NUMBER AND GROWTH OF THE UNINSURED AND UNDERINSURED

Health insurance is crucial to most people for access to needed health care services. Lack of insurance is associated with delays in seeking care, noncompliance with treatment regimens, and poorer health outcomes. (Committee on Consequences of Uninsurance [2002]; Hadley [2002]) Approximately 18 percent of the non-elderly adult US population was uninsured in 1998 and just more than 16 percent in 2000 and 2001. (Fronstin [2002]) Children and the elderly have lower rates of uninsurance due to more comprehensive public programs for these populations (ie, State Children's Health Insurance Programs [SCHIP] and Medicare). Our young adult, working poor, and Hispanic populations, however, bear a much greater burden of uninsurance than do other population subgroups. Some groups experience rates greater than 30 percent. For example, young adults have an uninsured rate of 30 percent; almost double that of the general non-elderly adult population and the Hispanics experience an uninsured rate of 32 percent. (Glied and Stabile [2001]; Mills [2002])

The probability of having health insurance coverage is related to employment status of the family, income, education, age, ethnicity, immigration status. Although public programs such as Medicare have greater expenditure toward health care, employers provide health insurance to more individuals than do public programs or individuals. Therefore, employment is strongly related to insurance coverage. Income, education and age also are positively related to the probability of being covered. The near-poor, individuals with incomes between 100 and 300 percent of the poverty level, have the greatest burden of uninsurance—and it is increasing. There is a disparity in health insurance coverage rates among ethnic groups. Hispanics, as mentioned, bear the greatest burden of uninsurance (32%). Coverage rates for White non-Hispanics, Blacks, and Asians and Pacific Islanders were 90.3, 81.5, and 82.0 percent, respectively. Geographic variation exists among states, with the lowest uninsured rate being 6.9 percent (Rhode Island) and the highest 22.6 percent (New Mexico); variations that closely mimic income patterns among states. (Mills [2002])

Such relationships, particularly the strong dependence on employer-sponsored health insurance, point to the strong dependence of the uninsurance rate on our economy's strength. Employers who experience market pressures do cut benefits, particularly among low-wage workers. These are the same workers who are most likely to experience difficulty retaining or obtaining a job during an economic downturn. Low-wage workers must often contribute higher proportions of the premium for less comprehensive coverage compared to workers who earn higher wages. Cost is the most common reason cited by the uninsured who turn down employer sponsored plans. These dynamics are mirrored in health insurance coverage patterns seen during the past decade—better economy, higher coverage rates.

Working in tandem to the employers' role in US health insurance coverage rates are the public programs. Recent policy changes, such as welfare reform and the SCHIPs impacted coverage rates among the poor. Uninsured rates for children have decreased to approximately 13 percent, but these rates vary among states. Tempering the enthusiasm for the SCHIPs, however, is the deep fiscal problems that states are currently experiencing. The SCHIPs are potential targets for reducing state budgets and the recent coverage increases may be temporary in some states. Welfare reform impacted the Medicaid programs in ways we cannot yet predict fully, although Garrett and Hudman (2002) found that the uninsured are for women who left welfare was 40 percent, much higher than the general population. Increases in employer-based coverage during the economic expansion of the late 1990s offset the decreased coverage available through Medicaid programs. As we analyze data for 2002 and 2003 we will better understand how those reforms impacted access to health care for those most at risk to economic downturns.

There is the additional issue of underinsurance. Underinsurance has no agreed-upon definition, and this has hampered efforts to address it or study its impact. Some define it as an undue burden based on cost versus income, some as the percent out-of-pocket expenses of total medical expenses, and others look at the coverage offered by a plan. (Bartlett [2000];

Mainous et al [1999]) Given the lack of census on a definition, even less discussion has occurred on a threshold level of acceptable burden or what level constitutes acceptable coverage. Perhaps the most relevant discussions occurred during the development of the Oregon Health Plan's coverage list (see the *Proposed Health Care System Reforms* section for articles related to the Oregon Health Plan). This area has received little attention because of the focus on gaining coverage of some sort for the entire population, but will become more important when universal or near-universal coverage is attained.

Access to health care is directly related to insurance status. Discussions that revolve around universal coverage relate directly to whether health is a basic human right. The United States currently has two answers to this question—yes and no. We treat it as a right at the individual level, but not at the population level. When pressured to make decisions at the individual level, we tend to support heroic medical efforts to cure, but we are unwilling to support system reforms to ensure basic coverage for all residents.

Not all nations are as ambivalent about health and access to basic health services. The 1978 World Health Organization's *Declaration of Alma Ata* states that "health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right…" and that "…The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries." (*Declaration of Alma-Ata*, http://www.who.int/hpr/archive/docs/almaata.html, accessed June 15, 2003) Extremely limited access to health care, which is the case for most uninsured individuals, results in decisions to not seek needed care, unfilled prescriptions or noncompliant behavior, inappropriate use of resources (eg, emergency department visits for non-life-threatening conditions), missed work and pay, lower productivity while at work, and in some cases unemployment and premature death. We know that continuous coverage is important to access and have found that even intermittent coverage has a similar impact as being uninsured. (Schoen and DesRoches [2000]). Our current health system is producing socially inefficient outcomes.

This literature review identified several focal areas: trends in the number of uninsured, state policy activities, disparities in access, health care access, and the health care safety net. This review takes these findings and presents them in sections, with overviews for each section. Discussions on reform efforts that address the uninsured are minimally represented in this section of the literature review, because they are included in the *Proposed Health Care System Reforms* section of this bibliography. Articles addressing states' approaches are most relevant to readers concerned with efforts to address uninsured rates. Reports on or studies investigating the SCHIPs are just beginning to appear, but they show an increase in the number of children with insurance. Their early success has prompted efforts to expand the SCHIPs to include other groups. The sustainability of these gains, however, given the current fiscal pressures remains to be seen.

General Trends in the Number of Uninsured

These reports highlight the importance of understanding where the data comes from and how it is gathered. The most commonly used data source was the Current Population Survey, a cross-sectional survey, which provides a snapshot of the population. Given the importance of continuous coverage reported by Schoen and DesRoches [2000], we should carefully consider the limitations of the results from cross-sectional surveys. Overall, these reports estimate the uninsured rate for the nonelderly to be approximately 18 percent at the time of the 1998 survey, but stress that particular groups bear a disproportionate share of uninsurance (eg, Hispanic, low-income). Garrett and Hudman (2002) find that women who left welfare were two-times more likely to be uninsured than their children and that these women had an uninsured rate of 40 percent. Cunningham et al (1999) report on the reasons individuals who have access to

employer-sponsored health insurance select not to enroll. They find that cost is the most commonly mentioned barrier to enrollment.

Much has changed in the US economy since 1998, and authors often predict increases in the number of uninsured, particularly among the low-income, as businesses cut their benefit packages. Gilmer and Kronick (2001) describe and test a model they developed to determine the effect of personal income and health care costs on the uninsured rate. They conclude that if health care costs grow faster than personal income, the uninsured rate will increase. Fronstin (2002) reports that the uninsured rate among the nonelderly increased from 16.1 percent in 2000 to 16.5 percent in 2001; an increase that ended a short period of rate declines. The primary reason for the increase was a decline in employment-based health insurance coverage, which decreased from 67.1 to 65.6 percent. The recent economic downturn has quickly eroded earlier gains in employment-based coverage. He also reports that public programs covered 39.7 million individuals and that 16.4 million people purchased individual policies in 2001.

Stone [2000] comments on the federal government's role in the health care market, and concludes that it provides consumers relatively little support in their interactions with this market.

Several authors address the outcomes of lacking insurance coverage and the resultant decreased access to care (also see discussion below about defining access to care). The Committee on the Consequences of Uninsurance (2002) and Hadley (2002) investigate the health status and economic consequences of being uninsured.

Special Populations

Working Poor

Cost of insurance and medical care can be prohibitive for low-income workers. Individuals who decline employer-sponsored coverage but who remain uninsured represent 20 percent of the total uninsured population. Most decliners do cite cost as their primary reason. Compounding these cost problems is the fact that employers who use mostly low-wage workers tend to have the highest employee contributions toward health insurance premiums. (see Bundorf and Pauly [2002]; Cunningham et al [1999]) Mothers who left welfare were found to have a 40 percent uninsured rate; with this likelihood of insurance relating to family employment status and time since welfare was last received. (Garrett and Hudman [2002])

Immigrants

Growth of the immigrant population is one of the primary drivers of change in the profile of the United States. Public policy addresses their needs poorly, in part because of misperceptions held by policy makers and other US citizens. As Ku and Matani (2001) show, immigrants remain shut out of our health care system at an alarmingly high rate—even for emergency services. Another issue for uninsured immigrants—and all uninsured individuals—is where and from whom to obtain health care. For those who live near the US-Mexico international border an alternative, cheaper, health care system exists. Macias and Morales (2001) investigated the health services-seeking behaviors of individuals near this border and provide interesting insights. Their findings raise ethical questions for health care providers, concerns about care quality and system incompatibilities in practice, and point to critical issues that need policymakers' attention (eg, costs of prescription drugs).

States' Policy Approaches to the Uninsured and Underinsured

The primary policy instruments in place to address health care access for the uninsured are federal programs (Medicaid and the State Children's Health Insurance Program), they are shaped and implemented by the states. Thus, the states can be viewed as 50 separate public policy laboratories. Although not prevalent in the literature, reports on states' activities provide important insight into these programs and their impacts. Many of these articles discussed the

well-known programs such as the Oregon Health Plan and Tennessee's TennCare. One article was selected to represent each of these innovative programs (Haber and Khatusky [2000] and Moreno and Hoag [2001], respectively). Two of the three remaining articles provide comparative analyses among selected groups of states (Guyer [2002], and Spillman [2000]). Kinney et al provide a review of the behind-the-scenes decision-making process that preceded the visible lack of public policy action to decrease the number of uninsured adults in Indiana. These reports show the importance of politics in states' health policies and the difficulties such programs experience in trying to impact their residents' health. Cunningham and Park (2000) provide early assessment of the State Children's Health Insurance Program. More discussion of state approaches (ie, Oregon Health Plan) and other reform efforts are included in the *Proposed System Reforms* section of this project.

Health Care Safety Net—Access to Health Care for the Un- & Under- Insured

A few words are needed about the health care safety net. Concerns have been raised that a highly competitive health-care market will force providers to pull in the safety net in order to survive. This is of particular importance—and concern—when policymakers rely on the nonprofit sector to pick up slack when resources tighten. The safety net is integrally tied to the condition of the uninsured; thus its presentation here.

The core problem for and concern about the uninsured is access to needed health care. A primary problem is our society's fuzzy conceptualization and understanding of what constitutes adequate access. The US people have been relatively unwilling to put limits on access to care at the individual level and this thwarts most policy measures to clearly define access. Gold, Higgs et al, and Mainous et al discuss perspectives on this issue. With the failure of a federally initiated health care reform effort, we once again focus on the main force behind the health care safety net—charity care. Davidoff et al, Kemble, and Malone provide insights into different roles and issues involved with various types of charity care (hospitals responses to state policies, attempts to coordinate physician-levels charity care, and emergency departments, respectively). It is unlikely that headway will be made in obtaining health insurance coverage for all US residents or in controlling skyrocketing health care costs until US policymakers and citizens can agree on a level of health care that is considered essential—an amount equated with a basic right to health care access. Once a baseline has been established and accepted, policies (both public and insurance) will have a guide to determine what defines reasonable, equitable coverage.

Nonprofit Hospitals

The changing environment of the health care market, with its move toward more investor-owned facilities, more managed care, and less fee-for-service reimbursement, has brought up the question of whether the tax-exempt hospital remains an appropriate ownership form. Overall, the problem arises from the tax exemption given to nonprofit institutions (both income and real estate). This gives rise to claims of an unfair competitive advantage in a currently mixed market. Additionally, boards of directors have begun questioning whether the direct provision of services remains the best means to deliver the institution's mission; several examples exist of boards selling the hospital and moving the money into a health-related foundation.

The justification for the tax-exempt status lies in the community benefit provided by the charity. For hospitals, the most common standard used has been forgone tax to the government and if the level of uncompensated care (charity care and bad debt) exceeded that forgone tax. Some researchers have used other measures, comparing quality (single-condition comparison), comparing cost of care to the patient, or including the direct cost of community service (eg, health fairs, screenings, health education). Noticeably missing from these investigations are substitutes provided for public services (eg, public health activities), intangibles such as increases in social capital, services provided that would otherwise not have and community

needs and perceptions. Any measure of these benefits is confounded by the fact that some investor-owned facilities are required to keep certain services open, even if losses occur, and that some tax-exempt hospitals have negotiated direct payments to jurisdictions in lieu of taxes. Results of previous research are contradictory as to the meeting of the foregone tax benchmark.

Community benefit measures may become more important as shifts in ownership occur, not only between sectors but as regional groups of nonprofit institutions are formed, because these networks of hospitals are less local and may be less responsive or connected to their communities in ways that are no different from investor-owned facilities. It is already known that tax-exempt hospitals in more competitive markets with higher managed care penetration behave more like their investor-owned counterparts. Additionally, when finding a benchmark for such benefits, we need to consider that investor-owned facilities must absorb bad debt and that governments sometimes provide such facilities with tax breaks to encourage location and growth.

Overall, the market may require that nonprofit hospitals act in ways that jeopardize their tax-exempt status. Some hospitals have provided profit-sharing incentives to executives, and the tight markets allow managers less discretion for nonmarket purposes.

Faith-Based Service Providers and Charitable Choice

The role of faith-based organizations in the provision of social services has varied historically in the United States. Such organizations were often the originators of service organizations, such as hospitals and poor houses. However, as government has taken an increasingly active role in enacting a rudimentary welfare state, the relationship between such service providers has altered and even become controversial. (Taylor et al [2000]) At issue is the use of public funds by such organizations to provide their services. Separation of church and state has been strictly interpreted in ways that restricted faith-based organizations from exhibiting any indications of their faiths.

Many faith-based organizations are unwilling to seek government funding to support their social service efforts out of distrust of government, unwillingness to restrict their evangelic efforts, or prohibitions within the organization against such liaisons.

Charitable Choice was introduced into law as part of the Welfare Act of 1996. *Charitable choice* allows the federal government to contract with faith-based organizations that serve single mothers with dependent children. The legislation prohibits grantees from using federal funds for proselytizing. (see Sider and Unruh [1999]) and Matsui and Chuman [2001] for discussions of these issues) President George W. Bush's establishment of a Committee on Community and Faith-Based Initiatives has further institutionalized government support of these service providers.

Summaries—

Bartlett DK III. The growth of the uninsured and the underinsured. *Journal of Financial Service Professionals*. 2000; 54(5): 62-66.

Keywords: General trends in the number of uninsured
Purpose: Review the issues underlying and related to US uninsured rates.
Data: Not applicable
Methods: Commentary. A synthesis of reported data and policy issues.
Results: The U.S. Census Bureau estimates show a rise in uninsurance rates among the nonelderly (14.8 to 18.3 percent from 1987 to 1998). Most observers cite the lack of affordability as the primary contributor to this rise. Evaluation of policy proposals to address this growth in the un- and underinsured requires examination of who and how many benefit, cost and who bears that cost, administrative feasibility, equity, and alignment with U.S. social values. In general, policies focus on extending availability of coverage to more individuals, making health insurance more affordable to individuals with insurance coverage—methods for increasing access. Federal policy initiatives that address the un/underinsured problem include Medicare, Medicaid, the Children's Health Insurance Plans (CHIP), Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA; requires employer-sponsored health insurance plans to offer coverage extensions at termination with premium limits), the Health Insurance Portability and Accountability Act of 1997 (HIPAA; requires health insurers who operate in a state where individual residents exhaust their COBRA coverage to offer individual policies without preexisting conditions exclusions), and the Health Insurance Portability and Accountability Act of 1996 (provides some tax preferences to individuals with qualifying long-term care insurance coverage). Estimates from 1988 indicate that at least 1.3 million individuals had health insurance as a result of their use of COBRA-based rights. State policy initiatives tend to focus on market reform for small-group (2 to 50 people) and individual health insurance plans. The National Association of Insurance Commissioners created model acts for use by states in reforming these markets, which have been adopted in most states. These reforms address such issues as guaranteed issue and renewability, preexisting condition exclusions, and restrictions on health status and past claims experience use. The number of people who gain coverage as a result of these reforms is likely small and uninsured rates have grown most rapidly in those states with the most aggressive forms of the model acts. While it is relatively difficult to determine uninsured rates, there is, at least, consensus on what constitutes being uninsured. There is no consensus on what constitutes being underinsured, simply that the out-of-pocket expenses are a substantial portion of total medical expenses.
Uses: Provides a thorough overview of the critical issues and policy initiatives related to the un-/underinsured. Good background reading and raises some important questions.
Limitations: No specific limitations noted.

Bundorf MK, Pauly MV. Is health insurance affordable for the uninsured? *National Bureau of Economics Research Working Paper,* No. 9281. 2002.

Keywords: Access to health care
Purpose: Investigate the meaning of affordability as it related to health care insurance coverage
Data and Methods: Theoretical discussion; empirical follow-up based on Current Population Survey (2001)
Results: The authors purpose that affordability of health insurance coverage cannot be considered without consideration of the cost of other necessary items. Additionally, adequate coverage must be defined in order to determine if insurance is affordable. They predict theoretically and show empirically that the availability of public coverage reduces demand for private insurance by reducing the cost of being uninsured. Their model predicts that a significant proportion of the uninsured could afford coverage. They find, however, that their normative approach does not adequately predict decisions to purchase or not purchase coverage; actual purchasing behavior is often contrary to that predicted by the normative model.
Uses: Provides an understanding of the barriers to health care coverage for all individuals

Limitations: Model is incomplete. Not all variables that impact purchasing behavior are accounted for; thus, although the background information is good and the process of model development informative, the conclusions of this study are of limited value.

Committee on the Consequences of Uninsurance, Board on Health Care Services, Institute of Medicine. *Care Without Coverage: Too Little, Too Late*. Washington, DC: National Academy Press. 2002.

Keywords: Access to health care
Purpose: Identify the health-related impacts of being uninsured
Data and Methods: Meta-analysis
Results: Based on their review, the Committee predicts that health insurance would reduce racial and ethnic disparities present in the receipt of preventive services. They find that the uninsured are less likely to receive timely preventive services and that this results in their presenting with chronic illness and cancers at later stages and in generally poorer health than their insured counterparts. Uninsured adults who have chronic illnesses are less likely to have those illnesses appropriately managed and more likely to suffer significant consequences of that mismanagement. Insured adults are more likely to receive care that is consistent with accepted clinical guidelines that uninsured adults. Uninsured adults are more likely to die while hospitalized. There appears to be greater decreases in health status among the uninsured and for those who lost insurance during the study period than for those with continuous health insurance coverage.
Uses: Because we do not view health coverage as a right, we need to justify why health coverage is (or is not) necessary. A view of the outcomes of being uninsured is striking and allows for informed decisions
Limitations: None as presented

Cunningham PJ, Park MH. *Tracking Recent Changes in Health Coverage for Low-Income Children With the Community Tracking Study, 1996-1997 and 1998-1999*. Washington, DC: Center for Studying Health System Change. Research Report Number 04. 2000.

Keywords: General trends in the number of uninsured
Purpose: Determine the success or failure of the State Children's Health Insurance Programs (SCHIP)
Data and Methods: Community Tracking Study (1996-1997, 1998-1999)
Results: Public coverage for children in families with incomes below 200 percent of the federal poverty level increased significantly. However, private insurance coverage decreased during this period so that no significant change in the uninsured rate occurred. These changes in coverage were experienced primarily by those children in families with incomes between 100 and 199 percent of the poverty level. The authors suggest that the increases in public coverage possibly offset by welfare reform and decreased availability of employer-sponsored insurance. Authors also discuss the dynamics impact the employer-sponsored insurance availability for this population.
Uses: Provides an early report of the impact of SCIP
Limitations: Results reflect early stages of SCHIP implementation

Cunningham PJ, Schaefer E, Hogan C. *Who Declines Employer-Sponsored Health Insurance and is Uninsured*? Washington, DC: Center for Studying Health System Change. Issue Brief Number 22. 1999.

Keywords: General trends in the number of uninsured
Purpose: Report on the characteristics of employees who decline employer-sponsored health insurance
Data and Methods: Center for Studying Health System Change 1996-1997 Household Survey
Results: One third of individuals who decline employer-sponsored coverage are uninsured—5 percent of those with access to employer-sponsored coverage. This equates to 20 percent of the total uninsured population. Most of the decliners cite cost as their primary reason. Employers who use mostly low-wage workers tend to have the highest required employee contributions toward health insurance premiums.

Uses: One of the difficult populations for policymakers is the group who opts to not take advantage of employer-sponsored health insurance. Solutions to the problems faced by those who opt against such insurance become possible only when we understand their behavior.
Limitations: None as presented

Davidoff AJ, LoSasso AT, Bazzoli GJ, Zuckerman S. The effect of changing state health policy on hospital uncompensated care. *Inquiry*. 2000; 37(Fall): 253-267.

Keywords: State roles, safety-net, nonprofit hospitals
Purpose: Determine if altering state policies change hospital behavior in providing uncompensated care.
Data: American Hospital Association survey data from 1990-1995
Methods: Regression analysis
Results: Davidoff and coworkers examine how changes in state policy impact hospital provision of uncompensated care. In particular, they examine differences among states in policies such as Medicaid eligibility levels, payment generosity as seen in reimbursements provided by states, and health maintenance organization enrollment. None of the policies examined produced anything more than small effects when any effects were detected. Overall, they find that increased HMO enrollment rates results in lower amounts uncompensated care provided by nonprofit hospitals. Based on this finding, the authors recommend that explicit payments for care of the uninsured may be needed in areas with high HMO or for-profit hospital penetration. They also found that increased Medicaid eligibility correlated with less uncompensated care provision by for-profit and public hospitals. They conclude that payment generosity, although effective in increasing uncompensated care provided by nonprofit hospitals, is an inefficient method for doing so.
Uses: Useful in understanding the implications of states' reimbursement policies on hospital actions.
Limitations: Although the authors examine many policy determinants of uncompensated care, this only considers part of the impacts of such policy changes and does not ask the question of whether the needs of the uninsured are being met in other ways or by the uncompensated care. They look only at micro-level behavior of hospitals and not the attainment of broader policy goals.

Feder J, Uccello C, O'Brien E. The Difference Different Approaches Make: Comparing Proposals to Expand Health Insurance. The Henry J Kaiser Family Foundation. 1999.

Keywords: General trends in the number of uninsured
Purpose: Estimate and compare the impacts of proposed health insurance expansions
Data and Methods: Current Population Survey
Results: The Project on Incremental Health Reform examined various proposals to expand health insurance coverage to the uninsured. These proposals included expansions to cover children only and others to include other family members and single adults. They predicted the outcomes of these various proposals and provided participation, cost and crowd-out estimations.
Uses: This document provides a focused examination of possible reforms aimed at increasing insurance coverage among the uninsured. Such discussions are valuable ways to inform policymakers of experts' opinions of anticipated outcomes.
Limitations: None as presented

Fronstin P. Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2002 Current Population Survey. *EBRI Issue Brief*. December 2002: No. 242. www.ebri.org/ibex/ib252.htm

Keywords: General trends in the number of uninsured
Purpose: Summarize trends in health insurance rates
Data: Current Population Survey (March 2002)
Methods: Descriptive statistics
Results: The uninsured rate among non-elderly Americans increased from 16.1 percent in 2000 to 16.5 percent in 2001. This increase ends a short period of rate declines. The primary reason for the increase was a decline in employment-based health insurance coverage, which decreased from 67.1 to 65.6 percent. The recent economic downturn quickly eroded gains in employment-based

coverage. Public programs covered 39.7 million individuals in 2001. Individual policies were purchased by 16.4 million people.
Uses: Provides information on health insurance coverage trends
Limitations: None as presented

Garrett B, Hudman J. Women Who Left Welfare: Health Care Coverage, Access, and Use of Health Services. The Henry J Kaiser Family Foundation, No. 4058. 2002.

Keywords: General trends in the number of uninsured, access to health care
Purpose: Investigate the relationship of health coverage to work status, health, access and use of health services by women who left welfare in 1997 or after and had not returned by 1999
Data: National Survey of American Families
Methods: Descriptive statistics
Results: The authors find that women who left welfare were two-times more likely to be uninsured than their children. They identified two primary factors that affected these women's likelihood of coverage: 1) time since last received welfare (likelihood of uninsurance increases as time increases); and 2) family income and work status (as income increases, Medicaid coverage declines and employer-sponsored insurance increases). The uninsured rate for these women remained high, however, at 40 percent.
Uses: These women are a population of concern because they are most likely to be single parents and lack of insurance can impair their ability to care for their families.
Limitations: None as presented

Gentry W, Penrod J. The tax benefits of not-for-profit hospitals. *National Bureau of Economics Research Working Paper,* No. 6435. 1999.

Keywords: Safety-net, nonprofit hospitals
Purpose: Provide a comprehensive overview of nonprofit hospitals' role within their market from an economic perspective.
Data: Cost reports submitted to the Health Care Financing Administration
Methods: Econometric analysis
Results: In this working paper, Gentry and Penrod focus on the tax provisions available to nonprofit hospitals: 1) exemption from capital taxes (income and property); 2) tax-exempt bonds (lenders do not pay income taxes on interest received); 2) donor-deductible charitable contributions. The economic theory underlying such policies is that the nonprofit hospitals provide community benefits that would otherwise not be provided or would need to be provided by the government. However, community benefit has never been defined clearly. The authors estimate the value of the capital tax exemptions at $1.7 billion. They find that the benefits of bond debt exemption and charitable contributions go to the larger organizations and estimate that the bond debt benefit was $354 million and forgone tax revenue from charitable contributions to be $1.1 billion in 1994.
Uses: Background reading for policymakers, hospital trustees, and others who desire an understanding of the role of nonprofit hospitals in the medical services market.
Limitations: Length (58 pages) and the focus on financial indicators. The authors caution that this overview cannot discriminate the behavioral factors and that more specific information is needed to make policy decisions about the utility of tax-exemption and the impact on the health care industry of removing this exemption.

Gilmer T, Kronick R. Calm before the storm: expected increase in the number of uninsured Americans. *Health Affairs*. 2001; 20(6): 207-210.

Keywords: General trends in the number of uninsured
Purpose: Test a model developed previously by the authors to see if it correctly predicts health care coverage rates based on the cost the rate of health care inflation compared with trends in personal income
Data and Methods: National Medical Expenditure Survey, Medical Expenditure Panel Survey, and Current Population Survey

Results: The authors determine that the ratio of per capita health spending for nonelderly insured adults to the median income of nonelderly adult workers declined slightly from 8.5% in 1995 to 8.4% in 1999. It is expected that the number of uninsured persons will increase if economic growth slows and the rate of health spending increases. They predict that if health care expenditures increase at two-times the rate at which personal income increases, then the uninsured population could rise from 16 percent to 21 percent of the population.
Uses: Provides the means to estimate how health care costs impact the uninsured rate.
Limitations: Readers need to access the 1999 article by these authors in order to fully critique their model

Glied S, Stabile M. Generation vexed: age-cohort differences in employer-sponsored health insurance coverage. *Health Affairs*. 2001; 20(1): 184-191.

Keywords: General trends in the number of uninsured
Purpose: Analyze changes in employer-sponsored health insurance rates to determine the effects of secular time trends, aging, labor-market experience, and birth cohort.
Data and Methods: Current Population Survey
Results: Levels of employer-sponsored health insurance generally increase with age. There are, however, differences in rates by birth cohort, education level, and general economic conditions. One interesting note is that birth cohort patterns do provide a means to predict future age-based coverage rates for that cohort that are more accurate than the existing age-based coverage rate. Other findings include the trends in employer-sponsored coverage by education level: the well-educated have relatively flat employer-sponsored insurance availability rates, whereas the age profile is much steeper (greater coverage with age) even though the coverage rates are much lower for the least educated.
Uses: This study provides guidance for policy creation and a means to anticipate future need for public services or needed policy changes across time
Limitations: None as presented

Gold M. Beyond coverage and supply: measuring access to healthcare in today's market. *Health Services Research*. 1998; 33(3): 625-652.

Keywords: Access to health care
Purpose: Provide an overview of the value of and issues surrounding different ways to describe access to health care.
Data and Methods: Commentary, not applicable
Results: The author emphasizes that the reconfigured US health care system requires greater attention to adapting current access frameworks so that they better illustrate the processes inherent in how diverse health delivery and financing arrangements influence access to services. Our use of access as a concept has evolved with shifts in health policy concerns. Recently, this is exhibited in the growing interest in measures that equate access with utilization to include concerns with service efficacy as judged by costs-effectiveness and outcomes. Current frameworks focus on access at the individual level and fail to capture healthcare system complexity. They miss the impacts of complex organization structures that may combine delivery and financing and fail to consider that these structures may vary substantially within and across markets or how these issues impact individuals' abilities to function within the health care system. Traditional access definitions focus on historic measures of access, such as insurance coverage, proximity to providers, and other barriers to system entry. However, although these measures continue to have relevance, stakeholders are now also concerned with value provided by services. This concern shifts focus on health care system entry toward a focus on how users negotiate the system and the associated outcomes.
Uses: This article provides a good platform for a discussion to clarify health care access.
Limitations: Although the issues associated with defining access are presented and future descriptions suggested, this article cannot resolve these issues and provide a conclusive, universal definition to guide future research.

Guyer J. *Medicaid and state budgets: an overview of five states' experiences in 2001*. Kaiser Commission on Medicaid and the Uninsured Issue Paper. March 2002. (http://www.kff.org, June 1, 2002)

Keywords: State roles
Purpose: Provide an understanding of the role of Medicaid in states' budgets.
Data: Commentary, not applicable
Methods: Essentially abbreviated case studies, reports were requested from individuals close to the states' policy processes
Results: The Kaiser Commission on Medicaid and the Uninsured asked researchers and policy experts in five states (Idaho, Indiana, Missouri, North Carolina, and Texas) to review the role of Medicaid in their state's budget. This publication is an executive summary that overviews these five cases and the concerns and approaches found to be common among the states. Overall, the states adopted tax cuts and, to a lesser extent, increased spending on Medicaid as responses to the high revenues they experienced in the mid-to-late 1990s. In almost all the cases this resulted in a structural deficit where the states' revenue structures are inadequate to meet long-term spending obligations. Other common points among the states included: 1) all of the states have now experienced dramatic reversal of their economic situations; 2) all of the states made significant improvements to their Medicaid programs during the latter half of the 1990s; 3) all of the states are experiencing an increase in the rate of Medicaid spending growth; 4) although two of the states have worked to protect their Medicaid and state children's health insurance program, three of them have adopted or are considering program cuts; 5) most of the states have viewed their Medicaid programs as a means to fund needs elsewhere in their state budgets; 6) for some states, budget rules and policies determine the role of Medicaid in the state budget to a significant degree (eg, Missouri's Hancock Amendment, which limits state revenue growth to a rate no greater than the growth of Missouri residents' income growth).
Uses: Guidance on possible ways to interact with budget processes, particularly with regard to Medicaid-related issues; Provide legislators and other interested parties with a perspective on how the budget process impacts Medicaid and how federal Medicaid policies are used by states.
Limitations: Although valuable for their insider's perspective and for the range of states covered, these reports are similar to interviews and have the corresponding weaknesses of verification. There is also the limited number of states covered and whether these states provide a representative cross-section.

Haber SG, Khatutsky G, Mitchell JB. Covering uninsured adults through Medicaid: lessons from the Oregon Health Plan. *Health Care Financing Review*. 2000; 22(2): 119-136.

Keywords: State roles
Purpose: To use the Oregon Health Plan experience to guide other states in Medicaid reform efforts.
Data: State-wide random survey of eligible non-elderly adults and state-level administrative data
Methods: Descriptive and epidemiologic statistics
Results: The Oregon Health Plan (OHP) has proven to be one of the most controversial of the state Medicaid experiments. A 1115 Medicaid waiver program, OHP expanded Medicaid eligibility to all uninsured persons with incomes below 100 percent of the federal poverty level, instituted a defined list of covered medical conditions and treatments, and instituted managed care for most enrollees. This study used survey data to characterize the expansion population. Policymakers erroneously assumed that the expansion population would resemble other, known, populations. In particular, they assumed that the childless adults among the expansion population would resemble the commercially insured population. The expansion group was, in reality, much sicker and thus more costly to cover than they anticipated. The authors conclude that the OHP has been successful at increasing insurance coverage, although coverage is brief, and that there is no evidence that there is crowding out of private insurance. Additionally, they found that recipients tended to enroll when they needed services (eg, emergency medical services, dental services) and that the OHP's exclusion of pre-existing conditions impacted use and enrollment patterns and worked to control costs by limiting access and coverage.

Uses: By understanding the attributes of the OHP's expansion population, other states can hope to better predict what impacts policy changes to decrease their uninsured rates may have.
Limitations: Survey data includes some self-reported information and was performed by telephone without provisions for sampling those without telephones. Additionally, as noted by the authors, the survey is a cross-sectional study that does not account for the effect of time factors and their impact on eligibility and population traits. The authors somewhat compensate for this with the use of multiple-year administrative data.

Hadley J. *Sicker and Poorer: The Consequences of Being Uninsured*. The Henry J Kaiser Family Foundation. 2002.

Keywords: General trends in the number of uninsured, access to health care
Purpose: Determine and summarize the effects of health insurance as presented in the literature
Data and Methods: Literature review
Results: This review concludes that health insurance leads to improved health and better access to health care services. Evidence was found that simply having insurance would reduce mortality rates for the uninsured by 10 to 15 percent. The author finds that the uninsured receive less preventive care, get diagnosed at later states of a disease, and that once they are diagnosed they receive less therapeutic care. This study sought to identify the impact of being uninsured on potential earnings and found that better health, as implied by having access to health care through insurance, would increase annual earnings by 10 to 30 percent and would increase educational attainment.
Uses: Because we do not view health coverage as a right, we need to justify why health coverage is (or is not) necessary. A view of the outcomes of being uninsured is striking and allows for informed decisions
Limitations: None as presented

Higgs ZR, Bayne T, Murphy D. Health care access: a consumer perspective. *Public Health Nursing*. 2000; 45(2): 119-136.

Keywords: Access to health care
Purpose: To report on the actions of a community partnership in Spokane, Washington, to understand health care access.
Data: Resident surveys and ethnographic data (thematic analysis of focus group discussions)
Methods: Convenience sampling by selected census tract
Results: Action research—an approach where researchers and practitioners collaborate to diagnose and address problems by integrating theory, research and practice—was used to provide an information base for policy formulation by a partnership in Spokane, Washington. Access to care by uninsured persons was recognized as a major community issue by local service providers; however, factors limiting consumers' access were unknown. Consumer information was collected via mailed surveys and focus groups. The primary factors affecting perceptions of the degree to which medical, dental, and mental health needs were being met included income, education, and ethnicity. Access to needed health care services was a problem for some residents, with low-cost dental and mental health services cited as the highest priorities. Barriers to accessing health services included cost, length of time before an available appointment, lack of comfort with providers, and the need to miss work for appointments. Consumer-focus input brought critical information to the local policy process.
Uses: Provides a model for future needs assessment related to understanding health care access.
Limitations: As presented, the approach was primarily elite-driven and did not provide a mechanism for inclusion of epidemiologic data or its evaluation by the consumers involved.

Holahan J. Health status and the costs of expanding insurance coverage. *Health Affairs*. 2001; 20(6): 279-286.

Keywords: General trends in the number of uninsured, access to health care
Purpose: Estimate the differences in health spending across different types of insurance and across incomes that are attributable solely to health status differences

Data and Methods: Medical Expenditure Panel Survey
Results: Based on health status alone, the uninsured are less costly than those on Medicaid, but are more costly than those with employer-sponsored insurance. Because they have better-than-average health, adults and children with private nongroup coverage are also less expensive than average. The author concludes that, regardless of coverage type, expenditures fall and health status improves with income.
Uses: Income and health status are correlated with each other and we need to understand their relationship in order to interpret the results of studies comparing the effects of health insurance coverage.
Limitations: None as presented

Holahan J, Kim J. Why does the number of uninsured Americans continue to grow? *Health Affairs*. 2000; 19(4): 188-196.

Keywords: General trends in the number of uninsured
Purpose: Compare changes in health insurance coverage for 1994 to 1997 with those for 1989 to 1993
Data: Current Population Survey (US Census)
Methods: Econometric analysis
Results: The uninsured, nonelderly population increased from 16.2 percent to 18.2 percent of the total population from 1989 to 1993, and again from 17.3 percent to 18.4 percent from 1994 to 1998. For the period from 1989 to 1993, Medicaid coverage grew and there were small increases in other public and private nongroup coverage, but this was inadequate to cover the decline in employer-based coverage and population growth. Comparatively, from 1994 to 1998, Medicaid coverage dropped along with other public coverage and nongroup private coverage. However, these losses were somewhat compensated for by an increase in employer-sponsored insurance coverage due to a strong economy. The drop in Medicaid coverage for this period was attributed more to a reduced probability of coverage than the decline in the number of people living at below 200 percent of the national poverty level. The authors conclude that low-income populations were adversely affected by Medicaid reductions and did not benefit as much as other groups by the rise in employer-based coverage. The rate of employer-sponsored coverage fell for the two highest income groups; there was no change for the rate among the lower income group. For adults living at above 200 percent of the poverty level, increases in uninsured rates were almost solely due to declines in employer-sponsored coverage. Hispanics, already the ethic group with the highest uninsured rate, accounted for almost half of the increase in the overall number of uninsured. These results highlight the question of what impact the economy will have on uninsured rates in the future.
Uses: Provides an understanding of the trends and apparent relationships of insurance coverage to guide policy decisions
Limitations: No specific limitations noted

Kemble S. Charity care programs: part of the solution or part of the problem? *Public Health Reports*. 2000; 115(September/October): 419-429.

Keywords: Safety-net, charitable choice
Purpose: To understand the impact of replacing the traditional charity-care system of primary health care with a more formal institutionalized charity-care system.
Data: Administrative data (financial and patient characteristic)
Methods: Case study
Results: Charity care, the provision of services without reimbursement, is an accepted part of the US health care system. In particular, it is expected that physicians and other health care providers will voluntarily provide some amount of free care to patients in need. However, this practice has been criticized due to problems with the shame involved with asking for free care, that care may be inadequate and episodic due to the incentives to provide minimal care, and that charity care cannot fill the health care access gap. These issues are more pertinent now that physicians can no longer easily cost shift to cover the losses due to charity care and thus a direct connection between charity care provided and the provider's income is evident. This case study examines a gatekeeping organization that developed one county that coordinated and administered charity

care. The author concludes that such organizations may provide limited benefits, due to excessive cost, and fragmentation of care. This is in part because the organization served to close the gate to standard-quality care rather than selecting the appropriate gate. Additionally, a limited commitment was observed among community physicians to providing charity care.

Uses: Background information for those involved with providing safety-net services and the public policies that impact these services.

Limitations: This case study only looks at those individuals served by the program and does not include those who were still unable to access health care. Additionally, a single case needs additional support to increase confidence in the findings.

King JG, Avery JE. Evaluating the sale of a nonprofit health system to a for-profit hospital management company: the Legacy experience. *Health Services Research*. 1999; 34(1): 103-121.

Keywords: Safety-net, nonprofit hospital

Purpose: Develop a decision model for nonprofit health care leaders for evaluating community benefits of selling their organization to a for-profit organization.

Data: Case study—financial and administrative records and published studies

Methods: Case study

Results: This study focuses on the need to develop a measure of community benefit that provides a broader decision-making criterion—one that considers an institution's social value. It presents a benefit-cost approach decision model that considers some community welfare variables. The authors' specific purpose is to provide the leaders of nonprofit healthcare organizations a means to evaluate whether selling to a for-profit organization is in their community's best interest. The model is developed around the case study of the Legacy Health System's consideration of a sale to a for-profit firm and the subsequent creation of a community foundation. In the Legacy case the authors conclude that a sale would negatively affect the local community.

Uses: Provides understanding of valuation issues involved in community benefit calculations. Application of the suggested model to other organizations to guide decision making by those organizations, the Internal Revenue Service and policy makers.

Limitations: The focus on financial measures limits understanding of social benefits provided by organizations.

Kinney ED, Tai-Seale M, Greene JY. Three political realities in expanding coverage for the working poor: one state's experience. *Health Affairs*. 1999; 18(4): 188-192.

Keywords: State roles

Purpose: Chronicle the efforts of Indiana policymakers to expand health insurance coverage to the working poor.

Data: Case study

Methods: Historical account; policymakers obtained data through focus groups and existing state reports.

Results: States are now considering the issue of coverage for remaining populations with high numbers of uninsured individuals—low-income workers and adult dependents. In the late 1990s, a bipartisan group called the Indiana Commission on Health Care for the Working Poor worked to expand coverage for such people in Indiana. Initial ideas of encouraging the insurance industry to provide private health insurance plans with state subsidies were rejected for an incremental approach to support and strengthen the existing safety net providers. Justifications for this approach included: (1) health insurance policies that provide adequate coverage are expensive and most state policymakers would not support such expenditures; (2) safety-net providers are already being used by the uninsured poor to obtain health care and these providers exist, in part, to serve such needs; (3) low-income workers can spare little of their own income for health insurance and are generally unwilling to purchase coverage with minimum benefits or large out-of-pocket costs; and state subsidies do not appear to impact this behavior. Overall, the commission worked to support the existing system by providing incentives for safety-net providers to organize into networks that provided coordinated care to these individuals and to establish a state sponsored stop-loss fund that protected network hospitals against large expenses. Implementation of these recommendations has proved difficult due to the distraction provided by the federally imposed

State Children's Health Insurance Program (CHIP) and the loss of the commissioner who served as a policy entrepreneur.

Uses: Provides overview of political forces involved in this case. Could be useful to advocacy groups and policymakers by helping them better understand what environmental factors could be important. Also provides report of actions taken to reform health care at the state level.

Limitations: None as presented

Ku L, Matani S. Left out: immigrants' access to health care and insurance. *Health Affairs*. 2001; 20(1): 247-256.

Keywords: Access to health care, immigrants

Purpose: Provide an understanding of how immigration status relates to health case access.

Data: National Survey of American Families (Urban Institute)

Methods: State-representative samples of 13 states, plus a wraparound sample of the remaining United States. Weighted analyses are performed using balanced, repeated replicates and 60 sets of replicate weights.

Results: Immigrants are disproportionately low-income and insured. Recent policy changes, at all levels of government, are intended to limit immigrants' access to both insurance and health care. For example, the 1996 federal welfare reform law restricted immigrant eligibility for Medicaid so that those admitted to the United States after August 1996 must wait five years for coverage with the exception of emergencies. This and other legislation have impeded efforts to enroll immigrants' eligible children in State Children's Health Insurance Programs. This study, which uses data from the National Survey of America's Families, found that more than 50 percent of low-income noncitizen adults were uninsured. Contrary to common perception regarding the uninsured and emergency services use, the authors found that noncitizen families had poor access to emergency services, even though the law allows for emergency care. Overall, noncitizen families have less initial access to medical care and often received less care than citizen families. The authors stressed that immigrants experience nonfinancial barriers to health care (eg, language, perceptual) beyond those of the general low-income population.

Uses: To guide health and immigration status policy decisions, particularly in geographic areas with high numbers of immigrants. Informative for service providers on issues related to access barriers experienced by immigrants.

Limitations: National Survey of American Families is a cross-section sample and this study does not try to address the inadequacies of these data in fully capturing the dynamic health-coverage market.

Macias E, Morales L. Crossing the border for health care. *Journal of Health Care for the Poor and Underserved*. 2001; 12(1): 77-87.

Keywords: Access to health care

Purpose: Identify how US residents in a California community use Mexican health care services

Data: Survey

Methods: Survey of adults attending a health fair at an elementary school

Results: This study reports on a survey of southern Los Angeles County residents (approximately 140 miles from the US-Mexico border) that characterizes health care service use and preferences with a particular focus on border-crossing behaviors related to health care. Responses showed that 14 percent of the sample had sought medical care in Mexico during the past year. Most of these people (80%) were uninsured and the lower cost of care in Mexico was most often cited as the reason for seeking care in Mexico. Common services sought included medication (28%; most often to purchase antibiotics, pain medication, or contraceptives) and dental care. Respondents preferred to receive medical care in the United States, although Mexican dental care was preferred; perhaps due to cultural or language preferences. The use of both the US and Mexican health care systems by individuals raises ethical, medical and policy questions: requested procedures may not be approved for use in the United States by the US Food and Drug Administration; complications may arise from treatments selected without knowledge of care received by the patient in Mexico (or in the United States); and cross-border travel with narcotics that are heavily regulated in the United States.

Uses: Provides health care service providers with information on how their proximity to the US/Mexico border may affect their practices and patients' behaviors. Assists policymakers in understanding the extent of border permeability related to health care and how changes to access (pricing, insurance coverage, etc) might impact health care use patterns in areas near the Mexican border.
Limitations: Nonrepresentative sample taken and analysis based on self-reported data related to issues on which subjects may have been unwilling to be open about rather than attempting to measure actual behaviors.

Mainous AG III, Hueston WJ, Love MM, Griffith CH III. Access to care for the uninsured: is access to a physician enough? *American Journal of Public Health*. 1999; 89(6): 910-912.

Keywords: Access to health care
Purpose: Evaluate the performance of the Kentucky Physicians Care program.
Data: Case study
Methods: Telephone survey of Kentucky adults based on a stratified random sample.
Results: This study examined Kentucky Physicians Care, a private sector, statewide program that provided medical and preventive health care through increased access to physicians for uninsured indigent persons. A survey was conducted of Kentucky adults; groups included individuals with private insurance, Medicaid recipients, and Kentucky Physicians Care recipients. The Kentucky Physicians Care participants received significantly lower rates of preventive services. Among individuals in this group, cost was cited as a barrier to getting services—38% had not filled prescribed medicines in the previous year. The authors conclude that although the provision of free access to physicians is important, it is insufficient for many uninsured patients.
Uses: Guidance for similar programs, policymakers, and service providers on the impacts, strengths, and weaknesses of programs providing coordinated charity care in this manner.
Limitations: Based on self-reported data, difficulty in matching such data, enrollment records, and use records. No measure of access to care before the program being evaluated or before program referrals.

Malone RE. Wither the almhouse? Overutilization and the role of the emergency department. *Journal of Health Politics, Policy and Law*. 1998; 23(5): 795-833.

Keywords: Access to health care, safety-net
Purpose: To better understand the dynamics of emergency department overutilization and its role in the health care safety net.
Data and Methods: Ethnographic study
Results: This study is based on an ethnographic study that characterizes heavy users of the emergency departments (ED) at two inner-city hospitals. One focus of cost-control efforts has been to promote the appropriate use of each type of medical care, with particular attention to ED use. Inappropriate use of EDs is usually thought of as the result of inadequate access to primary medical care. The true cause is likely to be much broader based. The author's fieldwork found that although heavy ED users often did need care, that the need was not acute or not the primary reason for accessing the ED. The author concludes that inappropriate use is also the result of the classic "almshouse" function of EDs and hospitals in general. The need to narrow the range of services provided in the ED setting has consequences for roles not considered when medical care policy changes--there are more general social functions that the ED serves for some patients. These social functions are exacerbated by concurrent changes in social policy that limit safety net options for the indigent, the homeless and other such marginalized groups.
Uses: This study provides useful insights for social service providers to increase understanding of the unmet social and physical needs of their clients or potential clients. It provides guidance to safety-net hospitals on their societal role beyond that of a medical care provider and helps their ED clinicians better understand chronic over-users of ED services. Because these hospitals are often public institutions and the unmet social needs are often related to government services, this study provides insight to policymakers of the dynamics involved with these issues at the individual level.
Limitations: None as presented.

Mills RJ. Health insurance coverage: 2000. *US Census Bureau Current Population Reports*. 2001; 20(1): 169-177. (http://www.census.gov/prod/2001pubs/p60-215.pdf, June 15, 2002)

Keywords: General trends in the number of uninsured
Purpose: To characterize and report on trends in health insurance coverage.
Data: Current Population Survey, 2000 (US Census Bureau)
Methods: Descriptive statistics
Results: This report summarizes findings from the 2000 Current Population Survey. The Current Population Survey estimated that 14 percent of the population was without health insurance coverage for all of 2000; the lowest rate was 6.9 percent in Rhode Island and the highest was 22.6 percent in New Mexico. The proportion of children without insurance coverage declined from 12.6 in 1999 to 11.6 in 2000. The uninsured rate for individuals living at below the poverty level also declined (29.5 percent in 2000, from 31.1 percent in 1999). However, the uninsured rate for the near-poor increased. The main driver for the rise in the coverage rate from 1999 was an increase in employment-based health insurance coverage (64.1 percent of people were covered by an employer-sponsored health plan at some time in 2000). Hispanics bear the heaviest burden of uninsurance, with an insured rate of only 68.0 percent. Coverage rates for White non-Hispanics, Blacks, and Asians and Pacific Islanders were 90.3, 81.5 and 82.0 percent, respectively. In general, full- and part-time workers were more likely to have insurance than nonworkers, however, poor workers were less likely to be covered than nonworkers. Men and young adults were less likely to have health insurance coverage than other groups.
Uses: Understanding the trends in health insurance coverage to guide decision making in health policy and education and advocacy efforts related to excess burdens of uninsurance among population subgroups.
Limitations: None as presented

Moreno L, Hoag SD. Covering the uninsured through TennCare: does it make a difference? *Health Affairs*. 2001; 20(1): 231-240.

Keywords: Access to health care, state roles
Purpose: To evaluate the impact of TennCare in addressing the health needs of the poor and uninsured.
Data: Survey
Methods: Random-digit, computer-assisted telephone survey of Tennessee households during 1998 and 1999
Results: TennCare, an expansion of Tennessee's Medicaid program, was created in 1994 to address the needs of the poor and uninsured. Originally, TennCare instituted managed care in its Medicaid Program and was able to use savings from the switch to expand insurance coverage to uninsured and uninsurable adults and children. Coverage for those with incomes below 400 percent of the federal poverty level was subsidized; others could receive unsubsidized coverage. This expanded program was later curtailed due to costs. Further changes were being considered due to continued financial difficulties with the program. This study finds that the expansion improved access to care, reduced unmet need, and encouraged use of preventive services, particularly for children. TennCare beneficiaries also stated high satisfaction with their care.
Uses: Assists states considering similar Medicaid reforms by evaluating an existing program, along with helping Tennessee residents and policymakers understand the impact of TennCare. Highlights recipients' barriers to care, which could allow programmatic changes that overcome those barriers.
Limitations: Other studies have already established that insurance coverage increases access to care. This study does assess recipient satisfaction, but does not relate access to better outcomes or the benefits per cost of this program; something that would allow for a more robust discussion of the true benefits of Medicaid expansions.

Nicholson S, Pauly MV, Burns LR, Baumritter A, Asch DA. Measuring community benefits provided by for-profit and nonprofit hospitals. *Health Affairs*. 2000; 19(6): 168-177.

Keywords: Safety-net, nonprofit hospitals

Purpose: To standardize the identification of community benefit activities and establish an acceptable level of benefit that a nonprofit hospital should provide its community.
Data: American Hospital Association survey data (1995)
Methods: Financial analysis
Results: In lieu of taxes, nonprofit hospitals are expected to provide community benefits. In fairness, they should provide benefits that equal those provided by for-profit hospitals and the profit earned by such hospitals. The authors, however, do not discriminate between profit that returns to the community in question and that which goes to recipients elsewhere. These authors provide one of the more comprehensive economic valuations of community benefit, but do not consider social value. The most important contribution is the emphasis that the same criteria be applied to hospitals of all corporate ownership forms so that meaningful comparisons may be made and actual behavior, regardless of motivation for such behavior (eg, marketing purposes vs community health promotion). This study's methodology finds that as a group nonprofit hospitals do not provide adequate community benefits and conclude that such services should increase or that nonprofit hospitals provide community benefits in ways that cannot be measured.
Uses: Provides understanding of valuation issues involved in community benefit calculations. Application of the suggested model to other organizations to guide decision making by those organizations, the Internal Revenue Service and policy makers.
Limitations: The focus on financial measures limits understanding of social benefits provided by organizations.

Quinn K, Schoen C, Buatti L. *On Their Own: Young Adults Living Without Health Insurance*. The Commonwealth Fund. 2000; Publication No. 391.

Keywords: General trends in the number of uninsured
Purpose: Examine young adults' access to health insurance and the consequence of this access on their health
Data and Methods: Current Population Survey (March 1999)
Results: Almost one third of adults aged 19 to 29 years are uninsured—almost twice the rate of other individuals. This rate has increased recently to 30 percent in 1999 from 22 percent in 1989. Although it benefits primarily individuals from upper-income families, young adults who attend college can usually retain their parent's coverage until age 23. Most, 75 percent, of uninsured workers in this age group do not have access to employer-sponsored health insurance. Many of the individuals in this study had done without needed medical care.
Uses: This age group is often ignored, as their needs are comparatively few and nonurgent if they are not parents. Understanding the challenges they face can help policymakers address their barriers when making decisions to decrease uninsured rates
Limitations: None as presented

Schoen C, DesRoches C. Uninsured and unstably insured: the importance of continuous insurance coverage. *Health Services Research*. 2000; 35(1): 187-206.

Keywords: Access to health care
Purpose: To examine the role of continuous health insurance in health care access
Data: Three survey databases: Robert Wood Johnson Foundation 1996-1997 Community Tracking Survey, Kaiser/Commonwealth 1997 National Survey of Health Insurance, and Kaiser/Commonwealth 1995-1997 State Low Income Surveys
Methods: Regression analysis
Results: This study examines the role of continuous health insurance in health care access. It does so by comparing access and cost experiences of insured adults who have experienced a recent uninsured period to those experiences of both uninsured adults and adults with no uninsured periods during a reference time frame. Compared to the continuously insured, the unstably insured were at high risk of going without needed care and of experiencing difficulties with paying medical bills. Problems with access and costs were nearly as prevalent among the unstably insured as among the uninsured. The authors conclude that research that focuses on current insurance status alone underestimates the extent instability in insurance status contributes to access difficulties and undermines quality of care, and that such research underestimates the

proportion of the population that remains at risk due to lack of health insurance. They underscore the differences in results that such approaches give: cross-sectional studies tend to underestimate the number of uninsured (eg, for the population under age 65 years the Current Population Survey, a cross-sectional survey, reports a 17 percent uninsured rate, compared to the Survey of Income and Program Participation, a longitudinal survey, which reports a 22 percent uninsured rate). They also recommend that policy reforms should work toward maintaining continuous insurance coverage.

Uses: Guide policy decisions related to bridging time gaps in insurance coverage. Provide guidance in survey development so that more complete information is gathered by cross-sectional surveys.

Limitations: None as presented

Sider RJ, Unruh HR. 'No aid to religion?' Charitable Choice and the First Amendment. *Brookings Review*. 1999; 17(2): 46-50. *and* Matsui E, Chuman J. The case against charitable choice. *Humanist*. 2001; 61(1): 31-34.

Keywords: Safety-net, nonprofit hospitals

Purpose: To present the issues related to charitable choice and the arguments for and against its use

Data and Methods: Commentary, not applicable

Results: These articles provide overviews of the arguments for (Sider and Unruh) and against (Matsui and Chuman) Charitable Choice. Although these are not detached reports of the issues, these commentaries provide useful insights, which are summarized in the section summary, into the complexities of this important policy issue.

Uses: To illustrate the breadth of the factors involved with the implementation of charitable choice to citizens, policymakers, and social service providers

Limitations: These are not detached reports of the issue; such reports are yet to be produced because this is a recent policy initiative.

Spillman BC. Adults without health insurance: do state policies matter? *Health Affairs*. 2000; 19(4): 178-187.

Keywords: General trends in the number of uninsured, state roles

Purpose: Examine how states' policy approaches impact the number of nonelderly adults who obtained public health insurance.

Data: National Survey of America's Families (Urban Institute)

Methods: Comparison of descriptive statistics

Results: Using data from the National Survey of America's Families, Spillman examines how different states' approaches affected the number of nonelderly adults who obtained public health insurance coverage in 1996. The analysis is based on data from the National Survey of America's Families, which includes 13 states: Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin. The study divided states into three groups based on the public coverage approaches taken—limited, moderate, or comprehensive expansiveness of their Medicaid eligibility rules and the willingness of the state to use state funds to expand public coverage of the uninsured. The percent privately insured was the primary determinant of the percentage uninsured. Limited coverage states cover only 3.5 percent of their populations through Medicaid; comprehensive coverage states, 6.1 percent. The author focuses on a measurement she names the Insurance Gap that intends to identify a state's impact on the uninsured. The insurance gap is the percentage of the coverage gap—those individuals without insurance—that the state covers through Medicaid and other state-sponsored programs. Nationally, the coverage gap is 21.3 percent of nonelderly adults; Medicaid and states' other programs fill 20 percent of this gap. As a group, the comprehensive-coverage states closed about 30 percent of their gaps; the limited-coverage states only 13 percent. Texas (11.5%) and Minnesota (40%) are the extreme examples of how extensively states chose to bridge their coverage gaps. It is noted that the presence of a medically needy program was not enough to increase the likelihood that those in poorer health would have Medicaid coverage. The author concludes that states' approaches do matter in relation to who among low-income adults will obtain Medicaid coverage and that considerations of

the current standards for adult eligibility are problematic and need future consideration by policymakers.

Uses: Illustrates the different states' approaches and how those approaches impact their uninsured percentages for those who want to see the interstate patterns and to use these examples as sample laboratory experiments to guide their own policies or to guide policy change.

Limitations: Although this study illustrates states' behavior, it does not and probably could not provide weights on how particular components of the states' policies impacted the uninsured rates.

Stone DA. United States. *Journal of Health Politics, Policy and Law*. 2000; 25(5): 953-958.

Keywords: General trends in the number of uninsured

Purpose: To characterize the relative importance of actors, particularly government, in the health care market in relation to their impact on the uninsured

Data and Methods: Commentary and theoretical discussion, not applicable

Results: Government's role in the health care market changes when different criteria are used to determine that role. If the criterion is the proportion of health care expenditures, then government predominates with 38 percent; more than any other category. If, however, the criterion is the proportion of people insured, government's role becomes secondary to employer-sponsored programs (24.8 vs 60 percent, respectively). The author proposes other criteria for characterizing the US government's role in the health care market: (1) Government's use of authority to ensure that all citizens are included in some community of medical risk sharing; determined by examining the number of uninsured and underinsured. The author concludes that government plays a weak role here because depending on what is included in this measure, anywhere from 16.3 to 33 percent of the population is left outside the health care market. (2) Government's role in regulating health insurance markets. The US government has a relatively passive role toward this market. It does not require that all citizens purchase coverage or participate in a program and it does not obligate other entities to insure most citizens. States and employers are provided relative freedom to operate as they see fit. Policy efforts toward incremental change in government roles (eg, State Children's Health Insurance Program of 1997 and the Health Insurance Portability and Accountability Act of 1996) are often offset by corresponding shifts in other government (eg, state welfare) or employer actions (eg, reduced family coverage); thereby minimizing the impact of government action. (3) Regulation of health care service delivery. Government involvement in regulation of service delivery has been, and remains, minimal, as evidenced by its reluctance to restrain payers' control over clinical decisions. Even in areas where government regulation was well established, such as Medicare and Medicaid, the movement toward voucher-like approaches such as managed care changes government's role from one of advocacy to one of monitoring financial transfers. This situation leaves consumers to fend for themselves in the managed health care market.

Uses: Provides an interesting perspective on the role of government in health care that can stimulate discussion to reexamine accepted beliefs on the impact of government on the health care industry.

Limitations: None as presented

Taylor RJ, Ellison CG, Chatters LM, Levin JS, Lincoln KD. Mental health services in faith communities: the role of clergy in black churches. *Social Work*. 2000; 45(1): 73-88.

Keywords: Safety-net, nonprofit hospitals

Purpose: To characterize the process used by faith communities to identify and address mental health needs.

Data and Methods: Literature review

Results: Health care professionals have only recently recognized the role that faith communities play in their members' and nonmembers' health—particularly mental health needs. This article discusses the history of church-based programs, particularly within the Black community, and how these initiatives are developed and structured. The authors find that ministers serve multifaceted roles that include gatekeeping (to formal services) and change-agent (behavioral and social) functions. They find that little systematic information is available on this role, however and that such information would be useful for developing integrated service delivery models of health and

human services. They do find that the church serves as a mediating structure between individuals and the formal services system. Factors identified as barriers or constraints against effective partnerships between churches and formal services agencies include congregation size and minister characteristics.

Uses: Instructs on the role and impact of nontraditional providers of mental health services. Such information would be useful to policymakers who work with charitable choice-related contracting; individuals who want to understand the potential impacts of charitable choice on mental health services.

Limitations: None as presented

Yegian JM, Pockell DG, Smith MD, Murray EK. The nonpoor uninsured in California, 1998. *Health Affairs*. 2000; 19(4): 171-177.

Keywords: General trends in the number of uninsured

Purpose: Understand why the nonpoor, those with incomes greater than 200 percent of the federal poverty level, do not purchase health insurance

Data and Methods: Survey of California uninsured adults with incomes greater than 200 percent of the federal poverty level

Results: Survey respondents were primarily white males under age 40. Most (60%) respondents reported excellent or very good health and only 12 percent fair or poor health. One third of respondents had household incomes less than $30,000; 10 percent had incomes of $75,000 or more. Eighty-one percent of the respondents were employed and cost was the primary reason given for declining coverage by those who were eligible for employer-sponsored insurance. Many of these individuals appeared to not view health insurance as a priority or a valuable product.

Uses: This study investigates a population that troubles policymakers. This group appears resistant to current incentives to purchase health insurance coverage and understanding their motivations may help in developing future policies directed toward their coverage.

Limitations: None as presented

Zuckerman S, Kenney GM, Dubay L, Haley J, Holahan J. Shifting health insurance coverage, 1997-1999. *Health Affairs*. 2001; 20(1): 169-177.

Keywords: General trends in the number of uninsured

Purpose: Assess how health insurance coverage changed between 1997 and 1999.

Data: National Survey of America's Families (Urban Institute)

Methods: Comparison of descriptive statistics

Results: National Survey of America's Families data was used to assess how health insurance coverage has changed between 1997 and 1999. Results show that economic expansion, welfare reform, and SCHIP have impacted who has insurance coverage as well as the relative importance of various types of coverage. The impact of these forces was not uniform among all adults and children or across all states. The analysis showed that 13 percent of all children and 16 percent of all adults lacked insurance coverage in 1999. Employer-sponsored coverage was being used by more than 80 percent of those with family incomes greater than 200 percent of poverty; an employer program covered only 39 percent of low-income children and 42 percent of low-income adults. The gains seen in employer-sponsored coverage for low-income adults occurred primarily among whites. The rate of employer-sponsored coverage did not rise significantly among low-income parents and they saw statistically significant declines in Medicaid and other state program coverage. The authors attribute this situation to a possible side effect of welfare reform. Massachusetts' MassHealth program showed success with increasing coverage to a broad population of the uninsured. This forms the basis for a recommendation that perhaps other states should consider a more seamless, broad-based approach that covers families rather than a focus limited to children.

Uses: Understanding the trends in health insurance coverage to guide decision making in health policy and education and advocacy efforts related to excess burdens of uninsurance among population subgroups.

Limitations: None as presented