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Medicaid and Other Public Programs for Low-Income Childless Adults: An Overview of Coverage in Eight States

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THE HENRY J. KAISER FAMILY FOUNDATION

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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

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EXECUTIVE SUMMARY

Low-income adults without dependent children are more likely to be uninsured than are any other Americans. In 2002, fully 42 percent of low-income childless adults were uninsured – a significantly higher proportion than for parents or children. Low-income adults without dependent children account for nearly a third of all the uninsured, and over half of all uninsured with incomes below poverty are adults without dependent children.

Low-income adults without dependent children have particularly high uninsured rates because few qualify for public coverage, no matter how low their income or how hard they work. Under current law, Medicaid excludes low-income adults without dependent children unless such adults are pregnant, elderly, or severely and permanently disabled. States can only cover these adults through Medicaid if they receive a waiver, and such waivers provide no additional federal financing. States can also cover childless adults through fully state-funded and state-designed programs. By contrast to childless adults, states can cover other low-income Americans (parents, children, pregnant women, people with severe disabilities, and seniors) without any need for waivers or limits on federal matching funds.

As of January 2004, 36 states did not cover any childless adults. As a result, childless adults are significantly less likely than other groups to have access to public coverage. Among the low-income uninsured, only 13 percent of childless adults had access to publicly financed insurance, compared to 34 percent of parents in 1999. Even among the very poor uninsured with incomes below 50 percent of the Federal Poverty Level (FPL), only 25 percent of childless adults had access to public coverage, compared to 89 percent of parents.

However, 14 states and the District of Columbia covered some childless adults in January 2004. Ten states provided coverage using Medicaid waivers; three states operated entirely state-funded programs; and two state-level jurisdictions operated both state-funded and waiver programs for different groups of childless adults. This report analyzes these coverage efforts by profiling childless adult programs in eight state-level jurisdictions: the District of Columbia, Maine, Massachusetts, Minnesota, New York, Oregon, Pennsylvania, and Washington. Based on document review, site visits, and interviews with multiple stakeholders and officials, our key findings include the following:

Most states assisted childless adults as part of broad efforts to cover the uninsured. Programs covering childless adults typically enjoyed considerable support from the public, policymakers, and stakeholders, in part because many beneficiaries were low-wage workers seen as deserving assistance. Bipartisan policymakers and stakeholders typically found little justification for distinguishing among uninsured, low-income workers based on the presence or absence of dependent children living at home. Health care providers supported these expansions, as did some employers.

Previous experiences, perceived political feasibility, and available federal funding influenced state decisions about whether to cover childless adults through Medicaid waivers or entirely state-funded programs. In many states, the perceived success or failure of previous waivers or state-funded health coverage greatly affected whether officials developing a state's program for childless adults preferred to replicate their state's prior approach. In some places, a state-only policy increased the political feasibility of coverage

expansions, because purely state-designed programs were perceived to have increased capacity to control spending through enrollment caps, benefit limits, and beneficiary cost-sharing. In other states, Medicaid waivers and accompanying federal matching funds were essential to coverage expansion.

Although many programs for childless adults were designed specifically to assist low-income workers, these programs also provided important assistance to people with disabilities. Such programs help people with disabilities in two ways. First, they provide health coverage while applicants wait to see whether they were found sufficiently disabled to receive Medicaid. Second, these programs cover people whose disabilities do not meet Medicaid's requirement of a severe and permanent disability that precludes substantial, gainful employment for at least twelve months.

Uninsured adults in their 50s and 60s constituted a surprisingly large proportion of enrollees in the childless adult programs in Washington and Minnesota.[†] More than a third of adults covered by these childless adult programs were in their 50s and 60s. This high proportion of near-elderly enrollees may have resulted, in part, from Medicaid's automatic termination of coverage when dependent children grow up and their formerly eligible caretaker parents become ineligible "empty nesters." This suggests that enhancing Medicaid's capacity to cover low-income adults without dependent children is worth serious consideration as a strategy to assist uninsured adults near retirement age.

In both waiver and state-only programs, childless adults often received less comprehensive benefits than Medicaid. A number of the childless adult programs, particularly those targeted at low-income workers, covered fewer benefits than the state's Medicaid benefit package and/or charged premiums and out-of-pocket cost-sharing that exceeded Medicaid amounts. However, a few programs, particularly those targeted to people with very low incomes and chronic illnesses, provided full Medicaid benefits to childless adults, with little or no cost sharing.

In Washington and Minnesota (two states with available data), average *per capita* costs varied greatly, depending on whether programs were designed for working adults or for very-low-income adults with possible chronic health problems that interfered with employment. In 2002, these states' programs for workers cost roughly $200 to $300 per childless adult member per month. By contrast, average, monthly costs for childless adults in programs for very-low-income individuals (many of whom had serious, chronic illness) exceeded $500 per person in 2000 and 2001.

Low-income, childless adults exhibited strong demand for insurance, but the number receiving coverage was sometimes limited by minimal outreach, enrollment caps, and premiums. In most cases, enrollment of childless adults took place quickly, rapidly outpacing the expectations of state officials. However, enrollment in some programs was hindered by lack of outreach. Further, several states hit their enrollment caps and stopped enrolling eligible adults. In Pennsylvania, for example, state officials believed that at least 300,000 adults qualified for coverage, but fewer than 45,000 could be enrolled during the average month, consistent with appropriated state funding. In Washington, researchers found that 74 percent of uninsured adults would have gained access to coverage if the state's waiting list had been

[†] These two states had the most comprehensive data, the oldest programs, and the broadest coverage. Both of their childless adult programs were entirely state-funded and state-designed.

eliminated and all eligible adults could enroll. Finally, even modest changes in required premium payments had a dramatic impact on enrollment in a number of states.

Coverage of childless adults had a positive impact on individuals and state health care systems. Many respondents indicated that adults without dependent children who received coverage improved their access to care and utilized services in more appropriate settings. However, in several states, benefit restrictions and out-of-pocket cost-sharing limited these improvements by creating barriers to care. In terms of fiscal impact, respondents in several states indicated that state costs to cover childless adults were partially offset by savings in various parts of the health care safety net and, in some cases, by substitution of federal matching funds for previous state spending on health care for childless adults.

Strong support for childless adult coverage helped preserve it during recent state fiscal crises. In 2003, leaders in several of the study states responded to state budget problems by proposing to single out childless adults for major eligibility reductions. Without exception, these proposals were rejected. Rather, policymakers in these states ultimately settled on a two-fold approach of modestly scaling-back childless adult coverage while distributing most health care cuts across a much broader population served by state programs. While programs that cover childless adults were not eliminated, some of the broader reductions in coverage affected childless adults along with others. Factors contributing to the survival of childless adult programs included the perceived arbitrariness of basing an adult's coverage on the presence or absence of minor children living at home; childless adults' frequent status as workers unable to afford insurance; program design features that helped control program costs; support from health care providers, including community hospitals in both urban and rural areas; and support from some employers who argued that public coverage for childless workers improved their workforce's stability and productivity.

These findings suggest that federal policymakers willing to devote new resources to health coverage may want to revisit the current denial of Medicaid matching funds for poor, childless adults. Statutory changes that would eliminate the need for a waiver when state Medicaid programs wish to cover low-income adults – regardless of whether they are pregnant, have dependent children, are elderly, or experience severe and long-term disabilities – could be an important element in strategies to reduce the number of uninsured Americans. No doubt, other coverage expansion groups and strategies are also worth considering, but childless adults comprise more than half of all Americans who are both poor and uninsured. They constitute the one group of low-income, uninsured Americans to whom standard Medicaid funding is currently denied. For policymakers who prioritize coverage expansions based on the inability of uninsured populations to purchase insurance on their own and the potential impact of health coverage on health status, childless adults with low incomes represent a logical focus for future health reform efforts.

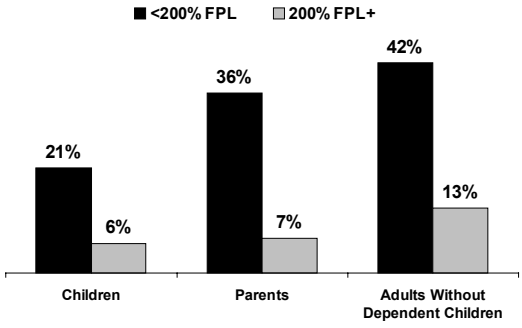
INTRODUCTION

Low-income adults without dependent children are more likely to be uninsured than are any other Americans. In 2002, over 40 percent of low-income childless adults were uninsured, a significantly higher proportion than among low-income children or parents (Figure 1). Low-income adults without dependent children accounted for nearly a third of all uninsured in 2002.[1] Further, over half of the uninsured with incomes below poverty were adults without dependent children (Figure 2).

Like other low-income Americans, adults without dependent children frequently have difficulty accessing and affording private coverage. However, unlike other low-income people, under current law, childless adults cannot receive Medicaid, no matter how poor they are or how hard they work. Without a waiver of ordinary Medicaid rules, states cannot use federal Medicaid funds to cover childless adults unless they are pregnant, elderly, or severely and permanently disabled. To cover these adults, slightly more than a dozen states have obtained Medicaid waivers or established fully state-funded programs. However, in the nation as a whole, only a small proportion of low-income childless adults benefit from such programs.[2]

Figure 1

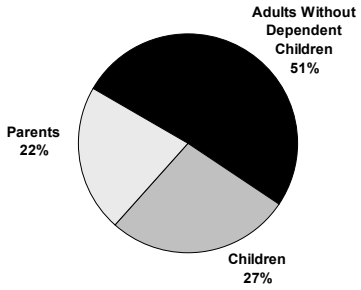
Uninsured Rates for Children and Adults by Income, 2002



Note: Excludes SSI recipients. 200% of the FPL was $30,040 for a family of three and $17,720 for an individual in 2002.
Source: KCMU and Urban Institute analysis of the March 2003 Current Population Survey.

Figure 2

The Nonelderly Poor Uninsured, 2002



Total = 15.5 million

Note: "Poor" is defined as those in households with incomes below 100% of the federal poverty level, which was $15,020 for a family of three or $8,860 for an individual in 2002.
Source: KCMU and Urban Institute analysis of the March 2003 Current Population Survey.

This report describes eight states' efforts to cover low-income childless adults, based on interviews with key stakeholders, site visits in four states, and document reviews. This paper examines which types of childless adults are covered, the factors associated with state decisions to provide coverage, and the impact of insuring childless adults. It concludes by exploring the sustainability of these programs, particularly during recent periods of fiscal stress, and by discussing the policy implications of the report's findings.

BACKGROUND

History of Medicaid's Exclusion of Coverage for Childless Adults

In important ways, Medicaid's exclusion of coverage for childless adults reflects decisions made as income support programs were established during the Great Depression, more than half a century ago. Enacted almost as an afterthought to Medicare, Medicaid began as an adjunct to cash assistance programs that were partially funded with federal dollars: namely, Old Age Assistance; Aid to the Blind; Aid to the Permanently and Totally Disabled; and Aid to Families with Dependent Children (AFDC). These federally-matched but state-administered cash assistance programs were created by the Social Security Act of 1935. They departed from the previous tradition of locally-based relief for the poor, which began in England with the Elizabethan Poor Law of 1601 and was then exported to Colonial America.[3] When the Depression-era cash aid programs began, localities remained responsible for low-income people outside the new programs' scope, including childless adults. With cash 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 beyond the limits of federally-funded cash assistance. This growth was incremental with eligibility categories added one at a time, each of which resembled previously covered groups. For example, AFDC-based eligibility grew to encompass children who would have received AFDC but for certain factors (such as their grandparents' income), then pregnant women who would have qualified for AFDC if their children had already been born, then children and pregnant women with income up to various percentages of the federal poverty level. 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 disabilities, on the other.

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 made in the 1930s, almost 70 years ago. Moreover, it developed in the context of income support, not health care. A key question facing policymakers today is whether Medicaid's exclusion of childless adults continues to make sense in 2004 and beyond.

Current Coverage of Childless Adults

Because current federal law does not allow state Medicaid programs to cover childless adults unless they are pregnant, severely disabled, or elderly, states have two available approaches to providing childless adults with health insurance:

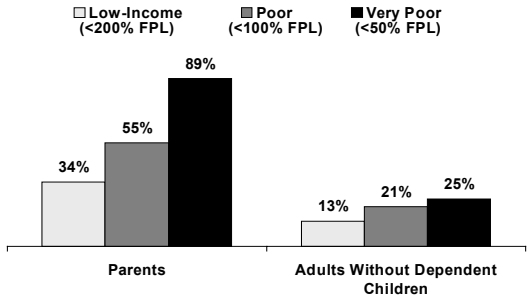
- **Section 1115 waivers** let states use federal matching funds under Medicaid or the State Children's Health Insurance Program (SCHIP) in ways not allowed under current law, such as to cover childless adults.[4] However, waivers must be "budget neutral," which means that federal costs under a waiver may not exceed a state's projected federal spending "baseline" without the waiver. Thus, a state must make room for expanded coverage by either redirecting unspent federal dollars (such as SCHIP or Disproportionate Share Hospital funds) or reducing other Medicaid program costs. Under Section 1115 waivers, states also can make other departures from ordinary Medicaid rules, such as certain benefit reductions, cost-sharing requirements, or coverage variations within eligibility groups.

- **State-only programs** are funded solely with state dollars. States have complete flexibility in how they structure these programs, including eligibility, benefits, and cost sharing. Accordingly, states can use these programs to cover adults without dependent children. However, these programs are subject to the constraints of available state funding.

Most states take neither approach, offering no public coverage to any childless adults. As a result, among the uninsured with family incomes below 200 percent of FPL, only 13 percent of childless adults had access to public coverage, compared to 34 percent of parents in 1999, the latest year for which data are available (Figure 3). Even among the very poor uninsured with incomes below 50 percent of the FPL, only 25 percent of childless adults had access to public coverage, compared to 89 percent of parents.[5]

Figure 3

Percent of Low-Income, Uninsured Adults Who Qualify for Public Coverage, 1999

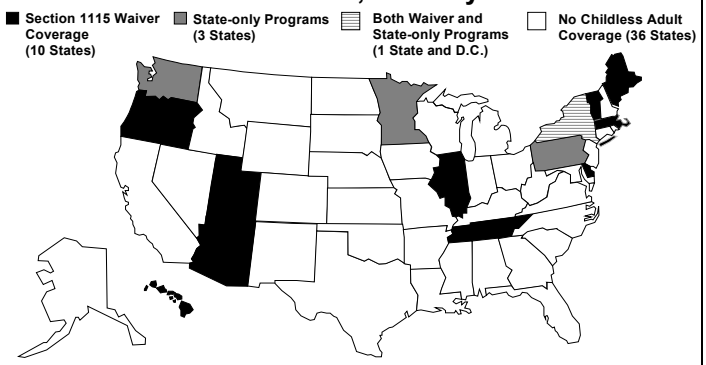


Note: Excludes SSI recipients.
The FPL was $8,240 for an individual and $13,880 for a family of three in 1999.
Source: Urban Institute analysis of National Survey of America's Families, 1999

As of January 2004, 14 states and the District of Columbia covered low-income childless adults; 36 states did not (Figure 4). Ten states provided this coverage through Section 1115 waivers, three operated state-only programs, and one state along with the District of Columbia operated both waiver and fully state-funded programs.[6]

Figure 4

States Providing Medicaid or Other Coverage to Childless Adults, January 2004



NOTES: New Mexico is not shown as covering childless adults because its waiver to provide such coverage has not been implemented.
SOURCE: ESRI Analysis

METHODS

During late 2002 and early 2003, a team from the Economic and Social Research Institute (ESRI) and the Kaiser Commission on Medicaid and the Uninsured interviewed officials and stakeholders in 8 of the 15 state-level jurisdictions that cover childless adults: the District of Columbia, Maine, Massachusetts, Minnesota, New York, Oregon, Pennsylvania, and Washington State. The eight study sites were chosen for diversity in program financing, structure, and longevity as well as geographic region and general population demographics. The team collected data through site visits to four states, document review, and interviews with state officials, legislators, legislative staff, advocates, providers, researchers, employers, and other stakeholders. This report provides an overview of childless adult coverage efforts in the eight study sites. State-specific findings are detailed in a series of papers available at www.kff.org.

FINDINGS

Factors Associated With Coverage Expansions for Childless Adults

Whether a state expands coverage via waiver or state-funded program, significant commitments of money and political capital may be required. Accordingly, it is important to observe what factors were associated with the states that took action to cover childless adults.

Strong history of expanding health coverage. Without doubt, the most important factor was a significant commitment by policymakers and stakeholders to expanded coverage in general. Both in the eight study states and elsewhere, many states that assist childless adults have a strong history of covering the uninsured broadly. Many analysts have long viewed Hawaii, Massachusetts, Minnesota, Oregon, Pennsylvania, Tennessee, Vermont, and Washington as national leaders in ground-breaking policies to cover the uninsured, joined recently by Maine. In states like Minnesota and Pennsylvania, other groups of uninsured received help before programs began serving childless adults. In states like Washington and Tennessee, uninsured childless adults received coverage at the same time as other uninsured residents. In either case, judged on the basis of their policy decisions, the states that covered childless adults had ongoing state leadership that placed a high value on coverage in general.

Childless adults folded into broader group of "working adults." In the study states, stakeholders generally did not believe it made sense for availability of coverage to depend on parental status. Rather, coverage expansion was perceived as necessary for low-income, working adults who lacked access to employer coverage and could not afford to purchase insurance on their own. Whether or not these adults had minor children living at home was seen as irrelevant to these workers' need for coverage.

Broad support from key stakeholders. In some states, hospitals and providers joined coverage efforts in hopes of reducing uncompensated care costs. In several states, important segments of the business community strongly supported this coverage as improving worker productivity or reducing cost-shifting to employers. States with childless adult coverage also tended to have at least one strong "champion" in either the Administration or Legislature.

Financing and Basic Structure of Childless Adult Programs

Using broad categories, Table 1 describes the financing and eligibility approaches that were taken by the 16 programs that covered childless adults in our eight study states. Nine of these programs involved waivers that provided states with federal matching funds, while seven were funded entirely with state dollars.

Based on interviews in these states, decisions about whether to provide coverage through an 1115 waiver or a state-funded program were generally driven by the following factors:

Previous experiences with waivers or state-only programs. State financing decisions reflected each state's history and previous experiences with health coverage expansions. For example, in the mid-90s Maine eliminated a state-funded program due to lack of funding. Accordingly, in developing their recent expansion, officials sought a Medicaid waiver, which allowed the state to draw down federal matching funds. In contrast, Pennsylvania's leaders viewed an earlier state-only program for uninsured children as a great success. When developing a new coverage program for childless adults, officials modeled the new program after the earlier effort for children, relying exclusively on state funds.

Perceived political feasibility. In some states, stakeholders noted that using state-only funds increased the political feasibility of coverage expansions, because this approach gave the state more control over program structure. Some respondents described concerns that Medicaid spending was hard to control because of the individual entitlement to coverage, that meeting federal budget neutrality requirements could be difficult, and that Medicaid suffered from perceived stigma. Further, in some states, structuring programs in ways that would not be allowed under Medicaid enabled the programs to garner necessary support from key stakeholders. For example, the programs in Washington and Pennsylvania had benefit limits, premiums, and cost sharing that exceeded what is allowed under Medicaid, but which some stakeholders viewed as essential to program adoption.

Available federal funding. In other states, respondents reported that coverage of childless adults was possible only because federal dollars were available through an 1115 waiver. For example, Maine's waiver let the state use unspent Disproportionate Share Hospital funds to cover childless adults. Further, both in the study states and elsewhere, a few states have obtained waivers that allow them to use unspent SCHIP funds to cover childless adults. While such waivers provide states with increased federal dollars because the federal government matches state spending at a higher rate for SCHIP than for Medicaid, some independent analysts have criticized the use of SCHIP funds, which were intended for low-income children, to cover childless adults.[7] However, in large part because of state fiscal problems, several waivers that approved the use of SCHIP funds to significantly expand childless adult coverage have not been implemented.[8]

Simplicity of program administration. In some cases, decisions about program structure were tied to simplicity of administration. Respondents in Maine, for example, noted that pursuing a Medicaid expansion for childless adults allowed for simpler administration than would have resulted from creating a new and separate state-funded program.

Table 1 - Program Characteristics in Eight Study States

State	Program Name	Eligibility for Childless Adults	Benefits			Prem-iums	Cost Sharing	Childless Adult Enrollment	State Can Cap Enrollment?
			Medicaid	Reduced	Premium Assistance				
Section 1115 Waiver Programs									
DC	Childless Adults Age 50-64	≤50% FPL and age 50-64	✓			No	None	1,420 in Sept. 2003	Yes
ME	MaineCare	≤100% FPL	✓			No	Nominal	16,250 in Sept. 2003	No[9]
MA	MassHealth *Essential*	≤100% FPL and unemployed >12 months		✓		No	Nominal	23,966 in April 2004[10]	Yes
	Family Assistance	≤200% FPL and has qualifying employer coverage			✓	Yes for >133% FPL	Above nominal	4,390 in April 2004	Yes
	Medical Security Plan	≤400% FPL and receives unemployment insurance		✓	✓	Yes for >200% FPL	Above nominal	6,720 in Sept. 2003 (includes others)	No
NY	Family Health Plus	≤100% FPL		✓		No	None	148,750 in May 2004	No
	Medicaid	≤50% FPL	✓			No	None	303,570 in Nov. 2003	No
OR	OHP Standard	≤100% FPL		✓		Yes	Above nominal	33,970 in April 2004	Yes
	Family Health Insurance Assistance Program	≤185% FPL			✓	Yes	Above nominal	4,014 in April 2004 (includes others)	Yes
State-funded Programs									
DC	DC Health Care Alliance	≤200% FPL		✓		No	None	24,560 in May 2004	Yes
MN	General Assistance Medical Care (GAMC)	≤75% FPL		✓		No	None[11]	46,840 in Jan. 2003	No
	MinnesotaCare	≤175% FPL and uninsured >4 months; no employer coverage for the last 18 months; no access to current employer coverage[12]		✓		Yes	Some above nominal	36,340 in Jan. 2003	No
NY	Healthy New York	≤250% FPL, except small business employees, for whom there are no income limits; no access to ESI; uninsured throughout previous year		✓[13]		Yes	Above nominal	55,000 in April 2004 (includes others)	Yes
PA	AdultBasic	≤200% FPL		✓		Yes	Above nominal	43,120 in Sept. 2003 (includes others)	Yes
WA	Basic Health (BH)	≤200% FPL		✓		Yes	Above nominal	44,560 in Feb. 2003	Yes
	General Assistance Unemployable	≤45% FPL and unemployable >90 days	✓			No	None	6,700 in Dec. 2002	No

NOTES: "Reduced" means a benefit package that is less comprehensive than the state's Medicaid benefit package. In some cases, the benefits are equivalent to SCHIP benefits; in other cases, benefits are severely restricted, for example, by excluding prescription drugs. For programs in which eligibility is not tied to parental status, states may lack data showing the number of childless adult enrollees. Enrollment for such programs includes childless adults and others, such as parents; these cases are indicated by the phrase, "includes others."

Characteristics of Childless Adults Receiving Coverage

Table 1 also shows the eligibility requirements for the 16 studied programs operated by our eight study states. Most of these programs based eligibility on income, though some also took into account employment status or age. Many of the studied programs targeted low-income working adults. However, two other groups of adults also were helped by these programs: the near-elderly and people with disabilities.

Low-income working adults. Many of the programs we examined were structured to serve the low-income working population. As Table 1 shows, 8 out of the 16 programs covered childless adults with incomes up to at least 175 percent of federal poverty line, providing benefits less comprehensive than Medicaid. Seven of these programs charged premiums and included at least some out-of-pocket cost sharing above nominal levels. MinnesotaCare, the only such program that reported specific data showing the employment status of childless adults receiving health coverage, found that 65 percent of these adults were employed. Because of program rules, none of these workers had access to employer-sponsored insurance from an employer who paid 50 percent or more of premiums.

Public coverage is important for low-income working adults because they often have difficulty accessing private coverage. More than 80 percent of low-income, uninsured workers have no access to employer-sponsored coverage, and few have the discretionary income to pay full premiums in the nongroup market.[14]

The near-elderly. This group was covered in large numbers in the two states we examined that had available data: Washington and Minnesota. People in their 50s and 60s comprised more than a third of childless adult enrollees in these two states' programs, which covered such adults up to 200 percent and 175 percent of the FPL, respectively.[15] To some degree, the extensive use of these childless adult programs by older adults results from such adults' disproportionate exclusion from Medicaid. Unlike their younger counterparts, older parents typically have grown children, rather than minor children, and therefore cannot qualify for Medicaid as custodial parents. This suggests that expanding Medicaid's capacity to cover childless adults could be worth considering as a strategy to help low-income, uninsured Americans who are nearing retirement.

Further illustrating the potential impact of this strategy, the District of Columbia designed the first phase of its waiver expansion program specifically for very-low-income adults (that is, those with incomes below 50 percent of the FPL) who were age 50-64. Greatly in need of medical care, many beneficiaries of this precisely targeted waiver had multiple health problems, such as diabetes, HIV, diabetes, and hypertension.

Adults with disabilities. Adults with disabilities benefit from programs covering childless adults in several ways. First, childless adult programs provide temporary but crucial "bridge" coverage for some people with disabilities whose Medicaid applications are on hold pending determinations of disability by the Social Security Administration (SSA). In 2002, the average processing time for such determinations was 104 days, according to SSA.[16] If SSA erroneously finds an applicant not disabled, appealing and correcting the finding takes an additional one to three years.[17] An eventual finding of disability and the resulting start of Medicaid could come too late for those who suffered serious, irreversible harm because they were uninsured and unable to obtain necessary health care while they waited for an accurate disability determination.

Second, these programs cover some adults with disabilities who are ineligible for Medicaid because they do not meet SSA's definition of disability, which requires a physical or mental impairment that precludes any substantial, gainful employment for twelve months or more.[18] This definition was originally developed for SSA's cash assistance program for low-income people with severe and permanent disabilities, Supplemental Security Income (SSI), and then applied to Medicaid coverage for certain additional people with disabilities. Viewed by some as outdated, the SSI definition of disability is far more limited than definitions used in other contexts.[19] For example, according to the Americans with Disabilities Act, disability is "a physical or mental impairment which substantially limits one or more of the major life activities."[20] Many people who have disabilities, according to this less restrictive definition, are ineligible for disability-based Medicaid, but still may be unable to access private health insurance, despite their great need for coverage. In the states that have them, childless adult programs could be the only realistic source of health insurance for many of these Medicaid-ineligible people with disabilities.

Finally, although a number of the childless adult programs appeared to target relatively healthy workers, others specifically focused on helping people with chronic conditions or disabilities. Typically (though not always), these programs limited eligibility to extremely low income levels, sometimes with additional eligibility requirements pertaining to disability or long-term unemployment. Such "safety net" programs tended to provide very comprehensive benefits without significant beneficiary cost-sharing. Examples included Washington's General Assistance Unemployable program, which covered very poor adults who have been unemployable for at least 90 days, and New York's Medicaid program, which covered childless adults (and others) with incomes at or below 50 percent of the FPL.

Benefits and Costs for Enrollees

While the programs we studied showed significant variation, the benefits covered for childless adults were often less comprehensive than under Medicaid (Table 1).

Several states obtained waiver authority to provide a limited benefit package. Some waivers to cover childless adults also authorized benefit restrictions or beneficiary costs not otherwise allowed under Medicaid. For example, the Oregon Health Plan departed from normal Medicaid practices in its limited benefits, premium charges, and the amount of out-of-pocket cost sharing it imposed on poor parents and childless adults.

State-only programs often provided limited benefit packages. Entirely state-funded programs often provided benefits that were less comprehensive than Medicaid-covered services; many also charged premiums or cost-sharing that exceeded the nominal amounts permitted under Medicaid. An example of one of the most limited programs, Pennsylvania's adultBasic program did not cover prescription drugs, mental health services, durable medical equipment, or vision, hearing, or dental services. Enrollees were required to pay a $30 monthly premium as well as out-of-pocket cost-sharing when they sought care. Some other state-funded programs in this study provided coverage more along the lines of typical employer-sponsored coverage. In some cases (such as Minnesota's General Assistance Medical Care program, which previously furnished full Medicaid-level coverage), benefits were reduced through budget cuts approved in 2003. In several states, benefits that once were quite limited later expanded, reflecting some policymakers' concern that limiting benefits may have harmed enrollees.

A few programs extended the full Medicaid benefit package. A number of the programs that offered comprehensive Medicaid benefits, without premiums and with little or no cost-sharing, were targeted at very low-income adults, including many who suffer from chronic illnesses. For example, Washington's state-funded General Assistance Unemployable program provided full Medicaid benefits, without premiums or out-of-pocket cost-sharing, to individuals with incomes below 45 percent of the FPL who had been unable to work for at least 90 days; and New York's Medicaid program covered adults with incomes at or below 50 percent of the FPL. Extending comprehensive coverage to a larger group, Maine offered Medicaid benefits, with nominal cost-sharing, to all adults with incomes at or below the poverty level.

Some programs provided premium assistance rather than direct coverage. These programs subsidized premium costs for employer-sponsored coverage (and in some cases nongroup plans), which often has fewer benefits and higher cost sharing than Medicaid. For example, Oregon's Family Health Insurance Assistance Program helped pay premium costs of private coverage for adults with incomes below 185 percent of poverty, permitting subsidized coverage to have such features as a waiting period prior to coverage of a pre-existing condition and a $500 individual deductible.

Per Capita Costs in Two States

Most of the studied programs did not have published data on the cost of covering childless adults. Minnesota and Washington published such data, which showed that, while costs were relatively modest for programs designed for low-income workers, per capita costs were considerably higher in safety-net programs structured to assist very-low-income people and individuals with health problems.

Programs for workers incurred costs for childless adults that were roughly comparable to expenditures for other adult workers. In Basic Health, Washington State's per member per month costs for childless adults averaged less than $223 in 2002.[21] In MinnesotaCare, spending for childless adults averaged $314 per member per month in 2002, influenced by more generous program benefits and higher regional health care costs.

On the other hand, programs designed for very-low-income adults experienced much higher costs. This was not surprising, given the combination of more generous benefits and a population that included many people with chronic illnesses. In 2001 and 2002, costs for both Washington's General Assistance Unemployable program and Minnesota's General Assistance Medical Care (GAMC) program exceeded $500 per member per month.

Enrollment

Table 1 provides data on enrollment in programs serving childless adults. Based on the experiences of the study states, low-income childless adults have significant unmet demand for coverage. The experiences in the study states also show that outreach activities, enrollment caps, and premiums have a significant impact on the number of eligible adults receiving coverage.

Enrollment showed strong demand for coverage among low-income childless adults. In a number of states enrollment occurred quickly immediately after initial implementation, sometimes exceeding states' expectations. For example, Maine officials expected they would have 11,000 childless adult enrollees after one year; however, 14,000 childless adults enrolled in the first nine months. Likewise, Pennsylvania officials expected that between 30,000 and

40,000 childless adults would enroll in adultBasic, which began in July 2002. Enrollment proceeded so rapidly that the state added 10,000 slots before the end of 2002. By January 2003, nearly 50,000 had enrolled. The state then established a waiting list, which included 44,000 adults by June 2003, and added another 5,000 enrollment slots in July 2003. Pennsylvania officials were particularly surprised by this rapid enrollment because the program received little state-funded outreach. Much enrollment occurred as a result of word-of-mouth within the community as well as the efforts of community-based nonprofit agencies. According to such officials, these results suggested that low-income, childless adults have a strong need for and interest in obtaining health coverage.

Older programs have also experienced strong childless adult enrollment that has been responsive to changing economic conditions. For example, since the phase-in of MinnesotaCare coverage of childless adults from 1996 through 1998, enrollment of such adults increased substantially, from 11.5 percent of program enrollees in 1998 to 20.2 percent in 2002. Enrollment into Minnesota's GAMC program, which serves adults with very low incomes, has risen and fallen throughout the past decade in response to economic changes; a booming economy during the 1990s caused enrollment to plunge, and enrollment increased significantly during the recent economic downturn.

Enrollment was sometimes limited by lack of outreach. For example, respondents commented that enrollment in the District of Columbia's Medicaid expansion for very poor childless adults age 50-64 was hindered by lack of outreach. The expansion was not accompanied by any broad community education effort and did not meet its initial enrollment targets. Instead, enrollment took place gradually (almost automatically) when individuals recertified their eligibility for food stamps and other public benefits.

Premium assistance programs had limited enrollment. For example, the Massachusetts premium support program for employers and employees never reached its goals for participation, in large part because of the perceived complexity of employer participation requirements.

Premiums served as enrollment barriers in some states. A strong, inverse relationship between required premium payments and enrollment suggested that the low-income adults served by these programs found even modest premium charges unaffordable and difficult to pay.

- After Washington's Basic Health Program began statewide operation, initial enrollment was lower than expected. The state then conducted some limited outreach and lowered premiums so that the average monthly payment dropped from $23 to $17. Within a year, enrollment more than doubled, increasing by 146 percent. Several years later, policymakers reversed direction on premiums, increasing average monthly payments from $19 to $24. Demand for Basic Health coverage, measured by the number of enrolled individuals plus those on program waiting lists, fell by 45 percent. After policymakers grew concerned about the decline in demand, premiums were reduced to an intermediate level, and demand rose by 23 percent. To further illustrate the difficulty experienced by many low-income uninsured when they were asked to pay even the modest premiums charged by Basic Health ($10 a month for the poorest enrollees), 19 percent of all beneficiaries charged premiums had them paid by financial sponsors as of February 2003; not surprisingly, uninsured Washingtonians with incomes below the poverty level comprised a much higher proportion of financially sponsored enrollees than of Basic Health beneficiaries in general (81 percent versus 54 percent).

- Oregon's experience also demonstrated the significant effect premiums have on enrollment. In January 2003, the state increased monthly premiums from $6 to $20 for poor adults. By October, enrollment fell by roughly 50 percent or 50,000 adults. Early observations suggest that more than 70 percent of the adults who disenrolled became uninsured.[22]

- Similarly, Pennsylvania officials estimated that about 80 percent of program attrition has resulted from nonpayment of premiums. Respondents noted that, in addition to the $30 monthly cost, the rules for premium payment contributed to program termination. The state provided no grace period, cutting off adultBasic if a beneficiary missed or was late with one payment. A beneficiary seeking to reenroll would be placed at the end of the program's waiting list.

Enrollment caps limited the number of eligible adults who received coverage. States had the authority to cap enrollment in six of the eight studied states (Table 1). Three out of the eight studied states operated only programs with such caps; two operated only programs without caps; and three operated programs in both categories, serving different groups of people. Unlike parents and other populations covered by Medicaid who are guaranteed coverage if they are eligible and apply, adults who tried to join capped programs could not enroll, even if they qualified. Some of these capped programs placed eligible individuals on waiting lists and enrolled them "first come-first serve" as program slots opened.

Enrollment caps limited these programs to serving a small proportion of eligible childless adults. For example, between 300,000 and 350,000 childless adults were estimated to qualify for Pennsylvania's adultBasic program, but enrollment was capped at an average of 44,000 per month. In Washington, 74 percent of adults who were uninsured in 2000 would have gained access to coverage if the Basic Health waiting list had been eliminated and all eligible adults could enroll**.** That proportion may be significantly higher today, since the Legislature reduced the number of Basic Health slots significantly in 2003, as part of a broader package of budget cuts.

The Impact of Covering Childless Adults

Coverage led to improved access to care and utilization of services. Like other populations, childless adults receiving coverage improved their access to care and obtained services in more appropriate medical settings. Washington is one state in which the impact of coverage for adults has been extensively studied. One carefully controlled study found that, compared to similar uninsured individuals, enrollees in Washington's Basic Health program were twice as likely to have a usual source of care and to have at least one physician visit a year.[23] To similar effect were observations without controls showing that when Basic Health expanded from a county demonstration to a statewide program: (1) the proportion of uninsured state residents dropped by almost a third; (2) the proportion of state residents who reported they could not see a doctor because of cost fell by 22 percent; (3) the proportion of women over age 40 who did not receive a mammography over a two-year period dropped by more than one-third; (4) uncompensated hospital charity care likewise fell by more than a third; and (5) the proportion of very-low-income residents who used hospital emergency rooms as their main source of care fell from 3 percent to less than 1 percent.[24]

Benefit limits and out-of-pocket cost-sharing created barriers to accessing necessary care. For example, according to respondents, many beneficiaries have expressed strong dissatisfaction with Pennsylvania's adultBasic program because it does not cover prescription drugs or mental health services. A number of respondents who supported these benefit

restrictions as allowing limited state funds to cover more people nevertheless agreed that such restrictions denied essential services, to enrollees' potential detriment. In Oregon, service cutbacks and increased co-payments created large unmet needs for health care, according to providers and beneficiaries.[25]

Coverage of childless adults created offsetting savings. Such savings are illustrated by anecdotal reports from hospitals in Maine and New York suggesting that the volume of uncompensated care declined following coverage expansions that included childless adults. To create other offsets, states receiving waivers have refinanced some existing state-funded health programs with federal Medicaid or SCHIP matching funds. For example, New York's Home Relief program, once funded entirely with state and local dollars, now receives federal matching funds under a Medicaid waiver. Similarly, the District of Columbia shifted some older, very-low-income adults from its self-funded Alliance program into the new Medicaid waiver for childless adults ages 55-64, and Maine moved some formerly state-funded mental health services into its new Medicaid waiver program. In some cases, this federal replacement of state dollars allowed states to cover more people. For example, after refinancing its previously state-funded premium assistance program, Oregon expanded program eligibility.

Programs did not appear to experience adverse selection. When state programs were first proposed in Washington and Minnesota, many experts predicted that only the sickest eligible individuals would enroll, causing costs to skyrocket. After program implementation began, researchers found that these programs did not experience this anticipated problem. In Washington, for example, the healthiest among workers eligible for Basic Health disproportionately enrolled, not the sickest.[26] A similar experience took place in the early 1990s, when the imposition of premium charges for adults in the Oregon Health Plan was predicted to create serious adverse selection. Officials anticipated that the healthiest enrollees would drop out of the program because they would not want to pay the premiums, while the sickest, highest-cost individuals would remain behind. However, while coverage declined due to inability to afford premiums, healthy and sick beneficiaries alike left the program in comparable numbers.[27] Likewise, according to state officials, predictions by insurance underwriters that Healthy New York would attract a disproportionately unhealthy group of enrollees have turned out to be unfounded.

Sustainability of Coverage

Broad-based coalitions of stakeholders along with key policymakers in both parties strongly supported continuing health coverage for low-income, childless adults in nearly every study state. Basing coverage on the presence or absence of a child living at home was widely seen as arbitrary and unfair; many state officials and stakeholders expressed pride in basing coverage, instead, on residents' need for assistance.

This proposition was put to a severe test in 2002-2003, as state officials faced their greatest budget shortfalls in decades.[28] Despite barriers posed by the harsh fiscal climate, several jurisdictions – D.C., Maine, and Pennsylvania – started operating new programs to cover childless adults. In New York, other health services were cut, but recently enacted childless adult coverage was never suggested for reduction.

Nevertheless, key political leaders in three other states – Massachusetts, Minnesota, and Washington State – proposed to single out childless adults for disproportionately heavy cutbacks, with complete elimination of coverage for all or most childless adults. In each state, a

bipartisan group of policymakers rejected these proposals and found other ways to achieve savings that spread the cutbacks more evenly across diverse populations:

- In Massachusetts, the Legislature proposed eliminating coverage for more than 80 percent of all beneficiaries of MassHealth Basic, the state's program for long-term unemployed adults. After the cut was made, the Legislature and the Administration reached a bipartisan agreement to restore most of the terminated coverage by redirecting funds from the state's uncompensated care pool, eventually creating MassHealth Essential as a replacement program for most individuals who lost eligibility for MassHealth Basic. Although the new program had slightly lower income eligibility (100 percent of FPL rather than 133 percent of FPL), fewer benefits, and enrollment capped below prior levels, most of the prior coverage for childless adults was restored.

- In Minnesota, the Governor proposed terminating all MinnesotaCare subsidies for working, childless adults with incomes above 75 percent of FPL and redirecting adults with incomes below that threshold into significantly less generous coverage. The Legislature rejected this proposal, instead capping benefits for childless adults with incomes above 75 percent FPL, eliminating certain narrow categories of coverage (such as retroactive benefits, spend-down coverage, and eligibility for certain immigrants and a small number of childless adults above 175 percent of FPL), and meeting budget targets primarily by applying across-the-board savings measures to all of the state's major health care programs, not just coverage for childless adults.

- Washington's Governor proposed ending coverage for all childless adults in Basic Health. Legislators across the political spectrum opposed this proposal, opting instead to achieve most savings by measures applicable to all Basic Health enrollees, including parents and children. Such measures included reduced benefits, increased premiums, and more restrictive enrollment caps for all applicants. However, intake of new enrollees was restricted slightly more for childless adults than for parents and children.

Each of these three outcomes is remarkable. In Massachusetts, the state's program for long-term, unemployed childless adults, rather than its more popular programs for workers, was targeted, but it survived with limited reductions. The Governors of Minnesota and Washington both proposed cutbacks to childless adult programs that were entirely state-funded. Reductions in such programs yield much more state savings than do equal cuts in programs receiving federal matching funds. In a federally matched program, one dollar of service cuts saves no more than 50 cents in state funds while denying the state at least 50 cents in federal matching funds. By contrast, in a state-funded program, one dollar of service cuts saves one dollar of state money and does not reduce the level of federal funding coming into the state. Nevertheless, to spare childless adults disproportionate cutbacks that were widely seen as unfair and inappropriate, policymakers shifted much of the burden of proposed savings from state-funded childless adult programs to other program beneficiaries for whom federal matching funds were available.

Well before the fiscal difficulties of recent years, the political viability and sustainability of childless adult coverage was evident. Washington State, for example, demonstrated remarkable support from the public, stakeholders, and policymakers for a broad-based health coverage program serving uninsured workers, including childless adults. Although numerous health policy changes have been enacted and repealed as the Legislature repeatedly changed hands since major health reforms were adopted in 1993, Basic Health is one of the few such reforms that has survived and even grown, regardless of which party controlled the State

House. In November 2001, the public showed its own strong support when it approved, by a 2 to 1 margin, a state ballot initiative that raised state tobacco taxes by 73 percent and devoted 90 percent of the proceeds to Basic Health.

A number of factors contributed to such broad support in the study states. Generally speaking, uninsured, childless adults' status as low-income workers without access to employer coverage was important to the popularity of most programs, although support was also present for programs targeting the most vulnerable of these adults, who often faced barriers to employment. Important as well was the perceived arbitrariness of basing an adult's coverage on the presence or absence of minor children living at home. In some states, bipartisan support was enhanced by program design features that controlled program costs such as cost-sharing, limited benefits, and enrollment caps.

Health care providers were also an important part of coalitions that helped create, expand, and defend these programs for childless adults. In 2003, they played an important role lessening proposed cuts. Proposals to cut or curtail programs serving low-income adults were seen as particularly harmful to public hospitals in urban areas, to sole community hospitals in rural counties, to mental health care providers, to community health centers, and to other primary care providers.

Although some employers resisted any kind of government-sponsored health coverage program, others played an important role defending childless adult coverage on pragmatic grounds. For example, growers in Western Washington supported Basic Health coverage, arguing that it made their workforce more stable and productive. Similarly, in Pennsylvania, some employers supported publicly-funded health coverage as preferable to uncompensated care, which they argued was ultimately financed by increased health insurance premiums for employer-based coverage.

CONCLUSION

Medicaid coverage remains tethered to eligibility categories that began in Depression-era cash assistance programs. These historical categories exclude adults without dependent children, making them by far the country's largest group of low-income uninsured. This group includes low-income workers as well as many near-elderly unable to obtain coverage elsewhere and people with disabilities who are either awaiting coverage decisions from the federal government or whose disabilities do not fit the limited definition developed for federally-funded cash assistance. Uninsured, childless adults include both relatively healthy, low-income workers without access to employer-sponsored coverage as well as adults suffering from serious, long-term health problems that create major obstacles to employment.

The experience of the states that have covered these individuals, whether through 1115 waivers or exclusively state-funded programs, shows a significant demand for coverage and a strong, positive impact on affected individuals and the health care system as a whole. These programs have generated tremendous support from policymakers in both parties, from the general public, from health care providers, and from many employers.

State policymakers concerned about the uninsured may wish to consider developing programs targeting this group, considering carefully the trade-offs involving 1115 waivers and departures from Medicaid benefits and cost-sharing rules. At a more basic level, federal policymakers may want to revisit the current denial of Medicaid matching funds for poor, childless adults. Statutory

changes that would eliminate the need for a waiver when state Medicaid programs wish to cover low-income adults – regardless of whether they are pregnant, have dependent children, are elderly, or experience severe and long-term disabilities – could be an important element in strategies to greatly reduce the number of uninsured Americans.

No doubt, other coverage expansion groups and strategies are also worth considering. But childless adults comprise more than half of all Americans who are both poor and uninsured. They constitute the one group of low-income, uninsured Americans for whom standard Medicaid funding is currently denied. For policymakers who prioritize coverage expansions based on the inability of uninsured populations to purchase insurance on their own and the potential impact of health coverage on health status, childless adults with low incomes represent a logical focus for future health reform efforts.

NOTES

[1] Amy Davidoff, Anna S. Sommers, Jennifer Lesko, and Alshadye Yemane. *Medicaid and State-Funded Coverage for Adults: Estimates of Eligibility and Enrollment,* Prepared by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, April 2004. http://www.kff.org/medicaid/upload/35461_1.pdf.

[2] Davidoff, et al., 2004.

[3] Robert L. Barker. *The Social Work Dictionary*, *3rd Edition*. National Association of Social Workers, 1995. Excerpted at http://www.socialworkers.org/profession/centennial/milestones_1.htm.

[4] For more information on waivers see Cindy Mann, Samantha Artiga, and Jocelyn Guyer. *Assessing the Role of Recent Waivers In Providing New Coverage*. Kaiser Commission on Medicaid and the Uninsured, December 2003. http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=28336.

[5] Davidoff, et al., 2004.

[6] The states that covered childless adults through waivers were Arizona, Delaware, Hawaii, Illinois, Maine, Massachusetts, Oregon, Tennessee, Utah, and Vermont. The states that fully funded their own programs for such adults were Minnesota, Pennsylvania, and Washington. The District of Columbia and New York operated both waiver programs and fully state-funded programs. Although New Mexico received a waiver program to cover childless adults, the waiver had not been implemented by January 2004 and remains unimplemented as this report goes to press. National Governors Association (NGA), Center for Best Practices, Health Policy Studies Division, *MCH Update 2002: State Health Coverage for Low-Income Pregnant Women, Children, and Parents,* June 9, 2003, http://www.nga.org/cda/files/MCHUPDATE02.pdf; Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, *KidCare Parent Coverage Demonstration, Special Terms and Conditions, Illinois Department of Public Aid* (Undated), http://www.cms.gov/hifa/ilkidcaretc.pdf.

[7] General Accounting Office, *SCHIP: HHS Continues to Approve Waivers That Are Inconsistent with Program Goals,* January 5, 2004, GAO-04-166R, www.gao.gov; General Accounting Office, *Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns*, July 2002, GAO-02-817, www.gao.gov.

[8] As of December 2003, only three states used SCHIP dollars for childless adult coverage: Illinois, which refinanced previously state-funded programs that covered fewer than 1,000 medically uninsurable adults; Arizona, which used SCHIP funds to refinance existing Medicaid-financed childless adult coverage; and Oregon, which used SCHIP and Medicaid funds to refinance and modestly expand a preexisting state-funded premium assistance program. See Cindy Mann, Samantha Artiga, and Jocelyn Guyer, *Assessing the Role of Recent Waivers in Providing New Coverage.* Kaiser Commission on Medicaid and the Uninsured, December 2003. As of December 2003, seven states (AZ, IL, MN, NH, NJ, RI and WI) used SCHIP funds to finance health coverage for a total of 268,246 adults, most of whom were parents. See Vernon Smith, David Rousseau, and Molly O'Malley, *SCHIP Program Enrollment: December 2003 Update*. Kaiser Commission on Medicaid and the Uninsured, July 2004. http://www.kff.org/medicaid/7134.cfm.

[9] Maine's waiver authorizes an expenditure cap. The state can reduce eligibility levels for childless adults to stay within this cap, but it cannot close enrollment to eligible childless adults.

[10] In addition to the nearly 24,000 childless adults covered through MassHealth Essential, 12,870 childless adults also were covered through the state's MassHealth Basic program, despite its narrowed eligibility criteria.

[11] Nominal copayments were imposed in response to state budget problems in 2003.

[12] If an employer pays less than 50 percent of premiums, an otherwise eligible worker can qualify for MinnesotaCare.

[13] The Healthy New York program subsidized coverage for a defined set of benefits that private plans in the state are required to offer. Because benefits are defined by the state and less comprehensive than the state's Medicaid coverage, Healthy New York's benefits are categorized as "reduced."

[14] See Bowen Garrett, *Employer-Sponsored Health Insurance Coverage: Sponsorship, Eligibility, and Participation Patterns in 2001*, Kaiser Commission on Medicaid and the Uninsured, July 2004. http://www.kff.org/uninsured/7116.cfm; Claudia Williams, Julie Hudman, and Molly O'Malley, *Challenges and Tradeoffs in Low-Income Family Budgets: Implications for Health Coverage*. April 2004. http://www.kff.org/medicaid/4147.cfm; and Carolyn A. Watts and James Matthisen. *Income Adequacy and the Affordability of Health Insurance in Washington State*. "Appendix D, The Adjusted Self-Sufficiency Standard as a Percent of the Federal Poverty Level for Eight Washington Counties." June 2002. http://www.ofm.wa.gov/accesshealth/research/33appendixd.pdf.

[15] In Minnesota, 35 percent of childless adult enrollees were age 50-64 in 2001, the most recent year for which such data are published. In Washington, 29 percent of childless adult enrollees in February 2003 were ages 55-64, and others were in their early 50s.

[16] 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

[17] General Accounting Office. *Electronic Disability Claims Processing: Social Security Administration's Accelerated Strategy Faces Significant Risks*. July 24, 2003. GAO-03-984T. www.gao.gov.

[18] Social Security Administration (SSA). *What are the disability requirements for an adult?* Accessed on June 26, 2003. http://ssa-custhelp.ssa.gov

[19] The President's Commission to Strengthen Social Security, *Strengthening Social Security And Creating Personal Wealth For All Americans* (Final Report), December 2001, http://www.ssa.gov/history/reports/pcsss/Final_report.pdf; National Commission on Social Security, *Social Security in America's Future,* Final Report, March 1981, http://www.ssa.gov/history/reports/80commission.html.

[20] Americans with Disabilities Act of 1990, Section 3(2)(A). http://www.usdoj.gov/crt/ada/pubs/ada.txt.

[21] Washington Health Care Authority, unpublished data. Calculations by ESRI, May 2003.

[22] Cindy Mann and Samantha Artiga. *The Impact of Recent Changes in Health Care Coverage for Low-Income People: A First Look at the Research Following Changes in Oregon's Medicaid Program.* Kaiser Commission on Medicaid and the Uninsured, June 2004. http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=36812.

[23] Stephen H. Long and M. Susan Marquis. "Participation in a Public Insurance Program: Subsidies, Crowd-Out, and Adverse Selection." *Inquiry.* 39:243-257 (Fall 2002).

[24] Mark Gardner, Patricia Lichiello, and Staci Richard, *The Pulse Report 2002*, Health Policy Analysis Program, University of Washington, November 2002, http://depts.washington.edu/hpap/pdf_reports/pulse_2002_full_web.pdf; University of Washington Health Policy Analysis Program, Rutgers University Center for State Health Policy, RAND, William M. Mercer, Incorporated, Foundation for Health Care Quality/Community Health Information Technology Alliance (CHITA), *Targeting the Uninsured in Washington State,* (Targeting the Uninsured), "Chapter 7. The Role of the Safety Net," April 2002, http://www.ofm.wa.gov/accesshealth/research/31chapt7.pdf; Lawrence Hettick and Richard Ordos, W*ashington State 2000: Charity Care in Washington Hospitals*, Center for Health Statistics, Washington State Department of Health, July 2002, http://www.doh.wa.gov/EHSPHL/hospdata/CharityCare/2000/2000CharityCareinWashingtonState.doc; *Targeting the Uninsured,* "Chapter 7. The Role of the Safety Net," http://www.ofm.wa.gov/accesshealth/research/31chapt7.pdf; Center for Health Statistics, Washington State Department of Health, *BRFSS Data Tables* (ESRI Calculations, March 2003), http://www.doh.wa.gov/EHSPHL/CHS/CHS-Data/brfss/BRFSS_tables.htm.

[25] Mann and Artiga, op cit.

[26] Long and Marquis, op cit.; Paula Diehr, Carolyn W. Madden, Diane P. Martin, Donald L. Patrick, Marilyn Mayers, Patti Char, Susan Skillman, Allen Cheadle, Paul Fishman, Geoffrey Hoare, and Victoria Moceri, "Who Enrolled in a State Program for the Uninsured: Was There Adverse Selection?" *Medical Care,* 1993, Vol. 30, No. 12; Donald Patrick, Carolyn Madden, Paula Diehr, Diane Martin, Allen Cheadle, and Susan Skillman, "Health Status and Use of Services Among Families With and Without Health Insurance," *Medical Care,* 1992, Vol. 30, No. 10; Geoffrey Hoare, Marilyn Mayers, and Carolyn Madden, "Lessons from Implementation of Washington's Basic Health Plan," *Health Affairs,* Summer 1992, Vol. 11, No. 2; Carolyn Madden, Allen Cheadle, Paula Diehr, Diane Martin, Donald Patrick, and Susan Skillman, "Voluntary Public Health Insurance for Low-Income Families: The Decision to Enroll," *Journal of Health Politics, Policy, and Law*, 1995, Vol. 20, No. 4.

[27] Susan G. Haber and Janet B. Mitchell. *Effects of Premiums on Eligibility for the Oregon Health Plan*. Health Economics Research, Inc., May 22, 2000.

[28] Vernon Smith, Rekha Ramesh, Kathleen Gifford, and Eileen Ellis, Health Management Associates, and Victoria Wachino and Molly O'Malley, Kaiser Commission on Medicaid and the Uninsured, *States Respond to Fiscal Pressure: A 50-State Update of State Medicaid Spending Growth and Cost Containment Actions,* January 2004, http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=30453; Donald Boyd and Victoria Wachino, *Is the State Fiscal Crisis Over? A 2004 State Budget Update,* Kaiser Commission on Medicaid and the Uninsured, January 2004, http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=30459.

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