
Medicaid Coverage for Poor Adults: A Potential Building Block for Bipartisan Health Reform

Stan Dorn
Economic and Social Research Institute

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About the Author

Stan Dorn, J.D., is a senior policy analyst at the Economic and Social Research Institute (ESRI). He has been working on health policy at the state and national levels for almost 20 years, focusing on low-income consumers, Medicaid, the State Children's Health Insurance Program (SCHIP), and the uninsured. Previously, Dorn served as director of the Health Consumer Alliance, a consortium of legal services groups in California helping low-income consumers obtain necessary health care. He also directed the Health Division at the Children's Defense Fund, where he led the health policy team in CDF's campaign that helped enact the State Children's Health Insurance Program in 1997. Before his work at CDF, Dorn directed the Washington, D.C., office of the National Health Law Program and served as a staff attorney in that program's Los Angeles headquarters.

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Executive Summary

This paper explores whether giving state Medicaid programs increased flexibility to cover uninsured, poor adults could be one element of a broader, bipartisan expansion in health coverage. Among households with incomes below the Federal Poverty Level (FPL),* 12 million working-age adults now lack coverage, comprising 27 percent of the uninsured.

Plausibility of bipartisan support

A number of analysts with widely divergent views about expanding public programs to near-poor and moderate-income uninsured nevertheless agree that the poorest uninsured have unique needs that make Medicaid coverage appropriate. Because it was structured to help Americans who lack the disposable income needed to pay for insurance or uncovered health services, Medicaid provides very comprehensive benefits at nominal cost, departing significantly from the design of most privately-funded coverage. Accordingly, even analysts who generally resist steps towards federalizing health care can make a principled distinction in the case of the poor, who may be ill-served by typical private health coverage.† To maximize the broad appeal of a Medicaid expansion to serve more poor adults, this paper explores new *options* for state Medicaid programs, rather than new federal *mandates* on states.‡

Key facts about uninsured, working-age poor adults

Several factors make poor, working-age adults (including both those with and those without dependent children living at home) promising candidates for incremental coverage expansion:

- Among all poor adults, 45 percent are uninsured, and only 16 percent have employer-based insurance. Accordingly, new public dollars could be targeted principally to cover the otherwise uninsured rather than to substitute for or “crowd out” existing employer-based coverage.
- Recent increases in uninsurance have been concentrated on this group. Between 2000 and 2003, as the total number of uninsured rose by 5 million, the number of uninsured adults with incomes below 100 percent of the FPL rose by 2.2 million – more than any other group.

* For 2004, the FPL is \$9,310 a year for a single individual, \$12,490 for a two-person household, \$15,670 for a three-person household, etc.

† For example, Professor Mark Pauly of the Wharton School proposes extending Medicaid or similar public coverage to all Americans with incomes under 125 percent of the FPL, as part of a broader plan that also uses market incentives. Similarly, Gail Wilensky of Project Hope suggests that Medicaid coverage of the uninsured with incomes below 100 or 125 percent of the FPL may be a good place to start in designing bipartisan coverage expansions, particularly if Medicaid beneficiaries gain new health plan options.

‡ Beyond the modest scope of this paper are two other strategies that could broaden the potential appeal of a Medicaid expansion to serve the poorest uninsured: first, including such an expansion as part of a broader proposal that also covers somewhat higher income workers by using more market-oriented reforms, such as federal income tax credits and purchasing pools that offer a variety of private health plans; and second, expanding the health plan choices that are available to Medicaid beneficiaries. Limited health plan options in Medicaid appear to be an increasing problem, with the number of participating plans dropping by 13 percent from 1998 to 2003, even though the number of beneficiaries enrolled in all such plans grew by 52 percent over that same period. Conversely, bipartisan support would be endangered by any attempt to couple the approach described in this paper with changes to the two basic guarantees that many view as the core of the current Medicaid program: namely, the guarantee that individuals who qualify for their state’s program will receive coverage; and the guarantee that a state willing to commit its resources to provide covered services will receive matching federal dollars.

Gaps in Medicaid coverage for poor adults

- Most poor adults without health coverage are uninsured for long periods of time. Altogether, 87 percent of poor adults who lack coverage at some point during the year are uninsured for at least 6 months, and two thirds (66 percent) are uninsured for 12 months or longer.
- Insurance makes a significant difference to poor adults' access to health care. In one state, for example, when low-income, uninsured adults enrolled in Medicaid, the proportion reporting that they did not obtain essential doctor visits dropped from 64 percent to 34 percent; and the percentage who took prescription drugs less often than prescribed fell from 22 percent to 11 percent. Another study drawing on data from 13 states found that, without health insurance, low-income adults were 25 percent more likely to have no regular source of care outside hospital emergency rooms.

Nearly two-thirds (64 percent) of uninsured, poor adults are ineligible for Medicaid and similar public programs. Poor childless adults and poor parents are ineligible for different reasons, as discussed below.

First, childless adults are categorically excluded from Medicaid. Federal law prohibits state Medicaid programs from covering adults—no matter how poor—unless they are pregnant, caring for dependent children, severely disabled, or elderly. While states can ask federal officials for waivers to relax this prohibition, these waivers do not provide additional federal resources. Altogether, only 14 states (plus the District of Columbia) use such waivers or state-only programs to cover childless, uninsured adults. Even among extremely poor people whose incomes are below 50 percent of the FPL (currently \$388 a month for an individual), only 25 percent of uninsured, childless adults qualify for Medicaid. It is therefore not surprising that childless adults comprise more than half (51 percent) of all uninsured Americans with incomes below poverty.

These so-called “childless adults” include older parents whose children have grown. Such “empty-nesters” do not qualify for Medicaid as parents of currently dependent children. Excluded from Medicaid, low-income, uninsured adults in their 50s and 60s comprise roughly a third of childless adults covered by the two state programs that specifically track such adults' demographics. For these low-income, older adults, health coverage has a dramatic impact on health status. According to one recent study, providing health coverage to uninsured adults age 55-64 in the lowest quartile of the income distribution reduces their risk of death over an eight-year period from 14 percent to 9 percent. Together, these facts suggest that permitting state Medicaid programs to cover low-income adults under age 65 who are not presently custodial parents could be an effective means of helping a relatively small group of uninsured – namely, low-income near-elders – who have particularly serious needs for coverage.

Second, most states cover uninsured parents up to very low income levels. Unlike childless adults, parents can receive Medicaid coverage, under federal law, up to any income level chosen by state officials. As with children, the elderly, people with disabilities, and pregnant women, parents can receive expanded coverage when a state changes its plan on file with the Center for Medicare and Medicaid Services (CMS). No waiver is needed (unless a state wishes to obtain a higher level of federal matching funds). Unfortunately, few states take full advantage of these options. The median state denies Medicaid to working parents if their income is above 69 percent of the FPL, which is currently \$901 a month for a family of three.

**How Medicaid
could be
restructured to
cover poor adults**

Covering uninsured, low-income parents would also help address the problem that more than half (56 percent) of all uninsured children are eligible for but not enrolled in Medicaid or the State Children's Health Insurance Program (SCHIP). Such children are significantly more likely to receive coverage through these programs when their parents also qualify.

Federal policymakers could give states a simple, new eligibility option that would cover adults (or households) with incomes up to a level chosen by the state. To increase prospects for bipartisan support by obviating concerns that an expanded Medicaid program could enroll middle-class Americans, national policymakers could cap such need-based coverage[§] at a specified percentage of the FPL, such as 100 or 125 percent.

Simply creating such a Medicaid option would expand coverage somewhat. A number of states would implement this option at least to a limited extent, if only to substitute federal matching funds for current state-only dollars spent on indigent care, inpatient mental health care, and other services for childless adults. However, if national policymakers are willing to invest additional resources to encourage state implementation of need-based Medicaid, the federal matching percentage could be raised above standard Medicaid levels, in either of two ways. First, policymakers could enhance federal matching rates significantly for members of the new, need-based group. Such an enhancement could be in the neighborhood of SCHIP federal matching rates, which reduce each state's share of health costs 30 percent below standard Medicaid levels.

Second, policymakers instead could enhance federal matching rates slightly (perhaps in the neighborhood of 5 percent) for all Medicaid costs in a state that fully implements need-based Medicaid. The goal of that enhancement would be to compensate the state for the increased costs that result from need-based Medicaid, without the federal government varying its matching percentages for different populations. A state that partially implemented need-based eligibility could receive a partial increase in its matching rate.

Under either approach, federal policymakers would need to pay careful attention to fiscal integrity. Without appropriate safeguards, states could have incentives (a) to maximize their receipt of enhanced federal funds for current Medicaid beneficiaries who fit within the new "need-based" category (poor parents, pregnant women, and adults with disabilities); while (b) limiting enrollment of newly eligible individuals (hence new state spending) by avoiding outreach and making the eligibility process hard for applicants to navigate. In recent years, precisely such steps to reduce Medicaid caseloads have been part of a number of states' responses to fiscal pressures.

To ensure that states have no incentive to use new federal dollars for present beneficiaries while making only token expansions in coverage, federal policymakers could adjust either of the two basic approaches to enhanced federal match described above. Under the first such approach, enhanced match for each need-based beneficiary could be limited to: (a) individuals who would have been ineligible for Medicaid under previous state rules; and/or (b) increased enrollment of poor adults, compared to aggregate baseline enrollment in the state. Under the second basic approach, program-wide enhanced match could

[§] Of course, current Medicaid eligibility groups all have requirements related to need. However, this new group would be more purely based on need in that household characteristics like disability, pregnancy, and parent-hood would be irrelevant to eligibility.

be limited to states that both enact need-based coverage on paper and meet process or outcome standards for outreach, enrollment, and retention.

While establishing such safeguards of federal fiscal integrity, policymakers could also take steps to limit federal spending. As with SCHIP, each state could receive a capped allotment of enhanced federal dollars. Such caps would eliminate any appreciable danger of large and unforeseen federal outlays for need-based Medicaid. They could also give some state officials incentives to expand coverage rather than face the public embarrassment of forfeiting available federal dollars. On the other hand, SCHIP has illustrated the difficulties of using relatively inflexible federal statutory formulas, rather than the natural ebb and flow of caseload, to determine the amount of federal matching funds that go to each state's health program. With SCHIP-type statutory caps, some states receive too little money, others get more than they can responsibly spend, and disputes over redistribution of unspent funds periodically land on the Congressional agenda.

A more modest approach to limiting federal spending (which could either supplement or replace caps on enhanced match) would phase in enhanced match over time. For example, in the first year legislation is effective, such match could be limited to need-based eligibles with incomes below 50 percent of the FPL; in year two, it would reach 60 percent; and it would continue rising, in similar fashion, until reaching its maximum level. Alternatively, enhanced match could be phased in by age, with either the youngest or oldest working-age adults going first.

Finally, policymakers could consider other incentives for states to implement need-based coverage. For example, a state that provides such coverage could receive recession protection, whereby its standard federal matching rate for Medicaid would automatically increase in the future if national and state unemployment levels exceed specified levels. That way, a state that decided to cover all its poor residents would thereby insulate itself, to some degree, against the fiscal stresses induced by future recessions, when caseloads climb and revenues plummet.

Conclusion

In the typical state, two poor families can have identical incomes, identical needs for health coverage, work at identical jobs that do not offer health insurance, and even live next door to one another – but the adults in one family get Medicaid and those in the other do not, because one family has a minor child living at home and the other does not. Giving states the flexibility to end this inequity by covering both families, without any need to seek a federal waiver, would be an important step towards expanded health coverage that appears potentially supportable across much of the political spectrum. Investing additional federal resources in enhanced match could be important in encouraging states to make full use of that new flexibility. A number of options are available for federal policymakers to define the terms under which states could cover poor adults while taking into account federal fiscal constraints, fairness among states, and administrative feasibility.

Medicaid Coverage for Poor Adults: A Potential Building Block for Bipartisan Health Reform

Introduction

In recent years, one high point of bipartisan health reform was the 1997 creation of the State Children's Health Insurance Program (SCHIP). The SCHIP statute was based on similar proposals by a broad range of key policymakers, including Senators Hatch (R-UT), Kennedy (D-MA), Chafee (R-RI) and Rockefeller (D-WV) along with Congresswoman Nancy Johnson (R-CT) and Congressman Bob Matsui (D-CA). While early implementation of SCHIP was slow,¹ it has now grown to reach, over the course of a year, 5.8 million children who would otherwise be uninsured² and is widely regarded, across much of the political spectrum, as a success.

By contrast, the recent low point of bipartisanship in health reform may have been reached during the recession in late 2001 and early 2002. At that time, the debate over economic stimulus legislation included both Republican and Democratic proposals to spend approximately \$7 billion a year providing health coverage for laid-off workers.³ Despite this unusual consensus on domestic priorities and resources, policymakers could not agree on how to provide coverage. No one in Congress or the Administration bridged the gap between Republican plans for federal income tax credits that laid-off workers could use to buy COBRA coverage or non-group insurance, on the one hand, and Democratic proposals to subsidize COBRA coverage and provide Medicaid to unemployed workers, on the other. As a result, health insurance subsidies ultimately were stripped out of stimulus legislation before it passed, leaving millions of uninsured, laid-off workers without the health coverage that both parties were willing to provide (albeit in different forms).

Since then, other health legislation has passed with at least some bipartisan support. To cover a number of workers displaced by trade and early retirees, Health Coverage Tax Credits (HCTCs) were created as part of the Trade Act of 2002. However, soon after the legislation was signed, strong disagreement about the meaning of key statutory provisions erupted along party lines. More recently, after Medicare coverage of prescription drugs was adopted with only a modicum of Democratic participation, many Democrats

have vigorously questioned the legislation's key elements, seeking significant policy change rather than implementation without major modification.

While this history illustrates the difficulty of reaching bipartisan agreement on major health policy questions, it also shows the potential benefits of bipartisan support. Such support can increase the chances of both legislative success and successful policy implementation after a bill becomes law.

In 2005, federal policymakers may have an opportunity to enact an incremental expansion in health coverage. Towards that end, this paper analyzes health policy options focused at the 27 percent of the uninsured – 12 million people⁴ – who are working-age, poor adults. In particular, it asks whether a new Medicaid option aimed at this group could expand coverage in a way that garners bipartisan support. After briefly exploring the plausibility of bipartisan support for such a Medicaid expansion, this report sets out key facts concerning poor, uninsured adults; discusses features of the Medicaid program that affect these adults' insurance status; and then analyzes policy options and tradeoffs that would be involved in structuring an expansion.

Is bipartisan support for Medicaid possible?

In recent years, many conservative policymakers have been uncomfortable with proposed Medicaid expansions, for understandable reasons. The federal government's share of American health care spending grew from 9 percent to 33 percent during the final four decades of the Twentieth Century.⁵ Accordingly, some conservatives fear that continued expansion of federal health programs could presage the eventual adoption of a British- or Canadian-style single payer system.

However, policymakers who strongly oppose movement towards universalizing federal health programs can make a principled distinction in the case of the poorest uninsured, whose unique needs are well-matched to many basic features of Medicaid. These Americans lack the income needed to pay for health care without jeopardizing other basic household needs, like food, shelter, and utilities.⁶ Accordingly, Medicaid imposes no more than nominal costs, departing significantly from the design of most privately-funded coverage. Recognizing that the poorest Americans cannot supplement insurance and pay for significant services out of pocket, Medicaid provides more comprehensive benefits than many other forms of health coverage. A number of analysts with widely divergent views about expanding public programs to near-poor and moderate-income uninsured thus agree that the unique needs of the poorest uninsured make them appropriate for Medicaid coverage.**

** For example, Professor Mark Pauly of the Wharton School proposes extending Medicaid or similar public coverage to all Americans with incomes under 125 percent of the FPL, as part of a broader plan that also uses market incentives. Mark V. Pauly. "An Adaptive Credit Plan for Covering the Uninsured." *Covering America: Real Remedies for the Uninsured* (Elliot Wicks, ed., Jack A. Meyer, Project Director). Economic and Social Research Institute. June 2001. <http://www.esresearch.org/RWJ11PDF/pauly.pdf>. Similarly, Gail Wilensky of Project Hope suggests that Medicaid coverage of the uninsured with incomes below 100 or 125 percent of the FPL

To focus on proposals that have reasonable chances for broad support, this paper discusses only new options for state Medicaid programs, rather than new federal mandates that compel state spending.⁷ At a more basic level, conservatives' receptiveness to a proposed Medicaid expansion may be affected by the broader policy context. For example, a two-pronged reform strategy could combine (a) a Medicaid expansion for the poorest uninsured (perhaps as described in this paper) with (b) federal income tax credits and voluntary state-based purchasing pools offering a variety of private health plans to help a group of somewhat higher-income uninsured workers. As long as each prong was designed carefully to avoid triggering the intense concerns of policymakers on either side of the political spectrum, there could be room for bipartisan agreement on such a policy expansion that would significantly reduce the number of uninsured.

In addition, bipartisan support for Medicaid expansion might be enhanced if, without compromising any of the program's key safeguards, poor adults enrolled in Medicaid could have the ability to enroll in a broader range of health plans. Resolving this issue is beyond the modest scope of this paper. However, two preliminary observations are warranted. First, more beneficiary choices could increase health plans' competitive incentives to provide quality care and good customer service as well as give beneficiaries more ability to choose the plans that best meet their needs. Second, beneficiaries appear to face a real issue of declining health plan participation in Medicaid. As of 2003, 59 percent of Medicaid beneficiaries were enrolled in managed care plans, the highest such proportion ever recorded.⁸ Nevertheless, from 1998 (the high water mark of health plan participation) to 2003, while beneficiary enrollment in Medicaid managed care grew by 52 percent, the number of plans serving these Medicaid beneficiaries declined by 13 percent.⁹ Understandably concerned about potential Medicaid cutbacks, state officials have had little opportunity to focus on strategies to increase health plan participation,¹⁰ but with the likely easing of state fiscal burdens in coming years, it may be time to reexamine seriously the issue of increasing health plan competition and expanding beneficiary options in Medicaid.

may be a good place to start in designing bipartisan coverage expansions, particularly if Medicaid beneficiaries gain new health plan options. See, e.g., Ed Howard, Diane Rowland, Jonathan Gruber, Stuart Butler, Jack Meyer, Jeanne Lambrew, Jeffrey Lemieux, Gail Wilensky. *Evaluating Proposals to Expand Health Insurance: Finding The Right Balance?* June 14, 2004 (discussion transcript). http://www.allhealth.org/event_061404.asp; Diane Rowland, John Holahan, Gail Wilensky, Jeanne Lambrew. *Briefing: The Latest Trends in Health Coverage And the Uninsured Population and the Implications for Coverage Proposals*. kaisernetwork.org. September 27, 2004 (discussion transcript).

http://www.kaisernetwork.org/health_cast/uploaded_files/092704_kcmu_uninsured_transcript.pdf.

Professors Judy Feder and Ellen O'Brien of Georgetown University and the Kaiser Family Foundation's Larry Levit and Diane Rowland likewise propose expanding Medicaid to 150 percent of the FPL, using other strategies to help higher-income uninsured. Judith Feder, Larry Levitt, Ellen O'Brien, and Diane Rowland. "Assessing the Combination of Public Programs and Tax Credits." *Covering America: Real Remedies for the Uninsured* (Elliot Wicks, ed., Jack A. Meyer, Project Director). Economic and Social Research Institute. June 2001.

<http://www.esresearch.org/RWJ11PDF/feder.pdf>. Expanding and restructuring Medicaid to cover all poor adults has also been proposed by leading analysts at the Urban Institute. John Holahan, Alan Weil, and Joshua M. Wiener. "Which Way For Federalism And Health Policy?" *Health Affairs*. Web Exclusive, July 16, 2003.

<http://content.healthaffairs.org/cgi/content/full/hlthaff.w3.317v1/DC1>.

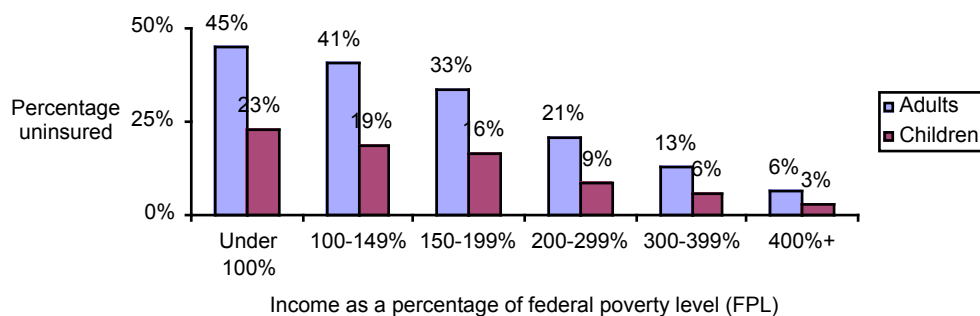
Conversely, bipartisan support would be endangered by any attempt to link the changes described in this paper to proposals that would weaken the two guarantees that many view as the core of today's Medicaid program: namely, the guarantee that individuals who qualify under their state's rules will receive health coverage; and the guarantee that the federal government will provide matching funds to any state that is willing to spend its own resources to provide coverage permitted under the federal Medicaid statute.

Key facts about uninsured, poor adults

As indicated above, 27 percent of the uninsured, or 12 million people,¹¹ are adults under age 65 with incomes below the Federal Poverty Level (FPL). For 2004, the FPL is \$9,310 a year for a single individual, \$12,490 for a two-person household, \$15,670 for a three-person household, etc.

Many features of this population make it a promising candidate for an incremental coverage expansion. First, compared to higher-income adults and to children of any income level, poor adults are particularly likely to be uninsured (Figure 1). They are also particularly unlikely to receive coverage from their employers (Figure 2). Among all poor adults, 45 percent are uninsured, and only 16 percent have employer-based insurance.¹²

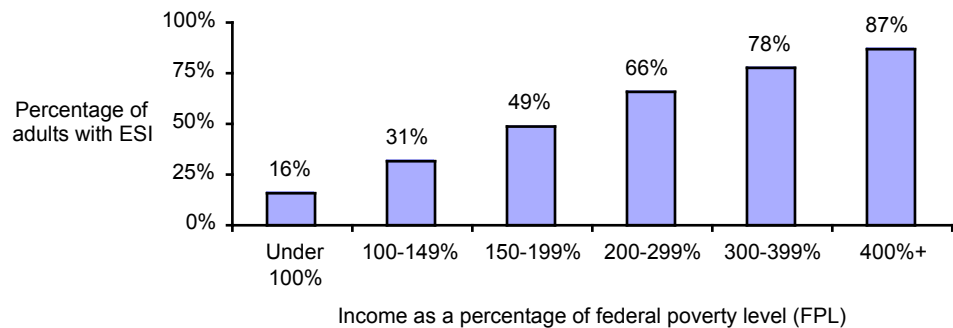
Figure 1. Uninsurance Among Children and Non-Elderly Adults, By Income: 2003



Source: Kaiser Commission on Medicaid and the Uninsured, September 2004.¹²

¹¹ These numbers are based on the March 2004 Annual Social and Economic Supplement to the Current Population Survey conducted by the U.S. Census Bureau. Other surveys have found similar results. For example, according to the National Health Interview Survey conducted by the National Center for Health Statistics during the first quarter of 2004, 42 percent of poor adults were then uninsured, compared to 37 percent of adults between 100 and 199 percent of FPL, and 11 percent of adults at or above 200 percent of the FPL; private coverage (including both employer-based coverage and privately purchased nongroup plans) reached 24 percent of poor adults, 46 percent of adults between 100 and 199 percent of the FPL, and 85 percent of adults with incomes at or over 200 percent of FPL; and 35 percent of poor adults (compared to 71 percent of poor children) received Medicaid or other publicly funded coverage. R.A. Cohen, C. Hao, and Z. Coriaty-Nelson. *Health Insurance Coverage: Estimates from the National Health Interview Survey, January – March 2004*. Division of Health Interview Statistics, National Center for Health Statistics. September 2004. <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur200409.pdf>.

Figure 2. Non-Elderly Adults' Receipt of Employer-Sponsored Insurance (ESI), by Income: 2003



Source: Kaiser Commission on Medicaid and the Uninsured, September 2004.¹³

The combination of high rates of uninsurance and low rates of employer-based coverage for poor adults suggest that targeting them for subsidies may be relatively efficient. That is, new public dollars could principally be used to cover the otherwise uninsured rather than substitute for or “crowd out” existing employer-based coverage.

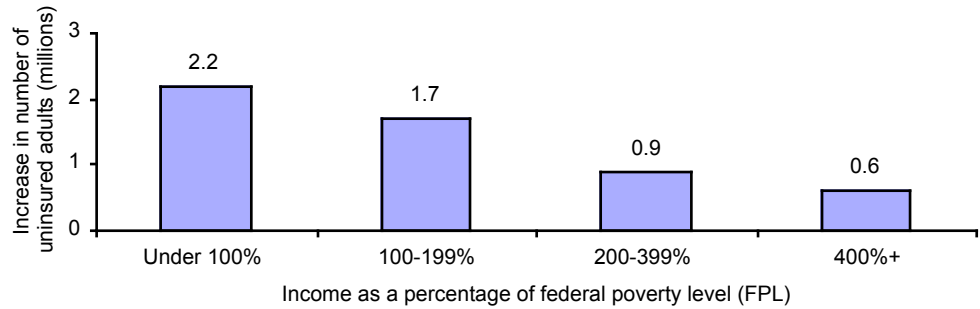
Poor, uninsured adults are important for a second reason as well. Between 2000 and 2003, the number of uninsured grew by more than 5 million, with the bulk of the increase coming among low-income adults. Notably, the number of uninsured adults with incomes below 100 percent of the FPL rose by 2.2 million — more than any other group (Figure 3).

Third, only a few uninsured, poor adults decline employer-based coverage. Among uninsured workers with incomes at or below the FPL, 64 percent have employers that do not offer insurance; 17 percent are ineligible for coverage their employers offer; and 20 percent qualify for their employers’ plans but are not enrolled.¹⁴

Fourth, uninsurance is rarely brief for poor adults. Altogether, 87 percent of poor adults who lack coverage at some point during the year are uninsured for at least 6 months, and two thirds (66 percent) are uninsured for 12 months or longer (Figure 4).^{**}

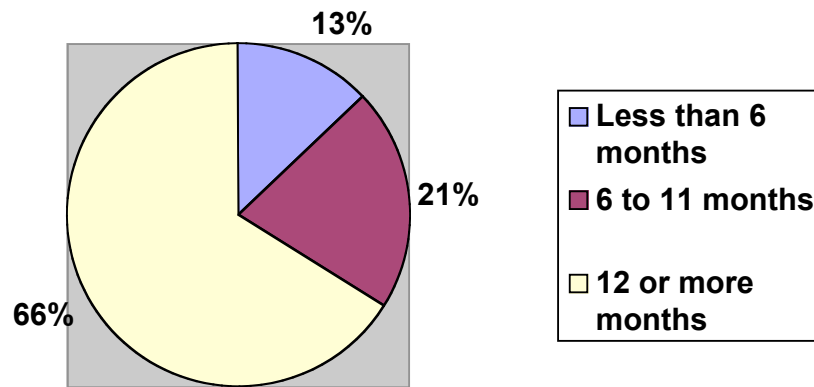
^{**} No published data reveal the proportion of uninsured, poor adults who are without coverage for specific periods longer than 12 months. However, the National Center for Health Statistics found that, among all children and adults with incomes under poverty who were uninsured when they answered the 2002 National Health Interview Survey, 59 percent had been without coverage for 36 months or longer. J. Schiller and L. Bernadel. *Summary Health Statistics for the U.S. Population: National Health Interview Survey, 2002*. National Center for Health Statistics. Vital Health Stat 10(220). May 2004. http://www.cdc.gov/nchs/data/series/sr_10/sr10_220.pdf. In all likelihood, that proportion would be even higher among poor adults, since uninsured, poor adults are more likely than are uninsured, poor children to lack coverage for long periods of time (12 months or longer). Jennifer Haley and Stephen Zuckerman. *Is Lack Of Coverage A Short- Or Long-Term Condition?* Urban Institute, for the Kaiser Commission on Medicaid and the Uninsured. June 2003. Calculations by ESRI, October 2004. <http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=45570/>

Figure 3. Increase In Number of Uninsured Adults, by Income: 2000 to 2003



Source: Urban Institute, September 2004 (Calculations by ESRI, October 2004).¹⁵ Note: This chart shows the distribution of increased uninsurance among adults. The number of uninsured children fell from 2000 to 2003.

Figure 4. Duration of Uninsurance Among Poor Adults Who Are Without Coverage at Any Point During the Year: 1998-1999



Source: Urban Institute, June 2003. Calculations by ESRI, October 2004.¹⁶

Finally, health coverage makes an enormous difference to poor adults' access to care. Several authoritative medical literature reviews have confirmed the overall impact of insurance coverage on receipt of health care and ultimately on health status.¹⁷ Similar conclusions have been reached by research that specifically concerns low-income adults. For example, one study found that, when uninsured, low-income adults in Tennessee received coverage through that state's expanded Medicaid program, the proportion reporting that they did not obtain essential doctor visits dropped from 64 percent to 34 percent; and the percentage who took prescription drugs less often than prescribed fell from 22 percent to 11 percent.¹⁸ Another study drawing on data from 13 states found that, when low-income adults were uninsured, their likelihood of obtaining any physician visits during the year declined by 29 percent and their chances of having any regular source of care outside hospital emergency rooms fell by 25 percent.¹⁹

In sum, poor, uninsured adults may be worth serious consideration by policymakers who wish to prioritize groups of uninsured for coverage based on factors that include the following:

- The prevalence of uninsurance within that group;
- The efficiency with which new resources can be targeted on uninsured members of the group;
- The group's contribution to recent increases in uninsurance;
- The group's lack of access to employer-sponsored insurance;
- The typical length of uninsurance within the group;
- The impact of health coverage on the group's access to necessary health care; or
- The inability of members of the group to purchase coverage on their own, without assistance.

Gaps in Medicaid coverage for working-age, poor adults

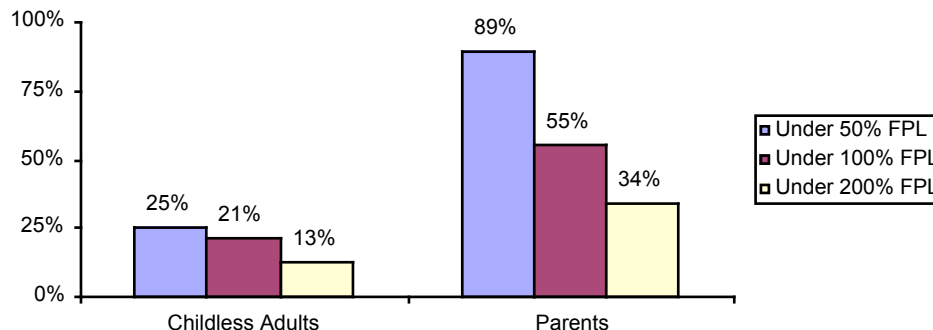
In 2003, Medicaid and similar publicly funded programs covered 61 percent of poor children but only 27 percent of poor adults.²⁰ Many well-informed observers of health policy believe that any poor, uninsured American can turn to Medicaid for help. While that is true of some in poverty – children, the elderly,²¹ and many people with permanent and total disabilities – millions of working-age, poor adults do not qualify for assistance. Among uninsured, poor adults, nearly two-thirds (64 percent) are ineligible for Medicaid and similar public programs.^{§§22}

There are two main reasons that most uninsured, poor adults are ineligible for Medicaid. First, federal law prohibits state Medicaid programs from covering adults—no matter how poor—unless they are pregnant, caring for dependent children, severely disabled, or elderly. Second, while states have the option to cover uninsured parents up to any income level, parental coverage in most states ends at some point between 50 and 100 percent of the FPL.

Accordingly, very few childless, low-income adults qualify for Medicaid, regardless of their income. Even among those with incomes below 50 percent of the FPL (currently \$388 a month for an individual), only one in four uninsured, childless adults qualifies for Medicaid. By contrast, the very poorest uninsured parents qualify for Medicaid in most states, with major gaps in coverage emerging as family incomes rise slightly above 50 percent of the FPL. While 89 percent of uninsured parents with incomes below 50 percent of the FPL qualify for Medicaid, only 55 percent of those with incomes below 100 percent of FPL are eligible (Figure 5).

^{§§} As noted above, poor, uninsured adults, as a whole, are typically uninsured for long periods of time. That is particularly true for such adults who are ineligible for Medicaid, of whom nearly three-fourths (72 percent) are uninsured year-round. Haley and Zuckerman, *op cit*.

Figure 5. Percent of Low-Income, Uninsured Adults Who Qualify for Medicaid or Similar Programs, by Income and Parenting Status: 1999



Source

Source: Urban Institute, April 2004 analysis of 1999 National Survey of America's Families.²³ Note: the childless adults portrayed in this chart do not include elderly or disabled recipients of Supplemental Security Income (SSI).

The following sections explore these limits on Medicaid coverage for low-income childless adults and parents, in turn.

Medicaid's prohibition on coverage for childless adults

Largely for historical reasons, the federal Medicaid program forbids states from covering adults—no matter how poor—unless they are pregnant, caring for dependent children, severely and permanently disabled, or elderly. While states can ask federal officials for waivers to relax this prohibition, such waivers do not provide additional federal resources.

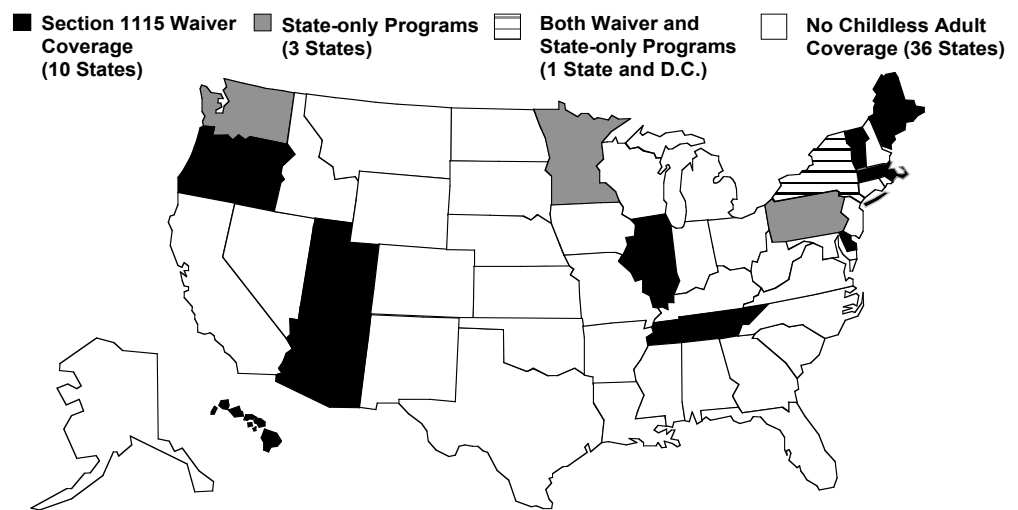
In 36 states – nearly three-fourths of the country – these childless adults are flatly ineligible for assistance since their states do not offer them coverage through either waivers of standard Medicaid rules or state-only funding (Figure 6).²⁴ It is thus no surprise that childless adults comprise slightly more than half (51 percent) of all uninsured Americans whose family incomes are below poverty (Figure 7).

Why doesn't Medicaid cover childless adults?

In many ways, Medicaid's exclusion of childless adults reflects decisions that were made in establishing national income support programs during the Great Depression. When Medicare and Medicaid were created in 1965, Medicaid started as a fairly simple adjunct to federally assisted cash assistance programs for the elderly, the disabled, and families with dependent children, without any revision to those programs' basic structure. These cash aid programs, in turn, had been created by the Social Security Act of 1935, departing significantly from the previous tradition of locally-based relief for the poor, which began in England with the Elizabethan Poor Law of 1601 and was later exported to Colonial America. When the Depression-era cash aid programs began, localities remained responsible for low-income people outside the new programs' scope, including childless, working-age adults. With income assistance that was locally-funded rather than federally matched, childless adults were thus outside Medicaid's original purview. During Medicaid's later evolution, eligibility expanded incrementally beyond the limits of federally-funded cash assistance, with eligibility categories added one at a time, each of which resembled previously covered groups. However, such step-by-step expansions have not directly addressed Medicaid's basic eligibility structure, which is limited to families with dependent children, on the one hand, and the elderly and people with permanent and total disabilities, on the other.

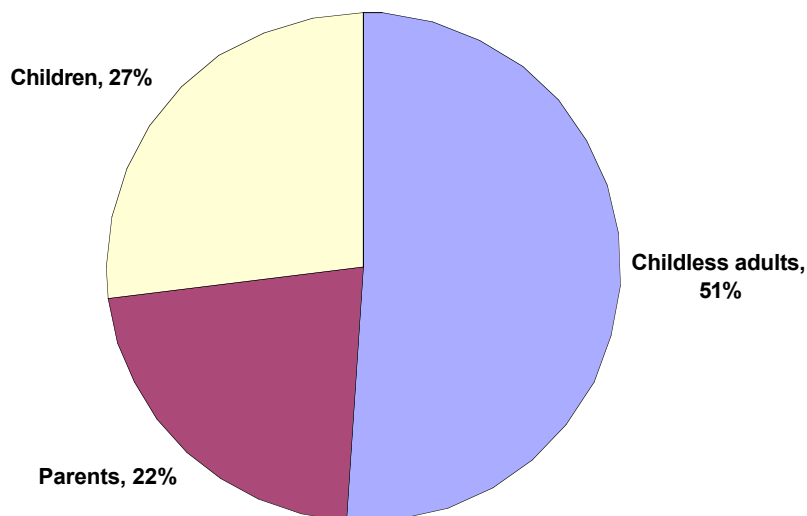
Of course, this history reflects attitudes about which groups of low-income people "deserve" assistance, with childless, non-disabled, working-age adults regarded, by some, as less deserving of help. However, that judgment was originally made in the 1930s, almost 70 years ago. Moreover, it developed in the context of income support, not health care. A key question for policymakers today is whether Medicaid's exclusion of childless adults continues to make sense in 2004 and beyond.

Figure 6. States Providing Medicaid or Other Coverage to Childless Adults: January 2004



Source: Economic and Social Research Institute, August 2004.²⁵ Note: New Mexico is not shown as covering childless adults because its waiver to provide such coverage had not been implemented as of January 2004.

Figure 7. Uninsured With Incomes Below Poverty, By Relationship To Children: 2002



Source: Urban Institute analysis of March 2003 CPS data, prepared for the Kaiser Commission on Medicaid and the Uninsured.²⁶

A special case: near-elderly childless adults

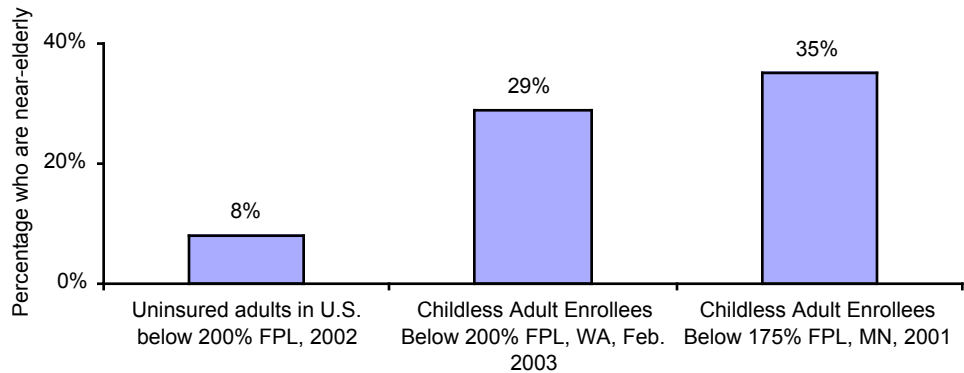
Before moving on to discuss Medicaid coverage of parents, it is important to make clear that so-called “childless adults” include older parents whose children have grown. Such “empty-nesters” do not qualify for Medicaid as parents of currently dependent children. That may be why the few non-Medicaid programs that have covered childless adults and tracked their demographics have found that roughly a third are in their 50s and 60s (Figure 8).

From the perspective of either duration of uninsurance or the impact of uninsurance on health status, this is a group of great concern. While adults nearing retirement age are, in general, unlikely to be uninsured, the comparatively few older adults who lack health coverage tend to be uninsured for long periods of time. Among adults who were uninsured at any point from 1996 to 1999, 22 percent of uninsured 55-64 year olds were without coverage for all four years, compared to 13 percent of uninsured adults ages 19-54.²⁷

The Institute of Medicine has concluded that older, uninsured adults would experience particularly great health status gains from receiving coverage.²⁸ Subsequent research suggests that this is especially true for near-elders with low incomes (Figure 9).

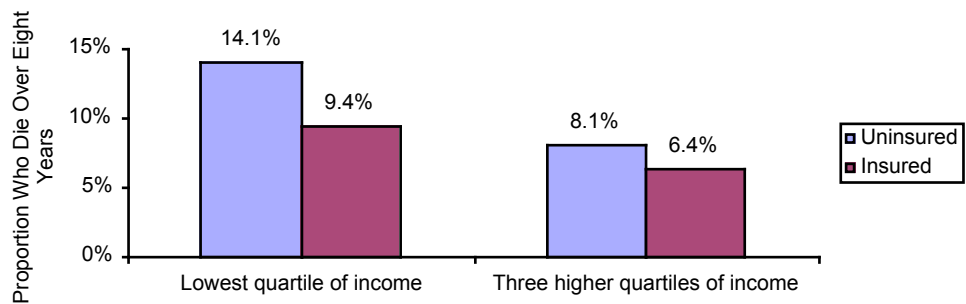
Overall, this analysis suggests that expanding Medicaid coverage to reach low-income adults under age 65 who are not current custodial parents could be an effective means of helping a relatively small group of uninsured – namely, low-income near-elders – who have particularly serious needs for coverage.

Figure 8. Share of Near-Elderly Among Uninsured Adults Nationally and Enrollees in Two States' Childless Adult Programs, 2001-2003



Source: Economic and Social Research Institute, August 2004;²⁹ Kaiser Commission on Medicaid and the Uninsured, January 2003.³⁰ Notes: (1) These two states are the only comprehensive programs that cover childless adults and that have published data showing the ages of childless adult enrollees. (2) For the U.S. and Washington, the bars show the percentage of 55-64 year-olds among all non-elderly adults within each category. Minnesota displays its published data differently, classifying adults as near-elderly starting at age 50.

Figure 9. The Impact of Insurance and Income on the Odds of Death Over an Eight-Year Period Among Adults Age 55 to 64: 1992-2000



Source: McWilliams, Zaslavsky, et al., July/August 2004.³¹ Notes: (1) This study by researchers at Brigham and Women's Hospital and Harvard University isolated the impact of insurance and income by adjusting mortality rates to control for factors like race and ethnicity, diagnosed illnesses, household size, census region, self-reported recent change in health, work limits imposed by health, job stress, physical effort required by job, daily alcohol consumption, exercise habits, expected probability of survival to age seventy-five, the number of hospital stays in the prior twelve months, etc. (2) While the researchers found a statistically significant relationship between insurance status and mortality rates among low-income near-elders, no such relationship obtained for near-elders in the three highest income quartiles. However, statistically significant relationships between insurance status and mortality were observed among various groups of near-elders that were defined without regard to income, including near elders who had been diagnosed with diabetes, hypertension, or heart disease.

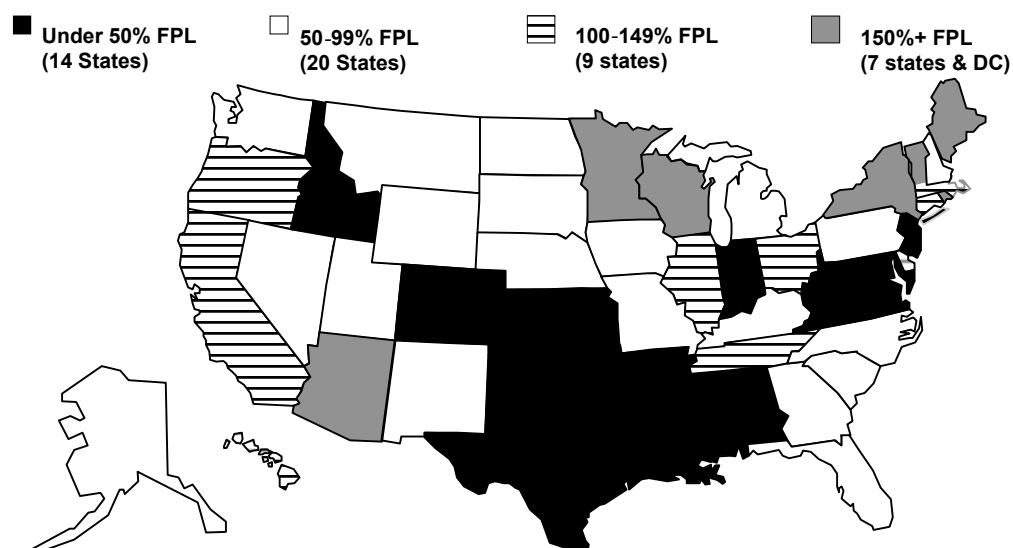
Limits on Medicaid coverage for parents

Unlike childless adults, low-income parents can receive Medicaid coverage up to any income level desired by state officials. No waiver is needed. As with children, people with disabilities, pregnant women, and seniors, parents can have their coverage expanded by a simple change in their state's Medicaid plan on file with the Center for Medicare and Medicaid Services (CMS). However, a waiver from CMS is required for a state to use unspent SCHIP funds to cover low-income parents. Such waivers offer states some financial advantages, since SCHIP's federal matching rate is higher than Medicaid's.

Despite these options, the median state denies coverage to working parents if their income exceeds 69 percent of the Federal Poverty Level (FPL), or \$901 a month for a family of three in 2004. The following figure shows the eligibility level at which each state covers uninsured, low-income parents.

Covering uninsured, low-income parents would yield a potentially significant, additional benefit. According to considerable research,³² uninsured children are much more likely to be enrolled in health programs when their parents also qualify. Accordingly, covering low-income parents up to income levels characteristic of Medicaid (typically 100 percent to 133 percent of FPL) or even SCHIP (200 percent of FPL) would help address the problem that more than half (56 percent) of all uninsured children nationally are eligible for but not enrolled in Medicaid or SCHIP.³³

Figure 10. Medicaid coverage of working parents, by income: July 2004



Source: Center on Budget and Policy Priorities, October 2004.³⁴ Notes: (1) In Pennsylvania, Utah, and Washington State, this map shows income eligibility for uncapped Medicaid, rather than programs with higher income levels but enrollment caps that prevent some eligible parents from receiving coverage. (2) In 40 states, income eligibility levels for non-working parents were lower than for working parents. In the median state, coverage for non-working parents ended at 42% of FPL, or \$548 a month for a 3-person family.

How could Medicaid be revised to increase coverage of poor adults?

To explore this basic issue, the following sections analyze two more specific questions in turn: First, what additional coverage options would allow states to cover poor adults without any need for federal waivers? Second, what additional federal funding (if any) should be offered that would encourage states to implement this new option and expand coverage significantly?

New state options to cover poor adults

One approach would define the covered group as poor adults who are neither pregnant, parenting, disabled, nor elderly. While it would be tailored specifically to fill the hole in Medicaid's current eligibility structure, that approach could prove cumbersome. For example, it would require applicants to prove that they are not disabled, bringing into play the costly and prolonged process whereby the Social Security Administration determines whether an individual meets the Medicaid program's stringent definition of permanent and total disability.³⁵ Defining the new eligibility category in this way could also raise concerns about equity, if its income eligibility exceeded levels that applied to other categories, such as low-income parents.

A more administratively feasible and equitable approach would define the new eligibility group in terms of need. That is, states could be given the option to provide "need-based Medicaid" to all adults or all households with incomes below a level chosen by the state.^{***36}

To increase prospects for bipartisan support by addressing the concerns of those who fear the indefinite expansion of federal health programs, policymakers may need to impose an upper income bound to this group – perhaps 100 or 125 percent of the FPL. If national officials wish to make this limit unyielding, states would need to be denied the flexibility to use less restrictive income methodologies than are applied to other beneficiaries. In the past, many states have used such methodologies to cover children and pregnant women above the nominal caps specified in federal law. For example, federal Medicaid law requires states to cover all children ages 6 through 18 with family incomes up to 100 percent of the FPL. Even before adoption of SCHIP, a state could cover and receive federal match for these school-aged children up to any desired level by using such "less restrictive methodologies." Typically, such a state would "disregard" enough earnings that children in moderate-income families would nevertheless be classified as having family income at or below 100 percent of the FPL.

Whether or not federal policymakers limit state flexibility to establish income methodologies, this eligibility category needs to be in addition to, rather than instead of, existing Medicaid eligibility groups. Some may advocate for program simplification by collapsing

***Of course, current Medicaid eligibility groups also have requirements related to need. However, this new group would be more purely based on need in that household characteristics like disability, pregnancy, parenthood, and potentially even age would be irrelevant to eligibility.

multiple eligibility categories into one, need-based group, but states need to retain the ability to keep current eligibility categories, many of which cover some individuals who could be outside the parameters of need-based Medicaid.³⁷ Not only could eliminating current state eligibility options endanger bipartisan support, expanding coverage to some low-income Americans while requiring states to take it away from others raises serious substantive questions. And as a practical matter, adoption of need-based Medicaid could simplify the program, even in states that choose to retain other, largely vestigial eligibility groups. Many individuals previously covered through multiple, discrete categories would fit into need-based eligibility, allowing modest savings in Medicaid administrative costs.

Enhanced federal matching funds to encourage state implementation

If policymakers simply created a new Medicaid eligibility option, with federal matching funds available as usual under Medicaid, some states would surely join the 15 jurisdictions that already cover childless adults. One reason would be the potential to replace some current state-only spending on such adults (such as for indigent care, mental health services, etc.) with federal matching funds. However, if federal matching funds were available at an enhanced level, implementation would be more extensive, and states would have increased incentives to raise eligibility for low-income parents above the current median income level of 69 percent of the FPL.

If policymakers decide to promote expanded coverage with enhanced federal funding, a key question is whether significantly enhanced funding (such as at SCHIP levels) would cover the new coverage group alone or whether a much smaller increase in federal matching rates (perhaps in the neighborhood of 5 percent) would apply to the entire Medicaid program of each state that enacts new coverage options. The next two sections of this paper discuss these two alternatives in turn, and the third explores additional design questions policymakers offering enhanced match would need to answer, regardless of which basic approach they take.

First basic approach: providing significantly enhanced funding that is limited to the new coverage category

This policy would give states incentives to enroll eligible individuals and expand coverage. However, states could also have incentives to manipulate such a system to receive federal matching funds for currently eligible adults while minimizing new state costs of covering previously ineligible individuals.³⁸ That is, a state could obtain enhanced federal funding by placing into the new need-based category many individuals who would have been covered under the state's former eligibility rules, such as adults with disabilities, pregnant women, and parents. At the same time, the state could minimize enrollment of previously ineligible adults (hence limit new state costs) by constraining outreach and creating procedural barriers such as long application forms, onerous documentation requirements, and short eligibility periods followed by burdensome requirements for recertifying eligibility.³⁹

Unfortunately, the interposition of procedural barriers to deter enrollment is not purely imaginary. For example, several years ago then-Governor Gray Davis of California pro-

posed cutting that state's Medicaid costs substantially by increasing the frequency of required eligibility re-certifications, explicitly anticipating that nearly 200,000 previously eligible individuals would not meet the new procedural burdens and so would lose coverage.⁴⁰ Since then, a number of additional states in fiscal difficulty have curbed enrollment of eligible families by reducing outreach and imposing procedural barriers to gaining and retaining coverage.⁴¹

To prevent such diversion of new federal funds away from their intended purpose of coverage expansion, policymakers could limit enhanced match to individuals who would not have qualified for coverage under their state's previous Medicaid rules. Such individuals could be identified during the eligibility determination process for each application. However, that would burden applicants by requesting information not necessary to determine contemporaneous Medicaid eligibility. Such burdens could both lower the number of uninsured individuals who enroll and increase Medicaid administrative costs.

Alternatively, the proportion of beneficiaries in the new eligibility group who would have qualified under the state's previous Medicaid eligibility rules could be determined by sampling a small but statistically valid percentage of each state's need-based enrollees, disallowing the corresponding portion of the state's claim for federal matching funds. For many years, Medicaid has used a similar approach to disallow improper state claims for federal match.

While it would forestall much state manipulation, limiting enhanced funding to individuals ineligible under prior state law would also create interstate inequities. The fewest new dollars would go to the states that previously did the most to cover their low-income adults. Something similar happened with the original SCHIP program, which denied enhanced matching funds to children covered under previous state law. The cumulative effect of such a policy for poor adults, following on the heels of SCHIP, could deter states in the future from expanding coverage in other ways, out of fear that such expansions could once again turn out to disqualify them from new federal dollars.

Another approach would provide enhanced match for *increased enrollment* of low-income, non-elderly adults. States that previously offered generous coverage to such adults could still qualify for enhanced federal match by improving their outreach and enrollment. More broadly, this approach would provide increased federal incentives, not just for expanding eligibility categories on paper, but also for actually enrolling eligible individuals.

A "caseload-based" approach could also be simpler to administer, particularly if the caseload involved was defined simply as Medicaid-covered adults under age 65. Such stark simplicity would have its consequences, of course. Enhanced match would not be limited to individuals receiving coverage through new eligibility categories. As a result, factors completely extraneous to the coverage expansion could have a major impact on a state's receipt of enhanced funding. For example, prevailing economic conditions entirely outside state control can increase or reduce overall enrollment significantly. Also, the number of non-elderly adults receiving Medicaid can be greatly affected by state coverage rules and outreach strategies for people with disabilities and pregnant women. While some policymakers would support increased federal funding during recession, and encouraging states to increase their coverage of people with disabilities and expectant mothers could yield important public health benefits, states would not be assured of en-

hanced funding for need-based eligibles in a predictable way under such a simple, caseload-based approach.

Alternatively, policymakers could use a composite strategy like the following to balance the above concerns about federal fiscal integrity, interstate equity, administrative feasibility, and predictability to state budget officers. First, officials would determine the baseline level of enrollment for low-income adults in a state, excluding people with disabilities, seniors, and pregnant women. Second, the state could then claim enhanced funding for both (a) any need-based eligibles who *would not* have qualified for Medicaid under previous state law; and (b) enrollment above the baseline level of low-income adults who *would* have qualified under previous state law (excluding pregnant women, seniors, and people with disabilities). Federal authorities could use caseload sampling to identify the extent of state claims for enhanced reimbursement that fall outside these two categories. Under this approach, states expanding coverage to new groups would be assured of enhanced federal funding for the resulting costs; and states that previously offered generous coverage could access enhanced funding by improving their outreach and enrollment of low-income adults.

Second basic approach: providing slight increases in federal funding for all Medicaid costs in states that implement the new coverage option

Policymakers instead could raise the general Medicaid matching percentage, for all program expenditures, in states that implement the new coverage category.⁴² The increased match across all program populations would be intended to compensate states for their share of new coverage costs without the federal government paying different matching rates for different eligibility groups.

To convert this general concept into specific policy, national policymakers would need to resolve several questions. As with the first basic approach described in the previous section, one important challenge is avoiding creating incentives for states to qualify for enhanced federal match by enacting need-based coverage on paper while limiting the number of new enrollees and the resulting state costs by conducting little or no outreach and creating barriers to enrollment and retention.

To prevent the development of such incentives, national policymakers could limit enhanced federal funding to states that meet process or outcome measures showing effective implementation of new coverage in reality, not just on paper. For example, process measures could include implementation of outreach and procedural simplification policies undertaken by most SCHIP programs. Outcome measures could consist of targets for enrollment and retention based on the number of uninsured residents potentially qualifying for new coverage. While some may view such process measures as unduly intrusive into state discretion, sound outcome measures may be difficult to establish with much validity, given the typical limitations of available data on the characteristics of uninsured residents in particular states.

Policymakers pursuing this approach also need to decide whether to provide enhanced federal matching funds for partial state implementation of the new coverage category. For example, if new legislation increased federal match by 5 percent for a state that covered all adults with incomes up to 100 percent of FPL, the federal share could increase by 2.5 percent in a state that covered adults with incomes up to 50 percent of FPL. Such an op-

tion would provide graduated incentives to implement the new coverage category, encouraging states to do what they believe they can afford.

Finally, policymakers would need to decide whether to exclude institutional long-term care costs from Medicaid expenses qualifying for increased matching funds. Since the expansion in coverage is limited to the so-called “acute care side” of Medicaid, it makes some sense to apply a similar limit to enhanced funding. Moreover, providing a higher matching rate for services other than institutional long-term-care could give states a modest incentive to provide services that forestall institutionalization.

Questions for both approaches to enhanced federal match

Regardless of which of these two, basic approaches policymakers use to enhance federal match, one important issue to resolve is whether to follow SCHIP’s model and cap the annual amount of enhanced federal funding available to each state. As with SCHIP expansions implemented through Medicaid, once a state exhausted its annual allotment of enhanced dollars, match could revert to standard Medicaid levels for the remainder of the year. A state failing to implement new optional eligibility or otherwise failing to spend its allotment would forfeit its dollars to other states. The amount of enhanced matching funds could start small and grow over time, reflecting program start-up in the first few years and perhaps some measure of health care inflation thereafter. The distribution of enhanced funds among the states would need to be determined as well.

One advantage of this approach is that it would avoid the possibility of federal spending outrunning projections. Paradoxically, such a limit could also encourage implementation in some states, since officials failing to provide new coverage and spend their allotment of federal funds would face the political embarrassment of returning “their state’s money” to the Treasury. On the other hand, the potential mid-year expiration of enhanced federal funds could deter states from establishing need-based coverage, which (depending on the details of state law)⁴³ might remain in place even if federal matching reverted to standard levels.⁴⁴

More broadly, SCHIP illustrates some of the challenges of basing a state’s allotment of federal matching funds on a formula fixed in federal law rather than the ebb and flow of state caseload. Some states quickly exhaust their annual SCHIP allotments, others find it difficult or impossible to spend more than a fraction of their grants responsibly, and disputes over redistributing unspent SCHIP allotments now come before Congress with increasing regularity.

A more modest approach to limiting federal costs (which could either supplement or replace caps on enhanced match) would phase in enhanced matching funds, perhaps based on income. For example, enhanced funding could be limited to beneficiaries with incomes at or below 50 percent of the FPL during the legislation’s first year in effect and 60 percent in the second year, with similar increases in subsequent years until reaching the maximum income level.

Alternatively, enhanced federal funding could be phased in based on age. Policymakers could start with the oldest adults and gradually extend enhanced match to progressively younger groups, since: (a) insurance coverage affects the health status of older adults more than younger ones; (b) older adults are less likely to be covered as Medicaid parents

of minor children living at home; and (c) coverage of older adults generates offsetting Medicare savings, as 65-year-olds need less care, on average, if they recently had insurance.⁴⁵ On the other hand, policymakers could start with the youngest adults, since: (a) they are the age group most likely to lack insurance; (b) they are the lowest-cost group to insure; and (c) the youngest workers tend to have the lowest incomes.⁴⁶

A final question facing policymakers under either approach is whether to offer additional incentives for states to expand coverage. For example, a state meeting certain benchmarks for coverage expansion (such as coverage up to specified and increasing percentages of FPL each year) could receive recession protection, whereby the state's matching percentage would automatically increase if both national and state unemployment rates exceeded specified levels. Under this approach, a state meeting its coverage benchmarks would be shielded during future recessions, to some degree, from significant increases in state Medicaid costs when economic downturns cause enrollment to spike and revenues to plummet.

The figures on the following pages illustrate the decisions facing policymakers who decide to offer enhanced federal funding to encourage state implementation of new, optional Medicaid coverage.

Conclusion

In most of America, two poor families who live next door to one another can have identical incomes, identical needs for health coverage, and work at identical jobs that do not offer health insurance – but the adults in one family get Medicaid and those in the other do not, because one family has a minor child living at home and the other does not. Giving states the flexibility to remedy this inequity by covering both families, without any need to seek a federal waiver, would be an important step towards expanded health coverage that could be supportable across much of the political spectrum. Investing additional resources in enhanced federal match could be important in encouraging states to make full use of that new flexibility. A number of options are available for federal policymakers to define the terms under which such a new option would allow coverage of poor, working-age adults while taking into account federal fiscal constraints, fairness among states, and administrative feasibility.

Figure 11. Decisions About Enhanced Match (EM), Part I

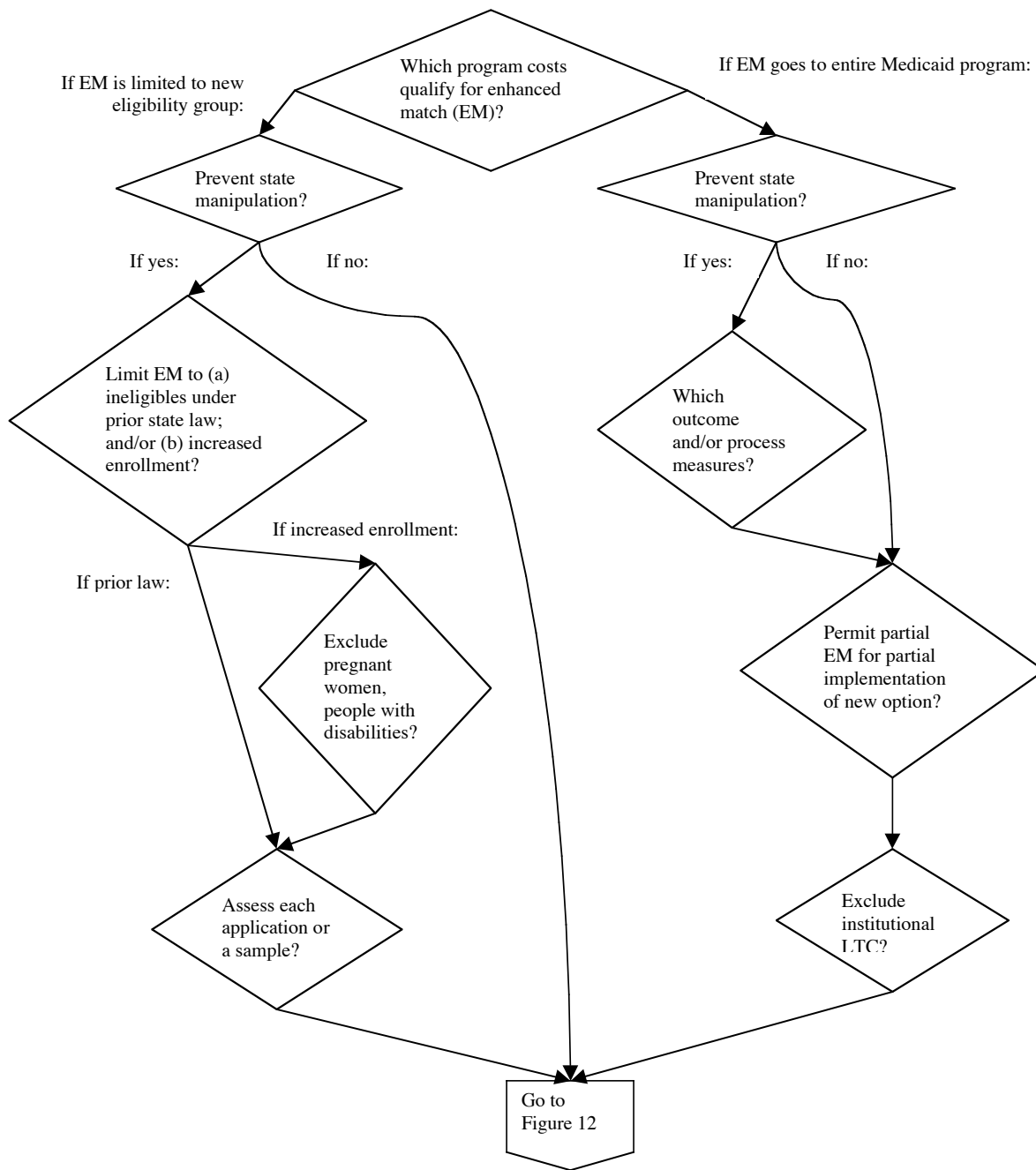
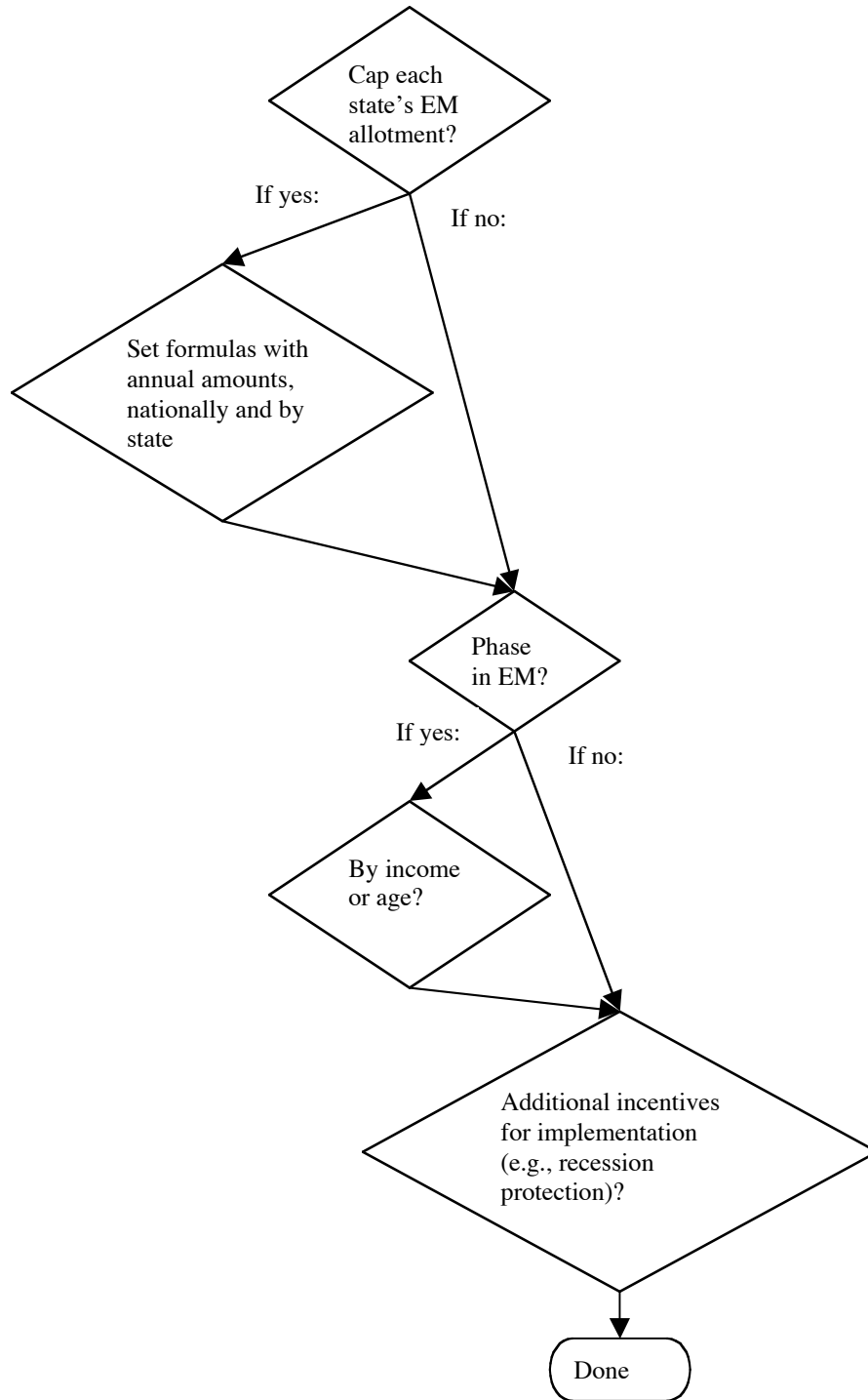


Figure 12: Decisions About Enhanced Match (EM), Part II



Notes

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<http://www.cms.hhs.gov/medicaid/managedcare/trends03.pdf>.

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¹⁸ Lorenzo Moreno and Sheila Hoag. "Covering The Uninsured Through TennCare: Does It Make A Difference?" *Health Affairs*. Vol. 20, No. 1 (January/February 2001). Mathematica Policy Research. <http://content.healthaffairs.org/cgi/reprint/20/1/231>.

¹⁹ Brenda C. Spillman, Stephen Zuckerman, and Bowen Garrett. *Does the Health Care Safety Net Narrow the Access Gap?* The Urban Institute. April 2003.

http://www.urban.org/UploadedPDF/310668_DP03-02.pdf.

²⁰ Kaiser 2003 Data Highlights, calculations by ESRI (October 2004).

²¹ All seniors with incomes at or below 120 percent of the FPL qualify for Medicaid coverage of certain unreimbursed Medicare costs. At lower income levels that vary by state, seniors qualify for all Medicaid services and costs that are outside Medicare's coverage.

²² Amy Davidoff, Anna S. Sommers, Jennifer Lesko, and Alshadye Yemane. *Medicaid and State-Funded Coverage for Adults: Estimates of Eligibility and Enrollment*. The Urban Institute, prepared for the Kaiser Commission on Medicaid and the Uninsured. April 2004.

<http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=35461>.

²³ Davidoff, et al., op cit.

²⁴ Stan Dorn, Sharon Silow-Carroll, Tanya Alteras, Heather Sacks, and Jack Meyer. *Medicaid and Other Public Programs for Low-Income Childless Adults: An Overview of Coverage in Eight States*. Economic and Social Research Institute, prepared for the Kaiser Commission on Medicaid and the Uninsured. August 2004.

<http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=46175>.

²⁵ Dorn, et al., op cit.

²⁶ Dorn, et al., op cit.

²⁷ Pamela Farley Short and Deborah R. Graefe. "Battery-Powered Health Insurance? Stability In Coverage Of The Uninsured." *Health Affairs*. Vol 22, Issue 6, 244-255. November/December 2003. Calculations by ESRI, October 2004.

http://content.healthaffairs.org/cgi/content/full/22/6/244?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=short&andorexactfulltext=and&searchid=1090871866134_2825&stored_search=&FIRSTINDEX=0&volume=22&resourcetype=1&journalcode=healthaff

²⁸ Committee on the Consequences of Uninsurance, op cit.

²⁹ Dorn, et al., op cit.

³⁰ Catherine Hoffman and Marie Wang. *Health Insurance Coverage in America: 2002 Data Update*. Kaiser Commission on Medicaid and the Uninsured. January 2003.

<http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=29340>.

³¹ J. Michael McWilliams, Alan M. Zaslavsky, Ellen Meara and John Z. Ayanian. "Health Insurance Coverage and Mortality Among The Near-Elderly." *Health Affairs*. Vol 23, Issue 4, 223-233. July/August 2004. <http://content.healthaffairs.org/cgi/content/abstract/23/4/223>.

³² Anna Aizer and Jeffrey Grogger, *Parental Medicaid Expansions and Health Insurance Coverage*, Economic Research Initiative on the Uninsured Working Paper 20, June 2003,

<http://www.umich.edu/~eriu/pdf/wp20.pdf>; Richard E. Curtis and Edward Neuschler, "Premium

Assistance," *Health Insurance for Children: Creative Solutions*, The Future of Children, Spring 2003, http://www.futureofchildren.org/usr_doc/tfoc13-1_syn11.pdf; Amy Davidoff, Lisa Dubay, Genevieve Kenney, Alshadye Yemane, "The Effects of Parents' Insurance Coverage on Access to Care for Low-Income Children," *Inquiry* 40, no. 3 (2003): 254-268,

<http://www.inquiryjournalonline.org/inqronline/?request=get-document&issn=0046-9580&volume=040&issue=03&page=0254>; and Lisa Dubay and Genevieve Kenney, "Expanding

Health Insurance Coverage to Parents: Effects on Children's Coverage under Medicaid," *Health Services Research* 38, no. 5 (2003): 1283-1302,

<http://www.ingenta.com/isis/searching/Availability/ingenta;jsessionid=5mefb4mgd222f.circus?pub=infobike://bpl/hesr/2003/00000038/00000005/art00007&targetId=1090871634097>.

³³ Genevieve M. Kenney, Jennifer M. Haley, Alexandra Tebay. *Children's Insurance Coverage and Service Use Improve*. Urban Institute. July 31, 2003.

<http://www.urban.org/Template.cfm?NavMenuID=24&template=/TaggedContent/ViewPublication.cfm&ionID=8496>

³⁴ Donna Cohen Ross and Laura Cox. *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families*. The Center on Budget and Policy Priorities, prepared for the Kaiser Commission on Medicaid and the Uninsured. October 2004.

<http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=47039>.

³⁵ Social Security Administration (SSA). *How long does it take to get notified of a decision about disability benefits?*

Accessed on March 14, 2003. <http://ssa-custhelp.ssa.gov>. See also SSA. *Fiscal Year 2004 Annual Performance*

Plan and Revised Final FY 2003 Annual Performance Plan. "Part V: Programs Rated Using OMB's Program

Assessment Rating Tool." http://www.ssa.gov/performance/2004/PartV-PART_312.pdf. Simi-

larly, this approach would require female applicants for need-based Medicaid to prove that they were not pregnant. Under federal law, every state Medicaid program covers pregnant women up to at least 133 percent of the FPL. If need-based Medicaid did not cover people above that income level, then women who were income-eligible for need-based Medicaid would necessarily qualify for pregnancy-related Medicaid as well, making a showing of non-pregnancy pointless (except in states where pregnant women receive fewer services than do other beneficiaries).

³⁶ For an earlier discussion of such "need-based Medicaid," see Lynn Etheredge and Judith Moore. "A New Medicaid Program." *Health Affairs*. August 27, 2003 (Web Exclusive).

<http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.426v1>.

³⁷ For example, many people with disabilities and seniors qualify for Medicaid through their receipt of Supplemental Security Income (SSI), which is limited to individuals with income below a defined level that is less than 100 percent of FPL. However, SSI typically disregards half of earnings in determining eligibility. If need-based Medicaid used a less generous income determination

method that did not include this disregard, many SSI recipients with nominal incomes below the federal poverty level would nevertheless be ineligible for need-based Medicaid.

³⁸ For examples of similar state actions in the past, see the following reports by the General Accounting Office (GAO): *Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed*. GAO-04-228. February 13, 2004; *Medicaid: HCFA Reversed Its Position and Approved Additional State Financing Schemes*. GAO-02-147. October 30, 2001; *Medicaid: State Financing Schemes Again Drive Up Federal Payments*. GAO/T-HEHS-00-193. September 6, 2000; *State Medicaid Financing Practices*. GAO/HEHS-96-76R. January 23, 1996; *Michigan Financing Arrangements*. GAO/HEHS-95-146R. May 5, 1995. *Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government*. GAO/HEHS-94-133. August 1, 1994. These reports are all available at <http://www.gao.gov/>

³⁹ Cohen Ross and Cox, op cit.

⁴⁰ The proposed budget for 2003-2004 projected that 193,000 eligible adults would lose coverage based on the reinstatement of quarterly income reporting. California Department of Finance, *Governor's Budget Summary 2003-2004, Health and Human Services*, January 10, 2003. http://www.dof.ca.gov/HTML/Budgt03-04/BudgetSum03/12_HHS_Trad.pdf.

⁴¹ Cohen Ross and Cox, op cit.

⁴² This approach is broadly based on ideas from Urban Institute analysts who have explored raising the federal government's share of Medicaid, across the board, as part of a general reshuffling of federal and state responsibilities for Medicaid and SCHIP that goes far beyond the more modest approach discussed here. John Holahan, Alan Weil, and Joshua M. Wiener. "Which Way For Federalism And Health Policy?" *Health Affairs*. Web Exclusive, July 16, 2003. <http://content.healthaffairs.org/cgi/content/full/hlthaff.w3.317v1/DC1>.

⁴³ In states with statutes that govern their Medicaid programs with great specificity, enactment of need-based eligibility could force a state Medicaid agency to return to the Legislature and request scaled-back eligibility, if the state's enhanced federal matching funds expired mid-year. On the other hand, no such return would be needed if the state's Medicaid statute gives health agencies the discretion to implement (or not to implement) any coverage for which federal match is available. Similarly, even a state with a tradition of statutory specificity could enact need-based coverage conditioned on the availability of enhanced match, permitting the Medicaid agency to scale back eligibility without returning to the Legislature if enhanced federal match ended. However, regardless of state statutes, Medicaid programs cannot simply close an eligibility group to new enrollment. Rather, Medicaid programs wishing to scale back need-based coverage would need to reduce it for applicants and beneficiaries alike, unless federal policymakers chose to adjust this basic feature of Medicaid as applied to need-based eligibility. Such adjustments could be difficult to fashion without losing bipartisan support, however.

⁴⁴ Consistent with this paper's premise of seeking bipartisan support, a cap on enhanced federal funding could not be accompanied by permission for states to cap enrollment, since that would endanger the basic character of Medicaid as an individual entitlement program with guaranteed coverage for eligible individuals, as discussed in the previous note.

⁴⁵ Li-Wu Chen, Wanqing Zhang, Jane Meza, Phani Tej Adidam, Keith Mueller, Louis Pol, Dennis Shea, and Roslyn Fraser. *The Pent-up Demand for Health Care of the Uninsured Near Elderly Approaching Age 65*. University of Nebraska Medical Center, for The Economic Research Initiative for the Uninsured (ERIU) at the University of Michigan. June 6, 2004. AcademyHealth 2004 Annual Meeting. <http://www.academyhealth.org/2004/ppt/chen3.ppt>.

⁴⁶ Regardless of how enhanced federal match is phased in, such a phase-in could either be independent of or accompanied by a corresponding phase-in of the option for expanded coverage. Suppose, for example, that federal policymakers establish a new category of need-based Medicaid; provide enhanced matching funds for all enrollees into this category; and phase in enhanced matching funds based on income, starting at 50 percent of the FPL in the first year the law is effective. Policymakers could decide, notwithstanding this phase-in, that states could provide need-based coverage up to 100 percent FPL; in year 1, such a state would get enhanced federal matching funds up to 50 percent of the FPL and standard Medicaid matching funds between 51 and 100

percent of FPL. Alternatively, federal policy-makers could phase-in the optional coverage category along with enhanced match, so that in year 1, enhanced match was available up to 50 percent FPL, and no federal match whatsoever was available above 50 percent of FPL.