerns about service use are a primary barrier to adolescents enrolling in coverage, but they cannot apply for coverage without parental involvement (Diaz et al. 2004).

Eligible but uninsured children/adolescents are also more likely than their enrolled counterparts to be non-citizens, perhaps reflecting immigration-related concerns about enrolling in public coverage. For example, while citizenship status is not a factor in eligibility for SCHIP in New York, advocates for immigrant populations indicate that even when these rules are understood, immigrants are reluctant to enroll in coverage because of misperceptions about the effect this will have on a determination of public charge, concerns about sponsor liability, difficulties completing work documentation requirements, the effect of mixed citizenship status within families, and language issues. Enrollment and retention efforts should therefore take special note of the large number of EBU children/adolescents whose parents may

not understand the eligibility requirements, or may not recognize the importance of coverage if their children/adolescents are in good health, and should consider ways to address adolescents' confidentiality concerns as well as immigration-related concerns.⁶

Implementation of New York's SCHIP expansion, in conjunction with a coordinated outreach campaign, would likely help to enroll many of the currently eligible but uninsured children/adolescents. Three-quarters of uninsured children/adolescents are already eligible for Medicaid and SCHIP, and research and experience in other states indicate that increased eligibility levels and associated outreach efforts can increase enrollment levels among those currently eligible (Seldon et al. 2004; Felland and Benoit 2001; Coughlin and Cohen 2007; Williams and Rosenbach 2007).

A review of the evolution of state outreach efforts under SCHIP indicates that states are increasingly focusing on hard-to-reach populations such as minorities, working families, and immigrants, targeting messages to the specific concerns of these groups and partnering with trusted local institutions, including schools, community-based organizations, providers, and employers. Many states have also shifted their emphasis from attracting new enrollees to retaining those already eligible and on the rolls, and, because of the correlation between use of services and retention, encouraging appropriate use of services (Williams and Rosenbach 2007).

⁵ Characteristics described here as *appearing* to be different are not statistically different from the reference group; all other comparisons are significant at the 90 percent or 95 percent confidence level (see Table 4 for more detail). A similar analysis at the national level, based on 1995-2006 Medical Expenditure Panel Survey data, found that eligible but uninsured children were somewhat healthier, more likely to be in families with income above 100 percent FPL, and less likely to have parents who are eligible for public coverage than children enrolled in public coverage (Hudson and Selden 2007).

⁶ Studies of the reasons that more eligible persons are not enrolled in public programs have found that knowledge gaps, such as being unaware that public coverage is available or misunderstanding eligibility criteria, frequently prevent EBU individuals and families from applying for coverage. Families that report not wanting or needing health insurance presumably do so because it is too expensive or they believe they are healthy enough to go without it (Kenney and Haley 2001).

Recent SCHIP reauthorization discussions have increasingly focused on enrolling and retaining low-income children/adolescents, and possibly making federal financial participation in coverage for higher-income children/adolescents contingent upon this. That possibility may create an even greater incentive to explore new and non-traditional enrollment and retention strategies such as automatic enrollment, which has been shown to yield high participation rates,⁷ or administrative renewal, which has significantly improved renewal rates (Schott and Parrott 2005; Ukaegbu and Schwartz 2006).

Eligible Adults

Less than a quarter (2.7 million) of adults in New York are eligible for public coverage.⁸ Compared with all New York adults, those who are eligible for public coverage are more likely to be younger (aged 19-34), non-workers, poor, black or Hispanic, and in worse health (Table 5). Four out of ten eligible adults are workers compared with three-quarters of all adults. Non-citizens make up a greater share (20 percent) of eligible adults than of all adults (14 percent). In addition, while most eligible adults are childless, more of them (43 percent) are parents than among all adults (36 percent).

Compared with all eligible adults, those who are enrolled in public coverage are more likely to be parents, non-workers, and in worse health, and have income above 200 percent FPL (largely reflecting those who have spent down to Medicaid eligibility),⁹ than the total population of eligible adults (Table 6). Among enrolled adults, almost half (48 percent) are parents and almost two-thirds (64 percent) are non-workers.

Among New York's eligible adults, 650,000 are uninsured. Seven out of ten of these eligible but uninsured adults are childless, over half are young adults (aged 19-34), and nearly 90 percent have income less than 100 percent FPL. Most are U.S. citizens (73 percent) and in excellent or very good health (57 percent). Relative to adults enrolled in public coverage, EBU adults are more likely to be younger (aged 19-34), childless, poor, workers, "other" races,¹⁰ non-citizens,¹¹ and in better health (Table 7).

Policy Implications As with eligible but uninsured children/adolescents, EBU adults are more likely to be in better health and to be non-citizens than adults who are enrolled in public coverage. As discussed above, healthier people may not feel as great a need for coverage, and non-

⁷ As part of its health care reform efforts, Massachusetts auto-enrolled residents with income below 100 percent FPL, who were enrolled in the state's free care pool, into Commonwealth Care. Further, research describes the success of auto-enrollment in retirement savings account programs, Medicare Part B, and Medicare's low-income subsidy program, compared with traditional means-tested programs: in child health, the earned income tax credit, SSI, Medicaid, WIC, Food Stamps, Head Start, TANF, Child Care and Development Fund, Housing Choice vouchers, and public housing programs, participation rates did not exceed 79 percent. Conversely, with seniors automatically enrolled in Medicare Part B unless they submit a form opting out of coverage, 96 percent of the eligible population participates. Similarly, 90 percent of employees participate in a 401(k) plan when they are automatically enrolled, while only 30 percent do so when they must sign up on their own (Dorn 2007; Dorn and Kenney 2006).

⁸ Because the CPS does not contain data to allow for identification of pregnant women, eligibility pathways for this group were not modeled, and hence adult eligibility estimates do not include estimates of pregnant women who might not otherwise have been eligible for public coverage. Because eligibility for parents and childless adults are simulated, however, it is likely that some pregnant women are included in these groups.

⁹ The small share (11 percent) of enrolled adults with incomes greater than 200 percent FPL includes those who are likely to have spent down to Medicaid eligibility and those whose incomes may have changed over the course of the year.

¹⁰ "Other" includes Asians, Pacific Islanders, American Indians, Alaskan natives, and those reporting mixed race.

¹¹ Estimates of eligible but uninsured non-citizen adults may contain some adults who are income-eligible but not eligible on the basis of documentation status.

**Table 5: All Adults Compared with Eligible Adults,
New York State, 2005**

	All Adults (thousands)	Percent of All Adults	Eligible Adults (thousands)	Percent of Eligible Adults
Total – Adults	11,680	100%	2,680	100%
Age				
19-34	3,970	34%*	1,180	44%
35-54	5,630	48%*	1,180	44%
55-64	2,080	18%*	320	12%
Parental Status				
Childless Adult	7,530	64%*	1,530	57%
Parent	4,150	36%*	1,150	43%
Family Poverty Level				
<100% FPL	2,070	18%*	1,970	73%
101-200% FPL	1,880	16%*	530	20%
201%+ FPL	7,720	66%*	180	7%
Adult Work Status				
Worker	2,820	76%*	1,140	42%
Non-worker	2,760	24%*	1,550	58%
Firm Size Among Working Adults				
<25	2,810	31.6%	470	42%
25-999	2,960	33.2%	400	35%
1000+	3,140	35.2%	260	23%
Race/Ethnicity				
White only (non-Hispanic)	7,080	61%*	1,050	39%
Black only (non-Hispanic)	1,700	15%*	640	24%
Hispanic	1,860	16%*	710	26%
Other	1,040	9%	280	10%
Citizenship				
U.S. Citizen	10,050	86%*	2,150	80%
Non-U.S. Citizen	1,620	14%*	540	20%
Health Status				
Excellent/Very Good	7,500	64%*	1,290	48%
Good/Fair/Poor	4,180	36%*	1,390	52%

* Estimate is significantly different from reference group at the 95% confidence level.
Note: These estimates reflect adjustments for the under-reporting of public coverage.
Numbers may not sum to totals due to rounding.

Table 6: Eligible Adults Compared with Adults Enrolled in Public Coverage, New York State, 2005

	Eligible Adults (thousands)	Percent of Eligible Adults	Enrolled Adults (thousands)	Percent of Enrolled Adults
Total – Adults	2,680	100%	1,520	100%
Age				
19-34	1,180	44%	630	41%
35-54	1,180	44%	710	47%
55-64	320	12%	180	12%
Parental Status				
Childless Adult	1,530	57%#	780	52%
Parent	1,150	43%#	740	48%
Family Poverty Level				
<100% FPL	1,970	73%	1,040	68%
101-200% FPL	530	20%	320	21%
201%+ FPL	180	7%*	170	11%
Adult Work Status				
Worker	1,140	42%*	550	36%
Non-worker	1,550	58%*	970	64%
Firm Size Among Working Adults				
<25	470	42%	210	39%
25-999	400	35%	200	37%
1000+	260	23%	130	24%
Race/Ethnicity				
White only (non-Hispanic)	1,050	39%	550	36%
Black only (non-Hispanic)	640	24%	390	26%
Hispanic	710	26%	460	31%
Other	280	10%	110	7%
Citizenship				
U.S. Citizen	2,150	80%	1,240	82%
Non-U.S. Citizen	540	20%	280	18%
Health Status				
Excellent/Very Good	1,290	48%*	600	39%
Good/Fair/Poor	1,390	52%*	920	61%

* Estimate is significantly different from reference group at the 95% confidence level.

Estimate is significantly different from reference group at the 90% confidence level.

Note: These estimates reflect adjustments for the under-reporting of public coverage.

Figures may not sum to totals due to rounding.

Table 7: Adults Enrolled in Public Coverage Compared with Eligible but Uninsured Adults, New York State, 2005

	Enrolled Adults (thousands)	Percent of Enrolled Adults	Eligible but Uninsured Adults (thousands)	Percent of Eligible but Uninsured Adults
Total – Adults	1,520	100%	650	100%
Age				
19-34	630	41%*	350	53%
35-54	710	47%*	230	36%
55-64	180	12%	80	12%
Parental Status				
Childless Adult	780	52%*	460	70%
Parent	740	48%*	200	30%
Family Poverty Level				
<100% FPL	1,040	68%*	580	88%
101-200% FPL	320	21%*	70	11%
201%+ FPL	170	11%*		0%
Adult Work Status				
Worker	550	36%*	320	48%
Non-worker	970	64%*	340	52%
Firm Size Among Working Adults				
<25	210	39%	140	44%
25-999	200	37%	110	33%
1000+	130	24%	70	22%
Race/Ethnicity				
White only (non-Hispanic)	550	36%	250	38%
Black only (non-Hispanic)	390	26%	160	25%
Hispanic	460	31%	160	24%
Other	110	7%#	80	13%
Citizenship				
U.S. Citizen	1,240	82%*	480	73%
Non-U.S. Citizen	280	18%*	180	27%
Health Status				
Excellent/Very Good	600	39%*	370	57%
Good/Fair/Poor	920	61%*	280	43%

* Estimate is significantly different from reference group at the 95% confidence level.

Estimate is significantly different from reference group at the 90% confidence level.

Note: These estimates reflect adjustments for the under-reporting of public coverage.

Figures may not sum to totals due to rounding.

citizens may have immigration-related concerns about enrolling in public coverage.¹² Childless adults—70 percent of all EBU adults—are also more likely to be eligible but uninsured than parents, who may be more likely to enroll in coverage at the same time they enroll their children.¹³ Furthermore, Medicaid eligibility rules and procedures are more complex for childless adults, who are subject to public assistance-based eligibility rules.¹⁴ EBU adults are also more likely to be younger than enrolled adults, a finding consistent with overall coverage data: young adults have the highest uninsured rates of any age group (24 percent) and comprise 43 percent of all uninsured New Yorkers (Cook et al. 2007; Collins et al. 2007). Further, EBU adults are more likely than enrolled adults to be workers and to be poor.

Policymakers planning outreach strategies should consider various ways to reach these different segments of the eligible but uninsured adult population. This might include campaigns appealing to healthy persons, by highlighting free screenings or coverage of unexpected health care costs; enrollment and renewal options that accommodate work schedules; and, possibly, coordinating enrollment and retention processes with other public programs (e.g., Food Stamps) for persons who are eligible for both (Serafi and Costello 2006; Schott and Parrott 2005). Finally, strategies should address language barriers and ways to mitigate immigrants' concerns (Williams and Rosenbach 2007).

Lessons from the Literature

While the data presented here do not indicate causality, the research literature can further refine our understanding of New York's EBU problem and identify policy options that hold potential for improving participation rates.

Problems at renewal play a large role in the EBU problem in New York. A study of eligible but uninsured children/adolescents in all states between 2001 and 2006 analyzed the share of EBU children/adolescents who were either never enrolled in public coverage, suggesting poor take-up, or had been previously enrolled but subsequently lost coverage, suggesting poor retention. The study found that a large share of New York's EBU children/adolescents had previously been enrolled in public coverage: 46 percent of them had lost public coverage in the previous year, compared with an average of 34 percent across all states, indicating that New York has significantly lower retention rates than other states (Sommers 2007).

A study of public program renewal in New York City found that 46 percent of Medicaid and Family Health Plus enrollees lost their coverage in 2004 (Boozang, Braslow, and Fiori 2006). Prior research found similar rates: 48 percent of Medicaid and Family Health Plus beneficiaries in New York City were disenrolled in 2000, and between 33 and 50 percent

¹² While federal law bars immigrants from Medicaid for their first five years in the country, there is no such bar in New York. Under New York State law, adults who meet other eligibility criteria are eligible for Medicaid regardless of their date of entry to the U.S. (*Aliessa v. Novello*, 2001 NY Int. 59, June 5, 2001).

¹³ A wide body of research has found a strong relationship between parents' and children's insurance status and type of coverage (Guendelman and Pearl 2004). Several studies also have found the likelihood of children being enrolled increases when parents are also eligible and enrolled in public programs (Rosenbaum and Whittington 2007). Finally, another study found that eligible but uninsured children are less likely to have parents who are eligible for public coverage (Hudson and Seldon 2007).

¹⁴ The terms of childless adults' eligibility were negotiated as part of New York's Section 1115 Medicaid waiver, so to continue to receive federal financial participation for their coverage, any changes to these rules would require an amendment to the waiver (personal communication with New York State Department of Health, November 2007).

of children/adolescents were disenrolled from SCHIP statewide between 1999 and 2001.¹⁵ Studies also found that despite high rates of disenrollment, many individuals who lose public coverage appear to remain eligible and return to the program at a later date.¹⁶

Several factors have been found to be associated with poor retention (Sommers 2005a, Ross and Cox 2005, Ross 2007, Dick et al. 2002, Sommers 2006, all cited in Sommers 2007). Administrative barriers, including income and employment verification, and SCHIP premiums have been shown to adversely affect retention in several states.¹⁷ Operating separate SCHIP and Medicaid programs, as in New York, has also been associated with lower retention rates, as many children/adolescents lose coverage when trying to transition between programs: children/adolescents in states with separate programs are 45 percent more likely to lose coverage and become uninsured, despite remaining eligible (Sommers 2005b). Moreover, the

Deficit Reduction Act of 2005, which requires applicants and beneficiaries to provide original documentation of citizenship and identity when they apply for or renew coverage, has exacerbated retention problems in many states.¹⁸ While New York has required citizenship documentation for its Medicaid program for several decades, the Deficit Reduction Act imposes stricter guidelines, not only requiring original documents but also allowing fewer exemptions, among other rules.

Several studies have identified policy reforms that have the potential to notably improve retention rates: administrative renewal, “ex parte” review, and telephone/internet renewal. Administrative renewal, which usually entails the state sending enrollees a pre-populated form, and asking that they return it only if there are changes in their information, has been found to result in significant improvements in renewal rates.¹⁹ Through ex parte review, a state uses available data, such as Food Stamp eligibility information, to

¹⁵ Various studies found a 58 percent retention rate for FFY 2000 (Birnbaum and Holahan 2003), a 50 percent retention rate for calendar year 1999 (Bachrach and Tassi 2000), a 65 percent retention rate for January-March 2000 (Hill and Westpfahl Lutzky 2003), and a 67 percent adjusted retention rate for January 1999-March 2001 (Dick et al. 2002).

¹⁶ Earlier studies found that 1 percent to 7 percent of those who failed to renew SCHIP coverage were no longer eligible (Lipson et al. 2003; Hill and Westpfahl Lutzky 2003). Another study found that two-thirds of children who were disenrolled from SCHIP returned to the program within twelve months (Birnbaum and Holahan 2003). National research showed that 16 percent of children disenrolled from SCHIP and Medicaid were ineligible (Sommers 2005b), and that 40 percent of SCHIP and Medicaid enrollees who leave the programs reenroll at a later date (Short, Graefe, and Schoen 2003).

¹⁷ After Wisconsin and Washington State increased their documentation requirements for renewal to include additional income and employment verification, both states saw a precipitous drop in enrollment, with declines of 22 percent and 11 percent respectively. Similarly, SCHIP enrollment in Texas declined by almost 30 percent after a twelve-fold premium increase (Ross and Cox 2005).

¹⁸ Following the implementation of the Act, the U.S. Government Accountability Office found that half of states saw an enrollment decline that they attributed to citizenship documentation. Several states lost close to 20,000 beneficiaries in seven months, and most reported that the majority of individuals losing coverage were eligible citizens (GAO 2007; Ross 2007).

¹⁹ Hawaii, Illinois, and Utah currently permit administrative renewal for some populations in either their SCHIP or Medicaid programs. Florida allowed administrative renewal from 1992 to 2004, as did Georgia, from 2001 to June 2007. A study of Florida’s renewal rates relative to three states without administrative renewal found marked positive differences. This study did not examine the effect on error rates, but other studies have found that reducing or eliminating verification requirements does not lead to high error rates. Florida and Georgia discontinued administrative renewal in their SCHIP programs due to budget pressures. Finally, Louisiana has implemented a number of streamlined renewal approaches, including ex parte review, which looks, from the household’s perspective, very much like administrative renewal (Schott and Parrott 2005; Dick et al. 2002; Cohen et al. 2008).

reduce or eliminate the need to collect information from Medicaid beneficiaries at renewal. Further, because federal law does not require signatures on renewal forms, states can allow enrollees to renew coverage via the phone or internet.

Louisiana is one state that has implemented such policies. It uses telephone contacts, coupled with ex parte review, to renew coverage for Medicaid and SCHIP. If workers need information that is not in the Food Stamps records, workers attempt to contact enrollees to conduct the review by phone. After four years of streamlined procedures (both ex parte review and telephone renewal), the share of Louisiana's children/adolescents who successfully retained eligibility grew from 72 percent to 92 percent and the share of children/adolescents losing coverage because they did not return renewal forms dropped from 17 percent to 2 percent (Summer and Mann 2006).²⁰ These and

other reforms, such as electronic applications and leveraging third-party data matching, highlight the promise of technology to ease the application and renewal processes, and ultimately increase participation and retention rates.

Forthcoming research for the United Hospital Fund's Medicaid Institute will identify other promising approaches to simplification reforms and program administration that are likely to have potential for improving participation rates among New York's eligible but uninsured.²¹ As the United Hospital Fund/Commonwealth Fund *Blueprint for Universal Health Insurance Coverage in New York* research and experience in other states have made clear, traditional simplification practices will only go so far. New and innovative methods are necessary to appreciably affect public program participation rates and ultimately reduce the number of uninsured.

²⁰ In addition, Arkansas, Illinois, and Louisiana use updated Food Stamp information to renew Medicaid and SCHIP eligibility (Schott and Parrott 2005).

²¹ Forthcoming reports by Manatt, Phelps & Phillips, LLP, and Health Management Associates, respectively, will explore opportunities for streamlining Medicaid enrollment and recertification and analyze Medicaid administration models in other states.

Appendix: 2005 New York State Eligibility Simulation

The estimates presented here were derived from the Urban Institute Health Policy Center eligibility simulation model, based on data from the 2006 Current Population Survey (CPS). Public program eligibility was simulated based on various pathways of eligibility for Medicaid, Family Health Plus, and the State Children's Health Insurance Program (SCHIP). New York State-specific eligibility requirements for 2005, including categorical eligibility requirements, income requirements, and income disregards were applied to determine eligibility through each pathway. A hierarchy (below) was used to ensure that there is no double counting due to eligibility through multiple pathways:

Children/Adolescents

- 1) Supplemental Security Income
- 2) AFDC
- 3) Poverty Expansion Medicaid
- 4) Medicaid Expansion SCHIP
- 5) Separate SCHIP

Adults

- 1) Supplemental Security Income
- 2) Section 1931
- 3) Section 1115
- 4) Transitional Medical Assistance
- 5) Ribicoff
- 6) Medically Needy

Finally, estimates were derived for the number of children/adolescents and adults who are eligible, enrolled, and eligible but uninsured. "Eligible" for public coverage refers to the number of children/adolescents and adults who are simulated to meet New York's public program eligibility rules. Only a portion of eligible persons enroll in public programs; the remainder either enroll in other coverage or are uninsured.

Notes:

For additional information on the simulation model, see <http://content.healthaffairs.org/cgi/reprint/26/1/w22>.

With regard to determining eligibility for immigrants, the CPS only contains information about citizenship status and date of entry to the United States. As a result, it is possible that the model overcounts some undocumented non-citizen adults as eligible for public coverage. One study estimates that, as of March 2005, there were some 550,000-650,000 undocumented residents in New York (Passel 2006).

The difference in estimates of public coverage reported in *Health Insurance Coverage in New York, 2004-2005* (United Hospital Fund/Urban Institute 2007) ("the chartbook") and those reported here as "eligible and enrolled" has to do primarily with the fact that public coverage estimates in the chartbook are based on CPS reported coverage and are not dependent on whether the individual was simulated to be eligible. The estimates reported in the chartbook contain a non-trivial number of "ineligible reporters" who do not appear to be eligible, yet reported Medicaid/SCHIP on the CPS. This may be due to the fact that income status and coverage status of some individuals changed throughout the year, making them eligible for public coverage at some point. Because the CPS does not capture income or health insurance status fluctuations, these individuals might not be simulated to be eligible in the model. The estimates of eligible enrollees reported here do not include ineligible reporters. In addition, the chartbook data pertain to 2004-05 and also include persons with Medicare and Tricare coverage, while estimates reported here are for 2005 alone and only pertain to persons enrolled in Medicaid, SCHIP, and Family Health Plus.

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