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Rx NY

A Prescription for More Accessible Health Care

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EXHIBITS

About the Author

TARREN BRAGDON serves as a health-policy analyst for the Manhattan Institute's Empire Center for New York State Policy. A former two-term member of the Maine House of Representatives, he served on the House Joint Standing Committee on Health and Human Services. He also was health policy researcher for the President of the Maine Senate, and provided oversight for community relations and licensing compliance at a non-profit child welfare agency with 260 employees. Mr. Bragdon has spoken on health policy issues before national organizations including the American Legislative Exchange Council's Health and Human Services Task Force, Golden Rule Insurance and the State Policy Network. His articles on health issues have been published in *The Wall Street Journal*, the *New York Post*, *Buffalo News* and Albany *Times Union*, among other publications. He has served as adjunct faculty member for the Maine Technical College System. Mr. Bragdon received his Bachelor of Science degree in Computer Science from the University of Maine and his Masters of Science of Business degree from Husson College. Effective January 2008, Bragdon will become chief executive officer of the Maine Heritage Policy Center, a nonprofit, nonpartisan research and educational organization based in Portland, Maine.

Overview

What's the best way to ensure that all New York State residents—adults and children alike—have access to affordable health-insurance coverage?

Over the past decade, the state government has answered that question by expanding publicly subsidized forms of health insurance, building on what was already the nation's most expensive Medicaid program, while maintaining insurance regulations that make private coverage both scarce and expensive.

Governor Spitzer's first major health care initiative would carry the trend a step further, by extending Medicaid-funded health care to children in middle-class families previously considered ineligible for such assistance.

But this approach is likely to have two unintended and apparently unanticipated consequences.

First, an increased reliance on such government-subsidized programs will inevitably encourage more New Yorkers to drop their private insurance. As a result, it is likely to be far more costly than the governor expects—adding to a Medicaid budget that already equals the amounts spent by Texas, Florida, and Pennsylvania *combined*.[1]

Second, offering more government-subsidized coverage to more people will add to the cost pressures on private insurers that effectively subsidize Medicaid's low reimbursement rates. That will ultimately shrink the availability of affordable private insurance options, casting some New Yorkers adrift in a broken market and resulting in a smaller net reduction in the state's uninsured population.

This report offers a way to make health care more accessible and affordable for all New Yorkers *without* expanding Medicaid. Instead, we offer market-driven reforms to make private insurance more affordable and accessible by:

- Restoring flexibility to New York's health-insurance regulations to permit more innovative and diverse health-plan offerings.
- Creating a guaranteed-access, high-risk pool for high-cost individuals who cannot obtain coverage through their employers and may not be "insurable" in the newly competitive individual insurance market.
- Allowing low-cost, temporary health-insurance plans.
- Requiring small businesses to allow employees to pay their share of premiums with pre-tax income, through payroll deductions.
- Basing Medicaid income eligibility on fixed-income limits rather than a percentage of the federal poverty limits, to target truly needy families on a regional basis.
- Reaching out to noncitizens by targeting private insurance coverage options to them.
- Making Health Savings Account—eligible plans available in the individual insurance market.

New York Medicaid Facts

Medicaid is a joint federal-state program, enacted by Congress in 1965, as part of Lyndon Johnson's War on Poverty, to provide health insurance for the poor, children, the disabled, and the elderly. In the 1980s and 1990s, the program was expanded to include children in moderate-income families, pregnant women, and, in states such as New York, low- and moderate-income parents and singles without children.

As of 2008, New York's Medicaid budget totals $47.8 billion—including $23.2 billion in federal funds, $17.5 billion in state funds, and $7.1 billion in local tax support. It serves 3.4 million people.

New York's is the most expensive Medicaid program in the country; the next largest is California, which spends $37 billion. New York spends nearly twice as much per Medicaid recipient on Medicaid as the national average, as shown in the table below:

Expenditure per Medicaid recipient

	NY	US average
Child	$1,900	$1,500
Adult	$3,600	$2,000
Disabled	$25,100	$13,000
Elderly	$22,800	$11,500

Sources: NY Division of Budget and Kaiser Family Foundation

I. The Quest for Coverage

In a major health-policy speech soon after taking office, Governor Eliot Spitzer said that one of his top priorities was to "cut New York's uninsured population in half over the next four years" and provide "affordable, universal health insurance for all New Yorkers."[2]

Few would argue that New York's health-insurance system isn't in need of improvement. Small businesses, in particular, are finding it increasingly difficult to afford health-insurance premiums for employees. Individuals without employer-sponsored insurance find it prohibitively expensive to seek coverage on their own in New York's individual direct-pay insurance market.

Expanding government-subsidized health insurance won't be effective or affordable in New York State.

The latest Census figures show that some 2.6 million New York residents are without health insurance. New York's uninsured rate of 16 percent for all those under age 65 is now below the average national rate of 17.8 percent. That marks a change compared with 1999, when New York's uninsured rate (then 17.1 percent) was above the national average (then 15.8 percent).[3]

In other states, the increase in the uninsured rate was due mainly to a drop in employer coverage—something not seen in New York, where total employer-provided health insurance was roughly the same in 2006 as in 1999.[4] Despite that stability, the state's Medicaid program has grown to be the costliest in the nation. at nearly $48 billion—almost as much as Texas, Florida, and Pennsylvania combined.

Yet, even with Medicaid's exploding costs in New York, Governor Spitzer's first budget featured a significant expansion of the state's Child Health Plus (CHP) insurance program—by extending the federal government's State Children's Health Insurance Program (SCHIP) and Medicaid eligibility to a large swath of New York's middle class. At the governor's direction, the state has stepped up its campaign to enroll more eligible New Yorkers in the Child Health Plus and Family Health Plus programs. And the Health Department has received funding to study "proposals for achieving universal health coverage in New York."

Under Governor Spitzer's plan, the state would provide coverage to children in families of four with incomes of up to $82,000 or families of five with incomes of up to $96,000. But as the Spitzer administration eyes enrolling tens of thousands of more people in government-subsidized programs, evidence from around the country suggests that the governor's initiative isn't the most effective or affordable way to expand access to health care.

In fact, just the opposite may be true; consider:

- Compared with New York, states with fewer uninsured residents tend to have *smaller* Medicaid populations and *higher* rates of private insurance coverage. These states also have more flexible insurance regulations, thus encouraging a more competitive marketplace offering a larger choice of health-insurance options with costs more

Table I. Health Insurance Status of Non-Elderly Adults*

I0 States with Lowest Uninsured and Largest Private Insured Populations
2005-2006 (BOLD = top I0 in both categories)

Uninsured Population, Ranked from Lowest					Private Insured Population, Rankled from Highest				
	State	Uninsured*	Private Ins	Medicaid		State	Uninsured*	Private Ins	Medicaid
1	**Minnesota**	**10.7%**	**81.2%**	**8.3%**	**1**	**Minnesota**	**10.7%**	**81.2%**	**8.3%**
2	**Hawaii**	**11.4%**	**78.0%**	**6.4%**	**2**	**New Hampshire**	**14.0%**	**81.1%**	**3.2%**
3	**Wisconsin**	**11.9%**	**79.2%**	**8.5%**	**3**	**Iowa**	**12.7%**	**80.1%**	**8.3%**
4	Maine	12.6%	71.5%	15.7%	**4**	**Pennsylvania**	**12.8%**	**79.9%**	**8.1%**
5	**Iowa**	**12.7%**	**80.1%**	**8.3%**	5	North Dakota	14.6%	79.5%	4.6%
6	**Pennsylvania**	**12.8%**	**79.9%**	**8.1%**	**6**	**Wisconsin**	**11.9%**	**79.2%**	**8.5%**
7	Massachusetts	13.2%	75.5%	12.0%	7	Nebraska	14.9%	78.5%	5.3%
8	Rhode Island	13.3%	75.2%	13.7%	8	Kansas	15.4%	78.2%	5.3%
9	**Connecticut**	**13.4%**	**78.1%**	**7.9%**	**9**	**Connecticut**	**13.4%**	**78.1%**	**7.9%**
10	**New Hampshire**	**14.0%**	**81.1%**	**3.2%**	**10**	**Hawaii**	**11.4%**	**78.0%**	**6.4%**
	New York	18.2%	69.5%	13.8%					
	U.S. Average	20.0%	70.9%	8.0%					

* All adults under 65
Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2006 through 2007

accurately reflecting the unique needs of different populations.

- Expanding eligibility for Medicaid and related government programs entices some employers and workers to drop the private insurance coverage that they already have. This well-documented "crowd-out" effect on the private market means that the Spitzer administration's effort to expand health coverage through government programs is likely to cost more than predicted—without producing the significant decrease in the uninsured population that the governor hopes for.

Individuals, particularly the uninsured, need more affordable private health- insurance options. The state can and should provide a safety net of guaranteed access to health insurance for otherwise "uninsurable" populations such as the chronically or seriously ill.

But while reforming health care and expanding access to coverage are imperative in New York, the state need not rely on its already overburdened taxpayers to shoulder the burden. Rather than simply expand the size of the state's already costly public-health programs, the answer can be found in restoring market forces and incentives to the regulatory apparatus of the state's health-insurance bureaucracy.

Back to the Future?

By attempting to "buy down" the uninsured rate through the expansion of Medicaid eligibility rules, Governor Spitzer is following the well-trod path of his predecessors Mario Cuomo, who established Child Health Plus (CHP), and George Pataki, who expanded CHP and established Family Health Plus.

Under Governor Spitzer's 2007 expansion of CHP—New York's version of the federally

Health-Care Coverage Programs in New York

Public

- **Medicare** – public health-insurance program with premiums, deductibles, and copays for almost all elderly or certain disabled individuals, funded and regulated solely by the federal government. Covers 2.2 million New Yorkers.

- **Medicaid** – public health insurance with no premiums and nominal copays for very low- income, disabled, or elderly New Yorkers with limited assets, funded with federal, state, and local dollars. State and local governments currently contribute over $24 billion to the program. Covers about 3.4 million New Yorkers at a cost of $47.8 billion.

    - **Child Health Plus/Family Health Plus** – public health-insurance program part of Medicaid for low- to middle-income adults and children with no or nominal premiums and nominal copays, funded with federal and state dollars.

Publicly Subsidized

- **Healthy New York** – state-subsidized plan for middle-income individuals and sole proprietors who have been uninsured for at least a year; also available to small businesses that have not offered coverage and have at least 30 percent of employees earning under $35,500 annually. Covers 147,000, with taxpayer costs of about $118 million in 2007.

Private

- **Individual Health Insurance (Standard Plans)** – state-regulated health-insurance plans for individuals purchasing insurance not through their employers. New York has individual standard plans that are uniform and very strictly defined by law but quite expensive at $520-$1,468 monthly per person (NYC rates). Reached only 57,000 New Yorkers in 2006.

- **Small-Group Health Insurance** – state-regulated private health-insurance products for small businesses or sole proprietors with one to 50 employees. Covered 1.7 million New Yorkers in 2006.

- **Large-Group Health Insurance** – federally regulated health-insurance benefits for companies with more than 50 employees; most tend to be self-insured and are completely outside state regulations and mandates. Covered 9 million in 2006.

subsidized State Children's Health Insurance Program (SCHIP)—the eligibility level would be expanded from 250 percent of the federal poverty limit (about $52,000 in annual income for a family of four) to 400 percent (over $82,000). New York's history notwithstanding, this "buy down" approach has proved unsuccessful in other states, serving only to increase the number on Medicaid but having little impact on the uninsured rates.

Although New York now has one of the highest SCHIP income-eligibility thresholds in the country, 11 states have lower rates of uninsured children, according to the Kaiser Family Foundation. Nine of those states even have Medicaid and SCHIP eligibility bars *below* New York's level of 250 percent of poverty.

The governor's expansion will promote the well-documented syndrome of "crowd out," which happens when those already covered by private insurance are enticed to drop their plans in order to obtain "free" coverage from the state. Nationwide, according to the Congressional Budget Office, for every 100 children enrolled in SCHIP, 25 to 50 children will be from families that drop their private coverage for SCHIP.[5]

A recent study by economists Jonatha Gruber and Kosali Simon documents a 60 percent "crowd-out" connected to SCHIP expansion strategies—meaning that for every two kids enrolled in the program from the uninsured population, the private coverage for another three is dropped.[6]

In New York especially, where private individual and small-business insurance are so expensive, those with private coverage have the most to gain from this expansion. But given even these conservative national ratios, New York, in theory, would need to place 750,000 more children on Child Health Plus –a 50 percent increase in that caseload—to eliminate the ranks of uninsured children. The Gruber-Simon study also suggests that charging modest premiums and imposing waiting periods for SCHIP enrollment, as incorporated in Governor Spitzer's latest Child Health Plus expansion, will do little to stem crowd-out.[7]

So what's the bottom line? By extending Medicaid coverage to all children living in families earning less than 400 percent of poverty, the Medicaid rolls could swell by as many as 710,000 as a result of the projected crowd-out effect, thus costing the state up to $400 million a year more.[8] In fact, Gov. Spitzer severely lowballed the expected cost of the state's SCHIP expansion, budgeting just $11 million in state funds for the 2007-08 fiscal year and $41 million for the year after.

Both the uninsured and the taxpayer may be better off without trying to achieve universal coverage—at least, not the kind that New York has been pursuing for the last 25 years. At the end of the day, taxpayer-supported universal coverage in New York would be even more burdensome and expensive than the existing system that everyone—from the governor on down—already regards as unworkable and unaffordable.

Diagnosing the Problem

A cure requires a diagnosis—and diagnosis begins with asking the right questions. To start with, who is uninsured in New York? Of the

Table 2. An Overview of New York's Uninsured Adults* (2005-2006)
Percent Uninsured by Family Income

	Total	Family Income - 2005-2006						
		Less than $10,000	$10,000 to $14,999	$15,000 to $24,999	$25,000 to $34,999	$35,000 to $49,999	$50,000 to $74,999	$75,000 and over
Age								
18 to 34	26%	41%	41%	36%	32%	24%	23%	17%
35 to 49	16%	30%	38%	31%	26%	19%	13%	6%
50 to 64	11%	25%	33%	22%	18%	12%	7%	5%
Nativity								
Native	15%	31%	32%	26%	23%	15%	12%	7%
Not a Citizen	39%	48%	58%	48%	43%	36%	34%	30%
Marital Status								
Married	11%	30%	33%	28%	20%	17%	11%	5%
Single	25%	35%	39%	32%	29%	21%	20%	18%
Sex								
Male	21%	39%	46%	36%	31%	21%	19%	11%
Female	15%	30%	31%	27%	21%	17%	10%	7%

* Under 65
Source: U.S. Census Bureau
Current Population Survey, Annual Social and Economic Supplement, 2006 through 2007

2.6 million New Yorkers without insurance, just under 400,000 are children. Here are some noteworthy characteristics of the 2.2 million adults who make up the bulk of New York's uninsured population:

- About a half are between the ages 18 and 34; almost a third are 35 to 49; and fewer than one in six are 50 to 64, approaching retirement.

- The average uninsured adult is 36 years old—five years younger than the average for adults who have health insurance.

- Thirty percent are noncitizens, consisting of legal and illegal immigrants, who are generally ineligible for traditional Medicaid coverage. Of these 714,000 uninsured noncitizens, fewer than 49,000 are children and almost half are young adults aged 18 to 34.[9]

- Ninety percent report that they are in good health.[10]

- Two-thirds have no dependent children at home, and 69 percent are single.

- Sixty-one percent have annual family incomes exceeding $25,000, and one-third earn over $50,000.

- The majority lack health coverage only temporarily. Nationally, 70 percent of adults are reinsured again within a year.[11]

The data show that most of the uninsured are not sickly, economically homogenous, or otherwise marginalized. Rather, they are a diverse and dynamic lot. They are relatively young, mostly childless, healthy and—for the most part—not poor (see Table 2).

So why are they uninsured? First, noncitizens aren't eligible for typical state-funded assistance through Medicaid, and many avoid seeking private coverage out of fear of jeopardizing their residency status—or, in the case of illegal immigrants, being found.

Also, among those with low incomes, a sizable number of uninsured simply fail to enroll in programs for which they are already eligible, including Child Health Plus and Family Health Plus. This, in fact, is the very reason the Empire State is promoting its subsidized health-insurance programs so aggressively. Of the 367,000 children who are uninsured in New York, 68 percent are eligible for Child Health Plus. Meanwhile, of the state's uninsured adults, 406,000 are eligible for coverage under Family Health Plus.[12]

Still, the majority of those uninsured are citizens who are ineligible for government assistance and can't—or won't—purchase private insurance, for a variety of reasons that are listed below.

The Lack of Affordable Options

Private health insurance throughout the United States has primarily been employment-based since the 1940s, when the internal revenue code was amended to provide an enormous tax incentive for employer-sponsored plans. There are 2.2 million New Yorkers who aren't covered by their employers for various reasons.[13]

Since the average employee has an eight-week waiting period before becoming eligible, some workers have not been on the payroll long enough. Others may not work enough hours to qualify for coverage or are not offered coverage at all. An unknown number of workers may have a health-insurance fallback—such as being covered by their spouse's employer-sponsored

Ante Up: Individual Health Insurance in New York

Any New Yorker wanting to buy individual health insurance faces some tough challenges. Only two standard plans—Health Maintenance Organization (HMO) and Point of Service (POS)—are allowed in the state. An HMO has a preferred network of providers. A POS allows an individual to go to any provider.

New York has 52 provider and service mandates on health insurance, 15 more than the national average of 37. Such mandates include coverage for chiropractic services, inpatient hospital care, outpatient services including laboratory tests and x-rays, care in a physician's office, maternity care, chemotherapy, prescription drug coverage, physical therapy, and inpatient and outpatient mental health care.

Here are what such mandates and regulations do to the cost of buying an individual policy:

Monthly Premiums — (June 2007)

	Single	Family
Albany:	$570 to $1,412	$1,709 to $3,749
NYC:	$501 to $1,513	$934 to $3,736

Average Monthly Premium for Individual* — (2006)

	Individual	Family
NY:	$338	$821
US:	$186	$386

*Includes sole proprietors, which are in NY small groups market. Individual equals 44- year-old. Family equals 49-year-old policyholder family of four.

Sources: NY Department of Insurance, Kaiser Family Foundation, Council for Affordable Health Insurance and Ehealthinsurance.com

plans. The rest—single and married alike—are left to shop on their own for insurance in the private individual market. In New York, this is an exceptionally expensive proposition.

In most regions of the Empire State, the monthly individual health-insurance premium (not purchased through an employer) *starts at* $500 for an individual policy and $1,400 for a family policy.[14] The average premium in the private market is roughly twice the national average. The only cheaper option available to New Yorkers in the private market has been the Healthy New York program, in which the state directly subsidizes premium rates starting at $300. But eligibility for this plan is limited to workers who earn less than $25,300 and have been uninsured for at least a year or have recently lost employer-sponsored coverage. Relatively few workers qualify, and the program has reached relatively few—only 147,000 have enrolled, or less than 0.8% of the state's population.[15]

Why the Affordability Problem Exists

The level of health-insurance premiums across the country reflects three principal factors: health-care costs, utilization rates, and state insurance regulations.

Despite a high cost of living in its most densely populated regions, New York's health-care costs are not excessive or out of line with national norms. Unit costs for hospital inpatient care in New York, for example, are right around the 50-state average.[16] Utilization in New York is not uniformly high, either. Prescription-drug use in the Empire State for adults aged 19 to 64 is actually below the national average.[17]

Perhaps one of the best indicators of New York's average health-care costs and utilization rates is the fact that very large New York companies, which are self-insured and self-administer their health benefits with very low administrative costs, report premiums for single and family

coverage at rates close to the national average. This has been true for over a decade.[18]

Where New York stands out, however, is in the breadth and scope of its health- insurance regulations on small businesses and direct-pay individuals. Two state rules, in particular, rob the system of flexibility:

1. **A "community rating" standard for establishing premiums.** This means that, for any given plan, insurers must charge the same premium regardless of the age, gender, and health propensities of the employees who make up the group. Thus, a law firm employing a dozen sedentary, cigar-smoking, middle-aged attorneys must be charged the same rate as a health club employing a dozen fitness fanatics in their twenties. For individuals buying insurance on their own, this is an even bigger problem. A healthy 25-year-old will pay the same for an individual policy as an obese 59-year-old with an unhealthy lifestyle.

New York's insurance regulations and coverage mandates drive up the cost of individual and small-group coverage.

2. **Mandated deductibles and covered health services.** All health-insurance plans in New York must cover at least 44 types of services, ranging from chiropractors to fertility treatments to mental health. Virtually all states mandate services to some extent—but New York has more mandates than most, adding an estimated 12 percent to insurance costs.

Taxes are another major element in the high cost of health insurance in New York. The state now collects over $2.2 billion in taxes and assessments from private health plans, including a $75 million increase in the so-called "covered lives assessment" adopted as part of Governor Spitzer's first budget. These taxes add roughly $222 a year to the cost of the average health insurance premium for the 11.3 million New Yorkers with private coverage, or $888 for a family of four.

Individual Extras

In the individual insurance market, New York is one of only five states requiring all insurers to sell a community-rated policy to anyone who can pay for it, regardless of health status. This "guaranteed-issue" provision—also known as open enrollment—was designed as a safety net to ensure that the chronically and seriously ill would not be denied coverage. But, in practice, it has encouraged people in many instances to delay buying insurance until they are ill and actually need it. The key to a functioning insurance market is to have the healthy enroll long before they need coverage. Guaranteed issue allows the healthy to wait with no financial penalty, leaving only those who "need" coverage now to buy into the costly individual market. What remains is a pool of ill people who use a lot of health care with few healthy individuals participating to spread the risk more evenly.

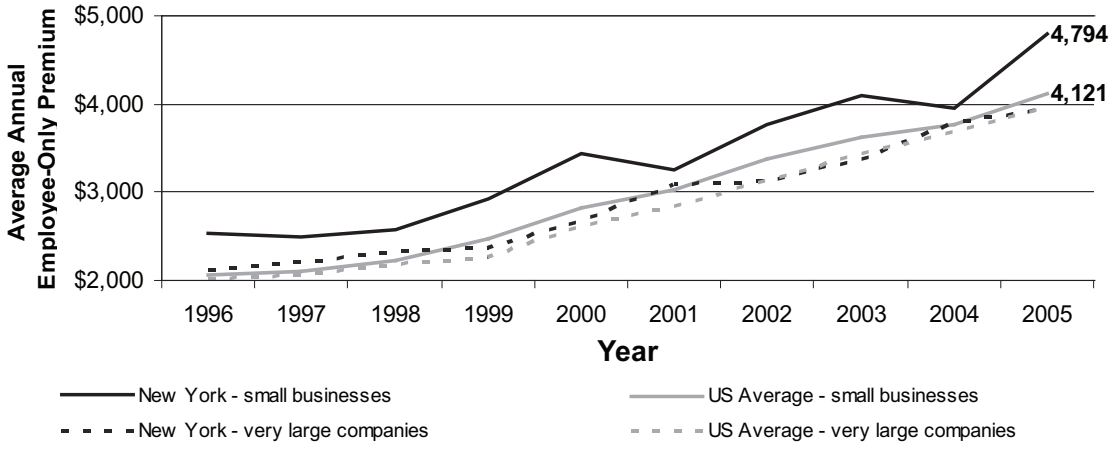
This is especially the case in New York , where the high cost of insurance is driving people out of the individual market. Only 57,000 New Yorkers were covered by an individually purchased health plan in 2006, down almost 50 percent from 2000.[19] In 1994, just as guaranteed issue was first being implemented in New York, there were more than 750,000 in New York's individual market.[20] That's a 94 percent drop in just over a decade.

By contrast, the number of people buying individual insurance plans nationwide is moving in the opposite direction, having increased by 6.8 percent between 2000 and 2006[21] and by 64 percent since 1994.[22]

In the end, New York's regulatory straitjacket has made the state inhospitable to private insurers, who maintain a reluctant presence here by charging some of the highest standard individual health-insurance rates in the nation. For the most part, New York insurers tolerate the oppressive regulations in the individual and small-group market (which has 1.8 million people) so that they can have access to the 9 million people working at large companies, which fall mostly outside state regulation. The state has 29 licensed insurers in its small-group market. Wisconsin—with a small-group market one-third the size of New York's—has 50.

As noted, the clearest evidence that excessive state regulations are the cause of high insurance premiums in the individual and small-group markets is the level of premiums charged by large, self-insured New York employers, which are regulated only by federal law. As illustrated below, these large-company premiums are equal to the national average.

Figure I. New York's High Cost Premiums for Small Businesses — 1996-2005



Source: Agency for Healthcare Research and Quality

2. Lessons from Other States

New York is actually below average in its proportion of adults and children without health coverage. However, to meet Governor Spitzer's goal of cutting the total uninsured population in half, the state will need to meet or exceed the performance of states that have done much better. Here are two key lessons that can be learned from these top performers:

More "public insurance" does not guarantee more insured. The states with the highest rates of adults on Medicaid or other public insurance are not the states with the lowest rates of uninsured. Similarly, the majority of states with a lower rate of uninsured children have more children with private health insurance. Expanding Medicaid is not an effective or fiscally reasonable solution to reducing the rate of uninsured New Yorkers. In fact, prior to New York's latest move to expand Child Health Plus eligibility, there were 14 states with a lower rate of uninsured children and 31 states with a higher proportion of privately uninsured children.

Top-performing states have fewer regulations and lower private insurance premiums. None of the states with low rates of uninsured adults imposes the array of insurance regulations that New York does. Regulations such as community rating, guaranteed issue in the individual market, and a multitude of coverage mandates and restrictions on plan design significantly reduce the availability of affordable private coverage options in New York.

The evidence suggests that more people will buy private insurance when carriers are allowed to tailor programs to meet the consumer's needs. For instance:

Reaching Young Adults

WellPoint, a multistate insurer, offers the Tonik Health Plans program, targeted at young adults between the ages of 19 and 34. Now available in six states—including Connecticut, New Hampshire and California—the plan will be expanding to five others soon.

Tonik is sold completely online (Tonik.com), has an innovative marketing campaign, and consists of three different plans: Calculated Risk Taker ($1,500 deductible); Part-Time Daredevil ($3,000 deductible); and Thrill Seeker ($5,000 deductible). Each of the plans covers inpatient, outpatient, primary care, preventive care (paid completely by the insurer with no deductible), prescriptions and mental-health treatment.

In Connecticut, for example, Tonik premiums vary from $105 to $202 a month, depending on age, gender, and plan selected.[23] By comparison, the least expensive private plan in New York City for a 25-year-old male who is not self-employed costs nearly $415 a month.[24]

It's worth noting, too, that 78 percent of those buying Tonik plans were previously uninsured.[25] In New York, where 44 percent of uninsured adults are between the ages of 18 and 34, a plan like Tonik would have a significant impact.

Consumer-Directed Health Plans

Across the country, consumer-directed health plans are increasing in popularity. These plans combine a high-deductible, low-premium plan with a tax-free Health Savings Account that allows an individual to save for out-of-pocket health costs. Deductibles for HSA-eligible plans must be at least $1,100 for individuals and $2,200 for family coverage. Premiums for HSA-eligible plans are typically 30 to 40 percent lower than traditional low-deductible, high-premium HMO/PPO plans.

In 2006, individuals may deposit up to $2,850 into the account for single coverage plans, and $5,650 for family HSA-eligible plans. The plans typically provide free preventive care outside the deductible.

A quarter of the people purchasing new individual health-insurance policies over the past year chose an HSA-eligible plan, and 27 percent of new HSA plan buyers were previously uninsured. More than 1.1 million individuals have purchased HSAs on their own.

For small businesses, 17 percent of new policies in 2006 were for HSA-eligible plans. For large companies, the figure is 8 percent.

The best-selling HSA-eligible plans—costing $120 a month for single coverage and $270 a month for a family plan—are primarily sold to young adults between the ages of 20 and 29. For those 30 to 54, single coverage costs $176 a month and family coverage is still an affordable $385.[26]

These plans may not be for everyone, but they are an affordable option and one that is being purchased voluntarily by the uninsured. In New York, however, no HSA-eligible plans are available in the individual market.

Short-Term Coverage

Two million New York adults are uninsured at any one time. As noted above, more than two-thirds of those uninsured are reinsured in less than a year. Despite such a healthy market of "temps," providers are not allowed to sell temporary private health insurance in New York.

Like term life insurance, such coverage is limited to a fixed period in order to reduce the risk to the insurer, thus lowering the cost to the individual. For example, a 40-year-old person living in Washington, D.C., can obtain a temporary, six-month health-insurance policy with a $500 deductible for just $119 a month. A 25-year-old Washingtonian could obtain a temporary policy for as low $34 a month. Meanwhile, a couple—each person 35 years old—with two children can purchase a six-month health-insurance policy with a $1,000 deductible for $265 a month.[27]

All but five states offer temporary health insurance to be sold to their residents. States that don't allow such coverage include Hawaii, Massachusetts, New Jersey, New York, and Vermont.

Reaching Small Business Employees

A competitive, flexible health-insurance market allows small businesses of all types to provide plans that meet the needs of their diverse workforces. However, as previously noted, New York's insurance marketplace is not competitive and is severely hampered by regulation. Therefore, it is much slower to replicate the kinds of innovative practices and plans available elsewhere.

For a business to simply offer health insurance greatly encourages employees to enroll, even when they are responsible for paying a share. Nationally, according to the Kaiser Family Foundation, companies with the most costly sharing packages—where the employee pays 37 percent or more of the premium—get an average of 68 percent of employees to take up the coverage. Even for expensive family coverage, where an employee is paying as much as 56 percent of the premium, enrollment rates are 77 percent. Meanwhile, at firms where workers are paid low wages—with 35 percent of employees earning less than $20,000 a year—enrollment rates are in the 70 percent range.[28]

In New York, only 69 percent of firms with fewer than 50 workers offer health insurance to their employees, and only 53 percent of those with fewer than 10 employees do so. Thus, more

should be done to enable and encourage small businesses to offer a menu of health plans.[29]

Short of mandating such an offer, flexibility in health-insurance offerings gives businesses more diverse and affordable choices.

Access for New York's Noncitizens

Almost a third of New York's uninsured are noncitizens—including legal and illegal—and most of them most likely don't realize that private health insurance is available to them. Thus, a greater effort should be made to reach out to the immigrant population to raise their awarness of their coverage options.

The more noncitizens covered by private insurance, the more the burden is reduced on taxpayers, since it is the public that incurs the cost whenever uninsured immigrants receive emergency care, which the state must provide by law.

De Facto Universal Coverage?

A major reason that so many New Yorkers can "afford" to be uninsured is that New York already has *de facto* universal health care. Those eligible for Medicaid have access to retroactive Medicaid coverage. For others, the state allows people to buy insurance at any time, even *after* being diagnosed with a serious illness. Also, thanks to various state and federal laws, New York hospitals and public clinics *must* treat anyone who walks through their doors, regardless of insurance status.

There are even programs to guarantee that no one is without a prescription drug when needed. Such "patient assistance" programs, operated by pharmaceutical companies and other organizations, provide no- or low-cost prescription medication to those without health insurance or prescription drug coverage.

Patient assistance clearinghouse RxAssist.org lists almost 1,400 brand-name drugs and almost 200 generics available at no or low cost. Generally, individuals must be U.S. residents and earn less than 200 percent of poverty ($20,400 for an individual, $27,400 for a couple, or $41,300 for a family of four, which accounts for about half of all uninsured New Yorkers) to receive the medication.

In addition, Wal-Mart offers more than 300 generic medications for $4 to everyone. And New York's EPIC (Elderly Pharmaceutical Insurance Coverage) provides low-cost drugs to seniors with incomes of under $35,000 for an individual or $50,000 for a couple, which effectively covers almost 80 percent of single seniors and 60 percent of senior couples.

Thus, there is no policy reason for any New Yorker going without medical care. However, health coverage does not necessarily translate into health quality. In fact, while New York has a higher than average rate of residents with health coverage, the federal Agency on Health Care Quality and Research reports that New York has below average (and falling) quality of health care.[i]

In 2005 (the last year for which data are available), all this compensated care for uninsured New Yorkers cost taxpayers $3.5 billion. Almost two-thirds of the money came from federal funds; the remainder was split equally between state and local governments.[ii] The state pays for only a small portion of this funding – under 18 percent, or $622 million. Meanwhile, the Family Health Plus (FHP) program, an offshoot of Medicaid, provided coverage to 515,000 New York adults at a nonfederal cost of $700 million as of 2004. Thus, if FHP is used as a model for extending universal health insurance coverage to the 2.4 million uninsured, the net cost is likely to be considerably more than the state now spends to reimburse uncompensated health care for the same group of people.

[i] New York State Snapshot, Agency for Healthcare Research and Quality; available at: http://statesnapshots.ahrq.gov/statesnapshots/statesummary.jsp?menuId=3&state=NY&level=0.

[ii] Randall R. Bovbjerg et al., "Caring for the Uninsured in New York: What Does It Cost, Who Pays, and What Would Full Coverage Add to Health Care Spending?," Urban Institute, October 2006, "Table 9. Predicted Medical Spending by the Uninsured if Fully Insured, 2005," p. 20; available at: http://www.urban.org/UploadedPDF/311372_uninsured_NY.pdf.

Sources: NY Department of Health and RxAssist.org

3. Rx for NY: Market-Based Reforms

Governor Spitzer has embraced the laudable goal of affordable and universal access to health care coverage. But he has just as clearly embarked on a reform path that promises only to take the state deeper into the woods. Based on our analysis of New York's policy and regulatory environment, as well as evidence from states that have more affordable insurance options and more people insured, we recommend seven initiatives that would help attain the governor's goal:

1. Restore flexibility to New York's insurance regulations and eliminate needless mandates.

New York should repeal its pure community rating laws in the small-group and individual markets and repeal guaranteed-issue rules in the individual market. Model legislation from the National Association of Insurance Commissioners (NAIC) provides a useful guide to creating regulations that allow reasonable, actuarially justified variations in premiums. This model is used in 36 states and strictly limits premium variations for health status and industry, but allows other actuarially justified variations, including age, gender, geography, family composition/size, wellness programs, and group size.

Though all states mandate that certain health providers or certain health benefits be covered in some form or another, only two states have more coverage mandates than New York.[30] Requiring plans to cover such a wide range of services in the Empire State adds an estimated 12 percent to insurance costs. It's time that New York rid insurers of so many needless mandates.

2. Create a guaranteed-access, high-risk pool for ill, high-cost individuals who cannot obtain coverage through their employer and may not be insurable in the newly competitive individual market.

A better and more cost-effective way to provide health care to the segment of people considered uninsurable would be to create a guaranteed-access, high-risk pool funded by a per-person assessment that is charged to all New Yorkers with private health insurance. With an estimated 10.9 million people in New York covered by private insurance, an annual assessment of just $5 per person would raise $54.5 million for the guaranteed-access program.

By providing a stable funding mechanism through an assessment—as is done in 34 other states—more people would have access to affordable private coverage, thus reducing the cost to taxpayers in the long run since the state would be able to reduce spending on Medicaid and other subsidized coverage programs.

> New York needs a guaranteed-access, high-risk pool for chronically ill individuals.

We've seen what happened when New York policymakers tried to ensure access to individual health insurance by passing guaranteed issue in the individual market. That public policy drove up costs in the individual market and made it less financially attractive for people to buy insurance. As a result, the number of people with individual health plans in New York

plummeted from 750,000 to 57,000. Creating a guaranteed-access, high-risk pool with a stable funding source would restore the state's private individual insurance market, while expanding access to affordable private coverage for those New Yorkers who need it most.

The Healthy New York plan—which was designed to provide subsidized coverage for people who would otherwise be uninsured—would be the perfect vehicle for implementing this plan.

Medicaid eligibility should be based on fixed income limits, rather than tied to federal poverty levels.

3. Allow low-cost, temporary health-insurance plans.

These plans, providing comprehensive coverage for up to one year at a fraction of individual market rates, would meet the needs of the roughly 70 percent of uninsured adults who lack coverage for less than a year and at rates as low as $35 per month. Forty-five other states allow this type of coverage. New York should, too.

4. Require small businesses to set up tax-free insurance plans.

Rhode Island now requires that all businesses with at least 25 employees must have by 2009 a Section 125 plan that allows for the purchase of health insurance, child care, and out-of-pocket medical expenses on a pretax basis through payroll deduction. Massachusetts, Connecticut and Missouri have similar laws.

Based on a part of the federal tax code regulating pretax premiums, a Section 125 plan can reduce the effective cost of health insurance by almost 40 percent in reduced federal (25 percent) and state (6.85 percent) income taxes, as well as FICA taxes (7.65 percent). Because the employer does not pay the 7.65 percent FICA tax on an employee's withholdings, the Section 125 represents a net savings over the small administrative payroll expenses associated with the plan.

Nationally, only 60 percent of small companies have employees pay their share of the premiums pretax through a Section 125 plan, and only 20 percent have employees use pretax funds for out-of-pocket health and child-care expenses.[31]

Though a Section 125 plan is slightly more complicated to administer, it ultimately pays for itself in savings.

5. Base Medicaid income eligibility on fixed-income limits for children and non-elderly, non-disabled adults rather than a percentage of the federal poverty limit.

This would not just simplify the eligibility rules; it would also make the system fairer by using a fixed-income-eligibility standard rather than different rules based on the size of households and the number of dependent children.

For instance, children—regardless of the number in the family or whether their parents are married—could qualify for government-subsidized coverage if family income were below $60,000 in New York City or $40,000 in upstate New York.

Right now, New York Medicaid does not target the truly needy. Instead, it targets those neatly fitting the national federal poverty-limit formula. With the Child Health Plus expansion, a single parent with one child cannot earn over $55,000 and qualify, but the married couple with three children can earn over $96,000 and receive Medicaid.

No other state has adopted a policy such as the one advocated here, but it seems a promising strategy to target expansion to the truly poor by region.

6. Reach out to noncitizens with private insurance-coverage options targeted specifically to them.

New York State should encourage insurers to develop and target private coverage plans to this population, which includes legal and illegal immigrants and makes up almost three-quarters of a million of New York's uninsured adults.

Because noncitizens are particularly vulnerable in not understanding their private insurance options, the state should increase its outreach efforts to better inform this population that one does not need to be a citizen to purchase private insurance and to have access to America's top-quality health-care system.

As stated previously, the more noncitizens pay out of their own pockets for coverage, the more the burden is lessened on taxpayers who foot the bill whenever uninsured immigrants receive emergency care, which by law must be provided.

7. Promote Health Savings Account and HSA-eligible plans as affordable private insurance for the uninsured.

HSA-eligible plans are very affordable, particularly for those groups that tend to be uninsured. A 25-year-old male living in Hartford, Connecticut, for instance, can buy an HSA-eligible individual insurance plan for as little as $59 a month.[32] He also can put $1,500 into his HSA tax-free and be assured that he has a 70 percent chance of having money left over in the HSA for future health expenses.

But if this same young adult lived in New York, where HSAs aren't allowed, he'd have to pay $400—$500 a month for a $0-deductible HMO individual plan that he has very little chance of significantly using.

HSAs and HSA-eligible plans provide comprehensive health coverage, financial protection from catastrophic health expenses, and a way to save and pay for out-of-pocket health expenses tax-free.

Conclusion

The time is certainly ripe for change in the Empire State. Governor Spitzer was elected by an overwhelming public mandate, providing New York with a golden opportunity to reverse a long and costly slide toward health-insurance bankruptcy. But reforming the state's ailing health-care system can't be done with an expansion of government programs unless that expansion is finely tuned and coupled with regulatory reform.

Other states are closing the gap between affordability and universal coverage by maximizing opportunities for quality, affordable, and accessible private insurance plans. They've shown that affordable private health insurance reduces the dependency on Medicaid and other publicly subsidized coverage programs. And in doing so, they've set themselves on the path toward fiscal sanity.

By freeing the private health-insurance market and having competitive regulations, 19 million New Yorkers could have access to the kind of cost-effective and affordable private health-insurance options available to most of the other 280 million residents of the United States.

Appendix I. Health Insurance Status of Non-Elderly Adult Population (2005-2006)

State	Totals	Covered			Private Insurance			Medicaid			Uninsured	
		#	%	Rank	#	%	Rank	#	%	Rank	#	%
US Total	185,516,095	148,462,262	80%		131,462,327	70.9%		14,918,171	8.0%		37,053,833	20%
Alabama	2,845,140	2,242,358	79%	37	1,962,970	69%	35	245,957	9%	15	602,781	21%
Alaska	429,578	336,364	78%	38	277,749	65%	46	34,951	8%	21	93,214	22%
Arizona	3,792,030	2,831,836	75%	47	2,368,139	62%	50	439,172	12%	7	960,194	25%
Arkansas	1,730,085	1,297,818	75%	46	1,119,511	65%	45	101,858	6%	36	432,267	25%
California	22,590,395	17,194,812	76%	44	14,907,590	66%	41	2,231,222	10%	11	5,395,583	24%
Colorado	3,071,069	2,448,719	80%	33	2,228,567	73%	28	161,558	5%	44	622,350	20%
Connecticut	2,196,203	1,902,608	87%	9	1,714,745	78%	9	174,186	8%	24	293,595	13%
Delaware	537,295	458,868	85%	15	410,266	76%	14	39,043	7%	29	78,427	15%
District of Columbia	378,333	320,555	85%	17	267,758	71%	31	57,222	15%	2	57,778	15%
Florida	11,048,159	8,113,794	73%	48	7,272,112	66%	42	632,334	6%	38	2,934,365	27%
Georgia	5,984,672	4,627,172	77%	42	4,052,942	68%	39	382,916	6%	34	1,357,500	23%
Hawaii	789,974	700,207	89%	2	616,408	78%	10	50,743	6%	33	89,767	11%
Idaho	893,869	723,054	81%	30	654,562	73%	24	65,360	7%	27	170,815	19%
Illinois	7,930,884	6,515,678	82%	25	5,925,430	75%	22	533,219	7%	32	1,415,205	18%
Indiana	3,984,937	3,340,997	84%	20	3,040,589	76%	15	250,277	6%	35	643,940	16%
Iowa	1,835,581	1,602,148	87%	5	1,470,258	80%	3	151,906	8%	20	233,434	13%
Kansas	1,654,884	1,399,490	85%	18	1,293,716	78%	8	87,751	5%	43	255,394	15%
Kentucky	2,601,991	2,119,285	81%	27	1,824,566	70%	32	222,817	9%	16	482,705	19%
Louisiana	2,517,907	1,834,882	73%	50	1,573,517	62%	49	211,308	8%	18	683,025	27%
Maine	856,470	748,392	87%	4	612,419	72%	29	134,435	16%	1	108,078	13%
Maryland	3,557,742	2,934,493	82%	24	2,717,663	76%	13	166,594	5%	46	623,250	18%
Massachusetts	4,054,165	3,520,037	87%	7	3,060,624	75%	19	484,652	12%	6	534,128	13%
Michigan	6,278,513	5,369,993	86%	13	4,777,205	76%	16	585,797	9%	12	908,520	14%
Minnesota	3,252,214	2,903,062	89%	1	2,642,245	81%	1	269,401	8%	19	349,151	11%
Mississippi	1,769,759	1,348,803	76%	43	1,123,645	63%	47	194,365	11%	8	420,956	24%
Missouri	3,618,702	3,018,359	83%	23	2,701,929	75%	23	254,553	7%	30	600,343	17%
Montana	592,755	472,644	80%	32	408,857	69%	36	43,274	7%	28	120,111	20%
Nebraska	1,108,430	943,310	85%	16	870,166	79%	7	59,201	5%	42	165,121	15%

State	Totals	Covered			Private Insurance			Medicaid			Uninsured	
		#	%	Rank	#	%	Rank	#	%	Rank	#	%
Nevada	1,531,978	1,188,952	78%	41	1,089,826	71%	30	64,661	4%	48	343,026	22%
New Hampshire	837,562	720,121	86%	10	679,258	81%	2	26,511	3%	51	117,441	14%
New Jersey	5,473,207	4,455,005	81%	28	4,185,507	76%	12	225,762	4%	49	1,018,202	19%
New Mexico	1,181,753	862,418	73%	49	725,898	61%	51	109,946	9%	13	319,335	27%
New York	12,005,823	9,823,960	82%	26	8,341,418	69.5%	34	1,655,047	13.8%	4	2,181,863	18.2%
North Carolina	5,460,360	4,306,190	79%	36	3,763,537	69%	37	431,600	8%	25	1,154,170	21%
North Dakota	398,624	340,544	85%	14	316,763	79%	5	18,292	5%	47	58,080	15%
Ohio	7,160,636	6,132,814	86%	12	5,412,864	76%	18	639,800	9%	14	1,027,821	14%
Oklahoma	2,139,127	1,605,348	75%	45	1,396,760	65%	44	124,090	6%	37	533,779	25%
Oregon	2,329,375	1,819,085	78%	39	1,626,302	70%	33	175,692	8%	26	510,290	22%
Pennsylvania	7,739,970	6,752,102	87%	6	6,184,218	80%	4	624,483	8%	22	987,868	13%
Rhode Island	683,189	592,335	87%	8	513,499	75%	20	93,901	14%	5	90,854	13%
South Carolina	2,654,640	2,066,696	78%	40	1,778,681	67%	40	212,417	8%	23	587,944	22%
South Dakota	472,027	398,619	84%	19	362,238	77%	11	24,796	5%	45	73,408	16%
Tennessee	3,655,905	2,968,882	81%	29	2,486,930	68%	38	381,929	10%	9	687,023	19%
Texas	14,001,645	9,824,627	70%	51	8,774,230	63%	48	791,207	6%	41	4,177,018	30%
Utah	1,546,207	1,227,627	79%	34	1,126,810	73%	27	87,867	6%	39	318,581	21%
Vermont	413,709	355,428	86%	11	302,005	73%	25	58,327	14%	3	58,281	14%
Virginia	4,874,388	4,080,507	84%	22	3,688,093	76%	17	192,351	4%	50	793,881	16%
Washington	4,058,432	3,399,637	84%	21	3,033,343	75%	21	282,303	7%	31	658,795	16%
West Virginia	1,169,648	925,248	79%	35	769,682	66%	43	116,508	10%	10	244,400	21%
Wisconsin	3,500,518	3,083,420	88%	3	2,770,970	79%	6	296,157	8%	17	417,098	12%
Wyoming	325,637	262,957	81%	31	237,346	73%	26	18,452	6%	40	62,680	19%

Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2006 through 2007
Current Population Survey, Annual Social and Economic Supplement, 2006 through 2007

Appendix 2. An Overview of New York's Uninsured Non-Elderly Adult (2005-2006)

Number of the Uninsured by Family Income

	Total	Family Income - 2005-2006							Income-to-Poverty Ratio in 2005 to 2006					
		Less than $10,000	$10,000 to $14,999	$15,000 to $24,999	$25,000 to $34,999	$35,000 to $49,999	$50,000 to $74,999	$75,000 and over	Below 100%	100% to below 200%	200% to below 300%	300% to below 400%	400% to below 500%	500% and above
Total - Number	2,181,863	332,700	172,824	343,868	293,823	283,687	327,565	427,397	496,745	559,775	392,889	278,838	157,422	296,194
Age														
18 to 34	1,121,369	180,101	75,234	158,143	139,350	135,298	178,435	254,808	254,198	269,219	183,333	150,523	102,628	161,470
35 to 49	681,186	87,254	52,582	127,805	103,556	99,130	106,246	104,612	150,325	189,021	139,431	89,018	34,287	79,104
50 to 64	379,308	65,345	45,008	57,919	50,917	49,258	42,885	67,976	92,222	101,535	70,126	39,298	20,507	55,619
Nativity														
Native	1,278,068	216,852	101,266	197,497	161,434	143,477	199,356	258,185	288,110	312,604	207,271	143,088	126,655	200,340
Naturalized Citizen	238,634	32,852	20,659	30,833	28,758	47,561	40,642	37,329	57,354	56,461	51,184	40,083	7,251	26,300
Not a Citizen	665,162	82,994	50,900	115,537	103,632	92,649	87,567	131,883	151,281	190,710	134,434	95,667	23,516	69,554
Marital Status														
Married	671,378	56,368	35,494	89,797	88,089	120,695	133,974	146,962	124,975	162,194	144,313	100,572	44,928	94,397
Single	1,510,485	276,331	137,330	254,070	205,735	162,992	193,591	280,434	371,769	397,582	248,576	178,267	112,494	201,798
Dependent Children under 18														
None	1,431,263	263,151	143,287	235,371	177,254	168,197	175,185	268,818	325,268	335,694	230,865	177,129	120,819	241,489
One or more	750,602	69,547	29,537	108,496	116,570	115,490	152,380	158,579	171,477	224,081	162,025	101,709	36,603	54,705
Race														
White alone	1,451,828	205,042	106,362	239,905	209,684	169,679	221,030	300,126	297,176	384,112	246,661	201,186	115,605	207,088
Black or African American alone	434,329	88,960	46,575	58,423	49,326	58,461	69,325	63,259	129,329	108,049	76,687	36,643	32,630	50,990
Asian alone	246,619	34,346	18,014	39,757	29,328	47,171	27,239	50,764	65,887	51,484	60,331	29,084	4,848	34,985
Two or more races	38,917	3,374	1,873	5,783	3,557	6,445	9,970	7,915	3,374	13,249	8,231	9,264	1,668	3,131
Sex														
Male	1,231,694	154,107	89,221	182,027	171,101	154,651	215,026	265,562	223,875	295,460	235,545	179,154	113,428	184,232
Female	950,169	178,593	83,603	161,841	122,723	129,036	112,539	161,835	272,870	264,315	157,344	99,684	43,994	111,962

	Total	Family Income - 2005-2006							Income-to-Poverty Ratio in 2005 to 2006					
		Less than $10,000	$10,000 to $14,999	$15,000 to $24,999	$25,000 to $34,999	$35,000 to $49,999	$50,000 to $74,999	$75,000 and over	Below 100%	100% to below 200%	200% to below 300%	300% to below 400%	400% to below 500%	500% and above
Percent of uninsured by applicable population														
Total population	18%	34%	38%	31%	26%	19%	15%	9%	33%	31%	23%	16%	12%	8%
Age														
18 to 34	26%	41%	41%	36%	32%	24%	23%	17%	38%	37%	29%	24%	21%	14%
35 to 49	16%	30%	38%	31%	26%	19%	13%	6%	32%	27%	22%	14%	7%	6%
50 to 64	11%	25%	33%	22%	18%	12%	7%	5%	27%	25%	17%	9%	5%	4%
Nativity														
Native	15%	31%	32%	26%	23%	15%	12%	7%	29%	28%	18%	11%	11%	6%
Naturalized Citizen	16%	30%	34%	24%	17%	21%	14%	7%	30%	20%	21%	18%	5%	6%
Not a Citizen	39%	48%	58%	48%	43%	36%	34%	30%	49%	45%	42%	41%	21%	23%
Marital Status														
Married	11%	30%	33%	28%	20%	17%	11%	5%	31%	22%	18%	11%	6%	4%
Single	25%	35%	39%	32%	29%	21%	20%	18%	34%	36%	29%	22%	19%	14%
Dependent Children under 18														
None	21%	39%	47%	34%	26%	19%	13%	11%	40%	36%	27%	19%	15%	9%
One or more	15%	22%	19%	26%	26%	19%	16%	7%	25%	25%	20%	13%	7%	4%
Race														
White alone	17%	36%	36%	32%	27%	17%	13%	8%	34%	32%	21%	16%	11%	6%
Black or African American alone	22%	29%	39%	22%	23%	22%	20%	13%	29%	28%	25%	12%	18%	13%
Asian alone	24%	39%	48%	41%	24%	28%	15%	15%	43%	26%	34%	22%	7%	12%
Two or more races	25%	18%	24%	47%	30%	32%	30%	16%	14%	47%	31%	31%	11%	10%
Sex														
Male	21%	39%	46%	36%	31%	21%	19%	11%	37%	34%	29%	20%	16%	9%
Female	15%	30%	31%	27%	21%	17%	10%	7%	30%	27%	18%	12%	7%	6%

Source: U.S. Census Bureau
Current Population Survey, Annual Social and Economic Supplement, 2006 through 2007

Endnotes

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