Technical Paper

Health Care Coverage

Uninsurance – The Unintended Consequence

Introduction

Throughout the 1990s, the number of uninsured Americans increased every year except 1999, despite a vibrant economy in the latter part of the decade. Now that the economy is slowing and health care costs are surging once again, the proportion of uninsured Americans is likely to climb significantly.

A reduction in health care coverage among low-income Americans was among the unintended consequences of welfare reform. While the welfare law officially severed the relationship between cash assistance and Medicaid, Congress provided states with several options to continue to offer Medicaid to those leaving welfare and to expand health coverage to more low-income families.

Nevertheless, many low-income people moving from welfare to work lost health coverage. Few entry-level jobs offered affordable health coverage, and welfare leavers frequently lost Medicaid, especially as their time off of welfare increased.

States now recognize these problems and have begun to correct them. By expanding coverage to low-income children and families, some states are reconceiving Medicaid as an insurance program rather than a welfare program. States have especially made strides in helping families obtain and retain health coverage for their children. On the other hand, policies in a number of states have caused many adults who are eligible for Medicaid to fail to receive it.

As state economies turn down and state budgets tighten – and as the incomes and employment of low-wage workers drop – the proportion of uninsured may increase. Recent double-digit increases in the cost of health insurance premiums reflect rising health care costs, which will place additional strain on states' abilities to meet the needs of the uninsured.[1]

Statistical Portrait

According to the Census Bureau, there were 39.3 million uninsured Americans in 1999 (16 percent of all 30.2 million adults and 12.6 percent of all 9.1 million children).[2] According to the 1997 National Survey of America's Families, 65 percent of these low-income uninsured persons live in families that have at least one full-time worker; approximately half of all uninsured adults have incomes below 200 percent of the federal poverty level ($29,260 of annual income for a family of three).[3] According to the 1999 National Survey of America's Families, more than 15.4 million uninsured adults are low income,[4] and more than 6.8 million uninsured children live in low income families.[5]

Census Bureau data indicate that during 1999, of the 39.3 million Americans without health insurance, 26.9 percent are Hispanic; 17.7 percent are Black; and 5.3 percent are Asian/Pacific Islander.[6]

Former welfare recipients are much less likely to have health insurance than the general public. Many employers of low-wage workers are not especially likely to offer coverage. When employers do offer coverage, many low-wage workers cannot afford it. In 1997, 34 percent of persons who have been off the welfare rolls for less than six months lack health insurance, as do 49 percent of those who have been off the welfare rolls for a year or more, according to the NSAF.[7]

All families who leave welfare are entitled to receive extended Medicaid benefits, called Transitional Medicaid Assistance, for six months regardless of their incomes. They may receive a second six months of Medicaid if their incomes (minus childcare expenses) are below 185 percent of the federal poverty level. Thirteen states have extended the duration of Transitional Medicaid Assistance to longer periods, typically for two years.[8]

In 14 states that separately report data for Transitional Medicaid Assistance, enrollment grew 33 percent between June 1997 and December 1999.[9] Despite this improvement, the high proportion of welfare leavers who are uninsured indicates that many families who are eligible for Transitional Medicaid Assistance are not receiving it.

Many families who were eligible for Medicaid or Transitional Medicaid Assistance lost coverage when they left welfare due to administrative problems. A number of states were slow to reprogram their computers or retrain their caseworkers to ensure that families meeting the Medicaid income and resource eligibility criteria, irrespective of *source* of income, continued to receive Medicaid. Many states still face significant challenges in this area.

Another administrative barrier is welfare "diversion." Since cash welfare assistance is no longer an entitlement for eligible families, states are allowed to require people to undertake job search activities or seek other forms of private help before applying for welfare. These diversion policies can improperly divert people from applying for Medicaid as well. Many uninsured low-income people do not know that they and their children are eligible for public health insurance coverage even if they are not receiving cash assistance. As a result, many families entitled to Medicaid remain uninformed about their right to complete Medicaid applications.

Finally, the welfare reform law barred the use of federal Medicaid matching funds to cover legal immigrants that enter the country after August 22, 1996. States wishing to preserve Medicaid eligibility for these recent immigrants have had to pay for such coverage entirely with state funds. As a result, many legal immigrants who previously would have been eligible for Medicaid have been rendered ineligible and remain uninsured.

There also has been a significant decline in health coverage among *eligible* immigrant parents and children due to the concern among many immigrants that accepting medical assistance for themselves or their families would render them "public charges" and lead to loss of immigration status. (For more on this issue, see the paper on immigrants.)

State Strategies & Innovations

To expand health coverage among children in low-income families, Congress created the State Children's Health Insurance Program (SCHIP) in 1997. States took advantage of increased funds from a booming economy and a large settlement with tobacco companies[10] to expand coverage.

SCHIP represents the largest potential increase in health care coverage since the enactment of Medicaid. The legislation was designed as a block grant and provided the states with an opportunity to expand health coverage for children in families with incomes below 200 percent of the federal poverty level.

All states have implemented SCHIP, and the vast majority have established income eligibility standards at or above 200 percent of the federal poverty level.[11] For example, the Children's Health Insurance Program in Washington covers 10,000 children in families with incomes up to 250 percent of the federal poverty level.[12] New York likewise covers children up to 250 percent of the federal poverty level, and three other states now cover children up to at least 300 percent of the federal poverty level.

Implementation of SCHIP started slowly, but between October 1, 1999, and September 30, 2000, approximately 3.3 million children gained access to the program.[13] In 1999, the number of uninsured children in the United States fell by 1 million, the first decrease in 12 years.[14] States' efforts to simplify application processes, combined with intensive outreach to eligible children, have also helped expand enrollment among children who are eligible for Medicaid. Notable state efforts to expand enrollment include that of Washington, which funded a marketing campaign to educate the public about public health coverage and other public benefits for people leaving public assistance.

As outreach efforts and efforts to streamline application and renewal procedures continue, it is likely that many additional children will gain access to Medicaid and SCHIP. Increasing enrollment is a sign of states' progress in reconceiving these programs as health insurance programs designed to expand coverage to low-income people.

Recent changes in the Medicaid law also make it easier for states to cover low-income workers with families. As noted above, 13 states have expanded Transitional Medicaid Assistance. In addition, 30 states[15] have used their authority under Section 1931 of the welfare law (which permits them to redefine income or assets) to extend Medicaid to a larger number of parents. Seventeen states have significantly expanded coverage for parents with incomes up to 100 percent of the poverty line or higher.[16]

For example, Family Health Plus, New York's expansion of coverage under Section 1931, will cover 600,000 uninsured low-income adults. Family Health Plus provides coverage to parents *and* single adults and contains no asset test.[17] Wisconsin, Minnesota, New Jersey, and

Rhode Island have obtained SCHIP waivers to cover uninsured parents of publicly insured children. In addition, half a dozen states have experimented with Medicaid's Health Insurance Premium Payment Program, a little-used (and administratively difficult) rule that allows the state to "buy into" employer health plans for eligible workers with Medicaid funds.[18]

While adults without dependent children at home are generally not eligible for Medicaid unless they are severely disabled, seven states have used waivers under Section 1115 of the Social Security Act to make uninsured childless adults eligible for Medicaid.[19] Also, three states have established state-funded programs that offer coverage to a limited number of childless adults.[20]

Implications for Federal Policy

As the federal government, states, and communities continue to look for ways to expand health insurance among low-income families and individuals, certain strategies appear particularly promising:

- Continue to expand health coverage for low-income parents so that all members of the family have coverage. One promising step in this direction is expanding health coverage for low-income parents so their income eligibility standards match those of their children. This would make an additional six million low-income parents eligible for public health coverage. Several studies indicate that parents are more likely to enroll their children in Medicaid or SCHIP if the parent can also enroll.
- Provide childless adults with the same level of coverage as other low-income people.
- Improve outreach. There are still approximately seven million uninsured children who are potentially eligible for Medicaid or SCHIP. With an economic downturn converging with increased health care costs and tightening state budgets improved outreach to former TANF recipients, especially non-workers, may become particularly important.
- Simplify application and recertification procedures and lengthen the time period between recertifications. Currently, approximately half of children reaching the end of their certification periods drop out of the program, either because their families are unaware of the need to recertify eligibility or because the renewal procedures are unduly cumbersome.
- Ensure that adults and children maintain Medicaid benefits as the parents move from welfare to work.
- Eliminate administrative barriers such as inappropriate computer coding and retrain eligibility workers to ensure that all eligible families continue to receive Medicaid.
- Given the high proportion of minority children and their parents without health insurance coverage, a study of the factors affecting their access to coverage should be undertaken with a view to designing effective measures to include in the general context of health reform.

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Endnotes

[1] "Health Insurance Coverage Status and Type of Coverage–All Persons by Sex, Race and Hispanic Origin: 1987 to 1999," *Current Population Survey* (U.S. Census Bureau, 2000).

[2] Charles T. Nelson and Robert J. Mills, *The March CPS Health Insurance Verification Question and Its Effect on Estimates of the Uninsured* (U.S. Bureau of the Census, August 2001). In March 2000, the Census Bureau made an important change to the Current Population Survey (CPS), the most widely used source of data on health insurance, to improve the survey's accuracy. Based on a methodology used in The Urban Institute's National Survey of America's Families, CPS included a confirmation question for the first time. As a result, the estimate of the number of uninsured people declined by 3.3 million, or 8 percent. This methodological change does not change the trends in health insurance coverage. Tens of millions are still uninsured – many millions more than ten years ago. Indeed, we now have a more accurate picture of the uninsured. They are poorer, in poorer health, and have less access to medical care than previously thought. See Stephen Zuckerman, Jennifer Haley, and John Holahan, "Health Insurance, Access, and Health Status of Nonelderly Adults: Findings from the National Survey of America's Families" and Genevieve Kenney, Lisa Dubay, and Jennifer Haley, "Health Insurance, Access, and Health Status of Children: Findings from the National Survey of America's Families," in *Snapshots of America's Families II: A View of the Nation and 13 States from the National Survey of America's Families, 1997–1999* (Urban Institute; October 2000).

[3] John Holahan and Niall Brennan, *Who Are the Adult Uninsured?* Policy Brief B-14 (The Urban Institute, March 2000).

[4] Zuckerman, Haley, and Holahan,"Health Insurance, Access, and Health Status of Nonelderly Adults.," *Snapshots of America's Families II: A View of the Nation and 13 States from the National Survey of America's Families, 1997-1999* (The Urban Institute; October 2000)

[5] People Without Health Insurance for the Entire Year: 1998 and 1999," Health Insurance Coverage: 1999, Table A, September 20, 1999, U. S. Census Bureau, U. S. Department of Commerce, Washington, D. C. Genevieve Kenney, Lisa Dubay, and Jennifer Haley, "Health Insurance, Access, and Health Status of Children: Findings from the National Survey of America's Families," in *Snapshots of America's Families II: A View of the Nation and 13 States from the National Survey of America's Families, 1997–1999* (Urban Institute; October 2000).

[6] Charles T. Nelson and Robert J. Mills, *The March CPS Health Insurance Verification Question and Its Effect on Estimates of the Uninsured* (U.S. Bureau of the Census, August 2001). Poor Children Without Health Insurance for the Entire Year by Age, Race, and Ethnicity: 1998 and 1999," Health Insurance Detailed Tables: 1999, Table 4, U. S. Census Bureau, November 3, 2000, U. S. Department of Commerce, Washington, D. C.

[7] Bowen Garrett and John Holahan, *Welfare Leavers, Medicaid Coverage, and Private Health Insurance*, Policy Brief B-13 (Urban Institute, March 2000).

[8] Arizona, California, Connecticut, Delaware, Nebraska, New Jersey, North Carolina, Rhode Island, South Carolina, Tennessee, Texas, Utah, and Vermont. See Madeleine Konig, State Coverage Matrix (Academy for Health Services Research and Health Policy, State Coverage Initiatives), http://www.statecoverage.org/matrix.htm.

[9] Eileen R. Ellis, Vernon K. Smith, and David M. Rousseau, *Medicaid Enrollment in 50 States (June 1997 to December 1999)* (Kaiser Commission on Medicaid and the Uninsured, October 2000).

[10] In 1998, the tobacco industry settled lawsuits with 46 states by agreeing to pay them $206 billion over 25 years. Four states (Florida, Minnesota, Mississippi, and Texas) had previously reached separate settlements with the tobacco industry amounting to $40 billion. States allocated over a third of the settlement funds ($3.678 billion in FY 2000 and FY 2001 and $3.12 billion in FY 2002) for health services, including Medicaid and SCHIP. New Jersey expanded Medicaid to 80,000 middle-class and working-poor adults without health insurance in a program called FamilyCare. Arizona directed tobacco settlement revenues to the Arizona Health Care Cost Containment Service program and provided coverage to an additional 100,000 uninsured people.

[11] Frank Ullman, Ian Hill, and Ruth Almeida, *CHIP: A Look at Emerging State Programs,* Policy Brief A-35 (Urban Institute, September 1999).

[12] Anne C. Petersen, *Building Bridges Between People and Policy: Devolution in Practice* (W.K. Kellogg Foundation, October 2001).

[13] Health Care Financing Administration, state-reported enrollment figures for October 1, 1998, through September 30, 2000. Available on the Internet at http://www.hcfa.gov/init/fy99-00.pdf.

[14] "Health Insurance Coverage Status and Type of Coverage–Children Under 18 by Age: 1987 to 1999," *Current Population Survey* (U.S. Census Bureau, 2000).

[15] Alaska, Arizona, Arkansas, California, Connecticut, District of Columbia, Florida, Iowa, Kansas, Maine, Maryland, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Vermont, Washington, Wisconsin, and Wyoming. Konig, State Coverage Matrix.

[16] California, Connecticut, Delaware, District of Columbia, Hawaii, Maine, Massachusetts, Minnesota, Missouri, New Jersey, New York, Ohio, Oregon, Rhode Island, Vermont, Washington, and Wisconsin. Konig, State Coverage Matrix and Jocelyn Guyer, Matthew Broaddus, and Annie Dude, *Millions of Mothers Lack Health Insurance Coverage* (Center on Budget and Policy Priorities; May 2001).

[17] Petersen, *Building Bridges Between People and Policy*.

[18] Iowa, Missouri, Pennsylvania, Texas, Virginia, and Wisconsin. Oregon's Family Health Insurance Assistance Program uses state dollars to help moderate-income families buy private coverage. Konig, State Coverage Matrix.

[19] Arizona, Delaware, Hawaii, New York, Oregon, Tennessee, and Vermont. Konig, State Coverage Matrix and Ellis, Smith, and Rousseau, *Medicaid Enrollment in 50 States*.

[20] Minnesota, Oregon, and Washington. Konig, State Coverage Matrix.

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