

Publicly Subsidized Health Insurance: A Typology Of State Approaches

Which state health insurance strategies are most successful in covering low-income Americans?

by Shruti Rajan

ABSTRACT: Using information from case studies, published documents, and the Current Population Survey, this paper describes and classifies state approaches to providing health insurance to low-income populations (as of 1997). It examines the link between the scope of state efforts and uninsurance rates for low-income populations. Findings indicate that the breadth of state policies contributes to differences in insurance coverage for low-income persons across states.

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EMPLOYER-SPONSORED HEALTH INSURANCE is the cornerstone of the U.S. health insurance system for the nonelderly population. Nearly 160 million children and nonelderly adults (66 percent) were covered by it in 1995.¹ Reliance on a voluntary system, however, inherently leaves a sizable gap in health insurance coverage: Persons without a connection to the workforce, and even many who are linked to the workforce, may not have access to affordable health insurance or may choose not to buy it. Nationwide, thirty-six million persons were uninsured in 1995.²

The rate of uninsurance varies greatly across states, from a low of 7.2 percent in Tennessee to a high of 25.7 percent in New Mexico. States have undertaken a number of strategies for addressing the needs of the uninsured.³ This paper focuses on publicly funded health insurance programs.⁴ States have used three main types of government-subsidized health insurance programs—Medicaid, General Assistance (GA) medical care, and other state-subsidized programs—to provide health insurance to low-income populations.

Medicaid covered thirty-five million persons at a cost of \$151 billion in 1995.⁵ With the passage of the Balanced Budget Act (BBA) of 1997, another federal/state program, the State Children's Health

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Insurance Program (CHIP), was created to provide subsidized health insurance to low-income children. Several states also have used GA programs to provide health insurance or have created state-subsidized health insurance programs to serve persons who are ineligible for Medicaid.

This paper examines the approaches states have taken in using these programs to cover the uninsured and the relationship between states' approaches and their uninsurance rates. As part of the Assessing the New Federalism (ANF) project, this research focuses on thirteen states: Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin.⁶ The ANF project is a large, multiyear research effort undertaken by the Urban Institute to monitor and analyze health care and social policies at the state level. This paper draws on information collected through in-depth case studies in the ANF states in late 1996 and early 1997, as well as on published documents. Unless otherwise noted, specific information on state programs is drawn from the case studies. Data from the March 1996 and 1995 Supplements to the Current Population Survey (CPS) are used to examine the composition of health insurance coverage nationally and across states.

Public Support For Health Insurance

Ultimately, the generosity of a state's approach is a function of how the state uses its subsidized programs to provide coverage to its low-income population. Before discussing the specific ways in which states have structured these programs, I present a brief description of each type of program.

■ **Medicaid.** Most prominent is the Medicaid program, a joint federal/state entitlement program that provides health insurance for certain low-income populations. Medicaid is administered at the state level, but responsibility for program funding and for setting program policy is shared by the federal and state governments.

States receive a federal financial match for their Medicaid expenditures. The federal match is adjusted to account for a state's fiscal capacity and ranges from 50 percent in states with higher capacity, such as New York, New Jersey, and Massachusetts, to 79 percent in states with relatively low capacity, such as Mississippi. Federal financial participation makes expansion of Medicaid eligibility appealing to states relative to expanding health insurance programs that are funded by state and local dollars.

States make many eligibility decisions within federal guidelines. Federal law requires states to provide Medicaid to three major populations. The largest group (56 percent of Medicaid enrollees in

1995) is made up of persons who receive cash assistance through either Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI).⁷ The second mandatory eligibility population, the “poverty-related” group, includes children up to age six and pregnant women with family incomes below 133 percent of the federal poverty line, as well as children under age nineteen with family incomes below the federal poverty level. Finally, the Medicaid program pays Medicare cost-sharing amounts on behalf of certain low-income Medicare beneficiaries.⁸

States may extend coverage to additional populations via “optional” Medicaid coverage rules. First, certain medically needy individuals may qualify for Medicaid. As of this writing, thirty-six states had such programs. Second, states may broaden poverty-related Medicaid coverage for pregnant women and for children under age one to as high as 185 percent of the federal poverty level. Twenty-eight states had exercised this option by 1996.⁹ In addition, through the 1902(r)(2) statute, states may disregard income and resources above the established limits for pregnant women, children under age nineteen, and qualified Medicare beneficiaries (QMBs). This statute has been particularly important in raising eligibility standards for children age six and older; twelve states used this option in 1996.¹⁰ Finally, states may set a special income standard for institutionalized persons. This standard may not exceed 300 percent of the basic SSI benefit.

States also may broaden Medicaid eligibility through Section 1115 waivers, which have grown increasingly popular among states since 1993. Some states have broadened eligibility to all uninsured persons with incomes below a certain level. Other states have leveraged federal matching funds by using Section 1115 waivers to extend Medicaid coverage to participants in GA and other state-subsidized programs.

■ **General Assistance.** State GA programs provide cash or in-kind assistance primarily to temporarily disabled, low-income persons who do not qualify for federal assistance programs, such as AFDC (Temporary Assistance to Needy Families [TANF] as of 1997), SSI, or Medicaid. Of the forty-two states with GA programs, thirty-two provide both medical and cash assistance.¹¹ Although the amount of cash or in-kind assistance offered by GA programs is generally low, medical coverage under such programs can be generous and in many instances is comparable to Medicaid coverage. Despite their significance to the safety net, the recession and subsequent state budget reductions in the early 1990s caused states to scale back GA spending, according to one report.¹²

■ **Other state-subsidized programs.** Freedom from federal oversight and mandates has made state-subsidized programs in-

“‘Comprehensive’ states tend to maximize Medicaid eligibility standards and thus take advantage of federal financial participation.”

creasingly attractive to state policymakers.¹³ Fourteen states had established state-subsidized programs as of 1996.¹⁴ Many of these programs target uninsured children, and several have expanded eligibility over the years to cover broader uninsured populations, such as low-income working adults without access to insurance.

These state programs depart from the Medicaid model by offering coverage to a wide range of populations (including childless adults), limiting service coverage and enrollment levels, and imposing beneficiary cost sharing. In fact, many states have designed their programs to promote self-sufficiency and avoid the “welfare stigma” often associated with Medicaid and GA. A major attraction of these programs is that they do not have to be open-ended entitlement programs.

Some states have used Section 1115 demonstrations to leverage Medicaid federal matching funds for their programs. A few states have integrated Medicaid, GA, and state-subsidized programs into a single program under these demonstrations. Other states have kept their state-subsidized programs separate from Medicaid but have negotiated a federal financial match for state spending on participants who would be eligible for Medicaid under a 1902(r)(2) expansion.

A Typology Of States’ Health Insurance Systems

States’ publicly supported health insurance programs can be classified into three broad coverage categories (comprehensive, moderate, and limited). The “comprehensive” category includes states that tend to maximize Medicaid eligibility standards and thus take advantage of federal financial participation. These states also use state funds to finance insurance coverage through GA medical care, state-subsidized programs, or both. The “moderate” category includes states that also tend to maximize federal financial participation and implement broad Medicaid eligibility standards but do little to provide insurance coverage using only their own funds. Finally, the “limited” category includes states that have extended Medicaid coverage little beyond federal requirements and thus have not taken advantage of the federal matching funds (despite the high federal matching rate in many of these states). In addition, these states typically have not used state or local monies to support health insurance programs for the uninsured.

Each state’s approach was classified based on the scope of the state’s Medicaid eligibility standards and the extent of coverage provided through its GA medical care and state-subsidized pro-

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grams. The generosity of Medicaid eligibility was assessed by considering, among other factors, AFDC income limits, the extent of expansion of eligibility beyond mandatory populations, and the percentage of low-income (below 200 percent of poverty) populations eligible for Medicaid.¹⁵ The existence and size (in terms of enrollment) of a GA medical care and/or another state-subsidized health insurance program also were taken into account. A comparison of the relative sizes of the programs was based on the ratio of enrollees (from each program) to uninsured persons in a state.¹⁶

■ **“Comprehensive” states.** Four states—Massachusetts, Minnesota, New York, and Washington—fall into the “comprehensive” category (Exhibit 1). These states traditionally have taken a progres-

EXHIBIT 1
Key Features Of Publicly Sponsored Health Insurance Programs And Insurance Market Reforms In ‘Comprehensive’ ANF States

	Massachusetts	Minnesota	New York	Washington
Medicaid				
AFDC income limit as percent of poverty for a family of three ^{a,b}	54%	49%	53%	51%
Income limit for pregnant women and infants (as percent of poverty) ^a	185	275	185	185
Income limit for children age 1 and older (as percent of poverty) ^a	133	275	133	200
Medically needy program ^a	Yes	Yes	Yes	Yes
Percent of nonelderly low-income population eligible for Medicaid ^{c,d,e}	50	43	53	56
Nonelderly participation rate (enrollees/eligibles) ^{c,f}	84	71	81	69
Enrollment (rounded to nearest thousand) ^g	693,000	438,000	2,902,000	772,000
General Assistance medical care programs				
Average monthly caseload ^h	20,395	15,312	279,179	17,167
Other state-subsidized programs				
Enrollment ⁱ	33,000 (4/97)	93,000 (7/96)	124,000 (7/97)	151,000 (7/96)
	16,700 (3/97)			
	3,500 (4/97)			

SOURCES: See below.

NOTES: ANF is Assessing the New Federalism (project). AFDC is Aid to Families with Dependent Children.

^a National Governors’ Association, *Maternal and Child Health Update—State Medicaid Coverage of Pregnant Women and Children* (Washington: NGA, 15 March 1996).

^b National average is 39 percent.

^c Tabulations from the March 1996 and March 1995 Supplements to the Current Population Survey (CPS) as edited by the Urban Institute’s Transfer Income Model (TRIM-2) microsimulation model.

^d Low-income population includes all persons in families with incomes below 200 percent of the federal poverty level.

^e National average is 47 percent.

^f National average is 81 percent.

^g D. Liska et al., *Medicaid Expenditures and Beneficiaries, 1995* (Washington: Urban Institute, 1995).

^h C. Uccello et al., *State General Assistance Programs—1996* (Washington: Urban Institute, October 1996).

ⁱ D. Lipson and S. Schrodell, *State Initiatives in Health Care Reform: State-Subsidized Insurance Programs for Low-Income People* (Washington: Alpha Center, November 1996). Also based on interviews with state officials for the ANF project. Massachusetts operates three other state-subsidized programs: CommonHealth, the Medical Security Plan, and the Children’s Medical Security Plan. The enrollment figures are listed in respective order.

sive approach toward their health care systems. All four have broad-based Medicaid eligibility and relatively far-reaching GA and state-subsidized insurance programs. Their commitment to creating a strong health care system is evident in other efforts, including the large uncompensated care pools to fund care for the uninsured in New York and Massachusetts, extensive insurance market reforms in New York, and the comprehensive health care reform legislation that was passed and implemented during the early 1990s in Minnesota, Massachusetts, and Washington.

Massachusetts. Massachusetts has developed a strong publicly funded health insurance system. It has set relatively high AFDC income limits and Medicaid coverage that extends beyond mandated levels to infants and pregnant women. The state operates a GA medical care program as well as three state-subsidized programs serving distinct target populations. The first of these, the Children's Medical Security Plan, offers coverage to all uninsured children; children from families with incomes below 200 percent of poverty receive subsidies. A second program, the Medical Security Plan, serves adults who have incomes up to 400 percent of the federal poverty line and are receiving state and federal unemployment benefits. The third program, CommonHealth, provides health insurance to working adults with disabilities and to children with disabilities who are ineligible for Medicaid. As of April 1997 the Children's Medical Security Plan was serving 33,000 children, the Medical Security Plan had 16,700 participants, and CommonHealth had about 3,500 enrollees.

Under its Section 1115 waiver program, the state plans to integrate the CommonHealth and Medical Security Plan into Medicaid. The structure of these programs would remain the same, but the state would begin to receive a federal financial match for program outlays. The demonstration also will expand Medicaid coverage to children with family incomes below 200 percent of poverty.

Minnesota. Minnesota has a long history of providing generous health care benefits to the poor. The state supports a comprehensive Medicaid program with broad service coverage and liberal eligibility standards. Through optional eligibility rules, Minnesota provides Medicaid coverage to children under age twenty-one and pregnant women with family incomes up to 275 percent of poverty. The state has been equally progressive with its GA medical care and state-subsidized health insurance program, MinnesotaCare. Eligibility for MinnesotaCare has been expanded since it began in 1992. Today the program covers children through age twenty-one with family incomes below 275 percent of poverty and single adults and childless couples with incomes up to 175 percent of poverty. Approximately

“New York has one of the most far-reaching publicly supported health insurance systems in the country.”

93,000 persons received health insurance through MinnesotaCare in 1995. In July 1995 the state expanded its Section 1115 waiver program and began receiving federal financial match for children and pregnant women enrolled in MinnesotaCare.

New York. New York has one of the most far-reaching publicly supported health insurance systems among the study states and in the country. The state’s AFDC income limit at 53 percent of poverty is among the highest across the study states. Medicaid eligibility for infants and pregnant women has been expanded beyond the federally mandated level, and the state offers a medically needy program. New York also is one of the most generous states in terms of its GA and other state-subsidized programs. Of the GA programs studied, New York’s Home Relief program stands out as being the most generous, in terms of both eligibility and service coverage; it is by far the largest, with an average monthly caseload of 279,200 in 1995. Similarly, New York’s state-subsidized Child Health Plus program for low-income children has relatively broad eligibility standards and covered 124,000 children as of July 1997. Reform legislation in 1996 nearly doubled funding for the Child Health Plus program. With this new funding, the state expanded both program benefits and eligibility. The program now covers children through age eighteen in families with incomes below 222 percent of poverty.

Washington. Washington State also has a history of implementing innovative, progressive health insurance programs for its low-income population. Medicaid eligibility is generous, covering all children under age nineteen with family incomes below 200 percent of the poverty line and pregnant women with incomes up to 185 percent of poverty (Exhibit 1). Washington’s Basic Health Plan (BHP) program was the first of its kind and has served as a model for other states. The BHP subsidizes individuals, families, or employers to purchase health insurance coverage from a specified group of plans. Persons with incomes up to 200 percent of poverty receive subsidies on a sliding scale, but those with higher incomes may join by paying the full premium. The employer buy-in option allows employers to purchase coverage for employees through the BHP, although few employers have chosen to participate. The state receives federal financial matching funds for children (under age nineteen) enrolled in the BHP.

■ **“Moderate” states.** The “moderate” category includes four

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states—California, Michigan, New Jersey, and Wisconsin—that have broad Medicaid eligibility standards but have not gone as far as states in the “comprehensive” group in terms of GA and fully state subsidized programs (Exhibit 2).

California. California has focused on maintaining broad eligibility for Medicaid and support for a county-based indigent (or uncompensated) care system. Moreover, unlike in most other states, health policy in California is complicated because of the large concentration of immigrants, many of whom are undocumented. With respect to Medicaid, the state’s AFDC income limit is well above the na-

EXHIBIT 2
Key Features Of Publicly Sponsored Health Insurance Programs And Insurance Market Reforms In ‘Moderate’ ANF States

	California	Michigan	New Jersey	Wisconsin
Medicaid				
AFDC income limit as percent of poverty for a family of three ^{a,b}	56%	51%	41%	48%
Income limit for pregnant women and infants (as percent of poverty) ^a	200	185	185	185
Income limit for children age 1 and older (as percent of poverty) ^a	133	150	133	185
Medically needy program ^a	Yes	Yes	Yes	Yes
Percent of nonelderly low-income population eligible for Medicaid ^{c,d,e}	57	54	44	45
Nonelderly participation rate (enrollees/eligibles) ^{c,f}	84	81	81	80
Enrollment (rounded to nearest thousand) ^g	6,192,000	1,302,000	747,000	525,000
General Assistance medical care programs				
Average monthly caseload ^h	- ⁱ	11,500 39,000	22,638	3,172
Other state-subsidized programs				
Enrollment ^j	250	- ⁱ	15,700 (3/97)	- ⁱ

SOURCES: See below.

NOTES: ANF is Assessing the New Federalism (project). AFDC is Aid to Families with Dependent Children.

^a National Governors’ Association, *Maternal and Child Health Update—State Medicaid Coverage of Pregnant Women and Children* (Washington: NGA, 15 March 1996).

^b National average is 39 percent.

^c Tabulations from the March 1996 and March 1995 Supplements to the Current Population Survey (CPS) as edited by the Urban Institute’s Transfer Income Model (TRIM-2) microsimulation model.

^d Low-income population includes all persons in families with incomes below 200 percent of the federal poverty level.

^e National average is 47 percent.

^f National average is 81 percent.

^g D. Liska et al., *Medicaid Expenditures and Beneficiaries, 1995* (Washington: Urban Institute, 1995).

^h C. Uccello et al., *State General Assistance Programs, 1996* (Washington: Urban Institute, October 1996). Counties in California have the choice of starting General Assistance (GA) programs and have broad discretion in designing these programs. GA is not a major source of publicly subsidized health insurance, however. Michigan’s GA enrollment reflects average monthly caseload for the State Medical Program (1995) and number of persons enrolled for the Wayne County PlusCare program (1996).

ⁱ Not applicable.

^j D. Lipson and S. Schrodel, *State Initiatives in Health Care Reform: State-Subsidized Insurance Programs for Low-Income People* (Washington: Alpha Center, November 1996). Also based on interviews with state officials for the ANF project. Average monthly caseload estimate from state.

tional average, and coverage has been extended to infants and pregnant women with incomes up to 200 percent of the federal poverty level. The state also operates a medically needy program. California does not have a GA program, and its Access for Infants and Mothers (AIM) Program serves an average monthly caseload of only 250.

Michigan. Michigan's Medicaid eligibility is broad, particularly for pregnant women and for children. Infants and pregnant women with incomes up to 185 percent of poverty and children up to age sixteen with incomes below 150 percent of poverty qualify to receive Medicaid benefits. Support for GA and other state-subsidized programs is limited. In the early 1990s the state's GA program suffered major cutbacks. A smaller residual GA medical care program, the State Medical Program, was established and had an average annual caseload of about 11,500 in 1995. Wayne County has continued operating a GA medical care program called PlusCare. This program served approximately 39,000 in 1996. The state has not established other subsidized health insurance programs.

New Jersey. New Jersey's Medicaid eligibility standards, although not as broad as Michigan's, are relatively generous. The state has set AFDC income limits above the national average, has established a medically needy program, and has expanded eligibility for pregnant women and for infants beyond the mandated level. Although the state operates a moderate-size GA program and a relatively small state-subsidized program for low-income persons, the primary focus of its health care reform efforts has been on market-based reforms. In fact, legislation creating the state-subsidized Health Access New Jersey program was passed in 1992, but efforts to implement the strong insurance market reforms (along with other factors) delayed its implementation until 1995.

Wisconsin. Wisconsin has extended Medicaid eligibility to children and pregnant women with family incomes up to 185 percent of poverty and operates a medically needy program. There is little support and, in fact, little need in Wisconsin for additional government efforts.¹⁷ Wisconsin has not established any other state-subsidized insurance program, and its GA program is small.

■ **"Limited" states.** The remaining five study states—Alabama, Colorado, Florida, Mississippi, and Texas—fall into the "limited" group (Exhibit 3). In these states Medicaid eligibility policies generally satisfy but do not go beyond federal requirements. Efforts to provide state-subsidized health insurance also are limited.

All five states have AFDC income standards lower than the mean national level. Alabama and Texas have the lowest limits, with AFDC income thresholds below 20 percent of poverty. Florida, Mississippi, and Texas have expanded eligibility to pregnant women

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EXHIBIT 3
Key Features Of Publicly Sponsored Health Insurance Programs And Insurance Market Reforms In 'Limited' ANF States

	Alabama	Colorado	Florida	Mississippi	Texas
Medicaid					
AFDC income limit as percent of poverty for a family of three ^{a,b}	15%	39%	28%	34%	17%
Income limit for pregnant women and infants (as percent of poverty) ^a	133	133	185	185	185
Income limit for children age 1 and older (as percent of poverty) ^a	133	133	133	133	133
Medically needy program ^a	No	No	Yes	No	Yes
Percent of nonelderly low-income population eligible for Medicaid ^{c,d,e}	33	30	44	45	38
Nonelderly participation rate (enrollees/eligibles) ^{c,f}	90	96	84	89	87
Enrollment (rounded to nearest thousand) ^g	490,000	297,000	1,899,000	457,000	2,573,000
Other state-subsidized programs					
Enrollment ⁱ	_h	_h	39,300 (8/97)	_h	_h

SOURCES: See below.

NOTES: ANF is Assessing the New Federalism (project). AFDC is Aid to Families with Dependent Children. None of these states offers a General Assistance medical care program.

^a National Governors' Association, *Maternal and Child Health Update—State Medicaid Coverage of Pregnant Women and Children* (Washington: NGA, 15 March 1996).

^b National average is 39 percent.

^c Tabulations from the March 1996 and March 1995 Supplements to the Current Population Survey (CPS) as edited by the Urban Institute's Transfer Income Model (TRIM-2) microsimulation model.

^d Low-income population includes all persons in families with incomes below 200 percent of the federal poverty level.

^e National average is 47 percent.

^f National average is 81 percent.

^g D. Liska et al., *Medicaid Expenditures and Beneficiaries, 1995* (Washington: Urban Institute, 1995).

^h Not applicable.

ⁱ Based on interviews with state officials for the ANF project.

and to infants beyond the federally mandated levels; medically needy programs are available only in Florida and Texas.

None of the states in this category has a GA medical care program, and only Florida operates a state-subsidized insurance program. The Florida Healthy Kids program operates in seventeen counties and provides coverage to uninsured children up to age nineteen. The program covered approximately 39,300 uninsured children (about 9 percent of all uninsured children in the state) in 1997.¹⁸

■ **Eligibility and enrollment.** The combined impact of these programs in reaching targeted populations is important to consider. That is, how far do Medicaid and other government programs go in offering health insurance to the uninsured? One measure of the overall impact of these policies is the percentage of the nonelderly low-income population that is eligible for Medicaid in each state.¹⁹

As shown in Exhibits 1–3, states in the “comprehensive” and “moderate” categories generally have a higher proportion of their

nonelderly poverty population eligible for Medicaid. (Recall that states in these two groups do not differ significantly in their Medicaid coverage but do vary in their support for state-funded programs.) California and Washington had the highest percentages of eligibles; Texas, Alabama, and Colorado, three states with more limited Medicaid eligibility standards, had the lowest.

Interestingly, however, several states with relatively generous eligibility guidelines (Wisconsin, New Jersey, and Minnesota) have a lower-than-average proportion of their poverty populations eligible for Medicaid. Although more restrictive in their eligibility standards for Medicaid, Florida and Mississippi had similar percentages of Medicaid eligibles. These results reflect in part the differing composition of low-income, nonelderly populations in these states (that is, a greater share of the poor populations had very low incomes).

Program eligibility rules by themselves do not tell the whole story. The extent to which eligible persons enroll in the program also is important to consider. In 1995, 81 percent of the 44.5 million eligible persons participated in Medicaid nationwide. Among the study states, participation rates ranged from 69 percent in Washington, a state with relatively generous eligibility standards, to 96 percent in Colorado, a state with narrower eligibility.

Similarly, several state-subsidized programs have had difficulty in reaching target populations for a variety of reasons, including insufficient funding and marketing and outreach difficulties. Participation rates in these programs are much lower than Medicaid participation rates; they ranged from a high of 64 percent in the Oregon Health Plan to a low of 3 percent in New Jersey Health Access.²⁰

Of the programs described here, MinnesotaCare has been one of the most effective in reaching its target population, with a participation rate of 56 percent.²¹ Nonetheless, actual enrollment levels in MinnesotaCare have consistently remained below projections. Washington's BHP also has experienced enrollment below estimated levels. In fact, policymakers there, concerned with low enrollment rates, reduced individual premium contribution levels to increase participation in the BHP. As a result, participation more than doubled from 69,000 in July 1995 to 151,000 in July 1996.

Impact In The States

Assuming that these state efforts to increase health insurance coverage are effective, we would expect states in the "comprehensive" and "moderate" groups to experience lower uninsurance rates, on average, than states in the "limited" group—especially for low-income persons, given that programs generally target coverage to them.

Our results support this hypothesis (Exhibit 4). The average un-

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EXHIBIT 4
Health Insurance Coverage Of Nonelderly Persons With Incomes Below 200 Percent
Of Poverty, By Scope Of Publicly Supported Health Insurance Programs, 1994-1995

State	Source of coverage			
	Employer-sponsored	Medicaid ^a	Other ^b	Uninsured
United States	34.6%	31.8%	6.9%	26.7%
Comprehensive	35.3	31.9	9.4	23.4
Massachusetts	39.5	30.6	7.0	22.9
Minnesota	38.9	24.6	17.2	19.3
New York	30.4	37.6	4.7	27.3
Washington	32.4	34.8	8.8	24.1
Moderate	35.9	33.2	6.1	24.8
California	25.9	40.9	4.0	29.1
Michigan	41.3	34.6	4.8	19.4
New Jersey	31.8	29.5	7.9	30.8
Wisconsin	44.6	27.8	7.7	19.9
Limited	35.2	26.9	7.4	30.5
Alabama	40.4	23.7	7.4	28.5
Colorado	44.6	19.3	8.9	27.2
Florida	30.5	31.2	9.0	29.3
Mississippi	33.3	32.2	6.2	28.2
Texas	27.1	28.3	5.3	39.2

SOURCE: Urban Institute tabulations of the March 1995 and March 1996 Supplement to the Current Population Survey (CPS).

^a Estimates have been corrected for underreporting of Medicaid coverage using the Urban Institute's Transfer Income Model (TRIM-2) microsimulation model.

^b Includes individually purchased plans, nonelderly Medicare enrollees, military insurance, and other state-subsidized health insurance programs. The CPS insurance categories do not allow us to distinguish clearly between other state-subsidized health insurance programs and other public programs.

insurance rate for low-income populations in states with the farthest-reaching public efforts is lower than the average for the "moderate" category. The states in the "limited" group have an uninsurance rate for low-income persons that is nearly 30 percent higher than the average for the remaining study states.

Given that the main distinction between the "comprehensive" and "moderate" categories is the existence and size of GA and other state-supported programs, the relatively small differential in uninsurance rates emphasizes the magnitude and importance of Medicaid in public health insurance systems. This is not surprising, given the size of GA and other state programs relative to Medicaid.

Although important for many persons, GA medical care programs generally have had a small impact on insuring indigent populations, even in the "comprehensive" states. Average monthly caseload estimates indicate that GA medical care programs in the eight study states with such programs covered about 595,000 nonelderly uninsured persons (7.9 percent). Likewise, the ten state-subsidized programs among our study states have covered 550,000 persons (3.3 percent).

Significance of Medicaid. Analysis of the composition of health insur-

“Nationally, Medicaid insured nearly the same proportion of low-income persons as did employer-sponsored coverage.”

ance coverage highlights the significance of Medicaid in providing coverage to low-income populations. Nationally, Medicaid insured nearly the same proportion of low-income persons as did employer-sponsored coverage (Exhibit 4). In contrast, the percentage of all nonelderly persons with employer-sponsored coverage was more than five times the percentage with Medicaid coverage.

Among the three groups of study states, employer-sponsored coverage rates were comparable at about 35 percent. However, Medicaid coverage levels were higher on average among states in the “comprehensive” and “moderate” groups than among states in the “limited” category. “Comprehensive” and “moderate” states had above-average Medicaid coverage rates (Exhibit 4). Medicaid coverage in the five states in the “limited” category fell nearly five percentage points below the national average.

Differences in the composition of insurance coverage across the three categories are similar for low-income adults but are more striking if we consider coverage for low-income children (Exhibit 5).²² Low-income adults in states with more limited publicly funded

EXHIBIT 5
Health Insurance Coverage Of Nonelderly Adults And Children With Incomes Below 200 Percent Of Poverty, By Scope Of Publicly Supported Health Insurance Programs, 1994–1995

Population	Source of coverage			
	Employer-sponsored	Medicaid ^a	Other ^b	Uninsured
United States	34.6%	31.8%	6.9%	26.7%
Adults	34.9	20.8	9.5	34.9
Comprehensive	34.9	21.6	11.6	32.0
Moderate	36.1	22.8	8.0	33.2
Limited	35.3	15.9	10.6	38.2
Children	34.2	48.5	4.1	14.3
Comprehensive ^c	36.0	49.7	6.2	8.7
Moderate	35.7	49.1	3.2	12.1
Limited ^c	35.2	43.9	2.8	18.7

SOURCE: Urban Institute tabulations of the March 1995 and March 1996 Supplement to the Current Population Survey (CPS).

^a Estimates have been corrected for underreporting of Medicaid coverage using the Urban Institute’s Transfer Income Model (TRIM-2) microsimulation model.

^b Includes individually purchased plans, nonelderly Medicare enrollees, military insurance, and other state-subsidized health insurance programs. The CPS insurance categories do not allow us to distinguish clearly between other state-subsidized health insurance programs and other public programs.

^c Sample size for “other” coverage of low-income children in some states is small. Estimates of “other” coverage in the comprehensive and limited categories include only those states where we have more than five unweighted observations.

insurance programs are more likely to be uninsured than are their counterparts in states with broader programs. The uninsurance rate is lowest in the “comprehensive” category and highest in the “limited” group. Employer-sponsored coverage levels for low-income adults are relatively comparable across the three categories. Medicaid coverage in the “comprehensive” and “moderate” categories is about 40 percent higher than in the “limited” category.

As with adults, more low-income children were uninsured in states with more restrictive publicly funded health insurance programs than in other states. Again, the uninsurance rate was lowest in the “comprehensive” states and highest in the “limited” states. Employer-sponsored coverage levels were similar across the three categories and were comparable to employer coverage levels for adults. However, Medicaid, with its focus on families with children, covered a much higher percentage of low-income children than did employer-sponsored coverage. As expected, Medicaid coverage rates are also highest in the “comprehensive” and “moderate” states.

“Crowd-out” effect. An important question is whether broad-based publicly funded insurance programs “crowd out” or substitute for private coverage. Many have argued, and it is generally agreed, that there is some “crowding out” of private insurance but that the extent of the problem is difficult to estimate.²³ If there were considerable crowding out of private insurance, one would expect to see states with moderate or comprehensive publicly supported programs having consistently lower rates of employer-sponsored coverage than is true in states with more limited public programs.

There appears to be low correlation between the generosity of public programs and employer-sponsored insurance levels. Some states have generous public programs and lower-than-average rates of employer coverage for low-income persons (New York and California), and some have limited public programs and relatively high employer coverage for low-income populations (Alabama and Colorado). At the same time, several states have far-reaching public programs and high levels of employer coverage (Minnesota, Massachusetts, Wisconsin, and Michigan), and some states have neither broad public efforts nor high employer coverage (Texas and Mississippi). These patterns support the notion that the amount of substitution of public for private coverage is small.

Conclusions

The publicly supported health insurance programs discussed in this paper have been successful, on average, in filling some of the gaps in health insurance coverage left by our employment-based health insurance system. States with more comprehensive publicly sup-

ported health insurance programs, particularly those with broad Medicaid standards, have higher Medicaid coverage rates than do states with limited initiatives, and their low-income populations are less likely to be uninsured. In fact, Medicaid provided insurance to nearly the same percentage of low-income nonelderly persons as did employer-sponsored coverage. The program has been a particularly important source of coverage for low-income children: Medicaid covered 49 percent, and employer-sponsored coverage, 35 percent, of low-income children.

However, even in states with more comprehensive programs, government-supported health insurance programs were not designed to achieve universal coverage. Thus, these programs have allocated some resources to the most vulnerable populations but have left many persons, primarily childless adults, without access to affordable health insurance.

It is also important to remember that publicly funded health insurance is only part of the picture. Virtually all fifty states have passed legislation reforming the small-group insurance market. States also have used other approaches not based on insurance to meet the health care needs of the uninsured, such as support of safety-net providers. Charity or uncompensated care has been another significant means of providing medical care to under- and uninsured persons.²⁴ In California, county-based indigent care programs provided \$2.5 billion in subsidies (1992–1993) to providers serving medically indigent persons. New York and Massachusetts have established uncompensated care pools to subsidize hospitals and health centers providing charity care. New York's subsidies amounted to \$1.2 billion and Massachusetts's pool amounted to more than \$300 million in 1996.

Several states, although less generous in providing publicly supported health insurance, have alternative systems to meet the health care needs of the uninsured. Hospitals and physicians in Alabama have experienced less financial pressure, given the slow development of managed care there. These providers have been able to preserve a substantial financial cushion to subsidize care to the under- and uninsured. Providers and policymakers in Mississippi and Texas have attempted to provide access to care for the uninsured through a system of public hospitals and clinics. Although improving access to care is important, it is not equivalent to providing insurance: Uninsured persons are more likely to postpone getting needed medical care and are less likely to receive routine physician services.²⁵

Within the context of a voluntary, employment-based health care system, many factors affect the delivery of care to the under- and uninsured. Medicaid, GA, and other state-subsidized health insur-

ance programs have served millions of persons and will serve as a foundation from which states will plan for the new CHIP program and other expansions of publicly funded insurance.

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NOTES

1. Urban Institute tabulations of the March 1996 Supplement to the Current Population Survey (CPS). CPS files have been edited for underreporting of Medicaid by the Urban Institute's Transfer Income Model (TRIM-2) micro-simulation model.
2. Ibid.
3. Federal tax policy and other federal regulation, such as the Employee Retirement Income Security Act (ERISA), also affect the supply of employer-sponsored insurance. There is little political will to alter these regulations, and states have had little success receiving federal exemptions from ERISA.
4. See L.M. Nichols and L.J. Blumberg, "A Different Kind of 'New Federalism'? The Health Insurance Portability and Accountability Act of 1996," *Health Affairs* (May/June 1998): 25-42, for a discussion of states' efforts to regulate private insurance markets.
5. D. Liska et al., *Medicaid Expenditures and Beneficiaries: National and State Profiles and Trends, 1988-1994* (Washington: Urban Institute, November 1996).
6. A. Kondratas, A. Weil, and N. Goldstein, "Assessing the New Federalism: An Introduction," *Health Affairs* (May/June 1998): 17-24.
7. Despite the delinking of AFDC and Medicaid by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, these persons will remain eligible for Medicaid as long as they continue to meet the financial and categorical eligibility criteria once used for AFDC/SSI eligibility determination. In the remainder of this paper, the cash assistance program is referred to by its former name, AFDC, rather than its new name, Temporary Assistance to Needy Families (TANF).
8. These populations are known as qualified Medicare beneficiaries (QMBs) and specified low-income Medicare beneficiaries (SLMBs).
9. National Governors' Association, *Maternal and Child Health Update—State Medicaid Coverage of Pregnant Women and Children* (Washington: NGA, 15 March 1996).
10. Ibid.
11. C. Uccello, H. McCallum, and L. Gallagher, *State General Assistance Programs, 1996* (Washington: Urban Institute, October 1996).
12. M. Nichols and K. Porter, *General Assistance Programs: Gaps in the Safety Net* (Washington: Center on Budget and Policy Priorities, March 1995).

13. There are also a number of private (often with some public financial support) health insurance subsidy programs for low-income populations. The Blue Cross/Blue Shield Caring programs for children are examples of such programs to address the health care needs of the uninsured. In this paper we focus on health insurance subsidy programs funded and operated by state (and local) governments and operating in several counties or statewide.
14. D. Lipson and S. Schrodel, *State Initiatives in Health Care Reform: State-Subsidized Insurance Programs for Low-Income People* (Washington: Alpha Center, November 1996).
15. Information on the generosity of Medicaid eligibility policies was drawn from case studies, published documents, and tabulations of the CPS.
16. The estimated ratios tend to understate the magnitude of these programs in reaching the uninsured. Because small sample size does not allow us to estimate the number of low-income uninsured persons by state, we must define the target population as all uninsured persons in the state. However, most GA and other state-subsidized programs are targeted to low-income persons. Estimates of the number of uninsured were tabulated using the CPS.
17. Wisconsin, like New Jersey and Michigan, enjoys a high rate of employer coverage (see Exhibit 4).
18. Estimates of number of uninsured children in Florida from Urban Institute tabulations of the March 1995 and 1996 Supplements to the CPS.
19. This includes the population with incomes up to 200 percent of poverty. The focus is on Medicaid eligibility because it is not possible to estimate the size of the population eligible for GA and other state-subsidized programs using the CPS. The CPS does not allow for accurate identification of persons covered by GA and other state-subsidized programs, nor does it have adequate sample size at the state level to make reliable estimates of narrow subpopulations.
Estimating Medicaid eligibility and enrollment levels using data available from the CPS is complex. For example, because the CPS does not contain information on individuals' medical expenditures, it is difficult to estimate eligibility for a state's medically needy program. It also is not possible to estimate full-year or person months of Medicaid enrollment and eligibility using the CPS.
20. Lipson and Schrodel, *State Initiatives in Health Care Reform*.
21. Ibid.
22. Insurance coverage estimates are presented for the three categories rather than for each state, because sample size is insufficient to produce state-level estimates for these subpopulations.
23. L. Dubay and G. Kenney, "Did Medicaid Expansions for Pregnant Women Crowd Out Private Coverage?" *Health Affairs* (January/February 1997): 185-193; and D.M. Cutler and J. Gruber, "Medicaid and Private Insurance: Evidence and Implications," *Health Affairs* (January/February 1997): 194-200.
24. Such programs are largely supported by public funding from various sources, including Medicaid disproportionate-share hospital (DSH) funds, federal block grant monies, and state and local revenues.
25. B.C. Spillman, "The Impact of Being Uninsured on Utilization of Basic Health Care Services," *Inquiry* (Winter 1992): 452-466; J. Hadley, E. Steinberg, and J. Feder, "Comparison of Uninsured and Privately Insured Hospital Patients: Condition on Admission, Resource Use, and Outcome," *Journal of the American Hospital Association* (16 January 1991): 374-379; and A.B. Bindman et al., "Preventable Hospitalizations and Access to Health Care," *Journal of the American Medical Association* (26 July 1995): 305-311.