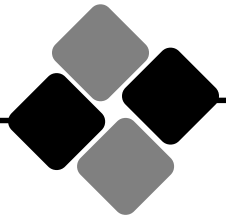

THE CENTER FOR STATE HEALTH POLICY

Willingness to Purchase Health Insurance among the Uninsured in New Jersey

Results from a Survey of Uninsured Adults in Three Counties

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Willingness to Purchase Health Insurance among the Uninsured in New Jersey
Results from a Survey of Uninsured Adults in Three Counties

Executive Summary

A survey of over 400 low to moderate income, medically uninsured adults in three northern New Jersey counties reveals a large gap in the affordability of health insurance coverage. Although interest in obtaining coverage is high, only coverage purchased directly from an insurance company or HMO is available to many of those surveyed. Directly purchased, or non-group, coverage is very expensive and very few survey respondents expressed a willingness to pay an amount approaching the prevailing cost of this type of coverage. A large majority of respondents cited affordability as the reason they were without coverage.

Fewer than one in eight of the uninsured adults surveyed reported that they turned down an offer of group health coverage, either from their own employer or that of a spouse or parent. Uninsured respondents with coverage available through their own employer predominantly cite affordability as the reason for passing up the offer, and many reported facing premium contribution rates that exceed the average for employer coverage in New Jersey. Survey findings suggest that if more of the uninsured were offered employer coverage at the statewide average employee premium contribution, many would accept it.

The survey predicts that a majority of moderate income uninsured adults (between 150% and 350% of the federal poverty level) would enroll in NJ FamilyCare if it were available to them. Under current program rules, children up to 350% of the federal poverty level (FPL), parents up to 200% FPL, and singles up to 100% FPL are eligible for coverage through Medicaid or NJ FamilyCare. The requirement that applicants for state-subsidized coverage must prove income does not appear to be a deterrent to enrollment for most survey respondents.

Although the majority of respondents said they would purchase coverage at the "right" price, there is a core of uninsured who say they would not enroll in coverage even at subsidized rates. Between about a quarter and a third of respondents who are or would be income-eligible to pay subsidized premium rates reported that they were not interested. Moreover, even those who say they would purchase at subsidized rates are more likely to say that they would "probably" sign up than "definitely" sign up. Indeed, roughly one in ten respondents with incomes low enough to make them or their families eligible for free state-sponsored coverage report that they are not interested in signing up even at no monetary cost.

Family income appears to be the major determinant of willingness to pay for coverage. Other factors, such as poor health status or utilization history, are not associated with higher willingness to pay in this study.

This survey was designed to examine willingness to purchase health insurance among modest income uninsured adults. It included uninsured non-elderly adults (ages 19 to 64) in Essex, Hudson, and Passaic counties in northern New Jersey. The survey was conducted by telephone in late 2000 and early 2001, with a response rate of 64%. Persons between 150% and 350% FPL were oversampled. The population interviewed is similar to adults without health coverage statewide, except that respondents are more likely to be Hispanic or foreign born. Because of the survey sampling strategy, respondents are also of lower income and less likely to be employed than the statewide uninsured population.

Willingness to Purchase Health Insurance among the Uninsured in New Jersey

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Introduction

One in six non-elderly New Jersey residents lacks health coverage, roughly the same as the nation as a whole.[1] Over 70% of non-elderly state residents are covered through an employer, but publicly sponsored coverage and the non-group, direct-purchase health insurance market play important roles for people without access to employer coverage.

Employers in New Jersey pay among the highest premiums in the nation for health coverage, yet they are as likely to offer coverage as firms nationally and pay a higher percentage of total premium costs compared to employers in other states. Even so, worker premium contributions here are among the highest in the nation, on average $36 per month for singles and $128 per month for families in 1998.[2] After a period of flat premium growth, employer health insurance costs are rising nationally.[3] If New Jersey follows this trend, as seems likely, employer health coverage in the state may once again begin to erode.

Costs in the non-group coverage market, where individuals and families buy coverage directly from an insurance company or HMO, are also quite high in New Jersey. For example, the most commonly purchased HMO plan cost $240 per month for singles and $720 per month for families at the time of this study.[4] Premiums in the non-group market have risen steadily and enrollment has declined in recent years.[5]

Even as high costs have put pressure on private coverage, New Jersey has moved to expand affordable coverage options. In 1998, New Jersey implemented among the most expansive State Children's Health Insurance Programs (SCHIP) in the nation, called NJ KidCare, extending free or subsidized coverage to children in families up to 350% of the federal poverty level (FPL). As of April 2001, over 75,000 children were enrolled in NJ KidCare.[6] Moreover, New Jersey led the nation in October 2000 by creating NJ FamilyCare, which offers coverage to parents of NJ KidCare enrollees up to 200% of the federal poverty level as well as some adults without children. The response to NJ FamilyCare has been considerable, with nearly 100,000 of an estimated target enrollment of 125,000 signing up in the first seven months of the program.[7]

In the coming years, the possibility of erosion in employer-sponsored coverage and continued decline in the non-group market will confront policymakers. One possibility is for policymakers to revisit regulations governing the non-group market, which in 1993 implemented community rating and other provisions designed to make coverage more available for older and higher risk persons.[8] Another option is to build on NJ FamilyCare by increasing income eligibility thresholds to make more families and adults eligible. To make informed decisions about these or other policy options, state policymakers will require information about the market for health coverage, such as data on the level of demand for coverage and acceptability of state subsidies.

Recent research suggests that expanding coverage through the non-group market may be difficult, as consumers in this market tend to be very price sensitive.[9] Experience of state-sponsored subsidized coverage programs enacted prior to SCHIP also suggests that willingness to pay (WTP) may be limited. For example, one study of three state programs in the early to mid-1990s showed that when premium contributions rose to about two percent of family income, take-up

rates (percent of eligible population enrolling) were only about 45 percent, and at five percent of income take-up declined to under 20 percent.[10] Factors beyond ability or willingness to pay for coverage may also limit the potential of strategies to extend coverage to the uninsured, such as the stigma of government assistance or lack of interest in coverage, particularly among healthy young individuals.

The purpose of this study is to assess how willing modest income uninsured adults in New Jersey would be to purchase health coverage and at what cost, and to describe the characteristics of those willing to purchase coverage. This report is based on a survey of low and moderate income uninsured in three northern New Jersey counties with a high uninsured rate (Essex, Hudson, and Passaic counties). In addition to responses to questions about willingness to purchase coverage, over 400 uninsured survey respondents provided information about their health status, health insurance history, health care utilization, access to care, socioeconomic and demographic characteristics, and attitudes toward coverage and health services as part of this study. After a description of survey and analytic methods, results are presented about willingness to purchase coverage at prevailing premiums in the non-group and employer-group health insurance markets as well as in the state-sponsored NJ FamilyCare program. Responses of uninsured adults who are now or could potentially become eligible for these types of coverage in the future are examined.

The methodology for this study is based on a 1997 survey sponsored by the California HealthCare Foundation (CHF). CHF surveyed uninsured adults in California with incomes at least 200% FPL.[11] The survey measured attitudes about coverage and willingness to purchase coverage available in the non-group health insurance market in that state. The California study is used as the foundation for the New Jersey survey, the results of which are reported here. However, the California questionnaire was modified to include questions about specific coverage offerings through the state-subsidized NJ KidCare and NJ FamilyCare programs and about attitudes toward participating in a state-subsidized program. The New Jersey sample was also not limited to persons over 200% of poverty, and in fact oversampled persons between 150% and 350% of poverty.

Survey-based measures of willingness to pay are common in health care studies.[12] There is no consensus among researchers on the best survey way to measure willingness to purchase, but most studies ask direct questions about the amount persons are willing to pay and others ask about specific prices persons are willing to accept (sometimes called “price points”). We use both of these methods in this study. Two recent studies, the California study mentioned above and one in Massachusetts, used the willingness-to-pay survey methods specifically to examine the market for health insurance among the uninsured.[13] Although research on the validity of the willingness-to-pay survey techniques in health care is limited, evidence suggests that fewer people will actually make a subject purchase than say they would in response to hypothetical questions.[14] This is natural given the social desirability of purchasing health coverage and using health services. Nevertheless, WTP surveys can provide a general guide for understanding market behavior, and may be of particular value in describing the characteristics of persons more and less willing to purchase coverage.

Methods

Sample

Uninsured adults (age 19-64) were reached through random-digit dialing of 13,077 telephone numbers located in Essex, Hudson, and Passaic counties in northern New Jersey. These are urban counties with high concentrations of low-income, uninsured persons, many of whom are minorities and immigrants. Nearly ninety seven percent (96.8%) of the interviewed population resided within the target counties. Individuals between 150% and 350% of the federal poverty level were oversampled.

The sample disposition is described in Appendix A. Interviews were completed with 413 adults. One-hundred-eighty-two (182) eligible (i.e., an uninsured adult aged 19-64) respondents refused to participate. Sufficient information was not available to compare respondents and non-respondents. Excluding those telephone numbers for which contact was not established after seventeen attempts (i.e., ring but never answered, even by an answering machine), our overall response rate was 64%.

Questionnaire

The survey consisted of 141 closed-ended questions, was administered by telephone by SRBI, Inc., a survey research firm, and averaged just under 20 minutes in length. Survey questions examined the willingness of uninsured NJ residents to pay for health insurance coverage, health status, health care utilization, access to care, out-of-pocket costs and payment history, health care coverage history, purchasing priorities, employment and income, family composition, family insurance coverage, insurance eligibility, attitudes toward coverage, perceptions of coverage costs, attitudes towards state-sponsored coverage, immigration status, and other demographic variables. (Copies of the survey instrument are available upon request. Please email your request to info@cshp.rutgers.edu, or call 732/932-3105 x245.)

Two sets of questions were used to gauge willingness to purchase coverage. First, respondents were asked directly how much they would be willing to pay for selected insurance plans. For example, all respondents were asked:

> How much if anything would you be willing to pay each month out of your own pocket for a health insurance plan that provided coverage for doctor visits, hospitalizations, and prescription drugs for yourself...how much per month would you be willing to pay?

In addition to the question about single coverage, questions were tailored to the family structure and coverage situation for each respondent. For instance, married respondents without children were asked about the amount they were willing to pay for couple coverage, and respondents with families were asked about their willingness to pay for family coverage. These questions did not indicate that the coverage would be subsidized by the state in any way. Respondents whose children were covered under NJ KidCare were also asked about the amount they would pay to add themselves (and their spouse, where appropriate) to the child(ren)'s plan.

Each respondent was also given a series of "price points" for selected coverage. They were read a plan description and asked about their likelihood of purchasing it at specified premium levels, for example:

> The next few questions are about whether you would be willing to purchase a health insurance plan through an HMO. Under this plan, you could choose from a list of doctors in your area, and you would pay a $30 co-payment for each visit to a doctor.
>
> How likely would you be to purchase this plan for yourself at a cost of $240 per month …would you definitely purchase it, probably, probably not, or definitely not purchase it?

As in earlier sets of questions, all respondents were asked about single coverage purchased in the individual, non-group market (the above question). Respondents were also asked price point questions that were tailored to their family structure and coverage.

An additional set of "price point" questions were asked specifically about state-subsidized coverage. Subsidized coverage was described to respondents as follows:

> The State of New Jersey has a program that helps pay the cost of health insurance for eligible families. The next few questions are about plans available through that program.

Price points were derived from two sources. First, for questions about the non-group (not subsidized) market, we used the monthly premiums of the least expensive and most popular HMO products offered in the New Jersey market, which are offered on a statewide, community-rated basis.[15] Second, for subsidized coverage, we used monthly NJ KidCare or NJ FamilyCare premiums offered by the state for eligible groups. For groups of respondents not eligible at the time of the survey through the NJ FamilyCare program due to their family or income category, we projected premiums in proportion to currently eligible groups.

Table 1: Monthly Premium "Price Points" for Health Coverage Option

Coverage Type and Eligibility Category		Family Status				
		Single No Children	Married No Children	1 Adult 1 Child	1 Adult >1 Child	Married with Children
Non-Group Market (Most popular HMO plan)	Premium for 1 adult	$240				
	Premium for family	Not Applicable	$480	$430	$720	
NJKidCare (no coverage for parents)	301-350% FPL	Not Applicable		$100		
	251-300% FPL			$60		
	201-250% FPL			$30		
	151-200% FPL			$15		
	Up to 150% FPL			Free		
NJFamilyCare (includes NJKidCare premiums for children where applicable)	301-350% FPL	$170	$240	$270		$340
	251-300% FPL	$100	$140	$160		$200
	201-250% FPL	$50	$70	$80		$100
	151-200% FPL	$25	$35	$40		$50
	101-150% FPL			Free		
	Up to 100% FPL					

Calculation of hypothetical premiums: Shaded areas are hypothetical monthly premium rates that are proportional to existing rates for NJKidCare for different federal poverty level (FPL) ranges. For instance, the FamilyCare policy for a married couple with children between 201% and 250% FPL is $50 (actual FamilyCare premium for such a family below 150% FPL) times two (the ratio of $30 to $15, the respective KidCare premiums in these two income groups). Single adult premiums for those between 151% to 200% FPL are set equal to the FamilyCare premium less the KidCare premium for families in this income group.

Table 1 shows the premiums we used for the price point questions. They are arrayed by coverage type and respondent eligibility category (rows) and by income (as a percentage of the federal poverty level). Since the survey did not ask income until near the end of the interview, all respondents were asked all price points, in descending order, until they responded that they would "definitely" or "probably" purchase the product.

The instrument was pre-tested in November and December 2000. A Spanish version of the questionnaire was developed and back-translated into English to determine accuracy of translation. The Spanish version was administered to 131 (31.7%) of the respondents.

Data Preparation and Analysis

In addition to examining the reported willingness to pay for coverage, we classify each respondent according to their eligibility for state-subsidized coverage to identify the premiums that they would be required to pay under programs for which they are income eligible.[16] Income was asked two ways in the survey. First, to enable screening for modest-income households, two broad income questions were asked at the start of the survey. Respondents who refused to answer these questions are considered non-respondents and are excluded from the study. Second, a more detailed income question was asked at the end of the study. Thirty four (8.2%) respondents either refused to answer the detailed income question or gave implausible answers. For these respondents, we used available information (income from the screener, family structure, employment and homeownership status) to impute income. One case lacked sufficient information to impute income and was excluded from the analysis.

We apply hypothetical NJ FamilyCare premiums for persons not eligible under current program rules, but who might become eligible under future expansions. In addition, we estimate premiums that respondents face in the non-group and employer group insurance markets based on family structure and, for group coverage, employment status and firm size. Estimates of employer-based premiums come from the 1999 Medical Expenditure Panel Survey – Insurance Component (Fox et al., 2001). Premiums are inflated to 2000 levels using available trend information on the national level,[17] and are matched to respondents by type of coverage (single or family) and firm size (up to 50, over 50 workers). We compare the amount that respondents said they were willing to pay for coverage to premiums in NJ FamilyCare, NJ KidCare, the non-group and group markets, as appropriate.

We found that some respondents reported that they were willing to pay premiums that were implausibly high. We compared consistency of responses to price point information to responses to willingness to pay questions and found 17 responses that were clearly not feasible. In these instances, the premium levels that respondents were willing to pay were much higher than a price point that they responded they were "definitely not" willing to pay. Since the answers to the former questions appear implausible, we excluded these cases from analyses using the affected variables.

We analyzed the willingness to pay for coverage according to respondent demographic characteristics, health status, and employment and socioeconomic status. One case was excluded from all analysis because it lacked income information, and other cases were excluded from selected analyses because of missing data on relevant items. We conducted bivariate comparisons with tests of statistical significance and multivariate regression analysis to confirm the bivariate findings. To analyze responses to willingness to pay questions, we used a natural logarithm transformation to account for the non-normality of the distribution of this variable. Where data for insured or uninsured populations in New Jersey are available, we compare our findings to these benchmarks.

The probability that each respondent was selected for the interview varied depending on their income and number of incoming telephone lines. SRBI calculated sample weights to adjust for these differentials, and all analyses were conducted weighted and unweighted. We observed no

Table 2: Characteristics of Uninsured Non-Elderly Adults, Survey of Willingness to Pay for Health Coverage and Statewide Estimates, 2000

Characteristics	WTP Sample		Statewide	
	n	%	n	%
Total	412	100.0	445	100.0
Age				
19-29	152	37.2	140	33.6
30-39	113	27.6	123	26.6
40-49	82	20.0	94	21.0
50-64	62	15.2	88	18.8
Race/Ethnicity				
White, non-Hispanic	90	22.3	201	51.9
Black, non-Hispanic	80	19.9	61	17.9
Hispanic	205	50.9	154	22.5
Other	28	6.9	29	7.8
Family Structure				
Single, no children	185	44.9	202	45.4
Married, no children	52	12.6	80	18.0
Single parent family[a]	92	22.3	73	16.4
Two parent family[a]	83	20.1	90	20.2
Single, no children	185	44.9	202	45.4
Married, no children	52	12.6	80	18.0
Single parent, one child[b]	48	11.7	41	9.2
Other families[b]	127	30.8	122	27.4
Poverty Status				
Under 150%	154	37.3	143	31.1
150% to 250%	177	43.1	112	23.6
Over 250%	81	19.6	190	45.3
Education				
Less than high school	82	20.0	96	20.2
High school graduate/GED	150	36.7	173	46.0
Some college or trade	118	28.9	108	29.9
College gradulate or higher	59	14.4	14	3.9
Employment Status				
Full time	187	45.9	222	48.0
Part time	111	27.3	150	34.9
Not working	109	26.8	73	17.1
Place of Birth				
United States	235	57.0	272	66.7
Foreign, in US under 2 years	18	4.4	15	3.5
Foreign, in US 2 years or more	159	38.6	158	29.9

[a]NJ FamilyCare rating categories; [b]Private coverage rating categories

Source: Rutgers CSHP/NJDHSS Survey of Willingness to Pay for Health Coverage and U.S. Current Population Survey

differences between these analyses, and only the unweighted analyses are presented. The weighting methodology is described further in the Appendix.

RESULTS

First we provide a description of the uninsured respondent characteristics and their circumstances then turn to findings about the perceived cost of insurance and respondent willingness to purchase private or publicly subsidized coverage.

Characteristics and Circumstances of Uninsured Adults

Demographic profile. The adult uninsured population in the three northern New Jersey urban counties is similar to the profile of the uninsured statewide in many important respects (Table 2). The population is largely young, many are single or married without children, although nearly a quarter are single parents and one in five is in a two-parent family with children. However, the three-county sample differs from the statewide uninsured population in several important ways: it is half Hispanic (compared to about a quarter statewide), more likely to be immigrant, and less likely to be employed. In addition, the willingness-to-pay (WTP) survey design assured that the sample would be disproportionately moderate income (over 40% are between 150% and 250% of the federal poverty level, compared to under a quarter statewide). The reader should bear these demographic differences in mind when extrapolating the results of this survey to the general uninsured population in New Jersey.

Health status. Respondents to the WTP survey, on average, reported poorer health and worse access to care compared to non-elderly adults statewide in the New Jersey sample of 1999 National Survey of American Families (NSAF).[18] Nearly one in five of the WTP survey respondents rated their health status as "fair or poor" on a five point scale (Table 3), compared to only 10.8% among non-elderly adults statewide (with or without coverage). Self-rated health status, a measure that research has shown to be highly correlated with professionally-assessed health and longevity, is closely associated with income in both the WTP and NSAF surveys. Over one in four of uninsured respondents below 150% of poverty rated their health as fair or poor, compared to only 12.5 percent among those over 250% of poverty. In the NSAF survey, 22.8% of non-elderly adults statewide below twice the poverty line rated their health poorly, compared to 7.7% of those at higher incomes. About one in six WTP respondents said that a member of their family experienced a "serious illness" in the past year, but this health status indicator was not associated with family poverty level.

Access to care. Access among the uninsured respondents in the WTP sample also compares unfavorably with statewide estimates. More than one in three uninsured respondents said that they would mostly likely use an emergency room or reported no likely place they would go for care should they need it (Table 3). This is more than twice the level reported in the NSAF, which showed 15.5% of non-elderly adult New Jersey residents without a usual source of care. Likewise, nearly half of WTP survey respondents said that they find getting needed medical care "somewhat difficult" or "very difficult", compared to about 10% of NSAF respondents who said they "are not confident" that they could get needed care. (Although the two surveys measured similar access-to-care concepts, the questions were not identical and differences should be interpreted with caution.)

Service utilization history. Table 3 also shows that very few of the uninsured adults in the WTP survey reported hospital stays in the past year (6.6%), but more than twice that number visited an emergency room and more than two in five visited a physician in a private office or health center. The likelihood of reporting a non-ER physician visit rises with income, although this difference is not statistically significant.

Table 3: Health Status, Access, Utilization, Coverage History and Eligiblity, Reason for Uninsurance, and Attitudes of Uninsured Non-Elderly Adults, by Poverty Status, 2000

		% Federal Poverty Level			
	Total	<150	150-250	251+	p-value
Health Status					
Fair or poor health (n=408)	19.6	27.0	16.5	12.5	0.012
Serious Illness in Family[a] (n=332)	15.7	13.6	17.2	17.0	0.669
Access to Care[b]					
Most likely place of care (n=412)					
Doctor office	36.2	33.1	35.6	43.2	0.597
Health center/OPD/Other place	27.7	29.9	28.2	22.2	
None or ER only	36.2	37.0	36.2	34.2	
Difficulty getting care[c] (n=350)					
Very/somewhat difficult	43.1	60.7	37.9	17.7	<0.001
Utilization in Prior Year					
Inpatient stay (n=412)	6.6	5.2	7.3	7.4	0.690
Emergency room visit (n=411)	18.0	16.9	18.8	18.5	0.899
Physician or health center visit (n=411)	43.3	37.3	45.8	49.4	0.140
Coverage History and Eligiblity					
Last time covered (n=412)					
During past year	17.2	13.0	19.8	19.8	0.006
One year ago or more	33.7	27.9	33.3	45.7	
Never covered	49.0	59.1	46.9	34.6	
Current eligiblity (n=412)					
Eligible for coverage	11.9	5.2	14.1	19.8	0.002
Not eligible for coverage	88.1	94.8	85.9	80.2	
Attitudes (strongly/somewhat agree)					
Doctors will provide care even without payment (n=396)	40.9	50.0	36.7	32.5	0.013
I am fine with public/free clinics (n=402)	54.2	57.3	56.1	44.3	0.138
I can get any needed medical care in the ER (n=404)	66.1	66.2	62.1	74.7	0.145
I am comfortable with HMO's (n=373)	69.2	76.3	67.7	58.6	0.028
I worry about others in my family not having coverage (n=303)	69.3	77.8	65.6	51.4	0.004
I can't afford needed medical care (n=407)	73.5	81.7	72.8	59.3	0.001
I live from paycheck to paycheck (n=405)	80.5	84.4	83.1	67.9	0.006
I worry about my own lack of coverage (n=410)	81.0	86.3	81.3	70.4	0.013

[a] Excludes single people living alone
[b] OPD is hospital outpatient department and ER is emergency room
[c] Excludes 56 cases where respondent volunteered that they did not need care
Source: Rutgers CSHP/NJDHSS Survey of Willingness to Pay for Health Coverage

Table 4: Characteristics of Uninsured Non-Elderly Adults by Eligiblity for Employer-Based Coverage, 2000

Characteristics	n	%Eligible	p-value
Total	**412**	**11.9**	
Age			
19-29	152	11.8	0.921
30-39	113	12.4	
40-49	82	13.4	
50-64	62	9.7	
Poverty Status			
Under 150%	154	5.2	0.002
150% to 250%	177	14.1	
Over 250%	81	19.8	
Race/Ethnicity			
White, non-Hispanic	90	13.3	0.019
Black, non-Hispanic	80	18.8	81.3
Hispanic	205	6.8	93.2
Other	28	17.9	82.1
Health Status			
Fair or poor health	408	6.3	0.077
Serious Illness in Family	332	17.3	0.237
Employment Status			
Full time	187	15.0	0.020
Part time	111	14.4	84.6
Not working	109	4.6	95.4
Firm Size			
Less than 50	185	11.9	0.166
50 or more	73	17.8	82.2

Source: Rutgers CSHP/NJDHSS Survey of Willingness to Pay for Health Coverage

Coverage history. About half of the sample reported that they had never had health insurance coverage, a percentage that ranges from nearly two-thirds among those with the lowest incomes to about one third for those over 250% of poverty (Table 3). Fewer than one in five, across all poverty status groups, reported having had coverage in the prior year.

Attitudes. Questions about respondent attitudes reveal a great deal of concern about lacking coverage, with more than four of five respondents agreeing with the statement "I worry a lot about my own lack of coverage" and two-thirds agreeing with a similar statement about coverage for other family members. Large majorities report that they can not afford needed medical care and that they live "paycheck to paycheck". Not surprisingly, worry about lacking coverage and affording care is highest among the lowest income groups. Attitude questions also show that more than

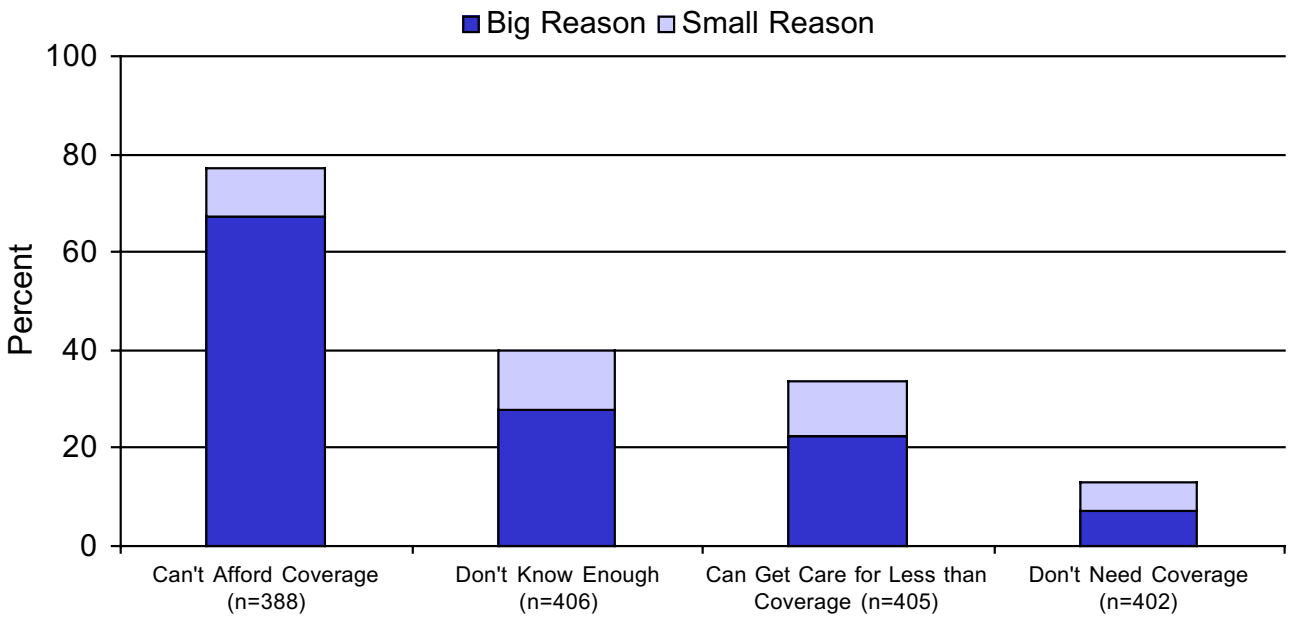
half of respondents believe that they could or would get discounted or free care in public or free clinics or an emergency room. Fewer, two in five, believe that "doctors will provide care even without payment." Finally, comfort levels with HMOs are high, especially among the lowest income groups.

Eligibility for Employer-Based Coverage. Fewer than one in eight respondents reported being eligible for private group coverage. The eligible population is about evenly divided between those eligible through the employer of a spouse or parent and those eligible through their own employer. Coverage eligibility ranges from 5.2% among those below 150% of poverty to nearly 20% among those over 250% of poverty (Table 3). Table 4 shows, not surprisingly, that the proportion of respondents with a coverage offer is highest among those with jobs, particularly those working for firms with 50 or more employees. The proportion eligible for coverage is also higher among blacks than other race/ethnic groups but is lower among those in fair or poor health.

Respondents with an offer from their own employer (n=30) were asked why they did not take offered coverage and the amount that they would have to pay for that coverage. Two thirds said that they could not afford the employee premium share, with the remainder reporting that they did not want the coverage or had not "gotten around" to signing up for coverage. One third of those with an employer offer could not recall the premium cost of the coverage, and two thirds of the remaining 20 respondents reported that they would have to pay over $50 per month for coverage, almost twice the average employee contribution for single coverage in large firms across New Jersey (discussed further below).

Reasons for Not Having Coverage. All of the survey respondents were read a list of possible reasons for not buying health insurance for themselves, and over three fourths agreed with the statement that they "can't afford to pay the monthly cost…." Some respondents agreed with statements reflecting other reasons, including lack of information about coverage, availability of care for less cost than coverage, or lack of interest in buying insurance (Figure 1).

Figure 1: Reasons for not Purchasing Health Insurance Coverage



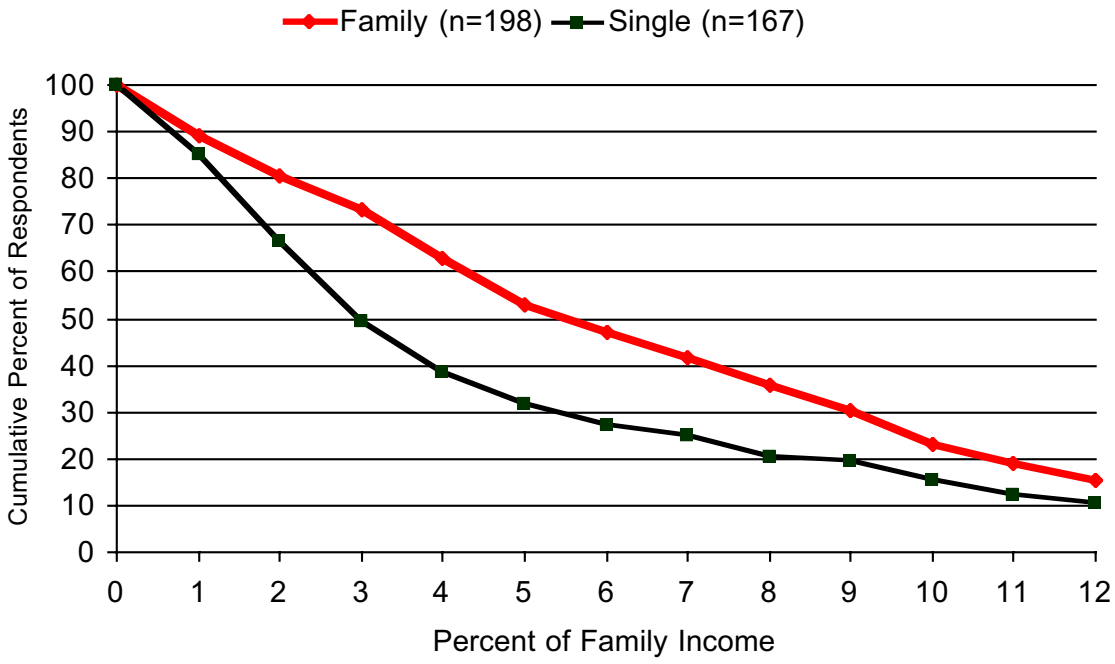
Source: Rutgers CSHP/NJDHSS Survey of Willingness to Pay for Health Coverage

Willingness to Purchase Coverage

Willingness to pay. Respondents were asked to report the amounts that they are willing to pay for health insurance for themselves and their families. Figures 2 and 3 show the distribution of responses as a percentage of family income. About two-thirds of respondents said that they would pay an amount equivalent to no more than two percent of their income to cover themselves, and about 80% would pay that much to cover their entire family.[19] The percentage of income the uninsured said they were willing to devote to health insurance declines rapidly, yet a significant number gave amounts over five or six percent of income.

Non-group market. Table 5 compares the actual premiums for the most popular HMO product in the non-group market to respondents' estimates of premiums (perceived premiums) and willingness to pay for coverage. At the median, perceived premiums do not vary by the type of family to be covered. About half of single respondents estimated premiums within 80% of the actual cost of single coverage, but only about one in four respondents with a family came close to estimating an accurate premium. Willingness to pay is well below even perceived premiums, and even further below actual premiums. Only about one in seven singles was willing to pay at least 80% of the actual cost of coverage, and very few respondents with families said they would pay near what family coverage costs. Answers to the willingness to pay questions were confirmed by the price point questions, to which similar proportions of respondents said that they would "definitely" or "probably" purchase coverage at prevailing premiums. Not surprisingly, the accuracy of respondent premium estimates and their willingness to pay rises with family income, but even among those over 250% of the federal poverty level, few are willing to purchase coverage at the current cost in the non-group market.

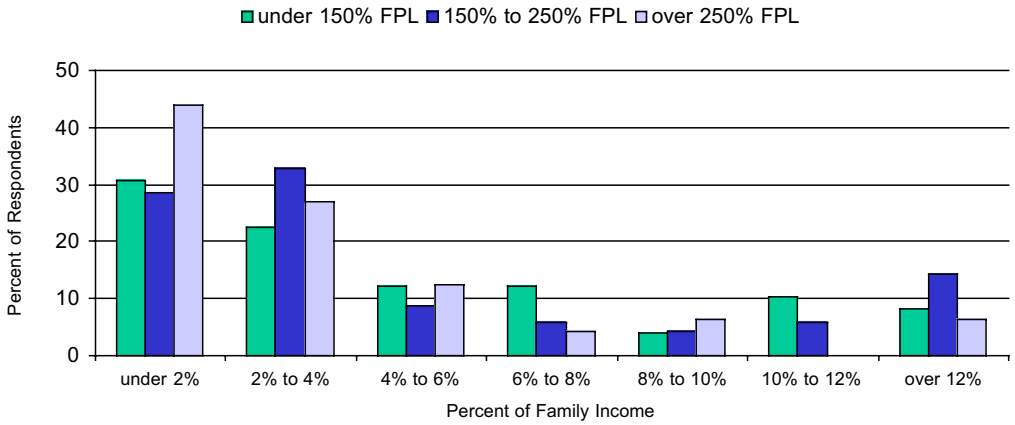
Figure 2: Willingness to Pay for Health Coverage
Cumulative Percent of Respondents by Percentage of Income



Source: Rutgers CSHP/NJDHSS Survey of Willingness to Pay for Health Coverage

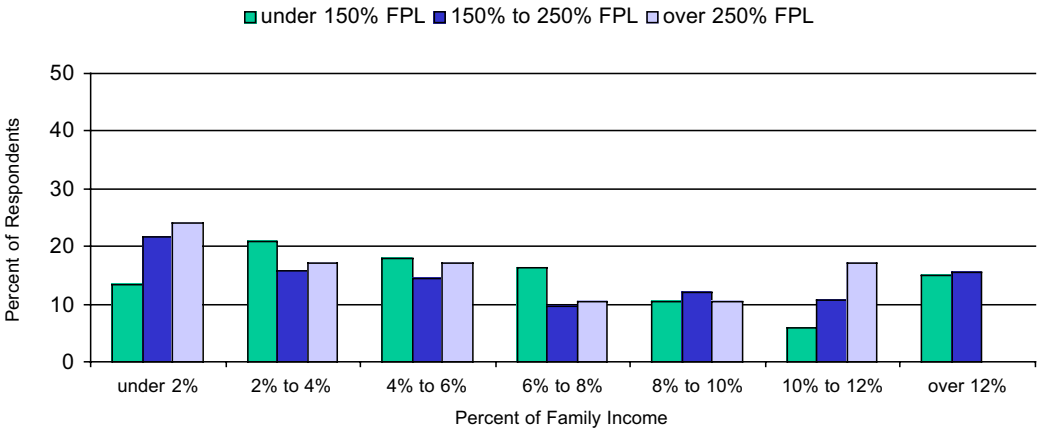
Figure 3: Willingness to Pay for *Single* and *Family* Health Coverage
Percent of Respondents by Percentage of Income

Single



Source: Rutgers/NJDHSS Survey of Willingness to Pay for Health Coverage

Family



Source: Rutgers/NJDHSS Survey of Willingness to Pay for Health Coverage

Group market. We conducted a similar analysis of employment-based group coverage among full-time workers by contrasting willingness to pay for the employee share of prevailing premiums for singles and families in private sector firms. In the group market, family premiums paid by employees are considerably higher than single premiums. Table 6 shows that three fourths of single respondents said they were willing to pay an amount equal or greater than the average single premium charged employees by New Jersey businesses. In contrast, only about two out of five respondents with families said that they would be willing to pay the prevailing employee share of group family premiums. These proportions may paint an overly optimistic picture. The analyses shown here use statewide average employee premiums (by firm size), but there is considerable variability in employee premium shares and currently uninsured individuals respondents are likely to face higher costs. This is confirmed by premium costs reported by respondents who currently have (and forgo) an offer employer coverage, two-thirds of whom report facing premiums of over $50 per month (discussed above).

Table 5: Actual and Perceived Premiums and Willingness to Pay for Coverage in the Non-Group Health Insurance Market by Family Structure and Poverty Status, 2000

	n	Actual Premium[a] ($)	Median Perceived Premium ($)	Perceived >80% of Actual[b] (%)	Median Willingness to Pay ($)	WTP >80% of Actual[b] (%)	"Definitely" or "Probably" Willing[b] (%)
Family Structure							
Single, no children	185	$240	$200	52.5	$50	15.6	15.7
Married, no children	52	$480	$200	28.9	$100	9.8	5.8
Single parent, one child	48	$430	$200	29.0	$100	2.6	6.3
Other families	127	$720	$200	23.3	$130	2.0	6.3
Poverty Status							
Under 150%	154	—	—	28.7	—	5.2	7.8
150% to 250%	177	—	—	36.4	—	9.2	10.2
Over 250%	81	—	—	60.0	—	16.9	16.0
Family Structure by Poverty Status							
Single, no children							
Under 150%	56	—	—	47.6	$50	10.2	14.3
150% to 250%	79	—	—	50.0	$50	17.1	15.2
Over 250%	50	—	—	62.1	$55	18.8	18.0
Families (non-singles)							
Under 150%	98	—	—	16.7	$90	1.5	4.1
150% to 250%	98	—	—	24.3	$140	2.4	6.1
Over 250%	31	—	—	56.5	$200	13.8	12.9

[a] Premium for the most popular HMO product in the NJ individual health coverage program
[b] actual premiums are for applicable family structure category
"WTP" is willingness to pay; — indicates not applicable
Source: Rutgers CSHP/NJDHSS Survey of Willingness to Pay for Health Coverage and Current Population Survey

Table 6: Willingness to Pay Average Employee Contributions for Employer-Sponsored Coverage Among Full-time Employees by Type of Coverage, 2000

	n	Average Employee Premium[a] ($)	Median Willingness to Pay ($)	Willingness to Pay as % of Actual (%)
Single Coverage	48	$29-$45	$60	75.0
Family Coverage	65	$140-$169	$125	43.1

[a]Average employee health insurance premium contribution in New Jersey, varies by firm size (see text)
Source: Rutgers CSHP/NJDHSS Survey of Willingness to Pay for Health Coverage

State subsidized programs. We also compare willingness to accept coverage at actual and hypothetical premium rates in NJ FamilyCare and NJ KidCare programs. Under current program rules, children up to 350% of the federal poverty level, parents up to 200% FPL, and singles up to 100% FPL are eligible for these programs. Early in the program, legal immigrants arriving after August 22, 1996 were ineligible for NJ FamilyCare for five years. Although this is no longer the case, respondents who are recent immigrants may not believe they are eligible for publicly subsidized coverage. As well, immigrants may falsely believe that the Immigration and Naturalization Service would consider them as a "public charge" if they participate in NJ FamilyCare, potentially putting their immigration status at risk or placing their sponsors at financial risk. As shown in Table 1, only 5.6% of the study population reported being foreign born and in living the US for less than four years (i.e., roughly since 1996). The survey did not ask the legal residency status of immigrants. Nevertheless, the small numbers of recent immigrants in the study should not have a significant effect on responses to questions about willingness to enroll in NJ FamilyCare.

We include responses to "price point" questions for respondents up to 350% of poverty, and apply hypothetical premiums for parents above 200% of poverty and adults without children over the poverty level. The hypothetical premiums were extrapolated from the existing premium structure (see Figure 1), but do not reflect actual state policy. We also provide estimates of the percentage of respondents willing to accept free coverage for those in the zero premium categories (i.e., up to 150% FPL for NJ FamilyCare and NJ KidCare and up to 100% FPL for adults without children). Results for child-only coverage (NJ KidCare) are limited to respondents who reported having uninsured children. These results apply only to uninsured children of uninsured parents, and should not be generalized to uninsured children of covered parents. Finally, for applicable categories, we also compare reported willingness to pay with the actual or hypothetical premiums.

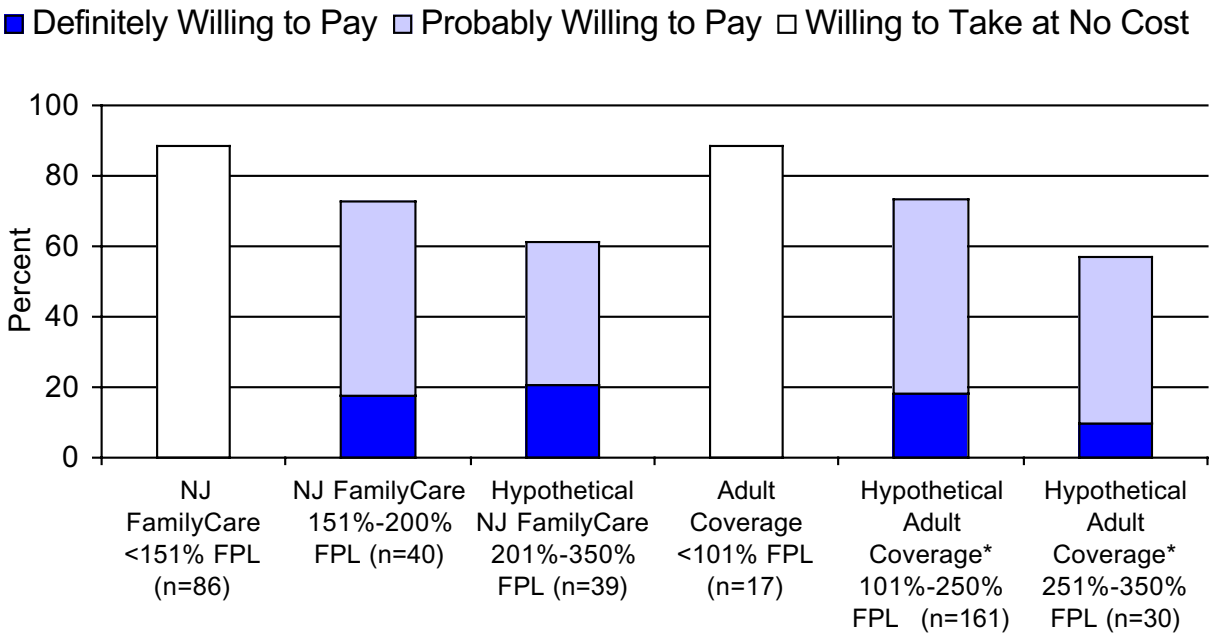
We find that a large majority of respondents reported willingness to purchase state subsidized coverage at the actual or hypothetical premium levels (Table 7 and Figures 4A and 4B). In the lowest income group where premiums are required (150% to 200% of poverty), willingness to purchase family and child-only coverage is between three-fourths and over 90%, depending on the measure examined. Above this income level, where higher premiums would be required, willingness to purchase declines. Still, almost two out of three families between 201% and 350% of poverty said they would buy NJ FamilyCare at the hypothetical premiums. Likewise, large proportions of adults without children say they would pay similarly subsidized premiums. Most (88% to 96%) respondents in the income categories where no premiums are required reported willingness to sign up for free coverage. Those not willing may not wish to participate in a public program or simply do not value health coverage.

Table 7: Premiums for State Subsidized Coverage and Willingness to Pay by Type of Coverage, 2000

Program[a]	Eligibilty (% of Federal Poverty Level)	"Actual" Family Premium[b] ($)	n	Median Willingness to Pay[c] ($)	WTP as % of "Actual" Cost[c] (%)	"Definitely" or "Probably" Willing[d] (%)	Willing to Take at No Cost (%)
NJ FamilyCare							
A and B	<151%	$0	86	—	—	—	88.4
C	151% - 200%	$40 - $50	40	$145	94.6	72.5	—
D (hypothetical)	201% - 350%	$80 - $340	39	$180	62.9	61.5	—
Adult Only	<101%	$0	17	—	—	—	88.2
Adult Only (hypothetical)	101% - 250%	$25 - $70	161	$50	77.9	73.3	—
Adult Only (hypothetical)	251% - 350%	$100 - $240	30	$60	37.9	56.7	—
NJ KidCare							
A and B	<151%	0$	46	—	—	—	95.7
C	151% - 200%	$15	24	—	—	91.7	—
D	201% - 350%	$30 - $100	21	—	—	85.7	—

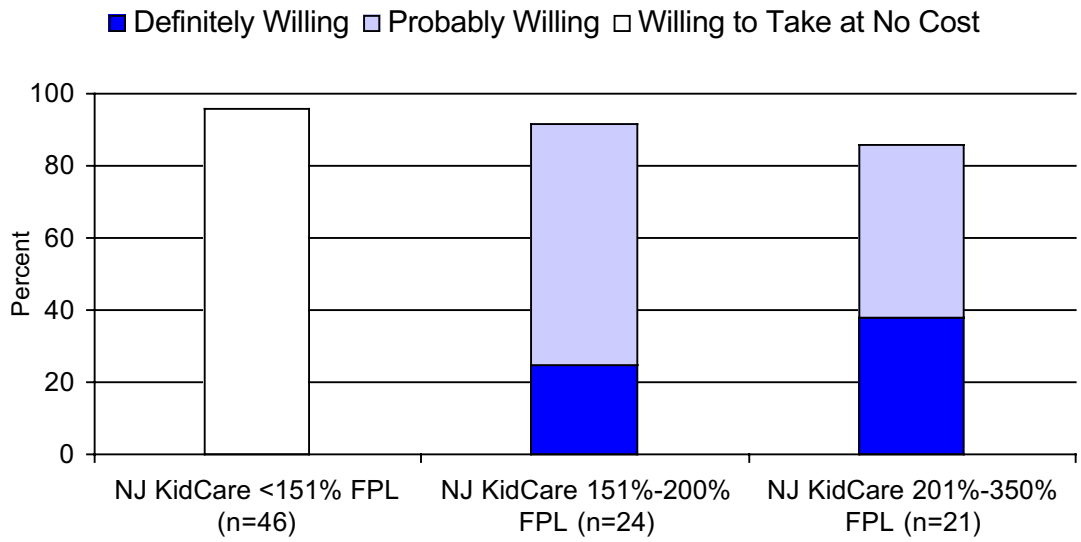
[a] Programs sponsored by the State of New Jersey and potental future expansions of those programs. Letters indicate income eligibility categories.
[b] Premiums vary by family size and maximum and minimum are given; some "actual" premiums are projected, see Table 1.
[c] Willingness to pay in the private non-group market; some "actual" premiums are projected, see Table 1.
[d] Expressed likelihood of purchasing a state-subsidized product of this type.
"WTP" is willingness to pay; — indicates not applicable
Source: Rutgers CSHP/NJDHSS Survey of Willingness to Pay for Health Coverage

Figure 4A: Many are Willing to Enroll in State Subsidized Coverage Under Current or Hypothetical Rate Structure
(Limited to Persons Below 350% of the Federal Poverty Level)



Source: Rutgers CSHP/NJDHSS Survey of Willingness to Pay for Health Coverage
*Singles and Couples without children

Figure 4B: Many are Willing to Purchase State Subsidized Coverage Under Current Rate Structure
(Limited to Persons Below 350% of the Federal Poverty Level)



Source: Rutgers CSHP/NJDHSS Survey of Willingness to Pay for Health Coverage

These results reveal some uncertainty about the level of commitment of respondents who say they are willing to purchase subsidized coverage. The percentage of respondents reporting willingness to pay amounts at least equal to the premiums for their respective income and family structure category are of the same order of magnitude as to responses to price point questions when "probably willing" and "definitely willing" categories are combined. However, many fewer respondents said they would "definitely" than "probably" purchase coverage.

State sponsorship does not appear to have a negative affect on willingness to purchase coverage. After questions about willingness to purchase state-subsidized coverage, respondents were asked if knowing that "These health insurance plans offered through the State of New Jersey require income verification" would make them more or less likely to purchase that coverage. Only about one in five responded they would less likely to purchase this coverage, while nearly a third said that they would be more likely to purchase under these conditions (Table 8). Reactions to being reminded that the coverage is state sponsored and that income verification is required is related to respondent income, with lower income respondents being much more positive about state sponsorship. A second indicator that state-sponsorship per se is not a barrier to enrollment in NJ FamilyCare is that over 80% of respondents who said that they were not willing to pay premiums to enroll said that they would take the coverage at no cost.

Table 8: Effect of Income Verification Requirement on Willingness to Purchase or Enroll in State-Subsidized Coverage Among Uninsured Non-Elderly Adults, by Poverty Status, 2000

		% Federal Poverty Level			
	Total	<150	150-250	251+	p-value
Response to Income Verification Requirement (%) (among those willing to purchase) (n=308)					
More likely to purchase	30.8	43.6	26.9	20.5	0.003
Just as likley to purchase	47.7	38.6	54.5	47.9	
Less likely to purchase	21.4	17.8	18.7	31.5	
Would be Willing to Enroll in Free Plan (%) (among those not willing to purchase at any price) (n=97)	81.4	83.0	88.2	50.0	0.054

Source: Rutgers CSHP/NJDHSS Survey of Willingness to Pay for Health Coverage

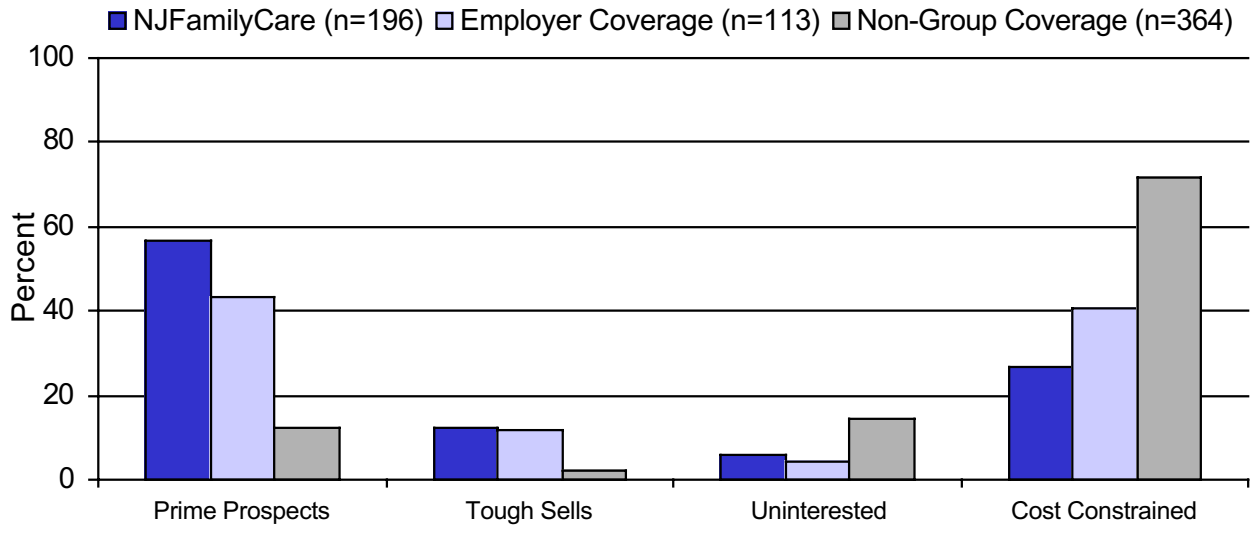
Summary of willingness to purchase: Market segment analysis. Figure 5 summarizes findings about willingness to purchase coverage at prevailing premiums in the non-group and employer-group markets and at prevailing and hypothetical rates in state subsidized programs. Respondents are classified by how their stated willingness to pay compares with prevailing (or hypothetical) premiums and their degree of "worry" about lacking coverage. Specifically, those willing to pay at least eighty percent of the actual cost of a policy for their family or themselves (i.e., for single persons) in the non-group market or the full cost of the employee or participant share of group or state-subsidized coverage, respectively, are classified as willing to pay. Then respondents are classified by whether they reported worrying "a lot" or "somewhat" about not having coverage for themselves and their families. Those classified as both willing and worried are considered "prime prospects" for coverage, and those not willing and not worried are classified as "uninterested." The others respondents are classified as "cost constrained" (worried but not will-

ing) or "tough sells" (willing but not worried). While this last group may well be willing to buy coverage, their lack of worry about going without coverage may make this group harder to reach with marketing or outreach efforts. Analyses of public and group coverage are limited to respondents who would be eligible to purchase from the respective source.

Not surprisingly, the lowest cost products would attract the largest numbers of "prime prospects." If NJ FamilyCare were available to respondents up to 350% of poverty at the hypothetical rates posed to them, over half seem likely to buy coverage. The market for employer-sponsored coverage, which is more expensive, is somewhat more limited. If full-time workers in the survey were offered group coverage at rates comparable to the market-wide average, more than two in five are likely prospects. There is a core of both the NJ FamilyCare eligible and full-time worker groups that may be harder to reach even though they report willingness to pay; just over one in ten in both of these groups say they are not worried about going without coverage and are classified as "tough sells". The analysis confirms that the non-group market appears to be out of reach for most respondents, the great majority of who worry about lacking coverage but are "cost constrained" in the face of prevailing premiums. Finally, there is a smaller but significant core, about one in seven respondents, who are both unwilling to pay the prevailing non-group premium and say they are not worried about lacking coverage.

Across all respondents in the non-group coverage analysis, "prime prospects" are slightly but significantly older on average, 38 years compared to an average of 35 years old for the "cost constrained" and 32 years for the combined "uninterested" and "tough sells" groups (p=.043). Of course income also plays a role in market segmentation, but not in an entirely expected way. Those who said they are not worried about lacking coverage (i.e., the "uninterested" and "tough sell" groups), were disproportionately represented among those over 250% of poverty (36%) compared to the "prime prospects" or "cost constrained (21% and 18%, respectively) (p=0.020). We did not find differences in the demographic profile of the market segment groups, except that immigrants were more likely to be "cost constrained" (78%) compared to the US born population (66%) (p=0.046).

Figure 5: Market Segments: Who is Most Likely to Purchase Coverage?



Source: Rutgers CSHP/NJDHSS Survey of Willingness to Purchase Health Coverage
Note: NJFamilyCare analysis is limited to persons between 150% and 350% of the federal poverty level and Employer analysis limited to full-time workers

Table 9: Willingness to Pay for Coverage by Respondent Characteristics, 2000

Characteristics	Singles (n=167) Mean	Singles (n=167) p-value[a]	Families (n=179) Mean	Families (n=179) p-value[a]
Total	$102	—	$156	—
Age				
19-29	$80	0.201	$123	0.036
30-39	$166		$177	
40-49	$110		$170	
50-64	$113		$145	
Race/Ethnicity				
White, non-Hispanic	$107	0.025	$197	0.580
Black, non-Hispanic	$51		$129	
Hispanic	$119		$146	
Other	$112		$278	
Poverty Status				
Under 150%	$71	0.036	$114	0.042
150% to 250%	$109		$156	
Over 250%	$123		$253	
Education				
Less than high school	$130	0.084	$121	0.672
High school graduate/GED	$99		$145	
Some college or trade	$84		$159	
College gradulate or higher	$112		$226	
Health Status				
Fair or poor health	$81	0.265	$144	0.161
Serious Illness in Family	—	—	$164	0.840
Access to Care[b]				
Usual place of care				
Doctor office	$107	0.728	$199	0.023
Health center/OPD/Other	$98		$108	
None or ER only	$99		$153	
Difficulty getting care				
Very/Somewhat difficult	$115	0.879	$141	0.071
Somewhat/Very easy	$95		$160	
Utilization in Prior Year				
Inpatient stay	$71	0.289	$138	0.981
Emergency room visit	$81	0.555	$162	0.531
Physician or health center visit	$86	0.899	$161	0.732
Coverage History and Eligiblity				
Last time covered				
During past year	$83	0.530	$204	0.023
Over one year	$99		$155	
Never covered	$111		$136	
Current eligiblity				
Eligible for coverage	$100	0.867	$212	0.139
Not eligible for coverage	$102			$143

(Table 9 continued from previous page)

Characteristics	Singles (n=167)		Families (n=179)	
	Mean	p-value[a]	Mean	p-value[a]
Reasons for not taking coverage				
Buying services costs less than insurance				
Big reason	$135	0.149	$132	0.719
Not a big reason	$95		$168	
Don't need coverage				
Big reason	$144	0.827	$171	0.300
Not a big reason	$99		$156	
Can't afford coverage				
Big reason	$104	0.387	$145	0.988
Not a big reason	$90		$181	
Don't know enough about it				
Big reason	$74	0.220	$139	0.585
Not a big reason	$110		$162	
Attitudes				
Doctors will provide care even without payment				
Strongly/Somewhat agree	$92	0.473	$165	0.638
Somewhat/Strongly disagree	$106		$148	
I am fine with public/free clinics				
Strongly/Somewhat agree	$100	0.568	$161	0.643
Somewhat/Strongly disagree	$104		$148	
I can get any needed medical care in the ER				
Strongly/Somewhat agree	$99	0.878	$155	0.322
Somewhat/Strongly disagree	$111		$159	
I am comfortable with HMO's				
Strongly/Somewhat agree	$115	0.500	$149	0.585
Somewhat/Strongly disagree	$87		$160	
I worry about others in family not having coverage				
Strongly/Somewhat agree	—	—	$156	0.686
Somewhat/Strongly disagree	—	—	$165	
I can't afford needed medical care				
Strongly/Somewhat agree	$107	0.281	$134	0.002
Somewhat/Strongly disagree	$90		$220	
I live from paycheck to paycheck				
Strongly/Somewhat agree	$104	0.513	$139	0.089
Somewhat/Strongly disagree	$94		$235	
I worry about my own lack of coverage				
Strongly/Somewhat agree	$101	0.782	$153	0.187
Somewhat/Strongly disagree	$108		$165	

[a] Based on the natural logarithm of willingness to pay to account for the skewed distribution of the data.
[b] OPD is hospital outpatient and ER is emergency room.
— indicates not applicable; p-values based on the natural logs to account for skewness
Source: Rutgers CSHP/NJDHSS Survey of Willingness to Pay for Health Coverage and Current Population Survey

Who is Most Willing to Pay for Coverage?

Table 9 shows the average reported willingness to pay for coverage by respondent characteristics. Not surprisingly, income is closely associated with willingness to pay. As well, older respondents are generally willing to pay more for coverage than others, although this relationship is not statistically significant for single people without dependents. Among respondents with families, we also find that those with a private doctor and a recent history of coverage are willing to pay more. These factors are most likely associated with higher socioeconomic status and ability to pay. Surprisingly, we did not find a correlation of low health status or a history of using health services with the level of willingness to pay. Those in poor health or with recent utilization might be expected to value coverage more highly than others, but those in poor health also tend to be of lower socioeconomic status. Finally, we find that African Americans are willing to pay less, on average, compared to other race/ethnic groups, although this finding is statistically significant only for single coverage. Multiple regression analysis confirms that poverty status is most closely associated with willingness to pay, but after controlling for poverty status we found that other factors, e.g., age, race and coverage history, were no longer consistently associated with willingness to pay.

DISCUSSION

Interest in Coverage is High

Interest in obtaining health insurance coverage among moderate income uninsured adults in this study is high. Over eighty percent say they "worry a lot" about not having coverage, and one in five report being in only "fair or poor" health. Nevertheless, the cost of coverage available to most of the survey respondents far exceeds what they say they could pay.

Private Coverage Out of Reach for Most

The cost of health insurance in the non-group market, where coverage is purchased directly from insurance companies or HMOs rather than through an employer, is far higher than the average willingness to pay among the survey respondents. For instance, the most commonly purchased HMO policy in the non-group market at the time of the survey cost $240 per month for a single person, but half of the survey respondents said they could only pay $50 per month or less for this coverage. The cost gap is even larger for families, for whom monthly premiums were up to $720 per month but median willingness to pay is $130 per month. These results suggest that the non-group market in New Jersey fills only a niche role for residents with high incomes and those willing to spend a large proportion of their income but who lack access to employer group coverage.

Survey results suggest that employer group coverage would be within reach for many more moderate-income full-time but uninsured workers. At the current average cost to workers of employer group coverage, our results suggest that two in five families and about three-fourths of singles would be willing to buy. However, nearly ninety percent of respondents are not eligible for an employer plan, and most of those who are eligible are required to pay more than the state average employee cost share. With employer health insurance costs expected to rise over the next few years, employment-based coverage does not appear to offer a route to coverage for moderate income working people, unless subsidies are available to help employees pay their premium contribution.

Expanded NJ FamilyCare Would be of Interest to Uninsured

State-subsidized coverage offers considerably more promise for covering moderate income uninsured. Currently, state-subsidized or free coverage is offered to uninsured children up to 350% of the federal poverty level, parents up to 200% FPL, and singles up to 100% of FPL. If hypothetical premiums of an expanded NJ FamilyCare were available to adults up to 350% of poverty, a large majority – about two thirds or more – of our sample say they would probably or definitely be willing

to purchase a plan. Moreover, income verification, which is required to determine eligibility for state-sponsored coverage, would not be a deterrent to signing up for most survey respondents.

Affordability is Key

Survey respondents most often cite the cost of health insurance as the major barrier to coverage, and very few say that they lack interest in coverage. Our analysis shows that family income is the main determinant of the level of willingness to pay for coverage. Those currently in good health appear to have a demand for coverage as high as those in poor health or with a recent history of service utilization. Although the findings suggest that the availability of charity care provides an alternative to buying coverage, the large gap between the cost of coverage and what respondents say they could pay suggests that charity care is not serving as a major deterrent to buying coverage.

The Hard to Reach Uninsured

Our findings show that an even a generous premium subsidy strategy will not reach many among the ranks of the uninsured, about one in three of the study population would not be willing to buy even at subsidized rates. Even one in ten of the lowest-income respondents say they would turn down free government-sponsored coverage. Indeed, many of the survey respondents were eligible for free or subsidized coverage at the time of the survey, but had not enrolled. Consistent with these results are the findings that about one in five of all respondents say they do not "worry a lot" about lacking coverage, and nearly of third of respondents with families express a similar lack worry that their dependents lack insurance.

Study Limitations

Readers should keep several study limitations in mind when interpreting findings. The study is limited to three northern New Jersey counties. These counties have large Hispanic and immigrant groups. In addition, the study is based on a sample survey which has a statistical margin of error. Differences that are statistically significant are noted in the report. In the tables, "p-values" over 0.05 should not be considered statistically significant. Although the response rate for this study was high by current standards (64%), the possibility remains that non-respondents differ in important ways from respondents. In addition, the survey was conducted by telephone, thus persons without phones were systemically excluded.

Finally, questions about willingness to pay are hypothetical by necessity and may not predict actual behavior. One recent study of actual health insurance purchasing behavior in a similar income range shows a lower coverage participation rate than our findings predict.[20] That study of publicly subsidized coverage in Hawaii, Minnesota and Tennessee showed about one-half to two-thirds fewer individuals enrolled in coverage compared to what our survey predicts for New Jersey. For example, with premiums at two percent of family income our study predicts that about two-thirds of the eligible individuals would enroll. In contrast, the three-state study showed an actual enrollment rate of 45%. This variance could be the result of many factors. Perhaps state sponsorship of coverage depressed willingness to pay in the states studies or perhaps respondents reported higher willingness to pay in response to our hypothetical scenario than they would to "real world" coverage. In any case, it is prudent to interpret our findings as the upper bound of how uninsured individuals might respond if they had the option of buying coverage at lower rates.

ENDNOTES

[1] Urban Institute and Kaiser Commission on Medicaid and the Uninsured, estimates based on pooled March 2000, 1999, and 1998 Current Population Surveys. http://statehealthfacts.kff.org/uninsured, July 11, 2001.

[2] Fox, K; Cuite, C; Diaz, Y; Cantor, J. Databook on Employer Health Insurance in New Jersey. Rutgers Center for State Health Policy, Forthcoming 2001.

[3] Hogan, C; PB Ginsberg; J Gabel, "Tracking Health Care Costs: Inflation Returns", Health Affairs (Nov./Dec., 2000) 19(217-223).

[4] New Jersey Individual Health Coverage Program Board, August 2000 Premium Rates, http://www.naic.org/nj/njhomepg.html, August 8, 2000.

[5] Personal communication with Wardell Sanders, Executive Director New Jersey Health Coverage Board, Fall 2000.

[6] New Jersey Department of Human Services, http://www.NJ FamilyCare.org/pages/enroll_chart.html, July 11, 2001.

[7] Op cit. New Jersey Department of Human Services, July 11, 2001.

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[9] Marquis MS and Long SH. "Worker Demand for Health Insurance in the Non-Group Market." Journal of Health Economics (May 1995) 14:47-63.

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[11] California HealthCare Foundation. To buy or not to buy: A profile of California's non-poor uninsured. California HealthCare Foundation. 1999. ISBN 1-929-008-20-1. www.chcf.org/uninsured/fieldsurvey.cfm.

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[14] Blumenschein K, Johannesson M, Yokoyama KK, and freeman PR. "Hypothetical versus Real Willingness to Pay in the Health Care Sector: Results from a Field Experiment." Health Economics (2001) 20:441-457.

[15] New Jersey Individual Health Coverage Program Board, August 2000 Premium Rates, http://www.naic.org/nj/njhomepg.html, August 8, 2000.

[16] Some may not be eligible because they had private coverage in the past six months.

[17] Op Cit., Hogan et al., Exhibit 3, p. 220.

[18] Urban Institute, http://newfederalism.urban.org/nsaf/pdf/statebystate.pdf. June 5, 2001

[19] Respondents were asked in separate questions about the amount of premium they would be willing to pay and about their income, and these responses were used to calculate willingness to pay as a percentage of income. Two questions were asked about premium amounts, one for themselves and the other for other family members (e.g., "for your spouse" if married without children). Responses to the two questions were added to estimate willingness to pay for a family policy. This technique may have yielded higher premium estimates than if respondents were asked only a single question about willingness to pay for a family policy.

[20] Op Cit. Ku and Caughlin, 1999/2000.

APPENDIX A

SCHULMAN, RONCA, & BUCUVALAS, INC.
145 East 32nd Street
New York, New York 10016
February 9, 2001

DISPOSITION OF CALLS – RESPONSE RATE

Attached are two excel spreadsheets containing sample dispositions for each of the three counties and total. 9217P_DISP provides a line for numbers which are probably not assigned, or are non-voice line phones. To identify probable unassigned numbers, SRBI identifies all numbers which have been attempted a minimum of seven times and the result of each attempt is either no answer or busy. The numbers are matched electronically against the most recent data base of listed and unlisted residential telephone numbers. (SRBI uses the services of Survey Sampling Inc. for this function.) Any number which is not assigned to a household (either as a listed or unlisted number) is believed to be an unassigned number, or one assigned only to a data port and to which a human will never respond. Unassigned numbers are not included in response rate calculations. 9217NP_DISP does not include this line. A comparison of total no answers and busy in 9217NP_DISP to 9217P_DISP will identify the original status of probable unassigned numbers.

An explanation of some dialing result categories are as follows:

Not in service, disconnected numbers are identified in two ways. 1) SRBI pre-dials all RDD generated numbers using a pre-dialer program. This software automatically dials phone numbers and detects, before the phone rings at the other end, as to whether the number is not in service, disconnected, etc. It then marks the number as to its status. 2) Additional numbers are indicated as not in service, disconnected, etc., during the field period as interviewers encounter these situations.

No answer, answering machine, busy: To be classified into one of these three categories it means that the last (most recent) dialing attempt resulted in this situation, AND we never spoke to anyone at the number previously. That is to say, every dialing attempt made to that number was always either a no answer, answering machine or busy.

Callback at a later time: Once a household has been contacted and we are asked to callback at a date and time that is within the legitimate field period of the study, it becomes a callback. Further dialing attempts which result in a no answer, busy or answering machine do not change the status of this number. It remains a callback. Only if there is some other "final" disposition" will the classification change.

Language problems non-Hispanic: This study was being conducted with English and Spanish speaking households. Therefore households speaking any other language are not part of the universe and are not included. Households in this category are not included in the calculation of response rate.

Health/deaf are categorized together mostly because this was done historically and most canned CATI software packages come "pre-assembled" this way. In truth, if someone is ill we should consider them eligible and callback at a later time. If someone is deaf, and this is a telephone survey being conducted among those without hearing challenges, they would not be part of the universe. The category is never high enough to warrant special treatment in most situations. This category is included in the calculation of response rate.

Refusals in this project include those who refused during the introduction, hung up on us before we were able to administer the introduction, and those who refused to answer specific screening questions so we could determine eligibility. SRBI attempted to convert all refusals and mid-interview terminates. Therefore the majority of the refusals reported on this study are people who refused twice.

The "not qualified" categories are self explanatory. In this project we later changed screening criteria so that individuals living in other counties of the state, or who had an income higher or lower than the initial range; were included. The number of households screened out here represent who we identified and screened out of the study before this change was made.

Mid interview terminates successfully completed all of the screening questions and qualified but into the body of the interview the respondent refused to continue or was not able to continue.

Because we believe calculating and excluding probable non-assigned numbers is the most correct, fair and defendable method of modifying the outdated response rate formula, and we are proposing that method for the more intensive family survey; I have used that method to calculate response rate by county and in total for this project.

The following chart, demonstrates the extensive dialing attempts employed. As it was, we needed to add sample at the end of the project in order to finish by the deadline, but we did dial it as much as possible, exceeding quota, in order to make as many contacts as possible…thereby increasing the response rate. Referring to the chart, the number in the left column is the number of call attempts made. (I cannot explain why some numbers were dialed less than 7 times. There are only 114 of them. The system was supposed to circulate all numbers the final weekend and for some reason these were not. It happens occasionally.) The number on the right is the number of pieces of sample which were dialed that many times. There were 20 pieces of sample dialed only 2 times, for example.

This is among numbers reported as no answer, busy, answering machine, etc. All numbers were stratified over time of day and day of week.

This report is generated as you see it within the CATI sample management module.

Att	Count of Att
2	20
3	22
4	21
5	29
6	22
7	18
8	19
9	22
10	41
11	41
12	56
13	20
14	11
15	11
16	32
17	1083
18	34
19	80
20	2
21	39
22	111
23	37
24	11
25	9
26	3
28	4
29	3
30	1
31	3
37	1
41	1
55	1
Over 55	12

* Over 55 was combined from dialing attempts ranging from 55 to over 100

The response rate calculation is as follows:

$$\frac{\text{Completed interviews + Not Qualified}}{\text{Total usable numbers less language problems non-Hispanic}}$$

Essex County is 64%
Hudson County is 63%
Passaic County is 66%
Total sample is 64%

All interviews were conducted from our centralized telephone facility in West Long Branch, New Jersey. All interviewing was conducted from December 1, 2000 to January 22, 2001. The interviewing scheduled was slowed down from December 24th to January 2nd in anticipation of a higher refusal rate during that time period. This interview was conducted in both English and Spanish.

The average length of interview was 20 minutes in the English version and 18.2 minutes in the Spanish version.

Final Sample Disposition Report for:
Rutgers Willingness to Pay Survey
Conducted by: Schulman, Ronca, & Bucuvalas, Inc.
For: Center for State Health Policy, Rutgers University

NOT SHOWING PROBABLE UNASSIGNED NUMBERS

Dialing Result	#	%	%	%
Total numbers attempted	13077	100.00%		
Not in service, disconnected numbers	1209	9.25%		
Business and other non-residential numbers	1502	11.49%		
Computer tones and fax tones	1364	10.43%		
Total usable numbers:	9002	68.84%	100.00%	
Households not contacted:	4075	31.16%	45.27%	
No answer	2425	18.54%	26.94%	
Answering Machine	450	3.44%	5.00%	
Busy	287	2.19%	3.19%	
Callback at later time	350	2.68%	3.89%	
Language problems non-Hispanic	393	3.01%	4.37%	
Health problem or deaf	140	1.07%	1.56%	
Respondent away for duration of field period	30	0.23%	0.33%	
Households contacted:	4927	37.68%	54.73%	100.00%
Refused	182	1.39%	2.02%	3.69%
Not Qualified:	4309	32.95%	47.87%	87.46%
DK if have health care coverage QA1	70	0.54%	0.78%	1.42%
All household members insured QA3	871	6.66%	9.68%	17.68%
Single person household insured QA3	2814	21.52%	31.26%	57.11%
Screened out for county lived in	415	3.17%	4.61%	8.42%
Screened out for income	99	0.76%	1.10%	2.01%
No uninsured in household QC3	40	0.31%	0.44%	0.81%
Total Qualified:	436	3.33%	4.84%	8.85%
Mid interview terminate	23	0.18%	0.26%	0.47%
Completed interview	413	3.16%	4.59%	8.38%

Screening Incidence: 9.19%