Snapshots of America's Families: Variations in Health Care across States

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Assessing the New Federalism

Assessing the New Federalism is a multiyear Urban Institute project designed to analyze the devolution of responsibility for social programs from the federal government to the states. It focuses primarily on health care, income security, employment and training programs, and social services. Researchers monitor program changes and fiscal developments. Alan Weil is the project director. In collaboration with Child Trends, the project studies changes in family well-being. The project provides timely, nonpartisan information to inform public debate and to help state and local decisionmakers carry out their new responsibilities more effectively.

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia. Publications and database are available free of charge on the Urban Institute's Web site: http://www.urban.org. This paper is one in a series of discussion papers analyzing information from these and other sources.

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Abstract

This paper presents preliminary findings from the 1997 National Survey of America's Families (NSAF), a household survey providing information on over 100,000 children and non-elderly adults representing the noninstitutionalized civilian population under age 65. Focusing on health insurance coverage and several measures of access to care we find that children are faring better than adults in terms of health insurance coverage, primarily due to recent Medicaid expansions, the CHIP program and other state-subsidized insurance efforts. We also find large variations in rates of uninsurance across states with such variations generally reflecting differences in private-sector coverage. Finally, we show that insurance coverage differences across states and between adults and children are correlated with differences in access to care and health status.

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Snapshots of America's Families: Variations in Health Care across States

The May/June 1998 issue of *Health Affairs* contained a series of articles describing the Urban Institute's *Assessing the New Federalism* (ANF) study and summarizing health policy case studies from 13 states (Kondratas, Weil, and Goldstein 1998). *Assessing the New Federalism* is a multiyear Urban Institute research project to analyze the devolution of responsibility for social programs from the federal government to the states, focusing primarily on health care, income security, job training, and social services. The case studies examined issues such as eligibility for public insurance, the effects of welfare reform, Medicaid managed care, Medicaid disproportionate share hospital (DSH) payments, long-term care for the elderly, and public health. The case studies found extensive variation in states' policies toward low-income families that tended to be a function of each state's political culture, values, and fiscal circumstances (Holahan, Wiener, and Wallin 1998).

In this paper, we present preliminary findings from the 1997 National Survey of America's Families (NSAF)—the household survey component of ANF—related to insurance coverage, health status, and access to care. The survey contains nationally representative data from almost 45,000 families throughout the entire distribution of income. NSAF is unique because (1) it contains information on a broad range of economic, social, and health care topics not otherwise available in a single survey; (2) the sample was designed to allow for state-specific estimates from the 13 case study states; and (3) low-income families (below 200 percent of the federal poverty level) were oversampled. The low-income oversample is particularly critical because the policies that ANF is studying have their greatest effect within this large and

potentially vulnerable group. The results discussed here focus on the differences across the 13 case study states for children and adults in low-income families.

These data, and the ANF project overall, should be viewed as a means of understanding the ongoing process of devolution that has been shifting more responsibility for designing social programs from the federal government to the states. Medicaid has always been a federal/state partnership. Within a set of federal rules, states have had flexibility in establishing criteria for eligibility, benefits, and provider payment and, with waivers, have moved to widespread adoption of managed care. States have also taken the initiative in developing DSH programs that play a major role in funding safety net hospitals. When Congress enacted a new program to provide coverage to more low-income children—the Children's Health Insurance Program—it gave the states even more of a role in setting eligibility rules and establishing the program's structure.

The results presented here serve as a starting point within the ANF study for analyzing how state policies may be affecting the well-being of low-income families.[1] We start by examining differences in current insurance coverage, health status, and usual source of care between adults and children at the national level. This overview documents the outcomes of policies within Medicaid, CHIP, and other state programs that have expanded coverage for children to a greater extent than they have for adults. We then report on state variation in these indicators for all children and adults and for low-income children and adults. The basic structure of the cross-state analysis is similar to earlier work by Cantor, Long, and Marquis (1998) using the 1993 Robert Wood Johnson Foundation Family Health Insurance Survey.

The National Survey of America's Families

The NSAF is a household survey that provides information on over 100,000 children and nonelderly adults representing the noninstitutionalized civilian population under age 65.[2] The NSAF sample was designed to provide both state-representative estimates in the 13 ANF sites *and* reliable national-level estimates. Approximately 3,000 interviews, on average, were completed in each of the 13 study sites, and 5,000 interviews in the balance of the nation.[3] In addition, the NSAF oversamples the low-income population. Over 40 percent of the interviews were conducted with low-income families (defined as those with incomes below 200 percent of the federal poverty level). In families with children, the respondent was the adult who knew the most about the children's education and health care.

The NSAF was conducted from February to November of 1997 using computer-assisted telephone interviewing (CATI) technology. Interviews were conducted in households with and without telephones. Families in households without telephones were interviewed using cellular telephones. The survey collected data on a broad range of topics, including income and employment, health care, child support, program participation, and family life, in addition to demographic and family structure information. In the area of health care, the survey asks about both current and past year's insurance coverage, managed care enrollment, health care use and access, and health status.

Responses to the interviews were weighted to provide estimates representative of the population in the 13 individual states as well as in the nation. The weights reflect the design features of the sample, including the oversampling of low-income households in the study states,

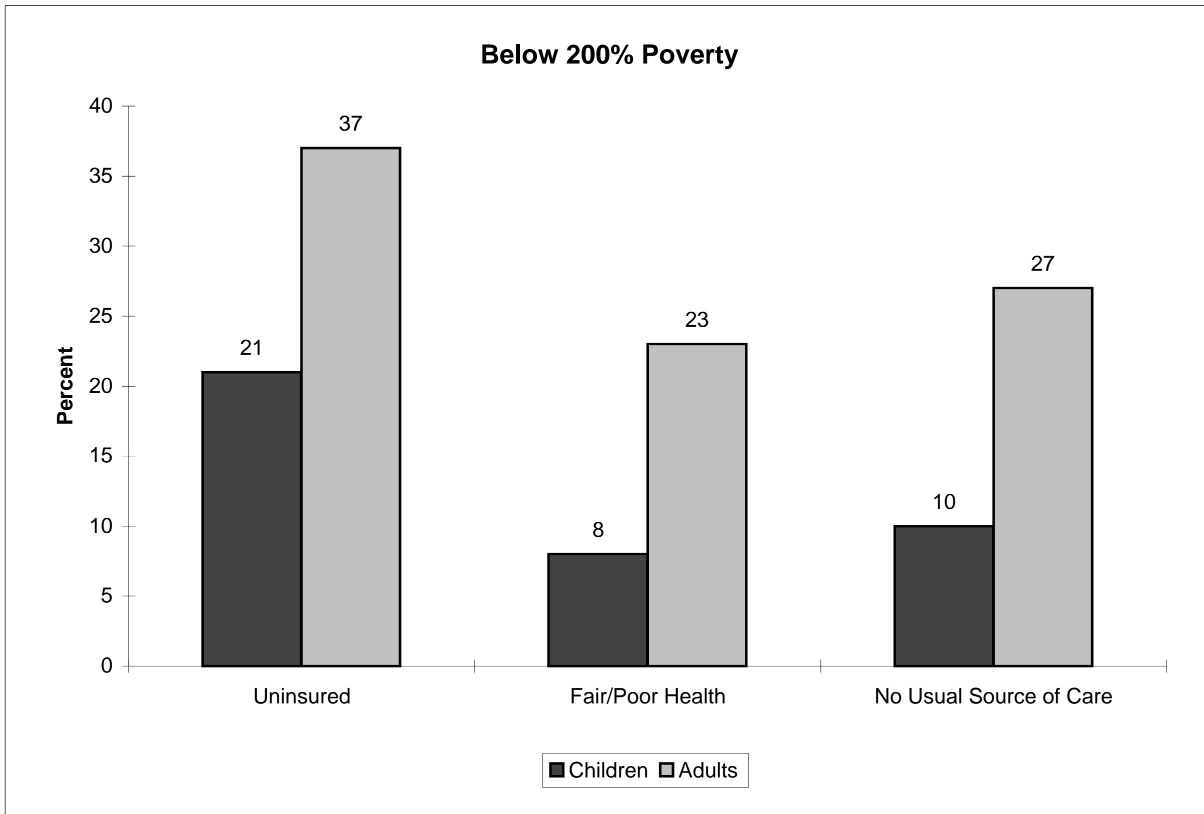
and contain adjustments for nonresponse and undercoverage. Because of the NSAF's complex sample design, we use the WesVar software package to compute accurate variance estimates.

Results

Adults and Children. We first present nationwide data that compare adults with children. Figure 1 provides data on rates of uninsurance, health status, and usual sources of care.[4] The upper panel shows that adults are much more likely to be uninsured, to be in fair or poor health, and to lack a usual source of care than children. For families of all incomes, 17 percent of adults are uninsured, compared with 12 percent of children. Adults are also three times more likely to lack a usual source of care (18 percent versus 6 percent) and more than twice as likely to be in fair or poor health (12 percent versus 5 percent). The gap in having a usual source of care is consistent with the gap in insurance coverage, but somewhat surprising, considering that adults are more likely to be in fair or poor health than children.

Both adults and children are worse off within low-income families, but the relative differences between adults and children are similar to those for all families. The upper panel of figure 1 shows that uninsurance rates were 21 percent for low-income children and 37 percent for low-income adults. Health status was worse for low-income adults—23 percent of low-income adults were in fair or poor health versus 8 percent of low-income children—and they were less likely to have a usual source of care—27 percent of low-income adults versus 10 percent of children lacked a usual source of care. Again, low-income adults are less likely to have a usual source of care, consistent with their being more likely to lack health insurance, but somewhat inconsistent with the fact that they are in poorer health.

Figure 1: Comparison of Adults and Children, by Income



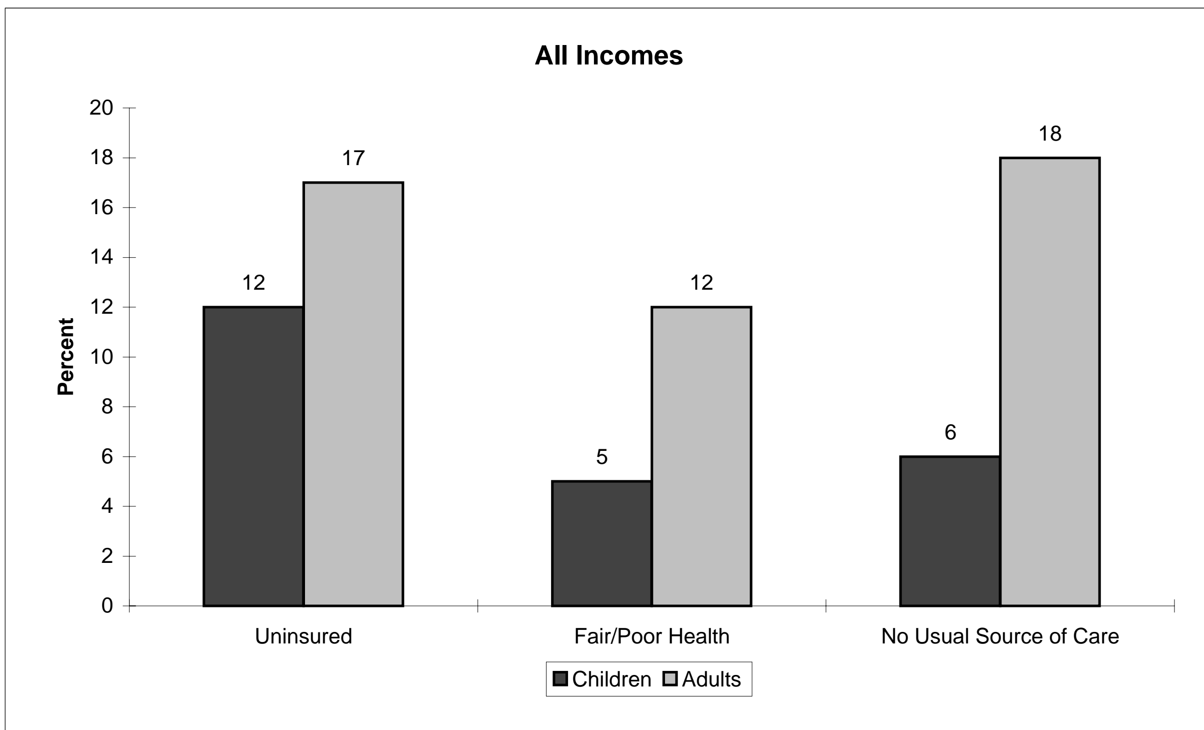


Table 1 examines the insurance coverage of adults and children in more detail. The data show that, for families of all incomes, adults are slightly more likely than children to have private coverage, 75 percent versus 69 percent. However, they are much less likely to be covered through public programs, 8 percent versus 20 percent. This results in a lower uninsurance rate for children than for adults.

Most of the differences between adults and children are because of the different insurance arrangements of those below 200 percent of poverty. Low-income adults are only slightly more likely to have private coverage than children, 44 percent versus 40 percent. However, low-income children are far more likely to have public coverage, 39 percent versus 20 percent, because of the poverty-related Medicaid expansions and because several states have other programs to subsidize health insurance for low-income children. The result of the more extensive public coverage of children is that the uninsurance rates for low-income children are substantially below those of low-income adults.

Children's Health Insurance. State differences in health insurance coverage of children are shown in figure 2. Employer-sponsored coverage for children of all incomes varies from a low of 56 to 58 percent (Mississippi, Texas) to a high of 84 percent (Wisconsin). Public coverage also varies from a high of 23 to 26 percent (California, Mississippi, New York, Texas, and Washington) to a low of 10 to 15 percent (Colorado, Minnesota, New Jersey, and Wisconsin). Public coverage is high where there are ambitious public programs that provide coverage, such as in California, New York, and Washington. Public coverage is also high where there is a large low-income population, such as Mississippi and Texas. The high levels of public coverage in California and New York reflect both broad coverage and large low-income populations. In

general, high levels of public coverage do not offset low levels of employer-sponsored coverage, with the result that states such as Mississippi and Texas have the highest uninsurance rates. Because of their high rates of employer-sponsored coverage, states such as Massachusetts, Michigan, Minnesota, and Wisconsin have the lowest rates of uninsurance.

Data in figure 3 show that public coverage has a greater impact among lower-income children than among all children. States with public programs that have had broad coverage expansions, e.g., Massachusetts and Washington, or where existing eligibility rules bring in large numbers of children because there are so many low-income families, e.g., California and New York, have the highest rates of public coverage. Public coverage does more to offset low employer-sponsored coverage among low-income children than for all children. For example, while New York and Washington have below-average rates of private coverage for low-income children, they have above-average rates of public coverage and, as a result, have below-average rates of uninsurance.

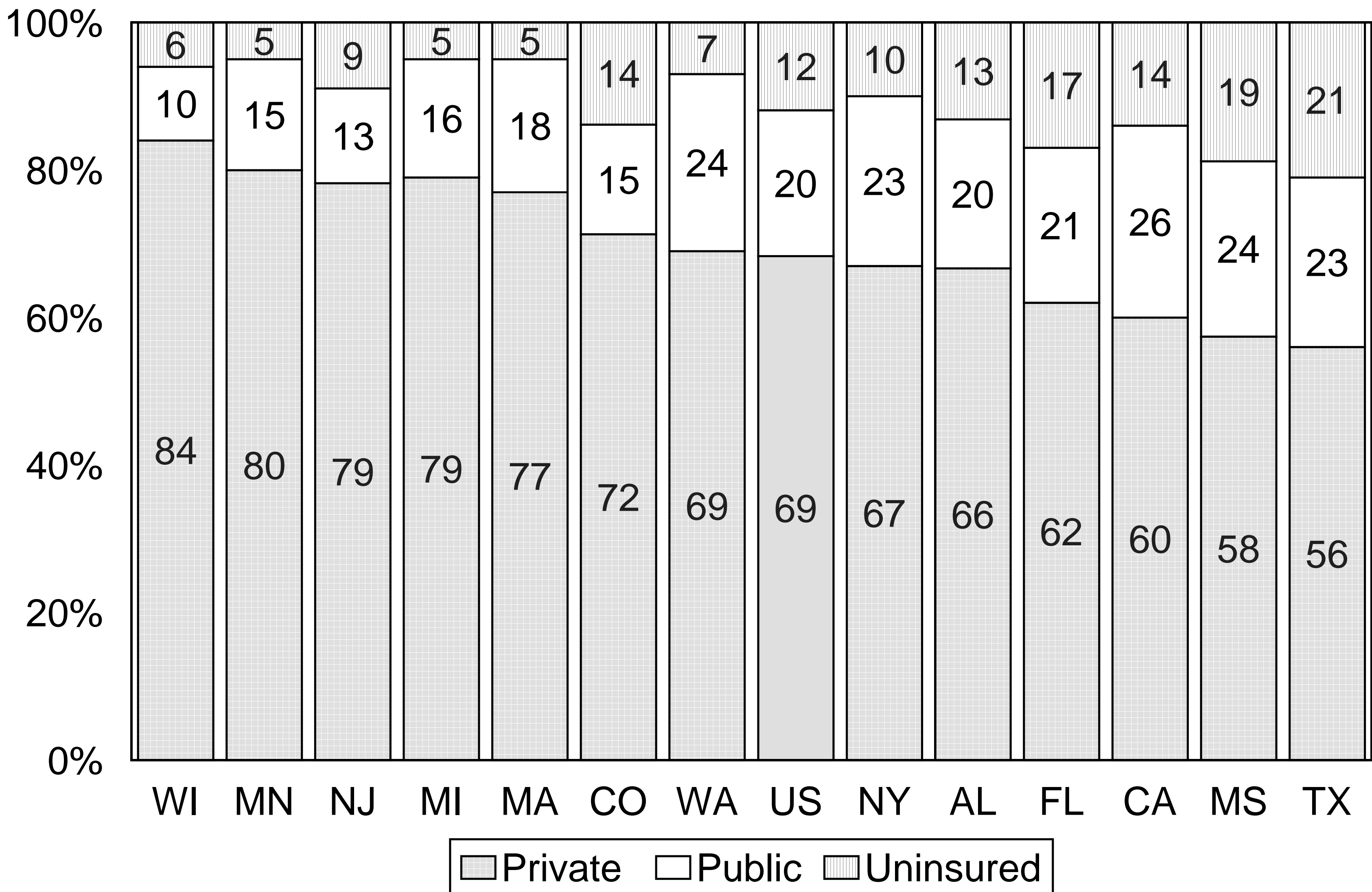
Public coverage, however, does not always offset low levels of private coverage. For example, Texas and Mississippi both have below-average levels of private coverage. Both have levels of public coverage that are not significantly different from the national average. As a result, they have uninsurance rates of 32 and 28 percent, respectively, that are well above the national average. Colorado has levels of private coverage of low-income children similar to the national average, but public coverage is considerably below average. The result is an uninsurance rate that is significantly higher than the national average. Finally, Massachusetts stands out as a state whose private coverage is equal to the national average, but that also has very high rates of

Table 1: Insurance Coverage of Adults and Children

	All Incomes		Below 200% Poverty	
	Adults	Children	Adults	Children
Private	75%	69%	44%	40%
Public	8%	20%	20%	39%
Uninsured	17%	12%	37%	21%

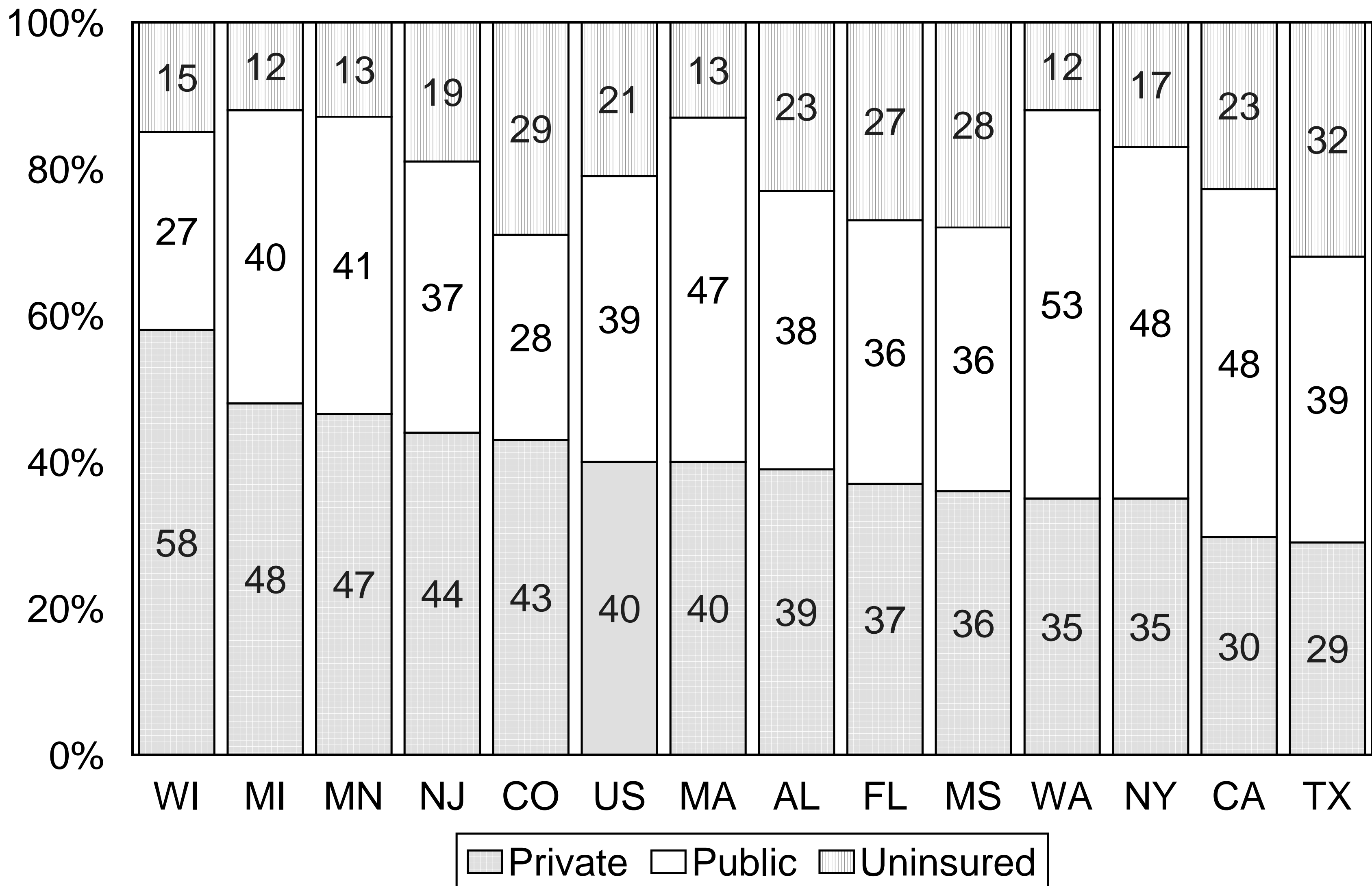
Source: Urban Institute, 1997 National Survey of America's Families.

Figure 2: Health Insurance Coverage of Children under 18, by State, 1997



Source: Urban Institute, 1997 National Survey of America's Families

Figure 3: Health Insurance Coverage of Low-Income Children under 18, by State, 1997



Source: Urban Institute, 1997 National Survey of America's Families

public coverage. The result is one of the lowest rates of uninsurance of low-income children in the nation.

Some states with high rates of public coverage of low-income children still end up with relatively low rates of public coverage of children overall because they have relatively small low-income populations—for example, Massachusetts. The opposite is true for a state like Texas. For example, Texas covers 39 percent of its low-income population (less than Massachusetts, at 47 percent) but 23 percent of its entire child population (versus 18 percent in Massachusetts). Another interesting contrast is that of Minnesota and Mississippi. Minnesota covers 41 percent of its low-income population but only 15 percent of its entire population. Mississippi, in contrast, covers 36 percent of its low-income population, about equal to the national average, but 24 percent of its entire population.

This suggests that it is both public policy and the size of the low-income population to which those policies are directed that will affect the proportion of children in a state covered by public programs. This explains why states such as Texas and Mississippi cover a higher proportion of their children through public programs than states such as Massachusetts and Minnesota, typically regarded as states with very generous policies.

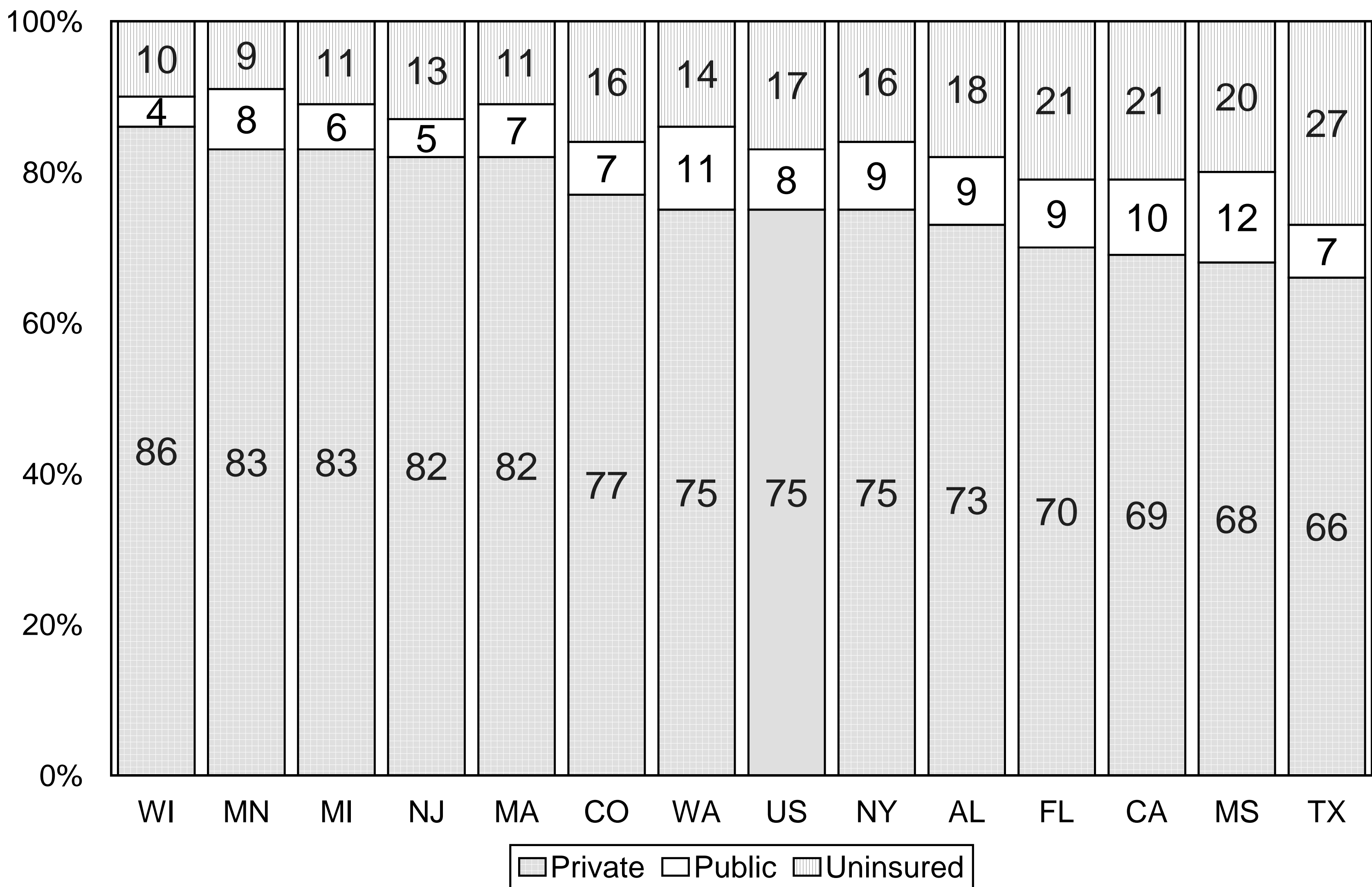
Adult Health Insurance. A similar picture emerges for adults. Figure 4 shows that employer-sponsored coverage varies from 66 to 70 percent (California, Florida, Mississippi, and Texas) to 82 to 86 percent (Massachusetts, Michigan, Minnesota, New Jersey, and Wisconsin). Public coverage varies from 10 to 12 percent in California, Mississippi, and Washington to as low as 4 percent in Wisconsin and 5 percent in New Jersey. Public coverage does less to offset variations in employer-sponsored coverage among adults than among children. Thus, states such

as California, Florida, Mississippi, and Texas have the highest rates of uninsurance (20 to 27 percent), while states such as Massachusetts, Michigan, Minnesota, and Wisconsin have the lowest rates of 9 to 11 percent. Because there is less variation in public coverage for adults than for children, the variation in uninsurance rates more closely tracks the variation in employer-sponsored coverage.

Public programs are, again, more important for low-income nonelderly adults than for all nonelderly adults. Figure 5 shows that states such as Massachusetts, Minnesota, New York, and Washington have the highest rates of coverage in public programs. But again, this public coverage usually does not offset the variations in employer-sponsored coverage. For example, California and Texas had very low rates of private coverage, 35 and 36 percent, respectively. California's 22 percent of low-income adults with public coverage and Texas's 14 percent did not offset these low rates of private coverage. Consequently, those states had higher-than-average uninsurance rates for low-income adults—43 percent in California and 50 percent in Texas. In New York, a relatively high rate of public coverage, 27 percent, did offset the low rate of private coverage, giving New York an uninsurance rate close to the national average. An exception is Colorado, which had such a low rate of public coverage, 14 percent, that it had an uninsurance rate comparable to the national average despite having relatively high rates of private coverage.

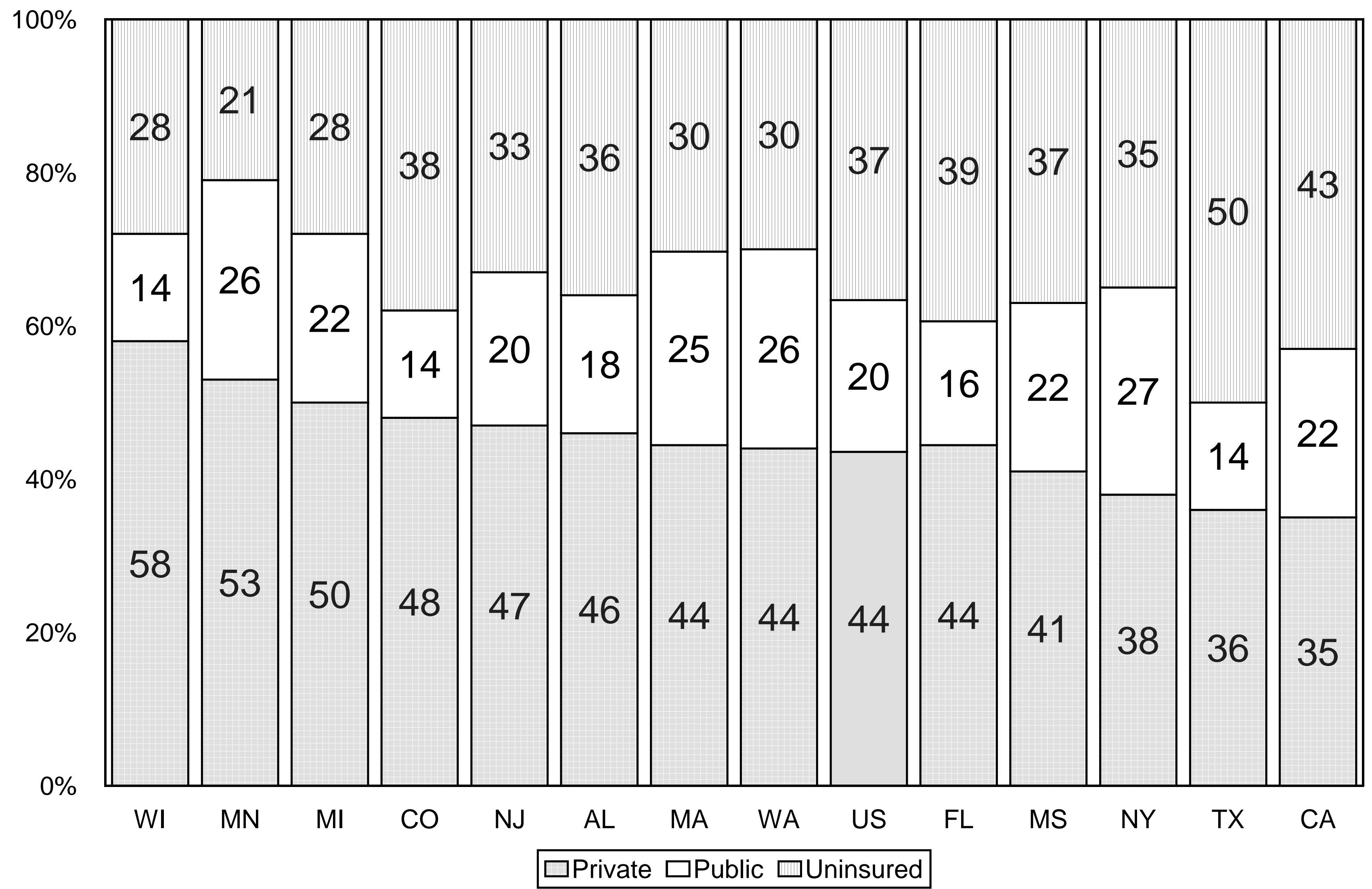
As was observed for children, some states typically thought of as having very generous public programs actually have below-average rates of public coverage for adults as a whole. For example, Massachusetts, which had above-average coverage of the low-income adult population, had slightly below-average coverage of the adult population as a whole. This is because Massachusetts has a relatively small low-income adult population. At the other extreme,

Figure 4: Health Insurance Coverage of Adults (18-64 Years of Age) by State, 1997



Source: Urban Institute, 1997 National Survey of America's Families

Figure 5: Health Insurance Coverage of Low-Income Adults (18-64 Years of Age), by State, 1997



Source: Urban Institute, 1997 National Survey of America's Families

Mississippi and California, which have about average coverage of the low-income adult population, have above-average coverage of the adult population as a whole because of their large low-income populations.

Health Status, Usual Source, and Confidence. Given that the size of a state's low-income population affects the health insurance distribution and that most efforts to extend health insurance coverage are aimed at low-income populations, the following data focus only on low-income adults and children.

Health Status. Figure 6 shows variations in health status among states for low-income adults and children. Health status was assessed by respondents who were asked to classify themselves and their spouse or children as generally being in excellent, very good, good, fair, or poor health. The percentage of low-income children in fair or poor health was greatest in California and Texas, at about 12 percent, and lowest in Minnesota and Wisconsin, at about 5 to 6 percent. The percentage of low-income adults reporting fair or poor health is above the national average in Alabama, California, Mississippi, and Texas and below the national average in Colorado, Minnesota, Washington, and Wisconsin. In Mississippi, almost 30 percent of low-income adults reported being in fair or poor health, versus 15 percent in Minnesota.

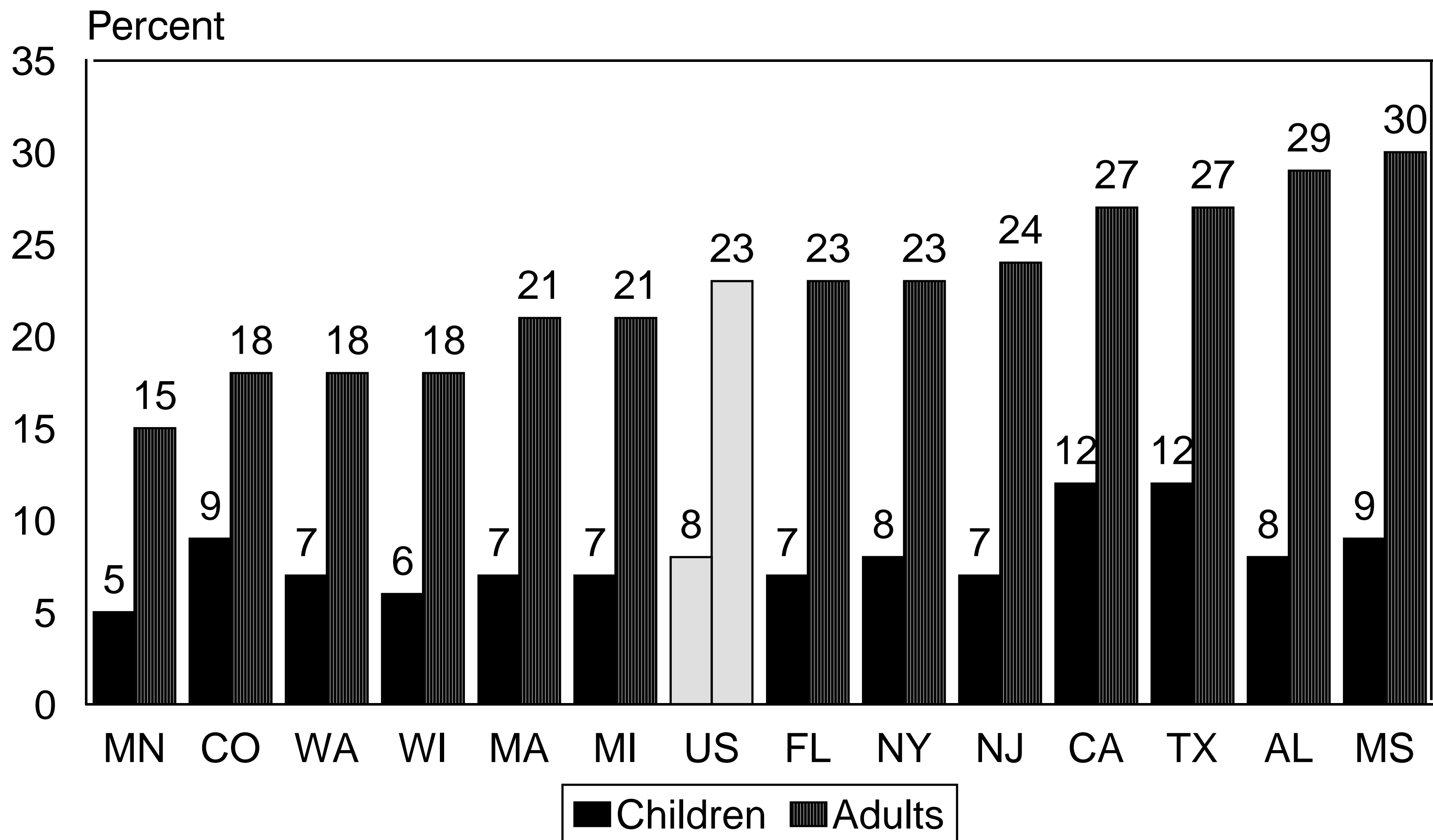
In almost every case, these patterns follow variations in uninsurance rates, with states with high uninsurance rates having large percentages of adults and children in fair or poor health. One cannot conclude, however, that there is a causal relationship between insurance coverage and health status. Most of the states with low rates of uninsurance also have high rates of poverty and other problems that could result in poor health status. The data do, however, suggest that higher rates of uninsurance are not attributable to the lack of need for insurance.

Usual Source of Care. Figure 7 shows variation among states in the likelihood of having a usual source of care for low-income adults and children. To determine the percentage of children and nonelderly adults with no usual source of health care, adults were asked if there was a place they and their children went to when they were sick or needed advice about their health care. Those who reported that they had no regular provider or that they went to a hospital emergency room when they needed health services were defined as having no usual source of care.

Low-income children in Alabama, California, Florida, and Texas were more likely than the national average to have no usual source of care. In contrast, children in Massachusetts, Michigan, Minnesota, New York, Washington, and Wisconsin were less likely to have no usual source of care than the national average. Across states, low-income adults in California and Texas were less likely to have a usual source of care than the national average, while low-income adults in Michigan, Minnesota, Mississippi, Washington, Wisconsin, and Massachusettes were more likely to have a usual source of care. These results are consistent with variations in insurance coverage. The one exception is Mississippi, which retains a large base of indemnity insurance (i.e., a low level of managed care penetration) and a large system of public health facilities and public hospitals that apparently affords even the low-income population that lacks insurance coverage access to non–emergency room care.

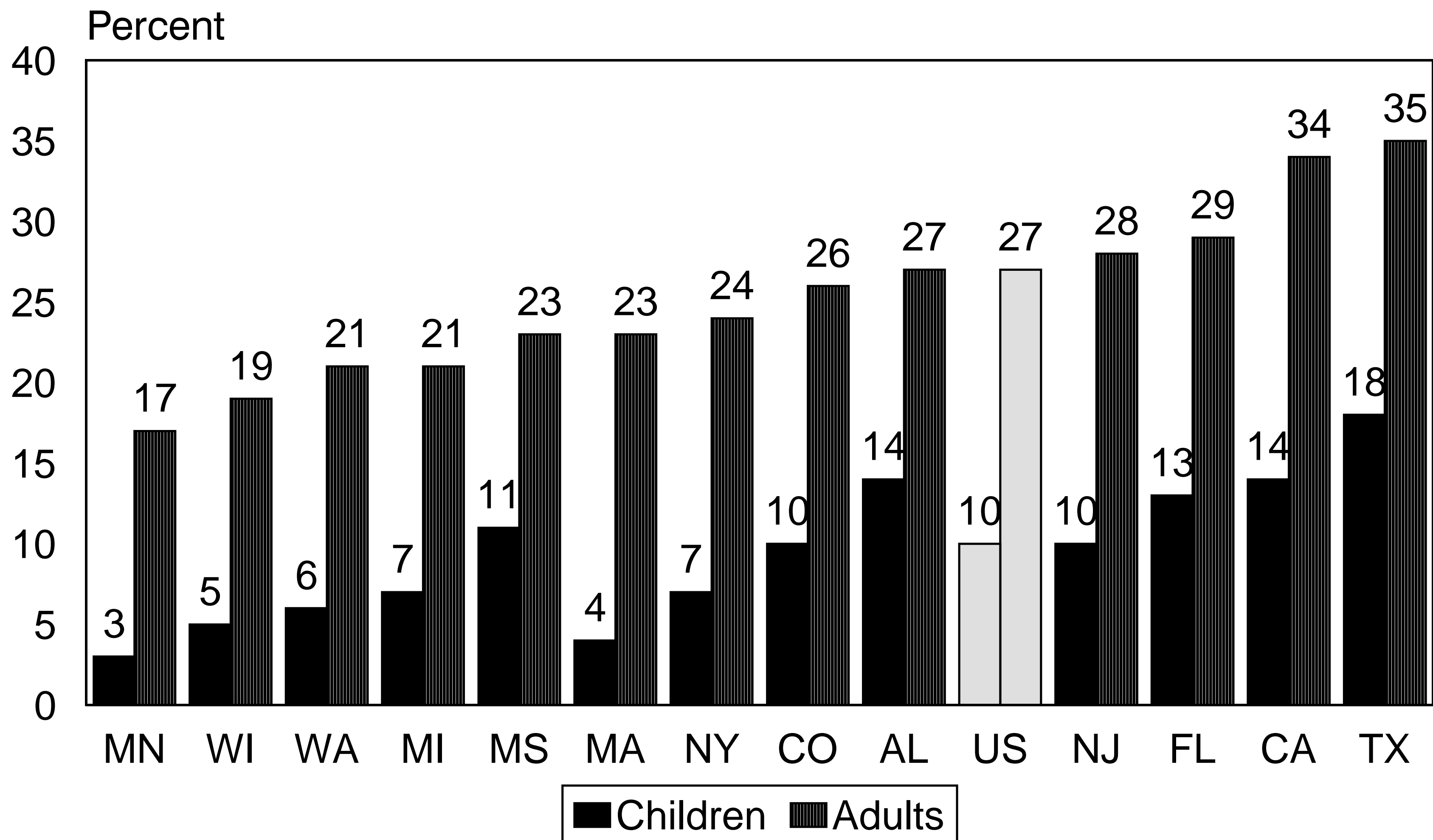
Confidence in the Ability to Get Children Medical Care. One way of assessing how well the medical system is serving children is by determining how confident parents are that they can get medical care for their families when they need it. If the persistent number of children lacking health insurance or the growing concern about the rights of patients in managed care has

Figure 6: Low-Income Children and Adults in Fair or Poor Health, by State, 1997



Source: Urban Institute, 1997 National Survey of America's Families

Figure 7: Low-Income Children and Adults with No Usual Source of Health Care, by State, 1997



Source: Urban Institute, 1997 National Survey of America's Families

undermined patients' confidence, the system may not be meeting children's needs. Parents were asked to rate the confidence about getting medical care for their families when needed by choosing the phrase that best described their feeling. Those who chose "not confident at all" or "not too confident" were classified as not confident.

Figure 8 shows that among low-income families, parents were significantly more likely to lack confidence in their ability to get care in only one state: California. Data on all families (not shown) also indicate that Texas and Florida, two other states with high uninsurance rates, have parents who are significantly more likely to lack confidence in getting care for their children. Low-income parents were generally less likely to lack confidence (relative to the national average) in Massachusetts, Michigan, Minnesota, Mississippi, Washington, and Wisconsin. All of these states except for Mississippi had low rates of uninsurance. Again, the results in Mississippi may be attributable to the low penetration of managed care (high rate of indemnity insurance) that has provided some protection to the safety net.

Discussion

Two principal conclusions emerge from these results. First, because of Medicaid's poverty-related expansions and because of state-subsidized insurance efforts that have disproportionately been focused on children, children are faring better than adults in terms of health insurance coverage. Children also fare better than adults in terms of health status and access to care. Adults, particularly low-income adults, are much more likely to lack health insurance and to lack a usual source of care despite being more likely to be in fair or poor health.

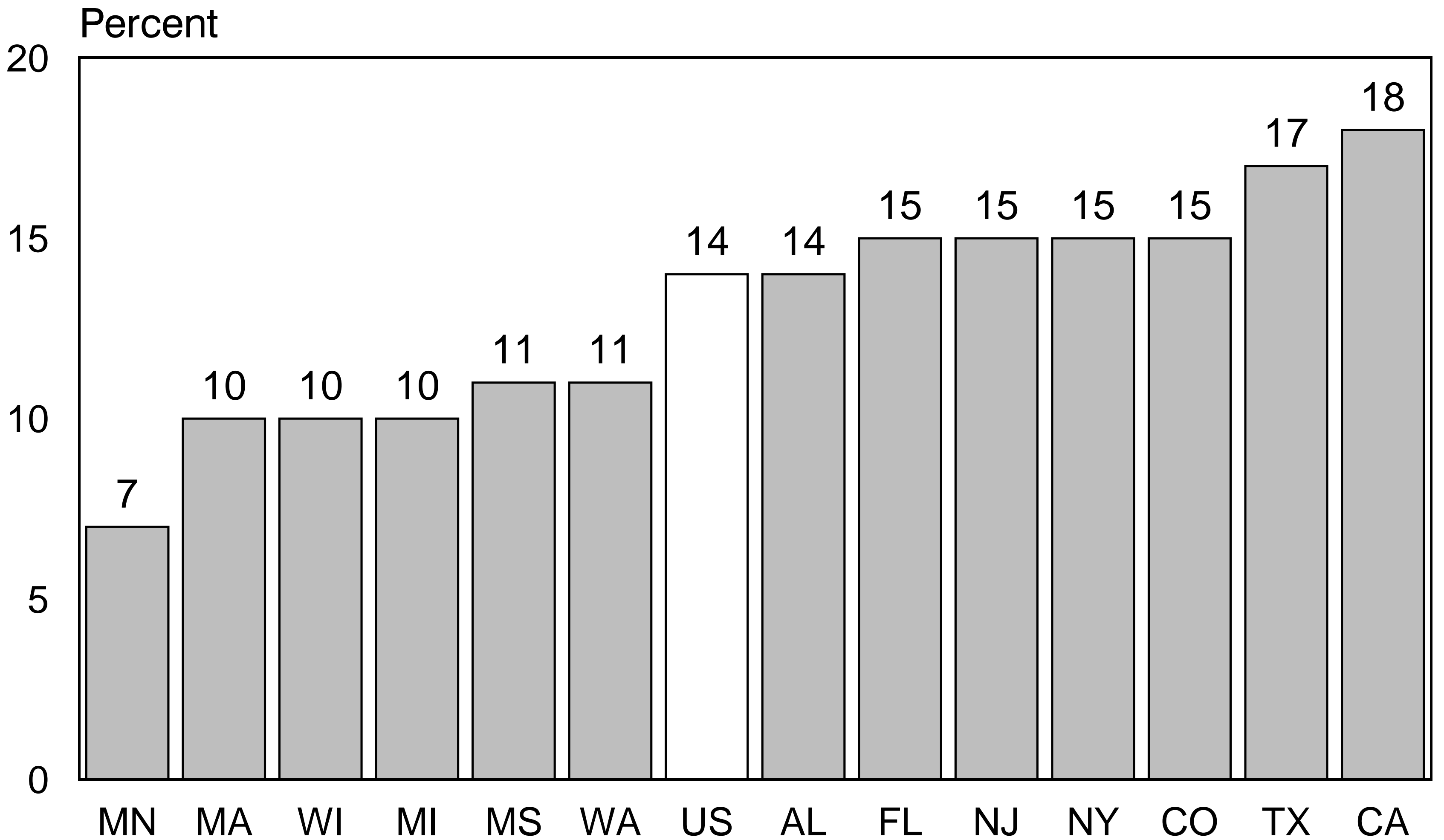
Second, there are extremely large variations in rates of uninsurance across states. For adults, these vary from about 27 percent in Texas down to 9 percent in Minnesota. These

variations in uninsurance rates largely reflect differences in private-sector coverage. Depending on employer provision or support for private health insurance, greater or lesser problems devolve to state and local governments. They can either provide coverage through Medicaid or state programs or support charity care at local hospitals and clinics. States such as Massachusetts and Minnesota have developed ambitious programs to cover low-income children and adults and have achieved low rates of uninsurance, but these states had small problems to begin with because of high levels of employer coverage in their states. On the other hand, states such as Texas, Mississippi, and California have much lower rates of private coverage and, as a result, state and local governments have larger problems to solve.

No matter how generous some states' public insurance eligibility rules may be, several other policies can affect access and use of services for low-income uninsured populations in all states. In addition, although welfare reform was not intended to affect eligibility for Medicaid, the fact that eligibility is no longer directly tied to the receipt of cash benefits could have a significant effect on enrollment in the program and, as a result, on the number of uninsured. If the low-income uninsured depend on the ability of safety net hospitals and clinics to provide uncompensated care, then they may be affected by a number of factors beyond states' eligibility rules and welfare reform.

First, many states have moved to enroll Medicaid beneficiaries in managed care. For Medicaid beneficiaries, this can improve access by increasing their likelihood of having a usual source of care or curtail access by reducing utilization and lowering families' confidence in their ability to obtain medical care when they need it. For the uninsured, Medicaid managed care can reduce access by lowering the revenues of safety net providers. Many states that are moving

Figure 8: Low-Income Children Whose Parents Are Not Confident of Getting Them Health Care, by State, 1997



Source: Urban Institute, 1997 National Survey of America's Families

Medicaid beneficiaries into managed care have implemented policies to protect safety net providers by setting more generous rates for plans that include them or by giving these plans preferences in the assignment of beneficiaries (see Hurley and Wallin, 1998).

Second, some safety net providers receive a considerable amount of direct support from federal, state and local governments. Massachusetts, New Jersey, and New York all provide a considerable amount of support to safety net providers through bad debt and charity care pools. States such as California, Colorado, Florida, Michigan, and Mississippi have fairly high levels of Medicaid DSH that have been used to support public hospitals. The 1997 federal Balanced Budget Act reduced the level of Medicaid DSH available to states. State efforts to directly support these institutions should, in principle, have positive implications for access to care for the uninsured. However, evidence is weak about the link between the subsidies and the level of uncompensated care provided by hospitals and clinics.

Finally, evolution of the health care market will affect access for low-income Americans. The growth in private-sector managed care seems to have been successful in controlling health care costs, making health care more affordable, but at the same time, it has reduced revenues to providers. Many of these providers, i.e., community health centers and public and nonprofit hospitals, have seen reduced revenues. In states such as California, Florida, Texas, and, to a lesser degree, Colorado, Massachusetts, Minnesota, and New York, competitive forces were strong and have reportedly had an adverse effect on revenues of hospitals that provide charity care (Norton and Lipson, 1998). The entry of for-profit hospitals into many markets also forces hospitals to be more competitive. Efforts to lower costs to compete in the marketplace make it more financially difficult to provide care to uninsured individuals. On the other hand, Alabama

and Mississippi, for example, have limited coverage of low-income populations but have very little managed care penetration. The Blue Cross/Blue Shield plans in those states seem to still be able to pay hospitals at rates that support missions of local hospitals to provide charity care.

The data presented here suggest that insurance coverage differences across states and between adults and children are correlated with differences in access to care and health status. Although insurance coverage is important, the ANF case studies identified numerous other factors that play a role in determining how well the health care needs of low-income groups are met. These factors include the reliance on managed care within Medicaid, the size of a state's Medicaid DSH program, and increased competition in the insurer and provider markets. As states play an ever-increasing role in developing health policies independent of the federal government, researchers are embarking on assessments of these policies. It is important to keep in mind the underlying differences across states in their low-income population as well as their health care policies and markets.

Notes

1. Future rounds of NSAF are planned and will allow us to try to explain how outcomes are changing under various policy regimes.

2. For more details on the survey see Kenney, Scheuren, and Wang (1999).

3. The overall response rate was 65 percent for interviews in families with children and 62 percent for interviews in families without children.

4. The information presented in this paper shows a lower percentage of children and nonelderly adults being uninsured than reported in the Current Population Survey (CPS). There are two fundamental reasons for the differences between the two surveys and their measures of insurance coverage. The first reason is that the NSAF measures insurance coverage at the time of the survey, whereas the CPS asks about coverage during the previous calendar year. The second reason for the difference is that the CPS asks a series of questions about insurance coverage and then assumes that any person not designated as being covered through any type of health coverage is uninsured. The NSAF uses a series of questions similar in wording and sequence to the CPS, but adds a question that verifies whether people who appear not to have coverage are, in fact, uninsured. A substantial number of people who are initially designated as uninsured change to being insured as a result of the verification question. A detailed discussion of these issues is presented in Rajan et al. (1999).

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John Holahan is director of the Health Policy Research Center at the Urban Institute. He has authored several publications on the Medicaid program. He has also published research on the effects of expanding Medicaid on the number of uninsured and the cost to federal and state governments. Other research interests include health system reform, changes in health insurance coverage, physician payment, and hospital cost containment.

Genevieve Kenney is a principal research associate in the Health Policy Center of the Urban Institute. Her health policy research has focused on assessing the effects of changes in public policies on access, use, and outcomes for children and pregnant women. She is currently conducting a multi-year evaluation of the Children's Health Insurance Program. Her past work includes analyses of Medicaid expansions for pregnant women and children and the Medicare home health benefit. Between 1996 and 1999, she directed the National Survey of America's Families.

Shruti Rajan is a senior member of the survey team working on the second wave of the National Survey of America's Families (NSAF). Previously, she was a research associate in the Health Policy Center at the Urban Institute where her work focused on Medicaid, other state-subsidized insurance programs, and trends in insurance coverage.