Health care for the poor: For whom, what care, and whose responsibility?

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Introduction

Public programs to help poor Americans obtain medical care have evolved as the country has grown richer and medical advances have increased life expectancy and improved quality of life.[1] The evolution has not been a direct path of increased generosity towards poor people. Instead, it reflects a mix of philosophical beliefs, greater understanding of the links between health and ability to work, and swings in the economy.

Since the late 1940s, when the share of Americans with employer-sponsored, private health insurance started to grow rapidly, the primary approach to helping poor people obtain medical care has been to make public health insurance available to a growing share of the poor. Underlying this approach is the assumption that if poor people have health insurance, physicians and other providers of medical care will provide the same services to poor people as they do to middle-class people. But as experience with public insurance has grown, it has become clear that poor people face barriers to obtaining health care beyond simply their inability to afford it. A shortage of physicians and nurses exists in many poor areas of the country, and not all physicians and other medical care providers are willing to treat people with public insurance coverage. Many poor people are unaware of symptoms of medical need or do not know how to explain their symptoms to medical personnel. Others face language or cultural difficulties when seeking care. As understanding of these barriers has increased, efforts to help low-income people obtain health care have expanded to include more funding for community health centers, public health clinics, language translators, and educational programs about health issues specifically targeted at groups of poor people. These public policy efforts, however, have been secondary to expanding health insurance coverage for low-income people.

The dramatic increase over the past 50 years in medicine's ability to increase life expectancy and improve quality of life (especially for people with chronic conditions) has made disparities in access to health care more troubling. There is no doubt that poverty is a contributing factor to poor health outcomes. Poor people have lower life expectancies, higher prevalence of chronic illnesses and health conditions, and more unmet health needs than people with middle-class and high incomes. But the causal path between poverty and poor health outcomes is complex. Other factors that are correlated with low income, such as low education, the inability to speak English, and residence in areas with high levels of pollution, also contribute to poor health.[2] Equally important, the link between poverty and poor health does not go in just one direction. Poor health is a contributing factor to low incomes and poverty. People with chronic medical conditions frequently are poor because they cannot work, and people who suffer a sudden decline in health often become poor after losing their job. Moreover, people with chronic illness often have difficulty accessing medical care because they are not good advocates for themselves and too few medical providers are nearby, and they then remain poor because they cannot work.

The fact that people in poor health often have low incomes as a result of their health problems is an increasingly important driver of efforts to expand eligibility for public insurance. This is especially the case in efforts to increase coverage of children. As we have come to appreciate how poor health can affect learning, which in turn is related to a person's productivity and earnings, awareness has grown that investing in ways to improve access to health care pays off in areas beyond health outcomes. Thus, the recent history of public policies to help poor people obtain health care is an evolving mix of efforts to address the reasons poor people have poor health. Some policies increase public insurance, and other initiatives are targeted at addressing language and cultural problems particular to the poor or increasing the supply of medical providers knowledgeable about difficulties facing poor people.

This article focuses on the recent history of public policies intended to help the poor obtain health care, including the concerns now surrounding public insurance.

Health care assistance for the poor, past and present

A brief history of major efforts to provide health care to the poor since 1900 is shown in the box on this page.[3] Two themes are apparent when examining the last century of health care assistance for the poor. First, there has been a preference for state rather than federal control of how health care assistance is administered. Second, health care assistance for the poor has been administered more as a welfare program than as part of a national system of financing health insurance and medical care. Both themes have contributed to large disparities across states in who among the poor has access to what types of medical care.

Recent state innovations in insurance programs for the poor and near-poor

Medicaid enrollment increased between 2000 and 2007, partly because of increases in the number of people who either lost or were not offered employer-sponsored insurance.

History of Major Efforts to Provide Health Care to the Poor Since 1900

1900–1935:	Medical care assistance provided ad hoc by civic and religious groups, primarily to "deserving poor"
1935–1945:	Social Security Act passed, rise of public hospitals and clinics for poor, beginning of two-tiered system of medical care
1945–1965:	Private insurance coverage expands, setting the stage for Medicaid
1965:	Medicare and Medicaid Implemented
1984–1990:	Expansion of Medicaid
1990s:	Efforts to slow Medicaid spending growth, waivers, and welfare reform
1997:	Creation of the State Children's Health Insurance Program (SCHIP)
Early 2000s:	Efforts to control Medicaid spending growth and state experiments to expand options for poor people

In 2007, 55 percent of the nonelderly uninsured had incomes below 200 percent of the poverty level; and almost a third of all nonelderly people with incomes below 200 percent of the poverty level were uninsured (Table 1). Most of these uninsured people were not eligible for Medicaid because they either did not meet categorical eligibility requirements or they had incomes exceeding their state's eligibility ceiling.

In response to the growing number of uninsured working people, several states created programs in the early 2000s to expand eligibility for public insurance or encourage low-income people who were not eligible for Medicaid to buy private health insurance with state subsidies. The states did this not only to expand coverage but also to reduce pressures on hospitals and physicians who were providing more uncompensated care to the uninsured. Three programs of note, described briefly below, are described in detail in the book chapter. Healthy New York, started in 2001, is available for people who are not eligible for Medicaid but whose income is below 250 percent of the poverty level. Commonwealth Care, implemented in late 2006 by Massachusetts, provides a choice of four managed care plans (with some further choice of benefits depending on a person's income) to people who do not qualify for Medicaid but have incomes below 300 percent of the poverty level. BadgerCare Plus began enrolling children under 19 years of age in Wisconsin in early 2008. The program is open to all children regardless of income who do not have access to health insurance, as well as self-employed parents, pregnant women with annual incomes up to 300 percent of the poverty level, and farmers.

Table 1
Distribution of Nonelderly Uninsured by Income Relative to Poverty, 2007

Family Income Relative to Poverty	Number Uninsured (millions)	Percentof Uninsured	Percent of Cohort Uninsured
Below poverty level	11.404	25.4%	33.4%
1–1.49 x poverty	7.371	16.4	32.4
1.5–1.99 x poverty	5.777	12.9	27.1
2–2.99 x poverty	8.784	19.5	20.1
3–3.99 x poverty	4.594	10.2	12.5
4 x poverty and higher	7.026	15.6	6.8
TOTAL	44.956	100	17.1

Source: Author's tabulations of March 2008 Current Population Survey.

Community Health Centers: An alternative to insurance coverage for the poor?

Since the "War on Poverty" was initiated in 1965, the federal government has funded Community Health Centers (CHCs) to provide medical care to the poor and uninsured. Over the last four decades, levels of enthusiasm for and disillusionment with these public providers of medical care have waxed and waned. Proponents of CHCs argue that they take better care of the health problems of low-income people because they know more about their clients' lives—their living conditions, willingness to discuss symptoms and tendency to follow directions about prescriptions or nutrition—than medical personnel in physicians' offices or health plans. They argue that expanding public health insurance programs is less efficient than expanding CHCs.

About a quarter of the people served by CHCs are uninsured while the rest are covered by public insurance, and almost two-thirds are members of minority or immigrant groups.[4] Despite a recent increase in funding for CHCs, there is a consensus of opinion that uninsured patients at CHCs who need specialty services, including diagnostic tests and medically necessary referrals for medical specialists and mental health and substance abuse services, face greater difficulties than do Medicaid enrollees.[5] Most analysts believe that CHCs need additional resources to provide better quality care, though it is not yet known whether it is more cost-effective to expand CHCs than to expand public insurance programs that pay for care by all types of providers.

Current concerns with public health insurance programs

Beyond concerns about the rising costs of Medicaid, SCHIP, and other public health programs, there are four major concerns about how these programs collectively meet the needs of low-income people.

Quality of care for elderly and disabled beneficiaries

Medicaid is the largest source of financing for long-term care; elderly and disabled beneficiaries make up only 25 percent of Medicaid enrollees, but account for about 70 percent of spending.[6] Recent efforts to limit Medicaid spending on elderly and disabled beneficiaries have focused on restrict-

Health Insurance in the United States

A brief explanation of the broad types of health insurance now held by Americans is useful for understanding why the primary approach to helping poor people obtain medical care has been to expand eligibility for public health insurance.

About 61 percent of people younger than 65 years old have employer-sponsored, private health insurance. Another 5 percent of the nonelderly have insurance policies that they buy themselves in the individual (or non-group) insurance market from private insurance companies. In addition, about 3 percent have military or Veterans Administration coverage and 2 percent to 3 percent have Medicare (either because they have end-stage renal disease or are otherwise disabled and cannot work). Of the remaining nonelderly, about 13 percent are covered by Medicaid and almost 18 percent have no insurance coverage at all. (Some people report having more than one type of insurance during a year so the numbers sum to more than 100 percent.) Medicaid covers about a third of all people in poverty; most recipients are children and pregnant women, but about a fourth of Medicaid recipients are disabled or elderly. Almost everyone 65 years of age or older is covered by Medicare.

Health insurance is available in many different forms. The most common are known as indemnity policies and managed care plans. Indemnity policies usually have a deductible (an amount of medical care expenses that a person has to pay all of before the insurance starts to pay anything) and a coinsurance rate (a percentage of the medical expenses that a person continues to pay after the deductible is met). Catastrophic health plans are indemnity policies with quite large deductibles—generally $2,000 for an individual and $5,000 for a family policy. The deductible and coinsurance are intended to make people aware of the costs of medical care and restrain unnecessary demands for care. In contrast, most managed care plans do not have deductibles although they may require a copayment for medical care. Copayments are relatively modest amounts ($10 to $25 for a physician visit in 2008) and are independent of the full costs of the encounter (for example, diagnostic tests ordered and length of visit). Some managed care plans try to restrain health care spending by tight restrictions on which physicians and hospitals their members can use; others have less restrictive networks of providers but create long waiting periods for certain types of specialists by not having many of them in their networks. Some managed care plans have strict guidelines on when further diagnostic testing or surgery is appropriate. Most of these managed care mechanisms for slowing health care spending have also been adopted by indemnity policy providers.

Health insurance provides the highly useful service of pooling millions of people's individual risks of needing expensive medical care. Since only a very small number of people will need expensive care during a year, insurance allows each enrolled individual to pay a relatively modest amount to avoid incurring large costs in the event of a medical emergency. But health insurance also creates what is known as moral hazard: because insurance pays most of the cost of care (above a deductible for those with indemnity policies), people are less hesitant to see a physician and request diagnostic and other services when something bothers them. Thus, health insurance is a double-edged sword; it protects us from catastrophic medical expenses but it may also increase demand for medical care above medically justifiable levels.

Competition in the market for health insurance has caused insurers to negotiate the fees they pay physicians, hospitals, and other health care providers in local markets. Medicare and Medicaid also negotiate the fees they pay providers, but they pay rates that are below the private insurance fees. People without any health insurance are charged much higher fees than insured people. Thus, for low-income people without employer-sponsored insurance, Medicaid and other publicly funded insurance programs provide access to medical care that they could not otherwise afford.

ing the supply of nursing home beds and increasing access to community and home care providers of long-term care. Several studies have shown large disparities in Medicaid spending on long-term care services across the states, which together with low payments to providers raise concerns about the quality of care provided to elderly and disabled Medicaid recipients.[7] As the population ages, pressures on states to expand the supply of long-term care services will increase. Because elderly and disabled beneficiaries have far higher per capita costs than do children and non-disabled adults, the tensions between improving quality of care and restraining spending will grow.[8]

The poor who are left out of Medicaid

A third of all nonelderly people in poverty were uninsured in 2006.[9] Some are eligible for Medicaid, but many are not because they are not members of the categorical groups of eligible people: children, pregnant women, some parents of children, elderly, and children and adults with physical or mental impairments. As Table 2 shows, in 2007 between 41 percent and 52 percent of poor adults between 19 and 54 years of age were uninsured, as were 31 percent of poor adults aged 55 to 64.

The proportion of people with private health insurance increases steadily with income. For a variety of reasons, fewer than half of those with incomes below 200 percent of the poverty level have private coverage. One reason a majority of low-wage workers do not have employer-sponsored insurance is that many work for small firms; only about a third of firms with fewer than 50 workers offer such insurance.[10] In addition, many low-wage workers may not be able to afford the employee share of the premium. While only about 3

Table 2
The Uninsured by Age Cohort and Income Relative to the Poverty Level, 2007

	Family Income Relative to Federal Poverty Level						
Age Cohort	< Poverty Level	1.0–1.49	1.5–1.99	2.0–2.99	3.0–3.99	>=4.0	Total
Younger than 19	18.4%	18.6%	15.9%	11.8%	7.2%	4.0%	100%
19–24	45.1	45.2	38.3	31.2	25.1	15.4	100
25–34	52.2	46.5	40.1	28.1	16.8	10.7	100
35–44	46.8	42.3	31.5	21.3	12.6	6.7	100
45–54	40.7	36.8	31.2	23.2	12.6	5.6	100
55–64	31.5	30.1	21.6	16.2	9.9	5.1	100

Source: Author's tabulations of March 2008 Current Population Survey.

percent of all workers who are offered employer-sponsored insurance turn it down and remain uninsured, increasing numbers of anecdotal stories indicate that low-wage workers decline insurance due to the rising cost.[11]

People who reside legally in the United States but are not yet citizens accounted for 22 percent of the uninsured in 2006.[12] Not quite half of the nonelderly foreign-born residents who were not yet citizens were uninsured, in contrast with 15 percent of native citizens and 20 percent of naturalized citizens. A majority of foreign-born noncitizens are younger adults with low levels of formal education and low wages who do not have employer-sponsored health insurance at their jobs. Under the 1996 welfare reform, legal immigrants who are not citizens are not eligible for Medicaid (or SCHIP) until they have lived in the United States longer than 5 years. The 2009 SCHIP reauthorization legislation removed this barrier for children who meet the income and categorical requirements.

Poor people who are disabled by mental health problems are categorically eligible for Medicaid. But low-income people who can work at least part time do not qualify for disability status and therefore cannot obtain Medicaid coverage for their mental health problems. Similarly, low-income people who have substance abuse problems are not likely to qualify for Medicaid and, if they do, are likely to receive only limited services to address their substance abuse problems.

Potential crowding out of employer-sponsored insurance by Medicaid and SCHIP

Since the establishment of Medicaid, policy analysts and politicians have raised concerns about the possibility that low-income people might substitute public coverage for private insurance. This concern was raised again after the Medicaid eligibility criteria were expanded in the late 1980s, and the term for such substitution became known as "crowding out" in the mid-1990s. Crowd-out could occur, it was reasoned, because low-wage workers would find it cheaper to enroll their children in Medicaid than to pay the additional premium for dependent coverage. Another proposed cause for crowd-out was that firms that employed mostly low-wage workers would no longer feel that they needed to offer insurance since Medicaid was available for more children and pregnant women. While the first three decades' experience with Medicaid did not confirm these fears, the law establishing SCHIP required states to take measures to prevent SCHIP from substituting for employer-sponsored insurance.

Increasing the enrollment and re-enrollment of eligible people

Not everyone who is eligible for public programs aimed at providing access to medical care for low-income people enrolls in them. Thomas Selden and colleagues estimated that not quite three-fourths of children eligible for either Medicaid or SCHIP were enrolled in 2002.[13] Efforts to raise take-up rates and retain people in the programs once they enroll have grown in recent years as evidence has mounted that people who do not have continuity of care often have avoidable health problems.

Short-term loss of eligibility is also a concern. For children whose family incomes are close to the income eligibility ceilings of public programs, income dynamics can cause "churning" in and out of enrollment in SCHIP or Medicaid.[14]

Issues that affect the future of public health insurance

Inequities in eligibility across states and by type of person

The current set of state-administered public insurance programs for low-income people—Medicaid, SCHIP, and state-only financed programs—create two kinds of inequities. One occurs across states: uninsured people with the same income and family circumstances who live in different states often do not have the same publicly financed coverage. The second inequity occurs across persons within states: Medicaid and SCHIP eligibility criteria do not allow people who have access to employer-sponsored insurance to enroll. This prevents low-income people who cannot afford the employee share of the premium from enrolling in the public programs even though their incomes are the same as other people who are eligible.

Disparities in states' ability to fund public programs and spending per enrollee

The inequities in income eligibility limits are largely due to differences in states' ability to fund public insurance programs. These differences occur despite the fact that federal matching rates under Medicaid and SCHIP are highest for the states with low per capita incomes. For example, in 2008, California, New York, and Massachusetts, with high per capita incomes, received one federal dollar for each state dollar spent on Medicaid, whereas Arkansas, Louisiana, and Mis-

sissippi, with low per capita incomes, received between $2.64 and $3.22 for each state dollar. The SCHIP matching formula is more generous than the Medicaid formula—the higher per capita income states received $1.86 and the lower per capita income states received up to $5.00 per state dollar in 2008.

A primary reason for the disparity in the generosity of public programs across states is that a state has to spend its own funds to obtain the federal matching dollars and the poorer states are not able to or choose not to spend as much of their own funds on Medicaid and SCHIP as the higher income states. Medicaid spending per enrollee in 2004 varied from about $10,200 in New Jersey and New York to $4,100 in Alabama and $3,700 in California.[15] The disparities in states' ability to pay for Medicaid and SCHIP and the differences across states in spending per enrollee raise questions about the wisdom of the state-federal structure of these programs. A design structure that provides benefits to some poor people and not to others simply because of where they live is not equitable.

How to slow the growth in spending on Medicaid

The growth in spending on Medicaid over the past 40 years has been driven to varying degrees by increases in enrollment and increases in health care costs. Enrollment has grown in response to downturns in the economy, expansions of eligibility criteria, stepped-up efforts to enroll eligible people, and a general increase in the U.S. population. The increases in the costs of health care provided to Medicaid beneficiaries are related to which services are covered, the costs of different types of services, changes in norms regarding the intensity of care provided, and the reimbursement rates paid to providers.

For policymakers, the fact that expenditures for the elderly and disabled have accounted for a majority of the spending growth in recent years makes it difficult to rein in spending on Medicaid. This is particularly true in the current environment of rising concerns about the quality of care provided in nursing facilities compounded by the expected rapid growth in need for long-term care as baby-boomers retire. Reversing the past two decades' expansions of eligibility criteria for children and non-disabled adults will not radically slow the growth in overall Medicaid spending. Given concerns about ensuring access to care, policymakers cannot cut Medicaid payments to health care providers much below what they are now. Thus, Medicaid spending growth is unlikely to fundamentally change without changes in the underlying medical care system.

The role of Medicaid and SCHIP in the system of financing health care

Medicaid has a particularly important role in providing access to health care for low-income people who are most likely to have high medical expenses: disabled and elderly people and pregnant women. Without Medicaid, private insurance markets would use even more mechanisms than they do now to avoid insuring potentially high-cost people, and there would be more uninsured.[16] Thus, because Medicaid insures people deemed high-risk for needing high-cost medical care, everyone who has private insurance experiences lower premiums and easier access to insurance than would be the case if Medicaid did not exist.

However, Medicaid cannot control the growth in its own costs caused by the rising intensity of services provided when someone is sick. Medicaid now accounts for almost 15 percent of total health spending, but this share of total spending is too small to have great influence on the costs of medical care services. Moreover, because states set the payment rates for Medicaid health care providers and there is great variation in those rates, Medicaid lacks sufficient coherence to influence the norms for the intensity of services provided for diagnoses. Changes in these norms, particularly the increase in the use of new technologies and pharmaceuticals, are believed by most policy analysts to explain most of the growth in health care spending since 1960.[17]

Because Medicaid by itself cannot control the share of spending growth that is due to greater intensity of services and use of new technologies, and because many poor people remain uninsured, questions can be raised about how financing health care for the poor might change in the future. A national system of health care financing that included everyone could be based on a combination of individual payments (premiums) and payroll-based taxes. This financing structure could ensure a progressive payment system that would subsidize low-income people. A universal national system would also reduce the expenses for administrative procedures that are in place now to verify a person's eligibility for Medicaid or SCHIP and that have discouraged eligible people from enrolling in both programs.

The present problems of employer-sponsored health insurance may be a catalyst for restructuring our financing of health insurance. Employers are increasingly likely to limit their role in paying for health insurance, thereby increasing the number of uninsured. Many of these newly uninsured will be low-income people but others will be middle-class workers. Thus, options for restructuring health care financing that include the poor should take on greater urgency.

Conclusions and recommendations

For at least the past century, Americans have charted an inconsistent course to providing health care assistance to poor people. When economic times have been good, the country has expanded the groups of low-income people who are eligible for assistance. When the costs of providing care have increased more rapidly than the economy or tax revenues, governments have either paid providers of health care less or made it more difficult for eligible people to enroll. Some of this inconsistency reflects our federalist system of government. Under Medicaid, the federal government provides at least half of Medicaid funding to states and sets general guidelines about which poor people are eligible, and the states have flexibility over optional services and people to cover as well as the payment rates to providers. The federal government pays more of the SCHIP costs but states have control over the income eligibility criteria.

Some of the inconsistency in how we provide assistance to the poor reflects tensions surrounding our views of different subgroups of the poor. Poor children and pregnant women have fared well compared to poor childless adults. Access to medical care for children is viewed as a good investment because healthier people are more productive members of society. The disabled poor and poor elderly are viewed as deserving of our help because they cannot earn more income. There is far less sympathy for non-disabled adults without children; many people believe they should be able to find a job with health insurance, despite the decline over the past decade in the fraction of employers offering insurance.

Thus, we return to the fundamental question of how medical assistance should be provided to the poor. Should poor people participate in the same health care financing system as other Americans, or should assistance with medical care be provided to the poor as a welfare program, and only to groups thought to be "deserving" of it? Answering this question involves examining our system of health insurance for everyone. Currently, most Americans rely on employer-sponsored coverage. However, because employers are not willing to continue to absorb the growth in health care spending, the number of uninsured workers is rising. Among the issues that must be considered are two that particularly affect the poor: how much higher-income people and companies should be taxed in order to provide subsidies to low-income people, and what package of health care services will be considered the minimum to which everyone is entitled regardless of income. How we answer these questions will determine how we share the responsibility for providing health care access to the poor in the coming decades.

The United States should move to a national system of health insurance so everyone—regardless of income—would have a minimum set of medical services that are covered, much like Medicare covers a minimum set of services. A national insurance system would achieve three other objectives. First, it would eliminate the current inequities in eligibility criteria for Medicaid and SCHIP, and states' ability to fund assistance programs for the poor. Second, it would provide a mechanism for slowing the rate of growth in health care spending. Without such a slowdown, the country will have increasing disparities in the medical care available to high- and lower-income people. Finally, a national system of health insurance would efficiently and quickly redistribute income to poor people when they get sick.

The federal government also should provide funding to expand the number of primary care medical personnel. Funding should be devoted particularly to increasing the number of registered nurses, nurse practitioners, and physicians who are knowledgeable about issues that affect low-income people's health and their ability to articulate symptoms and concerns. Community health centers are one mechanism for providing medical care in poor areas, but they are not a substitute for increasing the number of knowledgeable primary care providers.

Finally, greater attention must be paid to providing information about health issues to low-income people. Public health campaigns for brushing teeth and smoking cessation worked to increase oral health and reduce smoking in poor areas. Targeting understandable information about links between obesity and diabetes and cardiac problems would similarly help lower-income people avoid some health issues that restrict their ability to earn more. Moreover, because large shares of the poor are foreign-born, greater sensitivity to cultural nuances concerning health care must be included in information developed for low-income people. ■

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[1]This article draws upon "Health Care for the Poor: For Whom, What Care, and Whose Responsibility?" in *Changing Poverty, Changing Policies*, eds. M. Cancian and S. Danziger (New York: Russell Sage Foundation, 2009).

[2]See, for example, *Access to Health Care: Promises and Prospects for Low-Income Americans*, eds. M. Lillie-Blanton, R. M. Martinez, B. Lyons, and D. Rowland (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 1999).

[3]See the book chapter for a much more detailed version of this history.

[4]L. S. Hicks, A. J. O'Malley, T. A. Lieu, T. Keegan, N. L. Cook, B. McNeil, and colleagues, "The Quality of Chronic Disease Care in U.S. Community Health Centers," *Health Affairs* 25, No. 6 (2006): 1712–23.

[5]N. L. Cook, L. S. Hicks, A. J. O'Malley, T. Keegan, E. Guadagnoli, and B. E. Landon, "Access to Specialty Care and Medical Services in Community Health Centers," *Health Affairs* 26, No. 5 (2007): 1459–68.

[6]D. Rowland, "Medicaid's Role for People with Disabilities," testimony before the U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Health, January 16, 2008.

[7]See, for example, E. O'Brien, "Long-Term Care: Understanding Medicaid's Role for the Elderly and Disabled," Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2005.

[8]From J. Holahan, M. Cohen, and D. Rousseau, "Why Did Medicaid Spending Decline in 2006? A Detailed Look at Program Spending and Enrollment, 2000–2006," Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2007; the per capita costs have been adjusted to exclude all prescription drug spending for dual eligibles ($16,142 compared to $2,987, respectively, in 2006).

[9]K. Swartz, "Uninsured in America: New Realities, New Risks," In *Health at Risk: America's Ailing Health System – and How to Heal It*, ed. J. S. Hacker (New York: Columbia University Press, 2008).

[10]K. Swartz, *Reinsuring Health: Why More Middle-Class People Are Uninsured and What Government Can Do* (New York: Russell Sage Foundation, 2006).

[11]J. Haas and K. Swartz, "The Relative Importance of Worker, Firm, and Market Characteristics for Racial/Ethnic Disparities in Employer-Sponsored Health Insurance," *Inquiry* 44, No. 3 (2007): 280–302.

[12]Swartz, "Uninsured in America: New Realities, New Risks." The issues surrounding foreign-born legal residents who are uninsured are highly nuanced, and some relate to the delays they face in becoming citizens.

[13]T. M. Selden, J. L. Hudson, and J. S. Banthin, "Tracking Changes in Eligibility and Coverage among Children, 1996–2002," *Health Affairs* 23, No. 5 (2004): 39–50.

[14]B. D. Sommers, "Why Millions of Children Eligible for Medicaid and SCHIP Are Uninsured: Poor Retention Versus Poor Take-Up," *Health Affairs* Web Exclusive (26 July 2007): W560–7.

[15]Holahan, Cohen, and Rousseau, "Why Did Medicaid Spending Decline in 2006?"

[16]K. Swartz, "Let's Not Neglect Medicaid's Vital Role in Insurance Markets," *Inquiry* 33, No. 4 (1996/1997): 301–3.

[17]See for example, J. P. Newhouse, "Medical Care Costs: How Much Welfare Loss?" *Journal of Economic Perspectives* 6, No.3 (1992): 3–21.