

The Low Income Uninsured in North Carolina

Task Force on Covering the Uninsured
April 22, 2005

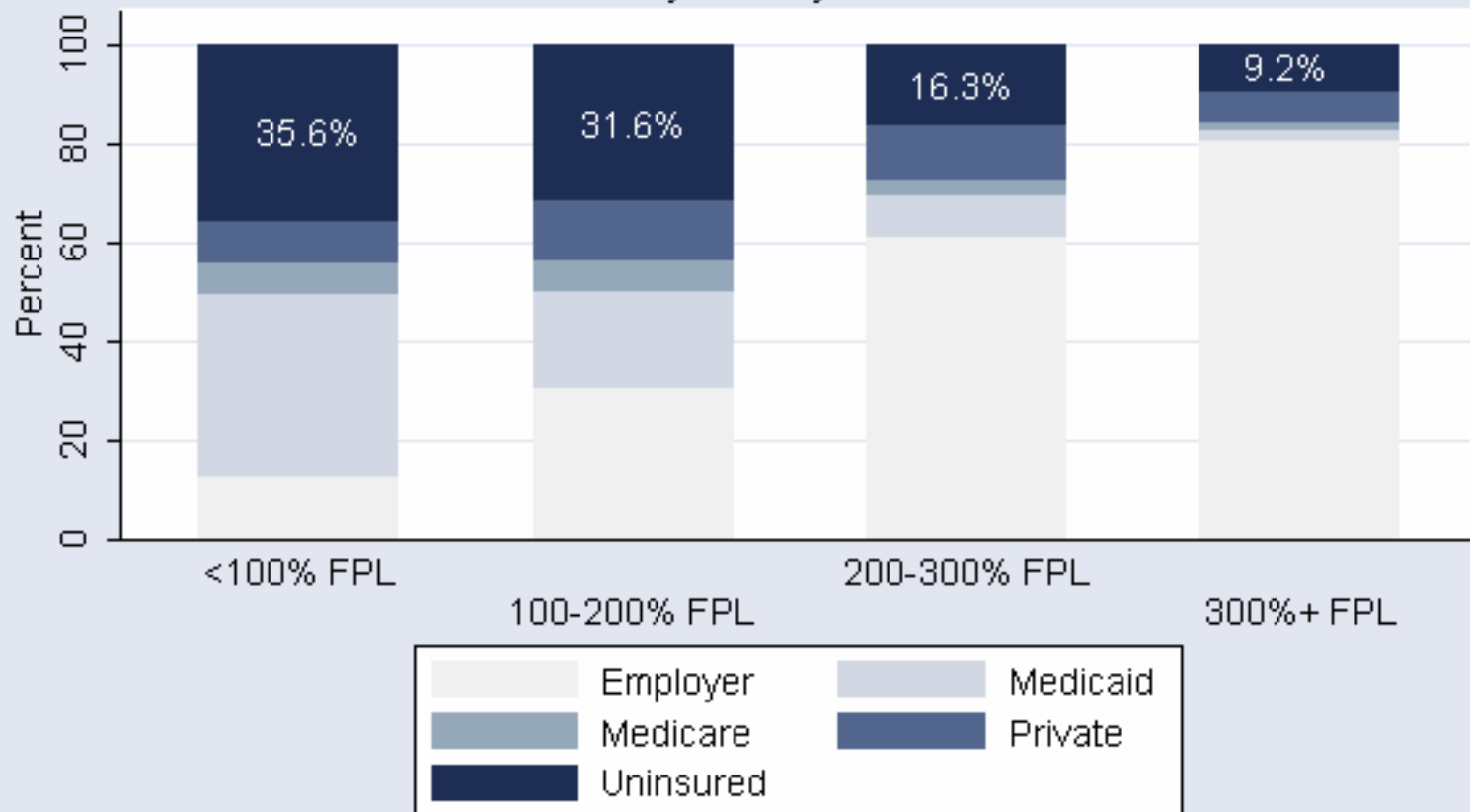
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Outline

- Why a focus on the Low Income UI?
 - Aside: Take-up, Crowd-out, and Program Efficiency
- Who are the Low Income UI?
- Where do they work? FT/PT?
- How many might be covered if the state expanded coverage (e.g. working parents)?
- OOP Payments
- Use of services

Insurance Coverage

by Poverty Status

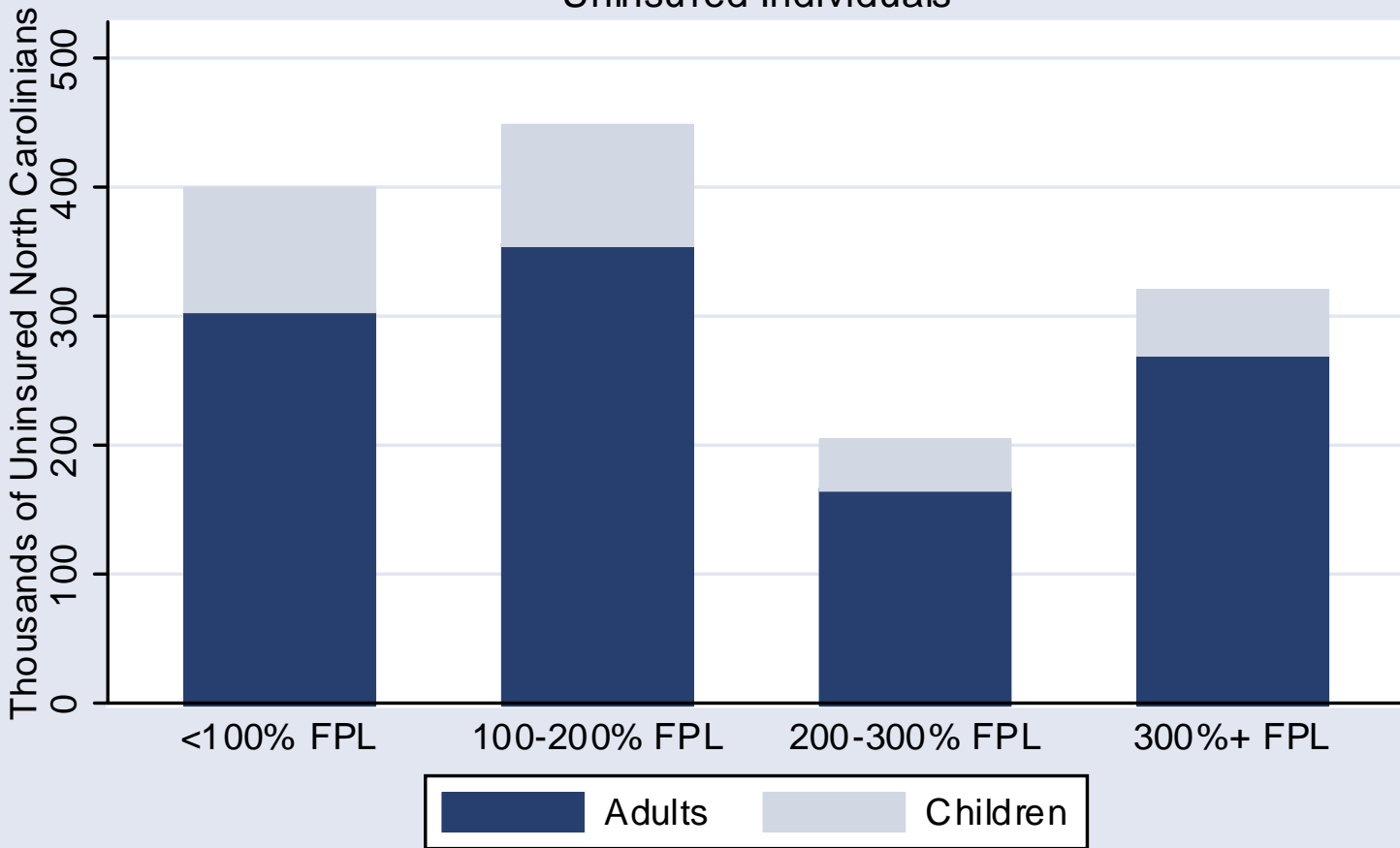


Source: CPS 2002-2004 (Calendar years 2001-2003).

Recall the (unsurprising) finding that low income individuals are more likely to be uninsured....

2004 Poverty Status

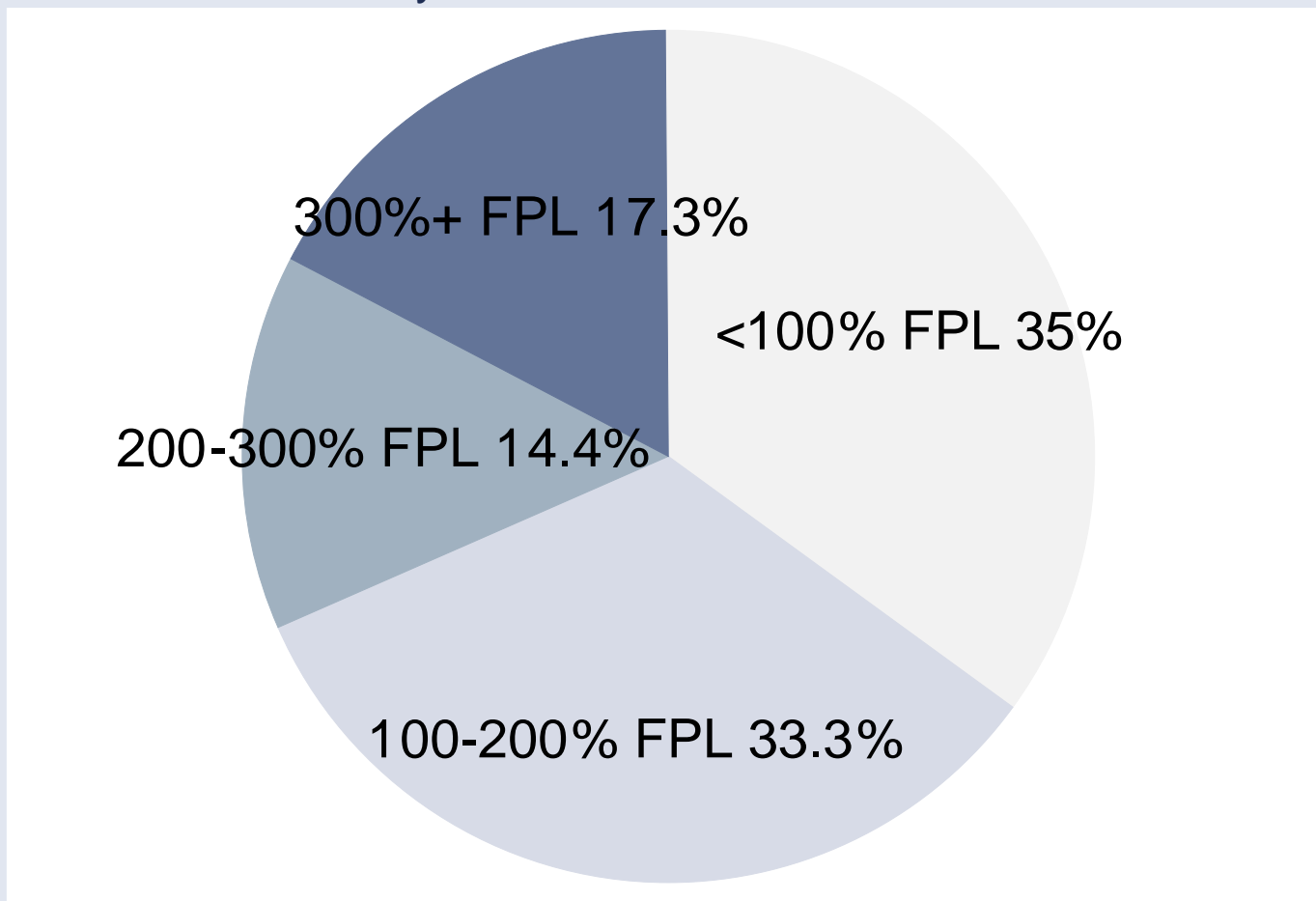
Uninsured Individuals



Source: CPS 2004.

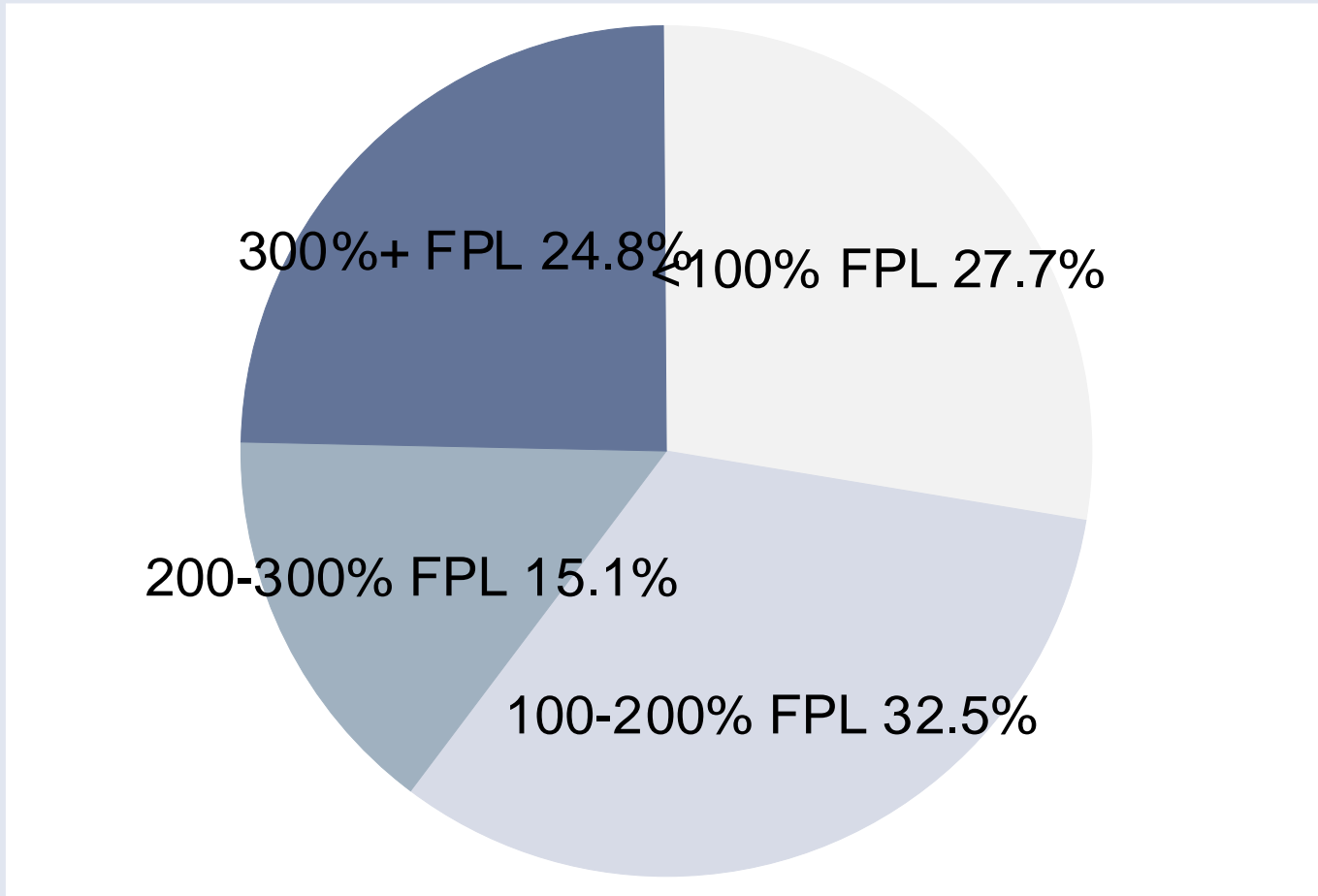
...and most uninsured are low-income.

Poverty Status of Uninsured Children



Most uninsured children (68%) have incomes below 200% of FPG. Recall that children under 200% of FPG are eligible for NCHC, although CPS seems to undercount NCHC.

Poverty Status of Uninsured Adults



More uninsured adults have incomes above 200% of FPG than children, although still over half the uninsured have incomes below 200% FPG.

Why are low income uninsured individuals “interesting” to us?

- The obvious reason: lower income → lower ability to pay. Government as safety net. With limited financial assets, providers end up providing care.
- More subtle reason: Since lower income are more likely to be uninsured, policy efforts targeted to them are more effective.
 - Join me for a quick aside into some insurance terminology...

Crowding Out

- The degree to which individuals other than those targeted respond to a policy. This is a consequence of not restricting eligibility to only those in the target group.
- Example: A program of publicly subsidized immunizations may lead to private insurers not covering immunizations
- Example: An expansion of public insurance eligibility may encourage some currently privately insured to discontinue private insurance

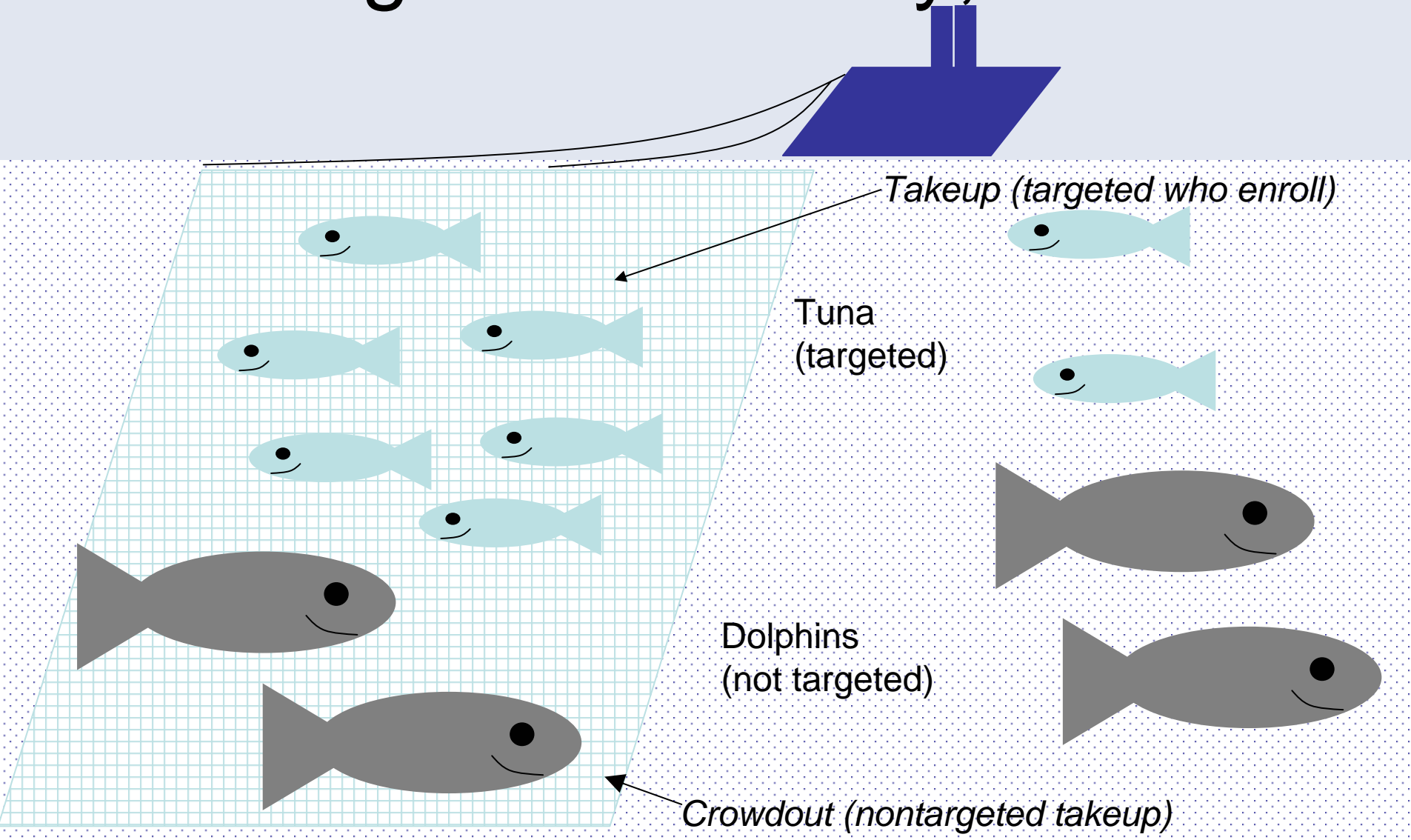
Takeup

- The rate at which those that are targeted for the program enroll in the program
- Example: Lots of people are eligible for the Earned Income Tax Credit each year but do not realize it
- Example: Lots of people are eligible for Medicaid but do not enroll in the program

Program Efficiency

- Programs that aim to decrease the uninsured suffer from a lack of exclusivity in targeting --- ideally, we want to cover those that would otherwise not be insured, but they are not easy to identify *individually*. Jonathan Gruber likens the principle to fishing for tuna --- sometimes you get dolphins in the net.
- Efficient programs have high takeup and low crowdout.

Program Efficiency, cont.



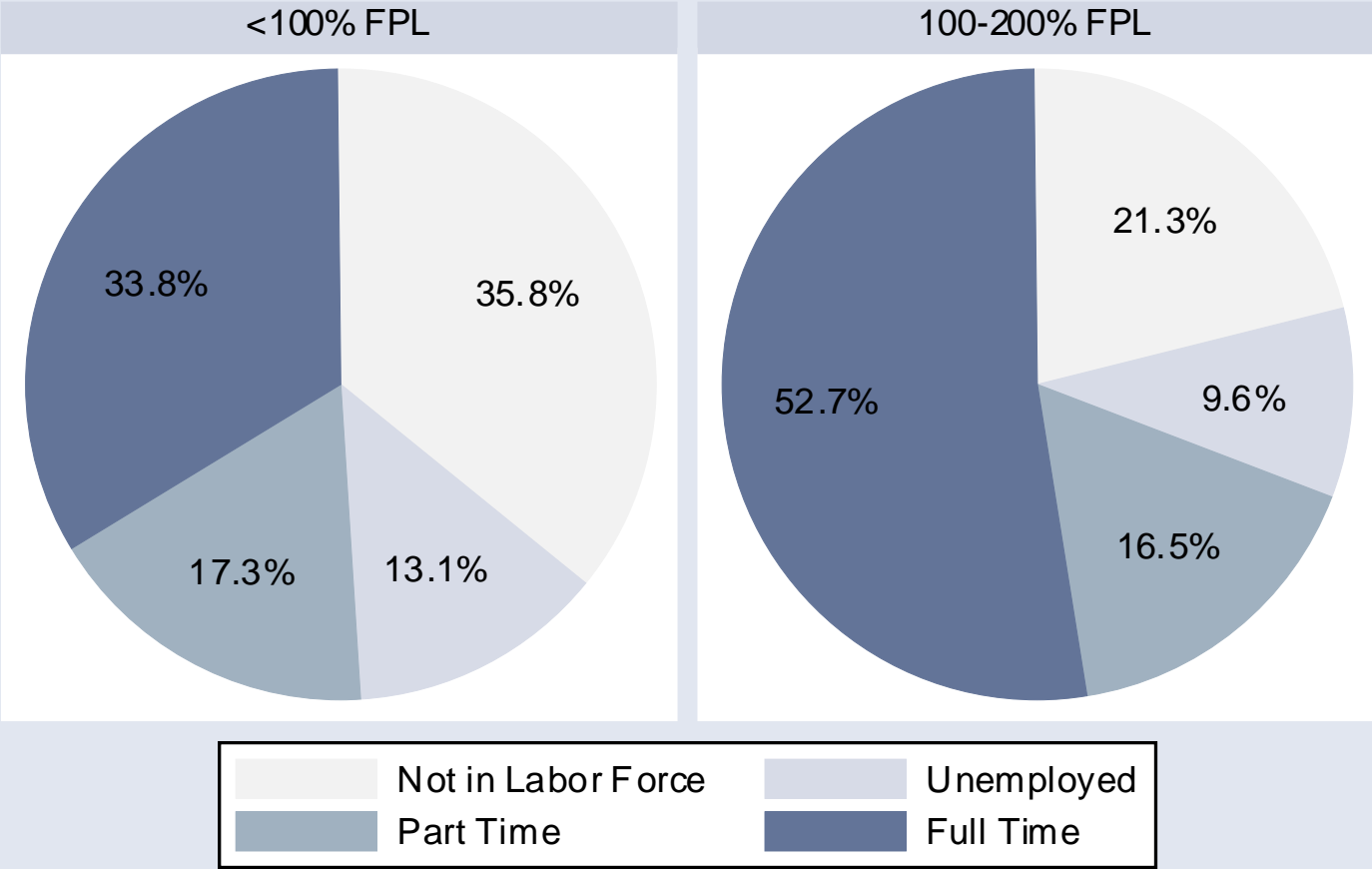
Program efficiency

- Efficient policies, then, have
 - Low Crowd-out
 - High Take-up
- Low income individuals meet the first standard more than high individuals
 - Want to avoid government outlays replacing private outlays
 - Think in terms of “dollars per newly insured”
- Targeting low income uninsured is likely to have a higher program efficiency (bang for the buck)

“Low-Income”

- We will use a couple definitions of low income:
 - Less than 100% Federal Poverty Guidelines
 - Individual: \$9,570 / year in 2004
 - Family of 4: \$19,350 / year in 2004
 - Less than 200% Federal Poverty Guidelines
 - Individual: \$19,140 / year in 2004
 - Family of 4: \$38,700 / year in 2004
 - One dataset only has income categories – we will use “<\$20K” as low income for that analysis

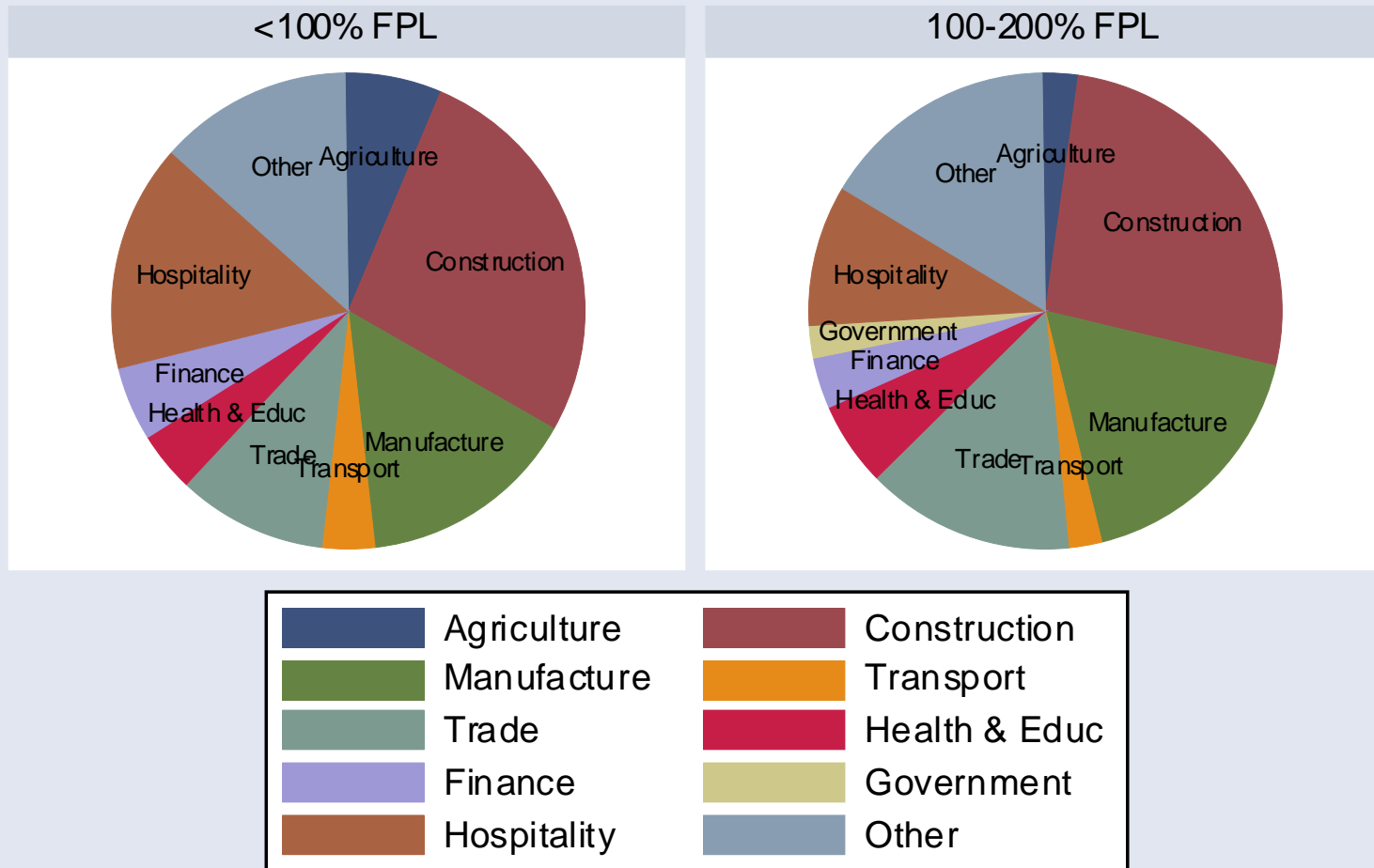
Labor Force Status of Uninsured Adults



Source: CPS 2002-2004.

A substantial number of uninsured adults work full time.

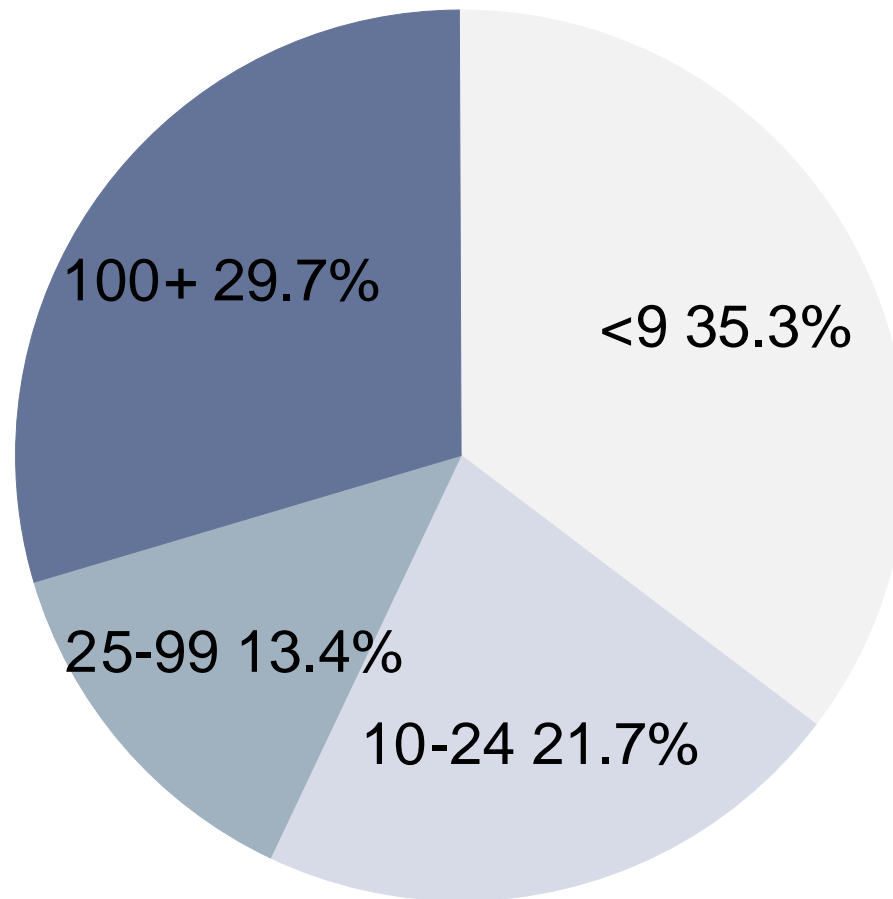
Industry of Full Time Uninsured Workers



Source: CPS 2002-2004. Full time adult workers only

Construction, manufacturing, and hospitality are major industries for low income uninsured full time workers.

Firm Size of Full Time Uninsured Workers



Source: CPS 2002-2004. Full time adult workers only. No difference by poverty status.

Low income uninsured full time workers tend to work at small firms.

Low Income Uninsured

By Current Eligibility and Possible Expansions



Currently Eligible	Possible Expansions
CHIP/Medicaid (current)	Working Parents (100%)
Disabled <100% FPG (current)	Working Parents (200%)
TANF (current)	Parents (100%)
Pregnant Woman (current)	Parents (200%)
	Not eligible

This considers only individuals below 200% FPG. Individuals are assigned to the first listed category that applies. Just less than one third of the uninsured are estimated to be eligible under an existing public program. One program the Task Force is considering is expanding Medicaid to parents. Note that requiring parents to work only marginally affects eligibility.

Low Income Uninsured Are In Poorer Health Than High Income Uninsured

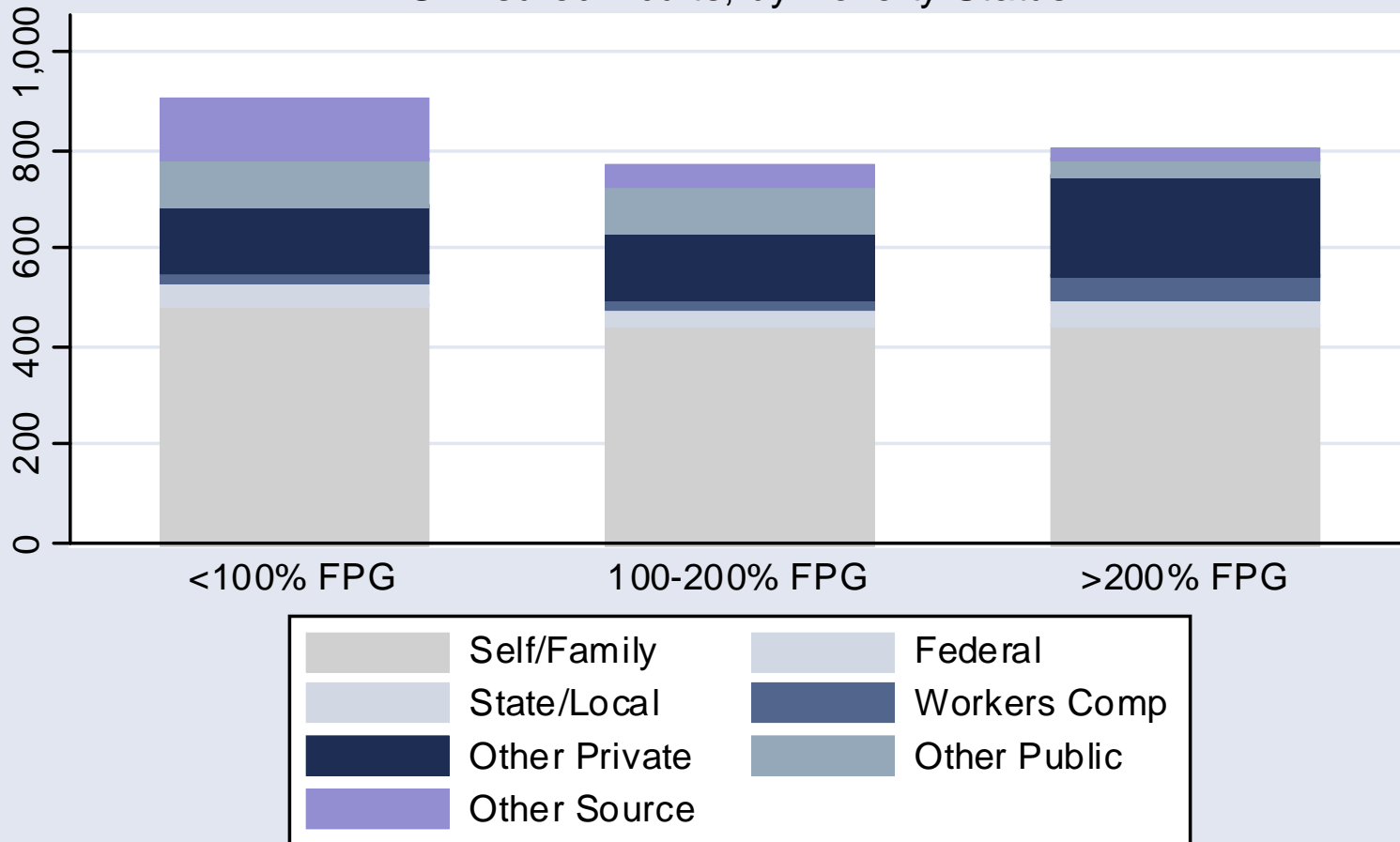
- From the 2003 Behavioral Risk Factor Surveillance System (BRFSS) [NC SCHS], uninsured with less than \$20K income are
 - 4.5 times more likely to have diabetes
 - 30% more likely to have high blood pressure
 - 50% more likely to have high cholesterol
 - Almost twice as likely to have fair or poor health
- Consistent with “rich & healthy” people not purchasing due to beliefs, low income not able to purchase regardless of health status.

Health Care Expenses of the Uninsured

- These data use the Medical Expenditure Panel Survey (MEPS)
- Analyses are for the Southeastern US, not just North Carolina. MEPS is not designed for state-level analysis, but in almost all respects North Carolina “looks similar” (statistically) to the Southeast.

Health Care Expenditures

Uninsured Adults, by Poverty Status



Source: MEPS 2002. Southeast residents.

Uninsured Adults spend roughly the same amount out of pocket independent of poverty status, although they spend more overall. Of course, the out of pocket represents a larger amount for low income individuals: [OOP percent of family income: 4.2%, 2.3%, 1.4%]

Utilization

- Low income UI adults (relative to high income UI adults)...
 - Have about three times the ED utilization
 - Have over twice the hospitalizations
 - Are slightly less likely to have a usual source of care
 - Are more likely to classify themselves as being in worse health
 - Have fewer office visits (holding health status constant), although they have about the same number of office visits overall

The Natural Question

Overall, low income uninsured see office-based providers less but hospital-based providers more.

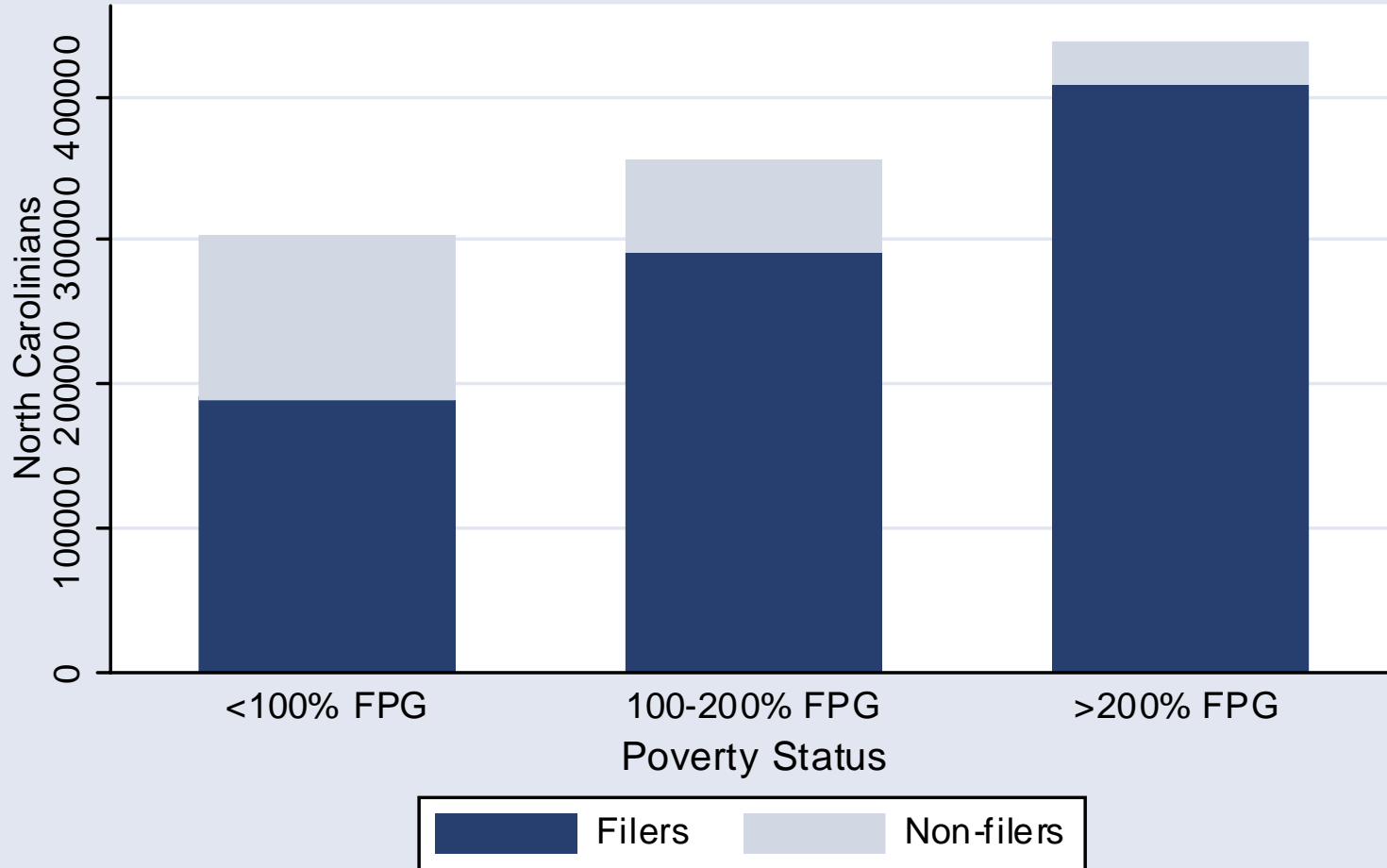
Is the higher ED/hospitalization utilization because low income uninsured have less access to office-based health care? Would access to health insurance increase the use of cheaper office-based care preventing expensive care in hospital settings?

A quick note on one point raised in prior discussions...

- One idea that has been mentioned both in Task Force meetings as well as the Focus Groups is requiring individuals to be covered by health insurance. Enforcement would likely be via state income tax returns.
- How many uninsured file income tax returns? We don't know much about state returns, but we do know something about federal returns.

Federal Income Tax Filing Status

Uninsured North Carolinians



This graph shows that although most uninsured over 200% FPG file federal income tax returns, about a third of uninsured below 100% FPG don't file.

