Health Insurance Coverage in Idaho: A Profile of the Uninsured and Those with Coverage

Report by
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Health Insurance Coverage in Idaho:

A Profile of the Uninsured and Those with Coverage

Final Report

July 24, 2007

Lynn Taylor
Kristen Andrews

Submitted to:

Office of Performance Evaluations
Idaho Legislature
700 W. State Street
Boise, Idaho 83702

Attn: Rakesh Mohan, Director

Submitted by:

Mathematica Policy Research, Inc.
600 Maryland Ave., S.W., Suite 550
Washington, DC 20024-2512
Telephone: (202) 484-9220
Facsimile: (202) 863-1763

Project Director: Lynn Taylor

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EXECUTIVE SUMMARY

In February 2006, the Idaho Health Care Task Force recommended that the state undertake a study to identify ways to expand access to health insurance coverage and health care services for the uninsured. In response to a request from the Joint Legislative Oversight Committee, the Idaho Office of Performance Evaluations contracted with Mathematica Policy Research, Inc. to prepare two reports that compile information for the Health Care Task Force on (1) the characteristics of the uninsured in Idaho, and (2) possible approaches for expanding coverage among subgroups of the uninsured. This report profiles the uninsured and those with health coverage in Idaho.

PROFILE OF THE UNINSURED IN IDAHO

About one in six nonelderly Idaho residents was uninsured in 2005, with a higher rate of uninsurance among nonelderly adults than children.

Between 16 and 18 percent of the non-elderly population in Idaho was uninsured in 2005—about the same as the U.S. average and similar to the rates in other nearby western states. Nonelderly adults were uninsured at rates twice that of children (22 percent versus 10 percent). The availability of public coverage through Medicaid and the State Children's Health Insurance Program (SCHIP) for children up to 185 percent of the federal poverty level (FPL) through age 19 may account for the lower uninsurance rates among children.

Among nonelderly adults, disproportionately high uninsurance rates were observed among young adults (ages 18 to 24), low-income adults (annual incomes below $25,000), and the unemployed. Idaho's uninsurance rates also vary substantially by county and urban/rural location.

The uninsured are a diverse group, encompassing all incomes, ages, and employment status. Certain subgroups, however, have particularly high uninsurance rates: young adults (38 percent), low-income adults (43 to 49 percent), and the unemployed (51 percent). The rate in rural areas, overall, was nearly eight points higher than the rate in urban areas (23 percent versus 15 percent). Lack of employer offer, low wages, and low family income are major obstacles to obtaining private coverage. The vast majority of uninsured Idahoans are currently ineligible for public coverage.

The most common reason for being uninsured is being unable to afford the premiums. However, certain subgroups reported other reasons related to their specific circumstances.

About half of all uninsured adults cited the unaffordability of premiums as the main reason for not having insurance coverage. This factor was important regardless of income. The most frequent reason cited by unemployed adults was "lost job or changed employers," while young adults most frequently reported other reasons, including "ineligible because of age or left school."

Seventy percent of uninsured adults report having been without coverage for at least one year, including 13 percent who had never had coverage.

A "snapshot" of uninsurance during 2005 suggests that 70 percent of uninsured adults have been without coverage for more than one year. About 13 percent have never had coverage. Low-income adults (family income less than $15,000) had the longest duration of uninsurance; about half have been without coverage for at least five years.

SOURCES OF INSURANCE COVERAGE IN IDAHO

The main source of coverage for insured nonelderly residents in Idaho is employer-sponsored coverage.

Employer-sponsored coverage is the most important source of health insurance for Idaho residents under age 65, covering an estimated 61 percent of this group. Among nonelderly adults with employer coverage in 2005, approximately two-thirds had coverage through their own employer and one-third had coverage through another employer (for example, as a dependent on a spouse's policy).

Like other states, Idaho is experiencing rapid escalation in average annual premiums for employer coverage. This escalation far outstrips annual increases in the state's average weekly wage.

Annual premiums in Idaho have increased steadily between 1998 and 2004 (from about $2,000 to $3,400, or 74 percent). The employee's share of the premium cost has grown even more dramatically. The average price paid by employees for single coverage during this period increased by 142 percent, compared with an average wage growth of just 20 percent.

Despite the rapid increase in the cost of health insurance coverage, the proportion of Idaho workers who were eligible for and enrolled in coverage offered by their employer appears to have remained relatively stable between 1998 and 2004. However, a small but significant decline in take-up was observed among employees in the largest firms. Participation of eligible employees in these firms declined from 88 to 78 percent between 1998 and 2004.

Rates of employer offer, eligibility, and take-up vary substantially by employer and employee characteristics. Low participation rates may signify lack of access to or affordability of group coverage.

Part-time employees, workers in low-wage firms, and employees in very small firms had the lowest participation rates in employer-sponsored coverage in Idaho in 2004. Participation differed nearly 8-fold between full- and part-time employees (60 percent versus 8 percent, respectively); more than 4-fold between employees in the highest-wage firms and the lowest-wage firms (72 percent versus 16 percent, respectively); and more than 2-fold between very small firms (less than 10 employees) and the largest firms (over 1,000 employees) (58 percent versus 23 percent, respectively).

Industry differences in workforce composition by firm size, wage level, and part-time status appear to contribute to large differences in rates of health insurance offer, eligibility, and take-up. Offer and eligibility rates were highest among manufacturing firms (more than 80 percent) and lowest among arts, entertainment, and recreation firms (about 30 percent). Take-up also varied widely, with manufacturing firms having the highest participation (about 75 percent) and accommodation and food service firms having the lowest (about 12 percent).

The commercial non-group insurance market is the only coverage option for Idaho residents who do not have access to employer-based coverage and who are ineligible for public programs. However, enrollment is low, accounting for eight percent of the nonelderly population.

More than 100,000 residents—eight percent of the nonelderly population—purchased individual or non-group coverage in 2005. Over 80 percent are covered by two health insurers (Blue Cross of Idaho and Regency BlueShield). Idaho permits insurers to set premiums based on case characteristics (age, gender, geography, and tobacco use) and to vary the premium by plus or minus 50 percent based on health status. If individuals are quoted a premium that exceeds 150 percent of the standard risk rate in the individual market, carriers are required to offer applicants a choice of policies through the high-risk pool. Nevertheless, cost appears to be a significant barrier, and only 1,400 people are enrolled in Idaho's high-risk pool.

About 13 percent of non-elderly Idahoans relied on public coverage during 2004-2005, the majority of whom were children under age 19 who were covered through Medicaid or SCHIP.

With the implementation of SCHIP, the availability of public coverage for children expanded substantially. Idaho covers children up to 185 percent of the FPL, but their parents (when eligible for coverage) are only covered up to 23 percent of the FPL. Average monthly enrollment of non-disabled children ages 0 to 19 was about 120,000, compared with about 13,000 parents. Idaho benefits from a very high match rate: the federal match rate is 70 percent for Medicaid and 79 percent for SCHIP.

In recent years, Idaho has initiated three programs to provide premium assistance for children and adults who are eligible for Medicaid or SCHIP. These programs are designed to leverage employer-sponsored coverage by subsidizing private health insurance premiums with Medicaid or SCHIP dollars. Enrollment in these programs is very low (200 to 400 per program), although the state is actively exploring ways to increase participation.

THE RELATIONSHIP BETWEEN COVERAGE AND ACCESS TO CARE

People who are uninsured are more likely to avoid going to the doctor because of concerns about cost, compared with those who are insured, regardless of their income level.

The policy focus on expanding coverage to the uninsured is motivated by extensive evidence that the lack of insurance coverage—coupled with high prices for medical services and low incomes—can pose financial barriers for Idaho residents needing to obtain health care. Overall, 17 percent of nonelderly adults in Idaho avoided going to the doctor because of cost in 2005; however, uninsured adults (36 percent) were three times more likely than insured adults (11 percent) to avoid going to the doctor due to cost. Additionally, low income is associated with financial barriers to care even when individuals are insured. An insured adult in the lowest income group is as likely to avoid going to the doctor due to cost as an uninsured adult in the highest income group (26 percent). Adults who face both barriers—low income and a lack of insurance—are the most likely to avoid going to the doctor due to cost (42 percent).

POPULATION SUBGROUPS OF PARTICULAR POLICY INTEREST

States use a variety of means to increase coverage among the uninsured and often target small subpopulations, for example, those with high rates of uninsurance, or those who may be eligible for attractive financing (such as the federal Medicaid or SCHIP match). This study examined five subgroups of particular policy interest, developing projections of the size of the uninsured population:

1. ***Individuals who are eligible for but not enrolled in public programs.*** We estimate that the majority of eligible children appear to be enrolled in Medicaid, but a far lower proportion of the eligible population is enrolled in SCHIP. Moreover, we estimate that if SCHIP eligibility were extended to children ages 0 to 19 with incomes between 185 and 200 percent of FPL, another 4,000 uninsured children might become newly eligible for coverage.

2. ***Workers who are not eligible for an offer of coverage from their employer.*** An estimated 128,000 private sector employees in Idaho worked for an employer that did not offer any type of health insurance coverage. About 65 percent are estimated to be uninsured, the majority of whom are below 200 percent of poverty. The remainder obtained coverage through a spouse or another source. Targeting coverage expansions toward low-income workers in non-offering firms can be difficult because each individual firm

typically has few uninsured workers and employers are concerned about treating all employees equally.

3. ***Workers who decline an employer's offer of coverage.*** Roughly 26,000 Idaho workers may be declining an employer offer of coverage and uninsured. Programs that target such workers typically offer premium subsidies to lower the cost of their share of the premium. The experience of other programs suggests that premium subsidies could also result in substitution of coverage or cost shifting, potentially resulting in higher costs without a reduction in the number of uninsured.

4. ***Workers in fully insured plans.*** Coverage expansion approaches sometimes target coverage offered by commercial carriers (for example, requiring coverage of certain procedures or using a premium assessment as a financing mechanism). These policies typically affect just a portion of the privately insured population—the portion that is fully insured (about 74 percent of the privately insured population in Idaho). Enrolled workers in smaller firms are disproportionately likely to be in fully insured plans, while larger firms are more likely to self insure their employees' coverage (and would, therefore, be exempt from such policies).

5. ***Sole proprietors.*** An estimated 13 percent of Idaho's non-elderly uninsured adults are self-employed. Whether to include sole proprietors without employees in a program to expand coverage for workers is a key question for policymakers. Sole proprietors suffer from high rates of uninsurance but it is generally assumed that they may make the program more vulnerable to adverse selection, compared to workers eligible for employer-sponsored insurance. However, adverse selection into new coverage options may be mitigated if there is a premium subsidy large enough to encourage relatively healthy individuals to buy coverage.

CONCLUDING REMARKS

This report has provided background information on health care coverage and uninsurance in Idaho. Information on the number of uninsured in various subgroups suggests the potential for various options to expand coverage, while noting the potential for unintended consequences, such as adverse selection or cost shifting, which could occur under some options. A companion report presents an overview of coverage options in other states to inform the discussion in Idaho. As the Idaho Health Care Task Force considers options for expanding access to health insurance coverage, the evidence in this report can provide insight into the magnitude of Idaho's uninsured population potentially served by certain coverage approaches.

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CHAPTER I

INTRODUCTION

In February 2006, the Idaho Health Care Task Force recommended that the state undertake a study to identify ways to expand health insurance coverage and health care services for the uninsured. Idaho's Joint Legislative Oversight Committee directed the Office of Performance Evaluations to commission several reports. Mathematica Policy Research, Inc. (MPR) has prepared this report on the characteristics of the uninsured in Idaho. A companion report by MPR examines coverage approaches in other states to inform the discussion of options for Idaho. The State Health Access Data Assistance Center (SHADAC) is producing separate reports on the current levels of public and private health care spending in the state.

ANALYTIC STRATEGY

An analysis of health insurance coverage in Idaho—or in any other state—is complex for several reasons. First, no one data source tells the full story; therefore, the analysis must draw on multiple data sources to profile health insurance coverage in Idaho. Second, existing data sources generally contain small sample sizes for Idaho, necessitating caution in interpreting results. This limits comparisons that can be made among population subgroups within Idaho or between states. Third, trends in health insurance coverage are dynamic—a function of the economy, federal and state policies, demographic shifts, and other factors. Existing state-level data sources may not precisely capture those trends due to small sample sizes and lack of precision in the estimates. Recognizing these complexities, this analysis displays error bars and confidence intervals, where available, to identify the level of precision (or imprecision) around specific estimates.

Where possible, this study uses Idaho-specific data to profile the uninsured in Idaho. The three main data sources are:

1. ***Behavioral Risk Factor Surveillance System (BRFSS).*** The BRFSS, sponsored by the Centers for Disease Control and Prevention (CDC), is an annual household survey conducted in all 50 states and the District of Columbia. The survey collects state-level information about health status,

knowledge, behaviors, and access (including health insurance coverage).[1] The analysis presented in this report is based primarily on 2005 data, the most recently available data at the time of this study. The 2005 survey contains approximately 4,000 nonelderly adults in Idaho. In addition, coverage trends from 1997 to 2005 are presented.

2. ***Medical Expenditure Panel Survey – Insurance Component (MEPS-IC).*** The MEPS-IC, sponsored by the Agency for Healthcare Research and Quality (AHRQ), provides state-level estimates for private sector employers on the health insurance plans they offer, eligibility requirements, employee participation, premiums, and employer/employee contributions.[2] The 2004 survey contains approximately 520 observations for Idaho.

3. ***Idaho Fringe Benefits Survey***. This survey provides information on supplemental compensation (including health insurance coverage) offered by 2,100 public and private sector employers in Idaho. The survey is conducted in collaboration with the U.S. Department of Labor Employment and Training Administration.[3]

This study uses Idaho tabulations from the Current Population Survey and presents national data to augment the Idaho-specific data, where necessary. In particular, to analyze health insurance coverage among population subgroups, this study developed synthetic estimates of the number and rate of uninsured people in the state. These results can be used to highlight populations that could be targeted in future coverage initiatives, as well as to suggest coverage options that might address the current gaps. Appendix A presents additional details on the methods used to develop the synthetic estimates.

ORGANIZATION OF THIS REPORT

This report contains four additional chapters. Chapter II examines the characteristics of the uninsured in Idaho, while Chapter III describes sources of private and public coverage. Chapter IV explores the relationship between coverage and access to health care services, including the consequences of underinsurance. Finally, Chapter V provides a more detailed discussion of population subgroups that are frequently the target of health coverage initiatives.

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[1] Additional information about the BRFSS is available at http://www.cdc.gov/brfss/index.htm.

[2] Additional information about the MEPS-IC is available at http://www.meps.ahrq.gov/mepsweb/survey_comp/Insurance.jsp.

[3] Additional information about the Idaho Fringe Benefits Survey is available at http://lmi.idaho.gov/admin/ uploadedPublications/4430_Benefits_Survey_brochure.pdf.

CHAPTER II

THE UNINSURED IN IDAHO

This chapter profiles the uninsured in Idaho, including their demographic characteristics, geographic distribution, reasons for being uninsured, and duration of uninsurance. This information provides a foundation for understanding the gaps in coverage as well as which populations may be targeted in future coverage initiatives.

KEY CHARACTERISTICS OF THE UNINSURED

In Idaho, about 18 percent of the nonelderly population was estimated to be uninsured at any given point in time during 2005 (Idaho Department of Health and Welfare 2006).[4] Representing approximately 238,000 residents, the uninsured are a diverse group, varying by age, income level, and employment status.[5]

Distribution of the Uninsured by Age

Nonelderly adults are uninsured at rates twice that of children (22 percent versus 10 percent) (Exhibit 1). The availability of public coverage for children through age 19 through Medicaid and the State Children's Health Insurance Program (SCHIP) is believed to be the dominant reason for lower uninsurance rates among children. Rates of uninsurance are particularly high for young adults between the ages of 18 and 24 for several reasons. For example, many young adults "age off" of Medicaid eligibility, or become too old to be

[4]Because an estimated 99 percent of adults age 65 and older have coverage through Medicare, this age group is excluded from the data presented in this report.

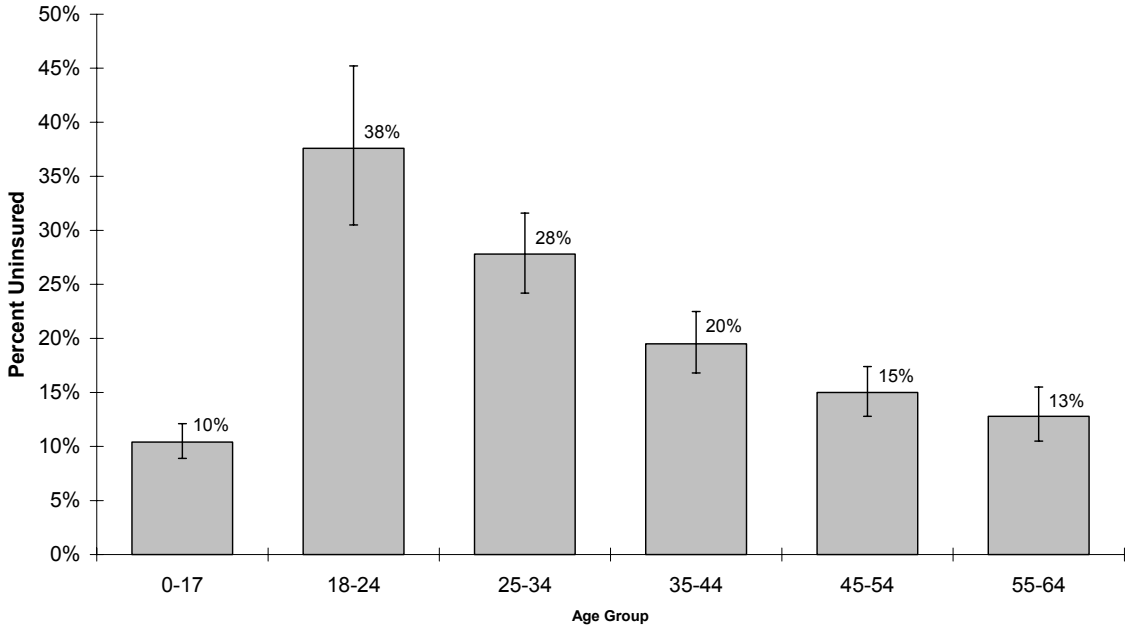
[5]These results are based on the Idaho-specific BRFSS data to examine key characteristics of the uninsured. It should be recognized that estimates of the uninsured in Idaho vary across data sources, reflecting differences in survey design, sample size, and definition of the uninsured. For example, in 2005, the BRFSS data suggest that 18 percent of the nonelderly population is uninsured, whereas a two-year average (2004-2005) from the CPS suggests the rate is 16 percent.

covered by their parents' insurance policies.[6] Additionally, young adults may not be working or may not be eligible for coverage through their employer because of short employment tenure.

Distribution of the Uninsured by Family Income

Most of Idaho's uninsured adults have modest family incomes. More than one-half of uninsured adults have annual family incomes less than $25,000, and almost all have incomes below $50,000 per year (Exhibit 2). The risk of being uninsured increases sharply as income declines. For example, 49 percent of the adults with family income of less than $15,000 per year are uninsured compared with 4 percent of those with family income above $50,000.

Exhibit 1. Rates of Uninsurance by Age, Idaho, 2005

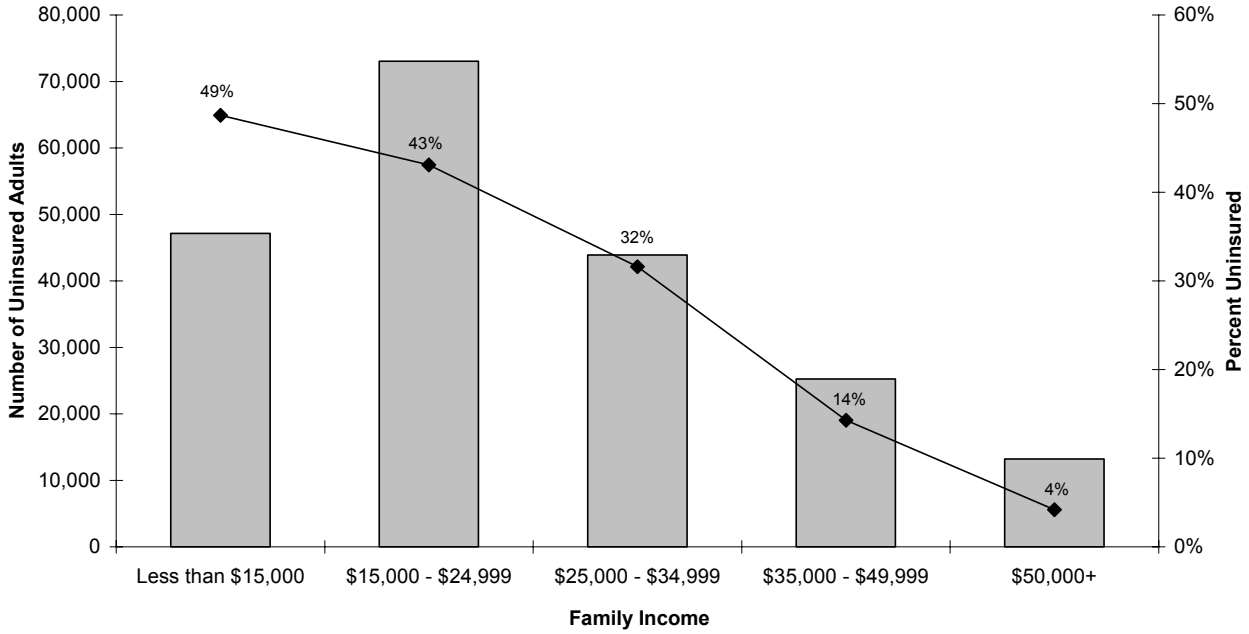


Source: 2005 BRFSS data for Idaho, supplied by the Idaho Department of Health and Welfare.

Note: Error bars indicate the range over which we are 95 percent confident in the indicated statistic. They can also be used to compare two rates to determine whether differences are statistically significant.

[6]Effective July 2007, Idaho will require that group policies permit parents to cover their full-time student dependents through age 25 and other dependents through age 21. As the state cannot directly regulate employer health plans, these requirements will apply only to fully insured groups through changes in insurer regulations.

Exhibit 2. Number of Uninsured Nonelderly Adults and Rate of Uninsurance, by Family Income, Idaho, 2007 Population Projections Based on 2005 Rates

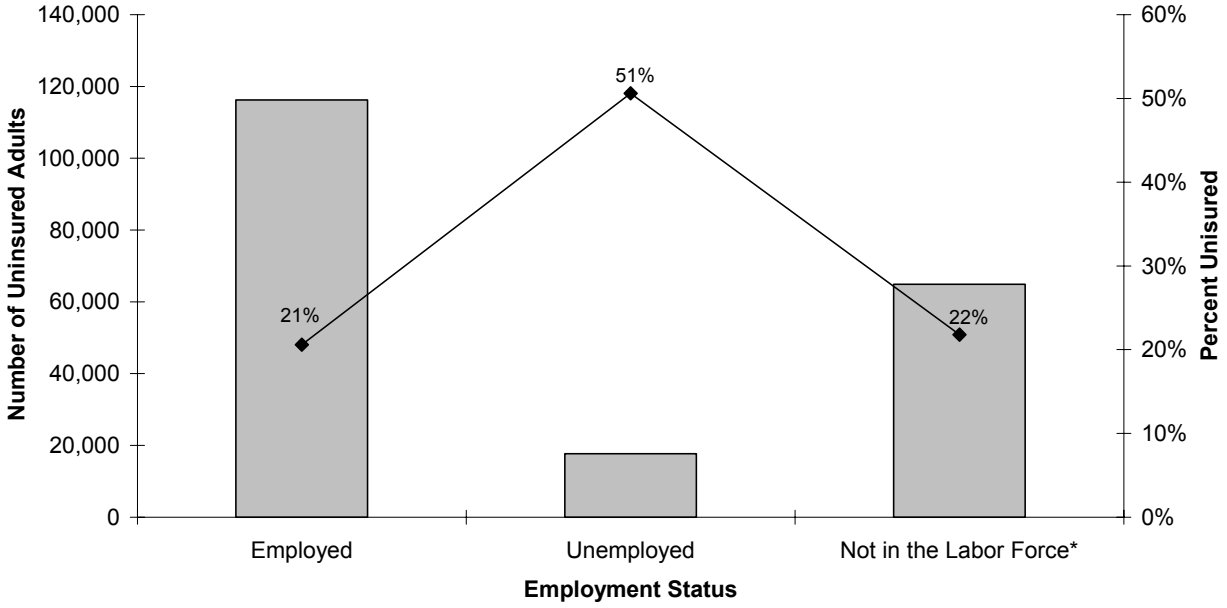


Source: 2005 BRFSS data for Idaho, supplied by the Idaho Department of Health and Welfare. The number of uninsured was estimated by applying the prevalence data in 2005 to estimates of the 2007 nonelderly population from the U.S. Census.

Distribution of the Uninsured by Employment Status

Most uninsured adults—about 60 percent—are employed (Exhibit 3). Unemployed workers comprise just 18,000, or nine percent, of all uninsured adults. However, being unemployed is a substantial risk factor for being uninsured. About one-half of unemployed adults in Idaho lack health insurance coverage. In contrast, about one-fifth of workers lack health insurance coverage. Many uninsured, while not employed themselves, live in families where at least one adult is employed. A 2001 study estimated that 80 percent of Idaho's uninsured (adults and children) live in families with at least one worker (Idaho Department of Commerce 2001).

Exhibit 3. Number of Uninsured Nonelderly Adults and Rate of Uninsurance, by Employment Status, Idaho, 2007 Population Projections Based on 2005 Rates



Source: 2005 BRFSS data for Idaho, supplied by the Idaho Department of Health and Welfare. The number of uninsured was estimated by applying the prevalence data in 2005 to estimates of the 2007 nonelderly population from the U.S. Census.

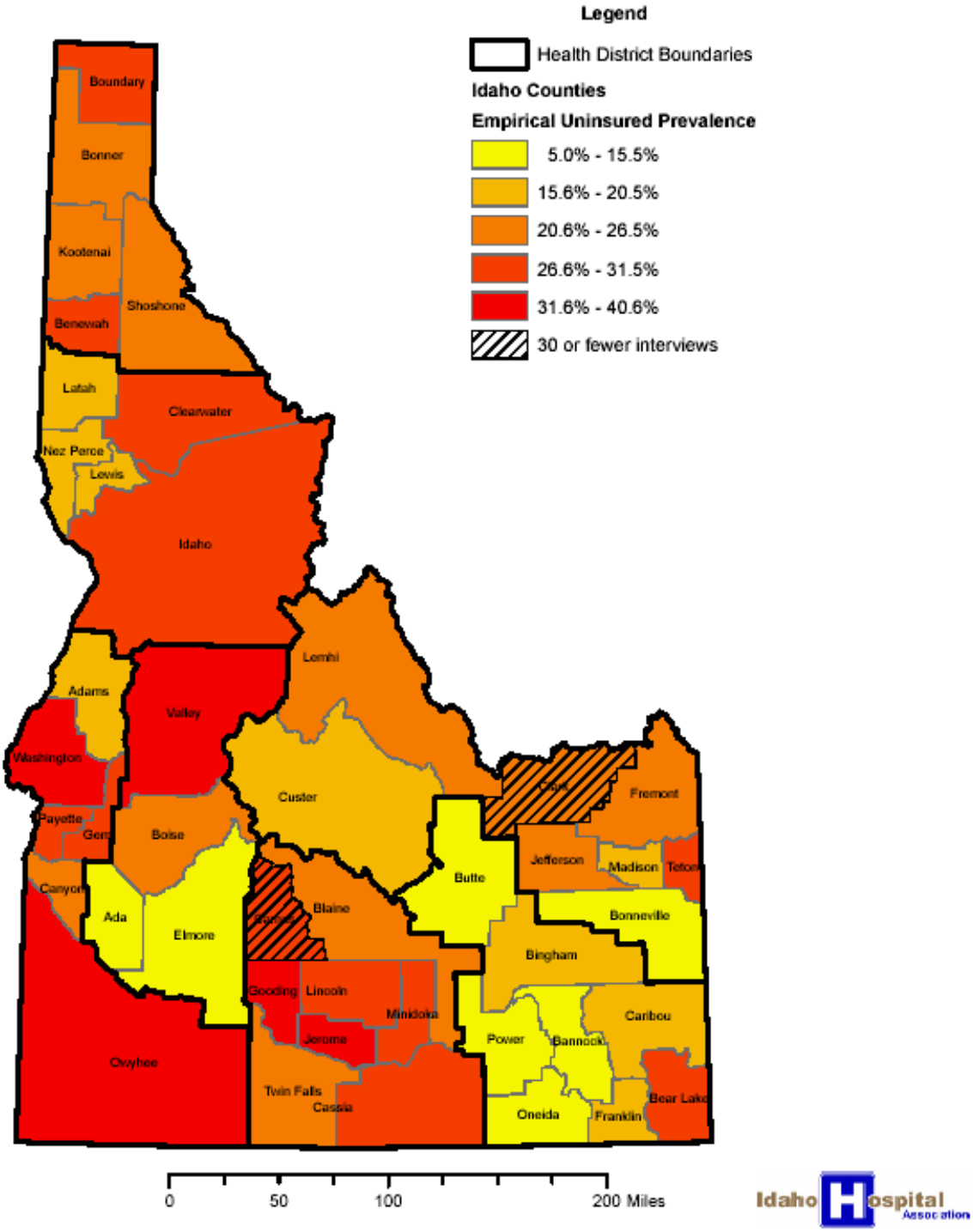
* "Not in the labor force" includes students, homemakers, retirees, and people who are unable to work.

UNINSURANCE RATES BY COUNTY AND URBAN/RURAL LOCATION

Uninsurance rates vary not only by demographic characteristics but also by geographic location. A comparison of the uninsured rates in urban and rural areas revealed a 7-point differential; overall, rural counties had a 23 percent uninsured rate and urban counties had a rate of 15 percent (data not shown).[7] County variation was also substantial. According to estimates made by an epidemiologist with the Idaho Hospital Association, rates of uninsurance among Idaho nonelderly adults range from a low of 6 percent in Butte county to a high of 40 percent in Owyhee county (Idaho Hospital Association 2007; Exhibit 4). Despite combining three years of BRFSS data, these estimates are still surrounded by large confidence intervals due to small sample sizes at the county level (see Appendix B). As a result, variation in uninsurance rates across counties should be interpreted with caution.

[7] The counties of Ada, Bannock, Bonneville, Canyon, Kootenai, Latah, Madison, Nez Perce, and Twin Falls were classified as urban counties.

Exhibit 4. Rates of Uninsurance Among Nonelderly Adults, by County, Idaho, 2003-2005



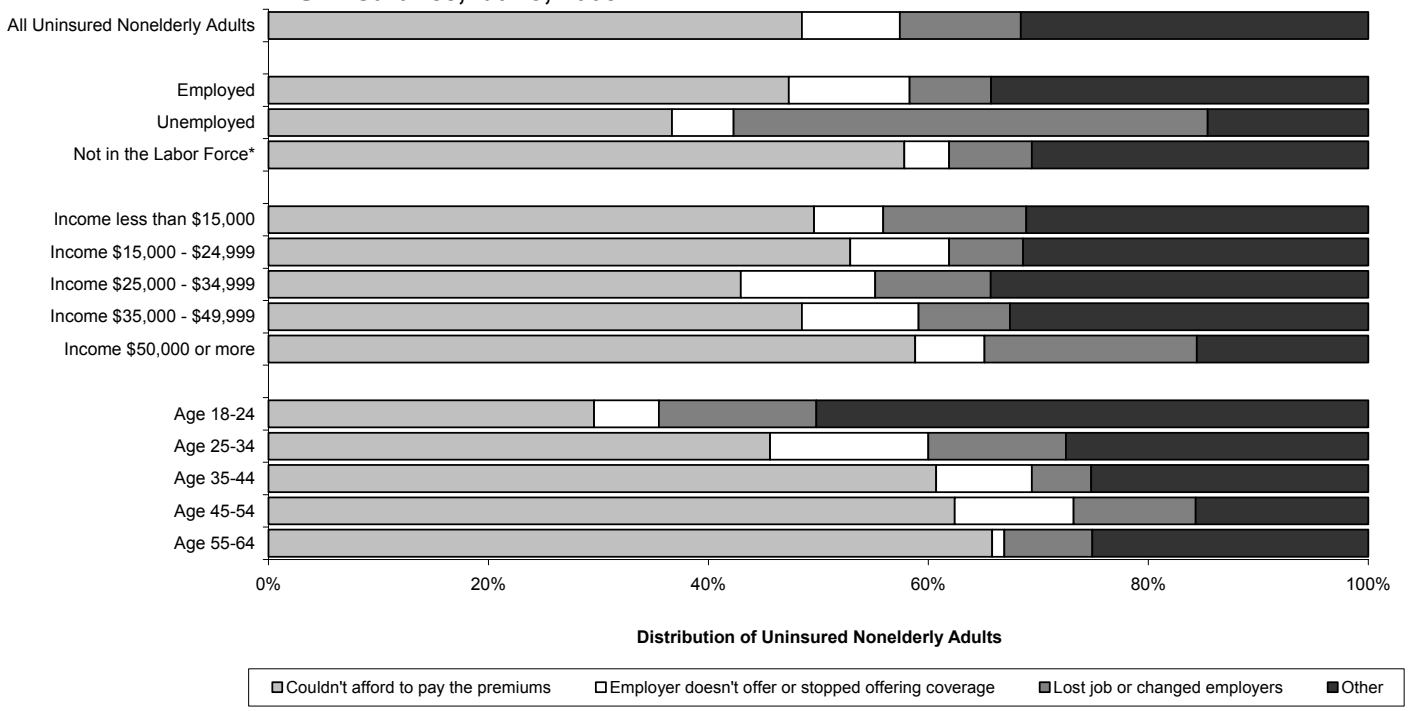
Source: Idaho Hospital Association, 2007.

Note: See Appendix B for underlying estimates by county.

REASONS FOR BEING UNINSURED

To understand the underlying variation in the uninsurance rates by demographic characteristics, we turn now to an analysis of the reasons people reported for being uninsured. The most common reason for being uninsured, as reported by nonelderly adults on the 2005 BRFSS survey, is being unable to afford the premiums. However, reasons for being uninsured vary considerably by population group (Exhibit 5). Unemployed adults are more likely to cite loss of employer coverage as the main reason, while employed adults are more likely to cite difficulty paying premiums or another reason. ("Other reasons" include job loss, employment change, divorce/separation, or ineligibility for public or private coverage.) Uninsured young adults are most likely to cite other reasons, including "ineligible because of age or left school." Unexpectedly, uninsured adults with household incomes over $50,000 are more likely than very low-income adults to cite difficulty affording premiums as a reason for being uninsured. In contrast, low-income adults are more likely to cite "other reasons" for lack of coverage. The diversity of reasons for being uninsured underscores the complexity of identifying effective coverage options for the uninsured.

Exhibit 5. Distribution of Uninsured Nonelderly Adults by Main Reason for Uninsurance, Idaho, 2005



Source: 2005 BRFSS data for Idaho, supplied by the Idaho Department of Health and Welfare.

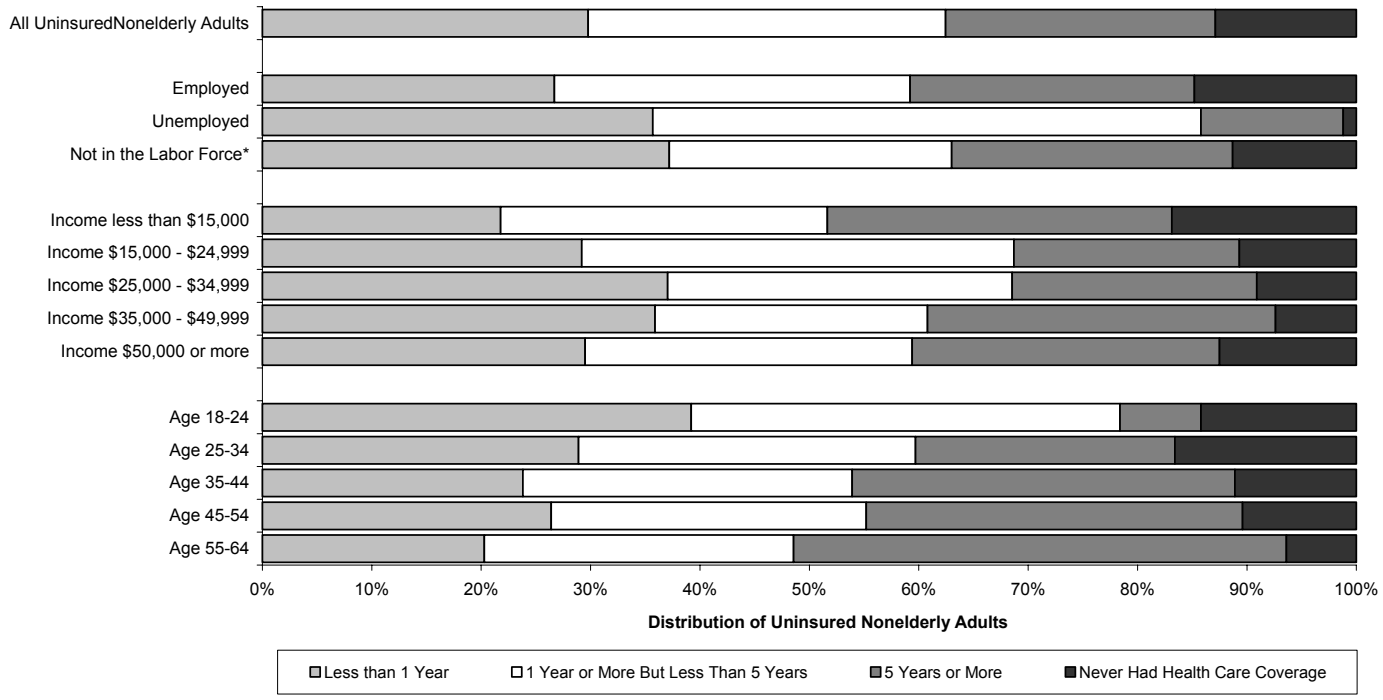
Notes: Survey respondents were asked to provide the "main reason" for being uninsured. Secondary reasons for being uninsured are not captured here. The survey's "other" reasons include: spouse/parent lost job/changed employers, became divorced or separated, became ineligible because of age or left school, cut back to part time or became temporary employee, benefits from employer or former employer ran out, insurance company refused coverage, and lost Medicaid or Medical Assistance eligibility.

*"Not in Labor Force" includes students, homemakers, retirees, and persons unable to work.

DURATION OF UNINSURANCE

For some of the uninsured population, the period of time without health insurance may be short while they are waiting to become eligible for coverage through their current employer or while they are temporarily between jobs. In 2005, 15 percent of uninsured adults in Idaho reported that their current spell of uninsurance had begun less than six months ago and 30 percent had been uninsured for less than one year (Idaho Department of Health and Welfare 2006). At the other end of the spectrum, however, some Idaho residents were considered to be "chronically" uninsured. In 2005, 13 percent of uninsured Idaho adults reported never having had coverage. As Exhibit 6 shows, the length of time since last coverage varies by type of uninsured adult. Short spells of uninsurance (less than one year) were more common among the unemployed, those not in the labor force, and young adults, while longer spells of uninsurance were more likely to occur among those who were employed.

Exhibit 6. Distribution of Uninsured Nonelderly Adults by Current Duration of Uninsurance Spell, Idaho, 2005



Source: 2005 BRFSS data for Idaho, supplied by the Idaho Department of Health and Welfare.

Notes: This exhibit design does not permit the display of confidence intervals but they are fairly large and hence the distributions should be viewed as a rough approximation of the true, underlying distribution.

*"Not in Labor Force" includes students, homemakers, retirees, and persons unable to work.

Measuring the duration of uninsurance while individuals are still uninsured tells only part of the story. Among those who were uninsured during a two-year period, national data show that 60 percent of uninsurance spells lasted 12 months or less, and one-third lasted five months or less (Exhibit 7). Overall rates of uninsurance go up when measured over a longer time period because more short spells are included. Nationally, one-third of nonelderly U.S. residents are uninsured at some point over a two-year period (Stoll and Jones 2004).[8]

Exhibit 7. Duration Without Health Insurance for Nonelderly U.S. Residents Experiencing Any Uninsurance in 2002-2003

Number of Months Uninsured	Percent of Population Ever Uninsured in Two-Year Period
Total	**100**
1-2	7
3-5	28
6-8	15
9-12	12
13-23	22
24	17

Source: Stoll and Jones, 2004.

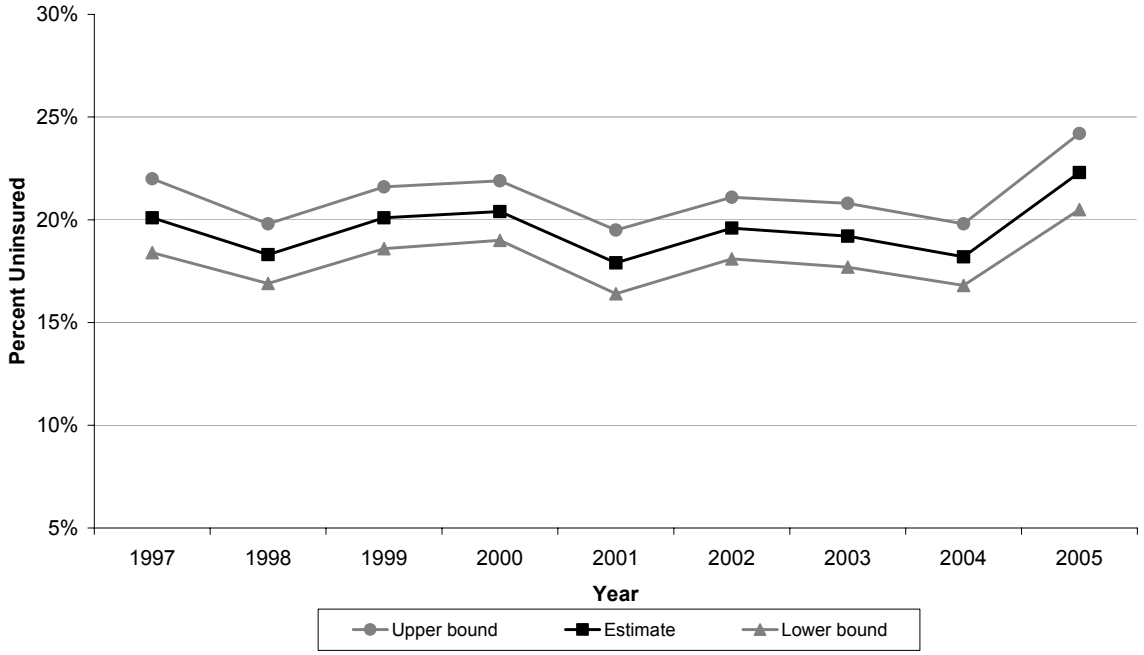
TRENDS IN UNINSURANCE RATES

State-level trends in uninsurance rates are an important indicator of the accessibility and affordability of health insurance coverage over time. As shown in Exhibit 8, the uninsured rate for nonelderly Idaho adults in 2005 was higher than the rate for 1998. These data, however, are subject to imprecision; as a result, this trend should be interpreted with caution. Due to small sample sizes, it is difficult to discern meaningful trends as the uninsurance rates vary from year-to-year and are bounded by a 95 percent confidence of plus or minus two points.

Nevertheless, the trend in Idaho is consistent with trends across the U.S. that uninsurance rates are increasing. Nationally, the primary driver of this trend is believed to be rising premium costs for private coverage, although expanded public coverage options (particularly for children) are believed to have mitigated this national trend to some extent.

[8] Stoll and Jones (2004) used a logistic regression model to create state-level estimates of health insurance coverage over a two-year period (2002-2003). The model predicted that 34 percent of nonelderly Idaho residents experienced a spell of uninsurance in the two-year period, similar to the rate at the national level.

Exhibit 8. Trends in Rates of Uninsurance Among Nonelderly Adults, Idaho, 1997-2005



Source: BRFSS data for Idaho (various years), supplied by the Idaho Department of Health and Welfare.

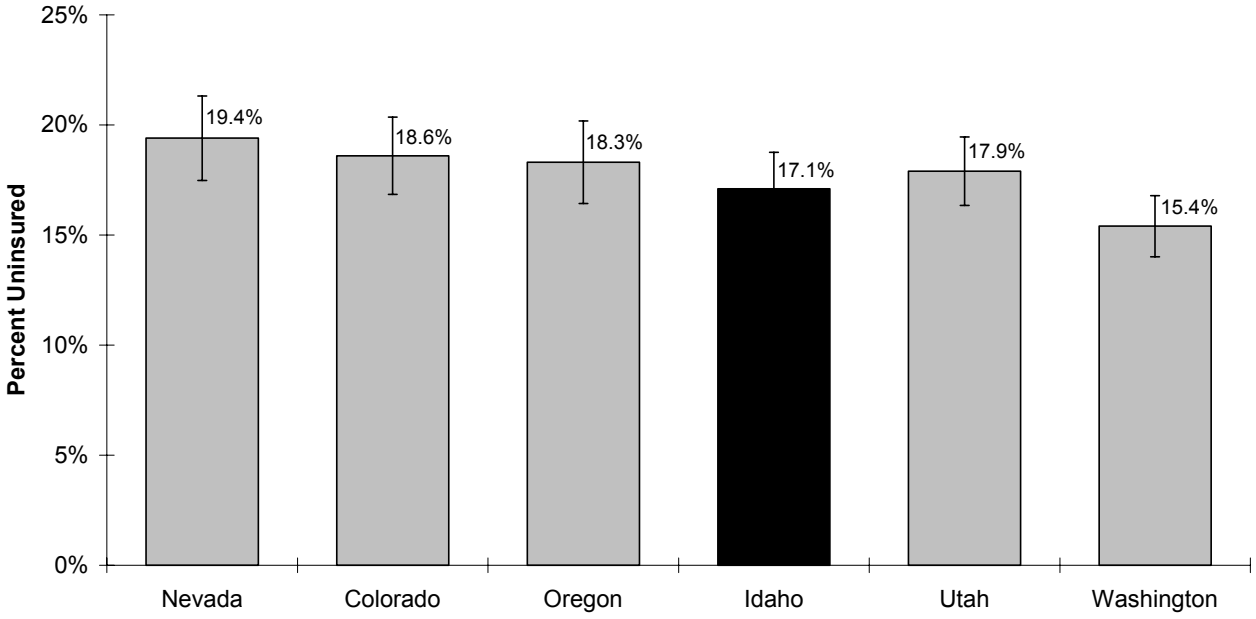
Note: The upper and lower bounds on the estimates indicate the range over which we are 95 percent confident in the indicated statistic.

UNINSURANCE RATES IN NEARBY STATES

Overall, the rate of uninsurance among the nonelderly population in Idaho is very similar to the rate in other nearby western states (Exhibit 9). These comparison states exhibit somewhat more variation when the uninsurance rate for children is examined separately (Exhibit 10). While quite a bit of uncertainty is associated with such estimates due to small sample sizes, Washington appears to have a lower rate of uninsured children under age 18.[9]

[9] It is not clear what drives variation across states. In Washington State, the Medicaid/SCHIP eligibility threshold is 200 percent of the FPL, whereas in Idaho, the threshold is at 185 percent of the FPL (statehealthfacts.org). Additional factors that may affect these coverage rates include the take-up rates among those who are eligible and the level of turnover at renewal.

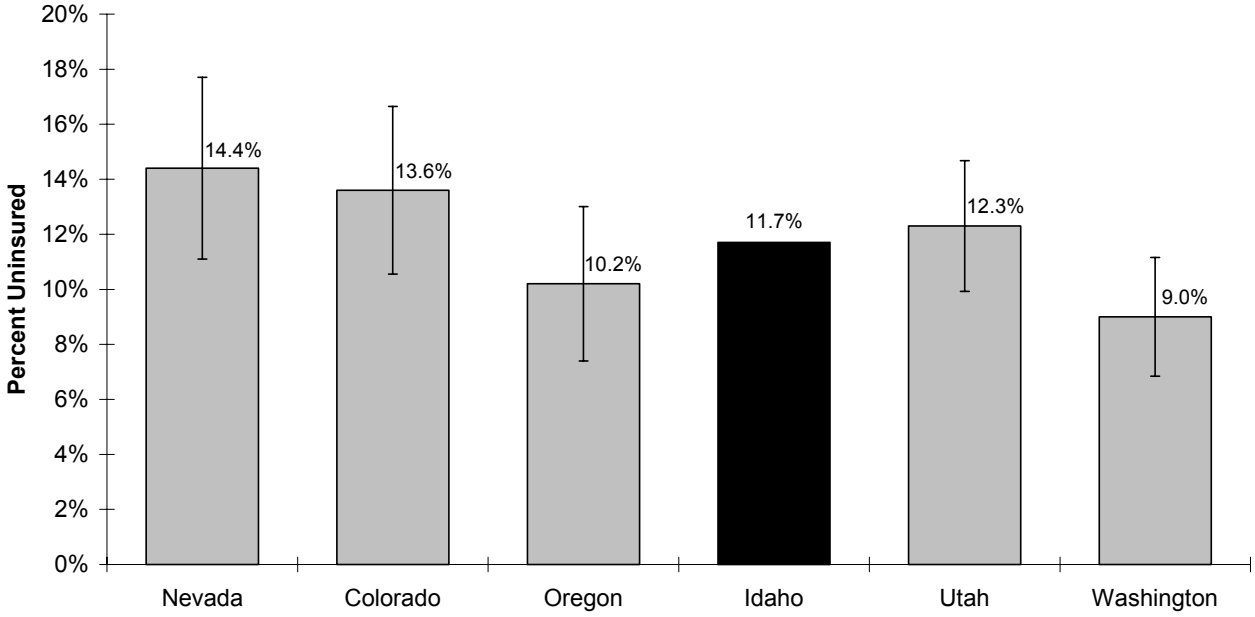
Exhibit 9. Percent Uninsured Among the Nonelderly Population, Idaho and Comparison States, 2005



Source: U.S. Census Bureau, "Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2005" available at: http://pubdb3.census.gov/macro/032006/health/h05_000.htm.

Note: Error bars show the 90 percent confidence interval of each estimate. These estimates do not reflect the recent CPS correction to the survey data which reduced rates of uninsurance by 0.6 percentage points overall.

Exhibit 10. Percent Uninsured Among Children Under Age 18, Idaho and Comparison States, 2005



Source: U.S. Census Bureau, "Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2005" available online at: http://pubdb3.census.gov/macro/032006/health/h05_000.htm.

Note: Error bars show the 90 percent confidence interval of each estimate. Due to small sample size, the confidence interval is not available for Idaho. These estimates do not reflect the recent CPS correction to the survey data that reduced rates of uninsurance by 0.6 percentage points overall.

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CHAPTER III

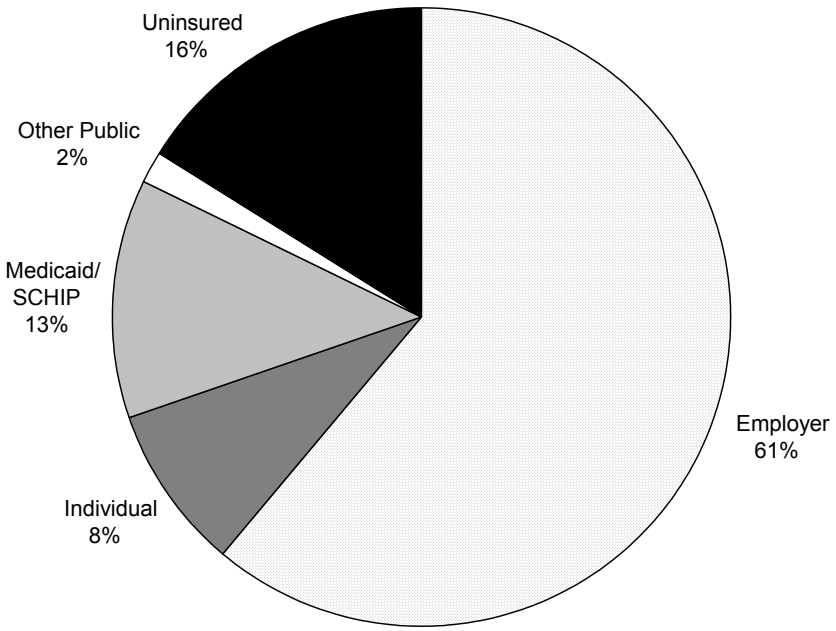
SOURCES OF COVERAGE FOR IDAHO RESIDENTS

OVERVIEW OF COVERAGE SOURCES

In addition to developing a profile of the uninsured population, it is important to examine the sources of coverage for those who are insured to place future coverage initiatives in the context of current coverage. As shown in Exhibit 11, the majority of Idaho's nonelderly residents carry some form of private health insurance. During 2004-2005, 61 percent had employer-sponsored insurance. Another 8 percent of nonelderly residents purchased individual coverage. Overall, the rate of privately insured in Idaho is very similar (within 1 to 4 percentage points) to both the U.S. average and rates in nearby western states (Oregon, Colorado, Nevada, Washington, and Utah) (statehealthfacts.org 2007). Approximately 13 percent of the nonelderly population has coverage through Medicaid or SCHIP. Another 2 percent had other sources of government-sponsored coverage, such as through military or veterans health care programs. Finally, 16 percent of the nonelderly population is estimated to be uninsured.[10] This chapter provides additional detail on the characteristics of private and public coverage in Idaho.

[10] This estimate is based on the CPS data for 2004-2005. The previous chapter presented 2005 BRFSS data. The uninsurance rates differ slightly between the two surveys (16 percent in CPS and 18 percent in BRFSS) because of differences in questionnaire wording, sample design, mode of survey administration, classification of the uninsured, and other factors. For example, the BRFSS estimates produced by the state consider the Indian Health Service as other public coverage. The CPS estimates produced by the U.S. Census classify those reporting on the Indian Health Service as uninsured.

Exhibit 11. Sources of Health Insurance Coverage Among Nonelderly Residents, Idaho, 2004-2005



Source: Estimates of the Urban Institute and Kaiser Commission on Medicaid and the Uninsured based on the Census Bureau's March 2005 and 2006 CPS (Annual Social and Economic Supplements). Available at: http://www.statehealthfacts.org. These estimates reflect the recent CPS correction to the survey data that reduced rates of uninsurance by .6 percentage points overall.

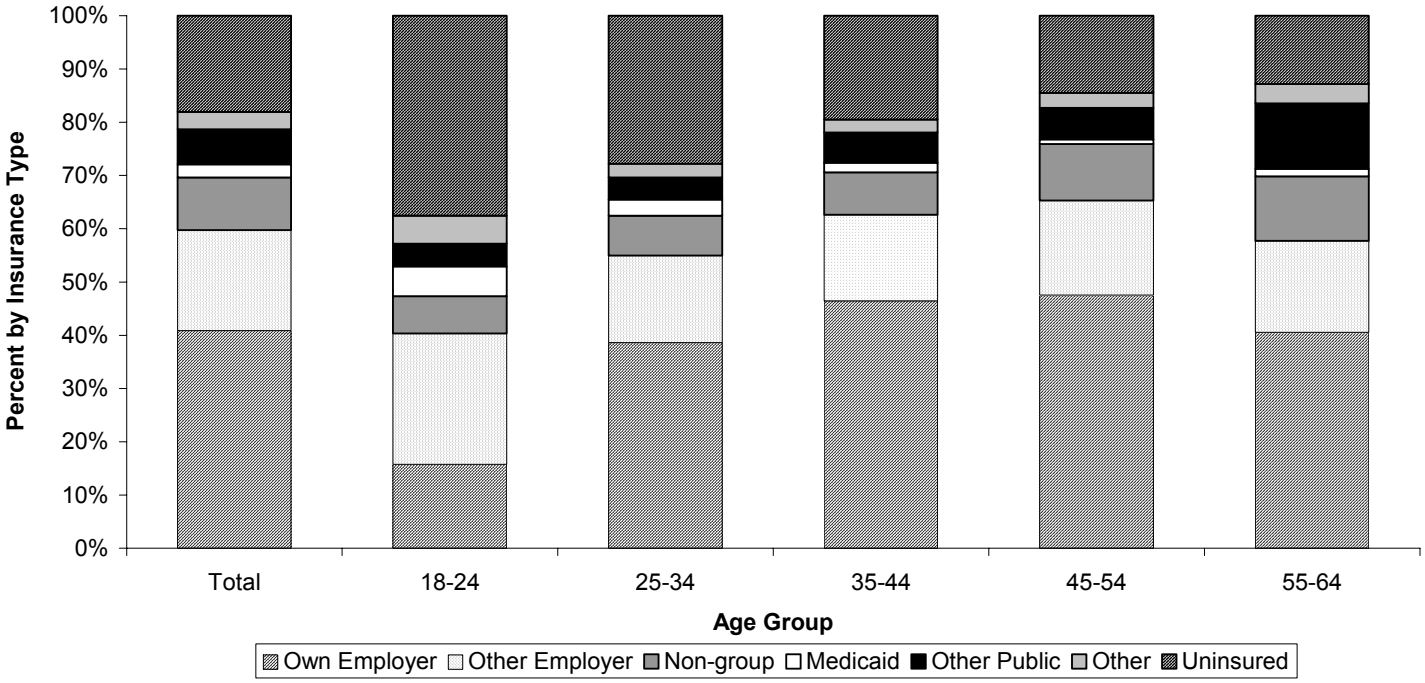
EMPLOYER-SPONSORED HEALTH INSURANCE COVERAGE

Employer-sponsored coverage is the most important source of health insurance for Idaho residents under age 65, covering an estimated 61 percent of this group (Exhibit 11). Among nonelderly adults with employer coverage in 2005, approximately two-thirds had coverage through their own employer and one-third had coverage through another employer (for example, as a dependent on a spouse's policy). Young adults (ages 18 to 24) were more likely than other age groups to obtain coverage as a dependent on someone else's employer policy (Exhibit 12).

The rate at which Idaho employers cover their own workers (40 percent) is somewhat below the U.S. average of 54 percent. In part, this may be due to the fact that Idaho has more workers in small firms (less than 50 employees) than the U.S. as a whole. About 40 percent of private sector Idaho workers are in small firms compared with 29 percent nationally. In addition, proportionately more Idaho employees work at the very smallest firms (less than 10 employees) than observed nationally. However, we also observe that rates of own-employer coverage within each firm size group are also lower in Idaho than observed nationally. Thirty percent of workers in Idaho firms with less than 50 employees have coverage from their own employer, compared with 38 percent nationally. Similarly, 23

percent of workers in Idaho firms of less than 10 employees have coverage from their own employer compared with 31 percent nationally (data not shown).

Exhibit 12. Sources of Health Insurance Coverage Among Nonelderly Adults, by Age Group, Idaho, 2005



Source: 2005 BRFSS data for Idaho, supplied by the Idaho Department of Health and Welfare.

Note: "Other Public" includes Medicare, TRICARE, CHAMPUS, and the Veteran's Administration. "Other" includes Indian Health Service. Medicaid includes Medical Assistance.

A major concern for workers, employers, and policymakers is the rapid and persistent escalation in health insurance premiums and point-of-service cost sharing. Premiums in Idaho have increased steadily between 1998 and 2004, and concurrently, the employee's share of the premium cost has also grown dramatically (Exhibit 13). The average price paid by employees for single coverage during this period increased by 142 percent compared with an average wage growth of just 20 percent. Point-of-service cost sharing (such as deductibles, coinsurance, and copayments) has also been rising—although not as rapidly as premiums. One national study estimates that cost sharing for an average family with employer-sponsored insurance has increased an average of 8 percent a year since 2001 (Milliman 2005).

Exhibit 13. Growth in Average Employee Contribution to Health Insurance Premiums vs. Average Wage, Idaho Private Sector Employees, Various Years

Year	Single Premium				Average Weekly Wage (Dollars)	Cumulative Percent Increase in Average Weekly Wage Since 1998 (Percent)
	Total Annual Premium Cost (Dollars)	Employee Share of Premium (Percent)	Annual Employee Contribution to Premium (Dollars)	Cumulative Increase in Employee Contribution to Premiums Since 1998 (Percent)		
1998	1,973	14	282	-	472	-
2001	2,703	14	376	33	528	12
2003	3,331	16	540	91	544	15
2004	3,429	20	682	142	566	20

Source: AHRQ, MEPS-IC Tables II.C.1, II.C.2, II.C.3, available online at: http://www.meps.ahrq.gov/mepsweb/data_stats/state_tables.jsp; Bureau of Labor Statistics, "Employment, Hours, and Earnings from the Current Employment Statistics survey (State and Metro Area)", available at: http://www.bls.gov/data/home.htm.

Note: Average weekly wage is reported for all private-sector employees whether insured or uninsured.

Despite the rapid increase in the cost of health insurance coverage, the proportion of Idaho workers who were eligible for and enrolled in coverage offered by their employer appears to have remained relatively stable between 1998 and 2004 (Exhibit 14). However, a small but significant decline in take-up was observed among employees in the largest firms. Participation of eligible employees declined from 88 to 78 percent between 1998 and 2004, mirroring national trends of declines in employer-sponsored coverage during the early 2000s (see, for example, Reschovsky et al. 2006). We turn now to an analysis of patterns of offers, eligibility, and take-up by type of worker in Idaho.

Exhibit 14. Percent of Private-Sector Employees Eligible for and Enrolled in Health Insurance in Firms That Offer Health Insurance, Idaho, Various Years

		Firm Size (Number of Employees)				
Year	All Sizes	Less than 10	10 to 24	25 to 99	100 to 999	1000 or more
1998	86	89	77	85	82	88
2001	79**	84	85	79	81	76*
2003	83	86	82	85	79	84
2004	81	86	85	89	82	78*

Source: MEPS IC Table II.B.2.a(1). Available online at: http://www.meps.ahrq.gov/mepsweb/data_stats/state_tables.jsp

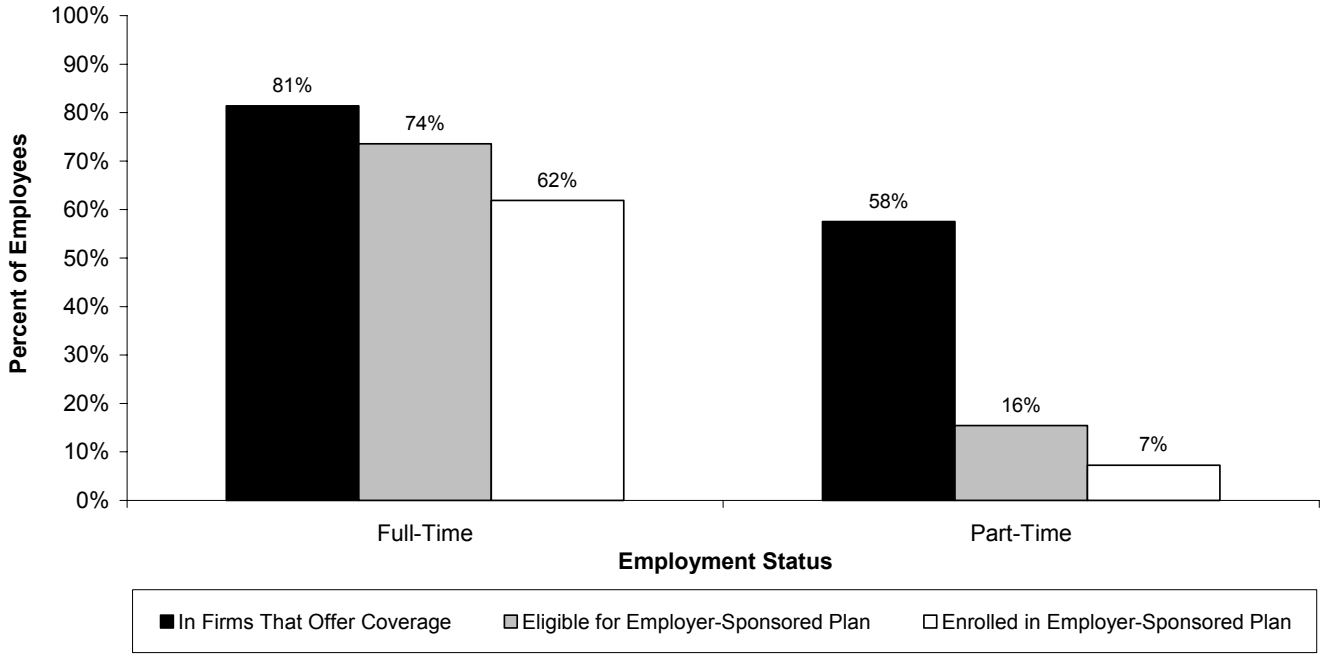
*Estimate is significantly different from the 1998 estimate with 90 percent confidence or more
**Estimate is significantly different from the 1998 estimate with 95 percent confidence or more

By Employment Status

Not surprisingly, rates of offer, eligibility, and enrollment are much higher among full-time employees compared with part-timers (Exhibit 15).[11] In 2004, 74 percent of full-time employees were eligible for health insurance at their firms. In contrast, only 16 percent of part-time employees were eligible for coverage. Among those eligible for health insurance, take-up rates were much lower among part-time employees compared with full-time workers, possibly because coverage was less affordable for part-timers, or because they were more likely to have coverage through other sources compared with full-time workers (Garrett et al. 2001).

[11] Similarly, findings from the 2005 Idaho Fringe Benefits Survey indicated that in 2004, 72 percent of all Idaho private sector employers offered coverage to at least some of their full-time workers, and 18 percent offered benefits to at least some of their part-time workers. This survey was conducted in 2004 and sampled 2,200 public and private sector firms with one or more employees. A similar survey (State of Idaho Employee Benefit Survey) was conducted in 2001 but differences in survey design make it difficult to compare survey results across years.

Exhibit 15. Percent of Full-Time and Part-Time Employees Offered, Eligible for, and Enrolled in Their Employer's Health Insurance Plan, Idaho, 2004



Source: AHRQ- MEPS IC Tables IIB3B, IIB3B1, IIB3B2, IIB4B, IIB4B1, and IIB4B2. Available online at: http://www.meps.ahrq.gov/mepsweb/data_stats/state_tables.jsp

One area of particular concern is health benefits for retirees, particularly those under age 65 who are generally not yet eligible for Medicare. Nationally, the availability of retiree health coverage has been declining, coupled with an increasing share of the costs paid for by retirees rather than their former employers (KFF/HRET 2006). As shown in Exhibit 16, 11 to 12 percent of private sector firms in Idaho offered health insurance to retirees in 2004. Trends from 1998 to 2004 suggest that the availability of such coverage has declined over time; however, the declines are not statistically significant (due in part to the small survey sample size).

Exhibit 16. Percent of Private-Sector Establishments Offering Health Insurance to Retirees, Idaho, 1998-2004

Year	Offer to Retirees Under Age 65	Offer to Retirees Age 65 and Over
1998	15	14
2001	12	11
2003	10	11
2004	12	11

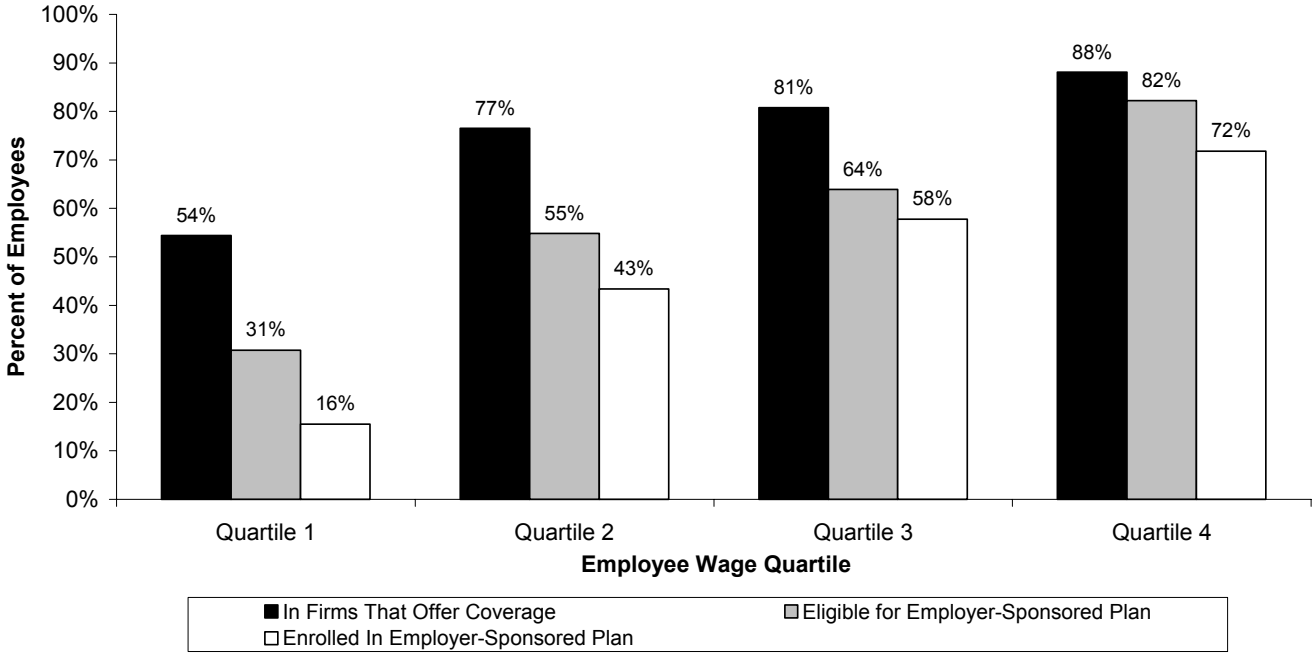
Source: MEPS IC Table II.A.2.e. Available online at: http://www.meps.ahrq.gov/mepsweb/data_stats/state_tables.jsp

Note: Differences between 1998 estimate and subsequent years' estimates are not statistically significant for either group.

By Employee Wage Level

Rates of offer, eligibility, and take-up increase as the average wage level in the firm increases (Exhibit 17). Average firm payroll was divided into four equal categories, called quartiles, to illustrate variation in patterns of coverage according to wage levels. While 72 percent of the employees in the top wage quartile were eligible and enrolled in their employer's health insurance plan in 2004, only 16 percent of workers in the lowest wage quartile were covered by their employer. The low level of take-up in the lowest wage quartile is a cumulative effect of the lower likelihood of being offered coverage, being eligible for coverage when it is offered, and taking up an offer of coverage when eligible.

Exhibit 17. Percent of Private-Sector Employees Offered, Eligible for, and Enrolled in Employer-Sponsored Coverage, by Wage Quartile, Idaho, 2004



Source: AHRQ- MEPS-IC Tables VIIIB2, VIIIB2A, and VIIIB2B. Available online at: http://www.meps.ahrq.gov/mepsweb/data_stats/state_tables.jsp

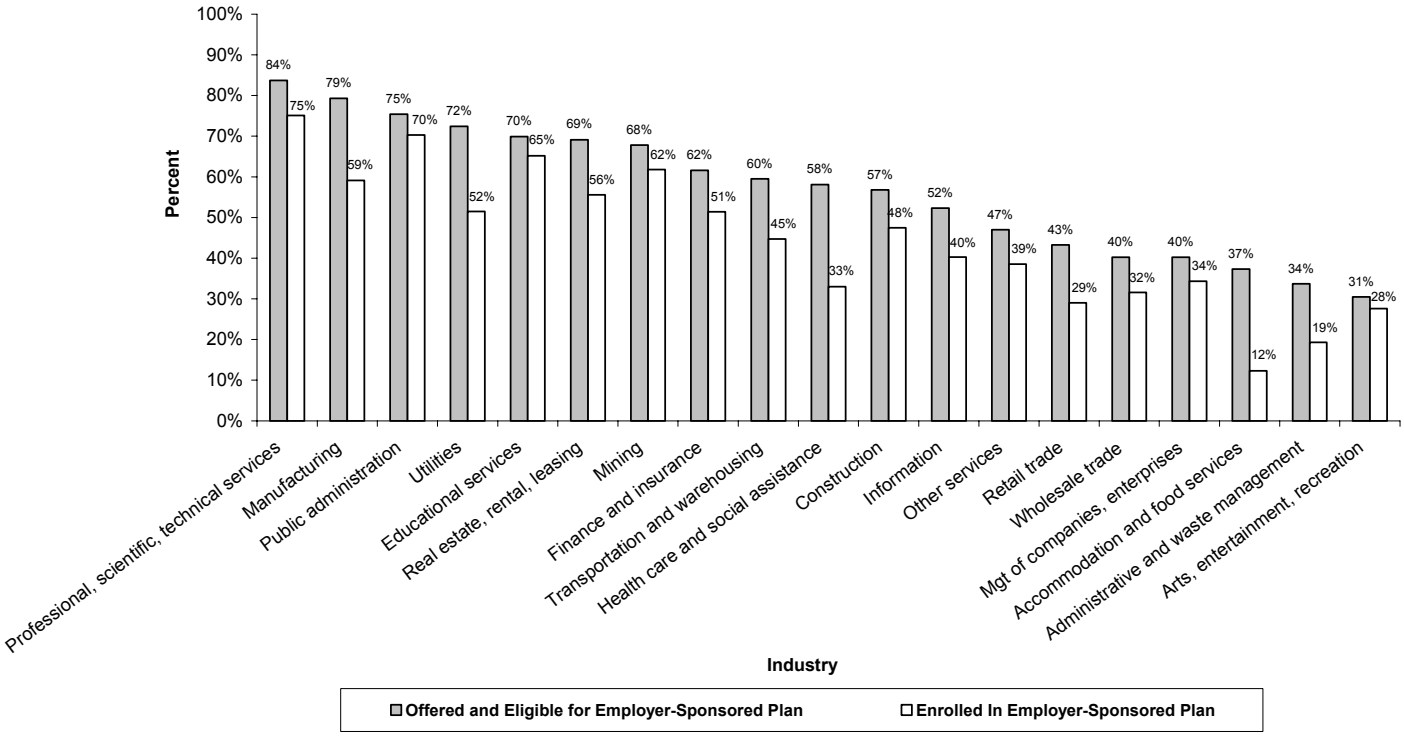
Note: Wage quartiles are based on the distribution of average wage level among Idaho private-sector establishments. Employees in the lowest wage quartiles (1 and 2) work in establishments with average wage levels that are less than the median.

By Industry

Industry differences in workforce composition by firm size, wage level, and part-time status contribute to large differences in rates of health insurance offer, eligibility, and take-up. Offer and eligibility rates range widely in Idaho, with manufacturing firms at the high end (more than 80 percent) and arts, entertainment, and recreation firms at the low end (about 30 percent) (Exhibit 18). Take-up also varies widely, with manufacturing firms having the highest participation (about 75 percent) and accommodation and food service firms having the lowest (about 12 percent).

The gap between the eligibility rate and the take-up rate is noteworthy in some industries. For example, 58 percent of employees in healthcare and social assistance firms were eligible for offered coverage, but just 33 percent were actually enrolled in their employer's plan. The gaps between offer and take-up rates likely reflect that low average wages may serve as barrier to affording premiums.

Exhibit 18. Percent of Employees Offered, Eligible for and Enrolled in Their Employer's Health Insurance, by Industry, Idaho, 2004



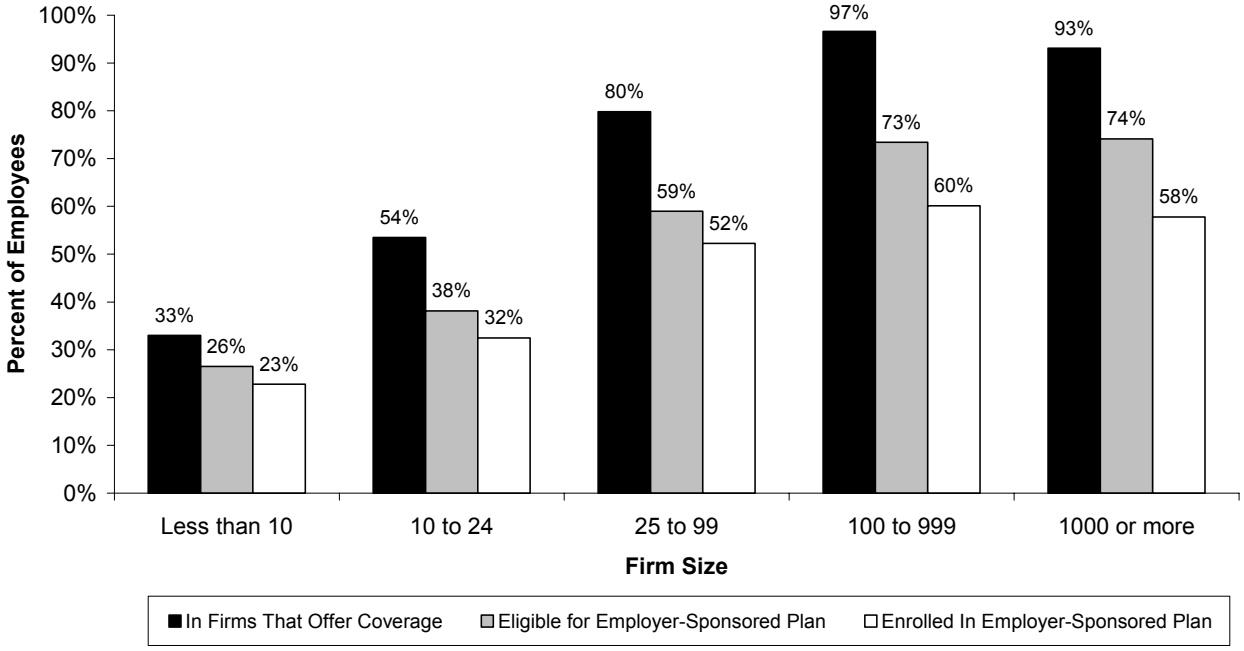
Source: 2005 Idaho Fringe Benefit Survey.

By Firm Size

Rates of health insurance offer, eligibility, and take-up vary dramatically by size of the firm. As firm size increases, so does the likelihood of an offer (Exhibit 19). In very small firms in Idaho (less than 10 employees), only 26 percent of all employees were offered and eligible for coverage in 2004. As a result of this variation in offer rates, the rate of own-employer coverage among small firm workers in Idaho is much lower than in larger firms, reaching only 23 percent for very small firms compared with 58 percent of employees in the largest firms.[12]

[12] Compared with the MEPS-IC, the Idaho Fringe Benefit Survey shows higher rates of enrollment in firms with 50 or fewer workers. A key difference is that the Idaho Fringe Benefit Survey includes public employers in its sampling frame, and these firms tend to offer coverage even at small sizes.

Exhibit 19. Percent of Private-Sector Employees Offered, Eligible for, and Enrolled in Employer-Sponsored Coverage, by Firm Size, Idaho, 2004



Source: MEPS IC Tables II.B.2, II.B.2.a, II.B.2.a(1), II.B.3.b, II.B.3.b(1), II.B.3.b(1).a, VIII.B.2, VIII.B.2.a, VIII.B.2.a(1). Available online at: http://www.meps.ahrq.gov/mepsweb/data_stats/state_tables.jsp

Nationally, cost is often identified as the greatest barrier to employers who would like to offer coverage to their workers but do not (Kaiser/HRET 2006).[13] An employer with one to nine workers, on average, pays 18 percent more for the same coverage as an employer with more than 1,000 workers; an employer with 10 to 24 workers is estimated to pay 10 percent more (Gabel et al. 2006). These higher premium costs are due to higher marketing costs to small groups, more underwriting activity per employee, and greater risk associated with very small groups.

To address barriers to coverage, Idaho has laws that limit variation in the cost of insurance premiums for small businesses. Idaho uses health status rate bands that limit the amount by which premiums can vary due to health status. Under this system, an insurance company sets an index rate for similar employers getting the same coverage (based on the composition of the workforce according to geography and age, gender, and tobacco use) and

[13] However, not all small employers believe their employees need the coverage, often because their employees have coverage elsewhere. A survey of small businesses in San Diego that did not offer coverage found that most of them had very few uninsured workers. Over 50 percent of non-offering businesses had either zero or one uninsured worker. There are very few small businesses that do not offer coverage and that have substantial numbers of uninsured workers (Kronick 2006).

can charge up to 50 percent more or 50 percent less than that rate for health status.[14] Carriers must also limit annual premium increases for small groups to 15 percent.

Idaho's Small Employer Health Reinsurance Program is another mechanism that can reduce premium volatility for small employers. Small group carriers can voluntarily reinsure any part of a small group that they cover, thereby limiting their exposure to high claims. In 2006, insurers were responsible for the first $13,000 in claims for each worker they reinsured. For the next $87,000 in claims (under the "standard" plan most commonly purchased), the insurer pays 10 percent, and the reinsurer pays the remaining 90 percent. The reinsurance coverage is funded primarily by premiums paid to the reinsurance carrier. In addition, all small group insurers can be assessed a fee if the reinsurance premiums in total fall short of actual total reinsurance expenditures. In December 2006, only 115 lives were reinsured under this program.[15] Blue Cross of Idaho and Regency BlueShield plans dominate the small group market, effectively limiting the risk spreading to a very small group of carriers.

INDIVIDUAL HEALTH COVERAGE

The only coverage option for Idaho residents who do not have access to employer-based coverage and who are ineligible for public programs is the commercial non-group insurance market. Over 100,000 residents—eight percent of the nonelderly population—purchased individual or non-group coverage in 2005 (Exhibit 11). Like many other small states, Idaho's individual health insurance market is concentrated among a few carriers. As in the small group market, the largest carriers are Blue Cross of Idaho followed by Regency BlueShield. These two carriers are estimated to insure 80 percent of all non-group lives in Idaho.

Accessing coverage in the non-group market can be expensive and difficult. The diseconomies of marketing and administering plans for small groups are exacerbated in the individual market. While estimates vary, one study estimated that administrative costs in this market may represent 40 percent of the premium (Pauly and Nichols 2002). More importantly, because non-group coverage is not subsidized by employers, each insured individual pays the full premium.

As in the small group market, Idaho health insurers can use the "case characteristics" of age, gender, geography, and tobacco use to set premiums in the individual market. For each combination of these characteristics, carriers may vary the premium by 50 percent (plus or minus) of the index rate to reflect the applicant's health status. This type of rating

[14] The Idaho Department of Insurance (DOI) has not been granted authority to investigate why health insurers are raising overall rates and to intervene in order to protect the public interest. Carriers file rates as a courtesy but face no statutory requirement to do so. Idaho does have a prior approval and oversight law that applies to managed care organizations, but DOI is not empowered to perform this function for other types of health insurers.

[15] Communication with Idaho Department of Insurance, May 11, 2007.

structure has the benefit of making coverage more affordable for the young and healthy, but it can also result in high premium quotes for older residents or those with past medical events.[16]

National data suggest that consumers respond to the higher prices in the non-group market by purchasing policies with lower actuarial values (that is, fewer benefits or higher cost sharing). One study found that the average actuarial value of non-group policies was 12 percent lower than the average employer policy (Gabel et al. 2002). For individuals whose annual health care spending was less than the median, the differences were much larger: the actuarial value of the average non-group policy was 50 percent lower than the average group policy (Gabel et al. 2002). The increasing prevalence of high deductible health plans (HDHPs)—those with deductibles of more than $1,000 for single coverage—may be contributing in a modest way to lower actuarial values. Researchers estimate that these plans still represent just three percent of the privately insured market nationally, with more than half being purchased in the non-group market (GAO 2006).

Another barrier to obtaining individual coverage—besides cost—may be pre-existing health conditions. In Idaho, insurers may decline to offer coverage at "market rates" or may exclude coverage related to a specific pre-existing health condition. And all policies may exclude coverage for up to 24 months for pre-existing conditions that emerged in the past five years, whether or not such conditions are active at the time the individual is accepted for coverage.

IDAHO'S HIGH-RISK POOL

In Idaho, if individuals are quoted a premium that exceeds that of the policies available through the state's high-risk pool, carriers are mandated to offer the applicant a choice among the five "high risk pool" policies.[17] All carriers selling in the non-group market must issue these policies and coverage must be the same, no matter which company sells the policy. Premiums for these products are set at 150 percent of the standard risk rates in the individual market. There is a 12-month waiting period for coverage of any pre-existing condition for most enrollees. As of February 2007, about 1,400 Idaho residents participated in the high-risk pool.[18]

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[16] A 2004 survey by America's Health Insurance Plans found that premiums for single coverage in Idaho averaged $2,207 —somewhat lower than premiums for other states (AHIP 2005). Absent information on the plan value, enrollee age, and health status, however, it is difficult to compare these averages across states or to other benchmarks.

[17] The term "risk pool" may be somewhat misleading. The high-risk pool does not "pool" healthy and unhealthy risks together as is commonly indicated by the term "pooling." Rather, the pool insures only individuals whose medical risks are uniformly high; the pool spreads the excess financial risk of covering otherwise uninsurable individuals among all private health insurers doing business in the state.

[18] Communication with Blue Cross of Idaho, May 8, 2007.

Compared to other states' high-risk pools, Idaho's is somewhat unique because it is paired with a reinsurance mechanism. All claims exceeding $25,000 are covered by the reinsurance pool, up to the lifetime maximums of the policies. Idaho is also unique because it has established a predetermined funding source (that is, an insurer assessment on all companies that have fully insured claims in Idaho, in addition to a "head tax" for all carriers participating in the health insurance market). Many states that have high-risk pools are subject to annual appropriation decisions.

CONTINUATION AND PORTABILITY OF PRIVATE COVERAGE

Job transitions and other life events can lead to a loss of employer-sponsored coverage. Federal laws have been enacted to reduce the disruption of health insurance coverage in selected situations. The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides continuation of coverage to employees and their dependents when they lose access to group coverage. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires guaranteed issue of individual coverage for people with prior continuous coverage in the group market. Together, COBRA and HIPAA seek to bridge gaps between the group and non-group markets as individual circumstances change.

Continuation of Coverage Through COBRA

Federal COBRA regulations require firms of 20 or more employees to offer continuation coverage to policyholders and their dependents who lose access to group coverage (including former employees, retirees, spouses and dependent children). Under this law, such plans must offer 18 months of continued coverage to qualifying policyholders and two years to dependents.[19] To qualify for COBRA benefits, former employees must have been covered by the employer's plan the day before they stopped working at the firm. The coverage is not available if the former employer discontinues health benefits to all employees, as in a company closure.

Employers are not required to contribute to this coverage but they may contribute indirectly because take-up of this benefit is more common among beneficiaries with high health care needs. As a result, the typical COBRA purchaser pays 102 percent of the group rate but incurs expenses that average 145 percent of the group rate—resulting in an indirect subsidy from other members of the group (Wolters Kluwer Law & Business 2006).

Portability of Coverage Through HIPAA

HIPAA requires that each state develop some means of guaranteeing issuance of coverage and portability to qualifying workers and their dependents. Individuals must apply

[19] In 2006, 40 states had a "mini-COBRA" law that extends COBRA-like requirements to employees in small firms (less than 20 employees). Idaho does not have such a law, except that it requires extension of health benefits up to 12 months for individuals who are pregnant or disabled (www.statehealthfacts.org).

within 63 days of prior group or COBRA coverage having lapsed. If offered, COBRA must have been taken and exhausted first.

Idaho uses its high-risk pool to fulfill the HIPAA guaranteed issue requirement. However, by federal law, the high-risk pool cannot impose pre-existing condition limitations on HIPAA applicants. While the number enrolling in the risk pool under these conditions is unknown, it is believed to be small. HIPAA applicants to the pool pay the same premiums as other enrollees.

PUBLIC COVERAGE

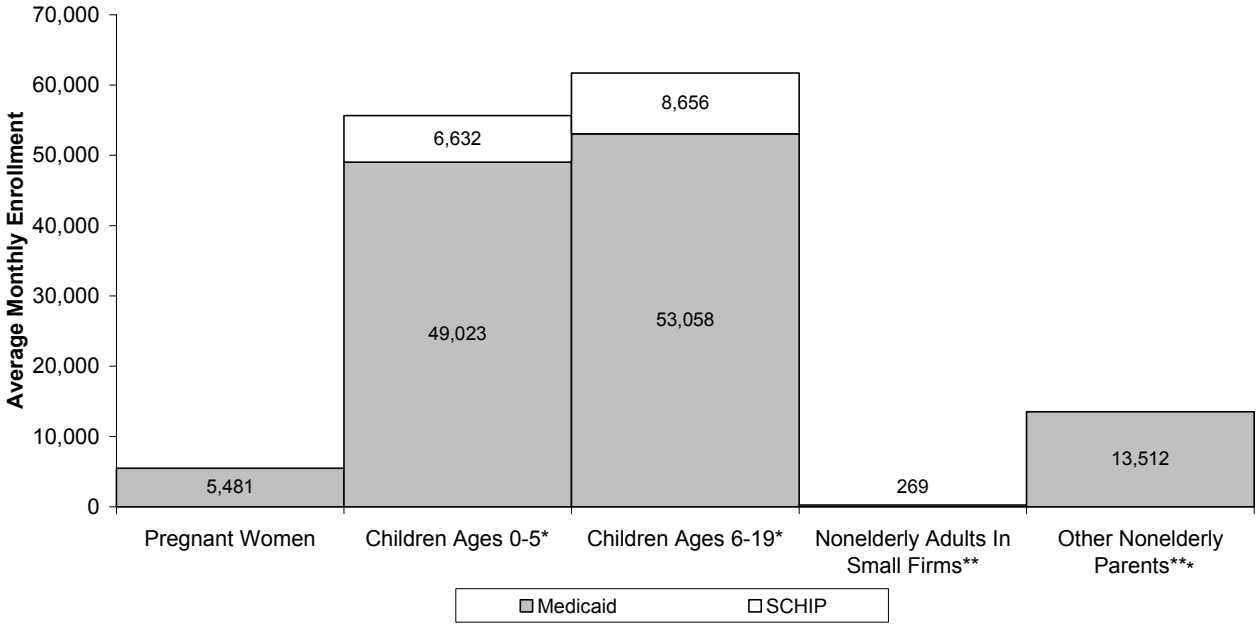
In 2006, an average of 170,200 nonelderly residents were enrolled each month in Idaho's Medicaid and SCHIP programs. Approximately 20 percent of this population is disabled, has Medicare as a primary payer (that is, they are dually eligible for Medicare and Medicaid), or in some way qualifies for the state's "enhanced" Medicaid plan.[20] The remaining 80 percent —about 137,000 residents—are the focus of this section of the report.

Children make up the bulk (86 percent) of nonelderly, non-disabled enrollees with public health insurance coverage (Exhibit 20). They are eligible for the state's programs through age 19 and at an income of up to 185 percent of the FPL (Exhibit 21). Eligibility for children at SCHIP income levels is restricted to uninsured residents. Immigrant children who have been in the country for less than five years are ineligible for both programs. Idaho has one of the most generous federal match rates in the country for its public programs, receiving 70 percent of the cost of the traditional Medicaid program and 79 percent for SCHIP.[21] Public coverage generally features low cost sharing and modest premiums (when enrollees are charged at all). In October 2006, the state began charging a premium of $10 to $15 per child per month. The state also eliminated the asset test for children, making it easier for them to qualify for coverage.

[20] The "enhanced plan" serves individuals with complex health care needs, such as the disabled, and provides all the traditional Medicaid benefits. Estimates of the population qualifying for Idaho's "enhanced" Medicaid plan may be understated because this subgroup is not easily identified in Idaho's Medicaid eligibility data system. Also, enrollees eligible for the state's Breast and Cervical Cancer program are currently intermingled with other categories (communication from the Idaho Division of Medicaid, April 4, 2007).

[21] The federal matching rate is known as the Federal Medical Assistance Percentage, or FMAP.

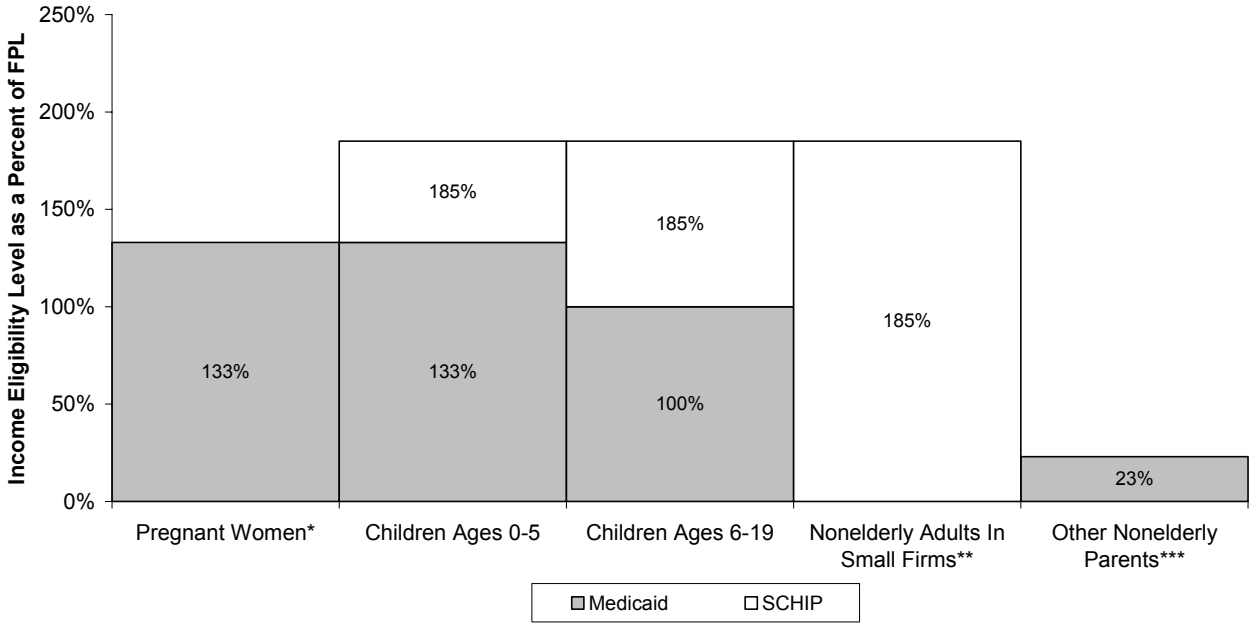
Exhibit 20. Average Monthly Enrollment of the Nonelderly in Public Coverage Options, Idaho, 2006



Source: Data supplied by the Idaho Division of Medicaid.

*Excludes 10,391 children with special needs who qualify for the enhanced plan. The age of 208 enrollees in the Access Card program is unknown. These children are apportioned to each age category using overall SCHIP enrollment.
**269 adults are enrolled in the Access to Health Insurance program.
***Excludes 23,142 nonelderly adults who are disabled or for whom Medicare is the primary payor.

Exhibit 21. Income Eligibility Levels for the Nonelderly Under Medicaid and SCHIP, Idaho, 2006



Source: Data supplied by the Idaho Division of Medicaid.

Notes: To be eligible for Medicaid or SCHIP, applicants must be U.S. natives or legal immigrants in the U.S. for more than five years. In addition, to qualify for SCHIP, applicants to must be uninsured at the time of application. FMAP is the Federal Medical Assistance Percentage and it is the federal government's share of a state's expenditures for Medicaid or SCHIP.

* Must have less than $5,000 in assets excluding home and car.
** Small employer must not have previously offered coverage and must pay 50 percent of the premium.
*** Must have less than $1,000 in assets excluding home and car.

Parents' eligibility for Medicaid in Idaho is determined by comparing family income to a fixed income threshold established in 1996. The threshold varies by family size and is currently equivalent to approximately 23 percent of the FPL. Reflecting this relatively low eligibility threshold, parents' enrollment in Medicaid is far below that of children (Exhibit 20).

Pregnant women are temporarily eligible for Medicaid at higher incomes (133 percent of FPL), although they must demonstrate that they have no more than $5,000 in assets (excluding their home and car). In 2006, approximately 5,500 pregnant women were enrolled per month in Medicaid (Exhibit 20).

Idaho has several programs that coordinate public coverage with available employer coverage.

- The *Health Insurance Premium Payment (HIPP)* program pays for private health insurance premiums, when it is deemed cost effective, for Medicaid-eligible individuals.

- The *Access Card* program gives SCHIP-eligible children the option of direct public coverage or premium assistance for private coverage.

- The *Access to Health Insurance* program for adults was introduced in 2005. The state used a Health Insurance Flexibility and Accountability (HIFA) waiver to qualify for SCHIP funding for this program. The adult program has more eligibility restrictions than the children's. For example, adults must be uninsured and work for a non-offering, small firm, and their employer must agree to contribute 50 percent or more to the premium.

Participation in all three programs is very small (Exhibit 22) although the state is actively looking at ways to increase participation.

Exhibit 22. Enrollment in Premium Assistance Options, Idaho, 2006

Program	Who is eligible?	Average 2006 Enrollment
Health Insurance Premium Payment	Medicaid-eligible adults and children when deemed cost-effective	403
Access Card	SCHIP-eligible children who are uninsured at time of application	208
Access to Health Insurance	Uninsured adults who are ineligible for Medicaid, with income under 185% FPL, and working for an eligible employer	269 (capped at 1,000 participants)

Source: Enrollment data supplied by the Idaho Division of Medicaid.

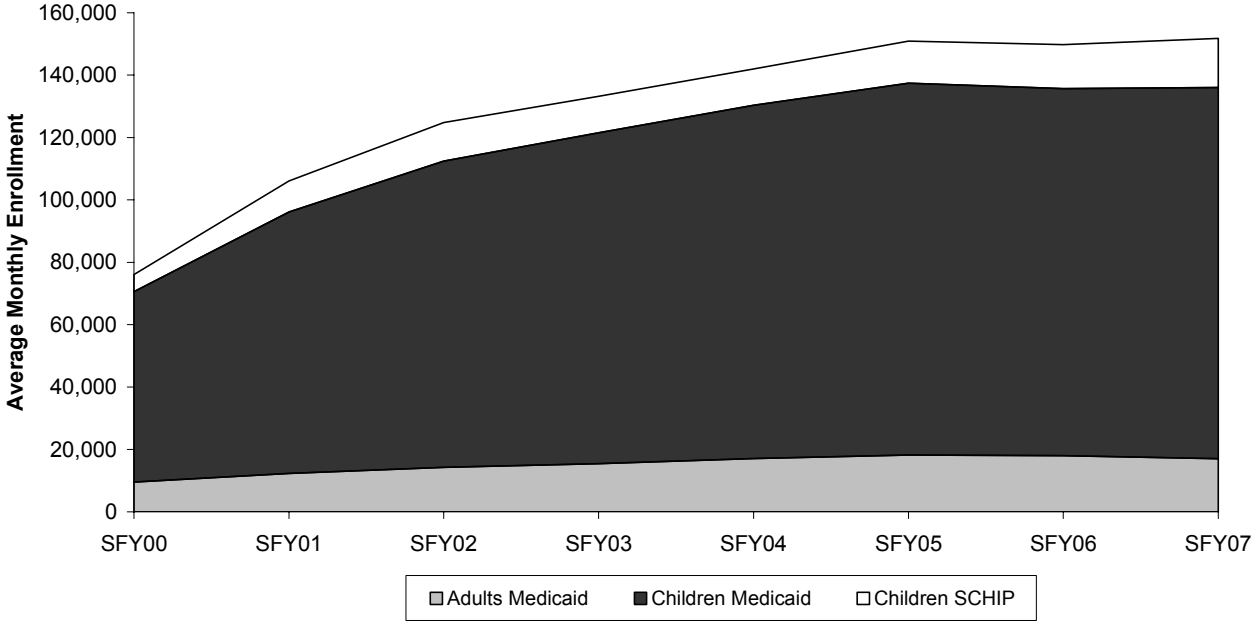
Note: The HIPP program covers several non-Medicaid-eligible lives for whom a policy was purchased in order to enroll the Medicaid eligible family member—for example, a parent who serves as the policyholder in order to cover a Medicaid eligible child.

Public Coverage Trends

Since state fiscal year (SFY) 2000, SCHIP enrollment has almost tripled, while children's and adults' Medicaid enrollment has nearly doubled (Exhibit 23). Most of this growth occurred between SFY 2000 and SFY 2005. This growth reflects, in part, two recent expansions of public coverage for children and a small expansion for adult workers. In

2004, the state increased children's SCHIP eligibility from 150 to 185 percent of the FPL.[22] The state also introduced the Access Card for children, followed by Access to Health Insurance for adults.

Exhibit 23. Public Coverage Enrollment Trends, Among the Nonelderly, Non-Disabled Population, Idaho, State Fiscal Year (SFY) 2000-2007



Source: Enrollment data supplied by the Idaho Division of Medicaid. SFY07 is estimated.

Notes: Data excludes disabled eligibles or those for whom Medicare is the primary payor.
State fiscal years are used, which differ from calendar year estimates provided in previous exhibits. Children's SCHIP includes a small amount of Access Health enrollment by adults.

In July 2006, Idaho became one of three states to implement benchmark benefits approved through the Deficit Reduction Act (DRA). The state redesigned its Medicaid benefit packages based on the age and health status of the enrolled population. Enrollees are assigned to one of three plans: basic, enhanced, or Medicare Coordinated Benefits. The "enhanced" plan serves individuals with complex health care needs, such as the elderly and disabled, and provides all the traditional Medicaid benefits. The "basic" plan serves healthy children and adults and covers most traditional Medicaid benefits, with the exception of long-term care, organ transplants, and intensive mental health treatment. The "coordinated" plan is designed for Idaho residents who are dually eligible for Medicare and Medicaid and coordinates benefits between the two programs. All three plans contain new preventive and nutrition services. As part of this package of reforms, the state also introduced premiums of

[22] This expansion was implemented as a separate SCHIP program, whereas the original SCHIP program was implemented as a Medicaid expansion.

$10 to $15 per child per month for enrollees with family incomes of 150 percent or more of FPL. In 2006, Idaho also eliminated the asset test for children, making it easier for them to qualify for coverage.

Not all low-income residents are eligible for these programs. Except for the small Access Health program, nonelderly, non-disabled childless adults are ineligible for public coverage in Idaho.[23] Likewise, federal Medicaid eligibility rules make it difficult for recent immigrants to qualify. Legal permanent residents (those with green cards) are ineligible for federal Medicaid or SCHIP match during their first five years in the U.S. After that, legal immigrants become eligible for Medicaid and SCHIP if they meet the programs' other eligibility requirements.[24] Undocumented immigrants and those in the U.S. on a temporary basis (such as with a temporary work visa or student visa) are generally ineligible for Medicaid and SCHIP.

[23] About a dozen states have applied for and received federal Medicaid Section 1115 demonstration or HIFA waivers to cover non-elderly, non-disabled childless adults with incomes below or even somewhat above the FPL.

[24] In addition, all pregnant women can receive a temporary medical card for prenatal care, labor, and delivery. Everyone, regardless of immigration status, is eligible for Medicaid coverage for emergency care. In 2004, 22 states and the District of Columbia used state funds to provide coverage to some immigrants who were ineligible for Medicaid and SCHIP (KFF 2004).

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CHAPTER IV

THE RELATIONSHIP BETWEEN COVERAGE AND ACCESS TO HEALTH CARE

The policy focus on expanding coverage to the uninsured is motivated by extensive evidence that the lack of insurance coverage—coupled with high prices for medical services and low incomes—can pose financial barriers for Idaho residents needing to obtain health care. Reports by the Institute of Medicine (2002) and others have documented the health and utilization impact associated with being uninsured. Compared to the insured population, the uninsured are three times more likely to report skipping a recommended medical test or treatment, two and one-half times more likely to report failing to fill a prescription, five times more likely to report postponing needed medical care, and six times more likely to report they did not receive care for a serious condition (KFF 2003). Uninsured individuals are also significantly less likely than those with insurance to receive diagnostic testing for treatable conditions, and are at higher-risk for complications and early death (IOM 2002). A recent report shows that this lower level of care among the uninsured occurs at every income level (Ross 2006).

COVERAGE AND ACCESS IN IDAHO

Idaho residents who are uninsured are more likely than those who are insured to avoid going to the doctor because of concerns about cost, regardless of their income level. Overall, 17 percent of nonelderly adults in Idaho avoided going to the doctor because of cost in 2005; however, uninsured adults (36 percent) were three times more likely than insured adults (11 percent) to avoid going to the doctor due to cost (Exhibit 24). These differences persist at all income levels.

Additionally, low income is associated with financial barriers to care even when individuals are insured. An insured adult in the lowest income group is as likely to avoid going to the doctor due to cost as an uninsured adult in the highest income group (26 percent). Adults who face both barriers—low income and a lack of insurance—are the most likely to avoid going to the doctor due to cost (42 percent). Not only do the uninsured bear the full cost of health care services, they more often pay undiscounted prices (being ineligible for the negotiated discounts achieved by large commercial insurers, Medicaid, or Medicare programs).

One-half of Idaho's uninsured adults report they do not have a personal health care provider compared to one-fourth of insured adults (Idaho Department of Health and Welfare 2006). The absence of a "medical home," or a reliable entry point where individuals can seek and obtain a continuum of health care services, is believed to be one of the greatest barriers to receiving adequate and timely care (Williams 2002; Ettner 1996).

Exhibit 24. Nonelderly Adults Who Avoided Going to the Doctor Because of Cost, Idaho, 2005

	Adults Who Avoided Going to the Doctor Due to Cost					
	With a Health Plan		Without a Health Plan		Total	
Family Income (Dollars)	Percent	(95% CI)	Percent	(95% CI)	Percent	(95% CI)
Total	**11**	**(10.0 - 12.8)**	**36**	**(31.0 - 40.0)**	**17**	**(15.3 - 18.2)**
Less than 15,000	26	(17.7 - 34.3)	42	(31.3 - 51.9)	34	(27.4 - 40.3)
15,000-24,999	23	(17.6 - 28.4)	40	(31.9 - 48.9)	31	(26.0 - 35.4)
25,000-34,999	17	(12.6 - 21.2)	36	(23.5 - 47.9)	23	(18.4 - 27.9)
35,000-49,999	14	(10.5 - 17.5)	34	(21.6 - 46.6)	17	(13.3 - 20.5)
50,000 or more	4	(2.9 - 5.3)	26	(14.2 - 38.2)	5	(3.9 - 6.5)

Source: 2005 BRFSS data for Idaho, supplied by the Idaho Department of Health and Welfare.

Note: The upper and lower bounds next to the estimates indicate the range over which we are 95 percent confident in the indicated statistic.

SAFETY NET SERVICES IN IDAHO

Depending on the area in which they live, the uninsured may have access to health care services at free or reduced-fee clinics. In 2005, the 10 community health centers in Idaho (which had 51 service delivery sites) served about 90,000 people. About one-half of their patients (about 44,000 people) were uninsured (NACHC 2006). Examined another way, these centers serve about 18 percent of the uninsured population in the state. Some uninsured residents are also served by the 44 rural health centers and 26 critical access hospitals in the state.

Despite the existing safety-net resources in Idaho, accessing safety-net services can be difficult. Several parts of the state lack community health centers (CHCs) (such as Idaho County) and existing centers are constrained in their ability to provide services. For example, Terry Reilly Center, the largest CHC in the state, reports that it has appointment wait times of five to six weeks for new patients.[25] Family Health Services in south central Idaho reports that it turns away 25 to 30 obstetrical patients every month due to a shortage of obstetricians

[25] Communication with Terry Reilly Center, February 12, 2007 and May 5, 2007.

and lack of physical capacity. Family Health Services also has waiting lists for dental, behavioral health, and medical services in selected locations.[26]

UNDERINSURANCE AND MEDICAL DEBT

Even with the availability of safety-net services, many uninsured continue to have high levels of debt. A national survey of uninsured people receiving care at safety-net hospitals and health clinics found that nearly one-half, 46 percent, reported having unpaid bills or being in debt to the facility where they received care (Andrulis et al. 2003).

High medical debt is not just a problem for the uninsured, but also for the underinsured. Being underinsured refers to having health care coverage but still being exposed to significant financial risk. Nationally, an estimated 12 percent of privately insured adults were underinsured in 2003 (Schoen et al. 2005).[27] The utilization patterns by the underinsured population closely resemble those of the uninsured population in their nature and prevalence. Nationally, underinsured adults report foregone care at rates two to four times higher than those reported by adults with more protective insurance (Schoen et al. 2005). When they cannot forego care, the underinsured often accumulate unmanageable levels of medical debt. Nationally, 70 percent of all adults with medical bills or debt problems in 2003 said they or a family member were insured at the time the debt was incurred (Doty et al. 2005).

Many are concerned that the prevalence of underinsurance may have increased over the past several years as individuals and employers have responded to rising premiums by purchasing insurance plans that offer less comprehensive coverage—a practice known as "buying down" the benefit. We found no source of data on the prevalence of underinsurance in Idaho. However, if the same proportion of the Idaho population is underinsured as nationally, we estimate that about 106,000 Idaho nonelderly residents may be underinsured in 2007. To address the problem of high medical debt, Idaho offers loans through the state's Catastrophic Health Care Cost program (also known as the Medically Indigent Health Care program). People who have incurred medical bills that would take more than five years to pay back can apply for a loan.

[26] Communication with Family Health Services, February 12, 2007 and April 30, 2007.

[27] There is no standard definition of underinsured. The approach used by Schoen et al. (2005) defines a person as underinsured if he or she was insured all year but reported at least one of three indicators: (1) out-of-pocket medical expenses amounting to 10 percent of income or more; (2) they were among low-income adults (below 200 percent of the federal poverty level) and their medical expenses amounted to at least five percent of income; and (3) their health plan deductible equaled or exceeded five percent of income (Schoen et. al. 2005).

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CHAPTER V

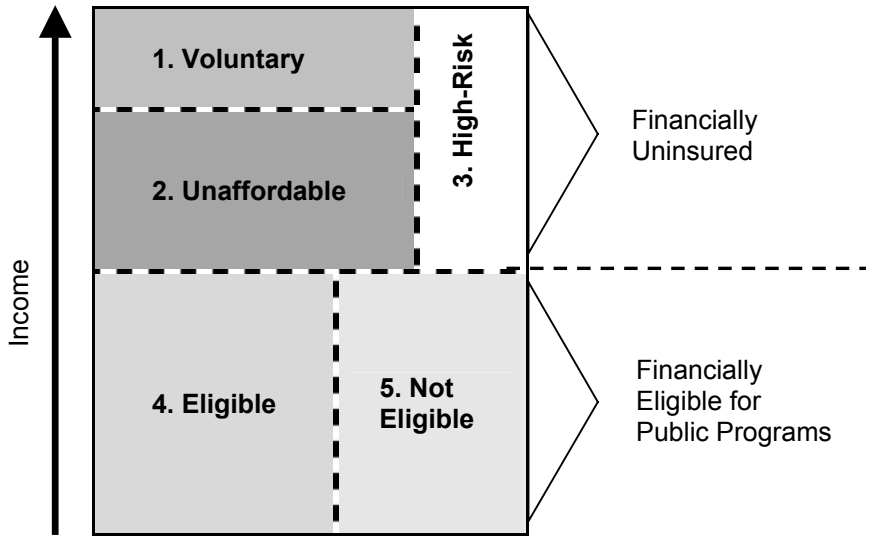
POPULATION SUBGROUPS OF PARTICULAR POLICY INTEREST

The preceding chapters have profiled individuals with and without health insurance coverage, the reasons for a lack of coverage, and the implications of not having coverage for access and utilization. This chapter probes a bit further and highlights the characteristics of the subgroups that are sometimes targeted by state coverage initiatives.

Important subgroups of uninsured can be thought of as belonging to one of five groups, each suggesting a different policy approach. Exhibit 25 illustrates these discrete groups of uninsured (American Academy of Actuaries 2005). Groups 1, 2, and 3 are ineligible for public programs due to their income level and they are considered "financially uninsured." They may be uninsured voluntarily because they choose not to purchase health insurance coverage (group 1); uninsured because they cannot afford to purchase coverage (group 2); or uninsured because they are not eligible for group coverage and nongroup coverage is either not affordable or not available due to their high-risk status (group 3).

Groups 4 and 5 are low income and financially eligible for but not enrolled in public programs. Group 4 is eligible but not enrolled, perhaps because they are unaware of the eligibility criteria, they experience barriers to applying (such as a face-to-face interview), or they do not perceive they (or their family members) need coverage. Group 5 is not eligible for coverage, even though they fall within the income eligibility threshold; among the non-financial reasons for ineligibility are assets that exceed the limits, citizenship or residency status, or age (as in the case of SCHIP or Medicaid, where children age out when they reach age 20).

Exhibit 25. Illustration of Major Categories of Uninsured



Source: Adapted from American Academy of Actuaries, December 2005 Issue Brief.

In response to the diversity within the uninsured population, states and communities around the country have implemented a variety of approaches to increase access to health care coverage and services.[28] The target groups of these initiatives are often small sub-groups of the uninsured population—making estimation difficult. In this final chapter, we briefly discuss five illustrative subgroups: (1) individuals who are eligible for but not enrolled in public programs; (2) workers who are not eligible for an offer of coverage from their employer; (3) workers who decline an employer's offer of coverage; (4) workers in fully insured plans; and (5) sole proprietors.[29] The estimates presented in this chapter rely on the methods described in Appendix A. The estimates are forecast to 2008, using workforce projections from the Idaho Department of Commerce and Labor.

INDIVIDUALS WHO ARE ELIGIBLE FOR BUT NOT ENROLLED IN PUBLIC PROGRAMS

While difficult to estimate, the take-up rate of Medicaid and SCHIP coverage among eligible uninsured children is generally believed to be around 50 to 70 percent nationally (Remler 2003). Some states have explored a variety of means to increase the penetration rate (such as expanding outreach or simplifying the application and/or renewal procedures). Using the procedures described in Appendix A, we estimate that the majority of eligible children below 133 percent of FPL appear to be enrolled in Medicaid, but a far lower proportion of the eligible population is enrolled in SCHIP. Specifically, we estimate that

[28] For additional information on the approaches used in other states, please see our companion report, *Options for Expanding Access to Health Care for the Uninsured.*

[29] These selected subgroups are not intended to be representative of all the subgroups that the state might want to consider targeting in its future health coverage initiatives.

about two-thirds of the children who are between 133 and 185 percent of FPL may be eligible for but not enrolled in SCHIP (Exhibit 26). Moreover, we estimate that if SCHIP eligibility were extended to children ages 0 to 19 with incomes between 185 and 200 percent of FPL, another 4,000 uninsured children might become newly eligible for coverage.

Exhibit 26. Estimated Number of Children Who Are Eligible for but not Enrolled in Medicaid or SCHIP, Idaho, 2008 Projections

	Enrolled Children			
Family Income (Percent of FPL)	Total Children	Eligible Children	Total	Percent of All Eligibles
Total	**289,000**	**170,000**	**127,812**	**75**
0-132	156,000	142,000	119,417	84
133-185	97,000	28,000	8,395	30
185-200	36,000	4,000*	n.a.	n.a.

Sources and Notes: "Enrolled Children" are 2007 estimates from Idaho Department of Health and Welfare. They include children assigned to the enhanced plan. "Eligible" estimates were imputed using the procedures described in Appendix A. The estimates use 2008 population projections from Census. Because of SCHIP eligibility criteria, we assume that children ages 6 to19 with incomes over 100 percent of FPL must be uninsured to participate and children ages 0 to 5 with incomes over 133 percent of FPL must be uninsured to participate. Our eligible estimates do not exclude the small number of children ineligible for coverage because they are recent immigrants. Children already enrolled in SCHIP are included in eligible estimates. Children with family incomes above 185 percent of FPL are not currently eligible for either Medicaid or SCHIP.

n.a. = not applicable

*SCHIP currently covers children up to 185 percent of poverty. This number is an estimate of how many children would be newly eligible for SCHIP if the income threshold were raised to 200 percent of the FPL.

WORKERS WHO ARE NOT ELIGIBLE FOR AN OFFER OF COVERAGE FROM THEIR EMPLOYER

Most workers who are uninsured work for an employer that does not offer coverage (Garrett et al. 2001; Collins et al. 2005). In 2008, we estimate that 128,000 private sector workers in Idaho will work for an employer that does not offer any type of health insurance coverage. About one-third of these employees, however, will have coverage through a spouse or another source (Exhibit 27). Among workers without an offer of coverage, 66 percent are estimated to be uninsured, the majority of whom are below 200 percent of poverty.

Exhibit 27. Estimated Number of Workers Without an Offer of Coverage from Their Employer, Idaho, 2008 Projections

Family Income (Percent of FPL)	Total	Workers Without an Offer of Coverage from Their Employer: Insured Through a Spouse or Other Source	Workers Without an Offer of Coverage from Their Employer: Uninsured
Total	**128,000**	**43,000**	**85,000**
0-199	74,000	21,000	53,000
200-399	38,000	16,000	22,000
400 or higher	16,000	6,000	10,000

Source: Estimates of the number of workers are based on the methodology described in Appendix A and national estimates of the relationship between offer and coverage (Collins et al. 2005; Garrett et al. 2001).

Targeting coverage expansions toward workers in non-offering firms can be very difficult. Employers that do not offer coverage typically have sound business reasons for doing so. Furthermore, it can be difficult to target coverage programs to just low-income workers in non-offering firms because they typically have workforces representing a range of family incomes. Firms also generally have a preference for treating all employees equally.[30] Similarly, it can be difficult to target coverage programs to only uninsured workers in non-offering firms because such firms typically have very few uninsured employees (Kronick 2006).

Nationally, about 20 percent of uninsured workers are employed in firms that offer health insurance coverage but the worker is ineligible for the coverage (Garrett et al. 2001). These workers are typically satisfying a waiting period for coverage after they are hired, or they work in job categories (part-time, temporary, or seasonal) that are permanently ineligible.[31] Programs to expand access to employer-based coverage rarely target these workers.

WORKERS WHO DECLINE THEIR EMPLOYER'S OFFER OF COVERAGE

Approximately 20 percent of uninsured workers nationally decline an offer of coverage for which they are eligible—typically because the premium is too high (Garrett et al. 2001; Collins et al. 2005). These workers can be found in firms of all sizes. Programs that target these workers often offer premium subsidies to lower the cost of the employee's share of the

[30] For ease of program administration, some coverage programs that target non-offering firms may use the average wage level of the firm to determine program eligibility instead of employee income.

[31] Nationally, 43 percent of ineligible workers cite insufficient time on the job as the reason for being ineligible (Garrett 2001). This suggests that some workers may lack coverage for only short periods. Another 37 percent report that they do not work sufficient hours or weeks in the year to qualify for coverage. The remaining ineligible workers (20 percent) cite various other reasons for ineligibility.

premium. For reasons of equity, many premium subsidy programs do not restrict eligibility to the uninsured portion of the workforce. As shown in Exhibit 28, however, if Idaho were to make subsidies available to both insured and uninsured workers, the program would reach many who already have coverage. Nevertheless, such programs may address other important policy goals such as providing overall support of the employer-based health insurance system or offering relief to low-income workers who are struggling with their premium payments.

WORKERS IN FULLY INSURED PLANS

Coverage expansion approaches that target coverage offered by commercial carriers (for example, the recently passed Idaho law expanding the definition of the age of dependency) typically affect the portion of the privately insured population that is fully insured.[32] Idaho commercial carriers bear all the risk in coverage arrangements whereas larger employers might self-insure their employees' coverage, taking on all the risk below a specified stop-loss amount. About 70 percent of policyholders with group coverage are in fully insured plans (Exhibit 29). As the exhibit shows, enrolled workers in smaller firms are disproportionately likely to be in fully insured plans, while larger firms are more likely to self insure their employees' coverage.

If we assume that dependents with group coverage are covered by fully-insured plans at the same rate as policy holders and incorporate the fact that all individual (or non-group) policies are fully insured, then approximately 448,000 residents, or 74 percent of the privately insured population, would be affected by policies that target the coverage insured by commercial carriers.

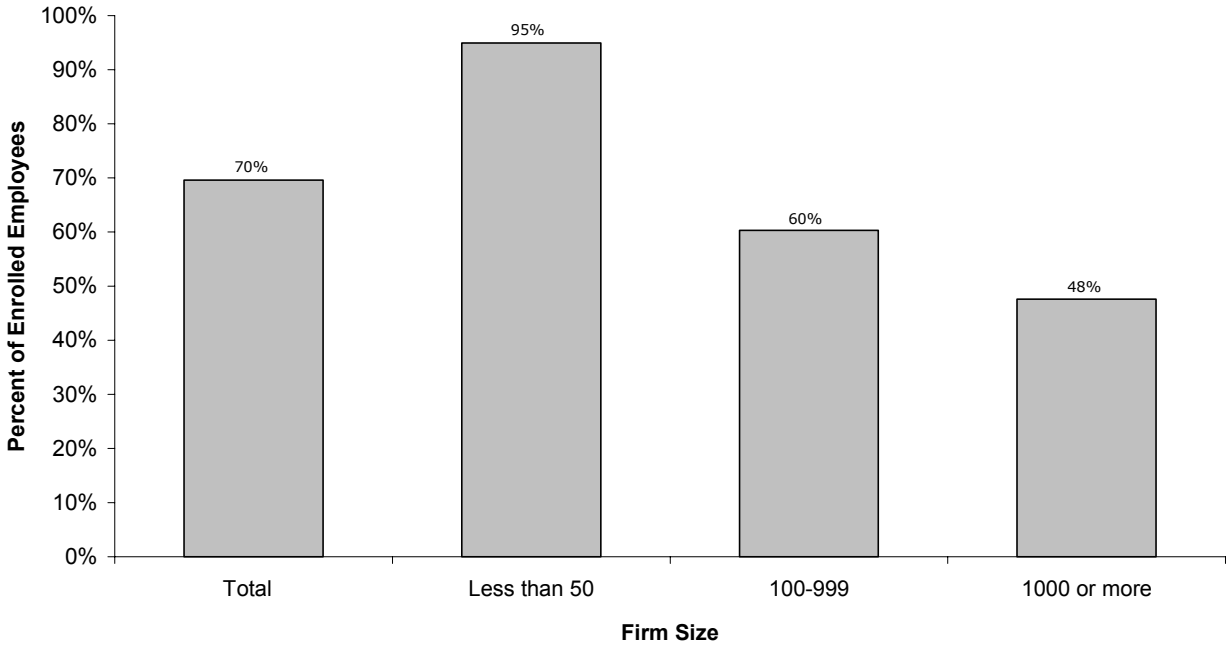
[32] Coverage financing mechanisms, such as a premium tax also target this population. Idaho pairs its current premium assessment with a "head tax" designed to generate revenue from self-insured plans subject to the state regulation (generally multiple employer self-funded plans). This tax is set at 4 cents per enrollee per month.

Exhibit 28. Estimated Number of Workers Who Accept/Decline An Offer Of Coverage From Their Employer, Idaho, 2008 Projections

Family Income (Percent of FPL)	Total	Workers Who Accepted an Offer of Coverage for Which They Were Eligible	Workers Who Declined an Offer of Coverage for Which They Were Eligible	
			Insured Elsewhere	Uninsured
Total	**483,000**	**299,000**	**158,000**	**26,000**
0-199	111,000	47,000	48,000	16,000
200-399	187,000	123,000	58,000	6,000
400 or higher	185,000	129,000	52,000	4,000

Source: Estimates of the number of workers are based on the methodology described in Appendix A and national estimates of the relationship between offer and coverage (Collins et al. 2005; Garrett et al. 2001).

Exhibit 29. Percent of Enrolled Private-Sector Employees in Fully Insured Plans, by Firm Size, Idaho, 2004



Source: Tables II.B.2.b and II.B.2.b.1. Available online at: http://www.meps.ahrq.gov/mepsweb/data_stats/state_tables.jsp

Note: Firm size 50-99 was not available due to small sample sizes.

SOLE PROPRIETORS

In Idaho, the definition of "small group" for coverage purposes does not include groups of one, also known as self-employed with no employees, or sole proprietors. If sole proprietors are unable to access coverage through a spouse, former employer, or public

program, they must purchase health insurance in the non-group market. An estimated 13 percent of the state's uninsured adults are self-employed.[33]

Whether to include sole proprietors without employees in a program to expand coverage for workers is a key question for policymakers. It is generally assumed that sole proprietors make the program more vulnerable to adverse selection.[34] However, adverse selection into new coverage options may be mitigated if there is a premium subsidy large enough to encourage relatively healthy individuals to buy coverage. Rates of uninsurance are high for this group—on average 25 percent were uninsured—and they tend to enroll in disproportionate numbers when allowed to participate in coverage expansions (Taylor and Forland 2003).

CONCLUDING REMARKS

This chapter has provided background information on health care coverage and uninsurance in Idaho. These data are subject to the caveat that estimates for Idaho are based on small sample sizes and, therefore, may be imprecise. Nevertheless, information on the number of uninsured in various subgroups suggests the potential for various options to expand coverage, while noting the potential for unintended consequences, such as adverse selection or cost shifting, which could occur under some options.

A companion report presents an overview of coverage options in other states to inform the discussion in Idaho. As the Idaho Health Care Task Force considers options for expanding access to health insurance coverage, the evidence in this report can provide insight into the magnitude of Idaho's uninsured population potentially served by various options. To improve the precision of estimates for Idaho—and establish a more accurate baseline for evaluating the impact of future health care reform efforts—we recommend that the state conduct a Health Insurance Survey with sample sizes that are large enough to produce robust estimates for populations of policy interest.

[33] Nationally, about 34 percent of the uninsured self-employed have employees and hence are not limited by the state's rules governing groups of one (Taylor and Forland 2003).

[34] Adverse selection into a pool occurs when the pool attracts relatively unhealthy (and high cost) risks instead of an "average" selection of risks. When faced with a high premium, individuals and sole-proprietors may choose to enroll in coverage only when they are relatively certain they will use sufficient services to justify the premium cost, thus contributing to adverse selection.

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APPENDIX A

OVERVIEW OF METHODOLOGY USED TO DERIVE SYNTHETIC ESTIMATES OF INSURANCE COVERAGE FOR SELECTED POPULATION SUBGROUPS

As discussed in Chapter I, existing Idaho-specific data sources typically have small sample sizes, limiting the types of analyses that can be performed for population subgroups of interest to policymakers. There is no one data source that contains all the information necessary to produce insurance coverage estimates for population subgroups within Idaho. (This data limitation is not only a concern for Idaho, but also applies to all but the largest states.) To address this data limitation, we developed synthetic estimates using multiple data sources that are calibrated to represent the characteristics of the Idaho population. This appendix provides an overview of our approach.

We identified data sources required to make the synthetic estimates of insurance coverage for population subgroups of interest to policy makers. The 2000 Census Bureau's Public Use Microdata Set (PUMS) contains observations for five percent of the Idaho population and provides extremely robust information on demographic dimensions of interest including family income, age group, family type (married/not married; parent/childless), employment status, and immigration status.[1] These data do not, however, contain information on health insurance status or firm size.

We obtained data on health insurance status and firm size from the March Supplement of the Current Population Survey (CPS). The March CPS is the most commonly cited source for estimates of individuals without health insurance coverage.[2] Based on a large nationally representative monthly sample of approximately 57,000 households, the CPS has

[1] The Idaho sample in the PUMS data contains 64,389 observations, as compared to the CPS, which contains just 2,605 observations for Idaho in 2005. The BRFSS data contains approximately 4,000 observations for Idaho adults.

[2] For example, the Census Bureau, the Congressional Budget Office, and the U.S. General Accounting Office use the CPS for estimates of those without health insurance.

been collecting data on health insurance status since 1980. Although the CPS sample is representative of each of the 50 states and the District of Columbia, for most states (including Idaho), the sample is too small for precise insurance coverage estimates typically desired by policy makers.[3]

The next step was to create population counts from PUMS and insurance coverage probabilities from CPS and then calibrate the resulting estimates according to population controls from Idaho-specific data sources. We created a matrix containing population estimates for each of the detailed demographic factors identified above (family income, age group, family type, employment status, immigration status), and then we applied probabilities derived from the national 2005 CPS to add information on health coverage and firm size to the PUMS data. The synthetic estimates were then calibrated to Idaho's population (from U.S. Census) and workforce projections (from Idaho Department of Commerce and Labor) for 2008. We also calibrated the population estimated to have Medicaid or SCHIP coverage to enrollment information from the Idaho Division of Medicaid.[4]

Some data, such as the prevalence of an employer offer of coverage by income level, is not available on the PUMS data or the CPS data. In these cases, national research estimates were applied to the synthetic data by income group.

Although these synthetic estimates add an important dimension to our understanding of the uninsured in Idaho, the caveats associated with this analysis should be recognized. Because the estimates required blending data from multiple data sources, they inherently are subject to error, and the magnitude of the error is unknown. Unfortunately, estimates produced using this method do not directly generate standard errors and, therefore, confidence intervals cannot be calculated. Thus, the synthetic estimates provided for uninsured subgroups in Chapter V should be viewed as approximations. While these estimates can be used to guide policy discussions about coverage options, especially assessments of the "relative" magnitude of uninsurance in a given population, they should not be viewed as precise point estimates.

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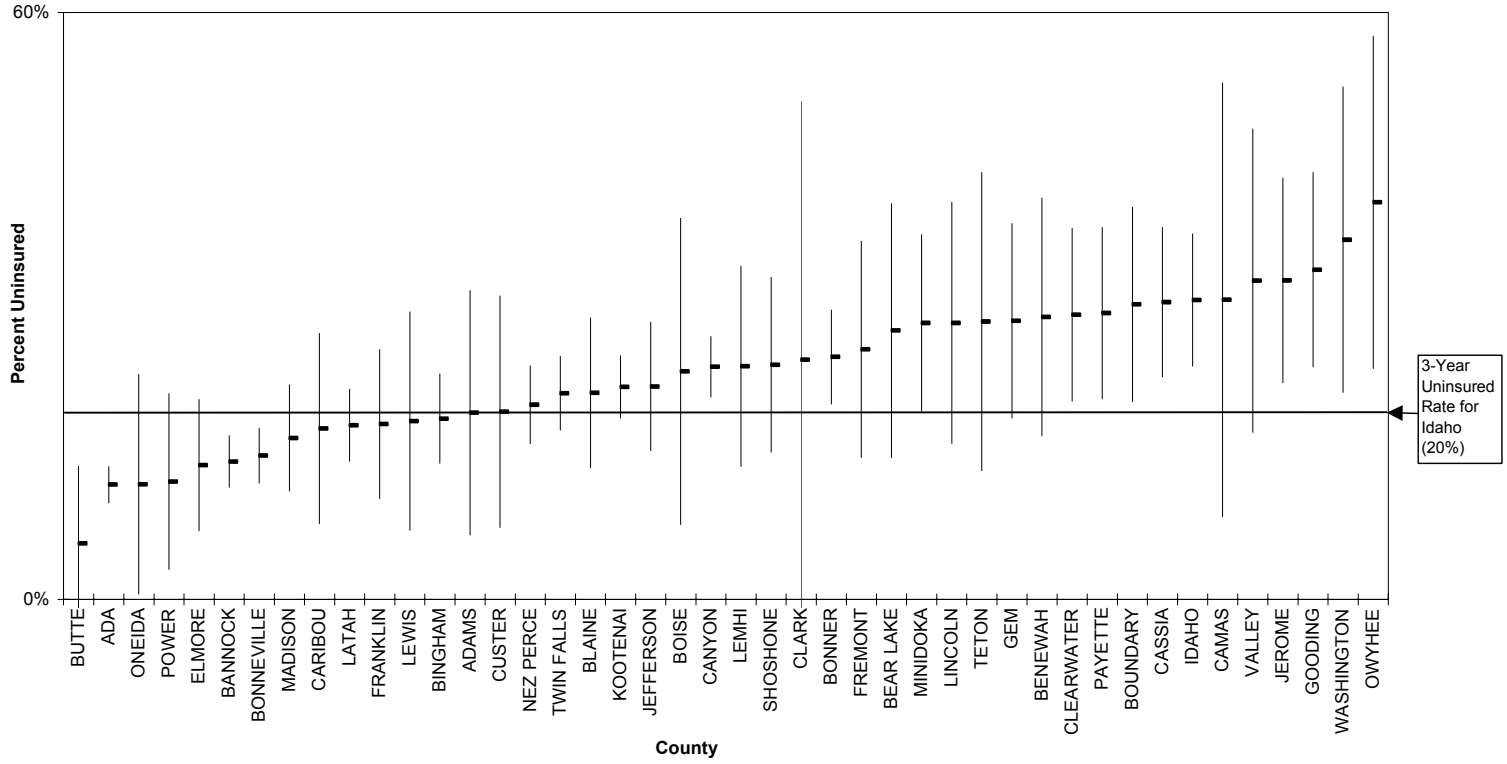
[3] Despite its widespread use for producing estimates of health insurance coverage, researchers and policymakers have acknowledged two caveats. First, although the CPS is designed to measure the number of people who lack health coverage for a whole year, it is believed to more closely approximate the number of people who are uninsured at a specific point in time during the year (Swartz 1986). Second, the CPS is believed to understate the number of people with Medicaid coverage (known as the Medicaid undercount) by about 35 percent, although validation studies are continuing to explore the magnitude and source of the Medicaid undercount. In contrast to many other surveys, the CPS logically imputes Medicaid to children under age 21 in families where either the householder or spouse reports being covered by Medicaid. In addition, all adult Aid to Families with Dependent Children (AFDC) recipients and their children, and Supplemental Security Income (SSI) recipients living in states that legally require Medicaid coverage of all SSI recipients are also assigned Medicaid coverage.

[4] Interestingly, these estimates were very close in Idaho, and we did not find evidence of a "Medicaid undercount" that is often observed in CPS.

APPENDIX B

PERCENT OF NONELDERLY IDAHO ADULTS WHO ARE UNINSURED, BY COUNTY, 2003-2005



Source: Analysis of Idaho-specific BRFSS data for 2003-2005 by the Idaho Hospital Association (2007).

Note: The county-level uninsured rate is based on a 3-year average of the Idaho Behavioral Risk Factor Surveillance System (BRFSS). The lines in the exhibit, also known as "error bars," reflect the 95 percent confidence interval around the point estimate for each county. The line signifies the range over which we are 95 percent confident in the indicated statistic. They can also be used to compare two rates to determine whether differences are statistically significant.

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05-01HTD	Use of Social Security Numbers for Drivers' Licenses, Permits and Identification Cards	February 2005
05-01F	Management of Correctional Data	March 2005
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05-04	State Substance Abuse Treatment Efforts	December 2005
06-01	Management in the Department of Health and Welfare	February 2006
06-02	Idaho Student Information Management System (ISIMS)—Lessons for Future Technology Projects	August 2006
06-01F	Public Works Contractor Licensing Function	August 2006
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06-07F	Higher Education Residency Requirements	August 2006
06-08F	Child Welfare Caseload Management	August 2006
07-01	Use of Average Daily Attendance in Public Education Funding	February 2007
07-02	Virtual School Operations	March 2007
07-03F	Higher Education Residency Requirements	July 2007
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