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## HOW SHOULD PUBLICLY SPONSORED HEALTH INSURANCE BE STRUCTURED?

Policymakers considering how to structure a program of publicly sponsored health insurance for low-income Americans face a set of fundamental issues about its design. This section addresses seven core elements that play a large part in determining the scope, shape, impact, and sustainability of a publicly financed health coverage program. In the following pages, we outline the issues and present the evidence relevant to these defining policy dimensions:

- **Eligibility**
- **Participation**
- **Use of Premiums**
- **Scope of Benefits**
- **Use of Cost-Sharing**
- **Access to Care**
- **Financing**

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## Eligibility

### The issue

Progressively over time, Congress has broadened eligibility for Medicaid to reach more of the nation's low-income children and families, seniors, and people with disabilities. Federal minimum eligibility standards for Medicaid have been raised for some groups, and states have been granted extensive authority to expand Medicaid coverage further. Also, the State Children's Health Insurance Program (SCHIP) was enacted in 1997 to expand coverage to low-income uninsured children who do not qualify for Medicaid. These changes reflect evolving public policy goals (e.g., assuring access to adequate prenatal care and early intervention services, supporting employment for individuals with disabilities), federal efforts to fill persistent and growing gaps in the private health insurance market, and Medicaid's effectiveness in covering the low-income population.

Although states have expanded coverage by broadening eligibility in their Medicaid and SCHIP programs, over 30 million low-income non-elderly Americans – mostly adults – were uninsured in 2005. Adults without children, who are categorically ineligible for Medicaid, are at particularly high risk of being uninsured. Indeed, low-income adults account for more than one-third of the uninsured. Among non-elderly Americans living below the poverty level, more than 1 in 3 were uninsured in 2005 and more than 1 in 4 of the near-poor (those between 100% and 200% of the poverty level) lacked coverage.

### The evidence

Nearly two-thirds of uninsured non-elderly Americans are low-income (income below 200% of the poverty level) – more than a third are poor and nearly another third are near-poor. Poor adults account for more than 1 in every 4 uninsured Americans and near-poor adults make up almost another quarter. Eighty percent of uninsured Americans come from working families.

People living below or near the poverty level have difficulty meeting even basic needs for housing, food, transportation, and childcare. Many poor families devote substantial resources to health care and the burden of health care costs on the poor is increasing.

Between 2000 and 2004, the number of uninsured Americans grew by 6 million, driven primarily by steady erosion in job-based health insurance. Two-thirds of the growth in the uninsured occurred among those below 200% of the poverty level, reflecting the movement of many middle-income Americans into poor and near-poor groups, where access to job-based coverage is limited and the odds of being uninsured are much higher. Although both children and adults were affected by declining employer-sponsored insurance, increased enrollment in Medicaid and SCHIP more than offset the private coverage losses among children. By contrast, although Medicaid mitigated coverage losses among adults, the number of adults without insurance still rose by 6 million. Between 2004 and 2005, the number of uninsured Americans grew by 1.3 million, 84% of whom were low-income.

Low-income adults are at especially high risk of being uninsured because their access to public as well as private coverage is very limited. Adults' eligibility for Medicaid generally hinges on their having dependent children. Adults without dependent children – regardless of how poor they may be – are excluded from Medicaid unless they are severely disabled or pregnant. To obtain federal matching funds to cover them under Medicaid, states must acquire a federal waiver.

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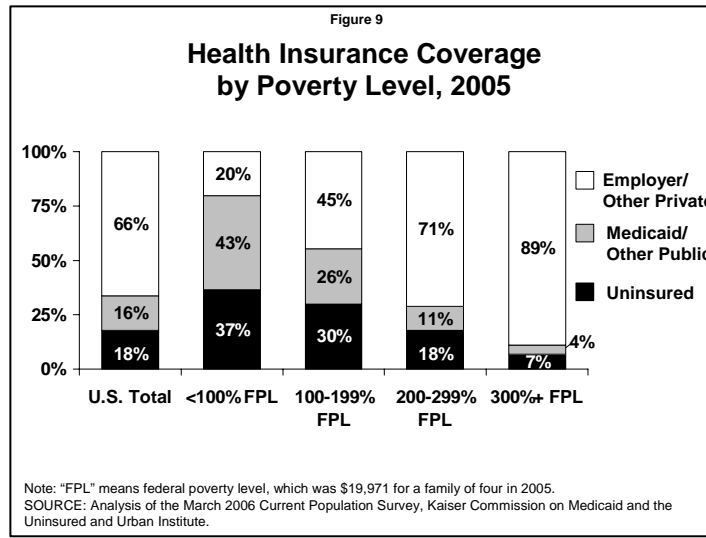
With respect to parents, federal Medicaid law ties minimum eligibility to the income standard each state used in its pre-1996 welfare assistance program. States have discretion to offer broader eligibility and many do; today, eligibility thresholds for parents vary widely across the states, ranging from 19% of the federal poverty level in Alabama and Arkansas to 275% in Minnesota. Because of narrow Medicaid eligibility for parents in most states, while virtually all children below 200% of the poverty level are eligible for Medicaid or SCHIP, many of their parents, even the poor, cannot qualify. Studies have found that when public insurance provides eligibility to low-income parents as well as their children, coverage and access also increase among children.

***Providing eligibility for public coverage on the basis of income, without the categorical restrictions that now apply in Medicaid, could substantially reduce the number of low-income uninsured Americans and assure coverage for those least able to pay. Evidence that poor people lack access to private health insurance and cannot afford to pay for health care out-of-pocket provides a strong basis for extending Medicaid to all Americans below the federal poverty level. Allowing federal matching dollars for coverage of adults without children would improve Medicaid's reach within the low-income population and target assistance to some of the poorest of the uninsured. As public dollars permit, income eligibility could be broadened for both parents and adults without dependent children to cover more low-income uninsured Americans.***

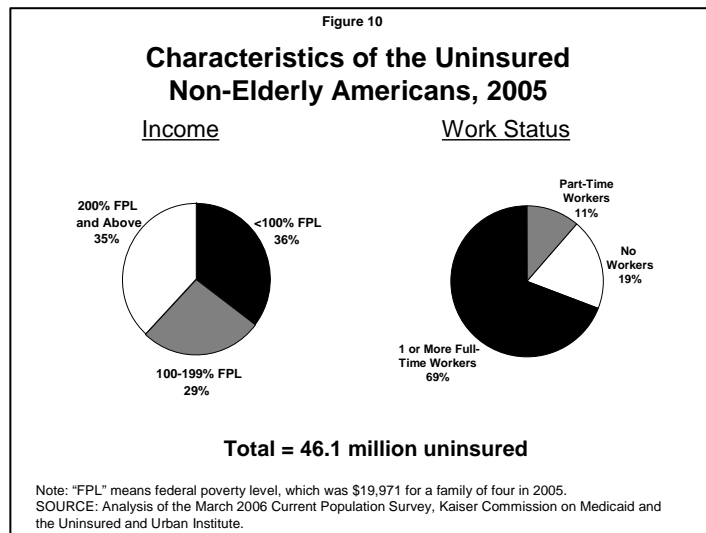
## Key Evidence

*Two-thirds of uninsured non-elderly Americans are poor or near-poor, and the vast majority of the uninsured come from working families. Most low-income working families lack access to health insurance through their jobs, and most uninsured workers are low-income.*

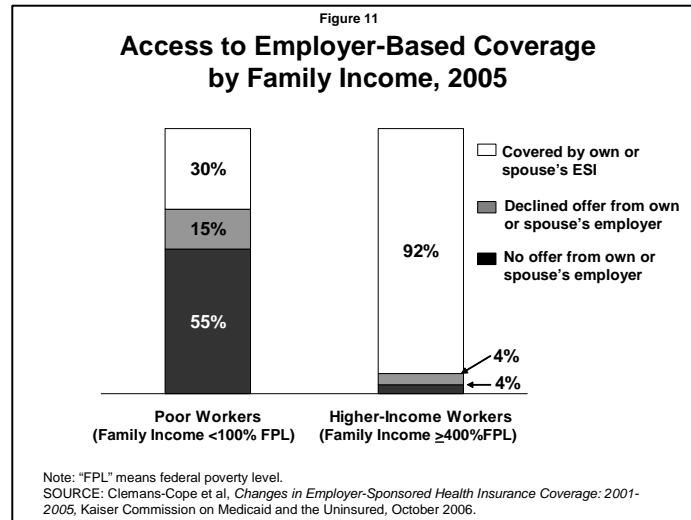
- More than 1 in 3 poor non-elderly Americans are uninsured and nearly a third of the near-poor lack coverage. By contrast, among those at or above 200% of the poverty level, about 1 in 10 is uninsured (Fig. 9).<sup>1</sup>



- Low-income individuals and families make up almost two-thirds of the uninsured. The 2005 federal poverty threshold ("federal poverty level") was \$10,160 for a non-elderly individual and \$19,971 for a family of four. Eighty percent of all the uninsured and nearly three-quarters of the low-income uninsured come from working families (Fig. 10).<sup>2 3 4</sup>



- In 2005, over 90% of higher-income workers (those at or above 400% of the federal poverty level) had access to employer-based coverage through their own work or their spouse's, but less than half of poor workers had an offer of health insurance from their own or their spouse's employer (Fig. 11).<sup>5</sup>



*Working families are sometimes at a disadvantage relative to non-working families in their access to health coverage.*

- Even after adjusting for demographic factors and health status, children of the working poor are less likely to have health insurance compared with children in non-working poor families. For these children, parental employment does not provide adequate access to employment-based coverage, yet it reduces the likelihood of eligibility for Medicaid.<sup>6</sup>

*The poverty level represents a standard of living below which people require assistance to meet even basic needs.*

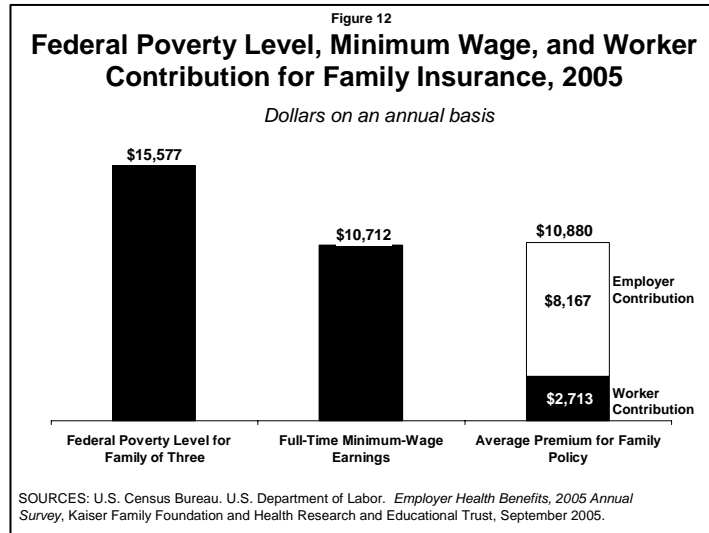
- Federal assistance programs commonly use the federal poverty level or a higher threshold as their eligibility standard. Examples include the Food Stamps Program (130%), WIC (185%), Low Income Home Energy Assistance Program (110%), the National School Lunch and School Breakfast Program (185%), and Head Start (100%).<sup>7</sup>
- Family budgets among those near poverty are extremely tight, dominated by basic needs for housing, food, transportation, and childcare. In many communities, income equivalent to 200% of the federal poverty threshold is not adequate to meet those needs, much less needs for health care.<sup>8</sup>

- About one-quarter of low-income families with a full-time, full-year worker are “food-insecure.” That is, they report that in the prior 12 months, they cut or skipped meals because of lack of money, worried that food would run out before they could afford to buy more, or ran out of food and lacked money to get any more. Likewise, one-quarter of such families are “housing-insecure,” reporting that they were unable to pay the mortgage, rent, or utility bill because of lack of money in the prior year. A study examining the extent of hardship among low-income non-elderly adults found that nearly three-quarters of this population had food (13%), housing (45%), or health care (54%) hardship in the past year, compared with 31% of adults with income above 200% of the poverty level.<sup>9 10</sup>
- Many analysts consider the federal poverty threshold to be inadequate as a measure of the basic income needs of a working family. An alternative measure, “family budgets,” uses a market-basket approach to determine adequate income, identifying the items necessary for a working family to maintain a safe and decent living standard and the cost of providing each item at an adequate level. Data from the Bureau of Labor Statistics Consumer Expenditure Survey reveal that low-income families tend to spend less on basic necessities than recommended by a basic family budget, a finding that poverty researchers have cited as evidence that such families are not fully meeting their basic needs.<sup>11</sup>

***Many low-income families devote substantial resources to health care and the burden of health care costs has been increasing.***

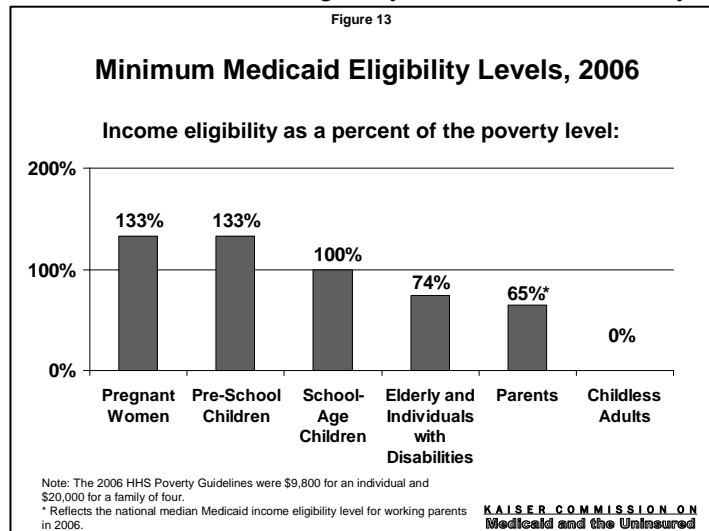
- Nationally, low-income families spend 7 of every 10 dollars on basic living expenses, including housing, transportation, and food, leaving little remaining income to cover other expenses. That remainder is split among many categories, with health care spending ultimately amounting to about 7% of their total spending. Many low-income families, even those who are insured, have large unpaid medical bills.<sup>12</sup>
- According to the Institute of Medicine, on average, food, shelter, transportation, and clothing account for 85% of the expenditures of families without health insurance.<sup>13</sup>
- Among the insured, low-income families are more likely than higher-income families to experience heavy health care cost burdens. More than one-quarter of low-income families report out-of-pocket health care costs (not including premiums or dental care) exceeding 5% of their family income, compared with 7% of higher-income people who report out-of-pocket burdens of this size.<sup>14</sup>
- The disparity in out-of-pocket burden as it relates to income is most pronounced among those with more extensive health needs. After taking differences in health insurance status into account, children with special health care needs in families below 200% of poverty are over 10 times more likely to experience burdensome out-of-pocket costs (i.e., exceeding 5% of family income) than those in families at or above 400% of poverty.<sup>15 16</sup>

- The minimum wage, last raised in 1997, has eroded relative to the cost of living, while health care costs have climbed steeply. In the 1960s and 1970s, a full-time worker earning the minimum wage typically made enough to keep a family of three out of poverty. In 2005, however, the earnings of a full-time minimum-wage worker totaled \$10,712 – just 69% of the federal poverty level for a family of three in that year (\$15,577). The employee share of the average premium for a family policy in 2005 was \$2,713, which would have consumed one-quarter of the family’s total annual earnings (Fig. 12). In 2006, the employee share of the average family premium rose to \$2,973.<sup>17 18 19</sup>

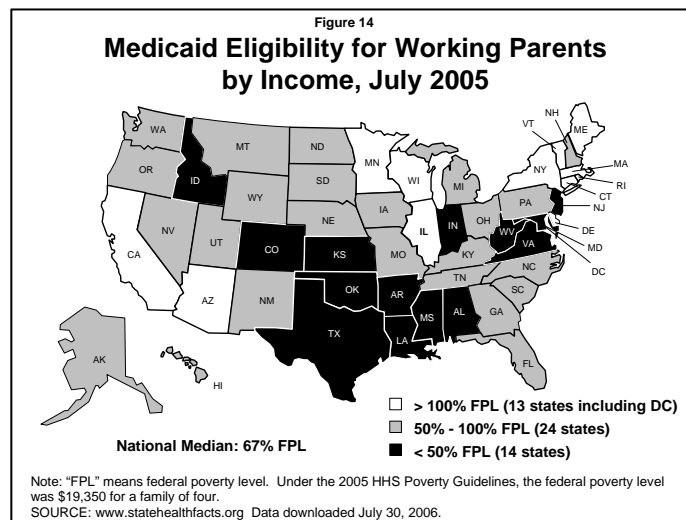


*Low-income adults’ eligibility for public coverage is very limited, depends on family structure, and varies widely by state of residence.*

- Federal law establishes minimum eligibility standards for the Medicaid program and gives states broad authority to expand beyond them. Federal Medicaid law establishes much more restrictive eligibility for adults than for children. Federal law guarantees Medicaid eligibility to infants and pre-school children up to 133% of the federal poverty level and to older children up to the poverty level. The federal “floor” for eligibility for seniors and severely disabled individuals is equivalent to about 74% of the federal poverty level. Federal minimum standards for other adults are much lower. The minimum eligibility standard for parents is tied to each state’s pre-1996 welfare assistance standard, rather than to the poverty level; in 2006 the median national eligibility standard for working parents was 65% of the federal poverty level. Federal law excludes adults without dependent children from Medicaid (Fig. 13).<sup>20</sup>



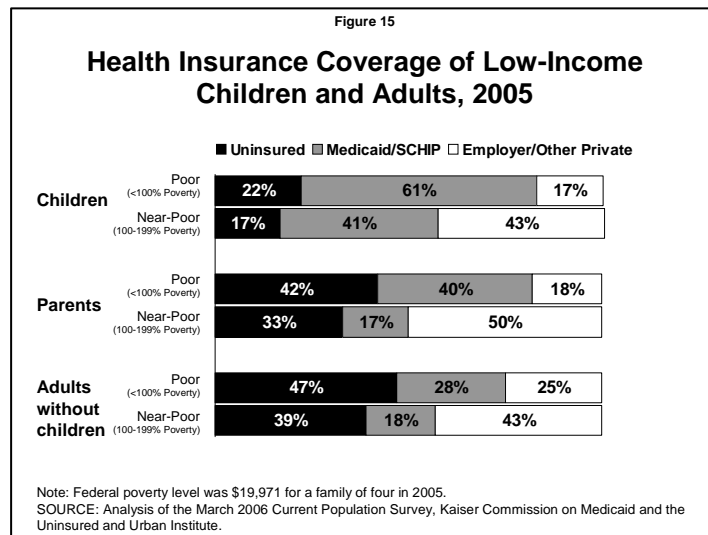
- Because Medicaid and SCHIP completely absorbed the declines in employer-based coverage between 2000 and 2004, none of the 6 million Americans added to the uninsured rolls were children and the number of uninsured children actually fell by 350,000. While public coverage did increase among adults during period, much more restrictive eligibility for adults prevented it from offsetting the losses of job-based coverage they experienced.<sup>21</sup>
- While virtually all low-income children qualify for Medicaid or SCHIP, only a third of low-income non-elderly adults were eligible for these programs in 2002. Even among adults below 50% of the poverty level, only about half qualified for publicly sponsored coverage.<sup>22</sup>
- Often, low-income parents do not qualify for public coverage even though their children do. Reflecting their much more limited eligibility for publicly sponsored insurance, more than a third of all low-income parents lack health insurance, and the uninsured rate among poor parents exceeds 40%.<sup>23</sup>
- Medicaid eligibility for low-income parents, because it is tied to states' pre-1996 welfare assistance standards, varies widely across the United States. To illustrate, eligibility for working parents ranges from 19% of the federal poverty level in Alabama and Arkansas to 275% of the federal poverty level in Minnesota (Fig. 14).<sup>24 25</sup>



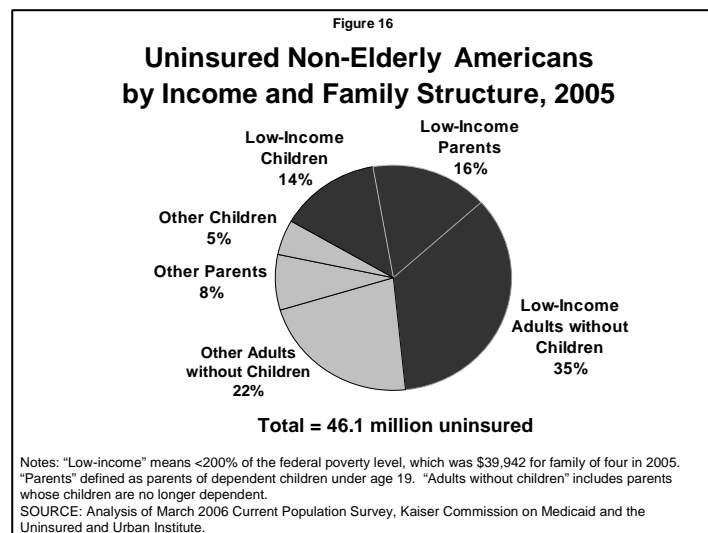
- Results from a simulation study show that if eligibility levels for parents were raised to the levels states have set for children in Medicaid and SCHIP, 70% of uninsured parents could be covered.<sup>26</sup>
- Low-income adults without dependent children are far less likely to be eligible for public coverage than low-income parents (23% versus 50%). Below the poverty level, the disparity in eligibility between childless adults and parents is even wider (34% versus 77%).<sup>27</sup>



- Because federal law categorically excludes adults without dependent children from Medicaid (unless they are severely disabled), states can receive federal Medicaid matching funds for adults only if they obtain a federal waiver. Some states cover childless adults under programs that are fully state-funded. As of January 2004, 14 states and the District of Columbia covered low-income childless adults. Ten states provided this coverage under Medicaid waivers, three operated state-only programs, and one state and D.C. operated both waiver and fully state-funded programs. In the other 36 states, adults without children – no matter how poor – were not eligible for any public coverage.<sup>28</sup>
- Because Medicaid eligibility is so much more limited for adults than for children, poor and near-poor adults are much more likely than poor and near-poor children to be uninsured (Fig. 15).<sup>29</sup>



- As a consequence of their limited eligibility for publicly sponsored health insurance, low-income adults are the largest group in the uninsured population. Low-income adults, including both parents and adults without children, make up half of all the non-elderly uninsured. Low-income childless adults alone constitute over one-third of the uninsured (Fig. 16).<sup>30</sup>



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***Medicaid programs that cover low-income parents along with their children have promoted increased coverage and access of children as well as their parents.***

- State experience and results from estimation models indicate that Medicaid eligibility expansions that include parents not only provide coverage to uninsured parents, but also increase the participation of eligible children. For example, one study found that about 80% of eligible children were enrolled in Medicaid in states with family coverage, compared with 57% of eligible children in states with less generous eligibility rules for parents.<sup>31 32</sup>
- Children whose parents have had at least one physician visit are more likely to have had a physician visit, and health insurance appears to amplify this relationship. Evidence that access to care is better among children whose parents also have coverage than among children in families with child-only coverage suggests that insuring parents is an important mechanism for improving children's access as well.<sup>33 34 35 36 37</sup>
- Medicaid/SCHIP coverage of low-income parents is associated with lower uninsured rates among low-income children. One analysis found that in states that expanded public coverage to parents at or above 133% of the poverty level, about 14% of low-income children were uninsured, compared with 25% of such children in states that did not cover all parents up to the poverty level. The study also found an insured rate of 90% among low-income children whose parents were insured, compared with 48% for low-income children whose parents were uninsured.<sup>38</sup>

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## Endnotes

<sup>1</sup> Analysis of March 2006 Current Population Survey, Kaiser Commission on Medicaid and the Uninsured and Urban Institute.

<sup>2</sup> Analysis of March 2006 Current Population Survey, Kaiser Commission on Medicaid and the Uninsured and Urban Institute.

<sup>3</sup> 2005 Poverty Thresholds, U.S. Census Bureau.

<sup>4</sup> Analysis of March 2006 Current Population Survey, Kaiser Commission on Medicaid and the Uninsured and Urban Institute.

<sup>5</sup> Clemans-Cope L et al, *Changes in Employer-Sponsored Health Insurance Coverage: 2001-2005*, Kaiser Commission on Medicaid and the Uninsured, October 2006.

<sup>6</sup> Guendelman S and M Pearl, "Access to Care for Children of the Working Poor," Archives of Pediatric and Adolescent Medicine, June 2001.

<sup>7</sup> Food and Nutrition Services, U.S. Department of Agriculture. Administration for Children and Families, U.S. Department of Health and Human Services.

<sup>8</sup> Boushey H et al, *Hardships in America: The Real Story of Working Families*. Economic Policy Institute, 2001.

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<sup>10</sup> Long S, *Hardship Among the Uninsured: Choosing Among Food, Housing, and Health Insurance*, Urban Institute, May 2003.

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<sup>12</sup> Williams C et al, *Challenges and Tradeoffs in Low-Income Family Budgets: Implications for Health Coverage*, Kaiser Commission on Medicaid and the Uninsured, April 2004.

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<sup>14</sup> Shen Y and J McFeeters, "Out-of-Pocket Health Spending Between Low- and Higher-Income Populations: Who is at Risk of Having High Expenses and High Burdens?" Medical Care, 44 (3), March 2006.

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<sup>17</sup> McNichol L and J Springer, *State Policies to Assist Working-Poor Families*, Center on Budget and Policy Priorities, December 2004.

<sup>18</sup> 2005 Poverty Thresholds, U.S. Census Bureau.

<sup>19</sup> *Employer Health Benefits, Annual Surveys, 2004-2006*, Kaiser Family Foundation and Health Research and Educational Trust.

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- <sup>20</sup> Title IX of the Social Security Act.
- <sup>21</sup> Holahan J and A Cook, “*Changes in Economic Conditions and Health Insurance Coverage, 2000-2004*,” Health Affairs, Web Exclusive, November 1, 2005.
- <sup>22</sup> Davidoff A et al, *Health Coverage for Low-Income Adults: Eligibility and Enrollment in Medicaid and State Programs, 2002*, Kaiser Commission on Medicaid and the Uninsured, February 2005.
- <sup>23</sup> Dubay L and G Kenney, “*Addressing Coverage Gaps for Low-Income Parents*,” Health Affairs, March/April 2004.
- <sup>24</sup> [www.statehealthfacts.org](http://www.statehealthfacts.org). Data downloaded July 30, 2006.
- <sup>25</sup> Cohen Ross D and L Cox, *In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families*, Kaiser Commission on Medicaid and the Uninsured, October 2005.
- <sup>26</sup> Dubay and Kenney, 2004.
- <sup>27</sup> Davidoff, 2005.
- <sup>28</sup> Dorn S et al, *Medicaid and Other Public Programs for Low-Income Childless Adults: An Overview of Coverage in Eight States*, Kaiser Commission on Medicaid and the Uninsured, August 2004.
- <sup>29</sup> Analysis of March 2006 Current Population Survey, Kaiser Commission on Medicaid and the Uninsured and Urban Institute.
- <sup>30</sup> Analysis of March 2006 Current Population Survey, Kaiser Commission on Medicaid and the Uninsured and Urban Institute.
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