

Health Care Access for Uninsured Adults: A Strong Safety Net Is Not the Same as Insurance

John Holahan and Brenda Spillman

Substantial gaps in service use and care access between the uninsured and the insured are evident in all states, and the vulnerability of a state's safety net does not affect these gaps.

Nearly 43 million Americans were uninsured in 1999. The large number of individuals living without insurance remains a major health and public policy concern. Although these individuals have less health care access and service use, the uninsured do have some sources of care. A health care system, or "safety net," for the poor, comprising public hospitals, community health centers, local clinics, and some primary health care physicians, exists in all communities. However, the capacity of these systems and their sources of financial support vary widely.

States' uninsured rates, marketplace competition, Medicaid payment policies, and state and local financial support all exert pressure on the safety net. As a result, access for the uninsured can vary considerably across states and communities. Cunningham and Kemper (1998), after controlling for personal and health characteristics, find considerable differences across communities in the extent of unmet need and delays in obtaining care among the uninsured.

This brief examines the extent to which differences in the safety-net environment account for differences in the uninsured's access to and use of health care. After grouping states according to the vulnerability of various aspects of their health care safety nets, we examine whether low-income uninsured adults get less care and have poorer access in states where the safety net is weaker. We then explore whether

utilization and access gaps between the uninsured and the insured are narrower in states with stronger safety nets. The brief focuses on low-income adults, who are more likely to be uninsured and therefore dependent on the safety net, and on residents of metropolitan areas, where most states' safety-net resources are concentrated. It draws on representative samples of the population from 13 states—Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin—using data from the Urban Institute's National Survey of America's Families.

The analysis reveals that differences across states in some measures of care access for uninsured adults are consistent with differences in the levels of safety-net vulnerability. More striking, however, is the finding that substantial gaps in service use and care access between the uninsured and the insured are evident in all states and that the vulnerability of a state's safety net does not affect these gaps. Uninsured adults' access to care appears to be no worse where the safety net is more threatened and no better where it is under less pressure.

Defining the Safety Net

The structure of the safety net varies by state (Norton and Lipson 1998). In some jurisdictions, state, county, and other publicly owned systems provide most uncom-

pensated hospital and emergency care. In others, a mix of public and privately owned systems provide the bulk of support to the uninsured. In every state, community health centers as well as county and city health departments also provide subsidized or free care to those who cannot pay, although the extent of such services varies. Some states rely more heavily on direct state and local funding in caring for the uninsured, while others largely depend on the ability of providers to pass costs along to third-party payers.

A number of financial stresses appear to be adversely affecting all safety-net providers, but providers in some areas appear to be under more pressure. In particular, providers in states with high uninsured rates, such as California, Florida, and Texas, are likely to see higher demand for care from individuals who cannot pay than do those in states with low uninsured rates, such as Massachusetts, Minnesota, and Wisconsin.

The growth of managed care may also affect some states' safety nets, as downward pressure on payments by plans tighten provider budgets. Such pressure is less likely in states where fee-for-service insurance remains prevalent, such as Alabama, Mississippi, and Michigan. Safety-net providers in these states are more likely to be able to finance charity care through cross-subsidies from third-party insurers. In contrast, in states where managed care is well established, such as California and Minnesota, intense marketplace competition among managed care plans could cause the surplus revenues from privately insured patients to shrink. As surpluses decline, fewer providers may be willing to serve indigent patients. Furthermore, if plans are able to negotiate more favorable contracts with other providers, higher-cost, lower-margin safety-net hospitals may not be able to compete. Similarly, increased competition in states with large numbers

of for-profit hospitals could make it harder for all hospitals, particularly low-margin safety-net hospitals, to provide free or subsidized care.

Medicaid managed care can also increase competition and erode the uninsured safety net. Under Medicaid managed care, Medicaid patients, particularly healthier, less costly ones, may be attracted away from safety-net hospitals to other hospitals. Even if safety-net providers can compete effectively for managed care patients, they may be hurt by managed care's impact on their payment rates. Some state Medicaid programs protect safety-net providers from the effects of managed care, but the extent of such protections varies widely.

States' safety nets also depend on disproportionate share payments (DSH)—direct Medicaid subsidies to hospitals that provide a large share of care to the low-income population. As with other sources of funding, state use of these programs varies considerably. Alabama, California, Mississippi, and Texas receive relatively high DSH payments, while Florida, Minnesota, Washington, and Wisconsin receive limited DSH support. Some states also rely on other kinds of financing. For example, in New Jersey, New York, and Massachusetts, state charity-care pools provide additional support to hospitals that provide high levels of charity care.

Finally, local revenues are important to safety-net providers. Often city or county governments fill in the gaps when all other sources of revenues have been exhausted. In Florida (Miami and Tampa), lawmakers increased local taxes in the early 1990s to support care to the poor. In contrast, the level of local support for the Harris County, Texas, hospital district (Houston) has been an ongoing issue (Meyer, Legnini, Fatula, and Stepnick 1999).

Based on case studies conducted for the Urban Institute's *Assessing the New Federalism* project in 1997,

Norton and Lipson (1998) concluded that despite the array of stresses on the safety net, providers were able to maintain their commitment to the low-income uninsured, even in areas experiencing the greatest financial pressure. They concluded that the safety net was holding steady because (1) few communities experienced all of the potentially adverse factors at the same time, (2) most safety-net providers responded quickly to pressures as they arose, and (3) states and localities also responded promptly to the needs of safety-net institutions. Safety-net providers responded to threats by joining or developing managed care plans, increasing efficiency, reducing costs, improving the quality of care or service to patients to compete with other providers, developing new ways to manage care for the uninsured, and effectively lobbying for financial support at the federal, state, and local levels.

Assessing State Vulnerability

This analysis divides 13 states' safety net systems into three categories—most vulnerable, somewhat vulnerable, and least vulnerable—using an approach developed by Norton and Lipson (1998). Norton and Lipson's original measure of vulnerability incorporated information on uninsurance rates, the percentage of commercial managed care penetration, the percentage of hospitals that are for-profit, the penetration of Medicaid managed care, and federal and state support for inpatient care. While using the same basic approach, several measures were added that resulted in some changes in the assignment of states (table 1).

California, Florida, and Texas are classified as having the most vulnerable safety nets in this study. These three states have the highest adult uninsurance rates, relatively high commercial managed care penetration, and/or a high share of for-profit hospitals. California also has a high percentage of enrollees in Medicaid

TABLE 1. Factors Affecting the Safety Net in Study States

	Percent Uninsured	State Programs Covering Low Income Adults, 1997	Bad Debt and Charity Case Pools	Federal DSH Payments per Uninsured	Percent of Medicaid Enrollees in HMOs 1997	Percent of State Population in HMOs	Ratio of For Profit Hospital Beds to All Beds	FQHCs per 100,000 Low-income Persons	Public Beds per 1,000 Low-income Persons
Most Vulnerable									
California	21.2			181	67.9	44.0	.18	1.7	2.0
Florida	18.8			46	0.0	29.0	.35	1.4	2.2
Texas	26.0			170	15.0	16.0	.35	0.9	1.7
Somewhat Vulnerable									
Alabama	14.4			422	0.0	12.0	.22	1.9	7.4
Mississippi	20.0			262	0.9	4.0	.18	4.2	12.0
New York	15.5	X	X	201	25.7	33.0	.04	2.2	4.5
New Jersey	13.9		X	276	73.8	29.0	.03	0.0	4.7
California	19.1			120	48.5	33.0	.18	4.1	2.5
Mississippi	11.1			53	63.4	27.0	.02	1.8	1.6
Least Vulnerable									
Massachusetts	8.3	X	X	277	62.4	39.0	.08	0.0	3.5
Minnesota	7.5	X		60	28.6	41.0	.01	3.7	4.1
Washington	12.9	X		170	54.5	27.0	.06	3.4	2.3
Wisconsin	9.7			11	61.7	36.0	.02	2.5	3.0

managed care and the lowest capita- tion rates in the nation (Holahan and Shirmer 2000). In 1997, none of these states had programs other than basic Medicaid that provided insurance to low-income adults. Compared with other states, federal DSH payments are moderate in California and Texas and low in Florida. Recent research also reports problems in sustaining local government support for providers in Texas (Meyer et al. 1999).

Massachusetts, Minnesota, Washington, and Wisconsin have the least vulnerable safety nets. These states have relatively low uninsurance rates, and in 1997, all but Wisconsin provided subsidized insurance cover- age to low-income adults. Each of these four states has fairly large Medicaid managed care programs, but none has been particularly aggres- sive in seeking cost savings.

The safety nets of the remaining six states—Alabama, Mississippi, New York, New Jersey, Colorado, and Michigan—are somewhat vulnerable. These states fall in the middle category for different reasons. While Alabama and Mississippi have rela- tively high rates of uninsurance, they have low private managed care pene- tration, virtually no Medicaid man- aged care, and high federal dispro- portionate share payments. Alabama and Mississippi also have a high number of Federally Qualified Health Centers

(FQHCs) per capita and the highest number of public hospital beds per low-income person among the 13 states. FQHCs are nonprofit, tax- exempt, or public facilities in medical- ly underserved areas, and they repre- sent a large share of community health centers serving the poor regardless of ability to pay. New York and New Jersey have moderate unin- surance rates, high disproportionate share payments and a history of sup- porting safety net institutions with bad debt and charity-care pools.

Colorado has a moderate uninsurance rate, high levels of market competi- tion, and moderate Medicaid man- aged care, but no specific program covering low-income adults and only moderate levels of disproportionate share payments. Michigan has a rela- tively low uninsurance rate, but no statewide programs providing subsi- dized insurance for low-income adults and an extensive program of Medicaid managed care.

The outcome measures examined here are having a usual source of care other than an emergency room, seeing a doctor, and having confidence in the ability to obtain care. The sample is low-income adults (incomes below 200 percent of the federal poverty level) living in urban areas. Limiting the sample to low-income individuals, who are more likely to use the safety net, keeps the economic situation of

the sample fairly homogeneous, except for insurance status.¹ We esti- mate regression models that control for differences in demographic charac- teristics, such as age, gender, family structure, race and ethnicity, educa- tion, income, self-reported health sta- tus, and presence of a disability. The models include a dummy variable for insurance status (full-year uninsured versus full-year insured), dummy variables for each state, and state- insurance interaction terms. The insurance status variable together with the state-insurance interaction terms allow us to measure state-by- state differences in access for the unin- sured; they also permit comparisons between the insured and uninsured within each state.

We also estimate models to assess the importance of differences in vul- nerability across states. In these mod- els, we include dummy variables to identify the three sets of states and interactions between insurance status and these vulnerability dummies. Unless otherwise noted, differences are significant at the 5 percent level in a two-tailed test.

The Safety Net's Effect on Three Outcome Measures

Figures 1 through 3 show the differ- ences among the three groups of states in the likelihood of having a usual source of care, a doctor visit, and confidence in the ability to obtain care when needed (full results are shown in table 2). In each figure, the states are grouped by safety-net vul- nerability and are shown from least vulnerable to most vulnerable.

Usual Source of Care

The uninsured in the most vulnerable states are less likely to have a usual source of care than are the uninsured in the other two groups (figure 1). (The difference between the least and somewhat vulnerable groups com- bined and the most vulnerable group is significant at the 10 percent level). Less than 60 percent of the uninsured

TABLE 2. Health Care Access and Utilization of Low-Income Adults, by Insurance Status and State Safety Net Vulnerability

	Has a Usual Source of Care		Had a physician visit last year		Has Confidence in Ability to Get Care	
	Insured	Uninsured ^(a)	Insured	Uninsured ^(a)	Insured	Uninsured ^(a)
Least vulnerable average	86.9 ^b	62.4 ^b	74.4 ^d	42.1	93.3 ^b	80.3
Massachusetts	87.3	62.9	76.5	38.0	92.8	82.3
Minnesota	84.5	63.1	76.4	43.9	95.5	77.4
Washington	88.6	61.0	73.2	46.1	92.8	78.2
Wisconsin	86.1	63.4	71.2	42.4	92.9	80.2
Somewhat vulnerable average	86.7 ^b	59.4	76.8 ^b	46.5	90.9	73.4
Alabama	84.3	64.3	76.1	45.4	93.3	76.1
Mississippi	79.8	55.1	65.3	40.6	90.9	77.4
New Jersey	82.2	61.6	70.0	48.8	89.1	77.3
New York	88.1	57.1	81.8	48.5	89.0	68.7
Colorado	85.9	62.4	66.4	38.4	91.0	79.4
Michigan	88.1	57.7	73.4	39.1	95.2	74.4
Most vulnerable average	79.4 ^c	52.1 ^e	65.2 ^c	36.9	87.6 ^e	72.6
California	77.9	49.4	61.6	33.8	84.6	68.3
Florida	85.5	57.5	74.8	37.0	91.6	73.1
Texas	74.9	51.2	60.3	39.3	89.7	77.3

Source: Regression estimates controlling for demographic characteristics and health.

a) Differences between the insured and the uninsured are significant at the 5 percent level in all case.

b) Significantly different from the most vulnerable group at the 5 percent level.

c) Significantly different from the somewhat vulnerable and least vulnerable groups combined at the 5 percent level.

d) Significantly different from the most vulnerable group at the 10 percent level.

e) Significantly different from the least and somewhat vulnerable groups combined at the 10 percent level.

in all three of the most vulnerable states have a usual source of care, with the percentage falling as low as 49.4 percent in California and 51.2 percent in Texas. In contrast, in all four least vulnerable states, the likelihood of having a usual source of care is more than 60 percent. The results for states in the somewhat vulnerable group vary. More than 60 percent of the uninsured have a usual source of care in Alabama, Colorado, and New Jersey; less than 60 percent do in New York, Mississippi, and Michigan.

Notably, a state’s vulnerability does not affect the magnitude of the access-to-care gap between the uninsured and the insured. The gap is at least 20 percentage points in all 13 states. The insured are at least 30 percent more likely than the uninsured to have a usual source of care in all states and more than 50 percent more likely in California, Michigan, and New York. Because both the insured and the uninsured are less likely to have a usual source of care in the most vulnerable states, however, the gap in access between them is not significantly larger than in the other two groups of states.

Seeing a Doctor

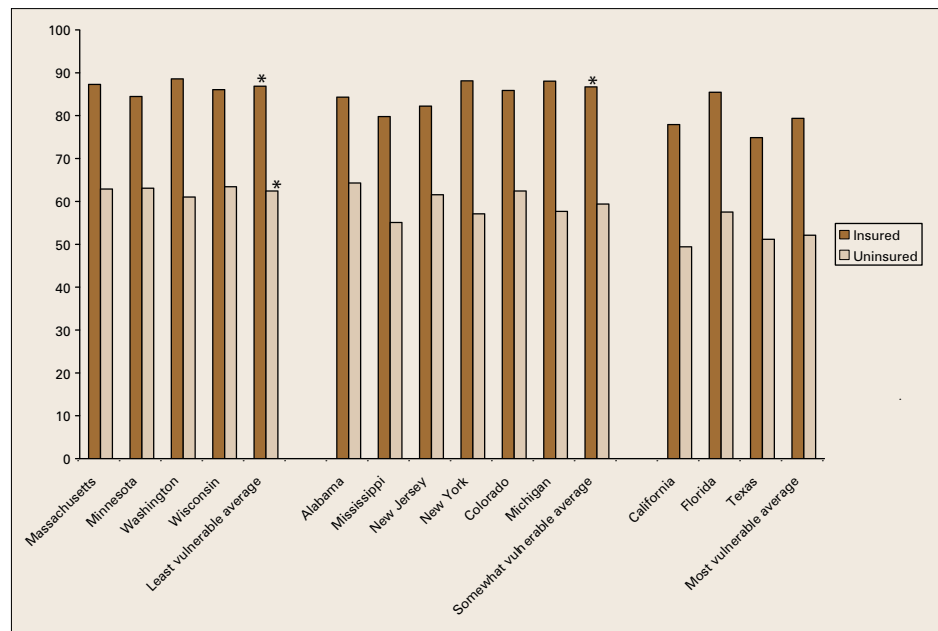
Figure 2 shows the percentage of low-income insured and uninsured

adults with a doctor visit. In the three states with the most vulnerable safety-net systems, 36.9 percent of the uninsured on average had a doctor visit; the results ranged from 33.8 percent in California to 39.3 percent in Texas. In contrast, in the four least vulnerable states, 42.1 percent of the uninsured had a doctor visit. However, the difference between the most and least vulnerable groups (42.1 percent and 36.9 percent) was not statistically significant. The larger

difference between the somewhat vulnerable and least vulnerable groups (46.5 percent and 36.9 percent) was significant at the 10 percent level. Again, more variation was evident within the somewhat vulnerable group, with the New Jersey and New York uninsured having almost a 50 percent likelihood of having a doctor visit, compared with 38.4 percent in Colorado and 39.1 percent in Michigan.

As with having a usual source of care, although the differences between the uninsured and the insured in every state are striking, they do not vary with the vulnerability of the safety-net system. The insured were more than 40 percent more likely than the uninsured to have a doctor visit in all 13 states; they were at least 50 percent more likely in 12 of the 13 states, and 75 percent more likely in four states: California, Florida, Massachusetts, and Michigan. Nevertheless, despite significant state-by-state differences in the likelihood of a doctor visit among insured adults (with a visit less likely, on average, in the most vulnerable states), the vulnerability of the safety-net system does not

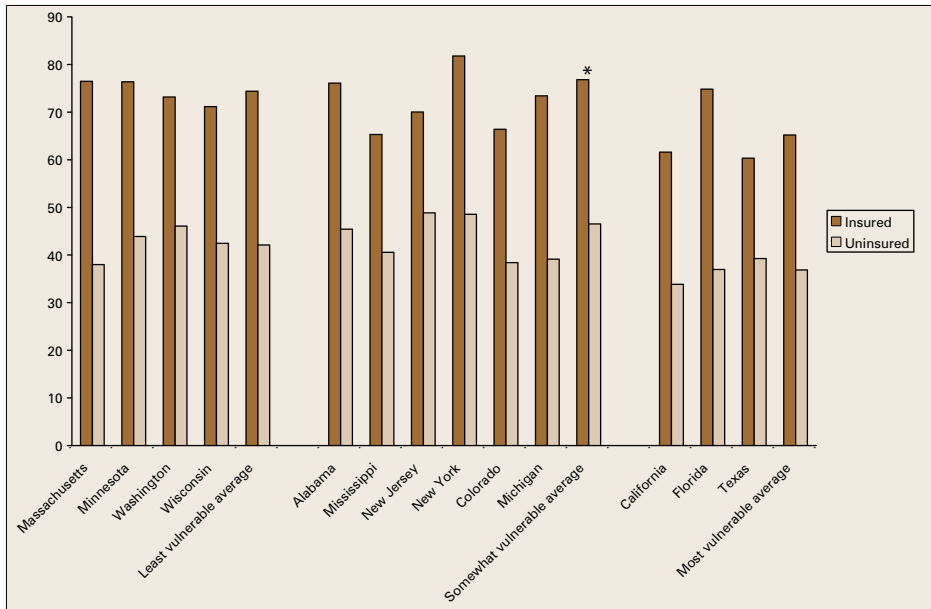
FIGURE 1. Predicted Probability of Having a Usual Source of Care (Low-Income Insured vs. Low-Income Uninsured)



Source: Regression estimates controlling for demographic characteristics and health.

* Significantly different from the most vulnerable group at the 5 percent level.

FIGURE 2. Predicted Probability of Having a Physician Visit (Low-Income Insured vs. Low-Income Uninsured)



Source: Regression estimates controlling for demographic characteristics and health.
* Significantly different from the most vulnerable group at the 5 percent level.

worsen the relative position of the uninsured. Indeed, the uninsured are no worse off relative to the insured in the most vulnerable states than in the other states.

Confidence in Obtaining Care

Overall, vulnerability of the safety net did not affect adults' confidence in their ability to obtain care when needed (figure 3). In the most vulnerable states, 72.6 percent of the uninsured were confident they could get care, compared with 80.3 percent in the least vulnerable states, but the difference between the two groups was not statistically significant. Some differences in confidence between individual states were significant. For example, 68.3 percent of the uninsured in California reported confidence in their access to care, versus 82.3 percent in Massachusetts.

The gaps between the uninsured and the insured are less dramatic for confidence than for the other measures. Still, the uninsured are significantly less likely than the insured to be confident in their ability to obtain care in all states. Almost all the insured in Michigan and Minnesota

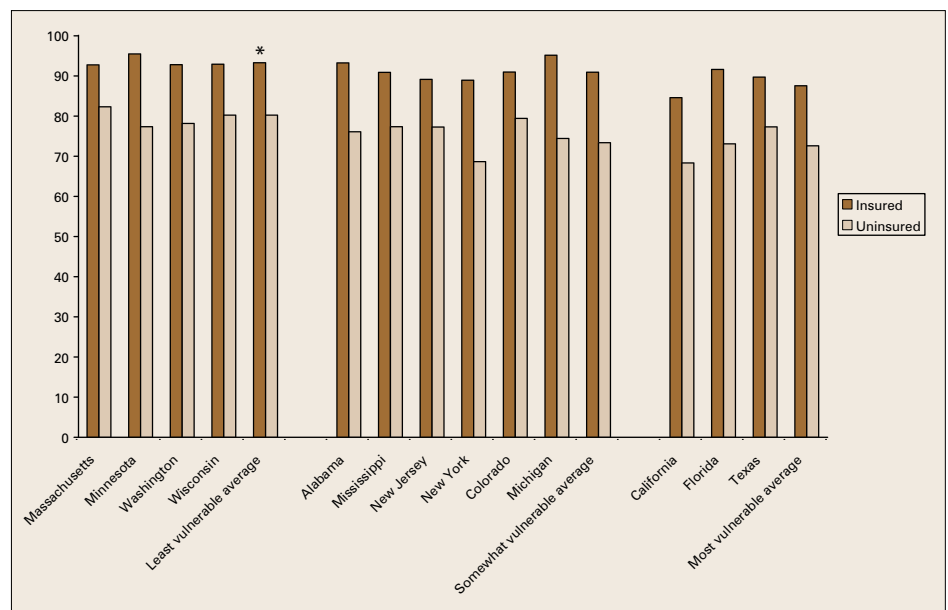
(more than 95 percent) reported having confidence, compared with about three-quarters of the uninsured in both states. In contrast, California had the lowest rate of confidence among the uninsured. In that state, however, the insured are also less likely to have confidence than the respondents in other states. Overall, the states' safety-

net vulnerability does not significantly affect the magnitude of the uninsured-insured gap. The least vulnerable states do no better than the most vulnerable in closing the confidence gap between the insured and uninsured.

Comparing the Low-Income Insured and High-Income Insured

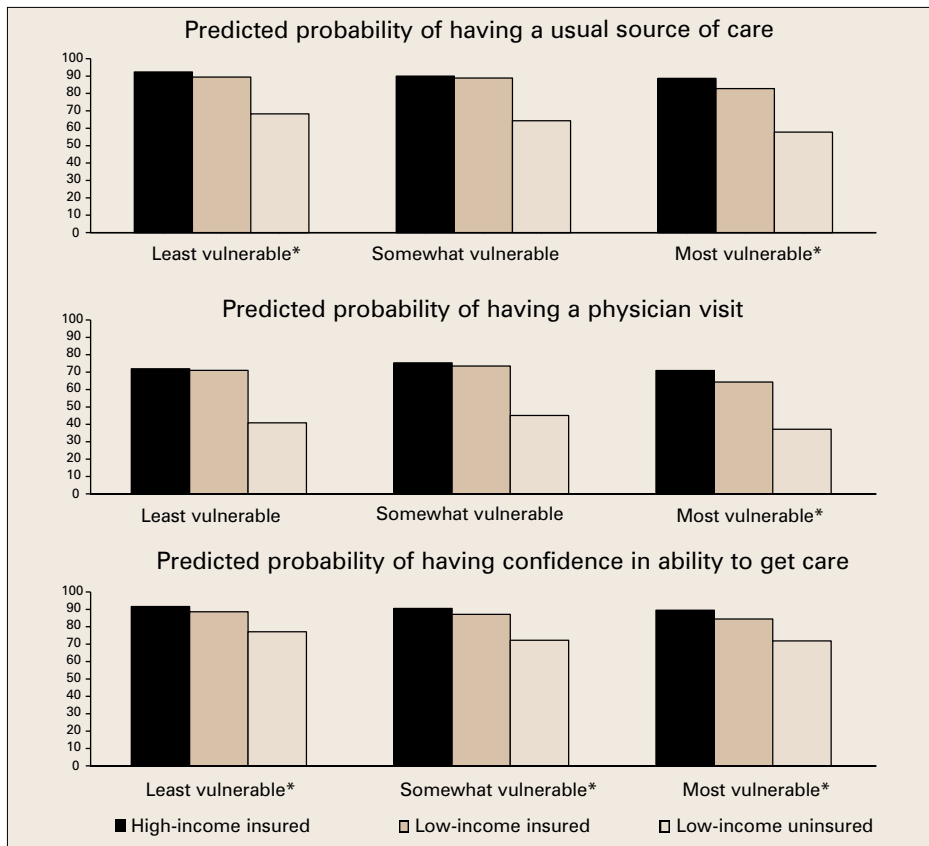
The vulnerability of a state's safety net adversely affects access to care, but it does not reduce or increase the gap in access that exists between the low-income uninsured and insured. As a final step, for all three outcome measures, we compare higher-income insured adults (incomes above 200 percent of the federal poverty level) with both low-income insured adults and low-income uninsured adults. This comparison shows whether obtaining insurance would likely increase currently uninsured adults' access to care to about the same levels shown for high-income insured adults. We would expect safety-net vulnerability to have a much smaller effect on higher-income insured adults, who generally have wide access to health care, than on both

FIGURE 3. Predicted Probability of Having Confidence in Ability to Get Care (Low-Income Insured vs. Low-Income Uninsured)



Source: Regression estimates controlling for demographic characteristics and health.
* Significantly different from the most vulnerable group at the 5 percent level.

FIGURE 4. Health Care Use and Access among High-Income Insured, Low-Income Insured, and Uninsured Adults, by State Safety-Net Vulnerability



Source: Regression estimates controlling for demographic characteristics and health.

*High income insured significantly different from low income insured at the 5 percent level.

low-income insured and uninsured adults.

As observed for the low-income population, higher-income insured adults in the states with the most vulnerable safety nets were less likely than those in the somewhat or least vulnerable states to have either a usual source of care, a physician visit, or confidence in their ability to get care (figure 4). This finding suggests that the factors that increase pressures on safety-net providers (e.g., managed-care penetration) also affect the broader health care system and access patterns in these states.

High-income insured adults, have higher care use and access than do low-income insured adults but differences are small when compared with use and access for the unin-

insured. In the most vulnerable states, the gap between low-income and high-income insured adults was only 5 to 7 percentage points for all three outcome measures. In contrast, the difference between uninsured adults and insured adults was more than 30 percentage points in the most vulnerable states for usual source of care and physician visits and about 19 percentage points for confidence. In the somewhat and least vulnerable states, differences between the high-income and low-income insured are even smaller, even where statistically significant. Being in a state with a less vulnerable safety net does not, however, improve the relative position of the uninsured. On the other hand, having insurance virtually eliminates differences in access to

care in the least and somewhat vulnerable states, and it nearly eliminates the gap where the safety net is most vulnerable.

Health Insurance Is the Best Way to Ensure Access

Our analysis shows some state-by-state differences among the uninsured according to the three measures we examined. With the exception of having a usual source of care, however, the differences are not related to safety-net vulnerability. Indeed, in states where the safety net is under greater stress because of higher uninsured rates among low-income adults, more managed care, less support of hospitals that provide charity care, and other factors, the uninsured do not appear to be significantly worse off than they are in states with less vulnerable safety nets. The health systems of the most vulnerable states appear to have found ways to respond despite the greater pressures.

More striking is the finding that the large gaps observed in care access and use between the low-income insured and uninsured populations are unrelated to the vulnerability of the safety net. The gaps in the most vulnerable states were no larger than in the other two groups of states for any of the measures. A true assessment of the impact of stress factors would need to examine shifts in access as safety-net conditions change. Nonetheless, our findings are consistent with providers' perceptions that they have managed to cope with demand in states where stresses were high.

The weakness of the safety net does not appear to worsen the uninsured's access to care. Conversely, a relatively strong safety net does not appear to improve their position relative to the insured. No matter how the uninsured are supported—whether by third-party payers, the presence of community health cen-

ters, a high level of disproportionate share payments, or local government subsidies—we find no evidence that these efforts have the ability to eliminate, or even narrow, barriers to access to the extent that insurance can.

Our results, which compare state-level aggregates of data for metropolitan areas, are consistent with results found in a companion study of access and use for low-income uninsured and insured adults by individual metropolitan areas (Spillman, Zuckerman, and Garrett 2001). That study uses a national sample and direct local measures of safety-net capacity (e.g. public hospital beds per capita and FQHCs per capita in the metropolitan area) and financial pressures on the safety net (e.g. the metropolitan area uninsurance rate, private managed care penetration, Medicaid managed care, and Medicaid hospital payment-to-cost ratios). It found a large and significant gap between the insured and uninsured for all measures of access and utilization that was not sensitive to safety-net conditions; more favorable safety-net conditions did not narrow the gap, nor did less favorable conditions widen it.

Our results have several implications. First, regardless of the safety net's vulnerability, the uninsured in all states do have access to and use services, although the levels are well below those of the insured. In 12 of the 13 states, more than 35 percent of the uninsured report having a physician visit. In 12 of 13 states, more than 50 percent have a usual source of care. And in all states, more than two-thirds have confidence in their ability to get care when they need it. The finding that the uninsured obtain care regardless of safety-net capacity or financial pressure, suggests that in areas with limited capacity or greater pressure either safety-net providers work harder to provide care, or other

providers in the community make up the difference.

An open question is whether local providers can continue to meet demand if financial pressures increase. Norton and Lipson (1998) argue that several vulnerability factors operating on a locality at once would likely hurt the area's safety net. Some sources of pressure may have worsened since 1997. An increase in the number of uninsured, declines in Medicare payments for graduate medical education, lower disproportionate share payments, growth of Medicaid managed care, a decline in federal DSH payments, and the spread of private managed care all may be putting greater pressure on local safety nets.

Finally, although the uninsured appear no worse off in states with the most vulnerable safety nets, that does not mean that the low-income population is not better off in some places. If the low-income population is significantly more likely to be insured within a state, they will have greater use of and access to care. For example, in Massachusetts, Minnesota, Washington, and Wisconsin, there are substantial programs providing insurance to low-income adults, and the low-income population is more likely to be insured. In California, Florida, and Texas, uninsured rates are considerably higher than elsewhere. Although the gaps between the uninsured and the insured show little variation among states, low-income populations clearly will be better off in states where they are more likely to be insured.

Endnotes

1. The sample includes only adults who are uninsured or insured for the entire year, to avoid potential bias in the estimated impact of insurance, or if we included those whose insurance status changed during the year (Marquis and Long 1994/5).

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This series presents findings from the 1997 and 1999 rounds of the National Survey of America's Families (NSAF). Information on more than 100,000 people was gathered in each round from more than 42,000 households with and without telephones that are representative of the nation as a whole and of 13 selected states (Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin). As in all surveys, the data are subject to sampling variability and other sources of error. Additional information on the NSAF can be obtained at <http://newfederalism.urban.org>.

The NSAF is part of *Assessing the New Federalism*, a multiyear project to monitor and assess the devolution of social programs from the federal to the state and local levels. Alan Weil is the project director. The project analyzes changes in income support, social services, and health programs. In collaboration with Child Trends, the project studies child and family well-being.

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