Nevadans without Health Insurance

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ABSTRACT

Individuals without health insurance in this country represent a serious public health concern. Nevada has one of the highest rates of uninsured in the country. This article provides a demographic and socioeconomic profile of the uninsured in Nevada and describes how Nevada's uninsured rates compare with other states. The article also addresses the impact of Nevada's private and public health insurance programs on the uninsured.

Keywords: Health Insurance, Uninsured, Nevada Uninsured, State Profiles

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INTRODUCTION

Individuals without health insurance in this country represent a serious public health concern. Approximately 18,000 Americans die prematurely every year, solely because they do not have health insurance coverage (Institute of Medicine, 2004). The Institute of Medicine (IOM) estimates that the aggregate cost of increased morbidity and mortality for the uninsured is between $65 billion and $130 billion per year. Costs to the health care system can be measured conservatively in terms of the value of uncompensated care provided to the uninsured, which was estimated at almost $35 billion in 2001, of which $24 billion was provided by hospitals. The development of health care policies aimed at reducing the number of the uninsured in Nevada must begin with a basic understanding of Nevada's uninsured population.

The uninsured are not a homogeneous group. Uninsured rates vary by key demographic and socioeconomic characteristics such as gender, age, race/ethnicity, citizenship, education, geographic location, employment, and income level. Rates also vary by the duration of time a person is uninsured. Some individuals are uninsured temporarily while changing jobs and/or insurance plans, while others are uninsured for longer periods of time.

This article provides a demographic and socioeconomic profile of the uninsured in Nevada. The article also describes how Nevada's uninsured rates compare with other states. Finally, the impact of Nevada's private and public health insurance system on Nevada's uninsured population will be discussed.

DEMOGRAPHIC PROFILE OF UNINSURED NEVADANS

About 443,000 people in the state, representing 18.5% of the population, did not have health insurance of any kind in 2004. The vast majority of Nevada's population lives in just two counties, Clark and Washoe, which also represent about 80% of the uninsured (Packham & Griswold, 2004). State-to-state comparisons using a three-year average (2002-2004) show that Nevada ranked fourth (19.1%) in the country in the highest percentage of uninsured residents, behind only Texas, New Mexico and Oklahoma. The national average for the uninsured over that period was 15.5% (U.S. Census Bureau Health Insurance Data, 2005).

Gender

In 2004, Nevada males were slightly more likely to be uninsured than females (19.6% vs. 18.2%). Nevada ranked third in the nation for near-poor uninsured males (annual income 100% to 200% of the federal poverty level or FPL). Nevada also ranked high in its rate of uninsured poor women (annual income below 100% FPL). Nevada ranked 8th in the country with 49% of poor women being uninsured (U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement (CPS-ASES), 2005).

Gender-based differences became more striking when considering the number of persons in female and male-headed households (no spouse present). In Nevada, 2004 data indicated that the ratio of female to male single parent households was 3 to 1. In addition, the number of uninsured persons in female-headed households (66,000) was almost twice that of male-headed households (37,000) (CPS-ASES, 2005).

Despite their smaller numbers, the rate of uninsured male-headed households was higher at all income levels than for female-headed households. In fact, the disparity *increased* with income. The uninsured rate was 26% in male-headed households with incomes above $52,500 versus just 5% in female-headed households (CPS-ASES, 2005). A 2002 national survey of attitudes toward health insurance found that males were more likely than females to feel that they did not need health insurance because they were healthy, and they felt that health

insurance was not worth the cost (Machlin & Carper, 2005). Males are also more likely to work in occupations that do not offer employer based health insurance, and are less likely than females to be covered by Medicaid (Kass, Weinick, & Monheit, 1999).

Age

In 2004, young adults (18-24) were the most likely of any age group to be uninsured (Table 1). Young adults are also the most likely to be uninsured nationwide for a number of reasons; they work in jobs without insurance benefits; they are in college and no longer covered by their parents' insurance; they prefer to spend their money on other goods and services; and/or they lose their public coverage when they reach 19 years (DeNavas, Proctor & Lee, 2005).

A considerable number of Nevada children were uninsured in 2004. Twenty-three percent of the uninsured in Nevada are under the age of 18 years, which is 16% of all Nevada children. This was the third highest rate of uninsured children in the nation behind Texas and Oklahoma (CPS-ASES, 2005).

Table 1.
Uninsured Population in Nevada by Age Group, 2004

Age Group	Number of Uninsured	Percent of Total Uninsured	Percent Uninsured within Age Category
0-17	100,000	22.5	16.1
18-24	79,000	17.8	38.0
25-34	102,000	23.0	28.2
35-44	77,000	17.3	21.0
45-54	54,000	12.1	16.9
55-64	28,000	6.3	11.9
65+	4,000	<1.0	1.4
Total	443,000	18.5	

Source: Adapted from U.S. Census Bureau, Health Insurance Data, Current Population Survey (CPS) Table Creator, 2005, Annual Social and Economic Supplement. Available athttp://www.census.gov/hhes/www/hlthins/data_access.html

Race/Ethnicity

Some racial/ethnic groups face a greater risk of being uninsured than others. Hispanics comprised 22% of the Nevada population and represented 40% of the total uninsured in 2004. The high rate of uninsured in this population is due to several factors. Almost half of the population is under 19 years old; over one-third are not citizens and do not qualify for Medicaid or SCHIP benefits; many work in low wage jobs or for employers that do not offer health insurance; and language barriers prevent many eligible Hispanics from obtaining health insurance coverage (National Council of La Raza, 2005).

In Nevada, one in five African Americans lacked health insurance coverage in 2004. (CPS-ASES, 2005). African Americans were less likely to be covered by employer-based health insurance than Caucasians (60% vs. 71%). Additionally, African Americans had the highest level of Medicaid health insurance coverage of all racial/ethnic groups; 21% versus 9% for Hispanics and Asian Pacific Islanders, 5% for Caucasians and less than 1% for American Indians/Alaskan Natives (Kaiser State Health Facts, 2003-2004; CPS-ASES, 2005). African Americans have disproportionately high rates of uninsured primarily due to economic factors. In 2000, African Americans in Nevada had the lowest median income of all racial/ethnic groups ($33,627), significantly less than Caucasians and Asians whose median incomes were approximately $46,300 (U.S.Census Bureau American Factfinder, 2000). In 2004, African Americans adults were also more than twice as likely to live in poverty than Caucasian adults (23% vs. 9%), and were three times more likely to be unemployed (CPS-ASES, 2005).

The Asian/Pacific Islander (A/PI) population in Nevada had the lowest uninsured rate (8.4%) in 2004. This was almost half the national rate for both total uninsured and A/PI uninsured in the U.S. (CPS-ASES, 2005). However, some ethnic groups within the A/PI category do have very high rates of uninsured (Families USA, 2006). Unfortunately, data on the uninsured rates among various A/PI ethnic groups in Nevada were not available.

In 2004, American Indians/Alaskan Natives (AIAN) in Nevada had the highest rate of uninsured within any racial/ethnic group. Over 41% of Nevada AIAN residents were uninsured in 2004 (CPS-ASES, 2005). Nationally, over half of uninsured AIAN identified the Indian Health Services (IHS) as a source of health coverage and care. The provision of health care is a federal trust responsibility of the American government and although IHS is an option for some, it is chronically under-funded and often geographically inaccessible for many uninsured AIAN people (Kaiser Family Foundation, 2004).

Citizenship Status

In 2004, Nevada ranked 6th in the nation for foreign-born residents at 17% (U.S. Census, American Factfinder, 2005). Immigrants who were not U.S. citizens constituted 24% of the total uninsured population in Nevada. Nationally, immigrants who were not U.S. citizens were twice as likely to be uninsured as those who were native born. Non-white immigrants were more severely impacted by lack of citizenship, particularly Hispanics. Interestingly and contrary to national statistics,

Asians in Nevada who were not citizens had a lower uninsured rate (4.8%) than all U.S. Asian Americans (7.2%) (CPS-ASES, 2005).

In 2004, the unemployment rate among Nevada residents who were not U.S. citizens was only 3.5%. This seems to indicate that the high rate of uninsured among these immigrants may be due to low wages or other job related factors (CPS-ASES, 2005). Low-income, legal immigrants face more barriers in qualifying for government sponsored health coverage. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 made significant changes in the eligibility of legal immigrants for Medicaid and SCHIP. Certain immigrants who entered the United States on or after August 22, 1996 are barred from Medicaid and SCHIP benefits for five years. Also, in determining eligibility for these programs, the income and resources of the immigrant's sponsor must be counted. Illegal immigrants are not eligible Medicaid and SCHIP benefits (Center for Medicare and Medicaid Services (CMS) website, http://www.cms.hhs.gov).

SOCIO-ECONOMIC PROFILE OF UNINSURED NEVADANS

Nationally, two-thirds of the growth in the number of uninsured since the year 2000 occurred among the poor and near-poor, the majority of which had at least one working adult in the family (The Kaiser Commission on Medicaid and the Uninsured, 2006). The lack of health insurance coverage does not only affect the poor and near poor. As the cost of employer based insurance increases and the number of employers offering health coverage decreases, middle- income persons are also more likely to be uninsured.

Income and Employment Status

In 2004, poor and near-poor residents, regardless of employment status, were most likely to be uninsured. Fifty-five percent of those who were full-time workers and uninsured had annual incomes below 100% FPL (CPS-ASES, 2005). The number of uninsured residents in Nevada was highest among those with annual incomes between 100% and 200% of the federal poverty level. In addition, 60% of near poor residents had household incomes that exceeded eligibility limits of the Nevada Medicaid program.

In 2004, 69% of the 339,000 non-elderly, uninsured adult residents in Nevada were employed (CPS-ASES, 2005). If dependent children were added, it is evident that the vast majority of the uninsured in Nevada are from working families. Employees with low incomes and those working in small businesses, service industries or blue-collar jobs, non-unionized workers and part-time workers were most likely to be uninsured (Agency for Health Care Research and Quality [AHRQ], September 2004).

Low Income Children

In 2004, Nevada had high rates of uninsured poor and near-poor children. Nationally, 2004 data indicated that Nevada ranked fourth in the highest percentage of children in families with incomes below 100% FPL, and fifth in the number of children in families with incomes between 100% and 200% FPL. However, three-year averages (2002-2004) ranked Nevada first (36.4%) and third (24.7%), respectively, with the highest percentage of poor and near-poor uninsured children (CPS-ASES, 2005). Uninsured children are less likely to receive any medical care than insured children. Almost half of Nevada's uninsured children did not receive needed medical care in 2003 (Covering Kids and Families, 2005). Nationally, Nevada ranked second in the number of uninsured children who did not receive any needed medical care (Covering Kids and Families, 2005).

The high rate of uninsured poor and near poor children in Nevada is due to several factors. One third of uninsured children are Hispanic, and almost 68% of the Hispanic population in Nevada is foreign born and entered the U.S. in the year 2000 or later (U.S. Census Bureau American Factfinder, 2005). Citizenship requirements for Medicaid and SCHIP may prevent many otherwise eligible low-income Hispanic children from obtaining coverage. Language and cultural barriers may also prevent many Hispanic parents from gaining access to these programs for their children. Other barriers may include: overly burdensome Medicaid and SCHIP procedures, parents' lack of knowledge about public health insurance programs, and/or resistance to participation in these programs due to perceived stigma and/or fear of detection by immigration authorities (Covering Kids and Families, 2006).

PRIVATE AND PUBLIC HEALTH INSURANCE IN NEVADA

Access to medical care is not a constitutional right in the U.S. Due to the prohibitive costs of medical care and prescription drugs, the majority of Americans cannot afford to pay for health care out-of-pocket. Access to health care requires the ability to purchase health insurance coverage. The U.S. health insurance system can be divided into two categories, (1) private insurance programs in which individuals and organizations purchase private group and individual health insurance plans, and (2) government insurance programs in which federal and state government programs provide insurance for eligible individuals.

The majority of Americans have private health insurance. Most Americans with private

insurance enroll in group insurance plans through their employers, or to a lesser extent, through their unions or other types of associations. Typically, the employer, union, or association pays the largest percentage of the group insurance plan premium and the employee contributes a lower percentage. Private health insurance plans are regulated by state health insurance agencies. However, over half of larger businesses in the U.S., including Nevada, have self-funded employee health insurance plans that are exempt from state insurance regulation (Hurst, 2005).

The government provides health care coverage for eligible individuals. This generally includes the poor, those who are disabled, and the aged. The two federal-state programs that cover low-income persons are Medicaid and the State Children's Health Insurance Program (SCHIP). The federal government matches state monies to fund these two programs and they are administered by the states with federal oversight.

Private Insurance Coverage in Nevada

The 2005, CPS-ASES estimates indicated that approximately 68% of Nevadans were covered by private insurance, primarily through employer-based insurance. Nevada employees paid less for their employer sponsored health insurance premiums than the national average. The employee contribution was only 13.3% or about $474, while, nationally, employee contributions averaged over 17% or $606 (AHRQ, Insurance Component of the Medical Expenditure Panel Survey, 2003). The reason for lower premium contributions by employees in Nevada is unclear. There are many factors that impact the variability in premiums across states, including the type of health plan offered, the size of the business, state health insurance regulations, the local cost of health care and workforce characteristics (Branscome, 2004).

Public Insurance Coverage in Nevada

According to the 2005 CPS-ASES, 21% of Nevadans were covered by government health insurance with slightly over 12% receiving Medicare, 6% receiving Medicaid, and 2% receiving SCHIP. The two health programs that have the largest impact on uninsured Nevadans are Medicaid and Nevada Check-Up (SCHIP).

Nevada Medicaid

Nevada Medicaid was enacted in 1965. Its purpose is to provide quality health care services to low-income Nevadans who qualify based on federal and state law. Nevada Medicaid does not provide medical assistance to all poor persons, even the very poor, unless they fall into one of the eligible categories designated by the program. Additionally, children may be eligible for Nevada Medicaid coverage if they are severely disabled or if they are receiving Supplemental Security Income (SSI). Persons must be U.S. citizens to qualify for Medicaid coverage (State of Nevada website, Division of Health Care Financing and Policy, 2005).

Income thresholds for Nevada Medicaid are set at the minimum federal standards: household incomes of less than 133% of FPL for adults, pregnant women or children under the age of six and household incomes of less than 100% FPL for children age six and older. Compared to other states, Nevada Medicaid has consistently ranked in the bottom quartile for setting the lowest income eligibility thresholds (Kaiser State Health Facts, 2004).

In 2002, Medicaid expenditures per enrollee were less than the U.S. average. The per capita spending for children was $1,247, about $200 less per child than the national average. The per capita spending for adults was $1,752, slightly less than the national average. Nevada ranked 39th in the nation in total Medicaid expenditures for both children and adults (Kaiser State Health Facts, 2004; Kaiser Family Foundation, 2004).

Although 23% of the state's general fund expenditures are spent on Medicaid, the percentage of Nevadans covered by Medicaid was consistently lower than the rest of the nation from 1987 to 2003 (Kaiser State Health Facts, 2004; Great Basin Primary Care Association, 2005). In 2001, Nevada ranked last in the nation in the percentage of low-income persons under 65 years who were covered by Medicaid (American Association of Retired Persons, 2003).

Nevada Check Up

Nevada began its SCHIP program in 1998 as Nevada Check Up. This program is designed for children of low-income families whose income is too high to qualify for Medicaid, but too low to afford private health insurance (State of Nevada website, Division of Health Care Financing and Policy). Requirements for children who may be eligible for Nevada Check Up include: the child must not be eligible for Medicaid; the child must be a U.S. citizen or legal resident; the child may not have had health insurance within the last 6 months; the child does not have access to the State Public Employee Benefits Program; the child must be under age 18 at the date of application; and the child must be in a household whose household income does not exceed 200% of the federal poverty level.

In fiscal year 2002, Nevada spent 11 million dollars on its Nevada Check Up program. This expenditure was matched by 20 million dollars in federal funds (CMS, 2002). Effective March 1, 2006, 27,000 children were enrolled in Nevada Check Up. This constitutes coverage for about 20%

of the total number of uninsured children in Nevada (GBPCA, 2005; State of Nevada website, Division of Health Care Financing and Policy, 2005). Compared to other states, Nevada SCHIP enrollment has seen significant growth. For example, between FY2000 and FY2001, the number of children enrolled increased by 76%, ranking Nevada 7th in the largest percentage increase in enrollment during that time period (Ellwood, Merrill & Conroy, 2003).

CONCLUSIONS

Nevada continues to have a relatively high rate of persons without health insurance. Nevada ranks above the national average in the percentage of uninsured low-income adults, low- income children and foreign-born residents. Groups most likely to be uninsured are young adults, single-parent women, low-income adults and children, immigrants, and minorities. There are many factors that contribute to the disparities in insurance coverage. These include, but are not limited to, socio-economic disparities, limited access to educational and occupational opportunities, discrimination, societal marginalization of some populations, immigration status, and language and cultural barriers (Kaiser Commission on Medicaid and the Uninsured, 2003).

The employer based-system for providing health insurance coverage also contributes to the increasing number of the uninsured. Many employers, particularly small businesses do not offer health insurance to workers. Minimum wage and low wage jobs, downsizing, corporate strategies of employing more temporary and contract workers, increasing health insurance premiums and the move towards dropping health insurance as an employee benefit all contribute to the increasing rates of uninsured (National Coalition on Health Care, 2004).

Compared with other states, Nevada has done very little to expand private and public insurance coverage for its uninsured residents. Many states have implemented private insurance reforms in an effort to expand private insurance coverage for employees of small businesses and/or for individuals who are unable to obtain insurance due to pre-existing chronic medical conditions (Fuchs, 2004). In Nevada, the Division of Health Insurance implemented a state reinsurance pool that would protect small businesses against catastrophic insurance costs, but as of 2005, no private insurer has joined the pool (Hurst, 2005). In 1991, the Nevada State Senate passed a bill (SB 503) that allowed insurers to offer basic benefits plans ("bare bones" plans) to small employers to reduce their premiums. There was very little demand for these plans, and SB 503 has since been repealed.

A number of states have undertaken plans to increase their publicly funded insurance coverage by expanding their Medicaid and/or SCHIP coverage (Austin, et al., 2005). Many states have obtained federal Medicaid waivers that allow them to experiment with different approaches to covering their uninsured populations. In 2005, the Nevada Medicaid program applied for a federal Medicaid waiver that would allow Nevada Medicaid to expand coverage for low income pregnant women, provide a $100 monthly insurance premium subsidy to employers of low income, non Medicaid eligible workers, and allow Medicaid to reimburse hospitals for uncompensated care provided to certain low income individuals who are ineligible for Medicaid (Nevada State Assembly, 2005). If granted, this waiver may have little impact on reducing the number of employed low income uninsured in Nevada, since, nationally, the average small business spends over $250 per month per employee to purchase private insurance for their employees.

Nevadans without health insurance represent a serious public health concern. In an era of reduced spending on government programs, rising costs of health care and the increasing numbers of workers losing employer based health insurance, the ranks of the uninsured will continue to grow. The development of public policies aimed at reducing the number of the uninsured Nevadans must begin with a basic understanding of its uninsured population, how Nevada compares to other states in providing health insurance coverage, as well as the abilities of the state and private sector to provide health insurance coverage for Nevada residents.

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