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The Legacy of the War on Poverty's Health Programs for Non-Elderly Adults and Children

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Abstract

Two of the major gaps between those living in poverty and those with higher incomes are gaps in access to health care and gaps in health. These disparities were considerably worse prior to the introduction of the Medicaid program, which was signed into law in 1965. In this paper I will review existing gaps in health care usage and, to the extent possible, document gaps in health, comparing those with incomes below the poverty line to those above it. The paper includes a systematic review of programs directed at helping those living in low-income families obtain health care from the demand and supply perspectives, beginning with the period just before the War on Poverty and at selected intervals after the initiation of the War on Poverty in January 1964. I will review Medicaid's history, including the number of persons who use the program, and discuss its strengths and weaknesses both historically and contemporaneously. I will explore major components of the Affordable Care Act (ACA), which appear to be built upon the successful components of the Medicaid and Community Health Center programs of the War on Poverty.

Keywords: Affordable Care Act; ACA; Health and Poverty; Health care reform; War on Poverty

The Legacy of the War on Poverty's Health Programs for Non-Elderly Adults and Children

Two of the major gaps between those living in poverty and those with higher incomes are gaps in access to health care and gaps in health. These disparities were considerably worse prior to the introduction of a federal-state program designed to alleviate the situation, the Medicaid program. In 1963, before the passage of Medicaid and Neighborhood Health Center legislation as part of the War on Poverty, 54 percent of the poor did not see a physician and children living in families below the poverty line were far less likely to see a physician than children living in higher-income families.

In this chapter I will review existing gaps in health care usage and, to the extent possible, document gaps in health, comparing those with incomes below the poverty line to those above it. I will do this beginning with the period just before the War on Poverty and at selected intervals after the initiation of the War on Poverty in January 1964.

The plan for this chapter is to systematically review programs directed at helping those living in low-income families obtain health care from the demand and supply perspectives. The primary demand-side program of the War on Poverty is the Medicaid program, which provides “insurance” to low-income families to reduce the price of receiving medical care. It is a joint federal-state program. I will review Medicaid’s history, including the number of persons who use the program, and discuss its strengths and weaknesses both historically and contemporaneously. This will include a discussion of eligibility and take-up; a discussion of the all-or-nothing character of the program and the negative incentives of this design; the variation across states; and the lack of coverage of large groups of persons living below the poverty line. It will also include a discussion of limits on access due to characteristics of the program including low reimbursement of providers, particularly specialists and oral health providers; differential coverage within families; and limited outreach. And it will document both the program’s growth as well as its countercyclical nature. It will also use existing literature to evaluate the success of the program in reducing gaps in access to care.

In addition to my discussion of the Medicaid program, I will discuss the two other programs that should be classified under medical programs for the non-elderly poor that are part of the War on Poverty: the first is the children’s health insurance program (CHIP), which is an extension of Medicaid; and the second is community health centers (originally known as neighborhood health centers). I will also briefly touch on a related program, the National Health Service Corps, set up to increase the availability of medical personnel to underserved largely poor areas.

PUBLICLY PROVIDED SUPPORT FOR HEALTH CARE PRIOR TO THE WAR ON POVERTY

In 1960, just prior to the War on Poverty, most health care was privately financed (and expenditures were far below those in recent decades). Health insurance financed less than 30 percent of private health spending. Early in the twentieth century, sickness funds were the dominant form of private coverage; these were designed to cover lost income due to illness rather than to pay for medical care. Private coverage for medical care was first provided by Blue Cross and then Blue Shield beginning in the 1940s, but grew rapidly only with modifications of tax policy (IRS code of 1954), which allowed employers to consider payments toward health insurance premiums as costs of business on which they and their employees paid no tax. Thus the first large expansion of public support for insurance to cover medical care was through the form of tax subsidies to the private sector.

In terms of providing access to medical care, the public sector intervened on the supply side by directly financing public hospitals, military health care, public medical research, school health programs, and other medical facilities. Excluding veterans’ medical programs, direct public supply side expenditures expanded from about 0.3 percent of GDP to 1 percent from 1929 to the 1970s (Fishback and Thomasson 2006). These included expenditures by the U.S. Children’s Bureau to promote maternal and infant health spurred by the Shephard-Towner Maternity and Infancy Act of 1921 (see Fishback and Thomasson, 714–15); expenditures under worker’s compensation; and direct expenditures on medical research following WWII (reaching $1 billion in 1957 and $5 billion by 1966 [in 1992 dollars]).

The Medicaid program was signed into law on July 30, 1965. Former President Truman was part of the signing-in ceremony in honor of his leadership on health insurance, which he first proposed in 1945. Figure 1 from the Centers for Medicare and Medicaid Services (CMS) documents the various stages of Medicaid legislation. Expenditures in the first year (1966) were under $1 billion, while enrollment stood at 4 million and per-enrollee spending was less than $200. Put another way, Medicaid spent about $4 per U.S. resident in 1966. At its inception, Medicaid was overseen by the Social Rehabilitation Administration.

Medicaid is a joint federal-state program where certain standards are set federally, including a minimum package of benefits. The federal government provides the majority of financial resources, though the states' contributions represent a far larger share of their revenues. At the beginning, participating states received matching federal payments between 50 percent and 83 percent of their outlays (depending on per capita income). Participating states were required to cover mandatory subpopulations and services and to supplement Medicare for dual-eligible low-income seniors. States had the option to cover additional groups and services and set the income-eligibility level for mandatory groups. This state-based determination of eligibility is one of the greatest issues with Medicaid, making the program one of considerable inequality across states. Over time, federal rules regarding eligibility have expanded so that now minimum standards cover children, pregnant women, and certain other groups.

Since its inception, Medicaid has grown significantly in the number of people and services it covers. In 2012, it is run by the CMS, covers around 60 million people, and is the largest source of financing for nursing home and community-based long-term care. Medicaid targets the neediest and most vulnerable individuals: children, pregnant women, people with disabilities and chronic health problems, and low-income seniors. Low-income adults are covered to various degrees in some states.

Medicaid is currently the third-largest domestic federal program in the budget, and in most states is the second largest. Most non-elderly and nondisabled Medicaid beneficiaries are enrolled in managed

Figure 1: Medicaid's Milestones

July 30, 1965: The Medicaid program, authorized under Title XIX of the Social Security Act, was enacted to provide health care services to low-income children deprived of parental support and their caretaker relatives, the elderly, the blind, and individuals with disabilities.

1967: The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) comprehensive health services benefit for all Medicaid children under age 21 was established.

1972: The newly enacted Federal Supplemental Security Income program (SSI) provided states with the opportunity to link to Medicaid eligibility for elderly, blind, and disabled residents.

1981: Freedom of choice waivers (1915b) and home and community-based care waivers (1915c) were mandated. States were required to pay hospitals treating a disproportionate share of low-income patients additional payments (called disproportionate share hospitals or "DSH").

1986: Medicaid coverage for pregnant women and infants (age one year or under) whose family income was at or below 100 percent of the federal poverty level (FPL) was established as a state option.

1988: The Qualified Medicare Beneficiary (QMB) eligibility rule required states to provide Medicaid coverage for pregnant women and infants whose family income was at or below 100 percent of the FPL. The criteria established special eligibility rules for institutionalized persons whose spouse remained in the community to prevent "spousal impoverishment."

1989: EPSDT requirements were expanded. Medicaid coverage of pregnant women and children under age six whose family income was at or below 133 percent of the FPL was mandated.

1990: The Medicaid prescription drug rebate program was enacted. The Specified Low-Income Medicare Beneficiary (SLMB) eligibility group was established to provide Medicaid coverage for children ages six through eighteen whose family income was at or below 100 percent of the FPL.

1991: DSH spending controls were established, provider donations were banned, and provider taxes were capped.

1996: The Aid to Families with Dependent Children (AFDC) entitlement program was replaced by the Temporary Assistance for Needy Families (TANF) block grant. The welfare link to Medicaid was severed and enrollment (or termination) of Medicaid was no longer automatic with the receipt (or loss) of welfare cash assistance.

1997: The Balanced Budget Act of 1997 (BBA) created the State Children's Health Insurance Program (SCHIP). Under this new state-based program, new managed care options were established. DSH payment limits were revised.

1999: The Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) expanded the availability of Medicare and Medicaid for certain disabled beneficiaries who return to work. The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 stabilized the SCHIP allotment formula and modified the Medicaid DSH program.

2000: The Benefits Improvement and Protection Act of 2000 (BIPA) modified the DSH program and modified SCHIP allotments. The Breast and Cervical Cancer Treatment and Prevention Act of 2000 allowed states to cover uninsured women with breast or cervical cancer regardless of income or resources at enhanced SCHIP federal matching rate. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act directs the Secretary of the U.S. Department of Health and Human Services (HHS) to issue regulations tightening upper payment limits (UPLs). This continued a trend of the federal government clamping down on state financing practices.

2001: The Bush Administration announces the section 1115 waiver initiative, Health Insurance Flexibility and Accountability (HIFA), allowing states to demonstrate comprehensive state approaches that would increase the number of individuals with health insurance coverage using current-level Medicaid and SCHIP resources.

2003: The Jobs and Growth Tax Relief Reconciliation Act of 2003 raises all state Medicaid matching rates by 2.95 percentage points for the period April 2003 through June 2004 tied to the downturn in the economy. Congress recognized that state revenue collection had declined just when Medicaid programs were facing increased enrollment by low-income families. Medicaid drug coverage for dual eligibles, those who qualify for both Medicaid and Medicare, is transferred to Medicare effective January 1, 2006. Congress raises state-specific DSH allotments by 16 percent for FY 2004 for all states, through FY 2009 for low-DSH states (states that historically had not been large users of DSH).

2005: Congress passes a budget resolution requiring $10 billion in cost savings from the Medicaid program.

2009: CHIP reauthorized through FY 2013 under Children's Health Insurance Program Reauthorization Act, phases out coverage for parents by 2014.

2010: The Patient Protection and Affordable Care Act (PPACA) expands Medicaid to nearly all individuals under age 65 with incomes up to 133 percent of the federal poverty line (FPL). Due to go into effect in 2014. Expected to increase enrollment in Medicaid by 15.9 million. Also increases payments for primary care services to 100 percent of the Medicare payment rates for 2013 and 2014. Requires all states to extend levels of CHIP coverage eligibility in place at time of ACA passage through 2019.

Sources: https://www.cms.gov/About-CMS/Agency-information/History/index.html?redirect=/History/ accessed 4/10/12 and http://healthreformgps.org/wp-content/uploads/MACPAC_March2011_web.pdf accessed 5/16/12.

care plans, which contract with the state. Medicaid outlays are largely spent on a small percentage of the beneficiaries. Most of the increase in spending has been due to an increased number of enrollees, rather than expanded spending per recipient. In fact, Medicaid spending per beneficiary has grown more slowly than premiums for job-coverage and national health expenditures (Kaiser Family Foundation [KFF], 2011b).

Broad Trends in Medicaid Since Its Beginnings

Medicaid expenditure and enrollment growth from its first year in 1966 through 1999 is depicted in Table 1. The growth of Medicaid during the first six years of its existence was substantial as states gradually implemented programs. By 1971, annual spending had reached $6.5 billion, and enrollment had topped 16 million. These levels were far above those initially forecast in part because numerous states offered coverage to optional groups, such as the medically needy, and offered optional services as well. Enrollment grew at an average annual rate of nearly one-third, reaching by 1971 almost one-half of what it would be by 2000. The Social Security Act (SSA) amendments of 1972 created the Supplemental Security Income (SSI) program, which federalized existing state cash assistance programs for disabled (and elderly) persons. Nearly all beneficiaries of SSI also receive Medicaid coverage, which led to substantial increases in enrollment. These amendments also added optional Medicaid-covered services such as intermediate care facilities for the mentally retarded (ICF/MR) and inpatient psychiatric services for beneficiaries under age twenty-two. Coverage of these disabled individuals led to substantial growth in enrollment and expenditures as disabled persons tend to be far more expensive to cover than others eligible for Medicaid. By 1976, enrollment was about 21 million. Expenditures during the late 1970s to the early 1980s were up dramatically although enrollment itself did not increase. Average annual expenditure growth from 1976 to 1981 was about 15 percent annually. This led to pressure to reduce spending and the passage of the Omnibus Reconciliation Act of 1981 (OBRA-81), which led to three years' of reductions in both eligibility for Aid to Families with Dependent Children (AFDC) and hence Medicaid, and in federal matching rates by about 4 percentage points, if states' growth exceeded specified

Table 1: Medicaid Expenditure Growth, by Era

			Annual Compound Rate of Growth		
Era	Description	Total Expenditure Growth	Enrollees	Price Inflation[a]	Growth in Expenditures per Enrollee in Excess of Price Inflation
			Percent		
1966–1971	Program Startup	52.3	32.2	4.0	10.7
1972–1976	Early Amendments	17.9	4.9	6.5	5.5
1977–1981	Medical Inflation	14.8	-0.7	8.4	6.7
1982–1984	Retrenchment	7.8	-0.3	4.5	3.4
1985–1990	Program Expansion	11.8	2.5	3.8	5.2
1991–1992	Taxes and Donations, DSH	27.3	12.2	3.4	9.7
1993–1996	Experimentation	7.9	3.6	2.2	1.9
1997–1999[b]	PRWORA, BBA	5.6	-0.4	1.6	4.4

[a] Measured by the gross national product implicit price deflator.

[b] Statistics for 1997–1999 do not include the State Children’s Health Insurance Program.

Notes: DSH is disproportionate share hospital. PRWORA is Personal Responsibility and Work Opportunity Reconciliation Act of 1996. BBA is Balanced Budget Act of 1997.

Sources: Expenditures: Medicaid Financial Management Reports (HCFA-84 and predecessors). Enrollment: 1968–1974 (Institute for Medicaid Management, 1978); 1975–1998 Medicaid Statistical Reports (HCFA-2082); and 1999 projections (Health Care Financing Administration, 2000).

targets. State flexibility was increased during this time period and this led to the development of a number of alternative delivery and financing mechanisms including capitation, health maintenance organizations, prospective payment to hospitals, and a variety of state-specific waiver programs. Medicaid expenditure growth slowed to 8 percent for three years beginning in 1981, while enrollment remained constant at about 20 million.

After this success in reducing growth in Medicaid, Congress reversed course and turned to expansions of Medicaid beginning in 1984. These expansions importantly included breaking the link between AFDC and Medicaid eligibility, thereby opening the possibility of increased work while maintaining Medicaid coverage for many low-income single-parent families. Of course, the improvement in work incentives came with an increase in expenditures and enrollment: over the 1984 to 1990 period expenditures increased 11.8 percent annually and even greater growth followed in 1991 to 1992 as some of the expansions in eligibility were phased in. The expansions in eligibility led to problems for states in financing their share of the expansions. Numerous states creatively used Disproportionate Share Hospital (DSH) payments to cover their share of Medicaid. (The official objective of DSH payments was to help hospitals cover uncompensated and undercompensated care but its design led to both abuse and poor targeting.[1]) By the end of 1991, Congress enacted Public Law 102-234, the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, in order to prohibit states from using donations and restricted provider tax programs to increase federal DSH payments, and it capped DSH payments at 12 percent of Medicaid spending. By the mid-1990s, states were hotbeds of reform tied to welfare and many of the reforms included Medicaid as well. The use of managed care increased, and by 1997, about half of the states had demonstration projects attempting to limit increases in Medicaid spending. Medicaid expenditure growth averaged less than 8 percent per year. A discussion of the

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[1] Thirty states increased DSH payments to providers, recouped the increased payment through a donation from or tax on that provider, and received federal matching funds thus protecting the state's own spending. By 1992, DSH payments reached $17 billion, or about 15 percent of total Medicaid spending (Coughlin, Ku, and Holahan 1994).

possibility of converting Medicaid into block grants led to an acceleration in spending, however, when states believed current spending would be the basis of block grants (U.S. General Accountability Office 1997). When this was not passed, increases decelerated with an especially low rate in 1996.

In 1996 to 1997, Congress passed welfare reform, which finally severed the tie between Medicaid eligibility and cash welfare assistance. Those who would have been eligible for Medicaid under cash assistance maintained their eligibility, but eligibility was extended to infants, children under age six, and pregnant women at levels above those for cash assistance prior to the reforms. A new program to cover children was passed, the State Children's Health Insurance Program (SCHIP), discussed below. Managed care was also encouraged for most Medicaid enrollees.

The result of these changes was actually a decrease in Medicaid enrollments and a slowing of the increase in expenditures. In 2001, the Bush Administration created a section 1115 waiver initiative, Health Insurance Flexibility and Accountability (HIFA), which increased state flexibility, allowing states to demonstrate comprehensive approaches to increase the number of individuals with health insurance coverage using current-level Medicaid and SCHIP resources. The success of these waivers in increasing enrollments and hence expenditures led to the Jobs and Growth Tax Relief Reconciliation Act of 2003, which raised state Medicaid matching rates by 2.95 percentage points for the period April 2003 through June 2004 as temporary federal fiscal relief to the states due to the downturn in the economy. Congress raised state-specific DSH allotments by 16 percent for fiscal year (FY) 2004 for all states, through FY 2009 for low-DSH states (states that historically had not been large users of DSH). However, as Medicaid expenditures continued to rise, reaching $271 billion and 17.1 percent of all personal health care expenditures in 2004, Congress passed a budget resolution requiring $10 billion in cost savings from the Medicaid program. Secretary Michael Leavitt of the Department of Health and Human Services established an advisory Medicaid Commission. The Commission was to submit two reports. The first was to outline recommendations to achieve $10 billion in savings during the next five years and ways to begin meaningful long-term enhancements that better serve beneficiaries. The second was to provide recommendations to help ensure the long-term sustainability of Medicaid.

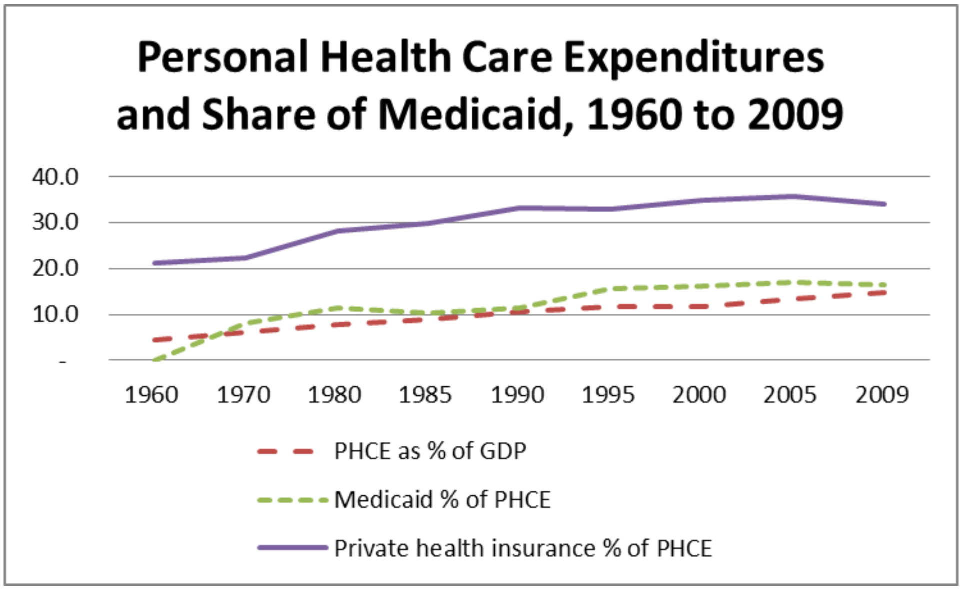
Figure 2 shows the tremendous growth of Medicaid in terms of expenditures over the period beginning in 1960 (at 0) and continuing to 2009. The average annual growth in Medicaid expenditures from 1970 to 2009 was an astronomical 11.5 percent; the highest growth was during the 1970s when it reached 17.2 percent. But the high trend did not stop there, and over the period from 2008 through 2009, the last calculated, it was 9.2 percent. Figure 2 also provides a picture of the overall growth in personal health care expenditures (PHCE) as a percentage of GDP. Over the entire period from 1960 to 2009, total PHCE increased by 9.6 percent, going from 4.4 percent of GDP in 1960 to 14.8 percent of GDP as of 2009 (Health Care Financing Administration [HCFA] 2010). In terms of a comparison, over the period from 1970 to 2009, when Medicaid grew by 11.5 percent annually, PHCE grew by 9.4 percent annually, a dramatic increase but still considerably less than the growth rate of Medicaid.

Who is Covered?

Initially, Medicaid program eligibility was largely confined to the populations traditionally eligible for welfare—single-parent families and the aged, blind, and disabled. But there were two exceptions: the “Ribicoff children,” which were children who met the financial standards of welfare programs but not the categorical standards because they were in a two-parent family; and the “medically needy,” identified as populations whose income was above the eligibility standards but who had very high medical bills. Initially, states did not face an upper-income limit for eligibility for the medically needy.

Eligibility for the Medicaid program grew substantially over time. First, there were added options to cover women without children who met the Aid to Families with Dependent Children (AFDC) income criteria for the expenses of their pregnancy only (Currie and Gruber 1996b). Then in 1984, the program began to expand eligibility for children and for pregnant women. From 1984 to mid-1987, eligibility expanded to persons in similar financial circumstances to AFDC families but not in single-parent families. Then under 1988 welfare reforms and the creation of the JOBS program, states were required to offer 12 months of transitional health care coverage to those who lost AFDC eligibility due to earnings (though they could charge a premium up to three percent of income after 6 months). These steps led to

Figure 2: Personal Health Care Expenditures and Share of Medicaid, 1960–2009



Source: Table 1.1 Centers for MMS, health care financing review/2010 statistical supplement.

some loosening of eligibility regardless of family structure and the covering of all children below specified income levels. By 1992, states were required to cover all pregnant women and children under the age of six up to 133 percent of poverty (independent of family composition), and were permitted (with federal matching funds extended) to expand coverage up to 185 percent of poverty. Federal mandates required that all children born after October 1983 be covered in families with income up to 100 percent of the federal poverty line (FPL).

Further loosening took place through the use of waivers permitting states to cover adults in low-income families and expansion of the income eligibility limit. This improved coverage, making the minimum thresholds more uniform, but allowed substantial variation in eligibility across states (and in some states, across counties).

This trend in expansion of coverage continued with SCHIP (discussed separately below) and with the 2010 Affordable Care Act (ACA), which will expand coverage to 133 percent of the FPL for all persons regardless of family status.[2]

Medicaid is valuable because it provides health coverage to people who need it most and would not have it on their own. In the United States, most individuals with private health insurance are covered through employer-sponsored plans. Individuals (or their parents) who cannot work because of a long-term health condition, whose employer does not offer a company plan (because the worker is a part-time employee or because the firm is a small business, for example), or who are simply unemployed may find

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[2] The ACA, formally known as the Patient Protection and Affordable Care Act, was signed into law on March 23, 2010. It was passed along largely party lines first by the Senate in December 2009 and then by the House in March 2010. Numerous states filed legal actions in federal courts challenging the constitutionality of the law. In addition to the expansion of Medicaid under the law discussed in the body of this chapter, the ACA creates an individual mandate for all persons to have health insurance (with an exemption for financial hardship); establishes state insurance exchanges to improve the functioning of the private insurance market; eliminates pre-existing condition clauses thus improving the insurability of and lowering the cost for those with such conditions; expands coverage under family coverage to children up to age 26; sets up numerous incentives to experiment with ways to improve access and reduce costs of care; and establishes an essential benefits package. For a longer discussion, see Commonwealth or KFF websites or Haveman and Wolfe 2011.

it difficult or extremely expensive to get health insurance on their own. These individuals are also likely to have the most serious health needs, especially those with chronic health conditions or disabilities.

Medicaid is a countercyclical program, so its expenditures and effects are larger during economic recessions. The Kaiser Family Foundation (KFF) estimates that between 2007 and 2009 (during the most recent recession), Medicaid enrollment grew by over 7 million people. For many of these individuals, Medicaid would be their only source of coverage for health services. Medicaid provides a safety net for persons and families who cannot participate in the private insurance market due to adverse health or economic conditions.[3]

MEDICAID'S SHORTCOMINGS

There continue to be numerous problems with Medicaid.[4] The first problem is its all-or-nothing character. Most low-income persons are either eligible or ineligible. If their income goes up by even one dollar over the eligibility limit, they lose their eligibility. This notch effect creates an incentive to keep income below the eligibility level and hence may lead to reduced labor force participation, working off the books, or even family breakups. But this form of eligibility is also likely to lead to higher levels of uninsured as individuals recognize that should anyone in the family face major health problems, the family or that individual can become eligible for Medicaid through a reduction in earnings by family members. And this lack of coverage may influence or reduce the use of health care, especially preventive care, and thus influence (reduce) health itself.

The second problem is that coverage varies by state. Eligibility levels, the coverage of optional groups, and the components of medical care covered all continue to vary. This creates inequity and for some an inducement to move. A third problem is that low reimbursement rates have led some providers to refuse to serve persons covered by Medicaid. This appears to especially be the case with specialists and

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[3] Under the ACA other options are extended to provide coverage to the newly unemployed.

[4] Much of this discussion is based on Wolfe 1994.

oral health care providers. Low reimbursement, or other rules to reduce costs, limits access and again may well have health consequences. Related to this is a fourth problem, the use of managed care for most Medicaid recipients; this policy may limit access either because of distances or because the pool of doctors may be very limited and exclude doctors who previously provided care to these individuals.

A final problem is that the Medicaid system (along with CHIP) functions as a parallel system to private coverage and may induce persons to turn down coverage at their place of employment, especially if there are considerable premiums to be paid and co-payments when care is received. For many low-income families, the additional benefit from private coverage is less than its cost, given the availability of Medicaid (and CHIP).

WHAT IS THE STATE OF THE EVALUATION LITERATURE?

Because of the variation in Medicaid programs across states, most evaluations of the program are either at the state level or, if across states, they evaluate the success of a particular program specification. There have been many studies of different Medicaid programs since the program's inception in the 1960s.

One example is an evaluation of the BadgerCare Medicaid demonstration in Wisconsin, published in 2000. BadgerCare is a public health insurance program developed by the State of Wisconsin to address the needs of low-income families who lack health insurance, and to assist families in their transition from welfare to work. The state received waivers of Title XIX (Medicaid) and Title XXI (State Child Health Insurance Program or SCHIP) rules under Section 1115 of the Social Security Act to provide public health insurance coverage to families normally ineligible for these programs, and to make other reforms. The key features of BadgerCare are eligibility expansion (to families with incomes up to 185 percent of the FPL), elimination of the asset test for eligibility, family coverage, monthly premiums for families with incomes above 150 percent of FPL, state subsidy of employer-sponsored health insurance, and additional outreach to encourage qualified families to participate.

By all accounts, BadgerCare has succeeded in achieving its main objective of bridging the gap between Medicaid and private insurance for the working poor. The program's success is attributed in part to the collaborative program planning process in which program planners sought and received input from all key stakeholders. Success is also attributable to the state's progressive tradition in health care and the determination of a handful of policymakers to develop a workable solution. The study assesses the effectiveness of increased outreach efforts, provisions to allow families to enroll in one plan, and efforts to improve continuity of enrollment and access to care.

Another example of an evaluation at the state level is a 1997 Inquiry report on Maryland's Access to Care program (Schoenman, Evans, and Schur 1997). A growing number of states are implementing Medicaid managed care programs, and primary care case management (PCCM) is an important component of many of these systems. Results are presented of an evaluation of one such PCCM program, the Maryland Access to Care (MAC) program. The evaluation uses five years' of Medicaid claims and eligibility data from the period before and after the program's introduction to determine the program's impact on expenditures and service utilization. Results indicate that the program increased the probability that a Medicaid enrollee would use primary care and preventive services, but had little impact on use of specialty or emergency room services. The gatekeeper program also was successful at controlling expenditures once an enrollee entered the health care system, largely through reductions in the use of ancillary services. The post-MAC increase in the probability of using services was so great, however, that all savings per user were neglected, resulting in an estimated increase of about 3.4 percent in Medicaid expenditures for the MAC-eligible population.

A 2002 study by Robert Kaestner, Lisa Dubay, and Genevieve Kenney (2005) examined the effects of Medicaid Managed Care (MMC) as a system for providing Medicaid care. In this study, the authors examine the effects of MMC on prenatal care utilization and infant health. They obtain separate estimates of the effect of primary care case management (PCCM) managed care programs and HMO managed care plans on prenatal care utilization, birth weight, and cesarean section. The results suggest the following: MMC was associated with a small, clinically unimportant decrease in the number of prenatal care visits; MMC had no statistically significant relationship to the Adequacy of Prenatal Care Utilization (APNCU) index of the adequacy of prenatal care; MMC was associated with a significant increase in the incidence of low-birth weight and pre-term birth; and MMC had no association with the incidence of cesarean section. They argue that a causal interpretation of the first and third findings is unsupported by a careful reading of the evidence, and conclude that Medicaid managed care had virtually no causal effect on prenatal care use, birth outcomes, and cesarean section.

Finally, a 2007 KFF study on Community Care of North Carolina (CCNC) examines the effectiveness of the medical home model. Local nonprofit community networks that are composed of physicians, hospitals, social service agencies, and county health departments provide and manage care. Within each network, each enrollee is linked to a primary care provider to serve as a medical home that provides acute and preventive care, manages chronic illnesses, coordinates specialty care, and provides 24/7 on-call assistance. Case managers are integral members of each network who work in concert with physicians to identify and manage care for high-cost, high-risk patients. The networks work with primary care providers and case managers to implement a wide array of disease and care management initiatives that include providing targeted education and care coordination, implementing best practice guidelines, and monitoring results. Evaluations of the program suggest it has resulted in both improved care and cost savings. As such, CCNC not only provides important lessons for broad reform efforts, but also demonstrates the Medicaid program’s ability to incorporate quality improvement strategies that enhance its ability to provide coordinated, cost-effective care to low-income individuals with significant health needs (KFF 2009).

WHAT DOES THE EXPERIENCE WITH MEDICAID MEAN FOR THE ACA REFORM?

The 2010 Affordable Care Act (ACA) includes many provisions to reform Medicaid. Income eligibility will be made uniform across states, based on a modified adjusted gross income (MAGI) without income disregards or an asset or resource test. This will simplify the process of determining eligibility, and give states less leeway to customize the populations they cover by tailoring their income determination process. In addition, it will lessen the disparities in coverage across states.

The largest provision in the ACA Medicaid reform is to require states to cover all adults, regardless of whether they have children or chronic health conditions, up to 133 percent of the federal poverty level. These new enrollees will be guaranteed some minimal standards of coverage. The federal government will initially absorb the costs of the new enrollees, but states will be required to take on a share of the costs after 2016, with states paying 10 percent of these costs after 2020. ACA Medicaid reform will also establish minimum Medicaid coverage thresholds for children ages six to nineteen and parents with incomes up to 133 percent of the FPL.

One of the primary concerns about this provision in the ACA is supplying health services for what will surely be an increased level of demand. There may be a shortage in supply of physicians and other health professionals. The supply of medical specialists available to Medicaid patients is a particular concern, because the ACA does not extend payment boosts to compensate beyond primary care. Another area of concern is the potential shortage of mental health specialists.

Some experts believe that the new provisions of the ACA give states incentives to cover patients through managed (capitated) care. The mandates of the ACA create a larger and more diverse population of Medicaid recipients, and a managed care structure will allow for a more efficient way of addressing such varied needs.

It is not clear whether MMCs are ideal for a Medicaid population that is churning (with people constantly being disqualified and re-qualified for coverage). This problem of churning is also an issue for people who need steady treatment for chronic conditions. States should be aware of patients potentially falling through gaps, and may consider guaranteeing twelve-month coverage intervals for adults as well as children. Individuals who do not qualify for Medicaid under the ACA will be required to obtain insurance privately through one of the newly created exchanges. The people who churn in and out of Medicaid will probably be churning in and out of these exchanges. Policymakers who are overseeing the new health system should focus on making the coverage and information sharing between these two systems as seamless as possible. It will be very problematic if these low-income individuals are treated by two very separate health systems that do not communicate with one another.

The ACA will fund new demonstration projects in Medicaid that (1) make bundled payments for episodes of care that include hospitalizations; (2) make global capitated payments to safety net hospital systems (five states); (3) allow pediatric medical providers organized as accountable care organizations to share in cost savings; and (4) provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition (Bazelon Center for Mental Health Law 2010). These demonstrations will test different methods of payments to providers, in an effort to improve health quality outcomes, provider performance, and cost-effectiveness. The demonstrations are tied to considering new ways to pay for health care over the coming decades, and should provide data on the more efficient ways to improve the health of low-income populations.

The ACA will create a new option for states to permit Medicaid enrollees with at least two chronic conditions (or one serious and persistent mental health condition) to designate a provider as their "health home." Providers can be a physician, clinic, home health agency, or others deemed qualified by the state. States that exercise this option would receive 90 percent Federal Medical Assistance Percentage (FMAP) for those patients' health-related services for the first two years of the program. This provision is a promising start to improving the efficiency and effectiveness of care for patients with extensive health needs. The health-home model is designed to centralize the care of patients in one place, to improve the coordination of different treatments across physicians and service-providers, and to improve patients' access to care by simplifying access for them. Health-home models so far have been moderately successful in achieving these goals, specifically for high-needs patients. It is worth remembering that Medicaid spending is concentrated largely among the neediest patients, so any improvement in efficiency or savings for this subpopulation would be significant for Medicaid as a whole.

(STATE) CHILDREN' S HEALTH INSURANCE PLAN (SCHIP AND CHIP)

The State Children's Health Insurance Program (SCHIP), later the Children's Health Insurance Program (CHIP), was initiated in the Balanced Budget Act of 1997, which set up the program for a ten-year period through the development of Title XXI of the Social Security Act. In February of 2009, the program was reauthorized under the Children's Health Insurance Program Reauthorization Act (CHIPRA), which included funding for the program over a period of four and a half years. More recently, the Patient Protection and Affordable Care Act (ACA) established a requirement that all states extend the levels of CHIP coverage eligibility in place at the passage of PPACA through 2019.

The CHIP is designed to meet the needs of low-income children who do not have a means of accessing affordable private insurance and who also do not qualify for insurance coverage under the Medicaid program. As a component of this objective, many states have extended SCHIP/CHIP to include coverage offerings for otherwise uninsured pregnant mothers and low-income parents.

Program Design and Administration.

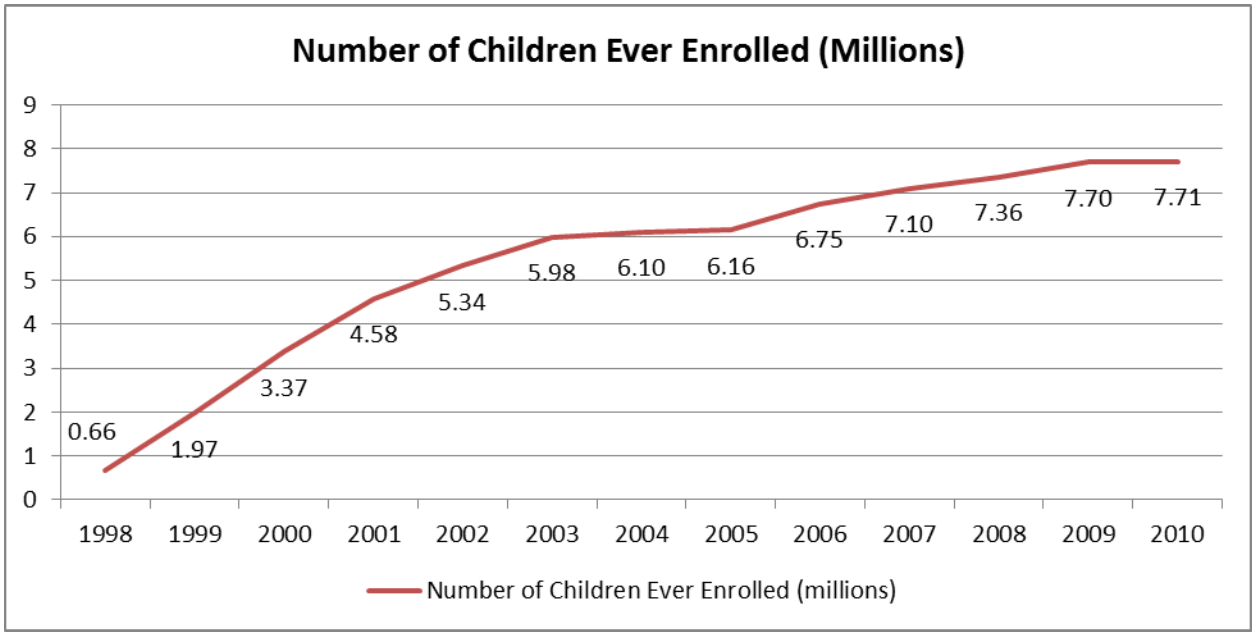
The SCHIP (and more recently CHIP) is supported jointly at both the state and federal levels. States design and administer the CHIP program independently, subject to programmatic guidelines set at the federal level. States may offer the CHIP program as an extension of the state Medicaid program, as a separate program in both administration and design, or as some combination of these two options.

Enrollment

The SCHIP experienced substantial growth in children's enrollment during the early years of the program. Since 2003, growth in enrollment has slowed but continues to demonstrate an overall upwards trend. Figure 3 below depicts the number of children ever enrolled annually from 1998 through 2010.

Program design and eligibility for (S)CHIP are set at the state level. According to recent CMS numbers, seven states, five territories, and the District of Columbia administer Medicaid expansion programs; seventeen states administer separate CHIP programs; and twenty-six states opt for a combined approach (CMS 2011). As of 2011, the upper-income limit for Medicaid/CHIP eligibility for children was lowest in North Dakota (160 percent FPL) and highest in New York (400 percent), multiple states also offered a buy-in option (KFF 2011c). Tables 2 and 3 below document trends in Medicaid and CHIP coverage eligibility for children and working parents.

Figure 3: Number of Children Ever Enrolled (Millions)



Source: Centers for Medicare and Medicaid Services 2011.

Table 2: Child Coverage Under Medicaid and CHIP, July 1997 to January 2011

	July 1997	Nov 1998	July 2000	Jan 2002	July 2004	July 2006	Jan 2008	Jan 2011
Number of children's health coverage programs	51 MCD	51 MCD 19 CHIP	51 MCD 32 CHIP	51 MCD 35 CHIP	51 MCD 36 CHIP	51 MCD 36 CHIP	51 MCD 37 CHIP[a]	51 MCD 38 CHIP[b]
Coverage ≥ 200% FPL	6[c]	22	36	40	39	41	45	47

Source: Heberlein et al. (2011), table A, page 26; available at: http://www.kff.org/medicaid/upload/8130.pdf.

[a] In 2008, Tennessee and Missouri created separate CHIP-funded programs and Maryland replaced its separate CHIP with a CHIP-funded Medicaid expansion.

[b] In 2010, South Carolina replaced its separate CHIP program with a CHIP-funded Medicaid expansion.

[c] In addition, two states, Massachusetts and New York, financed children's health coverage to this income level using state funds only.

Table 3: Working Parent Coverage, 2002 to 2011

	Jan 2002	July 2004	July 2006	Jan 2008	Jan 2011
Number of children's health coverage programs	51	51	51	51	51
Working parent coverage ≥100% FPL	20	17	16	18	18

Source: Heberlein et al. 2011, table B, page 28; available at http://www.kff.org/medicaid/upload/8130.pdf.

Alongside increasing enrollment, program spending has increased substantially over time. Figure 4 below documents total expenditures under (S)CHIP from FY1998 through FY2009.

Primary challenges to the program have been low take-up, churning enrollment, and concerns with crowd-out (parents dropping private coverage of their children or the entire family in response to eligibility for CHIP). Some states have undertaken rigorous efforts to effectively reach and serve the population targeted by (S)CHIP. Some of these have been found effective (Wolfe and Scrivner 2005). These include programs to minimize barriers to enrollment, outreach efforts including website enrollment, and translation services. States have also adopted program features to help ensure that those already enrolled in the program do not inadvertently transition out of the program due to the procedural burdens of the re-enrollment process. Tables 4 and 5, below, document trends in program features designed to ease the enrollment/retention process.

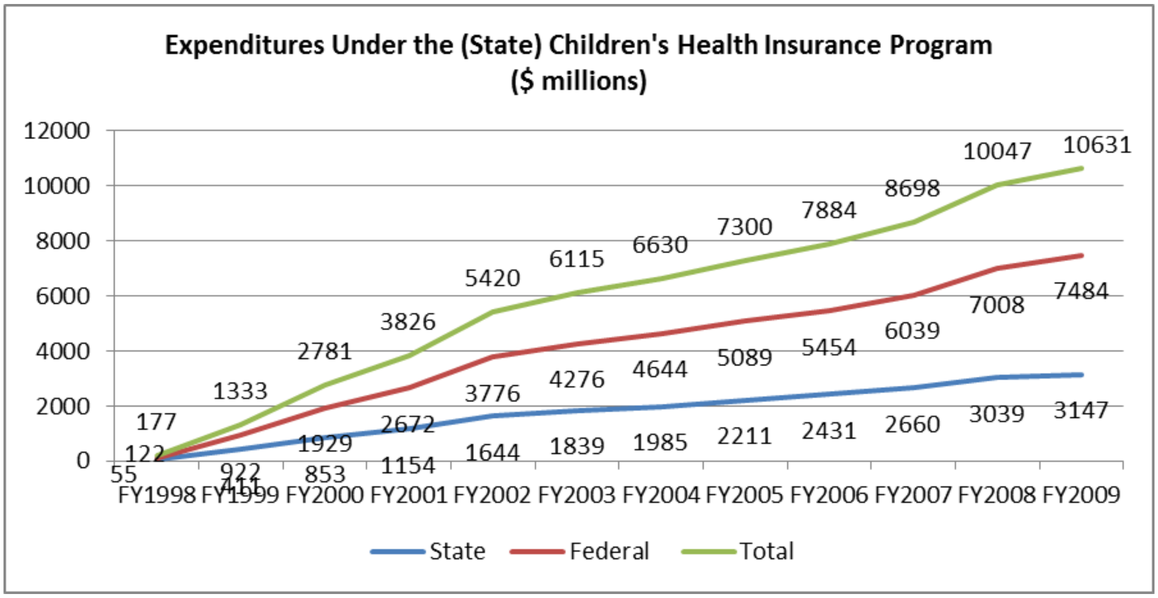
In contrast to establishing program policies aimed at increasing enrollment/retention among the program-eligible, states have also had to meet the challenges of containing program costs and ensuring that (S)CHIP enrollment—funded by state and federal dollars—is not substituted for private coverage among those with access to an (affordable) employer offer—that is, crowd-out.

This has not been an easy task. In some instances, states have taken the path of implementing an enrollment freeze. This has been very limited for Medicaid but for CHIP it reached seven states in July of 2004 and seventeen from 2003 to January 2011 (Heberlein et al. 2011, Table A, page 27).

States have also implemented a number of provisions designed to make it more difficult for families to drop private coverage in favor of Medicaid/CHIP enrollment. These include provisions such as requiring a period of uninsurance (a waiting period) before Medicaid/CHIP enrollment and implementing a lock-out period after a family has failed to pay Medicaid/CHIP premiums.

While implementing these policies, many states do recognize that the Medicaid/CHIP programs serve a particularly vulnerable population whose income and living circumstances can be subject to unpredictable and sometimes volatile fluctuations. As such, some states, for example, exclude certain low-income groups from the uninsurance waiting period and implement a grace period provision in

Figure 4: Expenditures Under the (State) Children's Health Insurance Program



Source*:* Centers for Medicare and Medicaid Services 2011.

Data for Fig. 4:

	FY1998	**FY1999**	**FY2000**	**FY2001**	**FY2002**	**FY2003**
State	54,697,382	411,369,675	852,595,347	1,154,185,797	1,644,134,410	1,838,893,286
Federal	121,824,487	921,779,016	1,928,813,382	2,671,629,729	3,776,225,221	4,276,446,614
Total	176,521,869	1,333,148,691	2,781,408,729	3,825,815,526	5,420,359,631	6,115,339,900
	FY2004	**FY2005**	**FY2006**	**FY2007**	**FY2008**	**FY2009**
State	1,985,313,257	2,210,994,559	2,430,646,010	2,659,535,528	3,038,512,514	3,146,869,445
Federal	4,644,490,670	5,089,144,622	5,453,682,860	6,038,524,568	7,008,011,446	7,484,292,627
Total	6,629,803,927	7,300,139,181	7,884,328,870	8,698,060,096	10,046,523,960	10,631,162,072

Source: KFF 2011b.

Table 4: Trends in Program Characteristics: Children

	July 1997	July 2000	July 2004	January 2008	January 2011
Number of children's coverage programs	51-Medicaid	51-Medicaid 32-CHIP	51-Medicaid 36-CHIP	51-Medicaid 37 CHIP	51-Medicaid 38-CHIP
Presumptive eligibility	Not available option	8-Medicaid 4-CHIP	8-Medicaid 6-CHIP	14-Medicaid 9-CHIP	16-Medicaid 10-CHIP
No face-to-face interview at enrollment	22	40-Medicaid 31-CHIP	45-Medicaid 33-CHIP	46-Medicaid 34-CHIP	49-Medicaid 37-CHIP
No face-to-face interview at renewal	Not collected	43-Medicaid 32-CHIP	48-Medicaid 35-CHIP	48-Medicaid 36-CHIP	50-Medicaid 37-CHIP
12 month continuous eligibility	Not available option	14-Medicaid 22-CHIP	15-Medicaid 21-CHIP	16-Medicaid 27-CHIP	23-Medicaid 28-CHIP

Source: Heberlein et al. 2011, table A, pages 26–27.

Table 5: Trends in Program Characteristics: Parents

	January 2002	July 2004	January 2008	January 2011
Number of parent coverage programs	51	51	51	51
No face-to-face interview at enrollment	35	36	40	44
No face-to-face interview at renewal	35	42	46	46
12 month eligibility	38	36	40	45

Source: Heberlein et al. 2011, table B, page 28.

combination with the lock-out period. Forty-one states implemented a waiting period that varied from one to twelve months; though of these, twelve states exempted certain very low-income groups from their waiting period; fifteen states permitted a buy-in option for children; five states started to charge premiums for optional groups under Medicaid; while thirty states charged for CHIP participants (of these the vast majority has some grace period though two did not); and fifteen of these states established lock-out periods if the premium was not paid (see Heberlein et al. 2011).

LITERATURE ON THE EFFECTIVENESS OF THE (STATE) CHILDREN'S HEALTH INSURANCE PROGRAM

Margo Rosenbach and colleagues (2007) find that (S)CHIP has been successful in "contributing to recent improvements in children's health insurance coverage, including substantial reductions in both the number and rate of uninsured children" (70). Based on analysis of data from the Current Population Survey (CPS) March supplement, the authors estimate that from 1997 to 2003 uninsurance among children fell from 11.7 to 9.9 million. This drop in uninsurance occurred among children below 250 percent FPL and occurred while adults (non-elderly) experienced an increase in uninsurance (by two percentage points). In further support of a targeted effect of the SCHIP program they find that over this same period, "low-income non-elderly adults had an even greater increase, at nearly three percentage points; and low-income parents of children under age nineteen had a four percentage point increase" (72).

A relatively large body of literature examines the effects of SCHIP enrollment on the utilization practices of program enrollees. In one recent example, Kenney (2007) finds improvement in likelihood of office visit, preventive care, dental care, and specialty care among children enrolled in SCHIP. Sherry Glied (2007) provides an informative discussion of this and related research. Laura Shone and colleagues (2005) document an SCHIP-associated decrease in disparities in care access and continuity among racial/ethnic groups.

Evidence suggests, however, that enrollment of CHIP-eligible children remains problematic. As of 2009, the national take-up rate among children eligible for Medicaid/CHIP was 84.8 percent. Lowest take-up was observed in Nevada and North Dakota (62.9 percent and 74.5 percent, respectively), and the highest take-up rates were observed in the District of Columbia and Massachusetts at 97.0 percent and 96.0 percent, respectively (KFF 2011a). Reaching the coverage-eligible and ensuring retention of the coverage-eligible remain challenging (see Sommers 2010 and 2007 for discussion of both of these issues).

According to the literature, disparities in access to care, including in particular specialty care, remain problematic. Improvements in access do not necessarily translate into a reduction in disparities across all important dimensions. For example, while Shone and colleagues (2005) document an SCHIP-associated decrease in racial disparities along the dimension of access and improvements in care quality irrespective of race and ethnicity, they find that racial and ethnic disparities in care quality persist withstanding these improvements.

A study by Joanna Bisgaier and Karin Rhodes (2011) examining differences in appointment scheduling by insurance status (private versus Medicaid-SCHIP) documented significant discrepancies in access to specialty services. Documenting the outcome of phone calls to 273 specialty clinics in Cook County, Illinois, where callers assumed the role of a mother wishing to schedule an outpatient specialty services appointment for her child, they observed significant differences in both the success of appointment scheduling and the number of days to appointment. Among the scheduling attempts where callers assumed the role of the mother of a Medicaid-CHIP covered child, 66 percent of all phone calls resulted in appointment denial. This figure was 11 percent for scheduling attempts where callers assumed the role of the mother of a privately insured child. The average wait time to appointment for clinics scheduling appointments under both scenarios (eighty-nine clinics) was twenty-two days greater for the Medicaid-SCHIP caller scenarios.

Similarly, an important consideration is whether or not SCHIP enrollees have access to the same managed care networks as the privately insured, or those enrolled in Medicaid. Marsha Gold and colleagues (2003), for example, collected information on plan decision to participate in Medicaid and/or SCHIP capitated coverage offerings. Of 109 plans interviewed in Arizona, Florida, Maryland, Michigan, Missouri, New York, New Jersey, Pennsylvania, Texas, Washington, and California (LA and Orange counties) in 2001, twenty-five plans offered Medicaid coverage only (seven offered SCHIP only).

Reasons cited by the twenty-five plans for not participating in SCHIP included “rates were too low” (four plans), “anticipated enrollment was too small” (three plans), “there was not an adequate provider network” (one plan), “SCHIP contract terms did not meet plan requirements” (three plans), and “SCHIP product did not fit into the company’s strategy” (four plans).

Finally, states continue to combat budgetary challenges associated with crowd-out of private insurance and expansion of the populations served by CHIP and other public programs (particularly in a weak economy). Wisconsin’s successful application for a waiver from the federal government to implement a number of changes to the BadgerCare program with a July 1, 2012, effective date, including changes in eligibility standards and premium requirements for certain categories of children and adults, illustrates the very real tensions between meeting the needs of vulnerable populations, targeting programs effectively, and balancing budgets.[5]

Overall, the (State) Children’s Health Insurance Program has been an important piece of the U.S. health system. While there have been important strides in access to coverage for low-income children under this program, there are still many components of the program that might benefit from careful evaluation and targeted improvements.

NEIGHBORHOOD HEALTH CENTERS

Neighborhood health centers (NHCs), which take a supply-centered approach to providing increased access to health care among low-income populations, was another major component of the War on Poverty. Now known as community health centers (CHCs), NHCs were created in 1965 by the Johnson administration to provide health and social services access points in poor and medically underserved communities and to promote community empowerment. By the early 1970s, about 100 health centers had been established to provide accessible, dignified personal health care to low-income families. Community health centers provide family-oriented primary and preventative health care services

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[5] See http://www.dhs.wisconsin.gov/em/ops-memos/2012/pdf/12-25.pdf.

in all fifty states, the District of Columbia, and the territories and commonwealths. Health centers serve populations with limited access to health care, including low-income populations, the uninsured, those with limited English proficiency, migrant and seasonal farmworkers, the homeless, and those living in public housing. CHCs are unique among primary care providers for the array of enabling services they offer, including case management, translation, outreach, eligibility assistance, and health education.

Since 1996, health centers have been redefined and include public and nonprofit community-based health care organizations defined within the Public Health Service Act. Administratively, CHCs fall within the Department of Health and Human Services, under the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC). In 2010, health centers served 19.5 million patients. CHC patients are primarily low income, with 92.8 percent of patients at or below 200 percent of FPL and 71.8 percent at or below the FPL; 37.5 percent of patients were uninsured; 38.5 percent were Medicaid recipients; and 7.5 percent were Medicare recipients. Health center patients tend to be relatively young (93 percent under the age of sixty-five); 27.9 percent of patients were women between the ages of fifteen and forty-four; and 22.7 percent were pediatric patients under the age of twelve, creating a high demand for obstetric/gynecologic, family practice, and pediatric services.[6]

Official Designation

Community health centers must meet specific program requirements found in Section 330 of the Public Health Services Act,[7] which entitle them to "cost-based" reimbursement through Medicare and Medicaid. Based upon a recommendation from the BPHC, health centers are also classified by the Centers for Medicare and Medicaid Services (CMS) into Federally Qualified Health Centers (FQHCs), which account for approximately 90 percent of health center programs, and FQHC Look-Alike Health

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[6] Data available online at http://bphc.hrsa.gov/uds/view.aspx?year=2010.

[7] For official recognition, centers must be located in a federally designated high-need and underserved area; centers accept all patients, regardless of insurance status, and provide either free care or fee-for-service care that is adjusted based on ability to pay; and centers are required to provide a defined set of primary health care services.

Centers (“Look-Alikes”), constituting the remaining 10 percent. While both FQHCs and Look-Alikes offer similar services and both are eligible to receive cost-based reimbursement from Medicare and Medicaid and are eligible to participate in the 340B pharmaceutical program, there are differences. Only FQHCs receive federal grant support from Section 330 and only FQHCs have access to malpractice coverage through the Federal Tort Claims Act.

Whether designated as an FQHC or as a Look-Alike, health centers may be further subdivided into specific categories representative of the populations served: (1) community health centers including urban, rural, and school-based sites; (2) migrant health centers, which care for seasonal workers and their families; (3) homeless program centers, which provide both outreach and on-site services to homeless populations; and (4) public housing-based centers, which provide care for resident families of those housing facilities.

Currently, health center budgets consist of a variety of funding sources including federal grants (Section 330 funds); Medicaid and Medicare reimbursement; state, local, and private grants; and donations. Federal grants represent about a quarter of overall CHC revenue, while state and local grants make up an additional 12 percent, and Medicaid and Medicare reimbursements represent 37 percent and 6 percent of funding, respectively. In order to receive federal Section 330 funds, a center must satisfy several statutory requirements: (1) be located in a federally designated medically underserved area or serve a federally designated medically underserved population; (2) have nonprofit, public, or tax exempt status; (3) provide comprehensive primary health care services, referrals, and other services needed to facilitate access to care, such as case management, translation, and transportation; (4) have a governing board, the majority of whose members are patients of the health center; and (5) provide services to all in the service area regardless of ability to pay and offer a sliding fee schedule that adjusts according to family income.

Over the course of the program's evolution, several adjustments have been made to health center reimbursements. In 1989, the Federal Qualified Health Center (FQHC) program was created in response to concerns that funds intended to support care for the uninsured were subsidizing low Medicaid rates.[8] The FQHC program established a preferential payment policy for health centers, requiring cost-based reimbursement for both Medicaid and Medicare. In response to concerns about potential disincentives to control costs, Congress passed a law to begin phaseout of cost-based Medicaid reimbursement rates in 1997. However, in response to advocates' protests of the phaseout, Congress created a prospective payment system for Medicaid in 2001.[9]

The federal 330 grant program has grown significantly in terms of both grantees and funds since funding was approved for the first two neighborhood health centers in 1965. By the early 1970s, about 100 NHCs had been established. In 2003 this number had grown to 890 federally funded health center grantees (providing care to over 12.4 million patients), and by 2010 there were 1,124 grantees (providing care to 19.5 million patients).

There is an extensive literature on community health centers, reaching back to the 1970s. Evaluations of CHCs on measures of quality of care, improving access, reducing disparities, and cost-effectiveness are overwhelmingly favorable. CHCs are credited with reducing the nationwide infant mortality rate, as well as the incidence of low birth weight (Goldman and Grossman 1982). A higher proportion of Hispanic, African-American, and poor women using health centers are up to date on cancer

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[8] The FQHC program was enacted under the Omnibus Budget Reconciliation Act of 1989 (ORBA 89) and expanded under the Omnibus Budget Reconciliation Act of 1990 (OBRA 90). They establish cost-based reimbursement under Medicare and Medicaid for legislatively specified services. The original CHC/MHC programs provided federal grants to community health centers (CHCs) or migrant health centers (MHCs) for the care of uninsured individuals. These facilities received no special Medicare or Medicaid payments. The FQHC program changed this, enabling grant dollars intended for the uninsured to be payable to CHCs. In order to extend the CHC/MHC concept, Congress also authorized the special Medicare and Medicaid payments for clinics that operate in compliance with the requirements of the FQHC program, but that do not receive grant funding under Section 330 of the PHS Act. These clinics are commonly known as "Look-Alikes."

[9] The Benefits Improvement and Protection Act of 2000 (BIPA) modified the way state Medicaid programs reimburse clinics, from a retroactive cost-based reimbursement, to a pay-per-service (PPS) methodology based on the historical reasonable costs of the center. This PPS methodology varies by state and the payment rate may be clinic-specific.

screening than comparable women not using health centers (Dor et al. 2008). Reviews of Medicaid claims have shown FQHCs have the highest proportion of pediatric patients who have received preventative services (Stuart et al. 1995), and FQHC patients have the lowest rate of ambulatory care sensitive hospitalizations (Reynolds and Javorek 1995). CHC patients are lower cost than comparable patients with other providers. More than half the cost reductions are thought to result from reduced inpatient care (Duggar et al. 1994). CHC Medicaid patients have lower hospitalization rates and fewer per patient annual hospital days (U.S. DHHS 1981; Freeman et al. 1982).

A 2000 Institute of Medicine (IOM) report identified increasing demand for care by the uninsured and uncertain public support as the primary challenges faced by safety net providers. Federal health center funding has not kept pace with the costs of care. The number of health centers has greatly expanded, along with the number of (uninsured) patients served. Meanwhile, between 1985 and 2006, real per capita health center appropriations steadily decreased (KFF 2011b).

The Affordable Care Act includes a number of provisions that will affect community health centers. The ACA allocates $11 billion for broad health center expansion over five years, with the ultimate goal of increasing the number of patients served. In addition, $1.5 billion is appropriated for the National Health Service Corps, which is a source of staffing for many health centers (see below). The planned Medicaid expansions to all individuals below 133 percent of the federal poverty level, along with the creation of health insurance exchanges, will have a major impact on the insurance status of CHC patients. Finally, the current Medicare payment cap will be eliminated, and a Medicare prospective payment system for CHCs will be developed.

Despite the ACA’s investment in community health centers, there are a number of concerns that will need to be addressed moving forward. First, health centers have struggled with recruiting and retaining health professionals since their inception, and CHCs are finding it increasingly difficult to keep up with 7 percent growth in medical visits, 36 percent growth in dental visits, and 76 percent growth in mental health visits (National Association of Community Health Centers [NACHC] 2008). Funded-staff vacancies are common in CHCs, particularly those in rural areas. The average CHC has 13.3 percent of its family physician FTEs unfilled. One-third of rural grantees have been recruiting for a family physician for over seven months, and one-half of rural grantees have been recruiting for a dentist for over seven months (Rosenblatt 2006). FQHC grantees rely on workforce programs, such as the NHSC and J-1 visa waivers. Further, 37.6 percent of rural CHCs have physician staff who are international medical graduates and 32.6 percent of rural dentists are either previous recipients of NHSC scholarships or are currently receiving loan repayment from state or federal governments (Rosenblatt 2006). The ACA includes $1.5 million in funding for NHSC program expansions, but it is not clear that the supply of medical professionals will be able to keep pace with planned health center expansions. The fact that so many health centers currently have funded vacancies would seem to be a hurdle for policy goals directed towards enhancing the capacity of existing sites (increased hours, broader range of services) while adding new health center grantees. Under the ACA, it is anticipated that service capacity will reach up to 44 million patients by 2015 and up to 50 million patients in 2019 (Ku et al. 2010). This represents a huge increase from the 19.5 million patients served in 2012. Health centers currently need 1,843 primary care providers and 1,384 nurses. In order to reach 30 million patients by 2015, it is estimated that health centers would need at least an additional 15,585 primary care providers (inclusive of physicians, nurse practitioners, physician assistants, and certified midwives) along with another 11,553 to 14,397 nurses (NACHC 2008).

Additional efforts will need to be made to recruit individuals to service in these areas. Such efforts may include exposing more students to these care environments while they are still in medical school and additional increases to NHSC funding. While NHSC participants often leave their initial placement at the conclusion of their service requirements, they are more likely to continue working in medically underserved areas, so this strategy may be viewed as more than just a short-term fix. In the past, health centers have relied on international medical graduates to address shortages in physician staff, but there is currently no such visa waiver program for dentists. Given the acute shortage of dentists willing to serve in these areas (26.7 percent vacancy rate across rural CHCs), it may be time to consider a similar program for international dental graduates willing to serve in underserved areas. (See IOM 2011 for more detail on oral health care for the poverty population and suggestions on ways to increase the supply of dentists to CHCs.)

Another concern is ensuring that health center patients have access to the full spectrum of care. Health center medical directors report major problems obtaining access to specialized medical and mental health services for uninsured patients and those covered by Medicaid. Given Nakela Cook and colleagues' (2007) finding that previous federal expansions of CHC sites "have not led to a substantial increase in the availability of many on-site specialty services, the problem of difficult access for services may increase if additional resources and planning are not devoted to assuring access to outside special services or bringing a greater array of services to CHCs." The Medicaid expansions and insurance exchanges outlined in the ACA will extend insurance coverage to far greater numbers of health center patients. However, if specialized medical and mental health providers are reluctant or unwilling to accept referred Medicaid patients, it is not clear that the extended coverage will lead to adequate access beyond primary care for this subgroup. CHCs affiliated with a medical school or hospital report greater access to specialty medical care (Cook et al. 2007). Establishing networks and referral arrangements may be the best option for ensuring that health center patients have access to the full spectrum of care.

The ACA recognizes the central role that community health centers have played as an access point for individuals in traditionally underserved areas, and makes a multi-faceted investment in health centers moving forward. Increased funding and expansions of the NHSC should increase service capacity, allowing community health centers to serve more patients and, ideally, offer a broader array of services. If the goals of more than doubling the number of patients served and providing access to the full spectrum of care are to be met, however, more work remains to be done. Efforts to recruit and retain qualified health professionals must be a priority. Moreover, establishing networks and referral arrangements will be necessary to guarantee access to specialized medical and mental health services. The current literature clearly documents that CHCs improve access and decrease disparities in the communities they serve, but no real effort has been made to assess what proportion of the target population has access to a community health center. This is a question that deserves attention as we move forward with plans to expand the number of grantees and service sites.

Programs Influencing the Supply of Providers

The National Health Service Corps was established in 1970 as part of the Emergency Health Personnel Act. The goal was to increase the availability of medical personnel to “medically underserved areas.” Basically the program offers financial assistance to medical school students and others in exchange for a promise to serve in underserved areas. There are two types of programs: one in which a student gets a full scholarship and for each year of scholarship must serve a year in an approved underserved site or two; and a program that reduces student loans, again tied to years of service in an underserved area. The initial program in 1970 was only a scholarship program; in 1987 the student loan program was initiated. From the beginning of the program through 1998 there were nearly 14,000 physicians and osteopaths enrolled. The Corps received $1.5 billion in funding from the 2010 health care reform law and the 2009 stimulus bill and was able to expand from 3,600 clinicians in 2008 to more than 10,000 in 2010. The student loan program is now the far larger program and expanding it goes part of the way to meet the new demands for medical care under new coverage of the ACA. This is especially the case for the anticipated expansion of CHCs, nearly all of which are qualified sites for persons covered by NHSC. The “fact” that physicians are not equally distributed makes sense from a market perspective (see Newhouse 1990); smaller areas have lower demand and thus offer far lower compensation. A similar argument applies to areas where many patients are not insured or are underinsured. The ACA creates a Fund for the Corps, which at the discretion of the Secretary of Health and Human Services can provide up to $1.5 billion over five years. The NHSC has established a new Students to Service Loan Repayment Program (S2S LRP) with part of this increased funding. The S2S LRP pilot awards $120,000 to fourth-year medical students entering their first year of residency (over four years) in exchange for three years of NHSC service. The ACA expands the benefits and flexibility of the scholarship and loan repayment programs including moving from a full-time practice requirement to permitting practice on a half-time basis (at double the number of years).

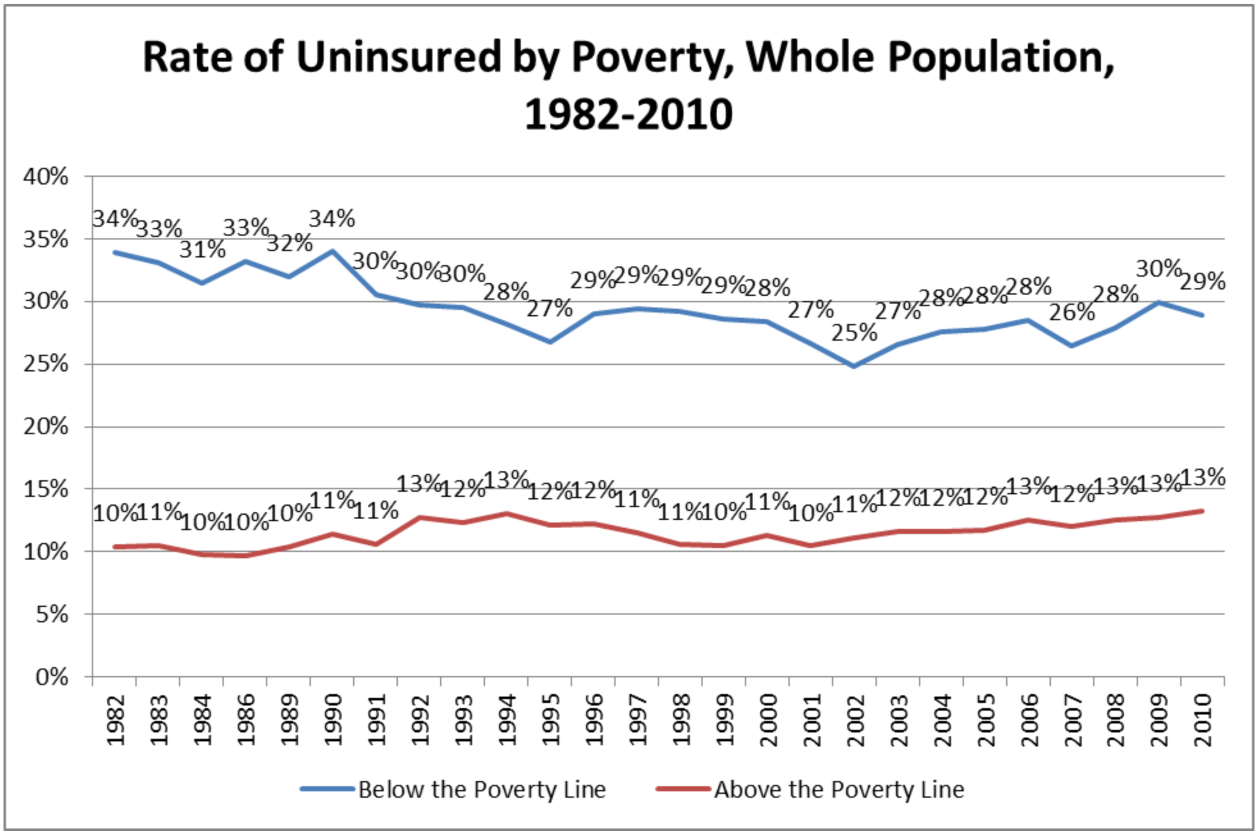
The ACA increases the maximum annual NHSC loan repayment amount from $35,000 to $50,000 and allows teaching to be considered as clinical practice for up to 20 percent of the period of obligated NHSC service. Today about 60 percent of the Corps serve in rural areas and 40 percent in inner-city areas; approximately 30,000 clinicians have been part of the Corps altogether.

Issues of concern toward the NHSC are whether they do in fact sufficiently increase the supply of medical providers to underserved areas: a primary concern is with retention. That is, are NHSC personnel likely to stay in service in the areas in which they meet their obligation or even move to other underserved areas or do they just spend their required time in these communities and then move on to other more affluent and less rural areas? Research has suggested mixed answers: medical personnel under the NHSR do not seem likely to stay in their initial area of service; George Holmes (2004) finds that they are more likely to serve in traditionally underserved areas, however, suggesting the Corps is a way to improve the distribution of medical personnel and increase access.

Have the Programs Improved Access and Health?

Perhaps the most direct indicator of the success of these War on Poverty programs is the proportion of the poor or low-income population who have health insurance coverage in the twenty-first century. According to Rosemary Stevens (1996), in 1965 just prior to the passage of Medicaid (and Medicare), more than 70 percent of the population had some form of coverage for hospital care, 67 percent has surgical insurance, but there was very little coverage for out of hospital care. Figure 5 below provides an overall picture on the proportion without coverage from 1982 onwards. Official records of the uninsured were not kept earlier; rather data were kept on numbers with policies and assumptions having to be made on overlap to estimate those without coverage. Christopher Conover (2012) subtracted the reported number insured from the non-institutionalized population and suggests that in 1960 slightly more than 25 percent of the population had no form of health insurance, which declined to under 15 percent in

Figure 5: Rate of Uninsured by Poverty, Whole Population, 1982 to 2010



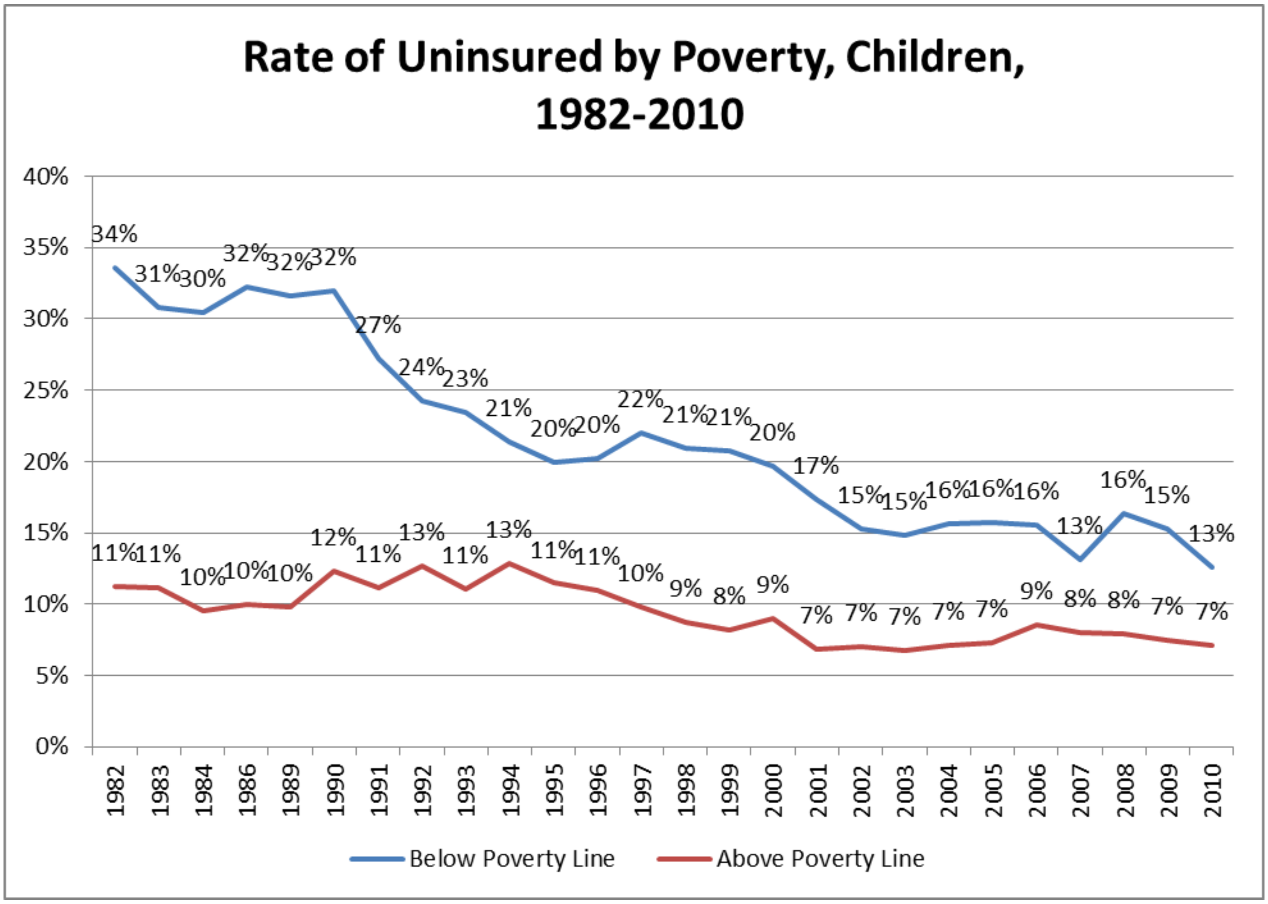
Source: Estimated using data from: Minnesota Population Center and State Health Access Data Assistance Center, ***Integrated Health Interview Series: Version 5.0.*** Minneapolis: University of Minnesota, 2012. Available at: **http://www.ihis.us.**

1970 following the introduction of Medicaid and Medicare and reached about 12 percent by 1980. But the proportion uninsured by income is not available.

In Figure 5, two things become clear: we still have many uninsured in this country, and proportion uninsured increase during periods of recession. In 1982, 34 percent of those living in families below the poverty line were uninsured as were 10 percent of those living in higher-income families. In 1987, 12.9 percent of the overall population was uninsured—the lowest rate over the entire period. But even then, more than 30 percent of the poor were not covered. In 2010, 16.3 percent of the overall population was uninsured, one of the highest percentages over the entire period; this included 29 percent of the poor and 13 percent of the nonpoor. Medicaid covered an increasing proportion of the population over this period: in 1987, 8.4 percent were covered by Medicaid, which increased steadily to the mid-1990s, when it reached 12.2 percent; then, after declining to 9.9 percent in 1999, the proportion has steadily increased, reaching 15.9 percent as of 2010 (U.S. Bureau of the Census, table C-1 2010).

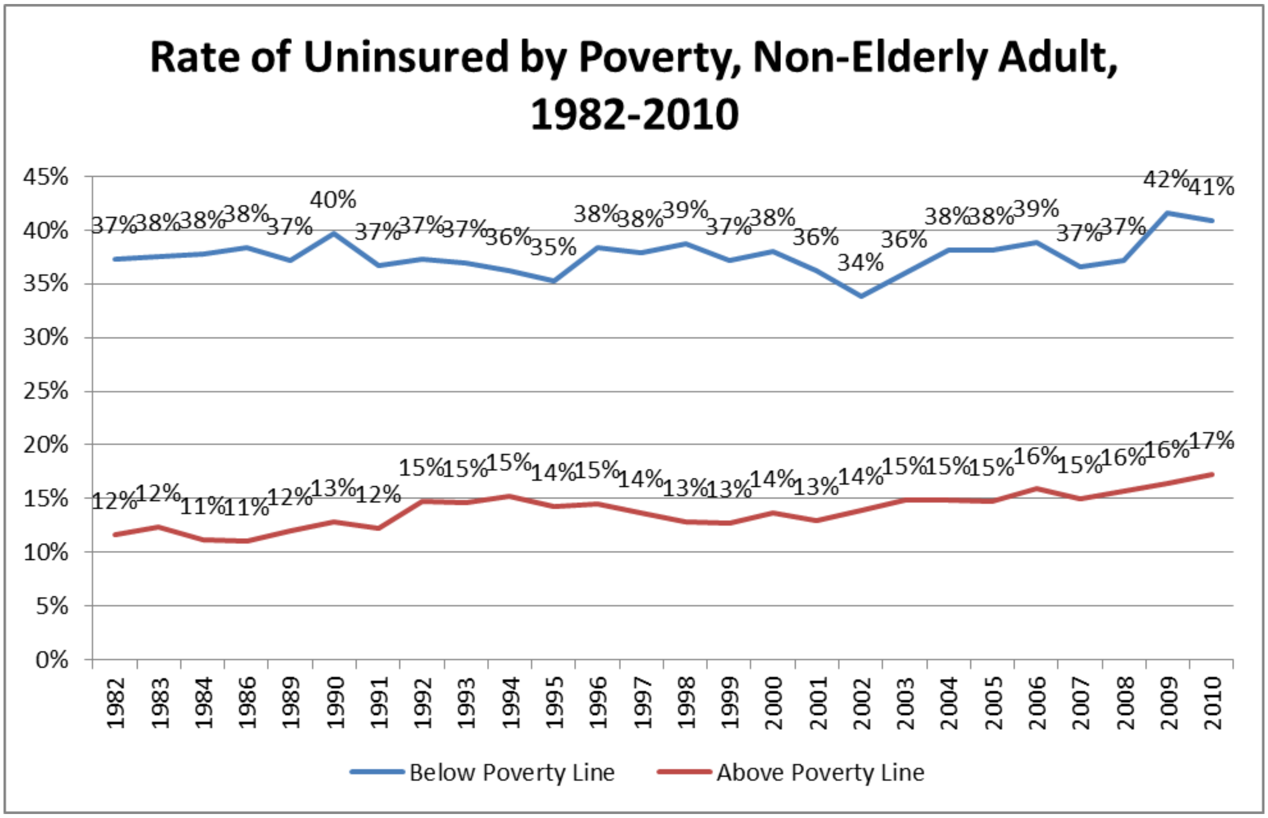
During this same period of time, from 1987 to 2010, private employer-based coverage decreased from 62.1 percent to 55.3 percent (ibid.). These overall numbers mask big differences by age. Figure 6 shows the rate of uninsured among children from 1982 onwards. The pattern here is quite impressive: over time a smaller and smaller percentage of children living in poor families are without coverage: in 1982 the percentage without coverage was 34 percent and since then it has steadily declined to 13 percent in 2010. The biggest declines are in the 1990s, when the tie between Medicaid and AFDC was broken, and in the period after SCHIP was passed and implemented. In contrast, the rate of uninsured among children in higher-income families was a much lower 11 percent in 1982, then increased through the 1990s before declining to 7 percent in about 2001. The latter likely also reflects the passage of SCHIP and its implementation. In contrast, Figure 7 shows the percentage uninsured among non-elderly adults. This pattern does not show improvement over the period; indeed, the percentage among the poor is higher in 2009 and 2010 than during any earlier period beginning in 1982. The rate for non-elderly adults in higher-income families also increased steadily throughout this period, beginning at 12 percent in 1982 and increasing to 17percent by 2010. The age breakdown then shows the success in terms of increasing

Figure 6: Rate of Uninsured by Poverty, Children, 1982–2010



Source: Estimated using data from: Minnesota Population Center and State Health Access Data Assistance Center, ***Integrated Health Interview Series: Version 5.0.*** Minneapolis: University of Minnesota, 2012. Available at: **http://www.ihis.us.**

Figure 7: Rate of Uninsured by Poverty, Non-Elderly Adult, 1982–2010



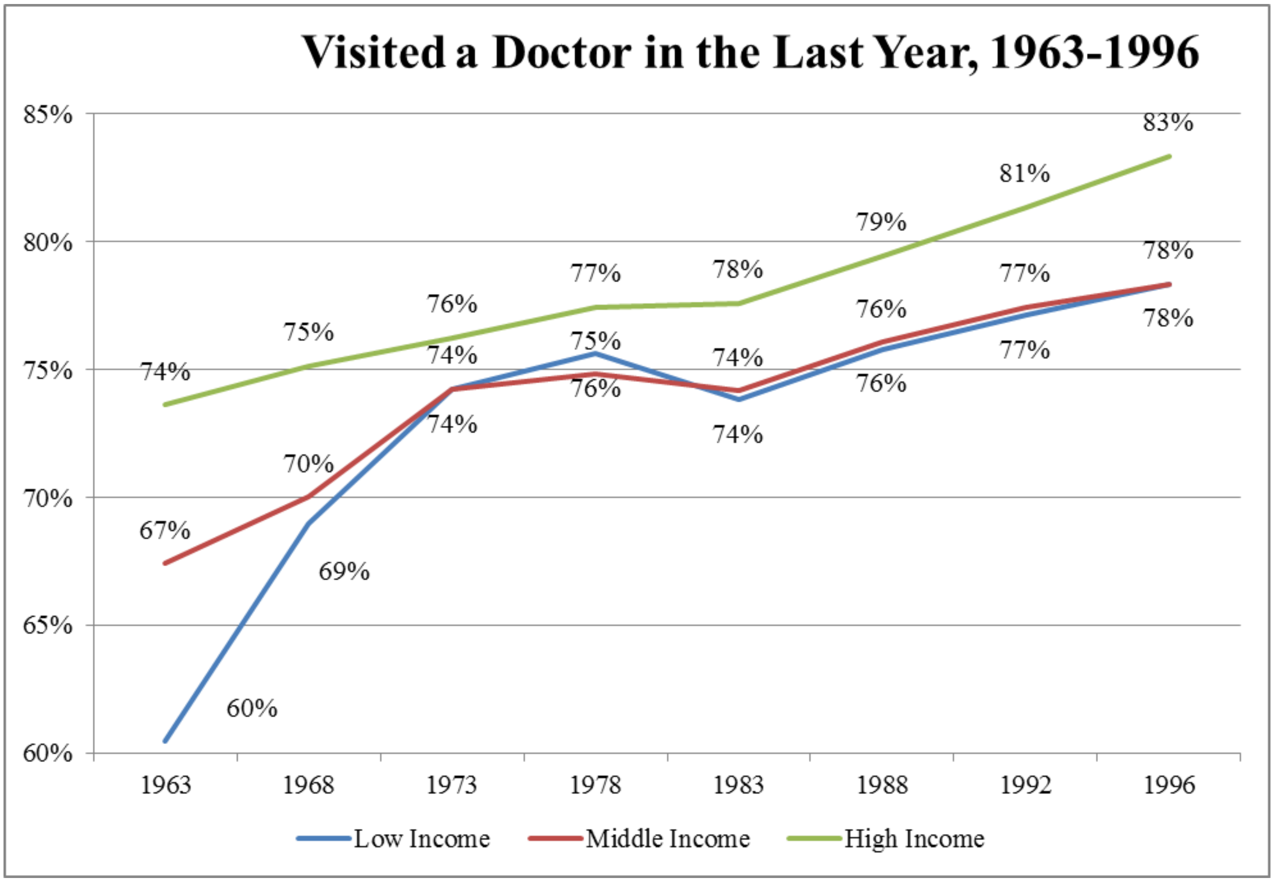
Source: Estimated using data from: Minnesota Population Center and State Health Access Data Assistance Center, ***Integrated Health Interview Series: Version 5.0.*** Minneapolis: University of Minnesota, 2012. Available at: **http://www.ihis.us**.

coverage among children (the targeted age group) compared to adults, who lost some private coverage and only gained limited eligibility for publicly provided programs such as Medicaid. As of 2010, less than 10 percent of all children (9.8 percent) under age eighteen were uninsured, with nearly 35 percent (34.8 percent) covered by Medicaid—the targeting of this group as discussed above was clearly successful in reducing the percentage of children without coverage (ibid., table C-3). In contrast, young adults have high rates of uninsured. As of 2010, 27.2 percent of those age eighteen to twenty-four were uninsured, as were 28.4 percent of those age twenty-five to thirty-four. Those in the next age group had higher rates of coverage: 21.8 percent for those age thirty-five to forty-four, 18 percent for those age forty-five to fifty-four, and 14.4 percent for those age fifty-five to sixty-four. Not surprisingly, those age sixty-five plus who are eligible for Medicare had the lowest percentage without coverage at 2 percent.

Of course the probability of being uninsured remains largely tied to income. Many low-income prime age adults either are not offered employer-based options or believe they cannot afford it. They may also recognize that in the event of a major episode of illness they would obtain publicly provided coverage. And many who are eligible for public coverage, especially children in low-income families, are not enrolled in either Medicaid or CHIP even though they are eligible. The data for 2010 show that 26.9 percent (or more than 16.1 million) families with incomes below $25,000 are not covered, nor are more than 15 million in families with income between $25,000 and $50,000, for a rate of 21.8 percent. In contrast, those with incomes over $75,000 have a rate of 8.0 percent (9.5 million) (ibid., table 8). Thus those with low incomes are much more likely to not have coverage even after the expansion of War on Poverty-tied programs. This is particularly true for working-age adults. There is strong empirical evidence of a link between insurance coverage and utilization of health care. Those with insurance use more care (controlling for health, age, and location) than those without coverage; those with more extensive coverage tend to use more care than those with more limited coverage (see, for example, Newhouse et al. 1993).

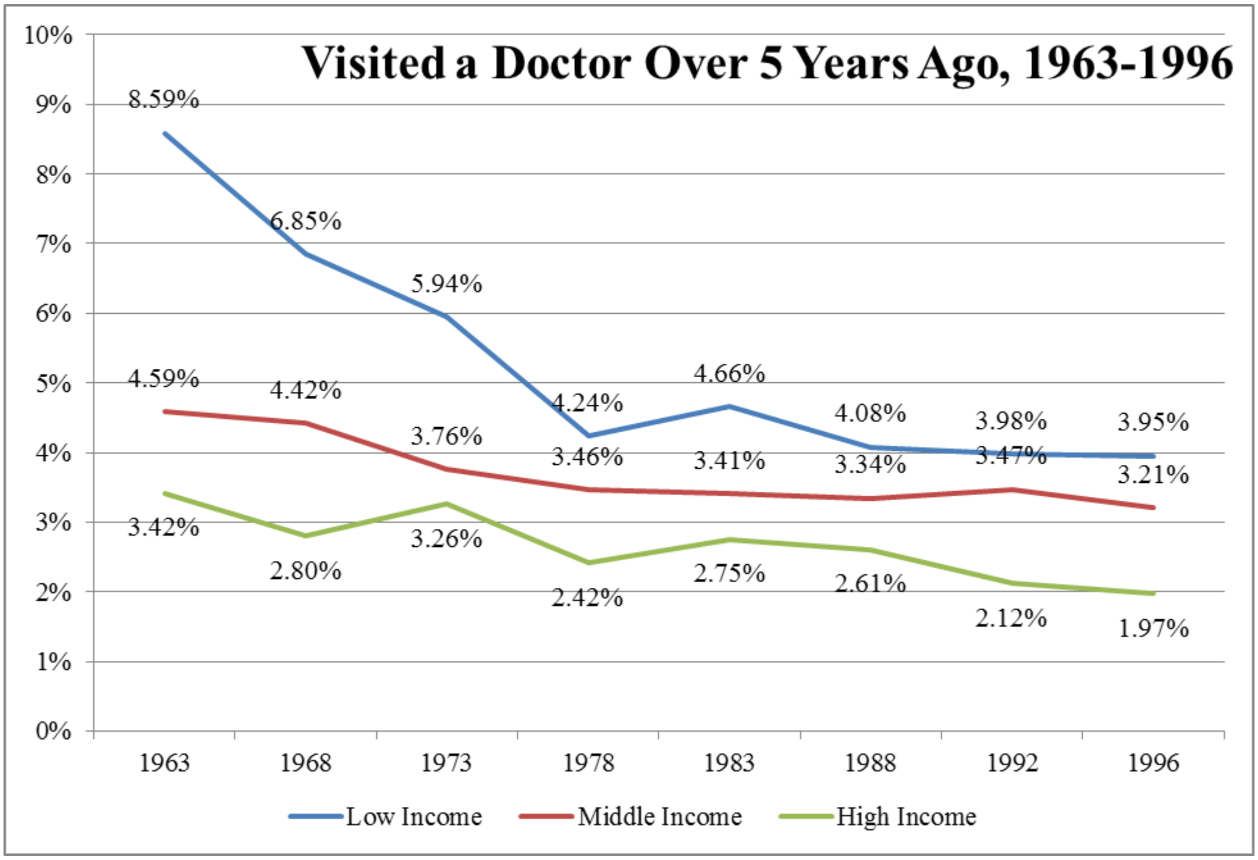
Coverage is one objective measure of the success of the War on Poverty medical programs, but it is also important to ask, did they increase and equalize utilization? Figures 8, 9, and 10 give us some

Figure 8: Visited a Doctor in the Last Year, 1963–1996



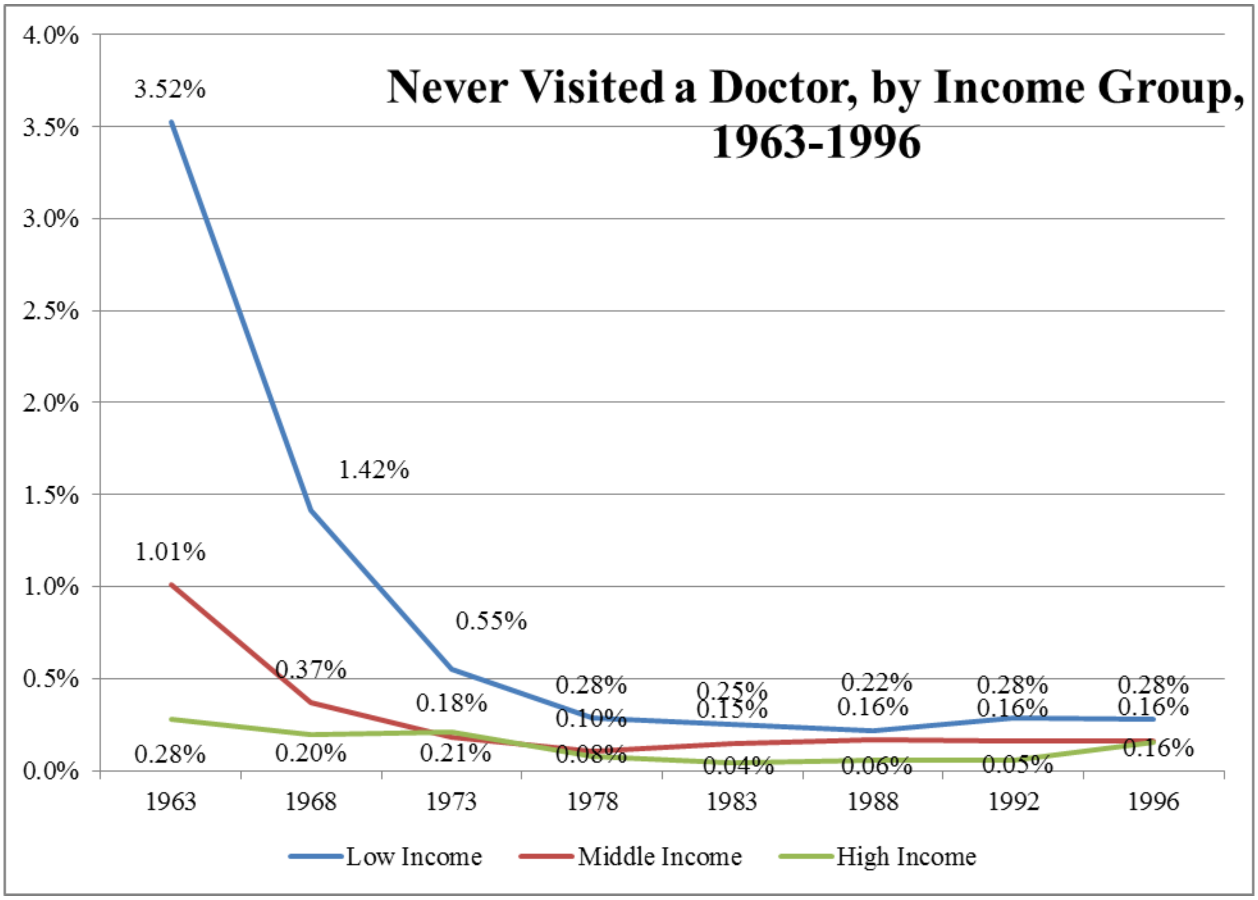
Source: Estimated using data from: Minnesota Population Center and State Health Access Data Assistance Center, ***Integrated Health Interview Series: Version 5.0.*** Minneapolis: University of Minnesota, 2012. Available at: **http://www.ihis.us**.

Figure 9: Visited a Doctor over Five Years Ago, 1963–1996



Source: Estimated using data from: Minnesota Population Center and State Health Access Data Assistance Center, ***Integrated Health Interview Series: Version 5.0.*** Minneapolis: University of Minnesota, 2012. Available at: **http://www.ihis.us**.

Figure 10: Never Visited a Doctor, by Income Group, 1963–1996



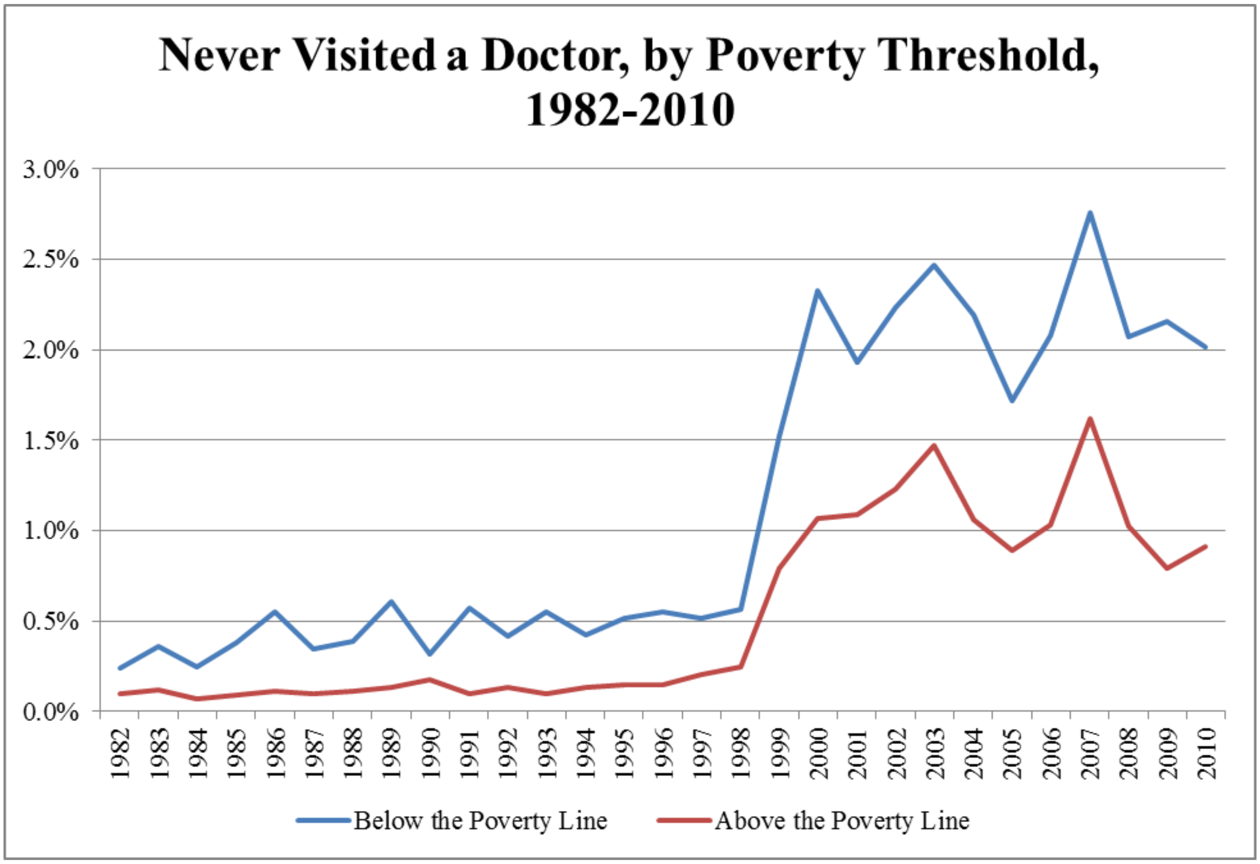
Source: Estimated using data from: Minnesota Population Center and State Health Access Data Assistance Center, ***Integrated Health Interview Series: Version 5.0.*** Minneapolis: University of Minnesota, 2012. Available at: **http://www.ihis.us**.

perspective on success using three utilization measures: (1) the percentage of the population by broad income categories who had a doctor visit in the last year; (2) the percentage who have not had a visit in more than five years; and (3) the percentage who report they never had a doctor visit. Turning to the first one, depicted in Figure 8, we see a dramatic improvement in utilization of medical care by those in low-income families. In 1963, only 60 percent of those living in low-income families had had a visit to a doctor in the last year. But others in the population also did not do well by this measure: 67 percent of moderate- or middle-income families had a visit, meaning that a third did not, while nearly three-quarters of those in high-income families had a visit, so that a quarter had no visit that year. Still, there were clear differences in this reported measure of access showing that the poor had less access.

But with the implementation of the War on Poverty access seems to have improved, especially for those in low-income families. The biggest increase was in the first years of the War on Poverty for those living in low-income families. By 1973, the rate of utilization was nearly identical for the low- and middle-income families by this measure. The second indicator, depicted in Figure 9, also suggests a reduction in the inequality in access and a substantial reduction of those whose last visit to a doctor was more than five years ago. But as of 1996, the last year of this series, the high-income group was about two percentage points below the low-income population. The next figure, 10, shows a very similar picture—the percentage by income who reported never having visited a doctor was quite unequal in 1963, but declined dramatically so that by ten years after the passage of the War on Poverty programs, only a very small percentage of the population reported never having seen a doctor, and these rates were only slightly higher among the low-income population.

These three indicators only go up to 1996 so we also want to ask what has happened more recently. For that we switch series to one that begins in 1982 and goes to 2010. Figure 11 showing the percentage who have never seen a doctor by poverty threshold shows the low percentage up through 1996, but then suddenly at the very end of the 1990s, this percentage increases for both the poor and nonpoor. It is low in 2010, but the percentage is double (2 percent) for the poor compared to the nonpoor. The increase is unexpected and troubling. A similar pattern is present in the graph showing the percentage

Figure 11: Never Visited a Doctor, by Poverty Threshold, 1982–2010



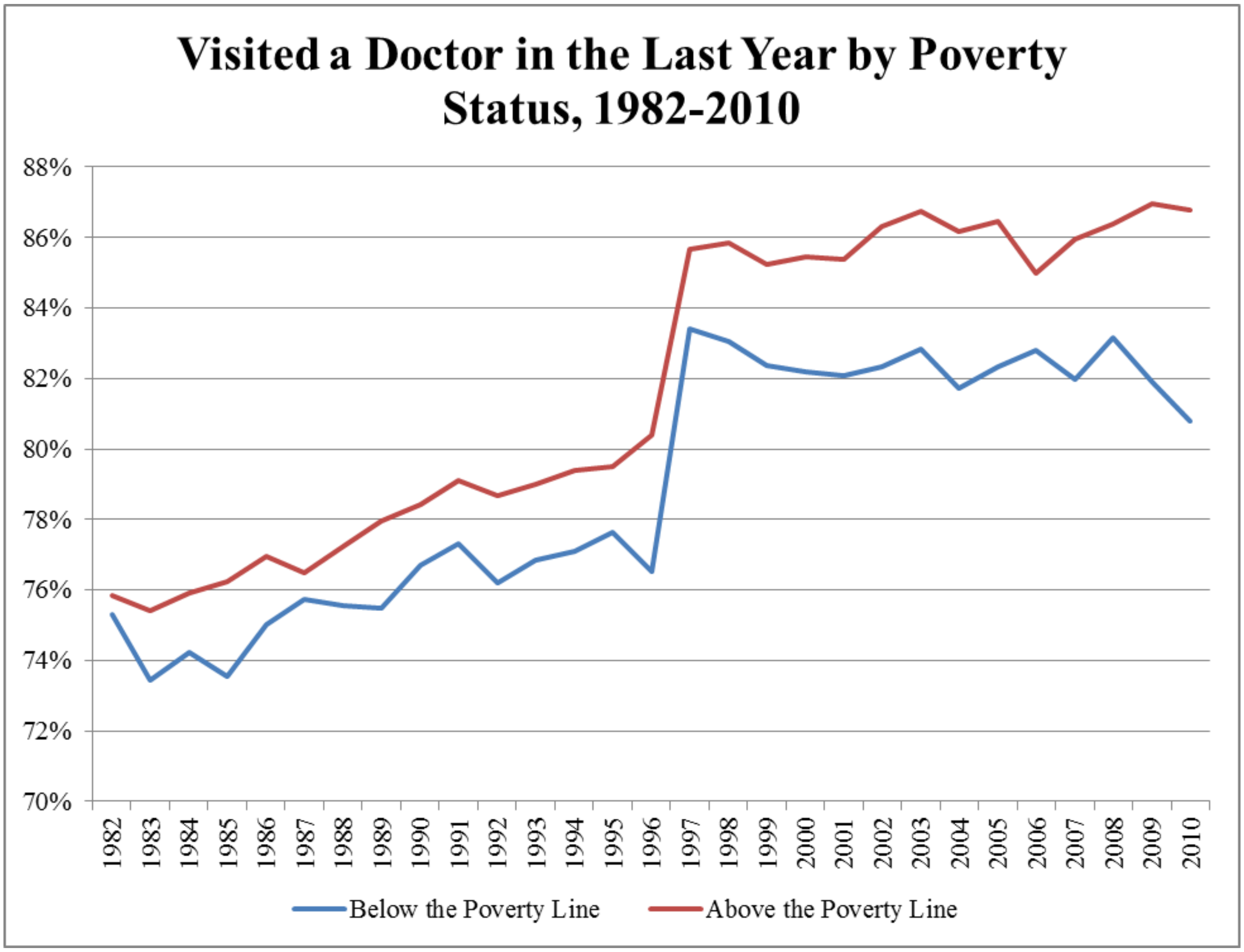
Source: Estimated using data from: Minnesota Population Center and State Health Access Data Assistance Center, ***Integrated Health Interview Series: Version 5.0.*** Minneapolis: University of Minnesota, 2012. Available at: **http://www.ihis.us**.

who visited a doctor in the last year from 1982 onwards, Figure 12. The proportion is increasing up though 1999 but then flat until about 2008, when this percentage decreases for the poor. Thus once again we see an increase in disparity comparing the two with a decline in access for the poor in the last three years.

Coverage and utilization are direct measures of success of these War on Poverty programs, but what about the core objective of improving and equalizing health? Our first measure is of infant mortality, depicted in Figure 13, and life expectancy, depicted in Figure 14, but these are available only by race so we mention them only briefly. By both measures, health has improved substantially overall, as we can see from the trend of decreasing twenty-eight-day infant mortality and increased life expectancy for both sexes and both races. And both figures show that in addition to improvements, the gaps have decreased across the races. This suggests that the War on Poverty programs may have reduced these gaps and led to improvements in health. But what about more direct measures by income?

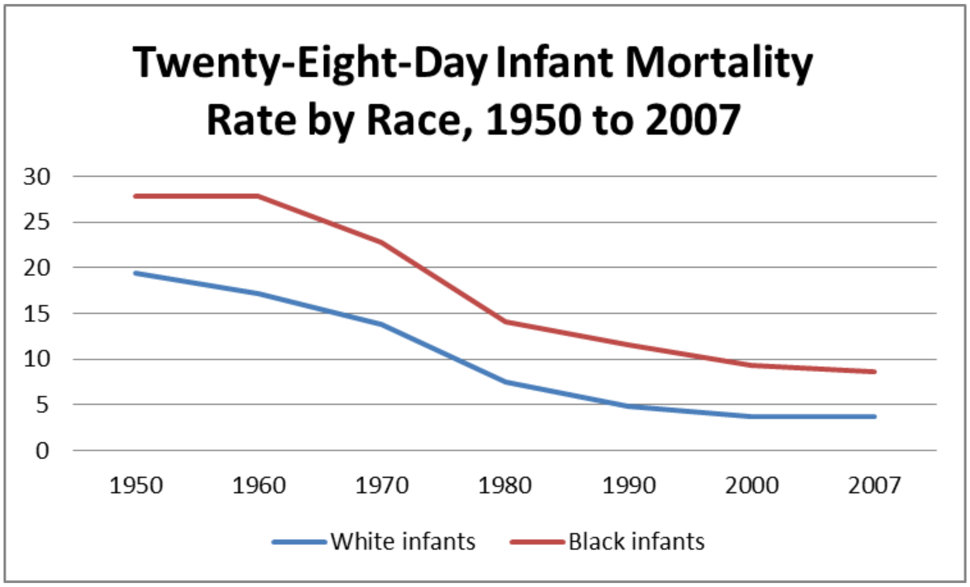
Data as of 1963, prior to the start of these programs, clearly show that health was unequally distributed. Among those in the lowest annual income group, less than $10,000, 14.7 percent reported having four or more conditions compared to 4.7 percent of those in the highest-income group (greater than $35,000.) This is a ratio of more than 3 (3.13). If instead we use another indicator of health that is available over this long span of time, the percentage that report being bedridden for fourteen or more days in the last year, that ratio comparing those with fourteen plus days is 1.8 percent compared to 0.7 percent or a ratio of 2.6. Twenty years later among those in the lowest-income group, a much lower 8.3 percent (versus 14.7 percent in 1963) reported having four or more conditions compared to 1.9 percent of those in the highest-income group (greater than $35,000). This is a ratio of more than 4, suggesting a somewhat complicated picture with absolute levels of health improving but inequality in health getting worse. Just prior to the start of the War on Poverty, 1.8 percent of the low-income group reported they had been bedridden for more than fourteen days, compared to about 7.5 percent for middle- and higher-income individuals. Over the first decade of the War on Poverty, this percentage declined dramatically for the low-income group, dropping to 1.3 percent before gradually increasing again.

Figure 12: Visited a Doctor in the Last Year, by Poverty Status, 1982–2010



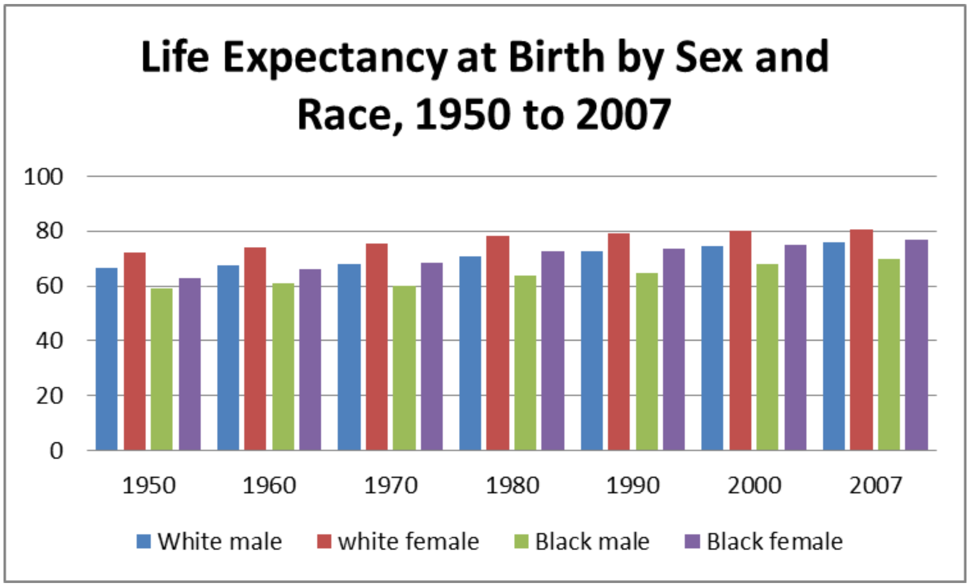
Source: Estimated using data from: Minnesota Population Center and State Health Access Data Assistance Center, ***Integrated Health Interview Series: Version 5.0.*** Minneapolis: University of Minnesota, 2012. Available at: **http://www.ihis.us**.

Figure 13: Twenty-Eight-Day Infant Mortality Rate by Race, 1950 to 2007



Source: *Health United States 2010*, table 17.

Figure 14: Life Expectancy at Birth by Sex and Race, 1950 to 2007

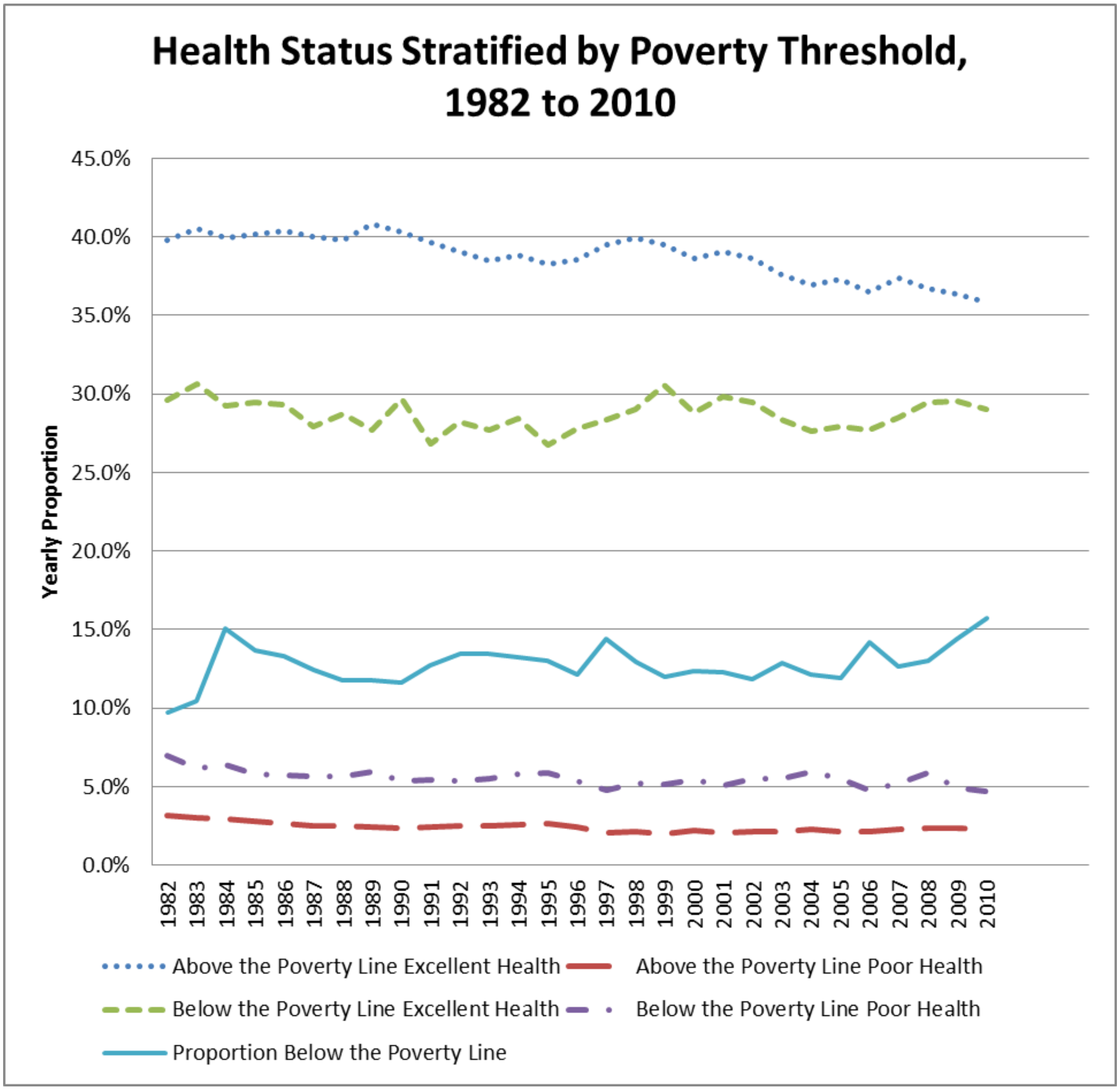


Source: *Health United States 2010*, table 22.

As of 1996, the last date for which we have this measure, 1.2 percent of the low-income population reported more than fourteen days bedridden—so by this measure, health clearly improved for the low-income population. Bedridden days also were improved among the other income groups [with 0.5 and 0.4 percent (middle and high income) reporting fourteen or more days by 1973] but here too the ratio shows greater inequality (going from a ratio of 2.5 low to high income in 1963 to 3.3 in 1973). So by both of these measures, absolute health improved among those with the lowest incomes but the gap in health compared to those with higher incomes increased. By 1996, (thirteen years later), and with changes in the categories marking income groups, the proportion of the lowest-income group reporting more than four conditions remained relatively constant (at 8.85 percent now), while again the proportion in the highest-income groups dropped slightly so that the relative ratio hit a high of nearly 5 (4.8); for those reporting fourteen or more days bedridden, health appears to have improved with “only” 1.2 percent of the lowest-income group reporting so many days bedridden compared to 0.2 percent of those in the highest-income group for a ratio of 6, again suggesting improved health but greater inequality in health.

From 1982 to 2010 we have reports of general health on a five-point scale. Figure 15 shows these proportions for those above and below the poverty line. In contrast to the two indicators we have that start prior to the War on Poverty, general health trends suggest less inequality over time but some deterioration of health among the higher-income group. The top line represents those whose incomes are above the poverty line and who have excellent health. That proportion is about 40 percent in 1982 but declined to nearly 35 percent by 2010. In contrast, the proportion of those with incomes below the poverty line is relatively steady over the entire period at about 30 percent. So by this indicator, health has become more equal, has been steady for those below the poverty line, but has deteriorated among the nonpoor. When we look at the other end of the scale, we see the proportion reporting poor health has declined slightly for both income groups with a gap that is slightly smaller in 2010 than in 1982. (The fifth line shows the proportion in poverty over this time period.)

Figure 15: Health Status Stratified by Poverty Threshold, 1982 to 2010



Source: Estimated using data from: Minnesota Population Center and State Health Access Data Assistance Center, ***Integrated Health Interview Series: Version 5.0.*** Minneapolis: University of Minnesota, 2012. Available at: **http://www.ihis.us**.

CONCLUSION

Just prior to the War on Poverty most health care was privately financed; few among the poverty population had hospital insurance, the dominant form of health insurance. The federal government subsidized the purchase of health insurance coverage as employee compensation via the tax system targeting the subsidy to the nonpoor. There were supply side public sector programs that provided subsidizes to institutions for providing care to the poor. The full set of these supply side programs increased from about 0.3 % of GDP to 1 % from 1929 to the 1970s. Utilization of health care was very unequal by all collected measures: nearly 4% of the low income but 1 % of middle and 0 of higher income had never seen a doctor; 9% of low income but less than 5 % of middle and higher incomes had their last doctor visit more than 5 years earlier and only 60% of the low income but 74 % of the high income had had at least one doctor visit last year, all as of 1963. The combination of limited health insurance and lower rates of utilization were accompanied by unequal health. The infant mortality rate differed considerably by income (and race) as did life expectancy (see evidence in text above).

If the war on poverty was to be successful in reducing poverty and providing a floor in terms of standard of living, clearly health was a vital part.

The core program to increase access to health care was Medicaid but it was initially targeted only on a limited group of people—low-income children in single parent families and their resident parent. Soon after implementation of Medicaid, low-income persons with disabilities were added; still many of the poor were not covered by Medicaid. States were free to set income thresholds for these children and parents but the core benefit package was set federally. States could also cover some additional groups but this still largely excluded adults without children (unless disabled.) Slowly coverage was expanded to additional children in low-income families and to pregnant women. The tie between cash assistance and eligibility for Medicaid was eliminated improving the potential for Medicaid to cover more of the targeted population of children in single parent households. Then a new program, the State Children's Health Insurance Program further expanded public insurance to low-income children and in some states their parents using an enhanced match; that is a greater contribution of the federal government to encourage states to both participate and expand eligibility. Still major differences in eligibility and take-up remain with inequality across states.

In terms of the goals of the Medicaid component of the War on Poverty, it is a success: the war on poverty has been won. More low-income children are covered; indeed the rate of coverage of children is higher than for all other groups of non-elderly. The combination of federal funding of the majority of the cost and the defining of a benefit package appears to have led to a great deal of success in coverage of the target group of low-income children. Indeed a far greater proportion of low-income children are covered—those in two-parent families—than were part of the initial design of the program. And these two-components, the defining of a benefit package and the federal government paying for the majority of the coverage, are part of the design of ACA. What was also a component of the success: establishing core groups, such as all pregnant women with family incomes below 133% of the FPL, that states were mandated to cover was part of the design of the ACA but was not upheld by the Supreme Court. This leads to concern that some states will not provide coverage to non-pregnant adults with incomes below the FPL leaving some individuals and couples without coverage and perpetuating the cross state inequality that exists for these groups currently. And that means that numerous citizens living below the poverty line may be left without coverage including parents in single-parent families, an initial target group of the Medicaid component of the War on Poverty.

The second major component of the medical component of the War on Poverty was establishment of neighborhood (now community) health centers. These are located in low-income and rural underserved areas with a goal of improving access to care. Evidence suggests that low-income persons in communities with a CHC indeed have access, at least to primary care, and that care that is available is both high quality and efficiently delivered. (Indeed these centers may be the key to providing access to care for in states that do not expand Medicaid to all those with incomes below the FPL.) Again, evidence suggests CHCs should be viewed as a successful part of the War on Poverty. In the case of CHCs, it took longer than anticipated to establish a sizeable number of them but today CHcs are viewed as part of the plan under the

ACA to provide care to those newly covered. A continuing issue with CHCs is staffing. The National Health Service Corp was established after the first few years of the War on Poverty to try to increase the supply of providers to CHCs and underserved areas more generally. The expansion of this program is another component of the ACA in its attempt to both increase coverage and access to medical care for those in lower income families. The issue of access to specialists including oral health providers has been far more difficult to accomplish.

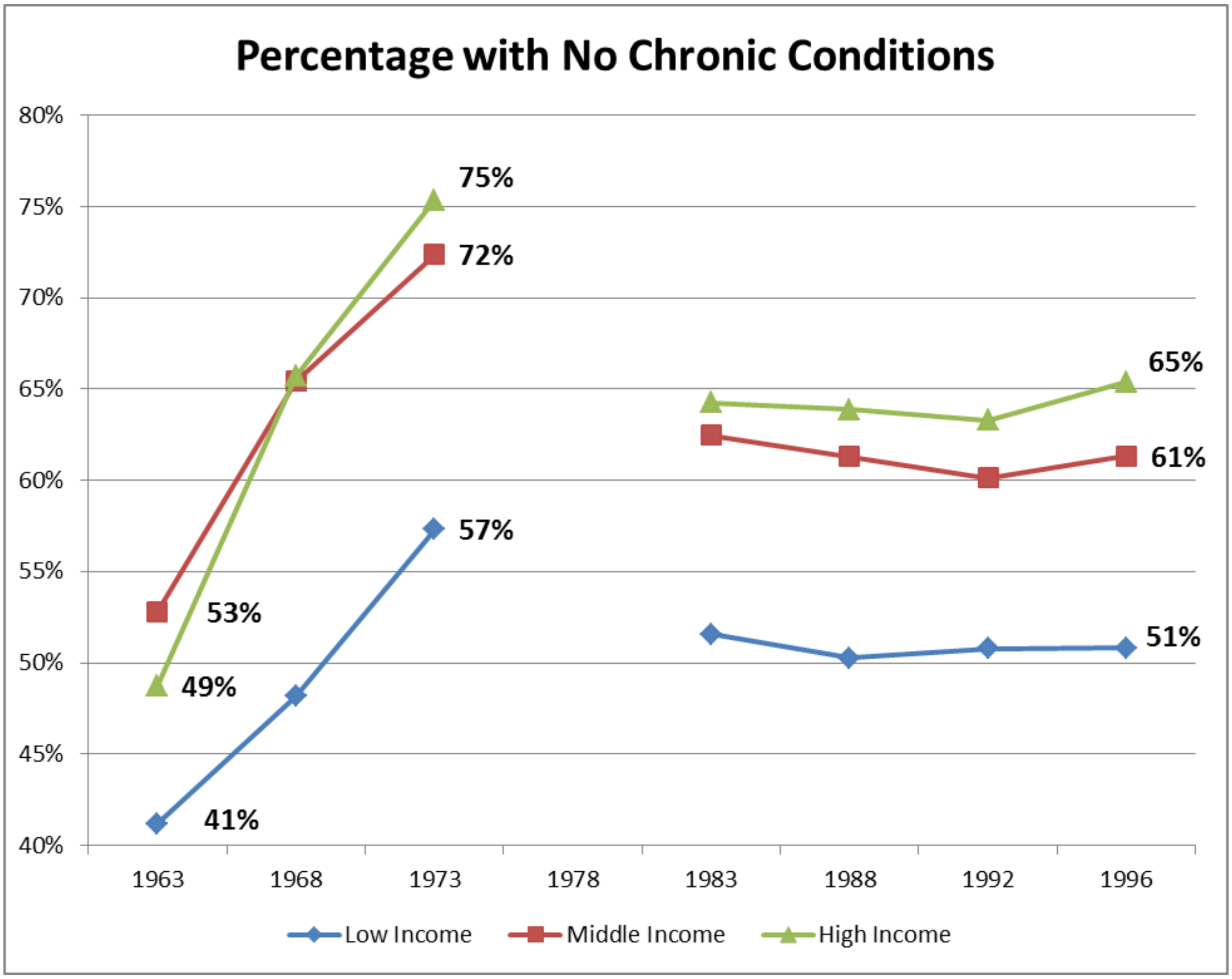
Major components of the ACA appear to be built upon the successful components of the Medicaid and CHC programs of the War on Poverty. And major additions of the ACA appear built upon the recognition of problems experiencing by these War on Poverty programs.

What is far more difficult to accomplish is reducing disparities in health, and disparities by income and other dimensions of SES continue to exist. This is discouraging as the ultimate purpose of health insurance and equalizing access to care is to improve health and reduce systematic disparities in health by socio-economic status. Some of the redesign of Medicaid (and CHIP), further pursued in ACA, removes disincentives to work, which may improve family incomes and hence health. But other components of the War on Poverty type programs including those tied to early childhood, education, training and making work pay (EITC for example) may all need to work together with health care programs to ultimately achieve greater equality in health.

APPENDIX

The following are Appendix figures, which are not called out in the text.

Estimated using data from: Minnesota Population Center and State Health Access Data Assistance Center, *Integrated Health Interview Series: Version 5.0.* Minneapolis: University of Minnesota, 2012. **http://www.ihis.us**



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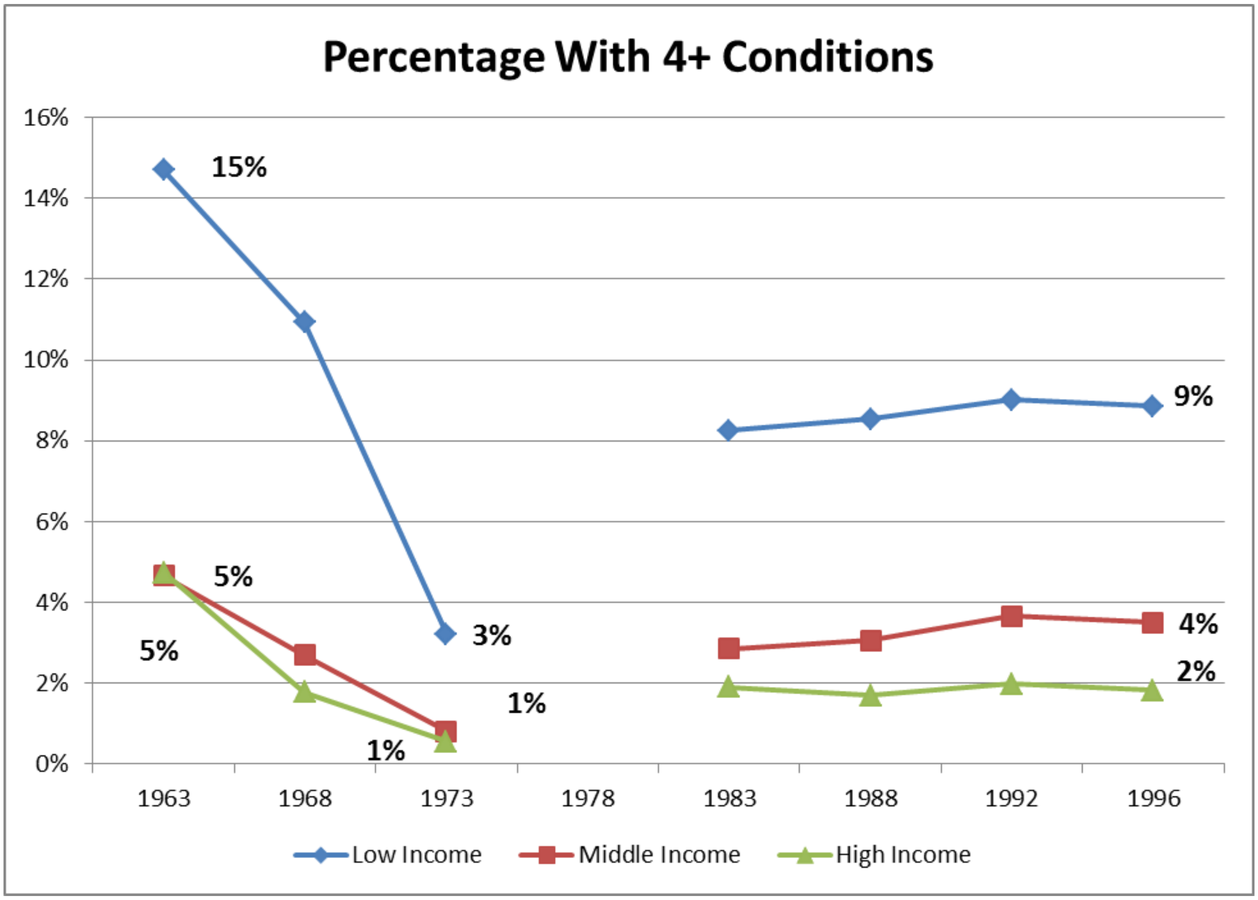

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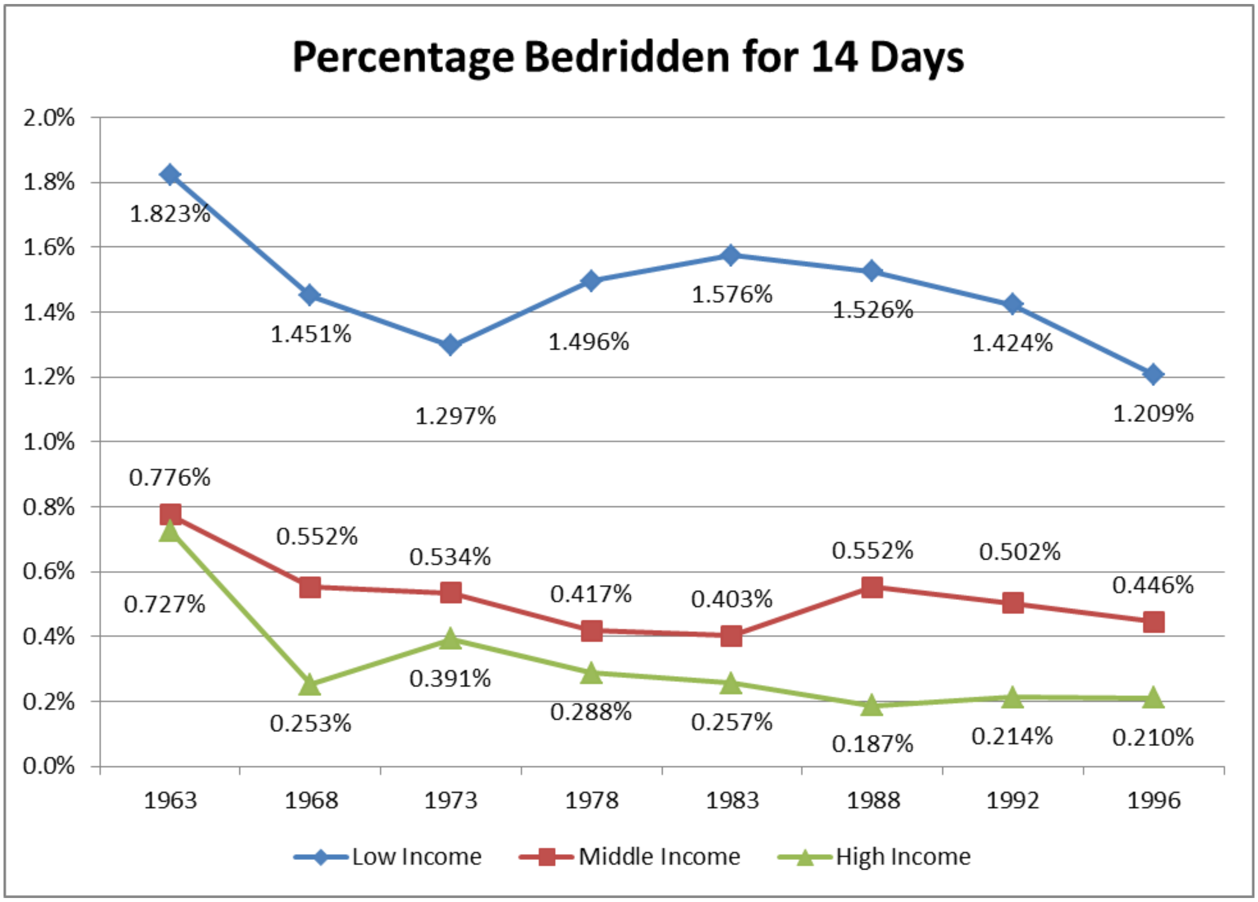

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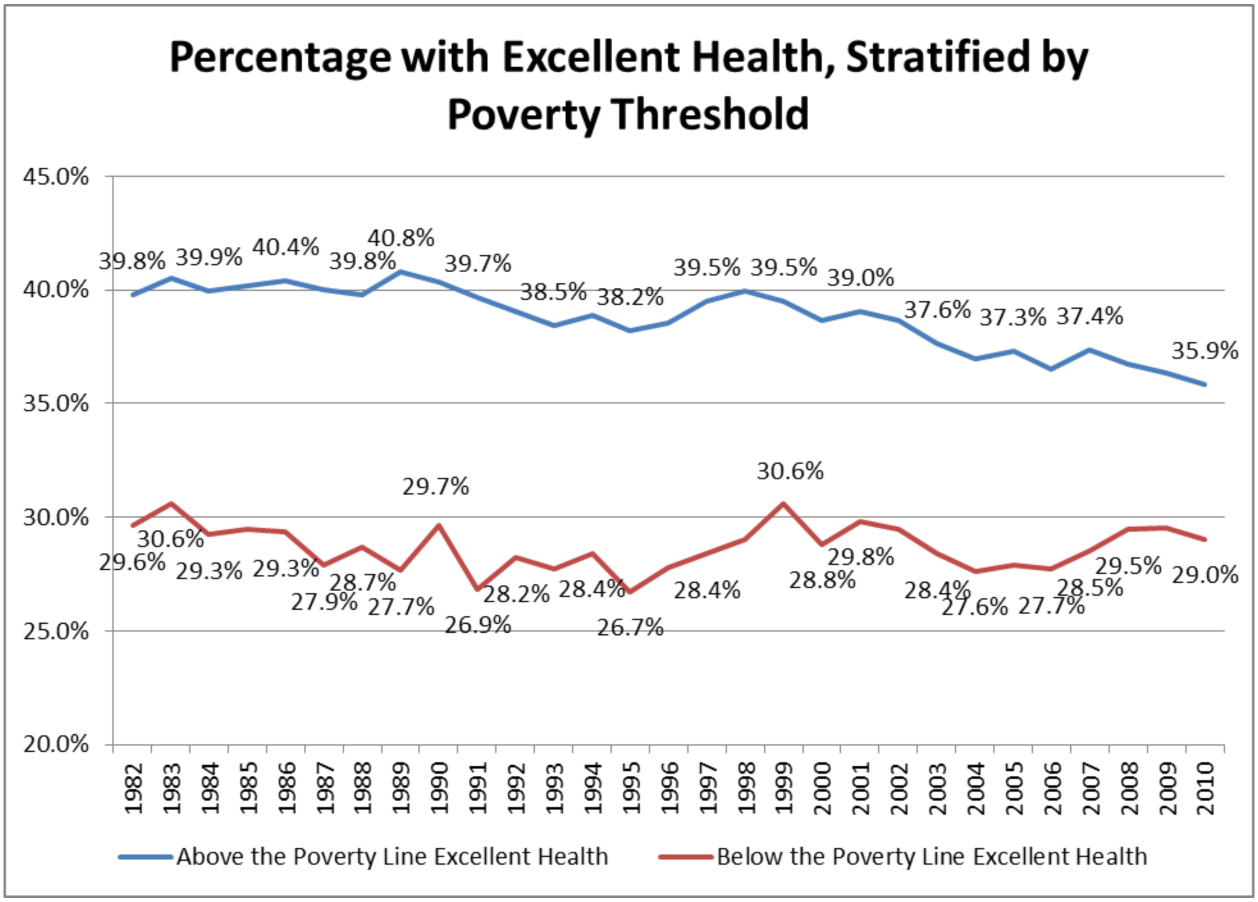

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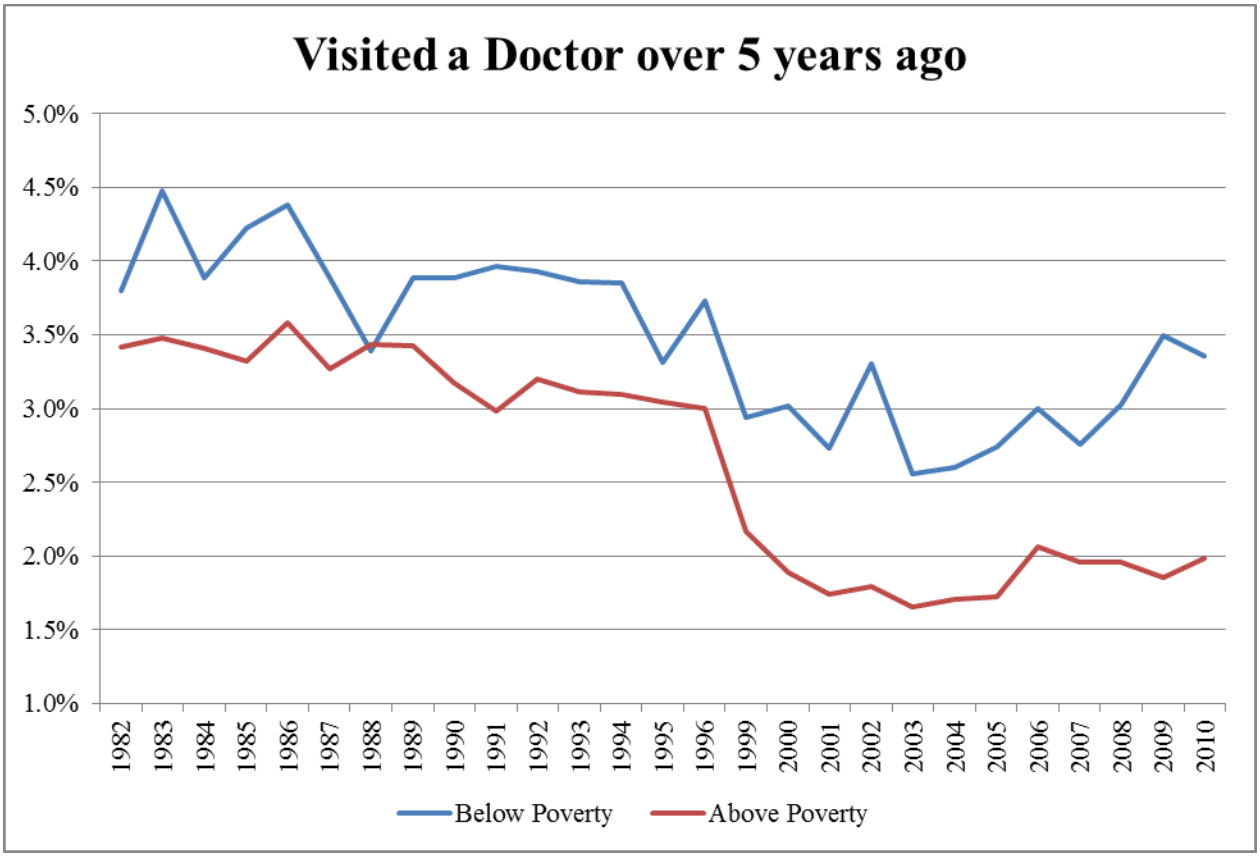

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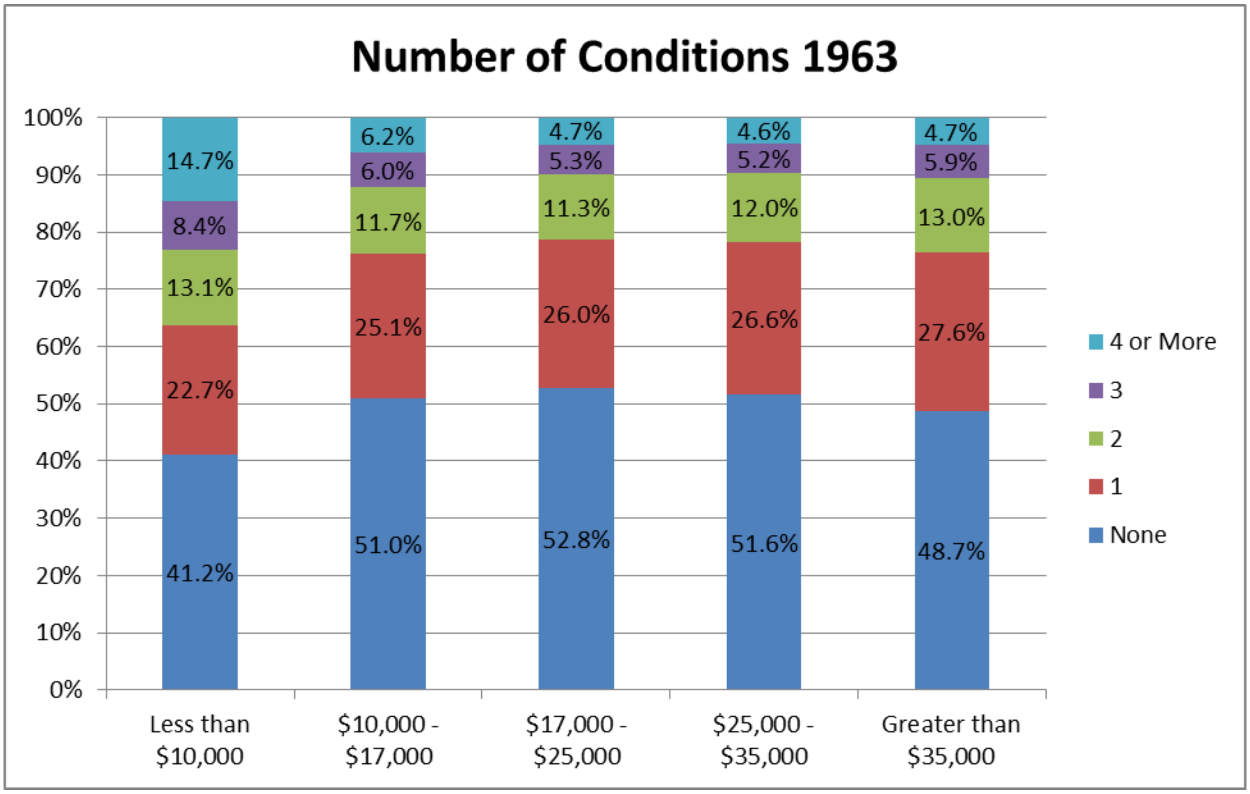
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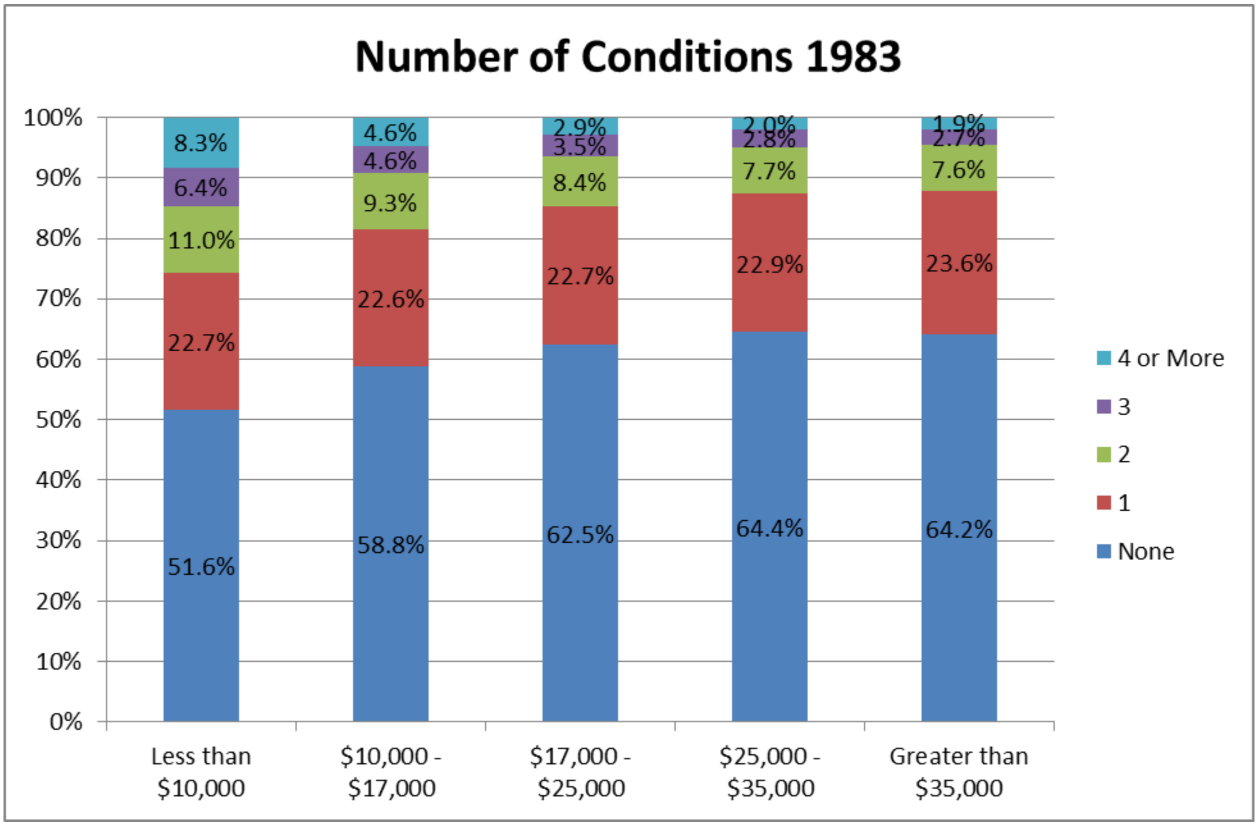
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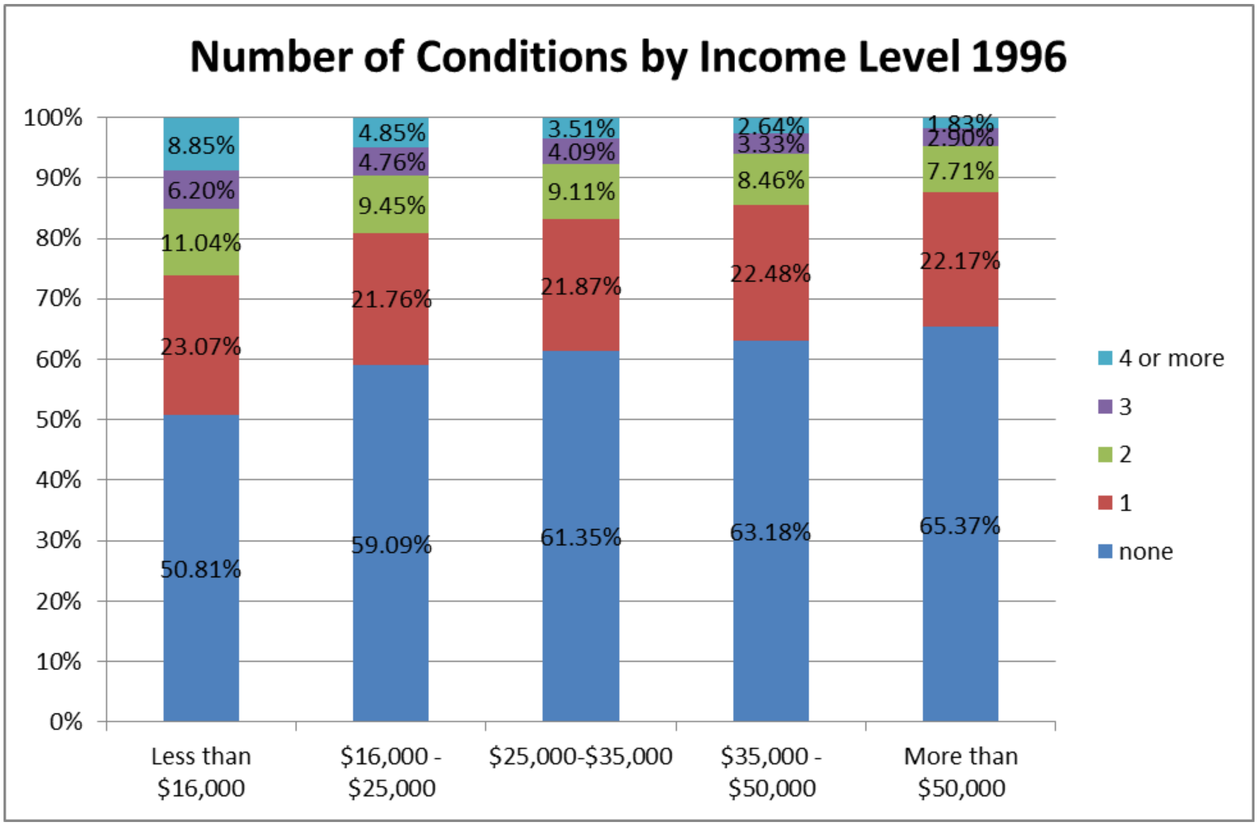
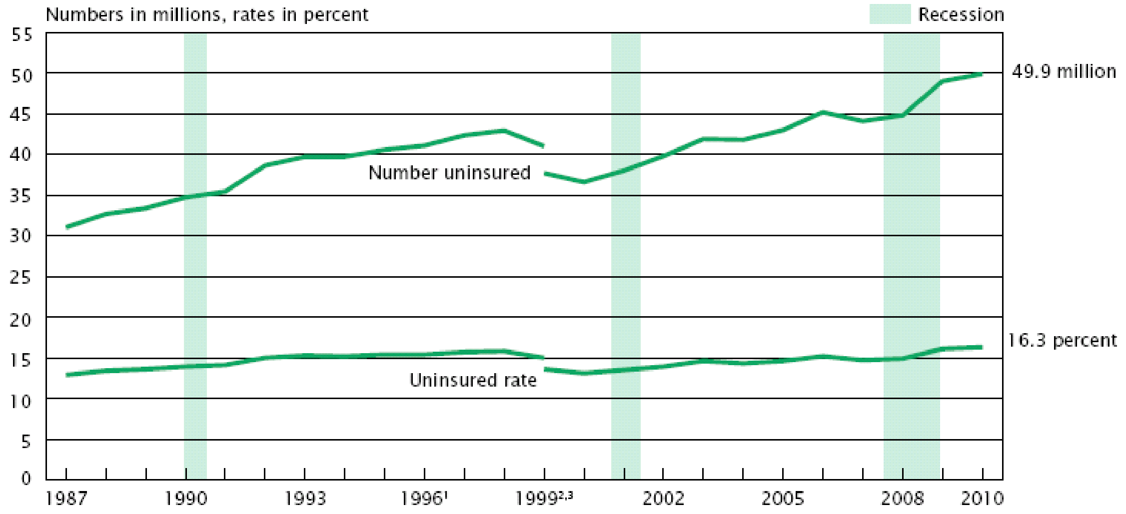
22.7%
62.5%
2.0%
2.8%
7.7%
22.9%
64.4%
1.9%
2.7%
7.6%
23.6%
64.2%
Less than $10,000
$10,000 - $17,000
$17,000 - $25,000
$25,000 - $35,000
Greater than $35,000
4 or More
3
2
1
None



Source: Estimated using data from: Minnesota Population Center and State Health Access Data Assistance Center, *Integrated Health Interview Series: Version 5.0.* Minneapolis: University of Minnesota, 2012. http://www.ihis.us.

Figure 7.

Number Uninsured and Uninsured Rate: 1987 to 2010



[1] The data for 1996 through 1999 were revised using an approximation method for consistency with the revision to the 2004 and 2005 estimates.

[2] Implementation of Census 2000-based population controls occurred for the 2000 ASEC, which collected data for 1999. These estimates also reflect the results of follow-up verification questions, which were asked of people who responded "no" to all questions about specific types of health insurance coverage in order to verify whether they were actually uninsured. This change increased the number and percentage of people covered by health insurance, bringing the CPS more in line with estimates from other national surveys.

[3] The data for 1999 through 2009 were revised to reflect the results of enhancements to the editing process.

Note: Respondents were not asked detailed health insurance questions before the 1988 CPS.
The data points are placed at the midpoints of the respective years. For information on recessions, see Appendix A.

Source: U.S. Census Bureau, Current Population Survey, 1988 to 2011 Annual Social and Economic Supplements.

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