Expanding Public Programs

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Covering The Low-Income Uninsured: The Case For Expanding Public Programs

With a little tweaking, public programs offer the least disruptive, most efficient way to extend insurance coverage.

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ABSTRACT: In a new administration and Congress, any health insurance coverage initiative will focus on some, rather than all, Americans. Because lack of affordability is the main reason people lack coverage, most observers acknowledge that government-financed subsidies are needed to expand coverage. But there is considerable disagreement about how these subsidies should be provided. Here we argue that priority in expanding coverage should go to the uninsured population that is least able to afford coverage and most likely to have difficulties getting appropriate and timely care. Despite flaws in existing public programs, which can and should be remedied, strengthening these programs establishes a foundation for truly effective health insurance coverage for all low-income Americans.

A NY INITIATIVE TO EXTEND HEALTH INSURANCE COVERAGE to the forty-three million Americans without it is likely to take an incremental rather than a universal or comprehensive approach. An incremental strategy inevitably requires decisions about whom to provide the financial wherewithal to obtain coverage, as well as how to effectively provide it.

In this paper we argue that an incremental initiative should give priority to the uninsured who are least able to afford coverage, and that the most effective way to do this is by expanding publicly provided insurance. Today more than thirty-five million low-income Americans receive their health coverage through Medicaid, and as many as three million additional children get assistance from the State Children’s Health Insurance Program (SCHIP). Strength-
ening and building on these programs to help the twenty-five million low-income uninsured persons is the most effective approach for targeting coverage to this group.

Gaps in coverage. More than half (56 percent) of the uninsured nonelderly Americans are in families with incomes below 200 percent of the federal poverty level ($32,900 for a family of four in 1998). Among the low-income uninsured, twelve million are from poor families with incomes below poverty. With insurance coverage for a family policy costing in excess of $6,000, purchasing such coverage without an employer contribution is clearly out of reach for most families earning less than $35,000 per year.

These are the families who fall through the cracks in employer-based health insurance, which has never reached everyone. Low-wage and less-educated workers have always been much less likely to be offered and covered by employer plans than workers who are better-paid and better-educated. Erosion of employer coverage rates from the late 1970s through the early 1990s greatly widened these gaps.

Although the slide in employer coverage stopped in 1993, employer coverage for nonelderly Americans in 1999 (65.8 percent) was still below its level in 1989 (68.6 percent)—the last business cycle peak—and far below its 1979 level. The recent prosperity has resulted in gains in coverage for workers across the wage distribution, but it has narrowed the gap between high and low wage earners only slightly. Although those in the second and third quintiles of the wage distribution gained coverage between 1995 and 1998 (with coverage rates rising by 5.1 and 5.4 percentage points, respectively), those at the very bottom of the wage distribution experienced much smaller gains (their coverage rates increased by just 1.9 percentage points). Just 29.6 percent of workers in the bottom fifth of the wage distribution had employer coverage in 1998, compared with 82.3 percent of those at the top.

Although the past few years have brought an increase in employer coverage offerings, especially among small firms, that increase has not occurred among low-wage firms. Even more so than a decade ago, most uninsured workers (70 percent in 1996) lack access to employer coverage, whether through their own job or that of a family member.

Public programs provide a safety net for some low-income persons, but practice and policy have limited these programs’ ability to fill the cracks in employer coverage for the low-income uninsured. Medicaid has for thirty-five years effectively provided health insurance protection to families receiving welfare assistance and to children and pregnant women who meet its income guidelines. In 1997 enactment of SCHIP supplemented Medicaid coverage by providing extra federal funds to states for extending coverage to children in
families with incomes up to 200 percent of poverty.

But both Medicaid and SCHIP have a limited reach. Part of the problem is participation. Cumbersome Medicaid eligibility requirements have long left many eligible children uninsured. More recently, welfare reform has created new participation problems by disrupting traditional patterns of enrollment and failing to effectively replace them. And since most people leaving welfare find themselves in low-paying jobs without coverage, loss of public coverage leaves them without coverage altogether. Although SCHIP has expanded coverage to an estimated three million children, this increase, together with recent increases in Medicaid enrollment, is only beginning to offset the decline in coverage associated with welfare reform.

Some states are now addressing these problems by applying streamlined enrollment procedures and outreach strategies developed under SCHIP to their Medicaid programs as well. But Medicaid’s inability to reach uninsured adults reflects restrictions on eligibility that are far less tractable. Although states have the option to include parents in Medicaid, in thirty-two states uninsured working parents are ineligible for Medicaid if they work full time at the minimum wage ($5.15 per hour). Equally important, low-income childless adults, no matter how poor, are ineligible for coverage under federal law unless they qualify as disabled. Without changes in federal law, Medicaid is unlikely to reach the bulk of uninsured adults—the vast majority of the low-income uninsured.

**Extending Public Programs To Cover Adults**

Changes in law and practice to make programs now available to low-income children available to low-income adults offer a straightforward approach to coverage for the low-income uninsured population. The attractiveness of this approach rests on two factors. First and foremost is the extension of a subsidy for the full cost of comprehensive insurance to persons with limited incomes. Research shows that those with low and modest incomes are unlikely to take advantage of subsidies that fall short of the costs of insurance and are unlikely to use care if they face large out-of-pocket costs. Medicaid and SCHIP are designed to address these problems. Second is the existence of an administrative apparatus in every state to determine eligibility for subsidies in advance and facilitate enrollment in health insurance plans. Medicaid and SCHIP programs—which now serve nearly forty million Americans—have contracts in place with providers and managed care plans and have established mechanisms for collecting and matching funds from the federal government. Although recent attention has focused on barriers to par-
ticipation, a decade ago attention focused on the speed of Medicaid expansions in response to changes in federal law. Enrollment increased from 19.2 million in 1989 to 26.7 million in 1992—with nearly half of the increase among women and children not eligible for welfare.\(^\text{12}\)

Simply stated, a public program expansion aimed at the low-income uninsured would extend protections that are now available to some low-income persons to all such persons. But enacting and implementing such an expansion requires decisions on exactly how to expand subsidies and how to make the new subsidies most effective. The following outlines a possible approach to these decisions, highlighting some of the choices necessary to efficiently and effectively ensure coverage for all low-income Americans.

**Redefining eligibility and benefits.** Extending coverage through public programs such as Medicaid and SCHIP means replacing the current eligibility standard, based on a variety of demographic or “categorical” requirements, with an eligibility standard based solely on income. Because they have little if any discretionary income, people with incomes below a minimum eligibility standard should be provided with comprehensive benefits, without premiums or cost sharing. For persons above that minimum, it may be appropriate to provide less comprehensive benefits and require some premium and cost sharing.

Evidence indicates that even modest premiums deter participation and even modest cost sharing deters use of necessary care among poor and low-income persons.\(^\text{13}\) At the same time, as incomes rise, people are more likely to gain job-based insurance, so subsidies provided to those at higher income levels may substitute for private insurance instead of inducing the purchase of new coverage by uninsured persons. The choice of an eligibility level is therefore largely a political one, governed by views on the appropriate balance between affordability and substitution as well as by the amount of tax dollars the nation is willing to spend.

One reasonable strategy would be to extend to low-income adults the political choice made for establishing eligibility levels for children in Medicaid and SCHIP. Medicaid offers full and comprehensive coverage for the lowest-income children, while SCHIP offers somewhat less generous benefits with modest premiums and cost sharing. Drawing on this model, persons with incomes below 150 percent of poverty would be guaranteed full access to comprehensive benefits without cost sharing or premium contributions. Clearly, at an income of 150 percent of poverty—about $12,500 for an individual in 1998—it is difficult to afford premiums and cost sharing. The rate of private coverage is modest among persons at
this income level, so the potential for substitution or crowding out is not a major policy impediment. Below this level private coverage is relatively rare—just 30 percent of the nonelderly have it.\textsuperscript{14}

However, even those earning just above $12,500 clearly cannot afford to purchase comprehensive private health insurance coverage on their own. To reach these workers and their families requires extensive (if not full) subsidies. Following eligibility levels modeled after SCHIP coverage, almost-full subsidies for almost-full benefits could be provided to those with incomes between 150 and 200 percent of poverty ($12,500–$16,700 for an individual in 1998). In this group, 60 percent of the nonelderly have existing private insurance (raising issues about the extent of possible substitution), but more than a quarter (28 percent) are uninsured, suggesting the need for substantial subsidies.

The need for subsidies does not stop at twice the poverty level, where a premium of $2,000 represents about 12 percent of a person’s income—an expenditure burden that historically has been considered “catastrophic.” But the higher up the income scale subsidies go, the more difficult it becomes to target the new subsidy dollars to the uninsured rather than to insured persons. For example, in the income range of 200–250 percent of poverty, 71 percent of the nonelderly already have private coverage. That proportion rises to 80 percent at 250–300 percent of poverty and 89 percent above 300 percent of poverty.\textsuperscript{15} A reasonable balance might be achieved by retaining a subsidy for persons with incomes above 200 percent of poverty but reducing it gradually as income rises until the subsidy disappears at 300 percent of poverty ($25,100)—at which point the vast majority of people (although still not all) have employer coverage.

According to unpublished estimates from the Urban Institute, 25.4 million uninsured poor and low-income Americans (with incomes below 300 percent of the poverty level) would be made newly eligible for publicly subsidized coverage under the proposed expansion. More than a third of those potentially eligible (9.5 million) are poor—mostly adults who are not eligible for Medicaid or SCHIP—and an additional five million are near-poor, with incomes between 100 and 150 percent of the poverty level. An additional 10.9 million uninsured low-income persons (150–300 percent of poverty) would be eligible for a partial subsidy.\textsuperscript{16}

Assuring program participation. Achieving the potential of expanded eligibility for public programs depends in large part on the ability to get people enrolled. The likelihood of achieving that objective is not as limited as critics might suggest, given evidence from previous experience. Establishing eligibility for a means-tested benefit has historically been complex and often difficult, because of
specific state policies that create barriers in the enrollment process (for example, lengthy applications, extensive documentation requirements to certify income, requirements for frequent redetermination of income, and inclusion of complex asset tests). The evidence also suggests that the culture and training of enrollment workers can have a significant effect on enrollment, and a commitment to simplify the process can broaden participation. The enrollment experience under SCHIP, and under Medicaid when streamlined enrollment processes have been adopted, suggests that such efforts can make a difference and are critical to the success of a strategy to expand publicly sponsored health insurance.

**Assuring access to care.** Although administrative barriers are the main stumbling block, other aspects of Medicaid can deter both participation and access to care. Specifically, Medicaid’s low payment rates to providers or health plans—relative to rates paid by Medicare or private insurers—may limit beneficiaries’ choice of providers and make the program less attractive to potential enrollees. The significance of these limitations should not, however, be exaggerated. Evidence on the difference Medicaid makes to access to services—when the experience of its beneficiaries is contrasted with that of the uninsured at comparable income levels—indicates that despite low provider payment rates, the program provides effective insurance protection and has largely closed the utilization gap between low-income persons with Medicaid and those with private insurance. Nevertheless, if the goal is to assure access to “mainstream” care, it may be necessary to reduce payment disparities by raising Medicaid payment rates.

The issue of payment disparities, and the need for a remedy, may become more compelling if Medicaid is expanded beyond the very poor. Near-poor persons are more likely to have had private insurance in the past, as well as established relationships with providers who may not now participate in Medicaid. Higher payment rates may be important in encouraging this group to participate. However, increasing rates means spending much more—not just for new enrollees, but also for those already covered. Whether policymakers will consider the benefit gained worth its costs will depend on how much they are willing to spend overall on a program expansion.

**Addressing the crowding out of private dollars and coverage.** In a world of unlimited resources, few would argue that the
substitution of public spending for private spending on health insurance by or on behalf of low-income persons—commonly characterized as “crowd-out”—is undesirable. Indeed, substitution does help to achieve equity by providing persons in similar economic circumstances with similar benefits, regardless of their insurance status. One analysis estimated savings of about $1,000 per family to previously insured low-income families made eligible for hypothetical Medicaid-like subsidies—a substantial financial benefit for low- or modest-income people.10

Having limited public dollars, however, means that there must be trade-offs. If the policy goal is increased coverage, it seems reasonable—from both a policy and a political perspective—to maximize the use of new dollars for the uninsured rather than for the already insured. As discussed above, some degree of substitution is unavoidable at any eligibility level. But other policy choices will influence success in targeting new benefits to the uninsured and have implications for equity and the scope of coverage. For example, improving the operations of a public program may affect the degree of crowding out. Making a public program more accessible and attractive to beneficiaries (for example, by making it easier to enroll or by raising provider payment rates) is essential to success. However, these policies will also tend to increase crowding out by making those who have private coverage more willing to drop that coverage in exchange for “good” public insurance.

At the other extreme, some measures aimed at preventing substitution may backfire or pose new problems. For example, previous analysis has concluded that charging modest premiums (at the level allowed in SCHIP) would deter participation by the uninsured, without greatly reducing the financial advantages of participation to those already spending a lot to participate in employer coverage.20 As a result, a larger share of new public dollars would go to the already insured than would have done so in the absence of premiums.21

Another approach to preventing crowding out is to establish “firewalls” that limit eligibility to those who have been uninsured for some period of time. Not only is that strategy difficult to enforce, but it also creates a new inequity by requiring people who have lost employer-sponsored insurance to go without protection for a period of time before they can get help.

Some crowding out is inevitable under any approach to expanding coverage, and its outcome—that is, financial relief for low-income insured persons—has value. However, so long as public dollars are limited, policymakers will have to make trade-offs among the often conflicting goals of equity, affordability, and the desire to limit public spending.
State/federal relationship. In concept, an expansion of existing public programs to cover the uninsured is relatively straightforward. In practice, with the existing complex web of state and federal roles and financial relationships, the mechanics and politics of designing such a program become more complicated. Extending Medicaid or SCHIP assumes that an expansion would be implemented by the states, subject to federal requirements. This strategy raises questions regarding the distribution of costs between the federal and state governments, the balance between federal requirements and state flexibility, and the acceptability of variation across states in the scope of coverage.

The federal government now matches state spending under Medicaid and provides matching funds under SCHIP at a higher rate (although federal funding under SCHIP is capped). This type of arrangement encourages states to spend more than they would otherwise on health coverage; it provides more federal money (higher matching rates) to offset the greater needs and diminished financial capacity of poorer states; and it compensates for economic downturns with higher federal payments.

State participation in Medicaid and SCHIP is voluntary; states do not have to take advantage of available federal funds. SCHIP offers states “enhanced” federal matching rates, to promote state participation. Any expansion in public programs would likely require federal financing at least as great as under SCHIP, particularly since states have yet to maximize eligibility under existing Medicaid or SCHIP rules. But the differential between Medicaid and SCHIP has created tension between the two programs, with some states showing greater willingness to improve and promote SCHIP than to expand and support Medicaid. An extension of differential matching rates could further complicate the system and provide states with additional perverse incentives to enroll some groups over others.

Flexibility and variation. Further complicating the state/federal relationship is the question of how much flexibility to allow states in using federal money. Medicaid has always provided states considerable flexibility in setting eligibility, benefits, and provider payment levels. But in recent years states have successfully advocated expanded flexibility in Medicaid (with respect to use of managed care) and SCHIP (with respect to benefits and cost sharing). The question would be where on the Medicaid/SCHIP spectrum to place a new expansion, especially since the new eligibles would range from very low income childless adults who are not now eligible for Medicaid to more modest income families and adults who are similar in many respects to current SCHIP enrollees.

This choice inevitably merges into another: how much variation
to tolerate across states. As long as states decide whether and how much to take advantage of federal funds, eligibility levels and generosity of coverage are likely to continue to vary. If the goal of an expansion is to achieve a uniform level of coverage, experience tells us that federally established floors are critical. However, the political or fiscal acceptability of federal mandates for insurance coverage for the low-income population, or federalization of all costs, is questionable. Without these actions, variation—and, in some states, inadequacy of protection—remains inevitable.

**Entitlement or block grant?** The most fundamental design question for a public program may be whether it will be a federal entitlement to individuals or a block grant to states. Medicaid provides the former, which means that everyone who satisfies eligibility requirements is guaranteed coverage and that federal and state funding follows the individual and cannot be capped. Although states can affect how easy or difficult it is for people to participate and how generous or restricted are their benefits and access to care, states cannot deny coverage to an eligible individual. By contrast, SCHIP provides capped federal funds to states and allows them to choose whether to create an individual entitlement. States can choose to use the new federal funds to expand Medicaid, thereby creating Medicaid-like obligations to individuals (and assuring access to federal funds at the regular Medicaid matching rates if the cap is exceeded). But, if they prefer—as many have—states can create separate programs in which they can cap enrollment and receive a capped federal allotment to help pay for services.

This aspect of SCHIP’s design was a critical element of the political compromise believed necessary both to enact the SCHIP legislation and to ensure that states would participate. So far, the capped nature of SCHIP has not proved to be a major issue in practice—the economy is good and enrollment is modest, in part because the program is so new. But an economic downturn could lead states to limit enrollment as federal funds are exhausted. (Although Medicaid allows states to control eligibility for some groups, its uncapped federal funds mitigate pressure on states to cut eligibility, and its entitlement prohibits waiting lists.)

The choice of which model to follow is a matter of fundamental philosophy and pragmatic politics. Philosophically, the question is whether coverage is the paramount goal—in which case, the guarantee of meaningful coverage to all those who qualify is essential—or whether coverage is subordinate to other goals, such as federal fiscal constraint or a preference for state over federal authority. Politically, the question is which goal will prevail.
Alternatives To Public Programs

Public programs have historically been the preferred mechanism to provide health insurance to low-income persons, but they are not the only possible approach. Recently, enthusiasm for an alternative mechanism has emerged: use of tax policy, rather than a public program, to provide subsidies. The appeal of this approach appears to be its potential to expand coverage with minimal government involvement. People would apply by filing tax returns and would choose a health plan on their own, rather than relying on the plan options selected by the government. Overall, a tax approach appears to be “hands-off.”

However, this tax model does not mesh well with the circumstances of low-income people. If they are the target population for a coverage expansion, the most prominent tax proposals pose a number of problems. First, about half of those without coverage have such low incomes that they do not pay taxes. Tax credits that only apply against taxes owed—the most common form of credit in the tax code—clearly cannot help them. Hence, most proposals to use tax credits would make them “refundable” or available without regard to tax liability, like the Earned Income Tax Credit (EITC), which has so successfully enhanced income for the working poor.

Second, the most prominent tax credit proposals involve credits in the neighborhood of $1,000 for individuals and $2,000 for families. Yet insurance premiums average about $2,000 for individuals and $6,000 for families (even more for persons in poor health). Experience suggests that those with low incomes are unlikely to be willing or able to fill that gap. Instead, the primary beneficiaries of such a credit will be persons with higher incomes who already have health insurance. One estimate indicates that three of every four dollars spent on such a credit would go to the already insured, while the bulk of the uninsured would remain unprotected.

Third, the most prominent tax credit proposals anticipate that...
recipients will use the credits to shop in the nongroup insurance market. But that market is riddled with problems. Except in a few states with comprehensive regulation, private insurers can reject applicants, limit benefits to exclude not only important services but also body parts or body systems, or charge rates well above the average. As a result, low- and modest-income persons with health conditions will face out-of-pocket costs (for insurance or services) that are well beyond their means.  

It is, of course, possible to adopt policies to remedy these limits to tax policy: determine eligibility and provide cash up front, cover the full cost of insurance, and guarantee the availability of benefits that are adequate to assure affordable access to needed care. However, these measures would require the very government involvement that tax credit advocates aim to avoid. In other words, to be effective, a hands-off tax mechanism would need to become a hands-on public program; even then, its impact would be uncertain. Although there may be differences of opinion as to the income level at which to draw the line, even some advocates of a tax approach recognize that a public program is needed to provide coverage to the low-income uninsured.

It is unclear when and if a new debate on health care coverage will begin in earnest. If not directed at all Americans, any proposals to extend coverage must be clear about which Americans they aim to reach. A variety of strategies—including use of the tax system—may be appropriate to assuring coverage for uninsured persons who are better off. But for low-income Americans, who are least able to obtain coverage on their own, reliance on public programs is essential.

Historically, public programs—most especially Medicaid—have been enormously effective in securing health insurance for poor children and their very poor mothers. Now, through SCHIP, they are extending coverage to children in better-off families. Disrupting these programs would put coverage at risk for the millions of persons who now depend upon them. By contrast, strengthening these programs establishes a foundation for truly effective health insurance coverage for all low-income Americans.
NOTES

4. L. Mishel, J. Bernstein, and J. Schmitt, *The State of Working America, 2000–2001* (Ithaca, N.Y.: Cornell University Press, 2000), 140, Table 2.15. These figures are for private wage and salary workers ages 18–64, who worked at least twenty hours per week and twenty-six weeks per year.
10. Coverage of childless adults is open to nondisabled adults through state-funded-only programs or a Medicaid 1115 waiver in only eight states. Families USA, *Disparities in Eligibility for Public Health Insurance between Children and Adults in 2000*, <www.familiesusa.org/pubs/dispar.htm> (13 November 2000).
14. Hoffman and Schlobohm, *Uninsured in America*. The estimate of “private coverage” includes private job-based coverage, other private insurance, and some “other” public insurance, such as Medicare and military-related coverage.
15. Ibid.
16. J. Holahan, “CHIP Simulations” (Washington: Urban Institute, 2000). This estimate of the number of newly eligible uninsured persons excludes uninsured children and adults who are now eligible for Medicaid or SCHIP. An estimated 12.6 million poor Americans are uninsured, for example, but more than 3.1 million are children and adults eligible but not enrolled in existing public programs, leaving 9.5 million eligible under the proposed expansion.


20. Ibid.


22. These proposals are summarized in R. Weiss and M. Garay, **Recent Tax Proposals to Increase Health Insurance Coverage** (Menlo Park, Calif.: Kaiser Family Foundation, 2000).


27. Gruber and Levitt, “Tax Subsidies for Health Insurance.”


29. See G.R. Wilensky, **Extending Health Insurance through Incremental Reform** (Menlo Park, Calif.: Kaiser Family Foundation, 1999); and the comments of Mark Pauly in Feder and Burke, **Options for Expanding Health Insurance Coverage**, 39.