State and Federal Approaches to Health Reform: What Works for the Working Poor?

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Abstract

Policies designed to expand insurance coverage may have very different implications beyond just the number newly insured, particularly among the working poor. These broader effects include employment, wages, and the distribution of costs and benefits across families. We compare likely effects of three common approaches to covering the uninsured: public insurance expansions, refundable tax credits for low-income people, and employer and individual mandates. The most common approaches being pursued by the states are likely to miss a large share of the uninsured working poor. Approaches that expand coverage most broadly have potentially significant negative labor market consequences, while market-based approaches redistribute dollars but insure relatively few. Policy makers must consider the full range of economic costs when designing health insurance expansions.

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Introduction

It is a well worn fact that more than 46 million people in America now lack health insurance. Less well-known is that 80 percent of the uninsured live in families with at least one worker, but the vast majority of these families have incomes under 300% of the federal poverty level (Kaiser Family Foundation, 2004). Although the national appetite for large-scale reform has waned since President Clinton's failed attempt at broad health system reform, rising health insurance costs and declining rates of employer coverage have motivated a wave of state legislative proposals to expand health insurance coverage, particularly among this population of low-income workers. These proposals run the gamut from employer mandates to Medicaid expansions to state-sponsored insurance pools. Massachusetts' April 2006 health reform legislation has attracted particular attention: that plan aims to expand coverage to every state resident through the combination of an individual mandate, employer requirements, redirection of existing Medicaid funds, and the creation of a new insurance infrastructure. Although it will take many years to fully evaluate the effect of this and other state programs, and approaches that work well in some states may not work in others (Glied and Gould, 2005) it is still possible to draw broad lessons about the likely

effects of different approaches (McDonough et al., 2006). [1] To choose among alternative policies, it is important to evaluate their effects not just on the number of people covered by health insurance, but also on public and private expenditures and on labor market outcomes such as employment and wages, outcomes of particular importance to workers in poor and near-poor families.

In this paper, we evaluate the likely effects of three prototypical approaches to covering the uninsured: public insurance expansions, refundable tax credits for low income people, and employer and individual mandates. We draw on existing estimates from the literature and individual-level data from the 2005 Current Population Survey to estimate how each approach affects (1) the number of people insured; (2) private and public health spending; (3) employment and wages; and (4) the distribution of subsidies across families based on income and work status.

We find that these approaches have substantially different public and private costs that must be traded off against differences in the number and composition of the newly insured. For example, while employer mandates are likely to increase insurance rates among the near-poor substantially, they do so at the cost of reduced employment for low-wage workers. Similarly, Medicaid expansions are likely to increase insurance coverage more modestly without

[1] Massachusetts has several idiosyncratic characteristics. It has fewer uninsured than most states and greater revenue available to fund subsidized insurance coverage in the short term, and progressive business leaders and policy makers that joined together to support the legislation.

reducing employment, but entail substantial deadweight loss from increased taxes. State and federal choices among these policies should be informed by these distributional considerations.

Three Common Approaches

Table 1 outlines three frequently considered approaches to covering the uninsured. First, *employer mandates* typically require employers either to provide sufficiently generous insurance to employees or to pay an assessment. The Massachusetts plan is an example of an employer mandate coupled with an individual mandate to purchase insurance, enforced through the tax system. Second, *Medicaid expansions* extend public insurance coverage to individuals with certain income or demographic characteristics. Some proposals also change the nature of the Medicaid entitlement, such as converting the publicly provided insurance policy to a voucher that recipients can use to purchase private insurance. Third, *tax credits* can subsidize the purchase of private health insurance coverage, and are usually refundable and often restricted to the non-group market. Such tax credits have been proposed in President Bush's budgets.

There are many variations on each of these proposals, often intended to make health insurance more affordable to the near-poor. For example, the President's 2007 budget proposal required people to have high deductible health

plans in order to collect the tax credit, encouraging the purchase of health plans with relatively low premiums, but higher out-of-pocket spending. Some have suggested that combining such tax credits with other reforms would reap the greatest potential increase in coverage, and tax credits more generally have garnered bipartisan support (Cogan, Hubbard, and Kessler, 2005; Etheredge, 2006).[2] Insurance pools are another strategy used in many states to provide lower-cost options for people without employer sponsored coverage. Often they are coupled with a subsidy (or tax credit) to make premiums more affordable, or with a mandate or public insurance expansion.

This list is by no means exhaustive, and two other approaches warrant particular mention. Multiple states have passed legislation to allow adult children to remain on their parents' insurance policies, typically until age 25, and until 30 in New Jersey (National Conference of State Legislatures, 2006). These provisions affect a relatively small portion of the uninsured, but can substantially affect the non-group health insurance market. Finally, many states are experimenting with Medicaid waivers. Most waivers are designed primarily to lower costs (through methods such as increased cost-sharing, limited benefits, or an increased role of managed care), but waivers have also allowed more comprehensive Medicaid reform. For example, in 2005 Florida employed a waiver to implement a defined contribution approach where Medicaid

[2] Our analysis explicitly considers the availability of low-cost health insurance policies in simulating the effect of tax credits, reported in Appendix A1 and A4.

beneficiaries can use their state-financed risk-adjusted premium to enroll in a Medicaid managed care plan or to subsidize purchase of private employer-sponsored or individual-market coverage. Successful cost-saving waivers could enable states to insure more people without expanding Medicaid budgets, particularly if they foster a better-functioning individual insurance market.

Evaluating the likely effects of these proposals is a difficult empirical exercise. Few of the reforms shown in Table 1 have been implemented, and many of their consequences remain unknown. Supporters of each proposal often argue that theirs will reduce the number of uninsured at the lowest cost, while pointing out the potential negative consequences of the others. For example, Medicaid expansions may encourage employers to drop private coverage as beneficiaries take advantage of lower premiums or more comprehensive benefits (known as 'crowd out'); employer mandates may lower wages and increase unemployment. Existing evidence, when available, offers some support for both sides of these debates (Lo Sasso, and Buchmueller, 2004). Any assessment of these health insurance reforms must consider both the effects on health insurance coverage and markets and the effects on labor markets, especially for low-wage workers, to get a complete picture of their distributional implications.

Methods for Comparing the Proposals

Because state initiatives are changing almost daily, we analyze stylized versions of the three major health insurance expansion approaches. Table 2 briefly describes the relevant eligibility rules, the size of benefits such as tax credits, and other information for the three policy simulations. We model an employer mandate applied to full-time workers at firms with more than 25 employees, a Medicaid expansion up to 300% of the federal poverty level, and a tax credit of up to $3,000 for families with income under $60,000. Our analysis is restricted to the non-elderly (under 65 years of age), non-institutionalized United States population represented in the 2005 Current Population Survey.

We compare the effects of the three policies on both insurance and employment outcomes. First, we estimate the number of people eligible, the number predicted to take up health insurance under that policy and the fraction of them who already had insurance from another source, and the average value of the health insurance benefit for those who take it up. We then calculate changes in private employer spending on health insurance, changes in public spending on health insurance, and any deadweight loss arising from policies that require raising public tax revenues. We next estimate changes in wages, employment, and hours worked per week per newly insured person. Finally, we show the distribution of newly insured separately by work status (whether the head of household or spouse in a family works), and by family poverty level (under 100%, 100-200%, 200-300%, and over 300%).

Performing these calculations requires estimates of: the take-up rate of publicly provided free coverage among various demographic groups; the rate of crowd-out (the percent of those taking up coverage who were previously insured); the price elasticity of demand for insurance coverage; the response of private employers to changes in employee costs and how this affects wages and employment; and the estimated costs of providing private or public coverage to individuals and families. A more comprehensive description of the source of these parameter estimates, our general approach, and the sensitivity of our results to choice of key parameters can be found in the Technical Appendix.

Our analysis of the labor market effects of insurance expansions builds on the literature predicting how labor market outcomes (i.e., participation, hours, and wages) change in response to mandated insurance benefits. Economic theory predicts that, when possible, employers will pass mandate costs on to employees through lower wages (Summers, 1989). Who ultimately bears the burden of any tax on wages is determined entirely by the relative responsiveness of workers and employers, but the burden of mandated benefits also depends on how much employees value the benefit. If employees value the benefits as much as the cost of providing them (and there are no institutional constraints to lowering wages), they will fully pay for the benefits with lower wages and still be as well off (Summers, 1989). Empirical evidence suggests that this is the case with mandated maternity benefits and workers' compensation benefits (Gruber, 1994;

Gruber, and Krueger, 1991). In the case where minimum wage laws limit employers' ability to reduce wages, however, the mandate will have the same effect as an increase in the minimum wage, potentially resulting in increased unemployment. Recent empirical evidence documents exactly this effect as health care costs rise (Baicker and Levy, 2005; Baicker and Chandra, 2006).

One should note that our simulations consider only the most direct, or "partial equilibrium," effects of changing health insurance costs, but these changes could have broader effects throughout the economy, including changes in prices of goods and services sold by firms, changes in profitability, or changes in the way firms produce goods (such as a shift towards using more technology and fewer workers if labor costs rise). These less-direct effects of insurance expansions are likely to be smaller in magnitude, especially given the empirical evidence on wage and employment changes in response to mandates and health care costs (Gruber, 1994; Gruber, and Krueger, 1991).

Effects on Health Insurance Coverage and Spending

Our simulation results, presented in Table 3, demonstrate important differences across these three insurance reform approaches. The typical Medicaid expansions and tax credits are available to more people, with 59.1 million eligible for Medicaid expansions and 54.5 million eligible for tax credits, but only 22.8

million eligible for employer mandates. The scope for crowd-out is likely biggest with the tax credit, since the most relevant evidence from the literatures suggests very little new insurance take-up in response to an increase in insurance premium subsidies (Chernew, Frick, and McLaughlin, 1997; Cutler, 2002; Glied, Remler, and Zivin, 2002; Gruber, and Washington, 2005).[3] Thus, since we assume virtually all those already purchasing insurance in the non-group market will take advantage of the credit, almost 90% of those taking up the tax credit, 11.9 million, are likely to have had prior insurance coverage. This group reaps substantial financial benefits,, with an average subsidy of nearly $1,500. In contrast, using the 35% public insurance expansion crowd-out estimate from the literature suggests that only 2.7 million of those gaining coverage through the Medicaid expansion would have been previously insured (Blumberg, Dubay, and Norton, 2000; Cutler, and Gruber, 1996; Dubay, and Kennedy, 1996). Low-income workers would also benefit from redistribution under this plan as they take-up Medicaid, since employer health care costs drop by an estimated $8.3 billion, which induces an increase in wages and the probability of employment.

Under employer mandates, private employer spending rises by an estimated $36.1 billion if employers continue to buy coverage at the typical prevailing premiums. This spending exceeds the public spending of $16.4 billion

[3] There is some variation about take-up rates in the literature, discussed in these papers and in Glied et al. We test the sensitivity of our results to our choice of parameter estimate in the Appendix.

for a Medicaid expansion and $19.8 billion for the tax credit. In exchange for the largest increases in spending, the number of uninsured is expected to fall most with employer mandates – by 28.6%, compared with 11% for Medicaid expansions and only 3.5% for tax credits. Employer mandates have even bigger effects on costs, insurance, and employment when coupled with individual mandates.

The social cost, or deadweight loss, of each policy varies widely. The tax credit carries the highest social cost of $3,793 per person newly insured, resulting from distortions caused by raising tax revenue to cover the credits. Medicaid expansions confer new insurance at a deadweight loss of $987 per newly insured. Finally, assuming that workers only value the health insurance mandated under an employer mandate at half of its cost, employer mandates generate $147 of deadweight loss because of the wedge between the total cost of compensation to employers and the total value of that compensation to workers.

While our simulations show that these policies would decrease the uninsured population overall, insurance coverage could decline for some groups. For example, if a policy that offered tax credits were limited to purchase of coverage in the individual market, some employers might stop offering coverage. If some workers fail to take up the tax credit to purchase coverage, they will become newly uninsured. These effects are likely to be relatively small,

however, especially if the new expansions cover only a minority of employees in any particular firm, and thus are not modeled here.

Effects on Labor Markets

Table 3 demonstrates that the aggregate labor market effects are negative for the employer mandates, neutral for tax credits, and neutral or even positive for Medicaid expansions. The Medicaid effects, though surprising at first glance, are intuitive. As individuals drop employer sponsored coverage to take up cheaper Medicaid coverage, employer health care costs fall, and cash wages and employment rise. In the aggregate, each 10% reduction in the number uninsured decreases annual wages by $24.9 billion under an employer mandate, but increases wages by $15 billion under Medicaid expansions. About 347,000 fewer workers would be employed with an employer mandate, while 209,000 more workers would be employed with Medicaid expansions. Hours worked would fall by 0.72% under mandates and rise 0.43% with expansions, due mainly to shifts from full-time to part-time work.

Effects for the Working Poor

Would poor working families benefit more from some expansion approaches than

others? Table 4 suggests that under employer mandates, two-thirds of the newly insured would live in working families with income under 300% of the poverty level. By design, Medicaid expansions target only families under 300% of the poverty level, and almost two-thirds of the newly insured would be in working families. About half of those newly insured by tax credits are in working families below 300% of poverty, with another 34% of the newly insured living in non-working poor families. The most striking feature of Table 4 is the low reduction in rates of uninsurance for every approach among individuals living below the poverty level. For employer mandates, this occurs mainly because many individuals in these families do not work full time. The design of employer mandates could address this by extending mandates to part-time workers, but not without additional effects on wages and/or employment. Most of those eligible under the Medicaid proposal were already eligible but not enrolled, so we have assumed that the expansion has no effect on them. The tax credit performs poorly at all income levels against the goal of reducing the number uninsured, and working families under 100% of poverty are no exception. However, the redistribution to these individuals is substantial because of the sliding scale of tax credits, averaging $1,500 per family purchasing insurance coverage. The vast majority of tax credit dollars, 85%, would accrue to families below 300% of poverty. Two thirds of the dollars would accrue to families under 200% of poverty. These distributional benefits would be relatively evenly distributed

across working and non-working families. The majority of the reductions in uninsured are in families with children. Among those newly insured under a Medicaid expansion, the newly insured are often the parents of children covered by SCHIP (data not shown). Tax credits have similar effects on families with and without children.

Implications of our Analysis for Current Health Reform Initiatives

While our analysis focuses on stylized reform approaches, our results offer insights into the likely effects and potential pitfalls of the recent flurry of new state-level initiatives to cover the uninsured.

California's proposal mirrors some aspects of the Massachusetts plan by imposing combined individual and employer mandate, although it relies more on public insurance coverage expansion. Our estimates suggest that the individual mandate may cover more people than other policies alone, but the employer mandate may dampen employment among those employers not currently offering health insurance. Some of the distributional issues raised, such as low voluntary take-up among low-income working individuals, would be mitigated by the individual mandates. However, undocumented immigrants will continue to

challenge state's efforts to cover the uninsured, and low-wage workers are at risk of lower employment rates as employers face higher payroll costs.

Many of the features discussed above are also present in Pennsylvania's recently announced Prescription for Pennsylvania, which includes an individual mandate for those over 300% of poverty, sliding scales for subsidized insurance coverage among employees of small firms unable to afford coverage, and a 3% payroll tax for employers not providing health insurance coverage. Among individuals below 300% of poverty, take-up will depend on the generosity of the sliding scales the individuals face when purchasing coverage.

In late 2006, Indiana's governor, Mitch Daniels, proposed a plan to cover moderate income individuals (up to 300% of FPL) without access to employer sponsored coverage. Indiana's plan would use cigarette taxes, Federal funds, and individual fees to allow individuals to buy into insurance coverage on a sliding fee scale. Individuals buying into this plan would have a Health Savings Account (called a power account) and would receive free preventive care. The issue of take-up of subsidized coverage among moderate-income individuals also looms large for the success of this plan. Among uninsured individuals with family income under 300% of the federal poverty level, however, over 17% already have access to employer sponsored coverage so would not be helped by the state plan. Even for the targeted individuals, it is unclear how many will take up coverage.

In his 2007 state of the union address, the President Bush proposed an overhaul of the tax treatment of health insurance. The proposed "Standard Deduction for Health Insurance" would replace the current preference for employer-sponsored health insurance with a flat deduction amount (for both payroll and income tax purposes) for anyone covered by private insurance, regardless of the source of the insurance or the size of the premium. The standard deduction amount would be $7500 for single coverage or $15,000 for family coverage. Like a flat tax credit, this would substantially lower the cost of obtaining insurance for most people, and would do so the most for people in the highest tax brackets, but unlike a credit that depended on the cost of the policy, it would give the same tax benefit for the purchase of low-cost policies as high-cost policies. This policy too leaves open the questions of take-up among low-wage workers with limited tax liability.

The value of different approaches to insurance expansion ultimately depends on policy priorities: tax credits generate the most redistribution, while mandates achieve the biggest overall reduction in the number of uninsured, but Medicaid expansions accomplish a moderate reduction in the uninsured that targets the working poor without negative labor market consequences.

The feasibility of each approach depends on the environment in which it is pursued. Medicaid expansions may not be feasible among states struggling to cut, rather than increase, budgets. For these reasons, states will closely watch the

success of current Medicaid waivers including cost containment strategies. Employer mandates meet with strong political backlash from business interests in all states, though perhaps less with more progressive business communities. Mandates in Massachusetts and those proposed in California and Pennsylvania may not withstand ERISA challenges. Tax credits achieve redistribution but at great taxpayer expense, and without much change in the rate of uninsurance.

The poorest working families are not the primary beneficiaries of any of the approaches examined here. Those in households earning less than 100% of poverty experience little change in insurance coverage, though a portion of them would benefit from redistribution through tax credits or Medicaid expansions. Employer mandates and Medicaid expansions provide insurance benefits mainly to working families between 100% and 300% of poverty. For employer mandates, one must weigh this benefit against the potentially negative employment and wage consequences that are likely to be borne disproportionately by these same working families. The low insurance coverage among the poorest families stems partly from the fact that most uninsured workers work part-time, and thus are not covered by most employer mandates. In addition, many low-income workers are currently eligible for public insurance but do not take it up. Similarly, the response to tax credits among those who are currently uninsured is likely to be low due to low take-up.

Finally, a large fraction of the working poor may not be eligible for tax credits or public insurance because of their immigration status, yet the health impact and the financial impact of uncompensated care is substantial in states with high immigrant populations. According to the March 2005 CPS, about one-third of the working uninsured with incomes below 300% of poverty were non-citizens. To address the gaps in coverage for the poorest families, an individual mandate, extensions of employer mandates to cover part-time workers, or the loosening of restrictions for non-citizen eligibility for Medicaid benefits might increase the share of low-income individuals accessing health insurance.

Our findings should be interpreted in light of several caveats. First, we have presented analyses of three stylized approaches to insurance expansion, but other approaches, including combinations of approaches currently being pursued by several states, are possible and might achieve desired outcomes more effectively.

Second, there are other potential labor market effects not considered explicitly in our simulation. For example, some researchers estimate that a large number of firms might alter the way they hire in order to avoid regulations that apply to firms over a particular size, such as 25 workers (Yelowitz, 2006). Regulations on employers could also accelerate an ongoing trend towards contingent workers (Swartz, 2006). Thus, low wage workers providing services even for large, relatively high-wage firms may fail to benefit from employer

sponsored insurance, or potentially worse, those previously employed and receiving employer sponsored coverage might be replaced by workers at firms not subject to employer mandates.

Finally, we estimated the changes in public and private spending based on typical insurance currently provided through private and public and group and non-group purchasers, but the cost and generosity of many insurance plans might change in response to policy changes. States may scale back optional Medicaid benefits, or purchasing pools paired with mandates may encourage high-deductible health plans, both of which have lower actuarial value. In these cases, the value of insurance coverage enjoyed by the insured and the costs of providing it may fall. Thus, our estimates may overstate changes in public and private spending, as well as the potential redistribution to those affected by each expansion approach.

Conclusion

States grappling with the growing number of uninsured face tradeoffs between approaches that expand coverage most broadly with potentially negative labor market consequences, market-based approaches that redistribute dollars but don't insure many, and expansion of public coverage that may be expensive to taxpayers, and thus politically infeasible. Our findings suggest that no single approach helps the working poor in exactly the ways policy makers might hope.

To the extent that states are motivated to help the uninsured in poor working families, health reforms must find ways to include those unlikely to take up optional policies, and states must address the challenge of the many uninsured likely to be excluded from policies (based on part-time status, firm size, or immigration status). While a combination of the policies currently under debate and some of the innovative approaches being taken by states offer the promise of expanded access to affordable insurance, advocates and policy makers should consider the full range of economic costs when designing health insurance expansions.

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Table 1. Forms of Current State Health Insurance Expansions

Expansion	Description	Variations	Examples these types of initiatives
Employer mandates	• Mandate that employers either provide health insurance benefits to employees or pay into a state-run program that provides health benefits to these workers • Often only applies to firms with a minimum number of workers	• May or may not be coupled with a mandate that individuals purchase health insurance • Can be coupled with a state managed health insurance purchasing pool for unemployed, self-employed, and/or workers at small firms to purchase private health insurance plans • Premiums often subsidized by the state according to a sliding scale based on family income	• California, Illinois, Massachusetts, Michigan, New Jersey, New York, Ohio (list as of July 2006)
Medicaid or other publicly provided insurance expansion[a]	• Expand eligibility for public health insurance under Medicaid or S-CHIP program to children and adults	• May include a buy-in option for state residents who don't meet income requirements • Can allow increased role for private market through offer of managed care plans or subsidized purchase of private coverage.	• Illinois, Massachusetts, Oregon, Tennessee, Wisconsin • Maine (Dirigo), Vermont (Catamount Health), Pennsylvania (AdultBasic)
Tax credits	• Tax credits for purchase of a health plan in the non-group market • Tax credit may be refundable	• May require purchase of a high-deductible health plan that meets a minimum deductible threshold • May also be extended to group health insurance products	• Bush administration

a. Although many state initiatives to reform their Medicaid programs may alter the eligible population, we focus here on major expansions in Medicaid eligibility.

Table 2 **Description of Policies Simulated**

	Employer Mandates	Medicaid Expansions	Tax credits*
Eligibility by insurance status	Uninsured full-time workers & dependents at firms with 25 or more workers	No requirements**	Individuals without employer-sponsored or public insurance coverage.
Income eligibility	No income cutoff	Income under 300% of poverty level	Adjusted gross income: Single tax filer - up to $30,000 Other tax filers- up to $40,000 for individual coverage, $60,000 for family
Maximum benefit	Family coverage through employer	Medicaid coverage	$1,000 per adult $500 per child $3000 max per family
Individual mandate?	Simulated with & without	none	none

*Details of tax credit are shown in appendix table A1.

**This assumes no "anti-crowd-out" provisions.

Table 3 **Comparison of Expansion Approaches**

	Employer Mandates[a]	Medicaid Expansions	Tax Credits[b]
Number eligible	22.8 million	59.1 million	54.5 million
Take-up by previously insured	0	2.7 million	11.9 million
Take-up by uninsured	13.0 million	5.0 million	1.6 million
(% reduction in uninsured)[c]	(28.6%)	(11.0%)	(3.5%)
Average value of benefit for those who take it up	$2,769	$2,138	$1,472
Public spending			
Total	0	$16.4 billion	$19.8 billion
Per newly insured	0	$3,289	$12,644
Deadweight loss/new insured	0	$987	$3,793
Private spending			
Total	$36.1 billion	-$8.3 billion	0
Per newly insured	$7,697	-$1,084	0
Deadweight loss/new insured	$147	n/a	0

Labor Market Effects per 10% Reduction in Uninsured

Change In:	Employer Mandates*	Medicaid Expansions	Tax Credits**
Employed workers	-347,000	209,000	
(%)	(-0.36)	(0.22)	None
Hours worked per week	-423,000	255,000	
(%)	(-0.72)	(0.43)	None
Annual wages, $millions	-$24,903	$15,001	
(%)	(-0.69)	(0.42)	None

Source: Authors' calculations and Meara, Rosenthal and Sinaiko 2007

a- Employer mandate assumes no accompanying individual mandate. With an individual mandate, the combined effect of the employer and individual mandates would be 22.8 million newly insured, a 1.8% reduction in aggregate employment, and a $63 billion rise in private spending.

b- Given the ambiguous sign of labor market effects accompanying tax credits, and the expectation that these are trivial in magnitude, these are set to equal zero.

c- Because empirical estimates of employers dropping offers of coverage in response to insurance expansions are negligible, these effects are not included, making the # newly insured = take-up by previously uninsured. The % change in ininsured is based on 2005 CPS estimate of 45.5 million uninsured.

Table 4. Distribution of newly insured and percent reduction of uninsured under each simulation by family income and employment

	Employer Mandate*		Medicaid Expansion		Tax Credit		
	% of newly insured	% reduction of uninsured in group	% of newly insured	% reduction of uninsured in group	% of newly insured	% reduction of uninsured in group	% of credit dollars
Working individuals & families							
<100% poverty	12%	10%	6%	6%	15%	5%	10%
100%-200% of poverty	29	15	20	11	24	5	16
200%-300% poverty	23	17	37	29	13	3	11
>300% poverty	36	18	0	0	11	2	7
Non-Working individuals & families							
<100% poverty	0	0	11	9	18	5	21
100%-200% of poverty	0	0	12	15	11	5	18
200%-300% poverty	0	0	14	30	5	4	10
>300% poverty	0	0	0	0	4	2	7

Source: Authors' calculations

* The percent reduction of the uninsured presented in the table corresponds to the case in which there is no individual mandate. With an individual mandate, the percent reductions in uninsured below 100% of poverty, between 100% and 200% of poverty, between 200% and 300% of poverty, and above 300% of poverty, respectively are: 18%, 26%, 30%, and 31%.