The Costs and Consequences of Uninsurance
A Virginia State Planning Grant Technical Briefing Paper

Introduction

According to the U.S. Census Bureau, the number of Americans without health insurance in 2003 was a record high 45 million, or 15.6 percent of the population (the highest percentage since 1998). In 2004, about 85 million, or about 32 percent of the population, were uninsured *for at least some period of time*.[i] A 2004 household survey found that in Virginia, nearly 9 percent of the population was uninsured *at a given point in time* and 11.5 percent had no health insurance *at some point during the year*.[ii] Data from state and national sources indicates the number of individuals without health insurance for all or part of the year is an endemic problem that continues to grow, adversely impacting public health and economic conditions. The purpose of this paper is to summarize the scope of the problem and discuss the costs and consequences of uninsurance.

Background

While 85 percent of Americans have health insurance coverage, uninsured citizens are found in just about every demographic group. The rate of uninsurance continues to increase, attributed to a number of factors, including the erosion of employer-sponsored private health insurance coverage (due to rising premiums and health care costs, and to some extent, a weak economy and rising unemployment in certain industry sectors).[iii]

Both nationwide, and in Virginia, the uninsured are most often low-wage (</=$9.50/hr), young, non-white, and employed (working in small businesses). Many low-wage workers do not have access to affordable insurance, primarily because their employers do not offer it.[iv] More than 30 percent of those without health insurance (about 14 million) are eligible for government-sponsored programs like Medicaid and SCHIP, but are not enrolled.[v] Moreover, many uninsured choose not to have coverage because they don't think they need it or are unwilling or unable to pay the price for insurance. In Virginia in 2004, a majority (65.4 percent) of the uninsured had neither requested nor received information about the state's public health insurance programs. When asked why they do not participate in employer-sponsored coverage (ESI), a significant proportion of Virginia's uninsured workers felt coverage was too expensive (28.9 percent), did not want it , or felt the benefits offered were inadequate (17.2 percent).[vi]

Erosion of Employer Sponsored Coverage

Although the majority of Americans receive their health insurance through an employment-based health plan, the proportion of individuals receiving employer-sponsored insurance (ESI) is declining. According to a 2004 Kaiser Family Foundation survey, ESI decreased from 65 percent in 2001 to 61 percent in 2004. Drivers influencing the decline in ESI include:

- Rising health insurance premiums,
- Increased cost sharing to employees,
- Fewer firms offering coverage to their workers, and
- Fewer workers who are employed where coverage is offered and are eligible for the benefits actually accepting the coverage benefits – decreasing take-up rates.[vii]

Declines in employer coverage occurred for both adults and dependent children between 1989 and 2003.[viii] A 2001 nationwide survey of employers found that 14 percent of respondents said that they were planning to reduce or eliminate health care coverage for their employees in response to growing health care costs.[ix] A 2005 study predicted the proportion of workers with employer-sponsored health coverage in California would drop to just over half by 2010 if insurance premiums continue to increase by 10 percent annually.[x] Looking ahead to 2006, another study projected more than three-fourths of large companies nationwide will require employees to pay more for coverage, and about one-fourth likely will reduce wage increases for employees because of rising health care costs.[xi] General Motors, in particular, has recently announced it will eliminate 25,000 jobs in the United States, in part due to financial losses stemming from rising health care costs. In the second quarter of 2005, those losses amounted to more than $1.1 billion.[xii]

In Virginia, employer-sponsored private insurance is a source of coverage for nearly three-quarters of adults under age 65. Currently, about a quarter of those with private insurance worry they will lose their coverage, and nearly half are concerned they won't be able to afford continued coverage.[xiii] Recent trends in reported business coverage further support this fear. Fewer than 60 percent of the state's private employers offered health insurance to their employees in 2003. By industry sector, agriculture and construction firms had the lowest offer rate (47 percent) followed by retail and other services (57 percent). Moreover, a growing number of employees who are offered insurance decided not to take it. Although about 79 percent of employees working for private employers that offer coverage are eligible, just 76 percent of them decided to enroll; a difference of nearly 56,000 workers.[xiv]

In recent years, some of the most significant changes in employer-sponsored insurance coverage have been concentrated among low-wage workers:

- Between 1999 and 2002, individuals ages 19-64 with incomes below 200 percent FPL realized a 3-percent decline in ESI to just 50.6 percent, compared to all working adults, of which 83 percent have ESI. During this period, gains in public insurance enrollment (e.g., Medicaid, SCHIP) for low-wage workers (2.7 percent) nearly offset this decline.
- Take-up rates for low-wage workers are declining, due to their small price tolerance for the cost of health insurance. About three-quarters of the 55 percent of low-wage workers offered ESI in 2002 took the offer, a greater than two percent decline in the ESI take-up rate from 1999.
- An estimated 48 percent of low-wage workers have no viable alternative for coverage outside of ESI.[xv]
- More than 11 million immigrants in the United States were uninsured in 2003. Immigrants are disproportionately employed in low-wage jobs and in small firms *(EBRI, 2005).*[xvi]

In Virginia, low-wage workers were much less likely to be offered health insurance through their employers. Just under half of all employees with household incomes of 150 percent or below the federal poverty level (FPL) said they were offered coverage.[xvii] In 2003, among firms that primarily employ low-wage workers, nearly two-thirds of small employers (less than 50 employees) did not offer employee health insurance.[xviii]

Nationwide, from 2001-2004, the overall decline in ESI coverage translated into 5 million fewer jobs providing health benefits, with the sharpest drop observed in small businesses. The proportion of small to medium firms (3-199 workers) offering health insurance dropped from 68 to 63 percent during this period.[xix]

- Small to medium firms are significantly less likely than large firms (200 or more workers) to make a significant contribution towards the cost of health insurance. Small

firms are more likely to pay their workers less than large firms and have a difficulty fitting family coverage into their employee compensation packages. Such businesses are financially constrained and have fewer employees to share the financial the risks of high insurance utilization; as well as lacking access to volume purchasing power available to large employers.[xx]

- In 2002, nearly one-quarter of small firms (2-50 employees) offering health benefits thought their firm would drop or alter coverage if costs increased an additional 5 percent. However, most small firms that did offer health insurance acknowledged a variety of benefits to the business.[xxi]

About 40 percent of Virginia's very small employers (those with 10 or fewer workers) offered health insurance to their employees in 2003.[xxii] Individuals working in companies with less than 50 employees were about twice as likely to be uninsured as those in companies with more than 50 employees. Small businesses represent over 75 percent of all businesses in Virginia and employ nearly a third of all workers (over 828,000 persons). Additionally, insurance coverage trends vary by business sector. Very small employers in the retail and other services sectors had the lowest health insurance offer rate (35 percent), followed by agriculture and construction sectors (38 percent).[xxiii]

Rising Insurance Costs

From 2000-2004, American workers and employers saw double-digit increases in health insurance premiums: Increases of 8 to 10 percent are expected in 2005. At nearly four times the rate of inflation, these increases have brought annual health insurance premiums for a typical family of four to nearly $10,000 ($3,700 for single coverage). Since 2000, workers' costs for health insurance have risen 36 percent nationwide; more than double the average earnings increase of 12.4 percent. Premiums in Virginia rose 2.4 times higher than the average rise in earnings.[xxiv] In 2003, the average annual premium in the state was about $3,300 for individuals and just over $9,100 for families.[xxv]

Increasingly, the high cost of coverage is making health insurance unaffordable. More than one in four American workers under age 65 is projected to have no health insurance by 2013 because they will be unable to afford the premiums. Unfortunately, the adverse impact of this trend affects entire communities, not just individuals and families. For each one percent rise in health spending relative to personal income, the number of uninsured is projected to increase by 246,000.[xxvi]

Major increases in health insurance costs have contributed to rising proportions of premiums and medical care costs being paid for by individuals with both private and public insurance. Workers are having to assume higher deductibles, co-payments and coinsurance, and greater limits on choice of physicians and hospitals, as employers increase patient cost sharing to lower business costs.[xxvii] At least one study examining the impact of higher co-payments in public insurance programs found that low-income Medicaid beneficiaries forgo essential care as a result of increasing out of pocket costs.[*xxviii*]

Virginia's 2004 household survey found that more than half of those with family coverage (54.6%) paid over $150 per month, while most of those with individual coverage (82.3%) paid $150 per month or less.[xxix] In 2003, the average proportion the employee contributed to the family premium was about 30 percent; for workers in firms with less than 50 employees, the rate was slightly higher.[xxx]

Personal Consequences of Uninsurance

Adverse Health Outcomes

It is generally accepted that lack of health insurance coverage contributes to poor personal health status. Having insurance is considered a key factor in ensuring access to appropriate and timely health care that impacts individual health.[xxxi] Thus, stable insurance coverage is an important consideration in overall efforts to improve public health status. Unfortunately, the problem of individuals entering and exiting health insurance coverage has been increasing. Between 1998 and 2000, nearly one in three of individuals up to age 62 experienced a 'spell' of uninsurance, a circumstance often referred to as 'churning.' Worse yet, the burden of insurance instability falls disproportionately on low-income families, young adults and minorities.[xxxii]

While many uninsured are without coverage for just part of the year, the number of those without coverage all year is growing nationwide. These individuals are more than three times as likely as full-year insured to not have a usual source of care and to lack confidence in getting access to needed care. More than half of uninsured individuals reported that they had not visited a doctor in the past 12 months.[xxxiii]

Furthermore, foregoing care or receiving inadequate care may lead to increased morbidity and mortality. According to a 2003 Institute of Medicine (IOM) study, being uninsured and not receiving adequate care may be life threatening. The IOM estimates that the lack of insurance leads to 18,000 deaths a year, making it the sixth leading cause of death among people ages 24 to 64. Additionally, other individual consequences of uninsurance are thought to include irregular and/or poor-quality care. Therefore, the uninsured are less likely to have a regular source of care, do not receive preventive care or benefit from early detection of medical problems, and do not receive appropriate care for chronic illness. Also, the uninsured are more likely to have difficulty obtaining care if they live in areas with a high percentage of uninsured, and are more likely to face burdensome medical bills. Unfortunately, the number of individuals affected is large: The IOM estimates there are 8 million uninsured with chronic illnesses who receive fewer services and have an increased rate of morbidity; another 41 million uninsured are less likely to receive preventive and screening services.[xxxiv]

In 2002, a synthesis review of 25 years of health services research (230 research articles) found that lack of insurance leads to the uninsured being hospitalized for conditions that should have been managed in ambulatory care settings, if care were provided in a timely manner. Consequently, the review extrapolated there were from three to five percent of avoidable hospital days attributable to the uninsured.[xxxv]

Adults who lack health insurance coverage are also less likely to have a personal doctor or health care provider than those with coverage. According to the Behavioral Risk Factor Surveillance System (BRFSS), more than half of uninsured adults (55.6 percent) do not have a personal doctor or health care provider compared with those who are insured (16.3 percent). The national survey also found that adults without health insurance are more likely to go without medical care. Nineteen percent of individuals with insurance (compared to 4.7 percent of uninsured individuals) reported not getting the medical care they needed in the past 12 months.[xxxvi] Another study on access to care by uninsured children found that 6 percent postponed receiving care; 13 percent missed doctor appointments and one in ten did not refill prescriptions because of cost.[xxxvii] More recently, a 2005 survey found 67 percent of all uninsured women reported delaying or going without care they needed in the past year because they could not afford it.[xxxviii]

In 2004, 41 percent of the uninsured in Virginia reported not seeing a doctor in the past year due to cost; even more (74 percent) reported not having an emergency room or urgent care visit within the past 12 months. Most unfortunate however, is that almost 13 percent of uninsured Virginians reported being in poor health.[xxxix] This raises concerns about increased costs related to foregone care and treatment of complications when extant conditions worsen and care cannot be avoided.

Adverse Economic Effects

The lack of health insurance contributes to financial hardship for families. Nearly one-quarter of the uninsured reported changing their way of life significantly in order to pay medical bills.[xl] The result of declining coverage and increased cost sharing has left many American families with medical debt that they cannot afford to pay. A recent Commonwealth Fund survey found 41 percent of all adults under the age of 65—and 60 percent of all uninsured adults under 65—had problems paying off medical debt incurred in the past year or were paying off debt accrued in the past three years.[xli] In Virginia, about 5 percent of the uninsured in 2004 reported bankruptcy caused by medical expense debt.[xlii]

Concern about health insurance coverage affects many family decisions, such when/whether to retire or change jobs. Nationwide, 'Job lock' (lack of job mobility because of fear of losing insurance coverage) is reported to be a growing a problem, but little research has been done to document the full economic effect of a person being unable to leave a job for higher wages due to the availability and extent of offered benefits at the new position of employment. [xliii] In Virginia in 2004, nearly 19 percent of those with private health insurance coverage and 7.7 percent of those with public coverage said they could not leave a job because it would result in loss of insurance.

The adverse effects of uninsurance on health have been shown to have economic consequences as well. The Institute of Medicine (IOM) estimates the greatest economic losses resulting from the growing number of uninsured Americans are attributable to worse health and shorter lifespan, not just higher health care costs. The IOM estimates the economic value of foregone health for at least 40 million uninsured to be between $65 and $130 billion annually. Each year, an individual who lacks insurance, experiences an average wage loss of $1,645 attributable to decreased life expectancy and a combined loss of $3,280 attributable to shorter life span and increased morbidity.

Societal Consequences of Uninsurance

Costs to Employers and Employees

Of equal concern is the impact the lack of health insurance has on society—particularly employers, the health care system, and tax-paying public. The rise in the number of uninsured in recent years is attributed almost entirely to decline in employer-sponsored health insurance coverage, due largely to health care cost increases. Without employer insurance coverage, the medical costs of uninsured workers are assumed by employers, government and tax payers. A recent study found that employers spent an estimated $31 billion in dependent coverage in addition to approximately $150 billion on their workers' health care costs. Of approximately 36 million workers without job-based health insurance, about 16 million are covered by other employers through dependent coverage. Another 13 million remain uninsured, leaving 7 million covered by public programs or private individual coverage.[xliv]

Families USA examined the higher costs of health care attributable to services provided to the uninsured and found just over half were paid by the uninsured themselves or through government programs, with the remainder paid for (subsidized) from higher private, employer-based health insurance. In 2005, premium costs for employee-based family health insurance coverage is estimated to include an extra $922 ($341 for individuals) attributable to the 'passed on' cost of care for the uninsured. Between 2004 and 2005, this represented an 8.5 percent increase in the cost of employer-sponsored insurance. The Families USA analysis also projected individual workers with employer-sponsored health insurance will pay an average of $532 in additional premiums (and an extra $1,052 for family coverage) by 2010 to subsidize those without insurance. Estimates for Virginia, 2005, indicate the additional premium costs for health services for the uninsured to be about $277 for individual plan premiums and $734 for family plan premiums (slightly below the national average).[xlv]

It is interesting to note that a small Virginia business survey found that more than half of employers that offered insurance used co-payments or deductibles to offset the costs of coverage. Premium assistance was ranked as the best public policy option by these employers to assist them in offering health insurance. Small firms not offering coverage cited the relative high cost of health insurance as the primary reason for not doing so.[xlvi]

Other consequences of uninsurance include the costs associated with employee absenteeism and reduced employee productivity. For example, a 2001 survey found that 16 percent of the uninsured (versus 8% insured) were absent from work during the year because of dental problems alone.[xlvii] Another study estimated that lost productivity from absenteeism hurts employers and lowers tax revenue by $130 to $285 billion annually.[xlviii]

Costs to the Healthcare System

Recently, Families USA reported the costs of uncompensated care will exceed $43 billion nationally in 2005, or about 35 percent of the total cost of health care services provided to the uninsured. By 2010, uncompensated care costs are estimated to be greater than $60 billion. In Virginia, uncompensated care costs were estimated at just under $1 billion ($995.3 million) in 2005, and expected to rise to nearly $1.4 billion by 2010[xlix]

These figures do not include certain hidden costs such as inefficient use of the health care system (e.g., using the hospital emergency room for primary care) and other difficulties in managing and monitoring care for the uninsured (e.g., issues associated with coverage dis-enrollment and reinstatement). Periodic lapses in insurance coverage (Churning) also increases health costs through higher administrative costs and affects the movement of medical records, provision of unnecessary care, and other costly activities for health care providers and insurers. These and other costs associated with care for the uninsured ultimately have pressured many physicians and other health care providers to curtail the amount of uncompensated care they deliver.

Public hospitals are typically the largest providers of care for the uninsured and underserved. A recent survey of public hospitals in eight states found that half of them had seen an increase in their uninsured populations. In 2002, nearly two-thirds of patients who received care from public hospitals were either uninsured or covered by Medicaid. Patients of these hospitals who received outpatient care were much more likely to be uninsured than were individuals receiving inpatient care. About a fifth of the total costs in these hospitals are considered uncompensated care, although an even greater percentage is un-reimbursed (payments received do not cover the full costs of providing services).[l] A Minnesota study found that an increase in enrollment in the state's Medicaid program in the 1990s helped to reduce the state's hospital uncompensated care by nearly $60 million.[li]

Virginia's teaching hospital centers, like other academic facilities across the country, are burdened with significant financial challenges threatening their future viability. The Virginia Joint Commission on Health Care released a report in 2000 that indicated that provision of uncompensated care for uninsured individuals poses the greatest financial threat to these centers, which provide valuable specialty and tertiary care services to Virginians.

Costs to the General Public

The majority of the money spent to cover uncompensated care costs comes from the federal government through disproportionate share hospital (DSH) payments under the Medicaid and Medicare programs. Some states have also financed the provision of uncompensated care by public hospitals and other providers by making direct payments to these providers and implementing uncompensated care pools. Virginia's Indigent Health Care Trust fund provided more than $4 million in payments to hospitals providing charity care in the Commonwealth in 2004. These monies are provided through federal and state tax subsidies funded by the general public and are distributed in the form of appropriations and/or service payments to public and teaching hospitals to assist in the provision of expensive services such as trauma and high-level burn care, support for federally-qualified and community health clinics, and public health departments. At least one study has documented these expenditures, estimated to be about $30 billion a year.[lii] In Virginia, about $160 million in Medicaid Disproportionate Share Hospital (DSH) payments are projected for 2005-2006.[liii] Lastly, the general public also assumes the burden of some of the hidden costs of the uninsured, such as the cost of communicable diseases that go untreated and costs to the criminal justice system associated with untreated mental illness.

The Impact of Medicaid

In recent years, Virginia has experienced an increase in the number of individuals who are eligible for and enrolled in Medicaid programs. From 2002-2003, the number of individuals eligible for Medicaid increased 6.5 percent. According to the Department of Medical Assistance Services (DMAS), 725,798 individuals were eligible for Medicaid in 2003, about half being children. Public insurance options provided coverage for approximately 19 percent of Virginia residents in 2003; in June 2004, more than 58,000 children were enrolled in the Commonwealth's FAMIS and SCHIP expansion programs.

While some of the increases in Virginia's Medicaid enrollment can be linked to expansion of eligibility for individuals under the Aged, Blind and Disabled categories and FAMIS outreach programs, some increase in Medicaid enrollment can be attributed to economic conditions.[liv] Enrollment rates for indigent adults increased 9.4 percent in 2004. According to analysis of U.S. Census data by the Weldon Cooper Center for Public Service, rates of individuals living in poverty in Virginia have been increasing. In 2000 some 8.3 percent lived in poverty compared to 10 percent in 2003,[lv] in line with national trends.[lvi] Spending projections for Virginia's Medicaid program are projected to see a 13.67 percent increase in expenditures for 2005, and an additional 9.49 percent increase in 2006, costing the Commonwealth $4.776 billion by 2007.[lvii]

While there is discussion in the professional literature about the impact of public health insurance coverage expansion causing reductions in private coverage (i.e., crowd out), data on the impact of private insurance expansions reducing or averting future public coverage is not readily available. However, a number of states have begun to consider the link between increases in Medicaid enrollment and erosion of affordable employer sponsored health uninsurance. In California, the hidden public costs of low-wage jobs have been studied. Simulation models using state administrative data and CPS data estimated a savings of $2.2 billion if low-wage families currently on public assistance programs had access to affordable health care.[lviii]

Summary

The rising number of uninsured in the US and Virginia generate significant costs and adversely impact individuals, employers, providers, government and the public in general. Costs of the uninsured in Virginia in 2004 alone included:

- An inestimable amount of indirect costs in resulting from poor health and reduced access to care.
- More than $ 4 million in monies from the General fund for payments made to providers by the Indigent Health Care Trust Fund
- More than $10 million in payments made to hospitals for uncompensated care under State and Local Hospitalization funds
- Provision of care of more than $69 million by free clinics in Virginia for care of the uninsured and an untold amount of uncompensated care by individual healthcare providers within the Commonwealth.

The impact of uninsurance is associated with escalating health care costs and rising insurance premiums; cost shifting to employees and erosion of employer-sponsored coverage; increased morbidity and mortality; adverse effects on individual finances and economic development; rapidly rising levels of uncompensated care; and increased enrollment in public assistance programs. Unfortunately the rising costs and adverse consequences of uninsurance will continue to worsen as the number and age of the uninsured increase, causing some to refer to the problem as "the perfect storm."

End Notes

---

[i] U.S. Census.

[ii] State Health Access Data Assistance Center (SHADAC). 2004 Virginia Health Care Insurance and Access Survey, 2005.

[iii] Kaiser Family Foundation. The Uninsured: A Primer. November 2004. http://www.kff.org

[iv] Kaiser Commission on Medicaid and the Uninsured. Health Insurance Coverage in America: 2003 Data Update. November 2004.

[v] Regence BlueCross BlueShield of Oregon. About the Uninsured: Primer. http://www.or.regence.com/about/uninsured/

[vi] Ibid., SHADAC 2005.

[vii] Kaiser Family Foundation. Employer Health Benefits 2004 Annual Survey. http://www.kff.org

[viii] Wiatrowski, W. Documenting Benefits Coverage for All Workers. Bureau of Labor Statistics May 2004. http://www.bls.gov/opub/cwc/cm20040518ar01p1.htm

[ix] Watson Wyatt Worldwide, *Sixth Annual National Business Group on Health/Watson Wyatt Survey 2001*, 2001, http://www.watsonwyatt.com/research.

[x] Center for Labor Research and Education. Falling Apart: Declining Job-Based Health Coverage for Working Families in California and the United States. University of California-Berkeley, June 2005.

[xi] T. Agovino, Health Costs Force No-Win Situations, *Detroit Free Press*, July 18, 2005.

[xii] General Motors Corporation. http://www.gm.com/company/news_events/press_releases/; Knight *Ridder/Baltimore Sun*, July 21, 2005.

[xiii] Ibid., SHADAC.

[xiv] U.S. Agency for Healthcare Quality and Research. Medical Expenditure Panel Survey-Insurance Component (MEPS-IC), 2003 Virginia-Specific Data. July 2005.

[xv] Assessing the New Federalism. National Survey of America's Families, 1999 and 2002. Urban Institute. http://www.urban.org/Content/Research/NewFederalism/NSAF/Overview/NSAFOverview.htm

[xvi] Employee Benefit Research Institute. NOTES: The Impact of Immigration on Health Insurance Coverage in the United States, June 2005. http://www.ebri.org

[xvii] Ibid., SHADAC.
[xviii] Ibid., MEPS-IC, 2005.
[xix] Ibid., Kaiser Family Foundation 2004 Employer Health Benefits Survey.
[xx] Mahon and Byrne. Press Release: Small businesses hit with larger annual premium hikes and employees with greater cost-sharing burdens. The Commonwealth Fund. http://www.cmwf.org/media/releases on 5/25/2004.
[xxi] Employee Benefit Research Institute. ISSUE BRIEF: Findings from the 2002 Small Employers Health Benefits Survey, January 2003. http://www.ebri.org
[xxii] Ibid., MEPS-IC.
[xxiii] Ibid.
[xxiv] Ibid., Kaiser Family Foundation 2004 Employer Health Benefits Survey.
[xxv] Ibid., MEPS-IC.
[xxvi] Gilmer and Kronick. It's the Premiums, Stupid: Projections of the Uninsured through 2013. Health Affairs, Web Exclusive, April 5, 2005.
[xxvii] Center for Studying Health System Change. Rising Health Care Costs: Spending Growth Stabilizes at High Rate in 2004. Data Bulletin #29, June 2005. http://www.hschange.org
[xxviii] Center on Budget and Policy Priorities. Out of Pocket Medical Expenses for Medicaid Beneficiaries are Substantial and Growing. L. Ku, May 2005. http://www.cbpp.org/5-31-05health.htm
[xxix] Ibid., SHADAC.
[xxx] Ibid., MEPS-IC.
[xxxi] McLaughlin, C. editor. Health Policy and the Uninsured. The Urban Institute, February 2004. http://www.urban.org; Hadley, J. Sicker and Poorer: The Consequences of Being Uninsured – A Review of the Literature. The Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, May 2002.
[xxxii] Glied et al. Presentation at 2005 Academy Health conference, "Entrances and Exits: Health Insurance Churning 1998-2000. http://www.academyhealth.org/2005/pdf/glied.pdf
[xxxiii] Assessing the New Federalism. National Survey of America's Families, 2002. Urban Institute. http://www.urban.org/Content/Research/NewFederalism/NSAF/Overview/NSAFOverview.htm
[xxxiv] Institute of Medicine. Hidden Costs, Values Lost: Uninsurance in America, 2003. Institute of Medicine. Care Without Coverage: Too Little, Too Late, 2002. Institute of Medicine. Coverage Matters: Insurance and Health Care, 2001.
[xxxv] Hadley, J. Sicker and Poorer: The Consequences of Being Uninsured – A Review of the Literature. The Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, May 2002.
[xxxvi] See www.cdc.gov/brfss retrieved on July 2004.
[xxxvii] A. Chang. Study: Gaps in Insurance Affects Kids, *Las Vegas Sun*, July 27, 2005.
[xxxviii] Kaiser Family Foundation. Women and Health Care: A National Profile, July 2005.
[xxxix] Ibid., SHADAC.
[xl] Ibid. Kaiser Foundation, Uninsured Primer, 2004.
[xli] Darby, M. et al. Press Release: Health care reform a major campaign issue for voters: New survey. Commonwealth Fund. http://www.cmwf.org/media/releases on 5/25/04.
[xlii] Ibid., SHADAC.
[xliii] Ibid., McLaughlin, Urban Institute, 2004.
[xliv] Collins, S. et al. A Shared Responsibility: U.S. Employers and the Provision of Health Insurance to Employees, Inquiry Spring 2005.
[xlv] Families USA. Paying a Premium: The Added Cost of Care for the Uninsured. June 2005.
[xlvi] L. Henry. Key Informant Survey of Small Business, 2005. GMU Center for Health Policy, Research and Ethics.
[xlvii] The Commonwealth Fund. In the Literature: Gaps in Health Coverage Among Working-Age Americans and the Consequences, 2001. http://www.cmwf.org/publications/publications_show.htm?doc_id=221510
[xlviii] Haveman, R. and Wolfe, B. The Determinants of Children's Attainments: A Review of Methods and Findings. Journal of Economic Literature 33, 1995.
[xlix] Ibid., Families USA, 2005.
[l] Kaiser Commission on Medicaid and the Uninsured. Stresses to the Safety Net: The Public Hospital Perspective, June 2005.
[li] State Health Access Data Assistance Center (SHADAC). Issue Brief: Expanding Access to Health Insurance Coverage Lessens the Burden of Uncompensated Care. December 2003.
[lii] Ibid., Collins, 2005.

[liii] DMAS. Projected Disproportionate Share Payments for State Fiscal Year 2005-2006.
[liv] Virginia Office of Planning and Budget , Official Medicaid Expenditure Forecasts FY2005-2007.
[lv] http://www.census.gov/hhes/poverty/histpov/hstpov21.html
[lvi] U.S. Census poverty report.
[lvii] Ibid., Virginia Office of Planning and Budget.
[lviii] Zabin, C. Dube, A, Jacobs, K. (2004) The Hidden Public Costs of Low-Wage Jobs in California. Prepared for the National Economic Development and Law Center.