Kaiser Report Takes a Closer Look at the Newly Uninsured Population

In August the U.S. Census Bureau reported that in 2006 the number of uninsured Americans increased by 2.2 million, largely because of a decrease in employer-sponsored insurance. Of this group, 2.1 million were under age 65, including 710,000 children age 18 and under. A new, in-depth analysis by the Kaiser Commission on Medicaid and the Uninsured takes a closer look at the 2.2 million increase, examining changes by age and income.

The overall likelihood of a child's being uninsured increased significantly between 2005 and 2006—from 11.2% to 12.1%. Nearly half (48%) of the newly uninsured children are from families with incomes between 200% and 399% of the federal poverty level, or about $40,000 to $80,000 for a family of four in 2006. As the issue brief notes, this is the income group that the Bush administration has argued should not be eligible for expansions in the State Children's Health Insurance Program (SCHIP). The proportion of children in this group with employer-sponsored coverage declined from 76.6% to 75.4% in 2006, resulting in an increase in the uninsurance rate from 7.6% to 9.1%—or 340,000 newly uninsured middle-income children.

Children in lower-income families accounted for a smaller share (31%) of the increase in uninsured children. The proportion covered by employer-sponsored insurance declined from 31.2% to 29.5% in 2006. This was partly offset by an increase in Medicaid and SCHIP coverage of 1.3%—from 44.5% to 45.7%. Thus the increase of 220,000 in the number of uninsured low-income children was not statistically significant.

Among children in families at 400% or more of the poverty level, employer-sponsored coverage declined from 89.5% to 88.5%, which resulted in an increase of 150,000 uninsured children in this income group in 2006.

Among adults in 2006, the number of uninsured increased by 1.4 million, bringing the adult total to 37 million. The uninsured rate increased from 19.8% to 20.4%. Adults experienced declines in employer-sponsored coverage at all income levels; the greatest declines were among those with low incomes. However, public coverage is limited for adults, even at low incomes. As a result, nearly half the growth in uninsured adults was among those with incomes below 200% of the poverty level. About 670,000 low-income adults joined the newly uninsured population in 2006. The number of uninsured middle-income adults increased by 340,000. Among adults with incomes above 400% of the poverty level, only small changes in employer-sponsored coverage were noted. However, because of large population increases in this income group, there was an increase of 370,000 adults without coverage.

Although the decline in the proportion of children with employer-sponsored insurance was steeper for children than adults, it does not appear to be driven by the availability of Medicaid and SCHIP coverage for children from families with low incomes. Employer-sponsored coverage declined for children at all income levels.

The average total premium cost for employer-sponsored coverage continues to increase—$12,106 for family coverage, with an average worker contribution of $3,281 in 2007. Premium amounts have nearly doubled since 2000, according to the issue brief, which is available on the Kaiser Commission Web site at www.kff.org.

Decline in Medicaid Enrollment and Modest Growth in Spending Allow States to Focus on Expansions for 2008

For the first time since 1998, enrollment in Medicaid has declined. The .5% drop in enrollment was accompanied by relatively modest growth in total Medicaid spending. After spending growth reached an all-time low of 1.3% in fiscal year (FY) 2006, it increased to 2.9% in FY 2007, according to the seventh annual 50-state survey of Medicaid officials released by the Kaiser Commission on Medicaid and the Uninsured. Moving into FY 2008, state legislatures have authorized program expansions that are estimated to yield a 6.3% growth rate.

State officials reported that the drop in enrollment was driven primarily by two factors. Two-thirds of states cited new requirements for documentation of identity and citizenship, which became effective in July 2006. New procedures were causing significant delays in processing applications, but most delays affected individuals who are eligible for the program. State officials also cited the relatively strong economy and resulting lower unemployment for reducing enrollment. Reasons cited for the slow growth in spending were the decline in enrollment and the continued transition from Medicaid to Medicare of prescription drug costs for enrollees dually eligible for Medicaid and Medicare. States are still obligated to pay a maintenance-of-effort payment each month (known as the "clawback"), which is based on the number of dually eligible enrollees and the cost of their drugs, but these payments are now counted as a source of financing for Medicare and not as Medicaid spending, even though most states appropriate these payments as part of their Medicaid budgets.

For state policy makers, the amount of funding for Medicaid that is allocated from the state general fund is a key factor, the survey notes. For the past few years the state share of Medicaid spending has increased more rapidly than total Medicaid spending because the federal matching rate has declined for more than half of states. The matching rate is recalculated annually based on average personal income for each state. Declines in the matching

rate place pressure on states to allocate additional state general revenues to maintain current program levels. State general fund spending for Medicaid increased on average by 3.0% in 2006 and by 3.2% in 2007. For 2008 state legislatures have appropriated an increase in state general funds for Medicaid that averages 7.8%.

An improved economy coupled with the drop in enrollment and slow spending growth has allowed states to focus on program restorations, improvements, and expansions that have not been possible for the past several years. Every state implemented some type of provider rate increase in 2007, and 49 states planned to increase rates for at least one provider group in 2008. More than half of states made positive eligibility changes in 2007 or plan to do so in 2008. Such changes include increasing income limits for eligibility; expanding coverage to include a new group, such as foster children or persons with disabilities who are working; or streamlining the application or renewal process. A few states restored or added new benefits in 2007 and 2008. For the first time since at least 2003, no state planned a cut in benefits for 2008.

In 2006 there were 47 million uninsured Americans, an increase of 2.2 million from 2005. Forty-two states reported that they have efforts under way to expand coverage to their uninsured population by using Medicaid as a financing vehicle. Many efforts, however, will depend on the outcome of the federal debate on the reauthorization of the State Children's Health Insurance Program in light of the President's veto.

Many states have made quality improvement a priority in order to get better value from Medicaid dollars. In 2008 a total of 44 states will be using performance data from managed care organizations in the Healthcare Effectiveness Data and Information Set (HEDIS) or the Consumer Assessment of Health Plans Study (CAHPS) to measure and provide incentives for improved performance.

The survey report, As Tough Times Wane, States Act to Improve Medicaid Coverage and Quality: Results From a 50-State Medicaid Budget Survey for State Fiscal Years 2007 and 2008, is available on the Kaiser Foundation Web site at www.kff.org. Related materials include an issue brief, *Why Did Medicaid Spending Decline in 2006? A Detailed Look at Program Spending and Enrollment, 2000–2006,* and updates with the most current Medicaid enrollment and spending data.

NEWS BRIEFS

Medicaid spending on enrollees with diabetes in 2003: More than one in seven Americans with diabetes rely on Medicaid for their health coverage. An issue brief from the Kaiser Commission on Medicaid and the uninsured provides a first look at what Medicaid spends on the nearly two million enrollees with diabetes. Included among the findings is that the 6% of enrollees with diabetes accounted for 16% of total Medicaid spending in 2003. Just under a third of these enrollees were also diagnosed as having a mental illness. Per capita spending for this group ($26,710) was nearly twice as high as spending for enrollees with diabetes without mental illness ($12,708). Total spending for the group with mental illness ($15 billion) accounted for almost half of expenditures for the larger group with diabetes. The ten-page issue brief is available on the Kaiser Web site at www.kff.org/medicaid.

New center on mental health research for Asian Americans: The National Institute of Mental Health (NIMH) has funded a project to establish a national center to study mental health issues affecting Asian Americans. The Asian American Center on Disparities Research will be housed at the University of California (UC), Davis, and will coordinate a network of U.S. researchers studying the unique mental health challenges faced by Asian Americans, including Chinese, Filipino, Vietnamese, Cambodian, Hmong, Lao, Korean, Japanese, Hawaiian, East Indian, and other Asian Pacific groups. The Asian-American community has been underrepresented in mental health research, and evidence suggests that services are inadequate or inappropriate for Asian Americans. The new center, led by Nolan Zane, Ph.D., of UC Davis, aims to counteract these obstacles by testing effective clinical treatments for Asian Americans, promoting and conducting research about cultural diversity and disparities, and helping bridge the gap between research and practice. The new center builds on the UC Davis–based National Research Center on Asian American Mental Health, which operated from 1988 to 2002 and also was funded by NIMH.

National voluntary consensus standards for treatment of substance use conditions: The National Quality Forum (NQF), with the support of the Robert Wood Johnson Foundation, has issued a set of standards for treating substance use disorders. The standards, which are the result of a project begun at a 2004 workshop conducted by NQF, were arrived at according to a consensus development process. The endorsed practices and their specifications have legal status as national voluntary consensus standards for the treatment of substance use conditions. Eleven evidence-based practices were endorsed. The practices fall into four domains: identification of substance use conditions, initiation and engagement in treatment, therapeutic interventions, and continuing care management. For each endorsed practice the target outcomes are identified and additional specifications are provided for what a practice entails, for whom it is indicated, who performs it, and the settings where it is provided. An executive summary listing the practice specifications is available on the NQF Web site at www.qualityforum.org/publications/reports/sud-2007.asp.