MEDICAID INSTITUTE
AT UNITED HOSPITAL FUND

ISSUE BRIEF

Gaps in Coverage Among the Elderly in New York

APRIL 2007

DANIELLE HOLAHAN, Senior Health Policy Analyst, United Hospital Fund
SARA FOLIT-WEINBERG, former Research Assistant, United Hospital Fund

Because only 1 percent of elderly New Yorkers are uninsured, most discussions of health insurance coverage focus exclusively on the non-elderly. However, while nearly all the elderly have *a* source of health insurance coverage—primarily Medicare—and some have multiple sources of coverage, many are underinsured.[1] These underinsured older adults have significant gaps in their health insurance coverage—gaps that have important implications both for the elderly, who face high out-of-pocket costs, and for the Medicaid program, which provides coverage to 21 percent of low-income elderly persons in New York. Further, current trends suggest that an even greater share of New York's elderly will be underinsured in the coming years, which will likely mean significantly increased Medicaid costs.

[1] In past research on the non-elderly, "underinsured" has been defined as being insured all year, but with out-of-pocket expenses exceeding 10 percent of income (Schoen et al. 2005; Short and Banthin 1995). In this analysis, we do not know the percentage of income that Medicare beneficiaries pay out of pocket. Past research by AARP estimated that non-institutionalized elderly Medicare beneficiaries spent an average of 22 percent of income on health care in 2003 (Caplan and Brangan 2004). Further, the Kaiser Family Foundation estimates that Medicare covers 45 percent of enrollees' total health care costs (Kaiser 2005). Based on these two findings, we assume that out-of-pocket spending for persons without Medicare supplemental coverage is not an insignificant share of income, and describe this group as "underinsured." Some seniors without Medicare or with limited Medicare supplemental coverage may also be underinsured.

The Medicaid Institute at United Hospital Fund is working to improve the Medicaid program in New York by providing information and analysis and developing a shared vision for change.

The Medicaid Institute at United Hospital Fund

James R. Tallon, Jr.
President

David A. Gould
Senior Vice President for Program

Medicaid Institute at United Hospital Fund
Empire State Building
350 Fifth Avenue, 23rd Floor
New York, New York 10118-2300
(212) 494-0700
www.medicaidinstitute.org

Medicare's coverage limitations have significant fiscal implications for New York's Medicaid program. Medicaid enrolled nearly 400,000 low-income elderly New Yorkers at some point during federal fiscal year (FFY) 2004. Eighty-eight percent of these elderly Medicaid beneficiaries (351,000 people) were "duals"—individuals enrolled in both Medicare and Medicaid programs, with Medicare being the primary source of coverage. (The other 12 percent of elderly Medicaid beneficiaries had no Medicare coverage, whether Part A or Part B.) Medicaid coverage fills in where Medicare coverage leaves off, paying for a large share of duals' total health care costs. In FFY 2004, elderly Medicaid enrollees represented only 8 percent of all Medicaid beneficiaries, but accounted for about one-quarter of Medicaid spending—$10.1 billion (for a detailed discussion, see Birnbaum 2006). This spending includes the assistance Medicaid provides to approximately 350,000 low-income seniors to meet Medicare's cost-sharing requirements through the Medicare Savings Programs (described later).[2]

This issue brief describes the limits of Medicare's coverage, explores the coverage profile of New York's elderly, and discusses relevant emerging trends.

Medicare Eligibility and Coverage

Medicare is an important source of health insurance for nearly all the elderly; however, not every elderly person is eligible, and not all health care needs are covered by the program. To qualify for Medicare as an elderly beneficiary, an individual must be over the age of 65 and must have worked (or have a spouse who worked) and paid payroll taxes to Social Security for at least 40 quarters (ten years).[3]

Medicare's benefits package has several limitations. Medicare provides only partial coverage of post-acute care, does not cover long-term care, and has no cap on out-of-pocket spending (Table 1). Prescription drug coverage provided through Medicare Part D (since January 2006) is more limited than under traditional coverage provided by employers and Medicaid. According to the Kaiser Family Foundation, in 2002 Medicare covered 45 percent of enrollees' total health care costs (Kaiser 2005). Further, AARP

[2] Note that Medicaid spending includes the Qualified Medicare Beneficiary and Specified Low-Income Beneficiary programs; the Qualified Individual program is a federal block grant program.

[3] Individuals may also qualify for Medicare if they are permanently disabled and have received Social Security Disability Insurance for 24 months, or if they have end-stage renal disease. While Medicare covers both elderly and disabled persons, this analysis is limited to the elderly because the data sources used do not identify people based on disability status.

estimates that elderly Medicare beneficiaries spent an average of nearly $3,500, or 22 percent of their income, on health care in 2003 (Caplan and Brangan 2004). Consequently, many gaps remain in Medicare's health care coverage for the elderly. Because of these limitations, many older adults supplement Medicare coverage with other sources of coverage, including employer-sponsored or retiree insurance, other private ("Medigap") coverage, or Medicaid.

Table 1
Medicare Benefits and Cost Sharing Requirements, 2006

Medicare Part A No Premium*

Benefits	Cost Sharing
Inpatient Hospital	Deductible: $952 per benefit period Coinsurance:
Days 0-60	None
Days 61-90	$238 per day
Days 91-150 (Lifetime Reserve Days)	$476 per day
Day 151 and beyond	All costs
Skilled Nursing Facility	Coinsurance:
Days 0-20	None
Days 21-100	$119 per day
Days 101 and beyond	All costs
Home Health	No Coinsurance
Hospice	Co-payment of up to $5 for outpatient drugs and 5% coinsurance for inpatient respite care

*There is no premium if an elderly individual or his/her spouse paid payroll taxes to Social Security for at least 40 quarters; the premium is $216.00 monthly if Medicare-covered employment is only 30-39 quarters and $393.00 monthly if ineligible for premium-free hospital insurance and Medicare-covered employment is less than 30 quarters.

Medicare Part B Premium: $88.50 per month

Benefits	Cost Sharing
	Deductible: $124 per year
Physician and other medical services	20% coinsurance
Outpatient hospital care	20% coinsurance
Ambulatory surgical services	20% coinsurance
X-rays	20% coinsurance
Durable medical equipment	20% coinsurance
Physical, occupational, and speech therapy	20% coinsurance*
Clinical diagnostic laboratory services	No coinsurance
Home health care	No coinsurance
Outpatient mental health services	50% coinsurance
"Welcome to Medicare" physical examination	20% coinsurance after deductible is met
Preventive services: Annual flu shots Pneumococcal vaccines, colorectal and prostate cancer screenings, Pap smears, mammograms	The Part B deductible and 20% coinsurance are waived for certain preventive services.
Bone mass measurement, diabetes monitoring, glaucoma screening	20% coinsurance after deductible is met

*Coverage limits on Medicare outpatient therapy services ($1,740 limit per year for occupational therapy services; $1,740 limit per year for physical and speech-language therapy services combined).

Continued...

Table 1 (continued)
Medicare Benefits and Cost Sharing Requirements, 2006

Medicare Part D*
Premium: varies by plan (range: approximately $4-85 per month)

Benefits	Cost Sharing
Outpatient prescription drugs	Deductible: $250 per year
	Coinsurance:
Costs between $250 and $2,250	25%**
Costs between $2,250 and $5,100	100%
Costs above $5,100	5%**

* Medicare Part D benefit information refers to "standard" coverage. Coverage and costs vary for other plan types. See www.cms.gov for further information.
**Coinsurance amounts refer to prescription drugs on the plan formulary.

Source: Centers for Medicare and Medicaid Services, 2006.

For the low-income elderly, several public programs supplement Medicare coverage. The Medicare Savings Programs—Qualified Medicare Beneficiary (QMB) program, Specified Low-Income Medicare Beneficiary (SLMB) program, and Qualified Individual (QI-1) program—provide assistance to low-income seniors with Medicare's cost-sharing requirements (Table 2). The QMB program pays for Medicare Part A and Part B premiums, deductibles, and coinsurance, and the SLMB and QI-1 programs pay for the Medicare Part B premium on behalf of low-income elderly persons. New York's Elderly Pharmaceutical Insurance Coverage (EPIC) program provides prescription drug coverage to low- and moderate-income elderly New Yorkers. Approximately 350,000 New Yorkers receive assistance from the QMB, SLMB, or QI-1 programs (CMS 2006), and over 360,000 are enrolled in EPIC (New York State 2007). The QMB and SLMB programs are jointly financed by the federal and state government through the Medicaid program, the QI-1 program is fully federally funded, and EPIC is fully state-funded.

Table 2
Eligibility Levels for the Elderly in New York's Public Programs, 2006

	Medicaid	QMB	SLMB	QI-1	EPIC
Income	85% FPL	100% FPL	100-120% FPL	121-135% FPL	366% FPL individual
Assets	$4,150 individual	$4,000 individual	$4,000 individual	No limit	No limit

Note: Income limits for Medicaid, QMB, SLMB, and QI-1 do not include monthly disregards. The 2006 Federal Poverty Level (FPL) is $9,800 for an individual. Note that the QI-1 program requires an annual appropriation.

Source: New York City Human Resources Administration Medical Assistance Program, 2006 New York State Income and Resource Standards and Federal Poverty Level Guidelines. Available online at http://www.nyc.gov/html/hra/downloads/pdf/income_level.pdf.

Demographic and Coverage Profile of the Elderly

The demographic distribution of the elderly in New York State mirrors that of the United States as a whole: about half are low-income (income less than or equal to 200 percent of the Federal Poverty Level, or FPL)[4], one-sixth are workers, and nearly all are citizens. In New York City, however, the elderly are more likely to be low-income or non-U.S. citizens than are their counterparts in the rest of the state and the country (Table 3 and, for greater detail, Appendix A).

Table 3
Demographic Characteristics of the Elderly, 2003-2004

	Number of Elderly Persons (in millions)	Percent of Elderly Who Are Low-Income (below 200% FPL)	Percent of Elderly Who Are Workers	Percent of Elderly Who Are Non-Citizens
United States	34.9	45%	18%	3%
New York State	2.4	48%	16%	5%
New York City	1.0	57%	15%	9%
Rest of State	1.5	42%	17%	1%

Numbers may not sum to totals due to rounding. See Appendix A for detailed data and information on confidence intervals.

Source: Urban Institute tabulations of the March 2004 and 2005 *Current Population Survey Annual Social and Economic Supplement*, prepared for the United Hospital Fund.

Income, work status, and citizenship status have important implications for the elderly's eligibility for and enrollment in health care coverage. Low-income elderly persons are more likely than their higher-income counterparts to be dually enrolled in both Medicare and Medicaid or, if ineligible for Medicaid, to have Medicare as their sole source of health insurance coverage (because they are also likely ineligible for retiree benefits, and cannot afford private supplemental coverage). Elderly persons who are not U.S. citizens are less likely than elderly citizens to be eligible for Medicare because they are less likely to meet Medicare's work history requirement, especially if they have been in the country less than ten years.

Compared with the rest of the state, New York City has larger shares of elderly persons who are duals or who have only Medicare, because of the city's larger low-income population. New York City also has a larger share of elderly persons who do not have Medicare, likely because of its larger non-U.S. citizen population. The city's working elderly are also more likely to have only employer-sponsored insurance than are elderly workers in the rest of the state and the nation as a whole (Table 4).

[4] In 2004, 200 percent FPL was $18,620 for an individual.

Table 4
Coverage Highlights Among the Elderly, 2003-2004

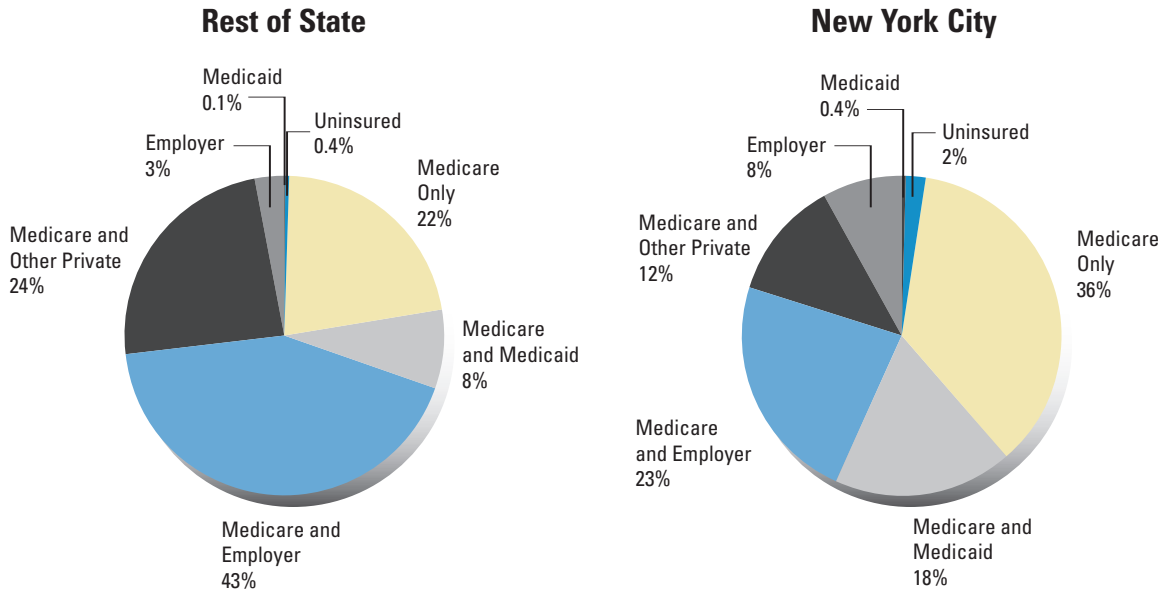
	Percent of Elderly Who are Dual Eligibles	Percent of Elderly Who Have Only Medicare	Percent of Elderly Who Do Not Have Medicare	Percent of Working Elderly Who Have Only ESI
United States	9%	27%	4%	12%
New York State	12%	27%	6%	19%†
New York City	18%	36%	10%	36%*
Rest of State	8%	22%	3%	10%†

†Estimate has a large 95% confidence interval of +/- 4.5 percentage points.
*Estimate has a large 95% confidence interval of +/- 9.5 percentage points.
See Appendix A for detailed data and additional information on confidence intervals.

Source: Urban Institute tabulations of the March 2004 and 2005 *Current Population Survey Annual Social and Economic Supplement,* prepared for the United Hospital Fund.

New York City's elderly are also far less likely to have private coverage in addition to Medicare than elderly persons in the rest of the state and the nation as a whole. Compared to the rest of the state, New York City has a smaller proportion of elderly persons with both Medicare and employer-sponsored insurance (23 percent versus 43 percent), a smaller proportion of elderly persons with both Medicare and other private (not employer-sponsored) coverage (12 percent versus 24 percent), and a larger proportion with only Medicare coverage (36 percent versus 22 percent) (Figure 1). Because fewer New York City seniors have additional coverage to supplement their Medicare coverage, they are more vulnerable to health care costs.

Figure 1 **Distribution of Coverage Among the Elderly, Rest of State and New York City, 2003-2004**



Source: Urban Institute tabulations of the March 2004 and March 2005 *Current Population Survey Annual Social and Economic Supplement,* prepared for the United Hospital Fund.

Note: Data are for 2003 and 2004 and include persons age 65 and up. Rest of State refers to New York State excluding New York City. Numbers may not add to 100% due to rounding.

The Medicare Gap: Implications for Seniors' Coverage

While retiree health benefits have been one of the sources of supplemental insurance for Medicare beneficiaries, such coverage has been declining, nationally, in recent years, in terms of both the number of retirees to whom it is offered and the scope of benefits. Between 1988 and 2005, the share of large employers (more than 200 workers) that offer retiree health benefits declined from 66 percent to 33 percent (Kaiser and HRET 2005, Kaiser and Hewitt 2005). The share of smaller firms that offer such benefits is likely to be even lower. Other firms reported that they controlled costs by increasing retiree premium contributions, cost sharing, deductibles, and out-of-pocket limits (Kaiser and Hewitt 2005). Trends in New York are likely to be similar. Other elderly persons who are not eligible for retiree coverage, cannot afford Medigap coverage, or do not meet Medicaid eligibility rules have only Medicare coverage. These seniors are most vulnerable to high out-of-pocket costs and unmet needs.

For example, Medicare's limited coverage of durable medical equipment (e.g., wheelchairs and walkers) or disposable supplies, which improve function but are not considered "medically necessary" by Medicare, leads to high out-of-pocket costs for elderly Medicare enrollees. Further, because Medicare does not cover long-term care (e.g., skilled nursing facility services beyond Medicare's 100-day limit), elderly Medicare enrollees face significant out-of-pocket expenses for these services, while state Medicaid programs pay these costs on behalf of duals.

Medicare's coverage gap has a measurable impact on those who rely on Medicare alone. Research indicates that Medicare beneficiaries without supplemental coverage are less likely to have appropriate health care use, more likely to report difficulty getting needed care, and less likely to receive preventive care.[5] The 1999 Medicare Current Beneficiary Survey indicates that 21 percent of respondents with traditional Medicare only (no supplemental coverage) delayed care due to cost, compared with 11 percent of those with Medicare and Medicaid, and 5 percent with Medicare and private supplemental coverage (Neuman and Rice 2003). Similarly, in 2003, 37 percent of U.S. seniors without drug coverage reported that they did not fill medications or they skipped or took smaller doses of prescription drugs,

[5] "Difficulty getting needed care" is defined as needing medical care but not getting it, putting off or postponing care, being unable to see a specialist when needed, or reporting that it was extremely, very, or somewhat difficult to get care (Davis K 2001; Rice and Matsuoka 2004; Schoen et al. 1998).

due to cost, compared with 22 percent of the elderly with prescription drug coverage (Kaiser/Commonwealth/Tufts 2003).

Gaps in coverage create financial demands on both the elderly and public health insurance programs. As a result of these coverage gaps, moderate- and high-income elderly persons must pay their extra health care costs out of pocket, while low-income elderly persons may have these coverage gaps filled by other public programs, primarily Medicaid but also the Medicare Savings Programs and EPIC. As health declines and expenses increase, many older adults "spend down" to Medicaid eligibility as the only way to meet their health care needs. Medicaid pays for long-term care and cost sharing that Medicare does not cover. Long-term care services account for 73 percent of Medicaid spending on the elderly in New York; acute care services account for the remaining 27 percent. Overall, the elderly represented only 8 percent of all Medicaid beneficiaries in FFY 2004, but accounted for about one-quarter of Medicaid's spending. This is notable not only because a small share of enrollees are driving a relatively large share of spending but also because Medicaid is the secondary source of coverage for nearly all elderly enrollees.

Long-Term Care. These coverage trends have different implications for Medicare beneficiaries with and without long-term care needs. The lack of retiree coverage will increase personal health costs in general for all Medicare beneficiaries, and could result in increased participation in Medicare Savings Programs, or make "Medicare Advantage"—Medicare coverage provided through private managed care plans—more attractive, if these plans continue to supplement Medicare's basic benefit package and offer reduced cost sharing. But for those with long-term care needs, which retiree plans typically do not cover, the erosion of retiree coverage could arguably make little added difference. Impoverishment in order to gain Medicaid eligibility is currently the only viable option for this group. The aging of the population will thus place increasing financial demands on the Medicaid program because of its coverage of long-term care services, regardless of retiree coverage. Only radical restructuring of Medicare coverage or public policy that makes long-term care insurance more affordable can alleviate this burden.

Medicare Prescription Drug Coverage. The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) enacted Medicare Part D to provide outpatient prescription drug coverage to Medicare enrollees as of January 2006. While this theoretically closes a traditional Medicare coverage gap, the impact of this benefit for the elderly depends in part upon the scope of their prior coverage, as well as on their drug utilization and whether they have private prescription drug coverage to supplement Part D. New York's duals have more limited prescription drug coverage today under Medicare than they had under Medicaid. In general, elderly persons who had prescription drug coverage through their former employers' or unions' retirement plans and who are now enrolled in the standard Part D benefit appear to fare worse under the new law. Many retirees, however, have so far been able to keep their old coverage, or their former employers or unions are providing some supplemental coverage through Part D plans. Elderly persons who had no prior prescription drug coverage make up the only group that appears to fare better as a result of the new law; even some of these seniors, however, may see their out-of-pocket costs increase if they enroll in the new benefit.

Further analysis is needed to determine how people with different drug utilization patterns will fare under the new law. States face many challenges as they try to determine how best to address the gaps in Medicare prescription drug coverage for beneficiaries who are also eligible for Medicaid or pharmacy assistance programs (such as New York's EPIC), as the design and complexity of the new benefit make it challenging and expensive for states to supplement. Finally, states face ongoing prescription drug costs for duals because they are required to pay the federal government for the drug expenses they would have otherwise paid if not for the implementation of Part D.

Conclusion

More than one in three elderly persons in New York City and one in five in the rest of the state have only Medicare coverage and, given the predictable range of health care needs, are thereby "underinsured." Because they must pay directly for services that Medicare does not cover, underinsured seniors often forego or delay receipt of important health care services, jeopardizing their physical and financial health. Two recent trends suggest

that coverage for the elderly may deteriorate further. Retiree coverage is expected to continue to erode, portending a greater share of elderly persons vulnerable to out-of-pocket costs and unmet medical needs. And Medicare prescription drug coverage is generally more limited than the coverage seniors had under Medicaid or through their employers. These trends suggest that an even greater share of New York's elderly will be underinsured in the coming years. This erosion of coverage will likely mean significantly increased Medicaid costs if more of these underinsured seniors "spend down" to Medicaid eligibility. Finally, the aging of the population will also place an increasing financial strain on the Medicaid program because of its coverage of long-term care services.

Sources

Birnbaum M. April 2006. *The Costs and Policy Implications of Covering Dual Enrollees of Medicaid and Medicare.* New York: United Hospital Fund.

Caplan C and N Brangan. September 2004. *Out-of-Pocket Spending on Health Care by Medicare Beneficiaries Age 65 and Older in 2003.* Washington, DC: AARP Public Policy Institute.

CMS (Centers for Medicare and Medicaid Services). Third Party Monthly Billing File for the October 2006 Billing Cycle.

Davis K. May 9, 2001. Medicare's Cost-Sharing: Implications for Beneficiaries. Testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, for the Hearing on Strengthening Medicare: Modernizing Beneficiaries' Cost-Sharing.

Kaiser/Commonwealth/Tufts-New England Medical Center. 2003. *Prescription Drug Coverage and Seniors: Findings from a 2003 National Survey of Seniors and Prescription Drugs.* Washington, DC: The Henry J. Kaiser Family Foundation.

Kaiser Family Foundation. Summer 2005. *Medicare Chart Book*, Third Edition. Washington, DC: The Henry J. Kaiser Family Foundation.

Kaiser Family Foundation and Hewitt Associates. December 2005. *Prospects for Retiree Health Benefits as Medicare Drug Coverage Begins: Findings from the Kaiser/Hewitt 2005 Survey on Retiree Health Benefits.* Washington, DC: The Henry J. Kaiser Family Foundation.

Kaiser Family Foundation and Health Research and Educational Trust. 2005. *Employer Health Benefits: 2005 Annual Survey.* Washington, DC: The Henry J. Kaiser Family Foundation.

Neuman P and T Rice. May 1, 2003. Medicare Cost-Sharing: Implications for Beneficiaries. Testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, for the Hearing on Medicare Cost-Sharing and Medigap.

New York State Department of Health, available online at http://www.health.state.ny.us/health_care/epic/.

Rice T, KY Matsuoka. December 2004. The Impact of Cost Sharing on Utilization and Health Status: A Review of the Literature on Seniors. *Medical Care Research and Review* 61(4):415-52.

Schoen C, MM Doty, SR Collins, AL Holmgren. June 2005. Insured but Not Protected: How Many Adults are Underinsured? *Health Affairs (Millwood)* Suppl Web Exclusives:W5-289-W5-302.

Schoen C, P Neuman, M Kitchman, K Davis, D Rowland. December 1998. *Medicare Beneficiaries: A Population at Risk. Findings from the Kaiser/Commonwealth Fund 1997 Survey of Medicare Beneficiaries.* Washington, DC: Henry J. Kaiser Family Foundation.

Short PF, and JS Banthin. October 25, 1995. New Estimates of the Underinsured Younger than Sixty-five Years. *Journal of the American Medical Association* 274(16):1302-6.

Data Notes and Explanations

Current Population Survey Data

Tabulations of the 2004 and 2005 *Annual Social and Economic Supplements to the Current Population Survey* (CPS) were prepared by the Urban Institute for the United Hospital Fund and reflect a two-year merge of data.

"Employer-Sponsored Insurance" refers to coverage provided to active workers and retiree coverage for seniors who are no longer active workers.

"Other private" is any private coverage that is not employer-sponsored insurance.

Medicaid includes "other government/residual," i.e., any public coverage that is not Medicare or Medicaid. This is a negligible number. A very nominal number of persons with "other public" coverage (other federal, TriCare, CHAMPUS, and VA) have been excluded from this analysis.

Centers for Medicare and Medicaid Services Data

This analysis uses Medicaid Statistical Information System (MSIS) data from the Centers for Medicare and Medicaid Services (CMS) for federal fiscal year (FFY) 2004 to estimate the number of elderly Medicaid beneficiaries, the share of those beneficiaries with any Medicare coverage (Part A and/or Part B), and the share of Medicaid spending by service area attributable to elderly beneficiaries. Shares of Medicaid spending are applied to actual Medicaid payments as reported on the CMS Medicaid Statement of Expenditures (Form 64) for FFY 2004. Long-term care spending consists of skilled nursing facility services, all home- and community-based long-term care, and care provided in intermediate care facilities and inpatient mental health facilities.

Comparing CPS to CMS Data

Note that CPS and CMS enrollment estimates vary. For example, the CPS reports that 288,000 seniors in New York have both Medicaid and Medicare, while CMS reports that 351,000 do; the CPS reports that 6,000 seniors have Medicaid only (no Medicare) while CMS reports that 46,000 do. These differences are explained by the fact that the CMS number is an ever-enrolled count of program enrollment while the CPS data are thought to reflect a point-in-time estimate. Further, researchers believe that the CPS "undercounts" Medicaid enrollment because of respondents' misunderstanding of their own coverage and of the CPS questions. The CPS is also subject to sample reliability issues, particularly where sample sizes are small, as in the sample of adults with Medicaid but no Medicare.

Appendix: Health Insurance Coverage of the Elderly

Health Insurance Coverage of the Elderly, United States, 2003-2004

Percent Distribution by Coverage Type

	Elderly (millions)	Medicare Only	95% CI	Medicare and Medicaid	95% CI	Medicare and ESI	95% CI
Total—Elderly	**34.9**	**27.4%**	**0.6**	**8.5%**	**0.4**	**31.4%**	**0.7**
Family Poverty Level[1]							
<100%	4.7	38.9%	2.6	24.8%	2.3	10.0%	1.6
100-199%	10.9	37.3%	1.2	10.8%	0.8	18.5%	1.0
200%+	19.3	19.0%	0.7	3.3%	0.3	44.0%	0.9
Work Status							
Worker	6.2	18.4%	1.3	3.7%	0.6	38.7%	1.6
Non-Worker	28.7	29.4%	0.7	9.6%	0.5	29.8%	0.7
Citizenship							
U.S. Citizen	33.8	27.3%	0.6	8.0%	0.4	32.1%	0.7
Non-U.S. Citizen	1.1	31.4%	4.3	27.3%	4.1	10.5%	2.8

[1] The 2004 federal poverty level for a family of three was $15,067.
Note: Individuals with other federal coverage (Tricare, Champus, etc.) are excluded from this analysis.
CI = Confidence Interval; FPL = Federal Poverty Level; ESI = Employer-Sponsored Insurance

Source: Urban Institute tabulations of the March 2004 and 2005 *Current Population Survey Annual Social and Economic Supplement*, prepared for the United Hospital Fund.

Health Insurance Coverage of the Elderly, New York State, 2003-2004

Percent Distribution by Coverage Type

	Elderly (millions)	Medicare Only	95% CI	Medicare and Medicaid	95% CI	Medicare and ESI	95% CI
Total—Elderly	**2.4**	**27.3%**	**2.5**	**11.8%**	**1.8**	**35.5%**	**2.7**
Family Poverty Level[1]							
<100%	0.4	35.7%†	9.1	31.7%†	8.8	10.5%†	5.8
100-199%	0.8	34.6%†	4.8	15.1%	3.6	21.9%	4.1
200%+	1.3	20.2%	3.1	3.4%	1.4	51.6%	3.8
Work Status							
Worker	0.4	15.6%†	5.0	5.1%	3.0	44.8%†	6.8
Non-Worker	2.0	29.6%	2.8	13.1%	2.0	33.6%	2.9
Citizenship							
U.S. Citizen	2.3	27.2%	2.5	10.7%	1.8	36.8%	2.7
Non-U.S. Citizen	0.1	29.6%*	13.6	35.8%*	14.2	7.1%†	7.7

[1] The 2004 federal poverty level for a family of three was $15,067.
Note: Individuals with other federal coverage (Tricare, Champus, etc.) are excluded from this analysis.
CI = Confidence Interval; FPL = Federal Poverty Level; ESI = Employer-Sponsored Insurance

† Estimate has a large 95% confidence interval of +/- 4.5 or more percentage points.

* Estimate has a large 95% confidence interval of +/- 9.5 or more percentage points.

Source: Urban Institute tabulations of the March 2004 and 2005 *Current Population Survey Annual Social and Economic Supplement*, prepared for the United Hospital Fund.

Medicare and Other Private	95% CI	ESI	95% CI	Medicaid	95% CI	Uninsured	95% CI
28.2%	**0.6**	**3.5%**	**0.3**	**0.1%**	**0.0**	**0.8%**	**0.1**
16.8%	2.0	4.9%	1.2	0.4%	0.3	4.3%	1.1
31.9%	1.2	1.1%	0.3	0.1%	0.1	0.4%	0.2
28.9%	0.9	4.5%	0.4	0.1%	0.1	0.3%	0.1
25.4%	1.4	12.2%	1.1	0.1%	0.1	1.5%	0.4
28.8%	0.7	1.6%	0.2	0.1%	0.1	0.7%	0.1
28.8%	0.6	3.3%	0.3	0.1%	0.0	0.5%	0.1
7.7%	2.4	9.9%	2.7	0.6%	0.7	12.6%	3.0

Medicare and Other Private	95% CI	ESI	95% CI	Medicaid	95% CI	Uninsured	95% CI
19.6%	**2.2**	**4.6%**	**1.2**	**0.2%**	**0.2**	**1.1%**	**0.6**
11.4%†	5.9	5.2%	4.2	0.6%	1.5	4.9%	4.1
27.4%	4.4	0.6%	0.8	0.1%	0.3	0.4%	0.6
17.6%	2.9	6.7%	1.9	0.1%	0.2	0.4%	0.4
13.1%†	4.6	19.1%†	5.3	0.0%	0.0	2.3%	2.1
20.8%	2.4	1.8%	0.8	0.2%	0.3	0.9%	0.6
20.3%	2.3	4.2%	1.1	0.2%	0.2	0.7%	0.5
3.7%†	5.3	13.0%*	10.0	0.0%	0.0	10.7%†	9.1

Health Insurance Coverage of the Elderly, New York City, 2003-2004

Percent Distribution by Coverage Type

	Elderly (millions)	Medicare Only	95% CI	Medicare and Medicaid	95% CI	Medicare and ESI	95% CI
Total—Elderly	**1.0**	**36.0%**	**4.2**	**18.0%**	**3.4**	**23.4%**	**3.7**
Family Poverty Level[1]							
<100%	0.3	35.8%*	11.3	35.4%*	11.2	8.4%†	6.4
100-199%	0.3	42.7%†	7.8	22.4%†	6.6	19.6%†	6.3
200%+	0.4	31.3%†	6.2	4.3%	2.7	35.3%†	6.4
Work Status							
Worker	0.1	16.4%†	8.5	6.3%†	5.5	31.5%*	10.6
Non-Worker	0.8	39.5%†	4.7	20.1%	3.8	22.0%	3.9
Citizenship							
U.S. Citizen	0.9	36.4%	4.4	16.0%	3.4	25.1%	4.0
Non-U.S. Citizen	0.1	31.6%*	15.3	37.5%*	15.9	7.0%†	8.3

[1] The 2004 federal poverty level for a family of three was $15,067.
Note: Individuals with other federal coverage (Tricare, Champus, etc.) are excluded from this analysis.
CI = Confidence Interval; FPL = Federal Poverty Level; ESI = Employer-Sponsored Insurance

† Estimate has a large 95% confidence interval of +/- 4.5 or more percentage points.

* Estimate has a large 95% confidence interval of +/- 9.5 or more percentage points.

Source: Urban Institute tabulations of the March 2004 and 2005 *Current Population Survey Annual Social and Economic Supplement,* prepared for the United Hospital Fund.

Health Insurance Coverage of the Elderly, New York State, Excluding New York City, 2003-2004

Percent Distribution by Coverage Type

	Elderly (millions)	Medicare Only	95% CI	Medicare and Medicaid	95% CI	Medicare and ESI	95% CI
Total—Elderly	**1.5**	**21.6%**	**2.9**	**7.7%**	**1.9**	**43.4%**	**3.5**
Family Poverty Level[1]							
<100%	0.2	35.7%*	14.5	26.1%*	13.1	13.7%*	9.9
100-199%	0.5	29.2%†	5.9	10.1%	3.9	23.5%†	5.5
200%+	0.9	14.9%	3.3	2.9%	1.6	59.5%†	4.6
Work Status							
Worker	0.3	15.2%†	6.1	4.3%	3.5	52.5%†	8.5
Non-Worker	1.2	22.9%	3.3	8.4%	2.2	41.5%	3.9
Citizenship							
U.S. Citizen	1.5	21.6%	3.0	7.4%	1.9	43.9%	3.6
Non-U.S. Citizen	0.0	21.0%*	27.7	28.7%*	30.7	7.8%*	16.3

[1] The 2004 federal poverty level for a family of three was $15,067.
Note: Individuals with other federal coverage (Tricare, Champus, etc.) are excluded from this analysis.
CI = Confidence Interval; FPL = Federal Poverty Level; ESI = Employer-Sponsored Insurance

† Estimate has a large 95% confidence interval of +/- 4.5 or more percentage points.

* Estimate has a large 95% confidence interval of +/- 9.5 or more percentage points.

Source: Urban Institute tabulations of the March 2004 and 2005 *Current Population Survey Annual Social and Economic Supplement,* prepared for the United Hospital Fund.

Medicare and Other Private	95% CI	ESI	95% CI	Medicaid	95% CI	Uninsured	95% CI
12.4%	**2.9**	**7.6%**	**2.3**	**0.4%**	**0.5**	**2.2%**	**1.3**
7.4%†	5.9	5.1%†	5.1	1.0%	2.3	6.9%†	5.9
13.2%†	5.3	1.4%	1.9	0.3%	0.7	0.5%	1.1
14.8%†	4.7	13.7%†	4.6	0.0%	0.0	0.7%	1.1
6.6%†	5.6	35.8%*	10.8	0.0%	0.0	3.4%	4.2
13.4%	3.2	2.7%	1.5	0.4%	0.6	2.0%	1.3
13.5%	3.1	7.1%	2.4	0.4%	0.6	1.5%	1.1
1.7%	4.3	13.3%*	11.3	0.0%	0.0	8.9%†	9.3

Medicare and Other Private	95% CI	ESI	95% CI	Medicaid	95% CI	Uninsured	95% CI
24.3%	**3.1**	**2.6%**	**1.1**	**0.1%**	**0.1**	**0.4%**	**0.5**
17.5%*	11.5	5.3%†	6.9	0.0%	0.0	1.8%	4.1
36.8%†	6.2	0.0%	0.0	0.0%	0.0	0.3%	0.7
19.0%	3.7	3.4%	1.7	0.1%	0.2	0.2%	0.4
16.9%†	6.4	9.5%†	5.0	0.0%	0.0	1.6%	2.2
25.8%	3.4	1.1%	0.8	0.1%	0.2	0.2%	0.3
24.4%	3.1	2.4%	1.1	0.1%	0.1	0.2%	0.3
12.3%*	16.6	11.6%*	18.9	0.0%	0.0	18.6%*	26.3

RELATED PUBLICATIONS

Administration of Medicaid in New York State: Key Players and Their Roles
The administration of Medicaid in New York is dispersed among multiple agencies, with no single entity controlling more than a portion of the program. This groundbreaking study analyzes the program's organization, and the implications for program goals and policies.
2006

A Blueprint for Universal Health Insurance Coverage in New York
The first comprehensive analysis of the elements needed for universal health insurance in New York State, this special report presents the costs and benefits of several model strategies for covering the State's uninsured and creating a more stable, affordable system for all.
2006.

The Costs and Policy Implications of Covering Dual Enrollees of Medicaid and Medicare
This examination of the coverage of "duals" focuses on spending associated with acute and long-term care, and on ramifications of possible changes to Medicare coverage.
2006

Health Insurance Coverage in New York 2003-2004
Newly updated with 2003-04 data, the latest available, the Fund's annual chartbook once again provides an invaluable snapshot of the uninsured in New York.
2006

Medicaid Coverage for Adults in New York 2001-2003
The expansion of Medicaid coverage among non-elderly, non-disabled adults, and the impact of that expansion on costs, have important implications for the debate about coverage and spending.
2006

Understanding the New State/County Paradigm: The 2005 New York State Medicaid Cap Legislation
With the new cap on the local share of Medicaid costs, it is New York State that will absorb the fiscal impact of all future changes to the program—and face unprecedented pressures, both fiscal and political, as a result.
2006

Bringing Information Technology Innovation to New York's Public Health Insurance Programs
New information technology, linked with promising policy changes and strategies, can simplify complicated application, enrollment, and renewal procedures, bringing coverage to hundreds of thousands of eligible but uninsured New Yorkers.
2004

Estimating the Costs of Enrolling New York City's Eligible but Uninsured Adults in Medicaid
How much would it cost to enroll the half-million New York City adults who are eligible for Medicaid but uninsured? About 40 percent less, per person, than coverage for the average non-disabled, non-elderly adult already enrolled.
2004

Lessons from States with Self-Declaration of Income Policies
Based on a survey of officials in 12 states, this working paper explores one particularly promising strategy for simplifying public health insurance programs: allowing applicants to attest to income instead of documenting it.
2004

These publications are available online at www.uhfnyc.org.