Written Statement for the Record by

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For the Senate Finance Committee

Roundtable on Coverage Issues in Health Reform

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Mr. Chairman, Members of the Committee:

Thank you for inviting Families USA to participate in today's roundtable about coverage issues in health care reform. We applaud Chairman Baucus's deep commitment to expanding quality, affordable health coverage and care to our nation's families. I want to take this opportunity to thank the Chairman for his leadership on the reauthorization of the Children's Health Insurance Program. I also would like to acknowledge the early, important contribution Senator Baucus and his staff made to the health care reform debate by issuing a very thoughtful "white paper" on health care reform in November of 2008. This paper has helped to focus the debate and encouraged diverse groups to coalesce around a common framework for expanding coverage.

For the American people, fundamentally reforming our nation's health care system is of utmost urgency. One out of three Americans under the age of 65 went without health insurance for some period of time during 2007 and 2008.[1] Of these uninsured, four out of five were from working families, and people from lower-income families were more likely to go without health insurance than their higher-income counterparts.[2] *And these data are for the time period before the worst of the current recession*. When you factor in the effects of the recession—job losses and the accompanying loss of job-based coverage, the tightening of family budgets, and pressure on the bottom lines of American businesses—you can expect the number of uninsured Americans to rise to record levels if nothing is done. Addressing the

crisis of the uninsured is critical to the economic security of American families and to the goals of improving the quality and lowering the costs of health care for those lucky enough to have insurance today.

At the same time that the number of uninsured is rising, people who have insurance are struggling to afford rising premiums. And these two problems—uninsurance and high premiums—are interrelated. In fact, the presence of uninsured people in our nation's health care system adds to the cost of the health insurance premiums that American consumers and businesses must pay for coverage.

Premiums for both job-based and individually purchased health insurance have risen rapidly over the last few decades: Between 2000 and 2008 alone, the average annual premium for job-based family health coverage doubled, rising from $6,351 to $12,680.[3] During the same period, the average worker's share of average annual family premiums rose from $1,656 to $3,354, an increase of nearly 103 percent.[4] Although families are paying more and more for coverage, they are getting less and less: On average, deductibles and copayments are increasing, there are more limits on covered services, and other limits are being placed on benefits in an effort to hold down the cost of coverage.[5]

Obviously, making sure that all Americans have access to quality, affordable health coverage will increase access to medical care for millions of Americans and will save countless lives. Less obvious, however, is the fact that covering the uninsured will help contain rising health care costs and improve the quality and efficiency of our health care system—both primary goals for national health reform. This is true for several reasons.

First, the cost of care for people who don't have insurance doesn't just disappear. We all pay— in the form of higher medical bills and higher insurance premiums—for the care provided to the uninsured. When people who don't have insurance get sick, many delay or forgo care.[6] And when they can no longer ignore serious symptoms, they see doctors and go to hospitals. They struggle to pay as much as they can of their medical bills (nationally, more

than one-third of the cost of care for the uninsured is paid by the uninsured themselves, out of their own pockets).[7] Much of the remaining cost is paid by doctors and hospitals charging higher rates for services covered by insurance. Insurance companies pass these increased costs on to purchasers of insurance through higher premiums. In 2005, on average, $922 of the cost of family health insurance coverage was attributed to the cost of caring for the uninsured[8]—an amount that can be characterized as a "hidden health tax" that all of us with insurance now pay. Later this month, Families USA will issue a report that updates this "hidden health tax."

Second, if everyone is in the health care system, we can slow down the growth of health care spending. If everyone has quality, affordable health care—including preventive services, as well as early diagnosis and treatment of conditions—we can *manage chronic disease* rather than *manage the crises* that result from delayed care. When everyone has coverage, health conditions can be treated early, before they become expensive problems that drive up total health care spending. If we can slow the growth of health care spending as a share of our GDP, we'll be better able to invest in education, our national infrastructure, and other national priorities.

Third, when everyone has quality, affordable coverage, cost-saving public health goals are achievable. Doctors play a key role in motivating patients to reduce obesity, control high blood pressure, lower cholesterol, and reduce other risk factors. Efforts to improve our nation's overall health through public health initiatives cannot be successful if millions of people are left behind because they don't have insurance.

Fourth, public health threats and epidemics cannot be monitored and addressed when so many people in our nation are uninsured. In order to address health threats such as flu viruses, Lyme disease, West Nile virus, and tuberculosis, we need to be able to develop a complete picture of disease prevalence and patterns of transmission. When we leave millions of people outside the health care system, we hinder our efforts to identify patterns and deal with these threats early and effectively.

Families USA's Recommendations for Expanding Coverage

Families USA has two core goals for health care reform: 1) that everyone who currently has satisfactory health care coverage can keep that coverage, and 2) that those who do not currently have health care coverage can get it. The most effective way to achieve these goals and reform our health care system is to build on and improve what currently works in our system. Health care coverage for Americans under the age of 65 is built on a foundation of two pillars—job-based health coverage and Medicaid. More than half of the population currently has health insurance through an employer, and Medicaid provides coverage for the low-income children, pregnant women, parents, seniors, and people with disabilities who often lack access to employer coverage and for whom coverage in the individual health insurance market is unaffordable. In our efforts to reform the health care system, it is imperative that we preserve, strengthen, and expand those two pillars as we move forward to cover all Americans.

Therefore, we recommend the following three-pronged framework for expanding coverage as part of health care reform:

- First, health care reform should build on and strengthen Medicaid for people who have low incomes or severe disabilities. Medicaid is a safety net that now covers approximately 60 million people who can't otherwise afford health insurance. But it is a safety net with holes, and it fails to protect many very vulnerable people. We recommend establishing a national eligibility floor for Medicaid for everyone, as well as improving and streamlining the enrollment process.
- Second, we believe that moderate-wage working families should receive significant subsidies to help make insurance premiums affordable. Sliding-scale subsidies are an integral part of the health reform initiative that was established in Massachusetts—an

initiative that has enabled Massachusetts to become the state with the highest rate of health coverage in the nation.

- Third, we believe that working families should receive help with out-of-pocket health care costs, such as deductibles and copayments. These costs should be capped, and the cap should be set at a percentage of family income. This will help to ensure that health care is affordable and that medical-related bankruptcies are prevented.

These three recommendations are critical to making health coverage affordable for those who today lack coverage or who are at risk of losing their health coverage. This framework, which uses a hybrid public-private approach to expanding coverage, mirrors key concepts in an agreement that was endorsed by 18 very diverse stakeholders on March 27, 2009. The Health Reform Dialogue participants included groups representing employers, physicians, nurses, consumers, insurers, public health professionals, and others.[9]

In addition to these three recommendations to address access to quality, affordable health care coverage, Families USA recommends that important improvements be made to the Medicare program. We recognize that low-income seniors and people with disabilities in the Medicare program also are in need of assistance with out-of-pocket health care costs.

The following sections provide additional detail regarding Families USA's recommendations.

Expand and Improve Medicaid for Low-Income Individuals

For the lowest-income Americans, the most appropriate vehicle for expanding coverage is undoubtedly the Medicaid program. Health reform must expand and improve Medicaid to ensure that all Americans can have affordable, high-quality health coverage. Medicaid is specifically designed to meet the unique needs of low-income people with complex health care needs, while the private insurance market is not. With respect to coverage for low-income Americans, Families USA recommends: (1) that a national Medicaid eligibility floor be established, (2) that the Medicaid enrollment process be streamlined to facilitate easier

enrollment for all eligible individuals, and (3) that provider reimbursement rates be increased to help broaden the provider network and improve access to care.

Why Medicaid?

Medicaid is already the backbone of the health care system for the most vulnerable Americans. It covers approximately 60 million low-income people: 29.4 million children, 15.2 million adults, 6.1 million seniors, and 8.3 million people with disabilities. What's more, it is specifically designed to meet the unique needs of these populations, who tend to be sicker and have more intensive health care needs than the general population.[10]

As with any coverage expansion, special attention will need to be paid to ensuring that the Medicaid delivery system is retooled to handle an increase in the number of Medicaid enrollees without compromising access to care. However, Medicaid is the most efficient and effective way to cover more low-income Americans who cannot obtain coverage in the private market. Every state already has a Medicaid program with an existing provider network and administrative infrastructure. It makes sense to build on this foundation, particularly since it has a proven track record of effectively serving low-income individuals.

A little-known fact is that Medicaid is actually *more efficient* at covering low-income people than private coverage. After controlling for health status (since Medicaid enrollees tend to have greater health care needs), it costs more than 20 percent *less* to cover low-income people in Medicaid than it does to cover them in private health insurance.[11] In this cost-conscious climate, it only makes sense to expand coverage in the most cost-effective ways possible. The most cost-effective way to expand coverage for low-income uninsured people is Medicaid.

Cost-Sharing Protections

Medicaid includes very important protections against out-of-pocket costs to ensure that these costs do not prevent people from getting the health care services they need. Unlike

private health insurance, Medicaid typically does not require premiums or enrollment fees, and there are limits on other forms of cost-sharing. Certain services (preventive care services for children, emergency services, pregnancy-related services, and family planning services) and certain populations (children of certain ages and incomes, foster children, hospice patients, institutionalized patients, and women in the Medicaid breast or cervical cancer programs) are exempt from any kind of cost-sharing, and copayments for individual services are limited to so-called "nominal" amounts of a few dollars or less.

These protections are absolutely imperative to the success of the Medicaid program for low-income people. Low-income adults with private insurance pay more than six times as much for out-of-pocket costs as do low-income adults with Medicaid.[12] There is extensive research that demonstrates the serious burden these out-of-pocket health care costs can pose for low-income people.[13] When people cannot afford these costs, they often delay or forgo care, which can result in more costly complications later on.[14] Because Medicaid incorporates such strong cost-sharing protections, people enrolled in Medicaid are more likely to get the care they need, when they need it.

Comprehensive Benefits

Medicaid's comprehensive benefit package ensures that the program provides appropriate coverage to people with diverse health care needs. For example, Medicaid has specific protections that are designed to ensure that children get both preventive care and treatments for any health complications they may have (referred to as Early and Periodic Screening, Diagnostic, and Treatment, or EPSDT, services). Medicaid also covers services that low-income people need that are not usually covered in private health insurance. For example, Medicaid covers transportation to doctors' appointments, services that help people with disabilities live independently, and services provided at rural and community health centers. It is unlikely that a private health insurance plan would ever cover these services.

Medicaid is also a key source of coverage for people who are very sick or who have disabilities. While most private health plans have annual or lifetime maximums that people with intensive health care needs can quickly exceed, Medicaid has no such limits. It provides coverage to all those who need it, even people with serious health care problems, whom the private market is simply not interested in serving. Similarly, while private coverage often excludes coverage for pre-existing health conditions, people enrolled in Medicaid are guaranteed to receive the health care services they need, regardless of any past or current health care problems. The Medicaid benefits package is specifically designed to meet the health care needs of low-income individuals, and, as a result, Medicaid enrollees are less likely than both the uninsured *and* those with private coverage to lack a usual source of health care or to have an unmet health care need.[15]

Medicaid Appeal Rights and Protections

Because low-income people cannot afford health care services that are not covered by their insurance, Medicaid's appeal rights are particularly important. These rights ensure that low-income people who are sick can appeal coverage denials without jeopardizing any ongoing treatment. They can also appeal enrollment or eligibility decisions, and they have the right to a fair hearing. Also, unlike in the private health insurance market, there are no pre-existing condition exclusions in Medicaid, nor are there waiting periods before an otherwise eligible person can enroll. Medicaid is guaranteed to be available to all who are eligible; people cannot be turned away because they are sick or have experienced health problems in the past, and they can begin receiving services as soon as they are determined to be eligible. In addition to the cost-sharing protections and the comprehensive benefits package, these design features make Medicaid particularly well-suited to providing coverage to low-income people.

Create a National Medicaid Eligibility Floor

To be eligible for Medicaid under federal law, a person must not only have a low income; he or she must also belong to one of the following Medicaid eligibility categories: children,

pregnant women, parents with dependent children, people with disabilities, and seniors. If a person does not fall into one of these categories, he or she can literally be penniless and still be ineligible for Medicaid. Also, because the Medicaid program is a state-federal partnership, states set their own eligibility levels. There are federal minimums, but eligibility levels vary widely from state to state. Only 16 states and the District of Columbia cover working parents with incomes at least up to the poverty level ($18,310 for a family of three), and the national median eligibility level for parents is a mere 67 percent of poverty ($12,268 for a family of three).[16] The picture is even grimmer for low-income adults who do not have dependent children: In 43 states, these individuals are ineligible for Medicaid no matter how low their income. (A table presenting the eligibility levels for these three groups in every state is attached to this testimony.) An estimated 45.1 percent of non-elderly Americans with income below the poverty level were uninsured in 2007.[17]

Health reform offers an opportunity to address these gaping holes in the health care safety net, and to ensure that, in addition to improving coverage for those with moderate incomes, the very lowest-income Americans are covered as well. Families USA recommends that Congress establish a national Medicaid income eligibility floor, below which any individual is guaranteed to be eligible for Medicaid, regardless of age, parental status, or health status. More than one in three uninsured Americans has an income below the poverty level.[18] Establishing a federal floor for Medicaid—preferably at approximately 133 percent of the federal poverty level—would significantly reduce the rate and number of uninsured Americans.

If a new national eligibility floor is established, the federal government should provide substantial funding assistance rather than relying on the federal-state Medicaid matching formula that is currently in place. There are a number of approaches to how you might restructure the Medicaid federal-state financial partnership; any approach should balance providing some fiscal relief to states while not shifting all current state investments in the Medicaid program to the federal government.

Establishing a national eligibility floor will also involve several important policy decisions with which Congress will have to grapple. These include the following: how a new national floor will affect states that have higher and lower eligibility levels for existing coverage; what funding will be available for coverage above the new floor; and how the new Medicaid coverage will intersect with any new subsidies for the purchase of private health coverage that may be provided to those with low and moderate incomes (see the following sections of this testimony). We urge that in addressing these issues, Congress follow a fundamental principle of "first, do no harm." No harm should come to those who currently rely on Medicaid coverage in the states, or to the fundamental characteristics of the Medicaid program that make it meaningful for low-income people and people with disabilities. Further, states should not be financially harmed by a coverage expansion. We look forward to the opportunity to help staff navigate the issues that may arise in crafting this new policy.

Streamline Medicaid Enrollment and Improve Access to Care

In order to ensure that the new Medicaid expansion enrolls as many eligible people as possible, Families USA recommends that Congress establish a new, simplified enrollment process for both currently and newly eligible people. Experience with the Children's Health Insurance Program (CHIP) has shown the importance of establishing simple, streamlined enrollment policies and procedures to help eligible people get and keep coverage.[19] Examples of these simplifications include allowing 12 months of continuous eligibility to individuals once they are enrolled in Medicaid, minimizing the amount of documentation people need to provide when they apply for and renew their coverage, eliminating asset tests, allowing application by mail and online, and simplifying the application itself so that it is short and easy to understand.

It will also be crucial that there be coordination between the application process for Medicaid and the subsidy for purchasing private health insurance coverage. Experience tells us that low-income people have fluctuating incomes, and those with incomes "at the margins" may not know in advance for which program they are eligible. It is imperative that any Medicaid

expansion and any new program that subsidizes private health coverage for moderate-income individuals require a process for screening applications that includes provisions to facilitate enrollment, such as a "screen and enroll" requirement similar to that in CHIP. Such a requirement would ensure that individuals who apply for the subsidy but who are actually eligible for Medicaid are enrolled in Medicaid, and vice versa. The enrollment process should ensure that the right people get into the right program, and it should not make people jump through unnecessary hoops to do so.

In addition, it will be important to make sure that there are enough providers participating in Medicaid to serve all the enrollees. There are already undeniable problems with provider participation in Medicaid, especially because of the generally lower payment levels to health care providers. This problem needs to be addressed so that Medicaid enrollment results in access to needed care.

Making Health Coverage Affordable in the Private Market

Moderate-income working American families are also struggling to afford health insurance coverage—whether they are offered coverage through a family member's job or are forced to seek coverage in the non-group private market. Even when employers pay a significant portion of the premiums, the share of the premium that working families must pay may be unmanageable. In 2008, the average annual premium contribution for job-based family coverage was $3,354. [20] That's approximately $280 per month in premiums alone. Once additional out-of-pocket costs such as deductibles, copayments, and fees for uncovered services are factored in, even those with high-quality job-based plans may face health care costs that are too great a burden to bear. In 2008, for example, 13.5 million Americans *with insurance* were in families that spent more than one-quarter of their pre-tax income on health care costs.[21]

Workers without an offer of job-based coverage—and those who cannot afford the out-of-pocket costs associated with their employer's plan—may seek coverage on their own in the

individual health insurance market. However, finding an individual insurance plan that meets both their needs and their budget is likely to be extremely challenging. One recent survey found that nine out of 10 people who sought individual coverage never purchased a plan—either because they couldn't find an affordable plan, they were rejected for coverage, or they were offered a plan that excluded coverage for the very care they were most likely to need.

As these data show, hard-working, moderate-income families—both those with an offer of job-based coverage and those who must seek coverage on their own—are likely to have difficulty affording the high cost of quality coverage on their own. To help these families who are above Medicaid eligibility levels, Families USA recommends a system of private market subsidies.

Subsidies for the Purchase of Coverage

To help moderate-income families afford the high cost of premiums—either for insurance through the workplace or in the individual market—subsidies will be essential. Sliding-scale subsidies should be designed to deliver greater assistance to those with greater need, and these subsidies should cover the cost of premiums up-front so that lower-income families with tight budgets do not have to pay for premiums out-of-pocket and wait for reimbursement. In addition, subsidies should be used for coverage that includes comprehensive benefits and protections against high out-of-pocket costs. The subsidy should be large enough to ensure that no individual or family spends more than a specific percent of income on total health care costs, including premiums, cost-sharing (such as copayments and deductibles), and fees for uncovered services. Finally, in order to protect the existing foundation of job-based insurance coverage and help to contain costs, subsidies should be available for job-based coverage when an offer of quality coverage exists.

Assistance for Out-of-Pocket Costs

While the high cost of premiums is undoubtedly a barrier to securing coverage for many moderate-income families, providing insurance coverage alone is not enough to ensure sufficient financial protection. It will be necessary to provide additional assistance with out-of-pocket costs, such as deductibles and copayments, to ensure that these families can both receive and afford the care that they need. This assistance could be provided by in a number of ways. One approach would be to provide subsidized plans with differing cost-sharing protections based on income. Another approach would be to provide one plan and also provide an additional subsidy based on income to help lower-income families cover out-of-pocket costs. The additional out-of-pocket subsidy would be on a sliding scale and protect individuals and families from spending more than a certain percentage of income on the total of their share of premiums plus deductibles, copayments, and other out-of-pocket costs (a cap on out-of-pocket costs based on income). Empirical research shows that reducing cost-sharing helps to ensure that lower-income people are able to obtain necessary care.[22]

Creating a Fair Marketplace for the Subsidies

In order to ensure that each person with a subsidy can use this subsidy to purchase quality coverage at a fair, affordable price, some key insurance market reforms must be implemented. First and foremost, insurers must provide an offer of coverage to all applicants regardless of health status, age, or other factors. In addition, the coverage offered must meet certain standards to ensure that federal subsidies are purchasing quality, cost-effective coverage. The federal government, together with states, should oversee this system to be sure that public dollars actually go to health care and that companies do not make unreasonable profits. Plans must include comprehensive benefits, and premiums should not discriminate against people because of health status, age, or other factors. To facilitate the comparison and selection of plans, a health insurance "exchange" or "connector" would be invaluable. Creating an exchange would help to facilitate the presentation of basic

information on different plans, such as benefits packages, out-of-pocket costs, and coverage limitations, in a clear, consumer-friendly way.

Improvements to the Medicare Program

Low-income seniors and people with disabilities also are in need of assistance with health care costs. Although these groups have coverage through Medicare, they must pay sizable Medicare premiums. Moreover, they can incur substantial out-of-pocket costs in the form of cost-sharing for in-patient and outpatient services when they develop serious illnesses.

Over the past two decades, Congress has created several programs to serve low-income Medicare beneficiaries. There are three Medicare Savings Programs (MSPs): Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualified Individual (QI). These programs, which are administered by state Medicaid programs, cover the Medicare Part B premium (currently $96.40/month) for people whose incomes are too high to qualify for Medicaid. The QMB program also covers beneficiaries' cost-sharing under Medicare Parts A and B, which can run into the thousands of dollars for people with substantial health care needs.

The Part D Low-Income Subsidy (LIS) was created in 2003 as part of the Medicare prescription drug benefit. The LIS pays for Part D premiums and other out-of-pocket costs and, perhaps most importantly, it protects low-income beneficiaries from falling into the infamous coverage gap (known colloquially as the "doughnut hole").

Both the Medicare Savings Programs and Low-Income Subsidy program have the potential to be of enormous help to low-income seniors. However, the programs have several flaws. First, the income eligibility standards for these programs are relatively low. Worse, these levels differ from each other, which causes confusion. The QMB program (the one that provides help with deductibles and copayments as well as with premiums) is available only to seniors and people with disabilities whose incomes are below the poverty line – $10,830 in annual

income for an individual, $14,570 for couples. The SLMB program's income limit is 120 percent of the poverty line; QI extends eligibility to 135 percent of poverty; and the LIS limits eligibility at 150 percent of poverty.

Second, all of the programs have asset tests whose eligibility levels are so low that they that disqualify Medicare beneficiaries who have even very modest savings. Although we applaud Congress for increasing and, at last, indexing asset limits for the MSPs as part of last year's Medicare Improvements for Patients and Providers Act (MIPPA), the level of qualifying assets is still quite low. Even taking the MIPPA improvements into account, asset limits for MSPs next year will be slightly above $8,100 for an individual and $12,910 for a couple.[23] In LIS, individuals with assets over $12,510 or couples with more than $25,010 are disqualified from even a partial subsidy. The assets eligibility test not only disqualifies many low-income Medicare beneficiaries from getting the subsidies they need. It also establishes a very cumbersome process requiring substantial documentation, thereby making it difficult for low-income seniors and people with disabilities to gain access to these important programs.

Finally, a substantial number of low-income seniors and people with disabilities who are eligible for the MSP and LIS programs are not participating in them. Simplification and alignment of the programs could substantially improve enrollment. In addition, cooperation among federal agencies and states could better target outreach and enrollment efforts.

Families USA urges Congress to include improvements to the programs serving low-income Medicare beneficiaries as part of health care reform. In particular, the following:

- Income eligibility levels should be increased for MSPs and the LIS (to, for example, 200 percent of poverty), and the levels should be aligned across the programs.
- The asset limits should be eliminated, or at a minimum, substantially increased, and should likewise be aligned across all programs.
- Include administrative simplifications and require inter-agency cooperation at both the federal and state levels to substantially increase enrollment.

In conclusion, health care reform presents a tremendous opportunity to move forward and provide quality, affordable health coverage to everyone in our country—and to do so within the framework of our uniquely American system. Families USA believes that we can build on the best of what we have today by melding both public and private approaches so that the strengths of each are preserved and fostered.

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[1] Kim Bailey, *Americans at Risk: One in Three Uninsured* (Washington: Families USA, March 2009).
[2] Ibid.
[3] Families USA calculations based on Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2000 Annual Survey* (Washington: Kaiser Family Foundation, 2000) and Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2008 Annual Survey* (Washington: Kaiser Family Foundation, September 2008).
[4] Ibid.
[5] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2008 Annual Survey*, op. cit.
[6] Kaiser Commission on Medicaid and the Uninsured, *The Uninsured: A Primer, Key Facts about Americans without Health Insurance* (Washington: Kaiser Family Foundation, October 2008); The Urban Institute and the University of Maryland, Baltimore County, *Uninsured Americans with Chronic Health Conditions: Key Findings from the National Health Interview Survey* (Washington: Robert Wood Johnson Foundation, May 2005).
[7] Jack Hadley and John Holahan, "How Much Medical Care Do the Uninsured Use, and Who Pays For It?" *Health Affairs* Web Exclusive (February 12, 2003): W3-66-W3-81; Jack Hadley and John Holahan, *The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending? Issue Updat*e (Washington: Kaiser Family Foundation, May 2004). See also Kathleen Stoll, *Paying a Premium: The Added Cost of Care for the Uninsured* (Washington: Families USA, June 2005).
[8] Kathleen Stoll, *Paying a Premium: The Added Cost of Care for the Uninsured*, op. cit.
[9] Organizations participating in the Health Reform Dialogue include the following: AARP, Advanced Medical Technology Association, America's Health Insurance Plans, American Cancer Society Cancer Action Network, American College of Physicians, American Hospital Association, American Medical Association, American Nurses Association, American Public Health Association, Blue Cross and Blue Shield Association, Business Roundtable, Catholic Health Association of the United States, Families USA, Federation of American Hospitals, Healthcare Leadership Council, National Federation of Independent Business, Pharmaceutical Research and Manufacturers of America, and U.S. Chamber of Commerce. A copy of the Health Reform Dialogue agreement is available online at http://www.familiesusa.org/assets/pdfs/health-reform/09healthreformdialogue.pdf.
[10] Teresa A. Coughlin, Sharon K. Long, and Yu-Chu Shen, "Assessing Access to Care under Medicaid: Evidence for the Nation and Thirteen States," *Health Affairs* 24, no. 4 (July/August 2005): 1073-1083.
[11] Jack Hadley and John Holahan, "Is Health Care Spending Higher under Medicaid or Private Insurance?" *Inquiry* 40, no. 4 (Winter 2003/2004): 323-342; Leighton Ku and Matt Broaddus, "Public and Private Insurance: Stacking Up the Costs," *Health Affairs* 27, no. 4 (July/August, 2008): w318-w327.
[12] Leighton Ku and Matt Broaddus, op. cit.
[13] Leighton Ku, *The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings* (Washington: Center on Budget and Policy Priorities, May 2005).
[14] Key Findings of the RAND Health Insurance Experiment Study are described in Geri Dallek, *A Guide to Cost-Sharing and Low-Income People* (Washington: Families USA, October 1997).
[15] Kaiser Commission on Medicaid and the Uninsured analysis of 2007 National Health Interview data.

[16] Families USA calculations.
[17] Kaiser Family Foundation, StateHealthFacts.Org, "Health Insurance Coverage of Adults 19-64, states (2006-2007), U.S. (2007)," available online at http://www.statehealthfacts.org/comparebar.jsp?cat=3&ind=130&typ=2&gsa=1.
[18] Kaiser Family Foundation, StateHealthFacts.Org, "Distribution of the Nonelderly Uninsured by Federal Poverty Level (FPL), states (2006-2007), U.S. (2007)," available online at http://www.statehealthfacts.org/comparebar.jsp?cat=3&ind=136&typ=2&gsa=1.
[19] Victoria Wachino and Alice Weiss, *Maximizing Kids' Enrollment in Medicaid and SCHIP: What Works in Reaching, Enrolling and Retaining Eligible Children* (Washington: National Academy for State Health Policy, February 2009).
[20] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2008 Annual Survey*, op. cit.
[21] Kim Bailey and Beth Wikler, *Too Great a Burden: America's Families at Risk* (Washington: Families USA, December 2007).
[22] Julie Hudman and Molly O'Malley, *Health Insurance Premiums and Cost Sharing: Findings from the Research on Low-Income Populations* (Washington: Kaiser Commission on Medicaid and the Uninsured, March 2003).
[23] The asset level increases under MIPPA take effect in 2010. The $8,100 and $12,910 asset levels cited in the text are the eligibility levels for the full LIS, which would apply to MSPs if the MIPPA provisions were in effect this year. The actual asset limits in 2010 will be slightly higher because they will be adjusted for inflation. The actual asset limit for MSPs in 2009 is still $4,000 for an individual and $6,000 for a couple.