Adults Without Health Insurance: Do State Policies Matter?

Whether uninsured adults can get coverage from public programs depends largely on the state they live in.

BY BRENDA C. SPILLMAN

POLICY ATTENTION for the uninsured has focused recently on children, despite the fact that nonelderly adults represent about three-quarters of the uninsured.[1] Nationally, adults are 40 percent more likely than children to be uninsured and less than half as likely to have public coverage.[2]

Although their approaches differ greatly, all states cover some adults through their Medicaid programs, partially funded by a 50–77 percent federal match. For nonelderly adults, eligibility is limited to specific categories—single parents, typically female; pregnant women; couples with an unemployed primary earner; and the disabled—but within categories, states determine eligibility through the income limits they set. Federal matching dollars are a strong incentive, but states willing to forgo the match may cover additional persons through state programs of two general types: general assistance and subsidized insurance. Using data from the National Survey of America's Families (NSAF), this paper examines how different state approaches affected the number of nonelderly adults who obtained public coverage in 1996.

Data And Methods

The NSAF is a household survey representing the civilian noninstitutionalized population under age sixty-five. It includes large state-representative samples for thirteen states and a sample representing the rest of the country.[3] The thirteen states, chosen to be diverse in geography, fiscal capacity, population, and traditions of providing government services, are Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin.[4]

This study analyzes adults age eighteen and older, resulting in roughly 3,000 to more than 4,000 observations in each of the thirteen states and about 6,000 observations in the balance of the country. The data are weighted to provide national estimates and estimates for the thirteen states, and variance estimates are adjusted for the complex survey design.[5]

■ **Public program approaches.** The thirteen states are grouped in this study using an *a priori* typology of public coverage approaches incorporating key public program parameters.[6] State programs are designated as limited, moderate, or comprehensive according to the expansiveness of Medicaid eligibility rules and the size of state-only programs (Exhibit 1).[7] In general, the states tend to be relatively generous on all Medicaid eligibility factors or on none, and this differentiates the states with moderate and comprehensive programs from those with limited ones. The primary factor used to distinguish comprehensive states from moderate ones was willingness to commit to large programs funded solely with state dollars (last column of Exhibit 1). The number of factors for which

Brenda Spillman is a senior research associate at the Urban Institute in Washington, D.C.

EXHIBIT 1
Characteristics Of Medicaid And State-Funded Programs For Adults In Thirteen States, 1996

State group	AFDC income limit[a]	Income limit for pregnant women[b]	Medically needy program	Estimated Medicaid adult eligibility[c]	Proportion of uninsured in state-only programs[d]
Limited approach					
AL	0.37	1.00	N	0.55	–[e]
CO	0.96	1.00	N	0.61	–[e]
FL	0.69	1.39	Y	0.88	–[e]
MS	0.84	1.39	N	0.80	–[e]
TX	0.42	1.39	Y	0.64	–[e]
Moderate approach					
CA	1.38	1.50	Y	1.24	–[e]
MI	1.26	1.39	Y	1.25	< 2%[f]
NJ	1.01	1.39	Y	0.95	2–10%[f]
WI	1.18	1.39	Y	0.99	< 2%[f]
Comprehensive approach					
MA	1.32	1.39	Y	1.13	2–10%[f]
MN	1.21	2.07	Y	0.81	> 10%[g]
NY	1.31	1.39	Y	1.19	> 10%[f]
WA	1.24	1.50	Y	1.12	> 10%[g]

SOURCES: 1995 Current Population Survey; C.E. Uccello et al., *State Assistance Programs, 1996* (Washington: Urban Institute, October 1996); and D. Lipson and S. Schordel, *State Subsidized Insurance Programs for Low-Income People* (Washington: Alpha Center, November 1996).

[a] Relative to national average of 42 percent of the federal poverty level for a family of three.

[b] Relative to federal minimum of 133 percent of federal poverty level.

[c] Percent of nonelderly adult poor persons eligible for Medicaid, relative to national average of 42.9 percent, based on Current Population Survey (CPS) data and the Urban Institute's Transfer Income Model (TRIM-2) microsimulation model.

[d] The entries are calculated as follows: divide the sum of enrollment in state-only general assistance programs and state-subsidized insurance programs by the state's uninsured population. Enrollment in state-only general assistance programs is derived from caseloads using a factor of 1.5 enrollees per case. "State-only" means that programs do not rely on federal funds.

[e] State had no state-only programs for adults.

[f] Predominantly general assistance–type programs.

[g] Predominantly subsidized health insurance programs.

a state was above average was used to discriminate between close cases.

■ **Health insurance variables.** The NSAF aimed to carefully identify public program participation, private insurance, and lack of insurance. Toward this end, all who had reported having none of the included coverages were asked to confirm that they were uninsured and, if not, to report their coverage. The estimates presented reflect the results of this confirmation probe, which reduced the national estimate of the percentage of uninsured adults to 17 percent, compared with 21 percent without using the probe.[8]

Current coverage was coded into a hierarchy classifying as covered by Medicaid or state programs all for whom these can be assumed to be the primary coverage. Thus, the category excludes 1.3 percent also reporting either employment-related private coverage or Medicare but includes the fewer than 0.2 percent also reporting private coverage not related to employment. Medicaid and state program coverage were combined because of the difficulty of being sure that respondents correctly distinguished between the two.

Of those remaining, all who reported employment-based insurance or other private coverage were classified as being privately insured. All who were covered by Medicare were classified as such (including about 0.8 percent dually eligible for Medicare and Medicaid); the remainder reporting insurance reported military-related coverage.

■ **Other variables.** Other variables identifying characteristics associated with access to or exclusion from Medicaid eligibility are used to examine how different groups fare un-

der different state approaches. The expectation is that states with moderate and comprehensive approaches would cover more persons with characteristics historically related to Medicaid eligibility than limited states would. The flexibility of state programs suggests that comprehensive states also may cover more persons in groups not historically eligible for Medicaid.

The most important facet of eligibility is states' income limits both for their Medicaid programs and for state programs. Individual income is categorized as below the federal poverty level, 100–199 percent of poverty, and 200 percent of poverty or higher.

Medicaid eligibility rules favoring single custodial parents—most often women—and pregnant women may result in different patterns of coverage by sex and family structure in states with supplemental programs. The family-structure variable identifies whether an adult is an unmarried custodial parent, a married custodial parent, or not a custodial parent. Full-time workers may be less likely to obtain Medicaid coverage because of the eligibility link with welfare and, more recently, with families having an unemployed primary earner. They may be more likely to be covered in states with supplemental programs. For this analysis, a variable identifies whether an adult is a full-time worker or is married to one.

Finally, coverage may differ by health status. Poorer health is an indicator of reduced access to private coverage and of greater need for health services. Medicaid rules do not generally favor those in poor health, although the disabled are an eligibility category. There is, however, a selection bias in enrollment in that eligible persons who seek acute care or have an existing health problem have a greater incentive to enroll. Providers also have an incentive to assist them in enrollment. In states with medically needy programs, high medical expenses can extend eligibility to additional persons who meet categorical criteria. The health indicator used here is self-reported health status, dichotomized to indicate fair or poor health.

Insurance Coverage By State

Nationwide, 17.0 percent of nonelderly adults lack health insurance, but the range is from a high of 26.9 percent in Texas to a low of 8.8 percent in Minnesota (Exhibit 2).

EXHIBIT 2
Insurance Status Among Nonelderly Adults, 1996

State group	Uninsured	Private	Medicaid and state-only	Other coverage			
				Total	Medicare and Medicaid	Other Medicare	Military and other
U.S. total	17.0%	74.8%	4.3%	3.9%	0.8%	1.1%	2.0%
Limited (mean)	22.9	68.8	3.5	4.8	0.8	1.3	2.8
TX	26.9[a]	65.6[a]	3.5	3.9	0.6	0.8[a]	2.5
FL	21.1	69.7	3.3	5.8	0.8	1.7	3.3
MS	20.3[a]	67.5	5.6[a]	6.5[a]	1.6[a]	2.4[a]	2.5
AL	17.9[a]	73.4[a]	3.8	5.0	1.1	1.7	2.1
CO	16.2[a]	76.7[a]	2.4[a]	4.7	0.7	1.2	2.8
Moderate (mean)	17.4[b]	74.2[b]	5.0[b]	3.3[b]	0.9	0.9	1.5[b]
CA	21.6[a]	68.2[a]	6.0[a]	4.3	1.2	1.0	2.1
NJ	13.1[a]	81.3[a]	3.3[a]	2.3[a]	0.5[a]	0.8	1.0
MI	11.1[a]	82.5[a]	4.6	1.8[a]	0.6[a]	0.8	0.4[a]
WI	9.9[a]	85.7[a]	2.4[a]	2.0[a]	0.6[a]	1.1	0.5[a]
Comprehensive (mean)	14.1[c]	76.8[c]	6.1[c]	3.0[b]	0.8	1.0[b]	1.2[b]
NY	16.3[a]	74.2[a]	7.0[a]	2.5	1.0	1.0	0.5[a]
WA	14.2	74.4[a]	5.6	5.7[a]	0.6	1.3	3.8[a]
MA	11.5[a]	81.8[a]	4.0[a]	2.7	0.6	1.0	1.1
MN	8.8[a]	83.7[a]	5.7	1.8[a]	0.5[a]	0.4[a]	0.9

SOURCE: Tabulations from the 1997 National Survey of American Families.
[a] State value is statistically different from group mean at the .05 level.
[b] Statistically different from group mean for limited states at the .05 level.
[c] Statistically different from group means for both limited and moderate states at the .05 level.

The primary determinant of the percentage uninsured is the percentage privately insured. The four states having the highest percentages of uninsured persons (Texas, Florida, Mississippi, and California) have the least private coverage. Similarly, the five states with the lowest percentages (New Jersey, Michigan, Wisconsin, Massachusetts, and Minnesota) all have more than 80 percent privately insured. This foundation of private insurance largely defines the magnitude of the problem states confront with their public programs.

Military-related coverage and Medicare each insure only about 2 percent of nonelderly adults nationally. Combined, they cover less than 7 percent of the population in each of the thirteen states. This population tends to be largest in the states where private coverage is below the national average of 75 percent, somewhat offsetting the impact of low private coverage.

As a group, states with limited public coverage cover only 3.5 percent of their populations through their Medicaid programs, while states with comprehensive approaches cover 6.1 percent, on average. The moderate states cover 5 percent. There are clear outliers in each group. Among the moderate states, Wisconsin covers only 2.4 percent of its nonelderly adults, tying with Colorado for the lowest ranking among the thirteen states. Unlike the other moderate states, California has both a large Medicaid program and a large residual uninsurance rate. Mississippi's Medicaid program is one of the largest (5.6 percent of the population), while the remaining four limited states cover less than the national average. Among the comprehensive states, Massachusetts is an outlier on the low side, covering only 4 percent of its population.

States And The Insurance Gap

A more meaningful comparison to use in examining states' approaches is to link public coverage with the magnitude of the underlying insurance gap it addresses. The coverage gap faced by the state is defined as the percentage of the state's population covered neither by private insurance, Medicare, nor military-related coverage (Exhibit 3). Each state's impact on the problem is defined as the percentage of this gap filled by its combined Medicaid and state-only programs.[9]

Nationwide, the coverage gap comprises 21.3 percent of nonelderly adults, and one in five of them obtains coverage through Medicaid or state programs. As a group, the limited-approach states face larger coverage gaps as a result of lower private insurance penetration, and they bridge smaller percentages of their gaps (on average, about 13 percent). As a group, the comprehensive states close about 30 percent of their gaps.

The extremes are Texas and Minnesota. In Texas 30.4 percent of nonelderly adults are otherwise uninsured, and the state covers only 11.5 percent of them (approximately 3.5 percent of the state's population). Minnesota's insurance gap is only 14.5 percent, but the state covers nearly 40 percent (5.7 percent of its population). Colorado and Washington face similar insurance gaps of 18.6 percent and 19.8 percent, respectively, but Washington's comprehensive approach reaches 28.5 percent, while Colorado's limited approach reaches only 13 percent. Similarly, Alabama and New York have comparable gaps, but New York reaches a far larger percentage.

The Effect Of Income

A state's effectiveness in filling its coverage gap depends on its approach and the size of its gap but also is related to the income and other characteristics of its population. Exhibit 4 controls for the impact of a state's income distribution by examining the percentage of the gap filled within income-limit classes. It focuses on the extent to which the higher income limits that are common to moderate and comprehensive states differentiate the reach of their programs from that of the limited-approach states. In all states the size of the coverage gap and the percentage of the gap bridged both fall as income rises. In every income category the moderate states as a group cover larger percentages than the limited states do, and the comprehensive states cover even more—twice the percentage for limited states.

EXHIBIT 3
Role Of Medicaid And State Programs In Filling The Coverage Gap, 1996

State group	Coverage gap[a]	Percent covered by Medicaid or state programs	Percent of coverage gap filled
U.S. total	21.3%	4.3%	20.2%
Limited (mean)	26.4	3.5	13.3
TX	30.4[b]	3.5	11.5
FL	24.5	3.3	13.6
MS	25.9	5.6[b]	21.8[b]
AL	21.7[b]	3.8	17.5
CO	18.6[b]	2.4[b]	13.0
Moderate (mean)	22.4[c]	5.0[c]	22.2[c]
CA	27.6[b]	6.0[b]	21.6
NJ	16.4[b]	3.3[b]	20.0
MI	15.7[b]	4.6	29.2[b]
WI	12.2[b]	2.4[b]	19.3
Comprehensive (mean)	20.2[d]	6.1[d]	30.2[d]
NY	23.4[b]	7.0[b]	30.2
WA	19.8	5.6	28.5
MA	15.5[b]	4.0[b]	25.7
MN	14.5[b]	5.7	39.3[b]

SOURCE: Tabulations from the 1997 National Survey of American Families.
[a] Percent of the nonelderly population not covered by private insurance, Medicare, or military-related coverage.
[b] State value is statistically different from group mean at the .05 level.
[c] Statistically different from group mean for limited states at the .05 level.
[d] Statistically different from group means for both limited and moderate states at the .05 level.

■ **Adults below poverty.** In all states, public coverage goes the farthest toward bridging the coverage gap for adults below the poverty level, but there is much variation across states even for this poorest group. Nationally, about two in three poor adults lack other coverage. The comprehensive states as a group cover about half of these otherwise uninsured, poor adults, compared with about a quarter in the limited states. The extremes again are Texas and Minnesota.

Texas, California, and New York provide a straightforward comparison of the implications of the three coverage approaches. They are similar with respect to percentage of adult population in poverty (14–16 percent) and percentage of poor adults who are otherwise uninsured (about 70 percent). However, Texas reaches only about one in five of its otherwise uninsured, poorest adults, compared with 35 percent for California and 51 percent for New York.

■ **Impacts across income groups.** In general, states that bridge larger proportions of the coverage gap for their poor also cover larger proportions for other income groups. Again focusing on the extremes, Texas has the largest coverage gaps and bridges the smallest proportion of its gaps in all income groups, and Minnesota fills the largest percentage of its coverage gaps in all income groups.

Differences Within The Low-Income Population

The remaining results are limited to persons with incomes below 200 percent of poverty, to focus on how subgroups of low-income adults fare under different approaches.

■ **Family structure.** Exhibit 5 compares unmarried parents (the primary Medicaid eligibility category among nonelderly adults), married parents, and adults who are not custodial parents. Low-income, unmarried parents face a much larger coverage gap. Nationally, more than two-thirds lack other

EXHIBIT 4
Coverage Gap Among Nonelderly Adults And Percent Filled By Medicaid Or State Programs, By Income Relative To The Federal Poverty Level, 1996

	Less than 100 percent of poverty			100–200 percent of poverty			More than 200 percent of poverty		
State group	Percent of population	Coverage gap	Percent of gap filled	Percent of population	Coverage gap	Percent of gap filled	Percent of population	Coverage gap	Percent of gap filled
U.S. total	12.5%	63.7%	35.1%	16.9%	39.1%	14.5%	70.6%	9.5%	8.1%
Limited (mean)	14.9	65.6	24.2	19.7	43.2	10.1	65.3	12.3	3.5
TX	16.3	72.8[a]	21.6	19.2	48.6	9.0	64.5	14.4	1.2[a]
FL	12.7[a]	59.3	26.9	21.9	41.1	10.0	65.5	12.2	5.2
MS	20.5[a]	63.8	31.1[a]	20.8	35.3[a]	15.4	58.7[a]	9.4[a]	8.0
AL	16.8[a]	57.3[a]	26.1	18.7	34.9[a]	15.2	64.5	8.5[a]	5.1
CO	10.3[a]	55.3[a]	23.9	15.6[a]	38.9	8.9	74.1[a]	9.2[a]	7.4
Moderate (mean)	13.0[b]	67.5	37.6[b]	16.8[b]	43.9	14.7[b]	70.2	9.0[b]	9.6[b]
CA	16.0[a]	70.5	35.2	19.2[a]	49.0	14.2	64.8[a]	10.6	9.3
NJ	8.2[a]	62.7	40.6	11.6[a]	36.7[a]	14.6	80.2[a]	8.7	8.2
MI	9.6[a]	62.2	50.6[a]	14.1[a]	32.8[a]	18.9	76.3[a]	6.7[a]	13.3
WI	7.7[a]	48.0[a]	37.3	14.8[a]	30.2[a]	13.6	77.5[a]	5.2[a]	9.0
Comprehensive (mean)	12.2[b]	64.4	50.4[c]	14.3[c]	41.0	21.0[c]	73.5[c]	8.8[b]	14.0[b]
NY	14.3[a]	68.4	51.4	15.4	43.4	15.2[a]	70.2[a]	9.8	14.5
WA	11.8	57.4[a]	42.6[a]	15.8	40.2	28.0[a]	72.4	9.3	14.7
MA	9.3[a]	60.2	47.5	10.6[a]	38.6	23.5	80.2[a]	7.3[a]	6.6[a]
MN	8.0[a]	55.2[a]	61.8[a]	13.2	34.2[a]	40.2[a]	78.8[a]	7.1	20.8

SOURCE: Tabulations from the 1997 National Survey of American Families.
[a] State value is statistically different from group mean at the 0.05 level.
[b] Statistically different from group mean for limited states at the 0.05 level.
[c] Statistically different from group means for both limited and moderate states at the 0.05 level.

coverage, compared with just under half of the other two groups. Wisconsin has the smallest coverage gap, but even there more than half of low-income, unmarried parents lack other coverage. In California the gap is nearly 80 percent for this group. Only in Texas, where about 60 percent of all three groups lack coverage, are unmarried parents no more likely than married parents and adults with no children are to lack other coverage. Married parents in general are no more likely to obtain other coverage than are adults without children in this low-income population.

All states bridge much larger percentages of their coverage gaps for unmarried parents. Nationally, about half of otherwise uninsured, unmarried parents obtain Medicaid or state program coverage, relative to just under 20 percent of the other two groups. Even for this group, disparities in coverage across states are large, although not as extreme as seen earlier for the poverty population as a whole. More than 40 percent of unmarried parents in limited-program states obtain coverage, compared with nearly 60 percent in moderate states and two-thirds in comprehensive states.

However, there is extreme variation across public coverage approaches for the other two groups, particularly for otherwise uninsured, married parents. Only 10.8 percent of this group obtains coverage in the limited-program states, compared with 20.4 percent in the moderate states and a third in the comprehensive states. Adults without children are not significantly more likely to obtain coverage in moderate states than they are in limited states, but they are twice as likely to obtain coverage in comprehensive states as in limited states.

■ **Sex, health, and work status.** The study results underscore the poor rate of private and other coverage among low-income adults. Nationally, the coverage gap includes about half of both women and men; about 60 percent of those who are less healthy and those who are nonworkers; and 44–48 per-

EXHIBIT 5
Coverage Gap And Public Program Coverage For Low-Income Adults, By Family Structure, 1996

State group	Coverage gap			Percent of gap filled		
	Unmarried parents[a]	Married parents	No children in household[b]	Unmarried parents[c]	Married parents	No children in household[d]
U.S. total	67.2%	46.1%	45.9%	51.1%	19.4%	17.6%
Limited (mean)	64.9	51.8	49.7	40.6	10.8	12.6
TX	63.1	58.8[e]	59.3[e]	43.8	12.5	9.5
FL	67.5	45.2[e]	43.2	40.9	6.8	12.0
MS	65.2	39.9[e]	47.8	40.4	14.4	21.9[e]
AL	64.7	40.6[e]	41.4[e]	29.9[e]	8.8	23.5[e]
CO	63.8	45.6	41.1[e]	37.4	6.9	13.4
Moderate (mean)	74.6[f]	49.6	50.0	58.2[f]	20.4[f]	15.7
CA	78.0	55.8	54.7	59.7	20.5	13.8
NJ	69.0	37.5[e]	45.1	54.3	15.8	21.3
MI	74.3	28.8[e]	39.7[e]	59.9	22.9	23.5[e]
WI	55.3[e]	28.9[e]	32.9[e]	42.1[e]	19.8	15.5
Comprehensive (mean)	69.5[g]	49.1	47.1	66.6[f,g]	33.3[f,g]	25.9[f,g]
NY	73.0	53.3	50.2	67.2	27.9	25.2
WA	62.7	49.3	43.2	60.3	39.3	24.9
MA	69.4	38.6[e]	45.5	66.2	36.0	23.0
MN	57.9[e]	37.8[e]	38.8[e]	70.5	55.3[e]	38.3

SOURCE: Tabulations from the 1997 National Survey of American Families.
NOTE: Low-income is defined as persons with incomes below 200 percent of the federal poverty level.
[a] Statistically different from comparison groups, except in Texas, at the .05 level.
[b] Not statistically different from married parents except in Mississippi and Michigan.
[c] Statistically different (at the .05 level) from comparison groups except for married parents in Minnesota and those with no children in the household in Alabama.
[d] Statistically different (at the .05 level) from married parents only in Alabama, Colorado, Washington, Massachusetts, Minnesota, and the comprehensive states as a group.
[e] State value is statistically different from group mean at the .05 level.
[f] Statistically different from group mean for limited states at the .05 level.
[g] Statistically different from group mean for moderate states at the .05 level.

cent of men, those in better health, and those with a link to full-time work (Exhibit 6). Coverage-gap differences between women and men are not generally statistically significant, but those in fair or poor health and those without a link to a full-time worker generally are far more likely than their comparison groups are to lack private and other coverage.

Three overarching observations can be made about the results in the lower panel of Exhibit 6. First, as expected, in most cases states bridge larger percentages of their coverage gaps for the groups more closely related to Medicaid eligibility—women, those in poorer health, and those without a link to full-time work—than for the comparison groups. Second, the comprehensive states bridge the largest percentages of their coverage gaps for all three Medicaid-favored groups within this low-income population. Being in a comprehensive state rather than a limited-program state nearly doubles the likelihood that an otherwise uninsured person in fair or poor health will obtain public coverage. The relative advantage of being in a comprehensive state is almost as large for women and nonworkers. Third, the comprehensive states also bridge the largest percentage of their gaps for the groups less associated with Medicaid eligibility—men, those in better health, and full-time workers and their spouses. The relative advantage of being in a comprehensive state is greater for these groups than for the more Medicaid-favored groups.

Having a medically needy program alone does not appear to increase the likelihood that those in poorer health obtain Medicaid coverage. Texas and Florida are the only limited states that have medically needy programs, but neither bridges a larger proportion of the coverage gap for their less healthy, low-income adults than other limited-program

EXHIBIT 6
Coverage Gap And Public Program Coverage For Low-Income Adults, By Sex, Health Status, And Work Status, 1996

State group	Coverage gap					
	Women	Men	Fair or poor health	Excellent or good health	No full-time workers	At least one full-time worker
U.S. total	51.1%	47.7%	59.6%	46.5%	58.4%	44.2%
Limited (mean)	53.3	52.4	60.0	50.4	61.7	48.4
TX	58.9[b]	60.7[b]	69.4[b]	56.1[b]	71.2[b]	54.9[b]
FL	48.9	46.4	50.5[b]	47.0	56.7	42.8[b]
MS	49.4	49.4	51.1[b]	48.7	61.8	41.4[b]
AL	48.7[b]	41.4[b]	53.1	42.4[b]	51.8[b]	41.0[b]
CO	47.3[b]	43.3[b]	53.4	43.7[b]	48.7[b]	43.8
Moderate (mean)	54.1	54.2	60.6	52.0	63.5	48.7
CA	58.5	59.1	63.4	57.1[b]	68.6	53.3
NJ	49.1	45.3[b]	54.9	45.1[b]	59.6	38.9[b]
MI	45.5[b]	43.6[b]	53.1	42.4[b]	52.5[b]	39.7[b]
WI	38.3[b]	33.9[b]	48.1[b]	33.8[b]	42.6[b]	33.1[b]
Comprehensive (mean)	54.2	48.5	62.6	48.9	58.9	46.3
NY	57.8	52.1	66.2	52.2	63.9	48.7
WA	48.4[b]	46.6	57.0	45.5	50.5[b]	45.7
MA	52.7	43.7	58.0	46.2	52.4	44.8
MN	45.0[b]	38.2[b]	51.0[b]	40.5[b]	50.9	36.5[b]
	Percent of gap filled[c]					
U.S. total	34.3	14.4	31.4	23.6	42.4	12.4
Limited (mean)	26.0	7.1	23.9	15.1	31.3	8.9
TX	24.4	6.3	22.0	13.3	31.3	7.8
FL	27.9	4.2	20.4	16.8	26.7	11.0
MS	31.6	16.7	41.6[b]	18.3	39.8[b]	11.5
AL	26.8	13.7	27.2	18.8	34.9	9.7
CO	22.1	8.8	29.2[b]	12.6	36.9	4.9[b]
Moderate (mean)	38.8[d]	13.6[d]	27.0	27.6[d]	44.5[d]	14.1[d]
CA	37.5	12.9	25.0	26.0	42.8	13.3
NJ	37.8	15.3	26.7	29.6	44.7	11.6
MI	48.7[b]	19.2	45.5[b]	33.8	56.2[b]	20.2[b]
WI	34.5	9.9	34.3[b]	21.2	38.1	15.4
Comprehensive (mean)	47.5[e]	23.3[e]	47.3[e]	34.6[e]	55.6[e]	20.5[e]
NY	45.8	22.4	47.2	32.7	56.2	16.4
WA	45.6	22.8	45.0	32.9	54.0	22.8
MA	49.8	18.9	47.7	33.9	51.9	20.0
MN	59.5[b]	37.3	52.3[b]	50.5	59.3	43.4[b]

SOURCE: Tabulations from the 1997 National Survey of American Families.

NOTE: Low-income is defined as persons with incomes below 200 percent of the federal poverty level.

[a] Coverage gaps for women are statistically different (at the .05 level) from those for men only in Alabama, Massachusetts, and the comprehensive states as a group; for health status, column differences are significant except in Florida, Mississippi, and Minnesota; for work status, column differences are significant except in Colorado, Washington, and Massachusetts.

[b] State value is statistically different from group mean at the .05 level.

[c] Percent of gap filled significantly different (at the .05 level) across comparison groups except for the health status comparison in Florida, Alabama, California, New Jersey, and Minnesota.

[d] Statistically different from group mean for limited states at the .05 level.

[e] Statistically different from group means for both limited and moderate states at the .05 level.

states do. In Florida being in fair or poor health does not increase the likelihood of public coverage. The moderate states all have medically needy programs, but as a group they do not cover a significantly larger percentage of otherwise uninsured adults than the limited states do, and in California and New Jersey those in worse health are no more likely to obtain public coverage.

Those with a link to full-time work are less likely to gain public coverage in all states. The disadvantage tends to be largest in the limited states, where fewer than 10 percent of full-time workers or their spouses obtain coverage, and smallest in the comprehensive states, where more than 20 percent do. This may be

because state programs provide more flexibility to cover the working poor than formerly existed in the Medicaid program. Nevertheless, Minnesota, with its large subsidized insurance program, is the only striking example. Minnesota covers the largest proportion both of full-time workers and spouses and of those without a link to full-time work, and the latter group is only about 40 percent more likely than full-time workers and spouses are to gain public coverage.

Concluding Comments

By removing the link between cash welfare and Medicaid, federal welfare reforms have the potential to increase states' willingness to provide health coverage because they do not also automatically incur the cost of cash benefits. Although there has been little expansion to date, states now have options for covering additional adults, since they can disregard higher levels of earned income and resources, establish higher limits on hours of work, and provide transitional coverage.[10] In theory, this also enables states with supplemental programs to shift some groups to Medicaid with its federal match and cover more persons with the same level of state funding. As of 1996, however, adult Medicaid enrollment was down in all but five states, with decreases in cash assistance–related enrollment not generally offset by increases in noncash enrollment.[11] This trend appears to be continuing.[12]

"Even the most expansive programs fail to reach substantial proportions of low-income adults who lack other coverage."

The results demonstrate that states' approaches do matter in whether and which low-income adults obtain coverage. However, even the most expansive programs fail to reach substantial proportions of low-income adults who lack other coverage. One factor that contributes to this is participation rates. Eligible persons may fail to enroll because they perceive a stigma or assign a low value to coverage in states with shallow benefit packages, and this factor may become more important now that coverage is no longer linked to cash benefits. More recent concerns, in the context of welfare reform, are burdensome application procedures, lack of information, and rules that vary across individuals. Evidence for children is that 22 percent of Medicaid-eligible children remained uninsured and that nonparticipation is greater among those in groups that are newly eligible through expansions.[13]

However, a more important factor is the income and categorical limits on adult eligibility for Medicaid. The highest income limit for most eligible persons in this analysis occurs in California (only about 60 percent of the federal poverty level), and even the poorest of those who do not meet categorical criteria remain ineligible. Under the current Medicaid structure, expansions of coverage for these groups will remain largely under the purview of state programs. An extension of the typology used here finds that only eight states have comprehensive programs, fifteen have moderate programs, and twenty-seven have limited programs. Given that the majority of states have not adopted the flexibility that has always existed in Medicaid, and only eight have expanded beyond Medicaid, it seems certain that even with post–welfare reform enhancements to flexibility and fiscal incentives, substantial across-state variation in adult access to care will persist. Barring a federal initiative to set and perhaps underwrite a higher income floor for Medicaid, expand or remove categorical requirements, or establish an adult counterpart to the State Children's Health Insurance Program (SCHIP), it is unlikely that state efforts alone will be able to greatly expand coverage of adults.

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NOTES

1. J.P. Vistnes and A.C. Monheit, *Health Insurance Status of the U.S. Civilian Noninstitutionalized Population*, MEPS Research Findings no. 1, Pub. no. 97-0030 (Rockville, Md.: Agency for Health Care Policy and Research, 1997).
2. Ibid.; N. Brennan, J. Holahan, and G. Kenney, "Health Insurance Coverage of Children," in *Snapshots of America's Families: A View of the Nation and Thirteen States from the NSAF* (Washington: Urban Institute, 1999); and S. Zuckerman and N. Brennan, "Health Insurance Coverage of Nonelderly Adults," in *Snapshots.*
3. See G. Kenney, F. Scheuren, and K. Wang, *National Survey of America's Families: Survey Methods and Data Reliability* (Washington: Urban Institute, February 1999), online at newfederalism.urban.org/nsaf/design.html.
4. A. Kondratas, A. Weil, and N. Goldstein, "Assessing the New Federalism: An Introduction," *Health Affairs* (May/June 1998): 17–24.
5. Estimates have relative standard errors less than 30 percent. Unless otherwise noted, all differences discussed are statistically significant at the 0.05 level in a two-tailed test.
6. S. Rajan, "Publicly Subsidized Health Insurance: A Typology of State Approaches," *Health Affairs* (May/June 1998): 101–117.
7. The typology was modified for this paper to exclude factors applying only to children.
8. Although the final estimate is below other comparable national estimates of nonelderly adults who are currently uninsured, the preconfirmation estimate is consistent with them. The 1997 National Health Interview Survey (NHIS) estimate is 19 percent. The Medical Expenditure Panel Survey (MEPS) estimate of adults uninsured on 31 December 1996 is 22 percent. The 1996–1997 Community Tracking Study (CTS), which also used a follow-up probe, also estimated that 17 percent of adults were uninsured at the time of interview. The adjustment resulting from the CTS probe was much smaller, however, about 0.8 percent. See M. Rosenbach and K. Lewis, "Estimates of Health Insurance Coverage in the Community Tracking Study and the Current Population Survey," report prepared for the Center for Studying Health System Change (Cambridge, Mass.: Mathematica Policy Research, 1998). The NHIS and MEPS estimates were provided by Diane Makuc of the National Center for Health Statistics and Jessica Vistnes of the Agency for Healthcare Research and Quality.
9. The impact is net of any substitution of public insurance for private, known as "crowding out." The presence of crowding out would imply that the size of a state's insurance gap is not independent of the generosity of its public program. Large insurance gaps are not generally associated here with large programs, but rather the reverse. However, the counterfactual, "What would the gaps be if the programs were less expansive?" is not observed. See L. Dubay, "Expanding Public Insurance Coverage and Crowd-Out: A Review of the Evidence," in *Options for Expanding Health Insurance Coverage: What Difference Do Different Approaches Make?*, ed. J. Feder and S. Burke (Washington: Henry J. Kaiser Family Foundation, 1999).
10. Health Care Financing Administration, *Supporting Families in Transition: A Guide to Expanding Health Coverage in the Post–Welfare Reform World* (Baltimore: HCFA, 1999), available online at www.hcfa.gov/medicaid/welfare.htm.
11. J. Holahan, B. Bruen, and D. Liska, *The Decline in Medicaid Spending Growth in 1996: Why Did It Happen?* (Washington: Kaiser Commission on Medicaid and the Uninsured, September 1998).
12. The decline in caseloads began with state welfare reforms prior to the passage of welfare reform and also is partially attributable to the strong economy. See L. Ku and B. Bruen, *The Continuing Decline in Medicaid Coverage*, New Federalism: Issues and Options for States, no. A-37 (Washington: Urban Institute, December 1999), available online at newfederalism.urban. org/html/anf_a37.html.
13. T.M. Selden, J.S. Banthin, and J.W. Cohen, "Medicaid's Problem Children: Eligible but Not Enrolled," *Health Affairs* (May/June 1998): 192–200.