Health Care Coverage for Children Who Are On and Off Welfare

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Abstract
Access to adequate health insurance is a key concern of families with children at all income levels. Since 1965, mothers and children on welfare have had health care coverage through the Medicaid program, which has provided a health care safety net for welfare recipients. Although most Americans are insured through their employers, families who leave welfare for employment often find themselves in jobs that do not offer health care coverage, adding to the ranks of the uninsured. This article examines the extent to which poor children and their mothers have private insurance, Medicaid, or no health insurance at all. It documents how recent expansions of Medicaid eligibility to low-income children who do not receive welfare have improved the insurance status of children, though these changes have not helped the mothers who leave welfare for work. Citing evidence that health insurance options influence the welfare and employment decisions of women whose families face health problems, the article suggests that implementing welfare reform at a time when rates of private insurance coverage are declining will be challenging and may expose some families to health risks.

Over the past 15 years, U.S. welfare policy has increasingly focused on attempts to move welfare recipients off the welfare rolls and into work and self-sufficiency. Beginning with the 1981 Omnibus Budget Reconciliation Act, continuing both with the 1988 Family Support Act and with the 1996 Personal Responsibility and Work Opportunity Reconciliation Act, the employment component of the welfare system has been strengthened, particularly through requirements that welfare recipients participate in work and employment programs and time limits that cut families from the rolls whether they find private-sector employment or not.

The feasibility and desirability of moving women off welfare and into work depends, in part, on the effect such a move may have on health insurance coverage for the mother and her children. Will women who move off welfare be able to obtain private health insurance coverage? Of those who do not, how many will not work at all and how many will end up in jobs...
without insurance? Of those without private coverage, how many will be covered by public programs and how many will remain uninsured?

These questions about the links between health insurance, employment, and welfare dependence have long been asked by welfare analysts, but they are acquiring new urgency as welfare reform discussions continue. Welfare reform and health care reform are closely related. In fact, the Clinton administration intentionally introduced its health care reform proposal in the summer of 1994 before its welfare reform proposal, in the hope that universal health care coverage would solve the problem of health insurance and make it unnecessary for welfare reform legislation to grapple with that obstacle to low-wage employment.

The answers to these questions are not yet complete, although study of the problem has recently accelerated. As this article points out, the main government program providing medical benefits to the poor—the Medicaid program—covers about half of the poor population and is a large source of assistance to them. At the same time, only 40% of the poor families not helped by Medicaid are covered by private insurance, leaving 29% of the poor uninsured. Children are more likely to be covered than adults, primarily because recent expansions have made more poor children eligible for Medicaid.

Evidence presented in this article indicates that fewer than half the mothers who leave welfare can replace their welfare-based health coverage with private insurance for themselves and their children three years after leaving welfare. Some are still covered by public programs, but about 45% of mothers and 12% of children are completely uninsured. Families contemplating the move from welfare into employment are aware of these gaps in the U.S. health insurance safety net. Although the Medicaid program may not weigh heavily in the decisions of the typical welfare recipient, it plays a strong role in the decisions made by families facing health problems who depend on the access Medicaid provides to needed health care. These families decide whether to work or remain on welfare, in part based on the health insurance coverage they can obtain through Medicaid or on their own. Consequently, reforms to increase the generosity of private health insurance or to make it universally available—although costly—could reduce welfare dependency and increase employment.

**Health Care Coverage for Poor Families**

Private health care coverage in the United States for those who are not elderly or disabled is predominantly provided through employers. This employment-based system leaves fairly large numbers of individuals and families without insurance because they do not work or have a family member who does. A large fraction of these are covered by government programs for the poor, largely by the Medicaid program. Remaining uninsured families and individuals rely on their own resources and also on charity care, which has historically been substantial but is now declining.

**Government Programs**

Those who are chronically unemployed because of poor skills or health problems began receiving significant federal government assistance in 1965, when the Medicaid program was introduced. The Medicaid program pays the cost of medical care for low-income individuals who are aged, blind, disabled, and—most important for the present discussion—women and dependent children. Families who receive benefits through
Health Care Coverage for Children Who Are On and Off Welfare

Aid to Families with Dependent Children (AFDC) have automatically qualified for Medicaid. (See Box 1 for a discussion of the changes introduced by the welfare reform law passed in 1996). Thus, from its beginning, government medical assistance to the poor has been strongly tied to receipt of welfare benefits. Since 1965, reform efforts have attempted to weaken the link between Medicaid and AFDC eligibility and to provide more universal health care coverage.

One attempt to weaken that link gave rise to the Medically Needy program that allows states to provide Medicaid assistance to families who meet most of the requirements of the AFDC program but have income and assets too high to qualify for AFDC. To be eligible for Medically Needy benefits, the family must “spend down” its assets and, effectively, become poor in order to qualify. About one-fifth of the states do not choose to have such a program. Relatively few families have qualified for or availed themselves of the Medically Needy program, and its caseload is only one-tenth that of the regular Medicaid program.2

Another attempt to extend eligibility came through a requirement in the 1988 Family Support Act that states provide up to 12 months of added Medicaid eligibility to families after they leave AFDC because of employment or increased income. This “transitional” coverage was intended to bridge the short-term gap in coverage after recipients leave the welfare rolls and before they find private coverage.3 However, the impact of this legislation is generally thought to be limited at best. States are required to provide full Medicaid benefits free of charge for only six months; they may charge premiums or restrict benefits in the second six months. Moreover, available evidence (discussed below) suggests that the problem of finding health care coverage is not transitional in the sense that the legislation envisaged. Instead, transitional assistance may merely postpone the problem without solving it.

The most important change in the Medicaid program’s coverage was a gradual extension of eligibility over the late 1980s and early 1990s to pregnant women and children in low-income families who are not on welfare.2 Beginning in 1986, states were required to provide Medicaid coverage to all pregnant women and children under age six in families with incomes below 133% of the poverty line. Since 1991, states have been required to cover older children, eventually up to age 18, in families with incomes below

Box 1

**Medicaid Availability Under Welfare Reform**

Until 1996, children and families receiving cash assistance through Aid to Families with Dependent Children (AFDC) have been automatically eligible for Medicaid, the government program providing health insurance to the poor. The welfare reform legislation passed in 1996 as the Personal Responsibility and Work Opportunity Reconciliation Act replaces AFDC with the Temporary Assistance for Needy Families (TANF) block grant. Under the new law, Medicaid eligibility will not be tied to receipt of block grant assistance. Instead, states are required to provide Medicaid coverage to all families who meet the income and family structure guidelines that applied to the state’s AFDC program on July 16, 1996. However, states have the option of lowering the income limits on eligibility to the level that applied on May 1, 1988. They may also deny Medicaid benefits to legal immigrants.

For the most part, therefore, Medicaid eligibility will not be affected by changes the states introduce into their welfare programs, although adults may lose Medicaid coverage if their cash aid through the block grant is terminated because of a refusal to work. Coverage for children and pregnant women will not be so affected. The availability of up to 12 months of transitional Medicaid coverage to those whose incomes rise above the eligibility guidelines will be maintained, as under current law.

100% of the poverty line. States have the option of extending coverage to children in families earning up to 185% of the poverty line. As of January 1993, some 33 states had exercised this option, and 24 of them had set their income limits at the 185% level. Under the Medicaid expansions, children’s eligibility for coverage depends on income alone and is not restricted by parental marital status or receipt of any other government benefit. This significant change greatly expanded the extent of health care coverage off welfare and, for the first time, decoupled medical assistance for the poor from receipt of welfare benefits.

**Sources of Health Care Coverage**

To compare the use of Medicaid with private insurance, Table 1 describes the sources of current health care coverage of the nonelderly U.S. population and of several subgroups relevant to welfare policy. The table shows that among all adults ages 18 to 64, about two-thirds are covered by employer-provided health insurance (either their own or through a spouse), 7% are covered by the Medicaid program, and 11% are covered by other forms of insurance (such as CHAMPUS, Civilian Health and Medical Program of the Uniformed Services, which serves the military, or insurance purchased by an individual). The remainder of the adult population—almost one-fifth—are uninsured. Children in the United States are more often covered by Medicaid than adults (21% compared with 7%), reflecting the program expansions just discussed. However, somewhat fewer children are covered by employer-provided and other forms of insurance, in part because employment rates are lower among parents than among childless adults. Overall, 11% of all children are uninsured.

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Table 1

<table>
<thead>
<tr>
<th>Categories</th>
<th>Employer</th>
<th>Medicaid</th>
<th>Other</th>
<th>Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Percentage of Adults Ages 18–64</strong></td>
<td>65</td>
<td>7</td>
<td>11</td>
<td>18</td>
</tr>
<tr>
<td><strong>Percentage of Children Under 18</strong></td>
<td>62</td>
<td>21</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td><strong>Percentage of Persons in Single-Parent Families</strong></td>
<td>38</td>
<td>44</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td><strong>Percentage of Individuals Under 64 by Poverty Status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Below poverty line</td>
<td>12</td>
<td>49</td>
<td>10</td>
<td>29</td>
</tr>
<tr>
<td>100% to 199% of poverty line</td>
<td>48</td>
<td>10</td>
<td>12</td>
<td>30</td>
</tr>
<tr>
<td><strong>Percentage of Families Off AFDC, Mothers Ages 24–34</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mothers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>83</td>
<td>1</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Unmarried</td>
<td>62</td>
<td>7</td>
<td>9</td>
<td>23</td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married mother</td>
<td>80</td>
<td>3</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Unmarried mother</td>
<td>49</td>
<td>17</td>
<td>16</td>
<td>19</td>
</tr>
</tbody>
</table>

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\[ a \] Medicaid coverage is simulated in the first four categories, but is directly reported by respondents in the last.

\[ b \] Percentages may not total 100% due to rounding.

Sources: For the first four categories the information was derived from Winterbottom, C., Liska, D., and Obermaier, K. State-level databook on health care access and financing. Washington, DC: Urban Institute Press, 1995, based on adjusted data from a combined sample of three waves of the Current Population Survey (CPS) in 1990, 1991, and 1992. For the last category, the authors relied on information from the National Longitudinal Survey of Youth (CD-ROM) Ohio State University, 1979–92. Available from NLS User Services, 921 Chatham Lane, Suite 200, Columbus, OH 43221.
Individuals in single-parent families—the major eligibility group for the AFDC program—are heavily covered by Medicaid, reflecting the historical importance of the link between Medicaid and AFDC, as well as the low incomes of such families. But they are less likely to be covered by private health insurance, leaving 12% uninsured. Similarly, individuals in families below the poverty line or not much above it—including married families as well as single individuals—rely heavily on Medicaid, but they are so much less often covered by private insurance that almost one-third are uninsured.

The last portion of the table shows coverage rates of mothers and children who do not receive AFDC benefits. Mothers off AFDC almost never receive Medicaid but are usually covered by employer plans, especially married mothers who are often covered by their spouse’s plan. The pattern for children of married mothers is almost identical. In families with unmarried mothers off AFDC, only 7% of the mothers are covered by Medicaid, compared with 17% of their children, who are helped by the Medicaid expansions. Nevertheless, almost one-fifth of children in such families remain uninsured.

The Medicaid figures in Table 1 describe the fractions of each group who are enrolled in the program, although substantial numbers of families are eligible but not enrolled. Approximately 72% of eligible adults and 75% of eligible children are actually enrolled in Medicaid. Although some of the unserved families are covered by private insurance, it has been estimated that 2.4 million currently uninsured children are in fact eligible for Medicaid. Similar patterns of nonparticipation have been found in other welfare programs, as well. For example, about 25% of AFDC-eligible families do not receive benefits, and about 40% of those eligible to receive food stamps do not participate. Nonparticipation may result from lack of knowledge of eligibility, from the costs of enrollment, and from the effects of welfare “stigma”—a desire on the part of families not to receive welfare. In the case of Medicaid, families that are relatively healthy may not feel the need to go to the trouble to enroll in the program.

Table 2 shows more clearly how the Medicaid expansions improved coverage for children. In families below the poverty line or not much above it, more than 10% of children gained Medicaid coverage over the four-year period from 1989 to 1993. Interestingly, however, over the same period private health insurance coverage has fallen for families at all income levels, offsetting some of the gains from the Medicaid expansions. Indeed, on the whole, there has been little change in the proportion of children who are uninsured. The possibility that the drop in private coverage might be related to the expansion of Medicaid coverage is discussed in more detail below.

These tabulations show clearly that there is still a major problem of inadequate health care provision for poor children in the United States. Despite the expansions of

**Twenty percent of poor children remained uncovered in 1993; only 19% of poor children were covered by the private health insurance system.**

the Medicaid system, 20% of poor children remained uncovered in 1993. The fact that only 19% of poor children were covered by the private health insurance system does not bode well for the prospects of moving women from welfare to work.

**Health Insurance Coverage When Moving Off Welfare**

Despite the importance of the question for welfare policy, only a few direct studies have followed women as they move off the welfare rolls to determine whether they and their children have health insurance coverage. Together, these studies show unequivocally that fewer than half of women who leave welfare have health insurance three years later. The exact proportion with insurance appears to depend on the time elapsed since leaving the welfare rolls and on the job skills of the recipient.

For example, a study based on interviews of a sample representing the U.S. population from 1990 to 1992 found that only 8% of women who left welfare and obtained jobs were covered by employer-provided health
insurance in the first month of their new jobs. This short time frame surely underestimates the fraction who would eventually be insured by their employers, however, and higher coverage rates are found in studies with longer follow-up periods. In a study of AFDC recipients who received employment and training services from the New Jersey Realizing Economic Achievement Program (REACH), almost 47% who left welfare for work had private health insurance 16 to 18 months later. However, because REACH selected the most skilled and job-ready welfare recipients, the 47% figure may represent a “best-case” scenario. A study of the California GAIN (Greater Avenues for Independence) employment and training program found that only 25% of those who left welfare for work had private health insurance through their jobs over a period of two to three years. This lower percentage is probably more representative of the experience for the average recipient, although it is difficult to generalize to the entire United States from state-specific studies.

Better information on this issue can be derived from the National Longitudinal Survey of Youth (NLSY), a representative sample of men and women who were ages 14 to 21 in 1979 and who have been interviewed annually since that time. (See the Appendix to this journal issue for details on the NLSY.) Figure 1 shows the health insurance coverage of women with children in this survey over the years 1989–92, focusing on those who were on AFDC in one interview and off AFDC in subsequent annual interviews. In the first year that the families were off welfare, 23% of the mothers and 21% of the children were covered by employer-provided health insurance. These figures rose to 38% for mothers and 47% for children after three years. Employment rates for these mothers were higher—by the third year, 69% were working. Clearly, then, many of the women were working at jobs without insurance. About one-half of the women covered by employer insurance in the third year were married and covered by their spouse’s health insurance plan. The rate of coverage on their own jobs was apparently quite low.

### Table 2

**Recent Trends in Sources of Health Insurance Coverage for Children**

<table>
<thead>
<tr>
<th>Categories</th>
<th>Employer</th>
<th>Medicaid</th>
<th>Other</th>
<th>Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of All Children&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1989&lt;sup&gt;b&lt;/sup&gt;</td>
<td>63.2</td>
<td>13.6</td>
<td>9.9</td>
<td>13.3</td>
</tr>
<tr>
<td>1993</td>
<td>57.6</td>
<td>19.9</td>
<td>9.0</td>
<td>13.5</td>
</tr>
<tr>
<td>Percentage change</td>
<td>-5.6</td>
<td>+6.3</td>
<td>-0.9</td>
<td>+0.2</td>
</tr>
<tr>
<td>Percentage of Children in Families Below Federal Poverty Level&lt;sup&gt;c&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1989</td>
<td>17.8</td>
<td>50.7</td>
<td>6.4</td>
<td>25.0</td>
</tr>
<tr>
<td>1993</td>
<td>14.0</td>
<td>61.3</td>
<td>4.7</td>
<td>20.1</td>
</tr>
<tr>
<td>Percentage change</td>
<td>-3.8</td>
<td>+10.6</td>
<td>-2.7</td>
<td>-5.1</td>
</tr>
<tr>
<td>Percentage of Children in Families at 100% to 150% of Federal Poverty Level&lt;sup&gt;d&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1989</td>
<td>46.9</td>
<td>13.7</td>
<td>12.9</td>
<td>26.5</td>
</tr>
<tr>
<td>1993</td>
<td>40.6</td>
<td>24.9</td>
<td>10.0</td>
<td>24.5</td>
</tr>
<tr>
<td>Percentage change</td>
<td>-6.3</td>
<td>+11.2</td>
<td>-2.9</td>
<td>-2.0</td>
</tr>
</tbody>
</table>

<sup>a</sup> Percentages may not total 100% due to rounding.

<sup>b</sup> In 1989, the federal poverty level for a family of four was $12,675; in 1993, it was $14,763.
Figure 1

Health Insurance Coverage of Women with Children After Leaving AFDC, 1989 to 1992

 Mothers' Health Coverage After Leaving Welfare

Children's Health Coverage After Leaving Welfare

Source: Authors' tabulations based on data from the National Longitudinal Survey of Youth (CD-ROM) Ohio State University, 1979-92. Available from NLS User Services, 921 Chatham Lane, Suite 200, Columbus, OH 43221. Sample is composed of all women and their children in the survey who were on AFDC in 1989 but off welfare in 1990, 1991, and 1992.
As for Medicaid coverage, 52% of mothers and 59% of children were covered in the first year after leaving AFDC, showing the effect of the Medicaid transition rules guaranteeing receipt for 6 to 12 months. However, Medicaid coverage falls steadily the longer the family is off AFDC, especially for the mothers (many children remained eligible because of the Medicaid expansions discussed earlier). After three years, Medicaid covered only 16% of women and 33% of children. For women, these declines outweigh the growth in private coverage, leading to a steadily growing rate of noninsurance. The percentage of children uninsured fluctuates but ends up at 12%.

Clearly, the lack of coverage is a continuing problem for families who leave welfare. While 100% of women on welfare are covered by health insurance (Medicaid), almost half of these mothers have no coverage of any kind three years after leaving the rolls, and about one-third of those who are covered rely on public rather than private insurance. For children, the situation is much less severe, as only 12% are completely uncovered three years after leaving welfare.

In fact, these figures probably underestimate the severity of the difficulties that would be faced by women who might be forced off the welfare rolls by welfare policy changes. Research on turnover among the welfare population has demonstrated that women who leave the rolls (and are thus included in studies like those cited above) are those who have more job experience and education, and fewer children, and who live in areas where the labor market is relatively healthy and jobs are available. (See the article by Burtless in this journal issue.) Women who remain on welfare for longer periods tend to be the worst-off families, with few skills, low levels of education, and often significant mental or physical health problems. They are less likely to find jobs with health insurance—which tend to be higher-wage jobs for the more skilled—than might be gathered from Figure 1.

Yet another limitation of the picture painted in Figure 1 is that it pertains only to women who have stayed off the welfare rolls for three years. As noted in the article by Hershey and Pavetti in this journal issue, many women return to AFDC fairly quickly after going off, and a key challenge surrounding employment strategies for welfare recipients is that of enabling recipients not only to get off welfare, but to stay off. It is likely that many of those who lack health insurance return to the welfare rolls when an adult or child experiences an illness because they need the security provided by Medicaid. Such families are omitted from Figure 1. The role that health insurance may play in the decision to rejoin the welfare rolls—a surprisingly unresearched topic—is easily underestimated when only the most successful families are studied.

**Incentive Effects of Medicaid**

The question of whether concern about losing Medicaid coverage discourages mothers from leaving welfare to work has attracted more research attention than Medicaid’s effects on returns to the welfare rolls. It would only be natural for mothers with children to be reluctant to leave welfare if the prospect of finding health care coverage off the rolls is so uncertain. Studies suggest that the coverage problem does indeed have that discouraging effect, but only for women and children with significant health problems and health expenditures.

Researchers interested in this topic have made use of the fact that the generosity of the Medicaid program varies across states, since states have considerable discretion in the level of services they provide. Household survey data on female heads and their children reveal whether women living in states with more generous Medicaid benefits are more likely to be on AFDC and less likely to work than women living in states with less generous Medicaid benefits. Such relationships gauge whether Medicaid discourages women from leaving the welfare rolls for work. Often, researchers can also take account of differences among women in their education levels, numbers of children,
and levels of health, which might independently affect propensities to be on AFDC or to work. Surprisingly, two early studies of this type, using 1980 data from the National Medical Care Utilization and Expenditure Survey\textsuperscript{10} and 1986 data from the Current Population Survey,\textsuperscript{11} found little relationship between Medicaid benefit levels and the likelihood that a woman was on AFDC, and weak or statistically insignificant relationships between benefit levels and the likelihood that a woman was employed.

It may be inaccurate, however, to assume that all women and children in a particular state put equal value on the Medicaid benefit. To the contrary, families whose heads and children are in worse health, who have higher medical expenditures, or who are larger in size or lower in income should be expected to value the Medicaid benefit more.

A later study by a different research team used data from the 1984 Survey of Income and Program Participation to include information on health care utilization of the mothers and their children when linking Medicaid benefits to welfare and employment rates.\textsuperscript{12}

The findings of that study clearly showed that the generosity of Medicaid benefits in a state has a strong relationship to the likelihood of being on AFDC for families with above-average medical expenditures and with family members in poor health, but not for the rest of the female-headed population. Similarly, women whose families had health problems and who lived in states with generous Medicaid benefits were less likely to work. A later study confirmed these findings using a more detailed set of health indicators.\textsuperscript{13} These findings indicate that although a large number of families on AFDC do not change their employment behavior or their decision to join or leave welfare because of Medicaid, Medicaid is still an important factor for the many families who face health problems.

These studies predate the expansion of Medicaid coverage discussed above, which might be expected to reduce the imbalance of health insurance coverage on and off welfare, especially for children. One study using data from 1989 to 1992 considered how much the expansions reduced the Medicaid incentive to stay on welfare. That study found that, although AFDC caseloads were rising nationwide, the likelihood that female-headed families would be on AFDC decreased less in states that enacted more generous Medicaid expansions or adopted them earlier, compared with other states.\textsuperscript{14} In addition, the study also found that employment rates of unmarried mothers rose faster in those states that provided more access to Medicaid for families who were not on the welfare rolls. Clearly, health insurance is taken seriously by mothers as they consider leaving welfare for employment.
Availability of Private Coverage

More discouraging to policymakers, recent studies suggest that the Medicaid expansions may be offset by reduced private health insurance coverage. Private health insurance coverage has been declining over the past 15 years, for reasons not clear to analysts. Employment-based health coverage rates for children dropped from 66% to 58% between 1988 and 1993, and private employer-based health care coverage for low-wage workers dropped by 10 percentage points from 1979 to 1989. These declines may result from rising health care costs, changes in the nature of the health insurance market, or changes in the types of jobs available to unskilled workers. For example, an increase in part-time work or in temporary jobs may have contributed to the decline.

Part of the decline, at least for the late 1980s and early 1990s, may have been a result of the Medicaid expansions themselves. One study found that private health insurance coverage fell more rapidly in those states where Medicaid expansions were more generous or were enacted earlier. Another study noted that private coverage rates have fallen more among women, who are eligible for Medicaid, than among men, who typically are not. These findings suggest that Medicaid may have a “crowd-out” effect of displacing private employer health insurance plans. There are many ways that such an effect could work, for instance by allowing women leaving the AFDC rolls to take jobs without private sector insurance benefits, or to not pay the premiums that are ordinarily required—in the knowledge that they and their children can be covered by Medicaid. The magnitude of the estimated crowd-out effect (that is, the decline in private coverage as a percentage of the increase in Medicaid coverage) differs from 12% to 18% in one study to 50% in the other—but both studies found crowd-out to occur. In addition, one study concluded that crowd-out was greater among near-poor families who more often have private coverage options in the job market than among poor families.

Crowd-out could be lessened by reducing the income eligibility limits of the Medicaid expansions to concentrate Medicaid expenditures on the very poor, or by creating mandatory universal private-sector coverage at benefit levels higher than those in the Medicaid system. The existence of crowd-out does not alter the fact that the Medicaid expansions have allowed many former recipients to move off the rolls and to take private-sector jobs offering no health care coverage, which, without Medicaid for their children, they would have been unable to accept. Thus, to some extent, Medicaid is serving as an indirect subsidy to employers by enabling them to hire former welfare recipients without offering health care coverage. However, Medicaid is a public expenditure and so must be justified. The policy goal of increasing employment (by continuing Medicaid coverage) may compete with the policy objective of seeing former recipients receive health care benefits from the private sector.

Another way of examining the incentive effects of health insurance is to assess whether the availability and generosity of private health insurance off welfare encourage women to move off the rolls. (This is the flip side of the question of whether Medicaid benefits available only if on welfare discourage women from moving off the rolls.) Echoing the findings with Medicaid, one study that examined this issue showed that the welfare decisions of women and children with minimal medical care expenditures were little affected by their access to private health insurance, but that the decisions of those with health problems or significant medical care expenditures were strongly affected. In the group with health problems, women living in areas with greater insurance availability and generosity were much less likely to be on welfare and much more likely to work than similar women living in areas with low probabilities of private coverage.

In an attempt to develop concrete estimates of the effect that universal health care reform would have on AFDC rolls and employment rates of welfare-eligible women, one research team simulated the

Universal private health insurance coverage could lower the AFDC caseload by 11% and raise employment rates by eight percentage points.
impact of increasing the generosity and availability of private health insurance coverage. (Private health insurance plans are, on average, less generous than Medicaid.) The study predicted that increasing the value of private insurance by $50 per month could lower the AFDC caseload by 16% and raise employment rates among women who head families by 12 percentage points. Universal private health insurance coverage could lower the AFDC caseload by 11% and raise employment rates by eight percentage points.

These figures are based on estimates from 1984, prior to the Medicaid expansions, so the effects of these types of private insurance reforms would presumably be more modest today. A later study estimated the Medicaid expansions to have decreased the AFDC caseload by only 4.6% and to have increased employment rates by only 3.3 percentage points. However, the Medicaid expansions are limited to pregnant women and children, while the larger estimates above represent the more substantial effects that truly universal coverage could have.

Policy Implications
The policy implications of the findings reported in this article are clear. Despite recent expansions of the Medicaid system to cover children and some mothers off welfare, gaps in coverage remain, and many women who move off welfare find themselves uninsured. Those uncertain insurance prospects discourage some women and their children—those with significant health care needs—from going off the rolls. Consequently, lack of health coverage when off welfare is a major obstacle to the attempt to move women from welfare to work, which is such a fundamental goal of current welfare policy.

The holes in the health insurance safety net have been considerably reduced by recent expansions of the Medicaid program to poor children off welfare, but the remaining gaps are still large. Except when pregnant, women off welfare are still largely uncovered by Medicaid, for example. Such women are not targeted by the Medicaid expansions, and they do not appear to be well covered by the Medically Needy program. The guaranteed 6 to 12 months of Medicaid coverage for women who leave AFDC does not appear to lead to a transition to private insurance, despite the hopes of policymakers that it would provide such a bridge. While it is worth keeping the transitional Medicaid coverage in place, it is also important that policymakers not have high expectations for its success in the absence of national health care reform. Until that reform takes place, there is no guarantee that women will be able to move to private coverage at the end of the 6-to-12-month period.

The findings reported here support the argument that welfare reform requires health care reform. A system with universal coverage would significantly reduce the welfare rolls and increase the labor force attachment of low-income women. Whether a system of universal health care coverage should come from national health insurance, mandatory private-sector coverage, a comprehensive government program of last resort, or some other way, is a separate issue that is less important than the guarantee of some type of coverage for women and children who move off welfare.

In the current policy environment of cost-cutting and government retrenchment, such increases in coverage may be difficult to achieve. Universal coverage requires federal legislation and cannot be provided by state governments alone, especially as they take on more of the fiscal burden of welfare provision. Large Medicaid expenditures are already seen as problematic by states, and many have engaged in cost-reduction initiatives such as instituting managed care or taking steps to lower the quality of care provided to Medicaid recipients. But these initiatives have their limits, and it will be difficult to achieve Medicaid savings without reducing the actual number of recipients by directly or indirectly restricting Medicaid eligibility. How states handle their stark budgetary tradeoffs remains to be seen over the next several years.

Conclusion
The lack of adequate health insurance coverage, public or private, for women who leave welfare for work puts a limit on the success that can be achieved through welfare-to-work programs that are currently so popular with the public and in Congress (see the article by Nightingale...
and Holcomb in this journal issue for a discussion). Without adequate private insurance, those programs may give women no more than temporary periods off welfare. Many will try to return to welfare to avail themselves of Medicaid when they or their children have medical needs. If time limits or budget restrictions cut off their access to welfare and Medicaid, some women and children may experience deleterious health consequences.

The authors would like to thank LaDonna Pavetti for alerting us to several references, Richard Behrman for his remarks at the conference where this article was first presented, and Jonathan Gruber and Aaron Yelowitz for their comments on this article.

1. Prior to 1965, state Aid to Families with Dependent Children (AFDC) programs provided small medical supplements to recipients, but the major source of health care for the poor was charity care.


4. However, it has also been noted that many women who report being uninsured are in fact covered for their pregnancy expenses alone, and many children who are reported as uninsured would be signed up for Medicaid at the hospital, leading to an additional type of “conditional” coverage. See Cutler, D., and Gruber, J. Does public insurance crowd out private insurance? The Quarterly Journal of Economics (May 1996) 111,2:391–430.


8. The interview also had an extremely high nonresponse rate, and the authors expressed caution in drawing conclusions from the results.


15. See note no. 5, Lewit and Baker, p. 199.


19. The value of the coverage was calculated by estimating the expected charges for health care that would be paid by the insurer (Medicaid or the private insurance), minus any out-of-pocket charges.