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The Urban Institute

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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

Lack of health insurance coverage for low-income adults remains a pressing policy challenge. In 2002, nearly 40% of low-income adults (below 200% of poverty or $18,620 for an individual in 2004) were uninsured and low-income adults accounted for nearly half of the uninsured population. Because low-income adults often cannot obtain employer-sponsored coverage and individual coverage is prohibitively expensive for them, Medicaid is an essential source of health coverage. However, in contrast to the significant gains in health coverage of children that have been achieved through expansions in Medicaid and the State Children's Health Insurance Program (SCHIP), coverage for low-income adults has lagged far behind.

There is little recent information available on the number and characteristics of nonelderly adults eligible for Medicaid or other public coverage or on their enrollment. Using 1999 National Survey of America's Families (NSAF) data, this report provides an overview of nonelderly adult eligibility for and enrollment in Medicaid and state-funded coverage, nationally and in 13 study states. Adults eligible for public coverage were identified using an algorithm that replicates the eligibility determination process for Medicaid and two state-funded public insurance programs (in Minnesota and Washington). Adults with disabilities who were eligible for Medicaid through receipt of Supplemental Security Income (SSI) were excluded from this analysis because their characteristics and enrollment patterns were fundamentally different than those of other adults.

Eligibility Findings

States have limited ability to extend coverage to low-income adults through Medicaid. States are required to provide Medicaid coverage to limited groups of parents, many with incomes below 50 percent of poverty, and have options to extend coverage to additional low-income parents. States are also required to provide coverage for some low-income pregnant women. However, with the exception of optional extensions of Ribicoff child coverage to young adults, there are no other Medicaid pathways for adults without dependent children who do not meet disability requirements. States can only cover these adults through Medicaid if they obtain a Section 1115 waiver or through a fully state-funded program. However, in either case, states cannot receive additional federal financing for coverage expansions to adults without dependent children.

As a result of low federal eligibility standards for coverage of parents and the limited options and financing available to states for expanding coverage to other adults, study findings show that nationally very few low-income adults were eligible for public coverage. While all states extended Medicaid eligibility to some low-income parents, in many states, eligibility thresholds were well below poverty—in a number of states, less than 50% of poverty ($653 per month for a family of three in 2004). Public coverage options were even more limited for low-income adults without dependent children. In 1999, only seven states offered public coverage to these adults; in other states, they were not eligible for any public coverage, regardless of their incomes. Specific findings regarding eligibility include:

- **Most low-income adults did not qualify for public coverage.** About one in four (25 percent) low-income adults were eligible for Medicaid or state-only funded coverage, and 39 percent) of poor adults were eligible for public coverage.

- **Adults who qualified for public coverage were overwhelmingly poor.** Two-thirds had incomes below poverty, and 45 percent had incomes below 50 percent of poverty.

- **The majority (65 percent) of eligible adults were parents.** Among poor adults, 66 percent of parents were eligible for public coverage, compared to only 24 percent of adults without dependent children.

- **Adult eligibility for public coverage varied significantly across states.** The proportion of low-income adults eligible for public coverage varied dramatically across the 13 study states, ranging from 10% in Colorado to 97% in Washington State.

Enrollment Findings

Although very few low-income adults qualified for public coverage, it appears that most who did needed and wanted the coverage. The majority of eligible adults who had no other source of coverage were enrolled. However, the enrollment process for adults is often more difficult than for children, outreach is more limited, and more frequent eligibility determinations are imposed. As a result of these hurdles, many eligible low-income adults remained uninsured. Certain adults, such as parents, were more likely to enroll than others, which is likely the result of a better connection to outreach efforts. Further, adults eligible for mandatory Medicaid coverage were more likely to enroll than adults eligible for optional or waiver Medicaid coverage or state-funded coverage. This could reflect additional enrollment requirements that are sometimes part of waiver or state-funded coverage, such as premiums. Finally, there were significant differences in enrollment rates across states, which may stem from different outreach efforts and enrollment procedures as well as different enrollment requirements in states with waiver or state-funded coverage. Specific enrollment findings include:

- **Over half of adults (54 percent) who were eligible for public coverage and had no other source of coverage were enrolled.** However, 46 percent of low-income adults who could be covered by public coverage were uninsured.

- **Eligible parents were more likely to enroll in public coverage (57 percent) than adults without dependent children (45 percent).** Eligible parents whose children were covered by Medicaid were the most likely to enroll themselves (76 percent). Still, nearly one quarter (24 percent) of eligible parents with children enrolled in Medicaid remained uninsured.

- **The poorest eligible adults were the least likely to be enrolled in public coverage.** Among eligible adults, the poorest adults (incomes less than 50 percent of poverty) had the lowest enrollment rate (40 percent) and the highest uninsured rate (60 percent).

- **Adults eligible for Medicaid were more likely to enroll than adults eligible for state-only programs.** Over 60 percent of eligible adults who qualified through a mandatory Medicaid pathway were enrolled, compared to 43 percent of adults eligible through optional or waiver Medicaid coverage, and 35 percent of adults eligible for a state-only funded program.

- **Enrollment rates varied dramatically among states.** Enrollment rates ranged from 36 percent in Mississippi to 81 percent in Massachusetts.

Policy Implications

These eligibility and enrollment findings demonstrate that Medicaid is an important vehicle that states have used to provide coverage to low-income adults who otherwise would be uninsured. However, low federal eligibility requirements for parents, the federal prohibition against using federal funds to cover adults without dependent children, and constraints on federal financing have impeded efforts to broaden coverage of low-income adults.

Low federal requirements for mandatory Medicaid coverage of parents have resulted in limited eligibility for parents and inconsistent coverage within families. While states that participate in Medicaid are required to offer coverage to all poor children, mandatory Medicaid coverage for parents is limited to those with very low incomes, often below 50 percent of poverty. States can choose to expand parent coverage to higher incomes but many have not done so or have only made minimal expansions. As such, many poor parents do not qualify for public coverage, and, in many families, children qualify for coverage but their parents do not.

As a result of lack of federal financing to cover adults without dependent children, very few of these adults are eligible for public coverage. Medicaid cannot be used to cover non-pregnant, non-disabled adults without dependent children unless a state obtains a waiver that assures that no additional federal dollars will be expended. The only other way a state can cover these adults is through a fully state-funded program. As a result, most states do not offer any coverage to adults without dependent children, regardless of income, and, therefore, the majority of these adults do not have any public coverage options available to them.

Eligible adults could benefit from reduced enrollment requirements and targeted outreach efforts. The enrollment process for adults is often more difficult than for children and less outreach is directed toward adults. Adults without dependent children who are eligible through a Medicaid waiver or for a state-funded program sometimes face additional enrollment requirements not found in Medicaid, such as a required uninsured period or payment of premiums. Reducing such enrollment requirements and increasing outreach efforts for adults might increase enrollment rates, particularly among the lowest income adults and adults without dependent children, who are the least likely to enroll.

Access to public insurance is largely dependent on where one lives. As a result of flexibility extended to states in determining the scope and structure of public coverage for adults, there is substantial variation in eligibility policy across states, resulting in stark differences in how many and which adults are eligible for public insurance. Further, there are significant state differences in enrollment rates, likely reflecting differences in outreach efforts and enrollment requirements.

Adults are likely to face increased difficulties accessing public coverage during periods of fiscal stress, when need for coverage increases. Most coverage available to adults is Medicaid coverage provided at state option or through a waiver or state-funded coverage. These types of coverage are vulnerable to state cutbacks during difficult economic periods. Thus, during

periods of fiscal stress, when need for public coverage increases, access to public coverage for low-income adults is likely to become even more limited. In fact, the recent economic downturn has demonstrated the precarious nature of public coverage for adults. Many of the cutbacks undertaken by states in the last few years have targeted coverage for parents and other adults. Further, during this recent period of fiscal stress, a number of states reinstated selected enrollment barriers, making enrollment more difficult at a time when more adults need coverage.

Conclusion

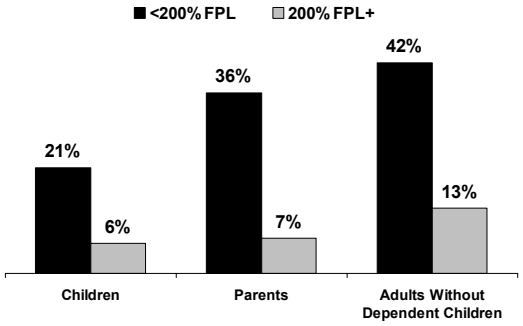
In sum, Medicaid, and to a lesser extent, state-funded programs provided important health insurance coverage for some low-income adults, but, overall, few low-income adults were eligible for public coverage and those who were eligible could have benefited from increased outreach and enrollment efforts. Eligibility for public coverage is largely restricted to parents with very low incomes, leaving many poor adults, particularly adults without dependent children, without access to any assistance. Adults who are eligible appear to need and want public coverage, as the majority who are eligible enroll. However, many eligible adults do not enroll and enrollment rates are particularly low for certain adults, such as the poorest adults and adults without dependent children. Recognizing that low-income adults have difficulty accessing private coverage and account for nearly half of the uninsured problem, it appears that increasing eligibility and outreach efforts for public coverage for low-income adults must be components any effort to reduce the number of uninsured. However, additional federal financing is likely necessary to make significant inroads in expanding coverage for low-income adults.

INTRODUCTION

Low-income adults have high uninsured rates relative to higher income adults and low-income children (Dubay et al. 2000). In 2002, 36 percent of low-income parents and over 40 percent of low-income adults without dependent children were uninsured (Figure 1) (Kaiser Commission on Medicaid and the Uninsured 2003). Further, in 2002, low-income adults made up nearly half of the nonelderly uninsured (Figure 2) (Kaiser 2003). Uninsured adults face substantial barriers in accessing care, including high levels of unmet need for care due to cost (Davidoff et al. 2001).

Figure 1

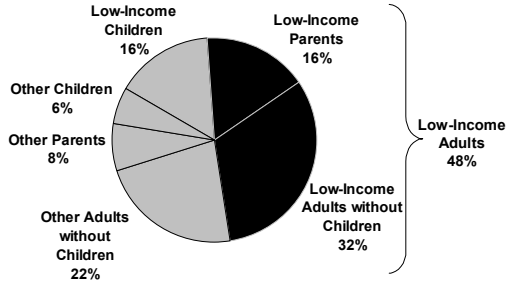
Uninsured Rates for Children and Adults by Income, 2002



Note: Excludes SSI recipients.
Low-income is less than 200% FPL or $31,340 for a family of three and $18,620 for an individual in 2004.
Source: KCMU and Urban Institute analysis of the March 2003 Current Population Survey.

Figure 2

The Nonelderly Uninsured by Age and Income Groups, 2002



Note: Low-income is less than 200% FPL or $31,340 for a family of three and $18,620 for an individual in 2004.
Source: KCMU and Urban Institute analysis of the March 2003 Current Population Survey.

These high uninsured rates for low-income adults reflect the difficulties they have accessing health insurance coverage. Low-income working adults are more likely to work for firms that do not offer group insurance, and those who are offered employer-sponsored insurance often cannot afford the cost of premiums (Blumberg et al. 2002; Garrett et al. 2001). Furthermore, non-group insurance is prohibitively expensive for most low-income adults. Medicaid and other public coverage play an important role in filling the gap in private coverage for some low-income adults. However, states vary dramatically in how broadly they extend Medicaid eligibility to adults, and, under current law, states cannot use federal Medicaid funds to cover adults without dependent children who are not elderly, disabled, or pregnant unless they obtain a waiver. Some states have created state-funded programs that cover low-income adults, but this coverage is limited to certain states and the programs vary in size and scope.

There is little recent information available on the number and characteristics of nonelderly adults eligible for Medicaid or other public coverage or on their enrollment. Previous estimates from 1997 show that over half of adults eligible for Medicaid reported enrollment, and a quarter were uninsured (Davidoff et al. 2001). Using 1999 National Survey of America's Families (NSAF) data, this report provides an overview of nonelderly adult eligibility for and enrollment in Medicaid and state-funded coverage, nationally and in 13 study states.

OVERVIEW OF MEDICAID AND OTHER PUBLIC COVERAGE FOR ADULTS

Medicaid eligibility for low-income adults tends to be limited. States are required to cover some low-income adults, including certain parents, pregnant women, elderly people, and people with

disabilities, and states have the option to expand coverage to a broader scope of these groups of low-income adults. However, under current law, states cannot cover other low-income adults without dependent children through Medicaid unless they obtain a waiver. Additionally, states cannot use federal funds to cover any illegal immigrants or legal immigrants who arrived in the United States after August 1996, for the first five years they reside in the United States.

In order to obtain Medicaid coverage, individuals must not only qualify for the coverage but they must also get enrolled. States have substantial discretion in how they structure their Medicaid enrollment processes. The enrollment requirements chosen by states as well as states' outreach efforts may have a significant impact on enrollment of eligible adults. In many cases, simplified enrollment procedures that have been adopted for children have not been applied when the entire family is applying for coverage (Maloy et al. 2002). The enrollment process for adults is often more difficult than for children, outreach is more limited, and more frequent eligibility determinations are imposed, making it more difficult for eligible adults to enroll.

Mandatory Medicaid Eligibility for Adults

States that participate in Medicaid must offer coverage to parents in families who would have been eligible for cash assistance, based on 1996 Aid to Families with Dependent Children standards (AFDC)—this eligibility pathway is known as Section 1931. AFDC income eligibility standards were very low, less than 50 percent of poverty in most states. States also must provide 12 months of Transitional Medical Assistance (TMA) to families leaving welfare for work who lose Medicaid eligibility due to increased earnings and they must offer coverage to pregnant women with incomes below 133 percent of poverty. Additionally, states must provide coverage to most adults with disabilities who receive Supplemental Security Income (SSI).

Optional Medicaid Eligibility for Adults

States can expand eligibility to parents[1] and pregnant women with higher incomes. States also have the option of covering medically needy individuals who "spend-down" to eligibility standards due to out-of-pocket medical expenses. Other optional Medicaid eligibility pathways include Ribicoff expansions in children's coverage to adults age 18-20 (see the Appendix for more detail regarding these pathways). Additionally, states can cover 18-year-olds through the State Children's Health Insurance Program (SCHIP).

Section 1115 Waiver Eligibility for Adults

States can apply for a Section 1115 waiver to cover adults without dependent children who are not elderly, disabled, or pregnant using federal Medicaid funds. However, Section 1115 waivers must be "budget neutral"—this means that a state must show that federal costs under the waiver would not be any more than the federal costs in that state without the waiver. Thus, a state must create savings within its program or redirect existing funding to expand coverage to adults without dependent children through a waiver. Under waivers, states can also change some of the

[1] Although states are limited in their ability to expand Section 1931 eligibility by raising countable income thresholds directly, a number of states have expanded eligibility by relaxing family composition rules or adopting more generous income disregards.

conditions of coverage in ways generally not otherwise allowed in Medicaid, for example, by charging premiums, reducing benefits, increasing cost sharing, or implementing enrollment caps.

State-Funded Program Eligibility for Adults

Additionally, states can expand coverage to adults without dependent children by establishing programs funded solely with state revenues. State-only programs can also be used to cover recent immigrants who cannot be covered with federal funds. States decide the eligibility, benefits, cost sharing, and other requirements of these programs.

METHODS

The NSAF is a household survey, sponsored by The Urban Institute, that collects information on family structure, demographics, income, insurance coverage, access to health care and use of services, as well as other non-health related information about child well-being. The sample includes 45,000 households and over 100,000 adults and children. It is nationally representative of the non-institutionalized, nonelderly population with an over-sample of low-income families (less than 200% of the federal poverty level or $30,520 for a family of three in 2003) in 13 study states (Safir, Scheuren, and Wang 2002). This analysis used the sample of adults age 18 to 64. Household survey data were supplemented with federal and state level data on eligibility policies, including categorical eligibility requirements, income and earnings disregards, and countable income and asset thresholds from sources including the Centers for Medicare and Medicaid Services, state Medicaid and SCHIP plans, and special surveys of state Medicaid and SCHIP programs.

For this analysis, an algorithm was created that replicates the eligibility determination process for Medicaid in the 50 states and the District of Columbia and the two large state-funded programs that provided coverage to adults in 1999—MinnesotaCare and Washington State's Basic Health plan. The algorithm was applied to data from the 1999 NSAF to identify adults likely to be eligible for public coverage, and eligibility rates were estimated nationally and by state, for 13 study states. The algorithm replicated the eligibility determination process by comparing various measures of family structure, work status, gross and net income, and assets captured on the NSAF to the various state standards and eligibility thresholds. Using information on insurance coverage, public insurance enrollment rates were estimated for eligible adults, nationally and in the 13 study states. (See the Appendix, "Methods for Modeling Public Insurance Eligibility for Adults," for more details regarding the eligibility algorithm.)

Net income was computed by summing income from adults in the family and applying relevant childcare, work expense, and earnings disregards. All family level measures were based on the Health Insurance Unit (HIU), which includes those who can be covered by health insurance within a family. The Medicaid eligibility pathways modeled by the algorithm include: (1) Section 1931 family coverage, (2) TMA, (3) medically needy coverage (without calculations for eligibility through spend-down), and (4) Section 1115 waivers.[2] Young adults (18-20 year-olds)

[2] In 1999, ten states extended coverage to somewhat higher income parents under Section 1115 waivers: Delaware, Hawaii, Massachusetts, Minnesota, Missouri, Oregon, Rhode Island, Tennessee, Vermont, and Wisconsin. Five of these states, Delaware, Hawaii, Oregon, Tennessee, and Vermont also used their waivers to cover childless adults.

were also evaluated for eligibility through Ribicoff expansions to children's coverage, and 18-year-olds were evaluated for SCHIP program eligibility. Analysis related to adults with disabilities who were eligible for Medicaid through receipt of SSI was conducted but not included in the data presented here since the characteristics and enrollment patterns of these adults are fundamentally different from other adults. Not all eligibility rules were modeled because of limitations in the NSAF data. In particular, medically needy spend-down eligibility and pregnancy-related eligibility were not modeled.

The model also tested eligibility through the state-only programs in Minnesota and Washington for adults who reside in these states. Additionally, eligibility was tested for programs that use state-only funds to cover legal immigrants that arrived in the U.S. after 1996.

The algorithm applied federal and state residency requirements to all non-citizen immigrants. However, the model did not distinguish between legal immigrants and undocumented aliens—who would not be eligible for Medicaid. As such, sensitivity analyses were conducted to determine the potential impact of including ineligible immigrants in the overall analysis.

Enrollment rates among eligible adults were calculated using NSAF measures of current insurance coverage. Any person reporting Medicaid, SCHIP, or other state sponsored insurance program was considered to participate in the public insurance program for which they were eligible. Enrollment rates may be understated relative to administrative estimates as a result of underreporting of public insurance enrollment on the NSAF. The analysis of enrollment rates presented here focuses on individuals without private or other coverage. As such, individuals reporting employer sponsored or non-group private insurance, CHAMPUS/TRICARE, Medicare, or other government coverage were excluded from the analysis.

FINDINGS

National Estimates of Adult Eligibility for Public Coverage

Overall, few adults were eligible for public coverage (Table 1)—about 8 percent of all adults were eligible accounting for about 13.4 million adults. Eligibility rates were higher among the subgroup of low-income adults—about one in four low-income adults (25 percent) and 39 percent of poor adults were eligible. Similar patterns hold true for low-income and poor uninsured adults.

Eligibility by Eligibility Category

The highest eligibility rates were for mandatory Medicaid coverage—coverage based on 1996 AFDC thresholds and TMA (Table 1). Overall, 47 percent of all eligible adults, 49 percent of low-income eligible adults, and 51 percent of poor eligible adults were eligible through a mandatory pathway. Fewer adults were eligible through optional Medicaid coverage expansions and Section 1115 waivers—about 44 percent of all eligible adults, low-income eligible adults, and poor eligible adults. The state-funded programs in Minnesota and Washington, as well as state-funded coverage for immigrants, accounted for a very limited amount of adult eligibility—less than one percent of all adults and 9 percent of all eligible adults.

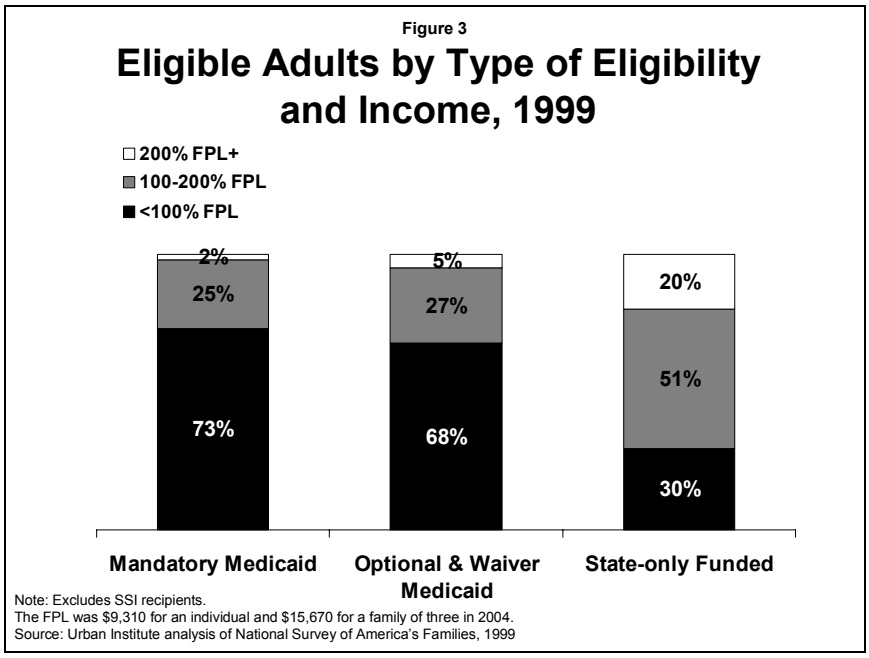
Table 1
Percent of Adults Eligible for Public Insurance by Type of Eligibility, U.S., 1999

	All Adults			Uninsured Adults		
	All	Low-Income (<200% FPL)	Poor (<100% FPL)	All	Low-Income (<200% FPL)	Poor (<100% FPL)
Percent of Adults Who Are Eligible:						
Mandatory Medicaid	4%	12%	20%	8%	12%	20%
Optional & Waiver Medicaid	4%	11%	18%	6%	9%	14%
State-only Funded	1%	2%	2%	1%	2%	1%
All Public Coverage	**8%**	**25%**	**39%**	**15%**	**22%**	**36%**
Percent of Eligible Adults:						
Mandatory Medicaid	47%	49%	51%	54%	54%	56%
Optional & Waiver Medicaid	44%	44%	45%	39%	39%	40%
State-only Funded	9%	8%	4%	7%	7%	4%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Note: Excludes SSI recipients.
Source: Urban Institute analysis of National Survey Of America's Families, 1999

As seen in Figure 3, over two-thirds of eligible adults in both the mandatory and optional and waiver Medicaid categories were poor, and over ninety percent were low-income. In contrast, adults eligible for state-funded coverage had higher incomes, with over seventy percent with incomes above poverty. The broad income range in the mandatory category reflects the inclusion of the somewhat higher income TMA eligibility thresholds.

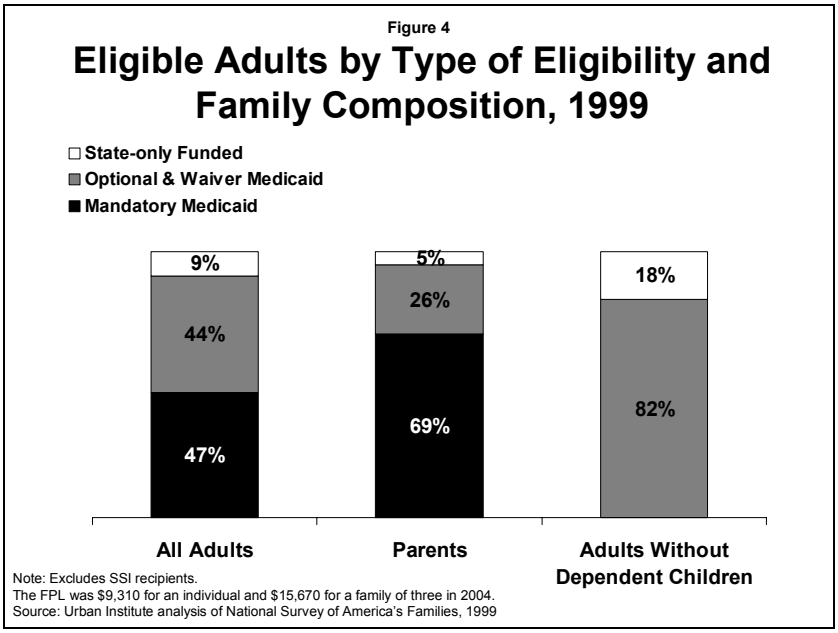
Figure 3



Among eligible adults, patterns of eligibility were significantly different for parents compared to adults without dependent children, reflecting the fact that adults without dependent children can

only be covered through a Medicaid waiver or a state-funded program. As seen in Figure 4, the majority of eligible parents were eligible for mandatory Medicaid coverage. In contrast, over 80 percent of eligible adults without dependent children were eligible through waiver coverage. In both cases, state-funded coverage accounted for a limited amount of eligibility, although it played a larger role for adults without dependent children than parents.

Figure 4



Eligibility by Family Composition

Nationally, 12 percent of all parents were eligible for public insurance, compared to 5 percent of adults without dependent children (Table 2). Over a third (37 percent) of low-income parents and two-thirds (66 percent) of poor parents were eligible for public coverage. In contrast, among adults without dependent children, 16 percent of low-income adults and 24 percent of poor adults were eligible.

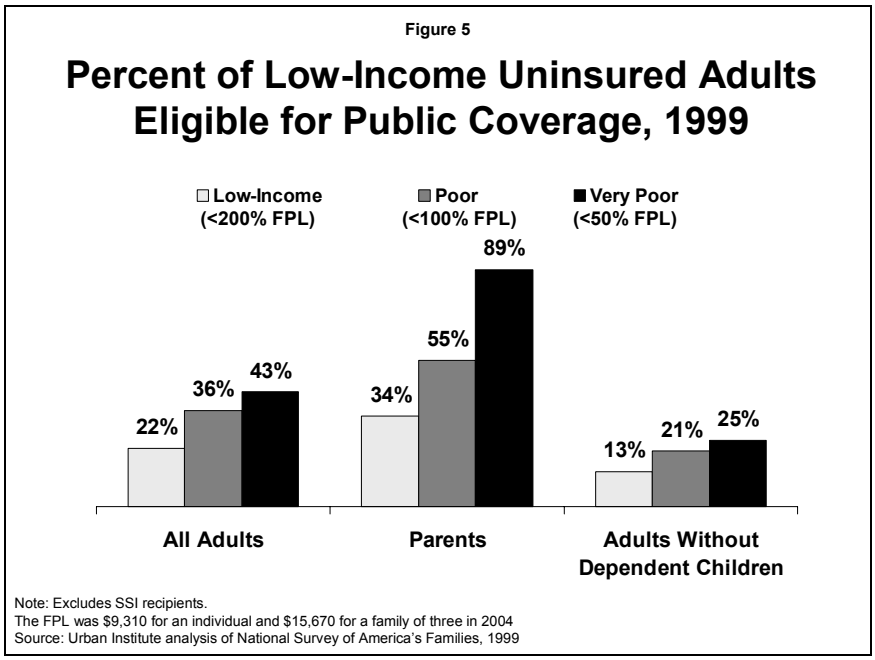
Table 2
Percent of Parents and Childless Adults Eligible for Public Insurance, U.S., 1999

	All Adults			Uninsured Adults		
	All	Low-Income (<200% FPL)	Poor (<100% FPL)	All	Low-Income (<200% FPL)	Poor (<100% FPL)
Percent of Adults Who Are Eligible:						
% of Parents Eligible	12%	37%	66%	26%	34%	55%
% of Childless Adults Eligible	5%	16%	24%	7%	13%	21%
Percent of Eligible Adults:						
Parents	65%	64%	60%	69%	69%	67%
Childless Adults	35%	36%	40%	31%	31%	34%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Source: Urban Institute analysis of National Survey Of America's Families, 1999
Note: Excludes SSI recipients; Low income defined as having family income less than 200% of FPL.

Among the uninsured, about a third (34 percent) of low-income parents and over half (55 percent) of poor parents were eligible (Figure 5). Far fewer uninsured adults without dependent children were eligible—about 13 percent of low-income adults and 21 percent of poor adults. Eligibility was limited even among very poor (less than 50 percent of poverty) uninsured adults without dependent children—only one in four were eligible compared to nearly 90 percent of very poor parents.

Figure 5



Note: Excludes SSI recipients.
The FPL was $9,310 for an individual and $15,670 for a family of three in 2004
Source: Urban Institute analysis of National Survey of America's Families, 1999

Characteristics of Adults Eligible for Public Coverage

We examined socioeconomic and health status characteristics of adults eligible for public coverage to better understand how eligibility policy shapes the pool of eligible adults (Table 3).

Age. Eligible adults tend to be young, with 36 percent between ages 18 and 24, and 24 percent between ages 25 and 34.

Gender. Two thirds of eligible adults were women.

Race and Ethnicity. More than half of eligible adults were white (56 percent), nearly a quarter (23 percent) were African American, and 17 percent were Hispanic. When non-citizens were excluded from the analysis, a smaller percentage of eligible adults were Hispanic (11 percent).

Citizenship. The overwhelming majority (90 percent) of eligible adults were citizens. Only one in ten eligible adults were non-citizens, reflecting those who met relevant residency requirements, in addition to meeting income, resource and categorical requirements.

Marital Status. Three out of four eligible adults (75 percent) were in single parent families, with 49 percent never married.

Education. Most eligible adults (68 percent) had completed high school, with 29 percent receiving some education beyond high school. Almost a third (32 percent) did not have a high school degree.

Family Composition. Almost two-thirds (65 percent) of eligible adults were parents, and nearly 60 percent of eligible adults were parents with children enrolled in Medicaid or SCHIP.

Health Status. Most eligible adults reported good to excellent health (76 percent), but almost one in four (24 percent) reported fair or poor health.

Income. The majority of eligible adults (68 percent) were poor and 45 percent were very poor, with incomes below 50 percent of poverty.

Employment. Most eligible adults (58 percent) did not have a full- or part-time worker in their family. This reflects the low incomes of eligible adults. However, 27 percent of eligible adults had at least one full time worker, and an additional 16 percent had no full time but at least one part time worker.

Welfare History. Very few eligible adults (7 percent) were current TANF recipients or had been on TANF within the previous three years (9 percent). The vast majority (85 percent) had no recent TANF experience.

Table 3
Characteristics of Adults Eligible for Public Insurance, U.S., 1999

	% of All Eligible
Total Number of Eligible Adults (N)	***13.4 million***
Age group	
18-24	36%
25-34	24%
35-44	21%
45-54	12%
55-64	7%
Gender	
Female	66%
Race/Ethnicity	
White, non-Hispanic	56%
Black, non-Hispanic	23%
Hispanic	17%
Other	4%
Citizenship	
Non-citizen	10%
Marital Status	
Never married	49%
Married, spouse in household	26%
Separated/Divorced/Spouse not in household	26%
Education	
No high school degree	32%
High school graduate	39%
Some college	22%
College graduate	7%
Family Composition	
Has children	65%
Has children enrolled in Medicaid or SCHIP	58%
Health Status	
Fair/Poor	24%
Income	
<50 % FPL	45%
50-100% FPL	23%
100-150%	16%
150-200%	11%
>200%	4%
Employment	
In family with at least one FT worker	27%
In family with no FT worker but at least one PT worker	16%
In family with no workers	58%
Welfare History	
TANF Recipient	7%
TANF Leaver	9%
No Recent TANF/AFDC	85%

Note: Nonelderly adults; excludes SSI recipients.

Estimates of Adult Eligibility for Public Coverage by State

Across the 13 study states, there was dramatic variation in the proportion of adults eligible for Medicaid or other state-funded coverage. This variation can be linked to differences in the underlying characteristics of the population in each state as well as differences in the income-eligibility thresholds and categorical groups covered. The percent of adults with income below poverty varied across the study states by more than a factor of two—from 8 percent in Minnesota to 19 percent in Mississippi (Table 4). If these states all set similar income thresholds, then those states with higher rates of poverty would have higher eligibility rates. However, states with higher rates of residents living in poverty tend to have fewer financial resources, and, therefore, lower effective income eligibility thresholds,[3] whereas wealthier states tend to have higher thresholds (Bovbjerg et al. 2002). On the low end, poorer states like Alabama, Texas, Florida, and Mississippi had very low effective income thresholds—all below 50 percent of poverty. On the other end of the spectrum, Minnesota, Washington, and Wisconsin extended coverage to at least some adults with incomes above 150 percent of poverty.

Table 4:
Scope of Public Coverage for Adults, Selected States, 1999

State	Percent of Adults <100% FPL	Highest Effective Income-Eligibility Threshold (%FPL)	Covers Legal Immigrants Post-1996	Coverage for Adults Without Dependent Children	Premium Required for Any Adults
Alabama	16.6%	22%			
Texas	16.5%	32%			
Florida	14.6%	34%			
Mississippi	18.6%	40%			
Colorado	11.3%	44%	PW only*		
New Jersey	11.1%	46%	PW only*		
Michigan	10.9%	57%			
New York	16.2%	82%			
California	17.8%	89%	X		
Massachusetts	9.7%	133%	X	133%**	
Wisconsin	9.4%	185%			X
Washington	11.0%	200%	PW only*	200%	X
Minnesota	8.4%	275%	X	175%	X

* Only pregnant women are eligible for coverage.
** Coverage only for premium assistance for employer-sponsored insurance.
Sources: Urban Institute analysis of 1999 NSAF; income thresholds from Urban Institute synthesis of estimates from: *States' Implementation of Selected Medicaid Provisions of the Personal Responsibility and Work Opportunities Reconciliation Act of 1996,* State Policy Documentation Project, January 2000, Center for Law and Social Policy and the Center on Budget and Policy Priorities; *Expanding Family Coverage: State's Medicaid Eligibility Policies for Working Families in the Year 2000*, December 2001, Center for Budget and Policy Priorities; and draft of Kathleen A. Maloy's Medicaid state rule book, 2001, Kaiser Family Foundation; Coverage thresholds for adults without dependent children and premium requirements from a 2002 Urban Institute phone survey of Medicaid administrators.

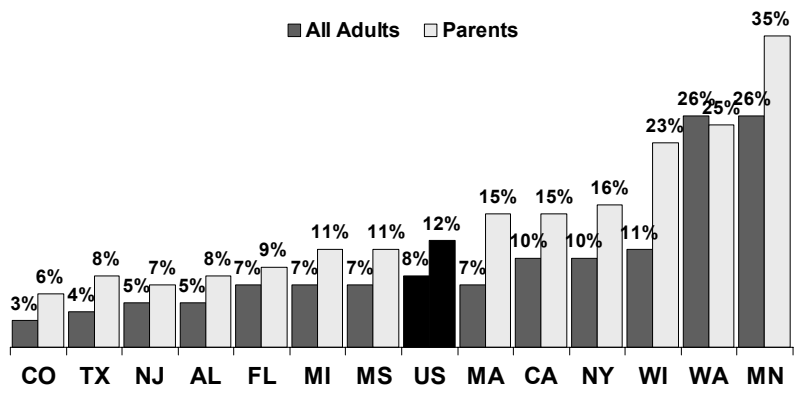
[3] Effective income eligibility thresholds represent the total non-transfer income that a working family may receive before taking disregards into account, and still meet the raw income eligibility threshold for the state. Dollar amounts for a family of size three are converted into a percent of the FPL.

Not only do adults need to meet income eligibility thresholds, but they also need to be categorically eligible. Although all states covered parents, only three of the thirteen states covered adults without dependent children (Massachusetts, Minnesota, and Washington).[4] Six states covered some legal immigrants who were residing in the U.S. for less than five years, but three of those only covered pregnant women.

As a result of the differences in the income of adults, the income-eligibility thresholds, and the categorical groups covered across the 13 study states, there was substantial variation in eligibility rates—ranging from 3 percent in Colorado to 26 percent in Minnesota (Figure 6). Further, a comparison of eligibility rates limited only to parents is important since most of the study states did not extend eligibility to adults without dependent children. When we limited our sample and examined eligibility rates only among parents, we found patterns across states that were similar to the overall eligibility rates (Figure 6). However, the eligibility rates were higher among parents than for all adults and ranged from 6 percent in Colorado to 35 percent in Minnesota.

Figure 6

Percent of Adults Eligible for Public Insurance, Selected States, 1999



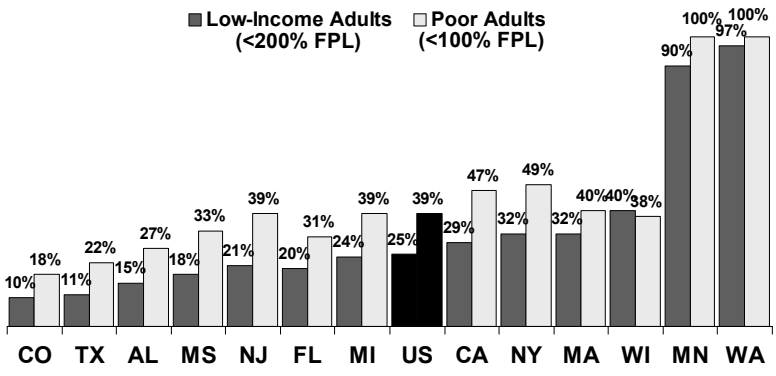
Note: Excludes SSI recipients.
Source: Urban Institute analysis of National Survey of America's Families, 1999

A comparison of eligibility rates across states that focuses on lower income groups also is important, since most of the study states had effective income thresholds below poverty. When we limited our comparison to low-income and poor adults (Figure 7), rates of eligibility were higher, but there was still a broad range across states—from 18 percent of poor adults in Colorado to 100 percent in Minnesota and Washington. Furthermore, the states that had low rates of eligibility among all adults also had low rates when we limit to the poor.

[4] New York covered a group of general assistance recipients up to 50 percent FPL, but, because the eligibility criteria varied from the usual Medicaid procedures, we did not model them.

Figure 7

Percent of Low-Income Adults Eligible for Public Insurance, Selected States, 1999



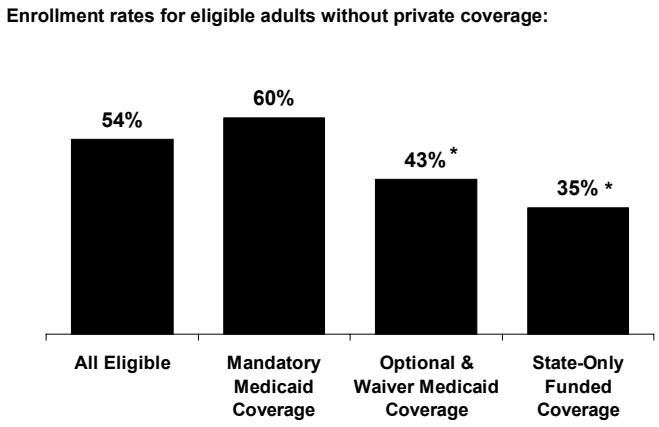
Note: Excludes SSI recipients.
The FPL was $9,310 for an individual and $15,670 for a family of three in 2004
Source: Urban Institute analysis of National Survey of America's Families, 1999

National Estimates of Public Coverage Enrollment Rates Among Eligible Adults

Over half of all eligible adults without private coverage were enrolled in public coverage[5] (Figure 8). However, coverage rates varied substantially by type of eligibility. Enrollment rates were highest among those eligible through mandatory Medicaid eligibility pathways (60 percent) compared to those eligible for optional or waiver Medicaid coverage (43 percent) and those eligible for state-funded programs (35 percent).

Figure 8

Enrollment Rates for Adults Eligible for Public Coverage by Eligibility Category, 1999

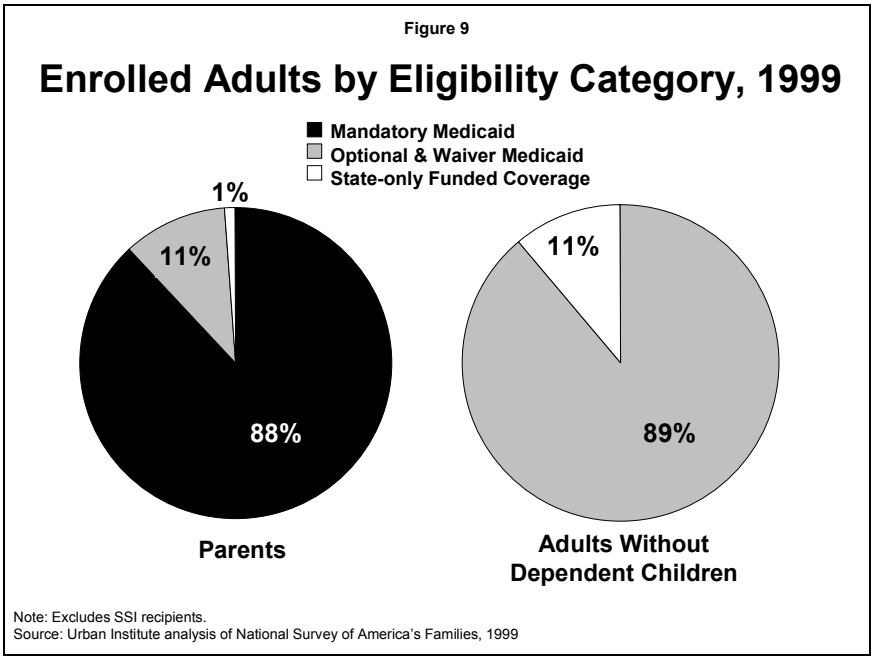


Note: Excludes SSI recipients.
* = significant differences in enrollment in these categories compared to mandatory Medicaid coverage (p<.05)
Source: Urban Institute analysis of National Survey of America's Families, 1999

[5] Only about one third of all eligible adults had private insurance or Medicare, leaving 64 percent of eligible adults without an alternate source of coverage. It is important to note that access to private insurance varied dramatically across subgroups of the eligible populations; thus, the size of the "gap" that can be filled by Medicaid varied as well.

Among enrolled adults, enrollment patterns by type of eligibility were significantly different for parents versus childless adults, reflecting their different eligibility pathways. Nearly 90 percent of enrolled parents had mandatory Medicaid coverage, with the remainder primarily enrolled in optional or waiver Medicaid coverage. In contrast about 90 percent of enrolled adults without dependent children had waiver coverage, and the remainder were covered by state-funded programs (Figure 9)

Figure 9



Note: Excludes SSI recipients.
Source: Urban Institute analysis of National Survey of America's Families, 1999

Characteristics of Eligible Adults Who Enroll in Public Coverage

Table 5 shows the characteristics of eligible adults without private or other coverage who enroll in public coverage and for those who are uninsured.

Age. Enrollment rates were lowest in the youngest age group and higher among the 25-34 year olds, those in prime parenting years, as well as for 55 to 64 year olds.

Gender. Women were significantly more likely to be enrolled in public coverage than men, with 59 percent enrolled compared to 41 percent of men.

Race/Hispanic Ethnicity. Minorities, including Hispanics and African Americans, were less likely to have private insurance than whites. Among those without private coverage, Hispanics and "other" minorities were significantly less likely to be enrolled in public coverage compared to whites. When non-citizens were dropped from the sample, there was no longer a difference in public coverage rates between Hispanics and whites. Thus, the low public coverage rate for all Hispanics was primarily due to the low rate for non-citizens.

Table 5
Enrollment by Demographic Characteristics for
Eligible Adults Who Do Not Have Private Insurance, U.S. 1999

	% Enrolled	% Uninsured
Age group		
18-24	49%	51%
25-34	58%**	42%
35-44	55%	45%
45-54	50%	51%
55-64	61%*	39%
Gender		
Female	59%	41%
Male	41%***	59%
Race/Ethnicity		
White, non-Hispanic	55%	46%
Black, non-Hispanic	61%	40%
Hispanic	45%**	55%
Other	44%*	56%
Citizenship		
U.S. born	57%	43%
Foreign born, US citizen	52%	49%
Non-citizen	33%***	67%
Marital Status		
Married, spouse in Household	53%	47%
Spouse not in household	57%	44%
Never married	52%	48%
Education		
No High School degree	53%	47%
HS graduate	56%	44%
Some college	50%	50%
College graduate	54%	46%
Family Composition		
No Children in Household	45%	55%
Children in Household	57%***	43%
Children Enrolled in Medicaid	76%	24%
Children Not Enrolled in Medicaid	10%***	90%
Health Status		
Excellent, very good	52%	48%
Good	53%	47%
Fair/Poor	57%	43%
Income		
<50% FPL	40%	60%
50-100% FPL	64%***	36%
100-150% FPL	65%***	35%
150-200% FPL	66%***	34%
Employment		
In family with at least one FT worker	59%	41%
In family with no FT worker but at least one PT worker	56%	44%
In family with no workers	51%**	49%
Welfare History		
TANF Recipient	100%	0%
TANF Leaver	59%***	42%
No Recent TANF/AFDC	47%***	53%

Note: Nonelderly adults; excludes SSI recipients. Differences in insurance coverage between each sub-category of adults and the first category in each set of estimates are significant at * = p<0.10, ** = p<0.05, *** = p<0.01. Rows may not total due to rounding.

Citizenship. Consistent with the patterns exhibited by Hispanics, eligible non-citizens were less likely (33 percent) than U.S.-born and foreign-born citizens (57 percent and 52 percent, respectively) to enroll in public coverage. The low enrollment rate for non-citizens may be reflective of enrollment barriers specific to them, but may also be partially due to our inability to distinguish documented from undocumented aliens. The latter group cannot participate because they are not truly eligible, but may have been identified as eligible in our analysis.

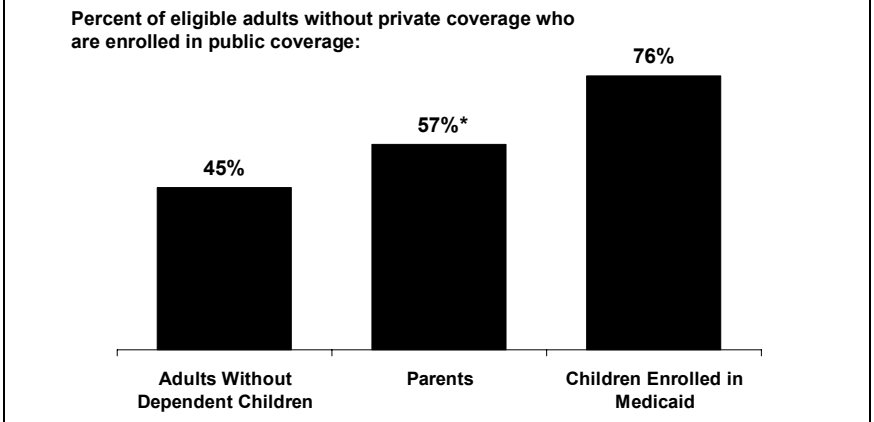
Marital Status. There were no significant differences in enrollment rates by marital status.

Education. There were no significant differences in enrollment rates by level of education.

Family Composition. Parents had a significantly higher enrollment rate (57 percent) than adults without dependent children (45 percent) (Figure 10). Further, eligible parents with children enrolled in Medicaid or SCHIP were the most likely to be enrolled in Medicaid themselves—over three-quarters (76 percent) were enrolled.

Figure 10

Enrollment Rates for Adults Eligible for Public Coverage by Family Composition, 1999



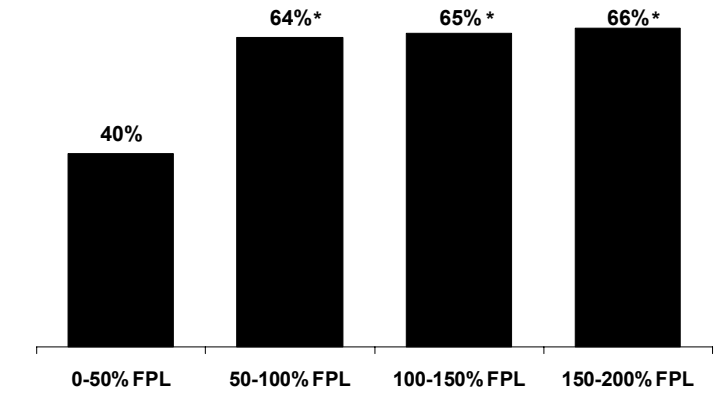
Note: Excludes SSI recipients.
* = significant difference in enrollment for parents compared to childless adults (p<.05).
Source: Urban Institute analysis of National Survey of America's Families, 1999

Health Status. Eligible adults in fair or poor health were less likely to have private coverage. Among eligible adults without private insurance, there were no significant differences in enrollment rates by health status.

Family Income. Enrollment varied with income, as revealed in Figure 11. Enrollment rates were significantly lower (40 percent) among the poorest adults compared with all the other income groups who had enrollment rates of about 65 percent.

Figure 11

Enrollment Rates for Adults Eligible for Public Coverage by Income, 1999



Note: Excludes SSI recipients.
* = significant differences in enrollment for income subgroups compared to those with incomes <50% FPL (p<.05).
Source: Urban Institute analysis of National Survey of America's Families, 1999

Employment. Enrollment varied inversely with labor force participation. The majority (59 percent) of eligible adults in a family with a full time worker enrolled. For adults in a family with only part time workers, a similar proportion (56 percent) enrolled. Only half of eligible adults with no workers in the family participated in public insurance.

Welfare History. The history of TANF receipt was an important determinant of enrollment in public insurance. All current TANF recipients were presumed to be enrolled in Medicaid.[6] The likelihood of enrolling in public coverage falls off as time without TANF increases. About 59 percent of TANF leavers (those who reported receipt of cash assistance within the past three years but not currently) were enrolled, and less than half of those with no recent TANF history (those who reported no receipt of cash assistance within the past three years) were enrolled.

Estimates of Public Coverage Enrollment Rates Among Eligible Adults by State

Figure 12 presents public coverage enrollment rates for eligible adults without private coverage across the 13 study states. Just as states varied in the proportion of adults who were eligible, there was tremendous variation across states in rates of enrollment, ranging from 36 percent in Mississippi to 81 percent in Massachusetts. When we limited the analysis to poor eligible adults, enrollment rates in most states dropped slightly, reflecting lower enrollment rates generally among the very poor.

Some of the differences in enrollment across states can be linked to differences in characteristics of the eligible populations and, possibly, the presence of premium requirements or waiting periods. However, states differ in the extent to which they have simplified enrollment processes

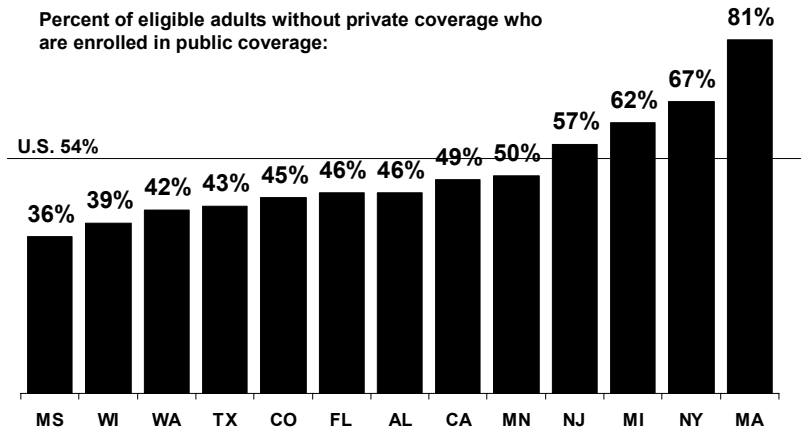
[6] Based on the assumption that states still enroll 100 percent of TANF recipients, the insurance imputation process in NSAF assigns Medicaid coverage to all current TANF recipients.

and engaged in aggressive outreach campaigns that affect eligible adults, and these differences may also be reflected in the enrollment rates.

Among the study states, Massachusetts had the highest enrollment rate at 81 percent. Massachusetts had a relatively high income-eligibility threshold (133 percent), and coverage for adults was available without premium contributions or crowd-out provisions (Krebs-Carter and Holahan 2000). Further, Massachusetts extended coverage to legal immigrants.

Figure 12

Enrollment Rates for Adults Eligible for Public Coverage by State, Selected States, 1999



Note: Excludes SSI recipients.
Source: Urban Institute analysis of National Survey of America's Families, 1999

SUMMARY OF FINDINGS AND DISCUSSION

The results of this analysis raise several important findings about low-income adults' access to and enrollment in public coverage. While Medicaid and other state-funded programs offered important protection to some low-income adults, many low-income adults remained outside the reach of this coverage.

- **Most low-income adults did not qualify for public coverage.** About one in four low-income adults were eligible for Medicaid or state-only funded coverage, and only about one third of poor adults were eligible for public coverage.

- **Adults who qualified for public coverage were overwhelmingly poor.** Over two-thirds had incomes below poverty, and 45 percent had incomes below 50 percent of poverty. The high proportion of poor eligible adults reflects the limited income-eligibility thresholds for adults in most states.

- **Few low-income adults without dependent children qualified for public coverage.** Among poor adults, two thirds of parents were eligible for public coverage, compared to only one fourth of adults without dependent children. The significant majority of eligible adults were parents. When we include the near poor who are eligible, the balance is even more

skewed to coverage of parents. This reflects the fact that states can only cover adults without dependent children if they obtain a waiver or establish a fully state-funded program and, even when states obtain a waiver, they do not gain any additional federal financing to expand coverage.

- **Over half of eligible adults qualified through coverage provided at state discretion, but states varied significantly in the extent to which they broadened coverage.** Among eligible low-income adults, just half were eligible through required categories of Medicaid coverage. The remaining half were eligible through optional or waiver Medicaid coverage or state-only funded coverage, which can be subject to state cutbacks during difficult economic times. Across the study states, eligibility ranged from 10 percent to 97 percent of low-income adults.

A majority of adults who were eligible for public coverage and had no other source of coverage were enrolled, suggesting that low-income adults need and want this coverage. However, the enrollment process for adults is often more difficult than for children, outreach is more limited, and more frequent eligibility redeterminations are imposed. As a result of these hurdles, many eligible low-income adults remained uninsured.

- **Over half of adults who were eligible for public coverage and had no other source of coverage were enrolled.** However, slightly less than half of these low-income adults were uninsured.

- **The poorest eligible adults were the least likely to be enrolled in public coverage.** Among low-income eligible adults, the poorest adults (with incomes less than 50 percent of poverty) had the lowest enrollment rate and the highest uninsured rate. This group of adults has the fewest resources to purchase private health insurance or to purchase health care services, and, as such, could greatly benefit from public coverage.

- **Adults eligible for mandatory Medicaid programs were more likely to enroll than adults eligible for optional and waiver or state-only programs.** Over 60 percent of eligible adults who qualified through a mandatory Medicaid pathway were enrolled, compared to less than half of adults eligible through optional or waiver Medicaid coverage, and about one third of adults eligible for a state-only funded program.

- **Enrollment rates varied dramatically across states**. This variation existed even when the comparison was limited to poor adults. Thus, these differences could reflect different outreach efforts and enrollment procedures as well as different eligibility requirements (e.g., an uninsured period) or premium requirements in states with waiver or state-only funded coverage.

In 1999, Medicaid and other state-funded health insurance programs offered important protection to one in four low-income adults. Most of the coverage available to these adults was available through Medicaid. However, Medicaid's reach remained limited, with many states setting eligibility thresholds well below poverty. In addition, Medicaid cannot be used to cover adults without dependent children unless a state obtains a waiver that assures that no additional federal

dollars will be expended. As a result, the majority of low-income adults did not have any public coverage options available to them.

Over half of the adults eligible for public coverage in 1999 were eligible for Medicaid coverage offered at state discretion or state-only coverage. While this demonstrates states' interest in covering low-income adults, this type of coverage is at risk for cutbacks during difficult economic times. Expansions in adult coverage since 1999 have all been in these coverage categories; therefore, today, an even greater proportion of eligible adults are at risk for cutbacks. Thus, during poor economic periods, when need for public coverage increases, access to public coverage for low-income adults is likely to become even more limited. In fact, the recent economic downturn has demonstrated the precarious nature of public coverage for adults. Many of the cutbacks undertaken by states in the last few years have targeted coverage for parents and other adults. Further, during this recent period of fiscal stress, a number of states reinstated enrollment barriers, making enrollment more difficult for eligible adults at a time when more adults need coverage.

Flexibility extended to states in determining the scope and structure of coverage for adults has resulted in substantial variation in eligibility across states. This resulted in stark differences in how many and which adults were eligible for public insurance. Thus, access to public insurance for adults is largely dependent on where one lives, and this likely impacts access to health care.

Overall, the findings suggest that low-income adults need and want public coverage. Over half of the adults who were eligible for public coverage and who did not have any other coverage options enrolled in public coverage. However, enrollment rates were surprisingly low for the poorest adults (less than 50 percent of poverty) who have the least ability to purchase health insurance coverage or to access care in the private market. Enrollment rates were also low for adults without dependent children and adults made eligible through coverage offered at state discretion. This suggests that there may be barriers to enrollment for these adults and that these adults might benefit from targeted outreach efforts. However, as noted, as states have dealt with increasing fiscal pressure in recent years, a number have reinstated enrollment barriers, such as face-to-face interviews, which will make it more difficult for eligible adults to enroll.

In conclusion, low-income adults have difficulty accessing private coverage and few are eligible for public coverage. As such, they have very high uninsured rates. Medicaid, and to a lesser extent, state-funded programs, have provided important health insurance coverage for some low-income adults. Increasing eligibility and outreach efforts for public coverage for low-income adults appear to be essential components of policy efforts to improve health coverage among low-income adults. However, additional federal financing is likely necessary to make significant inroads in covering uninsured low-income adults.

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